Creating a Common Data Model for Comparative Effectiveness with the Observational Medical Outcomes Partnership

F. FitzHenry¹,²; F.S. Resnic³; S.L. Robbins¹; J. Denton¹,⁴; L. Nookala¹,⁴; D. Meeker⁵; L. Ohno-Machado⁶; M.E. Matheny¹,²,⁴,⁷
¹Tennessee Valley Healthcare System, Veterans Affairs Medical Center, Nashville, TN; ²Department of Biomedical Informatics; Vanderbilt University, Nashville, TN; ³Division of Cardiology, Brigham and Women’s Hospital, Boston, MA; ⁴Division of General Internal Medicine and Public Health, Vanderbilt University, Nashville, TN; ⁵Department of Health, RAND Corporation, Santa Monica, CA; ⁶Division of Biomedical Informatics, University of California, San Diego, CA; ⁷Department of Biostatistics, Vanderbilt University, Nashville, TN

Keywords
Common data model, big data, comparative effectiveness

Summary
Background: Adoption of a common data model across health systems is a key infrastructure requirement to allow large scale distributed comparative effectiveness analyses. There are a growing number of common data models (CDM), such as Mini-Sentinel, and the Observational Medical Outcomes Partnership (OMOP) CDMs.

Objective: In this case study, we describe the challenges and opportunities of a study specific use of the OMOP CDM by two health systems and describe three comparative effectiveness use cases developed from the CDM.

Methods: The project transformed two health system databases (using crosswalks provided) into the OMOP CDM. Cohorts were developed from the transformed CDMs for three comparative effectiveness use case examples. Administrative/billing, demographic, order history, medication, and laboratory were included in the CDM transformation and cohort development rules.

Results: Record counts per person month are presented for the eligible cohorts, highlighting differences between the civilian and federal datasets, e.g. the federal data set had more outpatient visits per person month (6.44 vs. 2.05 per person month). The count of medications per person month reflected the fact that one system’s medications were extracted from orders while the other system had pharmacy fills and medication administration records. The federal system also had a higher prevalence of the conditions in all three use cases. Both systems required manual coding of some types of data to convert to the CDM.

Conclusion: The data transformation to the CDM was time consuming and resources required were substantial, beyond requirements for collecting native source data. The need to manually code subsets of data limited the conversion. However, once the native data was converted to the CDM, both systems were then able to use the same queries to identify cohorts. Thus, the CDM minimized the effort to develop cohorts and analyze the results across the sites.

Correspondence to:
Fern FitzHenry, RN, MM, PhD
Department of Biomedical Informatics
Eighth Floor, Suite 800
2525 West End Avenue
Nashville, TN
Tel.: 615 343–6316
Fax: 615 322–0502
Email: fern.fitzhenry@vanderbilt.edu

AppiClinInform 2015; 6: 536–547
http://dx.doi.org/10.4338/ACI-2014-12-CR-0121
received: December 31, 2014
accepted in revised form: July 17, 2015
published: August 26, 2015
http://dx.doi.org/10.4338/ACI-2014-12-CR-0121
1. Introduction

Worldwide, the business of healthcare research and quality improvement is increasingly focused on "big data" [1–3]. Evidence of the transformation is that observational outcomes from electronic health record (EHR) systems are increasingly important in comparative effectiveness analyses [4, 5]. Administrative claims databases have long been used (and criticized) for secondary analysis in research [6, 7]. However, the increasing adoption of EHRs as part of the Meaningful Use incentive program along with the availability of Medicare Part-D databases for outpatient prescription drug claims is spurring renewed interest in observational comparative effectiveness studies using secondary datasets [8, 9]. EHRs may become the focus of clinical effectiveness as informatics tools prove effective at divining knowledge and wisdom [10–12]. Big data research will certainly be lower cost than clinical trials, estimated between a low of $60 to $31 million to a high of $100 to $67 million for phase II or phase III trials, respectively [13]. The FDA has demonstrated its capability to research drug safety questions with its Mini-Sentinel System, a distributed electronic health data safety monitoring system [14, 15].

Adoption of a common data model (CDM) across health care systems is a key infrastructure requirement to allowing large scale distributed comparative effectiveness research [16]. Without a CDM, the investment in developing algorithms to identify cases and perform analyses is not transferrable to other organizations. Differences in data models and phenotyping algorithms across organizations may have contributed to the significant variance in results across sites seen in a recent review of rofecoxib [17].

2. Objective

To provide a case report of the challenges of moving a federal and civilian health system into a CDM [18], the Observational Medical Outcomes Partnership (OMOP) with three comparative effectiveness use cases. Systematic differences between data sources are highlighted in the context of the cohort selection.

3. Methods

The two health systems participating in the study were a community system, Partners Healthcare in Massachusetts (Partners), and a federal system, the Veterans Affairs (VA) MidSouth Healthcare Network (VISN9).

Partners, the larger of the two systems with twelve acute care hospitals, was ahead of many hospitals in mandating use of electronic systems in 2007 [19]. Partners harvested their systems to create a de-identified research patient data repository used for this study.

The federal system, MidSouth Healthcare Network (VISN9), included six hospital systems in Tennessee, Kentucky, and West Virginia. VISN9, as is true of the VA healthcare system overall, was an early adopter of electronic records. Although electronic charts were used exclusively at the VA, documentation received from outsourced fee based care was sometimes incomplete or not machine readable.

The OMOP CDM (Version 4) used in this study, selected after a syntactic and semantic interoperability review described elsewhere [20], was developed by a consortium of groups including PhRMA, the FDA, and the Foundation of the National Institutes of Health [21]. The OMOP CDM transforms observational data, both administrative and clinical, standardizing the content and format of the data allowing the use of common queries and analysis tools. The OMOP model included tools for extraction, loading, and transformation (ETL) to vocabularies described elsewhere [21–23]. The electronic data used in this study included administrative billing data and extended to laboratory results, physician orders, pharmacy dispensing, and medication administration. The OMOP data were demographics, visits, procedures, observations, medications, conditions, and death.
Cohort Development: Cohorts were developed for three comparative effectiveness use cases comparing emerging cardiac drug therapies to treatment standards, e.g. warfarin and dabigatran among patients with (1) atrial fibrillation, and (2) venous thromboembolism and clopidogrel and prasugrel among (3) patients with drug eluting stents. All patients hospitalized from January 1, 2009 to June 30, 2012 were eligible for inclusion in the clinical use cases. The VA performed the OMOP ETL process on all hospitalized patients during the study period and Partners conducted an ETL on all hospitalized patients meeting the first inclusion/exclusion step (Figure 1). The project used standard sequel query language (SQL) using concepts from the CDM to develop the cohort according to inclusion and exclusion criteria described in Figure 1.

4. Results

Table 1 presents a summary description of the two organizations in the study, and Table 2 presents a summary of the data record counts for the eligible population. We used percent of records loaded from the source to the CDM as a measure of data quality as have other studies [22–25]. The eligible population at the VA and Partners system differed not only in funding sources but also in representation of females (3% vs. 45%, respectively). The Partners health system was larger than VISN9. The higher ratio of inpatient to outpatient visits at Partners may reflect its tertiary-care model vs. the VAs comprehensive care model. There were some differences in billing datasets such as the lack of Ambulatory Patient Classification coding at the VA.

The biggest difference in record counts between the two sites was in the number of visits per person month – the VA had more than three times as many visits as Partners (6.44 vs. 2.05 per person month, respectively). There was a greater prevalence of outpatient vs. inpatient visits in the VA when compared with Partners. However, the VA also used “visits” to document professional services and mental health services in inpatient stays as required by VHA Directive 2009–002, Patient Care Data Capture [26]. For example, for a VA inpatient with a 28 day stay, the patient could have an average of 7 visits per day including group therapy, chaplain, pulmonary therapy, and the nursing unit. The ratio of deaths per person month was also higher at the VA (0.005 vs. 0.003), a possible reflection of more comorbidities [27].

The larger number of visits at the VA may account in part for a larger count of diagnoses at the VA vs. Partners (6.81 vs. 4.05 per person month, respectively). The only source data for conditions in both systems was ICD-9-CM codes. The OMOP common vocabulary for conditions, SNOMED-CT, did not cover all ICD-9-CM codes (88.6%) [21]. For example, all of the five digit codes for ‘453.7-Chronic venous embolism and thrombosis of other specified vessels’ were unavailable in SNOMED-CT. These critical codes were custom added to the data at higher less-specific SNOMED-CT concept levels so they could appear in outcomes (Table 3).

Medication and laboratory data sources were loaded for only a subset of the source data because manual coding was required at Partners for medications and at the VA for laboratory tests. Table 2 reflects this limited subset. Again VA had a higher count than Partners (2.04 vs. 1.45 per person month, respectively).

The count of drugs per person month was three times as high at the VA when compared to Partners (0.44 vs. 0.13 per person month, respectively). This higher count must also reflect the higher number of drug records in the VA resulting from the use of medication administration records for inpatients and fill records for outpatients while Partners used only physician orders for medications. Observation records were limited to laboratory test results.

Table 3 presents a summary of key challenges encountered in implementing the common data model, some of which are being addressed in subsequent releases of the CDM. The VA had a higher prevalence of the conditions in all three use cases (Table 4, Figure 2).

5. Discussion

Sample sizes and generalizability of findings can be increased by including multiple healthcare delivery systems, but researchers must assure that the data are standardized. In our initiative, the
adopted CDM, OMOP, was successful in allowing the case finding and outcome rules to be
developed once and applied with minimal adaptation across sites, but required substantial resources
to map local data into the underlying CDM. The process highlighted significant heterogeneity
between healthcare systems.

The algorithm logic for each of the cohort selection processes noted above were developed by a
single team and deployed across both healthcare systems. The same logic could be applied across
other OMOP installations with no additional development cost, underscoring the scalability in the
use of CDMs. Developing the logic for the 2nd and 3rd use case was also more efficient than for the
1st use case. The use cases also reinforced the need for large data sets to pursue comparative effec-
tiveness studies, as the volume of eligible patients declined rapidly when inclusion and exclusion
criteria were applied. However, cohort selection rigor is essential in improving the strength of find-
ings disseminated from observational data sources, as all observational cohort data suffer from
confounding and bias. One of the noted limitations of a similar study done by the Mini-Sentinel
initiative (although a comparative risk vs. comparative effectiveness assessment) was their reliance
on only administrative data, lack of adjustment for confounders, and less rigorous inclusion and
exclusion criteria [28–32]. These issues can impact study results, as biases and limitations of data
sources can be associated with 20–40% of outcome results moving from a statistically positive
association to a negative association depending on the database [33].

There were a number of systematic differences noted in the data collected within Partners and
the VISN9 VA healthcare systems. The VA population in general is older, poorer, may have disabili-
ities as part of military service, and have more comorbidities compared with civilians [34]. Previous
studies of prevalence for the conditions were higher than both organizations in the study (Table
4), possibly because of the stringent exclusion criteria we applied [35–37]. Although the two organi-
zations harmonized on drug ingredient, formulation and type/reliability (medication adminis-
tration/prescription fills vs. orders) of exposure differed. Observed medication administration
would be the most reliable, prescription refills next most reliable and orders least reliable [38].
Partners used drug orders where 12.6% of ordered doses may be omitted, 31% of prescriptions may
not be filled, and adherence to dose taking ranges from 43–78% even in clinical trials [39].

In the literature, an estimated 9.3% of drugs were typed in as free text [40], combination drugs
were frequently represented in structured data as only one of the two drug classes in the combi-
nation [41], and only 55.8 to 69.2% of NDC codes were mapped to a vocabulary although these
drugs accounted for 93.9 to 95.1% of the drugs in common use [25]. Our work adds to the literature
by describing a use case where the loss of even a small number of codes can affect the detection of
adverse outcomes, e. g. we could have potentially lost 75% of VTE cases had we not custom mapped
the ICD-9 pulmonary embolism codes absent in the standard CDM crosswalk.

Whether or not the patient continues care within the healthcare system administering the elec-
tronic records influences whether adverse outcomes will be captured. We deployed criteria for deter-
mining patient enrollment or connection to the participating sites using clinical visits relative to the
study index date, which may reduce the case volume available for analysis but was more rigorous
than previous studies using insurance enrollment data. Research indicates that 13–17% of patients
change health plans/providers over 1–2 year periods [42–44]. Persons aged 55–65, blacks, Hispanics
and those in fair or poor health would be less likely to change plans so will be more likely to be re-
presented in cohort data [42]. In two of the clinical use cases, the VA system had a higher rate of pa-
ient retention, very possibly because of the coverage benefits that would persist with moves or
changes in employment [27, 45]. VA patients were largely male, older with poorer health, more
medical conditions, more physician visits, and more admissions, matching most of Cunningham et.
al [42] criteria for patients less likely to change plans [27]. For these reasons, intra- and inter-health-
care system data quality assessments broadly across data domains and deeply within clinical use
cases are necessary to understand the data.

The data transformation to OMOP was time consuming as reported by others [22, 23]. In our
study, the ETL team first executed the VA data load over six person months and then performed the
Partners load in 1–2 person months. This suggests using an ETL team allowed gains in efficiency as
the knowledge and programming was partially transferrable regardless of the source data. At other
sites, the authors estimated transformation (full vs. partial data as in current study) and loading pro-
cesses to require four people over a six month period with conversion to OMOP concept codes and

© Schattauer 2015

F. FitzHenry et al.: Creating a CDM for Comparative Effectiveness
then loads running 4–11 days [22]. The conversion of 466 group practices from native data to OMOP took two person years [23]. This is consistent with expert panelists’ estimates of costs of data standardization [46].

6. Conclusion

Use of data within a CDM across multiple USA healthcare systems requires an understanding of the differences between the source data in the healthcare systems. Understanding the strengths and limitations of CDMs is useful, as there are a number of large initiatives promoting CDM development and implementation, such as the European Medicines Agency’s post authorization safety studies, FDA’s Mini-Sentinel/MDEpiNet, and the PCORnet [14, 47, 48].

Clinical Relevance Statement
It is feasible to develop and implement a common data model from electronic health record data sources. Early comparison of effectiveness in common data models could better inform the adoption recommendations for emerging therapies. The organization’s adoption of standard codes (like National Drug Codes) across care locations increases the percent of data that could be made available in a CDM.

Note: Preliminary data from this paper was used in a poster presented at the American Medical Informatics Association 2012 Annual Symposium.

Conflicts of Interest
The authors declare that they have no conflicts of interest in the research.

Protection of Human and Animal Subjects
The study was performed in compliance with the World Medical Association Declaration of Helsinki on Ethical Principles for Medical Research Involving Human Subjects. All research was conducted with the approval by the Partners and VA TVHS Institutional Review Board.

Financial Support
This study’s support was based upon work supported with resources and the use of facilities at the TVHS VA, the Integrating Data for Analysis, Anonymization and SHaring (iDASH), a National Center for Biomedical Computing (NCBC) grant U54HL108460 and by Scalable Network for Effectiveness Research (SCANNER), grant R01HS019913 funded by the Agency for Healthcare Research and Quality (AHRQ).
# Use case inclusion exclusion criteria

<table>
<thead>
<tr>
<th>Case Finding Steps</th>
<th>Atrial Fibrillation</th>
<th>Venous Thrombo Embolism</th>
<th>Drug Eluting Stent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1</strong></td>
<td>Identify patients with the diagnosis/procedure for an encounter from Jan 1, 2009 to Jun 30, 2012. If multiple encounters, take the earliest date in study period.</td>
<td><em>Atrial Fibrillation ICD-9 DX code ‘427.31’ (with % being the wildcard)</em></td>
<td><em>DES procedure (a) DRG Drug Eluting Stent: 246, 247 or (b) ICD Proc 36.07 or (c) CPT/HCPCS: G0290, G0291, C1874, C1875</em></td>
</tr>
<tr>
<td><strong>Step 2</strong></td>
<td>For the cases from step 1, identify connectedness (primary care/cardiology encounter in 30 days to 2 years prior). If none found at primary site, exclude from sample.</td>
<td><em>VTE ICD-9 DX code ‘415.11’ OR ‘415.10’ OR ‘451%’ OR ‘451%’ OR ‘453%’ (with % being the wildcard)</em></td>
<td><em>With qualifying condition by lab or DX (a) Unstable angina: 411, 411.81 or (b) 410% (with % being the wildcard) or (c) Troponin &gt;= 0.5 in 30 days prior to DC date of DES proc encounter or (d) CK MB High (also 30 days prior)</em></td>
</tr>
<tr>
<td><strong>Step 3</strong></td>
<td>For the cases from step 2, identify if the patient is in palliative or hospice care. Exclusion criteria: year prior to the index date for any of the following: (a) an encounter in clinic designated as hospice/palliative care; (b) a CPT for hospice/palliative care 99377-8, 99380, 99381, 99382, 99384, 99385; (c) diagnosis for hospice/palliative care V66.7%</td>
<td>Also exclude if: <em>pt on any of the four study drugs 30 days prior to DX date/visit (OP) or admission date (IP), or CHADS2 score = 0</em></td>
<td>*Also exclude if: <em>pt on any of the four study drugs 37 to 7 days prior to Proc admission date (IP), or if the patient is an OP, we would search from 37 days prior to proc date to 7 days prior to procedure visit start date</em></td>
</tr>
<tr>
<td><strong>Step 4</strong></td>
<td>For the cases identified in step 3, exclude if LOS greater than 30 days.</td>
<td>Principal study drugs are: Warfarin Dabigatran</td>
<td>Principal study drugs are: Flaxa Prasugrel</td>
</tr>
<tr>
<td><strong>Step 5</strong></td>
<td>For the cases remaining from step 4, identify and eliminate cases on the two principal study drugs in the year prior index date. Medications could search orders, OP fills, IP BCMA, and IP intravenous.</td>
<td><em>Principal study drugs are: Warfarin Plavix</em></td>
<td><em>Principal study drugs are: Warfarin Plavix</em></td>
</tr>
<tr>
<td><strong>Step 6</strong></td>
<td>For remaining cases from step 5, the only cases retained must be: (a) treated with one principal study in the 30 days after dx/procedure date or during admission if IP. Any exposure counted (amount or period of exposure was not considered) (b) not treated with any of the other study drugs (non-indexed drug) in the 30 days after dx/procedure date or during admission if IP.</td>
<td><em>Principal study drugs are: Warfarin Prasugrel</em></td>
<td>Treatment with principal study drug could start up to 7 days prior to procedure or admission for procedure</td>
</tr>
<tr>
<td><strong>Step 7</strong></td>
<td>For the cases remaining from step 6, we could identify and eliminate cases where the patient died within 30 days of the dx/procedure.</td>
<td><em>Principal study drugs are: Warfarin Plavix</em></td>
<td><em>Principal study drugs are: Flaxa Prasugrel</em></td>
</tr>
</tbody>
</table>

*Note: All case finding criteria were operationalized into OMOP concept codes, e.g. the diagnosis code 427.31-Atrial Fibrillation translated to OMOP concept code 313217.*
Fig. 2  Percent of cases eligible by case finding step
Note: Steps 1–7 reference the inclusion and exclusion criteria in Figure 1.
Table 1  Population and organizational characteristics

<table>
<thead>
<tr>
<th>Description</th>
<th>VA VISN9 (6 Hospital Systems)</th>
<th>Partners (2 Hospital Systems)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ownership</td>
<td>Federally owned budget-based costs of care</td>
<td>Not for profit, fee for service</td>
</tr>
<tr>
<td>Revenue-Partners/Cost-VA (billion)</td>
<td>$2.3</td>
<td>$6.1</td>
</tr>
<tr>
<td>Physicians/providers</td>
<td>1 544</td>
<td>6 400</td>
</tr>
<tr>
<td>Beds</td>
<td>1 676</td>
<td>2 700</td>
</tr>
<tr>
<td>Admissions</td>
<td>39 987*</td>
<td>151 000</td>
</tr>
<tr>
<td>OP Visits</td>
<td>3 283 572**</td>
<td>4 300 000</td>
</tr>
<tr>
<td>Percent electronic health record (estimate)</td>
<td>90–95%</td>
<td>Outpatient 95% Inpatient 20%</td>
</tr>
<tr>
<td>Average Age</td>
<td>67 Years</td>
<td>66 Years</td>
</tr>
<tr>
<td>Percent Females</td>
<td>3%</td>
<td>45%</td>
</tr>
<tr>
<td>Percent Caucasian</td>
<td>82%</td>
<td>81%</td>
</tr>
<tr>
<td>Percent African/American</td>
<td>14%</td>
<td>8%</td>
</tr>
<tr>
<td>Percent Other Unknown</td>
<td>4%</td>
<td>11%</td>
</tr>
</tbody>
</table>

*VA admissions do not include 34% non-VA bed days
**VA outpatient visits do not include 11% non-VA outpatient visits

Table 2  Records in OMOP Common Data Model for eligible persons

<table>
<thead>
<tr>
<th>Data Category</th>
<th>Percent of Qualified Records for 60 Study Months</th>
<th>Rows per Person Month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>VISN9 (n=21 002)</td>
<td>Partners (n=25 641)</td>
</tr>
<tr>
<td>Drug Exposure – Subset*</td>
<td>99.0% (out of 556 894)</td>
<td>94.9% (out of 215 145)</td>
</tr>
<tr>
<td>Condition Exposure</td>
<td>100.0% (out of 8 582 589)</td>
<td>90.2% (out of 6 909 958)</td>
</tr>
<tr>
<td>Observations – Subset**</td>
<td>99.8% (out of 2 579 109)</td>
<td>100.0% (out of 2 226 963)</td>
</tr>
<tr>
<td>Procedures</td>
<td>99.8% (out of 10 007 359)</td>
<td>99.28% (out of 8 011 290)</td>
</tr>
<tr>
<td>Visits/encounters</td>
<td>100.0% (out of 8 112 358)</td>
<td>100.0% (out of 3 147 382)</td>
</tr>
<tr>
<td>Deaths</td>
<td>100.0% (out of 5 909)</td>
<td>94.0% (out of 5 344)</td>
</tr>
</tbody>
</table>

*Partners native drug data used multiple drug coding standards, some of which were not included in the OMOP crosswalks to RxNorm. Since the uses cases did not require dose or formulation we identified drugs with string searches for generic and trade names for only the drugs used in study and manually coded them to the OMOP coding standard for drugs (RxNorm).

**Laboratory data in observations required manual coding because many laboratory tests were profiled without the OMOP coding standard for laboratory (LOINC). For example, about 16% of Prothrombin/INR test results were missing a LOINC code.
### Table 3  Challenges and opportunities in implementing the OMOP CDM

<table>
<thead>
<tr>
<th>Description</th>
<th>VA</th>
<th>Partners</th>
<th>Lessons learned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effort to load and transform</td>
<td>Over 6 person months</td>
<td>1–2 person months</td>
<td>CDM transformation probably not feasible for a single study</td>
</tr>
<tr>
<td>Memory/space requirements to load</td>
<td>Required partitioning the data into subsets*</td>
<td>Conduct feasibility assessments prior to execution of full ETL to estimate hardware requirements.</td>
<td></td>
</tr>
<tr>
<td>ICD-9-CM codes must map to specific SNOMED-CT codes or dropped</td>
<td>Rolled more specific ICD-9-CM codes to less specific SNOMED-CT codes**</td>
<td>Custom mapping minimized dropped codes</td>
<td></td>
</tr>
<tr>
<td>Diagnosis must connect to &quot;visits&quot;</td>
<td>Diagnosis with just dates and no &quot;visit&quot; were dropped</td>
<td>Within CDM parameters</td>
<td>Missing or mis-formatted data affects data limitations</td>
</tr>
<tr>
<td>Visits within &quot;visits&quot;</td>
<td>Selected the longest visit that included the diagnosis of interest</td>
<td>Within CDM parameters</td>
<td>Missing data affects data limitations and required standardization in rules</td>
</tr>
<tr>
<td>Start dates and end dates required for visits regardless of type of encounter</td>
<td>Populate the same date to both start and end date</td>
<td>Missing data affects data limitations for clinic encounters.</td>
<td></td>
</tr>
<tr>
<td>DRGs only profiled in &quot;costs&quot;</td>
<td>Populated the DRGs of interest for identifying drug eluting stent procedures</td>
<td>Also would have missed some cases but most drug eluting stents did have ICD-9-CM procedure codes</td>
<td>Custom mapping of DRG’s required to identify procedures</td>
</tr>
<tr>
<td>Abnormal flag for laboratory results</td>
<td>Missing flag field</td>
<td>Required custom field to hold the flag</td>
<td></td>
</tr>
<tr>
<td>CDM needed quantity field for procedures (needed especially the bleeding outcome, e.g. transfusions)</td>
<td>Took the quantity field used for CPT/HCPCS coding and populated custom field</td>
<td>Required custom field to hold the quantity</td>
<td></td>
</tr>
<tr>
<td>Manual coding of some data</td>
<td>Had LOINC codes but some missing, e.g. 10% of Troponin results had no LOINC Code, 16% of INR results had no LOINC code</td>
<td>No single drug vocabulary was used across Partners sites. Some sites did not use a medication vocabulary that had an available crosswalk to RXNORM.</td>
<td>If the organization wants to participate in a CDM model, then assign a group to code data where needed. If the organization has no long term commitment to supporting codified data, then assess the feasibility of coding the data only where the use case requires it.</td>
</tr>
</tbody>
</table>

*Merged columns represent similar processes/findings at VA and Partners.

**The pulmonary embolism outcome used for the atrial fibrillation use case would have missed 75% of cases had the unmapped ICD-9 codes been dropped at VISN9.
Table 4  Case counts by step with prevalence

<table>
<thead>
<tr>
<th>Step</th>
<th>Atrial Fibrillation Count</th>
<th>Venous Thromboembolism Count</th>
<th>Drug Eluting Stent Count</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>VISN9 % of Total</td>
<td>Partners % of Total</td>
<td>VISN9 % of Total</td>
</tr>
<tr>
<td>1</td>
<td>14204</td>
<td>16427</td>
<td>6998</td>
</tr>
<tr>
<td>2</td>
<td>11616</td>
<td>82%</td>
<td>13124</td>
</tr>
<tr>
<td>3</td>
<td>11350</td>
<td>80%</td>
<td>12981</td>
</tr>
<tr>
<td>4</td>
<td>4814</td>
<td>34%</td>
<td>5529</td>
</tr>
<tr>
<td>5</td>
<td>4591</td>
<td>32%</td>
<td>5313</td>
</tr>
<tr>
<td>6</td>
<td>1278</td>
<td>9%</td>
<td>908</td>
</tr>
<tr>
<td>7</td>
<td>1248</td>
<td>9%</td>
<td>889</td>
</tr>
</tbody>
</table>

Prevalence:
- Atrial Fibrillation: 0.011
- Venous Thromboembolism: 0.001
- Drug Eluting Stent: 0.006

Comparison Prevalence:
- Go AS et al., 2001: 0.950*
- White RH, 2003: 0.100
- Nielsen KM et al., 2007: 0.002

Population VA = 109,339
Population Partners = 1,275,000

*Go AS et al., 2001 included all atrial fibrillation vs. only newly diagnosed atrial fibrillation in this study.
References


31. Dabigatran (Pradaxa), warfarin & GI bleed, intracerebral hemorrhage (Modular Program) [http://www.mini-sentinel.org/work_products/Assessments/Mini_Sentinel_Modular-Program-Report_MSY3_MPR41_Dabigatran-Warfarin-GIH-ICH_Part-1.pdf]


