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.

Comments

No Comments

Pre Condition

No PreCondition

Post Condition

No PostCondition

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 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

Evaluation Criteria

No evaluation criteria

Notes for Testers

No Note