Test Plan Summary

HIMSS Immunization Integration Program CDC Test Plan v9.0

Description

Test Objectives	
Test Case Group: Initial Data I	Load
Description	
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Test Objectives	
The initial data load will consist of the vendor enter entry will include demographic data, Immunizatio populate the inventory used in the use case.	ering data during live interactive testing for 4 patients with various scenarios. The data n histories and specific conditions for each patient. The initial data load will also
Test Case	Juana Mariana Vazquez Initial Data Load

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).

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. The EHR or other clinical software system must be able to store information to successfully match with patients in immunization registries, if the information is available. Specific to immunization registries, that information includes the mother's maiden name, whether the patient was part of a multiple birth, and the birth order (i.e., ordinal number of birth, first, second, etc.). This information allows the provider to correctly identify the patient and also helps ensure a match when the EHR sends 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 stores 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.

Data Quality Checks: Integrate additional data quality checks into IIP Testing and Recognition to improve data quality and reduce rejections.

Note: The EHR or other clinical software system prevents specific data issues which would potentially result in IIS errors as defined by the AIRA Error Codes. This supports reducing data quality issues that could trigger the following AIRA-defined Error Codes:

- 2104: Indicates that a historical dose is being reported for the current date.
- 2204: Indicates that the administration being reported occurred too far in the past.

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 (Return Evaluated Immunization History and Forecast (Z42) – HL7 Version 2.5.1 Implementation Guide for Immunization Messaging Release 1.5). The EHR is able to display the evaluated 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.

The EHR vendor loads demographic data for Juana Mariana Vazquez.

Enter Initial Demographic **Data for New Patient Juana** Mariana Vazquez

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. The EHR or other clinical software system must be able to store information to successfully match with patients in immunization registries, if the information is available. Specific to immunization registries, that information includes the mother's maiden name, whether the patient was part of a multiple birth, and the birth order (i.e., ordinal number of birth, first, second, etc.). This information allows the provider to correctly identify the patient and also helps ensure a match when the EHR sends the patient's information to external systems such as an immunization registry.

Description

The EHR vendor loads immunization history data from the local practice for Juana Mariana Vazquez. This includes an MMR dose that was given too early. This MMR dose serves to seed checking for dose given too early in TestCaseGroup: Juana Mariana Vazquez Visit, TestCase: Query the Registry for Juana Mariana Vazquez, TestStep: Mark first MMR Dose as Invalid.

Test Objectives

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.

Enter Initial Mariana Vazquez: **Immunizations** from Practice

Request/Receive Patient Immunization Data and Identify Source: The EHR stores 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 Immunization entered by the clinician. When viewing such information, the provider can determine which immunizations were **Data for Juana** 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 (Return Evaluated Immunization History and Forecast (Z42) – HL7 Version 2.5.1 Implementation Guide for Immunization Messaging Release 1.5). The EHR is able to display the evaluated 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.

Receive Dose Not Indicated Alert for Single Vaccine Order: The EHR or other clinical software system notifies the provider in instances when there are single or combination vaccine orders that are inconsistent with the expected timing intervals included in the vaccine forecast. Inconsistencies include suggestion of different date(s) for ordering the vaccine(s) or indication the vaccine(s) is/are no longer required.

The EHR vendor loads immunization history data from another practice into the record for Juana Mariana Vazquez.

Test Objectives

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.

Enter Initial Immunization Data for Juana Mariana Vazquez from Another Practice

Request/Receive Patient Immunization Data and Identify Source: The EHR stores 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 (Return Evaluated Immunization History and Forecast (Z42) – HL7 Version 2.5.1 Implementation Guide for Immunization Messaging Release 1.5). The EHR is able to display the evaluated 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.

Description

The provider attempts to enter immunization data with a data entry error and is alerted that the date identified is too long ago, in this case, before birth.

Attempt to enter vaccination too long ago for Juana Mariana Vazquez

Test Objectives

Data Quality Checks: Integrate additional data quality checks into IIP Testing and Recognition to improve data quality and reduce rejections.

Note: The EHR or other clinical software system prevents specific data issues which would potentially result in IIS errors as defined by the AIRA Error Codes. This supports reducing data quality issues that could trigger the following AIRA-defined Error Codes:

- 2204: Indicates that the administration being reported occurred too far in the past.

Description The provider attempts to enter historical immunization for the current date and is alerted that of the possible data quality error. Attempt to enter historical vaccination for Test Objectives current date for Juana Data Quality Checks: Integrate additional data quality checks into IIP Testing and Recognition to improve data Mariana quality and reduce rejections. Vazquez Note: The EHR or other clinical software system prevents specific data issues which would potentially result in IIS errors as defined by the AIRA Error Codes. This supports reducing data quality issues that could trigger the following AIRA-defined Error Codes: - 2104: Indicates that a historical dose is being reported for the current date. Description The provider enters immunization data from a pharmacy as reported by the parent for Juana Mariana Vazquez. Test Objectives **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. **Enter Initial** Immunization | Request/Receive Patient Immunization Data and Identify Source: The EHR stores immunization history accepted Data for Juana electronically from other sources (such as a public health immunization registry consistent with HL7 version 2.5.1, Mariana Implementation Guide for Immunization Messaging Release 1.5) or communicated by the patient and manually Vazquez entered by the clinician. When viewing such information, the provider can determine which immunizations were Reported by administered by the practice, which were entered manually as patient-reported, and which were accepted **Parent** 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 (Return Evaluated Immunization History and Forecast (Z42) – HL7 Version 2.5.1 Implementation Guide for Immunization Messaging Release 1.5). The EHR is able to display the evaluated 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

Test Case	Juan Marcel Marina Initial Data Load

time of the update and the source of the new information.

must store the new information as structured data as part of the patient's local immunization history and include the

The practice site for the scenario is Shoreline Pediatrics. The EHR vendor loads demographic data and clinical history for Juan Marcel Marina. The data includes a clinical history of varicella, and serological evidence of Hepatitis A immunity.

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. The EHR or other clinical software system must be able to store information to successfully match with patients in immunization registries, if the information is available. Specific to immunization registries, that information includes the mother's maiden name, whether the patient was part of a multiple birth, and the birth order (i.e., ordinal number of birth, first, second, etc.). This information allows the provider to correctly identify the patient and also helps ensure a match when the EHR sends the patient's information to external systems such as an immunization registry.

Supporting data for:

Modify Antigen Recommendations Based on Active Diagnoses: The system notifies the provider of any conflicts between recommended vaccines in the updated forecast and the patient's current or historical diagnoses.

Test Steps

Description

The EHR vendor loads demographic data for Juan Marcel Marina.

Enter Initial Demographic Data for New Patient Juan Marcel Marina

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. The EHR or other clinical software system must be able to store information to successfully match with patients in immunization registries, if the information is available. Specific to immunization registries, that information includes the mother's maiden name, whether the patient was part of a multiple birth, and the birth order (i.e., ordinal number of birth, first, second, etc.). This information allows the provider to correctly identify the patient and also helps ensure a match when the EHR sends the patient's information to external systems such as an immunization registry.

Description

The clinical history of Chicken Pox (Varicella) is documented in the record created for Juan Marcel Marina.

The lab tests show serologic immunity to Hep A and a finding is added indicating Hepatitis A Immune.

Enter Clinical History for Juan Marcel Marina

Test Objectives

Supporting data for:

Modify Antigen Recommendations Based on Active Diagnoses: The system notifies the provider of any conflicts between recommended vaccines in the updated forecast and the patient's current or historical diagnoses.

Note: In this case, the vaccine is not recommended due to the history of the vaccine preventable condition (Varicella).

The practice site for the scenario is Shoreline Pediatrics. The EHR vendor loads demographic data and clinical history for twin Juana Mariela Gonzales.

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. The EHR or other clinical software system must be able to store information to successfully match with patients in immunization registries, if the information is available. Specific to immunization registries, that information includes the mother's maiden name, whether the patient was part of a multiple birth, and the birth order (i.e., ordinal number of birth, first, second, etc.). This information allows the provider to correctly identify the patient and also helps ensure a match when the EHR sends the patient's information to external systems such as an immunization registry.

Test Steps

Description

The EHR vendor loads demographic data for Juana Mariela Gonzales.

Enter Initial Demographic Data for Juana Mariela Gonzales

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. The EHR or other clinical software system must be able to store information to successfully match with patients in immunization registries, if the information is available. Specific to immunization registries, that information includes the mother's maiden name, whether the patient was part of a multiple birth, and the birth order (i.e., ordinal number of birth, first, second, etc.). This information allows the provider to correctly identify the patient and also helps ensure a match when the EHR sends the patient's information to external systems such as an immunization registry.

Test Case

Juana Maria Gonzales Initial Data Load

Description

The practice site for the scenario is Shoreline Pediatrics. The EHR vendor loads demographic data and clinical history for twin Juana Maria Gonzales.

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. The EHR or other clinical software system must be able to store information to successfully match with patients in immunization registries, if the information is available. Specific to immunization registries, that information includes the mother's maiden name, whether the patient was part of a multiple birth, and the birth order (i.e., ordinal number of birth, first, second, etc.). This information allows the provider to correctly identify the patient and also helps ensure a match when the EHR sends the patient's information to external systems such as an immunization registry.

Test Steps

Description The EHR vendor loads demographic data for Juana Maria Gonzales. 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. The EHR or other clinical software system must be able to store information to successfully match with patients in immunization registries, if the information is available. Specific to immunization registries, that information includes

the mother's maiden name, whether the patient was part of a multiple birth, and the birth order (i.e., ordinal number of birth, first, second, etc.). This information allows the provider to correctly identify the patient and also helps ensure a

match when the EHR sends the patient's information to external systems such as an immunization registry.

Test Case	Anita Francesca Marina Initial Data Load
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The practice site for the scenario is Metro Primary Care. The EHR vendor loads demographic data and clinical history for Adult Anita Francesca Marina.

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. The EHR or other clinical software system must be able to store information to successfully match with patients in immunization registries, if the information is available. Specific to immunization registries, that information includes the mother's maiden name, whether the patient was part of a multiple birth, and the birth order (i.e., ordinal number of birth, first, second, etc.). This information allows the provider to correctly identify the patient and also helps ensure a match when the EHR sends the patient's information to external systems such as an immunization registry.

Provide Access to Update Immunization Information: The patient is able to add or request an update to immunization information for review by the provider.

Review Patient-Provided Immunization Information: The EHR or other clinical software system provides a mechanism for the provider to review patient-generated immunization data. It also provides a mechanism for the provider to update or annotate the immunization history, indicating the source of the information.

Request/Receive Patient Immunization Data and Identify Source: The EHR stores 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.

Data Quality Checks: Integrate additional data quality checks into IIP Testing and Recognition to improve data quality and reduce rejections.

Note: The EHR or other clinical software system prevents specific data issues which would potentially result in IIS errors as defined by the AIRA Error Codes. This supports reducing data quality issues that could trigger the following AIRA-defined Error Codes:

- 2002: Indicates that the date of birth messaged in PID-7 is after the date of death messaged in PID-29.
- 2100: Indicates that any date field is in the future. Specific errors for date transmitted in an OBX are also provided.
- 2202: Indicates individual components of the address are valid, but overall, the address is invalid (conflict between elements, non-existent address, etc)
- 2007: Indicates a conflict between PID-29 and PID-30 or between PD1-16 and either PID field. In other words, one element indicates the patient is deceased and another element indicates the patient is not deceased.
- 2306: Indicates that the patient found is too old.

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 (Return Evaluated Immunization History and Forecast (Z42) – HL7 Version 2.5.1 Implementation Guide for Immunization Messaging Release 1.5). The EHR is able to display the evaluated 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.

Test Steps

The EHR vendor attempts to enter demographic data for new adult patient Anita Francesca Marina. These data quality checks primarily relate to improving patient matching information that will be included when submitting data to the immunization registry or when querying the immunization registry.

Test Objectives

Demographic Data Quality Checks for Anita Francesca Marina

Data Quality Checks: Integrate additional data quality checks into IIP Testing and Recognition to improve data quality and reduce rejections.

Note: The EHR or other clinical software system prevents specific data issues which would potentially result in IIS errors as defined by the AIRA Error Codes. This supports reducing data quality issues that could trigger the following AIRA-defined Error Codes:

- 2002: Indicates that the date of birth messaged in PID-7 is after the date of death messaged in PID-29.
- 2100: Indicates that any date field is in the future. Specific errors for date transmitted in an OBX are also provided.
- 2202 : Indicates individual components of the address are valid, but overall, the address is invalid (conflict between elements, non-existent address, etc)
- 2007: Indicates a conflict between PID-29 and PID-30 or between PD1-16 and either PID field. In other words, one element indicates the patient is deceased and another element indicates the patient is not deceased.
- 2306: Indicates that the patient found is too old.

Description

The EHR vendor loads demographic and social history data for Anita Francesca Marina.

Enter Initial Demographic Data for Anita Francesca Marina

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. The EHR or other clinical software system must be able to store information to successfully match with patients in immunization registries, if the information is available. Specific to immunization registries, that information includes the mother's maiden name, whether the patient was part of a multiple birth, and the birth order (i.e., ordinal number of birth, first, second, etc.). This information allows the provider to correctly identify the patient and also helps ensure a match when the EHR sends the patient's information to external systems such as an immunization registry.

Description

Anita Francesca Marina Electronically Submits Prior Immunization to Provider

The patient is able to provide information about the influenza vaccine that she received through her employer out of state using the patient facing features (e.g. portal) offered by the EHR.

Test Objectives

Provide Access to Update Immunization Information: The patient is able to add or request an update to immunization information for review by the provider.

The provider is able to review the patient provided vaccine information for the influenza vaccine that she received through her employer out of state. The provider is able to document this historical vaccine in the EHR.

Test Objectives

Review Patient-Provided Immunization Information: The EHR or other clinical software system provides a mechanism for the provider to review patient-generated immunization data. It also provides a mechanism for the provider to update or annotate the immunization history, indicating the source of the information.

Provider
Review and
Entry of
Immunization
Data for
Anita
Francesca
Marina
Provided by
Patient

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 stores 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 (Return Evaluated Immunization History and Forecast (Z42) – HL7 Version 2.5.1 Implementation Guide for Immunization Messaging Release 1.5). The EHR is able to display the evaluated 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.

Description

Lab tests show serologic immunity to Hepatitis A, and no serologic immunity to Hepatitis B. These finding are in the documented in the record created for Anita Francesca Marina indicating that she is Hepatitis A Immune, and that she has no immunity to Hepatitis B.

Enter Clinical History for Anita Francesca Marina

Test Objectives

Support for:

View Reconciled Immunization Forecast: The EHR or other clinical software system has the ability to re-evaluate and update the immunization forecast using a patient's newly updated immunization history. Forecasts are updated following reconciliation of immunization data contained in the public health immunization registry with immunization data contained in the EHR. Processing the new forecast can be internal to the EHR or it can use an external forecasting service, but should reference the most recent recommendations.

Note: clinical history for adult healthcare worker supporting vaccine recommendations.

Test Case Enter Inventory

The provider enters vaccine inventory data from available inventory.

Test Objectives

Update Vaccine Inventory from Stock Receipt: The EHR or other clinical software system updates the vaccine inventory when new stock is received at the site and updates the correct count of each vaccine, including those for use in guarantee programs (such as Vaccines for Children) and for private stock.

Display Available Vaccine Antigens: The system presents a list of vaccine antigens available for administration to patients (i.e., private stock vs. specific guarantee program).

Test Steps Description The provider receives a vaccine delivery and records the new vaccine data in available inventory. Enter Vaccine Test Objectives Inventory Update Vaccine Inventory from Stock Receipt: The EHR or other clinical software system updates the vaccine inventory when new stock is received at the site and updates the correct count of each vaccine, including those for use in guarantee programs (such as Vaccines for Children) and for private stock. Description The provider reviews the full list of vaccine inventory. View Inventory Test Objectives **Display Available Vaccine Antigens:** The system presents a list of vaccine antigens available for administration to patients (i.e., private stock vs. specific guarantee program).

Test Case	Manage Configuration
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Description

The user responsible for the EHR configuration updates the system with new vaccine codes, new vaccine schedules, and establishes SOAP-bases CDC WSDL configuration.

Test Objectives

Add new vaccine codes: Add codes to support new vaccines. This includes vaccine codes (CVX), National Drug Codes (NDC), and Vaccine Information Statement codes (VIS).

Update Patient Immunization Schedule: The EHR or other clinical software system displays a patient's anticipated immunization schedule routinely and updates the patient's schedule when immunization guidelines change.

Configure SOAP-based CDC WSDL for Transport: The EHR or other clinical software system configures connectivity using the SOAP-based CDC WSDL and demonstrates compliance with this standard transport

Test Steps

II.	
Add New Vaccine Information	Description The user responsible for the EHR configuration updates the system with new CVX, NDC, and VIS vaccine codes. Test Objectives Add new vaccine codes: This includes vaccine codes (CVX), National Drug Codes (NDC), and Vaccine Information Statement codes (VIS).
Update Vaccine Schedule Information	Description The user responsible for the EHR configuration updates the system with a new vaccine schedule Test Objectives Update Patient Immunization Schedule: The EHR or other clinical software system displays a patient's anticipated immunization schedule routinely and updates the patient's schedule when immunization guidelines change.
Configure SOAP- based CDC WSDL	Description The user responsible for the EHR configuration establishes SOAP-based CDC WSDL configuration and successfully submits a VXU record. Test Objectives Configure SOAP-based CDC WSDL for Transport: The EHR or other clinical software system configures connectivity using the SOAP-based CDC WSDL and demonstrates compliance with this standard transport.

Test Case Group: Juana Mariana Vazquez Visit

Description

Test Objectives

Juana Mariana Vazquez visits the provider where her immunization history is retrieved from the registry and reconciled with the local information in the medical record to determine vaccines that are due. Vaccinations are ordered and administered. The parents refuse the Polio vaccine due to prior issues. The vaccines are reported to the immunization registry and a vaccine summary is available for the patient.

patient.	
Test Case	Query the Registry for Juana Mariana Vazquez
Description	n
The EHR gen Vazquez.	nerates a Z44 query to the Immunization Registry to retrieve the Evaluated History and Forecast for Juana Mariana

Querying the registry will consist of the vendor creating Z44 messages for Juana Mariana Vazquez to be sent to the registry. The response will be processed as part of the 'Display, Reconcile, Import and Update Immunization Information' activity.

Using the Z42 Response to Immunization Registry Query, the EHR displays the Evaluated History and Forecast to the user for reconciliation and update. The vendor will receive information back from the registry and show the ability to view and reconcile, and import the information returned by the registry (NOTE: the Z42 message will be provided either manually, or as part of the tool). This test will also look at the system's ability to view the forecast returned by the registry and create a new forecast after reconciling the information.

Test Objectives

Select New Patient: The system must allow a user to distinguish information about patients with similar names or identifying information in order to select the right patient from the providers' EHR or other clinical software system. This information is crucial for identifying and selecting the correct patient. For example, twins living in the same household will have similar dates of birth, addresses, and may have similar sounding names. In order to match patients with those already in the immunization registry, the EHR or other clinical software should have the ability to record the mother's maiden name, whether the patient was part of a multiple birth, and if so, the order of birth (when such information is available). The provider should be aware of how often the protection indicator information must be updated based on local rules.

Request/Receipt of Patient Immunization History: The EHR or other clinical software system sends a request to the public health immunization registry "on demand," or in advance for those with scheduled appointments. The request includes the identifying information the immunization registry needs to match each patient with those in the registry including, if present, the mother's maiden name, a multiple birth indicator, and the birth order. The request also is sent in a pre-determined format the registry can read and interpret (Request Evaluated Immunization History and Forecast (Z44) - HL7 version 2.5.1 Implementation Guide for Immunization Messaging Release 1.5).

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 (Return Evaluated Immunization History and Forecast (Z42) – HL7 Version 2.5.1 Implementation Guide for Immunization Messaging Release 1.5). The EHR is able to display the evaluated 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.

Request/Receive Patient Immunization Data and Identify Source: The EHR stores 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.

View Immunization Forecast: The system provides a view of the immunization forecast provided by the IIS. The display includes the recommended vaccines and their associated dates (e.g., earliest, recommended, past due, latest) for each vaccine included in the forecast.

View Reconciled Immunization Forecast: The EHR or other clinical software system has the ability to re-evaluate and update the immunization forecast using a patient's newly updated immunization history. Forecasts are updated following reconciliation of immunization data contained in the public health immunization registry with immunization data contained in the EHR. Processing the new forecast can be internal to the EHR or it can use an external forecasting service, but should reference the most recent recommendations.

Review Patient Immunization History: The EHR or other clinical software systems displays vaccine history by vaccine series.

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.

Support for:

Receive Dose Not Indicated Alert for Single Vaccine Order: The EHR or other clinical software system notifies the provider in instances when there are single or combination vaccine orders that are inconsistent with the expected timing intervals included in the vaccine forecast. Inconsistencies include suggestion of different date(s) for ordering the vaccine(s) or indication the vaccine(s) is/are no longer required.

Test Steps

Description

Juana Mariana Vazquez is selected as the patient and her record is opened in the EHR.

Select **Patient** Juana Mariana Vazquez

Test Objectives

Select New Patient: The system must allow a user to distinguish information about patients with similar names or identifying information in order to select the right patient from the providers' EHR or other clinical software system. This information is crucial for identifying and selecting the correct patient. For example, twins living in the same household will have similar dates of birth, addresses, and may have similar sounding names. In order to match patients with those already in the immunization registry, the EHR or other clinical software should have the ability to record the mother's maiden name, whether the patient was part of a multiple birth, and if so, the order of birth (when such information is available). The provider should be aware of how often the protection indicator information must be updated based on local rules.

Description

The provider uses the EHR to query the Immunization Registry for an Evaluated History and Forecast based on information known to the Immunization Registry.

Test Objectives

Query forecast for Juana Mariana Vazquez

Registry for Request/Receipt of Patient Immunization History: The EHR or other clinical software system sends a request to the vaccination public health immunization registry "on demand," or in advance for those with scheduled appointments. The request history and lincludes the identifying information the immunization registry needs to match each patient with those in the registry including, if present, the mother's maiden name, a multiple birth indicator, and the birth order. The request also is sent in a pre-determined format the registry can read and interpret (Request Evaluated Immunization History and Forecast (Z44) - HL7 version 2.5.1 Implementation Guide for Immunization Messaging Release 1.5).

Support for:

Receive Dose Not Indicated Alert for Single Vaccine Order: The EHR or other clinical software system notifies the provider in instances when there are single or combination vaccine orders that are inconsistent with the expected timing intervals included in the vaccine forecast. Inconsistencies include suggestion of different date(s) for ordering the vaccine(s) or indication the vaccine(s) is/are no longer required.

Description

The Immunization Registry returns an Evaluated History and Forecast (Z42) to the EHR in response to the query for patient (Juana Mariana Vazquez). The provider reviews the immunization history from the registry and compares to the immunization history in the EHR. The provider reviews the information from these sources, identifying information known only to the registry, and identifying information that is more accurately reflected in the local EHR:

The physician accesses the record for Juana Mariana Vazquez and the EHR differentiates:

The following vaccinations are available only to the EHR:

diphtheria, tetanus toxoids and acellular pertussis vaccine, 5 pertussis antigens (CVX 106) administered 11/20/2019

poliovirus vaccine, inactivated (CVX 10) administered 2/21/2017, -- Adverse Reaction: febrile seizure (e.g. Simple febrile seizure (finding) 432354000) VXC11^convulsions (fits, seizures) within 72 hours of dose^CDCPHINV) Influenza, injectable, quadrivalent, preservative free, pediatric (CVX 161) administered 10/15/2019

The EHR differentiates the following vaccinations which differ between the EHR and the IIS:

For the hepatitis B vaccine, pediatric or pediatric/adolescent dosage (CVX 08) administered 12/20/2015, that EHR displays different text for the IIS (which documents a Non-specific formulation) and EHR (which documents hepatitis B vaccine, pediatric or pediatric/adolescent dosage) for Vaccine administered

The EHR differentiates the following vaccinations that are available from both the IIS and the local EHR:

measles, mumps, rubella virus vaccine (CVX 03) administered 8/22/2016 (an invalid dose)

The EHR differentiates the following vaccinations that are available from the IIS that are not known to the local EHR:

hepatitis B vaccine, pediatric or pediatric/adolescent dosage (CVX 08) administered 11/01/2015
hepatitis B vaccine, pediatric or pediatric/adolescent dosage (CVX 08) administered 05/20/2016
diphtheria, tetanus toxoids and acellular pertussis vaccine, 5 pertussis antigens (CVX 106) administered 1/22/2016
diphtheria, tetanus toxoids and acellular pertussis vaccine, 5 pertussis antigens (CVX 106) administered 3/23/2016
diphtheria, tetanus toxoids and acellular pertussis vaccine, 5 pertussis antigens (CVX 106) administered 5/22/2016
diphtheria, tetanus toxoids and acellular pertussis vaccine, 5 pertussis antigens (CVX 106) administered 2/21/2017
Haemophilus influenzae type b vaccine, PRP-OMP conjugate (CVX 49) administered 1/22/2016
Haemophilus influenzae type b vaccine, PRP-OMP conjugate (CVX 49) administered 3/23/2016
Haemophilus influenzae type b vaccine, PRP-OMP conjugate (CVX 49) administered 5/22/2016
Haemophilus influenzae type b vaccine, PRP-OMP conjugate (CVX 49) administered 11/21/2016
poliovirus vaccine, inactivated (CVX 10) administered 1/22/2016
poliovirus vaccine, inactivated (CVX 10) administered 3/23/2016 – Adverse Reaction: (VXC12^fever of >40.5C (105)

View and Compare response to request for vaccination history for Juana Mariana Vazquez

poliovirus vaccine, inactivated (CVX 10) administered 3/23/2016 – Adverse Reaction: (VXC12^fever of >40.5C (105F) within 48 hours of dose^CDCPHINVS) pneumococcal conjugate vaccine, 13 valent (CVX 133) administered 1/22/2016 pneumococcal conjugate vaccine, 13 valent (CVX 133) administered 3/23/2016 pneumococcal conjugate vaccine, 13 valent (CVX 133) administered 5/22/2016 oneumococcal conjugate vaccine, 13 valent (CVX 133) administered 1/11/2017 rotavirus, live, monovalent vaccine (CVX 119) administered 1/22/2016 rotavirus, live, monovalent vaccine (CVX 119) administered 3/23/2016 Influenza, seasonal, injectable (CVX 161) administered 9/25/2016 Influenza, seasonal, injectable (CVX 161) administered 10/29/2016 Influenza, injectable, quadrivalent, preservative free, pediatric (CVX 161) administered 10/2/2017 Influenza, injectable, quadrivalent, preservative free, pediatric (CVX 161) administered 11/4/2018 nepatitis A vaccine, pediatric/adolescent dosage, 2 dose schedule (CVX 83) administered 11/23/2016 hepatitis A vaccine, pediatric/adolescent dosage, 2 dose schedule (CVX 83) administered 5/23/2017 measles, mumps, rubella virus vaccine (CVX 03) administered 9/22/2019 Varicella virus vaccine (CVX 21) administered 12/15/2017

Test Objectives

Request/Receive Patient Immunization Data and Identify Source: The EHR stores 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.

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 (Return Evaluated Immunization History and Forecast (Z42) – HL7 Version 2.5.1 Implementation Guide for Immunization Messaging Release 1.5). The EHR is able to display the evaluated 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.

Review Patient Immunization History: The EHR or other clinical software system displays vaccine history by vaccine series

Support for:

Receive Dose Not Indicated Alert for Single Vaccine Order: The EHR or other clinical software system notifies the provider in instances when there are single or combination vaccine orders that are inconsistent with the expected timing intervals included in the vaccine forecast. Inconsistencies include suggestion of different date(s) for ordering the vaccine(s) or indication the vaccine(s) is/are no longer required.

Description

If the EHR does not already flag the first MMR as invalid, the provider updates the first MMR to indicate it is "invalid" as it was given too early (as notified by the registry).

Mark first MMR Dose as Invalid

Mark first Test Objectives

dose validity is an important aspect of:

View Reconciled Immunization Forecast: The EHR or other clinical software system has the ability to re-evaluate and update the immunization forecast using a patient's newly updated immunization history. Forecasts are updated following reconciliation of immunization data contained in the public health immunization registry with immunization data contained in the EHR. Processing the new forecast can be internal to the EHR or it can use an external forecasting service, but should reference the most recent recommendations.

Description

Test Objectives

The physician accesses the record for Juana Mariana Vazquez and:

View the vaccination forecast for Juana Mariana Vazquez

- Displays the registry forecast as returned by the immunization registry.

View Immunization Forecast: The system provides a view of the immunization forecast provided by the IIS. The display includes the recommended vaccines and their associated dates (e.g., earliest, recommended, past due, latest) for each vaccine included in the forecast.

Juana Mariana Vazquez immunization registry provided Evaluated History and Forecast is reconciled with the Immunization history information in the EHR.

Test Objectives

Request/Receive Patient Immunization Data and Identify Source: The EHR or other clinical software system stores 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.

Reconcile and import vaccinations from **Evaluated** Juana Mariana Vazquez

Compare Public Health Immunization Registry (IIS) Immunization History to EHR Immunization History: The History and public health immunization registry has returned the requested immunization history for a patient. The EHR is able to Forecast for 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.

Review Patient Immunization History: The EHR or other clinical software systems displays vaccine history by vaccine series.

Support for:

Receive Dose Not Indicated Alert for Single Vaccine Order: The EHR or other clinical software system notifies the provider in instances when there are single or combination vaccine orders that are inconsistent with the expected timing intervals included in the vaccine forecast. Inconsistencies include suggestion of different date(s) for ordering the vaccine(s) or indication the vaccine(s) is/are no longer required.

Description

Once the vaccine history is reconciled in the EHR, the vaccine forecast is updated.

View the updated vaccination forecast for Juana Mariana Vazquez

Test Objectives

View Reconciled Immunization Forecast: The EHR or other clinical software system has the ability to re-evaluate and update the immunization forecast using a patient's newly updated immunization history. Forecasts are updated following reconciliation of immunization data contained in the public health immunization registry with immunization data contained in the EHR. Processing the new forecast can be internal to the EHR or it can use an external forecasting service, but should reference the most recent recommendations.

Test Case

Juana Mariana Vazquez, Enter Orders and Immunizations

Description

This test will consist of ordering vaccines for the test patients, reviewing any alerts caused by specific scenarios, and documenting vaccinations administered to the patients.

Test Objectives

Notify of Previous Adverse Event: The EHR or other clinical software system alerts providers to previous adverse events for a specific patient, in order to inform clinical decision-making when providers view an existing immunization record.

Record Vaccine Administration Deferral: The EHR or other clinical software system allows a user to enter a reason or reasons why a specific immunization was not given to a patient (e.g., due to contraindication, refusal, etc.). The system also stores that information in a structured way so it can be reported and analyzed as needed.

Receive Dose Not Indicated Alert for Single Vaccine Order: The EHR or other clinical software system notifies the provider in instances when there are single or combination vaccine orders that are inconsistent with the expected timing intervals included in the vaccine forecast. Inconsistencies include suggestion of different date(s) for ordering the vaccine(s) or indication the vaccine(s) is/are no longer required.

Receive Dose Not Indicated Alert Upon Vaccine Administration: The system notifies the individual administering a vaccine that the vaccine is inconsistent with expected timing intervals as suggested by the vaccine forecast. The method and timing of notification can be specified to meet local clinical workflow. This requirement is a "failsafe" mechanism in case the provider orders a vaccine dose that is inconsistent with appropriate timing intervals.

Record Vaccine Administration: The EHR or other clinical software system records information about each vaccine administered. The EHR records this information as structured data elements, including, at a minimum: date administered, administering clinician, site of administration (e.g., left arm), immunization type, lot number, manufacturer, Vaccine Information Statement date, quantity of vaccine/dose size and ordering clinician. The system also assures data quality, i.e., data entered are appropriate (e.g., avoid "oral" route for IM vaccines, and assure dose is appropriate for the vaccine).

Receive Dose Not Indicated Alert Upon Vaccine Administration: The system notifies the individual administering a vaccine that the vaccine is inconsistent with expected timing intervals as suggested by the vaccine forecast. The method and timing of notification can be specified to meet local clinical workflow. This requirement is a "failsafe" mechanism in case the provider orders a vaccine dose that is inconsistent with appropriate timing intervals.

Enter Vaccination Order: The EHR or other clinical software system allows providers to order immunizations for a patient using filters for type of vaccine, including combination vaccines.

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 stores 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.

Data Quality Checks: Integrate additional data quality checks into IIP Testing and Recognition to improve data quality and reduce rejections.

Note: The EHR or other clinical software system prevents specific data issues which would potentially result in IIS errors as defined by the AIRA Error Codes. This supports reducing data quality issues that could trigger the following AIRA-defined Error Codes:

- 2008 : Indicates that either a refusal reason was messaged in RXA-18 when the completion status in RXA-20 was not RE or a valid refusal reason was not messaged when the completion status was RE
- 2014: Indicates that the administration amount is inconsistent with the vaccine administered
- 2016: Indicates that the administration route is inconsistent with the vaccine administered

The provider accesses the record for Juana Mariana Vazquez and:

- Selects order for IPV and views information about the prior febrile seizure post-IPV vaccine.
- IPV is ordered for the patient.

Order IPV and view prior reaction

Test Objectives

Enter Vaccination Order: The EHR or other clinical software system allows providers to order immunizations for a patient using filters for type of vaccine, including combination vaccines.

Notify of Previous Adverse Event: The EHR or other clinical software system alerts providers to previous adverse events for a specific patient, in order to inform clinical decision-making when providers view an existing immunization record.

Description

The provider attempts to document vaccine refusal information for the immunization for Juana Mariana Vazquez. These data quality checks primarily relate to improving vaccine refusal information and associated observations that will be included when submitting data to the immunization registry.

Vaccine Refusal Data Quality Checks

Test Objectives

Data Quality Checks: Integrate additional data quality checks into IIP Testing and Recognition to improve data quality and reduce rejections.

Note: The EHR or other clinical software system prevents specific data issues which would potentially result in IIS errors as defined by the AIRA Error Codes. This supports reducing data quality issues that could trigger the following AIRA-defined Error Codes:

- 2008 : Indicates that either a refusal reason was messaged in RXA-18 when the completion status in RXA-20 was not RE or a valid refusal reason was not messaged when the completion status was RE.

Description

The mother is concerned about administering the IPV due to the prior adverse reaction and refuses to have the child immunized for IPV. The provider documents mother's refusal for IPV vaccine indicating the parent decision, the reason and documents a deferral at the time of attempted administration.

IPV Parental Refusal

Test Objectives

Record Vaccine Administration Deferral: The EHR or other clinical software system allows a user to enter a reason or reasons why a specific immunization was not given to a patient (e.g., due to contraindication, refusal, etc.). The system also stores that information in a structured way so it can be reported and analyzed as needed.

The EHR vendor loads immunization history data for an MMR dose entered 2 weeks prior to the current visit date and an MMR dose that was given too early. These MMR doses serve to seed checking for the condition that it is too early to give a live vaccine in TestCaseGroup: Juana Mariana Vazquez Visit, TestCase: Juana Mariana Vazquez, Enter Orders and Immunizations, TestStep: Attempt to order Varicella Dose.

Test Objectives

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

Enter Data for MMR Given 2 Weeks Prior

Immunization | Request/Receive Patient Immunization Data and Identify Source: The EHR stores 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:

Receive Dose Not Indicated Alert for Single Vaccine Order: The EHR or other clinical software system notifies the provider in instances when there are single or combination vaccine orders that are inconsistent with the expected timing intervals included in the vaccine forecast. Inconsistencies include suggestion of different date(s) for ordering the vaccine(s) or indication the vaccine(s) is/are no longer required.

Receive Dose Not Indicated Alert Upon Vaccine Administration: The system notifies the individual administering a vaccine that the vaccine is inconsistent with expected timing intervals as suggested by the vaccine forecast. The method and timing of notification can be specified to meet local clinical workflow. This requirement is a "failsafe" mechanism in case the provider orders a vaccine dose that is inconsistent with appropriate timing intervals.

Description

The provider attempts to give a Varicella dose and is warned that it is too soon to give a live vaccine dose.

Attempt to order Varicella Test Objectives Dose

Receive Dose Not Indicated Alert for Single Vaccine Order: The EHR or other clinical software system notifies the provider in instances when there are single or combination vaccine orders that are inconsistent with the expected timing intervals included in the vaccine forecast. Inconsistencies include suggestion of different date(s) for ordering the vaccine(s) or indication the vaccine(s) is/are no longer required.

Description

The physician accesses the record for Juana Mariana Vazquez and:

- Selects order for Influenza vaccine.

Order Influenza Vaccine

Test Objectives

Enter Vaccination Order: The EHR or other clinical software system allows providers to order immunizations for a patient using filters for type of vaccine, including combination vaccines.

The provider attempts to document vaccine route, site, and administration amount for the influenza immunization for Juana Mariana Vazquez. These data quality checks primarily relate to improving vaccine dosing and administration information that will be included in the vaccination details when submitting data to the immunization registry.

The nurse documents administration route for the IM inactivated influenza vaccine as 'intranasal':

- Is alerted when documenting "intranasal" for intramuscular inactivated influenza vaccine.
- Is alerted when documenting the incorrect administration amount for the vaccine administered.

Vaccine Dosing and Administration Test Objectives **Data Quality** Checks

Data Quality Checks: Integrate additional data quality checks into IIP Testing and Recognition to improve data quality and reduce rejections.

Note: The EHR or other clinical software system prevents specific data issues which would potentially result in IIS errors as defined by the AIRA Error Codes. This supports reducing data quality issues that could trigger the following AIRA-defined Error Codes:

- 2014: Indicates that the administration amount is inconsistent with the vaccine administered
- 2016: Indicates that the administration route is inconsistent with the vaccine administered

Description

The nurse administers the inactivated influenza vaccine:

- Documents all required information for the vaccine.

Record Influenza Vaccine administration

Test Objectives

Record Vaccine Administration: The EHR or other clinical software system records information about each vaccine administered. The EHR records this information as structured data elements, including, at a minimum: date administered, administering clinician, site of administration (e.g., left arm), immunization type, lot number, manufacturer, Vaccine Information Statement date, quantity of vaccine/dose size and ordering clinician. The system also assures data quality, i.e., data entered are appropriate (e.g., avoid "oral" route for IM vaccines, and assures dose is appropriate for the vaccine).

Test Case

Juana Mariana Vazquez Transmit Immunization Report

Following the vaccinations given during the visit, the EHR transmits an Immunization report to the Immunization Registry using the VXU/Z22. The Vaccination report includes all newly administered vaccines. The report should include vaccines incorrectly recorded in the IIS. The report MAY send the immunizations that the EHR imported from the IIS.

Test Objectives

Transmit Standard Patient Immunization History Report: The EHR or other clinical software system directly or indirectly through an intermediary creates and transmits a report of a patient's newly administered or newly identified immunization history to public health immunization registries.

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

Notify Public Health Immunization Registry (IIS) of Update from Adverse Event: The EHR or other clinical software system notifies the public health immunization registry (IIS) of an update due to an adverse event.

Link Standard Codes to Immunization Data: The EHR or other clinical software system links standard codes (i.e., LOINC for lab tests or evaluation tools, SNOMED CT for conditions or observations, NDC codes for current immunizations, CVX for historical immunizations, appropriate codes for administration site, route, method, etc.) to discrete data elements associated with an immunization.

Note: Testing for NDC codes, CVX for immunizations.

Test Steps

Description

Following the vaccinations given during the visit, the EHR transmits an Immunization report to the Immunization Registry using the VXU/Z22. The Vaccination report includes all newly administered vaccines. The report should include vaccines incorrectly recorded in the IIS. The report MAY send the immunizations that the EHR imported from the IIS.

Transmit the immunization report to the Immunization Registry

Test Objectives

Transmit Standard Patient Immunization History Report: The EHR or other clinical software system directly or indirectly through an intermediary creates and transmits a report of a patient's newly administered or newly identified immunization history to public health immunization registries.

Link Standard Codes to Immunization Data: The EHR or other clinical software system links standard codes (i.e., LOINC for lab tests or evaluation tools, SNOMED CT for conditions or observations, NDC codes for current immunizations, CVX for historical immunizations, appropriate codes for administration site, route, method, etc.) to discrete data elements associated with an immunization.

Note: Testing for NDC codes, CVX for immunizations.

	Description
Receive ACK Z23 from Immunization Registry	The Immunization Registry returns a positive acknowledgement message indicating that no errors were found during the course of filing the message.
	Test Objectives Transmit Standard Patient Immunization History Report: The EHR or other clinical software system directly or indirectly through an intermediary creates and transmits a report of a patient's newly administered or newly identified immunization history to public health immunization registries.
Record an adverse reaction	Description Following the vaccine administration, the mother reports that the patient had a rash within 14 days of dose.
	Test Objectives Identify Adverse Event: The EHR or other clinical software system enables capture of structured data regarding adverse events.
	Support for: Notify Public Health Immunization Registry (IIS) of Update from Adverse Event: The EHR or other clinical software system notifies the public health immunization registry (IIS) of an update due to an adverse event.
Transmit the updated vaccination report with adverse reaction to the registry	Description The adverse reaction to the Influenza vaccination of rash within 14 days of dose is reported to the Immunization Registry using a Z22/VXU message.
	Transmit Standard Patient Immunization History Report: The EHR or other clinical software system directly or indirectly through an intermediary creates and transmits a report of a patient's newly administered or newly identified immunization history to public health immunization registries. Identify Adverse Event: The EHR or other clinical software system enables capture of structured data regarding adverse events. Notify Public Health Immunization Registry (IIS) of Update from Adverse Event: The EHR or other clinical software system notifies the public health immunization registry (IIS) of an update due to an adverse event. Link Standard Codes to Immunization Data: The EHR or other clinical software system links standard codes (i.e., LOINC for lab tests or evaluation tools, SNOMED CT for conditions or observations, NDC codes for current immunizations, CVX for historical immunizations, appropriate codes for administration site, route, method, etc.) to discrete data elements associated with an immunization. Note: Testing for NDC codes, CVX for immunizations.

Receive ACK Z23 from Immunization Registry for Updated Transmission

The Immunization Registry returns a positive acknowledgement message indicating that no errors were found during the course of filing the message.

Test Objectives

Transmit Standard Patient Immunization History Report: The EHR or other clinical software system directly or indirectly through an intermediary creates and transmits a report of a patient's newly administered or newly identified immunization history to public health immunization registries.

Test Case

Juana Mariana Vazquez Display Immunization Report

Description

Following the vaccination visit, the provider uses the EHR to produce an immunization report for the patient including all history (the report can be provided in various formats - e.g., print, send to patient portal, etc.).

Test Objectives

Produce Standard Patient Immunization History Report: The EHR or other clinical software system produces a report of a patient's immunization history that is appropriate for various entities, such as schools and day-care centers.

Produce Immunization Forecast Report: The EHR or other clinical software system creates a list of immunizations to be administered within a specified time frame.

Test Steps

Description

Following the vaccination visit, the provider uses the EHR to produce an immunization report for the patient including all history (the report can be provided in various formats - e.g., print, send to patient portal, etc.).

Produce an immunization report for Juana Mariana Vazquez including all history

Test Objectives

Produce Standard Patient Immunization History Report: The EHR or other clinical software system produces a report of a patient's immunization history that is appropriate for various entities, such as schools and day-care centers.

Produce Immunization Forecast Report: The EHR or other clinical software system creates a list of immunizations to be administered within a specified time frame.

Test Case

Juana Mariana Vazquez Provide Patient Access to Immunization Report

Following the vaccination visit, the provider uses the EHR to produce an immunization report that can be accessed by the patient including all history and forecast information. The report can be provided in various formats, including view, and print. The patient is also able to access the Vaccine Information Statements.

Test Objectives

Provide Access to Patient Immunization Record: The EHR or other clinical software system provides patients and their authorized representatives with electronic access to immunization records (either directly or by interacting with an external system such as a patient portal).

Provide Access to Recommendations and Vaccine Information Statement(s): The immunization record displays immunization recommendations to be discussed with a provider, displaying the relevant Vaccine Information Statement.

Provide Access to Printable Immunization Record: The EHR or other clinical software system provides a printable version of the immunization record.

Test Steps

Description

Following the vaccination visit, the patient/parent uses the specified interface to access the immunization report for the patient including all history (the report can be provided in various formats - e.g., print, send to patient portal, etc.).

Produce an immunization report for Juana Mariana Vazquez including all history

Test Objectives

Provide Access to Patient Immunization Record: The EHR or other clinical software system provides patients and their authorized representatives with electronic access to immunization records (either directly or by interacting with an external system such as a patient portal).

Provide Access to Recommendations and Vaccine Information Statement(s): The immunization record displays immunization recommendations to be discussed with a provider, displaying the relevant Vaccine Information Statement.

Description

Following the vaccination visit, the patient/parent uses the specified interface to print the immunization report for the patient including all history and forecast information.

Provide access to Printable Immunization Record for Juana Mariana Vazquez

Test Objectives

Provide Access to Patient Immunization Record: The EHR or other clinical software system provides patients and their authorized representatives with electronic access to immunization records (either directly or by interacting with an external system such as a patient portal).

Provide Access to Printable Immunization Record: The EHR or other clinical software system provides a printable version of the immunization record.

	Description The EHR is used to provide the patient access to the Vaccine Information Statements (VIS) for those vaccines administered during the visit.
Provide access to Vaccine Information Statements	Test Objectives
	Provide Access to Recommendations and Vaccine Information Statement(s): The immunization record displays immunization recommendations to be discussed with a provider, displaying the relevant Vaccine Information Statement.

Test Case Group: Juan Marcel Marina Visit

Description

Test Objectives

Juan Marcel Marina visits the provider where his immunization history is retrieved from the registry and reconciled with the local information in the medical record to determine vaccines that are due. Vaccinations are ordered and administered. The vaccines are reported to the immunization registry and a vaccine summary is available for the patient.

Test Case	Query the Registry for Juan Marcel Marina
•	

Querying the registry will consist of the vendor creating Z44 messages for Juan Marcel Marina to be sent to the registry. The response will be processed as part of the 'Display, Reconcile, Import and Update Immunization Information' activity.

Using the Z42 Response to Immunization Registry Query, the EHR displays the Evaluated History and Forecast to the user for reconciliation and update. The vendor will receive information back from the registry and show the ability to view and reconcile, and import the information returned by the registry (NOTE: the Z42 message will be provided either manually, or as part of the tool). This test will also look at the system's ability to view the forecast returned by the registry and create a new forecast after reconciling the information.

Test Objectives

Select New Patient: The EHR or other clinical system system must allow a user to distinguish information about patients with similar names or identifying information in order to select the right patient from the providers' EHR or other clinical software system. This information is crucial for identifying and selecting the correct patient. For example, twins living in the same household will have similar dates of birth, addresses, and may have similar sounding names. In order to match patients with those already in the immunization registry, the EHR or other clinical software should have the ability to record the mother's maiden name, whether the patient was part of a multiple birth, and if so, the order of birth (when such information is available). The provider should be aware of how often the protection indicator information must be updated based on local rules.

Request/Receipt of Patient Immunization History: The EHR or other clinical software system sends a request to the public health immunization registry "on demand," or in advance for those with scheduled appointments. The request includes the identifying information the immunization registry needs to match each patient with those in the registry including, if present, the mother's maiden name, a multiple birth indicator, and the birth order. The request also is sent in a pre-determined format the registry can read and interpret (Request Evaluated Immunization History and Forecast (Z44) - HL7 version 2.5.1 Implementation Guide for Immunization Messaging Release 1.5).

Request/Receive Patient Immunization Data and Identify Source: The EHR stores 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.

View Reconciled Immunization Forecast: The EHR or other clinical software system has the ability to re-evaluate and update the immunization forecast using a patient's newly updated immunization history. Forecasts are updated following reconciliation of immunization data contained in the public health immunization registry with immunization data contained in the EHR. Processing the new forecast can be internal to the EHR or it can use an external forecasting service, but should reference the most recent recommendations.

Review Patient Immunization History: The EHR or other clinical software system displays vaccine history by vaccine series.

Support for:

Receive Dose Not Indicated Alert for Single Vaccine Order: The EHR or other clinical software system notifies the provider in instances when there are single or combination vaccine orders that are inconsistent with the expected timing intervals included in the vaccine forecast. Inconsistencies include suggestion of different date(s) for ordering the vaccine(s) or indication the vaccine(s) is/are no longer required.

Test Step	S
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Juan Marcel Marina is selected as the patient and his record is opened in the EHR.

Select Patient Juan Marcel Marina

Test Objectives

Select New Patient: The system must allow a user to distinguish information about patients with similar names or identifying information in order to select the right patient from the providers' EHR or other clinical software system. This information is crucial for identifying and selecting the correct patient. For example, twins living in the same household will have similar dates of birth, addresses, and may have similar sounding names. In order to match patients with those already in the immunization registry, the EHR or other clinical software should have the ability to record the mother's maiden name, whether the patient was part of a multiple birth, and if so, the order of birth (when such information is available). The provider should be aware of how often the protection indicator information must be updated based on local rules.

Description

Query Registry for vaccination history and forecast for Juan Marcel Marina

The provider uses the EHR to query the Immunization Registry for an Evaluated History and Forecast based on information known to the Immunization Registry.

Test Objectives

Request/Receipt of Patient Immunization History: The EHR or other clinical system sends a request to the public health immunization registry "on demand," or in advance for those with scheduled appointments. The request includes the identifying information the immunization registry needs to match each patient with those in the registry including, if present, the mother's maiden name, a multiple birth indicator, and the birth order. The request also is sent in a predetermined format the registry can read and interpret (Request Evaluated Immunization History and Forecast (Z44) - HL7 version 2.5.1 Implementation Guide for Immunization Messaging Release 1.5).

The physician accesses the record for Juan Marcel Marina and:

- Accepts the vaccines provided by the registry as this is a new patient and there are no prior vaccines recorded.

Test Objectives

Request/Receive Patient Immunization Data and Identify Source: The EHR or other clinical system stores 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.

View and import response to request for vaccination history for Juan Marcel Marina

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.

Review Patient Immunization History: The EHR or other clinical software system displays vaccine history by vaccine series.

Supporting data for:

Receive Dose Not Indicated Alert for Single Vaccine Order: The EHR or other clinical software system notifies the provider in instances when there are single or combination vaccine orders that are inconsistent with the expected timing intervals included in the vaccine forecast. Inconsistencies include suggestion of different date(s) for ordering the vaccine(s) or indication the vaccine(s) is/are no longer required.

Description

The physician accesses the record for Juan Marcel Marina and, once the vaccine history is reconciled in the EHR, the vaccine forecast is updated.

- The provider views the updated vaccine forecast (either as provided by the Immunization Registry or as determined through EHR defined methods).

View the vaccination forecast for Juan Marcel Marina

Test Objectives

View Reconciled Immunization Forecast: The EHR or other clinical software system has the ability to re-evaluate and update the immunization forecast using a patient's newly updated immunization history. Forecasts are updated following reconciliation of immunization data contained in the public health immunization registry with immunization data contained in the EHR. Processing the new forecast can be internal to the EHR or it can use an external forecasting service, but should reference the most recent recommendations.

Modify Antigen Recommendations Based on Active Diagnoses: The system notifies the provider of any conflicts between recommended vaccines in the updated forecast and the patient's current or historical diagnoses.

This test will consist of ordering vaccines for the test patients, reviewing any alerts caused by specific scenarios, and documenting vaccinations administered to the patients.

Test Objectives

Modify Antigen Recommendations Based on Active Diagnoses: The EHR or other clinical software system notifies the provider of any conflicts between recommended vaccines in the updated forecast and the patient's current or historical diagnoses.

Enter Vaccination Order: The EHR or other clinical software system allows providers to order immunizations for a patient using filters for type of vaccine, including combination vaccines.

Receive Dose Not Indicated Alert for Single Vaccine Order: The EHR or other clinical software system notifies the provider in instances when there are single or combination vaccine orders that are inconsistent with the expected timing intervals included in the vaccine forecast. Inconsistencies include suggestion of different date(s) for ordering the vaccine(s) or indication the vaccine(s) is/are no longer required.

Receive Dose Not Indicated Alert Upon Vaccine Administration: The EHR or other clinical software system notifies the individual administering a vaccine that the vaccine is inconsistent with expected timing intervals as suggested by the vaccine forecast. The method and timing of notification can be specified to meet local clinical workflow. This requirement is a "failsafe" mechanism in case the provider orders a vaccine dose that is inconsistent with appropriate timing intervals.

Notify of Vaccine Dose Expiration: The EHR or other clinical software system notifies the provider administering a vaccine if the dose chosen for administration is expired.

Record Vaccine Administration: The EHR or other clinical software system records information about each vaccine administered. The EHR records this information as structured data elements, including, at a minimum: date administered, administering clinician, site of administration (e.g., left arm), immunization type, lot number, manufacturer, Vaccine Information Statement date, quantity of vaccine/dose size and ordering clinician. The system also assures data quality, i.e., data entered are appropriate (e.g., avoid "oral" route for IM vaccines, and assure dose is appropriate for the vaccine).

Notify of Vaccine Dose Ineligibility: The EHR or other clinical software system provides a method for alerting a provider if a vaccine is selected for a patient who is not eligible for the inventory item selected.

Data Quality Checks: Integrate additional data quality checks into IIP Testing and Recognition to improve data quality and reduce rejections.

Note: The EHR or other clinical software system prevents specific data issues which would potentially result in IIS errors as defined by the AIRA Error Codes. This supports reducing data quality issues that could trigger the following AIRA-defined Error Codes:

- 2013: Indicates that the funding source code in an OBX segment conflicts with other data in the message (eligibility, age etc).
- 2016: Indicates that the administration route is inconsistent with the vaccine administered
- 2001: Indicates a conflict between the administration date in RXA-3 and the expiration date in RXA-16. In other words it indicates that an expired vaccine was administered.

Test Steps

Orders Administration	As indicated by the vaccine forecast, the third Hepatitis B is overdue, and is ordered.
of Hepatitis B vaccine	Test Objectives Enter Vaccination Order: The EHR or other clinical software system allows providers to order immunizations for a
	patient using filters for type of vaccine, including combination vaccines.
	Description
	The fifth DTaP is ordered, and the provider is notified that the dose is too early.
Orders administration	Test Objectives
of DTaP vaccine and alerted that the dose is too early	
	Enter Vaccination Order: The EHR or other clinical software system allows providers to order immunizations for a patient using filters for type of vaccine, including combination vaccines.
	Description
	The nurse documents administration route for the HepB vaccine: - Is prevented from documenting "oral" for HepB vaccine.
	Test Objectives
	Record Vaccine Administration: The EHR or other clinical software system records information about each vaccine administered. The EHR records this information as structured data elements, including, at a minimum: date administered, administering clinician, site of administration (e.g., left arm), immunization type, lot number, manufacturer, Vaccine Information Statement date, quantity of vaccine/dose size and ordering clinician. The system also assures data quality, i.e., data entered are appropriate (e.g., avoid "oral" route for IM vaccines, and assure dose is appropriate for the vaccine).
	Data Quality Checks: Integrate additional data quality checks into IIP Testing and Recognition to improve data quality and reduce rejections.
	Note: The EHR or other clinical software system prevents specific data issues which would potentially result in IIS errors as defined by the AIRA Error Codes. This supports reducing data quality issues that could trigger the following AIRA-defined Error Codes:
	- 2016 : Indicates that the administration route is inconsistent with the vaccine administered

The nurse documents administration lot number for the Hepatitis B vaccine:

- Is prevented from ordering the Hepatitis B lot as it has expired.
- Documents administration from a different lot that is not expired.

Records Hepatitis B Vaccine lot number with expired lot alert

Test Objectives

Notify of Vaccine Dose Expiration: The EHR or other clinical software system notifies the provider administering a vaccine if the dose chosen for administration is expired.

Data Quality Checks: Integrate additional data quality checks into IIP Testing and Recognition to improve data quality and reduce rejections.

Note: The EHR or other clinical software system prevents specific data issues which would potentially result in IIS errors as defined by the AIRA Error Codes. This supports reducing data quality issues that could trigger the following AIRA-defined Error Codes:

- 2001: Indicates a conflict between the administration date in RXA-3 and the expiration date in RXA-16. In other words, it indicates that an expired vaccine was administered.

Description

The nurse administers the Hepatitis B vaccine:

- Documents all required information for the vaccine.

Record Hepatitis B Vaccine administration

Test Objectives

Record Vaccine Administration: The EHR or other clinical software system records information about each vaccine administered. The EHR records this information as structured data elements, including, at a minimum: date administered, administering clinician, site of administration (e.g., left arm), immunization type, lot number, manufacturer, Vaccine Information Statement date, quantity of vaccine/dose size and ordering clinician. The system also assures data quality, i.e., data entered are appropriate (e.g., avoid "oral" route for IM vaccines, and assure dose is appropriate for the vaccine).

The nurse documents administration for the inactivated influenza vaccine from a VFC source:

- Is alerted that the patient is not eligible for VFC.
- Orders a different non-VFC lot of inactivated influenza vaccine.

Records Influenza Vaccine administration with VFC eligibility checking

Test Objectives

Notify of Vaccine Dose Ineligibility: The EHR or other clinical software system provides a method for alerting a provider if a vaccine is selected for a patient who is not eligible for the inventory item selected.

Data Quality Checks: Integrate additional data quality checks into IIP Testing and Recognition to improve data quality and reduce rejections.

Note: The EHR or other clinical software system prevents specific data issues which would potentially result in IIS errors as defined by the AIRA Error Codes. This supports reducing data quality issues that could trigger the following AIRA-defined Error Codes:

- 2013: Indicates that the funding source code in an OBX segment conflicts with other data in the message (eligibility, age etc).

Description

The nurse administers the inactivated influenza vaccine:

- Documents all required information for each vaccine.

Record Influenza Vaccine administration for Juan Marcel Marina

Test Objectives

Record Vaccine Administration: The EHR or other clinical software system records information about each vaccine administered. The EHR records this information as structured data elements, including, at a minimum: date administered, administering clinician, site of administration (e.g., left arm), immunization type, lot number, manufacturer, Vaccine Information Statement date, quantity of vaccine/dose size and ordering clinician. The system also assures data quality, i.e., data entered are appropriate (e.g., avoid "oral" route for IM vaccines, and assure dose is appropriate for the vaccine).

Attempt to administer DTaP vaccine and alerted that the dose is too early Test Objectives Receive Dose Not Indicated Alert Upon Vaccine Administration: The system notifies the individual administering a vaccine that the vaccine is inconsistent with expected timing intervals as suggested by the vaccine forecast. The method and timing of notification can be specified to meet local clinical workflow. This requirement is a "failsafe" mechanism in case the provider orders a vaccine dose that is inconsistent with appropriate timing intervals.

Test Case	Juan Marcel Marina Transmit Immunization Report

Description

Following the vaccinations given during the visit, the EHR transmits an Immunization report to the Immunization Registry using the VXU/Z22. The Vaccination report includes all newly administered vaccines. The report should include vaccines incorrectly recorded in the IIS. The report MAY send the immunizations that the EHR imported from the IIS.

Test Objectives

Transmit Standard Patient Immunization History Report: The EHR or other clinical software system directly or indirectly through an intermediary creates and transmits a report of a patient's newly administered or newly identified immunization history to public health immunization registries.

Link Standard Codes to Immunization Data: The EHR or other clinical software system links standard codes (i.e., LOINC for lab tests or evaluation tools, SNOMED CT for conditions or observations, NDC codes for current immunizations, CVX for historical immunizations, appropriate codes for administration site, route, method, etc.) to discrete data elements associated with an immunization.

Note: Testing for NDC codes, CVX for immunizations.

Test Steps

Following the vaccinations given during the visit, the EHR transmits an Immunization report to the Immunization Registry using the VXU/Z22. The Vaccination report includes all newly administered vaccines, and an indication that Varicella was not administered due to a history of the disease as evidence of immunity. The Vaccination report also includes an indication that Hepatitis A was not administered due to serological evidence of immunity. The report MAY send the immunizations that the EHR imported from the IIS.

Transmit the Immunization Report for Juan Marcel Marina

Test Objectives

Transmit Standard Patient Immunization History Report: The EHR or other clinical software system directly or indirectly through an intermediary creates and transmits a report of a patient's newly administered or newly identified immunization history to public health immunization registries.

Link Standard Codes to Immunization Data: The EHR or other clinical software system links standard codes (i.e., LOINC for lab tests or evaluation tools, SNOMED CT for conditions or observations, NDC codes for current immunizations, CVX for historical immunizations, appropriate codes for administration site, route, method, etc.) to discrete data elements associated with an immunization.

Note: Testing for NDC codes, CVX for immunizations.

Description

The Immunization Registry returns a positive acknowledgement message indicating that no errors were found during the course of filing the message.

Receive ACK Z23 from Immunization Registry

Test Objectives

Transmit Standard Patient Immunization History Report: The EHR or other clinical software system directly or indirectly through an intermediary creates and transmits a report of a patient's newly administered or newly identified immunization history to public health immunization registries.

Description

The provider identifies that the vaccine administration of Hepatitis B for this visit was documented in error. The vaccine was not administered during the visit but was inadvertently documented as administered. A delete notification for the Hepatitis B vaccination administered is transmitted to the Immunization Registry for Juan Marcel Marina.

Test Objectives

Transmit Delete for Vaccine Recorded in Error

Transmit Standard Patient Immunization History Report: The EHR or other clinical software system directly or indirectly through an intermediary creates and transmits a report of a patient's newly administered or newly identified immunization history to public health immunization registries.

Link Standard Codes to Immunization Data: The EHR or other clinical software system links standard codes (i.e., LOINC for lab tests or evaluation tools, SNOMED CT for conditions or observations, NDC codes for current immunizations, CVX for historical immunizations, appropriate codes for administration site, route, method, etc.) to discrete data elements associated with an immunization.

Note: Testing for NDC codes, CVX for immunizations.

Support for delete functionality.

Description The Immunization Registry returns a positive acknowledgement message indicating that no errors were found during the course of filing the message.
Test Objectives Transmit Standard Patient Immunization History Report: The EHR or other clinical software system directly or indirectly through an intermediary creates and transmits a report of a patient's newly administered or newly identified immunization history to public health immunization registries.

Test Case Group: Juana Mariela Gonzales Visit

Description

Test Objectives

Infant twin, Juana Mariela Gonzales visits the provider where her immunization history is retrieved from the registry and reconciled with the local information in the medical record to determine vaccines that are due. Vaccinations are ordered and administered. The vaccines are reported to the immunization registry and a vaccine summary is available for the patient.

Test Case	Query the Registry for Juana Mariela Gonzales
l	

The EHR generates a Z44 query to the Immunization Registry to retrieve the Evaluated History and Forecast for Juana Mariela Gonzales. Querying the registry will consist of the vendor creating Z44 messages for Juana Mariela Gonzales to be sent to the registry. The response will be processed as part of the 'Display, Reconcile, Import and Update Immunization Information' activity.

Using the Z42 Response to Immunization Registry Query, the EHR displays the Evaluated History and Forecast to the user for reconciliation and update. The vendor will receive information back from the registry and show the ability to view and reconcile, and import the information returned by the registry (NOTE: the Z42 message will be provided either manually, or as part of the tool). This test will also look at the system's ability to view the forecast returned by the registry and create a new forecast after reconciling the information.

Test Objectives

Select New Patient: The EHR or other clinical software system must allow a user to distinguish information about patients with similar names or identifying information in order to select the right patient from the providers' EHR or other clinical software. This information is crucial for identifying and selecting the correct patient. For example, twins living in the same household will have similar dates of birth, addresses, and may have similar sounding names. In order to match patients with those already in the immunization registry, the EHR or other clinical software should have the ability to record the mother's maiden name, whether the patient was part of a multiple birth, and if so, the order of birth (when such information is available). The provider should be aware of how often the protection indicator information must be updated based on local rules.

Request/Receipt of Patient Immunization History: The EHR or other clinical software system sends a request to the public health immunization registry "on demand," or in advance for those with scheduled appointments. The request includes the identifying information the immunization registry needs to match each patient with those in the registry including, if present, the mother's maiden name, a multiple birth indicator, and the birth order. The request also is sent in a pre-determined format the registry can read and interpret (Request Evaluated Immunization History and Forecast (Z44) - HL7 version 2.5.1 Implementation Guide for Immunization Messaging Release 1.5).

Request/Receive Patient Immunization Data and Identify Source: The EHR or other clinical software stores 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.

View Reconciled Immunization Forecast: The EHR or other clinical software system has the ability to re-evaluate and update the immunization forecast using a patient's newly updated immunization history. Forecasts are updated following reconciliation of immunization data contained in the public health immunization registry with immunization data contained in the EHR. Processing the new forecast can be internal to the EHR or it can use an external forecasting service, but should reference the most recent recommendations.

Test	Steps	
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Juana Mariela Gonzales is selected as the patient and her record is opened in the EHR.

Select **Patient** Juana Mariela Gonzales

Test Objectives

Select New Patient: The EHR or other clinical software system must allow a user to distinguish information about patients with similar names or identifying information in order to select the right patient from the providers' EHR or other clinical software. This information is crucial for identifying and selecting the correct patient. For example, twins living in the same household will have similar dates of birth, addresses, and may have similar sounding names. In order to match patients with those already in the immunization registry, the EHR or other clinical software should have the ability to record the mother's maiden name, whether the patient was part of a multiple birth, and if so, the order of birth (when such information is available). The provider should be aware of how often the protection indicator information must be updated based on local rules.

Description

Query Registry for vaccination forecast for Juana Mariela Gonzales

The provider uses the EHR to query the Immunization Registry for an Evaluated History and Forecast based on information known to the Immunization Registry.

history and Test Objectives

Request/Receipt of Patient Immunization History: The EHR or other clinical software system sends a request to the public health immunization registry "on demand," or in advance for those with scheduled appointments. The request includes the identifying information the immunization registry needs to match each patient with those in the registry including, if present, the mother's maiden name, a multiple birth indicator, and the birth order. The request also is sent in a pre-determined format the registry can read and interpret (Request Evaluated Immunization History and Forecast (Z44) - HL7 version 2.5.1 Implementation Guide for Immunization Messaging Release 1.5).

Description

The physician accesses the record for Juana Mariela Gonzales and:

View and import response to request for vaccination Test Objectives history for Juana Mariela Gonzales

- Accepts the single vaccine in the registry record into the EHR history.

Request/Receive Patient Immunization Data and Identify Source: The EHR or other clinical software system stores 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.

The physician accesses the record for Juana Mariela Gonzales and:

- Views the vaccine forecast (either as provided by the Immunization Registry or as determined through EHR defined methods).

View the vaccination forecast for Juana Mariela Gonzales

Test Objectives

View Reconciled Immunization Forecast: The EHR or other clinical software system has the ability to re-evaluate and update the immunization forecast using a patient's newly updated immunization history. Forecasts are updated following reconciliation of immunization data contained in the public health immunization registry with immunization data contained in the EHR. Processing the new forecast can be internal to the EHR or it can use an external forecasting service, but should reference the most recent recommendations.

Test Case

Juana Mariela Gonzales, Enter Orders and Immunizations

Description

This test will consist of ordering vaccines for the test patients, reviewing any alerts caused by specific scenarios, and documenting vaccinations administered to the patients.

Test Objectives

Supporting data for documenting contraindications (it could also trigger an alert as a locally configured alert rule)

Modify Antigen Recommendations Based on Active Diagnoses: The EHR or other clinical software system notifies the provider of any conflicts between recommended vaccines in the updated forecast and the patient's current or historical diagnoses.

Record Vaccine Administration Deferral: The EHR or other clinical software system allows a user to enter a reason or reasons why a specific immunization was not given to a patient (e.g., due to contraindication, refusal, etc.). The system also stores that information in a structured way so it can be reported and analyzed as needed.

Data Quality Checks: Integrate additional data quality checks into IIP Testing and Recognition to improve data quality and reduce rejections.

Note: The EHR or other clinical software system prevents specific data issues which would potentially result in IIS errors as defined by the AIRA Error Codes. This supports reducing data quality issues that could trigger the following AIRA-defined Error Codes:

- 2101: Indicates that a contraindication effective date messaged in OBX-5 is in the future

Test Steps

Description

The triage nurse enters basic information on Juana Mariela Gonzales - she has a fever (Temperature of 100.8 degrees F).

Enter Initial Clinical Information for Juana Mariela

Test Objectives

Supporting data for documenting contraindications (it could also trigger an alert as a locally configured alert rule):

Modify Antigen Recommendations Based on Active Diagnoses: The EHR or other clinical software system notifies the provider of any conflicts between recommended vaccines in the updated forecast and the patient's current or historical diagnoses.

The provider attempts to document vaccine deferral information for the immunization for Juana Mariela Gonzales. These data quality checks primarily relate to improving vaccine deferral information and associated observations that will be included when submitting data to the immunization registry.

Vaccine Deferral | Test Objectives **Data Quality** Checks

Data Quality Checks: Integrate additional data quality checks into IIP Testing and Recognition to improve data quality and reduce rejections.

Note: The EHR or other clinical software system prevents specific data issues which would potentially result in IIS errors as defined by the AIRA Error Codes. This supports reducing data quality issues that could trigger the following AIRA-defined Error Codes:

- 2101: Indicates that a contraindication effective date messaged in OBX-5 is in the future

Description

The physician accesses the record for Juana Mariela Gonzales and:

- Enters a deferral for the vaccines due (Hepatitis B, DTaP, Hib, Pneumococcal conjugate (PCV13) and Rotavirus) due to medical reason, indicating low grade fever, and defers for 1 month.

Enters a medical deferral for the vaccines due

Test Objectives

Record Vaccine Administration Deferral: The EHR or other clinical software system allows a user to enter a reason or reasons why a specific immunization was not given to a patient (e.g., due to contraindication, refusal, etc.). The system also stores that information in a structured way so it can be reported and analyzed as needed.

Test Case

Juana Mariela Gonzales Transmit Immunization Report

Description

Following the vaccinations given during the visit, the EHR transmits an Immunization report to the Immunization Registry using the VXU/Z22. The Vaccination report includes deferrals for the vaccines that were due this visit indicating the medical reason. The report MAY send the immunizations that the EHR imported from the IIS.

Test Objectives

Transmit Standard Patient Immunization History Report: The EHR or other clinical software system directly or indirectly through an intermediary creates and transmits a report of a patient's newly administered or newly identified immunization history to public health immunization registries.

Link Standard Codes to Immunization Data: The EHR or other clinical software system links standard codes (i.e., LOINC for lab tests or evaluation tools, SNOMED CT for conditions or observations, NDC codes for current immunizations, CVX for historical immunizations, appropriate codes for administration site, route, method, etc.) to discrete data elements associated with an immunization.

Note: Testing for NDC codes, CVX for immunizations.

Description Following the visit, the EHR transmits an Immunization report to the Immunization Registry using the VXU/Z22. The Vaccination report includes the vaccine deferrals. The report MAY send the immunizations that the EHR imported from the IIS. **Test Objectives** Transmit the Transmit Standard Patient Immunization History Report: The EHR or other clinical software system directly **Immunization** or indirectly through an intermediary creates and transmits a report of a patient's newly administered or newly Report for Juana identified immunization history to public health immunization registries. Mariela Gonzales Link Standard Codes to Immunization Data: The EHR or other clinical software system links standard codes (i.e., LOINC for lab tests or evaluation tools, SNOMED CT for conditions or observations, NDC codes for current immunizations, CVX for historical immunizations, appropriate codes for administration site, route, method, etc.) to discrete data elements associated with an immunization. Note: Testing for NDC codes, CVX for immunizations. Description The Immunization Registry returns a positive acknowledgement message indicating that no errors were found during the course of filing the message. Receive ACK Z23 from **Immunization** Test Objectives Registry Transmit Standard Patient Immunization History Report: The EHR or other clinical software system directly or indirectly through an intermediary creates and transmits a report of a patient's newly administered or newly identified immunization history to public health immunization registries.

Test Case Group: Juana Maria Gonzales Visit

Description

Test Objectives

Infant twin, Juana Maria Gonzales Morales visits the provider where her immunization history is retrieved from the registry and reconciled with the local information in the medical record to determine vaccines that are due. Vaccinations are ordered and administered. The vaccines are reported to the immunization registry and a vaccine summary is available for the patient

est Case	Query the Registry for Juana Maria Gonzales	

The EHR generates a Z44 query to the Immunization Registry to retrieve the Evaluated History and Forecast for Juana Maria Gonzales. Querying the registry will consist of the vendor creating Z44 messages for Juana Maria Gonzales to be sent to the registry. The response will be processed as part of the 'Display, Reconcile, Import and Update Immunization Information' activity.

Using the Z42 Response to Immunization Registry Query, the EHR displays the Evaluated History and Forecast to the user for reconciliation and update. The vendor will receive information back from the registry and show the ability to view and reconcile, and import the information returned by the registry (NOTE: the Z42 message will be provided either manually, or as part of the tool). This test will also look at the system's ability to view the forecast returned by the registry and create a new forecast after reconciling the information.

Test Objectives

Select New Patient: The EHR or other clinical software system must allow a user to distinguish information about patients with similar names or identifying information in order to select the right patient from the providers' EHR or other clinical software. This information is crucial for identifying and selecting the correct patient. For example, twins living in the same household will have similar dates of birth, addresses, and may have similar sounding names. In order to match patients with those already in the immunization registry, the EHR or other clinical software should have the ability to record the mother's maiden name, whether the patient was part of a multiple birth, and if so, the order of birth (when such information is available). The provider should be aware of how often the protection indicator information must be updated based on local rules.

Request/Receipt of Patient Immunization History: The system sends a request to the public health immunization registry "on demand," or in advance for those with scheduled appointments. The request includes the identifying information the immunization registry needs to match each patient with those in the registry including, if present, the mother's maiden name, a multiple birth indicator, and the birth order. The request also is sent in a pre-determined format the registry can read and interpret (Request Evaluated Immunization History and Forecast (Z44) - HL7 version 2.5.1 Implementation Guide for Immunization Messaging Release 1.5).

Request/Receive Patient Immunization Data and Identify Source: The EHR stores 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.

View Reconciled Immunization Forecast: The EHR or other clinical software system has the ability to re-evaluate and update the immunization forecast using a patient's newly updated immunization history. Forecasts are updated following reconciliation of immunization data contained in the public health immunization registry with immunization data contained in the EHR. Processing the new forecast can be internal to the EHR or it can use an external forecasting service, but should reference the most recent recommendations.

Description Juana Maria Gonzales is selected as the patient and her record is opened in the EHR. Select **Test Objectives** Patient Juana Select New Patient: The EHR or other clinical software system must allow a user to distinguish information about Maria patients with similar names or identifying information in order to select the right patient from the providers' EHR or other Gonzales clinical software. This information is crucial for identifying and selecting the correct patient. For example, twins living in the same household will have similar dates of birth, addresses, and may have similar sounding names. In order to match patients with those already in the immunization registry, the EHR or other clinical software should have the ability to record the mother's maiden name, whether the patient was part of a multiple birth, and if so, the order of birth (when such information is available). The provider should be aware of how often the protection indicator information must be updated based on local rules. Description The provider uses the EHR to query the Immunization Registry for an Evaluated History and Forecast based on information known to the Immunization Registry. This query will result in an error that too many matches are found. **Ouerv** Registry for **Test Objectives** vaccination history and Request/Receipt of Patient Immunization History: The EHR or other clinical software system sends a request to the forecast too public health immunization registry "on demand," or in advance for those with scheduled appointments. The request many includes the identifying information the immunization registry needs to match each patient with those in the registry matches including, if present, the mother's maiden name, a multiple birth indicator, and the birth order. The request also is sent in a found pre-determined format the registry can read and interpret (Request Evaluated Immunization History and Forecast (Z44) response HL7 version 2.5.1 Implementation Guide for Immunization Messaging Release 1.5). Setup step to test error handling: Test the capability of the EHR to process a response message that returns no persons found and to provide an indication to the end user. Description The EHR processes notifies the user that there were too many matches found in response to the query the Immunization Registry for an Evaluated History and Forecast. Error **Test Objectives** Handling -Too many Request/Receive Patient Immunization Data and Identify Source: The EHR or other clinical software system stores matches immunization history accepted electronically from other sources (such as a public health immunization registry consistent found 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. Tests error handling: Test the capability of the EHR to process a response message that returns too many matches found and to provide an indication to the end user.

Query

Description

The provider uses the EHR to query the Immunization Registry for an Evaluated History and Forecast based on information known to the Immunization Registry. This query will result in an error that no persons are found.

Test Objectives

Registry for vaccination forecast no persons found response

history and Request/Receipt of Patient Immunization History: The EHR or other clinical software system sends a request to the public health immunization registry "on demand," or in advance for those with scheduled appointments. The request includes the identifying information the immunization registry needs to match each patient with those in the registry including, if present, the mother's maiden name, a multiple birth indicator, and the birth order. The request also is sent in a pre-determined format the registry can read and interpret (Request Evaluated Immunization History and Forecast (Z44) HL7 version 2.5.1 Implementation Guide for Immunization Messaging Release 1.5).

Tests error handling: Test the capability of the EHR to process a response message that returns no persons found and to provide an indication to the end user.

Description

The EHR processes notifies the user that there were no persons found in response to the query the Immunization Registry for an Evaluated History and Forecast.

Error Handling -No persons found

Test Objectives

Request/Receive Patient Immunization Data and Identify Source: The EHR or other clinical software system stores 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.

Tests error handling: Test the capability of the EHR to process a response message that returns no persons found and to provide an indication to the end user.

Description

Query Registry for history and Test Objectives vaccination forecast for Juana Maria Gonzales

The provider uses the EHR to query the Immunization Registry for an Evaluated History and Forecast based on information known to the Immunization Registry.

Request/Receipt of Patient Immunization History: The EHR or other clinical software system sends a request to the public health immunization registry "on demand," or in advance for those with scheduled appointments. The request includes the identifying information the immunization registry needs to match each patient with those in the registry including, if present, the mother's maiden name, a multiple birth indicator, and the birth order. The request also is sent in a pre-determined format the registry can read and interpret (Request Evaluated Immunization History and Forecast (Z44) HL7 version 2.5.1 Implementation Guide for Immunization Messaging Release 1.5).

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The physician accesses the record for Juana Maria Gonzales and:

View and import response to request for vaccination history for Juana Maria Gonzales

- Accepts the single vaccine in the registry record into the EHR history.

vaccination Test Objectives

Request/Receive Patient Immunization Data and Identify Source: The EHR or other clinical software system stores 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.

Description

The physician accesses the record for Juana Maria Gonzales and:

- Views the vaccine forecast (either as provided by the Immunization Registry or as determined through EHR defined methods).

View the vaccination forecast for Juana Maria Gonzales

Test Objectives

View Reconciled Immunization Forecast: The EHR or other clinical software system has the ability to re-evaluate and update the immunization forecast using a patient's newly updated immunization history. Forecasts are updated following reconciliation of immunization data contained in the public health immunization registry with immunization data contained in the EHR. Processing the new forecast can be internal to the EHR or it can use an external forecasting service, but should reference the most recent recommendations.

Test Case

Juana Maria Gonzales, Enter Orders and Immunizations

Description

This test will consist of ordering vaccines for the test patients, reviewing any alerts caused by specific scenarios, and documenting vaccinations administered to the patients.

Test Objectives

Supporting data for error handling tests.

Record Vaccine Administration: The EHR or other clinical software system records information about each vaccine administered. The EHR records this information as structured data elements, including, at a minimum: date administered, administering clinician, site of administration (e.g., left arm), immunization type, lot number, manufacturer, Vaccine Information Statement date, quantity of vaccine/dose size and ordering clinician. The system also assures data quality, i.e., data entered are appropriate (e.g., avoid "oral" route for IM vaccines, and assure dose is appropriate for the vaccine).

The nurse administers the DTaP-hepatitis B and poliovirus vaccine:

- Documents all required information for the vaccine.

Record Combo Vaccine administration

Test Objectives

Record Vaccine Administration: The EHR or other clinical software system records information about each vaccine administered. The EHR records this information as structured data elements, including, at a minimum: date administered, administering clinician, site of administration (e.g., left arm), immunization type, lot number, manufacturer, Vaccine Information Statement date, quantity of vaccine/dose size and ordering clinician. The system also assures data quality, i.e., data entered are appropriate (e.g., avoid "oral" route for IM vaccines, and assure dose is appropriate for the vaccine).

Test Case

Juana Maria Gonzales Transmit Immunization Report - Error Handling

Description

Following the vaccinations given during the visit, the EHR transmits an Immunization report to the Immunization Registry using the VXU/Z22. The Vaccination report includes all newly administered vaccines. The report MAY send the immunizations that the EHR imported from the IIS.

This transaction will result in an error or warning from the IIS.

Test Objectives

Transmit Standard Patient Immunization History Report: The EHR or other clinical software system directly or indirectly through an intermediary creates and transmits a report of a patient's newly administered or newly identified immunization history to public health immunization registries.

Verify that the EHR is able to receive and display the error or warning response from the IIS.

Link Standard Codes to Immunization Data: The EHR or other clinical software system links standard codes (i.e., LOINC for lab tests or evaluation tools, SNOMED CT for conditions or observations, NDC codes for current immunizations, CVX for historical immunizations, appropriate codes for administration site, route, method, etc.) to discrete data elements associated with an immunization.

Note: Testing for NDC codes, CVX for immunizations.

Following the visit, the EHR transmits an Immunization report to the Immunization Registry using the VXU/Z22. The report MAY send the immunizations that the EHR imported from the IIS. This will result in a warning from the IIS to assess the EHR ability to receive and display the error.

Test Objectives

Transmit the Immunization Report for Juana Maria Gonzales - Fatal Error Handling

Transmit Standard Patient Immunization History Report: The EHR or other clinical software system directly or indirectly through an intermediary creates and transmits a report of a patient's newly administered or newly identified immunization history to public health immunization registries.

Setup to verify that the EHR is able to receive and display the error response from the IIS.

Link Standard Codes to Immunization Data: The EHR or other clinical software system links standard codes (i.e., LOINC for lab tests or evaluation tools, SNOMED CT for conditions or observations, NDC codes for current immunizations, CVX for historical immunizations, appropriate codes for administration site, route, method, etc.) to discrete data elements associated with an immunization.

Note: Testing for NDC codes, CVX for immunizations.

Description

The Immunization Registry returns a fatal error message indicating a table mapping error for the CVX code submitted was found during the course of filing the message.

Test Objectives

Receive ACK Z23 Fatal Error - CVX Code

Transmit Standard Patient Immunization History Report: The EHR or other clinical software system directly or indirectly through an intermediary creates and transmits a report of a patient's newly administered or newly identified immunization history to public health immunization registries.

Error Handling Support for a fatal error returned by the IIS, and the ability of the EHR to display a notification of this error to the user.

Description Following the visit, the EHR transmits an Immunization report to the Immunization Registry using the VXU/Z22. This will result in multiple warnings from the IIS to assess the EHR ability to receive and display the error. Test Objectives Transmit Standard Patient Immunization History Report: The EHR or other clinical software system Transmit the directly or indirectly through an intermediary creates and transmits a report of a patient's newly administered **Immunization Report** or newly identified immunization history to public health immunization registries. for Juana Maria **Gonzales - warning** handling Set up to verify that the EHR is able to receive and display the multiple warning response from the IIS. Link Standard Codes to Immunization Data: The EHR or other clinical software system links standard codes (i.e., LOINC for lab tests or evaluation tools, SNOMED CT for conditions or observations, NDC codes for current immunizations, CVX for historical immunizations, appropriate codes for administration site, route, method, etc.) to discrete data elements associated with an immunization. Note: Testing for NDC codes, CVX for immunizations. Description The Immunization Registry returns a warning message indicating an unrecognized administration site code submitted was found during the course of filing the message. Receive ACK Z23 **Test Objectives** Warning - Invalid Value Transmit Standard Patient Immunization History Report: The EHR or other clinical software system directly or indirectly through an intermediary creates and transmits a report of a patient's newly administered or newly identified immunization history to public health immunization registries. Error Handling Support for a warning returned by the IIS, and the ability of the EHR to display a notification of this warning to the user.

Description Following the visit, the EHR transmits an Immunization report to the Immunization Registry using the VXU/Z22. This will result in multiple warnings from the IIS to assess the EHR ability to receive and display the warnings. Test Objectives Transmit Standard Patient Immunization History Report: The EHR or other clinical software system Transmit the directly or indirectly through an intermediary creates and transmits a report of a patient's newly administered **Immunization Report** or newly identified immunization history to public health immunization registries. for Juana Maria **Gonzales - Multiple** warning handling Set up to verify that the EHR is able to receive and display the multiple warning response from the IIS. Link Standard Codes to Immunization Data: The EHR or other clinical software system links standard codes (i.e., LOINC for lab tests or evaluation tools, SNOMED CT for conditions or observations, NDC codes for current immunizations, CVX for historical immunizations, appropriate codes for administration site, route, method, etc.) to discrete data elements associated with an immunization. Note: Testing for NDC codes, CVX for immunizations. Description The Immunization Registry returns a message with multiple warnings indicating unrecognized administration site codes submitted were found during the course of filing the message. Receive ACK Z23 Test Objectives **Multiple Warnings** Transmit Standard Patient Immunization History Report: The EHR or other clinical software system directly or indirectly through an intermediary creates and transmits a report of a patient's newly administered or newly identified immunization history to public health immunization registries. Error Handling Support for multiple warnings returned by the IIS, and the ability of the EHR to display a notification of these warnings to the user.

Test Case Group: Cohort Report

Description

Test Objectives

This test will consist of generating a cohort report to list all patients who are due or overdue for immunizations showing all overdue immunizations with the associated due/overdue dates.

Test Case	Due and Overdue Immunizations

The provider periodically uses the EHR to identify the cohort of patients that are due or overdue for immunizations along with their contact information in order to send reminder notifications to the patients/parents.

Test Objectives

Produce Population-Level Report: The EHR or other clinical software system generates aggregate, population-level reports based on known patient immunization data.

	Test Steps		
Produce Overdue Immunizations Cohort Report	Description The provider periodically uses the EHR to identify the cohort of patients that are due or overdue for immunizations along with their contact information in order to send reminder notifications to the patients/parents. Test Objectives Produce Population-Level Report: The EHR or other clinical software system generates aggregate, population-level reports based on known patient immunization data.		

Test Case Group: Anita Francesca Marina Visit

Description

Test Objectives

Test Case

Anita Francesca Marina works as a CNA, and is identified as a high-priority candidate for a new adult vaccine. She makes an appointment for the vaccination clinic where she will receive the vaccination. The provider identifies the list of patients that will be vaccinated the following day and requests the patient history from the registry. Anita is one of these patients. Her immunization history is retrieved from the registry and reconciled with the local information in the medical record to determine vaccines that are due. Vaccinations are ordered and administered. The vaccines are reported to the immunization registry and a vaccine summary is available for the patient.

Notify Patients of Immunization Status

Description
The EHR is used to identify patients that are high-priority candidates for a new adult vaccine campaign due to their status as a healthcare worker. The EHR is used to notify patients. Anita Francesca Marina is one of these candidates.
Test Objectives
Notify Patients of Immunization Status: The EHR or other clinical software provides the ability to notify patients of recommendations based on their individual preferences for receiving notification.
Test Stens

The provider is able to use the EHR to identify the cohort of patients that work in the healthcare industry that are prioritized for a newly available vaccine.

Notify New Vaccine Candidate Patients

Test Objectives

Notify Patients of Immunization Status: The EHR or other clinical software provides the ability to notify patients of recommendations based on their individual preferences for receiving notification.

Test Case Query the Registry for Anita Francesca Marina

Description

The EHR allows the provider to select the patients that will be seen in the clinic for the day. Anita Francesca Marina is one of these patients, and a query will be sent to the registry to retrieve her vaccine history.

Querying the registry will consist of the vendor creating a Z44 message for Anita Francesca Marina.

Using the Z42 Response to Immunization Registry Query, the EHR displays the Evaluated History and Forecast to the user for reconciliation and update. The vendor will receive information back from the registry and show the ability to view and reconcile, and import the information returned by the registry. This test will also look at the system's ability to view the vaccine recommendation returned by the registry and create a new recommendation after reconciling the information.

Test Objectives

Select One or More Patients: The EHR or other clinical software system must allow a provider to specify one or more patients in real time or those scheduled for appointment(s) in the future (e.g., the next day, week, month, etc.) so that a request can be sent to the public health immunization registry for each patient's complete immunization history.

Select New Patient: The EHR or other clinical software system must allow a user to distinguish information about patients with similar names or identifying information in order to select the right patient from the providers' EHR or other clinical software. This information is crucial for identifying and selecting the correct patient. For example, twins living in the same household will have similar dates of birth, addresses, and may have similar sounding names. In order to match patients with those already in the immunization registry, the EHR or other clinical software should have the ability to record the mother's maiden name, whether the patient was part of a multiple birth, and if so, the order of birth (when such information is available). The provider should be aware of how often the protection indicator information must be updated based on local rules.

Request/Receipt of Patient Immunization History: The EHR or other clinical software system sends a request to the public health immunization registry "on demand," or in advance for those with scheduled appointments. The request includes the identifying information the immunization registry needs to match each patient with those in the registry including, if present, the mother's maiden name, a multiple birth indicator, and the birth order. The request also is sent in a pre-determined format the registry can read and interpret (Request Evaluated Immunization History and Forecast (Z44) - HL7 version 2.5.1 Implementation Guide for Immunization Messaging Release 1.5).

Request/Receive Patient Immunization Data and Identify Source: The EHR or other clinical software system stores 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.

View Reconciled Immunization Forecast: The EHR or other clinical software system has the ability to re-evaluate and update the immunization forecast using a patient's newly updated immunization history. Forecasts are updated following reconciliation of immunization data contained in the public health immunization registry with immunization data contained in the EHR. Processing the new forecast can be internal to the EHR or it can use an external forecasting service, but should reference the most recent recommendations.

Review Patient Immunization History: The EHR or other clinical software system displays vaccine history by vaccine series.

Description The EHR allows the provider to select the patients that will be seen in the clinic for the day. Anita Francesca Marina is selected as the patient from this list and her record is opened in the EHR Select the Set of Patients to be Seen in the Test Objectives Vaccination Clinic Select One or More Patients: The EHR or other clinical software system must allow a provider to specify one or more patients in real time or those scheduled for appointment(s) in the future (e.g., the next day, week, month, etc.) so that a request can be sent to the public health immunization registry for each patient's complete immunization Description The provider uses the EHR to query the Immunization Registry for an Evaluated History and Vaccine Recommendations for an adult patient based on information known to the Immunization Registry. **Query Registry** Test Objectives for vaccination history and recommendations Request/Receipt of Patient Immunization History: The EHR or other clinical software system sends a request to the public health immunization registry "on demand," or in advance for those with scheduled appointments. The for Anita request includes the identifying information the immunization registry needs to match each patient with those in the Francesca registry including, if present, the mother's maiden name, a multiple birth indicator, and the birth order. The request Marina also is sent in a pre-determined format the registry can read and interpret (Request Evaluated Immunization History and Forecast (Z44) - HL7 version 2.5.1 Implementation Guide for Immunization Messaging Release 1.5). Note: Adult Patient Description The physician accesses the record for adult patient Anita Francesca Marina and: - Accepts the vaccines provided by the registry as the complete vaccination history for this patient had not yet been recorded in the EHR. View and import **Test Objectives** response to request for Request/Receive Patient Immunization Data and Identify Source: The EHR or other clinical software system vaccination stores immunization history accepted electronically from other sources (such as a public health immunization history for adult registry consistent with HL7 version 2.5.1, Implementation Guide for Immunization Messaging Release 1.5) or patient Anita communicated by the patient and manually entered by the clinician. When viewing such information, the provider Francesca can determine which immunizations were administered by the practice, which were entered manually as patient-Marina reported, and which were accepted electronically from the public health registry. Review Patient Immunization History: The EHR or other clinical software system displays vaccine history by vaccine series. Note: Adult Patient

The physician accesses the record for Anita Francesca Marina and:

- Views the vaccine recommendations (as determined through EHR defined methods with consideration for both the IIS vaccine history and forecast and the information available through the EHR).

As a healthcare worker:

- 1. The EMR indicates that given her immunity status of negative for Hepatitis B, that she should receive the Hepatitis B vaccination.
- 2. Anita has been identified to receive a new vaccine as a campaign for healthcare workers.

View the vaccination recommendations for Anita Francesca Marina

Test Objectives

View Reconciled Immunization Forecast: The EHR or other clinical software system has the ability to reevaluate and update the immunization forecast using a patient's newly updated immunization history. Forecasts are updated following reconciliation of immunization data contained in the public health immunization registry with immunization data contained in the EHR. Processing the new forecast can be internal to the EHR or it can use an external forecasting service, but should reference the most recent recommendations.

Note: Recommendation for new vaccine; Vaccine Recommendation for Adult Patient

Test Case

Anita Francesca Marina, Enter Orders and Immunizations

Description

This test will consist of ordering vaccines for the test patients, reviewing any alerts caused by specific scenarios, and documenting vaccinations administered to the patients.

Test Objectives

Record Vaccine Administration: The EHR or other clinical software system records information about each vaccine administered. The EHR records this information as structured data elements, including, at a minimum: date administered, administering clinician, site of administration (e.g., left arm), immunization type, lot number, manufacturer, Vaccine Information Statement date, quantity of vaccine/dose size and ordering clinician. The system also assures data quality, i.e., data entered are appropriate (e.g., avoid "oral" route for IM vaccines, and assure dose is appropriate for the vaccine).

Note: New vaccine, adult

Data Quality Checks: Integrate additional data quality checks into IIP Testing and Recognition to improve data quality and reduce rejections.

Note: The EHR or other clinical software system prevents specific data issues which would potentially result in IIS errors as defined by the AIRA Error Codes. This supports reducing data quality issues that could trigger the following AIRA-defined Error Codes:

- 2100: Indicates that any date field is in the future. Specific errors for date transmitted in an OBX are also provided.
- 2102: Indicates that a VIS given date messaged in OBX-5 is in the future
- 2103: Indicates that a VIS publication date messaged in OBX-5 is in the future
- 2013: Indicates that the funding source code in an OBX segment conflicts with other data in the message (eligibility, age etc)
- 2017: Indicates that the administration site is inconsistent with the vaccine administered

The provider attempts to document vaccine administration information for the immunization for Anita Francesca Marina. These data quality checks primarily relate to improving vaccine administration information and associated observations that will be included when submitting data to the immunization registry.

Test Objectives

Data Quality Checks: Integrate additional data quality checks into IIP Testing and Recognition to improve data quality and reduce rejections.

Vaccine Administration Data Quality Checks

Note: The EHR or other clinical software system prevents specific data issues which would potentially result in IIS errors as defined by the AIRA Error Codes. This supports reducing data quality issues that could trigger the following AIRA-defined Error Codes:

- 2100: Indicates that any date field is in the future. Specific errors for date transmitted in an OBX are also provided.
- 2102: Indicates that a VIS given date messaged in OBX-5 is in the future
- 2103: Indicates that a VIS publication date messaged in OBX-5 is in the future
- 2013: Indicates that the funding source code in an OBX segment conflicts with other data in the message (eligibility, age etc)
- 2017: Indicates that the administration site is inconsistent with the vaccine administered

Description

Since Anita is a healthcare worker with no evidence of immunity to Hepatitis B, the nurse administers a Hepatitis B vaccination to adult patient, Anita Francesca Marina:

- Documents all required information for the Hepatitis B vaccine

Record Vaccine Administration for Hepatitis B

Administration Test Objectives

Record Vaccine Administration: The EHR or other clinical software system records information about each vaccine administered. The EHR records this information as structured data elements, including, at a minimum: date administered, administering clinician, site of administration (e.g., left arm), immunization type, lot number, manufacturer, Vaccine Information Statement date, quantity of vaccine/dose size and ordering clinician. The system also assures data quality, i.e., data entered are appropriate (e.g., avoid "oral" route for IM vaccines, and assure dose is appropriate for the vaccine).

Note: Adult Patient

The nurse administers the new vaccine to adult patient, Anita Francesca Marina:

 Documents all required information for the vaccine using the new vaccine information entered in the Manage Configuration test steps.

Record Vaccine Administration for New Vaccine

Administration Test Objectives

Record Vaccine Administration: The EHR or other clinical software system records information about each vaccine administered. The EHR records this information as structured data elements, including, at a minimum: date administered, administering clinician, site of administration (e.g., left arm), immunization type, lot number, manufacturer, Vaccine Information Statement date, quantity of vaccine/dose size and ordering clinician. The system also assures data quality, i.e., data entered are appropriate (e.g., avoid "oral" route for IM vaccines, and assure dose is appropriate for the vaccine).

Note: Adult Patient

Test Case

Anita Francesca Marina Transmit Immunization Report

Description

Following the vaccinations given during the visit, the EHR transmits an Immunization report to the Immunization Registry using the VXU/Z22. The Vaccination report includes all newly administered vaccines. The report should include vaccines incorrectly recorded in the IIS. The report MAY send the immunizations that the EHR imported from the IIS.

Test Objectives

Transmit Standard Patient Immunization History Report: The EHR or other clinical software system directly or indirectly through an intermediary creates and transmits a report of a patient's newly administered or newly identified immunization history to public health immunization registries.

Note: Adult Patient

Link Standard Codes to Immunization Data: The EHR or other clinical software system links standard codes (i.e., LOINC for lab tests or evaluation tools, SNOMED CT for conditions or observations, NDC codes for current immunizations, CVX for historical immunizations, appropriate codes for administration site, route, method, etc.) to discrete data elements associated with an immunization.

Note: Testing for NDC codes, CVX for immunizations.

Following the vaccinations given during the visit, the EHR transmits an Immunization report to the Immunization Registry using the VXU/Z22. The Vaccination report includes all newly administered vaccines, and an indication that Varicella was not administered due to a history of the disease as evidence of immunity. The Vaccination report also includes an indication that Hepatitis A was not administered due to serological evidence of immunity. The report MAY send the immunizations that the EHR imported from the IIS.

Transmit the Immunization Report for Anita Francesca Marina

Test Objectives

Transmit Standard Patient Immunization History Report: The EHR or other clinical software system directly or indirectly through an intermediary creates and transmits a report of a patient's newly administered or newly identified immunization history to public health immunization registries.

Note: Adult Patient

Link Standard Codes to Immunization Data: The EHR or other clinical software system links standard codes (i.e., LOINC for lab tests or evaluation tools, SNOMED CT for conditions or observations, NDC codes for current immunizations, CVX for historical immunizations, appropriate codes for administration site, route, method, etc.) to discrete data elements associated with an immunization.

Note: Testing for NDC codes, CVX for immunizations.

Description

The Immunization Registry returns a positive acknowledgement message indicating that no errors were found during the course of filing the message.

Receive ACK Z23 from Immunization Registry

Test Objectives

Transmit Standard Patient Immunization History Report: The EHR or other clinical software system directly or indirectly through an intermediary creates and transmits a report of a patient's newly administered or newly identified immunization history to public health immunization registries.

Test Case Group: Review Inventory

Description

Test Objectives

Demonstrates the ability to view inventory supply, including deprecated inventory used.

Test Case	View Inventory	
·		

The provider reviews the available inventory following vaccine administrations used during the day.

Test Objectives

Update Vaccine Inventory from Patient Dosage Administration: The EHR or other clinical software system updates the vaccine inventory to ensure the correct count of remaining available vaccine inventory.

Test Steps

Description

The provider reviews the available inventory following vaccine administrations used during the day.

View updated vaccine inventory

Test Objectives

Update Vaccine Inventory from Patient Dosage Administration: The EHR or other clinical system updates the vaccine inventory to ensure the correct count of remaining available vaccine inventory.

Test Case	Produce Inventory Report of Remaining Stock

Description

The provider periodically uses the EHR to review inventory of remaining stock. The report may be sorted by expiration date or funding source.

Test Objectives

Produce Vaccine History Report: The EHR or other clinical software system generates inventory reports of remaining stock. The reports can be sorted by expiration date and source (e.g., private or guarantee program).

Produce Stock Inventory Report - Expiration Date Sort Test Objectives Produce Vaccine History Report: The EHR or other clinical software software system generates inventory reports of remaining stock. The reports can be sorted by expiration date and source (e.g., private or guarantee program).

The provider periodically uses the EHR to review the stock inventory sorted by funding source to inform orders for new vaccine stock.

Produce Stock Inventory Report - Funding Source Sort

Test Objectives

Produce Vaccine History Report: The EHR or other clinical software system generates inventory reports of remaining stock. The reports can be sorted by expiration date and source (e.g., private or guarantee program).