Florida Department of Health (DOH) Electronic Case Reporting (eCR) Guidance

Local implementation and validation guide for the electronic initial case reporting HL7 V3 clinical document architecture

Version 1.0
07/10/2025

Scope of document

The Florida eICR local guide was developed to be a companion implementation and validation guide and intended to provide further context for health care analysts and developers who must understand and implement elements of the most recent CDA R2 Implementation guide.

This local guide will provide the following information:

- Florida DOH local specifications for data elements to be retrieved from the EHR to produce the eICR. (Requirements sheet)
- Structural formats and specification of the eICR data requirements as specified by CSTE and Florida DOH (HL7 CDA R2 format). (Requirements sheet)
- Data elements required for message acceptance. (Requirements sheet)
- Onboarding procedures, including preproduction and postproduction eCR validation. (ReadMe sheet)
- Education on the data elements included in the HL7 CDA® R2 Implementation Guide: Release 2 - US Realm - the Electronic Initial Case Report (eICR) [1] (ReadMe sheet)

How to use this document

In the "CDA Conformance Verbs" table there are columns which can be referred to for specific information regarding data that may be sent in the eICR document. Florida DOH has defined each of these data elements as "SHALL," "SHOULD," or "MAY" in accordance with statewide standards, Rule 64D-3, Florida Administrative Code (F.A.C.). Please refer to the list below for the definitions of each column in the "Requirements" sheet.

- eICR Data Element: The name for the specified element within the eICR. Please note that due to the hierarchical/nested structure of many of the data elements (e.g. address contains elements such as street, city, postcode, country, etc.; dosage contains dose unit and dose quantity), not all elements have been listed on a separate row. There are some data elements in this data needs workbook that are rolled up to one line representing several related data elements in the implementation guide.
- Description: The description of the specified eICR data element. This may also contain examples and formats for how this data should be displayed.
- eICR Template: eICR Template that should be used to send the data in the CDA document.
- CDA Section/Location: The section or location in which the data should be located.
- eICR Data Classification Legend: The national classification for requirements for each data elements, from the **eICR Data Needs workbook.** [5] Definitions for each category are in the table "eICR Data Classification Categories." There can be more than one category for each data element.
- eICR XPath: This is the expression language designed to suppose the query or transformation of extensible markup language (XML) documents. The XPath should be specifically to where the data element may be found in the XML.
- CDA Terminology: The CDA terminology should be used to determine which data set should be used for a coded value for certain data elements.
- Florida's Requirement: This is the conformance verbs as defined by Florida. This can be different that conformance verbs as defined in the R2 CDA implementation guide.

- Florida's Minimal Data Element Completeness Score: This is the percentage of data element completeness required by DOH. The Data Element Completeness Score range is from 50% to 98% and varies by data element.

The *Requirements* sheet is sorted first by CDA Section/Location, then by eICR Data Element, and finally by the Florida's Minimal Data Element Completeness Score.

eICR Data Classification Categories	
USCDI V1 Required	**The ONC Cures Act Final Rule requires EHRs to support USCDI V1 as of December 2022.**
US Core 4.0.0 Required	**The 21st Century Cures Update requires EHRs to support US Core US Core STU 3.1.1 (SVAP 4.0.0) as of December 2022 *[API Criteria §170.315 (g)(10): Standardized API for Patient and Population Services].*** **FHIR Value set binding is "Required": to be conformant, the concept in this element SHALL be from the specified value set.**
US Core 4.0.0 Extensible	**The 21st Century Cures Update requires EHRs to support US Core STU 3.1.1 (SVAP 4.0.0) as of December 2022 [API Criteria §170.315 (g)(10): Standardized API for Patient and Population Services].** **FHIR Value set binding is "Extensible": to be conformant, the concept in this element SHALL be from the specified value set if any of the codes within the value set can apply to the concept being communicated. If the value set does not cover the concept (based on human review), alternate coding (or, data type allowing, text) may be included instead.**
eICR Implementation Guide Required	**Required binding in the eICR IG.**
Required for RCKMS/eCR Operations	**Required for operational functioning of eCR.**
Necessary for PHA Use	**Required to support PHA surveillance and case investigation practice - without these data elements, Public Health Agencies may continue to require manual reporting processes.**
Terminology not applicable	**No terminology needed for this data element (e.g. time, identifier, reference, etc.).**

CDA Conformance Verbs	
Verb	**Interpretation**
SHALL	**Required**
SHOULD	**Best practice or recommendation**
MAY	**Optional**

Onboarding

Register:

1. To ensure prompt and consistent eRSD updates from AIMS, please register for Electronic Case Reporting Update Notifications at Electronic Reporting and Surveillance Distribution 2.
2. The Florida Department of Health requires registration from the HCO communicating intent to participate in eCR: http://www.floridahealth.gov/electronicreportingregistration 3

Promoting Interoperability Measures by CMS for Critical Access Hospitals (CAHs) and eligible hospitals:

- Active Engagement Option 1: Pre-production and Validation: The eligible hospital or CAH registered to submit data with the PHA or, where applicable, the CDR to which the information is being submitted; registration was completed within 60 days after the start of the EHR reporting period; and the eligible hospital or CAH is awaiting an invitation from the PHA or CDR to begin testing and validation. Then, the eligible hospital or CAH begins the process of testing and validation of the electronic submission of data. Eligible hospitals or CAHs must respond to requests from the PHA or, where applicable, the CDR within 30 days; failure to respond twice within an EHR reporting period would result in that eligible hospital or CAH not meeting the measure.
- Active Engagement Option 2: Validated Data Production: The eligible hospital or CAH has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or CDR.

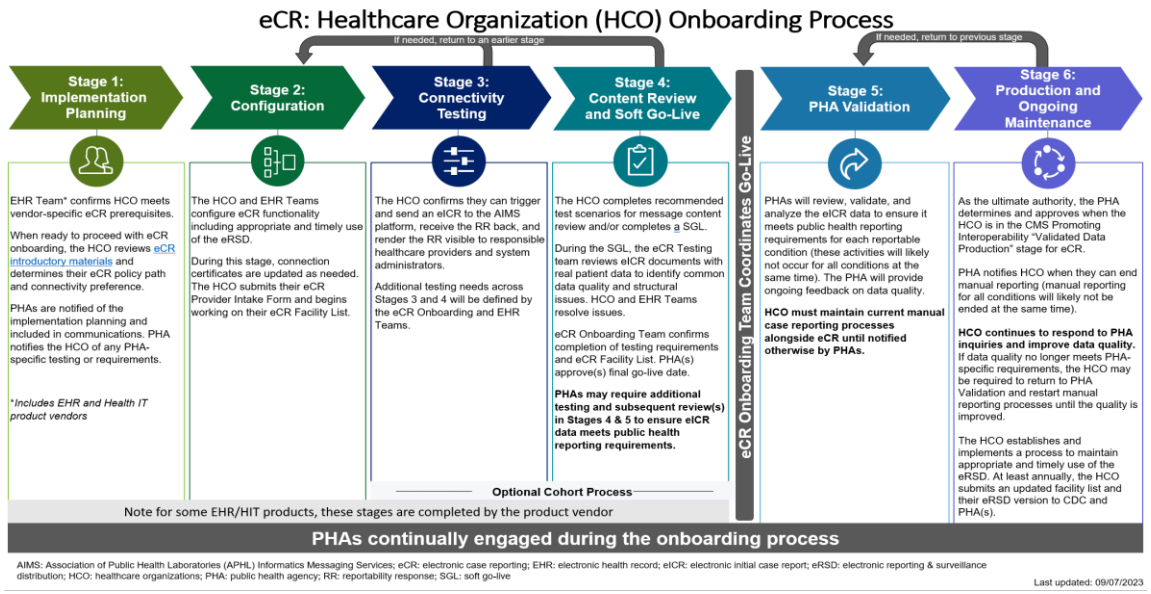
Health care organizations work closely with DOH to validate the eICR data sent to DOH so all applicable reportable diseases are received and the data are timely and complete. Prior to validation, please ensure your HCO is using the most recent Electronic Reporting and Surveillance Distribution (eRSD) package in its EHR.

DOH will contact the HCO when DOH is ready to begin post production validation. The HCO must continue manual reporting until DOH approves paper shut off. At this time, there is no expected timeline for DOH's evaluation period for an HCO to be approved to discontinue manual reporting. **The HCO is not considered in production until DOH validates the data and provides confirmation through email that the HCO has been moved into production. Receiving RRs is not an indication that the HCO is in production. DOH reserves the final say regarding if an HCO is in production versus in testing.**

Should you have any questions regarding your status, please contact the Florida eCR Team inbox at **ElectronicCaseReporting@FLHealth.gov** .

After the HCO has been successfully moved to production, it is the responsibility of the HCO to ensure that the latest version of the Electronic Reporting and Surveillance Distribution (eRSD) continues to be utilized, diseases are reported accurately and are in accordance with the requirements of Rule 64D-3, F.A.C., and non-eCR processes are still in place until notified by the DOH eCR team to discontinue. Health care and laboratory providers are required to report conditions of public health importance to DOH as defined in Rule 64D-3, F.A.C.[4]

Pre-production/ Soft go live validation stages:



Parallel validation process

DOH will begin the evaluation process to discontinue paper reporting for select diseases when the facility:

- Is in production for all conditions.
- Enough eCR data is received.
- Minimum of 90 days has passed since moving to production.

Evaluation:

- All facilities listed under the parent HCO will be included in the evaluation
- If the eCR was received correctly
- If the eCR was complete and formatted properly with all required Florida eICR data elements
- If all IC9, IC10, SNOMED CT, and LOINC codes are properly mapped for their respective diagnoses and lab results

After the HCO evaluation is complete, the HCO will receive an email which will include:

- Date range of the evaluated eCRs
- Reportable Conditions that were reviewed
- Criteria fulfilled or unfulfilled to discontinue non-eCR reporting via a Pass/Fail Result
- Notes for improvement, if applicable

If the HCO fails one or more criteria:

- DOH will provide detailed information on areas of improvement.
- The HCO will not be allowed to discontinue non-eCR processes.
- The HCO will then be placed at the end of the queue.
- Reevaluation timeline will be determined by DOH and can vary.

When the HCO passes all six criteria:

- DOH will provide further instructions.
- The HCO is still responsible for ensuring all facilities under the parent organization are submitting accurate and complete data and there are no server or connection issues.
- DOH will continue to monitor and reevaluate data received from an HCO at minimum twice yearly.
- If errors are identified, the HCO will be notified promptly, and a response from the HCO must be received within 24 hours confirming receipt of the notification and action will be taken within 72 hours. Failure to do so will result in the need to revert to non-eCR processes in addition to eCRs.

Relevant Links

1) HL7 CDA® R2 Implementation Guide: Release 2 - US Realm - the Electronic Initial Case Report (eICR)
2) Electronic Reporting and Surveillance Distribution
3) Register for Electronic Case Reporting
4)https://www.floridahealth.gov/diseases-and-conditions/disease-reporting-and-management/disease-reporting-and-surveillance/surveillance-and-investigation-guidance/_documents/64-d3-3-11-08.pdf
5) eICR Data Needs workbook

Glossary

AIMS: APHL Informatics Messaging Services
APHL: Association of Public Health Laboratories
CAHs: critical access hospitals
CD: Concept Descriptor
CDA: Clinical Document Architecture
CDC: Centers for Disease Control and Prevention
CMS: Centers for Medicare and Medicaid Services
CSTE: Council of State and Territorial Epidemiologists
DOH: Florida Department of Health
eCR: electronic case reporting
EHR: electronic health record
eICR: electronic initial case report
eRSD: Electronic Reporting and Surveillance Distribution
FAC: Florida Administrative Code
FHIR: Fast Healthcare Interoperability Resources
HL7: Health Level Seven
HTML: HyperText Markup Language
LOINC: Logical Observation Identifiers Names and Codes
PHA: public health agency
PQ: Point Quantity
RCKMS: Reportable Conditions Knowledge Management System
RR: reportability response
SNOMED-CT: Systemized Nomenclature of Medicine Clinical Terms
ST: String
XML: Extensible Markup Language
XPath: XML Path
XSLT: Extensible Stylesheet Language Transformations

Requirements								
eICR Data Element	Description	eICR Template	CDA Section/Location	eICR Data Classification	eICR XPath	CDA Terminology	Florida's Requirement	Florida's Minimal Data Element Completeness Score
Chief Complaint	Patient's chief complaint (the patient's own description).	Chief Complaint Section	Chief Complaint Section	eICR Implementation Guide Required Necessary for PHA Use	section[templateId/@root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1 ']/text	n/a	SHALL	90%
Date of the Report	The date on which the reporting party (e.g., physician, nurse practitioner, physician assistant, etc.), completes collection of minimum data for the eICR.	US Realm Header (V3)	ClinicalDocument	eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	ClinicalDocument/effectiveTime	n/a	SHALL	98%
ID	The ID is a globally unique identifier for the document. This is the eICR Document ID value.	US Realm Header (V3)	ClinicalDocument	eICR Implementation Guide Required Necessary for PHA Use	ClinicalDocument/id	n/a	SHALL	98%
Set ID	The set ID is a unique identification associated with the eICR triggering event. The data elements ID, set ID, version number, and related document work together to guide the replacement of an eICR document. All the documents in one set, across all document revisions, have the same setId.	US Realm Header (V3)	ClinicalDocument	eICR Implementation Guide Required Necessary for PHA Use	ClinicalDocument/setId	n/a	SHALL	98%
Version Number	Version number is an integer value used to version successive replacement documents.	US Realm Header (V3)	ClinicalDocument	eICR Implementation Guide Required Necessary for PHA Use	ClinicalDocument/versionNumber	n/a	SHALL	98%
Author	The creator of the clinical document. The author may be a device or a person.	US Realm Header (V3)	ClinicalDocument/author	eICR Implementation Guide Required Necessary for PHA Use	ClinicalDocument/author	n/a	SHALL	98%
Author Assigned Authoring Device	The author element represents the creator of the clinical document. The author may be a device or a person. The assigned authoring device shall include the manufacturerModelName and the softwareName (eg. "Epic - Version 10.9").	US Realm Header (V3)	ClinicalDocument/author	Necessary for PHA Use	ClinicalDocument/author/assignedAuthor/assignedAuthoringDevice	n/a	SHALL	90%
Author ID	The ID for the author representing the creator of the clinical document. The author may be a device or a person. If the author is a person, the ID should be taken from the National Provider Identificaiton (NPI) number.	US Realm Header (V3)	ClinicalDocument/author	eICR Implementation Guide Required Necessary for PHA Use	ClinicalDocument/author/assignedAuthor/id	n/a	SHALL	90%
Custodian	The organization that is in charge of the maintaining and is entrusted with the care of the clinical document. This shall include the ID, name, address, and telecom.	US Realm Header (V3)	ClinicalDocument/custodian	eICR Implementation Guide Required Necessary for PHA Use	ClinicalDocument/custodian	n/a	SHALL	98%
Custodian Organization Address	The physical address for the organization that is in charge of maintaining and is entrusted with the care of the clinical document. The custodian may be the document originator, a health information exchange, or other responsible party.	US Realm Header (V3)	ClinicalDocument/custodian	eICR Implementation Guide Required Necessary for PHA Use	ClinicalDocument/custodian/assignedCustodian/representedCustodianOrganization/telecom	n/a	SHALL	98%
Custodian Organization ID	The identification value for the organization that is in charge of maintaining and is entrusted with the care of the clinical document. The custodian may be the document originator, a health information exchange, or other responsible party.	US Realm Header (V3)	ClinicalDocument/custodian	eICR Implementation Guide Required Necessary for PHA Use	ClinicalDocument/custodian/assignedCustodian/representedCustodianOrganization/id	n/a	SHALL (SHOULD be NPI)	98%
Custodian Organization Name	The name of the organization that is in charge of maintaining and is entrusted with the care of the clinical document. The custodian may be the document originator, a health information exchange, or other responsible party.	US Realm Header (V3)	ClinicalDocument/custodian	eICR Implementation Guide Required Necessary for PHA Use	ClinicalDocument/custodian/assignedCustodian/representedCustodianOrganization/name	n/a	SHALL	98%
Custodian Organization Telecom	The telephone for the organization that is in charge of maintaining and is entrusted with the care of the clinical document. The custodian may be the document originator, a health information exchange, or other responsible party.	US Realm Header (V3)	ClinicalDocument/custodian	eICR Implementation Guide Required Necessary for PHA Use	ClinicalDocument/custodian/assignedCustodian/representedCustodianOrganization/addr	n/a	SHALL	98%
Encounter (EncompassingEncounter)	The encompassing encounter represents the setting of the clinical encounter during which the document act(s) or ServiceEvent(s) occurred (CDA R2). For the public health case report, the provider in charge of care and the facility in which care was provided when the case was triggered are contained within this element, along with the visit/encounter ID.	eICR Initial Public Health Case Report Document	ClinicalDocument/encompassingEncounter	US Core 4.0.0 Required eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	ClinicalDocument/componentOf/encompassingEncounter	n/a	SHALL	98%
Encounter ID	The ID for the clinical encounter.	eICR Initial Public Health Case Report Document	ClinicalDocument/encompassingEncounter	eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	ClinicalDocument/componentOf/encompassingEncounter/id	n/a	SHALL	95%

Requirements								
eICR Data Element	Description	eICR Template	CDA Section/Location	eICR Data Classification	eICR XPath	CDA Terminology	Florida's Requirement	Florida's Minimal Data Element Completeness Score
Encounter Type	Whether patient is outpatient, inpatient, emergency, or urgent care.	eICR Initial Public Health Case Report Document	ClinicalDocument/encompassingEncounter	US Core 4.0.0 Required Required for RCKMS/eCR Operations Necessary for PHA Use	ClinicalDocument/componentOf/encompassingEncounter/code	http://terminology.hl7.org/ValueSet/v3-ActEncounterCode	SHALL	90%
Facility Address	The mailing address for the facility where patient received or is receiving health care for the reportable condition. Must include street address, city/town, county, state, and ZIP Code.	eICR Initial Public Health Case Report Document	ClinicalDocument/encompassingEncounter	eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	ClinicalDocument/componentOf/encompassingEncounter/location/healthCareFacility/location/addr	n/a	SHALL	98%
Facility Email	The facility's email address.	eICR Initial Public Health Case Report Document	ClinicalDocument/encompassingEncounter	Necessary for PHA Use	ClinicalDocument/componentOf/encompassingEncounter/location/healthCareFacility/serviceProviderOrganization/telecom[mailto:]	n/a	MAY	50%
Facility FAX	The facility's FAX number with area code.	eICR Initial Public Health Case Report Document	ClinicalDocument/encompassingEncounter	Necessary for PHA Use	ClinicalDocument/componentOf/encompassingEncounter/location/healthCareFacility/serviceProviderOrganization/telecom[fax:]	n/a	MAY	50%
Facility ID Number	Identification code for the facility (e.g., Facility NPI).	eICR Initial Public Health Case Report Document	ClinicalDocument/encompassingEncounter	Necessary for PHA Use	ClinicalDocument/componentOf/encompassingEncounter/location/healthCareFacility/id	n/a	SHALL	98%
Facility Name	The facility's name that is where care occurred related to the reportable event.	eICR Initial Public Health Case Report Document	ClinicalDocument/encompassingEncounter	Necessary for PHA Use	ClinicalDocument/componentOf/encompassingEncounter/location/healthCareFacility/serviceProviderOrganization/name	n/a	SHALL	98%
Facility Phone	The facility's phone number with area code.	eICR Initial Public Health Case Report Document	ClinicalDocument/encompassingEncounter	Necessary for PHA Use	ClinicalDocument/componentOf/encompassingEncounter/location/healthCareFacility/serviceProviderOrganization/telecom[tel:]	n/a	SHALL	95%
Facility Type/Hospital Unit	The type of facility where patient received or is receiving health care for the reportable condition (e.g., hospital, ambulatory, urgent care, etc.).	eICR Initial Public Health Case Report Document	ClinicalDocument/encompassingEncounter	Necessary for PHA Use	ClinicalDocument/componentOf/encompassingEncounter/location/healthCareFacility/code	ServiceDeliveryLocationRoleType (https://terminology.hl7.org/5.1.0/ValueSet-v3-ServiceDeliveryLocationRoleType.html)	SHALL	95%
Provider Address	The provider's geographical location or mailing address.	eICR Initial Public Health Case Report Document	ClinicalDocument/encompassingEncounter	Required for RCKMS/eCR Operations Necessary for PHA Use	ClinicalDocument/componentOf/encompassingEncounter/responsibleParty/assignedEntity/representedOrganization/addr	n/a	SHALL	95%
Provider Email	The provider's email.	eICR Initial Public Health Case Report Document	ClinicalDocument/encompassingEncounter	Necessary for PHA Use	ClinicalDocument/componentOf/encompassingEncounter/responsibleParty/assignedEntity/telecom/[mailto:]	n/a	MAY	50%

Requirements								
eICR Data Element	Description	eICR Template	CDA Section/Location	eICR Data Classification	eICR XPath	CDA Terminology	Florida's Requirement	Florida's Minimal Data Element Completeness Score
Provider Facility/Office Name	The geographical location or mailing address of the provider's office or facility. Address must include street address, office or suite number (if applicable), city or town, state, and ZIP Code.	eICR Initial Public Health Case Report Document	ClinicalDocument/encompassingEncounter	Necessary for PHA Use	ClinicalDocument/componentOf/encompassingEncounter/responsibleParty/assignedEntity/representedOrganization/name	n/a	SHALL	95%
Provider Fax	The provider's FAX number with area code.	eICR Initial Public Health Case Report Document	ClinicalDocument/encompassingEncounter	Necessary for PHA Use	ClinicalDocument/componentOf/encompassingEncounter/responsibleParty/assignedEntity/telecom/[fax:]	n/a	MAY	50%
Provider ID	The provider's national provider identification (NPI) number.	eICR Initial Public Health Case Report Document	ClinicalDocument/encompassingEncounter	Necessary for PHA Use	ClinicalDocument/componentOf/encompassingEncounter/responsibleParty/assignedEntity/id	n/a	SHOULD (needs to be NPI)	85%
Provider Name	The first and last name of the health care provider.	eICR Initial Public Health Case Report Document	ClinicalDocument/encompassingEncounter	Necessary for PHA Use	ClinicalDocument/componentOf/encompassingEncounter/responsibleParty/assignedEntity/assignedPerson/name	n/a	SHALL	95%
Provider Phone	The provider's phone number with area code.	eICR Initial Public Health Case Report Document	ClinicalDocument/encompassingEncounter	Necessary for PHA Use	ClinicalDocument/componentOf/encompassingEncounter/responsibleParty/assignedEntity/telecom/[tel:]	n/a	SHALL	95%
Visit End Date/Time (outpatient) Discharge Date/Time (inpatient)	The date and time in which the encounter ended or the patient was discharged.	eICR Initial Public Health Case Report Document	ClinicalDocument/encompassingEncounter	Required for RCKMS/eCR Operations Necessary for PHA Use	ClinicalDocument/componentOf/encompassingEncounter/effectiveTime/high	n/a	MAY	50%
Visit Start Date/Time (outpatient) Admission Date/Time (inpatient)	This should be either the date and time of the provider's most recent encounter with the patient regarding the reportable condition or date and time the patient was admitted to the treatment facility; e.g., hospital. This defines when the individual may have been ill; a point in time to which can link other potential cases of reportable event; necessary to ensure follow-up within key time frames/helps triage priority followup and ensure control measures are implemented in a timely way.	eICR Initial Public Health Case Report Document	ClinicalDocument/encompassingEncounter	Required for RCKMS/eCR Operations Necessary for PHA Use	ClinicalDocument/componentOf/encompassingEncounter/effectiveTime/low	n/a	SHALL	90%
Date of Death	The patient's date of death.	eICR Initial Public Health Case Report Document	ClinicalDocument/recordTarget	eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	ClinicalDocument/recordTarget/patientRole/patient/sdtc:deceasedTime	n/a	SHALL	98%
Death Indicator	The indication that the patient has died or is dead, marked as "True" if applicable. Must also include the date of death. (example: sdtc:deceasedInd value="true" if died; sdtc:deceasedInd value="false" if patient has not died)	eICR Initial Public Health Case Report Document	ClinicalDocument/recordTarget	eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	ClinicalDocument/recordTarget/patientRole/patient/sdtc:deceasedInd	n/a	SHALL	98%
Ethnicity (Detailed)	The coded value for the expanded patient ethnicity. For example, if patient's ethnicity is Hispanic or Latino, and their detailed ethnicity is Cuban, then the code "2182-4" for Cuban should be used in this field.	US Realm Header (V3)	ClinicalDocument/recordTarget	Necessary for PHA Use	recordTarget/patientRole/patient/sdtc:ethnicGroupCode	Detailed Ethnicity (https://vsac.nlm.nih.gov/valueset/2.16.840.1.114222.4.11.877/expansion/Latest)	SHALL	50%

Requirements								
eICR Data Element	Description	eICR Template	CDA Section/Location	eICR Data Classification	eICR XPath	CDA Terminology	Florida's Requirement	Florida's Minimal Data Element Completeness Score
Ethnicity (OMB Ethnicity Categories)	The patient's ethnicity.	US Realm Header (V3)	ClinicalDocument/recordTarget	USCDI V1 Required eICR Implementation Guide Required Necessary for PHA Use	recordTarget/patientRole/patient/ethnicGroupCode	Ethnicity (https://vsac.nlm.nih.gov/valueset/2.16.840.1.114222.4.11.837/expansion/Latest)	SHALL	90%
Language Code (was Preferred Language) see: https://jira.hl7.org/browse/FHIR-40773	A coded value that indicates the patient's preferred language at the time of the reportable event. This code is defined by the IETF RFC 5646. Examples include af (Afrikaans), ab (Abkhazian), etc. These values can be found in value set: Language.	US Realm Header (V3)	ClinicalDocument/recordTarget	USCDI V1 Required eICR Implementation Guide Required Necessary for PHA Use	ClinicalDocument/recordTarget/patientRole/patient/languageCommunication/languageCode	Language (http://www.loc.gov/standards/iso639-2/php/code_list.php)	SHOULD	75%
Parent/ Guardian Address	The home address for the parent and/or guardian of the patient.	US Realm Header (V3)	ClinicalDocument/recordTarget	Necessary for PHA Use	Clinical Document/record target/patientRole/patient/guardian/addr	n/a	SHALL	95%
Parent/ Guardian Code	A coded value that indicates the relationship to the patient from the reportable event. Examples include ADOPTF (adoptive father), ADOPTP (adoptive parent), AUNT (aunt), etc. These values can be found in value set: Personal And Legal Relationship Role Type.	US Realm Header (V3)	ClinicalDocument/recordTarget	Necessary for PHA Use	Clinical Document/record target/patientRole/patient/guardian/code	Value Set: Personal And Legal Relationship Role Type urn:oid:2.16.840.1.113883.11.20.12.1 (https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.113883.11.20.12.1)	SHOULD	50%
Parent/ Guardian Email	The email for the parent and/or guardian of the patient.	US Realm Header (V3)	ClinicalDocument/recordTarget	Necessary for PHA Use	Clinical Document/record target/patientRole/patient/guardian/telecom[mailto:]	n/a	SHALL	90%
Parent/ Guardian Name	All names for the patient's parent or guardian, including legal names and aliases (if patient age is <18 years). Must include name type (i.e., legal or alias), first name, middle name, and last name.	US Realm Header (V3)	ClinicalDocument/recordTarget	Necessary for PHA Use	Clinical Document/record target/patientRole/patient/guardian/guardianPerson/name	n/a	SHALL	95%
Parent/ Guardian Phone	A coded value that indicates the type of telecom used. Examples incude AS (answering service), EC (emergency contact), HP (primary phone), MC (mobile contact), etc. These values can be found in value set: Telecom Use (US Realm Header).	US Realm Header (V3)	ClinicalDocument/recordTarget	Necessary for PHA Use	Clinical Document/record target/patientRole/patient/guardian/telecom[tel:]	n/a	SHALL	95%
Patient Address	All addresses for the patient, including current and residential addresses. Must include street address, apartment or suite number, city or town, county, state, ZIP Code, and country.	US Realm Header (V3)	ClinicalDocument/recordTarget	USCDI V1 Required US Core 4.0.0 Required eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	ClinicalDocument/recordTarget/patientRole/addr	n/a	SHALL	98%
Patient Birth Date	The patient's date of birth.	US Realm Header (V3)	ClinicalDocument/recordTarget	USCDI V1 Required US Core 4.0.0 Required eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	ClinicalDocument/recordTarget/patientRole/patient/birthTime	n/a	SHALL	98%
Patient Birth Place	The coded value and name of the country and ZIP Code for where the patient was born.	US Realm Header (V3)	ClinicalDocument/recordTarget	Necessary for PHA Use	ClinicalDocument/recordTarget/patientRole/patient/birthPlace	Value Set: Country urn:oid:2.16.840.1.113883.3.88.12.80.63 Value Set: PostalCode urn:oid:2.16.840.1.113883.3.88.12.80.2	SHOULD	50%
Patient Contact (Email)	A text value that indicates the email address for the patient.	US Realm Header (V3)	ClinicalDocument/recordTarget	USCDI V1 Required eICR Implementation Guide Required Necessary for PHA Use	ClinicalDocument/recordTarget/patientRole/telecom[mailto:]	n/a	SHALL	50%
Patient Contact (Phone)	All phone numbers and phone number types for the patient or parent/guardian.	US Realm Header (V3)	ClinicalDocument/recordTarget	USCDI V1 Required eICR Implementation Guide Required Necessary for PHA Use	ClinicalDocument/recordTarget/patientRole/telecom[tel:]	n/a	SHALL	95%

Requirements								
eICR Data Element	Description	eICR Template	CDA Section/Location	eICR Data Classification	eICR XPath	CDA Terminology	Florida's Requirement	Florida's Minimal Data Element Completeness Score
Patient Gender	AdministrativeGenderCode, which SHALL be selected from ValueSet Administrative Gender (HL7 V3)	US Realm Header (V3)	ClinicalDocument/recordTarget	USCDI V1 Required US Core 4.0.0 Required eICR Implementation Guide Required Necessary for PHA Use	ClinicalDocument/recordTarget/patientRole/patient/administrativeGenderCode	Administrative Gender (HL7 V3) https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.1.11.1/expansion	SHALL	98%
Patient ID Number	Patient social security number, medical record number, or other identifying value as required or allowed under jurisdictional laws governing health data exchange.	US Realm Header (V3)	ClinicalDocument/recordTarget	US Core 4.0.0 Required eICR Implementation Guide Required Necessary for PHA Use	ClinicalDocument/recordTarget/patientRole/id	n/a	SHALL	98%
Patient Name	All names for the patient, including legal names and aliases. Must include the name type (i.e., legal or alias), first name, middle name, and last name.	US Realm Header (V3)	ClinicalDocument/recordTarget	USCDI V1 Required US Core 4.0.0 Required eICR Implementation Guide Required Necessary for PHA Use	ClinicalDocument/recordTarget/patientRole/patient/name	n/a	SHALL	98%
Race (Detailed)	The coded value for the expanded patient race. For example, if patient's race is Chinese Asian, then the detailed race code "2034-7" for Chinese would be used in this field.	US Realm Header (V3)	ClinicalDocument/recordTarget	Necessary for PHA Use	recordTarget/patientRole/patient/sdtc:race	Race Value Set (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.1.11.14914/expansion/Latest)	SHALL	50%
Race (OMB Race Categories)	The patient's race.	US Realm Header (V3)	ClinicalDocument/recordTarget	USCDI V1 Required eICR Implementation Guide Required Necessary for PHA Use	recordTarget/patientRole/patient/race	Race Category Excluding Nulls (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.3.2074.1.1.3/expansion)	SHALL	90%
Emergency Outbreak Information	Information that is required during a public health emergency/outbreak. Risk indicator; ability to share critical information with public health associated with an outbreak.	Emergency Outbreak Information Observation	Emergency Outbreak Information Section	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.15.2.3.40']/code		MAY	50%
Date of Diagnosis (Encounter Diagnosis)	A date/time value that represents the relevant problems or diagnoses at the close of a visit or that need to be followed after the visit.	Encounter Activity (V3)	Encounters Section (entries required) (V3)	eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	encounter[templateId/@root='2.16.840.1.113883.10.20.22.4.49']/effectiveTime	n/a	SHALL	98%
Date of Onset (Encounter Diagnosis)	The date and time value of the encounter diagnosis for the reportable event. The encounter diagnosis is the health care provider's diagnoses of the patient's health condition.	Problem Observation (V3)	Encounters Section (entries required) (V3)	eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.4']/effectiveTime	n/a	SHALL	95%
Diagnoses (Encounter)	A pathology or disorder identified in a patient. The observation/value and all the qualifiers together make up one concept. This will include a coded value, the code system, and string text description of that coded value. For example, 10000006 SNOMED-CT Radiating chest pain (finding).	Encounter Activity (V3)/Encounter Diagnosis/Problem Observation (V3)	Encounters Section (entries required) (V3)	US Core 4.0.0 Required eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.4']/value	Problem (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.3.88.12.3221.7.4/expansion)	SHALL	95%
Encounter Disposition	The place or setting to which the patient discharged or transfered at the time of the encounter. For example, if the patient is admitted then Code "09" for "Admitted as an inpatient to this hospital" should be used, or if the patient is discharged home then Code "01" for "Discharged to home care or self care (routine discharge)."	Encounter Activity (V3)	Encounters Section (entries required) (V3)	Required for RCKMS/eCR Operations Necessary for PHA Use	encounter[templateId/@root='2.16.840.1.113883.10.20.22.4.49']/sdtc:dischargeDispositionCode	ValueSet 2.16.840.1.113883.3.88.12.80.33 NUBC UB-04 FL17-Patient Status (code system 2.16.840.1.113883.6.301.5) DYNAMIC or, if access to NUBC is unavailable, from CodeSystem 2.16.840.1.113883.12.112 HL7 Discharge Disposition	SHALL	90%
History of Present Illness	Physician's narrative of the history of the reportable event. Information about possible contacts and/or exposures may be captured here.	History of Present Illness Section	History of Present Illness Section	eICR Implementation Guide Required Necessary for PHA Use	section[templateId/@root='1.3.6.1.4.1.19376.1.5.3.1.3.4']/text	n/a	SHALL	90%

Requirements								
eICR Data Element	Description	eICR Template	CDA Section/Location	eICR Data Classification	eICR XPath	CDA Terminology	Florida's Requirement	Florida's Minimal Data Element Completeness Score
Immunization Date	The date/time value which the immunization was given.	Immunization Activity (V3)	Immunizations Sections (entries required) (V3)	US Core 4.0.0 Required	substanceAdministration[templateId/@root='2.16.840.1.113883.10.20.22.4.52']/effectiveTime	n/a	SHALL	98%
Immunization Dose Quantity	The numerical amount and scale used to measure vaccine quantity. For example, <doseQuantity value="50" unit="ug" />.	Immunization Activity (V3)	Immunizations Sections (entries required) (V3)	Necessary for PHA Use	substanceAdministration[templateId/@root='2.16.840.1.113883.10.20.22.4.52']/doseQuantity	n/a	SHALL	90%
Immunization ID	The immunizaiton ID is the ID value given to the immunization activity instance.	Immunization Activity (V3)	Immunizations Sections (entries required) (V3)	Necessary for PHA Use	substanceAdministration[templateId/@root='2.16.840.1.113883.10.20.22.4.52']/id	n/a	SHALL	90%
Immunization Manufacturer Organization	The name of the manufacturer of the immunization product.	Immunization Activity (V3)/Immunization Medication Information (V2)	Immunizations Sections (entries required) (V3)	Necessary for PHA Use	manufacturedProduct[templateId/@root='2.16.840.1.113883.10.20.15.2.3.38']/manufacturerOrganization	n/a	SHALL	95%
Immunization Performer	The provider who performed the immunization procedure.	Immunization Activity (V3)	Immunizations Sections (entries required) (V3)	Necessary for PHA Use	substanceAdministration[templateId/@root='2.16.840.1.113883.10.20.22.4.52']/performer	n/a	SHOULD	50%
Immunization Repeat Number	The number of doses in a immunization series. In "INT" (intent) mood, the repeatNumber defines the number of allowed administrations. For example, a repeatNumber of "3" means that the substance can be administered up to 3 times. In "EVN" (event) mood, the repeatNumber is the number of occurrences. For example, a repeatNumber of "3" in a substance administration event means that the current administration is the 3rd in a series.	Immunization Activity (V3)	Immunizations Sections (entries required) (V3)	Necessary for PHA Use	substanceAdministration[templateId/@root='2.16.840.1.113883.10.20.22.4.52']/repeatNumber	n/a	SHOULD	95%
Immunization Route Code	The route of immunization administration as selected from the SPL Drug Route of Administration Terminology. Examples: oral, soft tissue, intramuscular, etc.	Immunization Activity (V3)	Immunizations Sections (entries required) (V3)	Necessary for PHA Use	substanceAdministration[templateId/@root='2.16.840.1.113883.10.20.22.4.52']/routeCode	n/a	SHALL	80%
Immunization Status (given)	The patient's current immunization status, if the patient received the immunization.	Immunization Activity (V3)	Immunizations Sections (entries required) (V3)	US Core 4.0.0 Required	substanceAdministration[templateId/@root='2.16.840.1.113883.10.20.22.4.52']/@moodCode='EVN'	n/a	SHALL	98%
Immunization Status (not given)	The patient's current immunization status, if the patient did not receive the immunization.	Immunization Activity (V3)	Immunizations Sections (entries required) (V3)	US Core 4.0.0 Required	substanceAdministration[templateId/@root='2.16.840.1.113883.10.20.22.4.52']/@negationInd='true' AND substanceAdministration[templateId/@root='2.16.840.1.113883.10.20.22.4.52']/@moodCode='EVN'	n/a	SHALL	98%
Immunization Status (other)	The patient's current immunization status, such as: aborted, active, cancelled, completed, held, new, normal, nullified, obsolete, or suspended.	Immunization Activity (V3)	Immunizations Sections (entries required) (V3)	US Core 4.0.0 Required	substanceAdministration[templateId/@root='2.16.840.1.113883.10.20.22.4.52']/statusCode	ActStatus (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.1.11.15933/expansion)	SHALL	98%
Immunization Vaccine Code	This is a coded value that corresponds with the CDC Vaccine Code (CVX) vaccine concepts. These concepts respresent actual vaccine types, including those that are historical record of a vaccine administered where the exact formulation is unknown. For example, 03 CVX measles, mumps, and rubella virus vaccine. These values can be found in value set: CVX Vaccines Administered Vaccine Set.	Immunization Activity (V3)/Immunization Medication Information (V2)	Immunizations Sections (entries required) (V3)	USCDI V1 Required US Core 4.0.0 Required eICR Implementation Guide Required Required for RCKMS/eCR Operations	manufacturedProduct[templateId/@root='2.16.840.1.113883.10.20.22.4.54']/manufacturedMaterial/code	CVX Vaccines Administered Vaccine Set (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1010.6/expansion) Vaccine Clinical Drug (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1010.8/expansion)	SHALL	95%

Requirements								
eICR Data Element	Description	eICR Template	CDA Section/Location	eICR Data Classification	eICR XPath	CDA Terminology	Florida's Requirement	Florida's Minimal Data Element Completeness Score
Immunization Vaccine Code (trigger)	The immunization medication information coded value. This should be taken from the RCTC Subset for the immunization trigger code value for the trigger template.	Immunization Activity (V3)/Initial Case Report Trigger Code Immunization Medication Information	Immunizations Sections (entries required) (V3)	USCDI V1 Required US Core 4.0.0 Required eICR Implementation Guide Required Required for RCKMS/eCR Operations	manufacturedProduct[templateId/@root='2.16.840.1.113883.10.20.15.2.3.38']/manufacturedMaterial/code	Medications Triggers for Public Health Reporting (RCTC Subset) (https://ersd.aimsplatform.org/) (At publication time the Immunization trigger code value set had not been defined)	SHALL	95%
Vaccine Credential Patient Assertion	This value respresents whether or not the patient has asserted that they have verifiable vaccine credentials. This is an indicator of self-reported vaccine history.	Vaccine Credential Patient Assertion	Immunizations Sections (entries required) (V3)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.15.2.3.55']/value	Yes No Unknown (YNU) (https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.888)	SHALL (if sent)	50%
Medication Administration Dose Quantity	The numerical amount used to measure the given medication dose. doseQuantity is a unitless number that indicates the number of products given per administration. It is limited to the active dose given (e.g., "2", meaning 2 x "metoprolol 25mg tablet" per administration).	Medication Activity (V2)	Medications Administered Section (V2)	eICR Implementation Guide Required Necessary for PHA Use	substanceAdministration[templateId/@root='2.16.840.1.113883.10.20.22.4.16']/doseQuantity	n/a	SHALL	95%
Medication Administration ID	The medication administration ID is the ID value given to the medication activity instance. A Medication Activity describes substance administrations that have actually occurred (e.g., pills ingested or injections given) or are intended to occur (e.g., "take 2 tablets twice a day for the next 10 days").	Medication Activity (V2)	Medications Administered Section (V2)	eICR Implementation Guide Required Necessary for PHA Use	substanceAdministration[templateId/@root='2.16.840.1.113883.10.20.22.4.16']/id	n/a	SHALL	90%
Medication Administration Rate Quantity	The numerical amount for the medication rate quantity.	Medication Activity (V2)	Medications Administered Section (V2)	Necessary for PHA Use	substanceAdministration[templateId/@root='2.16.840.1.113883.10.20.22.4.16']/rateQuantity	n/a	SHALL	90%
Medication Administration Route	The route of medication administration as selected from the SPL Drug Route of Administration Terminology. Examples: oral, soft tissue, intramuscular, etc.	Medication Activity (V2)	Medications Administered Section (V2)	Necessary for PHA Use	substanceAdministration[templateId/@root='2.16.840.1.113883.10.20.22.4.16']/routeCode	SPL Drug Route of Administration Terminology (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.3.88.12.3221.8.7/expansion) Medication Route (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1099.12/expansion)	SHALL	80%
Medication Administration Status	What the current status of the medication, such as active or completed.	Medication Activity (V2)	Medications Administered Section (V2)	eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	substanceAdministration[templateId/@root='2.16.840.1.113883.10.20.22.4.16']/statusCode	Medication Status (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1099.11/expansion)	SHALL	98%
Medication Administration Time	The datetime stamp of the medication administration activity.	Medication Activity (V2)	Medications Administered Section (V2)	eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	substanceAdministration[templateId/@root='2.16.840.1.113883.10.20.22.4.16']/effectiveTime [ivl_ts]	n/a	SHALL	98%

Requirements								
eICR Data Element	Description	eICR Template	CDA Section/Location	eICR Data Classification	eICR XPath	CDA Terminology	Florida's Requirement	Florida's Minimal Data Element Completeness Score
Medications Administered (list)	The medications which have been given. It is required to send RXNORM code and Display name.	Medication Activity (V2)/Medication Information (V2)	Medications Administered Section (V2)	eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	manufacturedProduct[templateId/@root='2.16.840.1.113883.10.20.22.4.23']/manufacturedMaterial/code	Medication Clinical Drug (RXNORM) (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1010.4/expansion) Clinical Substance (RXNORM, SNOMED CT) (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1010.2/expansion)	SHALL	95%
Medications Administered (trigger)	The trigger code template for the medications administered. Medications relevant to the reportable event (includes admission, administered, historical, planned medications).	Medication Activity (V2)/Initial Case Report Trigger Code Medication Information	Medications Administered Section (V2)	eICR Implementation Guide Required Necessary for PHA Use	manufacturedProduct[templateId/@root='2.16.840.1.113883.10.20.15.2.3.36']/manufacturedMaterial/code	Medications Triggers for Public Health Reporting (RCTC Subset) (https://ersd.aimsplatform.org/)	SHALL	95%
Therapeutic Response to Medication	Codes that document the therapeutic response to an administered medication (e.g. code= '268910001', codesystemname= 'SNOMED CT', displayname= 'Patient's condition improved (finding)')	Therapeutic Medication Response Observation	Medications Administered Section (V2)	Required for RCKMS/eCR Operations	observation[templateId/@root='2.16.840.1.113883.10.20.15.2.3.37']/value	Therapeutic Response to Medication (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.10.20.15.2.5.12/expansion)	SHOULD	75%
Medication	Medications relevant to the reportable event (includes admission, administered, historical, planned medications). It is required to send RXNORM code and Display name.	Medication Activity (V2) /Medication Information (V2)	Medications Section (entries required) (V2)	USCDI V1 Required US Core 4.0.0 Required eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	manufacturedProduct[templateId/@root='2.16.840.1.113883.10.20.22.4.23']/manufacturedMaterial/code	Medication Clinical Drug (RXNORM) (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1010.4/expansion) Clinical Substance (RXNORM, SNOMED CT) (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1010.2/expansion)	SHALL	90%
Medication (trigger)	A code trigger for manufacturedMaterial. A medication should be recorded as a pre-coordinated ingredient + strength + dose form (e.g., “metoprolol 25mg tablet”, “amoxicillin 400mg/5mL suspension”) where possible. This includes RxNorm codes whose Term Type is SCD (semantic clinical drug), SBD (semantic brand drug), GPCK (generic pack), BPCK (brand pack).	Medication Activity (V2)/Initial Case Report Trigger Code Medication Information	Medications Section (entries required) (V2)	USCDI V1 Required US Core 4.0.0 Required eICR Implementation Guide Required Necessary for PHA Use	manufacturedProduct[templateId/@root='2.16.840.1.113883.10.20.15.2.3.36']/manufacturedMaterial/code	Medications Triggers for Public Health Reporting (RCTC Subset) (https://ersd.aimsplatform.org/)	SHALL	90%
Medication Dose Quantity	The numerical amount used to measure the active medication dose. doseQuantity is a unitless number that indicates the number of products given per administration (e.g., "2", meaning 2 x "metoprolol 25mg tablet" per administration).	Medication Activity (V2)	Medications Section (entries required) (V2)	eICR Implementation Guide Required Necessary for PHA Use	substanceAdministration[templateId/@root='2.16.840.1.113883.10.20.22.4.16']/doseQuantity	n/a	SHALL	90%
Medication ID	The medication administration ID is the ID value given to the medication activity instance. A Medication Activity describes substance administrations that have actually occurred (e.g., pills ingested or injections given) or are intended to occur (e.g., "take 2 tablets twice a day for the next 10 days").	Medication Activity (V2)	Medications Section (entries required) (V2)	eICR Implementation Guide Required	substanceAdministration[templateId/@root='2.16.840.1.113883.10.20.22.4.16']/id	n/a	SHALL	90%
Medication Manufacturer Organization	The name of the manufacterer of the medication.	Medication Activity (V2) /Medication Information (V2)	Medications Section (entries required) (V2)	Necessary for PHA Use	manufacturedProduct[templateId/@root='2.16.840.1.113883.10.20.22.4.23']/manufacturerOrganization	n/a	MAY	50%
Medication Rate Quantity	rateQuantity contains one unit selected from the ValueSet UnitsOfMeasureCaseSensitive.	Medication Activity (V2)	Medications Section (entries required) (V2)	Necessary for PHA Use	substanceAdministration[templateId/@root='2.16.840.1.113883.10.20.22.4.16']/rateQuantity	n/a	SHALL	90%

Requirements								
eICR Data Element	Description	eICR Template	CDA Section/Location	eICR Data Classification	eICR XPath	CDA Terminology	Florida's Requirement	Florida's Minimal Data Element Completeness Score
Medication Route	The route of medication administration as selected from the SPL Drug Route of Administration Terminology. Examples: oral, soft tissue, intramuscular, etc.	Medication Activity (V2)	Medications Section (entries required) (V2)	Necessary for PHA Use	substanceAdministration[templateId/@root='2.16.840.1.113883.10.20.22.4.16']/routeCode	SPL Drug Route of Administration Terminology (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.3.88.12.3221.8.7/expansion) Medication Route (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1099.12/expansion)	SHALL	80%
Medication Status	This status code, which shall be selected from ValueSet Medication Status codeset. https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1099.11/expansion	Medication Activity (V2)	Medications Section (entries required) (V2)	US Core 4.0.0 Required eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	substanceAdministration[templateId/@root='2.16.840.1.113883.10.20.22.4.16']/statusCode	Medication Status (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1099.11/expansion)	SHALL	98%
Medication Time	At a minimum, a Medication Activity shall include an effectiveTime indicating the duration of the administration (or single-administration timestamp). Ambulatory medication lists generally provide a summary of use for a given medication over time - a medication activity in event mood with the duration reflecting when the medication started and stopped. Ongoing medications will not have a stop date (or will have a stop date with a suitable NULL value). Ambulatory medication lists will generally also have a frequency (e.g., a medication is being taken twice a day). Inpatient medications generally record each administration as a separate act.	Medication Activity (V2)	Medications Section (entries required) (V2)	eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	substanceAdministration[templateId/@root='2.16.840.1.113883.10.20.22.4.16']/effectiveTime[ivl_ts]	n/a	SHALL	98%
Planned Medication Status	This is the status code for the planned medication to be given, which shall be selected from ValueSet Medication Status codeset. https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1099.11/expansion	Medication Activity (V2)	Medications Section (entries required) (V2)	US Core 4.0.0 Required eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	substanceAdministration[templateId/@root='2.16.840.1.113883.10.20.22.4.16']/statusCode	Status='active'	SHALL	98%
Current Employer Address	Address of patient's current employer. Version 3.1. only.	Past or Present Occupation Observation (V2)	Occupational Data for Health Template Requirements Section (V2)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.217'][statusCode="active"][not(effectiveTime/high)]/participant/participantRole/playingEntity/addr (For current employer, statusCode="active" and effectiveTime/high is omitted.)	n/a	SHALL	80%
Current Employer Name	Name of patient's current employer. Version 3.1. only.	Past or Present Occupation Observation (V2)	Occupational Data for Health Template Requirements Section (V2)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.217'][statusCode="active"][not(effectiveTime/high)]/participant/participantRole/playingEntity/name (For current employer, statusCode="active" and effectiveTime/high is omitted.)	n/a	SHALL	85%
Current Employer Phone	Phone number of patient's current employer. Version 3.1. only.	Past or Present Occupation Observation (V2)	Occupational Data for Health Template Requirements Section (V2)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.217'][statusCode="active"][not(effectiveTime/high)]/participant/participantRole/playingEntity/telecom (For current employer, statusCode="active" and effectiveTime/high is omitted.)	n/a	SHALL	85%

Requirements								
eICR Data Element	Description	eICR Template	CDA Section/Location	eICR Data Classification	eICR XPath	CDA Terminology	Florida's Requirement	Florida's Minimal Data Element Completeness Score
Current Industry	Type of business (industry) in which the subject currently holds a job.	Past or Present Industry Observation (V2)	Occupational Data for Health Template Requirements Section (V2)	Required for RCKMS/eCR Operations	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.216']/value	Industry CDC Census 2010 (https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7187) Industry NAICS Detail (ODH) (https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7900)	SHALL (IF POPULATED)	90%
Current Job Title	Title of the currently held job.	Past or Present Occupation Observation (V2)	Occupational Data for Health Template Requirements Section (V2)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.217'][statusCode="active"][not(effectiveTime/high)]/text (For current job title, statusCode="active" and effectiveTime/high is omitted.)	n/a	MAY	50%
Current Occupation	The occupation which the subject currently holds or has held for the longest duration through his or her working history. For current occupation, statusCode='active' and effectiveTime/high is omitted.	Past or Present Occupation Observation (V2)	Occupational Data for Health Template Requirements Section (V2)	Required for RCKMS/eCR Operations	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.217'][statusCode="active"][not(effectiveTime/high)]/value (For current occupation, statusCode="active" and effectiveTime/high is omitted.)	Occupation CDC Census 2010 (https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7186) Occupation ONETSOC Detail (ODH) (https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7901)	SHALL	95%
Employment Status	Concepts representing whether a person does or does not currently have a job or is not currently in the labor pool seeking employment. A person's Employment Status is independent of Job characteristics, e.g., not "full-time work" or "part-time work," because many people have more than one job. (ie: Employed, NotInLaborForce, or Unemployed)	History of Employment Status Observation	Occupational Data for Health Template Requirements Section (V2)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.212']/value	Employment Status ODH (https://terminology.hl7.org/ValueSet-v3-employmentStatusODH.html)	SHOULD	80%
Exposure/Contact Information	Information that is required during a public health emergency/outbreak. This would be the type of exposure/contact (environmental, activity, event, location, person, animal, etc.).	Exposure/Contact Information Observation	Occupational Data for Health Template Requirements Section (V2)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.15.2.3.52']/code	Exposure Setting (https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7942) Exposure Location (https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.3209) Social History Type (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.3.88.12.80.60/expansion)	SHOULD	50%
Occupational Exposure	Actual contact or interaction with a specific hazard at work that increases an individual's risk of a detrimental physical or mental health outcome.	Occupational Hazard Observation	Occupational Data for Health Template Requirements Section (V2)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.215']/value	n/a	SHALL (IF POPULATED)	98%

Requirements								
eICR Data Element	Description	eICR Template	CDA Section/Location	eICR Data Classification	eICR XPath	CDA Terminology	Florida's Requirement	Florida's Minimal Data Element Completeness Score
Usual Industry	The industry (type of business) which the subject has worked in for the longest duration while in the occupation they have held for the longest duration. For example, the usual industry could be hospitality and the occupation could be clerk.	Usual Industry Observation (V2)	Occupational Data for Health Template Requirements Section (V2)	Required for RCKMS/eCR Operations	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.219']/value	Industry CDC Census 2010 (https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7187) Industry NAICS Detail (ODH) (https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7900)	SHALL (if sent)	95%
Usual Occupation	The type of work (paid or unpaid) done by the patient for the longest amount of time during his or her working history, not including voluntary work. For example, the usual occupation could be "welder." These data can be used by public health entities to investigate the relationship between conditions and exposures at work and illnesses, causes of death, or cancer.	Usual Occupation Observation (V2)	Occupational Data for Health Template Requirements Section (V2)	Required for RCKMS/eCR Operations	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.221']/value	Occupation CDC Census 2010 (https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7186) Occupation ONETSOC Detail (ODH) (https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7901)	SHALL (if sent)	90%
Past Medical History (code)	A coded value of the patient's past complaints, problems, and diagnoses, taken from the Problem ValueSet. For a provider seeing a patient in the clinic today, observing a history of heart attack that occurred five years ago, the effectiveTime is five years ago. If the problem is known to be resolved, then an effectiveTime/high would be present.	Problem Observation (V3)	Past Medical History (V3)	Required for RCKMS/eCR Operations	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.4']/value	Problem (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.3.88.12.3221.7.4/expansion)	SHALL	95%
Past Medical History (text)	A text value that contains a record of the patient's past complaints, problems, and diagnoses. It contains data from the patient's past up to the patient's current complaint or reason for seeking medical care.	Problem Observation (V3)	Past Medical History (V3)	Necessary for PHA Use	section[templateId/@root='2.16.840.1.113883.10.20.22.2.20']/text	n/a	SHALL (if sent)	90%
Lab Order Body Site/Location	This is used to identify the part of the body of concern for the planned observation. All SNOMED CT anatomic structures, locations, abnormal structures that can be considered to describe an anatomical site.	Planned Observation (V2)	Plan of Treatment Section (V2)	Required for RCKMS/eCR Operations Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.44']/targetSiteCode	Body Site Value Set (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.3.88.12.3221.8.9/expansion)	SHALL	75%
Lab Order Code (ordered)	Ordered tests for the patient during the encounter. This should be the LOINC code of the laboratory test ordered.	Planned Observation (V2)	Plan of Treatment Section (V2)	eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.44']/code	LOINC	SHALL	75%
Lab Order Code (trigger) (ordered)	This set of values contains laboratory test names that may be used for placing a lab order for a test that represents that the patient may have a potentially reportable condition. These pertain to laboratory orders placed, coded in LOINC, where the lab order includes at least one test for a condition reportable upon suspicion of the condition.	Initial Case Report Trigger Code Lab Test Order	Plan of Treatment Section (V2)	eICR Implementation Guide Required Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.15.2.3.4']/code	Diagnosis_Problem Triggers for Public Health Reporting (RCTC Subset) (https://ersd.aimsplatform.org/)	SHALL	75%
Lab Order ID/Placer Order Number	Identifier for the laboratory order from the encounter for the reportable event.	Planned Observation (V2)	Plan of Treatment Section (V2)	eICR Implementation Guide Required Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.44']/id	n/a	SHOULD	75%
Lab Order Orderer	The author in a planned observation represents the clinician who is requesting or planning the observation. This segment shall contain ordering ID, name, telecom, and address.	Planned Observation (V2)	Plan of Treatment Section (V2)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.44']/author	n/a	SHOULD	50%

Requirements								
eICR Data Element	Description	eICR Template	CDA Section/Location	eICR Data Classification	eICR XPath	CDA Terminology	Florida's Requirement	Florida's Minimal Data Element Completeness Score
Lab Order Orderer ID	The Orderer ID of the author in a planned observation represents the clinician who is requesting or planning the observation.	Planned Observation (V2)	Plan of Treatment Section (V2)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.44']/author/assignedAuthor/id	n/a	SHALL (if sent)	90%
Lab Order Orderer Name	The name value of the author in a planned observation represents the clinician who is requesting or planning the observation.	Planned Observation (V2)	Plan of Treatment Section (V2)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.44']/author/assignedAuthor/assignedPerson/name	n/a	MAY	50%
Lab Order Orderer Telecom	The telecom value of the author in a planned observation represents the clinician who is requesting or planning the observation.	Planned Observation (V2)	Plan of Treatment Section (V2)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.44']/author/assignedAuthor/assignedPerson/telecom	n/a	MAY	50%
Lab Order Performer	The clinician who is requesting or planning the intended laboratory test during the reportable event.	Planned Observation (V2)	Plan of Treatment Section (V2)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.44']/performer	n/a	SHOULD	75%
Lab Order Performer (Organization) ID	The clinician who is expected to perform the observation could be identified using procedure/performer. This is the represented Organization ID value within the performer segment of the clinician who is expected to perform the observation.	Planned Observation (V2)	Plan of Treatment Section (V2)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.44']/performer/assignedEntity/representedOrganization/id	n/a	MAY	50%
Lab Order Time (time should occur)	This is a date/time value that represents when the lab test should occur.	Planned Observation (V2)	Plan of Treatment Section (V2)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.44']/effectiveTime	n/a	SHALL	75%
Planned Medication	Medications relevant to the reportable event (includes planned medications). A medication should be recorded as a pre-coordinated ingredient + strength + dose form (e.g., "metoprolol 25mg tablet", "amoxicillin 400mg/5mL suspension") where possible.	Planned Medication Activity (V2)/Medication Information (V2)	Plan of Treatment Section (V2)	USCDI V1 Required US Core 4.0.0 Required eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	manufacturedProduct[templateId/@root='2.16.840.1.113883.10.20.22.4.23']/manufacturedMaterial/code	Medication Clinical Drug (RXNORM) (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1010.4/expansion) Clinical Substance (RXNORM, SNOMED CT) (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1010.2/expansion)	SHALL	90%
Planned Medication (trigger)	This is a coded value. It should reference CVX, RXNORM, SNOMED for the planned medication codes that may represent that the patient may have a potentially reportable condition. These pertain to medications administered and medications prescribed, where the medication, coded in CVX, RXNORM, SNOMED, may be indicative of a reportable condition.	Medication Activity (V2)/Initial Case Report Trigger Code Medication Information	Plan of Treatment Section (V2)	USCDI V1 Required US Core 4.0.0 Required eICR Implementation Guide Required Necessary for PHA Use	manufacturedProduct[templateId/@root='2.16.840.1.113883.10.20.15.2.3.36']/manufacturedMaterial/code	Medications Triggers for Public Health Reporting (RCTC Subset) (https://ersd.aimsplatform.org/)	SHALL	90%
Planned Medication Dose Quantity	The numerical amount used to measure the planned medication dose. This is a unitless number that indicates the number of products planned to be administered. It is limited to prospective, unfulfilled, or incomplete orders and requests only. (e.g., "2", meaning 2 x "metoprolol 25mg tablet" per administration).	Medication Activity (V2)	Plan of Treatment Section (V2)	Necessary for PHA Use	substanceAdministration[templateId/@root='2.16.840.1.113883.10.20.22.4.16']/doseQuantity	n/a	SHALL	75%
Planned Medication ID	The medication administration ID is the ID value given to the planned medication activity instance. A Medication Activity describes substance administrations that have actually occurred (e.g., pills ingested or injections given) or are intended to occur (e.g., "take 2 tablets twice a day for the next 10 days").	Medication Activity (V2)	Plan of Treatment Section (V2)	eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	substanceAdministration[templateId/@root='2.16.840.1.113883.10.20.22.4.16']/id	n/a	SHALL	90%
Planned Medication Rate Quantity	This is the time component used to administer the planned medication during the reportable event. It is limited to prospective, unfulfilled, or incomplete orders and requests only.	Medication Activity (V2)	Plan of Treatment Section (V2)	Necessary for PHA Use	substanceAdministration[templateId/@root='2.16.840.1.113883.10.20.22.4.16']/rateQuantity	n/a	SHALL	75%

Requirements								
eICR Data Element	Description	eICR Template	CDA Section/Location	eICR Data Classification	eICR XPath	CDA Terminology	Florida's Requirement	Florida's Minimal Data Element Completeness Score
Planned Medication Route	Planned medication route (i.e. by mouth, intraosseous, intravenous, etc.) activity relevant to the reportable event. It is limited to prospective, unfulfilled, or incomplete orders and requests only. Medication activities in "INT" mood are reflections of what a clinician intends a patient to be taking.	Medication Activity (V2)	Plan of Treatment Section (V2)	Necessary for PHA Use	substanceAdministration[templateId/@root='2.16.840.1.113883.10.20.22.4.16']/routeCode	SPL Drug Route of Administration Terminology (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.3.88.12.3221.8.7/expansion) Medication Route (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1099.12/expansion)	SHALL	75%
Planned Medication Time	At a minimum, a Medication Activity shall include an effectiveTime indicating the duration of the administration (or single-administration timestamp). Ambulatory medication lists generally provide a summary of use for a given medication over time - a medication activity in event mood with the duration reflecting when the medication started and stopped. Ongoing medications will not have a stop date (or will have a stop date with a suitable NULL value). Ambulatory medication lists will generally also have a frequency (e.g., a medication is being taken twice a day). Inpatient medications generally record each administration as a separate act.	Medication Activity (V2)	Plan of Treatment Section (V2)	eICR Implementation Guide Required Necessary for PHA Use	substanceAdministration[templateId/@root='2.16.840.1.113883.10.20.22.4.16']/effectiveTime[ivl_ts]	n/a	SHALL	98%
Planned Procedure (act)	The planned procedure code template act. The planned procedure is a procedure that has not yet been completed or performed. This template represents planned acts that are not classified as an observation or a procedure according to the HL7 RIM. Examples of these acts are a dressing change, the teaching or feeding of a patient, or the providing of comfort measures.	Planned Act (V2)	Plan of Treatment Section (V2)	eICR Implementation Guide Required Necessary for PHA Use	act[templateId/@root='2.16.840.1.113883.10.20.22.4.39']/code	LOINC SNOMED CT	SHOULD	75%
Planned Procedure (observation)	The planned procedure code template observation value, should be a LOINC code. The planned procedure is a procedure that has not yet been completed or performed. This template represents planned observations that result in new information about the patient which cannot be classified as a procedure according to the HL7 RIM, i.e., procedures alter the patient's body. Examples of these observations are laboratory tests, diagnostic imaging tests, EEGs, and EKGs.	Planned Observation (V2)	Plan of Treatment Section (V2)	eICR Implementation Guide Required Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.44']/code	LOINC	SHALL	90%
Planned Procedure (procedure)	The planned procedure procedure template coded value. The planned procedure is a procedure that has not yet been completed or performed. This template represents planned alterations of the patient's physical condition. Examples of such procedures are tracheostomy, knee replacement, and craniectomy.	Planned Procedure (V2)	Plan of Treatment Section (V2)	eICR Implementation Guide Required Necessary for PHA Use	procedure[templateId/@root='2.16.840.1.113883.10.20.22.4.41']/code	LOINC SNOMED CT CPT-4 ICD10 PCS	SHALL	90%
Planned Procedure (Trigger) (act)	The planned procedure trigger code template act. The planned procedure is a procedure that has not yet been completed or performed. The Initial Case Report Trigger Code Planned Act template indicates that the act (procedure) code is a trigger code contained in the Reportable Condition Trigger Codes and this template must be present.	Initial Case Report Trigger Code Planned Act	Plan of Treatment Section (V2)	eICR Implementation Guide Required Necessary for PHA Use	act[templateId/@root='2.16.840.1.113883.10.20.15.2.3.41']/code	Reportable Condition Trigger Codes (RCTC) (https://ersd.aimsplatform.org/)	SHALL	90%
Planned Procedure (Trigger) (observation)	The planned procedure trigger code template observation value, should be a LOINC code selected from ValueSet Diagnosis_Problem Triggers for Public Health Reporting (RCTC Subset). The planned procedure is a procedure that has not yet been completed or performed.	Initial Case Report Trigger Code Planned Observation	Plan of Treatment Section (V2)	eICR Implementation Guide Required Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.15.2.3.43']/code	Reportable Condition Trigger Codes (RCTC) (https://ersd.aimsplatform.org/)	SHALL	90%

Requirements								
eICR Data Element	Description	eICR Template	CDA Section/Location	eICR Data Classification	eICR XPath	CDA Terminology	Florida's Requirement	Florida's Minimal Data Element Completeness Score
Planned Procedure (Trigger) (procedure)	The planned procedure procedure trigger template coded value, which should be selected from ValueSet Diagnosis_Problem Triggers for Public Health Reporting (RCTC Subset). The Initial Case Report Trigger Code Procedure Activity Procedure template indicates that the procedure code is a trigger code contained in the Reportable Condition Trigger Codes and this template must be present. The planned procedure is a procedure that has not yet been completed or performed.	Initial Case Report Trigger Code Planned Procedure	Plan of Treatment Section (V2)	eICR Implementation Guide Required Necessary for PHA Use	procedure[templateId/@root='2.16.840.1.113883.10.20.15.2.3.42']/code	Reportable Condition Trigger Codes (RCTC) (https://ersd.aimsplatform.org/)	SHALL	90%
Estimated date of delivery (EDD)	A date/time value of the anticipated date when the individual will give birth.	Estimated Date of Delivery (SUPPLEMENTAL PREGNANCY)	Pregnancy Section	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.297']/value	n/a	SHALL	90%
Estimated date of delivery (EDD) method	The method used to determine the EDD.	Estimated Date of Delivery (SUPPLEMENTAL PREGNANCY)	Pregnancy Section	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.297']/code	Estimated Date of Delivery Including Method (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.11.20.9.81/expansion)	SHALL (if pregnant status if = YES)	90%
Estimated gestational age (expressed in days)	A numerical value of the estimated gestational age, in days, of the pregnancy beginning from the time of fertilization.	Estimated Gestational Age of Pregnancy	Pregnancy Section	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.280']/value	n/a	SHALL	90%
Estimated gestational age determination date	This is a date/time value of when the provider determined the estimated gestational age of the pregnancy.	Estimated Gestational Age of Pregnancy	Pregnancy Section	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.280']/effectiveTime	n/a	SHALL	90%
Estimated gestational age determination method	A coded value that indicates the method of determination by which the gestational age was estimated (i.e. from last menstrual period, delivery date, abodminal circumference on ultrasound, etc.)	Estimated Gestational Age of Pregnancy	Pregnancy Section	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.280']/code	Estimated Gestational Age Code Including Method (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.11.20.9.82/expansion)	SHOULD* (same as IG)	50%
Last menstrual period (LMP)	The value should be the date of last menstrual period. Example: <value xsi:type="TS" value="20121104"/>	Last Menstrual Period	Pregnancy Section	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.30.3.34']/value	n/a	SHALL (IF POPULATED)	90%
Postpartum status	The postpartum status of a patient. If the template is present, the patient is in the postpartum period.	Postpartum Status	Pregnancy Section	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.285']/value	Postpartum Status (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.11.20.9.87/expansion)	SHALL (IF POPULATED)	90%
Pregnancy Effective Time	Pregnancy status date range. Use the effectiveTime to indicate the date range over which the patient was pregnant/possibly pregnant/not pregnant/unknown.	Pregnancy Observation (SUPPLEMENTAL PREGNANCY)	Pregnancy Section	eICR Implementation Guide Required Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.293']/effectiveTime	n/a	SHALL (IF POPULATED)	90%
Pregnancy outcome	A coded value that represents the result of a pregnancy such as live birth, still birth, miscarriage, etc. This includes the description of the outcome of the pregnancy.	Pregnancy Outcome	Pregnancy Section	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.284']/value	Pregnancy Outcome (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.11.20.9.86/expansion)	SHALL	90%
Pregnancy outcome date	A date/time value that represents when the outcome such as live birth, still birth, miscarriage, etc of the pregnancy occurred.	Pregnancy Outcome	Pregnancy Section	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.284']/effectiveTime	n/a	SHALL	90%
Pregnancy status (yes, no, possible, unknown)	Trigger code template value for the laboratory result value.	Pregnancy Observation (SUPPLEMENTAL PREGNANCY)	Pregnancy Section	Required for RCKMS/eCR Operations Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.293']/value	Extended Pregnancy Status (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1099.24/expansion) plus nullFlavor = "UNK"	SHALL	95%

Requirements								
eICR Data Element	Description	eICR Template	CDA Section/Location	eICR Data Classification	eICR XPath	CDA Terminology	Florida's Requirement	Florida's Minimal Data Element Completeness Score
Pregnancy status determination method aka Certainty of status (i.e., ultrasound, lab test evidence)	Pregnancy status determination method.	Pregnancy Observation (SUPPLEMENTAL PREGNANCY)	Pregnancy Section	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.293']/methodCode	Pregnancy Status Determination Method (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.11.20.9.80/expansion)	SHOULD	75%
Pregnancy status recorded date	A date/time value for when the patient's pregancy status (yes, no, possible, unknown) at the time of the reportable event.	Pregnancy Observation (SUPPLEMENTAL PREGNANCY)	Pregnancy Section	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.293']/author/time	n/a	SHALL	95%
Date of Diagnosis (Problem List)	A date/time value when the concern (diagnosis/problem) became active.	Problem Concern Act (V3)	Problem Section (entries required) (V3)	eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	act[templateId/@root='2.16.840.1.113883.10.20.22.4.3']/effectiveTime	n/a	SHALL	98%
Date of Onset (Problem List)	A date/time value that asserts when the condition became clinically active.	Problem Observation (V3)	Problem Section (entries required) (V3)	eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.4']/effectiveTime	n/a	SHALL	95%
Date of Onset (Symptom)	The date/time value that asserts when the condition became clinically active.	Problem Observation (V3)	Problem Section (entries required) (V3)	eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.4'][code='symptom']/effectiveTime	n/a	SHALL	95%
Diagnoses (Problem List)	List of pathology or disorders identified in a patient [i.e. radiating chest pain (finding), bacterial sepsis (finding), etc.]. This combines the observation/value/code.	Problem Concern Act (V2)/Problem Observation (V3)	Problem Section (entries required) (V3)	USCDI V1 Required US Core 4.0.0 Required eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.4']/value	Problem (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.3.88.12.3221.7.4/expansion)	SHALL	95%
Diagnosis (trigger)	The suspected diagnoses or problems that represent that the patient may have a potentially reportable condition. These could be diagnoses recorded in an HER problem list and diagnosis codes used for billing for the encounter.	Initial Case Report Trigger Code Problem Observation	Problem Section (entries required) (V3)	USCDI V1 Required US Core 4.0.0 Required eICR Implementation Guide Required Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.15.2.3.3']/value	Diagnosis_Problem Triggers for Public Health Reporting (RCTC Subset) (https://ersd.aimsplatform.org/) Suspected_Disorder Triggers for Public Health Reporting (RCTC Subset) (https://ersd.aimsplatform.org/)	SHALL	95%
Problem Type	This code respresents the problem observation categorization of the condition as represented in the SNOMED CT code system. Examples include "Clinical Finding," "Complaint," "Problem," "Disease," "Diagnosis Interpretation," etc.	Problem Concern Act (V2)/Problem Observation (V3) (observation)	Problem Section (entries required) (V3)	US Core 4.0.0 Required eICR Implementation Guide Required Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.4']/code observation[templateId/@root='2.16.840.1.113883.10.20.22.4.4']/code/translation	Problem Type (SNOMED CT) (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.3.88.12.3221.7.2/expansion) Problem Type (LOINC) (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.3.88.12.3221.7.2/expansion)	SHALL	95%

Requirements								
eICR Data Element	Description	eICR Template	CDA Section/Location	eICR Data Classification	eICR XPath	CDA Terminology	Florida's Requirement	Florida's Minimal Data Element Completeness Score
Symptoms (list)	A pathology or disorder identified in a patient. The observation/value and all qualifiers together make up one concept. For example, SNOMED CT allows constructing concepts as a combination of multiple codes. SNOMED CT defines a concept "pneumonia (disorder)" (233604007) an attribute "finding site" (363698007) and another concept "left lower lobe of lung (body structure)" (41224006).	Problem Observation (V3)	Problem Section (entries required) (V3)	eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.4'][code='symptom']/value	Problem (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.3.88.12.3221.7.4/expansion)	SHALL	95%
Procedure (act)	Interventional, surgical diagnostic, or therapeutic procedures or treatments pertinent to the patient historically at the time the document is generated. Any act that cannot be classified as under the "procedure" or "observation" section. Procedure act is for procedures that alter the physicalcondition of a patient (e.g., splenectomy). Example of these acts are a dressing change, teaching or feeding a patient, or providing comfort measures.	Procedure Activity Act (V2)	Procedures Section (entries required) (V2)	US Core 4.0.0 Required Necessary for PHA Use	act[templateId/@root='2.16.840.1.113883.10.20.22.4.12']/code	LOINC SNOMED CT CPT-4 ICD10 PCS CDT-2	SHALL	95%
Procedure (observation)	Interventional, surgical diagnostic, or therapeutic procedures or treatments pertinent to the patient historically at the time the document is generated. The "observation" should be used for proceudres that result in additional information about the patient. Examples of these procedures include diagnostic imaging procedures, EEGs, and EKGs.	Procedure Activity Observation (V2)	Procedures Section (entries required) (V2)	US Core 4.0.0 Required	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.13']/code	LOINC SNOMED CT CPT-4 ICD10 PCS CDT-2	SHALL	95%
Procedure (procedure)	This is a coded value that should contain a SNOMED code, CPT-4, ICD-10, or CDT-2 code. This template represents procedures whose immediate and primary outcome (post-condition) is the alteration of the physical condition of the patient. Examples of these procedures are an appendectomy, hip replacement, and a creation of a gastrostomy.	Procedure Activity Procedure (V2)	Procedures Section (entries required) (V2)	US Core 4.0.0 Required Necessary for PHA Use	procedure[templateId/@root='2.16.840.1.113883.10.20.22.4.14']/code	LOINC SNOMED CT CPT-4 ICD10 PCS CDT-2	SHALL	95%
Procedure (Trigger)(act)	The coded value in the trigger template for procedure. Procedure should be interventional, surgical, diagnostic, or therapeutic procedures or treatments pertinent to the encounter.	Initial Case Report Trigger Code Procedure Activity Act	Procedures Section (entries required) (V2)	US Core 4.0.0 Required Necessary for PHA Use	act[templateId/@root='2.16.840.1.113883.10.20.15.2.3.45']/code	Reportable Condition Trigger Codes (RCTC) (https://ersd.aimsplatform.org/)	SHALL	95%
Procedure (Trigger)(observation)	The Initial Case Report Trigger Code Procedure Activity Act template indicates that the act (procedure) code is a trigger code contained in the Reportable Condition Trigger Codes and this template must be present. This code SHOULD be selected from ValueSet Diagnosis_Problem Triggers for Public Health Reporting (RCTC Subset). This indicates the template code.	Initial Case Report Trigger Code Procedure Activity Observation	Procedures Section (entries required) (V2)	US Core 4.0.0 Required Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.15.2.3.46']/code	Reportable Condition Trigger Codes (RCTC) (https://ersd.aimsplatform.org/)	SHALL	90%
Procedure (Trigger)(procedure)	The Initial Case Report Trigger Code Procedure Activity Procedure template indicates that the procedure code is a trigger code contained in the Reportable Condition Trigger Codes and this template must be present. This code SHOULD be selected from ValueSet Diagnosis_Problem Triggers for Public Health Reporting (RCTC Subset). This indicates the template code.	Initial Case Report Trigger Code Procedure Activity Procedure	Procedures Section (entries required) (V2)	US Core 4.0.0 Required Necessary for PHA Use	procedure[templateId/@root='2.16.840.1.113883.10.20.15.2.3.44']/code	Reportable Condition Trigger Codes (RCTC) (https://ersd.aimsplatform.org/)	SHALL	90%
Reason for Visit	Provider's interpretation for the patient's visit for the reportable event, given as text.	Reason for Visit Section	Reason for Visit Section	eICR Implementation Guide Required Necessary for PHA Use	section[templateId/@root='2.16.840.1.113883.10.20.22.2.12']/text	n/a	SHALL	98%
Filler Order Number	The laboratory result filler order number from the observation template. This is the laboratory accession number, which is a unique identifier assigned to a specimen to track it.	Result Observation (V3)	Results Section (entries required) (V3)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.2']/id	n/a	SHALL	98%
Filler Order Number	The laboratory result filler order number from the organizer template. This is the laboratory accession number, which is a unique identifier assigned to a specimen to track it.	Result Organizer (V3)	Results Section (entries required) (V3)	Necessary for PHA Use	organizer[templateId/@root='2.16.840.1.113883.10.20.22.4.1']/id	n/a	SHALL	98%

Requirements								
eICR Data Element	Description	eICR Template	CDA Section/Location	eICR Data Classification	eICR XPath	CDA Terminology	Florida's Requirement	Florida's Minimal Data Element Completeness Score
Lab Code (resulted)	The result observation code value, selected from the LOINC valueset.	Result Observation (V3)	Results Section (entries required) (V3)	USCDI V1 Required US Core 4.0.0 Required eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.2']/code	LOINC Local code	SHALL	98%
Lab Code (resulted)	The coded value for the result organizer, which SHOULD be selected from code system LOINC. This value represents the laboratory test order code.	Result Organizer (V3)	Results Section (entries required) (V3)	USCDI V1 Required US Core 4.0.0 Required eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	organizer[templateId/@root='2.16.840.1.113883.10.20.22.4.1']/code	LOINC Local code	SHALL	98%
Lab Order Code (trigger) (resulted)	This template indicates that the result observation code (test name) and/or result observation value (test result) are/is a trigger code contained in the Reportable Condition Trigger Codes and this template must be present. This indicates the template code.	Initial Case Report Trigger Code Result Observation	Results Section (entries required) (V3)	USCDI V1 Required US Core 4.0.0 Required eICR Implementation Guide Required Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.15.2.3.2']/code	Lab Obs Test Triggers for Public Health Reporting (RCTC Subset) (https://ersd.aimsplatform.org/)	SHALL	98%
Laboratory Result	The result value for the laboratory result. Should be sent as numeric (PQ) units, or as a coded value (CD) using SNOMED. String (ST) text can be sent, but is not preferred.	Result Observation (V3)	Results Section (entries required) (V3)	USCDI V1 Required Required for RCKMS/eCR Operations Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.2']/value	SNOMED CT (for CD results) UCUM (for physical quantity (PQ) units)	SHALL	98%
Laboratory Result (trigger)	Trigger code template value for the laboratory result value.	Initial Case Report Trigger Code Result Observation	Results Section (entries required) (V3)	USCDI V1 Required eICR Implementation Guide Required Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.15.2.3.2']/value	Organism_Substance Release Triggers for Public Health Reporting (RCTC Subset) (https://ersd.aimsplatform.org/)	SHALL	98%
Result Observation Author	The author of the results from a laboratory, radiology, and other study performed on a patient. This should include the ID, address, telecom, and assigned person.	Result Observation (V3)	Results Section (entries required) (V3)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.2']/author	n/a	SHOULD	50%
Result Observation Author ID	This is a coded value for the author of the results from a laboratory, radiology, and other study performed on a patient.	Result Observation (V3)	Results Section (entries required) (V3)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.2']/author/assignedAuthor/id	n/a	SHALL (if sent)	50%
Result Observation Interpretation	The interpretation code for the laboratory result value. Example: High, Low, Abnormal, etc.	Result Observation (V3)	Results Section (entries required) (V3)	Required for RCKMS/eCR Operations Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.2']/interpretationCode	Observation Interpretation (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.1.11.78/expansion/Latest)	SHALL	98%
Result Observation Method	The method or test type in which the laboratory test was performed.	Result Observation (V3)	Results Section (entries required) (V3)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.2']/methodCode	none	SHALL	95%
Result Observation Reference Range	The laboratory reference range of the test. Preferred low and high value sent if possible. Otherwise, sent as text.	Result Observation (V3)	Results Section (entries required) (V3)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.2']/referenceRange	n/a	SHALL	98%
Result Observation Status	The status of the result observation such as active or completed.	Result Observation (V3)	Results Section (entries required) (V3)	US Core 4.0.0 Required eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.2']/statusCode	Result Status (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.11.20.9.39/expansion/Latest)	SHALL	98%
Result Observation Target Site	The coded value for the result observation target site.	Result Observation (V3)	Results Section (entries required) (V3)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.2']/targetSiteCode	none	MAY	50%
Result Observation Time	The datetime that the result observation was resulted.	Result Observation (V3)	Results Section (entries required) (V3)	eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.2']/effectiveTime	n/a	SHALL	98%
Result Organizer Author	The author of grouped result observations. The result organizer code categorizes the contained results into one of several commonly acceptable values (e.g. hematology, chemistry, nuclear medicine).	Result Organizer (V3)	Results Section (entries required) (V3)	Necessary for PHA Use	organizer[templateId/@root='2.16.840.1.113883.10.20.22.4.1']/author	n/a	SHOULD	50%

Requirements								
eICR Data Element	Description	eICR Template	CDA Section/Location	eICR Data Classification	eICR XPath	CDA Terminology	Florida's Requirement	Florida's Minimal Data Element Completeness Score
Result Organizer Author (Organization) ID	A coded value used in the identification of the author of the grouped result observations.	Result Organizer (V3)	Results Section (entries required) (V3)	Necessary for PHA Use	organizer[templateId/@root='2.16.840.1.113883.10.20.22.4.1']/author/assignedAuthor/representedOrganization/id	n/a	MAY	50%
Result Organizer Code	The coded value for the result organizer, which SHOULD be selected from code system LOINC. This value represents the laboratory test order code.	Result Organizer (V3)	Results Section (entries required) (V3)	USCDI V1 Required US Core 4.0.0 Required eICR Implementation Guide Required Necessary for PHA Use	organizer[templateId/@root='2.16.840.1.113883.10.20.22.4.1']/code	LOINC SNOMED CT CPT-4	SHALL	85%
Result Organizer Code (trigger)	The Initial Case Report Trigger Code Result Organizer is a flag to indicate that the organizer code (test battery/cluster name) is a trigger code contained in the Reportable Condition Trigger Codes and this template must be present. This indicates the template code.	Initial Case Report Trigger Code Result Organizer	Results Section (entries required) (V3)	USCDI V1 Required US Core 4.0.0 Required eICR Implementation Guide Required Necessary for PHA Use	organizer[templateId/@root='2.16.840.1.113883.10.20.15.2.3.35']/code	Diagnosis_Problem Triggers for Public Health Reporting (RCTC Subset) (https://ersd.aimsplatform.org/)	SHALL	98%
Result Organizer Status	The status of the result. Example: Active or Completed	Result Organizer (V3)	Results Section (entries required) (V3)	US Core 4.0.0 Required eICR Implementation Guide Required Necessary for PHA Use	organizer[templateId/@root='2.16.840.1.113883.10.20.22.4.1']/statusCode	Result Status (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.11.20.9.39/expansion/Latest)	SHALL	98%
Result Organizer Status	The status of the result organizer such as active or completed.	Result Organizer (V3)	Results Section (entries required) (V3)	US Core 4.0.0 Required eICR Implementation Guide Required Required for RCKMS/eCR Operations Necessary for PHA Use	organizer[templateId/@root='2.16.840.1.113883.10.20.22.4.1']/statusCode	Result Status (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.11.20.9.39/expansion/Latest)	SHALL	98%
Result Organizer Time	The datetime that the laboratory result was ordered.	Result Organizer (V3)	Results Section (entries required) (V3)	US Core 4.0.0 Required	organizer[templateId/@root='2.16.840.1.113883.10.20.22.4.1']/effectiveTime	n/a	SHALL	85%
Specimen collection date	The date and time for which the laboratory specimen was collected. The following effectiveTime can either be a date range, represented by including both low and high, or a point in time, represented by including only @value.	Specimen Collection Procedure (ID)	Results Section (entries required) (V3)	Necessary for PHA Use	procedure[templateId/@root='2.16.840.1.113883.10.20.22.4.415']/effectiveTime	n/a	SHOULD	80%
Specimen ID	The laboratory specimen ID or accession number.	Specimen Participant (ID)	Results Section (entries required) (V3)	Necessary for PHA Use	participant[templateId/@root='2.16.840.1.113883.10.20.22.4.410']/participantRole/id	n/a	SHALL	98%
Specimen source	The specimen source is the body site value of the laboratory specimen.	Specimen Collection Procedure (ID)	Results Section (entries required) (V3)	Required for RCKMS/eCR Operations	procedure[templateId/@root='2.16.840.1.113883.10.20.22.4.415']/targetSiteCode	Body Site Value Set (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.3.88.12.3221.8.9/expansion)	SHALL	98%
Specimen type	The type of laboratory specimen collected, such as Whole Blood, Abscess, Stool, Tissue, etc. This should be a SNOMED coded value.	Specimen Participant (ID)	Results Section (entries required) (V3)	Required for RCKMS/eCR Operations	participant[templateId/@root='2.16.840.1.113883.10.20.22.4.410']/participantRole/code	HL7 Specimen Type (https://terminology.hl7.org/5.1.0/ValueSet-v2-0487.html)	SHALL (if sent)	90%
Review of Systems	Relevant collection of symptoms and functions systematically gathered by a clinician. It includes symptoms the patient is currently experiencing, some of which were not elicited during the HPI, as well as potentially a large number of negatives, for example, symptoms that the patient denied experiencing.	Review of Systems	Review of Systems Section	Necessary for PHA Use	section[templateId/@root='2.16.840.1.113883.10.20.22.2.18']/text	n/a	SHALL (if sent)	90%
Country of Nationality	The patient country of nationality, preferred sent if patient has recent travel.	Country of Nationality Observation	Social History Section (V3)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.15.2.3.54']/value	Country (https://hl7.org/fhir/valueset-iso3166-1-2.html)	SHOULD (if recent travel, SHALL)	85%; if travel 95%
Country of Residence	The patient country of residence, preferred sent if patient has recent travel.	Country of Residence Observation	Social History Section (V3)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.15.2.3.53']/value	Country (https://hl7.org/fhir/valueset-iso3166-1-2.html)	SHOULD (if recent travel, SHALL)	85%; if travel 95%
Disability Status	The patient's disability status assessment answers.	Disability Status Observation	Social History Section (V3)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.15.2.3.47']/code	Disability Status Assessment (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1099.49/expansion)	SHOULD	80%
Estimated date of delivery (EDD)	Estimated date a woman will give birth.	Estimated Date of Delivery	Social History Section (V3)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.15.3.1']/value	n/a	SHALL (if pregnant status if = YES)	90%

Requirements								
eICR Data Element	Description	eICR Template	CDA Section/Location	eICR Data Classification	eICR XPath	CDA Terminology	Florida's Requirement	Florida's Minimal Data Element Completeness Score
Homeless	The patient's homeless status.	Characteristics of Home Environment	Social History Section (V3)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.109']/value="105526001"	SNOMED CT codes 32911000, 105526001	SHALL	90%
Occupation	Occupation which the subject currently holds.	Social History Observation (V3)	Social History Section (V3)	Required for RCKMS/eCR Operations Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.38']/value[xsi:type="CD"]		SHALL	90%
Patient Sex	The patient's sex	Birth Sex Observation	Social History Section (V3)	USCDI V1 Required Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.200']/value[xsi:type="CD"]	ONC Administrative Sex (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1/expansion) plus nullFlavor = "UNK"	SHALL	95%
Pregnancy Effective Time	Pregnancy status date range. Use the effectiveTime to indicate the date range over which the patient was pregnant/possibly pregnant/not pregnant/unknown.	Pregnancy Observation	Social History Section (V3)	eICR Implementation Guide Required Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.15.3.8']/effectiveTime	n/a	SHALL (IF POPULATED)	90%
Pregnant	The patient's pregnancy status.	Pregnancy Observation	Social History Section (V3)	Required for RCKMS/eCR Operations Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.15.3.8']/value	R1.1 Asserts that the patient is pregnant (SNOMED 77386006 | Pregnant)	SHALL	50%
Purpose of Travel	Purpose of Travel is the patient's reason for traveling (i.e. Business, Tourism, Military, etc.), and is included as part of patient's Travel History. The @code should be "280147009" Type of activity, and the travel purpose will be given @value with @xsi:type="CD," where the code SHOULD be selected from ValueSet Travel Purpose (CDC).	Purpose of Travel Observation	Social History Section (V3)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.15.2.3.51']/code	Travel Purpose (CDC) (https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.8064)	MAY	50%
Transportation Details (Associated Information - ship name, flight number, airport, seat number, etc.)	The type of transport along with any associated information. The observation represents the information associated with the specific type of transport (e.g. name of cruise ship, flight number, airport, seat number, cabin number).	Transportation Details Observation	Social History Section (V3)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.15.2.3.49']/code observation[templateId/@root='2.16.840.1.113883.10.20.15.2.3.49']/value		SHALL (if sent)	90%
Transportation Details (Type of Transport)	The type of transport along with any associated information. The organizer/code contains the type of transportaion (plane, train, ship, etc.).	Transportation Details Organizer	Social History Section (V3)	Necessary for PHA Use	organizer[templateId/@root='2.16.840.1.113883.10.20.15.2.3.50']/code	Transport vehicle type (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1099.50/expansion)	SHALL (if sent)	50%
Travel History Dates	The patient's travel history, includes purpose of travel, dates of travel, locations of travel, details of transportation (ship, plane, etc.). The travel history date of travel, effective time low and high.	Travel History	Social History Section (V3)	Necessary for PHA Use	act[templateId/@root='2.16.840.1.113883.10.20.15.2.3.1']/effectiveTime	n/a	SHALL	95%
Travel History Location - Address	The address related to the patient's travel history. Where a more granular address than state is known (e.g. city, street) it is appropriate to use address rather than the coded location.	Travel History	Social History Section (V3)	Necessary for PHA Use	act[templateId/@root='2.16.840.1.113883.10.20.15.2.3.1']/participant/participantRole/addr	n/a	SHOULD	75%
Travel History Location - Coded	The patient's travel history, includes purpose of travel, dates of travel, locations of travel, details of transportation (ship, plane, etc.). The travel hstory location, coded value for location of travel.	Travel History	Social History Section (V3)	Necessary for PHA Use	act[templateId/@root='2.16.840.1.113883.10.20.15.2.3.1']/participant/participantRole/code	Geographical location history (https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.3201)	SHALL (if travel has occurred)	95%
Travel History Location - Free Text	The patient's travel history, includes purpose of travel, dates of travel, locations of travel, details of transportation (ship, plane, etc.). The travel history location, free text of loction of travel.	Travel History	Social History Section (V3)	Necessary for PHA Use	act[templateId/@root='2.16.840.1.113883.10.20.15.2.3.1']/text	n/a	SHALL (if travel has occurred)	95%
Tribal Affiliation	The affliated tribe name of the patient.	Tribal Affiliation Observation	Social History Section (V3)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.15.2.3.48']/code	Tribal Entity US (https://terminology.hl7.org/5.1.0/ValueSet-v3-TribalEntityUS.html)	SHALL (if sent)	90%

Requirements								
eICR Data Element	Description	eICR Template	CDA Section/Location	eICR Data Classification	eICR XPath	CDA Terminology	Florida's Requirement	Florida's Minimal Data Element Completeness Score
Tribal Enrollment	The tribal enrollment status of the patient. This should indicate whether or not the patient is an enrolled member.	Tribal Affiliation Observation	Social History Section (V3)	Necessary for PHA Use	observation[templateId/@root='2.16.840.1.113883.10.20.15.2.3.48']/value=true	Tribal Entity US (https://terminology.hl7.org/5.1.0/ValueSet-v3-TribalEntityUS.html)	SHALL (if sent)	90%
Vital Signs	Vital signs are represented with the name of the vital sign and unit of measure. Examples inclue: PulseOx %, weight kg, and BMI kg/m2. This represents the patient's relevant vital signs at the time of the reportable event.	Vital Sign Observation (V2)	Vital Signs Section (entries required) (V3)	Required for RCKMS/eCR Operations	observation[templateId/@root='2.16.840.1.113883.10.20.22.4.27']/value	Vital Sign Result Type (https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.3.88.12.80.62/expansion)	SHALL	98%

Frequently Asked Questions	
Question(s)	**Answer(s)**
Is DOH able to actively receive and process eCRs?	Yes, the Florida Department of Health is actively able to receive and process eCRs for all conditions, except for cancer. This includes all conditions listed in Rule 64D-3, F.A.C, such as infectious and communicable conditions, STI/STDs, HIV, and birth defects.
When did DOH first declare readiness for eCR?	Florida Department of Health declared readiness for eCR in 2021.
How does the HCO attest for the Promoting Interoperability "Active Engagement Option 1: Pre-production and Validation" status?	To attest the HCO must first register intent to participate in eCR with the PHA, which would be Florida Department of Health if the HCO is located in Florida. DOH will send an email confirmation to the HCO after registration is confirmed. At that time, the HCO will be able to self-attest for Active Engagement Option 1. For more information, please contact your CMS representative.
How does the HCO attest for the Promoting Interoperability "Active Engagement Option 2: In production" status?	The HCO must be sending real patient data for all conditions into DOH's production environment. This is a self-selected 180-day reporting period.
When are the self-selected 180-day reporting periods?	The self-selected 180-day reporting period would be any continuous 180 day period within the calendar year. The last day to begin a 180 day reporting period would by July 4.
Are there exclusions for eCR? or How does an HCO receive an exclusion from sending production data via eCR?	The Florida Department of Health does not offer an exclusion letter for eCR related to the CMS PIP and the CMS MIPS programs. If you are an eligible hospital, CAH, or MIPS-eligible clinician, you are excluded from the eCR measure if you do not treat or diagnose any reportable disease for which data is collected per 64D-3, Florida Administrative Code, during the EHR reporting and performance period.
How does an HCO get started with eCR?	https://www.cdc.gov/ecr/php/getting-started/index.html
How does the HCO know if their EHR is compatible?	https://chpl.healthit.gov/#/search
Where can the HCO register intent?	http://www.floridahealth.gov/electronicreportingregistration
Does my HCO need to submit the eCR registration form more than once?	The registration form only needs to be submitted once, unless additional health care locations need to be added to the current registration or other information needs to be updated, such as HCO contacts.
How long does it take to onboard?	Onboarding timeline is variable and dependant on your EHR vendor or product. Please contact your EHR vendor to determine an appropriate timeline for implementation. Testing with PHA and CDC may take additional time as well.
When will an HCO be considered in production?	The HCO is considered in production when DOH validates the data and provides confirmation through email that the HCO has been moved into production. Receiving RRs is not an indication that the HCO is in production. DOH reserves the final say regarding if an HCO is in production versus in testing.
How long does it take to discontinue non-eCR reporting?	The timeline will vary and is set by DOH depending on the quality and completeness of the data received by the HCO.
How do I contact DOH if I have questions?	Please reach out to ElectronicCaseReporting@FLHealth.gov