



Pat Quinn, Governor

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To: Hospital CEOs

From: Craig Conover, MD MPH, State Epidemiologist

Date: February 15, 2012

Re: Meaningful Use and Syndromic Surveillance Reporting

Please distribute this memo to relevant hospital staff (eg IT, EHR incentive program staff).

To stimulate investment and use of health information technology to improve health care, the federal government has encouraged the “meaningful use (MU)” of electronic health records. In order to meet meaningful use requirements, eligible hospitals must comply with a core set of requirements, as well as one of the public health reporting options—electronic transmission of immunization records, laboratory results, or syndromic surveillance data.

To date, IDPH has focused on reporting of immunization records and laboratory results to meet meaningful use requirements, based on published standards. On October 18, 2011, the “[PHIN Messaging Guide for Syndromic Surveillance: Emergency Department and Urgent Care Data Version 1.0](#)” was released. This is a milestone that will help realize the syndromic surveillance public health objective for hospitals under MU in Illinois.

In order to fulfill the MU syndromic surveillance objective, IDPH plans to begin accepting syndromic surveillance data from hospital EDs beginning in April 2012, using the Public Health Node (PHN).¹ IDPH will be using CDC’s [Biosense 2.0](#) System for reporting, analysis, and visualization of syndromic surveillance data, as described below.

Using the PHN, hospitals will have two options for fulfilling the syndromic surveillance MU requirement: 1) send data in HL7 version 2.3.1 or 2.5.1, using a certified system; or 2) send data in another format (e.g. flat file) that can be accepted and mapped by the PHN to an acceptable HL7 format. It is anticipated that the PHN will be certified to perform this latter function later this month.

Hospitals that wish to send data directly to Biosense (bypassing the PHN) to meet MU criteria can discuss this option with IDPH. At present, sending data to ESSENCE and other syndromic surveillance systems will not allow hospitals to meet MU criteria.

CDC’s Biosense system is available at no cost to IDPH and local health departments, and

¹ For more Information about the public health node, see:
[http://www2.illinois.gov/gov/HIE/Documents/Public%20Health%20Reporting%20through%20ILHIE%2010-7-11%20\(final\).pdf](http://www2.illinois.gov/gov/HIE/Documents/Public%20Health%20Reporting%20through%20ILHIE%2010-7-11%20(final).pdf)

allows for “cloud”-based analysis and visualization of syndromic surveillance data, thereby obviating the need for the state to purchase and maintain additional servers or other infrastructure in order to perform these functions. Local health departments can obtain access to Biosense data through IDPH. As desired, Local Health Departments using other systems (e.g. ESSENCE), can continue to receive syndromic surveillance data from hospitals based on pre-existing arrangements, or via the PHN, using locally supported hardware and software.

A fact sheet on data specifications for MU reporting under syndromic surveillance reporting is attached.

The on-boarding process for hospitals to submit syndromic surveillance data to fulfill MU requirements will begin on February 22, 2012, in order to begin receiving data on April 1st. The IDPH contact for the on-boarding process will be Mike Jadala (mike.jadala@illinois.gov). Please contact me with questions or comments about other issues, at craig.conover@illinois.gov, or at 312-814-4846.

c: Illinois Hospital Association
Laura Zaremba, OHIT

Illinois Department of Public Health Syndromic Surveillance Data Fact Sheet for Stage 1 of Meaningful Use

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

- Guidance was developed by the International Society for Disease Surveillance Meaningful Use Workgroup (www.syndromic.org).

Data Element Name	Description of Field	Usage (R + required & field must contain a value; RE = required but field can be empty O = optional)
Facility Identifier (Treating)	Unique facility identifier of facility where the patient originally presented (original provider of the data)	R
Facility Name (Treating)	Name of the treating facility where the patient originally presented	O
Facility/Visit Type	Type of facility or the visit where the patient presented for treatment	RE
Report Date/Time	Date and time of report transmission from original source (from treating facility)	R
Unique Patient Identifier	Unique identifier for the patient	R
Medical Record #	Patient medical record number	O
Insurance Coverage	High level description of insurance, such as Medicare, Medicaid, Private Insurance and Self-pay	RE
Age	Numeric value of patient age at time of visit	R
Age Units	Unit corresponding to numeric value of patient age (e.g., Days, Month or Years)	R
Gender	Gender of patient	RE
City/Town	City/Town of patient residence	O
Zip Code	Zip Code of patient home address	RE
State	State of patient home address	RE
Country	Country of patient home address	RE
Race	Race of patient	RE
Ethnicity	Ethnicity of patient	RE
Unique Visiting ID	Unique identifier for a patient visit	R
Visit Date/Time	Date/Time of patient presentation	R
Date of onset	Date that patient began having symptoms of condition being reported	RE
Patient Class	Patient classification within facility	RE
Chief Complaint/Reason for visit	Short description of the chief complaint or reason of patient’s visit, recorded when seeking care	RE*
Triage Notes	Triage notes for the patient visit	RE*
Data Element Name	Description of Field	Usage (R = required & field must contain a value;

		RE = required but field can be empty O = optional
Diagnosis/External Cause of Injury Code	Diagnosis code or external cause of injury code (for injury-related-visits) of patient condition	RE
Clinical Impression	Clinical impression (free text) of the diagnosis	RE*
Diagnosis Type	Qualifier for Diagnosis/Injury Code specifying type of diagnosis	RE
Discharge Disposition	Patient's anticipated location or status following ED visit	RE
Disposition Date/Time	Date and time of disposition	RE
Initial Temperature	1 st recorded temperature, including units	RE
Initial Pulse Oximetry	1 st recorded pulse oximetry value	RE
Initial Blood Pressure	1 st recorded blood pressure (SBP/DPB)	RE
*This value is critical for Public Health Syndromic Surveillance and is considered REQUIRED. However, there are settings or scenarios where this field may be blank (e.g., trauma patient).		

Record Format:

Flat file extract delimited as ASCII text file format**, 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 (MU) reporting requirements.

** 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.