

# *Kansas Department of Health and Environment Syndromic Surveillance Technical Specifications for Stage 2 / Stage 3 Meaningful Use*

Syndromic surveillance gives public health authorities (PHA, like the Kansas Department of Health and Environment) timely access to emergency department; this information is used to monitor trends in emergency departments for early event detection and enhanced awareness of patterns that can be used to improve community health. Kansas is utilizing the National Syndromic Surveillance Program (NSSP) to conduct syndromic surveillance. For more details on [Syndromic Surveillance \(SyS\) at the Kansas Department of Health & Environment](#) (KDHE), click here: [KDHE Syndromic Surveillance Overview](#)

## Certification Standard

KDHE is requiring that hospitals use the [PHIN Messaging Guide for Syndromic Surveillance - Emergency Department, Urgent Care, Inpatient and Ambulatory Care Settings \(v.2.0\)](#)<sup>1</sup> (henceforth referred to as “PHIN Messaging Guide”) as their guide for implementation of their syndromic surveillance system.

**MU Stage 2:** 2014 Certified EHR Technology is required.

**MU Stage 3:** 2015 Certified EHR Technology is required.

Check the [Certified Health IT Product List](#) to determine if your EHR product is 2014 CEHRT or 2015 CEHRT.

## Which ED Messages to Send

- **ADT message types A01, A04, A03, and A08** (corresponding to patient admission, registration, discharge, and updates) are used in the reporting of syndromic surveillance data.
- Only messages related to **CURRENT** visits should be sent.
- It is required that all initial patient information, including chief complaint, be submitted **within 24 hours** and preferred that all information regarding a patient encounter be submitted **within 14 days** of the visit date.
- **All relevant data fields related to a patient visit should be sent in each message (NOT just the updated fields).** For example, if the chief complaint field is reported during the visit, but diagnosis codes are not reported until the next day, the chief complaint field should also be sent in the same message with the diagnosis codes.

## Accepted Message Types

If reporting directly to BioSense: HL7 (preferred message type), CSV, flat file  
If reporting to BioSense through KHIN: HL7

## Accepted Transport Type

If reporting directly to BioSense: sFTP

- **SSH File Transfer Protocol:** SFTP is the protocol used to transfer files to the BioSense Platform servers. The following tools are suggested for use:
  - WinSCP – <http://winscp.net>
  - FileZilla – <https://filezilla-project.org/>

If reporting to BioSense through KHIN: VPN

## Batch or Continuous Transmission

**Facilities reporting directly to BioSense** must submit data in batches; a batch of records can be sent as often as once every hour. However, each batch must be accompanied by an MSH header.

- Filename Convention:
  - Files uploaded to the BioSense Platform cannot be processed unless the file format is valid:
  - {State}\_{Provider}\_{Date}\_{Hour}\_{FileNumber}.{Suffix}

Example: GA\_MetroClinic\_20160101\_15\_001.hl7

**Note:** No white-space characters are permitted in the filename.

**Messages must be transmitted at the time of patient encounter or within 24 hours.**

**Facilities reporting to BioSense via KHIN** can submit data continuously (real-time) or in batches. A batch header will be generated by KHIN for transmission to BioSense. **Messages must be transmitted at the time of patient encounter or within 24 hours.**

## Pre-testing – Validating HL7 Messages

Use the NIST file validation tool to validate your Syndromic Surveillance file format:

- NIST Validation Tool: <http://hl7v2-ss-testing.nist.gov/mu-syndromic/>
- Select “Context-free Validation”
- Select the correct profile from the attached HL7 message (A01, A03, A04 or A08)
- Select “Refresh” yields

Please be sure to validate your own messages before proceeding to the next onboarding stage.

Refer to the [PHIN Messaging Guide for Syndromic Surveillance](#) for details as to how HL7 messages should be formatted.

Download the NIST HL7 Validation Report and submit it to Sophia Crossen ([kdhe.syndromic@ks.gov](mailto:kdhe.syndromic@ks.gov)) to validate test messages with a KDHE representative. Successful results for two messages of each message type must be submitted to proceed.

## Identifiable Data

**IMPORTANT NOTE:** While the [PHIN Messaging Guide](#) stipulates some patient identifiable information as R (Required), RE (Required but may be left empty) or O (Optional), **patient identifiable data should NOT be submitted to BioSense.** This includes, but is not limited to: patient name, patient social security number, patient street address, next-of-kin information, and more.

The following HL-7 fields frequently contain identifiable data and should **NOT** be submitted to BioSense:

- PID.2.1
- PID.3.2-4
- PID.5.1-6
- PID.5.8-12
- PID.6
- PID.9
- PID.11.1-2
- PID.11.8
- PID.13-17
- PID.19-21
- PID.23-28
- PID.30.2
- NK Segments
- MRG.7
- IN1.16
- IN1.19
- GT1.3-6
- GT1.12
- GT1.19

While patient street address must be null, **patient state, zip code, county code and country code are required for submission.**

Minimum Fields Needed to create a record in BioSense		
MSH-4.2	Sending_Facility	Facility NPI number that has been registered with NSSP.
	Any change in this field without proper care will result in all sent messages being rejected.	
MSH-7	Message_Date_Time	Date and time that the message is sent, including time zone.
MSH-9.1	Message_Type	'ADT'
PID-3.1	Medical_Record_Number	Unique identifier for patient across all visits to facility.
PV1-44.1	Admit_Date_Time	Date and time of encounter for admission.
	All records with any date/time set more than 12 hours in the future will be rejected.	

**Note:** PID MUST BE IN THE SAME ORDER IN EVERY RECORD; BioSense will only utilize the first PID to tag the record

## ICD-9 or ICD-10?

ICD-10 is the preferred set of codes we should receive. SNOMED are acceptable in addition to ICD-10, not replacing it.

## Optional Data

KDHE will gladly accept any optional data a facility is willing to share.

Refer to the [PHIN Messaging Guide for Syndromic Surveillance](#) for details as to how these fields should be populated.

*(Continued on next page.)*

## Data Field Requirements by KDHE / NSSP – MMU2 / MU3

All fields listed as R or RE must be submitted to meet syndromic surveillance guidelines.

Data Element Name	Description of Field	Additional Implementation Notes/ Value Set	PHIN Usage	HL7 Location
Field Separator	Separator between the segment ID and the first real field, MSH-2-encoding characters.	Default value is  , (ASCII 124).	R	MSH-1.1
Encoding Characters	Four characters in the following order: the component separator, repetition separator, escape character, and subcomponent	Default values are ^~\& (ASCII 94, 126, 92, and 38, respectively).	R	MSH-2.1
Sending Application	Name of the EHR vendor and product used by the facility.		O	MSH-3.1
Sending Facility	Unique facility identifier of facility where the patient originally presented (original provider of data).  <b>Use NPI (National Provider Identifier) : ie, 1234567890</b>	This ID must be approved by and submitted to the BioSense technical team prior to submission of any test or production messages. ID must appear in the header of every message or batch.	R	MSH-4.2
Receiving Application	Identification of the receiving application.	This will be valued with either “KHIN” if sending to KHIN, or “SYS-P” otherwise.	O	MSH-5.1
Receiving Facility	Identification of the receiving application among multiple	This will be valued with “KDHE” for all Kansas facilities sending via KHIN or directly to BioSense.	O	MSH-6.1
Date/Time of Message	Date and time that the message is sent, including time zone.		R	MSH-7.1
Message Code		<a href="#">PHVS MessageType SyndromicSurveillance</a>	R	MSH-9.1
Trigger Event		<a href="#">PHVS EventType SyndromicSurveillance</a>	R	MSH-9.2
Message Structure		<a href="#">PHVS MessageStructure SyndromicSurveillance</a>	R	MSH-9.3
Message Control ID	Contains a number or other identifier that uniquely identifies the message.		R	MSH-10.1

Data Element Name	Description of Field	Additional Implementation Notes/ Value Set	PHIN Usage	HL7 Location
Processing ID	Used to decide whether to process the message as defined in HL7 Application (level 7) Processing rules. Note: Indicates how to process the message as defined in HL7 processing rules	Conformance Statement SS-015: MSH-11 (Processing ID) SHALL have a value in the set of literal values: "P" for Production, "D" for Debug or "T" for Training.	R	MSH-11.1
Version ID	HL7 version number used to interpret format and content of the message.	<b>Conformance Statement SS-016:</b> MSH-12 (Version ID) SHALL have a value '2.5.1'	R	MSH-12.1
Accept Acknowledgement Type	HL7 table 0155: HL7 defined: Accept/application acknowledgment conditions	Must be left empty for the Accept Acknowledgment.	CE	MSH-15.1
Application Acknowledgement Type	HL7 table 0155: HL7 defined: Accept/application acknowledgment conditions	Must be left empty for the Accept Acknowledgment.	CE	MSH-16.1
Message Profile Identifier	Assert adherence to, or reference, a message profile. Message profiles contain detailed explanations of grammar, syntax, and usage for a particular message or set of messages	<b>Conformance Statement SS-017:</b> **See p. 57 of the PHIN Guide for Syndromic Surveillance**	R	MSH-21
Report Date/Time	Date and time of report transmission from original source (from treating facility)		R	EVN-2.1
Event Facility	This field identifies the location where the patient was actually treated.	Use NPI followed by "E": le, 1234567890E	R	EVN-7.2
Unique Patient ID <sup>2</sup>	Unique identifier for the patient	Unique Patient Identifier should be used that will allow the matching and linking of a patient's records across multiple encounters. <sup>2</sup>	R	PID-3.1
Medical Record #	Patient medical record number	This is taken from the first non-null PID-3.1 value WHERE PID-3.5 = "MR". See below. <sup>3</sup>	R	PID-3.1
Date/Time of Birth	Date of birth for patient		R	PID-7

Data Element Name	Description of Field	Additional Implementation Notes/ Value Set	PHIN Usage	HL7 Location
Gender	Gender of patient	Use HL7 administrative sex codes as the following: <a href="#">2.16.840.1.114222.4.11.3403</a> <a href="#">PHVS Gender SyndromicSurveillance</a>	RE*	PID-8
Race	Race of patient	Use CDC Race & Ethnicity codes as the following: <a href="#">2.16.840.1.114222.4.11.836/PHVS RaceCategory CDC</a>	RE*	PID-10
City/Town	City/Town of patient residence		RE*	PID-11.3
Zip Code <sup>4</sup>	Zip Code of patient home address	See below <sup>4</sup>	RE*	PID-11.5
State	State of patient home address	Field must be formatted as a 2-digit FIPS code and valid state codes for ALL state in the US must be included.  Use the following code value set for state FIPS codes: <a href="#">2.16.840.1.114222.4.11.830 PHVS State FIPS 5-2</a>	RE*	PID-11.4
County <sup>6</sup>	County of residence for patient	Field must be formatted as a 5-digit FIPS code and valid county codes for ALL counties in the US must be included.  Use the following county FIPS code value set: <a href="#">2.16.840.1.114222.4.11.829 PHVS County FIPS 6-4</a>	RE*	PID-11.9
Country	Country of patient home address	Valid codes for ALL countries must be included.  Use the following code value set: <a href="#">2.16.840.1.114222.4.11.828</a> <a href="#">PHVS Country ISO 3166-1</a>	RE*	PID-11.6
Ethnicity	Ethnicity of patient	Use CDC Race & Ethnicity codes as the following: <a href="#">2.16.840.1.114222.4.11.837 PHVS EthnicityGroup CDC</a>	RE*	PID-22

Data Element Name	Description of Field	Additional Implementation Notes/ Value Set	PHIN Usage	HL7 Location
Patient Death Date/Time	The date and time at which the patient death occurred. This field shall not be populated on an admission message	<p><b>Conformance Statement SS-036:</b> If valued, PID-29 (Patient Death and Time), SHALL be expressed with a minimum precision of the nearest minute and be represented in the following format: 'YYYYMMDDHHMM[SS[.S[S[S[S]]]]] [+/-ZZZZ]'</p> <p><b>Condition Predicate:</b> If valued, PID-30 (Patient Death Indicator) SHALL be valued to the Literal Value 'Y'. Condition Predicate: If PV1-36 is valued with any of the following: '20', '40', '41', '42' then PID-29 (Patient Death and Time) SHALL be populated.</p>	CE	PID-29
Patient Death Indicator	This field indicates whether the patient is deceased.	<p>Conformance Statement SS-037: If valued, PID-30 (Patient Death Indicator) SHALL be valued to the Literal Value 'Y'.</p> <p><b>Condition Predicate:</b> If PV1-36 (Discharge Disposition) is valued with any of the following: '20', '40', '41', '42' and PID-29 (Patient Death and Time) SHALL be populated.</p>	C	PID-30
Patient class	Patient classification within facility	Data should be limited to emergency room/department patients only; limit to E=Emergency. Use HL7 Patients Class codes as the following: <a href="#">2.16.840.1.114222.4.11.3404</a> <a href="#">PHVS PatientClass_SyndromicSurveillance</a>	RE*	PV1-2.1
Admit Source	Indicates where the patient was admitted	This field is checked only for invalid entries	O	PV1-14.1
Unique Visiting ID	Unique identifier for a patient visit	A visit is defined as a discrete or unique clinical encounter within a service department or location. <b>Notes:</b> Every visit will generate a record.	R	PV1-19
Discharge Disposition	Patient's anticipated location or status following ED visit (i.e., discharged to home, inpatient, expired, etc.)	Uses National Uniform Billing Committee (NUBC) –Patient Status (UB04 -Field 17 Codes): <a href="#">2.16.840.1.114222.4.11.915</a> <a href="#">PHVS DischargeDisposition HL7 2x</a>  <b>Required on all A03 messages and any messages received thereafter.</b>	RE*	PV1-36.1

Data Element Name	Description of Field	Additional Implementation Notes/ Value Set	PHIN Usage	HL7 Location
Admit or Encounter Date/Time	Date and time of patient presentation	<b>Conformance Statement SS-010:</b> PV1-44 (Admit Date/Time) <b>SHALL</b> be expressed with a minimum precision of the nearest minute and be represented in the following format: 'YYYYMMDDHHMM[SS[.S[S[S[S]]]]] [+/- ZZZZ]'	R	PV1-44.1
Discharge Date/Time	This field contains the discharge date/time and shall be populated in a Discharge message	<b>Conformance Statement SS-045:</b> PV1-45 (Discharge Date/Time) <b>SHALL</b> be expressed with a minimum precision of the nearest minute and be represented in the following format: 'YYYYMMDDHHMM[SS[.S[S[S[S]]]]] [+/-ZZZZ]'  <b>Required on all A03 messages and any messages received thereafter.</b>	RE	PV1-45
Admit or Encounter Reason	Short description of the provider's reason for admitting the patient – Code and Description	This field is the provider's reason for admitting the patient. It is distinct from the Chief Complaint / Reason for Visit field which is the patient's selfreported chief complaint or reason for visit. Senders should send the richest and most complete description of the patient's reason for admission or encounter.	RE	PV2-3
Diagnosis/External Cause of Injury	Diagnosis code or external cause of injury code (for injury-related-visits) of patient condition  This field is a repeatable field; multiple codes may be sent. The first diagnosis code should be the primary diagnosis.	If the DG1 Segment is provided, DG1-3 (Diagnosis Code) is required to be valued. Diagnosis from the provider (EHR) is preferred over the diagnosis provided through billing. Include V-codes and E-codes. When the primary diagnosis code is an injury, also provide one or more supplemental external-cause-ofinjury codes or E-codes. Data should be sent on a regular schedule and should not be delayed for diagnosis or verification procedures. Regular updating of data should be used to correct any errors or send data available later.	RE*	DG1-3
Diagnosis Type	This field contains a code that identifies the type of diagnosis being sent .	If the DG1 Segment is provided, DG1-6 (Diagnosis Type) is required to be valued. Values are: A = Admitting, F = Final, W = Working  Use the following HL7 Diagnosis Type codes: <a href="#">2.16.840.1.114222.4.11.827 PHVS DiagnosisType HL7 2x</a>	RE*	DG1-6

Data Element Name	Description of Field	Additional Implementation Notes/ Value Set	PHIN Usage	HL7 Location
Procedure Code	Procedures administered to the patient.		O*	PR1-3
Procedure Date/Time	This field contains the date/time that the procedure was performed.		R	PR1-5.1
Facility Visit/Type	Type of facility or the visit where the patient presented for treatment.		R	OBX-2, OBX-3,
Age	Numeric value of patient age at time of visit	OBX-3 uses a LOINC observation identifier (specified in the value set: <a href="#">2.16.840.1.114222.4.11.3589</a> <a href="#">PHVS ObservationIdentifier SyndromicSurveillance</a> ) 21612-7 Age – Reported (LOINC)	R	OBX-2, OBX-3, OBX-5
Age Units	Unit corresponding to numeric value of patient age (e.g., Days, Month or Years)	OBX-6 Units uses UCUM or Null Flavor as the following: <a href="#">2.16.840.1.114222.4.11.3402</a> <a href="#">PHVS AgeUnit SyndromicSurveillance</a>	R	OBX-2, OBX-3, OBX-6
Chief Complaint/ Reason for visit <sup>5</sup>	Short description of the chief complaint or reason for patient's visit, recorded when seeking care	See additional notes below <sup>5</sup>	RE*	OBX-2, OBX-3, OBX-5
Facility/Visit Type	Type of facility that the patient visited for treatment	For OBX-3 Use the following the National Claim Committee , NUCC, codes 2.16.840.1.114222.4.11.35 89 <a href="#">PHVS ObservationIdentifier SyndromicSurveillance</a> SS003 Facility / Visit Type (PHIN Questions) For OBX-5 use: 2.16.840.1.114222.4.11.34 01 <a href="#">PHVS FacilityVisitType SyndromicSurveillance</a>	R	OBX-2, OBX-3, OBX-5

Data Element Name	Description of Field	Additional Implementation Notes/ Value Set	PHIN Usage	HL7 Location
Triage Notes	Triage notes for the patient visit	<p><b>Though this field is optional, it is highly recommended, as this field often contains more nuanced information regarding the patient's visit; travel history is often also included in this field).</b></p> <p>OBX-3 uses a LOINC observation identifier (specified in the value set: <a href="#">2.16.840.1.114222.4.11.3589</a> <a href="#">PHVS ObservationIdentifier SyndromicSurveillance</a>) 54094-8 Emergency department Triage note (LOINC)</p> <p>For OBX-5 use: Free text. For further guidance refer to column 'Recommended HL7 Location' in the <a href="#">PHIN Messaging Guide</a>.</p>	O*	OBX-2, OBX-3, OBX-5
Clinical Impression	Clinical Impression (free text) of diagnosis		O	OBX-5
Date of onset	Date that patient began having symptoms of condition being		O*	OBX-2, OBX-3,
Pregnancy Status	Whether the patient is pregnant during the encounter	OBX-3 uses a LOINC observation identifier 11449-6 Pregnancy Status (LOINC) OBX-5 is Yes, No or Unknown <a href="#">PHVS YesNoUnknown CDC</a>	O	OBX-2, OBX-3, OBX-5
Initial Temperature	1 <sup>st</sup> recorded temperature	OBX-3 uses a LOINC observation identifier (specified in the value set: <a href="#">2.16.840.1.113883.3.88.12.80.62</a> <a href="#">PHVS VitalSignResult HITSP</a> ) 11289-6 Body Temperature:Temp:Enctrfirst:Patient:Qn (LOINC)	O	OBX-5
Initial Temperature Units	Units corresponding to 1 <sup>st</sup> recorded temperature (e.g., Fahrenheit, Celsius)	OBX-6 uses the following UCUM - Unified Codes for Units of Measure: <a href="#">2.16.840.1.114222.4.11.920</a> <a href="#">PHVS BloodPressureUnit UCUM</a>	CE	OBX-6
Initial Pulse Oximetry	1 <sup>st</sup> recorded pulse oximetry value	OBX-3 uses a LOINC observation identifier (specified in the value set: <a href="#">2.16.840.1.114222.4.11.3589</a> <a href="#">PHVS ObservationIdentifier SyndromicSurveillance</a> ) 59408-5 Oxygen saturation in Arterial blood by Pulse Oximetry (LOINC)	O	OBX-5

Data Element Name	Description of Field	Additional Implementation Notes/ Value Set	PHIN Usage	HL7 Location
Initial Pulse Oximetry Units	Units for 1 <sup>st</sup> recorded pulse oximetry value	OBX-6 uses a single Unit of Measure value from UCUM: <a href="#">2.16.840.1.114222.4.11.3590</a> <a href="#">PHVS_PulseOximetryUnit_UCUM</a>	CE	OBX-6
Initial Blood Pressure	1 <sup>st</sup> recorded blood pressure (SBP/DPB)	OBX-3 uses a LOINC observation identifier (specified in the value set: <a href="#">2.16.840.1.113883.3.88.12.80.62</a> <a href="#">PHVS_VitalSignResult_HITSP</a> ) 8480-6 Systolic blood pressure (LOINC) and 8462-4 Diastolic blood pressure (LOINC)	O	OBX-6
Initial Blood Pressure Units	Units for 1 <sup>st</sup> recorded blood pressure	OBX-6 uses the following UCUM - Unified Codes for Units of Measure: <a href="#">2.16.840.1.114222.4.11.920</a> <a href="#">PHVS_BloodPressureUnit_UCUM</a>	CE	OBX-6
Insurance Plan ID	Insurance plan associated with the patient		R	IN1-2.1
Insurance Company ID	Insurance Company ID		R	IN1-3.1
Insurance Coverage	High-level description of insurance, such as Medicare, Medicaid, Private Insurance and Self-pay	For IN1-15 Insurance Plan ID, use Source of Payment Typology (PHDSC) <a href="#">2.16.840.1.114222.4.11.3591</a>	O	INI-15

## Additional Data Required by KDHE / NSSP – MU3

All fields listed as R or RE must be submitted to meet syndromic surveillance guidelines.

Data Element Name	Description of Field	Additional Implementation Notes/ Value Set	PHIN Usage	HL7 Location
Height	Height of the patient  <b>NOTE:</b> Units of measure must be included defining the numeric value.	OBX-3 uses a LOINC observation identifier specified in the value set: 2.16.840.1.113883.3.88.12.80 .62 <a href="#">PHVS VitalSignResult_HITS</a> P 8302-2 Body height (LOINC)  For OBX-6 use the following UCUM - Unified Codes for Units of Measure: 2.16.840.1.114222.4.11.891 <a href="#">PHVS HeightUnit_UCUM</a>	RE*	OBX-3 OBX-2 OBX-6
Weight	Weight of the patient  <b>NOTE:</b> Units of measure (OBX-6, (CE Data Type) must be included defining the numeric value.	OBX-3 uses a LOINC observation identifier specified in the value set: 2.16.840.1.113883.3.88.12.80 .62 <a href="#">PHVS VitalSignResult_HITS</a> P 3141-9 Body weight Measured (LOINC)  For OBX-6 use the following UCUM - Unified Codes for Units of Measure: 2.16.840.1.114222.4.11.879 <a href="#">PHVS WeightUnit_UCUM</a>	RE*	OBX-3 OBX-2 OBX-6
Smoking Status	Smoking Status of Patient  This data element is a Meaningful Use requirement. Allows monitoring of chronic conditions.	OBX-3 uses a LOINC observation identifier specified in the value set: 2.16.840.1.114222.4.11.3589 <a href="#">PHVS ObservationIdentifier_SyndromicSurveillance</a> 72166-2 Tobacco smoking status (LOINC)	RE	OBX-3 OBX-2 OBX-5
Problem List	Problem list of the patient conditions	OBX-3 uses a LOINC observation identifier specified in the value set: 2.16.840.1.114222.4.11.3589 <a href="#">PHVS ObservationIdentifier_SyndromicSurveillance</a> 11450-4 Problem List - Reported (LOINC)	O*	OBX-3 OBX-2 OBX-5
Medication List	Current medications entered as narrative.	OBX-3 uses a LOINC observation identifier specified in the value set: 2.16.840.1.114222.4.11.3589 <a href="#">PHVS ObservationIdentifier_SyndromicSurveillance</a> 10160-0 Medication Use Reported (LOINC) OBX-5 allows formatted text/narrative only	O*	OBX-3 OBX-2 OBX-5

Data Element Name	Description of Field	Additional Implementation Notes/ Value Set	PHIN Usage	HL7 Location
Medications Prescribed or Dispensed	Current medications  Collection of this data may be relevant to more in-depth analyses, individual patient follow-up or other surveillance process.	OBX-3 uses a LOINC observation identifier specified in the value set: 2.16.840.1.114222.4.11.3589 <a href="#">PHVS ObservationIdentifier SyndromicSurveillance</a> 8677-7 History of Medication Use - Reported (LOINC) OBX-5 (1) Standard and OBX-2 Value Type of CWE.	O*	OBX-3 OBX-2 OBX-5
Travel History	Travel History as Narrative	OBX-3 uses a LOINC observation identifier specified in the value set: 2.16.840.1.114222.4.11.3589 <a href="#">PHVS ObservationIdentifier SyndromicSurveillance</a> 10182-4 History of Travel Narrative (LOINC) Oximetry (LOINC) and OBX-2 Value Type of TX.	O*	OBX-3 OBX-2

#### 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. **Once the Sender has data, the data must be sent.** However, if there is no data captured in the field due to the setting 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. As an implemented interface must follow known rules for populating segments, a specific interface for a particular Sender or Receiver must constrain this usage to either R, RE, C, CE, or X. This must be determined locally by each jurisdiction.

**O\*** = Though this field is optional, it is highly recommended, as this field often contains more nuanced information regarding the patient's visit; travel history is often also included in this field)

**C** = Conditional. If field evaluates to 'TRUE', then considered the same as 'R'; otherwise, Senders must not populate the field.

**CE** = Conditionality empty. If associated field is empty, Sender should not populate this field.

*(List continues on next page)*

<sup>1</sup>[PHIN Messaging Guide for syndromic Surveillance: Emergency Department, Urgent Care, Inpatient and Ambulatory Care Settings](#). ADT messages A01, A03, A04 and A08 HL7 Version 2.5.1 (version 2.3.1 Compatible). Centers for Disease Control and Prevention. Release 2.0. September, 2014.

<sup>2</sup>**Unique Patient ID:** It is recommended that data providers submit the patient medical record number to facilitate identification of the patient, in the event of a required follow-up investigation. Unique Patient Identifier should be used that will allow the matching and linking of a patient's records across multiple encounters; it **must NOT be a patient's social security number**, but may be the same as the Medical Record Number. Patient ID is generated from the first non-null PID-3 segment, regardless of the Type (PID-3.5). PATIENT ID MUST BE IN THE SAME ORDER IN EVERY RECORD; BioSense will only utilize the first PID to tag the record.

<sup>3</sup>**Medical Record Number:** This field this must NOT be a patient's social security number and may be the same as the Unique Patient ID. This is taken from the first non-null PID-3.1 value WHERE PID-3.5 = "MR".

<sup>4</sup>**Zip Code:** Valid zip codes for ALL zip codes in the US must be included. Provide a minimum of 5 digits for domestic ZIP codes. Foreign postal codes should be supported.

<sup>5</sup>**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. **Chief complaint fields are text only and should not contain ICD-9 or ICD-10 codes.**

For Chief Complaint OBX-3 Use: 8661-1 Chief complaint – Reported (LOINC)

For Chief Complaint OBX-5 Use: Free text

<sup>6</sup>**County:** Valid county codes for ALL counties/parishes in the US must be included. The 5-digit FIPS county code is required.

Refer to the [PHIN Messaging Guide for Syndromic Surveillance](#) for additional details as to how all fields should be populated.