

Kentucky Health Information Exchange (KHIE)

Foodborne and Waterborne Diseases Case Report:

Listeriosis (Listeria) & Listeria, Neonatal

Quick Reference Guide

May 2024

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Table of Contents

1 Introduction	4
Overview	4
Supported Web Browsers	4
Mobile Device Considerations	5
Accessing the ePartnerViewer	5
2 Listeriosis (<i>Listeria</i>) Patient Information	6
3 Listeriosis (<i>Listeria</i>) Laboratory Information	15
4 Listeriosis (<i>Listeria</i>) Applicable Symptoms.....	17
5 Listeriosis (<i>Listeria</i>) Additional Information	20
6 Listeriosis (<i>Listeria</i>) Hospitalization, ICU, & Death Information	21
7 Listeriosis (<i>Listeria</i>) Vaccination History	24
8 Listeriosis (<i>Listeria</i>) Treatment Information.....	24
9 Listeriosis (<i>Listeria</i>) Additional Comments	25
10 Listeriosis (<i>Listeria</i>) Review and Submit.....	25
11 <i>Listeria</i>, Neonatal Patient Information	28
Contact Information of the Person With Whom the Patient Lives.....	31
12 Technical Support.....	34
Toll-Free Telephone Support	34
Email Support.....	34

1 Introduction

Overview

This training manual covers the unique functionalities for the Listeriosis (*Listeria*) and *Listeria*, Neonatal conditions in the Foodborne and Waterborne Diseases eICR Form in the ePartnerViewer. The Listeriosis (*Listeria*) condition contains unique birth-related fields on the **Patient Information** screen and unique validation pop-ups on the **Review & Submit** screen. The *Listeria*, Neonatal condition captures the contact information of the person with whom the patient lives and contains unique validation pop-ups on the **Patient Information** screen. All other screens for Listeriosis (*Listeria*) and *Listeria*, Neonatal conditions follow the generic workflow for the Foodborne and Waterborne Diseases Case Report. For specific information about the Foodborne and Waterborne Diseases Case Report, please review the [Direct Data Entry for Case Reports: Foodborne and Waterborne Diseases User Guide](#).

Users with the *Manual Case Reporter* role can submit case reports from the ePartnerViewer by completing an online case report. The process generates a manual electronic initial case report (eICR) which is routed to the Kentucky Department for Public Health (KDPH). All examples and screenshots used in this guide are simulated with mock data; no Protected Health Information (PHI) is present.

Please Note: All screenshots shown throughout this document reflect how Users would interact with the ePartnerViewer while using a desktop or tablet device. While core functionality remains the same across multiple devices, interface components may vary in presentation.

Supported Web Browsers

Users must access the ePartnerViewer with a supported web browser. The ePartnerViewer is configured to support the following modern browsers on desktop, tablet, and mobile devices:

Desktop Browser Version	Mobile Browser Version
Microsoft Edge	
Version 44+	Version 40+
Google Chrome	
Version 70+	Version 70+
Mozilla Firefox	
Version 48+	Version 48+
Apple Safari	
Version 9+	iOS 11+

Please Note: The ePartnerViewer does **not** support Microsoft Internet Explorer. To access the ePartnerViewer, Users must use a modern browser such as Google Chrome, Microsoft Edge, Apple Safari, or Mozilla Firefox.

Mobile Device Considerations

The ePartnerViewer is based on responsive design. This means it renders in the best format based on the user's device size. Responsive design applies to mobile, tablet, and desktop devices. Tablet devices in landscape display mode are considered desktop.

Accessing the ePartnerViewer

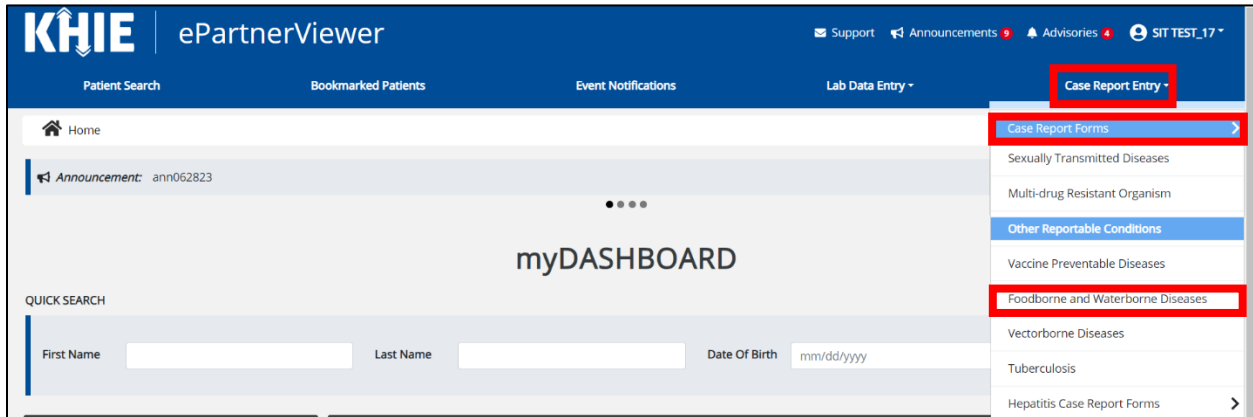
To access the ePartnerViewer, Users must meet the following specifications:

1. Users must be part of an organization with a signed Participation Agreement with KHIE.
2. Users are required to have a Kentucky Online Gateway (KOG) account.
3. Users are required to complete Multi-Factor Authentication (MFA).

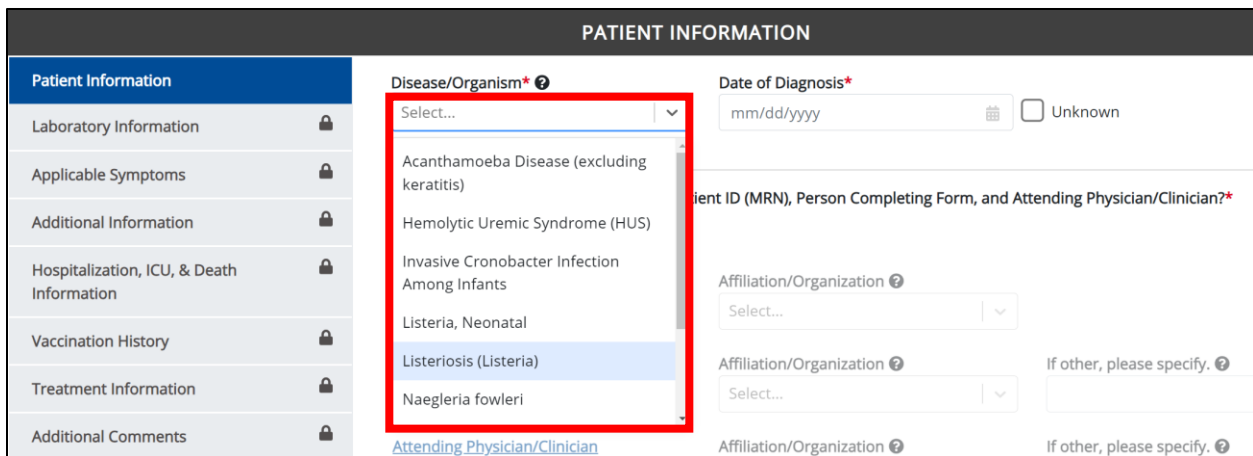
Please Note: For specific information about creating a Kentucky Online Gateway (KOG) account and how to complete MFA, please review the [ePartnerViewer Login: Kentucky Online Gateway \(KOG\) and Okta Verify Multi-Factor Authentication \(MFA\) User Guide](#).

2 Listeriosis (*Listeria*) Patient Information

1. To enter Foodborne and Waterborne Diseases case report information, click the **Case Report Entry** Tab in the blue Navigation Bar at the top of the screen, then select **Case Report Forms** from the dropdown menu.
2. Select **Foodborne and Waterborne Diseases** from the dropdown menu.



3. To start the Listeriosis (*Listeria*) Case Report entry, select **Listeriosis (*Listeria*)** from the *Disease/Organism* field on the **Patient Information** screen.



4. You must complete the mandatory fields on the **Patient Information** screen.

The screenshot shows the 'PATIENT INFORMATION' form. Red boxes highlight the following fields: 'Disease/Organism*' (containing 'Listeriosis (Listeria)'), 'Date of Diagnosis*' (containing 'mm/dd/yyyy'), 'Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?*' (with 'Yes' selected), 'First Name*', 'Middle Name', 'Last Name*', 'Date of Birth*' (containing 'mm/dd/yyyy'), 'Patient Sex*', 'Ethnicity*', and 'Race*'. Other fields include 'Patient ID (MRN)', 'Affiliation/Organization', 'Person Completing Form', 'Attending Physician/Clinician', 'Prefix', 'Suffix', and 'If other, please specify'.

5. Enter the **Date of Diagnosis**. If the date of diagnosis is unknown, click the **Unknown** checkbox.

This close-up shows the 'Date of Diagnosis*' field. The date 'mm/dd/yyyy' is entered in the input box, and the 'Unknown' checkbox is visible to the right.

6. Select the **appropriate answer** for the conditional field: *Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?*

This close-up shows the conditional field: 'Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form and Attending Physician/Clinician?*' with 'Yes' selected. Below it are three rows of 'Affiliation/Organization' dropdown menus, each with an 'If other, please specify' text box.

- Click **Yes** to apply the **same** Affiliation/Organization to the Patient ID (MRN), the Person Completing the Form, and the Attending Physician/Clinician.

Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?
*

Patient ID (MRN)* ? <input type="text"/>	Affiliation/Organization* ? <input type="text" value="Select..."/>	
Person Completing Form* <input type="text" value="Select..."/>	Affiliation/Organization ? <input type="text" value="Select..."/>	If other, please specify: ? <input type="text"/>
Attending Physician/Clinician* <input type="text" value="Select..."/>	Affiliation/Organization ? <input type="text" value="Select..."/>	If other, please specify: ? <input type="text"/>

- Click **No** to select a **different** Affiliation/Organization for the Patient ID (MRN), Person Completing Form, and the Attending Physician/Clinician.

Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?
*

Patient ID (MRN)* ? <input type="text"/>	Affiliation/Organization* ? <input type="text" value="Select..."/>	
Person Completing Form* <input type="text" value="Select..."/>	Affiliation/Organization* ? <input type="text" value="Select..."/>	If other, please specify: ? <input type="text"/>
Attending Physician/Clinician* <input type="text" value="Select..."/>	Affiliation/Organization* ? <input type="text" value="Select..."/>	If other, please specify: ? <input type="text"/>

- Enter the patient's **Medical Record Number (MRN)** in the *Patient ID (MRN)* field. An MRN is an organization specific, unique identification number assigned to a patient by a healthcare organization. If your organization does not use an MRN, you **MUST** create a way to uniquely identify your patient so that the patient is registered in the KHIE system.

Patient ID (MRN)* ? <input type="text"/>	Affiliation/Organization* ? <input type="text" value="Select..."/>
--	--

- 8. From the dropdown menu, select the **Affiliation/Organization** that applies to the Patient ID (MRN).

Please Note: If **Yes** is selected for the conditional field: *Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?* the same Affiliation/Organization will apply to each. The *Affiliation/Organization* field is enabled only for the Patient ID (MRN).

- 9. From the dropdown menu, select the name of the **Person Completing Form**.

- 10. If applicable, select the **Affiliation/Organization** that applies to the Person Completing the Form.

Please Note: The *Affiliation/Organization* field that applies to the Person Completing Form is enabled only if you selected **No** to the conditional question: *Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?*

11. Select the **Attending Physician/Clinician** from the dropdown menu.

12. If applicable, select the **Affiliation/Organization** that applies to the physician attending the patient.

Please Note: The *Affiliation/Organization* field that applies to the Attending Physician/Clinician is enabled only when you select **No** to the conditional question: *Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?*

13. If available for the patient, select the **Prefix** and **Suffix** from the dropdown menus.

14. Enter the patient's **First Name** and **Last Name**.

15. If available, enter the patient's **Middle Name**.

16. Enter the patient's **Date of Birth**.

17. Select the **Patient Sex** from the dropdown menu.

18. Select the patient's **Ethnicity** and **Race** from the appropriate dropdown menus.

A screenshot of a patient information form. The 'Patient Sex*' dropdown is highlighted in red. The 'Ethnicity*' dropdown is also highlighted in red and contains the text 'Not Hispanic or Latino'. The 'Race*' dropdown is highlighted in red and is open, showing a list of race categories: American Indian or Alaska Native, Asian, Asked but Unknown, Black or African American, Native Hawaiian or Other Pacific Islander, Other, and Unknown.

19. Enter the patient's **Street Address, City, State, Zip Code,** and **County.**

20. Enter the patient's **Phone Number.**

21. If available, enter the patient's **Email Address.**

A screenshot of a patient information form. The 'Address 1*' text box is highlighted in red. The 'Address 2' text box is highlighted in red and contains the text 'Unit, Suite, Building, etc.'. The 'City*' text box is highlighted in red. The 'State*' dropdown is highlighted in red. The 'Zip Code*' text box is highlighted in red. The 'County*' dropdown is highlighted in red. The 'Phone*' text box is highlighted in red and contains the text '(XXX) XXX-XXXX'. The 'Email' text box is highlighted in red and contains the text 'name@domain.com'.

22. Select the **type of patient visit** from the *Visit Type* dropdown menu.

A screenshot of a patient information form. The 'Visit Type*' dropdown is highlighted in red and is open, showing a list of visit types: Ambulatory, Emergency, Field, Home Health, Inpatient Acute, Inpatient Encounter, and Inpatient Non-Acute. The 'Encounter ID/Visit #' field is highlighted in red and contains the text 'Generate'.

• The *Encounter ID/Visit #* field allows Users to enter a **unique 20-digit Encounter ID/Visit #.**

A screenshot of a patient information form. The 'Visit Type*' dropdown is highlighted in red and contains the text 'Ambulatory'. The 'Encounter ID/Visit #' field is highlighted in red and contains the text 'Generate'.

- The **Encounter ID/Visit #** hyperlink allows Users to view the *Patient Case History* which includes the historical case report details and Encounter IDs (when available) that were previously submitted for the patient. The *Patient Case History* search is based on the **Patient First Name, Last Name,** and **Patient ID (MRN)** entered.

Visit Type* **Encounter ID/Visit #** Generate

- The **Generate** checkbox triggers the system to generate a **unique 20-digit Encounter ID/Visit #** if the Encounter ID/Visit # is unknown.

Visit Type* **Encounter ID/Visit #** Generate

- Upon clicking the **Generate** checkbox, the *Encounter ID/Visit #* field will be grayed out and disabled. The *Encounter ID/Visit #* field will display the system-generated Encounter ID/Visit # only after the **Patient Information** screen has been completed and saved.

Visit Type* **Encounter ID/Visit #** Generate

23. If applicable, select the **appropriate answer** to *Is the patient currently pregnant?*

Is the patient currently pregnant?*

Yes No Unknown

If yes, please enter the due date (EDC). Unknown

Please Note: The *Is the patient currently pregnant?* field is enabled and required only when the *Patient Sex* field is marked as **Female**.

- If **Yes** is selected for the *Is the patient currently pregnant?* field, the subsequent field is enabled. Enter the **estimated due date (EDC)** in the subsequent field: *If yes, please enter the due date (EDC)*. If the due date is unknown, click the **Unknown** checkbox.

Is the patient currently pregnant?*

Yes No Unknown

If yes, please enter the due date (EDC).*

Unknown

Please Note: If **No** or **Unknown** is selected for the *Is the patient currently pregnant?* field, the subsequent field is disabled: *If yes, please enter the due date (EDC).*

24. If applicable, select the **appropriate answer** to *Did the patient recently give birth?*

25. If **Yes** is selected for the conditional question, the subsequent fields on the screen are enabled.

26. Select the **appropriate answer** from the subsequent dropdown menu: *Did the patient have a miscarriage, stillbirth, or livebirth?*

27. If **Livebirth** is selected for the conditional question, the subsequent fields on the screen are enabled.

Did the patient recently give birth?*

Yes No Unknown

Did the patient have a miscarriage, stillbirth, or livebirth?*

Livebirth x | v

Please enter the name and DOB of the infant.

Infant First Name* Infant Last Name* Infant Date of Birth*

mm/dd/yyyy

28. Enter the **First Name** and **Last Name** of the infant.

29. Enter the **Date of Birth** of the infant.

Did the patient recently give birth?*

Yes No Unknown

Did the patient have a miscarriage, stillbirth, or livebirth?*

Livebirth x | v

Please enter the name and DOB of the infant.

Infant First Name* Infant Last Name* Infant Date of Birth*

mm/dd/yyyy

30. Enter the **gestational age of the fetus at the time of delivery in weeks and days** in the *Weeks* and *Days* textboxes for the field: *What was the gestational age of the fetus at the time of delivery? Please enter the age in weeks and days.*

What was the gestational age of the fetus at the time of delivery? Please enter the age in weeks and days.

Weeks* ? Days* ?

of Weeks # of Days

31. When the **Patient Information** screen has been completed, click **Save** to save your progress or click **Next** to proceed to the **Laboratory Information** screen.

What was the gestational age of the fetus at the time of delivery? Please enter the age in weeks and days.

Weeks* ? Days* ?

39 4

Save Next

3 Listeriosis (*Listeria*) Laboratory Information

1. On the **Laboratory Information** screen, select the **appropriate answer** for the conditional question at the top: *Does the patient have a lab test?*

Please provide laboratory information related to this case.

LABORATORY INFORMATION

Patient Information

Laboratory Information

Does the patient have a lab test?*

Yes No Unknown

2. If **Yes** is selected, the subsequent laboratory-related fields on the screen are enabled. You must enter details for a lab test.

LABORATORY INFORMATION

Patient Information

Laboratory Information

Applicable Symptoms

Additional Information

Hospitalization, ICU, & Death Information

Vaccination History

Treatment Information

Additional Comments

Review & Submit

Does the patient have a lab test?*

Yes No Unknown

Laboratory Information

Laboratory Name*

Test Name*

Select...

If other, please specify. ?

Filler Order/Accession Number ?

Specimen Source*

Select...

If other, please specify. ?

Test Result*

Select...

If other, please specify. ?

Test Result Date

mm/dd/yyyy Unknown

Specimen Collection Date*

mm/dd/yyyy Unknown

Additional Information ?

0/300 Characters

+ Add Test

3. Once the **Laboratory Information** screen is complete, click **Next** to proceed to the **Applicable Symptoms** screen.

Applicable Symptoms	🔒
Additional Information	🔒
Hospitalization, ICU, & Death Information	🔒
Vaccination History	🔒
Treatment Information	🔒
Additional Comments	🔒
Review & Submit	🔒

Laboratory Information

Laboratory Name*
Test Lab

Test Name*
Listeria monocytogenes Ab [Units/volume] in Serum

If other, please specify. ?

Filler Order/Accession Number ?
110110101

Specimen Source*
Abscess

If other, please specify. ?

Test Result*
Pending

If other, please specify. ?

Test Result Date: mm/dd/yyyy Unknown Specimen Collection Date*: 05/07/2024 Unknown

Additional Information ?
0/300 Characters

+ Add Test

Save Previous **Next**

4 Listeriosis (*Listeria*) Applicable Symptoms

1. On the **Applicable Symptoms** screen, select the appropriate answer for the conditional question at the top: *Were symptoms present during the course of illness?*

2. If **Yes** is selected for the conditional question, the subsequent fields on the screen are enabled.

Please Note: If **No** is selected for the conditional question, all subsequent symptom fields are disabled and marked with **No**. If **Unknown** is selected for the conditional question, all subsequent symptom fields are disabled and marked as **Unknown**.

3. Enter the **Onset Date** for the symptoms.
 - If the onset date is unknown, click the **Unknown** checkbox.

- 4. To report whether the patient had a fever during the illness, select the **appropriate answer** for the field: *Fever*.

If symptomatic, which of the following did the patient experience during illness?

Fever*

If yes, please enter the highest temperature. ?

- If **Yes** is selected, the subsequent field is enabled. Enter the **patient's highest temperature** in the subsequent textbox: *If yes, please enter the highest temperature.*

Fever*

If yes, please enter the highest temperature.* ?

- 5. To report the patient had diarrhea during the illness, select the **appropriate answer** for the field: *Diarrhea (>3 loose stools/24hr period)*.

Diarrhea (>3 loose stools/24hr period)*

If yes, please enter the number of days with diarrhea. ?

- If **Yes** is selected, the subsequent field is enabled. Enter the **number of days with diarrhea** in the subsequent textbox: *If yes, please enter the number of days with diarrhea.*

Diarrhea (>3 loose stools/24hr period)*

If yes, please enter the number of days with diarrhea.* ?

6. Select the **appropriate answers** for the following fields to indicate the symptoms the patient experienced during illness:

Altered mental status*	Yes	No	Unknown	Meningitis*	Yes	No	Unknown
Amnionitis*	Yes	No	Unknown	Muscle aches*	Yes	No	Unknown
Bacteremia*	Yes	No	Unknown	Non specific flu-like illness*	Yes	No	Unknown
Chills*	Yes	No	Unknown	Preterm labor*	Yes	No	Unknown
Confusion*	Yes	No	Unknown	Seizures*	Yes	No	Unknown
Gastroenteritis*	Yes	No	Unknown	Sepsis*	Yes	No	Unknown
Headache*	Yes	No	Unknown	Stiff neck*	Yes	No	Unknown
Loss of balance*	Yes	No	Unknown	Vomiting*	Yes	No	Unknown

7. To report additional symptoms not listed on the screen, select the **appropriate answer** for the field: *Did the patient have any other symptoms?*

Did the patient have any other symptoms?*

Yes No Unknown

If yes, please specify. ?

- If **Yes** is selected, the subsequent field is enabled. Enter the **patient’s other symptoms** in the subsequent textbox: *If yes, please specify.*

8. Once complete, click **Next** to proceed to the **Additional Information** screen.

Did the patient have any other symptoms?*

Yes No Unknown

If yes, please specify.* ?

Other symptoms

Save Previous Next

5 Listeriosis (*Listeria*) Additional Information

1. On the **Additional Information** screen, select the **appropriate answer** for the conditional question at the top: *Does any of the following apply to the patient?*

ADDITIONAL INFORMATION

Does any of the following apply to the patient?*

2. If **Yes** is selected for the conditional question, the subsequent fields on the screen are enabled. You must complete the required fields on the screen.

ADDITIONAL INFORMATION

Patient Information

Laboratory Information

Applicable Symptoms

Additional Information

Hospitalization, ICU, & Death Information

Vaccination History

Treatment Information

Additional Comments

Review & Submit

Does any of the following apply to the patient?*

Domestic travel within the last 30 days (outside state of normal residence)*

If yes, please specify state(s). ?

Select...

International travel within the last 30 days*

If yes, please specify country(s). ?

Select...

School/daycare attendee*

If yes, please specify the name of school/daycare. ?

School/daycare employee*

If yes, please specify the name of school/daycare. ?

Food handler*

If yes, please specify the name of food handler service. ?

4. Once complete, click **Next** to proceed to the **Hospitalization, ICU, & Death Information** screen.

Is this part of an outbreak?*

If yes, please specify the name of the outbreak. ?

Save Previous

6 Listeriosis (*Listeria*) Hospitalization, ICU, & Death Information

1. On the **Hospitalization, ICU, & Death Information** screen, select the **appropriate answer** for the conditional question at the top: *Was the patient hospitalized?*

The screenshot shows the 'HOSPITALIZATION, ICU, & DEATH INFORMATION' form. The left sidebar contains navigation tabs: Patient Information, Laboratory Information, Applicable Symptoms, Additional Information, Hospitalization, ICU, & Death Information (selected), Vaccination History, Treatment Information, Additional Comments, and Review & Submit. The main content area features a conditional question: 'Was the patient hospitalized?*' with three radio button options: 'Yes', 'No', and 'Unknown'. This question and its options are highlighted with a red box. Below the question, there is a text input field for 'If yes, please specify the hospital name.*'. Further down, there are fields for 'Admission Date' and 'Discharge Date', each with a date picker and an 'Unknown' checkbox. A 'Still hospitalized' checkbox is also present. Below these are fields for 'Was the patient admitted to an intensive care unit (ICU)?' with 'Yes', 'No', and 'Unknown' options, and corresponding 'Admission Date to ICU' and 'Discharge Date from ICU' fields. At the bottom, there is a question 'Did the patient die as a result of this illness?*' with 'Yes' and 'No' options, and a 'Date of Death' field.

2. If **Yes** is selected for the conditional question, the subsequent hospitalization-related and ICU-related fields on the screen are enabled. You must complete the required fields.

This screenshot shows the same form as above, but with the 'Yes' radio button selected for the 'Was the patient hospitalized?*' question. The subsequent fields, including the hospital name, admission and discharge dates, ICU admission status, and death-related questions, are now enabled and highlighted with a red box. The 'Admission Date' and 'Discharge Date' fields are now active, as are the 'Admission Date to ICU' and 'Discharge Date from ICU' fields. The 'Still hospitalized' checkbox is also visible.

Please Note: If **No** or **Unknown** is selected for the conditional question, all subsequent hospitalization-related and ICU-related fields are disabled. Death-related questions are not impacted by the selected answer for the conditional question: *Was the patient hospitalized?*

Admission Date* Unknown Discharge Date* Unknown Still hospitalized

Was the patient admitted to an intensive care unit (ICU)?*

Admission Date to ICU Unknown Discharge Date from ICU Unknown

Did the patient die as a result of this illness?

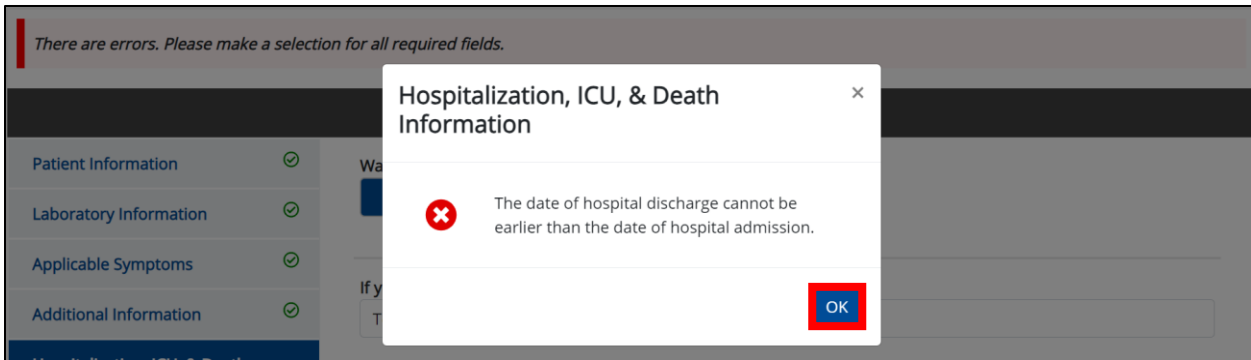
If yes, please provide the date of death.
Date of Death

Please Note: The Admission Date **cannot** occur **after** the Discharge Date. The Admission Date must occur on the **same date** or any date **BEFORE** the Discharge Date.

If you enter an Admission Date that occurs after the Discharge Date and click **Next**, both fields are marked as invalid, and the screen is grayed out and displays a pop-up message that states:

The date of hospital discharge cannot be earlier than the date of hospital admission.

To proceed, you must click **OK** and enter a valid Discharge Date that occurs **on** or **after** the Admission Date.



Hospitalization, ICU & Death Information

Admission Date* Unknown Discharge Date* Unknown
Invalid Admission Date Still hospitalized *Invalid Discharge Date*

3. If applicable, select the **appropriate answer** for the field: *Did the patient die as a result of this illness?*

Did the patient die as a result of this illness?*

If yes, please provide the date of death.

Date of Death

mm/dd/yyyy

• If **Yes** is selected, the subsequent *Date of Death* field is enabled. Enter the patient's **Date of Death**.

Did the patient die as a result of this illness?*

If yes, please provide the date of death.

Date of Death*

mm/dd/yyyy

4. Once complete, click **Next** to proceed to the **Vaccination History** screen.

Did the patient die as a result of this illness?*

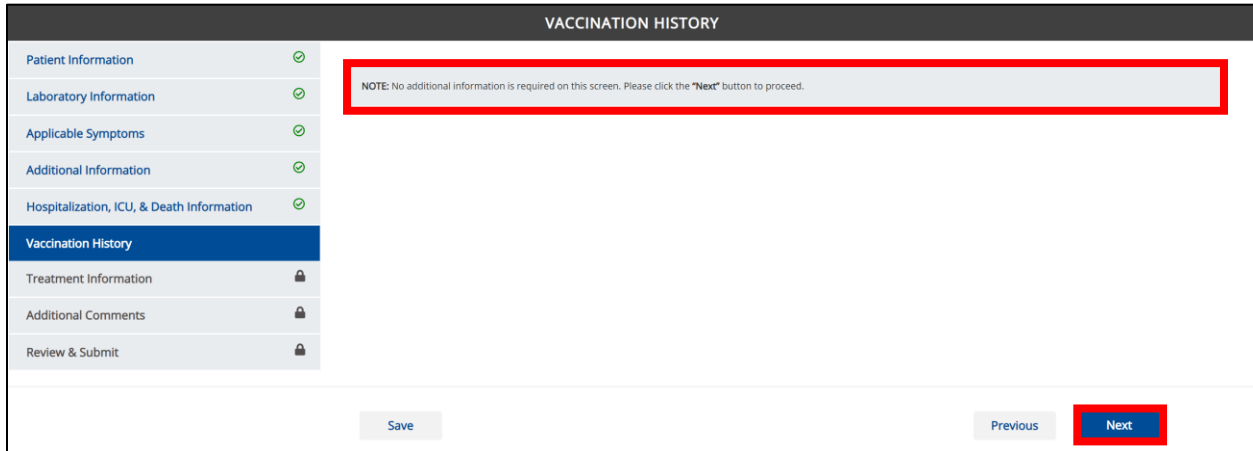
If yes, please provide the date of death.

Date of Death

mm/dd/yyyy

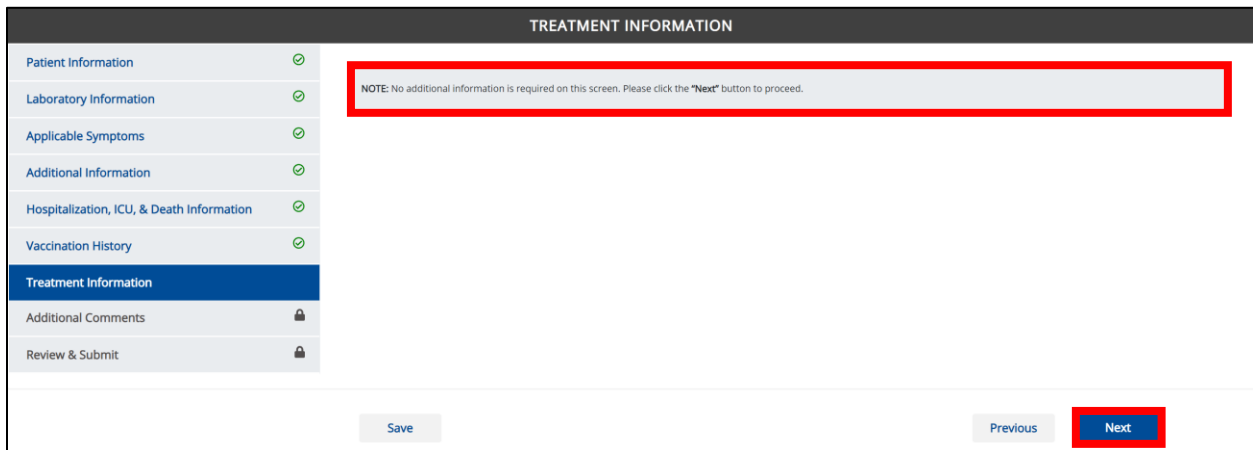
7 Listeriosis (*Listeria*) Vaccination History

1. On the **Vaccination History** screen, the following message displays at the top: **NOTE: No additional information is required on this screen. Please click the "Next" button to proceed.**
2. Click **Next** to proceed to the **Treatment Information** screen.



8 Listeriosis (*Listeria*) Treatment Information

1. On the **Treatment Information** screen, select the **appropriate answer** for the conditional question at the top: *Is the patient undergoing any treatment for the condition being reported?*
2. Click **Next** to proceed to the **Additional Comments** screen.



9 Listeriosis (*Listeria*) Additional Comments

1. On the **Additional Comments** screen, enter **additional comments or notes about the patient**, if applicable.
2. Once complete, click **Next** to proceed to the **Review & Submit** screen.

10 Listeriosis (*Listeria*) Review and Submit

1. On the Review and Submit screen, review the summary of information you have entered. Click the **appropriate section header** to make edits to the section's information.

- 2. After verifying the information is accurate and/or the appropriate changes have been made, you must click **Submit** to submit the Listeriosis (*Listeria*) Case Report Entry.

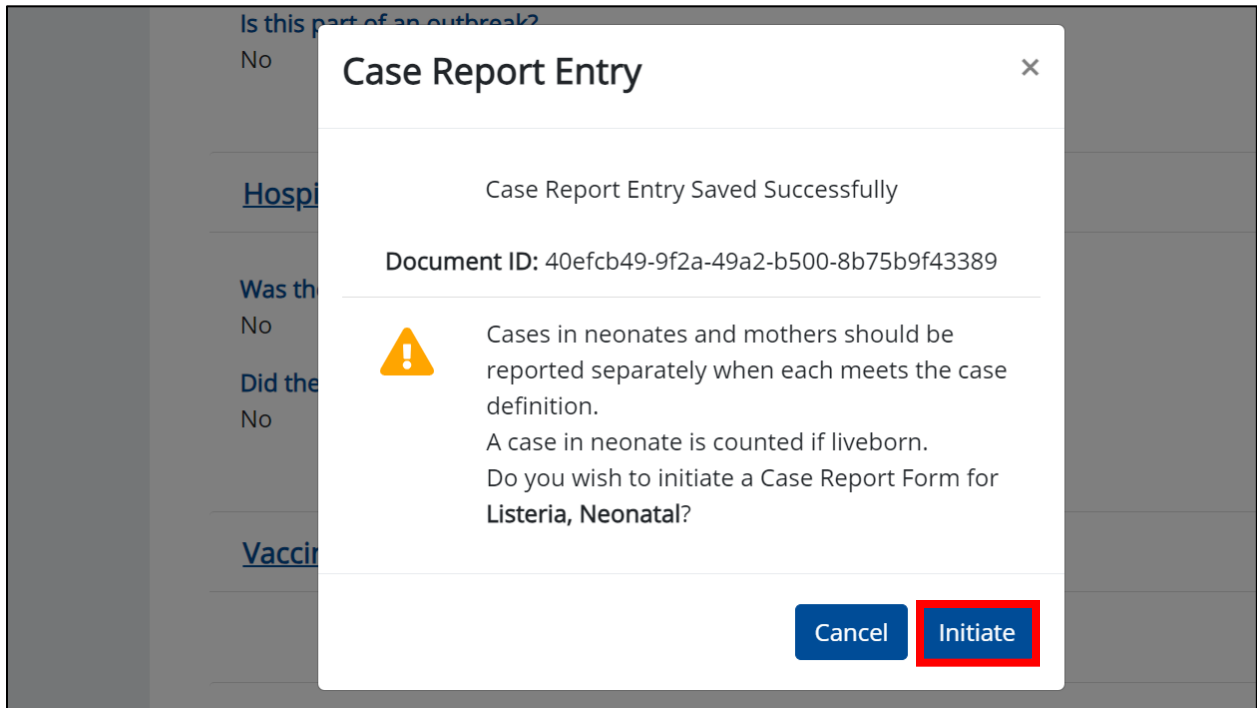
- All case report submissions are final. You have one more opportunity to select **Cancel** to continue reviewing the Case Report or click **Submit** to submit the report.

Please Note: Once a case report has been submitted, it is final. Should you later discover that you have entered inaccurate information, please use the **Support Tab** in the ePartnerViewer to report this information.

- 3. If **Livebirth** was selected for the *Did the patient have a miscarriage, stillbirth, or livebirth* dropdown menu on the **Patient Information** screen, then the *Case Report Entry* pop-up displays the following message:

- *Cases in neonates and mothers should be reported separately when each meets the case definition. A case in neonate is counted if liveborn. Do you wish to initiate a Case Report Form for **Listeria, Neonatal**?*

- 4. This pop-up allows you to create a new *Listeria*, Neonatal Case Report Form for the patient’s child. To initiate a *Listeria*, Neonatal Case Report for the patient’s child, click **Initiate** on the pop-up.



Please Note: Upon clicking **Initiate** on the *Case Report Entry* pop-up, you are automatically navigated to the **Patient Information** screen of the Foodborne and Waterborne Diseases Case Report with **Listeria, Neonatal** preselected for the *Disease/Organism* field.

11 *Listeria*, Neonatal Patient Information

1. Upon clicking **Initiate** on the *Case Report Entry* pop-up after submitting the Listeriosis (*Listeria*) Case Report, you are automatically navigated to the **Patient Information** screen of the Foodborne and Waterborne Diseases Case Report with ***Listeria*, Neonatal** preselected for the *Disease/Organism* field.

PATIENT INFORMATION

Patient Information
Laboratory Information

Disease/Organism*
Listeria, Neonatal

Date of Diagnosis*
mm/dd/yyyy Unknown

2. You must complete the mandatory fields on the **Patient Information** screen.

Disease/Organism*
Listeria, Neonatal

Date of Diagnosis*
mm/dd/yyyy Unknown

Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?*

Yes No

Patient ID (MRN) Affiliation/Organization*
Select...

Person Completing Form Affiliation/Organization* If other, please specify.*
Select... Select...

Attending Physician/Clinician Affiliation/Organization* If other, please specify.*
Select... Select...

Prefix
Select...

First Name* Middle Name Last Name*

Suffix Date of Birth* Birth Weight
Select... mm/dd/yyyy lb oz

Patient Sex* Ethnicity* Race*
Select... Select... Select...

Visit Type* Encounter ID/Visit #* Generate

With whom does the infant/child live?*

Select...
If other, please specify.

Please enter the contact information of the person with whom the infant/child is living.

First Name* Middle Name Last Name*

Address 1* Address 2
 Unit, Suite, Building, etc.

City* State* Zip Code*
Select... Select...

County* Phone* Email
Select... (XXX) XXX-XXXX name@domain.com

3. Enter the **Date of Diagnosis**. If the Date of Diagnosis is unknown, click the **Unknown** checkbox.

Disease/Organism*
Listeria, Neonatal

Date of Diagnosis*
mm/dd/yyyy Unknown

4. If available for the patient, select the **Prefix** and **Suffix** from the dropdown menus.

Prefix
Select...

First Name* Middle Name Last Name*

Suffix
Select...

Date of Birth* mm/dd/yyyy

Birth Weight lb oz

5. Enter the patient's **First Name** and **Last Name**.

6. If available, enter the patient's **Middle Name**.

First Name* Middle Name Last Name*

7. Enter the patient's **Date of Birth**.

Suffix
Select...

Date of Birth*
mm/dd/yyyy

8. If available, enter the patient's **Birth Weight** in the *lb* and *oz* textbox fields.

Date of Birth* 04/26/2024

Birth Weight lb oz

9. Select the **Patient Sex** from the dropdown menu.

Patient Sex*
Select...
Female
Male
Other
Unknown

Ethnicity*
Select...

Race*
Select...

Address 2
Unit, Suite, Building, etc.

State*
Select...

Zip Code*

10. Select the patient's **Ethnicity** and **Race** from the appropriate dropdown menus.

The screenshot shows a patient information form. The 'Ethnicity*' dropdown is set to 'Not Hispanic or Latino' and the 'Race*' dropdown is open, showing options: American Indian or Alaska Native, Asian, Asked but Unknown, Black or African American, Native Hawaiian or Other Pacific Islander, Other, and Unknown. Both dropdowns are highlighted with a red border.

11. Select the **type of patient visit** from the *Visit Type* dropdown menu.

The screenshot shows the 'Visit Type*' dropdown menu open, with options: Ambulatory, Emergency, Field, Home Health, Inpatient Acute, Inpatient Encounter, and Inpatient Non-Acute. The dropdown is highlighted with a red border.

- The *Encounter ID/Visit #* field allows Users to enter a **unique 20-digit Encounter ID/Visit #**.

The screenshot shows the 'Encounter ID/Visit #' field highlighted with a red border. The 'Visit Type' dropdown is set to 'Ambulatory'.

- The ***Encounter ID/Visit #*** hyperlink allows Users to view the *Patient Case History* which includes the historical case report details and Encounter IDs (when available) that were previously submitted for the patient. The *Patient Case History* search is based on the **Patient First Name, Last Name,** and **Patient ID (MRN)** entered.

The screenshot shows the 'Encounter ID/Visit #' field with a red box around the text and a red arrow pointing to the right, indicating the hyperlink.

- The ***Generate*** checkbox triggers the system to generate a **unique 20-digit Encounter ID/Visit #** if the Encounter ID/Visit # is unknown.

The screenshot shows the 'Generate' checkbox highlighted with a red border.

- Upon clicking the **Generate** checkbox, the *Encounter ID/Visit #* field will be grayed out and disabled. The *Encounter ID/Visit #* field will display the system-generated Encounter ID/Visit # only after the **Patient Information** screen has been completed and saved.

Visit Type*
Emergency

Encounter ID/Visit #* ?

Generate

Contact Information of the Person With Whom the Patient Lives

The *Listeria*, Neonatal Case Report captures details of the person with whom the patient lives.

12. Select the **appropriate answer** from the dropdown menu for the field: *With whom does the infant/child live?*

With whom does the infant/child live?*

Select...

Father

Grandparent

Mother

Other

Person with whom the infant/child is living.

Middle Name

Last Name*

Address 1*

Address 2
Unit, Suite, Building, etc.

City*

State*
Select...

Zip Code*

County*

Phone*
(XXX) XXX-XXXX

Email
name@domain.com

13. If **Other** is selected from the dropdown menu, enter the **appropriate answer** in the text box: *If Other, please specify.*

With whom does the infant/child live?*

Other

If other, please specify.*

- 14. Enter the **First Name** and **Last Name** of the person with whom the patient lives.
- 15. If available, enter the **Middle Name** of the person with whom the patient lives.

Please enter the contact information of the person with whom the infant/child is living.

First Name*	Middle Name	Last Name*
<input type="text"/>	<input type="text"/>	<input type="text"/>
Address 1*	Address 2 Unit, Suite, Building, etc.	
<input type="text"/>	<input type="text"/>	
City*	State* Select... v	Zip Code*
<input type="text"/>	<input type="text"/>	<input type="text"/>
County* Select... v	Phone* (XXX) XXX-XXXX	Email name@domain.com

- 16. Enter the **Address, City, State, Zip Code,** and **County** of the person with whom the patient lives.

Address 1*	Address 2 Unit, Suite, Building, etc.	
<input type="text"/>	<input type="text"/>	
City*	State* Select... v	Zip Code*
<input type="text"/>	<input type="text"/>	<input type="text"/>
County* Select... v	Phone* ⓘ (XXX) XXX-XXXX	Email name@domain.com

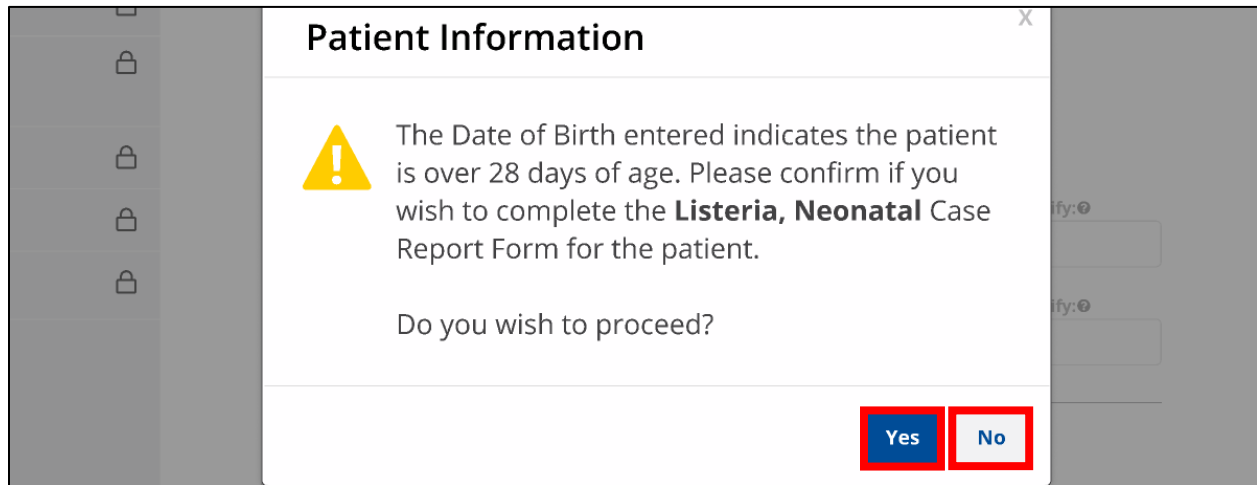
- 17. Enter the **Phone Number** of the person with whom the patient's lives.
- 18. If available, enter the Email **Address** of the person with whom the patient's lives.

County* Fayette x v	Phone* ⓘ (XXX) XXX-XXXX	Email name@domain.com
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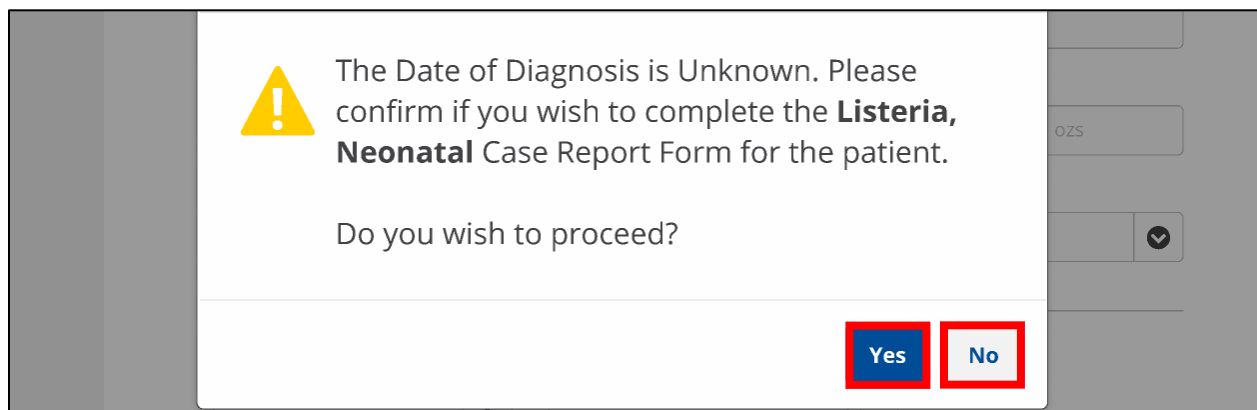
- 19. When the **Patient Information** screen has been completed, click **Save** to save your progress or click **Next** to proceed to the **Laboratory Information** screen.

City* Frankfort	State* KY x v	Zip Code* 40601-
County* Franklin x v	Phone* (555) 000-0000	Email name@domain.com
<input type="button" value="Save"/>		<input type="button" value="Next"/>

20. Upon clicking **Save** or **Next**, the *Patient Information* pop-up displays the following message when the Date of Birth entered indicates the patient is older than 28 days of age.
 - *The Date of Birth entered indicates the patient is over 28 days of age. Please confirm if you wish to complete the **Listeria, Neonatal** Case Report Form for the patient. Do you wish to proceed?*
21. To update the Date of Birth, click **No** to close the *Patient Information* pop-up and enter the **appropriate Date of Birth** to indicate that the patient is 28 days of age or younger.
22. If the Date of Birth is accurate, click **Yes** to close the *Patient Information* pop-up and proceed to the **Laboratory Information** screen.

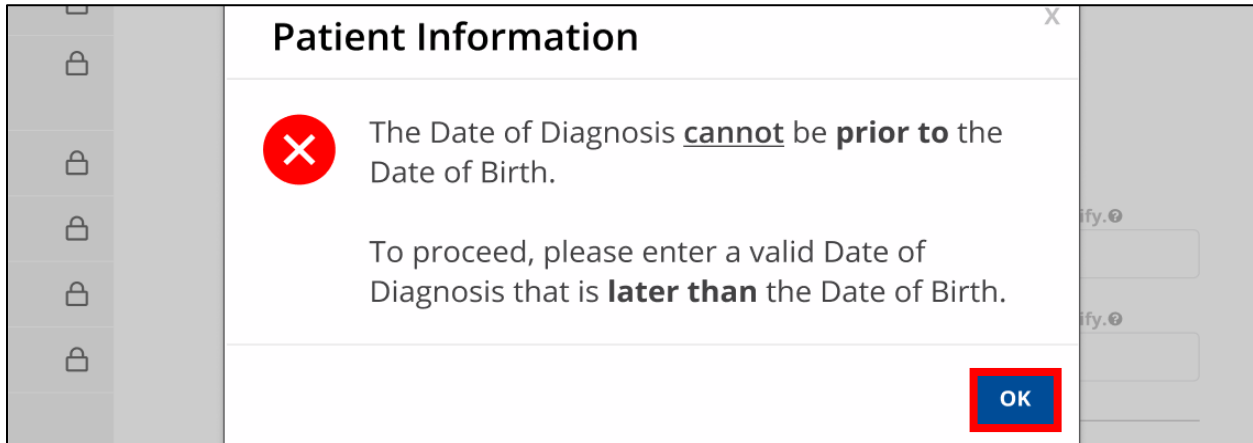


23. Upon clicking **Save** or **Next**, the *Patient Information* pop-up displays the following message when the Date of Diagnosis entered is unknown.
 - *The Date of Diagnosis is Unknown. Please confirm if you wish to complete the **Listeria, Neonatal** Case Report Form for this patient. Do you wish to proceed?*



24. To update the Date of Diagnosis, click **No** to close the *Patient Information* pop-up and enter the **appropriate Date of Diagnosis**. If the Date of Diagnosis is not known, click **Yes** to close the *Patient Information* pop-up and proceed to the **Laboratory Information** screen.

- 25. Upon clicking **Save** or **Next**, the *Patient Information* pop-up displays the following message when the Date of Diagnosis entered occurs before the patient’s Date of Birth.
 - The Date of Diagnosis cannot be **prior to** the Date of Birth. To proceed, please enter a valid Date of Diagnosis that is **later than** the Date of Birth.
- 26. To update the Date of Diagnosis, click **OK** to close the *Patient Information* pop-up and enter the **appropriate Date of Diagnosis**.



Please Note: From this point forward, the workflow screens are the same as Foodborne and Waterborne Diseases Case Reports. For more information, please review the [Direct Data Entry for Case Reports: Foodborne and Waterborne Diseases User Guide](#).

12 Technical Support

Toll-Free Telephone Support

For questions and assistance regarding the ePartnerViewer, please call 1 (800) 633-6283.

Email Support

To submit questions or request support regarding the ePartnerViewer, please email KHIESupport@ky.gov.

Please Note: To seek assistance or log issues, you can use the **Support Tab** located in the blue navigation bar at the top of the screen in the ePartnerViewer.

