Flat File Outbound ADT

Specification

Version 01.02
04.04.2024

Connie

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1. Overview

This specification is for curated outbound ADT messages from Connie to provider organizations regarding patient encounters.

2. Message Details

2.1. File Format

The file must be:
- flat files;
- comma delimited formatted for CSV output;

Naming Convention:
{SourceCode}_OB_ADT_YYYYMMDDmm.csv
SourceCode is provided by CSS/Connie to each organization.

2.2. File Details

*Please see "Appendix A – Code Tables" for applicable codes

Description	Required, Optional	Description
Destination Facility ID	Required	Assigned by CSS at the time of onboarding that reflects the sender source code.
Destination Practice Name	Required	
Destination Location		
Destination MRN		
Source Facility		
Patient Class*	Required if available	Categorize patients by site
Patient_ID	Required	MRN
First_Name	Required	
Middle_Name		
Last_Name	Required	
Gender*		See appendix for standard codes
Birthdate	Required	Format: CCYYMMDD
Address_1	Required	
Address_2	Required if available	
City	Required	
State	Required	
Zip	Required	
Home_Phone	Required if available	
Work_Phone	Required if available	
Cell_Phone	Required if available	
Event_Type	Required	i.e A01 = Admit; A04 = Register a patient; A08 = Update patient information

Admit_Source	Optional	Format: CCYYMMDD at a minimum
Patient Complaint Code	Optional	
Patient Complaint	Optional	
Death_Indicator	Optional	
Date_of_Death	Optional	Format: CCYYMMDD at a minimum
Diagnosis Codes	Required if available, Repeating	Coded diagnoses associated with an episode of care. Applicable vocabulary standards: International Classification of Diseases Clinical Modification (ICD-10, ICD-11)
Diagnosis_Description		
Discharge Disposition*	Optional	This data element is established to represent the type of facility that a patient is discharged to following a hospitalization or episode of care.
Discharge_to_Location	Optional	Freeform field with the location patient was discharged to
Hospital_Service	Optional	
Race*	Optional	See appendix for standard codes
Ethnicity*	Optional	See appendix for standard codes
Past_Emergency_Visits	Optional	
Past_Inpatient_Visits	Optional	

3. Output Options

3.1. CSV Output

DEST_FACILITY,DEST_PRACTICE,LOCATION,DEST_MRN,SOURCE_FACILITY,PTCLASS,SOURCE_MRN,FNAME,MNAME,LNAME,GENDER,DOB,ADDR1,ADDR2,CITY,STATE,ZIP,HOME_PHONE,CELL_PHONE,WORK_PHONE,EVENT,ADMIT_SOURCE,PATIENT_COMPLAINT
CODE,PATIENT_COMPLAINT,DEATH_INDICATOR,DATE_OF_DEATH,DIAGNOSIS_CODE,DIAGNOSIS_DESCRIPTION,DISCHARGE_DISPOSITION,DISCHARGE_TO_LOCATION,HOSPITAL_SERVICE,RACE,ETHNICITY,PAST_EMERGENCY_VISITS,PAST_INPATIENT_VISITS

3.2. HTML Output

```
$LOGO$
<h3>Encounter Notifications</h3>

<div>
<div class="heading" style="float: left;font-size: 15px; font-weight: bold;margin: 0 0 20px 0; width: 100%; overflow: auto"> $FNAME$ $LNAME$ $ValueMap.(SOURCE_PTCLASS)$ $ValueMap.(EVENT)$ at $SOURCE_FACILITY$ </div>
   </div>

<div style="font-weight: bold;">Patient Information:</div>
   <table style="border: 0;margin: 0 0 15px 0; table-layout:fixed; width:500px;">
<tr>
<td width="40%">Patient Name:</td>
<td width="60%">$FNAME$ $MNAME$ $LNAME$</td>
</tr>
<tr>
<td>Gender:</td>
<td >$ValueMap.(GENDER)$</td>
</tr>
<tr>
<td>DOB:</td>
<td >$DOB;format="yyyy-MM-ddformat_nostrict"$</td>
</tr>
<tr>
<td style="vertical-align:top;">Address:</td>
<td >$ADDR1$</td>
</tr>

<tr>
<td style="vertical-align:top;"/>
<td >$ADDR2$</td>
</tr>

<tr>
<td style="vertical-align:top;"></td>
<td >$CITY$, $STATE$ $ZIP$</td>
```

```
</tr>
<tr>
<td>Home Phone:</td>
<td >$HOME_PHONE$</td>
</tr>

<tr>
<td>Work Phone:</td>
<td>$WORK_PHONE$</td>
</tr>

<tr>
<td>Cell Phone:</td>
<td>$CELL_PHONE$</td>
</tr>

$if(pat.RosterFields.PCP)$
<tr>
<td>Primary care provider: </td>
<td>$pat.RosterFields.PCP$</td>
</tr>
$endif$

</table>

<div style="font-weight: bold;" >Facility Information:</div>
<table style="border: 0; margin: 0 0 15px 0; table-layout:fixed; width:500px;">
<tr>
<td width="40%">Hospital/Org. Name:</td>
<td width="60%">$SOURCE_FACILITY$</td>
</tr>
<tr>
<td>Hospital MRN:</td>
<td >$SOURCE_MRN$</td>
</tr>
<tr>
<td>Event:</td>
<td >$ValueMap.(SOURCE_PTCLASS)$ $ValueMap.(EVENT)$</td>
</tr>
<tr>
<td>Event Time:</td>
<td >$ADTEVENTDATETIME;format="fullformat"$</td>
</tr>
</table>

<div style="font-weight: bold;" colspan="2">Additional Information:</div>
<table style="border: 0; margin: 0 0 15px 0; table-layout:fixed; width:500px;">
```

```
<tr>
<td width="40%">Admit Source:</td>
<td width="60%">$ADMIT_SOURCE$</td>
</tr>
<tr>
<td width="40%">AdmitReason:</td>
<td width="60%">$PATIENT_COMPLAINT$</td>
</tr>
<tr>
<td width="40%">DeathIndicator:</td>
<td width="60%">$DEATH_INDICATOR$</td>
</tr>
<tr>
<td width="40%">DeathDate:</td>
<td width="60%">$DATE_OF_DEATH$</td>
</tr>
<tr>
<td width="40%">DiagnosisCode:</td>
<td width="60%">$DIAGNOSIS_CODE$</td>
</tr>

<tr>
<td width="40%">DiagnosisDescription:</td>
  <td width="60%">$DIAGNOSIS_DESCRIPTION$</td>
</tr>

<tr>
<td width="40%">DischargeDisposition:</td>
<td width="60%">$DISCHARGE_DISPOSITION$</td>
</tr>

<tr>
<td width="40%">DischargeToLocation:</td>
<td width="60%">$DISCHARGE_TO_LOCATION$</td>
</tr>

<tr>
<td width="40%">HospitalService:</td>
<td width="60%">$HOSPITAL_SERVICE$</td>
</tr>

<tr>
<td width="40%">Race:</td>
<td width="60%">$RACE$</td>
</tr>

<tr>
```

<td width="40%">Ethnicity:</td>

<td width="60%">$ETHNICITY$</td>
</tr>
</table>

Past Encounter Information:
<table style="border: 0; margin: 0 0 15px 0; table-layout:fixed; width:500px;">
<tr>
<td width="40%">Past Emergency Visits:</td>
<td width="60%">$PAST_EMERGENCY_VISITS$</td>
</tr>
<tr>
<td width="40%">Past Inpatient Visits:</td>
<td width="60%">$PAST_INPATIENT_VISITS$</td>
</tr>
</table>

<table style="border: 0; margin: 0 0 15px 0; table-layout:fixed; width:500px;">
<tr>
<td style="width:40%;font-weight: bold;">Your Facility Site:</td>
<td >$DEST_PRACTICE$</td>
</tr>
<tr>
<td style="width:60%;font-weight: bold;">Your Facility MRN:</td>
<td >$DEST_MRN$</td>
</tr>
</table>
$FOOTER$
$SPONSOR$

3.3. HL7 Output

MSH|^~\&|CRISP|$SENDER_SOURCECODE$|$RECEIVER_SOURCECODE$||$MESSAGE_TIME;format="hl7format_nostrict"$||ADT^$EVENT$|$MESSAGEID$|P|2.5|||||
EVN|$EVENT$|$ADTEVENTDATETIME;format="hl7format_nostrict"$
PID|1||$DEST_MRN$^^^$RECEIVER_SOURCECODE$^PI~$SOURCE_MRN$^^^$SENDER_SOURCECODE$^MR||$LNAME$^$FNAME$^$MNAME$||$DOB;format="yyyyMMddformat"$|$GENDER$||$RACE$|$ADDR1$^$ADDR2$^$CITY$^$STATE$^$ZIP$||$HOME_PHONE$~$CELL_PHONE$|$WORK_PHONE$|||||||$ETHNICITY$|||||||$DATE_OF_DEATH;format="hl7format_nostrict"$|$DEATH_INDICATOR$|
PV1|1|$SOURCE_PTCLASS$||$ADMIT_TYPE$||||||$HOSPITAL_SERVICE$||||$ADMIT_SOURCE$|||||||||||||||||||||$DISCHARGE_DISPOSITION$|$DISCHARGE_TO_LOCATION$|||||||$ADMIT_TIME;format="hl7format_nostrict"$|$DISCHARGE_TIME;format="hl7format_nostrict"$|
PV2|||$PATIENT_COMPLAINT$
DG1|||$DIAGNOSIS_CODE$|$DIAGNOSIS_DESCRIPTION$
ZSH|$PAST_EMERGENCY_VISITS$|$PAST_INPATIENT_VISITS$

3.4. XDR Output

```
<?xml version="1.0"?>
<?xml-stylesheet type="text/xsl" href="Discharge_Summary_cda.xsl"?>
<ClinicalDocument xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"
xsi:schemaLocation="urn:hl7-org:v3 ../../../../cda-schema/infrastructure/cda/CDA.xsd"
xmlns="urn:hl7-org:v3" xmlns:voc="urn:hl7-org:v3/voc">
<realmCode code="US"/>
<typeId root="2.16.840.1.113883.1.3" extension="POCD_HD000040"/>
<templateId root="2.16.840.1.113883.10.20.22.1.1"/>
<templateId root="2.16.840.1.113883.10.20.3"/>
<templateId root="2.16.840.1.113883.10.20.16.2"/>
<templateId root="2.16.840.1.113883.10.20.22.1.8"/>
<id extension="$CCDA_DOCID$" root="@CRISPENSOID@"/>
<code code="18842-5"
  displayName="$ValueMap.(SERVICE_CLASS)$ DISCHARGE NOTIFICATION"
  codeSystem="2.16.840.1.113883.6.1"
  codeSystemName="LOINC"/>
<title>$ValueMap.(SERVICE_CLASS)$ Discharge Notification</title>
<effectiveTime value="$CURRENT_TIME$-0500"/>
<confidentialityCode code="N" codeSystem="2.16.840.1.113883.5.25"/>
<languageCode code="en-US"/>
<recordTarget>
<patientRole>

<id extension="$SOURCE_MRN$" root="$SENDER_OID$"/>

<id extension="$DEST_MRN$" root="2.16.840.1.113883.9.173" assigningAuthorityName="$DEST_FACILITY$"/>
<addr>
<streetAddressLine>$ADDR1$</streetAddressLine>
$if(ADDR2)$<streetAddressLine>$ADDR2$</streetAddressLine>$endif$
<city>$CITY$</city>
<state>$STATE$</state>
<postalCode>$ZIP$</postalCode>
<country>US</country>
</addr>
$if(HOME_PHONE)$ <telecom value="tel:$HOME_PHONE$" use="HP"/> $endif$
$if(WORK_PHONE)$ <telecom value="tel:$WORK_PHONE$" use="WP"/> $endif$
$if(CELL_PHONE)$ <telecom value="tel:$CELL_PHONE$" use="MC"/> $endif$
<patient>
<name>
<given>$FNAME$</given>
$if(MNAME)$ <given>$MNAME$</given> $endif$
<family>$LNAME$</family>
</name>
<administrativeGenderCode code="$GENDER$"
```

```
 displayName="$GenderMap.(GENDER)$"
 codeSystem="2.16.840.1.113883.5.1"/>
$if(DOB)$ <birthTime value="$DOB;format="yyyyMMddformat"$"/> $endif$
$if(RACE)$
<raceCode code="$RaceMap.(RACE)$"
 displayName="$RACE$"
 codeSystem="2.16.840.1.113883.6.238"
 codeSystemName="Race &amp;amp; Ethnicity - CDC"/>
$endif$
$if(ETHNICITY)$
<ethnicGroupCode code="$EthnicMap.(ETHNICITY)$"
        displayName="$ETHNICITY$"
codeSystem="2.16.840.1.113883.6.238"
codeSystemName="Race &amp;amp; Ethnicity - CDC"/>
$endif$
</patient>
</patientRole>
</recordTarget>
<author>
<time value="$pat.RunTimeFields.CurrentTime$-0500"/>
<assignedAuthor>
<id root="@CRISPENSOID@"/>
<addr>
<streetAddressLine>(CRISP)5523 Research Park Drive</streetAddressLine>
<streetAddressLine>Suite 370</streetAddressLine>
<city>Baltimore</city>
<state>MD</state>
<postalCode>21228</postalCode>
<country>US</country>
</addr>
<telecom value="(301) 560-6999" use="WP"/>
<assignedAuthoringDevice>
<manufacturerModelName nullFlavor="UNK" />
<softwareName>Encounter Notification Service</softwareName>
</assignedAuthoringDevice>
</assignedAuthor>
</author>
<custodian>
<assignedCustodian>
<representedCustodianOrganization>
<id root="@CRISPENSOID@"/>
<name>CRISP</name>
<telecom value="(301) 560-6999" use="WP"/>
<addr>
<streetAddressLine>5523 Research Park Drive</streetAddressLine>
<streetAddressLine>Suite 370</streetAddressLine>
<city>Baltimore</city>
```

```
<state>MD</state>
<postalCode>21228</postalCode>
<country>US</country>
</addr>
</representedCustodianOrganization>
</assignedCustodian>
</custodian>
<!--Destination practice name.-->
<informationRecipient>
<intendedRecipient>
<receivedOrganization>
<name>$pat.RosterFields.PracticeName$</name>
</receivedOrganization>
</intendedRecipient>
</informationRecipient>
<!--PCP, limitation since the first name and last name of PCP is combined.-->
<documentationOf>
  <serviceEvent classCode="ACT">
<performer typeCode="PRF">
  <assignedEntity>
<assignedPerson>
  <name>
$PCP$
  </name>
</assignedPerson>
<representedOrganization>
<id root="$SENDER_OID$"/>
<name>"$SOURCE_FACILITY$"</name>
</representedOrganization>
  </assignedEntity>
</performer>
  </serviceEvent>
</documentationOf>

<componentOf>
<encompassingEncounter>
<effectiveTime>
<low nullFlavor="$ADMIT_TIME;format="hl7format_nostrict"$"/>
<high value="$DISCHARGE_TIME;format="hl7format_nostrict"$"/>
</effectiveTime>
<dischargeDispositionCode code=""
  displayName="$DISCHARGE_DISPOSITION$"
  codeSystem="2.16.840.1.113883.12.112"
  codeSystemName="HL7 Discharge Disposition"/>
</encompassingEncounter>
</componentOf>
```

```
<component>
<structuredBody>
<component>
<section>
<templateId root="2.16.840.1.113883.10.20.22.2.6"/>
<code code="48765-2"
  displayName="Allergies, adverse reactions, alerts"
  codeSystem="2.16.840.1.113883.6.1"
  codeSystemName="LOINC"/>
<title>Allergies</title>
<text></text>
</section>
</component>

<component>
<section>
<templateId root="1.3.6.1.4.1.19376.1.5.3.1.3.5"/>
<code code="8648-8"
  displayName="Hospital Course"
  codeSystem="2.16.840.1.113883.6.1"
  codeSystemName="LOINC"/>
<title>Hospital Course</title>
<text></text>
</section>
</component>

<component>
<section>
<templateId root="2.16.840.1.113883.10.20.22.2.24"/>
<code code="11535-2"
  displayName="Hospital Discharge Diagnosis"
  codeSystem="2.16.840.1.113883.6.1"
  codeSystemName="LOINC"/>
<title>Hospital Discharge Diagnosis</title>
<text>
<table border="1" width="100%">
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Diagnosis Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>$if(DIAGNOSIS_CODE)$ $DIAGNOSIS_CODE$ $endif$</td>
<td>$if(DIAGNOSIS_DESCRIPTION)$ $DIAGNOSIS_DESCRIPTION$ $endif$</td>
</tr>
```

```
</tbody>
</table>
</text>
</section>
</component>

<component>
<section>
<templateId root="2.16.840.1.113883.10.20.22.4.79"/>
<code code=""
 displayName="Death Indicator"
 codeSystem="2.16.840.1.113883.6.1"
 codeSystemName="LOINC"/>
<title>Death Indicator</title>
<text>
<table border="1" width="100%">
<thead>
<tr>
<th>Death Indicator</th>
<th>Death Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>$DEATH_INDICATOR$</td>
<td>$DATE_OF_DEATH$</td>
</tr>
</tbody>
</table>
</text>
</section>
</component>

<component>
<section>
<templateId root="2.16.840.1.113883.10.20.22.2.11"/>
<code code="10183-2"
 displayName="Hospital Discharge Medications"
 codeSystem="2.16.840.1.113883.6.1"
 codeSystemName="LOINC"/>
<title>Hospital Discharge Medications</title>
<text></text>
</section>
</component>

<!-- ************************ Problems section to include death indicator ***************************** -->
<component>
```

```
<section>
<templateId root="2.16.840.1.113883.10.20.22.2.5"/>
<!-- Problems section template(s) -->
<code code="11450-4" codeSystem="2.16.840.1.113883.6.1"/>
<title>Problem List</title>
<entry typeCode="DRIV">
<act classCode="ACT" moodCode="EVN">
<templateId root="2.16.840.1.113883.10.20.22.4.3"/>
<entryRelationship typeCode="CAUS">
<observation classCode="OBS" moodCode="EVN">
<templateId root="2.16.840.1.113883.10.20.22.4.79"/>
<!-- Deceased observation template -->
<id root="6898fae0-5c8a-11db-b0de-0800200c9a77"/>
<text>$DEATH_INDICATOR$</text>
<code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>
<statusCode code="completed"/>
<effectiveTime>
<low value="$DATE_OF_DEATH$"/>
</effectiveTime>
</observation>
</entryRelationship>
</act>
</entry>
</section>
</component>

<component>
<section>
<templateId root="2.16.840.1.113883.10.20.22.2.10"/>
<code code="18776-5"
  displayName="Treatment Plan"
  codeSystem="2.16.840.1.113883.6.1"
  codeSystemName="LOINC"/>
<title>Plan of Care</title>
<text></text>
</section>
</component>

<component>
<section>
<templateId root="2.16.840.1.113883.10.20.22.2.13"/>
<code code="46239-0"
   displayName="Chief Complaint and Reason for Visit"
   codeSystem="2.16.840.1.113883.6.1"
   codeSystemName="LOINC"/>
<title>Chief Complaint and Reason for Visit</title>
<text>$if(PATIENT_COMPLAINT)$ $PATIENT_COMPLAINT$ $endif$</text>
```

</section>
</component>
</structuredBody>
</component>
</ClinicalDocument>

3.5. Plain Text Output

Patient Information:
Patient Name: $FNAME$ $MNAME$ $LNAME$
Gender: $ValueMap.(GENDER)$
DOB: $DOB;format="yyyy-MM-ddformat_nostrict"$
Address: $ADDR1$ $ADDR2$, $CITY$, $STATE$ ZIP
Home Phone: $HOME_PHONE$
Work Phone: $WORK_PHONE$
Cell Phone: $CELL_PHONE$
$if(pat.RosterFields.PCP)$Primary care provider: $pat.RosterFields.PCP$$endif$

Facility Information:
Hospital/Org. Name: $SOURCE_FACILITY$
Hospital MRN: $SOURCE_MRN$
Event: $ValueMap.(SOURCE_PTCLASS)$ $ValueMap.(EVENT)$
Event Time: $ADTEVENTDATETIME;format="fullformat"$

Additional Information:
Admit Source: $ADMIT_SOURCE$
Admit Reason: $PATIENT_COMPLAINT$
Death Indicator: $DEATH_INDICATOR$
Death Date: $DATE_OF_DEATH$
Diagnosis Code: $DIAGNOSIS_CODE$
Diagnosis Description: $DIAGNOSIS_DESCRIPTION$
Discharge Disposition: $DISCHARGE_DISPOSITION$
Discharge To Location: $DISCHARGE_TO_LOCATION$
Hospital Service: $HOSPITAL_SERVICE$
Race: $RACE$
Ethnicity: $ETHNICITY$

Past Encounter Information:
Past Emergency Visits: $PAST_EMERGENCY_VISITS$
Past Inpatient Visits: $PAST_INPATIENT_VISITS$

Your Facility Site: $DEST_PRACTICE$
Your Facility MRN: $DEST_MRN$

4. Message Example

4.1. HL7 Example

MSH|^~\&|CRISP|CTTEST|ENS_TESTCT||20231026024748||ADT^A08|20231026024788711|P|2.5|||||
EVN|A08|20231025111600
PID|1||123456789^^^ENS_TESTCT^PI~M000654321^^^CTBRISTOL^MR||PINESDS^MABEL^A||19870612|F|||2221 GRAVITY FALLS DR^^GRAVITY^CT^78214-1324||2023339678~2023339678|2023339678|||||||||||||||
PV1|1|O|||||||||||PHY|||||||||||||||||||||HOME, SELF-CARE|||||||20231024150000||
PV2|||LABWORK
DG1|||L98.9|
ZSH|0|0

4.2. CSV Example

CTTEST,Bristol Practice,,123456789,CTBRISTOL,O,M000654321,MABEL,A,PINESDS,F,19870612,2221 GRAVITY FALLS DR,,GRAVITY,CT,78214-1324,2023339678,2023339678,,A08,20231025111600,,,LABWORK,,,L98.9,,"HOME, SELF CARE",PHY,,,0,0

5. Appendix A – Code Tables

5.1. Gender

CRISP uses this to determine the gender of the patient and must contain one of the following codes:

Code	Description
F	Female
M	Male
O	Other
U	Unknown
A	Ambiguous
N	Not applicable

5.2. Race

CRISP uses these values for race of the patient and must contain one of the following codes:

Code	Description
1002-5	American Indian or Alaska Native
2028-9	Asian
2054-5	Black or African American
2076-8	Native Hawaiian or Other Pacific Islander
2106-3	White
2131-1	Other Race
PHC1175	Refused to answer
UNK	Unknown

5.3. Ethnicity

CRISP uses this to determine the ethnicity of the patient and must contain one of the following codes:

Code	Description
H	Hispanic or Latino
N	Not Hispanic or Latino
U	Unknown

5.4. Patient Class

CRISP uses this to determine the patient class and must contain one of the following codes:

Code	Description
I	Inpatient
O	Outpatient
OBS	Obstetrics
E	Emergency

5.5. Discharge Disposition

Code	Display	Definition
home	Home	The patient was dicharged and has indicated that they are going to return home afterwards.
alt-home	Alternative home	The patient was discharged and has indicated that they are going to return home afterwards, but not the patient's home - e.g. a family member's home.
other-hcf	Other healthcare facility	The patient was transferred to another healthcare facility.
hosp	Hospice	The patient has been discharged into palliative care.
long	Long-term care	The patient has been discharged into long-term care where it is likely to be monitored through an ongoing episode-of-care.
aadvice	Left against advice	The patient self-discharged against medical advice.
exp	Expired	The patient has deceased during this encounter.
psy	Psychiatric hospital	The patient has been transferred to a psychiatric facility.
rehab	Rehabilitation	The patient was discharged and is to receive post-acute care rehabilitation services.
snf	Skilled nursing facility	The patient has been discharged to a skilled nursing facility for the patient to receive additional care.
oth	Other	The discharge disposition has not otherwise defined.

Revision History

Date	Version	Author	Comments
3/6/2024	1.0	Connie	Create initial document.
1/5/2024	1.1	Connie	Incorporate feedback from CRISP
4/4/2024	2.0	Connie	Updated message examples