**Use this Planning Form inside your organization to provide sponsors, IT, clinical and program staff with an understanding of the purpose of this project and its value to the organization, patients, staff and the community. It addresses various impacts of implementing the use case and includes details about what the use case requires and how it operates at a high level.**

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| Use Case Information  |
| Name (For example, Discharge instructions sent from hospital inpatient unit to skilled-nursing facility prior to patient being admitted to SNF) |  |
| Description Example: When a patient is discharged from the Hospital (sending Organization), clinical data is sent from the Hospital EHR system in an agreed upon format, received by the SNF, combined with existing patient data and made available to staff immediately. If this is a new patient, a new patient record is created. |  |
| Goals The strategic (clinical and business) results the organization wants to achieve. Check all that apply.  | \_\_ Ensure receiving provider/organization has access to patient’s clinical information, including medications, prior to and when they are providing care/services to the patient \_\_ Improve operational efficiency for staff\_\_ Improve patient experience by reducing the need for patient to repeat their medical history\_\_ Reduce adverse events\_\_ Improve the quality of care provided to the patient\_\_ Ensure that the clinical/social information being sent from one organization to the next is accurate and complete\_\_ Ensure that clinical information is sent securely through electronic means\_\_ To satisfy the HIE requirements for ACO membership\_\_ Ensure ACO/CP care plans are being sent in a timely manner for review and sign off\_\_ To meet Meaningful Use requirements, please list:\_\_ Search and Retrieve accessible patients’ medical history recorded by other providers (Query HIE)\_\_ Receive timely secure notifications from hospitals regarding admissions, transfers, and discharges (ENS)\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Primary Objectives Define strategies to attain identified goals above. Include business and clinical objectives. For example: 1. Ensure that staff recognize the efficiencies and improvement in patient care that can be achieved through new technology and workflow.2. Train staff to use updated HIE workflow and ensure this new workflow is adopted consistently among staff.  |  |
| Outcome metrics being tracked (for example, decrease the number of faxes being received from Hospital A from 60 a month to 15 a month within the next 3 months.)  |  |
|  |  |
| Organization Information  | Sending Organization  | Receiving Organization  |
| Name |  |  |
| Organization Type |  |  |
| Executive Sponsor (include contact info.) |  |  |
| Project Lead (include contact info.) |  |  |
| EHR System and product  |  |  |
| HISP  |  |  |
| Can data be exchanged between networks/EHRs now? |  |  |
| Investment requiredWhat additional modules and/or development are required if any? What level of staff training will be required? Consider initial cost and ongoing support. |  |  |
| Project Start Date Kick off meeting  |  |  |
| Proposed Key dates and MilestonesFor example:Sending Organization:1. Required technology in place by 1/31 2. Send test messages to SNF by 2/13. Train hospital staff on new workflow to send messages by 3/314. Send first production message for patient by May 15, 2020Receiving Organization:1. Required technology in place by 1/312. Validate incoming test message from hospital by 2/283. Train SNF staff on new workflow to receive incoming messages/documents by April 30, 2020 |  |  |
| Direct address(es) to be used  |  |  |
| How will Direct addresses be added to the sender’s internal directory? |  |  |
|  |
| Project Team  | Sending Organization | Receiving Organization |
| Sponsor (from sending OR Receiving Organization)  |  |  |
| Project Lead |  |  |
| Clinical/Direct Care/Program Staff RepresentativeA representative from each department involved. Ideally, a technology super-user, or other champion of HIE, but someone who understands the workflow in that dept.  |  |  |
| IT Main contact |  |  |
| IT Support Contact |  |  |
| EHR Vendor Support Contact |  |  |
| Other if not listed above(Staff trainer, workflow champion) |  |  |
|  |  |
| Patient Consent | Sending | Receiving |
| Data sharing Is there a process in place to ensure that patient’s will have signed a consent to share their clinical information for treatment purposes through a Consent to Treat or Notice of Privacy Practices form? |  |  |
| 42 CFR Part 2If behavioral health (BH) or substance use disorder (SUD) information is going to be exchanged, is there a process in place to ensure that the patient has signed a general designation to share their BH/SUD information (part of updated 42 CFR Part 2 Rule)?  |  |  |
|  |  |
| Data Requirements (see Recommended Clinical Documents for receiving organizations below for additional information)  | Sending | Receiving |
| C-CDA document templates or other document types supported in EHR or HIE environment (e.g. PDF, Word, Excel, JPEG) C-CDA document template types:Available in C-CDA R1.0/R1.1:Continuity of Care Document (CCD)Discharge SummaryHistory and Physical (H&P)Consultation NoteDiagnostic Imaging Report (DIR)Operative NoteProcedure NoteProgress NoteUnstructured DocumentAdditional Document Types available in C-CDA R2.0:Care PlanReferral NoteTransfer Summary |  |  |
| C-CDA document template or other document type required for use case |  |  |
| What kind of information/document will be sent as part of this use case? For example:1. Continuity of Care document (CCD)2. Care Plan3. Discharge Instructions 4. BH Comprehensive assessments5. MOLST |  |  |
| When will document be sent (after patient encounter, in hourly or daily batch)?  |  |  |

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| Basic Flow |
| High level overview of the steps required to exchange data.For example:1. Sender at ED updates patient record and discharges patient to SNF
2. Sender EHR creates CCD and sends via Direct to Direct address for admissions @ direct.SNF.org
3. SNF validates incoming data. The message is rejected if a new patient.
4. If this is a new patient, a new record is created, otherwise the relevant patient medical record is updated.
 |  |
|  |
| Other | Sending | Receiving |
| Barriers/Challenges:List issues that could have a major impact on the proposed timeline of this project. For example: major infrastructure investment required, vendors do not support the plan, existing policies and procedures must change |  |  |
| Does the primary organization plan to extend this project to other trading partners? |  |  |

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| Query HIE | Sending | Receiving |
| Query HIE NetworkHas the organization joined a Query HIE network (Commonwell, Carequality)? If not, do they plan to join a Query HIE network, if so, which one? |  |  |
| Patient ConsentHow will the organization track patient consent? |  |  |
| WorkflowHow will the organization incorporate Query HIE in to everyday workflow(s)?* Staff involved?
* Timing of query
 |  |  |
| Patient Information sharingWill the organization make their records accessible to other organizations via Query HIE? |  |  |

|  |  |  |
| --- | --- | --- |
| Event Notification Services (ENS) | Sending | Receiving |
| ENS vendor(s)Which vendor or vendors is the organization using? |  |  |
| What Acute Care Hospitals would the organization like to receive notifications from, and which organizations would the ACH like to send to?  |  |  |
| Patient RostersIs this only for ACO patients (either Medicare or Medicaid)? |  |  |
| Patient Matching: workflow(s) to ensure that all patients coming in for visits have all demographics updated |  |  |
| Workflow(s) once ADTs received at organization, what are next steps? * Which staff is responsible for responding to ADTs?
* What is the timeline for follow up and the required actions to address patient needs?
 |  |  |

**Appendix**

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| Recommended clinical documents, document templates and components for receiving organizations |
| Sending Organization Type | Receiving Organization Type(s) | Recommended clinical document templates and components for receiving organizations |
| Hospital (inpatient unit) | Skilled Nursing Facility/Home Care/Long Term Services and Supports (LTSS) | * Discharge Summary
* Medication List
* Lab Results
* Diagnosis
* Discharge Instructions (if Discharge Summary is not available at time of discharge)
 |
| Emergency Department | Primary Care/Community Health Center | * Discharge Summary
* Medication list
* Discharge Instructions (if Discharge Summary is not available)
 |
| Emergency Department | Behavioral Health Organization/Community Health Center | * Discharge Summary
* Medication list
* Discharge Instructions (if Discharge Summary is not available)
* BH Comprehensive Assessment
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