

Description

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

Comments

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

Pre-condition

No Pre-Condition

Post-Condition

The EHR has recorded all of the adult demographic data, historical immunizations, and clinical conditions in the record created for Anita Francesca Marina using the test data provided.

Test Objectives

Register New Patients: The system must allow a user to enter distinguishing information about patients so that providers can uniquely identify patients who have similar sounding names or other similar identifying information. For example, twins living in the same household will have similar dates of birth, addresses, and may have similar names. 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.

Evaluation Criteria

Evaluation criteria is defined within each test step.

Notes

No Note

