Test Plan Summary

Vital Records Death Reporting

Test Case Group: Provider Supplied Death Information Group

This use case examines the ability of an EHR to create an ADT messages for delivery of relevant clinical information to the Electronic Death Registration System (EDRS).

Test Case	VR-1 Death at Home

Description:

Sending death information from the provider for a death that occurred at home.

Test Steps

Report_PSDI_A04_V1.0	**Description:** **On November 2, 2010, upon arriving at his home, John Smith found his wife, Madelyn Smith, lying on the couch unconscious and not breathing. He quickly called 9-1-1 and started cardiopulmonary resuscitation (CPR). Within ten minutes, the paramedics arrived at the scene. They transported Madelyn to the Emergency Room at the Llewellyn Hospital in Rosemont, NC where Dr. Tom Delaney examined Madelyn and pronounced her dead on arrival at 1400. He spoke to Madelyn's husband John and learned that the couple had just returned from a trip overseas and that Madelyn had a 40 year history of lupus. Dr. Delaney started an electronic health record for Madelyn and populated the patient death indicator with a "Y" to confirm her death, along with his full name and his NPI number. Meanwhile, a nurse collected and entered basic identifying information, including patient name, birth date, sex, address, zip code, and social security. The case was referred to the medical examiner's office for an autopsy and Dr. Delaney noted Madelyn's history of lupus and recent overseas travel in his referral note.** **The Medical Examiner (ME), Dr. Revel, assigned a case ID and conducted the autopsy. After speaking to Madelyn's husband, Dr. Revel consulted the referral notes and he immediately suspected that a blood clot might have formed in one of Madelyn's legs during her recent overseas flight. He notes Madelyn's 40 year history of lupus, which is a risk factor for developing deep vein thrombosis. The autopsy results revealed that Madelyn's immediate cause of death was a pulmonary embolism which resulted from deep vein thrombosis. He entered the estimated date and time of death, the immediate cause of death as well contributing conditions, and the underlying cause He also entered the code which indicated that the autopsy results were available for the decedent and entered all information required to identify the death certifier. Finally, the ME signed Madelyn Smith's death certificate which completed the data entry for this decedent and the all information related to filing the death certificate is transmitted via an ADT^A04 message from the EHR to the jurisdictional vital records office.** **Test Objectives:** **The message must provide: Patient demographic information in the PID segment to provide basic demographics to allow identification of the person and matching of the record with information from the funeral director as well as death reporting observations in the OBX Observation/Result segments and further information on the patient death and possible autopsy in the PDA segment. The test case provides an example of relevant elements of recording the death of a patient, and of collecting the information needed to support filing a death certificate.**

	Support for Date/Time of Birth **Support for Death Location** **Support for Autopsy Indicator** **Support for Coroner Indicator** **Support for Observation Value** **Support for Death Certificate Signed Date/Time** **Support for Death Certified By** **Support for Coroner - Medical Examiner Case Number** **Support for Death Certifier Address** **Support for Death Certifier Type** **Support for Did death involve any injury of any kind** **Support for Did Tobacco use contribute to death** **Support for Disease onset to death interval** **Support for Manner of Death** **Support for Part\Line Number** **Support for Referral Note**
Revise_PSDI_A08_V1.0	**Description:** **After Madelyn's death was reported to the jurisdictional vital records office via an A04 message from the EHR, a nurse at Llewellyn Hospital realized that Madelyn's first name had been entered incorrectly into the hospital's EHR as "Madeline."** **The nurse updates the decedent's first name in the medical record with the correct spelling. The updated record for Madeline Smith is transmitted via an ADT^A08 message from the EHR to the jurisdictional vital records office.** **Test Objectives:** **This test case examines the ability of an EHR to create an ADT A08 message for revising of relevant clinical information to the Electronic Death Registration System (EDRS).** **Support for revised patient name.**
Cancel_PSDI_A11_V1.0	**Description:** **Several days after transmission of updated information, it was discovered that Madeline was not actually the proper name for Ms. Smith, and that an electronic report had been previously sent using her correct name which was Josephine Madeline Smith. It becomes necessary to send a retraction of the previous report. The cancellation record for Madeline Smith is transmitted via an ADT^A11 message from the EHR to the jurisdictional vital records office.**

	Test Objectives: **This test case examines the ability of an EHR to create an ADT A11 message for cancellation of relevant clinical information to the Electronic Death Registration System (EDRS).**

Test Case	VR-1 Death caused byTransportation Injury at work

Description:

Sending death information from the provider for a death that occurred at home.

Test Steps

Report_PSDI_A04_V1.0	**Description:** **While driving to work on October 5, 2010 at 0800am, Javier Luis Perez, lost control of his vehicle near 921 Automobile Blvd in Silver Spring, MD and crashed into several other vehicles. He sustained head and neck injuries and lacerations to his face. Witnesses on the scene called 9-1-1 and reported that Javier suddenly began driving erratically.** **He was taken by ambulance to Memorial hospital where Dr. Samuel Spade performed emergency surgery. Unfortunately, the surgery was not successful and Dr. Spade pronounced him dead at October 5, 2010 at 11:25am. A nurse started an EHR and entered basic identifying information, including the patient's name, his birth date, sex, home address (including Country and County of residence) and social security number. Dr. Spade added his own details as the death pronouncer, including his name and provider NPI.** **Mr. Perez's medical record indicated that he had a twenty year history of Epilepsy. Dr. Spade suspected that Javier had suffered a seizure while he was driving that morning, causing him to lose control of his vehicle. The doctor completed the cause of death section of the death certificate and included "Blunt head trauma" on line 1a and "Auto accident" on line 1b. He added "Epilepsy" to line 1c because he was of the opinion that this was the underlying cause of death. He indicated that the death was associated with a transportation event and that Javier was the driver. He also entered "Cerebrovascular Accident" as a significant condition related to the cause of death.** **Dr. Spade entered the injury location and the death location and entered the date and time and location at which the injury occurred, as well as the date and time that he signed the death certificate. He also entered the manner of death was an accident and noted that Javier was a non-smoker and that the death did not result from an injury at work. He also noted that no autopsy results were available for this decedent. Finally, he noted his own identifying information as the death certifier and noted the death certifier type as a "Physician certified death certificate". All information related to filing the death certificate is transmitted via an ADT^A04 message from the EHR to the jurisdictional vital records office.** **Test Objectives:** **The message must provide: Patient demographic information in the PID segment to provide basic demographics to allow identification of the person and matching of the record with information from the funeral director as well as death reporting observations in the OBX Observation/Result segments and further information on the patient death and possible autopsy in the PDA segment. The test case provides an example of relevant elements of recording the death of a patient, and of collecting the information needed to support filing a death certificate.** **Support for Date/Time of Birth** **Support for Death Location** **Support for Autopsy Indicator** **Support for Coroner Indicator**

	Support for Observation Value **Support for Death Certificate Signed Date/Time** **Support for Death Certified By** **Support for Death Certifier Type** **Support for Death Cause Other Significant Conditions** **Support for Death Pronouncer Details** **Support for Did death involve any injury of any kind** **Support for Did Tobacco use contribute to death** **Support for Disease onset to death interval** **Support for Manner of Death** **Support for Part\Line Number** **Support for Street Address where death occurred if not facility**
Revise_PSDI_A08_V1.0	**Description:** **After Javiers death was reported to the jurisdictional vital records office via an A04 message from the EHR, an update is made to correct the decedent's street address in his hospital medical record from 143 Taylor Street to 14355 Taylor Street. The updated record is transmitted via an ADT^A08 message from the EHR to the jurisdictional vital records office.** **Test Objectives:** **This test case examines the ability of an EHR to create an ADT A08 message for revising of relevant clinical information to the Electronic Death Registration System (EDRS).** **Support for revised decedent's street address.**
Cancel_PSDI_A11_V1.0	**Description:** **Several days after transmission of updated information, it was discovered that a more complete medical record exists for Javier under a different SSN. It becomes necessary to send a retraction of the previous report. The cancellation record for Javier Smith is transmitted via an ADT^A11 message from the EHR to the jurisdictional vital records office.**

	Test Objectives: **This test case examines the ability of an EHR to create an ADT A11 message for cancellation of relevant clinical information to the Electronic Death Registration System (EDRS).**

Test Case	VR-1 Death of a Pregnant Woman
Description: Sending death information from the provider for a death that occurred at home.	
Test Steps	
Report_PSDI_A04_V1.0	**Description:** **On the night of January 22, 2003, in Concord, New Hampshire, Sarah Wright and her pregnant daughter Vivienne Wright were at their home watching television when Vivienne suddenly started having convulsions. Sarah immediately called 9-1-1 and the paramedics arrived at the home. They found Vivienne in respiratory failure. Vivienne was rushed to the hospital. When they arrived, a group of emergency room staff, including Vivienne's obstetrician, were unable to resuscitate Vivienne and pronounced her dead at 2100. Vivienne's obstetrician accessed her EHR which was populated with Vivienne's basic identifying information including her name, birth date, sex, address, zip code, and social security number. Vivienne had been treated for preeclampsia during her pregnancy and this seemed the most likely cause of death; however her doctor indicated that he wanted an autopsy to be performed and added a referral note. The pathologist/medical examiner, performed an autopsy on January 23rd. He noted in the EHR that Vivienne was pregnant at the time of her death. He noted pulmonary edema and other blood protein and urine results that pointed to eclampsia as the underlying cause of death, although he listed "Cardiopulmonary arrest" as the immediate cause and entered the duration.** **He listed "Eclampsia" as the underlying cause of death with a separate duration. He entered his identifying information as the death certifier, signed the death certificate and indicated that the autopsy results were available. At that point, all information related to filing the death certificate is transmitted via an ADT^A04 message from the EHR to the jurisdictional vital records office.** **Test Objectives:** **The message must provide: Patient demographic information in the PID segment to provide basic demographics to allow identification of the person and matching of the record with information from the funeral director as well as death reporting observations in the OBX Observation/Result segments and further information on the patient death and possible autopsy in the PDA segment. The test case**

	provides an example of relevant elements of recording the death of a patient, and of collecting the information needed to support filing a death certificate. **Support for Date/Time of Birth** **Support for Death Location** **Support for Autopsy Indicator** **Support for Coroner Indicator** **Support for Observation Value** **Support for Death Certificate Signed Date/Time** **Support for Death Certified By** **Support for Coroner - Medical Examiner Case Number** **Support for Death Certifier Type** **Support for Did death involve any injury of any kind** **Support for Did Tobacco use contribute to death** **Support for Disease onset to death interval** **Support for Part\Line Number** **Support for Referral Note**
Revise_PSDI_A08_V1.0	**Description:** **After Vivienne's death was reported to the jurisdictional vital records office via an A04 message from the EHR, an update is made to correct the decedent's birth date in her hospital medical record from "1984" to June 6, 1984. The value for the decedent's age at death was updated in the medical record as well. The updated record is transmitted via an ADT^A08 message from the EHR to the jurisdictional vital records office.** **Test Objectives:** **This test case examines the ability of an EHR to create an ADT A08 message for revising of relevant clinical information to the Electronic Death Registration System (EDRS).** **Support for revised Date/Time of Birth** **Support for Age at Death** **Support for Units**
Cancel_PSDI_A11_V1.0	**Description:** **Several days after transmission of updated information, it was discovered that a more complete medical record exists for Vivienne under a different SSN. It becomes necessary to send a retraction of the previous report. The cancellation record for Vivienne Wright is transmitted via an ADT^A11 message from the EHR to the jurisdictional vital records office.**

	Test Objectives: **This test case examines the ability of an EHR to create an ADT A11 message for cancellation of relevant clinical information to the Electronic Death Registration System (EDRS).**