**International Society for Disease Surveillance**

***PHIN Messaging Guide for Syndromic Surveillance: Emergency Department, Urgent Care And Inpatient Settings Release 1.9***

**Frequently Asked Questions**

This Frequently Asked Questions (FAQ) document addresses common or key questions raised by stakeholders during the revision and development process of the *PHIN Messaging Guide for Syndromic Surveillance: Emergency Department, Urgent Care And Inpatient Settings, Release 1.9 (Guide/Release 1.9)*.

If you have any additional questions, please submit them to: meaningfuluse@syndromic.org and a response will be posted. Thank you!

**General Questions**:

1. For the purposes of this Guide, what is the meaning of Syndromic Surveillance?
2. ADT A03 messages are not regularly used by hospitals. Why were they still included in Release 1.9?
3. It would be useful to see a mention of transport methods in this Guide. Why is that not included?
4. Can you provide a sample acknowledgment message?

**Data Elements of Interest**:

5. It is confusing to have a separate data elements of interest table in Chapter 2 (Table 2-5), as those elements are noted again throughout the ADT messages in Chapter 5.
6. It would be useful to identify which data elements related to Meaningful Use Stage 1 versus Meaningful Use Stage 2.
7. Why is Procedure Date/Time not required? It is needed if Procedure Codes are sent.
8. Why is the OBX segment preferred for carrying Chief Complaint information?
9. How does chief complaint differ from diagnosis code?
10. What does the presentation of Unique Patient Identifier and Unique Visit Identifier as a single data element mean for implementation?

**General Questions**

1. For the purposes of this *Guide*, what is the meaning of Syndromic Surveillance?

Syndromic Surveillance is defined in the beginning of Chapter 1 (Introduction) as follows: "Syndromic surveillance is a process that regularly and systematically uses health and health-related data in near 'real-time' to make information available on the health of a community. This information includes statistics on disease trends and community health seeking behaviors that support essential public health surveillance functions in governmental public health authorities (PHAs). Syndromic surveillance is particularly useful to local, state, and federal PHAs for supporting public health situational awareness, emergency response management, and outbreak recognition and characterization."

2. ADT A03 messages are not regularly used by hospitals. Why were they still included in *Release 1.9*?

This *Guide* is designed to be national in scope and serve as the baseline for guiding implementations; in other words, individual jurisdictions and data senders may always constrain this *Guide* further based on their local needs. While some hospitals do not use A03 messages within their administrative or clinical workflows, some settings do.

Additionally, syndromic surveillance message triggers do not necessarily need to be an ADT (e.g., registration, admit, discharge) event. The messages may, for example, be sent from the sending facility to the PHA every hour; in this case reaching the next hour would be the message trigger, as opposed to a particular event.

3. It would be useful to see a mention of transport methods in this *Guide*. Why is that not included?

In Chapter 1, the Scope of the *Guide* specifically notes that, "The Guide is *not* intended to specify other issues such as: a standard transport layer". This issue is one of many left up to local implementers who may further constrain the *Guide*. If you would like some specific information on transport mechanisms, please see *Architectures and Transport Mechanisms for Health Information Interchange of Clinical EHR Data for Syndromic Surveillance*, prepared for ISDS by HLN Consulting, LLC in November 2012.

4. Can you provide a sample acknowledgment message?

*Sample ACK Message:*
MSH|^~\&|State_SS|State_Public_Health||MIDLAND HLTH CTR^9876543210^NPI|201102091119||ACK^A04^ACK|ACK-201102091119-0001|P|2.5.1<cr>
MSA|AA|201102091114-0078<cr>

**Data Elements of Interest**

5. It is confusing to have a separate data elements of interest table in Chapter 2 (Table 2-5), as those elements are noted again throughout the ADT messages in Chapter 5.

This *Guide* is designed to suit the needs of a range of audiences, some of whom prefer a simple reference table in the beginning of the *Guide* that clearly and specifically notes the data elements of interest. Table 2-5 address the business purposes of all intended audiences, ranging from EHR vendors to local health departments, and this inclusion was one way of doing so.

6. It would be useful to identify which data elements related to Meaningful Use Stage 1 versus Meaningful Use Stage 2.

This *Guide* is meant to be Meaningful Use-Stage agnostic. In other words, this *Guide* should be useful to urgent care centers and hospitals in any stage of Meaningful Use. To maintain this aim, data elements are not identified in relation to the applicable stage of Meaningful Use.

7. Why is *Procedure Date/Time* not required? It is needed if *Procedure Codes* are sent.

Procedure Codes are Optional. However, if Procedure Codes are sent as part of a local implementation , then Procedure Date/Time must also be sent.

8. Why is the OBX segment preferred for carrying *Chief Complaint* information?

The OBX segment is used for *Chief Complaint* because it is best structured for this type of information which may be any or all of the following vocabularies: Unstructured, free-text (strongly preferred); ICD-9/ICD-10 diagnosis codes; or SNOMED codes. See Question 9 for an explanation of how this differs from information carried in the DG1 segment.

9. How does chief complaint differ from diagnosis code?

*Chief Complaint* identifies the patient's reason for visiting the hospital or urgent care center in his/her own words, ideally as an unstructured, free text note. In contrast, diagnosis codes are structured data assigned based on a clinician's assessment of the patient's reason for visit or admission.

10. What does the presentation of *Unique Patient Identifier* and *Unique Visit Identifier* as a single data element mean for implementation?

The notation in *Release 1.9* means that **either** *Unique Patient Identifier* **OR** *Unique Visit Identifier* is required. The *Guide* does not specify which one is required; if desired, both may be sent. Data receivers who wish to have the capability to link a patient's health history over time may prefer a *Unique Patient Identifier* that follows a single patient across multiple visits. Others may prefer to use a *Unique Visit Identifier* that only tracks each individual patient over the course of a single visit.