Table Descriptions

Patient centric Tables (Files)

These will be views that are exported to comma separate value files.

DEMOGRAPHIC

COLUMN	DATATYPE	POSSIBLE VALUES	DESCRIPTION
STUDY_PAT_ID	Integer		See PATIENT_MAP table description. STUDY_PAT_ID is a pseudo identifier with a consistent crosswalk to the true identifier retained by the source Data Partner. For analytical data sets requiring patient-level data, only the pseudo identifier is used to link across all information belonging to a patient.
BIRTH_DATE	Date	MM/DD/YYYY	Date of birth. Shifted
PCORI_GENDER_CD	Text(2)	F = Female M = Male UN = Unknown	
PCORI_RACE_CD	Text(2)	01 = American Indian or Alaska Native 02 = Asian 03 = Black or African American 04 = Native Hawaiian or Other Pacific Islander	Please use only one race value per patient. Details of categorical definitions: American Indian or Alaska Native: A person having origins in any of the original peoples of North and South

		05 = White 06 = Multiple race 07 = Refuse to answer NI = No information UN = Unknown OT = Other	America (including Central America), and who maintains tribal affiliation or community attachment. Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. Black or African American: A person having origins in any of the black racial groups of Africa. Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

PCORI_HISPANIC_CD	Text(2)	Y = Yes N = No R = Refuse to answer NI = No information UN = Unknown OT = Other	A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
GENDER_DESCR	Text(255)		
RACE_DESCR	Text(255)		
ETHNICITY_DESCR	Text(255)		
LANGUAGE_DESCR	Text(255)		Optional field for originating value of field
PEDS_GEST_AGE_NUM_WEEKS	Integer		The patient's gestational age truncated to the nearest full week.
PEDS_GEST_AGE_NUM_DAYS	Integer		This is a patient's gestational age in days when available.

ENCOUNTER (VISIT)

COLUMN	DATATYPE	POSSIBLE VALUES	DESCRIPTION
STUDY_ENC_ID	Integer		Arbitrary encounter-level identifier. Used to link across tables, including the ENCOUNTER, DIAGNOSIS, and PROCEDURE tables.
STUDY_PAT_ID	Integer		Arbitrary person-level identifier used to link across tables.
ENCOUNTER_DATE	Date	MM/DD/YYYY	This may be the date the visit was scheduled.
VISIT_START_DATETIME	DateTime		MM/DD/YYYY HH24:MI Encounter or Hospital admission time. (HH:MI using 24-hour clock and zero-padding for hour and minute)
VISIT_END_DATETIME	DateTime		Encounter or Hospital discharge time

ADT_ARRIVAL_DATETIME	DateTime		Discharge date. Should be populated for all Inpatient Hospital Stay (IP) and Non-Acute Institutional Stay (IS) encounter types. May be populated for Emergency Department (ED) and ED-to-Inpatient (EI) encounter types. Should be missing for ambulatory visit (AV or OA) encounter types.
ED_DEPARTURE_DATETIME	DateTime		ED Discharge time.(HH:MI using 24-hour clock and zero-padding for hour and minute). Populated when the patient is transferred into the hospital for IP or observation stay.
ENCOUNTER_TYPE	Text(x)		Some encounter types: Office Visit, Hospital Encounter, Appointment, Travel, Pharmacy Visit, Orders Only, Speech Therapy, Physical Therapy, Refill, Occupational Therapy, Procedure Pass, Surgery, Anesthesia Event, Anesthesia, Scan, Nurse Triage, PCTC Call, Resolute Professional Billing Hospital Prof Fee, Ancillary Orders, Abstract, Home Care Visit, Wait List, Nurse Only, BPA, Nutrition, Social Work, Prep for Surgery, Specialty Pharmacy, Community Orders, Athletic Training, Procedure Visit, Ophth Exam, Allied Health Visit, Therapeutic Recreation, Intake, Therapy Plan, Home Care Update, Acupuncture Visit, Home Health Admission, Massage Therapy, Respiratory Therapy, Recurring Plan, Contact Moved,Education, Remote Consult, Dialysis, Unmerge, Walk-In, Hospital, Hospice Admission, Immunization
VISIT_TYPE_CD	Text(2)	AV = Ambulatory Visit ED = Emergency Department	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.

		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	Emergency Department (ED): Includes ED encounters that become inpatient stays (in which case inpatient stays would be a separate encounter). Excludes urgent care 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. 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 facility 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.
VISIT_TYPE_DESCR	Text	Hospital Encounter, Nurse Triage Office Visit,	Removed History, Documentation Only, Letter, and Telephone (reminders)…

ICU_VISIT_YN	Text	Y, N	Indicates if the patient was in an ICU as part of their encounter.
PROV_ID	Integer		De-identified pseudo-identifier. This is the attending physician.
PROV_TYPE	Text		Physician, Technician,
DEPT_ID	Integer		De-identified pseudo-identifier. This is the department the patient was seen in.
DEPT_SPECIALTY	Text		Specialty of the DEPT_ID.
ADMIT_SOURCE	Text		Blank if No Information. Admitting source. Should be populated for Inpatient Hospital Stay (IP) and Non-Acute Institutional Stay (IS) encounter types. May be populated for Emergency Department (ED) and ED-to-Inpatient (EI) encounter types. Should be missing for ambulatory visit (AV or OA) encounter types.
HOSP_ADMIT_SOURCE	Text		Blank if No Information.
DISCHARGE_DISPOSITION	Text		Vital status at discharge. Should be populated for Inpatient Hospital Stay (IP) and Non-Acute Institutional Stay (IS) encounter types. May be populated for Emergency Department (ED) and ED-to-Inpatient (EI) encounter types. Should be missing for ambulatory visit (AV or OA) encounter types.
DISCHARGE_DESTINATION	Text		The last recorded event in the Clarity ADT.

DRG_CODE	Text(3)		3-digit Diagnosis Related Group (DRG). Should be populated for IP and IS encounter types. May be populated for Emergency Department (ED) and ED-to-Inpatient (EI) encounter types. Should be missing for AV or OA encounters. Use leading zeroes for codes less than 100. The DRG is used for reimbursement for inpatient encounters. It is a Medicare requirement that combines diagnoses into clinical concepts for billing. Frequently used in observational data analyses.
DRG_NAME	Text		DRG code version. MS-DRG (current system) began on 10/1/2007. Should be populated for IP and IS encounter types. May be populated for Emergency Department (ED) and ED-to-Inpatient (EI) encounter types. Should be missing for AV or OA encounters.
VISIT_REASON	Text		The initial reason for the visit

DIAGNOSIS

COLUMN	DATATYPE	POSSIBLE VALUES	DESCRIPTION
STUDY_DX_ID	Integer		Arbitrary identifier for each unique record. Does not need to be persistent across refreshes, and may be created by methods such as sequence or GUID
STUDY_ENC_ID	Integer		Pseudo identifier for encounters. Used to link across tables.
STUDY_PAT_ID	Integer		Pseudo identifier for patient. Used to link across tables.

DX_START_DATETIME	DateTime		
DX_END_DATETIME	DateTime		
DX_SOURCE_TYPE	Text(18)	Admit Dx, Encounter Dx, Final Dx, Problem List Dx, Medical History Dx,	Diagnosis code. Leading zeroes and different levels of decimal precision are permissible in this field. Please populate the exact textual value of this diagnosis code, but remove source-specific suffixes and prefixes. Other codes should be listed as recorded in the source data.
DX_ENC_TYPE	Text(2)		Primary, Secondary,
DX_CODE_TYPE	Text(x)	ICD9, ICD10	Indicates the type of value in the DX_CODE column.
DX_CODE	Text(x)		The actual ICD-9 or ICD-10 code for the
DX_NAME	Text		
DX_ALT_CODE	Text(x)		The alternate (or opposite code) found in DX_CODE. So, if DX_CODE is an ICD-9 value this column will contain the ICD-10 value.
CLASS_OF_PROBLEM	Text(x)	Stage 1, Chronic, Acute, Present upon Admission	
CHRONIC_YN	Text(x)		
PROV_ID	Text(x)		DIAGNOSIS PROV ID

MEASUREMENT (VITALS)

BMI, BMI percentile and BP are the only measurements currently included in the Sleep Study. BP at a face-to-face encounter or the first recorded value of an inpatient encounter.

COLUMN	DATATYPE	POSSIBLE VALUES	DESCRIPTION
STUDY_MEAS_ID	Integer		Arbitrary identifier for each unique record. Does not need to be persistent across refreshes, and may be created by methods such as sequence or GUID
STUDY_ENC_ID	Integer		Pseudo identifier for encounters. Used to link across tables.
STUDY_PAT_ID	Integer		Pseudo identifier for patient. Used to link across tables.
MEAS_RECORDED_DATETIME	DateTime		
MEAS_TYPE	Text	BMI, BMIPCT, BP,	Only including these three measurements at this time.
MEAS_VALUE_NUMBER	Number		Actual recorded value for the visit.
MEAS_VALUE_TEXT	Text		If the value is not a number,
MEAS_SOURCE	Text		
STUDY_PROV_ID	Integer		Pseudo identifier for provider. This is the taken by user or the attending provider.

MEDICATION (DRUG_EXPOSURE)

COLUMN	DATATYPE	POSSIBLE VALUES	DESCRIPTION
STUDY_MED_ID	Integer		Arbitrary identifier for each unique record. Does not need to be persistent across refreshes, and may be created by methods such as sequence or GUID

STUDY_ENC_ID	Integer		Arbitrary encounter-level identifier. Used to link across tables.
STUDY_PAT_ID	Integer		Arbitrary person-level identifier. Used to link across tables.
MED_START_DATETIME	DateTime		
MED_END_DATETIME	DateTime		
MED_ORDER_DATETIME	DateTime		
MED_TAKEN_DATETIME	DateTime		
MED_SOURCE_TYPE	Text	IP Meds, OP Meds,	Inpatient, Outpatient
QUANTITY	Text		May contain: 90 Tablets 2 Inhaler 1 Kit
DAYS_SUPPLY	Integer		Only on prescription scripts.
FREQUENCY	Text	BID PRN, CONTINUOUS, ONCE, ONCE-IN CLINIC, TID, QDAY Q8H PRN Q6H PRN	
EFFECTIVE_DRUG_DOSE	Text(x)		
EFF_DRUG_DOSE_SOURCE_VALUE	Text(x)		
DRUG_DOSE_UNIT	Text(x)	mcg/kg/hr,	

		mL, puff(s), mL/hr, mEq, unit, mcg/kg/min, mcg, drop(s), gram, …	
REFILLS	Text(x)		Integer value for the number of refills remaining.
RXNORM_CODE	Text(x)		RxNorm code if available.
RXNORM_TERM_TYPE	Text(x)	Brand Name Pack	RxNorm classification type.
MEDICATION_DESCR	Text(x)		The name of the medication
GENERIC_DRUG_DESCR	Text(x)		The generic, non-proprietary name for this medication.
DRUG_ORDER_STATUS	Text	Completed, Discontinued, Dispensed, Sent, Suspend	
DRUG_ACTION	Text	Given, New Bag, Stopped	
ROUTE		Aerosol, INTRA-CATHETER, Inhalation, Injection, Intramuscular, Intravenous,	The avenue that the medicine was taken or administered. The list of values is not an exhaustive list.

		Misc.(Non-Drug; Combo Route), Mucous Membrane, Nasal, Ophthalmic, Oral, Otic, Rectal, Topical, Transdermal, Urethral	
ROUTE_SOURCE_VALUE	Text	Aerosol, Both Ears, Both Eyes, Each Nostril, Feeding Tube, Gastric Tube (GT-NG-OG), INTRANASAL, IV Continuous, Inhalation, Inhale with spacer, Intercatheter, Intra-arterial, Intradermal, Intramuscular, Intravenous, Jejunal Tube (JT-NJ-OJ), Left Ear, One Nostril, Oral, Oral/Gavage, PO/Tube, Rectal, Subcutaneous, Sublingual, TPN, Topical	This is not an exhaustive list.

PRESCRIBING_PROV_ID	Integer		
PHARM_CLASS	Text(x)		The pharmaceutical class that indicates the chemical families the drug belongs to, such as penicillins.
PHARM_SUBCLASS	Text(x)		The category value associated with the first pharmaceutical subclass listed for each medication.
THERA_CLASS	Text(x)		The therapeutic class that indicates the accepted purpose of the drug, such as "antibiotic" or "antipsychotic."
THERA_SUBCLASS	Text(x)		

PROCEDURE

COLUMN	DATATYPE	POSSIBLE VALUES	DESCRIPTION
STUDY_PROC_ID	Integer		Arbitrary identifier for each unique record. Does not need to be persistent across refreshes, and may be created by methods such as sequence or GUID.
STUDY_ENC_ID	Integer		Pseudo identifier for encounters. Used to link across tables.
STUDY_PAT_ID	Integer		Pseudo identifier for patient. Used to link across tables.
PROCEDURE_DATETIME	DateTime		
STUDY_PROV_ID	Integer		Pseudo identifier for performing provider id.
PROC_ID_NCH	Text(x)		Nationwide Children's Hospital internal procedure Id.
PROC_CODE	Text		Procedure code. Use in tandem with PROC_CODE_tYPE
PROC_CODE_TYPE	Text(x)	CPT HCPCS, ICD-9-CM,	This field designates the type of data stored PROC_CODE field.

		ICD-10-PCS	
PROC_DESCR	Text(x)		Procedure Description.

PROCEDURE_SURG_HX

This data is built on patient reported history on encounters. When a procedure or surgery was reported multiple times, the earliest reported event was used pulled into this file (data may be duplicated or missing in this file)

COLUMN	DATATYPE	POSSIBLE VALUES	DESCRIPTION
STUDY_SURGHX_ID	Integer		Arbitrary identifier for each unique LAB_RESULT_CM record. Does not need to be persistent across refreshes, and may be created by methods such as sequence or GUID.
STUDY_PAT_ID	Integer		Pseudo identifier for patient. Used to link across tables.
PROC_NOTED_DATE	Date		This is the date the procedure or surgical history was noted on patient visit.
PROC_START_TIME	DateTime		This is not always populated, because it is history taken from the patient at a visit.
PROC_END_TIME	DateTime		
PROC_CODE	Text		
CPT_CODE	Text		
PROC_DESCR	Text		

SLEEP_STUDY

This data provides a mapping between the patients, sleep study IDs, sleep study dates, and the age of the patient at the time of the sleep study. The sleep study dates, start times and durations are pulled from the sleep study database using the NATUS Sleepworks front end, and not from the EHR which may have slightly different times.

COLUMN	DATATYPE	POSSIBLE VALUES	DESCRIPTION
STUDY_PAT_ID	Integer		Pseudo identifier for patient. Used to link across tables.
SLEEP_STUDY_ID	Integer		Pseudo identifier for each unique sleep study
SLEEP_STUDY_START_DATETIME	DateTime		The date and time that the sleep study began.
SLEEP_STUDY_DURATION_DATETIME	DateTime		The duration of the sleep study
AGE_AT_SLEEP_STUDY_DAYS	Integer		The age of the patient in days at the time of the sleep study

SLEEP_ENC_ID

This data provides a mapping between the patients, sleep study IDs, and encounter IDs

COLUMN	DATATYPE	POSSIBLE VALUES	DESCRIPTION
STUDY_PAT_ID	Integer		Pseudo identifier for patient. Used to link across tables.
SLEEP_STUDY_ID	Integer		Pseudo identifier for each unique sleep study
STUDY_ENC_ID	Integer		Arbitrary encounter-level identifier. Used to link across tables.