THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

The Ohio State University Research Data Repository (RDR)

Available Data Fields

1 General data availability

- Data is limited to a rolling five year period determined at each extract interval.
    - Legacy data is sourced from the IW and normalized to values present in IHIS.
- Data is limited to patient encounters at OSUWMC.
- Prisoner data is not available.

2 Patient – Demographics

2.1 Available elements

- Vital Status indicates if the patient has been identified as deceased
- Birth Date
- Death Date
- Sex
- Age in Years
- Preferred Language
- Race
- Marital Status
- Religion
- Ethnicity
- Zip Code

2.2 Filters used

- Current prisoners are excluded
- Test patients are excluded
- Patients without a valid date of birth are excluded
- Patients with a death date preceding their birth date are excluded
- Patients without a valid encounter/observation during the time period are included

2.3 Merge logic

- IHIS data takes precedence over legacy data when there is a data conflict

3 Encounter

3.1 General notes

- Outpatient visits sourced from legacy data only include hospital-based outpatient visits

3.2 Available elements

- Start Date

- End Date
- Encounter location
- For hospital admissions, the discharge location is used
- e.g. University Hospital, James, Dodd, etc.
- For outpatient encounters, the department is used
- Encounter MDC codes
- Encounter MSDRG codes
- Encounter admission source
- Encounter discharge disposition
- Primary provider specialty
- Primary provider type

3.3 Filters used

- Encounters that did not result in patient care are excluded
- Prisoner encounters are excluded

3.4 Merge logic

- Inpatient admissions are sourced from hospital billing data
- Outpatient visits are sourced from clinical visit data

4 Diagnosis

4.1 General notes

- Diagnosis is considered an observation on a clinical encounter. It is not a representation of a duration of diagnosis, merely an indication that a diagnosis was either given or active during an encounter.

4.2 Available elements

- ICD9 diagnosis code
- ICD10 diagnosis code
- IMO description sourced from IHIS

4.3 Merge Logic

- Billing diagnoses are used for legacy data.
- Both billing and clinical diagnoses are used for IHIS data.

5 Labs Results

5.1 General notes

- Labs are associated with the encounter where the order for the lab was placed

5.2 Available elements

- Start date – for this lab observations, the result date is used as the start date
- LOINC code

- Lab result value
- Lab result value units

5.3 Filters used

- Non-numeric lab results, e.g. text, are excluded
- Labs that could not be associated with a LOINC code are excluded

5.4 Merge logic

- Legacy lab results associated with IHIS orders were sourced from IHIS
- Retrospective assigned of LOINC codes was automated based on current COMPONENT_ID to LOINC mappings.

6 Medication (RXNORM)

6.1 General notes

- Medications are considered observations on an encounter. They are indications that a certain medication was either positively administered or reported as an active medication by the patient at the time of the encounter.
- Medication strength and form are not extracted from clinical data, but are represented by the med-form-strength RXNORM coding level.
- Duration of medication and specific dosage administration information are not present.

6.2 Available elements

- RXNORM ingredient code – mapping for pharmaceutical ingredient
- RXNORM med-form-strength code – mappings included for semantic clinical drug, semantic branded drug, brand name pack and generic packs

6.3 Filters used

- Administered medications that cannot be verified as a positive administration are excluded
- Self-reported or prescribed medications that are not verified as active are excluded
- Medications without an RXNORM representation are excluded
  - Most excluded medications are custom formularies or investigative drugs

6.4 Merge logic

- Legacy medication information is sourced from medication administration records
- IHIS medication information is sourced from both medication administration records, self-reported medications and active medications prescribed by OSUMC outside of the observational encounter.

7 Procedures (CPT, ICD9)

7.1 Available elements

- CPT code – final billed CPT codes
- ICD9 procedure code – final billed ICD9 procedure code

- Instance number – multiple procedures with identical codes performed during an encounter will sorted in ascending order and assigned an instance number
- Start date – procedure date from the billing data

7.2 Filters used

7.3 Merge logic

For any assistance with the OSUWMC RDR, contact the CCTS at the following **Email Address**: ccts-informatics@osumc.edu