

Oregon ESSENCE Data Fact Sheet

Requested Emergency Department Data Elements reflect meaningful use requirements for Oregon public health syndromic surveillance.

- Guidance was developed by the International Society for Disease Surveillance Meaningful Use Workgroup (<http://www.syndromic.org/meaningfuluse>).
- Sending data elements in HL7 format fulfills the public health syndromic surveillance meaningful use objective, but HL7 message transmission is **not** required to participate in ESSENCE.

Data Element Name	Description of Field	Usage (R = required and 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
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
Sex	Sex of patient	RE
City / Town	City / Town of patient residence	O
County	County of patient home address	RE
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 and Time of patient presentation	R

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Data Element Name	Description of Field	Usage (R=required and field must contain a value; RE=required but field can be empty; O=optional)
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*
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	1st recorded temperature, including units and location on body	RE
Initial Pulse Oximetry	1st recorded pulse oximetry value	RE

* This value is critical for PHSS and is considered REQUIRED.
However, there are settings or scenarios where this field may be blank (e.g. trauma patient).

Source: www.syndromic.org

Record Format:

- HL7 2.3.1 or HL7 2.5.1, flat file extract delimited as ASCII text file format. Only messages sent as HL7 2.3.1 or HL7 2.5.1 meet the syndromic surveillance meaningful use objective.
- HL7 message validation resources are available at: <https://phinmqf.cdc.gov/>.
- Flat file data fields should be delimited by a “|” (pipe) symbol.



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Points of Contact:

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