ELDRS Call Notes – March 18, 2020 @ 3:00 PM ET

ONC Updates (Jim Daniel)

- ONC has reviewed some current business processes regarding issues related to COVID-19 to identify the core problems. Would like to get feedback from community to address those issues
- More data from commercial labs
    - ONC is working with partners at APHL and AIMS platform to see if there are other large commercial labs doing testing from which we can get data using the AIMS platform
    - May be easier to get data through AIMS than another mechanism?
- Data quality issues with lab data coming from commercial labs. Main problems: 1) address, 2) phone number and 3) specimen source are often missing
    - ONC wants to do something to address this
    - Could address this by figuring out which business process is causing the issue
        - Providers/hospitals are collecting info, but sometimes this info isn't passed to commercial labs (only name/DOB)
        - Want to provide messaging to labs on what's important to include. Patient demographics need to be passed to commercial lab so it can be shared with public health.
        - PULSE – used in ER situations to look up clinical information. Lexus Nexus is also sometimes used. Could we be doing something at national level to target that?
        - Specimen source: NP, OP, etc. – is this a problem?

Discussion from States

- Other than commercial labs, questions regarding smaller regional labs that are starting to do testing, including big research/academic testing labs:
    - They're supposedly exempt from PH reporting? Can we start getting those funneled through AIMS to health departments?
    - In CT, hoping for negatives and positives (to see how much testing is being done)
- The 'exempt from PH reporting' is a myth. There is language from FDA regarding required reporting to PH departments from all labs doing testing
    - We will circulate this language to the Subcommittee
- When labs don't have ELR in place already, it would be helpful to have a secure email excel file come in to MAVEN at least
    - WA is tackling this by going back to standard national flat file. WA was able to implement with work done a while ago. It would be good to agree on national standard so regional labs could use that (then Rhapsody route)
    - OR built flat file spec for labs that can't do HL7
        - We will post to the ELR workgroup Basecamp.
- If we can agree on flat file spec, Jim Daniel can work on implementing with large volume stand-up labs, which are run by regional labs that don't have HL7 capacity
- Need to get ready for point of care testing as well
- What does flat file contain?
    - HL7 specifications for lab data only

- HHS can share message that hospital labs need to pass info on about demographics through ACLA and CLIA
- Are people using Lexus Nexus?
    - CA uses for confirming patient identity on occasion (some valuable info there).
    - WA uses Lexus Nexus product Accurint to reach back into Medicaid repository to extract address information
    - TN – HIV surveillance uses for large scale matches
    - Jim will follow up on Lexus Nexus for matching patients with demographics if missing
- Jim Daniel: Could we partner with APHL or another commercial partner to work with HL7 experts to feed these into AIMS?
    - Good option: submit flat file to some validation service and get feedback on individual basis. It is converted to HL7 and shipped to states
    - If we want to say to all labs "do it this way," where do we point them to for resources?
        - Maybe PHIN VADS? Trying to collect resources on COVID coding. Do labs look here?
        - CDC website or CSTE? Single source of truth for ELR?
        - Needs more discussion
- In NYC, the volume of cases is so gigantic that we can't investigate them all (way overloaded).
    - Trying to get simple info like was person hospitalized? In ICU? With ventilator? We're exploring ways to get info from hospitals (send CCDs?) or send via HIE to run queries and match to known lab positives.
    - Not eCR yet. Once the case load becomes that high, it's very hard to get even that information. Don't want to add burden to hospitals so how else to get this info?
    - What is the next step beyond ELR?
        - WA suggested exploring getting hospitals to send identified syndromic surveillance feed to match, ICU and ventilator info might be in existing syndromic feed
        - ONC suggested PULSE (Patient Unified Lookup) – it's one at a time but can build in batch capacity
        - Conduent outreach?
- Ask on order entry (AOE): Can we agree on standardized AOE questions instead of taking a piecemeal approach? What kinds of questions would they like to have?
    - Data or info to rapidly prioritize case investigations
    - NE public health labs does AOE to collect epi data (travel history or pregnancy status)
    - We reached a national consensus for AOE questions for Zika. What format did this take?
    - Next steps for AOE discussion: CSTE staff will set up a call this week to further vet questions, understand how to communicate that consensus fro public health to labs