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Kentucky Health Information Exchange (KHIE)

Other Reportable Diseases Case Report:

Melioidosis (Whitmore's Disease)

Quick Reference Guide

June 2024

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1 Introduction

Overview

This training manual covers the unique functionalities for the Melioidosis (Whitmore's Disease) condition in the Other Reportable Conditions eICR Form in the ePartnerViewer. The Melioidosis (Whitmore's Disease) condition contains unique **Applicable Symptoms** and **Additional Information** screens. All other screens for Melioidosis (Whitmore's Disease) condition follow the generic workflow for the Other Reportable Conditions Case Report. For specific information about the Other Reportable Conditions Case Report, please review the ***Direct Data Entry for Case Reports: Other Reportable Conditions 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:

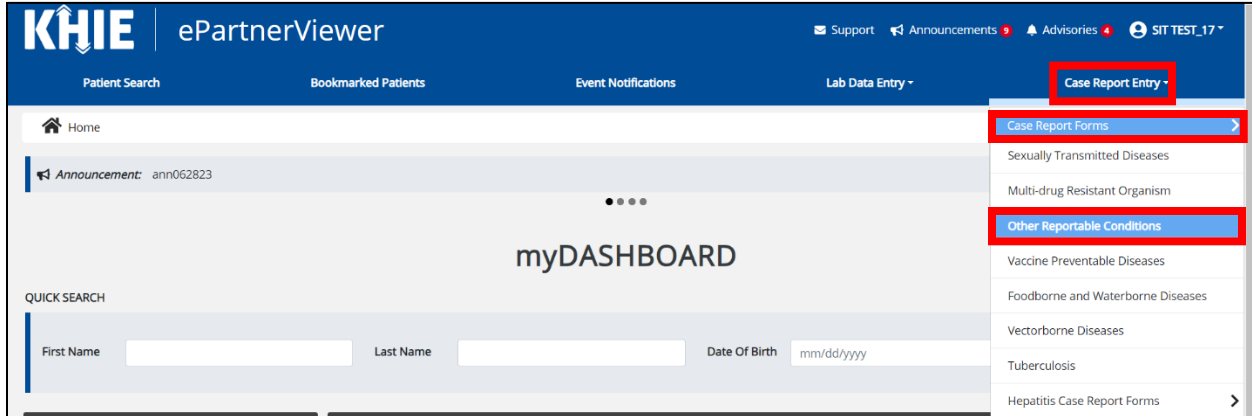
1. Users must be part of an organization with a signed Participation Agreement with KHIE.
2. Users are required to have a Kentucky Online Gateway (KOG) account.
3. Users are required to complete Multi-Factor Authentication (MFA).

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***.

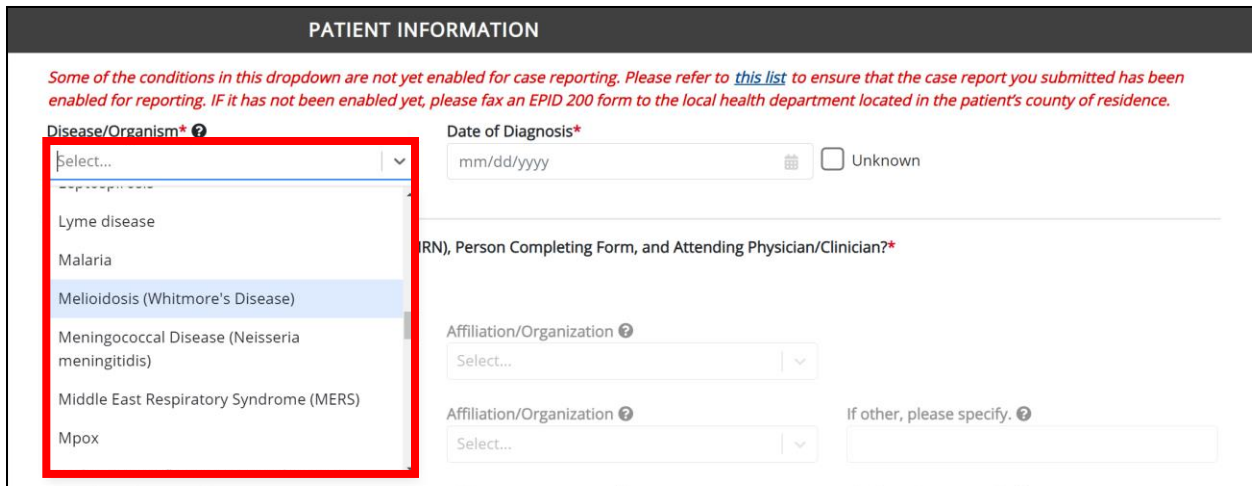
2 Patient Information

1. To enter Other Reportable Conditions 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 **Other Reportable Conditions** from the dropdown menu.



3. To start the Melioidosis (Whitmore's Disease) Case Report entry, select **Melioidosis (Whitmore's Disease)** from the *Disease/Organism* field on the **Patient Information** screen.



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

PATIENT INFORMATION

Some of the conditions in this dropdown are not yet enabled for case reporting. Please refer to this list to ensure that the case report you submitted has been enabled for reporting. If it has not been enabled yet, please fax an EPID 200 form to the local health department located in the patient's county of residence.

Disease/Organism* — Melioidosis (Whitmore's Disease)
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 — Select... — Affiliation/Organization — Select... — If other, please specify.
Attending Physician/Clinician — Select... — Affiliation/Organization — Select... — If other, please specify.

Prefix — Select...
First Name* — Middle Name — Last Name*
Suffix — Select... — Date of Birth* — mm/dd/yyyy
Patient Sex* — Select... — Ethnicity* — Select... — Race* — Select...

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

Disease/Organism* — Melioidosis (Whitmore's Disease)
Date of Diagnosis* — mm/dd/yyyy — Unknown

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?*

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

- Click ***Yes*** to apply the **<u>same</u>** 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? *

Yes No

Patient ID (MRN)*
Affiliation/Organization* Select...
Person Completing Form* Select...
Affiliation/Organization Select...
If other, please specify:
Attending Physician/Clinician* Select...
Affiliation/Organization Select...
If other, please specify:

- Click ***No*** to select a **<u>different</u>** 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? *

Yes No

Patient ID (MRN)*
Affiliation/Organization* Select...
Person Completing Form* Select...
Affiliation/Organization* Select...
If other, please specify:
Attending Physician/Clinician* Select...
Affiliation/Organization* Select...
If other, please specify:

7. 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)*
Affiliation/Organization* 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.

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**.

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

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

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

- 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.

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

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).*
mm/dd/yyyy | 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. When the **Patient Information** screen has been completed, click **Save** to save your progress or click **Next** to proceed to the **Laboratory Information** screen.

Is the patient currently pregnant?*
Yes | No | Unknown
If yes, please enter the due date (EDC).*
06/28/2024 | Unknown
Save | Next

3 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?*

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

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

LABORATORY INFORMATION

Does the patient have a lab test?*

Yes No Unknown

Laboratory Information

Laboratory Name*

Test Lab

Test Name*

Burkholderia pseudomallei Ab [Units/volume] in Serum

If other, please specify.

Filler Order/Accession Number

11010101

Specimen Source*

Abscess

If other, please specify.

Test Result*

Positive

If other, please specify.

Test Result Date*

06/02/2024 Unknown

Specimen Collection Date*

05/29/2024 Unknown

Additional Information

0/300 Characters

Add Test

Save Previous Next

4 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*
Yes No Unknown
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*
Yes No Unknown
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)*
Yes No Unknown
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)*
Yes No Unknown
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:

Abdominal discomfort* Yes No Unknown
Anorexia (loss of appetite)* Yes No Unknown
Chest pain* Yes No Unknown
Disorientation* Yes No Unknown
Encephalomyelitis* Yes No Unknown
Headache* Yes No Unknown
Joint pain* Yes No Unknown
Meningitis* Yes No Unknown
Muscle aches* Yes No Unknown
Nodule* Yes No Unknown
Pneumonia* Yes No Unknown
Respiratory distress* Yes No Unknown
Seizures* Yes No Unknown
Skin abscess* Yes No Unknown
Ulcer* Yes No Unknown

7. Select the **appropriate answer** for the conditional question: *Organ abscess.*

Organ abscess* Yes No Unknown
If yes, please specify the organ(s) with abscess formation. Please select all that apply.
Select...

8. If ***Yes*** is selected, select the **appropriate answer(s)** from the multiselect dropdown menu for the field: *If yes, please specify the organ(s) with abscess formation. Please select all that apply.*

Organ abscess* Yes No Unknown
If yes, please specify the organ(s) with abscess formation. Please select all that apply.*
Select...
Brain
Liver
Lung
Prostrate
Spleen
Other
Did the patient have any other symptoms?*

9. If ***Other*** is selected, enter the **other organ(s) with abscess formation** in the textbox for the field: *If other, please specify.*

If yes, please specify the organ(s) with abscess formation. Please select all that apply.*
Brain × Other ×
If other, please specify.*

10. Select the **appropriate answer** for the field: *Weight loss (lb)*

Weight loss (lb)*
Yes | No | Unknown
If yes, please enter the number of pounds lost.

11. If ***Yes*** is selected, enter the **number of pounds lost** in the textbox for the field: *If yes, please enter the number of pounds lost.*

Weight loss (lb)*
Yes | No | Unknown
If yes, please enter the number of pounds lost.*

12. 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.

13. If ***Yes*** is selected, enter the **patient's other symptoms** in the subsequent textbox: *If yes, please specify*.

14. 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.*

Save | Previous | Next

5 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?*

- 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***.

2. Select the **appropriate answer** for the field: *Domestic travel within the last 30 days (outside state of normal residence)*.

- If ***Yes*** is selected for the *Domestic travel (outside state of normal residence)* field, the subsequent *If yes, please specify state(s).* field is enabled. From the multi-select dropdown menu, select the **state(s) in which the patient traveled**.

Domestic travel within the last 30 days (outside state of normal residence)*
Yes | No | Unknown
If yes, please specify state(s).*
Select...
KY
AK
AL
AR
AS
AZ
CA

3. Select the **appropriate answer** for the field: *International travel within last 30 days*.

International travel within the last 30 days*
Yes | No | Unknown
If yes, please specify country(s).
Select...

- If ***Yes*** is selected, the subsequent field *If yes, please specify country(s).* is enabled. From the multi-select dropdown menu, select the **country or countries in which the patient traveled**.

International travel within the last 30 days*
Yes | No | Unknown
If yes, please specify country(s).*
Select...
United States
Afghanistan
Albania
Algeria
Andorra
Angola
Antigua and Barbuda

4. Select the **appropriate answers** for the following fields to indicate descriptions that apply to the patient:
   - *School/daycare attendee*
   - *School/daycare employee*
   - *Food handler*
   - *Healthcare worker*
   - *Long-term care facility resident*
   - *Long-term care facility employee*
   - *Correctional facility resident*
   - *Correctional facility employee*
   - *Homeless shelter resident*
   - *Homeless shelter employee*
   - *College/university student*
   - *College/university teacher*
   - *Substance abuse or misuse*
   - *Military*
   - *Other congregate setting resident*
   - *Other congregate setting employee*

School/daycare attendee*

Yes | No | Unknown

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

School/daycare employee*

Yes | No | Unknown

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

Food handler*

Yes | No | Unknown

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

Healthcare worker*

Yes | No | Unknown

If yes, please specify the name of healthcare facility.

Long-term care facility resident*

Yes | No | Unknown

If yes, please specify the name of long-term care facility.

Long-term care facility employee*

Yes | No | Unknown

If yes, please specify the name of long-term care facility.

Correctional facility resident*

Yes | No | Unknown

If yes, please specify the name of correctional facility.

Correctional facility employee*

Yes | No | Unknown

If yes, please specify the name of correctional facility.

Homeless shelter resident*

Yes | No | Unknown

If yes, please specify the name of homeless shelter.

Homeless shelter employee*

Yes | No | Unknown

If yes, please specify the name of homeless shelter.

College/university student*

Yes | No | Unknown

If yes, please specify the name of college/university.

College/university teacher*

Yes | No | Unknown

If yes, please specify the name of college/university.

Military*

Yes | No | Unknown

If yes, please specify the name of military base.

Other congregate setting resident*

Yes | No | Unknown

If yes, please specify the name of other congregate setting.

Other congregate setting employee*

Yes | No | Unknown

If yes, please specify the name of other congregate setting.

Please Note: If ***Yes*** is selected for **any** of the descriptive questions, the subsequent textbox is enabled for Users to specify the name of the appropriate setting.

For example, if ***Yes*** is selected for the *Healthcare worker* field, the subsequent textbox field is enabled. To proceed, you must enter the **name of the healthcare facility** in the subsequent field: *If yes, please specify the name of the healthcare facility*.

Healthcare worker*
Yes No Unknown
If yes, please specify the name of healthcare facility.*

5. Select the **appropriate answer** for the field: *Did the patient inject drugs not prescribed by a doctor*?

6. Select the **appropriate answer** for the field: *Did the patient use street drugs, but not inject*?

Did the patient inject drugs not prescribed by a doctor?*
Yes No Unknown
Did the patient use street drugs, but not inject?*
Yes No Unknown

7. Select the **appropriate answer** for the conditional question: *Did the patient have any known exposure to B. pseudomallei?*

Did the patient have any known exposure to B. pseudomallei?*
Yes No Unknown
Date of Known Exposure
mm/dd/yyyy Unknown
Please provide known exposure information.

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

Did the patient have any known exposure to B. pseudomallei?*
Yes No Unknown
Date of Known Exposure
mm/dd/yyyy Unknown
Please provide known exposure information.
0/500 Characters

9. Enter the **Date of Exposure.** If the date of exposure is unknown, click the ***Unknown*** *checkbox.*

Date of Known Exposure
mm/dd/yyyy Unknown

10. If known, enter the **exposure information** in the textbox for the field: *Please provide known exposure information.*

Please provide known exposure information.
0/500 Characters

11. Select the **appropriate answer** for the field: *Is this part of an outbreak*?

Is this part of an outbreak?*
Yes No Unknown
If yes, please specify the name of the outbreak.

12. If ***Yes*** is selected, the subsequent field is enabled. Enter **the name of the outbreak** in the subsequent textbox: *If yes, please specify name of the outbreak*.

Is this part of an outbreak?*
Yes No Unknown
If yes, please specify the name of the outbreak.*

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

Is this part of an outbreak?*
Yes No Unknown
If yes, please specify the name of the outbreak.*
Unknown outbreak.
Save Previous Next

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***.

6 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.