Description

The practice site for the scenario is Shoreline Pediatrics. The EHR vendor loads demographic data and clinical history for Juana Mariana Vazquez. The data includes immunizations provided by the practice.

The vendor also enters:

-Two vaccines administered at other sites

1. an influenza vaccine given at a local pharmacy
2. an inactivated polio vaccine given elsewhere and not reported to the registry - the history includes an adverse reaction (febrile seizure) 8 hours after the vaccine was administered

- Adverse reaction to inactivated polio vaccine (febrile seizure) and the date and source of information

NOTE: the historical vaccines will be imported during the Registry query (e.g. from another practice)

Comments

Set-up step evaluating EMR functions for capturing and storing patient pediatric demographic data, historical immunizations, and clinical conditions. There is no transaction associated with this test step.

Pre-condition

No PreCondition

Post-Condition

The EMR has recorded all of the pediatric demographic data, historical immunizations, and clinical conditions in the record created for Juana Mariana Vazquez using the test data provided.

Test Objectives

Register New Patients: The system must allow a user to enter distinguishing information about patients so that providers can uniquely identify patients who have similar sounding names or other similar identifying information. For example, twins living in the same household will have similar dates of birth, addresses, and may have similar names. EHRs or other clinical software must be able to store information to successfully match with patients in immunization registries, if the information is available. The information includes the mother's maiden name, whether the patient was part of a multiple birth, and the order of the multiple birth. This information allows the provider to correctly identify the patient and also helps assure a match when the EHR send the patient's information to external systems such as an immunization registry.

Record Past Immunizations: The EHR or other clinical software system allows providers to enter information about immunizations given elsewhere (e.g., by another doctor, at a public health clinic, pharmacy, etc.) with incomplete details.

Request/Receive Patient Immunization Data and Identify Source: The EHR or other clinical software is able to store immunization history accepted electronically from other sources (such as a public health immunization registry consistent with HL7 version 2.5.1, Implementation Guide for Immunization Messaging Release 1.5) or communicated by the patient and manually entered by the clinician. When viewing such information, the provider can determine which immunizations were administered by the practice, which were entered manually as patient-reported, and which were accepted

electronically from the public health registry.

Supporting data for:

Compare Public Health Immunization Registry (IIS) Immunization History to EHR Immunization History: The public health immunization registry has returned the requested immunization history for a patient. The EHR is able to display the immunization history received from the registry as well as the immunization history already present in the EHR so that a user can compare them. The EHR provides a way for the provider to view both histories, determine what is different (if anything), and update the existing EHR immunization history with new information from the public health registry if he or she chooses to do so. The system must store the new information as structured data as part of the patient's local immunization history and include the time of the update and the source of the new information.

Identify Adverse Event: The EHR or other clinical software system enables capture of structured data regarding adverse events.

Evaluation Criteria
Evaluation criteria is defined within each test step.

Notes
No Note