VID Catalogue

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1 Preamble

This document represents the description of the Valencia Health System Integrated Database (VID) for the Health Services Research and Pharmacoepidemiology (HSRP) unit at The Foundation for the Promotion of Health and Biomedical Research of Valencia Region (FISABIO). On one hand, the VID data has been used in several projects (using VID data alone or in multi-centric studies). On the other hand, FISABIO is a research center with different groups and tendencies. Each group is independent, and, although the underlying source of information is the same, the extraction, the curation and the interpretation of the data could be dissimilar. Therefore, several groups are working in FISABIO institution and some of them are working with the VID data. However, this document only applies to FISABIO-HSRP group (see Figure 2).
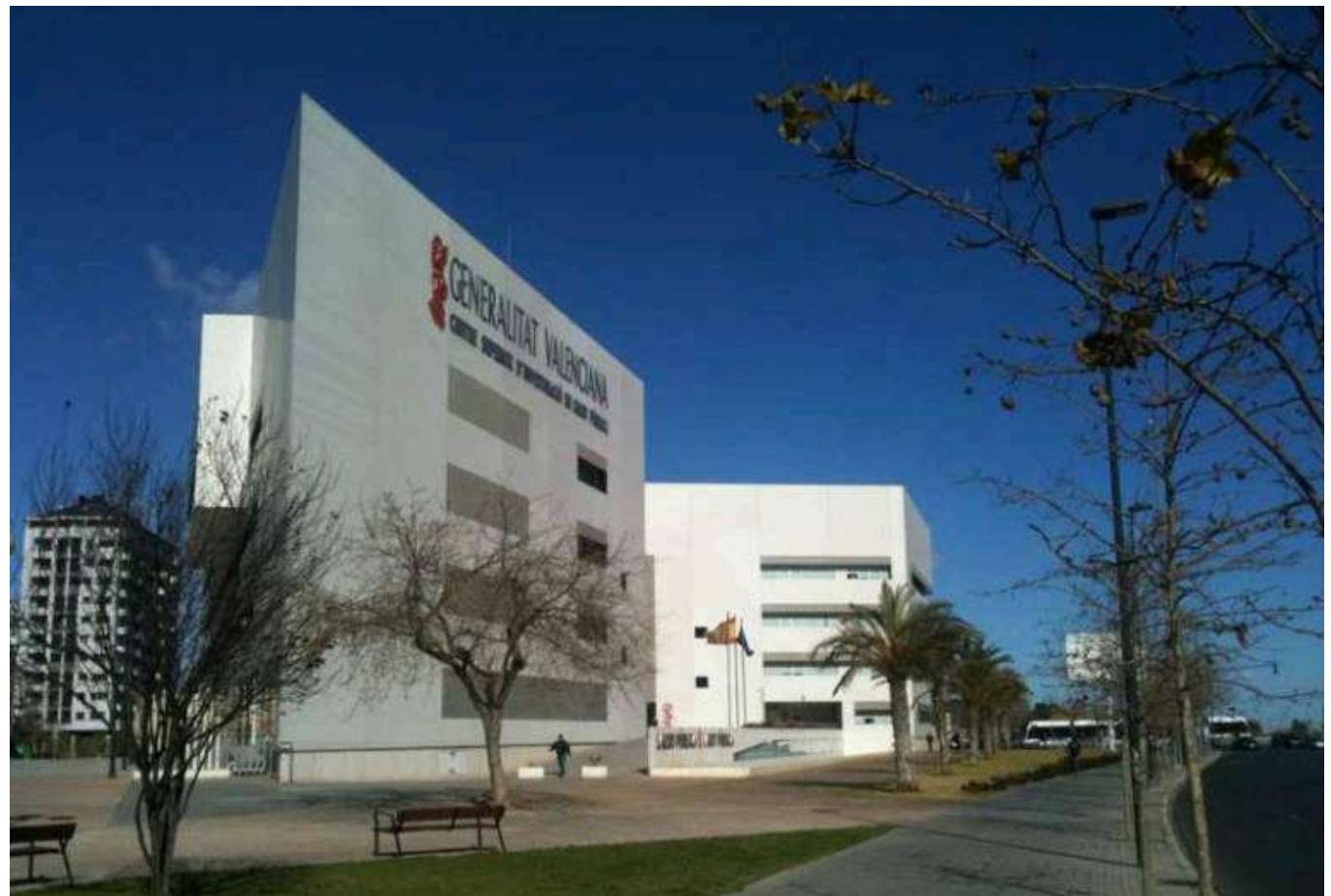

Figure 1: Main FISABIO building
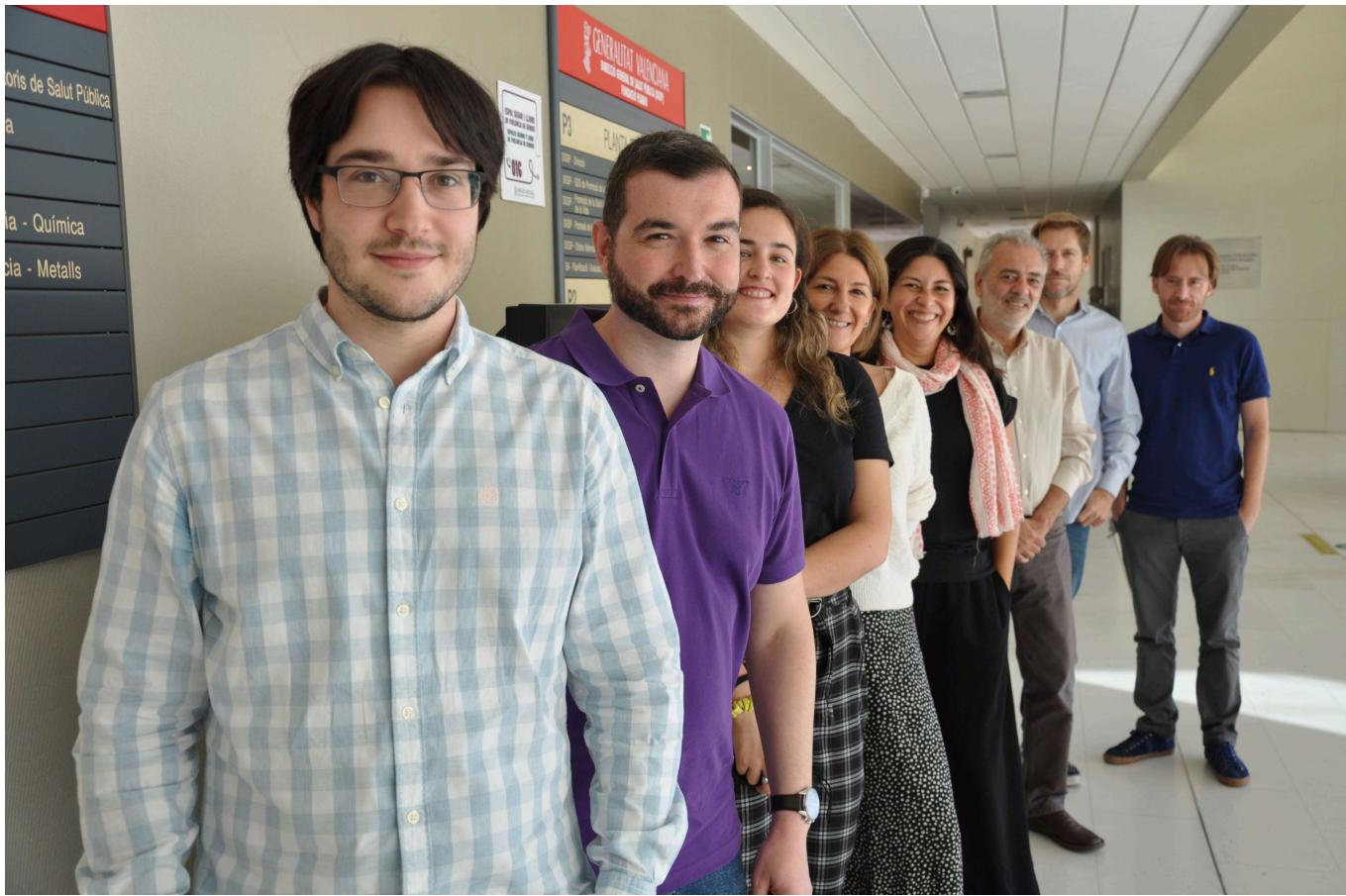
Figure 2: FISABIO-HSRP group members

This document are structured as follows: In Section 2 the VID data source is described. In Section 3 the origin tables of VID are depicted and, finally, in Section 4 the Common Data Models (CDM) used by the FISABIO-HSRP unit with the VID data are presented.

2 Data Source: VID

The data used by FISABIO-HSRP group are extracted from the Valencia Health System Integrated Database (VID). The VID is a set of multiple, population-wide electronic databases for the Valencia Region, the fourth most populated Spanish region, with $\approx$ 5 million inhabitants, representing 10.7% of the Spanish population and around 1% of the European population. The VID provides exhaustive longitudinal information including sociodemographic and administrative data (sex, age, nationality, etc.), clinical (diagnoses, procedures, diagnostic tests, imaging, etc.), pharmaceutical (prescription, dispensation) and healthcare utilization data from hospital care, emergency departments, specialized care (including mental and obstetrics care), primary care and other public health services. It also includes a set of associated population databases and registries of significant care areas such as cancer, rare diseases, vaccines, congenital anomalies, microbiology and others, and also public health databases from the population screening programmes. All the information in the VID databases can be linked at the individual level through a single personal identification code. The databases were initiated at different moments in time, but all in all the VID provides comprehensive individual-level data fed by all

the databases from 2008 to date. More information about the VID data source could be find elsewhere in [Garcia-Sempere 2020](#).

The data used for research by FISABIO-HSRP group is study dependent and should to be approved by the ethical and data extraction committee. Therefore, only a subset of the whole population and of the bases are extracted accordingly to each study protocol.

3 Origin Tables

As it was commented in the aforementioned [Section 2](#), each study leads to a different extraction. However, there are a set of bases that are usually used in the projects by FISABIO-HSRP. These bases, before the harmonization into any CDM (if apply), are called *Origin Tables* or *Source Tables*. The bases are: **01_SIP**, **02_PCV**, **03_CEX**, **04_MBDS**, **05_AED**, **06_DIAGNOSES**, **07_GAIA**, **08_SIV**, **09_MDR**, **10_PMR**, **11_EOS**, **12_TESTS**, **13_CONG** and **14_REDMIVA**. Following, a brief description of each base along with the name of the variables are shown.

01_SIP

The SIP base is the Information population system. In the SIP base there are contained population and social information of the VID population (such as sex, birth date, income, etc.). A record is created when anyone, resident or foreigner (e.g. tourists), contacts the system. Everyone is assigned an ID that is linkable across the tables. The table is updated each year and there are information from 2008 to current date. This table is used for cohort definition/creation and it is also used to identify deaths. In [Table 1](#) is shown the description of the SIP origin table.

Table 1: 01_SIP Origin Table description

Variable	Type	Description	Mandatory	Data dictionary
sip	VARCHAR	pseudonymised id number (unique for each patient)	yes	
fecha_calculo	DATE	calculation date (year of the information)	yes	
fecha_nacimiento	DATE	birth date	yes	
sexo	VARCHAR	sex	yes	
pais_nacimiento	VARCHAR	country of birth (INE code + name)	yes	

Variable	Type	Description	Mandatory	Data dictionary
sit_empadronamiento	VARCHAR	census situation	yes	
derecho_farmacia	VARCHAR	pharmacy rights	yes	
dpto_salud	VARCHAR	health department	yes	
zona_salud	VARCHAR	health zone	yes	
fecha_alta	DATE	activation date	yes	
fecha_baja	DATE	deactivation date	yes	
causa_baja	VARCHAR	deactivation cause	yes	

02_PCV

PCV is the Primary Care Visits. In this base are get the information of primary care visits (general practice).

Table 2: 02_PCV Origin Table description

Variable	Type	Description	Mandatory	Data dictionary
sip	VARCHAR	pseudonymised id number (unique for each patient)	yes	
fecha_consulta	DATE	date of the visit	yes	
serv_at_cod	VARCHAR	diagnosis code	yes	PCV service dictionary
serv_at_desc	VARCHAR	diagnosis description	yes	PCV service dictionary
diag_cod	VARCHAR	contact type code	yes	
diag_desc	VARCHAR	contact type description	yes	
tipo_codigo	VARCHAR	diagnosis code vocabulary	yes	

03_CEX

In CEX there are get the information of specialist care visits.

Table 3: 03_CEX Origin Table description

Variable	Type	Description	Mandatory	Data dictionary
sip	VARCHAR	pseudonymised id number (unique for each patient)	yes	
fecha_consulta	DATE	date of the visit	yes	
especialidad_cod	VARCHAR	especiality code	yes	[CEX service dictionary](#)
especialidad_desc	VARCHAR	especiality description	yes	[CEX service dictionary](#)
tipo_contacto	VARCHAR	contact type	yes	
d1_cod	VARCHAR	diagnosis code 1	yes	
d1_desc	VARCHAR	diagnosis description 1	yes	
d2_cod	VARCHAR	diagnosis code 2	yes	
d2_desc	VARCHAR	diagnosis description 2	yes	
d3_cod	VARCHAR	diagnosis code 3	yes	
d3_desc	VARCHAR	diagnosis description 3	yes	
d4_cod	VARCHAR	diagnosis code 4	yes	
d4_desc	VARCHAR	diagnosis description 4	yes	
tipo_codigo1	VARCHAR	diagnosis code 1 vocabulary	yes	
tipo_codigo2	VARCHAR	diagnosis code 2 vocabulary	yes	
tipo_codigo3	VARCHAR	diagnosis code 3 vocabulary	yes	
tipo_codigo4	VARCHAR	diagnosis code 4 vocabulary	yes	
num_cons	INT	monthly number of visits of the individual to the service	no	

04_MBDS

MBDS is the hospital admission minimum basic data set triggered by hospital admissions and capture the information about anyone who has an admission, regardless of their residency status. There are two different ICD codes: from 2008 to 2015 the codes are ICD9CM and from 2016 there are ICD10CM.

Table 4: 04_MBDS Origin Table description

Variable	Type	Description	Mandatory	Data dictionary
sip	VARCHAR	pseudonymised id number (unique for each patient)	yes	
fecha_ingreso	DATE	date of the hospitalisation admission	yes	
fecha_alta	DATE	date of the hospitalisation discharge	yes	
dpto_cod	VARCHAR	health department code	yes	
hosp_cod	VARCHAR	health department name	yes	
serv_ing_cod	INT	hospital code	yes	MBDS service dictionary
serv_ing_desc	VARCHAR	hospital name	yes	MBDS service dictionary
tipo_activ	VARCHAR	admission service code	yes	
circ_ing_cod	VARCHAR	admission service description	yes	
circ_ing_desc	VARCHAR	activity type: ambulatory or overnight	yes	
circ_alta_cod	INT	admission circumstances code	yes	MBDS and AED Discharge type dictionary
circ_alta_desc	VARCHAR	admission circumstances description	yes	MBDS and AED Discharge type

05_AED

AED is a base with the information of emergency visits. Thus, the records are triggered by any emergency department visit. The AED visits that led to hospitalization can be linked with the MBDS. In this base we find ICD9CM and ICD10CM codes.

Table 5: 05_AED Origin Table description

Variable	Type	Description	Mandatory	Data dictionary
sip	VARCHAR	pseudonymised id number (unique for each patient)	yes	
fecha_registro	DATE	date of emergency room visit record	yes	
fecha_alta	DATE	date of emergency room discharge	yes	
dpto_cod	INT	health department code	yes	
centro_cod	INT	centre code	yes	
circ_alta_cod	INT	discharge circumstances code	yes	MBDS and AED Discharge type dictionary
circ_alta_desc	VARCHAR	discharge circumstances code	yes	MBDS and AED Discharge type dictionary
motivo_urg_cod	INT	emergency admission code	yes	
motivo_urg_desc	VARCHAR	emergency admission description	yes	
diag_cod	VARCHAR	diagnosis code 1	yes	
diag2_cod	VARCHAR	diagnosis code 2	yes	
tipo_codigo1	VARCHAR	diagnosis code 1 vocabulary	yes	
tipo_codigo2	VARCHAR	diagnosis code 2 vocabulary	yes	
prioridad_cod	INT	priority code	yes	
prioridad_desc	VARCHAR	priority description	yes	

Variable	Type	Description	Mandatory	Data dictionary
fecha_alta_admin	DATE	date of administrative emergency room discharge	no	
dpto_desc	VARCHAR	health department name	no	
centro_desc	VARCHAR	centre name	no	
diag_desc	VARCHAR	main diagnosis description	no	
diag2_desc	VARCHAR	secondary diagnosis description	no	

06_DIAGNOSES

In this base are collected the information about the active (and non-active) diagnoses of the population.

Table 6: 06_DIAGNOSES Origin Table description

Variable	Type	Description	Mandatory	Data dictionary
sip	VARCHAR	pseudonymised id number (unique for each patient)	yes	
fecha_act	DATE	date of diagnosis activation	yes	
fecha_desact	DATE	date of diagnosis deactivation	yes	
diag_cod	VARCHAR	diagnosis code	yes	
diag_desc	VARCHAR	diagnosis description	yes	
tipo_codigo	VARCHAR	diagnosis code vocabulary	yes	

07_GAIA

GAIA consists of 3 tables (prescription, dispensing and treatment episodes). Prescribers create the episode/regimen and include this. Treatment episode has an ID – consecutive prescriptions (each with an ID) – which is linked to the dispensation data at individual level, to verify that the medication has been dispensed as intended by the physician. The trigger of GAIA base is a "treatment episode" order from a physician. The dispensing record is created when dispensed. There is also an option for paper prescription (manual) – can also captured (those that are dispensed) – very low, $\approx 2\,\%$. But these do not have a treatment episode (maybe during home visits, for example). The table is collected for all the population of with an encounter with the health system. GAIA started in 2006, but have reliable data available from 2008. From 2008-1013 there is electronic prescribing, but not electronic dispensing - instead there is billing information (linked pharmacy claims – we don't know the exact day of dispensing for these claims, this could result in 7-10 day delay in recorded date). The claims data is used in this period. However, prescriptions and dispensations are linked thorough a unique identifier. Electronic dispensing started in 2014.

07a_pres

Table 7: 07a_pres Origin Table description

Variable	Type	Description	Mandatory	Data dictionary
sip	VARCHAR	pseudonymised id number (unique for each patient)	yes	
receta_id	VARCHAR	pseudonymised prescription id, which links prescription and dispensing information	yes	
tx_id	VARCHAR	pseudonymised treatment id, which links prescription and treatment information	yes	
fecha_pres	DATE	prescription date	yes	
atc_cod	VARCHAR	level 4 (5 digits) or level 5 (7 digits) atc code	yes	
atc_desc	VARCHAR	level 4 (5 digits) or level 5 (7 digits) atc code	yes	
prin_act_cod	VARCHAR	active ingredient code	yes	
prin_act_desc	VARCHAR	active ingredient description	yes	
pres_farma_cod	INT	pharmaceutical presentation code	yes	
pres_farma_desc	VARCHAR	pharmaceutical presentation description	yes	
via_cod	VARCHAR	route of administration code	yes	

Variable	Type	Description	Mandatory	Data dictionary
via_desc	VARCHAR	route of administration description	yes	
precio	REAL	cost of the product (in euros)	yes	
estado_receta	VARCHAR	prescription state	yes	
elec_manu	VARCHAR	electronic or manual prescription	yes	
reg_receta	VARCHAR	work regime: active work, retired, etc.	no	
caf_cod	VARCHAR	code of the patient aportation to the cost of the product	no	
caf_desc	VARCHAR	description of the patient aportation to the cost of the product	no	

07b_fact

Table 8: 07b_fact Origin Table description

Variable	Type	Description	Mandatory	Data dictionary
sip	VARCHAR	pseudonymised id number (unique for each patient)	yes	
receta_id	VARCHAR	pseudonymised prescription id, which links prescription and dispensing information	yes	
fecha_fact	DATE	billing dispensing date (year and moth)	yes	
fecha_disp	DATE	dispensing date (year, month and day)	yes	
atc_cod	VARCHAR	level 4 (5 digits) or level 5 (7 digits) atc code	yes	
atc_desc	VARCHAR	level 4 (5 digits) or level 5 (7 digits) atc code	yes	
prin_act_cod	VARCHAR	active ingredient code	yes	
prin_act_desc	VARCHAR	active ingredient description	yes	

Variable	Type	Description	Mandatory	Data dictionary
pres_farma_cod	INT	pharmaceutical presentation code	yes	
pres_farma_desc	VARCHAR	pharmaceutical presentation description	yes	
via_cod	VARCHAR	route of administration code	yes	
via_desc	VARCHAR	route of administration description	yes	
reg_receta	VARCHAR	electronic or manual prescription	no	
elec_manu	VARCHAR	work regime: active work, retired, etc.	no	

07c_rele

Table 9: 07c_rele Origin Table description

Variable	Type	Description	Mandatory	Data dictionary
sip	VARCHAR	pseudonymised id number (unique for each patient)	yes	
receta_id	VARCHAR	pseudonymised prescription id, which links prescription and dispensing information	yes	
fecha_fact	DATE	billing dispensing date (year and moth)	yes	
fecha_disp	DATE	dispensing date (year, month and day)	yes	
atc_cod	VARCHAR	level 4 (5 digits) or level 5 (7 digits) atc code	yes	
atc_desc	VARCHAR	level 4 (5 digits) or level 5 (7 digits) atc code	yes	
prin_act_cod	VARCHAR	active ingredient code	yes	
prin_act_desc	VARCHAR	active ingredient description	yes	
pres_farma_cod	INT	pharmaceutical presentation code	yes	
pres_farma_desc	VARCHAR	pharmaceutical presentation description	yes	

Variable	Type	Description	Mandatory	Data dictionary
via_cod	VARCHAR	route of administration code	yes	
via_desc	VARCHAR	route of administration description	yes	
reg_receta	VARCHAR	work regime: active work, retired, etc.	no	

07d_tx

Table 10: 07d_tx Origin Table description

Variable	Type	Description	Mandatory	Data dictionary
sip	VARCHAR	pseudonymised id number (unique for each patient)	yes	
tx_id	VARCHAR	pseudonymised treatment id, which links prescription and treatment information	yes	
unidades	VARCHAR	dosing units	yes	
cadencia	INT	dosing (in hours)	yes	
estado_tx	VARCHAR	treatment state	yes	
fecha_ini_trat	DATE	date of treatment start	yes	
fecha_fin_trat	DATE	date of treatment end	yes	
atc_cod	VARCHAR	level 4 (5 digits) or level 5 (7 digits) atc code	yes	
atc_desc	VARCHAR	level 4 (5 digits) or level 5 (7 digits) atc code	yes	
prin_act_cod	VARCHAR	active ingredient code	yes	
prin_act_desc	VARCHAR	active ingredient description	yes	
pres_farma_cod	INT	pharmaceutical presentation code	yes	
pres_farma_desc	VARCHAR	pharmaceutical presentation description	yes	

Variable	Type	Description	Mandatory	Data dictionary
via_cod	VARCHAR	route of administration code	yes	
via_desc	VARCHAR	route of administration description	yes	
diag_cod	VARCHAR	diagnosis code for the treatment	yes	
tipo_codigo	VARCHAR	diagnosis code vocabulary	yes	
diag_desc	VARCHAR	diagnosis description in text	no	
reg_receta	VARCHAR	work regime: active work, retired, etc.	no	
env_durac	REAL	'in origin' estimation of the prescription duration	no	

07_GAIA (Processed)

Table 11: GAIA Origin Table description

Variable	Type	Description	Mandatory	Data dictionary
sip	VARCHAR	pseudonymised id number (unique for each patient)	yes	
receta_id	VARCHAR	pseudonymised prescription id, which links prescription and dispensing information	yes	
tx_id	VARCHAR	pseudonymised treatment id, which links prescription and treatment information	yes	
fecha_pres	DATE	prescription date	yes	
fecha_fact	DATE	billing dispensing date (year and moth)	yes	
fecha_disp	DATE	dispensing date (year, month and day)	yes	
fecha_ini_trat	DATE	date of treatment start	yes	

Variable	Type	Description	Mandatory	Data dictionary
fecha_fin_trat	DATE	date of treatment end	yes	
atc_cod	VARCHAR	level 4 (5 digits) or level 5 (7 digits) atc code	yes	
atc_desc	VARCHAR	level 4 (5 digits) or level 5 (7 digits) atc	yes	

08_SIV

Table 12: 08_SIV Origin Table description

Variable	Type	Description	Mandatory	Data dictionary
sip	VARCHAR	pseudonymised id number (unique for each patient)	yes	
tipo_vacuna	VARCHAR	type of vaccine (COV-2, Flu, etc.)	yes	
nombre_vacuna	VARCHAR	vaccine brand name	yes	
dosis	INT	dose number	yes	
fecha_vacuna	DATE	vaccination date	yes	
publico_privado	VARCHAR	payer of the vaccine (public or private)	yes	

09_MDR

This is the Metabolic Diseases Register and acts as a birth register. It allows to link the mother person id with the newborn person id.

Table 13: 09_MDR Origin Table description

Variable	Type	Description	Mandatory	Data dictionary
sip_madre	VARCHAR	pseudonymised id number (unique for each patient) of the mother	yes	
sip_hijo	VARCHAR	pseudonymised id number (unique for each patient) of the newborn	yes	
fecha_nac_hijo	DATE	date of the birth	yes	
semana_gest	INT	gestational age (in weeks)	yes	
peso	INT	newborn weight (in g)	yes	
edad_madre	INT	mother age (in years)	yes	
hospital_nacimiento_cod	INT	birth hospital code	yes	
hospital_nacimiento_desc	VARCHAR	birth hospital name	yes	
hospital_muestra_cod	INT	results hospital code	yes	
hospital_muestra_desc	VARCHAR	results hospital name	yes	
talon	heel test results	heel test results	no	
pais_origen	mother country of birth	mother country of birth	no	

10_PMR

This is the perinatal mortality register. It contains the information about fetal deaths occurred from 21 gestational weeks and newborn deaths produced to 28 days after birth.

Table 14: 10_PMR Origin Table description

Variable	Type	Description	Mandatory	Data dictionary

Variable	Type	Description	Mandatory	Data dictionary
sip	VARCHAR	pseudonymised id number (unique for each patient)	yes	
tipo_muerte	VARCHAR	type of death (neonatal or fetal)	yes	
fecha_muerte_hijo	DATE	date of newborn/fetus death	yes	
fecha_nac_hijo	DATE	date of newborn birth	yes	
semana_gest	INT	gestational age (in weeks)	yes	
peso	INT	newborn weight (in g)	yes	
d1	VARCHAR	diagnosis code 1	yes	
d2	VARCHAR	diagnosis code 2	yes	
d3	VARCHAR	diagnosis code 3	yes	
d4	VARCHAR	diagnosis code 4	yes	
d5	VARCHAR	diagnosis code 5	yes	
d6	VARCHAR	diagnosis code 6	yes	
d7	VARCHAR	diagnosis code 7	yes	
d8	VARCHAR	diagnosis code 8	yes	
d9	VARCHAR	diagnosis code 9	yes	
d10	VARCHAR	diagnosis code 10	yes	
causa_muerte	VARCHAR	death cause	yes	
patologia_m1	VARCHAR	mother patology1	yes	
patologia_m2	VARCHAR	mother patology2	yes	
patologia_h1	VARCHAR	newborn patology1	yes	
patologia_h2	VARCHAR	newborn patology2	yes	
patologia_h3	VARCHAR	newborn patology3	yes	

11_EOS

This is the electronic obstetric sheet. It is used in order to detect spontaneous abortions (and to confirm births and stillbirths).

Table 15: 11_EOS Origin Table description

Variable	Type	Description	Mandatory	Data dictionary
sip	VARCHAR	pseudonymised id number (unique for each patient)	yes	
embarazo_id	VARCHAR	pseudonymised pregnancy id number (unique for each pregnancy)	yes	
fecha_visita_emb	DATE	date of record	yes	
semana_gest	INT	gestational age (in weeks)	yes	
fecha_fin_emb	DATE	date of event	yes	
resultado_rn1	VARCHAR	event type of the first child delivered: birth, spontaneous abortion or stillbirth	yes	
resultado_rn2	VARCHAR	event type of the second (if apply) child delivered: birth, spontaneous abortion or stillbirth	yes	
resultado_rn3	VARCHAR	event type of the third (if apply) child delivered: birth, spontaneous abortion or stillbirth	yes	

12_TESTS

There are four different categories inside the tests:

- **12a_solicitudes**: is the table with the requests of a test (without results).

- **12b_resultados**: is the table with the results of a test.

- **12c_hcg**: is the table with the measures of chorionic gonadotropin (hcg) in blood or urine.

- **12d_apertura**: is the table with the opening of a sheet of pregnancy follow-up.

12a_solicitudes

Table 16: 12a_solicitudes Origin Table description

Variable	Type	Description	Mandatory	Data dictionary
sip	VARCHAR	pseudonymised id number (unique for each patient)	yes	
fecha_solicitud	DATE	date of the test request	yes	
prueba	VARCHAR	type of the test request	yes	

12b_resultados

Table 17: 12b_resultados Origin Table description

Variable	Type	Description	Mandatory	Data dictionary
sip	VARCHAR	pseudonymised id number (unique for each patient)	yes	
fecha_resultado	DATE	date of the test results	yes	
resultado	VARCHAR	test result	yes	
fecha_solicitud	DATE	date of the test request	yes	

12c_hcg

Table 18: 12c_hcg Origin Table description

Variable	Type	Description	Mandatory	Data dictionary
sip	VARCHAR	pseudonymised id number (unique for each patient)	yes	
fecha_resultado	DATE	date of the test results	yes	
prestacion_cod	VARCHAR	type of test code	yes	
prestacion_desc	VARCHAR	type of test description	yes	
text_result	VARCHAR	result in text	yes	
numeric_result	REAL	numerical result	no	

12d_apertura

Table 19: 12d_apertura Origin Table description

Variable	Type	Description	Mandatory	Data dictionary
sip	VARCHAR	pseudonymised id number (unique for each patient)	yes	
embarazo_id	VARCHAR	pseudonymised pregnancy id number (unique for each pregnancy)	yes	
fecha_inicio	DATE	date of the opening of the sheet	yes	

13_CONG

In this base are collected the information about congenital anomalies.

Table 20: 13_CONG Origin Table description

Variable	Type	Description	Mandatory	Data dictionary
sip_madre	VARCHAR	pseudonymised id number (unique for each patient) of the mother	yes	
nacidos_vivos	REAL	livebirth number	yes	
fecha_nacimiento_hijo	DATE	child's date of birth	yes	
semana_gest	REAL	gestational age (in weeks)	yes	
n_hijos_parto	REAL	number of newborns in the pregnancy	yes	
sexo	INT	sex of the newborn	yes	
peso	REAL	newborn weight (in g)	yes	
nbrmalf	INT	type of malformations	yes	
fecha_muerte_hijo	DATE	newborn death date	yes	
fecha_dx_anomalia	DATE	date of the anomaly detection	yes	
dx_anomalia	VARCHAR	anomaly code	yes	
dx_vivo_muerto	VARCHAR	diagnosis when aliver or death	yes	
tipo_nacimiento	VARCHAR	type of birth	yes	
tot_malf	INT	total number of malformations	yes	

14_REDMIVA

This is the table where the microbiological surveillance network information is collected. It contains the information about COVID-19 test results.

Table 21: 14_REDMIVA Origin Table description

Variable	Type	Description	Mandatory	Data dictionary

Variable	Type	Description	Mandatory	Data dictionary
sip	VARCHAR	pseudonymised id number (unique for each patient)	yes	
tipo_prueba	VARCHAR	test type: Antigen or PCR	yes	
fecha_prueba	DATE	date of the test	yes	
fecha_resultado	DATE	date of the result	yes	
resultado	VARCHAR	result of the test	yes	

Caveats

- Some centers are hospitals, so the variables *hosp_cod* and *hosp_desc* are a subset of the *center_cod* and *center_desc* variables.

- In SIP table, the codes and descriptions are stored together for the next variables: health departments, health areas, and health centres. Split these cases into two different variables in the curation process may be considered.

- The database *CONG* should be revised carefully.

Dictionaries

In this subsection there are the dictionaries of codes and description of different categories used in VID by FISABIO-HSRP unit.

Table 22: PCV service dictionary

Speciality	Description (in spanish)
ACE	ENFERMERIA ATENCION CONTI
ACM	MEDICO ATENCION CONTINUAD
ECA	ENFERMERIA UCAS

Speciality	Description (in spanish)
EEE	ENF EDUCACION ESPECIAL
EEM	ENFERMERIA DE EMPRESA
EGC	ENF. GEST CASOS COMUNITAR
EIP	ENFERMERO INSPECTOR
ENF	ENFERMERIA A.P
ENFS	ENFERMERIA SABADO
ERE	ENFERMERIA RESID 3A EDAD
ESM	ENFERMERIA SALUD MENTAL
ESMI	ENF SALUD MENTAL INFANTIL
ESS	ENFERMERIA SSYR
FARA	FARMACIA DE AREA
FISI	FISIOTERAPIA A.P
HDEN	HIGIENISTA DENTAL
ISM	PSIQUIATRA INF S. MENTAL
MAT	MATRONA A.P
MCA	MEDICINA UCAS
MEM	MEDICO EMPRESA
MFC	MEDICINA FAMILIAR
MFS	MEDICO FAMILIA SABADO
MIP	MEDICO INSPECTOR
MRE	MED. RESID. 3ª EDAD
MSS	MEDICINA SSYR
ODP	ODONTOLOGIA PREVENTIVA
PAP	PEDIATRIA A.P
PAPS	PEDIATRA SABADO

Speciality	Description (in spanish)
PCA	PSICOLOGIA UCAS
PLA	PLANIFICACION FAMILIAR
PSM	PSIQUIATRA SALUD MENTAL
PSMI	PSICOL SALUD MENTAL INF
PSS	SEXOLOGIA SSYR
RILA	PREVENCION RIESGOS LABOR
SMP	PSICOLOGIA SALUD MENTAL
TSM	TRAB.SOCIAL SALUD MENTAL
TSO	TRABAJADOR SOCIAL
TSU	TRABAJADOR SOCIAL UCAS
USO	PERSONAL OTROS
USP	PERSONAL PRIMARIA

Table 23: CEX service dictionary

Speciality	Description (in spanish)
-2	[Sin referencia]
ACL	ANÁLISIS CLÍNICOS
ALE	ALERGIA
ALI	ALERGIA INFANTIL
ANE	ANESTESIA
APL	APARATO LOCOMOTOR
ARE	CONSULTA DE ALTA RESOLUCIÓN
AXE	AUX. ENFERMERIA A.E
CAI	CARDIOLOGÍA INFANTIL
CAR	CARDIOLOGÍA

Speciality	Description (in spanish)
CCA	CIRUGÍA CARDIACA
CCV	CIRUGÍA CARDIOVASCULAR
CGC	CONSEJO GENÉTICO DE CÁNCER
CGD	CIRUGÍA GENERAL Y DIGESTIVO
CGI	CIRUGÍA PEDIÁTRICA
CIR	CIRUGÍA GENERAL
CMI	CIRUGÍA MAXILOFACIAL INFANTIL
CMX	CIRUGÍA MAXILOFACIAL
COT	CIRUGÍA ORTOPÉDICA Y TRAUMATOLOGÍA
CPI	CIRUGÍA PLÁSTICA INFANTIL
CPL	CIRUGÍA PLÁSTICA
CTO	CIRUGÍA TORÁCICA
CVA	CIRUGÍA VASCULAR
CVI	CARDIOVASCULAR INFANTIL
DEP	MEDICINA DEPORTIVA
DER	DERMATOLOGÍA
DIE	NUTRICIÓN Y DIETÉTICA
DII	MEDICINA DIGESTIVA INFANTIL
EAE	ENFERMERIA A.E
ECI	ENDOCRINOLOGÍA INFANTIL
ECR	ENDOCRINOLOGIA
EGH	ENFERMERA GESTORA DE CASOS HOSPITALARIA
EHD	ENFERMERÍA UHD
EIP	ENFERMERO INSPECTOR
END	ENDOSCOPIAS

Speciality	Description (in spanish)
ENE	ENFERMERÍA ESPECIALIZADA (NO COMPRENDIDO EN OTRAS UNIDADES)
ESA	ENFERMERÍA SAIP
ESC	ESCOLARES
EST	ESTERILIDAD
FAE	FISIOTERAPIA A .E
FAR	FARMACIA ESPECIALIZADA
FMA	UNIDAD DE FIBROMIALGIA Y FATIGA CRÓNICA
FMC	FARMACOLOGÍA CLÍNICA
FON	FONIATRÍA-LOGOPEDIA
GER	GERIATRÍA
GIN	GINECOLOGIA
HDI	HOSPITAL DE DÍA
HEM	HEMATOLOGÍA
HMD	HEMODINÁMICA
HMI	HEMATOLOGÍA INFANTIL
INM	INMUNOLOGÍA
LAB	LABORATORIO
LAC	LACTANTES
LIT	LITOTRICIA
LOC	APARATO LOCOMOTOR
MAE	MATRONA A.E
MAT	MATRONA ESPECIALIZADA
MCE	UNIDAD CORTA ESTANCIA
MDI	MEDICINA DIGESTIVA
MEN	UNIDAD DE MENOPAUSIA

Speciality	Description (in spanish)
MET	METABOLOPATÍAS
MHD	MÉDICO UHD
MIN	MEDICINA INTERNA
MIP	MEDICO INSPECTOR
MNU	MEDICINA NUCLEAR
MPR	MEDICINA PREVENTIVA
MSA	MEDICINA SAIP
MUHD	MEDICO UHD
MUR	MEDICINA DE URGENCIAS
NCG	NEUROCIRUGÍA
NCI	NEUROCIRUGÍA INFANTIL
NEF	NEFROLOGÍA
NEM	NEUMOLOGÍA
NEN	NEONATOLOGÍA
NER	NEUROLOGÍA
NFI	NEFROLOGÍA INFANTIL
NFL	NEUROFISIOLOGÍA
NMI	NEUMOLOGÍA INFANTIL
NRI	NEUROLOGÍA INFANTIL
OAE	OTROS ATENCIÓN ESPECIALIZADA
OBS	OBSTETRICIA
ODO	ODONTOESTOMATOLOGÍA
OFI	OFTALMOLOGÍA INFANTIL
OFT	OFTALMOLOGIA
ONC	ONCOLOGÍA

Speciality	Description (in spanish)
ONH	ONCOLOGÍA-HEMATOLOGÍA
ONI	ONCOLOGÍA INFANTIL
OPM	OPTOMETRIA
ORI	OTORRINOLARINGOLOGÍA INFANTIL
ORL	OTORRINOLARINGOLOGÍA
ORP	ORTÓPTICA-PLEÓPTICA
OTI	ORTOPEDIA INFANTIL
PAL	CUIDADOS PALIATIVOS
PED	PEDIATRÍA ESPECIALIZADA
PIN	INFECCIOSOS PEDIATRÍA
PSC	PSICOLOGIA CLINICA
PSI	PSIQUIATRIA
QUE	QUEMADOS
REA	ANESTESIA / REANIMACIÓN
REP	REPRODUCCIÓN
REU	REUMATOLOGÍA
RHB	REHABILITACIÓN
RHI	REHABILITACIÓN INFANTIL
RTE	RADIOTERAPIA
RXD	RADIODIAGNÓSTICO
SII	PSIQUIATRIA INFANTIL
TRI	TRAUMATOLOGIA INFANTIL
TSE	TRABAJO SOCIAL ESPECIALIZADA (NO COMPRENDIDO EN OTRAS UNIDADES)
UCI	MEDICINA INTENSIVA
UCP	UCI PEDIÁTRICA

Speciality	Description (in spanish)
UDA	UNIDAD DE DOCUMENTACIÓN CLÍNICA Y ADMISIÓN
UDC	UNIDAD DE DAÑO CEREBRAL
UDO	UNIDAD DE DOLOR
UEI	UNIDAD DE ENFERMEDADES INFECCIOSAS
UHD	UNIDAD DE HOSPITALIZACIÓN A DOMICILIO
UHP	UNIDAD HEPÁTICA
UMA	UNIDAD DE MANO
UNC	UNIDAD DE NEUROLOGÍA DE LA CONDUCTA Y DEMENCIAS
UPM	UNIDAD DE PATOLOGÍA MAMARIA
URD	URODINÁMICA
URG	URGENCIAS HOSPITALARIAS
URI	UROLOGÍA INFANTIL
URO	UROLOGÍA
URQ	UNIDAD RAQUIS
UTH	UNIDAD DE TERAPIA HIPERBÁRICA
UTP	UNIDAD DE TRASPLANTES PULMONARES
UTS	UNIDAD DE TRASTORNOS SUEÑO

Table 24: MBDS service dictionary

Speciality	Description (in spanish)
ALE	ALERGIA
ALI	ALERGIA INFANTIL
ARR -	NA
CAI	CARDIOLOGIA INFANTIL
CAR	CARDIOLOGIA

Speciality	Description (in spanish)
CCA	CIRUGIA CARDIACA
CCV	CIRUGIA CARDIOVASCULAR
CGD	CIRUGIA GENERAL Y DIGESTIVO
CGI	CIRUGIA PEDIATRICA
CIR	CIRUGIA GENERAL
CMA -	NA
CMI	CIRUGIA MAXILOFACIAL INFANTIL
CMX	CIRUGIA MAXILOFACIAL
COT	CIRUGIA ORTOPEDICA Y TRAUMATOLOGÍA
CPI	CIRUGIA PLASTICA INFANTIL
CPL	CIRUGIA PLASTICA
CSI -	NA
CTO	CIRUGIA TORACICA
CUR	CURIE -TERAPIA
CVA	CIRUGIA VASCULAR
DER	DERMATOLOGIA
DII	MEDICINA DIGESTIVA INFANTIL
ECI	ENDOCRINOLOGIA INFANTIL
ECR	ENDOCRINOLOGIA
ESC	ESCOLARES
GEL -	NA
GIN	GINECOLOGIA
HEM	HEMATOLOGIA
HMD	HEMODINAMICA
HPL -	NA

Speciality	Description (in spanish)
MCE	UNIDAD CORTA ESTANCIA
MDI	MEDICINA DIGESTIVA
MIN	MEDICINA INTERNA
MNU	MEDICINA NUCLEAR
MUR	MEDICINA DE URGENCIAS
NCG	NEUROCIRUGIA
NCI	NEUROCIRUGIA INFANTIL
NEF	NEFROLOGIA
NEM	NEUMOLOGIA
NER	NEUROLOGIA
NFI	NEFROLOGIA INFANTIL
NFL	NEUROFISIOLOGIA
NMI	NEUMOLOGIA INFANTIL
NRI	NEUROLOGIA INFANTIL
OBS	OBSTETRICIA
ODO	ODONTOESTOMATOLOGIA
OFI	OFTALMOLOGIA INFANTIL
OFT	OFTALMOLOGIA
ONC	ONCOLOGIA
ONH	ONCOLOGIA -HEMATOLOGIA
ONI	ONCOLOGIA INFANTIL
ORI	OTORRINOLARINGOLOGIA INFANTIL
ORL	OTORRINOLARINGOLOGIA
OTI	ORTOPEDIA INFANTIL
PAL	CUIDADOS PALIATIVOS

Speciality	Description (in spanish)
PED	PEDIATRIA
PIN	INFECCIOSOS PEDIATRIA
PSA	PSIQUIATRIA ADOLESCENTES
PSI	PSIQUIATRIA
QUE	QUEMADOS
REA	ANESTESIA / REANIMACION
REP	REPRODUCCION
REU	REUMATOLOGIA
RHB	REHABILITACION
ROD	UNIDAD RODILLA
RXD	RADIODIAGNOSTICO
SII	PSIQUIATRIA INFANTIL
TRI	TRAUMATOLOGIA INFANTIL
UCI	MEDICINA INTENSIVA
UDC	UNIDAD DE DAÑO CEREBRAL
UDO	UNIDAD DE DOLOR
UEI	UNIDAD ENFERMEDADES INFECCIOSAS
UHP	UNIDAD HEPATICA
UMI -	NA
UML	UNIDAD MEDICA LARGA ESTANCIA
UPM	UNIDAD DE PATOLOGIA MAMARIA
URI	UROLOGIA INFANTIL
URO	UROLOGIA
URQ	UNIDAD RAQUIS
UTA	UNIDAD TRANSTORNOS ALIMENTARIOS

Speciality	Description (in spanish)
UTP	UNIDAD TRANSPLANTES PULMONARES
UTT	UNIDAD TOXICOMANIAS

Table 25: MBDS and AED Discharge type dictionary

Discharge code	Description (in spanish)
-2	[Sin referencia]
-1	[Vacío]
1	Domicilio
2	Equipo atención primaria
3	Consultas externas
4	Hospital de Día
5	Unidad de Hospitalización a Domicilio
6	Alta voluntaria
7	Traslado Hospital de agudos
8	Traslado a Hospital de Media y Larga Estancia
9	Traslado Residencia o Centro Socio-Sanitario asistido
10	Éxitus
11	Fuga
12	In extremis
13	Alta disciplinaria
14	Unidad de Salud Mental
15	Hospitalización
16	Desconocido
99	Otros

4 CDM

The VID Data can be harmonized to different CDM.

4.1 ConcePTION

The FISABIO-HSRP has transformed their data to the ConcePTION CDM in the **RETINOIDS (LOT 4)** and **CONSIGN** EMA-funded projects. Following is show a brief description of the Target Tables obtained of the CDM.

4.1.1 Target Tables

4.1.1.1 Routine Healthcare Data

4.1.1.1.1 VISIT_OCCURRENCE

This table contains a summary description of the visits during which records of EVENTS, PROCEDURES, but possibly also MEDICAL_OBSERVATIONS or MEDICINES were recorded. This serves both to collect visit-level information, and to enable grouping sets of records that were recorded concurrently. This may be useful for data sources that are structured in a way that links events/observations/procedures/medications within a single healthcare visit.

4.1.1.1.2 EVENTS

This table collects diagnoses, symptoms and signs ('events') observed during routine healthcare, such as a hospital admission, a primary care or specialist visit, or other.

4.1.1.1.3 MEDICINES

This table collects data on drug prescriptions, dispensings or administrations occurred during routine healthcare.

4.1.1.1.4 PROCEDURES

This table collects procedures administered during routine healthcare. Can be a surgery, or a diagnostic procedure, a rehabilitation procedure, a therapeutical procedure.

4.1.1.1.5 MEDICAL_OBSERVATIONS

This table collects observations recorded during routine healthcare. Can be a result from a laboratory test, or a physical measurement, but also level of education, or sex, or a pathology report.

4.1.1.2 Surveillance

4.1.1.2.1 SURVEY_ID

This table contains a summary description of the survey during which records of SURVEY_OBSERVATIONS were recorded. This serves both to collect survey-level information, and to enable grouping sets of records that were recorded concurrently.

4.1.1.2.2 SURVEY_OBSERVATIONS

List of observations in a survey (such as a medical birth register).

4.1.1.3 Curated Tables

4.1.1.3.1 PERSONS

This table records persons that are to enter analysis of this instance of the CDM.

4.1.1.3.2 OBSERVATION_PERIODS

Periods during which data is collected in the datasource for this person. This table contributes to defining the datasource population.

4.1.1.3.3 PERSON_RELATIONSHIPS

For any person, this table collects the pairing with the identifier of mother or of other relationships that may be available.

4.1.1.4 Metadata

4.1.1.4.1 PRODUCTS

This table collects the information associated to each marketed product that may have been prescribed, dispensed or administered to a patient. It contains one row per product.

4.1.1.4.2 CDM_SOURCE

In this table, a high-level, machine-readable description of the instance of the CDM is contained. The scripts of the studies that are deemed to run on this instance will use this information to tailor some choices to the specific DAP and datasource.

4.1.1.4.3 METADATA

This table contains some general information about how the local data fit the CDM: for instance, they are used to describe which tables of the standard CDM are populated in this instance; and what coding systems are used for the various data domains. This information is used by the scripts for quality checks (e.g. the coding systems that are observed in the data are indeed those listed here).

4.1.1.4.4 INSTANCE

This table displays the list of the tables and columns of the local data dictionary that are mapped to the instance of the CDM, together with date of last update (both in terms of when the data was accessed by

the DAPs, and when the data was actually recorded and can be considered complete). This is to be used, together with a machine-readable version of the ETL, to match the inclusion of the study population and the creation of the study variables to the actual data loaded in the CDM instance. The list is restricted to tables and columns of the local data dictionary that are included in the current ETL document.

4.2 OMOP

Currently, the FISABIO-HSRP group has applied to the 6th Open for Data Partner call. The ETL design specification for converting VID origin data sources into OMOP CDM v.5.4. are contained in the file *1_1_FISABIO_HSRP_ETL_Design.qmd*.