PHIN MESSAGING GUIDE FOR SYNDROMIC SURVEILLANCE: EMERGENCY DEPARTMENT AND URGENT CARE DATA RELEASE 1.0 QUESTIONS & ANSWERS

Question # 1:

What I s the relationship between the "*Final Recommendation: The Core Processes & EHR Requirements of Public Health Syndromic Surveillance*" (PHSS)[1] document released by the International Society for Disease Surveillance (ISDS) and the PHIN Messaging Guide for Syndromic Surveillance: Emergency Department and Urgent Care Data?

Answer:

The ISDS document[1], in Section 1.1, states that its purpose is "…to define the core of PHSS practice and the EHR data requirements widely needed to support the core." CDC's PHIN Messaging Guide for Syndromic Surveillance: Emergency Department and Urgent Care Data provides technical specifications and implementation guidance to support the exchange of the core syndromic surveillance data from healthcare to public health in accordance with the ISDS document.

Question # 2:

How will the PHIN Messaging Guide for Syndromic Surveillance: Emergency Department and Urgent Care Data be maintained and updated in the future?

Answer:

The CDC will issue new versions of this guide as necessary to incorporate additions and modifications to the syndromic surveillance business standards and data requirements. The CDC will collaborate with ISDS to address and incorporate modifications based on but not limited to ISDS input; public comments; feedback from CDC, state and local public health agencies and vendors; and input from public health partner organizations in the development of future versions of this guide.

Note: *Refer to Section 2.5 of the PHIN Messaging Guide for Syndromic Surveillance: Emergency Department and Urgent Care Data for a more details.*

Question # 3:

What data sources do the PHIN Messaging Guide for Syndromic Surveillance: Emergency Department and Urgent Care Data support?

Answer:

The ISDS document[1]; Section 1.2.1 defines the following most important data sources for syndromic surveillance: Emergency Department (ED) and Urgent Care (UC) patient visits captured by health information system and sent to a public health authority. These data sources are in scope of the ISDS Recommendations[1] and provide the foundation for the PHIN Messaging Guide for Syndromic Surveillance: Emergency Department and Urgent Care Data. In the future, ISDS will extend the scope of data sources including ambulatory providers for syndromic surveillance and a subsequent PHIN Messaging Guide for Syndromic Surveillance: Ambulatory Data will be published.

Question # 4:

The PHIN Messaging Guide for Syndromic Surveillance: Emergency Department and Urgent Care Data, Section 6, indicates the PHIN Message Quality Framework (MQF) will support real time validation of syndromic surveillance messages. How will MQF support the validation of these messages?

Answer:

Implementers will be able to use MQF to validate messages they create during their development and testing phases. The MQF tool will perform several validations on syndromic surveillance messages based on the technical specification contained in the PHIN Messaging Guide for Syndromic Surveillance: Emergency Department and Urgent Care Data.

[1] International Society for Disease Surveillance, *Final Recommendation: The Core Processes and EHR Requirements of Public Health Syndromic Surveillance.* International Society for Disease Surveillance, Brighton, MA (January 2011); http://www.syndromic.org/projects/meaningful-use

Question # 5:

If a sender does not have a value for a data element with a usage type of "RE" and the data element is sent in an OBX segment, is it necessary to include an OBX segment for that data element with an empty OBX-5 field?

Answer:

No, since the usage is "RE" and the sender does not have a value for the data element it is not necessary to include an OBX segment for that data element.

Question # 6:

Can a single batch contain different types of syndromic surveillance messages?

Answer:

Yes, for example, a batch may contain Admin/Visit Notifications (ADT^A01) and Discharge/End Visit (ADT^A03) messages.

Question # 7:

Are receivers required to acknowledge all syndromic surveillance messages?

Answer:

The guide includes the specifications for the acknowledgement messages, but the sender and receiver will decide whether to use acknowledgement in their specific, data exchange implementation.

Question # 8:

Why did the CDC not publish separate PHIN Messaging Guides for Syndromic Surveillance: Emergency Department and Urgent Care Data for each of the supported HL7 Versions (2.3.1 and 2.5.1)?

Answer:

Based on the current ISDS data element recommendations, there are two basic differences between the syndromic surveillance message for HL7 version 2.3.1 and 2.5.1. HL7 2.3.1 does not have the MSH-21 (Message Profile Identifier) and the ENV-7 (Event Facility) fields. For this reason, the guide identifies how to construct both HL7 2.3.1 and HL7 2.5.1 messages to accommodate these differences.

Note: Refer to the PHIN Messaging Guide for Syndromic Surveillance: Emergency Department and Urgent Care Data, Section 2.4, for additional details.

Question # 9:

Our state requires triage notes for a patient visit and the clinical impression of the diagnosis for syndromic surveillance. However, the PHIN Messaging Guides for Syndromic Surveillance specifies the usage of the triage notes and clinical Impression data elements is optional. Can we make these data elements required for our jurisdiction?

Answer:

Yes. As necessary, states may add data elements, modify the data element usage, and/or constrain message elements to support their specific requirements, laws, and regulations.

Question # 10:

Why are three, syndromic surveillance data element tables provided in Section 4?

Answer:

The table in Section 4.2.1 contains the syndromic surveillance, core data elements that ISDS identified as the minimum set commonly used by public health for syndromic surveillance. The other two tables, in Sections 4.2.2 and 4.2.3, are provided to inform implementers of the other data elements identified by ISDS that may be used by jurisdictions to extend the core data set or that will be considered for inclusion into the core minimum data set in the future.

Question # 11:

What is the preferred method of sending a Chief Complaint?

Answer:

The desired method of sending a Chief Complaint in an OBX segment is to populate the Observation Value as free text, expressed in a patient's own words; although, coded values are secondary and are only sought in addition to free text or in those instances where free text is not available. Using the "CWE" allows for the possibility of coding systems and free text. If data flows through an intermediary or third party, the intermediary or third party must keep the original text (CWE-9) of the transmission. Implementers should check with their local jurisdiction for their version of an adopted coding system.

Question #12:

Should the implementation guide be amended to contain a reference regarding the frequency for sending syndromic surveillance messages?

Answer:

Yes, a business rule has been added to the guide that states data must be timely for syndromic surveillance; therefore, data transmission frequency should be at least once every 24 hours. Optionally, batch processing may be used as described in section 3.8 of the PHIN Messaging Guide for Syndromic Surveillance: Emergency Department and Urgent Care Data.

Question #13:

The guide specifically addresses the requirements for messaging from hospitals and urgent care facilities, but not the message from eligible professionals, there remains a gap between the message guidance available and the requirements of the rule. Will a comparable guide be developed to bridge the gap for the eligible professionals?

Answer:

The CDC and the syndromic surveillance community will collaboratively define the requirements and make recommendations for syndromic surveillance reporting from ambulatory care providers. Following those recommendations, the CDC will develop a draft ambulatory provider implementation guide for public comment.

Question # 14:

PID-11, Patient Address, shows only one repeat which ISDS considers to be the "Current" address. Can multiple addresses be sent in a single message?

Answer:

PID-11, Patient Address, expects to receive only the patient primary (current) address information in the supported components.

Question # 15:

The time stamp fields for PID-29, Patient Death Date and Time, and PV1-45, Discharge Date/Time, show the minimum, acceptable precision should be to the nearest minute. Is it acceptable to send the date only?

Answer:

PID-29, Patient Death Date and Time, and PV1-45, Discharge Date/Time, are not required fields, but it is desirable to send the maximum precision available; however, sending only the date is allowed.

Question # 16:

Can "patient age" be sent in years or does it need to be a separate OBX for years and months, or possibly days?

Answer:

Common practice is to send the patient's age in years without decimals. Any patient under one (1) year is sent as Age=0, Age Units=Years, and a patient age of two (2) years and six (6) months is sent as Age=2, Age Units=Years

Question # 17:

Patient Information – what type of de-identification needs to be done for PID-5, Patient Name?

Answer:

In order to send de-indentified data, send "~^^^^^^S" in PID-5, illustrating that the information is removed. However, the patient ID and other low-level information that could not identify the patient by looking at the message should be sent.

Question # 18:

For MSH-4, Sending Facility, and EVN-7, Event Facility, what values are expected?

Answer:

MSH-4, Sending Facility, uniquely identifies the facility associated with the facility that sends the message.
EVN-7, Event Facility, identifies the actual facility where the event occurred. The message should contain theEVN-7, Event Facility, where the patient was actually treated.

Question # 19:

Under the CWE data type in the PHIN Messaging Guide for Syndromic Surveillance: Emergency Department and Urgent Care Data, the Value/Value Set information for OBX 5.1 indicates that "Implementers should check with their local jurisdiction for version of adopted coding system." What coding systems and what versions should we be considering?

Answer:

If you are focusing on the bare minimum of reporting, in table 4-2-1, there are two, CWE OBX segments defined in this guide, which have defined value sets and links to these value sets. These segments are Facility/Visit Type and Chief Complaint / Reason for visit. You will need to decide with your sender which value sets should be used. If you look beyond that to extended or future data elements, you may find other data elements of interest that require the use of coded elements. These data elements are not specified in this guide, but if you would like to receive that data, you may need to define the use of coding systems for those items as well.

Question # 20:

What kinds of IDs should public health be expecting or requesting for MSH-4, Sending Facility? Do facilities have NPIs or only individual physicians?

Answer:

ISDS recommends the use of National Provider Identifier (NPI). The use of 'NPI' should be discussed during the implementation process as local jurisdictions may differ on their use of identifiers for this field.
Please refer to item #1 in Minimum Data Elements table 4.2.1 for further information or the NPI website at http://www.cms.gov/NationalProvIdentStand/.

Question # 21:

The naming conventions are not consistent between the PHIN Messaging Guide for Syndromic Surveillance: Emergency Department and Urgent Care Data and the ISDS recommended data elements of interest for syndromic surveillance. Will this be changed? For example, "event facility" versus "treating facility"; recorded date/time" versus "report date/time."

Answer:

HL7 data element names cannot be changed and the ISDS recommended data elements have been approved; therefore, at this time the following translation table has been provided.

PHIN Messaging Guide	ISDS Recommended Data Elements
EVN-7 Event Facility	Treating Facility
EVN-2 Recorded Date / Time	Report Date/Time
PID-3 Patient Identifier List	Unique Patient Identifier/ Medical Record #
PID-8 Administrative Sex	Gender
PID-11.3 City	City/Town
PID-11.4 State or Province	State
PID-11.5 ZIP or Postal Code	ZIP Code
PV1-19 Visit Number	Unique Visiting ID
PV1-44 Admit Date/Time	Visit Date / Time
DG1-3 Diagnosis Code	Diagnosis / Injury Code

Question # 22:

Is PID-7, Date of Birth, month and year required? Furthermore, how should it be handled if the patient age or age unit cannot be obtained for the OBX segment since they are both required?

Answer:

PID- 7, Date of Birth, is an optional field in HL7 and the PHIN Messaging Guide for Syndromic Surveillance: Emergency Department and Urgent Care Data with a data type of TS (YYYYMMDD) that allows for a minimum population of just the year (YYYY). Jurisdictions may further require a level of specificity beyond just the population of the year. On the other hand, Age and Age Units are both required (Usage = R) and sent in the OBX segment. The value of "Unknown" has been added to the value set to allow for instances where the patient age unit may not be obtained. The Age field sent in (OBX-5) can contain zero (0) while the Age Unit field (OBX-6) can be populated with the value of "Unknown."

Question # 23:

Should race and race category be defined according to the HL7 specifications similar issue to how gender was handled?

Answer:

ISDS recommended consistency across meaningful use public health reporting by using the CDC value set, Race Category (CDC). This value set is the same value set used in the Immunization and Electronic Laboratory Reporting Implementation Guides.

Question # 24:

Admit reason may be applied to patients who are admitted to the hospital in the ED setting. Is this different from chief complaint?

Answer:

Admit Reason and Chief Compliant are not always defined as the same concept. Chief Complaint is expected to provide a level of granularity beyond that of Admit Reason. Admit Reason uses ICD-9 codes or SNOMED codes; whereas, Chief Complaint, located in an OBX, is free text or local codes. For this reason, capturing both concepts is preferred, if possible.

Question # 25:

If the public health jurisdiction is authorized to collect the medical record number, should it be a required field?

Answer:

PID-3, Patient Identifier List, which populates medical record number, is required in the PHIN Messaging Guide for Syndromic Surveillance: Emergency Department and Urgent Care Data. Implementers should check with their local jurisdiction in order to determine if receiving the medical record number in this field is necessary.

Question # 26:

Should important, optional measures such as laboratory orders and results be added to the syndromic surveillance implementation guide?

Answer:

Laboratory orders and results are included in the guide within the Extended Data Elements section of the guide, Table 4.2.2 data element 37 Laboratory Results data set. This section requires further analysis but a timeline for this analysis has not been determined. For laboratory results, implementers can reference the HL7 Version 2.5.1 ELR Implementation Guide: Electronic Laboratory Reporting to Public Health, Release 1 (US Realm) which is available through the HL7 website. The guide can be found in the HL7 Standards Listed in HHS' Final Rule section of the HL7 website by accessing:
https://www.hl7.org/store/index.cfm.\

Question # 27:

Is ADT the correct message type for this guide or is ORU/REF being considered?

Answer:

The current state business processes defined by the ISDS workgroup are primarily based on point-to-point data exchange of Admit Discharge Transfer (ADT) messages between healthcare and public health; therefore, ADT is the correct message type based on the use case for addressing the core data elements. Applicability of candidate HL7 messages in other data exchange scenarios has yet to be determined and may vary by public health jurisdiction and data exchange partner.

The decision to use ADT message constructs instead of the ORU message construct was reviewed and approved by ISDS, Public Health Data Standards Consortium (PHDSC), and other CDC partners. Compared to ORU structure, the ADT structure provides more flexibility for message exchange that captures data from Emergency Department (ED) and Urgent Care (UC) patient visits, by health information systems, sending to a public health authority in the scope of the ISDS recommendation. Health Information Systems (HIS) transmit ADT messages as part of their normal operation and configuration; they generally lack any function enabling transmission of observation related data through ORU messages. Hospital Information Systems typically are recipients of such messages.

Question # 28:

Should a data type section be added to the PHIN Messaging Guide for Syndromic Surveillance: Emergency Department and Urgent Care Data?

Answer:

There is a data type section in this guide that shows the supported, data types. Some complex data types are expanded in various section of the PHIN Messaging Guide for Syndromic Surveillance: Emergency Department and Urgent Care Data. For further detailed information about these data types, please refer to the HL7 standards version 2.5.1. in chapter 2A.

Question # 29:

Why does the scope of the implementation guide not include transport mechanism guidance?

Answer:

The transportation mechanism is implementation-specific and should be discussed and agreed upon between the data sender and receiver.