Testing Instruction & Scenarios:

EHR Implementers - Triggering

Overview

The purpose of these tests is to confirm that Electronic Initial Case Reports (eICRs) are triggered correctly based on the trigger code value sets (RCTC) found in the Electronic Reporting Surveillance Distribution (eRSD). This test suite will be focused specifically on triggering, and not eICR creation or delivery. Please note that it is limited to trigger code matching, and excludes any functionality related to timing of triggering events. The following outlines the recommended process and available resources for testing Electronic Case Reporting (eCR) triggering functionality in your system. These resources apply to both new development, and implementation of eCR features within an existing Electronic Health Record (EHR) system.

Learn More about Triggering

Testing Resources

Testing Scenarios

This document provides all the information needed to validate eCR Triggering functionality. The Test Scenarios are broken into the following sections:

1. Initial Notes - Contains all the information that will be specific to the implementing system, like facility, location, etc.
2. Summary Table - A high level view of all eleven testing scenarios. It provides the reference name of the scenario, a description of the triggering match, and the expected outcome all at a quick glance.
3. Test Scenarios - All ten scenarios are laid out in detail here. It includes all necessary patient, encounter, and triggering information in order to perform the tests. It includes all necessary pre-conditions, post-conditions, and evaluation criteria for each scenario.

Triggering eICR Testing Samples

The Triggering eICR Testing Package contains sample eICR documents that correspond to each test scenario. Other than information in the Initial Notes section of the Testing Scenarios resource noted as being specific to the implementing system, the sample eICR documents should match successful reportable test outputs.

Using the Testing Resources

Complete the following steps in order to use the provided resources to test eCR Triggering.

Step 1 - Review the Initial Notes section of the Testing Scenarios, and make note of the expected values specific to the implementing system.
Step 2 - For the first test scenario, confirm all items listed in the “Pre-Conditions” section have been met.
Step 3 - Input all the provided patient and encounter information into the system being test as provided in the Testing Scenarios resource.
Step 4 - Confirm all items in the “Post-Conditions” section have been met.
Step 5 - Confirm all items in the “Evaluation Criteria” section have been met.
Step 6 - If applicable, compare the eICR output to the sample eICR document provided in the Triggering eICR Testing Bundle corresponding to the first scenario.
Step 7 - Repeat steps 2-6 for the remaining ten scenarios. Note: If your system does not support Manually Initiated eICRs, skip scenario 9.

If any tests fail resulting in updates to your system to remediate, perform all these tests again until each one is successful.

Test Scenarios

Initial Notes

- The **Facility ID, name and type** should be generated by the test facility.
- The **Facility street address, city, state, zip code** should be in the address where care was given.
- The **Facility phone and fax** should be associated with valid test phone and fax at the site where care was given.
- The **Provider ID** should be generated by the test facility. Provider IDs in test package are samples only.
- The **Provider city, state, zip code, country** should be in the address where care was given.
- The **Provider email** should be valid test email associated with a test provider at the site where care was given.
- The **Patient ID** should be generated by the test facility. Patient IDs in test package are samples only.
- *Unless otherwise noted* - The **Patient’s city, state, county and zip code** should be in the same state as the facility.

Summary Table

The following table provides a summary of the objectives for each test case included in the test scenarios.

Test Scenario	Description of EHR Triggering match against RCTC
eCR-TC-1_DiagnosisSNOMED CT	Diagnosis code matched against SNOMED CT trigger code Condition = Pertussis.
eCR-TC-2_LabTestNameLOINC _LabTestResultValueSNOMED CT	Multiple trigger codes matches - Lab test name against LOINC - Lab test result code against SNOMED CT Condition = Chlamydia.
eCR-TC-3_LabTestNameLOINC _DiagnosisSNOMED CT	Multiple trigger code matches Multiple Conditions - Lab test name codes for Chlamydia and gonorrhea against LOINC, - Diagnosis code for gonorrhea against SNOMED CT. Conditions = Chlamydia & gonorrhea
eCR-TC-4_LabTestResultValue SNOMED CT	Test result code matched against SNOMED CT trigger code Condition = Salmonellosis
eCR-TC-5_LabTestOrderLOINC	Test order code matched against LOINC test order trigger code Condition = Zika Virus Infection
eCR-TC-6_DiagnosisICD10CM	Diagnosis code matched against ICD-10CM diagnosis trigger codes Conditions = Chlamydia and gonorrhea (Chlamydial conjunctivitis and ICD-10CM Gonococcal infection of lower genitourinary tract, unspecified)

eCR-TC-7_LabTestOrderedLOINC _DiagnosisICD10CM	Multiple trigger code matches - Diagnosis code against ICD-10CM for chlamydia - Test order code against LOINC order codes for pertussis. Conditions = Chlamydia and pertussis
eCR-TC-8_NoReportGenerated	Trigger Codes not matched and no eICR generated.
eCR-TC-9_ManualTrigger_Optional	Manually triggered – Depending on EHR implementation Zika Order trigger may also be included.
eCR-TC-10_ LabTestNameLOINC	Lab test name against LOINC Condition = Hepatitis C
eCR-TC-11_ ProblemSNOMED CT	Problem list code matched against SNOMED CT trigger cod. Problem has a status of active Condition = Pertussis.

Test Scenarios

eCR-TC-1_DiagnosisSNOMED CT

Test Objective: To demonstrate the generation of an eICR based on a match of the diagnosis code against an RCTC SNOMED CT diagnosis code for pertussis.

- This test case is based on a match of the diagnosis against RCTC SNOMED CT diagnosis codes for Pertussis.

Pre-conditions

- Trigger codes are implemented in clinical care system for matching against encounter information.
- Codes are implemented for use on or before the Effective Start Date provided in the RCTC file.

Data to Input

- On January 5th, 2016, a 2 year old Asian female, Kari Kidd is brought to visit pediatrician at outpatient clinic by mother

- Birth date is December 27, 2014
- Race -- Asian
- Patient Ethnicity -- Not Hispanic or Latino
- SSN – XXX-XX-XXXX
- Preferred Language – English
- The child resides at 2222 Home Street.
- Patient email is kkkidd@email.com
- Patient phone is 555-555-2005
- The parent is Mum Martha
- Parent/Guardian email is mmmum@email.com
- Parent/Guardian mobile number is 555-555-5006
- Outpatient clinic visit duration is 15 minutes
- Parent reports reason for visit as patient having persistent cough
- Patient presents to the pediatrician with a persistent cough lasting for 5 days and apnea.
- The patient has a temperature of 102.6F, which was recorded as a symptom of fever.
- Whooping respiration was not reported.
- Post-tussive vomiting was not reported.
- Pediatrician, Dr. Henry Seven:
- Records history of present illness as "Since December 31, 2016 the patient has had a whooping cough and trouble sleeping at night"
- Records a SNOMED CT code for diagnosis of pertussis in the child's electronic health record
- Prescribes a 5 – day course of azithromycin, oral suspension.

Post Conditions & Evaluation Criteria

- The clinical system matches the diagnosis code entered in the encounter record against one of the RCTC diagnosis codes.
- The match of the diagnosis code against the RCTC diagnosiscodes initiates creation of an eICR for electronic transmission.
- An eICR for electronic transmission is created.
- eICR includes the SNOMED CT diagnosis code matched the RCTC for pertussis.
- The eICR follows the HL7 CDA® R2 Implementation Guide: Public Health Case Report, Release 2 - US Realm - the Electronic Initial Case Report (eICR) http://www.hl7.org/implement/standards/product_brief.cfm?product_id=436

eCR-TC-2_LabTestNameLOINC_LabTestResultValueSNOMED CT

Test Objective: To demonstrate the generation of an eICR based on multiple trigger code matches against a RCTC LOINC lab test name, and an RCTC SNOMED CT lab test result code for Chlamydia.

- This test case is based on a match of the lab result entry from the resulted lab report against RCTC LOINC lab test name codes for Chlamydia.
- There is also a match of the lab result code from the resulted lab report against RCTC SNOMED CT test result value organism codes for Chlamydia.

Pre-conditions

- Trigger codes are implemented in clinical care system for matching against encounter information.
- Codes are implemented for use on or before Effective Start Date provided in RCTC file.

Data to Input

- On March 2nd, 2016, a 29 year old Caucasian female, Eve Everywoman visits physician at STD clinic
- Birthdate is October 2nd, 1987
- Race – White
- Patient Ethnicity – Not Hispanic or Latino
- SSN: XXX-XX-XXXX
- Preferred Language – English
- Occupation –Teacher
- Not Pregnant
- The patient resides at 2222 Home Street
- Patient email is eeeverywoman@email.com
- Patient mobile number is 555-555-2003
- Outpatient clinic visit duration is 15 minutes
- Patient reports reason for visit as having learned that partner was diagnosed with Chlamydia, though she exhibits no symptoms
- Patient reports recent travel to visit family in Louisville, Kentucky for holidays from December 22, 2015 to January 2, 2016
- Physician, Dr. Amanda Assigned:
- Collects a cervical swab
- March 2, 2016 – Places an order for Chlamydia trachomatis culture test
- The lab result report is received March 9, 2016
- Includes a result of Chlamydia trachomatis organism detected
- The lab result report, including test names and results, is recorded in the clinical system

Post Conditions & Evaluation Criteria

- The clinical system matches the test name of the resulted lab report against the RCTC lab test name codes.
- The clinical system also matches the test result value of the resulted lab report against the RCTC lab test result organism codes.
- One eICR should be transmitted for this test cases, with data populated for the lab test and lab test result value.
- An eICR for electronic transmission is created.

- eICR includes the LOINC lab test name code and the SNOMED CT lab test result code that matched the RCTC for Chlamydia.
- The eICR follows the HL7 CDA® R2 Implementation Guide: Public Health Case Report, Release 2 - US Realm - the Electronic Initial Case Report (eICR) http://www.hl7.org/implement/standards/product_brief.cfm?product_id=436

eCR-TC-3_LabTestNameLOINC_DiagnosisSNOMED CT

Test Objective: To demonstrate the generation of an eICR based on multiple trigger code matches for Chlamydia and gonorrhea LOINC test name codes, and SNOMED CT diagnosis code for gonorrhea.

- This should NOT trigger a report based on the lab test order placed.
- This test case is based on a match of the lab result entry from the resulted lab report against RCTC LOINC lab test name codes for Chlamydia and gonorrhea.
- There is also a match of the diagnosis entry against the RCTC SNOMED CT diagnosis codes for gonorrhea.
- These matches initiate an eICR for electronic transmission.

Pre-conditions

- Trigger codes are implemented in clinical care system for matching against encounter information.
- Codes are implemented for use on or before the Effective Start Date provided in the RCTC file.

Data to Input

- On March 20, 2016 a 22 year old Asian male, Adam Everyman visits physician at public health department
- Birth date is October 2, 1993
- Race – Asian
- Patient Ethnicity – Not Hispanic or Latino
- SSN – XXX-XX-XXXX
- Preferred Language – English
- Occupation – Plumber
- The patient resides at 2222 Home Street
- Patient email is aaeveryman@email.com
- Patient mobile number is 555-555-2004
- Outpatient clinic visit duration is 15 minutes
- Patient reports reason for visit as complaint of a “burning sensation during urination”
- Patient presents with symptoms of scalding pain on urination, skin rash for small pustules, penal discharge and fever
- Symptoms recorded in history of present illness section
- Physician, Dr. Harold Hippocrates:

- Suspects a STI of Chlamydia or gonorrhea, but does not record Chlamydia nor gonorrhea in the diagnosis field
- March 20, 2016 – Collects a genital swab and places an order for a Chlamydia and gonorrhea PCR panel
- The lab result report is received March 29, 2016
- Includes a result of Not Detected for Chlamydia trachomatis and Detected for Neisseria gonorrhea
- The lab result report, including test names and results, is recorded in the clinical system.
- The clinician reviews the results and records a SNOMED CT code for diagnosis of gonorrhea in the patient's electronic health record

Post Conditions & Evaluation Criteria

- The clinical system DOES NOT match the code for the lab test order and DOES NOT initiate a case report for electronic transmission.
- The clinical system matches the test name of the resulted lab report entered in the encounter record against one of the RCTC lab test name codes and initiates an eICR for electronic transmission.
- The match of the diagnosis code entered in the encounter record against the RCTC diagnosis codes would also initiate creation of an eICR for electronic transmission.
- One eICR should be transmitted for this test case, with data populated for the lab test ordered, lab testing resulted, and the diagnosis entry.
- An eICR for electronic transmission is created.
- eICR includes the LOINC lab test name codes that matched the RCTC for Chlamydia and for gonorrhea, and the SNOMED CT diagnosis code that matched the RCTC for gonorrhea.
- The eICR follows the HL7 CDA® R2 Implementation Guide: Public Health Case Report, Release 2 - US Realm - the Electronic Initial Case Report (eICR) http://www.hl7.org/implement/standards/product_brief.cfm?product_id=436

eCR-TC-4_LabTestResultValueSNOMED CT

Test Objective: To demonstrate the generation of an eICR based on a match of the test result code to a RCTC SNOMED CT test result code for Salmonellosis.

- This test case is based on a match of the test result value code against RCTC test result organism codes for Salmonella Enteritidis (organism). The initial placement of the test order for the general culture test should NOT have initiated a case report.

Pre-conditions

- Trigger codes are implemented in clinical care system for matching against encounter information.
- Codes are implemented for use on or before Effective Start Date provided in RCTC file.

Data to Input

- On May 4th, 2016, Kari Kidd, a 17 year old Latino female is brought to visit pediatrician at outpatient clinic by mother
- Birth date April 25, 1999
- Race -- White
- Patient Ethnicity -- Hispanic or Latino
- SSN – XXX-XX-XXXX
- Preferred Language -- English
- Occupation -- Student
- Not pregnant
- The adolescent resides at 2222 Home Street.
- Patient email is kkkidd@email.com
- Patient mobile number is 555-555-2003
- The parent is Mum Martha
- Parent/Guardian email is mmmum@email.com
- Parent/Guardian mobile number is 555-555-5006
- Outpatient clinic visit duration is 15 minutes
- Patient reports reason for visit is complaint of “abdominal pains, vomiting, and diarrhea”; symptoms have persisted for 5 days
- Patient presents to the pediatrician with symptoms of abdominal pains, vomiting, and diarrhea.
- No fever or elevated temperature was reported.
- No chills were reported.
- Pediatrician, Dr. Karen Kidder:
- Suspects a stomach virus, but decides to order a general test for bacteria identified in stool by culture, since symptoms have persisted
- The lab result report is received May 9th, 2016
- The result for the general culture shows a presence of Salmonella Enteritidis (organism).
- The lab result report, including test names and results, is recorded in the clinical system.
- The pediatrician has not yet reviewed the report nor made a diagnosis based on the results.

Post Conditions & Evaluation Criteria

- The clinical system matches the test result value of the resulted lab report entered into the encounter record against an RCTC test result organism code and initiates a case report for electronic transmission.
- An eICR for electronic transmission is created.
- eICR includes the SNOMED CT lab test result value that matched the RCTC for Salmonellosis
- The eICR follows the HL7 CDA® R2 Implementation Guide: Public Health Case Report, Release 2 - US Realm - the Electronic Initial Case Report (eICR) http://www.hl7.org/implement/standards/product_brief.cfm?product_id=436

eCR-TC-5_LabTestOrderLOINC

Test Objective: To demonstrate the generation of an eICR based on a match of the test order code against an RCTC test order code for Zika Virus Infection.

- This test case is based on a match of the lab test order code against RCTC LOINC test order codes for Zika Virus Infection.
- Lab orders are optional criteria for public health jurisdictions. eICR may be filtered out under secondary adjudication using Public Health Decision Support (e.g., RCKMS, ESP), if the jurisdiction does not opt to receive related reports based on suspicion of Zika Virus Infection.

Pre-conditions

- Trigger codes are implemented in clinical care system for matching against encounter information.
- Codes are implemented for use on or before Effective Start Date provided in RCTC file.

Data to Input

- On February 2nd, 2016, a 25 year old Caucasian female Eve Everywoman visits a physician at an outpatient clinic
- Birth date December 27, 1990
- Race – White
- Patient Ethnicity – Not Hispanic or Latino
- SSN – XXX-XX-XXXX
- Preferred Language -- English
- Occupation: Sales
- Pregnant, estimated delivery date September 29, 2016
- The woman resides at 2222 Home Street.
- Patient email is eeeverywoman@email.com
- Patient Mobile number is 555-555-2003
- Outpatient clinic visit duration is 15 minutes
- Patient reports reason for visit is complaint of “fever, night sweats and cough”; symptoms have persisted for 18 days
- Patient reports recent travel to Brazil for holidays from December 15, 2015 to December 29, 2015
- Patient presents to the doctor with symptoms of fever, night sweats, and cough
- General Practitioner Dr. Henry Seven:
- Suspects Flu, but is concerned due to recent trip to Brazil
- Records in History of Present Illness that patient recently returned from a trip to Brazil with her husband and learned she was pregnant upon her return to the US
- Orders blood to be drawn and submitted to the reference lab for testing

- February 2nd, 2016 - Places an order for a Zika Virus IgM testing of serum which is sent to the reference lab.

Post Conditions & Evaluation Criteria

- The clinical system matches the lab test order code entered in the encounter record against one of the RCTC test order codes and initiates a case report for electronic transmission.
- An eICR for electronic transmission is created.
- eICR includes the LOINC lab test order code that matched the RCTC for Zika Virus Infection.
- The eICR follows the HL7 CDA® R2 Implementation Guide: Public Health Case Report, Release 2 - US Realm - the Electronic Initial Case Report (eICR) http://www.hl7.org/implement/standards/product_brief.cfm?product_id=436

eCR-TC-6_DiagnosisICD10CM

Test Objective: To initiate an eICR based on a match of the diagnosis codes against RCTC ICD-10CM diagnosis codes for Chlamydia and gonorrhea.

- This should NOT trigger a report based on the lab test order placed.
- Because the resulted lab report was not entered into the encounter record, this should also NOT trigger based on the lab test name of the resulted lab report.
- This test case is based on a match of the diagnosis code against RCTC ICD-10CM diagnosis codes for Chlamydia and gonorrhea.

Pre-conditions

- Trigger codes are implemented in clinical care system for matching against encounter information.
- Codes are implemented for use on or before Effective Start Date provided in RCTC file.

Data to Input

- On March 2nd, 2016, a 30 year old Caucasian female, Eve Everywoman visits a physician at an outpatient clinic
- Birth date is October 2nd, 1987
- Race – White
- Patient Ethnicity – Not Hispanic or Latino
- SSN – XXX-XX-XXXX
- Preferred Language -- English
- Occupation—Swim Coach
- Not pregnant
- The patient resides at 2222 Home Street
- Patient email is eeeverywoman@email.com
- Patient mobile number is 555-555-2003
- Outpatient clinic visit duration is 15 minutes

- Patient reports reason for visit as having discharge from right eye and burning pain during urination; symptoms have persisted 3 days
- Patient also recently learned that partner was diagnosed with Chlamydia
- Patient presents to physician with symptoms of discharge from right eye and scalding pain on urination
- Physician, Dr. Amanda Assigned:
- Suspects an STI of Chlamydia and/or gonorrhea
- February 2nd, 2016 - Orders a PCR Panel for Chlamydia and gonorrhea
- Also swabs the eye discharge to check for chlamydial conjunctivitis and Neisseria gonorrhea presence in the conjunctival specimen
- The lab result report is received on March 9th, 2016
- The clinician reviews the results and records a ICD-10CM diagnosis of Chlamydial conjunctivitis and ICD-10CM Gonococcal infection of lower genitourinary tract, unspecified.
- The lab results are not recorded in the patient clinical record
- This test case is initiated at the time the diagnoses are recorded.

Post Conditions & Evaluation Criteria

- The clinical system matches the diagnosis codes entered in the encounter record against one of the RCTC diagnosis codes and initiates an eICR.
- An eICR for electronic transmission is created.
- eICR includes the ICD-10CM diagnosis code matched the RCTC for Chlamydia and gonorrhea.
- The eICR follows the HL7 CDA® R2 Implementation Guide: Public Health Case Report, Release 2 - US Realm - the Electronic Initial Case Report (eICR) http://www.hl7.org/implement/standards/product_brief.cfm?product_id=436

eCR-TC-7_LabTestOrderedLOINC_DiagnosisICD10CM

Test Objective: To demonstrate the generation of an eICR based on multiple trigger code matches against an ICD-10CM diagnosis code for chlamydia and a LOINC test order code for pertussis.

- This test case is based on a match of the encounter diagnosis against RCTC ICD-10 CM diagnosis codes for Chlamydia.
- There is also a match of the lab test order code against RCTC LOINC test order codes for pertussis.

Pre-conditions

- Trigger codes are implemented in clinical care system for matching against encounter information.
- Codes are implemented for use on or before the Effective Start Date provided in the RCTC file.

Data to Input

- On February 20, 2016, a 1 month, 18 day old white male, Kari Kidd is brought to visit pediatrician at outpatient clinic by mother
- Birth date is January 2, 201
- Race – White
- Patient Ethnicity – Not Hispanic or Latino
- SSN – XXX-XX-XXXX
- Preferred Language -- English
- The child resides at 2222 Home Street
- Patient email is kkkidd@email.com
- Patient mobile number is 555-555-2005
- The parent is Mum Martha
- Parent/Guardian email is mmmum@email.com.
- Parent/Guardian phone is 555-555-5006.
- Outpatient clinic visit is 15 minutes
- Parent reports reason for visit as patient being feverish to touch, is crying constantly, and has discharge from eye and has trouble opening eyes upon awakening. Patient also has persistent cough that triggers vomiting.
- Patient presents to the pediatrician with elevated temperature, constantly crying, discharge from eye, persistent cough, and post-tussive vomiting
- The persistent cough, constant crying and ocular discharge started 5 days prior
- The elevated temperature and post-tussive vomiting started 3 days prior
- Pediatrician, Dr. Karen Kidder:
- Notes that parent indicates she had chlamydia which was under treatment at the time her child was born
- Based on maternal report, decides treatment for chlamydial conjunctivitis to be the best course of action and records an ICD-10 code for the final diagnosis of chlamydial conjunctivitis in the child's electronic health record
- Also takes a nasopharyngeal swab and places an order for Bordetella Pertussis Ag presence

Post Conditions & Evaluation Criteria

- The clinical system matches the diagnosis code entered in the encounter record against one of the RCTC diagnosis codes.
- The clinical system also matches the lab test order entered in the encounter record against one of the RCTC test order codes.
- One eICR should be transmitted for this test case, with data populated for the lab test ordered and diagnosis.
- An eICR for electronic transmission is created.
- eICR includes the ICD-10 CM diagnosis code that matched the RCTC for chlamydia and the LOINC test order code that matched the RCTC for pertussis.

- The eICR follows the HL7 CDA® R2 Implementation Guide: Public Health Case Report, Release 2 - US Realm - the Electronic Initial Case Report (eICR) http://www.hl7.org/implement/standards/product_brief.cfm?product_id=436

eCR-TC-8_NoReportGenerated

Test Objective: To demonstrate when the system should not generate an eICR based on no trigger code matches.

- This should NOT trigger a match and should NOT initiate an eICR for electronic transmission.

Pre-conditions

- Trigger codes are implemented in clinical care system for matching against encounter information.
- Codes are implemented for use on or before the Effective Start Date provided in the RCTC file.

Data to Input

- On October 17, 2016, a 46 year old White male, Adam Everyman visits physician at an outpatient clinic
- Birth date is August 10, 1970
- Race – White
- Patient Ethnicity – Not Hispanic or Latino
- SSN – XXX-XX-XXXX
- Preferred Language – English
- Occupation – Food Handler
- The patient resides at 2222 Home Street
- Patient email is aaeveryman@email.com
- Patient mobile number is 555-555-2004
- Outpatient clinic visit duration is 15 minutes
- Patient reports reason for visit as complaint of "fever, headache, diarrhea and abdominal pain"; symptoms have persisted 2 days
- Patient presents with symptoms of fever, headache, diarrhea and abdominal pain.
- Physician, Dr. Harold Hippocrates:
- Orders a general test for bacteria identified in stool by culture

Post Conditions & Evaluation Criteria

- The clinical system DOES NOT match against a code in the RCTC and DOES NOT initiate a case report for electronic initiation.
- NO eICRs should be transmitted for this test case.
- No eICR for electronic transmission is created.

eCR-TC-9_ManualTrigger_Optional

Test Objective: To demonstrate the generation of an eICR based on a manual trigger

- This is an OPTIONAL test case based on a manual triggering of an eICR.

Pre-conditions

- Clinical care system supports manual triggering of an eICR

Data to Input

- On February 2nd, 2016, a 25 year old Caucasian male Eve Everywoman visits a physician at an outpatient clinic
- Birth date December 27, 1990
- Race – White
- Patient Ethnicity – Not Hispanic or Latino
- SSN – XXX-XX-XXXX
- Preferred Language -- English
- Occupation: Sales
- Pregnant, estimated delivery date September 29, 2016
- The woman resides at 2222 Home Street.
- Patient email is eeeverywoman@email.com
- Patient Mobile number is 555-555-2003
- Outpatient clinic visit duration is 15 minutes
- Patient reports reason for visit is complaint of “fever, night sweats and cough”; symptoms have persisted for 18 days
- Patient reports recent travel to Brazil for holidays from December 15, 2015 to December 29, 2015
- Patient presents to the doctor with symptoms of fever, night sweats, and cough
- General Practitioner Dr. Henry Seven:
- Records in History of Present Illness that patient recently returned from a trip to Brazil with her husband and learned she was pregnant upon her return to the US
- Suspects Flu but is concerned about Zika due to the travel to Brazil
- February 2nd, 2016 - Places an order for a Zika Virus IgM testing of serum which is sent to the reference lab.
- Decides to notify public health before lab results return and manually initiates the sending of an initial case report to public health

Post Conditions & Evaluation Criteria

- The clinical system initiates a case report for electronic transmission upon manual triggering
- An eICR for electronic transmission is created.
- eICR includes the code for a manually initiated trigger

- The eICR follows the HL7 CDA® R2 Implementation Guide: Public Health Case Report, Release 2 - US Realm - the Electronic Initial Case Report (eICR) http://www.hl7.org/implement/standards/product_brief.cfm?product_id=436

eCR-TC-10_LabTestNameLOINC

Test Objective: To demonstrate the generation of an eICR based on multiple trigger codes matches against RCTC LOINC lab test names for Hepatitis C

- This test case is based on a match of the lab result entry from the resulted lab report against RCTC LOINC lab test name codes for Hepatitis C

Pre-conditions

- Trigger codes are implemented in clinical care system for matching against encounter information.
- Codes are implemented for use on or before Effective Start Date provided in RCTC file.

Data to Input

- On March 10th, 2016, a 30 year old Caucasian male, Adam Everyman visits physician at an outpatient clinic
- Birthdate is May 4th, 1985
- Race – White
- Patient Ethnicity – Not Hispanic or Latino
- SSN: XXX-XX-XXXX
- Preferred Language – English
- Occupation – Sales
- The patient resides at 2222 Home Street
- Patient email is aaeveryman@email.com
- Patient mobile number is 555-555-2004
- Outpatient clinic visit duration is 15 minutes
- Patient reports reason for visit as general illness including fatigue and abdominal pain; symptoms have persisted for 4 weeks (28 days)
- Patient reports he was a previous injection drug user
- Physician, Dr. Harold Hippocrates
- March 10, 2016 – Places an order for both a Hepatitis C antibody test and HCV RNA test
- The lab result report is received March 15, 2016
- Includes a result of Positive for the Hepatitis C antibody test and Detected for the Hepatitis C nucleic acid test
- The lab result report, including test names and results, is recorded in the clinical system

Post Conditions & Evaluation Criteria

- The clinical system matches the test name of the resulted lab report against the RCTC lab test name codes.

- One eICR should be transmitted for this test cases, with data populated for the resulted lab test
- An eICR for electronic transmission is created.
- eICR includes the LOINC lab test name code that matched the RCTC for Hepatitis C
- The eICR follows the HL7 CDA® R2 Implementation Guide: Public Health Case Report, Release 2 - US Realm - the Electronic Initial Case Report (eICR) http://www.hl7.org/implement/standards/product_brief.cfm?product_id=436

eCR-TC-11_ProblemSNOMED CT

Test Objective: To demonstrate the generation of an eICR based on a match of the problem list code against an RCTC SNOMED CT problem list code for pertussis.

- This test case is based on a match of the problem list against RCTC SNOMED CT problem list codes for Pertussis.

Pre-conditions

- Trigger codes are implemented in clinical care system for matching against encounter information.
- Codes are implemented for use on or before the Effective Start Date provided in the RCTC file.

Data to Input

- On January 4th, 2016, a 2 year old Asian female, Kari Kidd is brought to visit pediatrician at outpatient clinic by mother
- Birth date is January 01, 2014
- Race -- Asian
- Patient Ethnicity -- Not Hispanic or Latino
- SSN – XXX-XX-XXXX
- Preferred Language – English
- The child resides at 2222 Home Street.
- Patient email is kkkidd@email.com
- Patient phone is 555-555-2005
- The parent is Mum Martha
- Parent/Guardian email is mmmum@email.com
- Parent/Guardian mobile number is 555-555-5006
- Outpatient clinic visit duration is 15 minutes
- Pediatrician, Dr. Henry Seven
- Records a SNOMED CT code for an active problem of pertussis in the child’s electronic health record

Post Conditions & Evaluation Criteria

- The clinical system matches the problem list code entered in the encounter record against one of the RCTC problem list codes.
- The match of the problem list code against the RCTC problem list codes initiates creation of an eICR for electronic transmission.
- An eICR for electronic transmission is created.
- eICR includes the SNOMED CT problem list code matched the RCTC for pertussis.
- The eICR follows the HL7 CDA® R2 Implementation Guide: Public Health Case Report, Release 2 - US Realm - the Electronic Initial Case Report (eICR) http://www.hl7.org/implement/standards/product_brief.cfm?product_id=436