Syndromic Surveillance Data Fact Sheet for Stage 2 of Meaningful Use

Emergency Department Data Elements reflect meaningful use requirements for syndromic surveillance.

Data Element Name	Description of Field	Usage[1,2]	HL7 Location[2]
Facility Identifier (Treating)	Unique facility identifier of facility where the patient originally presented (original provider of the data) **Use OID from www.HL7.org or NPI (National Provider Identifier)**	R	MSH-4.2
Facility Name (Treating)	Name of the treating facility where the patient originally presented	O	EVN-7.1 (2.5.1) OBX-5 (HD) (2.3.1)
Facility/Visit Type	Type of facility or the visit where the patient presented for treatment	R	OBX
Report Date/Time	Date and time of report transmission from original source (from treating facility)	R	EVN-2
Unique Patient Identifier	Unique identifier for the patient	R	PID-3
Medical Record #	Patient medical record number	O	PID-3
Insurance Coverage	High level description of insurance, such as Medicare, Medicaid, Private Insurance and Self-pay	O	INI-15
Age	Numeric value of patient age at time of visit	R	OBX-5 Alt: DoB PID-7
Age Units	Unit corresponding to numeric value of patient age (e.g., Days, Month or Years)	R	OBX-6
Gender	Gender of patient	RE*	PID-8
City/Town	City/Town of patient residence	O	PID-11.3
Zip Code	Zip Code of patient home address	RE*	PID-11.5
State	State of patient home address	O	PID-11.4
Country	Country of patient home address	O	PID-11.6
County	County of residence for patient	RE	PID-11.9
Race	Race of patient	RE*	PID-10
Ethnicity	Ethnicity of patient	RE*	PID-22
Unique Visiting ID	Unique identifier for a patient visit	R	PV1-19
Visit Date/Time	Date/Time of patient presentation	R	PV1-44
Date of onset	Date that patient began having symptoms of condition being reported	O	OBX-5.1
Patient Class	Patient classification within facility	RE	PV1-2 Limit to E=Emergency
Chief Complaint/Reason for visit[3]	Short description of the chief complaint or reason of patient's visit, recorded when seeking care	RE*	OBX-5
Triage Notes	Triage notes for the patient visit	O	OBX-5
Diagnosis/External Cause of Injury Code[4]	Diagnosis code or external cause of injury code (for injury-related-visits) of patient condition	RE*	DG1-3
Clinical Impression	Clinical impression (free text) of the diagnosis	O	OBX-5
Diagnosis Type	Qualifier for Diagnosis/Injury Code specifying type of diagnosis	RE	DG1-6
Discharge Disposition	Patient's anticipated location or status following ED visit	RE	PV1-36
Disposition Date/Time	Date and time of disposition	RE	PV1-45
Initial Temperature	1st recorded temperature, including units	O	OBX-5

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Data Element Name	Description of Field	Usage[1,2]	HL7 Location[2]
			OBX-6 (units)
Initial Pulse Oximetry	1st recorded pulse oximetry value	O	OBX-5 OBX-6 (units)
Initial Blood Pressure	1st recorded blood pressure (SBP/DPB)	O	OBX

[1]**Usage defined**
R = required & field must contain a value; A value must be present in order for the message to be accepted
RE = required but field can be empty. <u>If the Sender has data, the data must be sent.</u> However, if there is no data captured in the field due to the setting (e.g. no chief compliant data for a trauma patient) and the field is blank, the message may be sent with the field containing no data.
RE* This value is critical for Public Health Syndromic Surveillance and is considered REQUIRED.
O = optional

[2]PHIN Messaging Guide for syndromic Surveillance: Emergency Department and Urgent Care Data. ADT messages A01, A03, A04 and A08 HL7 Version 2.5.1 (version 2.3.1 Compatible). Centers for Disease Control and Prevention. Release 1.1. August 2012.

[3] **Chief Complaint/Reason for Visit**: This field is the patient's **self-reported** chief complaint or reason for visit. It should be distinct from the diagnosis code which based on provider's assessment for the visit. Free text is the preferred value set. If the chief complaint is only available from drop down list fields, then concatenate all drop-down list chief complaints. The chief complaint text should NOT be replaced either manually or by the system. Keep the chief complaint the same as how it was captured at admission.

[4] **Diagnosis / External source of injury code**: ICD-9 code (preferred). This field is the **provider's assessment** of why the patient visit occurred. It can be associated with the admitting, working or final diagnosis type. This should be distinct from the self-reported chief complaint/reason for visit from the patient.

Record Format:
Flat file extract delimited as ASCII text file format[5], HL7 2.3.1 or HL7 2.5.1. Only messages sent as HL7 2.3.1 or HL7 2.5.1 meet the syndromic surveillance meaningful use objective. If pre-approved, IDPH will accept flat files for transformation into an acceptable HL7 format, in order to meet Meaningful Use reporting requirements. Based on available resources, the TAT for IDPH to transform flat file data will vary. Updated information on the TAT will be posted on the OHIT website.

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[5] Flat file data fields should be delimited by an "I" (pipe) symbol, otherwise delimited by a comma with quotes around the data values. Other formats may be accommodated on a case-by-case basis.
Guidance was developed by the International Society for Disease Surveillance Meaningful Use Workgroup (www.syndromic.org).