National Syndromic Surveillance Program (NSSP) List of Healthcare Data Elements

State and Local Public Health Departments

Data Element Name	Data Element Description
Facility Identifier (Treating)	Unique facility identifier where the patient was treated (original provider of the data)
Facility Name (Treating)	Name of the treating facility where the patient is treated
Treating Facility Address (Street address, City, State, ZIP, and County)	Address of treating facility location: Street Address, City, ZIP Code, County, State
Facility/Visit Type	Type of facility that the patient visited for treatment
Message (Event) Date / Time	Date and time that the report is created/generated from original source (from treating facility)
Unique Physician Identifier	Unique identifier for the physician providing care
Provider Type	Type of provider
Unique Patient Identifier / Medical Record Number	Unique identifier for the patient or visit
Unique Visit Identifier	Unique identifier for the visit/encounter
Age/Age Units	Numeric value of patient age at time of visit
Gender	Stated gender of patient
Race	Race of patient
Ethnicity	Ethnicity of patient
Patient City / Town	City or town of patient residence
Patient ZIP Code	ZIP Code of patient residence
Patient County	County of patient residence
Patient State	State of patient residence
Patient Country	Country of patient residence
Chief Complaint / Reason for Visit	Patient's self-reported chief complaint or reason for visit
Admit or Encounter Reason	Short description of the provider's reason for admitting the patient
Admit or Encounter Date / Time	Date and Time of encounter or admission
Date of Onset	Date that the patient began having symptoms of condition being reported
Patient Class	Patient classification within facility
Admission Type	This field indicates the circumstances under which the patient was or will be admitted
Admit Source	This field indicates where the patient was admitted
Hospital Unit	Hospital unit where patient is at the time the message is sent (admission and discharge)
Previous Hospital Unit	Hospital unit where patient was prior to the current transaction
Diagnosis Type	Qualifier for Diagnosis / Injury Code specifying type of diagnosis
Primary Diagnosis	Primary diagnosis of the patient's condition
Additional Diagnosis	Additional diagnoses of the patient's condition(s)
Discharge Disposition	Patient's anticipated location or status following discharge
Discharge or Disposition Date/Time	Date and time of discharge

State and Local Public Health Departments - Continued

Data Element Name	Data Element Description
Procedure Code	Procedures administered to the patient
Triage Notes	Triage notes for the patient visit
Clinical Impression	Clinical impression (free text) of the diagnosis
Problem List	The problem list contains a narrative description of the conditions currently being monitored for the patient
Problem List	Problem list of the patient condition(s)
Medication List	Current medications entered as narrative
Medications Prescribed or Dispensed	Current medications entered as standardized codes
Height	Height of the patient
Weight	Weight of the patient
BMI	Body Mass Index
Systolic and Diastolic Blood Pressure (SBP/DBP) – Most recent	Most recent Systolic and Diastolic Blood Pressure of the patient
Initial Temperature	Initial temperature of the patient
Initial Pulse Oximetry	1st recorded pulse oximetry value
Smoking Status	Smoking status of patient
Initial Acuity	Assessment of the intensity of medical care the patient requires.
Insurance Coverage	Health insurance coverage of the patient
Travel History	Patient Travel History

Department of Defense

Data Element Name	Data Element Description
Patient ZIP Code	The postal zip code for the city located. For outside contiguous United States (OCONUS) location an APO/FPO (Military Post Office Zip Code) or country zip code
Clinic ZIP Code	The Postal zip code for the city clinic is located. For OCONUS code is used to correspond to obtained from CHCS (Composite Health Care System). Zip code are indicative of OCONUS loc
Appointment Prefix	Designates whether the appointment is CHCS, Ambulatory Data System (ADS), Clinical Integrated Workstation (CIW), CHCSII
Appointment Identifier Number	The appointment identifier number is a system generated unique app that system. The appointment combine to create a unique identifier
Appointment Standard Ambulatory Data Record (SADR) Status	Status of appointment record SADR extract. (Ready or Updated)
Appointment SADR Extract Date	Date the SADR was extracted
Appointment Status Type	Coded: appointment scheduled, walk-in, sick call, cancelled by provider, telephone consult, no-show, cancelled by facility, or canceled by patient
CPT4 Version Year	Indicates the year of the most Current Procedural Terminology in ADM (Ambulatory Data Module)
E&M code with Level “E”	Evaluation and Management appointment
CPT4 Codes with Diagnosis Flag	Field correlates CPT4 to diagnosis
Patient Age at Appointment	Age of patient at the day of the appointment. Age given in years
Disposition Code	Code that indicates circumstance under which patient leaves the facility. (Code: released without limitations, released with work/duty restrictions, sick at home/quarters, immediate referral, transferred to another facility, left without being seen, left against medical advice, admitted, continued stay, discharged home, or expired)
Administrative Disposition Code	Codes: Consultation requested, Referred to another provider, Convalescent leave, Medical Board, or Medical hold
Treatment DMIS ID	The Defense Medical Information identification number that identifies patient was treated
Gender	Code: Male or Female
Appointment (Encounter) Date	Date of the appointment
ICD-9 Version Year	Indicates the year of the most current ICD Code Table in ADM
ICD-9 Codes, Including Extenders	Four ICD-9 codes, 9 character level
Treatment MEPRS Code	Describes each work center
Patient Status	Code: inpatient or outpatient
Provider Specialty Code	Code that identifies the health providers medical specialty
End of Record Flag	End of record marker

Department of Veterans Affairs

Data Element Name	Data Element Description
AnalysisVisitID	Created by BioSense to provide a consistent definition of a visit regardless of how a visit is defined by a given hospital. Combines patient visits, if they occur within 24 hours of each other.
PatientID	Uniquely distinguishes a patient across all visits to a single facility or across all visits to a healthcare system when a common patient identification system is used.
DateofVisit	Date of Visit based on the visit date associated with this specific clinical data, for this specific Analysis Visit ID, in DATE format (mm/dd/yyyy).
AnalysisVisitDate	Date and time of Visit based on the visit date associated with this specific clinical data, for this specific Analysis Visit ID
FacID	Unique facility identifier of the facility where the patient originally presented (original provider of the data)
ServicingFacility	Primary VA Local Facility ID
PatientCounty	Patient county
PatientZip	Patient Zip code
Acuity	Indicates how quickly care is required. 30="Time to evaluation or treatment not critical "; 20="Request Prompt Evaluation or Treatment" "10=Request Immediate Evaluation or Treatment"
Age	Numeric value for patient age
AgeUnit	Unit for numeric value (years, days, months)
BirthDate	Year and Month of patient birth
DeathDate	Date of death (mm/dd/yyyy)
Ethnicity	Patient ethnicity
Gender	Patient gender
Race	Patient race
Admit (1=Yes 0=No)	Numeric 1/0 indicator. Set to 1 if there is evidence of a hospital admission having taken place
AdmitDate	Date of admission of patient into hospital (mm/dd/yyyy)
DeathCode	Hospital death disposition code that was reported
DischargeDate	Date patient was discharged from hospital
Disposition	Most recent non-Admit/Death Hospital Discharge Disposition Code (admit, discharge, transfer, left, expiration)
BP	Max Blood Pressure associated with an Analysis Visit ID
MinBp	Min Blood Pressure associated with an Analysis Visit ID
Pulse	Max pulse oximetry associated with an Analysis Visit ID
MinPulse	Min pulse oximetry associated with an Analysis Visit ID
Temperature	Max temperature among recorded temperatures assoc w/ an Analysis Visit ID
MinTemperature	Min temperature among recorded temperatures assoc w/ an Analysis Visit ID
OnsetDate	Date the patient began having symptoms of condition
PatientClass	Emergency, outpatient, inpatient
ActivityCode	ICD-9-CM, ICD-19-CM, or SNOMED
Diagnosis / Injury Description OR Chief Complaint/Reason for Visit	Text: description of activity code OR description of the reason the patient has presented to the healthcare facility
Activity Status	Diagnosis type – admitting, working, final
Activity Type	Diagnosis/Injury Description, Chief Complaint, or Procedure

Laboratory

Data Element Name	Data Element Description
BioSense Patient ID	Uniquely distinguishes a patient across all visits to a single facility or across all visits to a healthcare system when a common patient identification system is used
BioSense Visit ID	Used to uniquely distinguish a patient visit based on the healthcare facility account identifier. Created to reflect the visit as defined by the healthcare facility
Date of Birth	Patient date of birth (month/year)
Sex	Patient gender
Zip code	Patient or provider zip code
State	Patient or provider state
Ethnic group	Patient ethnicity
Race	Patient race
Date into Point of Care/location	Date patient arrived at healthcare facility
Test Code / Name	Local codes or local text names used to describe a laboratory test
Reason for Test	ICD-9CM code
Specimen Type	Type of sample taken for testing
Order Date/time	Date and time test was ordered
Ordering Facility Name	Name of facility that ordered test
Ordering Facility Address	Address of facility that ordered test
Ordering Facility Phone Number	Phone number of facility that ordered test
Ordering provider address	Address of healthcare provider that ordered test
Diagnostic Service	Type of diagnostic Service (immunology, microbiology…)
Performing laboratory	Lab within performing the service
Result Status	Final or pending
Report date/time	Date lab reports the result of the test
Collection date	Date sample was collected for test
Collection method	Method used to collect sample
Specimen site	From where on patient's body the sample came
Accession date	Date the sample was received
Accession ID	Unique ID number assigned to sample when it is received by the laboratory
Sequence number	Number assigned to each lab order
Ordered Test Code/Name	LOINC codes and Descriptive text
Resulted Test Code/Name	LOINC or SNOMED codes and Descriptive text
Organism identified	Name of organism identified by a specific test
Method type	Ordered method for testing the specimen
Result other than organism	Result of a lab test that does not give the name of an organism
Result unit	Unit of measure for a lab test
Test Interpretation	Interpretation of the lab test result
Susceptibility test interpretation	Antimicrobials to which a microorganism is susceptible
Result notes	Important issues regarding the results
References Range	Range of what is normal or range of results that can be seen with that test
Last Update Date	Most recently updated date
Analysis Visit ID	Unique ID assigned for each visit
Lab Result Key ID	Unique ID for each patient
Coding Sys	Order or Result coding system (LOINC, SNOMED, NULL flavor)

Pharmacy

Data Element Name	Data Element Description
RXNumber	Prescription number
QuantityDispensed	Total amount medication dispensed
DaysSupply	Number of days worth of medication dispensed
ProductName	Name of medication dispensed
GPICode	Generic Product Identifier number for medication
GPIText	Generic Product Identifier name for medication
RXNormCode	RXNORM number for medication
Pharmacy UID	Unique ID for Retail Pharmacy
Pharmacy5 digit zip	Pharmacy Zip code (5 digits)
Age	Patient age
PatZIP3	Patient Zip code (3 digits)
PatState	Patient State
PatCounty	Patient County
RecordUID	Record number
DateofService	DateRXTransactionatPharmacy
PrescriberIDQualifier	Prescriber type
PrescriberID	Unique ID number of prescribing healthcare provider
Insurance Type	Indicates Client type