# Electronic Initial Case Reporting (EICR) Registration

Greetings,

Thank you for your interest in pursuing electronic initial case reporting (EICR) with the Iowa Department of Public Health.

Please answer these questions. Once the survey is completed, you will receive an e-mail confirming your registration with an attachment containing all of the information you provided.

Please send any questions to ELR@idph.iowa.gov

Thank you!

John Satre

Informatician, Iowa Department of Public Health

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NOTE: this question may require research by your vendor contact; it is likely that someone within your vendor's organization is engaged with this national initiative.
Is your main facility EHR capable of generating a message following the "HL7 CDA R2 Public Health Case Report, Release 2 Standard for Trial Use Release 1.1" implementation guide?

◯ Yes
◯ No

http://www.hl7.org/implement/standards/product_brief.cfm?product_id=436

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Unfortunately, if your electronic health record (EHR) is not capable of sending the standards-based electronic initial case reporting message, IDPH cannot accept your registration.

Thank you for your interest and your time. If you have questions, please enter a note here.

_____

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First Name

_____

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[poc_first], what is your last name?

_____

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[poc_first], what is your title?

_____

[poc_first], what is your e-mail address?

_____

[poc_first], what is your phone number?

_____

## Registration Information

| | |
|---|---|
| Registration Date | _____ |
| What type of facility are you registering? | ◯ Healthcare Clinic/Provider<br>◯ Hospital (single site facility)<br>◯ Hospital and affiliated clinic locations or network of clinics<br>◯ Multi-hospital health system with network of clinics |
| Facility, main clinic, or healthcare provider name | _____ |
| Main facility address line 1 | _____ |
| Main facility address line 2 | _____ |
| Main facility city | _____ |
| Main facility state | _____ |
| Main facility zip code | _____ |
| Main facility contact for electronic initial case reporting | _____ |
| Main facility point of contact e-mail address | _____ |
| Main facility point of contact phone # | _____ |
| Only for multiple-site organizations/facilities, state the # of sites covered by this registration. | _____<br>(if many sites, please send a spreadsheet with facility name, address, city, state, zip to elr@idph.iowa.gov. Otherwise, enter this in next section.) |

If multiple sites are involved with this registration, it is necessary to collect facility name (or healthcare provider name), address, and phone # information for each site. In order to streamline this registration, please download the spreadsheet template below which includes the following fields:
>Name (additional facility, clinic, or healthcare provider name)
>Electronic health record (EHR) name
>EHR Version
>EHR Vendor
>Facility Street address
>Facility City
>Facility State
>Facility Zip
>Facility Phone #
Upload the completed spreadsheet using the upload feature below.

[Attachment: "Additional Facility List Spreadsheet.xlsx"]

Upload the completed "Additional Facility List Spreadsheet" document here.

## Electronic Health Record (EHR) Functionality

Can your EHR system:
1. flag a record that meets specific criteria,
2. generate an HL7 CDA message,
3. attach the HL7 CDA message to a Direct Secure Messaging e-mail, and
4. send the e-mail automatically (without manual intervention)?

◯ Yes
◯ No
◯ More complex response needed - see box below.

Automation: Please explain response to the question about EHR system automation.

_____

Does your EHR system have a way to consume 'Trigger Codes' (LOINC, SNOMED, ICD-10 codes) downloaded from an external source which are used to define the specific reporting criteria?

◯ Yes
◯ No
◯ More complex response - see box below

Consume Trigger Codes: Please explain response to the question above...

_____

Is there a mechanism in your EHR to check for 'Trigger Code' updates on a periodic schedule (monthly, quarterly, semi-annually)?

◯ Yes
◯ No
◯ More complex response needed - see box below

Update Trigger Codes: Please explain your response to the question above.

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**Electronic Initial Case Report (EICR) Data Elements**

**There is a pre-defined list of data elements in the HL7 CDA R2 Public Health Case Report, Release 2 Standard for Trial Use Release 1.1 Implementation Guide. These data elements are listed below; please identify those data elements that your EHR is capable of sending by marking the appropriate box beside each element.**

| | | Yes, this facility's EHR can send this data element | No, this facility's EHR cannot send this data element currently, but expect to be able to in the future | No, this facility's EHR cannot send this data element currently and do not expect to be able to in the future |
|---|---|---|---|---|
| 1 | Date of Report: The date on which the reporting party (e.g., physician, nurse practitioner, physician assistant, etc.) completes collection of minimum data for the EICR | ○ | ○ | ○ |
| 2 | Report Submission Date/Time: The date and time at which the EHR system sends the EICR data to the jurisdictional public health agency or designee | ○ | ○ | ○ |
| 3 | Sending Application: The name of the sending software application | ○ | ○ | ○ |
| 4 | Provider ID: Identification code for the healthcare provider (e.g., NPI) | ○ | ○ | ○ |
| 5 | Provider Name: The first and last name of the healthcare provider | ○ | ○ | ○ |
| 6 | Provider Phone: The provider's phone number with area code | ○ | ○ | ○ |
| 7 | Provider fax: The provider's fax number with area code | ○ | ○ | ○ |
| 8 | Provider Email: The provider's email address (for secure communication) | ○ | ○ | ○ |
| 9 | Provider Facility/Office Name: The provider facility's full name, not necessarily where care was provided to patient | ○ | ○ | ○ |
| 10 | | | | |

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|---|---|---|---|---|
| | Provider Address: 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 | ○ | ○ | ○ |
| 11 | Facility ID Number: Identification code for the facility (e.g., Facility NPI) | ○ | ○ | ○ |
| 12 | Facility Name: The facility's name where the patient received healthcare; for follow up to identify contact exposure, appropriate treatment, etc. | ○ | ○ | ○ |
| 13 | Facility Type: the type of facility where the patient received or is receiving healthcare for the reportable conditions (e.g., hospital, ambulatory, urgent care, etc.) | ○ | ○ | ○ |
| 14 | Facility Phone: The facility's phone number with area code | ○ | ○ | ○ |
| 15 | Facility Address: The mailing address for the facility where the patient received or is receiving healthcare for the reportable condition. Must include street address, city/town, county, state, and zip code. | ○ | ○ | ○ |
| 16 | Patient ID Number: Patient medical record number, or other identifying value - something OTHER THAN Social Security Number | ○ | ○ | ○ |
| 17 | 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 | ○ | ○ | ○ |
| 18 | | | | |

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| | Parent/Guardian Name: All names for the patient's parent or guardian, including legal names and aliases (if patient age is < 18); Must include the name type (i.e., legal or alias), first name, middle name, and last name | ○ | ○ | ○ |
| 19 | Patient or Parent/Guardian Phone: All phone numbers and phone number types for the patient or parent/guardian | ○ | ○ | ○ |
| 20 | Patient or Parent/Guardian Email: The email address for the patient or the patient's parent/guardian | ○ | ○ | ○ |
| 21 | Patient Street 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 | ○ | ○ | ○ |
| 22 | Birth Date: The patient's date of birth | ○ | ○ | ○ |
| 23 | Patient Sex: The patient's biological sex (not gender) | ○ | ○ | ○ |
| 24 | Race: The patient's race | ○ | ○ | ○ |
| 25 | Ethnicity: The patient's ethnicity | ○ | ○ | ○ |
| 26 | Preferred Language: The patient's preferred language | ○ | ○ | ○ |
| 27 | Occupation: The patient's occupation (student, job title, etc.) | ○ | ○ | ○ |
| 28 | Pregnant: The patient's pregnancy status | ○ | ○ | ○ |
| 29 | Visit Date/Time: Date and time of the provider's most recent encounter with the patient regarding the reportable condition | ○ | ○ | ○ |
| 30 | Admission Date/Time: Date and time when the patient was admitted to the treatment facility (e.g., hospital, clinic) | ○ | ○ | ○ |
| 31 | | | | |

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| | History of Present Illness: Physician's narrative of the history of the reportable event. Hopefully a place where information such as travel, contacts, etc. is captured | ○ | ○ | ○ |
| 32 | Reason for Visit: Provider's interpretation for the patient's visit for the reportable event | ○ | ○ | ○ |
| 33 | Date of Onset: The earliest date of symptoms for the reportable event | ○ | ○ | ○ |
| 34 | Symptoms (list): List of patient symptoms (structured) for the reportable event | ○ | ○ | ○ |
| 35 | Laboratory Order Code: Ordered tests for the patient during the encounter | ○ | ○ | ○ |
| 36 | Placer Order Number: Identifier for the laboratory order from the encounter | ○ | ○ | ○ |
| 37 | Diagnoses: The healthcare provider's diagnoses of the patient's health condition (all) | ○ | ○ | ○ |
| 38 | Date of Diagnosis: The date of provider diagnosis | ○ | ○ | ○ |
| 39 | Medications Administered (list): List of medications administered for the reportable event | ○ | ○ | ○ |
| 40 | Death Date: The patient's date of death | ○ | ○ | ○ |
| 41 | Patient Class: Whether the patient is outpatient, inpatient, emergency, urgent care, etc. | ○ | ○ | ○ |

## Business Associates Agreement

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|---|---|
| Would a business associates agreement (BAA) be required to route reportable information from your organization/facility to a third party, the Association of Public Health Laboratories (APHL), on its way to the Iowa Department of Public Health? | ◯ Yes<br>◯ No<br>◯ More complex response needed - see box below |
| Business Associates Agreement (BAA): Please explain your response to the BAA question above. | _____ |
| It is also possible that the reportability response could provide condition-specific treatment information or outbreak-specific guidance back to the healthcare provider after the report is made. | ◯ Yes<br>◯ No<br>◯ More complex response needed - see box below. |
| Reportability Response: Please explain your response to the Reportability Response question above. | _____ |