

DATA QUALITY REQUIREMENTS FOR IDENTITY MANAGEMENT AND MASTER PATIENT INDEX FUNCTIONS

1. PURPOSE: This Veterans Health Administration (VHA) Directive defines data quality requirements for support of Identity Management and the Master Patient Index (MPI) operations at VHA medical facilities.

2. BACKGROUND

a. Accurate and complete person-identifying information is critical to VHA in the areas of patient care, management reporting, resource allocation, corporate forecasting, and for other business and clinical needs. The amount of patient and other person information now stored electronically in VHA databases has increased and become more complex. This information is widely distributed, residing at each of the VHA health care facilities, as well as in corporate (Austin Automation Center (AAC) and other) databases.

b. Catastrophic edits to identity are defined as those that change the original patient record in a local Veterans Health Information Systems and Technology Architecture (VistA) system to that of another patient by inappropriately editing that existing record through mis-selection (error).

(1) These errors can also occur as a result of improper due diligence by staff using the duplicate record merge tool when two potential duplicate patient records are not properly reviewed and screened. This results in two different patient entries being merged into one.

(2) All types of errors affect the patient entry (record) at other facilities that have treated the patient and they specifically affect patient care. These errors are considered a significant patient safety risk.

c. Administrative, clinical, billing, and interdepartmental processes within the Department of Veterans Affairs (VA), such as eligibility data sharing between the Veterans Benefits Administration (VBA) and VHA, depend on accurate person information and identity management. Accuracy of person information and identity management has a direct impact on patient safety and the provision of health care.

d. In order to ensure that individuals are correctly identified by the staff during patient selection and entry and to prevent catastrophic edits to identity, extreme care must be exercised when entering and editing identity information.

3. POLICY: It is VHA policy that databases, including the MPI, maintain accurate and complete person-identifying information, and that vital processes related to resolving identity data quality issues be performed.

THIS VHA DIRECTIVE EXPIRES JUNE 30, 2011

June 1, 2006

4. ACTION

a. **Facility Directors.** Each facility Director is responsible for:

(1) Ensuring that the entry of person identity data into the VistA applications is accurate and complete.

(2) Designating individuals as points-of-contact (POCs) responsible for processing Exception Handling and Patient Data Review cases, and resolving Integration Control Number (ICN) issues and exceptions in VistA on a daily basis, as well as resolving any other data quality issues brought to their attention by the national Identity Management Data Quality (IMDQ) team.

(3) Ensuring that personnel are assigned to resolve, in a timely manner, issues with exceptions, patient data reviews, data quality issues, communication links, infrastructure, and applications that support data communications. This includes assigning staff members to the following roles (including alternates for each of these categories):

(a) Administrative POC,

(b) Information Resource Management (IRM) POC, and

(c) Health Level 7 (HL7) POC.

NOTE: POC information for Master Patient Index/Patient Demographics (MPI/PD) is updated using the Add/Edit Point-of-Contact [RG UPDATE POINT OF CONTACT] option on the MPI/PD Patient Admin Coordinator Menu [RG ADMIN COORD MENU].

(4) Ensuring that national IMDQ staff are apprised of staffing changes.

(5) Ensuring that potential catastrophic edits are reviewed and resolved, if necessary, in a timely and accurate manner.

(6) Ensuring that management and staff are made aware of policies and procedures related to catastrophic edits to patient identity. This includes ensuring that staff members involved in the entry, editing, and merging of patient records receive certification for the mandatory training.

NOTE: The mandatory training, "Preventing Catastrophic Edits to Patient Identity," can be found at the following VistA University website: <http://vaww.vistau.med.va.gov/vistau/PCEI>

(7) Ensuring that staff directly involved with identity data entry into information systems are aware of the guidelines contained within this Directive and are aware of their responsibility for entering complete identity data elements in a consistent and accurate format. This also includes staff at facilities with outpatient clinics and community-based outpatient clinics assigned to their jurisdiction.

(8) Ensuring that each supervisor involved in the activities of entering demographic data follows the guidance on data quality of the non-identity elements provided by the VHA Chief Business Office (CBO).

(9) Ensuring that staff members responsible for data entry of administrative and demographic information are informed of these requirements mandated by the CBO. **NOTE:** Links to up-to-date guidance on data quality are posted on the IMDQ team's Web site at http://vista.med.va.gov/mpi_dqmt/

b. **Facility Administrative POCs.** Each facility MPI POC is responsible for:

(1) Working with their counterparts, national IMDQ staff, and other Office of Information (OI) personnel in correcting anomalies and addressing issues related to identity data for shared patients.

(2) Processing Exception Handling and Patient Data Review cases in VistA to ensure accuracy and completeness of identity data.

(3) Taking appropriate action to resolve exceptions and patient data review cases within 5 business days. **NOTE:** *Specific information regarding these processes can be found in Attachment A.*

(4) Reviewing potential duplicate patients on the MPI within 2 business days

(5) Using electronic mail, i.e., FORUM and Outlook, to facilitate communications.

(6) Ensuring that contact information maintained by the IMDQ team is current.

(7) Obtaining the necessary VistA access to verify information.

(8) Making appropriate changes to patient data in respective facility's VistA system and perform POC functions, such as processing Exception Handling and Patient Data Review cases.

c. **Facility IRM and HL7 POCs.** Facility IRM and HL7 POCs are responsible for:

(1) Working with their counterparts and Enterprise VistA Support (EVS) staff to maintain communication links, infrastructure, and applications supporting data communications; and

(2) Resolving data quality issues.

(a) In general, responses to inquiries and requests for assistance to resolve data quality issues must be completed within 5 business days.

(b) Requests from the IMDQ team to resolve catastrophic edits that overwrite original patient entry with another patient must be completed within 1 business day.

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5. REFERENCES

- a. M-1, Part I, Chapter 4.
- b. M-1, Part I, Chapter 16.

6. FOLLOW-UP RESPONSIBILITY: The Director, Health Data and Informatics (HDI) (19F) is responsible for the content of this Directive. Questions may be referred to the Identity Management Team Lead at (205) 554-3449.

7. RESCISSIONS: None. This VHA Directive expires June 30, 2011.

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ATTACHMENT A

**GUIDELINES FOR DATA ENTRY AND MAINTENANCE RELATED
TO IDENTITY MANAGEMENT**

It is imperative that staff take the utmost care when entering identity data for patients and other persons. Incomplete or inaccurate data (including typographical errors) are the leading cause of duplicate entries in the Master Patient Index (MPI) and the failure to link records via the Integration Control Number (ICN). The following guidelines are intended to increase the accuracy and completeness of the essential identity data elements and to clarify practices that need to be followed when data is not available or duplicate entries exist. These guidelines emphasize the intended use of some identity fields within the Veterans Health Information Systems and Technology Architecture (VistA). It is important that identity data for patients: be reviewed for accuracy and completeness; and updated, as necessary, each and every time contact is made with the individual.

1. NAME: The NAME field is an important element in the unique identity of a person. Sites need to ensure that the name entered is the complete legal proper name, and includes a full middle name, when available. Avoid using nicknames or ambiguous information. Additional guidance for the entry of the name field includes the following procedures:

- a. All data must be entered using uppercase letters.
- b. No parenthesis may be used.
- c. Commas, apostrophes, and hyphens are the only punctuation that may be used.
- d. Enter full middle names. Do not use only an initial unless an initial is the person's given middle name. The middle name will be left blank if one does not exist; NMI (no middle initial) or NMN (no middle name) will not be used.
- e. Multiple last name components must be separated by spaces. People with hyphenated names are to be entered with the hyphen included.
- f. When entering a full name, it must contain a comma (i.e., Last Name, First Name). Individuals with a legal name as a single value must be entered with the name followed by a comma.
- g. Suffixes must be used for junior (JR), senior (SR) and birth positions. Numeric birth position identifiers must be entered in Roman numeral values (i.e., I, II, III, etc.). Suffixes must be entered without punctuation.
- h. If entering a Prefix, (such as MR, MRS, MS, and MISS), no punctuation must be used.
- i. The Degree field may be used to denote the degree or profession (such as MD, PHD, REV), and must be entered without punctuation.

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j. Legal Spanish names must be entered with the mother's maiden name first, a hyphen and the father's name all in the LAST NAME field.

k. Alias names must be entered in the ALIAS NAME field for any previously used names (including maiden names). An entry in this field must be automatically cross-referenced and the record can be accessed using the alias name.

l. To enter another entry with the same name as an existing person in the file on VistA, use quotes when entering the full name and a new entry will be created (i.e., "ZZTEST,FIRSTNAME MIDDLE").

m. TEST patient records must be designated by the last name being prefixed by ZZ, i.e. ZZLASTNAME, FIRSTNAME MIDDLE.

n. Official documentation must be required for a name change. Official documentation is defined as court documents or Social Security card. If an individual state's procedures for driver's license application, or similar documents, meet the standard for official documentation, VHA staff should accept such documents as proof of a legal name change.

2. SOCIAL SECURITY NUMBER (SSN): Official SSNs issued by the Social Security Administration are the only values entered into this field. If a valid SSN is not known, then a "P" must be entered into the field for the calculation of a pseudo SSN only for patients. SSNs are not to be created and no other numbers may be entered in this field, including prison-issued numbers or Canadian SSNs. SSNs beginning with five leading zeros are considered TEST patients and are not be used for any other purpose.

3. MOTHER'S MAIDEN NAME: Enter the last name only of individual's mother at the time of her birth. Leave blank if unknown or not provided. Values such as "deceased," "unknown," and other inappropriate responses are not to be used.

4. GENDER: Male or Female must be entered. In case of gender reassignment, legal documentation (amended birth certificate, court documents, etc.) must be required as proof of a legal gender change.

5. DATE OF BIRTH: Day, Month, and Year of Birth must be entered, whenever available. Imprecise (month/year or year only) can be entered, but only if the full Date of Birth is not available.

6. PLACE OF BIRTH [CITY]: Enter the birth city only. For persons born outside of the United States, enter the city, province, or other designated area.

7. PLACE OF BIRTH [STATE]: Enter the birth state only. For persons born outside the United States, choose FOREIGN COUNTRY from the list of state options.

8. PLACE OF BIRTH [COUNTRY] (not yet available): Enter the birth country only (future implementation in VistA). The default country must be the UNITED STATES.

9. MULTIPLE BIRTH INDICATOR (Patients only): Enter YES in the Multiple Birth Indicator field only if the patient is part of a multiple birth (i.e., is a twin, triplet, etc.). This field assists in the unique identification of patients who are part of a multiple birth and may have identity traits similar to other patient entries.

10. DATES OF DEATH (Patients only): Death certificates are generally required to enter a Date of Death. Dates of Death must not be entered from newspaper obituaries, phone calls, or other unofficial sources. Information from these sources may be used as a mechanism to further research the death information. However, they must not be entered unless they have been verified by an official source. Medical facilities are required to use the following as authoritative sources in order of precedence:

a. Veterans Health Administration (VHA) facility is an authoritative source for date of death if the person died in the VHA facility or while under VA auspices.

b. Social Security Administration.

c. Department of Vital Statistics.

d. Death Certificate.

e. National Cemetery Administration (NCA) is an authoritative source for the date of death if the veteran has received NCA benefits.

f. Veterans Benefit Administration (VBA) is an authoritative source if veteran received monetary benefits.

11. MOTHER'S NAME and FATHER'S NAME (patients only): The patient's mother's and father's complete legal names need to be entered in the appropriate fields, when known. Values such as "deceased," "unknown," and other inappropriate responses are not be used.

12. INCAPACITATED OR UNRESPONSIVE PATIENTS (for whatever reason): Records for incapacitated patients must be entered with a pseudo SSN, 1900 for the Date of Birth, and name entered as UU-UNRESPONSIVE, PATIENT. Subsequent patient records must be entered as UU-UNRESPONSIVE,PATIENT A, UU-UNRESPONSIVE,PATIENT B, etc. Records must be completed with appropriate identity data elements once the patient has been identified.

13. TEST PATIENTS: It is essential that TEST patients who exist in local VistA production systems be designated with a SSN containing five leading zeros (i.e., 000001111) and the last name prefixed by ZZ (i.e., ZZTESTPATIENT,FIRSTNAME MIDDLE). Test entries should not be used for categories of persons outside of patients, or for patients that are other than those used exclusively for testing purposes.

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14. RESEARCH PATIENTS: Research patients must have all valid information (i.e., legal name, real SSN, etc.) collected and entered.

15. SSN, DATE OF BIRTH, MOTHER'S MAIDEN NAME, PLACE OF BIRTH [CITY], PLACE OF BIRTH [STATE] and PLACE OF BIRTH [COUNTRY]: The SSN, DATE OF BIRTH, MOTHER'S MAIDEN NAME, PLACE OF BIRTH [CITY], PLACE OF BIRTH [STATE] and PLACE OF BIRTH [COUNTRY] identity data fields important in the unique identification of individuals, since these are fields that do not generally change over time. If these fields are inaccurate or incomplete, it is difficult to ensure that duplicates are not being created and that the record is being linked to the correct Integration Control Number (ICN) on the MPI.

16. PATIENT RECORDS INVOLVED IN IDENTITY THEFT: Records for a patient that is determined to be an "imposter," where staff are unable to obtain the true identity of a patient, need to be edited to reflect the NAME field of THEFT, IDENTITY A (where the trailing letter would be incremented for each subsequent entry that exists in the local VistA PATIENT file). The record needs to be edited to use a pseudo SSN and have the Date of Birth recorded as 1900. Identity theft must be reported through VA Police and Security and the appropriate Regional Counsel. Any electronic documentation that is determined not to belong to the real patient (if identified) must be retracted in the same manner that any document found to be erroneously attributed to a patient is removed.

17. ALIAS FIELDS: The ALIAS fields are only to be used to enter previously-used names and SSNs, or names and SSNs that may be used at other treating facilities; these assist in recognizing potential duplicate entries. Name changes due to marriage, divorce, etc., need to be entered into the ALIAS field as well.

18. MPI EXCEPTIONS IN VISTA: When processing MPI exceptions in VistA, if potential duplicates are identified while matching the individual to the MPI, the record is not to be matched with any of the entries, but a request for assistance with duplicate resolution needs to be sent via an e-mail message to the MPIF EXCEPTIONS mail group on VistA or VHA OI IA MPI DQ TEAM distribution group on Outlook with a password-protected Word document containing sensitive information. A request for national support can also be entered via the OI national problem management system (Remedy). This helps identify potential duplicates and resolve them with as minimal impact to data as possible. When submitting requests for assistance via Remedy, do not include the individual's identifying information (Name, SSN, etc.). The specialist assigned to the request must obtain this information directly from the Point-of-Contact (POC).

19. DUPLICATE PATIENT ENTRIES: To resolve local duplicate patient entries in VistA and to merge the data from one record to the other, use the process outlined in the DUPLICATE RECORD MERGE: Patient Merge User Manual located at the following website:
http://www.va.gov/vdl/VistA_Lib/Infrastructure/Dupl_Rec_Merge/xt_73_p23_um.doc

20. ADDITIONAL INFORMATION: Additional information can be found on the Identity Management Data Quality website at http://vista.med.va.gov/mpi_dqmt/. Extreme caution must be taken when merging duplicate records to ensure the records are for the same individual. Many identity fields for individuals of multiple birth (i.e., twins) will be the same or similar. Once patients are identified as part of a multiple birth, the Multiple Birth Indicator needs to be set to “Yes” on all applicable records. It is essential that appropriate clinical ancillary staff review potential duplicate records, to verify whether or not they should be merged.

21. THE PATIENT DATA REVIEW PROCESS AND LOCAL EXCEPTIONS: The Patient Data Review process and Local Exceptions processing must be performed on a daily basis, to ensure that inconsistencies are addressed in a timely manner. Failure to resolve data quality issues may result in incorrect operation of the Remote Data View-VistA Web and Inter-facility Consults functions for facility clinicians.

a. In addition, various Health_eVet applications require data quality issues to be resolved before implementation can be completed. National reporting of data quality issues may be performed, as necessary, to facilitate timely resolution of such issues.

b. Further information on these functions can be found in the following manuals:

(1) The Exception Handling instruction document can be found at the following website: [http://www.va.gov/vdl/VistA_Lib/Infrastructure/Master_Patient_Index_\(MPI\)/RG1_0_EH.doc](http://www.va.gov/vdl/VistA_Lib/Infrastructure/Master_Patient_Index_(MPI)/RG1_0_EH.doc)

(2) The Patient Data Review Process can be found in Appendix C at the following website: [http://www.va.gov/vdl/VistA_Lib/Infrastructure/Master_Patient_Index_\(MPI\)/RG1_0_UM.doc](http://www.va.gov/vdl/VistA_Lib/Infrastructure/Master_Patient_Index_(MPI)/RG1_0_UM.doc).

c. Additional information regarding the Identity Management Data Quality team and its role, along with a current listing of the national team and the VHA facility Points-of-Contact can be found on the Identity Management Data Quality website at http://vista.med.va.gov/mpi_dqmt/.