P2 FHIR Task Force

Use Case – Patient Information Request, Plan Requesting to Provider

Version 1.07

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Revision History

Version	Date	Author	Description of change
1.00	8/22/2018	Nancy Beavin/Ranjan Saxena	Initial Version in Word Template Review and changes including removing 25 million from frequency. That will be TBD.
1.01	08/29/2018	Ranjan Saxena	08/23 Tiger Team weekly meeting feedback based changes Replaced 'ONC' with Federal and State Govt. Added language for active vs long-term/future stakeholders.
1.02	09/04/2018	Ranjan Saxena	08/30 Tiger Team weekly meeting feedback based changes - Added Table of Contents - Added/Changed language. Some examples below ❖ Changed enable optimization to 'improving provider outcomes and provide value based care' ❖ Changed clinical referral to clinical event to make it more generic. ❖ Removed 'To do - Get consensus on the format and level of granularity - Changed flow diagrams accordingly - Formatting and indentation 09/04 – Changes suggested by Christol Green & Jackie Hardison - Language changes - Formatting
1.03	09/6/2018	Nancy Beavin	9/6 Tiger Team weekly meeting feedback - Added assumption on Minimum necessary - Moved In Scope bullets to Assumptions - Moved requirements to In Scope - Added Minimum Necessary as a reason for requesting a record in scenario 1 and moved Scenario 2
1.04	09/7/2018	Nancy Beavin	Update to Main Success Scenario to be consistent across use cases. Update to TOC for page numbers
1.05	09/13/2018	Nancy Beavin	Update to Stakeholders, Main Requirements, and removing Scenario 2 per Core team feedback
1.06	09/24/2018	Ranjan Saxena	Added definition for public health agencies as stakeholder per discussion in weekly meetings and definition provided by Chris J.
1.07	09/24/2018	Jackie Hardison	Format changes

Use Case: Patient Information Request, Plan Requesting to Provider

ID: UC – P2_1c

Introduction & Background

The purpose of the P2 FHIR Task Force is to augment and support recent FHIR efforts focused on ecosystem issues that, if mitigated, can accelerate adoption. One of the focus areas identified is the ability for providers to request patient information from plans.

P2 Model

Accelerate use of FHIR

Identify	**Why**	**How**
Barriers to adoption and opportunities for synergy: • endpoint services • Security Approaches • Identity Resolution • Testing Approaches	Removing barriers and aligning consensus based adoption via the network effect accelerates adoption.	• Tiger teams • Best practices • Leverage existing resources

The P2 use case model is somewhat unique in that it describes ecosystem needs as opposed to specific functional needs. Use cases for P2 are derived in one of 3 approaches as described in the graphic below.

Use Case Approaches

Use cases approaches can be used exclusively or in combination to define the dimensions of the model.

Barrier UC	**Generic UC**	✓ **Da Vinci UC Base**
Align use cases directly to an identified barrier such as resource locator, security, and identity.	Instead of aligning directly to a barrier, use generic ecosystem use cases which identify and spotlight barriers.	Use Da Vinci uses cases a foundation for P2. P2 provides the highway, Da Vinci provides the cars, trucks, and busses. Use the vehicles to help define the dimensions of the highway.

This use case focuses on the ability for provider to request information from health plans at scale. The focus is not on the clinical functionality of the use case but instead in ensuring that the ecosystem supports an efficient and scalable model.

Overview & Description

This use case focuses on the ability for payers to be able to request and retrieve information from providers for the purposes of clinical and/or administrative optimization. As noted previously, focus is not on the clinical or administrative functionality (which is covered under other use cases such as those in the Da Vinci initiative), but is instead on the ecosystem which support those specific functional use cases.

Variations and Extensions Overview & Description

This use case focuses on ecosystem functionality supporting plan to request for patient information. Variations in the primary use case help to illustrate and define the desired functionality and include the following scenarios:

In Scope

1) Full medical record for any encounter when member is covered under payer's plan
2) Additional clinical information including history on medical conditions and lab results
3) Decomposed data from all sections of medical record or from specific sections
4) Any medical Information needed for patient by plan

Out of Scope

1) Any HIPAA defined functional transactions

Assumptions

1) Other initiatives, such as Da Vinci, are covering the clinical or administrative functional use cases
2) The primary goal of the use case is to describe ecosystem needs to support the functional use cases
3) Transactions will explicitly be declared as synchronous or asynchronous
4) Minimum Necessary requirements will be addressed by core capability use cases, CC2
5) Endpoint discovery, Security, Versioning and Patient Provider Identification are out of scope for this document

Primary Actors

1) Payer/Plan
2) Treating clinician or organization
3) Support staff working on behalf of treating clinician or organization

Supporting Actors

1) Payer systems
2) Patient/Member
3) E H R
4) Endpoint resolution capability

Stakeholders and Interests

1) Payer/plan – As an active stakeholder has interest in receiving timely, actionable, accurate patient/member information to enable better care outcomes and participation in value based care arrangements.
2) Provider – As an active stakeholder has interest in providing timely, actionable, accurate patient information to improve patient outcomes and provide value based care.
3) Patient – As an active stakeholder has interest in receiving optimized care and relies on the timely, actionable, and accurate exchange of information.
4) Caregiver (Typically a family member) – As an active stakeholder has interest in the patient receiving optimized care and relies on the timely, actionable, and accurate exchange of information,
5) Federal and State Govt. – As a stakeholder, in long term has interest to ensure that the exchange models are highly scalable and meet ecosystem needs to help enable interoperability and efficient data exchange for better outcomes for all stakeholders.
6) CMS – As an active stakeholder has interest in Medicare/Medicaid patients benefitting from the timely, actionable, and accurate exchange of information
7) E H R – As a stakeholder in long term, has interest to ensure that solutions work well in their systems and the healthcare network.
8) Standards Organization - As a stakeholder, in long term has interest to ensure that the exchange models are highly scalable and efficient.
9) Public Health Entities: As a stakeholder, in long term have interest in patients benefitting from timely, actionable, and accurate exchange of information that prevent diseases, prolong life and promote the human health of a community or society.

Pre-Conditions

1) The process is triggered by the Payer's systems.
2) The payer system has adequate information about the treating provider or provider group, to determine requesting endpoint.
3) The E H R or other clinical system has adopted the FHIR model, including those arising from the P2 initiative
4) The payer/plan has adopted the FHIR model, including those arising from the P2 initiative

Post Conditions

1) Payer has received the requested information or specific information otherwise
2) The information was received in a manner timely enough to be effective and as to not impact workflow
3) The information is understandable by the payer's clinical and support staff, or the machine
4) The transaction did not cause undue burden in terms of wait time or unusable message
5) In the event of an error, the information returned does not leave the clinician, support staff, or system in a state not knowing the path forward

Failure end condition

The post conditions defined above are not met.

Trigger

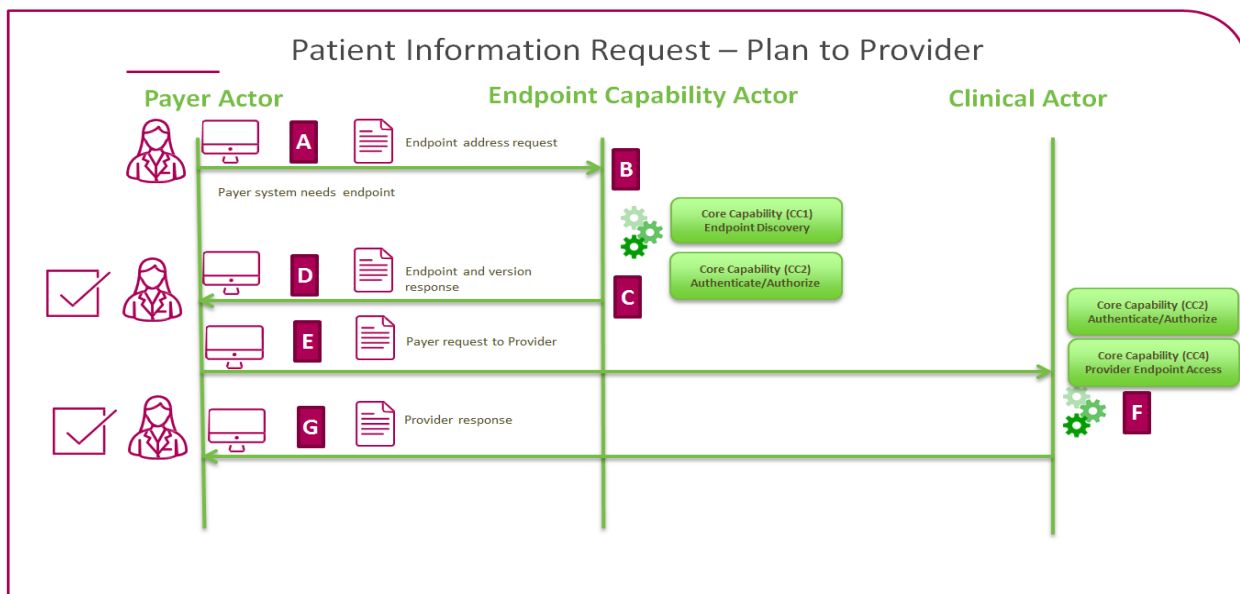The process is triggered by the Payer's systems

Requirements & Main Success Scenario

Primary Feature: As a payer/plan, I need to be able to access patient's (member) information to improve outcomes, to promote value based care and to optimize clinical and administrative workflow.

1) As a payer, I need my system to be able to securely determine the endpoint and version of a provider's resource. Please see core capability 1 (CC1) and core capability 2 (CC2). **(A:B:C:D referencing CC1 and CC2)**

2) As a payer, I need to send the appropriate payload to the provider for processing. See core capability 4 (CC4). **(E:F referencing CC4)**

3) As a payer, I need my system to be able to send the request for data to the provider's endpoint in a trusted and secure way and to ensure proper authentication and authorization. **(E:F:G referencing CC2)**

4) As a payer, I need some interactions to be synchronous and some to be asynchronous, but not necessarily both. If asynchronous, the request and response will be FHIR bulk data access compliant. **(E:F:G referencing CC4)**

5) As a payer, I need the provider's system to respond in an agreed upon time frame. **(F:G referencing CC4)**

6) As a payer, in the case of an error on the part of the mechanism or provider, I need a meaningful and useful response. **(F:G referencing CC4)**

Supporting Diagrams & Flows
<Actor's actions, relationships, & flows, sequence diagram, activity diagram in swim lanes, alternate flows>


Patient Information Request – Plan to Provider

Extensions & Variations, UC-P2_1c.1– Medical Record / Clinical Data

Primary Feature: As a payer, I need my systems to determine when a single Medical Record or piece of Clinical data is required for payer processes including Quality, Claims, Risk Adjustment, Medical Necessity, etc. The request will define the medical record, attached document, or specific data element of the medical record from the respective providers EHR to send to payer systems.

The flow for this scenario is exactly the same as the main flow but does include that the response back from the providers system or E H R and the response can be a CARDS, text (e.g. reminder) or message (e.g. request to submit a prior authorization), a FHIR structured resource, FHIR binary resource, FHIR based record locations e.g. links for docs, plugins etc.).
This scenario can operate synchronously or asynchronously depending upon need.
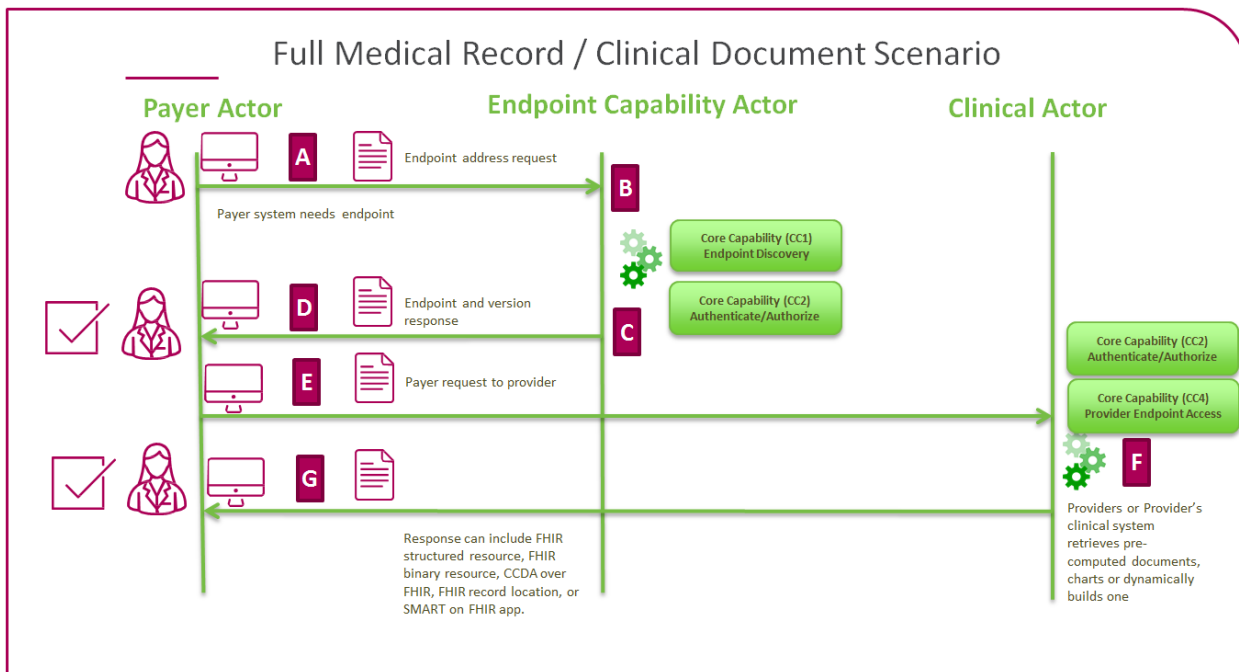
Extensions & Variations, UC-P2_1c.2 – Bulk Data (Medical /Clinical records or specific data elements needed for multiple members & multiple encounters)

Primary Feature: As a payer, I need my systems to understand when medical records or clinical data is needed for multiple patient/members from a provider/provider group.   The identification should trigger a request or provide an option for the system to request the medical record or clinical data so the information can be retrieved at the appropriate time.

The flow for this scenario is exactly the same as the main flow but does include that the response back from the payer can be CCDA over FHIR, FHIR structured document, a FHIR binary resource, FHIR based record locations e.g. links for docs, plugins or a SMART on FHIR App. The content of the deliverable can be specific section of data such as medications, labs, gaps in care, and etc. or a medical record.

Bulk Data Export
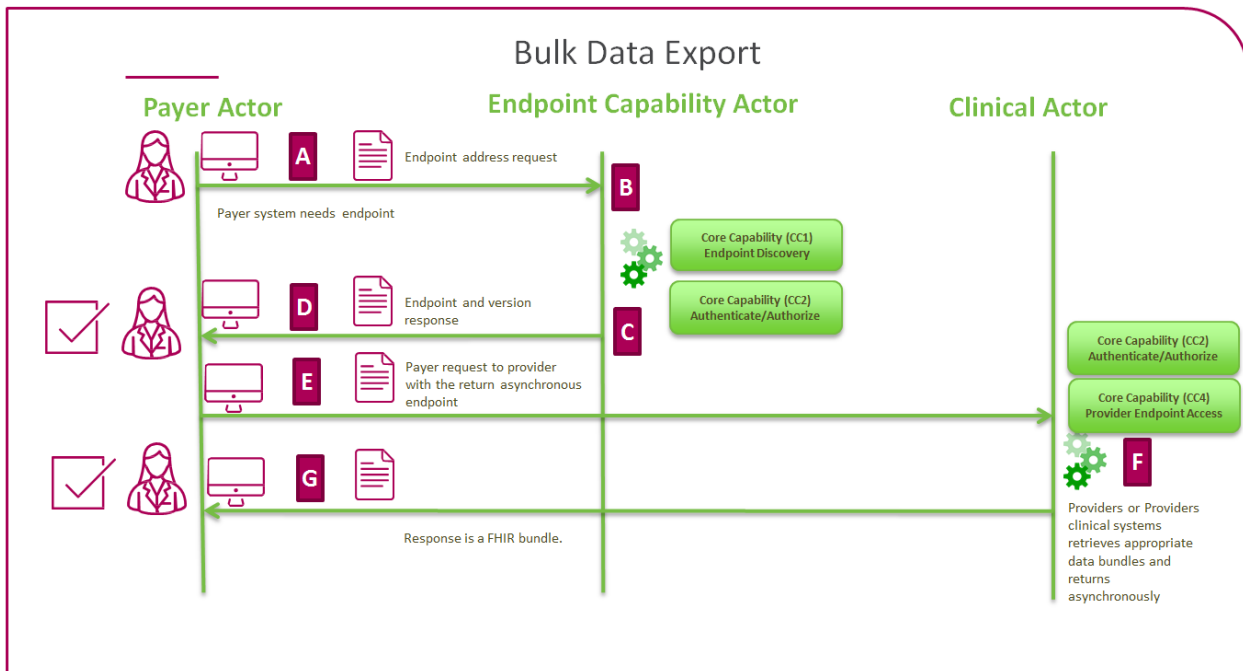
Frequency: TBD

Special Requirements & Considerations

Issues

P2 Use Case Template