NC DHHS Public Health
Meaningful Use Update: ELR to the North Carolina Division of Public Health for Meaningful Use

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Currently, for Meaningful Use Stage 1 and Stage 2, the ELR Objective is the capability to submit electronic reportable lab results to public health agencies, except where prohibited, and in accordance with applicable law and practice.

Eligible Hospitals:
- Menu objective for Stage 1
- Core objective for Stage 2

Eligible Providers:
- DPH is not accepting ELR from providers

This objective was a menu objective for Stage 1 and required for Stage 2 (under the current rules) for Eligible Hospitals.

At this time, NC DPH is not accepting ELR from eligible providers/professionals.
According to current stage 2 rules, an Eligible Hospital can meet the measure for ELR with successful “on-going submission” of ELR data to their Public Health Agency.
Ways to Meet Stage 2 Public Health Objectives

- **Ongoing submission was already achieved** for an EHR reporting period in a prior year and continues throughout the current EHR reporting period using either the current (2014 Edition) standards, 45 CFR 170.314(f)(1) and (f)(2), or the standards included in the 2011 Edition EHR certification criteria adopted by ONC during the prior EHR reporting period when ongoing submission was achieved.

- **Registration of intent** to initiate ongoing submission was made with the PHA [N.C. DPH] by the deadline (within 60 days of the start of the EHR reporting period) and ongoing submission was achieved [during the reporting period].

Current Stage 2 regulations define “on-going submission” 4 different ways:

1. Ongoing submission was achieved prior to the start of the reporting period and continues throughout that time

2. An Eligible hospital registered their intent to submit data with their PHA, they completed testing, and ongoing submission was achieved during the reporting period
Ways to Meet Stage 2 Public Health Objectives

- **Registration of intent** to initiate ongoing submission was made with the PHA [N.C. DPH] by the deadline (within 60 days of the start of the EHR reporting period) and the **eligible hospital is still engaged in testing and validation** [the on-boarding process for implementing ELR to N.C. DPH] of ongoing electronic submission.

- **Registration of intent** to initiate ongoing submission was made with the PHA [N.C. DPH] by the deadline (within 60 days of the start of the EHR reporting period) and the **eligible hospital is awaiting invitation** [from N.C. DPH] to begin testing and validation [the on-boarding process for implementing ELR to N.C. DPH].

3. An Eligible Hospital registered their intent and they are still engaged in testing and validation with their PHA

4. An Eligible Hospital registered their intent and they are waiting for their PHA to begin testing and validation with their facility
Visual representation of those four definitions for “on-going submission” that allow an EH to meet the ELR measure.
In March 2015, CMS published the proposed rules for Stage 3 of Meaningful Use.

Stage 3 rules would go into effect as early as 2017 and be required for all EPs, EHS, and CAHs in 2018.

Active Engagement replaces “Ongoing Submission” from the prior Stage 1 and 2 rules.
Active engagement is defined in three ways, similar to the previous definitions for ways to meet Stag 2 objectives:

1. Completed registration and waiting for testing and validation stage
   The EP, 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 EP, eligible hospital, or CAH is awaiting an invitation from the PHA or CDR to begin testing and validation.

2. In testing and validation with PHA
   The EP, eligible hospital, or CAH is in the process of testing and validation of the electronic submission of data. Providers 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 provider not meeting the measure.

3. In production (on-going submission) of data to PHA
   The EP, eligible hospital, or CAH has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or CDR.
Addition of Case Reporting and Clinical Data Registry reporting as new measures.

Inclusion of Cancer Registry reporting in the Public Health Registry Reporting Measure. Unfortunately, there is very little clarity on what qualifies as a clinical data or public health registry. Two public health registries are referenced: the National Hospital Care Survey and the National Healthcare Safety Network for antimicrobial use and resistance.

For the purposes of meaningful use, “public health registries” are those administered by, or on behalf of, a local, state, territorial, or national public health agencies; and “clinical data registries” are administered by, or on behalf of, other non-public health agency entities.
Eligible Providers and Hospitals (including Critical Access Hospitals) can choose which of the proposed measures they want to meet, as long as they meet the required number of measures. This removes the “core” versus “menu” criteria from certain objectives (immunization, syndromic, and ELR reporting).

The NC Division of Public Health would hope and expect that any Eligible Hospital currently in the on-boarding (testing and validation) process for implementing ELR will continue that process until on-going submission of production ELR data is achieved.
Certain measures can be attested to multiple times:

i.e. Public health Registry Reporting and Clinical Data Registry Reporting
For example, if in NC the available measures for Eligible Hospitals include:

Measure 1 – Immunization registry (exclusion)
Measure 2 – Syndromic surveillance reporting
Measure 3 – Case reporting (exclusion)
Measure 4 – Public health registry reporting
Measure 5 – Clinical data registry reporting
Measure 6 – ELR

Then an EH could attest to 4 measures by reporting any of the four available data types once or by reporting either multiple public health registries (measure 4) or clinical data registries (measure 5).

For Eligible Providers, the landscape in NC might be:

Measure 1 – Immunization registry (exclusion)
Measure 2 – Syndromic surveillance reporting (exclusion)
Measure 3 – Case reporting (exclusion)
Measure 4 – Public health registry reporting
Measure 5 – Clinical data registry reporting

An EP could meet measures 4 and 5 multiple times to attest to the 3 required measures.
ON-BOARDING FOR IMPLEMENTING ELR TO NCDPH
Three key documents, all of which are available via the ELR website.

The first document is the ELR checklist that outlines each of the steps involved in implementing an ELR interface to the Division of Public Health.

The second document is the Guidelines for Electronic Laboratory Reporting to the North Carolina Division of Public Health. This document is additional information regarding each of the steps in the process that we will be reviewing during this presentation.

The final document is the ELR Mapping template which is a tool developed by the North Carolina Division of Public Health to assist laboratory facilities with mapping their local codes to the standard vocabularies required for electronic reporting. We will discuss this process in more detail during this presentation.
Currently On-boarding

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<th>On-Boarding Steps</th>
<th>Not Started</th>
<th>In Process</th>
<th>Completed</th>
<th>Total</th>
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<tr>
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*Includes the 12 hospitals currently in on-going submission with at 2.3.1 interface that are in the process on-boarding a system upgrade to a 2.5.1 interface.

Current as of July 2015.

Shows where all of our currently on-boarding partners are with completing the 10 step ELR checklist for on-boarding a new interface with NC DPH

The majority of our on-boarding partners are in either step 4, completing their vocabulary translation to the standard vocabularies of LOINC and SNOMED, or they are working with their vendors to complete step 5, which is creating an HL7 message that is conformant with the HL7 standard required by Meaningful Use.
Challenges

- Availability of resources and personnel
- Competing priorities
- New standards required for Meaningful Use

What are some of the challenges that our partners are facing as they attempt to complete these steps and implement ELR to NCDPH?

The biggest challenge, especially in the vocabulary translation step, are the availability of resources and personnel at the hospital level with the skills and knowledge to complete this translation task. These coding vocabularies can be very specific to the laboratory methods used at each facilities an often the individuals with the knowledge to accurately translate local codes to standard codes, have competing priorities.

Competing priorities are also a major hurdle for IT staff that are often the same team members required to transition to new systems and help bring on new facilities as the Health system grows and acquires additional facilities or upgrades to new systems.

Obviously, Meaningful use is a constantly moving target and so as the testing process to implement new interfaces often spans months and years, interfaces need to be continually updated to stay current. NC DPH is currently working with multiple health systems that are going through the on-boarding process for the 2\textsuperscript{nd} or 3\textsuperscript{rd} time because of software system changes and upgrades.
The NC Division of Public Health can only receive a single batch file of all the reportable results for the day. We cannot accept real-time reporting. The reason for this is that the laboratory results must be uploaded into our system during off-peak hours when user traffic is low. If a record is being edited by a user when the system attempts to upload a lab result, the upload fails and must be manually reloaded.

If different test results on the same specimen are released by the laboratory at different times of the day between the daily file transmissions, a separate message should NOT be sent each time. It is a N.C. Division of Public Health requirement that a single message per specimen be sent per day, containing a message snapshot that portrays all the reportable test results as they were the last time a laboratory report was released for that specimen.

For ELR sent to N.C. EDSS, a message snapshot should include the latest version of all test results which are reportable to N.C. EDSS for the same specimen. There may be other test results on the same specimen that are not reportable to N.C. EDSS and those are not required to be included in the snapshot. Each time a message is sent for a particular specimen the message snapshot is a cumulative report that includes new or changed results as well as previously reported results that have not changed.
Every health care system that has multiple laboratories would be required to elect one of the following two choices.

**Choice 1**
Send a separate file per day per laboratory per health care system.

**Choice 2**
Send one file per day per health care system, even when there are multiple laboratories within that health care system. This requires some additional restrictions on the HL7 message that are outlined in our Guidelines for ELR to NC DPH document found on our website.
As of July 2015, these are the interfaces that are currently in on-going submission of production ELR data to NCDPH via NCEDSS.

**Reporting Electronically**

- NCDPH currently receives electronic reports from:
  - LabCorp (HL7 2.3.1)
  - State Laboratory of Public Health (HL7 2.5.1)
  - Mayo Clinical Laboratories (HL7 2.3.1)
  - Carolinas Healthcare System (13 facilities, HL7 2.3.1)
  - Rex Health (HL7 2.5.1)
  - Vidant Health (8 facilities, HL7 2.5.1)
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Questions and Answers