MISSISSIPPI STATE DEPARTMENT OF HEALTH

Readiness Assessment Questionnaire

*for the purposes of this form clinics and hospitals are both referred to as **facilities.**

1. What is the name of your organization?

   _____

   a. Office manager or Meaningful Use Coordinator _____
   b. Phone number _____
   c. Email _____
2. Does your facility(s) participate in the Vaccines for Children (VFC) program? Yes / No
3. Who is your VFC Coordinator (if valid): _____
4. If your organization is not VFC do you maintain your private inventory in MIIX? Yes / No
5. Does the organization have more than one facility/location? Yes / No
   *If more than 1 facility will submit immunizations from the same server please answer yes and complete #6 for each location.
6. Please **list all facilities, addresses, VFC PINs (if valid) and contact information for each.**

Clinic/Hospital name	Email address	VFC pin (if valid)	Clinic manager	Phone number

7. What is the name of your EHR vendor and the version of your EHR
    a. Name: _____
    b. Version: _____
8. How long has this version been in production in your facility? _____
9. When do you plan to upgrade your EHR system? _____
    To What version? _____
10. Please provide the contact information for your EHR provider.
    a. Name: _____
    b. Email: _____
    c. Phone: _____
11. Who provides support for EHR software application? ____Local support or ____help desk. If there is a primary contact, please provide contact information.
    a. Name: _____
    b. Email: _____
    c. Phone:_____
12. What age patients are given immunizations in this facility? _____
13. Approximately how many immunizations are given at this facility per month? _____
14. What categories of vaccines are provided? _____VFC, ____ Private, or ____Both
15. Is your EHR currently 2014 certified?_____
16. Does your facility intend to do bi-directional messaging? Yes / No / Unknown
17. What version of HL7 messaging is your EHR capable of transmitting? (2.3.1, 2.5.1 etc..)
    _____
18. Is your facility a birthing hospital? _____
19. Do you have a policy/process for updating a newborns name from Baby Boy / Baby Girl to the name given by the parent(s) or guardian(s)? Yes / No

** Birthing Facilities Only **

This policy/process needs to be sent to the State with this form.