

# Kentucky Health Information Exchange (KHIE)

## **Respiratory Virus Associated Pediatric Mortality Case Report**

### Quick Reference Guide

July 2024

**Copyright Notice**

© 2024 Deloitte. All rights reserved.

**Trademarks**

"Deloitte," the Deloitte logo, and certain product names that appear in this document (collectively, the "Deloitte Marks"), are trademarks or registered trademarks of entities within the Deloitte Network. The "Deloitte Network" refers to Deloitte Touche Tohmatsu Limited (DTTL), the member firms of DTTL, and their related entities. Except as expressly authorized in writing by the relevant trademark owner, you shall not use any Deloitte Marks either alone or in combination with other words or design elements, including, in any press release, advertisement, or other promotional or marketing material or media, whether in written, oral, electronic, visual, or any other form. Other product names mentioned in this document may be trademarks or registered trademarks of other parties. References to other parties' trademarks in this document are for identification purposes only and do not indicate that such parties have approved this document or any of its contents. This document does not grant you any right to use the trademarks of other parties.

**Illustrations**

Illustrations contained herein are intended for example purposes only. The patients and providers depicted in these examples are fictitious. Any similarity to actual patients or providers is purely coincidental. Screenshots contained in this document may differ from the current version of the HealthInteractive asset.

**Deloitte**

Deloitte refers to one or more of Deloitte Touche Tohmatsu Limited, a UK private company limited by guarantee ("DTTL"), its network of member firms, and their related entities. DTTL and each of its member firms are legally separate and independent entities. DTTL (also referred to as "Deloitte Global") does not provide services to clients. In the United States, Deloitte refers to one or more of the US member firms of DTTL, their related entities that operate using the "Deloitte" name in the United States and their respective affiliates. Certain services may not be available to attest clients under the rules and regulations of public accounting. Please see [www.deloitte.com/about](http://www.deloitte.com/about) to learn more about our global network of member firms.

## Document Control Information

### Document Information

<b>Document Name</b>	Respiratory Virus Associated Pediatric Mortality Case Report Quick Reference Guide
<b>Project Name</b>	KHIE
<b>Client</b>	Kentucky Cabinet for Health and Family Services
<b>Document Author</b>	Deloitte Consulting
<b>Document Version</b>	1.0
<b>Document Status</b>	Finalized Draft
<b>Date Released</b>	07/01/2024

### Document Edit History

Version	Date	Additions/Modifications	Prepared/Revised by
0.1	06/27/2024	Initial Draft	Deloitte Consulting
0.2	06/28/2024	KHIE Review	KHIE
1.0	07/01/2024	Finalized Draft per KHIE Review	KHIE/Deloitte Consulting

## Table of Contents

<b>1 Introduction</b>	<b>4</b>
Overview	4
Supported Web Browsers	4
Mobile Device Considerations	5
Accessing the ePartnerViewer	5
<b>2 Patient Information</b>	<b>6</b>
<b>3 Laboratory Information</b>	<b>15</b>
CDC Laboratory Specimens	16
<b>4 Applicable Symptoms</b>	<b>17</b>
Clinical Diagnoses and Complications	20
<b>5 Additional Information</b>	<b>23</b>
Sterile Culture Results	23
Adding Multiple Sterile Culture Results	25
Non-Sterile Culture Results	26
Adding Multiple Non-Sterile Culture Results	27
<b>6 Hospitalization, ICU, &amp; Death Information</b>	<b>29</b>
<b>7 Vaccination History</b>	<b>33</b>
<b>8 Treatment Information</b>	<b>34</b>
<b>9 Additional Comments</b>	<b>35</b>
<b>10 Review and Submit</b>	<b>36</b>
<b>11 Technical Support</b>	<b>38</b>
Toll-Free Telephone Support	38
Email Support	38

# 1 Introduction

## Overview

This training manual covers the unique functionalities for the Respiratory Virus Associated Pediatric Mortality eICR Form in the ePartnerViewer. The Respiratory Virus Associated Pediatric Mortality eICR Form contains unique birth-related fields on the **Patient Information** screen, a unique *CDC Laboratory Services* section on the **Laboratory Information** screen, a unique *Clinical Diagnoses and Complications* section on the **Applicable Symptoms** screen, and unique **Additional Information** and **Hospitalization, ICU, and Death Information** screens. All other screens on the Respiratory Virus Associated Pediatric Mortality eICR Form follow the generic eICR Case Report workflow.

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
<b>Microsoft Edge</b>	
Version 44+	Version 40+
<b>Google Chrome</b>	
Version 70+	Version 70+
<b>Mozilla Firefox</b>	
Version 48+	Version 48+
<b>Apple Safari</b>	
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

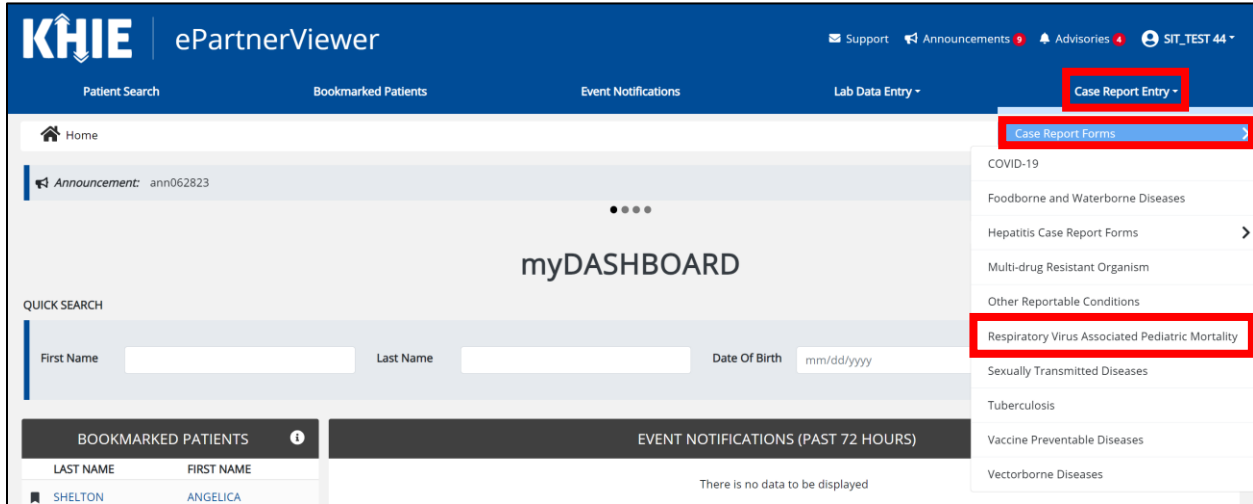
To access the ePartnerViewer, Users must meet the following specifications:

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).

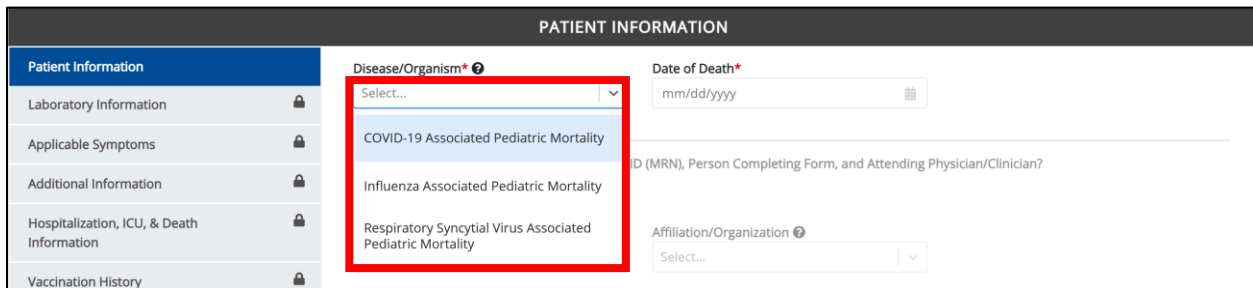
**Please Note:** For specific information about creating a Kentucky Online Gateway (KOG) account and how to complete MFA, please review the [ePartnerViewer Login: Kentucky Online Gateway \(KOG\) and Okta Verify Multi-Factor Authentication \(MFA\) User Guide](#).

## 2 Patient Information

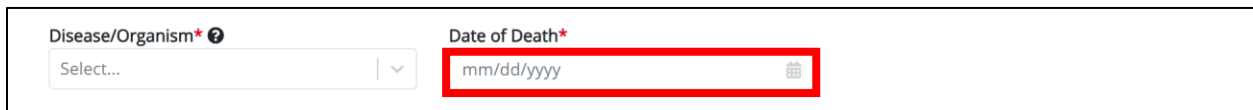
1. To enter Respiratory Virus Associated Pediatric Mortality case report information, click the **Case Report Entry** Tab in the blue Navigation Bar at the top of the screen, then select **Case Report Forms** from the dropdown menu.
2. Select **Respiratory Virus Associated Pediatric Mortality** from the dropdown menu.



3. To start the Respiratory Virus Associated Pediatric Mortality Case Report entry, select the **appropriate condition** from the *Disease/Organism* field on the **Patient Information** screen.



4. Enter the **Date of Death**.



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

**PATIENT INFORMATION**

Disease/Organism\* COVID-19 Associated Pediatric Mortality x | v Date of Death\* 06/04/2024

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

Yes No

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

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

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

Prefix  
Select...

First Name\* Middle Name Last Name\*

Suffix Date of Birth\*  
Select... mm/dd/yyyy

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

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... Select...

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

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



- 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?  
\*

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

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

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

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

The screenshot shows a form with several fields. The 'Patient ID (MRN)\*' field contains 'EB19039283'. Below it are 'Person Completing Form\*', 'Attending Physician/Clinician\*', and 'Prefix' fields, all with 'Select...' dropdown menus. To the right, the 'Affiliation/Organization\*' dropdown menu is open, showing a list of hospitals: Eugene Hospital, Evergreen General Hospital, Green Hosp, Heartland Clinic, Hilton Hospital, Howell Hospital, and Knight Hospital. This dropdown menu is highlighted with a red border. To the right of the dropdown are two 'If other, please specify:' fields.

**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**.

The screenshot shows the 'Person Completing Form\*' dropdown menu open, with options: 'Jane Doe (jane@mailinator.com)' and 'Mr. Marty Craine, Sr (marty@email.com)'. This dropdown menu is highlighted with a red border. To the right, there are two 'Affiliation/Organization' fields, each with 'Evergreen General Hospital' selected and a 'If other, please specify:' field.

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

The screenshot shows the 'Person Completing Form\*' field with 'Mr. Arthur Vandelay, II (arthur@email.com)'. Below it is the 'Attending Physician/Clinician\*' field with 'Select...' dropdown. The 'Prefix' field has 'Select...' dropdown. The 'Affiliation/Organization\*' dropdown menu is open, showing options: Eugene Hospital, Evergreen General Hospital, Green Hosp, Heartland Clinic, Hilton Hospital, Howell Hospital, and Justin Hospital. This dropdown menu is highlighted with a red border. To the right are two 'If other, please specify:' fields. At the bottom, there are 'First Name\*', 'Last Name\*', and 'Date of Birth\*' fields.

**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 options: 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 and contains the text 'Select...'. The 'Zip Code\*' text box is highlighted in red. The 'County\*' dropdown is highlighted in red and contains the text 'Select...'. 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 options: 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\*    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\*    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\*    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).*

Is the patient currently pregnant?\*

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

mm/dd/yyyy  Unknown

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

Did the patient recently give birth?\*

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

Select... | v

Date of Delivery

mm/dd/yyyy  Unknown

Please enter the name and DOB of the infant.

Infant First Name Infant Last Name Infant Date of Birth

mm/dd/yyyy

25. If **Yes** is selected, select the **appropriate answer** from the subsequent dropdown menu: *Did the patient have a miscarriage, stillbirth, or livebirth?*

Did the patient recently give birth?\*

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

Select... | v

Livebirth

Miscarriage

Stillbirth

Infant First Name Infant Last Name Infant Date of Birth

mm/dd/yyyy

26. If **Livebirth** or **Stillborn** is selected, enter the **Date of Delivery**. If the date of delivery is unknown, click the **Unknown** checkbox.

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

Livebirth x | v

Date of Delivery\*

mm/dd/yyyy  Unknown

- 27. If **Livebirth** is selected, the infant details fields are enabled. Enter the **Infant First Name**, **Infant Last Name**, and **Infant Date of Birth** in the appropriate enabled fields.
- 28. Once complete, click **Next** to proceed to the **Laboratory Information** screen.

Please enter the name and DOB of the infant.

Infant First Name*	Infant Last Name*	Infant Date of Birth*
<input type="text"/>	<input type="text"/>	<input type="text" value="mm/dd/yyyy"/>

### 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?*

Please provide laboratory information related to this case.

**LABORATORY INFORMATION**

Patient Information

**Laboratory information**

Applicable Symptoms

Additional Information

Does the patient have a lab test?\*

Yes No Unknown

Laboratory Information

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

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 Lab

Test Name\*  
Influenza virus A Ag [Presence] in Specimen by Immunofluorescence

If other, please specify.

Filler Order/Accession Number

Specimen Source\*  
Blood

If other, please specify.

Test Result\*  
Positive

If other, please specify.

Test Result Date\*   Unknown

Specimen Collection Date\*   Unknown

Additional Information

0/300 Characters

+ Add Test



### CDC Laboratory Specimens

The Respiratory Virus Associated Pediatric Mortality case report captures CDC laboratory specimen information.

3. Select the **appropriate answers** for the following fields:

- *Were pathology specimens sent to the Division of Laboratory Services (DLS)?*
- *Were viral isolates or original clinical material sent to the Division of Laboratory Services (DLS)?*

CDC Laboratory Specimens

Were pathology specimens sent to the Division of Laboratory Services (DLS)?\*

Yes	No	Unknown
-----	----	---------

Were viral isolates or original clinical material sent to the Division of Laboratory Services (DLS)?\*

Yes	No	Unknown
-----	----	---------

4. Once complete, click **Next** to proceed to the **Applicable Symptoms** screen.

CDC Laboratory Specimens

Were pathology specimens sent to the Division of Laboratory Services (DLS)?\*

Were viral isolates or original clinical material sent to the Division of Laboratory Services (DLS)?\*

## 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\*

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:

Encephalitis*	Yes	No	Unknown	Respiratory acidosis*	Yes	No	Unknown
Hypoxia*	Yes	No	Unknown	Respiratory distress*	Yes	No	Unknown
Kidney failure*	Yes	No	Unknown	Respiratory failure*	Yes	No	Unknown
Myocarditis*	Yes	No	Unknown	Rhabdomyolysis*	Yes	No	Unknown
Myositis*	Yes	No	Unknown	Sepsis*	Yes	No	Unknown
Pneumonia*	Yes	No	Unknown	Tachypnea*	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.\* ⓘ

### Clinical Diagnoses and Complications

The Respiratory Virus Associated Pediatric Mortality case report captures details about the patient's clinical diagnoses and complications.

9. Select the **appropriate answers** for the following fields:

- Was the patient placed on mechanical ventilation?
- Did complications occur during the acute illness?

Clinical Diagnoses and Complications

Was the patient placed on mechanical ventilation?\*

Yes No Unknown

Did complications occur during the acute illness?\*

Yes No Unknown

10. If **Yes** is selected for the *Did complications occur during the acute illness?* field, the subsequent field is enabled. Select the **complication(s) during the acute illness** from the multiselect dropdown menu for the field: *If yes, please specify the complication(s) during the acute illness. Please select all that apply.*

Did complications occur during the acute illness?\*

Yes No Unknown

If yes, please specify the complication(s) during the acute illness. Please select all that apply.\*

Select...

- Acute respiratory distress syndrome (ARDS)
- Bronchiolitis
- Cardiomyopathy/myocarditis
- Croup
- Enecephalopathy/encephalitis
- Hemorrhagic pneumonia/pneumonitis
- Pneumonia (chest x-ray confirmed)

11. If **Other** is selected, enter the **other complication(s) during the acute illness** in the textbox for the field: *If other, please specify.*

Did complications occur during the acute illness?\*

Yes No Unknown

If yes, please specify the complication(s) during the acute illness. Please select all that apply.\*

Other x Bronchiolitis x

If other, please specify.\*

0/200 Characters

12. Select the **appropriate answer** for the field: *Did the patient have any medical conditions that existed before the start of acute illness?*

Did the patient have any medical conditions that existed before the start of acute illness?\*

Yes	No	Unknown
-----	----	---------

13. If **Yes** is selected, the subsequent field is enabled. Select the **medical condition(s) that existed before the acute illness** from the multiselect dropdown menu for the field: *If yes, please specify the medical condition(s) that existed before the acute illness. Please select all that apply.*

Did the patient have any medical conditions that existed before the start of acute illness?\*

**Yes** No Unknown

If yes, please specify the medical condition(s) that existed before the acute illness. Please select all that apply.\*

Select...

- Asthma/reactive airway disease
- Cancer (diagnosis and/or treatment began in previous 12 months)
- Cardiac disease/congenital heart disease
- Cerebral palsy
- Chromosomal abnormality/genetic syndrome
- Chronic pulmonary disease
- Cystic fibrosis

14. If **Other** is selected, enter the **other medical condition(s) that existed before the acute illness** in the textbox for the field: *If other, please specify.*

Did the patient have any medical conditions that existed before the start of acute illness?\*

**Yes** No Unknown

If yes, please specify the medical condition(s) that existed before the acute illness. Please select all that apply.\*

Asthma/reactive airway disease x **Other** x

If other, please specify.\*

0/200 Characters

- 15. Include any **additional relevant patient details** in the textbox for the field: *Please include any relevant patient details.*
- 16. Once complete, click the **Next** button to proceed to the **Additional Information** screen.

Please include any relevant patient details.\*

0/1000 Characters

Save Previous **Next**

## 5 Additional Information

### Sterile Culture Results

1. On the **Additional Information** screen, select the **appropriate answer** for the conditional question at the top: *Was a specimen for bacterial culture collected from a normally sterile site?*

**ADDITIONAL INFORMATION**

Was a specimen for bacterial culture collected from a normally sterile site?\*

Yes	No	Unknown
-----	----	---------

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.

Was a specimen for bacterial culture collected from a normally sterile site?\*

Yes	No	Unknown
-----	----	---------

---

**Sterile Culture Result**

Please specify the microorganism detected from the culture.\*

Select... | v

If other, please specify.

**Specimen Source\***

Select... | v

If other, please specify.

**Specimen Collection Date\***

mm/dd/yyyy   Unknown



- 3. Select the **appropriate answer** from the dropdown menu for the field: *Please specify the microorganism detected from the culture?*

Sterile Culture Result

Please specify the microorganism detected from the culture.\*

Select...

- Group A streptococcus
- Haemophilus influenzae not-type b
- Haemophilus influenzae type b
- Staphylococcus aureus, methicillin resistant (MRSA)
- Staphylococcus aureus, methicillin sensitive
- Staphylococcus aureus, sensitivity not done
- Streptococcus pneumoniae

- 4. If **Other invasive bacteria** is selected, enter the **other invasive microorganism** in the textbox for the field: *If other, please specify.*

Please specify the microorganism detected from the culture.\*

Other invasive bacteria

If other, please specify.\*

- 5. Select the **appropriate answer** from the *Specimen Source* dropdown menu.

Specimen Source\*

Select...

- Blood
- CSF
- Lung tissue
- Pleural fluid
- Other
- Unknown

- 6. If **Other** is selected, enter the **other specimen source** in the textbox for the field: *If other, please specify.*

Specimen Source\*

Other

If other, please specify.\*

- 7. Enter the **Specimen Collection Date**. If the specimen collection date is unknown, click the **Unknown** checkbox.

Specimen Collection Date\*

mm/dd/yyyy  Unknown

### Adding Multiple Sterile Culture Results

- 8. Click the **Add Sterile Culture Result** button to log the details for multiple sterile culture results. This means that you can easily enter additional sterile culture results details on the same patient.

Specimen Collection Date\*


05/26/2024  Unknown

---

Add Sterile Culture Result

**Please Note:** When you click the **Add Sterile Culture Result** button, at least one sterile culture section must be entered.

- 9. To delete an additional sterile culture result section, click the **Trash Bin Icon** located at the top right.

Sterile Culture Result 

Please specify the microorganism detected from the culture.\*

Select...

If other, please specify.

Specimen Source\*

Select...

If other, please specify.

Specimen Collection Date\*

mm/dd/yyyy  Unknown

**Non-Sterile Culture Results**

10. Select the **appropriate answer** for the conditional question: *Were other respiratory specimens collected for bacterial culture (e.g., sputum, ET tube aspirate)?*

Were other respiratory specimens collected for bacterial culture (e.g., sputum, ET tube aspirate)?\*

Yes	No	Unknown
-----	----	---------

11. 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.

Were other respiratory specimens collected for bacterial culture (e.g., sputum, ET tube aspirate)?\*

---

Non-Sterile Culture Result

Please specify the microorganism detected from the culture.\*

Select...

If other, please specify.

Specimen Source\*

Select...

If other, please specify.

Specimen Collection Date\*

mm/dd/yyyy   Unknown

12. If **Other invasive bacteria** is selected, enter the **other invasive microorganism** in the textbox for the field: *If other, please specify.*

Please specify the microorganism detected from the culture.\*

Other invasive bacteria

If other, please specify.\*

13. Select the **appropriate answer** from the *Specimen Source* dropdown menu.

Specimen Source\*

select... | v

- ET tube aspirate
- Sputum
- Other
- Unknown

14. If **Other** is selected, enter the **other specimen source** in the textbox for the field: *If other, please specify*.

Specimen Source\*

Other x | v

If other, please specify.\*

15. Enter the **Specimen Collection Date**. If the specimen collection date is unknown, click the **Unknown** checkbox.

Specimen Collection Date\*

mm/dd/yyyy | v  Unknown

### Adding Multiple Non-Sterile Culture Results

16. Click the **Add Non-Sterile Culture Result** button to log the details for multiple non-sterile culture results. This means that you can easily enter additional non-sterile culture results details on the same patient.


Specimen Collection Date\*

05/21/2024 | v  Unknown

**+ Add Non-Sterile Culture Result**

**Please Note:** When you click the **Add Non-Sterile Culture Result** button, at least one non-sterile culture section must be entered.

17. To delete an additional non-sterile culture result section, click the **Trash Bin Icon** located at the top right.

Non-Sterile Culture Result 

Please specify the microorganism detected from the culture.\*

Select... | v


If other, please specify.

Specimen Source\*

Select... | v

If other, please specify.

Specimen Collection Date\*

mm/dd/yyyy   Unknown

18. Select the **appropriate answer** for the field: *Was a specimen collected by a local or state pathologist during an autopsy for testing of bacterial pathogens?*

19. Once complete, click **Next** to proceed to the **Hospitalization, ICU, and Death Information** screen.

Was a specimen collected by a local or state pathologist during an autopsy for testing of bacterial pathogens?

Yes	No	Unknown
-----	----	---------

Save Previous **Next**

## 6 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?*

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.

3. If the patient has been hospitalized, enter the **name of the hospital where the patient is/was hospitalized** in the textbox: *If yes, please specify the hospital name.*

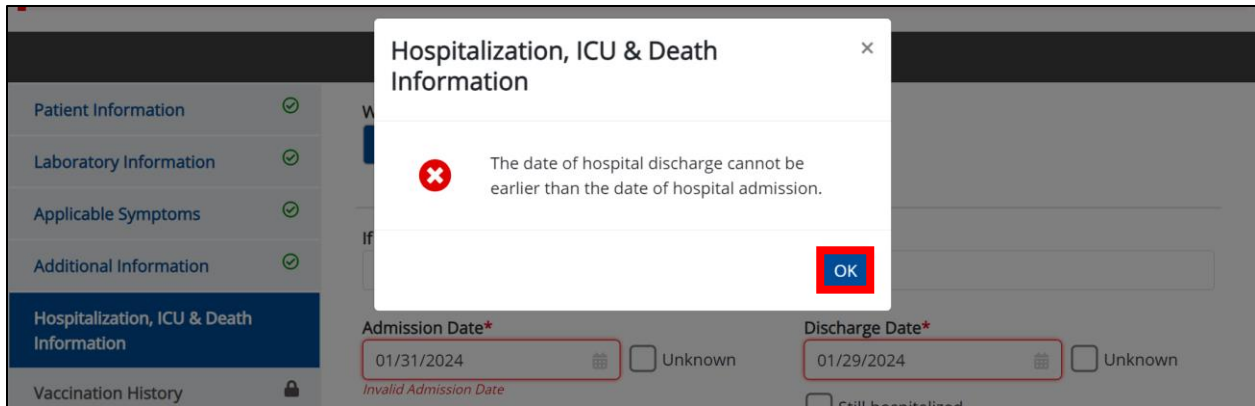
4. Enter the patient's hospitalization **Admission Date**. If the admission date is unknown, click the **Unknown** checkbox.
5. Enter the patient's hospitalization **Discharge Date**. If the discharge date is unknown, click the **Unknown** checkbox.

**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.



6. Select the **appropriate answer** for the field: *Was the patient admitted to an intensive care unit (ICU)?*

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

Yes     No     Unknown

7. If **Yes** is selected, the subsequent *Admission Date to ICU* and *Discharge Date from ICU* fields are enabled. Enter the dates for the **Admission Date to ICU** and the **Discharge Date from ICU**.

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

Yes     No     Unknown

Admission Date to ICU\*    Discharge Date from ICU\*

    Unknown         Unknown

**Please Note:** The Respiratory Virus Associated Pediatric Mortality Case Report automatically selects **Yes** for the field: *Did the patient die as a result of this illness?* The **Date of Death** field displays the date that the User entered in the **Date of Death** field on the **Patient Information** screen.

Did the patient die as a result of this illness?  
   
If yes, please provide the date of death.  
Date of Death

**PATIENT INFORMATION**

Disease/Organism\*   
Date of Death\*

20. Select the **appropriate answer** for the conditional question: *Was an autopsy performed?*

Was an autopsy performed?\*

<input checked="" type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
---	-----------------------------------	--

21. 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.

Was an autopsy performed?\*

<input checked="" type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
---	-----------------------------------	--

If yes, please provide the date of autopsy.  
Date of Autopsy\*  
  Unknown

Please include the findings from the histopathology report.\*

0/1000 Characters

22. Enter the **Date of Autopsy**. If the date of autopsy is unknown, click the **Unknown** checkbox.

Was an autopsy performed?\*

<input checked="" type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
---	-----------------------------------	--

If yes, please provide the date of autopsy.  
Date of Autopsy\*  
  Unknown



- 8. Enter the **histopathologic evidence of inflammation** in the textbox for the field: *Please include any histopathologic evidence of inflammation largely involving the anterior horn of the spinal cord.*

Please include the findings from the histopathology report.\*

0/1000 Characters

- 9. Select the **appropriate answer** for the field: *Did cardiac/respiratory arrest occur outside the hospital?*

Did cardiac/respiratory arrest occur outside the hospital?\*

Yes	No	Unknown
-----	----	---------

- 10. Select the **appropriate answer** from the dropdown menu the field: *Please specify the location of death.*

Please specify the location of death.\*

Select...

Emergency department (ED)

ICU

Inpatient ward

Outside the hospital (e.g., home or in transit to hospital)

Other

- 11. If **Other** is selected, enter the **other location of death** in the textbox for the field: *If other, please specify.*

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

Please specify the location of death.\*

Other

If other, please specify.\*

Save Previous **Next**

## 7 Vaccination History

1. On the **Vaccination History** screen, select the **appropriate answer** for the conditional question at the top: *Is the patient vaccinated for the condition being reported?*

VACCINATION HISTORY

Is the patient vaccinated for the condition being reported?\*

Yes  No  Unknown

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.
3. Once complete, click **Next** to proceed to the **Treatment Information** screen.

VACCINATION HISTORY

Patient Information

Laboratory Information

Applicable Symptoms

Additional Information

Hospitalization, ICU, & Death Information

**Vaccination History**

Treatment Information

Additional Comments

Review & Submit

Is the patient vaccinated for the condition being reported?\*

Yes  No  Unknown

Vaccine Details

If yes, please provide vaccine name.\* ?

Select...

If other, please specify. ?

If yes, please enter the number of doses.\* ?

Select...

Date Administered (1st dose) mm/dd/yyyy  Unknown

Date Administered (2nd dose) mm/dd/yyyy  Unknown

Date Administered (3rd dose) mm/dd/yyyy  Unknown

+ Add Vaccine

Save Previous **Next**

## 8 Treatment Information

1. On the **Treatment Information** screen, select the **appropriate answer** for the conditional question at the top: *Was the patient receiving medication or therapy prior to illness onset?*

**TREATMENT INFORMATION**

Was the patient receiving medication or therapy prior to illness onset?\*

Yes	No	Unknown
-----	----	---------

2. If **Yes** is selected, select the **antibiotic or antiviral therapy received** from multiselect dropdown menu for the field: *If yes, please specify the antibiotic or antiviral therapy received. Please select all that apply.*

If yes, please specify the antibiotic or antiviral therapy received. Please select all that apply.\*

Select...

- Antiviral prophylaxis
- Chemotherapy or radiation therapy
- Chronic aspirin therapy
- Steroids by mouth or injection
- Other

Yes	No	Unknown
-----	----	---------

3. If **Other** is selected, enter the **other antibiotic or antiviral therapy received** in the textbox for the field: *If other, please specify.*

If yes, please specify the antibiotic or antiviral therapy received. Please select all that apply.\*

Chronic aspirin therapy x Other x

If other, please specify.\*

0/200 Characters

4. Select the **appropriate answer** for the field: *Did the patient receive medication or therapy after illness onset?*

Did the patient receive medication or therapy after illness onset?\*

Yes	No	Unknown
-----	----	---------

- 5. If **Yes** is selected, enter the **other medication or therapy received after illness onset** in the textbox for the field: *If yes, please specify.*
- 6. Once complete, click **Next** to proceed to the **Additional Comments** screen.

Did the patient receive medication or therapy after illness onset?\*

If yes, please specify.\*

0/200 Characters

## 9 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.

**ADDITIONAL COMMENTS**

Patient Information	✔
Laboratory Information	✔
Applicable Symptoms	✔
Additional Information	✔
Hospitalization, ICU, & Death Information	✔
Vaccination History	✔
Treatment Information	✔
<b>Additional Comments</b>	
Review & Submit	🔒

Please include additional comments or notes, if applicable.

0/1000 Characters

## 10 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.

REVIEW & SUBMIT	
Patient Information	✓
Laboratory Information	✓
Applicable Symptoms	✓
Additional Information	✓
Hospitalization, ICU, & Death Information	✓
Vaccination History	✓
Treatment Information	✓
Additional Comments	✓
<b>Review &amp; Submit</b>	

**Patient Information**

Disease/Organism	Date of Death
Influenza Associated Pediatric Mortality	2024/06/20
Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?	
Yes	
Patient ID (MRN)	Affiliation/Organization
123	Baxter Hospital
Person Completing Form	Affiliation/Organization
Dr. Niles Crane (niles@mailinator.com)	Baxter Hospital
Attending Physician/Clinician	Affiliation/Organization
Dr. Frasier Crane (frasier@mailinator.com)	Baxter Hospital

2. After verifying the information is accurate and/or the appropriate changes have been made, you must click **Submit** to submit the Respiratory Virus Associated Pediatric Mortality Case Report Entry.

Additional Comments

Previous **Submit**

4. 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.

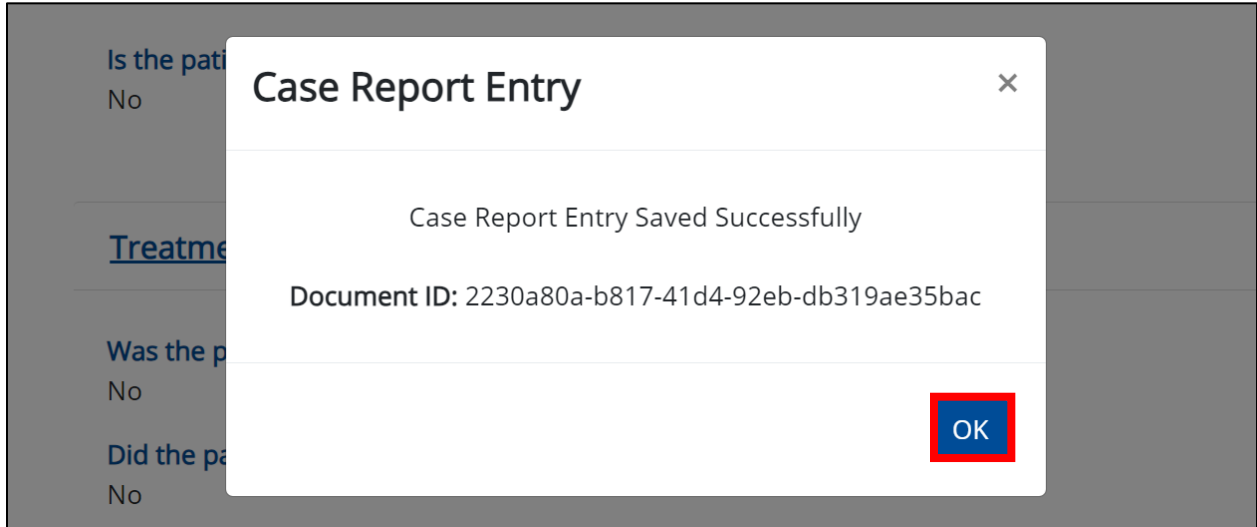
**Case Report Entry**

All data submissions are final. Please ensure that your data is accurate before clicking on the Submit button. If you would like to make changes now, please click the Cancel button.

**Cancel** **Submit**

**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.

- 5. Click **OK** to acknowledge the case report has been submitted successfully.



**Please Note:** Clicking **OK** when the case report entry has been submitted successfully will automatically navigate you to the **Case Report Entry User Summary** screen.

**Congratulations! You have submitted the Respiratory Virus Associated Pediatric Mortality Case Report using KHIE’s Direct Data Entry functionality.**

Please visit the KHIE website at <https://khie.ky.gov/Public-Health/Pages/Direct-Lab.aspx> to access additional training resources and find information on reporting requirements from the Kentucky Department for Public Health.

## 11 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](mailto: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.

