

# P2 FHIR Task Force

## Use Case – Patient Information Request, Provider Request to Plan

Version 1.11

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## Revision History

Version	Date	Author	Description of change
1.00	8/16/2018	Patrick Murta	Initial Version in Word Template
1.01	8/19/2018	Patrick Murta	Additional Detail Added
1.02	8/22/2018	Patrick Murta	Additional clarifications based upon feedback
1.03	8/22/2018	Patrick Murta	Updated diagrams to show Core Capabilities (CC1 & CC2)
1.04	08/22/2018	Patrick Murta	Abstracted Core Capabilities CC1 and CC2
1.05	8/24/18	Nancy Beavin/Ranjan Saxena	Additional clarifications
1.06	08/29/2018	Ranjan Saxena	08/23 Tiger Team weekly meeting feedback based changes <ul style="list-style-type: none"> <li>• Replaced 'ONC' with Federal and State Govt.</li> <li>• Added language for active vs long-term/future stakeholders.</li> </ul>
1.07	08/31/2018	Ranjan Saxena	08/30 Tiger Team weekly meeting feedback based changes <ul style="list-style-type: none"> <li>• Added Table of Contents</li> <li>• Added/Changed language. Some examples below <ul style="list-style-type: none"> <li>❖ Changed enable optimization to 'improving provider outcomes and provide value based care'</li> <li>❖ Changed clinical referral to clinical event to make it more generic.</li> <li>❖ Removed 'To do – Get consensus on the format and level of granularity</li> </ul> </li> <li>• Changed flow diagrams accordingly</li> <li>• Formatting and indentation</li> </ul>
1.08	09/04/2018	Ranjan Saxena	Below changes suggested by Cristol Green. <ul style="list-style-type: none"> <li>• Language changes</li> <li>• Added 'Medicaid' for CMS interest.</li> </ul> Changes suggested by Jackie Hardison <ul style="list-style-type: none"> <li>• Language changes</li> <li>• Color scheme and formatting</li> </ul>
1.09	09/13/2018	Nancy Beavin	Format changes for consistency between UC documents
1.10	09/20/2018	Ranjan Saxena	Language changes around 'Prior Authorization' example under Coverage Requirement Discovery scenario.
1.11	09/24/2018	Ranjan Saxena	Added definition for public health agencies as stakeholder per discussion in weekly meetings and definition provided by Chris J.

## Introduction & Background

**Use Case:** Patient Information Request, Provider Request to Plan

**ID:** UC – P2\_1b

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

Barriers to adoption and opportunities for synergy:

- endpoint services
- Security Approaches
- Identity Resolution
- Testing Approaches

#### Why

Removing barriers and aligning consensus based adoption via the network effect accelerates adoption.

#### How

- Tiger teams
- Best practices
- Leverage existing resources

The P2 use case model is 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

Align use cases directly to an identified barrier such as resource locator, security, and identity.

#### Generic UC

Instead of aligning directly to a barrier, use generic ecosystem use cases which identify and spotlight barriers.

#### Da Vinci UC Base

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 or administrative 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 providers to request and retrieve information from plans 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 provider to plan requests 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) Coverage requirements discovery
- 2) Full plan clinical record
- 3) Decomposed section of a plan clinical record
- 4) Patient attribution/roster request
- 5) Bulk data transfer of claims based upon provider roster

### 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) Treating clinician or organization
- 2) Support staff working on behalf of treating clinician or organization
- 3) Payer/plan

### Supporting Actors

- 1) Patient/Member
- 2) E H R
- 3) Payer systems
- 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 clinician, supporting staff, or E H R on behalf of the clinician
- 2) The provider system has the patient's plan and identifier information prior to this execution of the use case
- 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 the adopted the FHIR model, including those arising from the P2 initiative

## Post Conditions

- 1) Provider has received the requested information or specific information otherwise from plan.
- 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 clinical, 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 clinician, supporting staff, or E H R on behalf of the clinician

## Requirements & Main Success Scenario

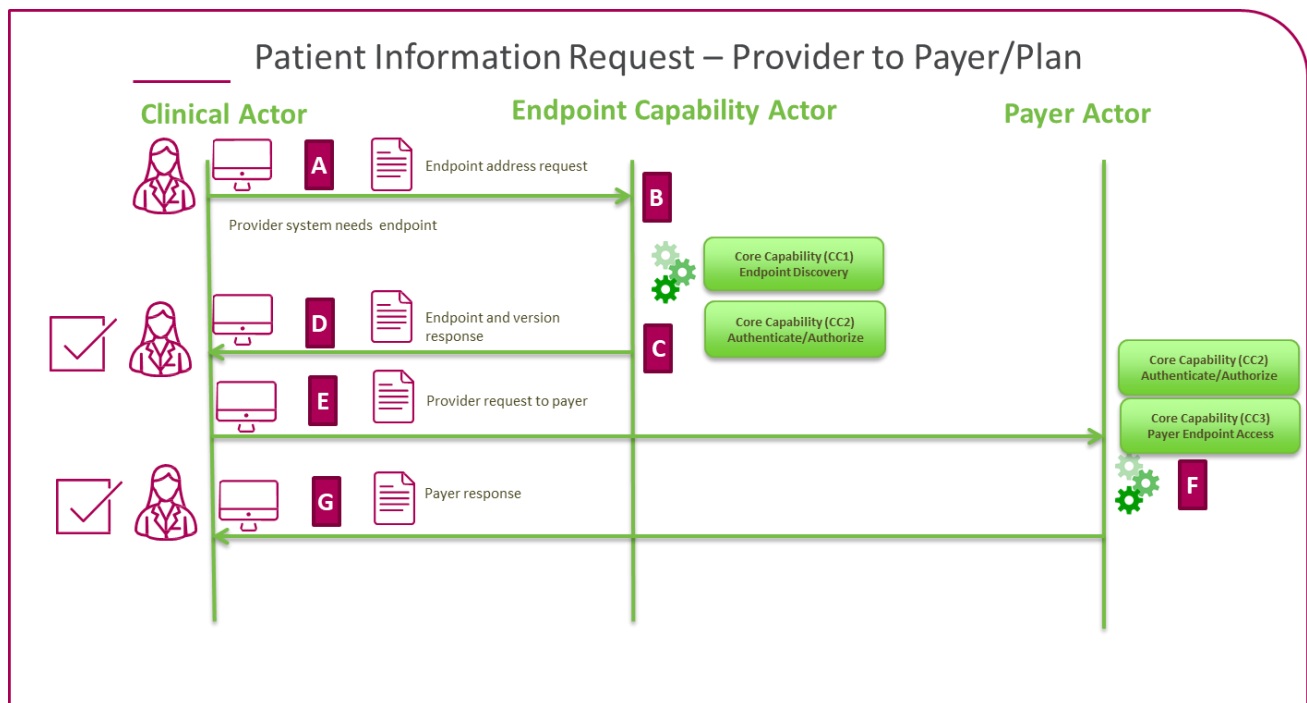
Primary Feature: As a provider, I need to be able to access payer/plan information to improve outcomes and provide value based care to patients and to optimize clinical and administrative workflow.

Please note that core capabilities are defined in separate documents and referenced from here. Please see those documents for full details of the core capabilities.

- 1) As a provider, I need my system to be able to securely determine the endpoint and version of a payer's resource. Please see core capability 1 (CC1) and core capability 2 (CC2). **(A:B:C:D referencing CC1 and CC2)**
- 2) As a provider, I need to send the appropriate payload to the payer for processing. See core capability 3 (CC3). **(E:F referencing CC2)**
- 3) As a provider, I need my system to be able to send the request for data to the payer's endpoint in a trusted and secure way and to ensure proper authentication and authorization. **(E:F:G referencing CC2)**
- 4) As a provider, 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 CC3)**
- 5) As a provider, I need the payer's system to respond in an agreed upon time frame. **(F:G referencing CC3)**
- 6) As a provider, in the case of an error on the part of the mechanism or payer, I need a meaningful and useful response. **(F:G referencing CC3)**

### Supporting Diagrams & Flows

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

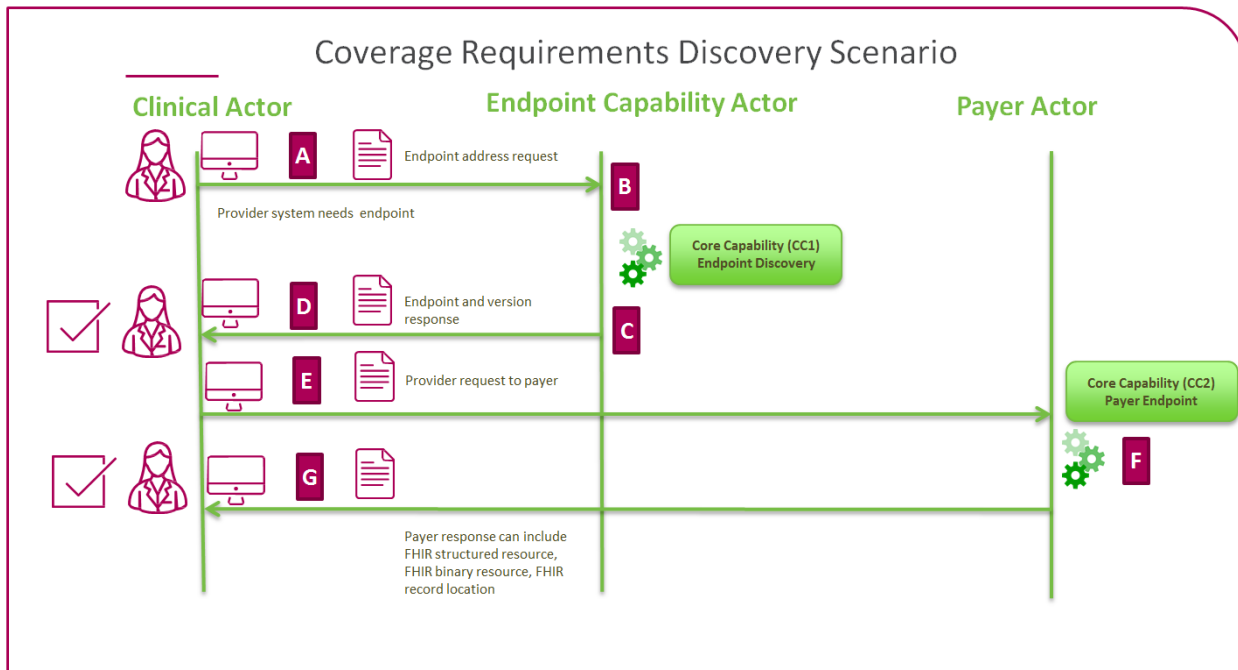


# Extensions & Variations, Scenario 1 - Coverage Requirement Discovery

## Flow

Primary Feature: As a provider, I need my clinical workflow system to understand that when a clinical event is underway, it should request coverage information from the respective payer to determine if a payer specific requirement applies to the respective clinical event.

The flow for this scenario is the same as the main flow but does include that the response back from the payer and can be CARDS, text (e.g. reminder) or message (e.g. determine need for prior authorization), a FHIR structured resource, FHIR binary resource, FHIR based record locations e.g. links for docs, plugins etc.). This scenario can operate only synchronously.



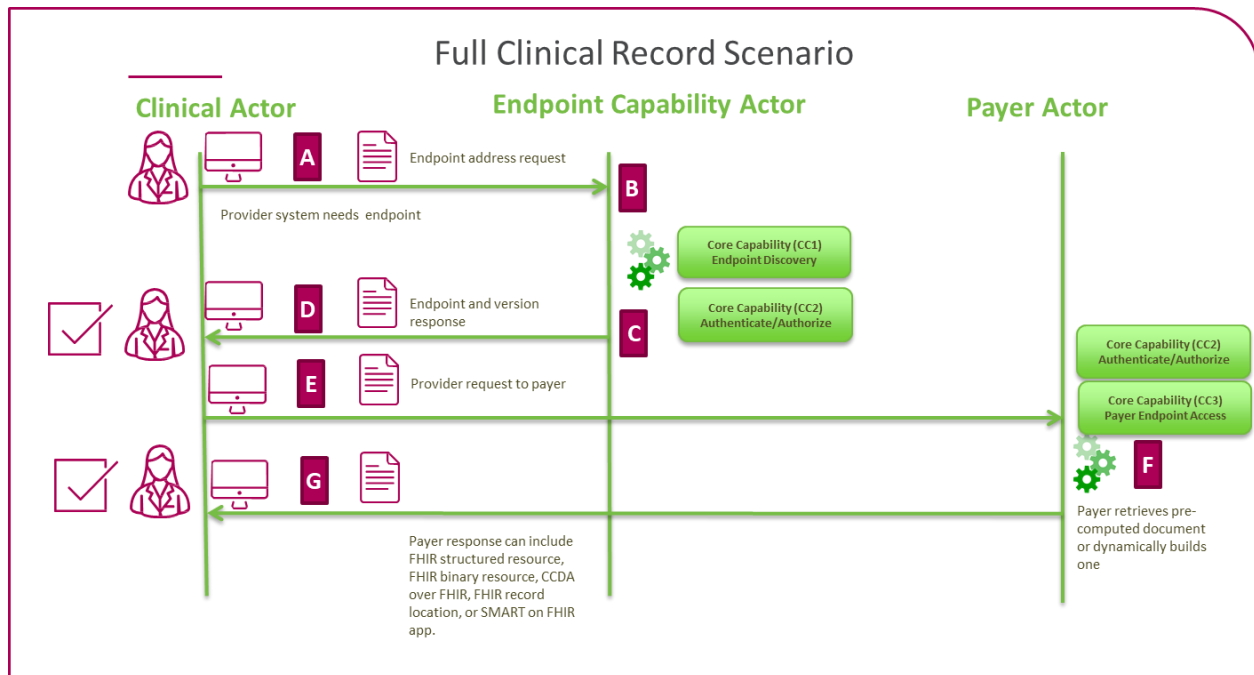
## Extensions & Variations, Scenario 2 – Full Clinical Record

### Flow

Primary Feature: As a provider, I need my clinical workflow system to understand that a clinical document may be available for a patient from a payer and that it should be automatically requested or provide an option for the clinician to manually request it so the information can be retrieved at the appropriate time in workflow.

The flow for this scenario is 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, or a SMART on FHIR App. The content of the deliverable is a full payer summary.

This scenario can operate synchronously or asynchronously.



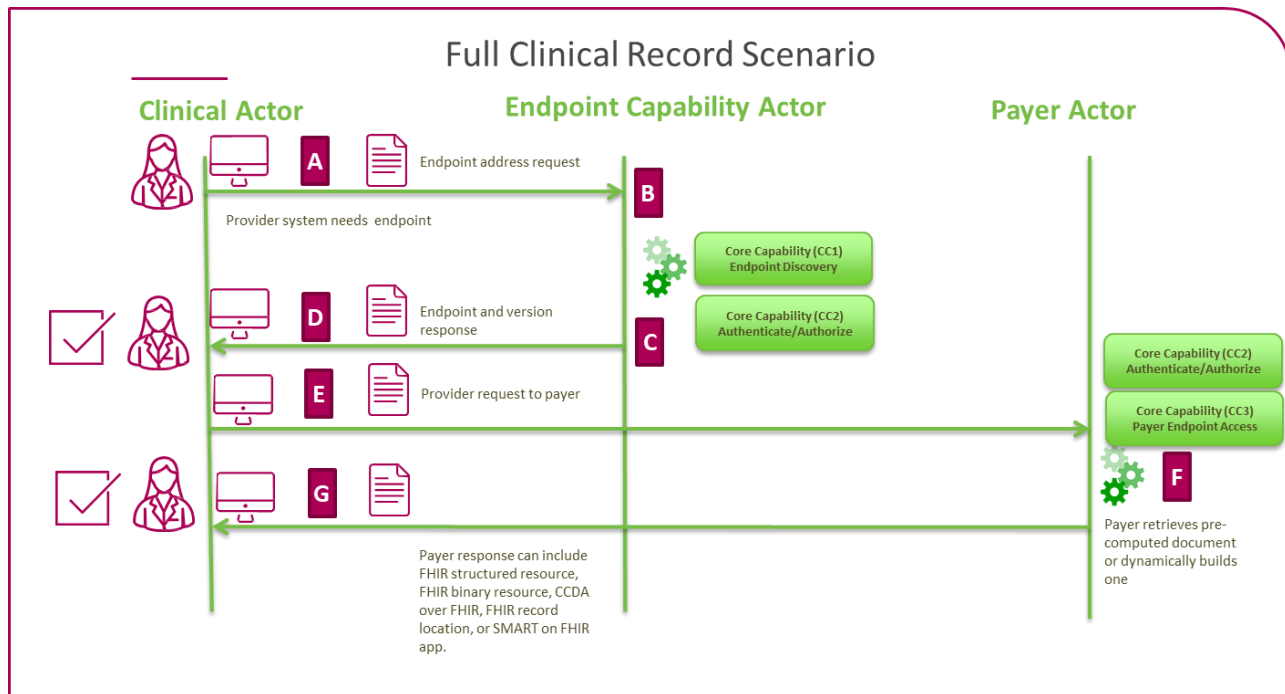


## Extensions & Variations, Scenario 3 – Specific Clinical Record Section

### Flow

Primary Feature: As a provider, I need my clinical workflow system to identify that a clinical document may be available for a patient from a payer and that it should be automatically requested, or provide an option for the clinician to manually request it, so the information can be retrieved at the appropriate time in workflow.

The flow for this scenario is 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, or a SMART on FHIR App. The content of the deliverable is a specific section of data such as medications, labs, gaps in care, and etc.

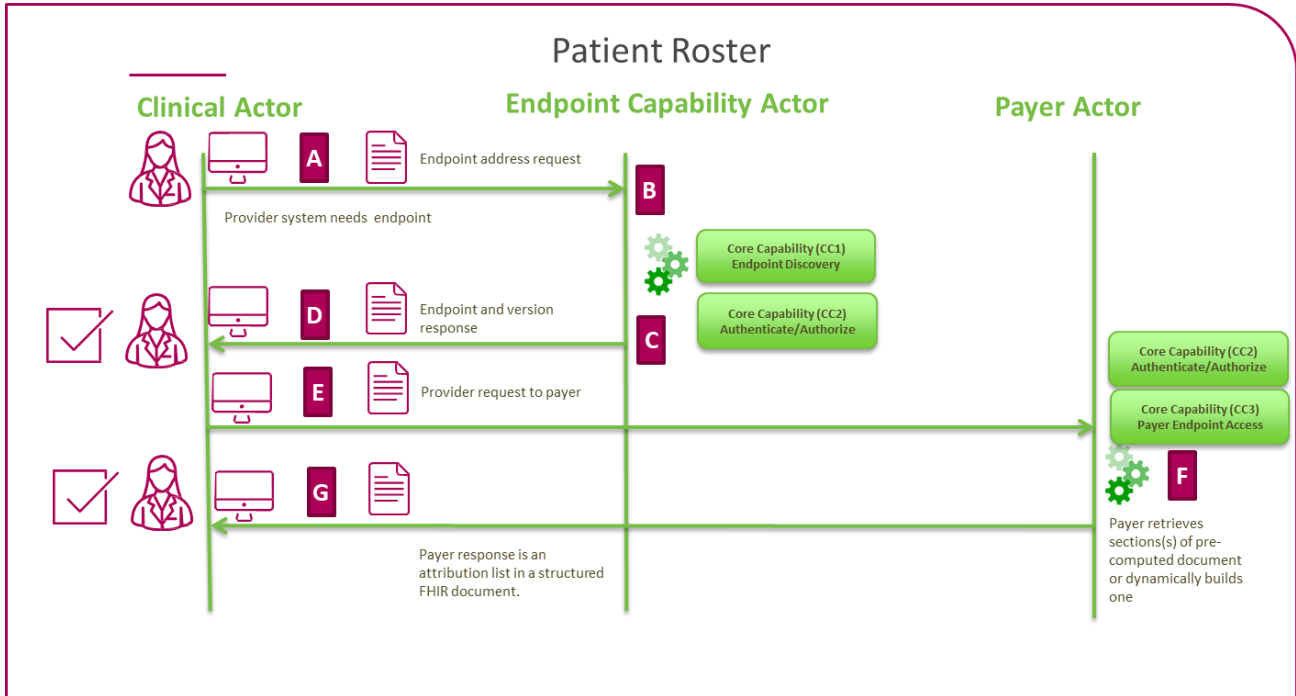


## Extensions & Variations, Scenario 4 – Attributed Roster Request

### Flow

Primary Feature: As a provider, I need my clinical system to be able to request an attributed patient roster so that I can better understand who the payer considers to be my panel. This helps in the value based care arrangements.

The flow for this scenario is the same as the main flow but does include that the response back from the payer is a FHIR structured document. The content of the deliverable is a payer created list of attributed members/patients to a clinical entity.

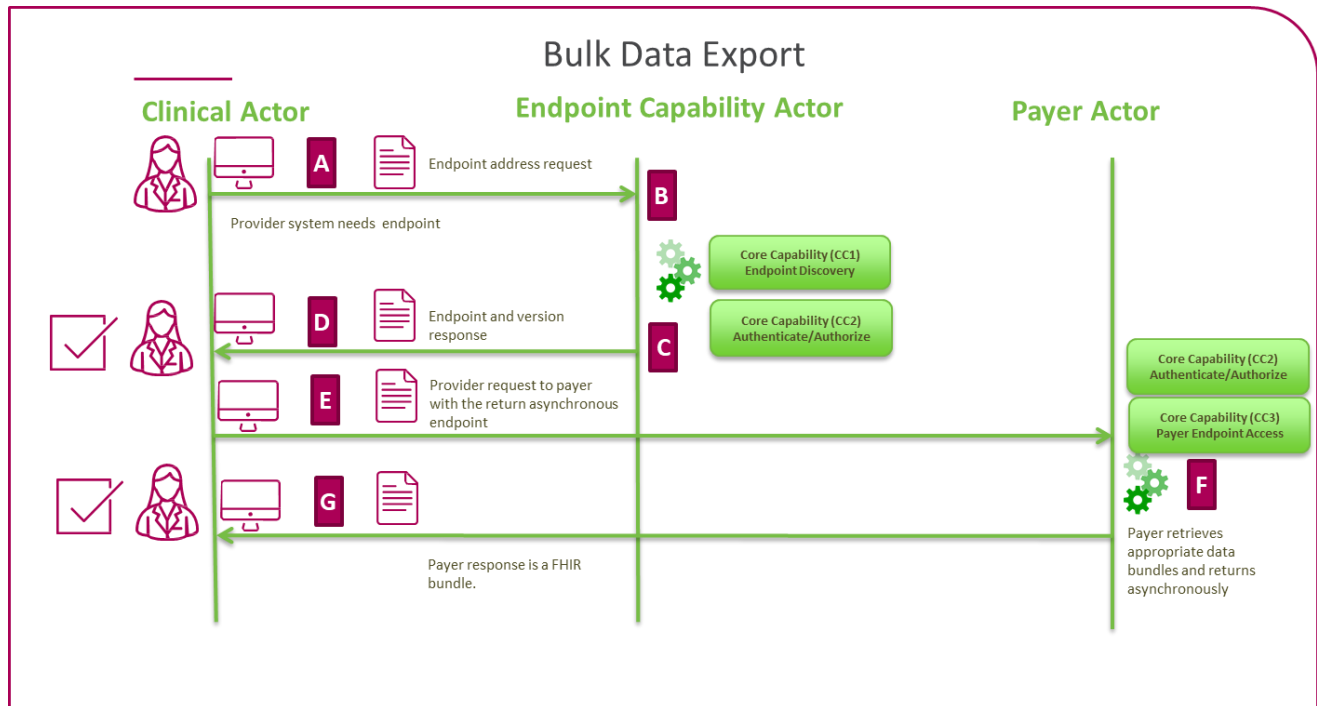


## Extensions & Variations, Scenario 5 – Bulk Data Claims

### Flow

Primary Feature: As a provider, I need my clinical system to be able to request claims information for my panel.

1. The flow for this scenario is the same as the main flow but does include that the response back from the payer is an asynchronous FHIR structured document bundle including resources such as claim, coverage, and patient.
2. The operation will follow the FHIR Bulk Data Access model and specifically the roster/claims interaction model.



## Special Requirements & Considerations

### Issues

Frequency: 25 Million per Day