# Workgroup Spotlight: Eye Care & Visions Research and Rehabilitation

## OHDSI Community Call
## Aug. 18, 2026 • 11 am ET

OHDSI
OBSERVATIONAL HEALTH DATA SCIENCES AND INFORMATICS

# Upcoming Community Calls

| Date | Topic |
|---|---|
| Aug. 18 | Workgroup Spotlight: Eyecare and Vision Research, Rehabilitation |
| Aug. 25 | Asia-Pacific Regional Updates |
| Sept. 1 | Vocabulary Refresh, Summer 2026 Version |
| Sept. 8 | Medical Imaging Workgroup Spotlight, CDM 5.5 Review |
| Sept. 15 | Global Symposium Preview |
| Sept. 22 | TBA |
| Sept. 29 | OHDSI/OMOP Research Spotlight |

# Three Stages of The Journey

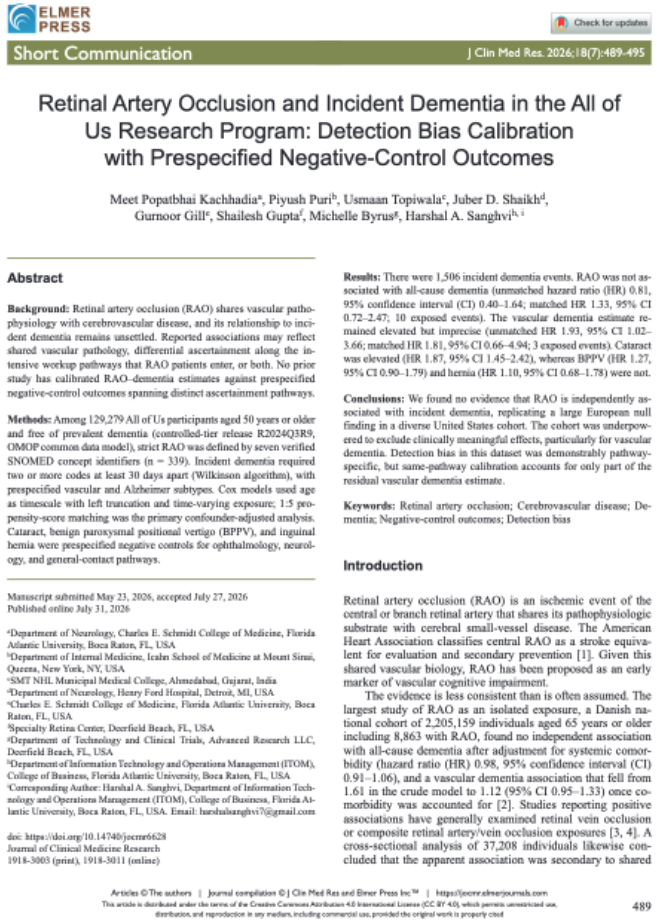
## Where Have We Been?

## Where Are We Now?

## Where Are We Going?

# OHDSI Shoutouts!

Congratulations to the team of **Meet Popatbhai Kachhadia, Piyush Puri, Usmaan Topiwala, Juber D Shaikh, Gurnoor Gill, Shailesh Gupta, Michelle Byrus, and Harshal A Sanghvi** on the recent publication of **Retinal Artery Occlusion and Incident Dementia in the All of Us Research Program: Detection Bias Calibration with Prespecified Negative-Control Outcomes** in the *Journal of Clinical Medicine Research*.



ELMER PRESS

Short Communication

J Clin Med Res. 2026;18(7):489-495

Retinal Artery Occlusion and Incident Dementia in the All of Us Research Program: Detection Bias Calibration with Prespecified Negative-Control Outcomes

Meet Popatbhai Kachhadia[a], Piyush Puri[b], Usmaan Topiwala[c], Juber D. Shaikh[d], Gurnoor Gill[e], Shailesh Gupta[f], Michelle Byrus[g], Harshal A. Sanghvi[h, i]

**Abstract**

**Background:** Retinal artery occlusion (RAO) shares vascular pathophysiology with cerebrovascular disease, and its relationship to incident dementia remains unsettled. Reported associations may reflect shared vascular pathology, differential ascertainment along the intensive workup pathways that RAO patients enter, or both. No prior study has calibrated RAO–dementia estimates against prespecified negative-control outcomes spanning distinct ascertainment pathways.

**Methods:** Among 129,279 All of Us participants aged 50 years or older and free of prevalent dementia (controlled-tier release R2024Q3R9, OMOP common data model), strict RAO was defined by seven verified SNOMED concept identifiers (n = 339). Incident dementia required two or more codes at least 30 days apart (Wilkinson algorithm), with prespecified vascular and Alzheimer subtypes. Cox models used age as timescale with left truncation and time-varying exposure; 1:5 propensity-score matching was the primary confounder-adjusted analysis. Cataract, benign paroxysmal positional vertigo (BPPV), and inguinal hernia were prespecified negative controls for ophthalmology, neurology, and general-contact pathways.

**Results:** There were 1,506 incident dementia events. RAO was not associated with all-cause dementia (unmatched hazard ratio (HR) 0.81, 95% confidence interval (CI) 0.40–1.64; matched HR 1.33, 95% CI 0.72–2.47; 10 exposed events). The vascular dementia estimate remained elevated but imprecise (unmatched HR 1.93, 95% CI 1.02–3.66; matched HR 1.81, 95% CI 0.66–4.94; 3 exposed events). Cataract was elevated (HR 1.87, 95% CI 1.45–2.42), whereas BPPV (HR 1.27, 95% CI 0.90–1.79) and hernia (HR 1.10, 95% CI 0.68–1.78) were not.

**Conclusions:** We found no evidence that RAO is independently associated with incident dementia, replicating a large European null finding in a diverse United States cohort. The cohort was underpowered to exclude clinically meaningful effects, particularly for vascular dementia. Detection bias in this dataset was demonstrably pathway-specific, but same-pathway calibration accounts for only part of the residual vascular dementia estimate.

**Keywords:** Retinal artery occlusion; Cerebrovascular disease; Dementia; Negative-control outcomes; Detection bias

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Journal of Clinical Medicine Research
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**Introduction**

Retinal artery occlusion (RAO) is an ischemic event of the central or branch retinal artery that shares its pathophysiologic substrate with cerebral small-vessel disease. The American Heart Association classifies central RAO as a stroke equivalent for evaluation and secondary prevention [1]. Given this shared vascular biology, RAO has been proposed as an early marker of vascular cognitive impairment.

The evidence is less consistent than is often assumed. The largest study of RAO as an isolated exposure, a Danish national cohort of 2,205,159 individuals aged 65 years or older including 8,863 with RAO, found no independent association with all-cause dementia after adjustment for systemic comorbidity (hazard ratio (HR) 0.98, 95% confidence interval (CI) 0.91–1.06), and a vascular dementia association that fell from 1.61 in the crude model to 1.12 (95% CI 0.95–1.33) once comorbidity was accounted for [2]. Studies reporting positive associations have generally examined retinal vein occlusion or composite retinal artery/vein occlusion exposures [3, 4]. A cross-sectional analysis of 37,208 individuals likewise concluded that the apparent association was secondary to shared

# OHDSI Shoutouts!

Congratulations to the team of **Seyedmostafa Sheikhalishahi, Mathias Kaspar, Johanna Schwinn, Matthaeus Morhart, Philipp Simon, and Ludwig Christian Hinske** on the recent publication of **Cross-Silo Federated Learning for Predicting Successful Mechanical Ventilation Weaning Across 5 Intensive Care Unit Databases: Retrospective Database Analysis** in *JMIR Medical Informatics*.



Original Paper

## Cross-Silo Federated Learning for Predicting Successful Mechanical Ventilation Weaning Across 5 Intensive Care Unit Databases: Retrospective Database Analysis

Seyedmostafa Sheikhalishahi[1*], PhD; Mathias Kaspar[1*], PD, Dr rer nat; Johanna Schwinn[1], MSc; Matthaeus Morhart[1], BSc; Philipp Simon[2], Prof Dr Med; Ludwig Christian Hinske[1], Prof Dr Med

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*Abstract*

**Background:** The prediction of weaning from mechanical ventilation (MV) can support clinical decision-making and help reduce the risk of weaning failure in intensive care units (ICUs). Cross-silo federated learning (FL) offers a promising approach to developing robust predictive models across multiple institutions without requiring the sharing of patient-level data.

**Objective:** This study aimed to evaluate the feasibility and efficacy of FL for predicting successful weaning from MV across 5 diverse ICU databases and to compare its performance with local learning (LL) and centralized learning (CL) approaches that differ in their data-sharing requirements.

**Methods:** We conducted a retrospective analysis using 5 ICU databases, namely the eICU Collaborative Research Database (eICU-CRD), Medical Information Mart for Intensive Care IV (MIMIC-IV), Universitätsklinikum Augsburg (UKA), High-Resolution ICU Dataset (HiRID), and Amsterdam University Medical Centers (AUMC), transforming clinical variables into the Observational Medical Outcomes Partnership (OMOP) Common Data Model. We defined successful weaning as a sustained reduction in positive end-expiratory pressure. We compared 3 learning approaches, FL, LL, and CL, using extreme gradient boosting (XGBoost). Performance was evaluated using the area under the receiver operating characteristic curve (AUROC), area under the precision-recall curve (AUPRC), precision, recall, and $F_1$-score. All data use complied with local ethical regulations and institutional review board approvals, and all databases contained deidentified patient data accessed under institutional data use agreements and governed by applicable privacy regulations.

**Results:** A total of 24,521 patients were included across 5 databases. The CL model achieved an AUROC of 0.81, AUPRC of 0.57, and $F_1$-score of 0.54 on pooled test data. The FL model achieved a macroaveraged AUROC of 0.74, AUPRC of 0.56, and $F_1$-score of 0.52. LL model performance varied across databases (AUROC=0.68-0.84, AUPRC=0.51-0.68, $F_1$-score=0.49-0.67), reflecting differences in data distribution and class balance.

**Conclusions:** Our findings highlight performance differences between learning approaches for MV weaning prediction. LL models achieved the highest performance within their respective institutions (AUROC=0.68-0.84), CL achieved the highest performance on pooled test data (AUROC=0.81), and FL showed lower but reasonable performance while avoiding direct sharing of patient-level data (AUROC=0.74). The choice between approaches depends on institutional data-sharing constraints, local dataset characteristics, and acceptable performance thresholds. As privacy was not formally measured, these findings should be read as a performance comparison rather than a privacy-performance trade-off.

***(JMIR Med Inform 2026;14:e79713)*** doi: 10.2196/79713

# Three Stages of The Journey

## Where Have We Been?

## Where Are We Now?

## Where Are We Going?

# Upcoming Workgroup Calls

| Date | Time (ET) | Meeting |
|---|---|---|
| Tuesday | 12 pm | CDM Vocabulary |
| Wednesday | 10 am | Common Data Model |
| Wednesday | 7 pm | Medical Imaging |
| Thursday | 9 am | Oncology Vocabulary/Development Subgroup |
| Thursday | 10 am | GIS-Geographic Information System |
| Thursday | 10:30 am | Evidence Network |
| Thursday | 12 pm | HADES |
| Thursday | 7 pm | Dentistry |
| Friday | 9 am | Waveform |
| Friday | 10 am | Transplant |
| Friday | 10:30 am | Education |
| Friday | 11:30 am | Steering |
| Tuesday | 9 am | Oncology Genomic Subgroup |
| Tuesday | 9 am | Data2Evidence |
| Tuesday | 9 am | OpenEHR & OMOP |

# Titan Nominations Are OPEN!

The OHDSI Titan Awards recognize those who have gone above and beyond to foster community engagement, lead research and development efforts and make significant contributions towards OHDSI's mission.

Individuals, teams or collaborating institutions can be nominated for an award, and you can make as many nominations as you would like.

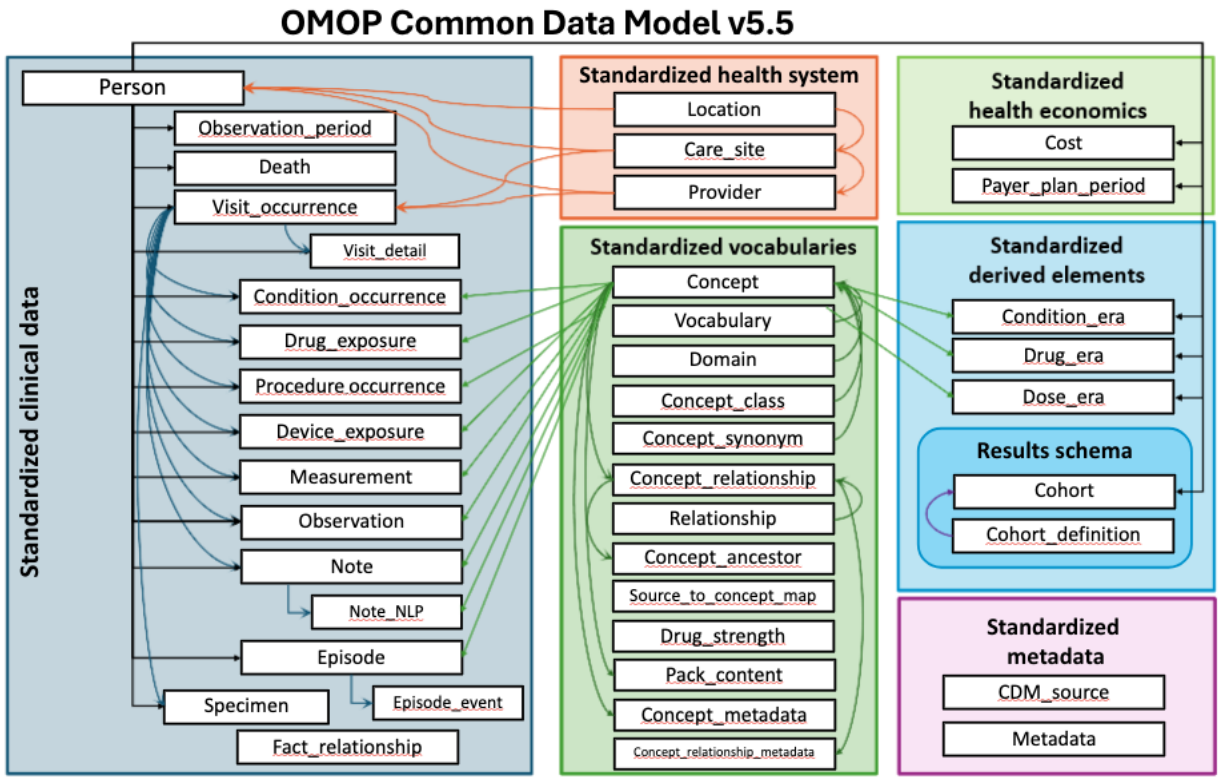
**Nominations will be accepted until 8pm ET Tuesday, Sept. 22, 2026.**

**ohdsi.org/titan-awards**

# Collaborate on OMOP CDM v5.5

The Common Data Model working group has been planning CDM v5.5 over the last 18 months and there is now a development version to share. Please take a look, review, and test in your environment if you are able.

This version will be released alongside the August 2026 vocabulary and will support community needs and continued vocabulary updates.




github.com/OHDSI/CommonDataModel/tree/develop

# 2026 OHDSI Global Symposium

Registration is OPEN for the **2026 OHDSI Global Symposium**, which will be held Oct. 20-22 in New Brunswick, N.J., USA.

**Oct. 20:** Tutorials
**Oct. 21:** Plenaries, Showcase
**Oct. 22:** Workgroup Activities




**ohdsi.org/OHDSI2026**

# 2026 Symposium Tutorials – Session 1

- An Introduction to the Journey from Data to Evidence Using OHDSI
- An Introduction to ATLAS
- Bringing FAIR to Imaging Research with the Medical Imaging OMOP Extension
- Complex Phenotyping at Scale with and without LLMs Using PhenotypeR
- OHDSI Leadership Storytelling Workshop
- Mastering OMOP: Transforming EHR Data with Practical Strategies, Best Practices, and OHDSI Integration

# 2026 Symposium Tutorials – Session 2

- Building and Using the OHDSI Evidence Network: From Data Partner to Federated Study Execution
- From Multi-Modal Data to Real-World Evidence: Hands-on with the Data2Evidence Platform for OMOP Data Curation and Analytics
- Integrating Geospatial Data Into OMOP CDM
- Introduction to OHDSI Phenotype Development & Evaluation
- OHDSI Standardized Vocabularies on FHIR: A Deep Dive Using the Echidna Terminology Server
- Using OMOP Model in Registry Context & Clinical Trials Standardization Context: Conventions, Past Use Cases, SDTM & Regulatory Consideration, Challenges

# 2026 Global Symposium Agenda

| Start | End | Topic | Presenter/Lead |
|---|---|---|---|
| 7:15 am | 8:00 am | Newcomer Welcome | Paul Nagy/Marc Suchard |
| 8:00 am | 8:30 am | State of the Community | George Hripcsak |
| 8:30 am | 9:15 am | OHDSI Year In Review | Early-Stage Researcher WG |
| 9:15 am | 10:00 am | Collaborator Showcase: Posters and Demos (Session 1) | |
| 10:00 am | 11:00 am | Plenary 1: Federated Learning Meets Negative Control Calibration: Toward Reliable Multi-Site Evidence Generation | Yong Chen |
| 11:00 am | 12:00 pm | Plenary 2: Beyond the Defaults: How the OHDSI Community is Adapting, Extending, and Reimagining Its Tools | Scott Duvall |
| 12:00 pm | 1:00 pm | Network & Lunch | |
| 1:00 pm | 2:00 pm | Plenary 3: The role of national initiatives in supporting sustainability, collaboration, and growth of OHDSI | Ed Burn |
| 2:00 pm | 2:45 pm | Collaborator Showcase: Lightning Talks (Session 1) | 5 presenters |
| 2:45 pm | 3:30 pm | Collaborator Showcase: Posters and Demos (Session 2) | |
| 3:30 pm | 4:15 pm | Collaborator Showcase: Posters and Demos (Session 3) | |
| 4:15 pm | 5:00 pm | Collaborator Showcase: Lightning Talks (Session 2) | 5 presenters |
| 5:00 pm | 6:00 pm | Titan Awards, Closing | Patrick Ryan |
| 6:00 pm | 8:30 pm | Dinner on your own | |
| 8:30 pm | 11:30 pm | OHDSI Jam Session | Martijn Schuemie |

# 2026 Symposium Workgroup Activities

**Session 1 (8 am – 10 am):** Eyecare and Vision Research, GIS – Geographic Information Systems, Early-Stage Researchers, Industry, Tidy R Programming with OMOP, HADES Hackathon, Generative AI and Foundation Models, Phenotype Development and Evaluation, Oncology, Health Equity, Vocabularies, APAC

**Session 2 (10:30 am – 12:30 pm):** Perinatal and Reproductive Health, Waveform, Medical Imaging, Industry, Tidy R Programming with OMOP, HADES Hackathon, Generative AI and Foundation Models, Phenotype Development and Evaluation, Oncology, Health Equity, Vocabularies, Rare Disease

**Session 3 (1:30 pm – 3:30 pm):** Dentistry, GIS & Waveform Cross-Pollination Meeting, Evidence Network, Women of OHDSI, Psychiatry, HADES Hackathon, Natural Language Processing, Health Economics & Value Assessment, ATLAS/WebAPI, CDM Survey, Surgery & Perioperative Medicine

**Session 4 (3:30 pm – 5 pm):** Workgroup Summary Session

# 2026 OHDSI Global Symposium

There are opportunities to be both a **sponsor** and an **exhibitor** at the Global Symposium.

Please reach out to **symposium@OHDSI.org** for more information.


ohdsi.org/OHDSI2026

EUROPE


# You've built your OMOP CDM. Now let's make it shine!

## Take your OMOP implementation to the next level

- 2.5-day hands-on expert training (max. 30 participants)
- Work with Data Quality Dashboard, ATLAS, CohortDiagnostics
- Learn study design, validation, execution
- Optional: bring your own ETL + OMOP CDM

### What to expect

- Practical OMOP expertise
- Concrete CDM improvements
- Skills for evidence generation

### Practical

🗓️ 7–9 September 2026
📍 Rotterdam

# APAC Symposium: Nov. 13-15

The 2026 APAC Symposium will be held Nov. 13-15 at Yonsei University in Seoul, South Korea.

**Nov. 13:** Main Conference
**Nov. 14:** Tutorials, Datathon
**Nov. 15:** Datathon Team Activities


Registration will open soon, and the showcase submission deadline is August 23 at 10 pm ET.

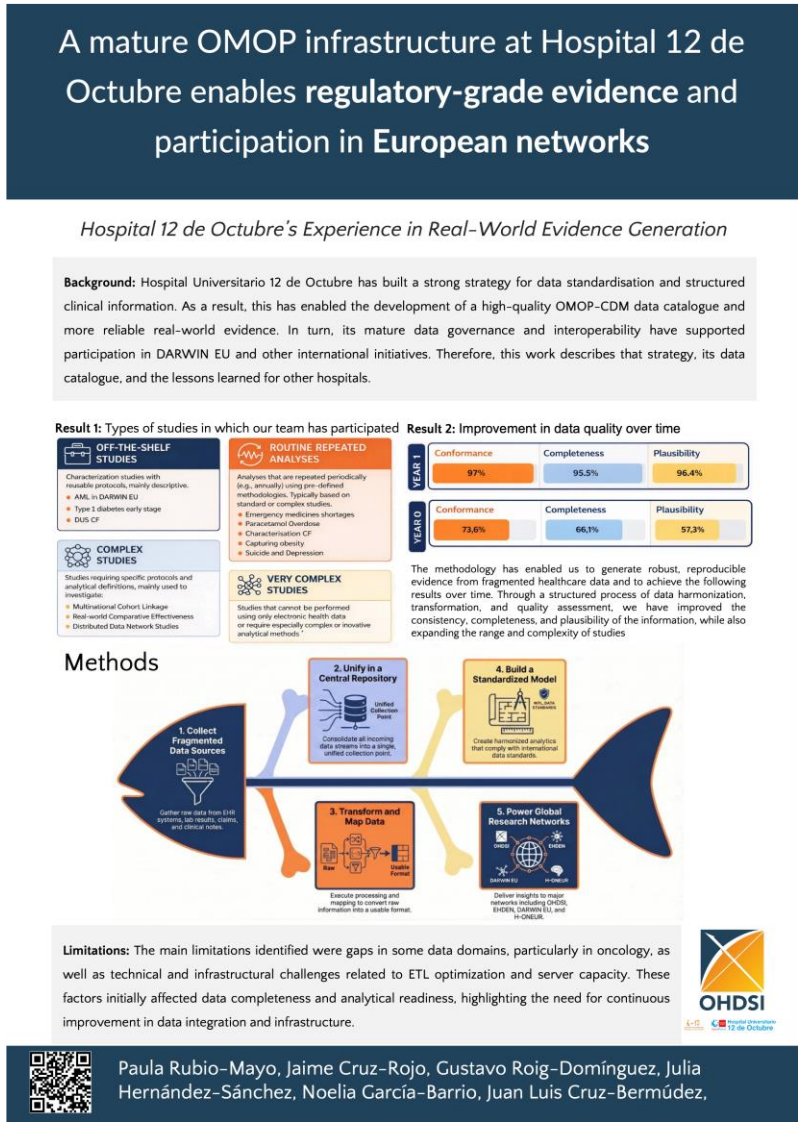
**ohdsi.org/APAC2026**

# #OHDSISocialShowcase This Week

## Monday

## Hospital 12 de Octubre's Experience in Real-World Evidence Generation

(Paula Rubio Mayo, Jaime Cruz Rojo, Gustavo Roig Domínguez, Julia Hernández Sánchez, Noelia García Barrio, Juan Luis Cruz Bermúdez)

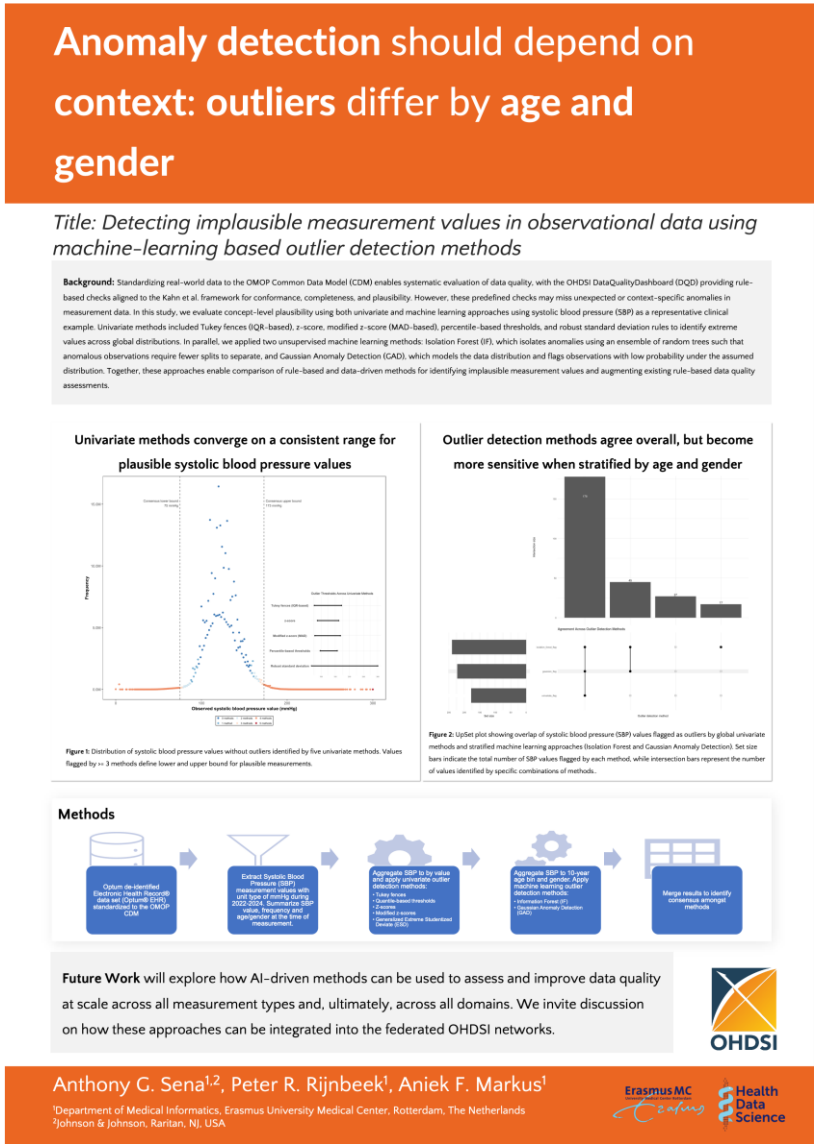


# #OHDSISocialShowcase This Week

## Tuesday

## Detecting implausible measurement values in observational data using machine-learning based outlier detection methods

(Anthony G. Sena, Peter R. Rijnbeek, Aniek Markus)



# #OHDSISocialShowcase This Week

## Wednesday

## Lessons Learned from Implementing OMOP ETLs Across EHR and Registry-Based Data Sources

(Renata Silva, Sofia Gomes, Mariana Canelas-Pais, Ana Sá-Sousa, Tiago Taveira-Gomes)

Lessons Learned from Implementing OMOP ETLs Across EHR and Registry-Based Data Sources

Renata Silva[1], Sofia Gomes[1], Mariana Canelas-Pais[1,2,3], Ana Sá-Sousa[1], Tiago Taveira-Gomes[2,4]

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### Background

Data diversity between Electronic Health Records (EHRs) and clinical registries is a major barrier to multi-center research[1,2]. ETL design is strongly influenced by the structural and semantic characteristics of the source system[3].

This work compares ETL experiences across European EHRs and registries, to identify methodological challenges and support cross-border interoperability initiatives (e.g. European Health Data Space - EHDS).

### Methods

Review of 17 OMOP-CDM ETL Implementations

6 Clinical Registries (ex: oncology, rheumatic disease) vs 11 EHR Systems (e.g: primary care, inpatient care)

### Results

**Registry ETLs:** focuses on the structural reshaping of denormalized datasets and the reconstruction of implicit clinical meaning from disease-specific variables to resolve fragmented data lineage

**EHR ETLs:** prioritizes navigating complex normalized schemas and interpreting workflow-driven semantics to extract relevant clinical events from high-volume transactional data

Table 1. Comparative characteristics observed during OMOP CDM ETL development across registry-based and EHR-based clinical data sources

| Dimension | Registry | EHR |
|---|---|---|
| Data Structure | Wide, partially denormalized; JSON/XML attributes | Normalized relational schemas across linked tables |
| Vocabulary Availability | No standardized vocabularies; source-derived mappings | Controlled vocabularies with reference tables |
| SQL Transformation Patterns | Unpivot, UNION ALL, GROUP BY | Multi-table JOINs and filtering (WHERE) |
| Data Lineage Traceability | Fragmented lineage from manual curation | Strong lineage via transactional models |
| Relational Consistency | No referential integrity constraints; | Referential integrity enforced; Infrequent inconsistencies |
| Source Data Origin | Periodic data extracts or reporting datasets | Transactional clinical systems |
| Data Semantics Preservation | Reconstruction of registry-specific semantics | Workflow-driven data semantics |
| Access and Integration | Structured data exports | APIs, DB connections, vendor-mediated extractions |
| Temporal Data Representation | Simplified or aggregated time context | Reconstruction of clinical timelines |
| Historical System Evolution | Variable additions and schema drift | System migration and legacy workflow logic |

CDM: Common Data Model; DB: Database; EHR: Electronic Health Record; OMOP: Observational Medical Outcomes Partnership.

### Conclusion

To build scalable pipelines, OMOP-CDM ETL designs must be specifically tailored to the unique structural, semantic, and data-generation characteristics of each source system.

References

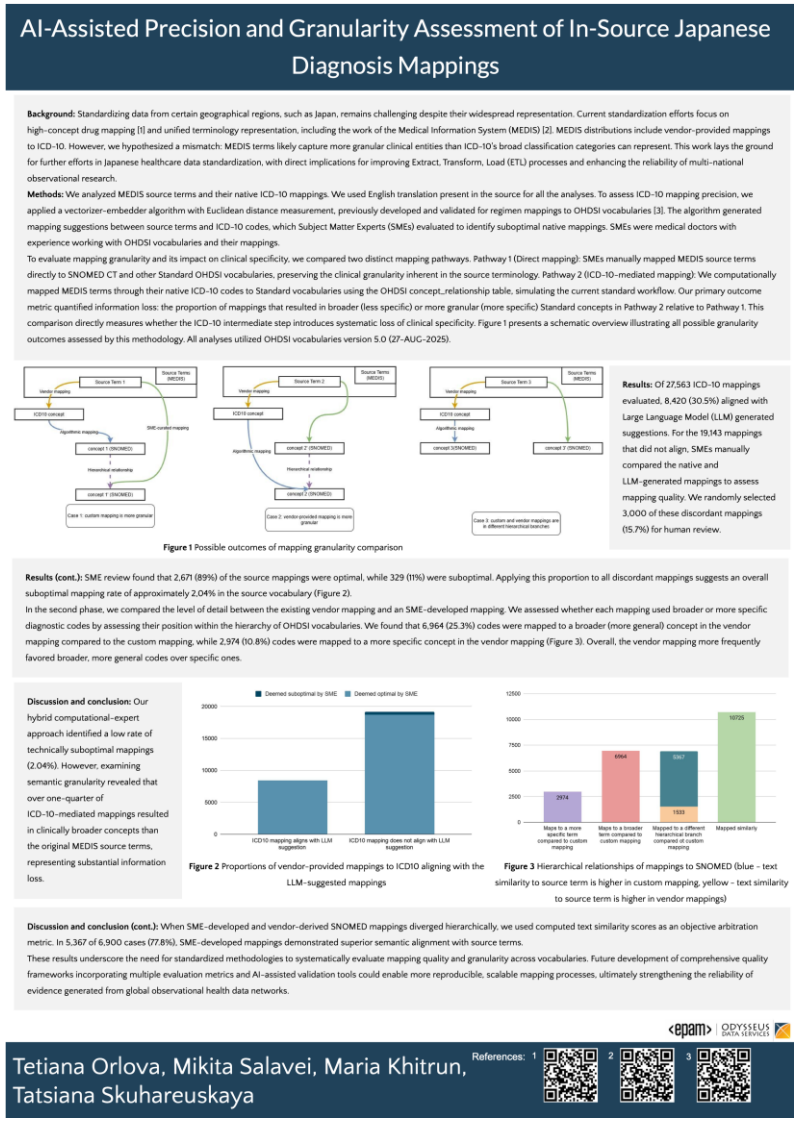
1. Ehrenstein V, Kharrazi H, Lehmann H, Taylor CO. Obtaining Data From Electronic Health Records [Internet]. Agency for Healthcare Research and Quality (US); 2019 [cited 2026 Feb 5]. Available from: https://www.ncbi.nlm.nih.gov/books/NBK551878/
2. Biedermann P, Ong R, Davydov A, Orlova A, Solovyev P, Sun H, et al. Standardizing registry data to the OMOP Common Data Model: experience from three pulmonary hypertension databases. BMC Med Res Methodol [Internet]. 2021 Nov 2;21(1):238. Available from: https://doi.org/10.1186/s12874-021-01434-3
3. Papez V, Moinat M, Payralbe S, Asselbergs FW, Lumbers RT, Hemingway H, et al. Transforming and evaluating electronic health record disease phenotyping algorithms using the OMOP common data model: a case study in heart failure. JAMIA Open [Internet]. 2021 July;4(3):ooab001. Available from: http://dx.doi.org/10.1093/jamiaopen/ooab001

# #OHDSISocialShowcase This Week

## Thursday

## AI-Assisted Precision and Granularity Assessment of In-Source Japanese Diagnosis Mappings

(Tetiana Orlova, Mikita Salavei, Tatsiana Skuhareuskaya)



AI-Assisted Precision and Granularity Assessment of In-Source Japanese Diagnosis Mappings

**Background:** Standardizing data from certain geographical regions, such as Japan, remains challenging despite their widespread representation. Current standardization efforts focus on high-concept drug mapping [1] and unified terminology representation, including the work of the Medical Information System (MEDIS) [2]. MEDIS distributions include vendor-provided mappings to ICD-10. However, we hypothesized a mismatch: MEDIS terms likely capture more granular clinical entities than ICD-10's broad classification categories can represent. This work lays the ground for further efforts in Japanese healthcare data standardization, with direct implications for improving Extract, Transform, Load (ETL) processes and enhancing the reliability of multi-national observational research.

**Methods:** We analyzed MEDIS source terms and their native ICD-10 mappings. We used English translation present in the source for all the analyses. To assess ICD-10 mapping precision, we applied a vectorizer-embedder algorithm with Euclidean distance measurement, previously developed and validated for regimen mappings to OHDSI vocabularies [3]. The algorithm generated mapping suggestions between source terms and ICD-10 codes, which Subject Matter Experts (SMEs) evaluated to identify suboptimal native mappings. SMEs were medical doctors with experience working with OHDSI vocabularies and their mappings.

To evaluate mapping granularity and its impact on clinical specificity, we compared two distinct mapping pathways. Pathway 1 (Direct mapping): SMEs manually mapped MEDIS source terms directly to SNOMED CT and other Standard OHDSI vocabularies, preserving the clinical granularity inherent in the source terminology. Pathway 2 (ICD-10-mediated mapping): We computationally mapped MEDIS terms through their native ICD-10 codes to Standard vocabularies using the OHDSI concept_relationship table, simulating the current standard workflow. Our primary outcome metric quantified information loss: the proportion of mappings that resulted in broader (less specific) or more granular (more specific) Standard concepts in Pathway 2 relative to Pathway 1. This comparison directly measures whether the ICD-10 intermediate step introduces systematic loss of clinical specificity. Figure 1 presents a schematic overview illustrating all possible granularity outcomes assessed by this methodology. All analyses utilized OHDSI vocabularies version 5.0 (27-AUG-2025).

**Figure 1** Possible outcomes of mapping granularity comparison

**Results:** Of 27,563 ICD-10 mappings evaluated, 8,420 (30.5%) aligned with Large Language Model (LLM) generated suggestions. For the 19,143 mappings that did not align, SMEs manually compared the native and LLM-generated mappings to assess mapping quality. We randomly selected 3,000 of these discordant mappings (15.7%) for human review.

**Results (cont.):** SME review found that 2,671 (89%) of the source mappings were optimal, while 329 (11%) were suboptimal. Applying this proportion to all discordant mappings suggests an overall suboptimal mapping rate of approximately 2.04% in the source vocabulary (Figure 2).

In the second phase, we compared the level of detail between the existing vendor mapping and an SME-developed mapping. We assessed whether each mapping used broader or more specific diagnostic codes by assessing their position within the hierarchy of OHDSI vocabularies. We found that 6,964 (25.3%) codes were mapped to a broader (more general) concept in the vendor mapping compared to the custom mapping, while 2,974 (10.8%) codes were mapped to a more specific concept in the vendor mapping (Figure 3). Overall, the vendor mapping more frequently favored broader, more general codes over specific ones.

**Discussion and conclusion:** Our hybrid computational–expert approach identified a low rate of technically suboptimal mappings (2.04%). However, examining semantic granularity revealed that over one-quarter of ICD-10–mediated mappings resulted in clinically broader concepts than the original MEDIS source terms, representing substantial information loss.

**Figure 2** Proportions of vendor-provided mappings to ICD10 aligning with the LLM-suggested mappings

**Figure 3** Hierarchical relationships of mappings to SNOMED (blue – text similarity to source term is higher in custom mapping, yellow – text similarity to source term is higher in vendor mappings)

**Discussion and conclusion (cont.):** When SME-developed and vendor-derived SNOMED mappings diverged hierarchically, we used computed text similarity scores as an objective arbitration metric. In 5,367 of 6,900 cases (77.8%), SME-developed mappings demonstrated superior semantic alignment with source terms.

These results underscore the need for standardized methodologies to systematically evaluate mapping quality and granularity across vocabularies. Future development of comprehensive quality frameworks incorporating multiple evaluation metrics and AI-assisted validation tools could enable more reproducible, scalable mapping processes, ultimately strengthening the reliability of evidence generated from global observational health data networks.

Tetiana Orlova, Mikita Salavei, Maria Khitrun, Tatsiana Skuhareuskaya

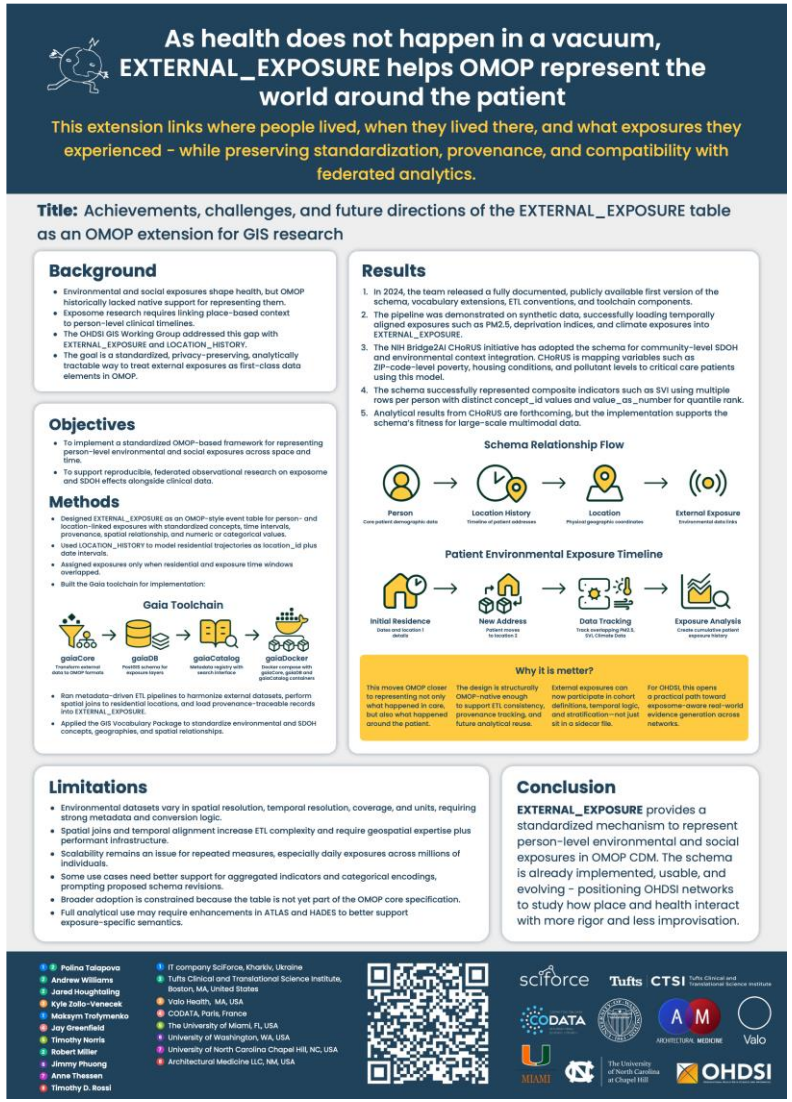
References: 1 2 3

# #OHDSISocialShowcase This Week

## Friday

**Achievements, challenges, and future directions of the EXTERNAL_EXPOSURE table as an OMOP extension for GIS research**

(Polina Talapova, Andrew Williams, Jared Houghtaling, Kyle Zollo-Venecek, Maksym Trofymenko, Jay Greenfield, Timothy Norris, Robert Miller, Jimmy Phuong, Anne Thessen, Timothy D. Rossi)



# Where Are We Going?

**Any other announcements of upcoming work, events, deadlines, etc?**

# Three Stages of The Journey

## Where Have We Been?

## Where Are We Now?

## Where Are We Going?

# The weekly OHDSI community call is held every Tuesday at 11 am ET.

# Everybody is invited!

# Links are sent out weekly and available at:

# ohdsi.org/community-calls-2026

# Find your workgroup.

# Fuel our mission.

ohdsi.org/workgroups