Nebraska Public Health Data Exchange Registration

Please complete the survey below.

Thank you!

Today's Date

_____

Password

_____

First Name (person completing this form)

_____

Last Name

_____

For which public health data registries are you registering?

☐ NESIIS (Immunization Data)
☐ NEDSS (Reportable Laboratory Results)
☐ SSEDON (Syndromic Surveillance)
☐ eCR (Electronic Case Reporting)
☐ PDMP (Prescription Drug Monitoring Program)
☐ Cancer Registry
☐ Other (please specify)

Other Public Health Registry

_____

Organization Type:

☐ Critical Access Hospital
☐ EHR Vendor
☐ Hospital
☐ Eligible Provider (Promoting Interoperability Clinicians)
☐ Physician's office or clinics
☐ Pharmacy
☐ Pathology laboratory
☐ Surgery center/ambulatory surgery clinics
☐ Other

Other Organization Type

_____

Hospital CCN

_____

Cancer Registry

Is your Electronic Health Record (EHR) system capable of sending pathology reports electronically?

○ Yes
○ No

Please contact DHHS.NebraskaCancerRegistry@nebraska.gov to send pathology reports electronically using software called eMaRC Plus (instead of Web Plus).

Is the cancer program Commission on Cancer (CoC) accredited?

○ Yes
○ No

For more information please visit:
https://www.facs.org/quality-programs/cancer-programs/commission-on-cancer/coc-accreditation/categories/

Category of CoC accreditation:

○ Academic Comprehensive Cancer Center Program (ACAD
○ Community Cancer Program (CCP)
○ Comprehensive Community Cancer Program (CCCP)
○ Free-Standing Cancer Center Program (FCCP)
○ Hospital Associate Cancer Program (HACP)
○ Integrated Network Cancer Program (INCP)
○ NCI-designated Comprehensive Cancer Center Program (NCIP)
○ NCI-Designated Network Cancer Program (NCIN)
○ Pediatric Cancer Program (PCP)
○ Veterans Affairs Cancer Program (VACP)

Report volume in the previous year

○ Less than 50 cases
○ More than or equal to 50 cases

Hospital registry software used for electronic reporting

_____

Report file format

○ NAACCR
○ Non-NAACCR standard

Standard XML file
(https://www.naaccr.org/data-standards-data-dictionary/)

Has your facility ever reported pediatric, adolescent, and young adult cancer (PAYAC) patients, aged from 0-29 years?

○ Yes
○ No

Please report those cases within 30 days of diagnosis

Site information

Site Information

*Fields with an asterisk are required

 *Site Name: Department:

_____ _____
*Site Address:

_____
*City: *State: *Zip:

_____ _____ _____
County:

_____
Phone:

_____

Primary Contact (with whom will Nebraska DHHS work?):

*Fields with an asterisk are required.

 *First Name: *Last Name: *Title:

_____ _____ _____
Phone number: Ext.: Fax:

_____ _____ _____
*E-mail:

_____

Is this reporter a Certified Tumor Registrar (CTR)? ◯ Yes
◯ No

Contractor Agency Name, if applicable.

_____

Alternate Contact (in case primary contact is unavailable):

First Name: Last Name: Title:

_____ _____ _____

Phone number: Ext.: Fax:

_____ _____ _____

E-mail:

_____

Is this reporter a Certified Tumor Registrar (CTR)? ◯ Yes
◯ No

Contractor Agency Name, if applicable.

_____

Are you submitting for multiple providers, provider
sites, and/or hospital sites? ◯ Yes
◯ No

STEP 1: Download this Excel File and complete the fields listing all affiliated health systems or provider organizations.

[Attachment: "Mult Provider Name_ Facility List_.xlsx"]

STEP 2: Upload the file by pressing the upload button
on the right.

Name of Individual EP's (Eligible Professionals) or
Hospital applying for attestation:

_____

NPI#'s of Individual EP's (Eligible Professionals) or
Hospital NPI# (this is a 10 digit number)

_____

Group NPI# (for those using the Group NPI to apply for
PI):

_____

Are you registering for Promoting Interoperability
attestation? ◯ Yes
◯ No

Do you have your Promoting Interoperability reporting
period dates established?
NOTE: You CAN test any time before the end date of
your attestation reporting period. You CANNOT test
after your attestation reporting period has ended. ◯ Yes
◯ No

Start Date of Promoting Interoperability Reporting
Period:

_____

End Date of Promoting Interoperability Reporting
Period:

_____

Name:

_____

Title:

_____

Mailing Address:

_____

City:

_____

State:

_____

Zip Code:

_____

Email address:

_____

Current EHR Software Vendor:

_____

EHR product and version:

_____

ONC Certified EHR Number

Note: If you don't know your ONC#, please go to: https://chpl.healthit.gov/

_____

What version of HL7 is the EHR using?
NOTE: HL7 2.5.1 is required for Promoting Interoperability Stage 3.

◯ 2.3.1
◯ 2.5.1
◯ Both

Technical (IT) Contact Person

Name:

_____

Title:

_____

Phone:

_____

Ext

_____

Email address:

_____

REDCap

The Public Health Information Network Messaging System (PHINMS) Contact (if other than technical/IT contact)

Name:

_____

Title:

_____

Phone:

_____

Ext:

_____

Email Address:

_____

For purposes of sending us data, do you have PHINMS already installed and configured with us?

◯ Yes
◯ No

If you have a CDC-assigned OID for use as your PartyID for PHINMS, please enter it below:

_____