



NHIN Trial Implementations

Emergency Responder Use Case Requirements Document

Use Case Title: Emergency Responder Use Case

Workgroup: Provider Use Case WorkGroup

Version: Version 1.0, April 30, 2008

Description:

- The requirement for the Emergency Responder Use Case will be written for the demonstration such that patient information can be requested related to 911 Dispatch, Authentication and Authorization, On-site Care, Emergency Care, Definitive Care, and reporting to a public health entity. PHI, which will include patient demographics, Allergies, Medications, Labs, and any ADT information being gathered from the LCF HIE participants, will be made available for the demonstration. This will allow the other 8 NHIN HIE participants to access this patient information through their software applications being developed. In addition, situational awareness will be addressed by providing data to the New Mexico Department of Health services through an HL7 interface.

Priority Information Exchanges:

Emergency Responder EHR Use Case Priority Information Exchanges as requested by ONC

Page 16, Scenario 1: Emergency response Summary Data Flow Diagram

Priority Info Exchanges	Use Case Description
Information Exchange II	Health Information system shares patient information necessary for patient care
Information Exchange V	Care providers share information about patient(s) disposition, condition and location

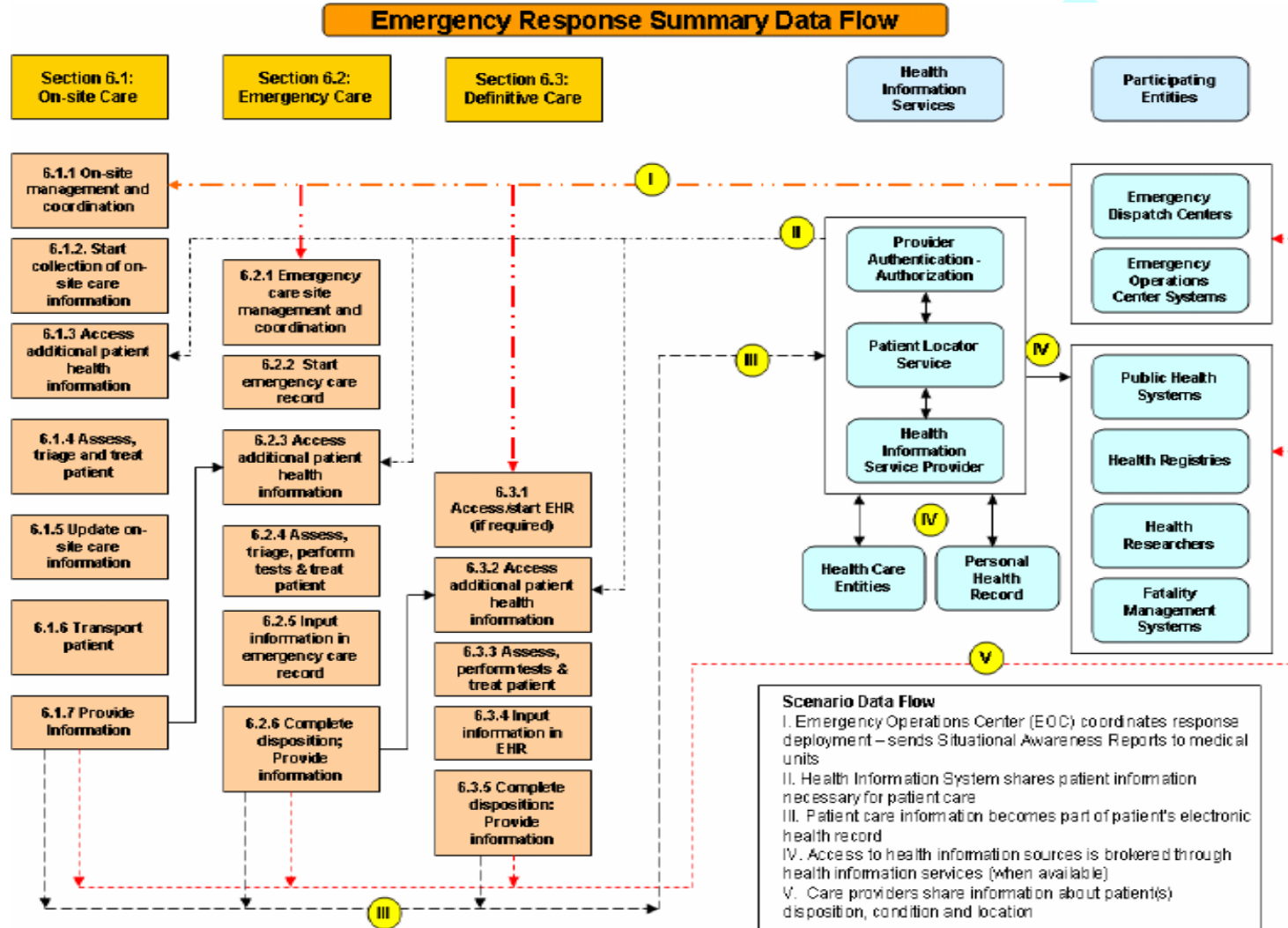
Page 30, scenario 2: Emergency responder Provider Authentication and Authorization

Priority Info Exchange	Use Case Description
Information Exchange V	Incident control Personnel at the scene request confirmation of the medical credentials for an on-site or emergency care provider; Emergency dispatch or EOC systems provide confirmation of medical credentials, either from their own information sources, or via a query to the Health Information Service



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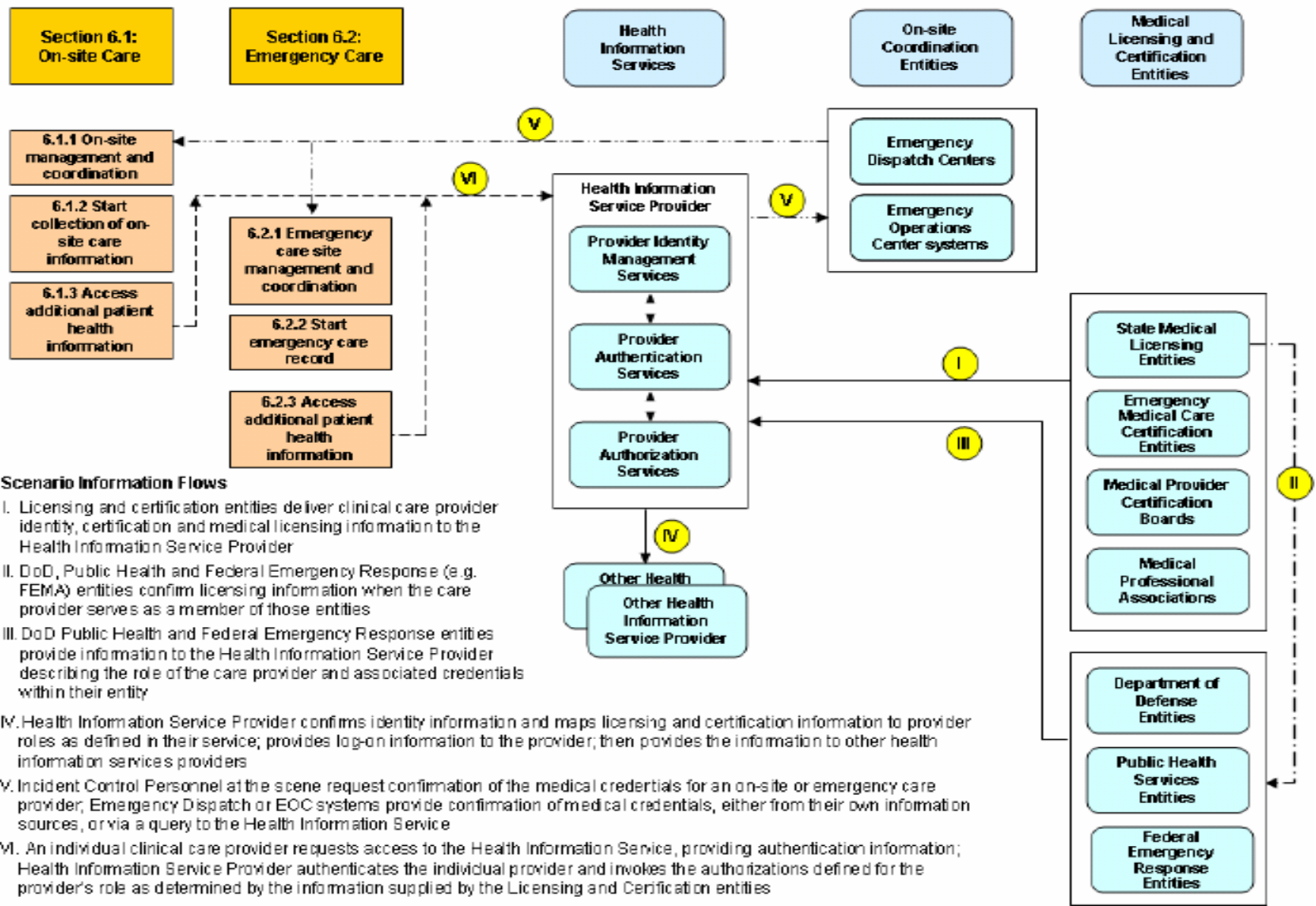




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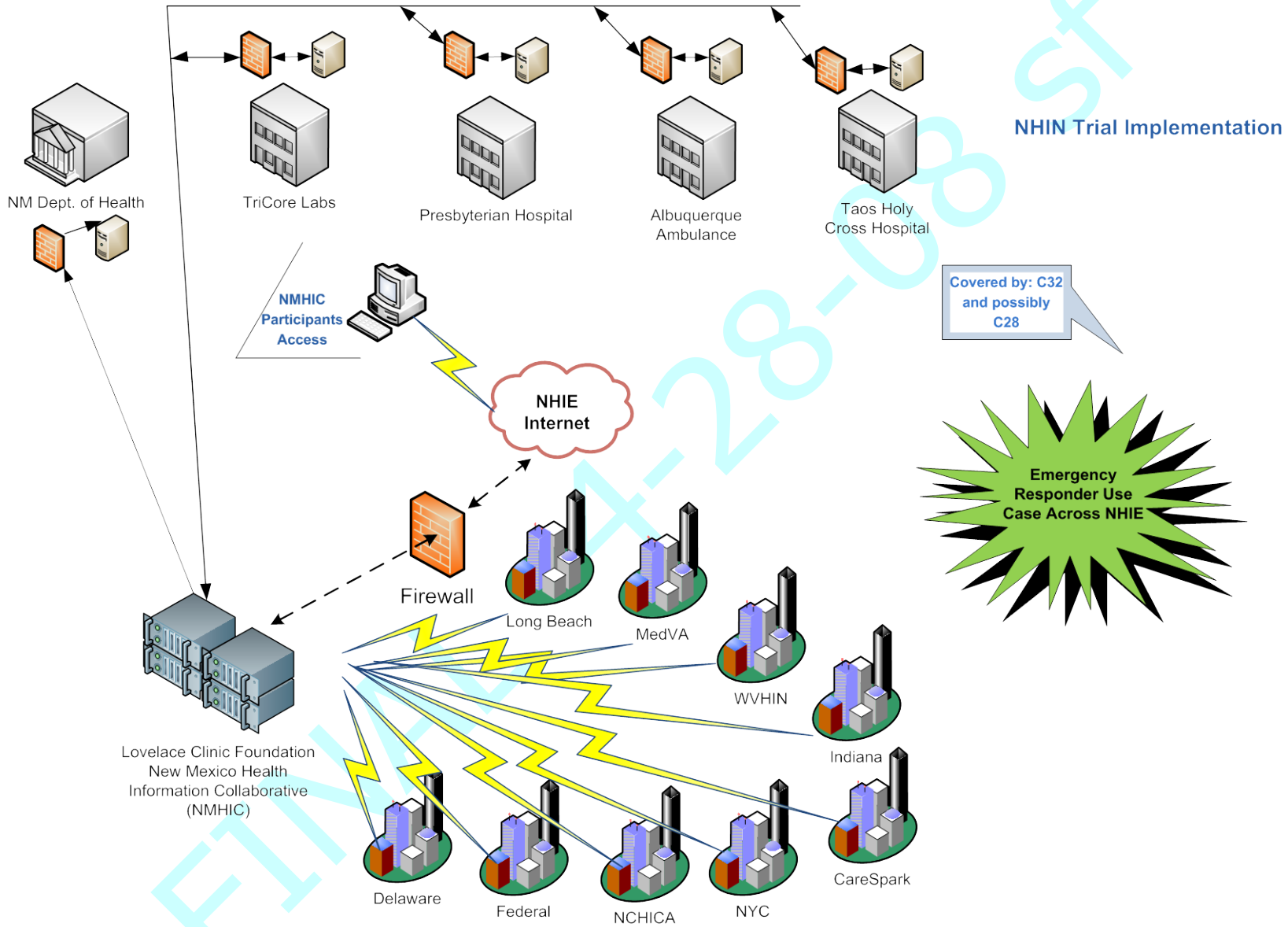
Emergency Responder Provider Authentication and Authorization





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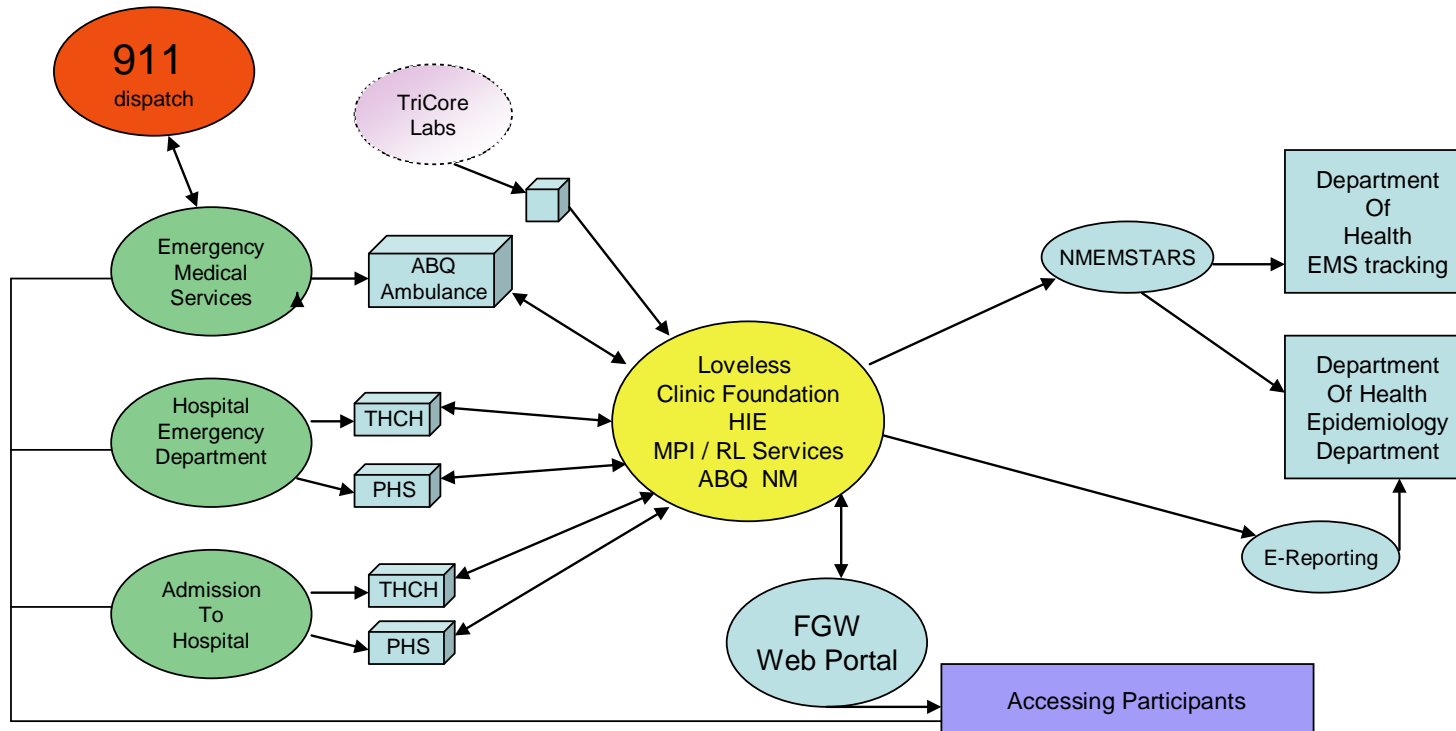
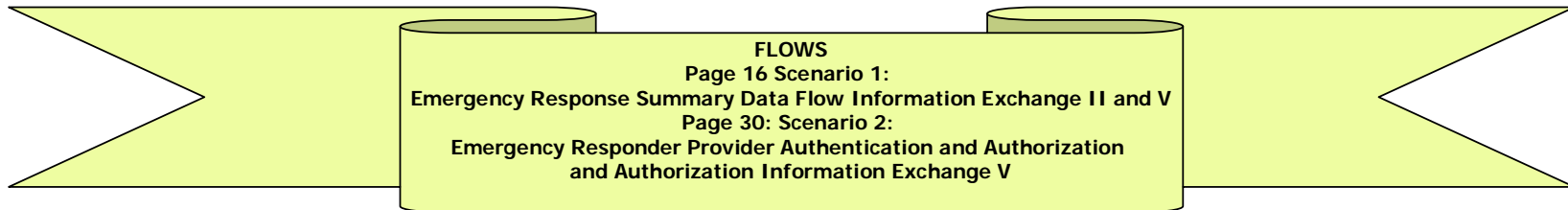
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 = Edge Server on Site

Initial NMHC Design for the NHIN Trail Implementation Project



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AHIC recommendation for an ER-EHR:

The second source was comments received on the ER-EHR Use Case Synopsis. This listing is not to be treated as all-inclusive; rather, it is illustrative of the types of data elements various stakeholder groups felt were important.

The use case recognizes that there may be some differences as well as similarities in the information being collected during on-site care as compared to emergency care. In some instances, information collected during on-site activities will also be confirmed in emergency care (e.g. medication history). In other instances, the same information will be collected in multiple care settings to document the current patient condition (e.g. vital signs). Further, there is some information which may not be practical to gather at an on-site care location, and may only be gathered during emergency care (e.g. advance directives)

The following table illustrates some of the potential differences and similarities in the information collected. However, it is not intended to fully define the information gathered in either care setting:

Items listed are examples that may include:

Item	On-Site Care	Emergency Care Record		Item	On-site Care	Emergency Care Record
Demographics: Name, Age, Gender, Primary language spoken	X	X		Medication History: Long term maintenance meds, OTC, current meds, admin of blood/blood products	X	X
Treatment History: Last 2 episodes of care for chief complaint, last 5 episodes of care		X		Problem List: Current problems(s), other chronic or on-going problems	X	X
Allergies : Meds, food, latex	X	X		Immunizations		
Pain Status: Level (1-10)	X	X		Emergency contract Information	X	X
Present Episode: complaint(s), vital signs, meds administered, visual assessment	X	X		Patient Location: Location of incident, current location, receiving facility location; date/time arrival	X	X
Triage Category: Delayed, immediate, minimal, expectant	X	X		Advance directive Status: Living will, DNR orders, Medical Power of Attorney		X



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HITSP List of Standards

- It is important to understand that the standards selected here are within the context of the specific Use Case requirements and do not necessarily reflect selection in other contexts. See HITSP Registration and Emergency Responder Use Case (HITSP/C32) for the list of standards supported. The following standards are used to implement this Component specification

Standard Description

- American Medical Association (AMA) Current Procedural Terminology (CPT®) Fourth Edition (CPT-4) A uniform coding system used primarily to identify medical services and procedures furnished by physicians and other healthcare professionals.

Standard

- Health Level Seven (HL7) Version 3.0 Continuity of Care Document (CCD)

Description

The Continuity of Care Document (CCD) constrains the HL7 Clinical Document Architecture Release 2 (CDA R2) in accordance with requirements specified in American Society for Testing and Materials (ASTM) standard E 2369-05, "Standard Specification for Continuity of Care Record (CCR)." The resulting CCD specification is developed as a collaborative effort between ASTM and HL7, and is intended as an alternate implementation to the one specified in ASTM E 2369-05 for those organizations preferring to use HL7 Clinical Document Architecture (CDA) to communicate this information.

Standard

- Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®)

Description

SNOMED CT consists of a technical design, core content architecture, and Core content. SNOMED CT Core content includes the technical specification of SNOMED CT and fully integrated multi-specialty clinical content. The Core content also includes a concepts table, description table, relationships table, history table, ICD-9-CM mapping, and Technical Reference Guide. Additionally, SNOMED CT provides a framework to manage language dialects, clinically relevant subsets, qualifiers and extensions, as well as concepts and terms unique to particular organizations or localities.



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Requirements:

Use Case Scenario: Emergency Responder Use Case – Summary Data Flow Chart

Information Exchange:

Information Exchange II	Health Information system shares patient information necessary for patient care
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6.1.3 EVENT: Access Additional Patient health Information

6.1.3.1	<p>Action: Additional patient information may be accessed and viewed from health information repositories such as existing patient electronic health records (either from an individual healthcare entity or a health information service provider), handheld storage devices, or web-hosted personal health records. Other sources such as patient registries may be accessed to view information such as emergency contact information and prescriptions. The queries for information are secondary to the stabilization and treatment of the patient(s).</p>	<p>On-site care providers attempt to identify the patient. If the patient can be identified the on-site care providers send a query to receive relevant patient specific information from the EHR or a physical PHR storage device (if available). Both the query and retrieval are auditable. If the patient can not be identified, a patient identifier is added to the on-site information.</p>
6.1.3.1a	<p>Alternative Action: Information from the EHR and/or PHR is not available (this would include jurisdictions that have not yet implemented electronic on-site care information collection).</p>	<p>If information is not available from the EHR/PHR, the on-site crew will enter as much information as possible in a manual mode, on a treatment non-interference basis. The information source could be the patient, family member, or friend, who has knowledge about certain basic aspects of the patient's health condition, such as allergies, past episodes of care, current medications, primary care physician, etc.</p>



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911
Dispatch

Information Exchange V	Incident control Personnel at the scene request confirmation of the medical credentials for an on-site or emergency care provider; Emergency dispatch or EOC systems provide confirmation of medical credentials, either from their own information sources, or via a query to the Health Information Service
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6.1.1 Event On site Management and Coordination

6.1.1.1	Action: On-site care providers are dispatched. Patient location information from emergency dispatch center systems will be communicated to on-site care providers. Emergency medical operations personnel coordinate response deployment.	Calls for assistance are received at the Emergency Dispatch Center. For small scale incidents, basic information such as patient's name, location, and chief complaint are gathered by the 911 telecommunicator from the individual making the emergency call when possible. For larger scale incidents, dispatchers may gather less specific information about individual patients. Information provided by the caller on the size and nature of the incident, and characteristic injuries of the patients associated with the incident will allow the proper personnel/units/apparatus to be dispatched. All gathered information is sent to the responding on-site care team answering the dispatch call.
6.1.1.2	Action: EOC system sends situational awareness reports to all involved medical units and systems.	As information is gathered from a number of sources, EOC systems will prepare and disseminate situational awareness reports keeping all involved medical entities informed of the situation.
6.1.1.3	Action: On-site care providers assess the situation, determine the scope of required care and evacuation, notifying responding agencies of the situational assessment, and organize additional units if required.	On-site medical personnel arrive on-site and perform an assessment of the incident site to determine the scope of medical care and evacuation required. In certain incidents, care and evacuation will require multiple on-site teams. If the initial on-site team recommends that additional resources maybe required such as additional EMT teams, fire and rescue, police and other response units, they shall be able to convey this information back to the Emergency Dispatch Center. After on-site assessment and communication with the Emergency Dispatch Center, the need for an on-site triage collection point and or a medical incident command post shall be established. Until an incident command post is operational, the first team may serve as to organize subsequent arriving units. Once the command post has become operational they will assume command over the incident site and all assigned personnel.



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On-Site Care Giver – Ambulance / Rescue Response Team

1 Information Exchange Workflow

1.1 Workflow Steps and Description

- a. 911 Dispatch receives a call for emergency assistance
- b. 911 Dispatcher enters the call on their computerized system in addition to activating a radio call to all EMS within the range of the incident.
- c. EMS receives the notification via their computerized dispatch systems, showing the location of the incident as well as chief complaint(s) about the people involved and number of units that need to be dispersed. In a large scale incident less specific individual patient information may be gathered. Information provided by the caller on the size and nature of the incident, and characteristic injuries of the patients associated with the incident will allow the proper personnel/units/apparatus to be dispatched
- d. In a large scale incident where multiple EMS units have been dispersed Information Exchange V would be utilized. In a small scale incident the responding units contain all individuals who will be presenting patient care and credentials have been verified and on file with the responding units, i.e. ambulance service, fire department rescue.
- e. All gathered information from the EMS dispatch is sent to the responding on-site care team answering the call
- f. On-site care givers assess the situation upon arrival and continuously update dispatch of the situation
- g. EMS personnel access the HIE web portal via an electronic device having the capability of Internet access to retrieve and view all information available to assist with patient care. (currently the ability to enter information back into the patient record is not in scope for this portion of the project)
- h. Stabilization of the patient takes priority. Post procedures to stabilizing: EMS continue updating dispatch on events and ETA to ED
- i. Upon arrival at ED, EMS produce paper documents to ED staff and hand off patient(s) to the definitive care practitioners Note: In the very near future the ambulance service will be able to access the hospital ED and provide updates pre, during and post transport
- j. After transferring patient to ED, EMS documents run notes into the software which in turn is used for billing



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1.2 Use Case References (e.g. Events/Actions)

a. The operational workflow, beginning with the initial call by an individual to '911' requesting an emergency responder corresponds to the events and actions described in the Emergency Responder Use Case. Steps described above follow the use case assumptions from that initial call through the actions taken by the EMS team to stabilize the patient, keeping in direct contact with the dispatch for the purpose of ETA at the ED and then showing the ability to gather data which will be later sent to a public health department for situation awareness tracking.

1.3 Key Assumptions

- a. Using the example set from the ER-EHR orientation and HITSP training sessions
- b. Talking with EMS responders directly and observing the operational workflow currently being used by the services here in New Mexico
- c. Reading and reviewing the processes desired by ONC while meeting the standards and security requirements

2 Information Exchange Requirements

2.1 Triggers

- a. An individual (s) contact 911 dispatch to report an incident / event
- b. Information retrieved thru 911 dispatch system, routed to EMS within the jurisdiction of the incident/event
- c. Responders receive request (call), routing and dispatching equipment to the location of the incident / event
- d. Each stage of the incident is recorded by the EMS on site, either manually or electronically which triggers the ED to be notified of the upcoming event
- e. Transporting of the individual triggers another event in recording where the patient will be taken, ETA and what will be needed upon arrival
- f. Upon arrival triggers another event in that the ED accepts the incoming patient and begins entering information on their ED software application as to the situation and begins a 'chart' for this patient
- g. At the time of the 'transfer' of care to the ED from the EMS team, this continues the continuity of care process for the patient



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2.2 Data Content Requirements

- a. Incident / location (data) information needed: type of incident, number of individuals involved (if possible), complete address, phone number where the call is coming from
- b. Information should conform to a standard so all EMS vehicles are viewing the information that is consistent and accurate as possible
- c. When accessing the HIE for patient information the following minimum data should be available: (assuming the EMT / Rescue team have identified the individuals by name involved through identification at the scene) allergies, medication history, any demographics such as address, phone number, emergency contact and current labs. This would assist the EMS clinicians in providing a higher quality of care at the scene of the incident.
- d. C32 and possibly C28 are required at this point of contact. Additional analysis will be done with the Core Content team to see what criteria will need to be met to accomplish this scenario.

2.3 Other unique requirements

- a. For the NHIN Trail Implementation demonstration in December 2009 for the Emergency Responder Use Case, I do not see any additional unique requirements needed. As the project evolves, additional participants are brought on board the local HIE, we begin to work with 'live data' in a production environment and different scenarios are explored, I am sure there will be additional requirements.

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Information Exchange: Emergency Care – Hospital Emergency Room

Input Information in Emergency Record

6.2.5.1	Action: As treatment progresses, information such the results of diagnostic tests, treatment and medications rendered, and any changes to the treatment plan are entered into the emergency care record. Information is continually sent to public health agencies for population health monitoring purposes.	COMMENT: Information is added to the emergency care record by the clinical care staff. This will update the working diagnosis, treatment rendered, medications given, and profiles for limits to Activities of Daily Living (ADL). Diagnostic testing results are also collected and updated into the emergency care record. This may include information feeds from automated medical devices such as blood pressure monitors.
	Emergency Care Site Management & Coordination	
6.2.1.1	ACTION: The emergency care facility is notified by the Emergency Dispatch Center regarding the in-bound patient.	COMMENT: clinical care personnel are notified by the Emergency Dispatch Center of the in-coming patient. If information recorded during on-site care is available, ED clinical care personnel receive and review the record (demographics, diagnosis, triage outcome, treatment provided) to ensure appropriate resources are available (e.g. specialists, lab tests, blood products, radiology etc) to appropriately treat the patient upon arrival. An alert may be sent to the patient's primary care physician (if applicable). All information exchanges are auditable.
	Access Additional Emergency Health Information	
6.2.3.1	ACTION: Additional patient information may be accessed and viewed from health information repositories such as existing patient electronic health records (either from an individual healthcare entity or a health information service provider), handheld storage devices or web hosted personal health records. Other sources such as patient registries may be accessed to view information such as emergency contact information, prescriptions and insurance claims databases (if available).	COMMENT: A query is sent to the Health Information System (HIS) for information on the patient. The local HIS utilizes available information exchange services to request, locate, and retrieve patient information from other sources. The on-site care information and the retrieved electronic health record are accessible to the clinical staff and should be integrated into the emergency care record. For ease of use, the information may be summarized according to the clinical staff's preferences. If available and feasible, the personal health records may also populate the emergency care record. All information exchanges are auditable.
	Alternative Action	
6.2.3.1a	Patient presents without an on-site care record.	COMMENT: Patients who enter the emergency facility through a means other than on-site care, such as self-referral, brought in by family or friends, etc. will have their relevant demographics, allergies, past episodes of care captured by the ED staff that shall log them in and start a new emergency care record for the new patient encounter. A query for the patient's health information will be sent out through the HIS. The local HIS utilizes available information exchange services to request, locate, and retrieve patient information from other sources. All information exchanges are auditable.



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Hospital
Emergency
Department

3 Information Exchange Workflow

3.3 Workflow Steps and Description

- (a) EMS documents on a “paper record” all procedures done for the patient while at the scene of the incident as well as during transport. This paper record is handed off to the Emergency Department upon arrival
- (b) ED staff accepts patient into their facility by signing off on the EMS document / EMS transmits back to dispatch
- (c) Triage is done to determine nature of injury/incident and assigned a room for treatment in the ED
- (d) Access to the HIE Portal is done to request additional information on the patient
- (e) Practitioners begin assessment of the injuries / emergency situation, recording findings in the electronic ED software
- (f) Electronically, orders for labs, medications / imaging / etc. are done during this process
- (g) Results of the orders are sent to the ED for evaluation by the practitioner
- (h) At this point, if medical specialists, operating rooms, transfer to a ‘trauma center’ (if this is not one) all done via electronic system.
- (i) Individual is stabilized and follows one of several scenarios from ED:
 - Taken to surgery and additional / referring practitioners are call to the event – all being documented electronically
 - Individual is treated by the ED physician on staff and send home (discharged)
 - Individual is admitted to the hospital for further evaluation by a referring physician (discharged from ED system and admitted to hospital system)
 - Individual is transferred to another facility, i.e. burn center, skill nursing facility, head trauma unit, etc. (transfer)
 - Individual has deceased and sent to the morgue (discharged from ED system and transferred to either medical examiner or morgue system)



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3.4 Use Case References (e.g. Events/Actions)

- (a) At each stage of the event the emergency department staff / practitioners have the ability to access the NHIE / HIE for the purpose of obtaining any and all information available on the patient
- (b) Having the ability to access this information allows them to present a high quality of treatment to the patient
- (c) This workflow meets the use case information exchange in that it follows the continuity of care for the patient from the onset of the event through treatment , admissions / discharge / or transfer

3.5 Key Assumptions

- (a) Based upon the assumption that the EMS would be transporting the individual to an ED
- (b) Alternative would be to transport the individual directly to a morgue or triage area is when a large scale incident occurred
- (c) Based upon the operational workflow steps it would take to gather and transmit PHI on the individual for patient safety and to provide quality care
- (d) Having the ability to access the web portal to obtain clinical information on the arriving patient prior to actual arrival give ED a heads up and also alerts the EMS team if in fact they need to divert the patient to another hospital due to overcrowding, equipment needed to assist the patient is not available at that hospital or they do not have the correct medical team available to treat the patient.

4 Information Exchange Requirements

4.3 Triggers

- (a) Arrival of the individual by EMS to the hospital ED triggers the event to begin documentation on the situation
- (b) Access to the NHIE/HIE to obtain additional PHI on the individual triggers the triage event
- (c) Additional information obtained from the NHIE/HIE triggers the ED medical chart to be updated
- (d) Continuity of care for this individual is present by triggering one stage of care to the next via the electronic systems available.



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4.4 Data Content Requirements

- (a) The ability to access the following across HIEs in the ED environment would be essential to quality triage and treatment:
- Patient Name
 - Emergency contract information
 - Allergies
 - Medications
 - Problem List
 - Labs
- (b) Developing standards and specifications, and adhering to these, is the key for success in this project. Having the ability to access the information shows success, but having the ability to conform to specifications so everyone accessing this information can rely on having the most accurate and readable results, is I believe the goal.
- (c) At the onset of the NHIE/HIE, information will be limited, but as use is increased and additional participants are brought on board willing to share PHI, the ability to expand on the above list will increase and will assist the ED staff / practitioners in providing faster and more knowledgeable care.
- (d) C32 and possibly C28 are required at this point of contact. Additional analysis will be done with the Core Content team to see what criteria will need to be met to accomplish this scenario.

4.5 Other unique requirements

- (a) Having the ability to have direct contact with the EMS team pre and during transport is essential to quick response for quality treatment by the ED



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Information Exchange: Definitive Care – Hospital or Admission to another facility

5 Information Exchange Workflow

5.3 Workflow Steps and Description

- (a) Patient has been treated, diagnosis confirmed, all ancillary testing completed, medications dispensed and patient either:
- Admitted to the hospital
 - This is done via their electronic ADT system. Patient is discharged from the ED system and Admitted to the hospital system
 - Admitting /registration department at the hospital completes the process and the patient is taken to a room
 - Discharged
 - Next of kin, friend, family, other means of transportation is provided for transport to home
 - Another option may be transfer to a Nursing Home / Skilled Nursing facility or another hospital that has the medical equipment needed to continue with the medical treatment of the patient
 - Deceased – Medical Examiner or Morgue contacted for pickup

5.4 Use Case References (e.g. Events/Actions)

- (a) This covers the Definitive Care scenario portion of the Emergency Responder Use Case diagram on page 16. The actions taken by the Hospital staff to admit, discharge or transfer the patient has completed the event from 911 dispatch to end of the scenario.

5.5 Key Assumptions

- (a) The priority information exchanges covered with this covers the continuity of care requirement from the beginning of the event until the completion.



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6 Information Exchange Requirements

6.3 Triggers

- (a) When EMS team notifies the ED they are in route this triggers an event for the ED to triage the situation and respond to the EMS team on the availability of ED staff, beds and equipment
 - At this time the ED staff would have the ability to access the web portal to the HIE to acquire PHI about the incoming patient
- (b) Upon arrival of the patient this triggers the handoff of paperwork for the ED staff to accept and begin documenting in their ED system
- (c) After patient is admitting to the ED this triggers the ED staff for triage and evaluation of the situation
- (e) Direct patient care is then begun trigger many events to take place such as ordering labs, medications, x-rays, EKGs, etc.
- (f) Ancillary results are routed to the specific practitioners providing the patient care, triggering the documenting of these results

6.4 Data Content Requirements

- (a) C32 and possibly C28 are required at this point of contact. Additional analysis will be done with the Core Content team to see what criteria will need to be met to accomplish this scenario.
- (b) Where the ED staff would have the ability to access the web portal to obtain any and all information available on the patient.

6.5 Other unique requirements

- (a) For the NHIN Trial Implementation demonstration I do not see any additional requirements that will need to be met.



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Information Exchange: Public Health System – Department of Health (New Mexico)

7 Information Exchange Workflow

Information Exchange V	Care providers share information about patient(s) disposition, condition and location
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6.1.7 Event: Provide Information

6.1.7.1	Action: The on-site care information is made available to the receiving facility.	On-site care information is made available to the receiving facility and/or the appropriate repositories. The on-site treatment team updates the patient on-site information with treatment provided to the patient by the transportation team (if required). If the patient requires transport, the on-site treatment team transmits the updated on-site information to the designated receiving facility so that appropriate resources (including clinicians) may be available at the time of patient arrival. Appropriate information is sent to EOC systems and public health agencies that use the information to track health resources and conduct bio-surveillance respectively. The information sent to EOC systems is non-identifying or anonymized. All information exchanges are auditable.
6.1.7.1a	Alternative Action: Power or communication failures.	A paper copy of the health record is kept for the patient, a copy of which is transferred with the patient to the staff at the receiving facility. Once power and IT communications are restored, the information can be re-entered into the electronic health record, after the fact, possibly by scanning the record. All information exchanges are auditable.

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7.3 Workflow Steps and Description

- a. Information gathered from the participants will be filtered to meet the state and federal requirements for forwarding information on to the Department of Health.
- b. LCF / NMHIC will present each of the participants with a Business Associate Agreement
- c. LCF/ NMHIC will present each of the participants with a Network Subscriber Agreement which will outline any and all information that will be agreed upon. These will formally and legally accepted by the Department of Health and outline all the specifics needed to comply with data requirements.
- d. If required, the information will be anonymized. This policy has not been agreed upon at the time this document is being created (4-18-2008). Additional information will be added when the decisions have been made

7.4 Use Case References (e.g. Events/Actions)

- a. This meets the requirements for the Emergency Responder Use Case scenario showing the ability to transfer situational awareness information on to a public health department.
- b. All events and actions that are reportable within state and federal laws will be transmitted to the DOH

7.5 Key Assumptions

- a. Interpretation of the scenario to meet with requirement was discussed during the Emergency Responder Use Case orientation meeting.

7.6 Triggers

- a. In an event that has been completed, i.e. patient admitted to hospital, the situation which caused this even will be recorded within the On-Site Care and/or Emergency Care software.
- b. This will trigger the request by the DOH for this information to be forwarded to them



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7.7 Data Content Requirements

(a) C32 and possibly C28 are required at this point of contact. Additional analysis will be done with the Core Content team to see what criteria will need to be met to accomplish this scenario.

7.8 Other unique requirements

(a) For the NHIN Trail Implementation Demonstration I will be exploring additional possible requirements, but until I have met with the vendor and mapping teams I am unable to make any assumptions on this section at this time.

4-28-08

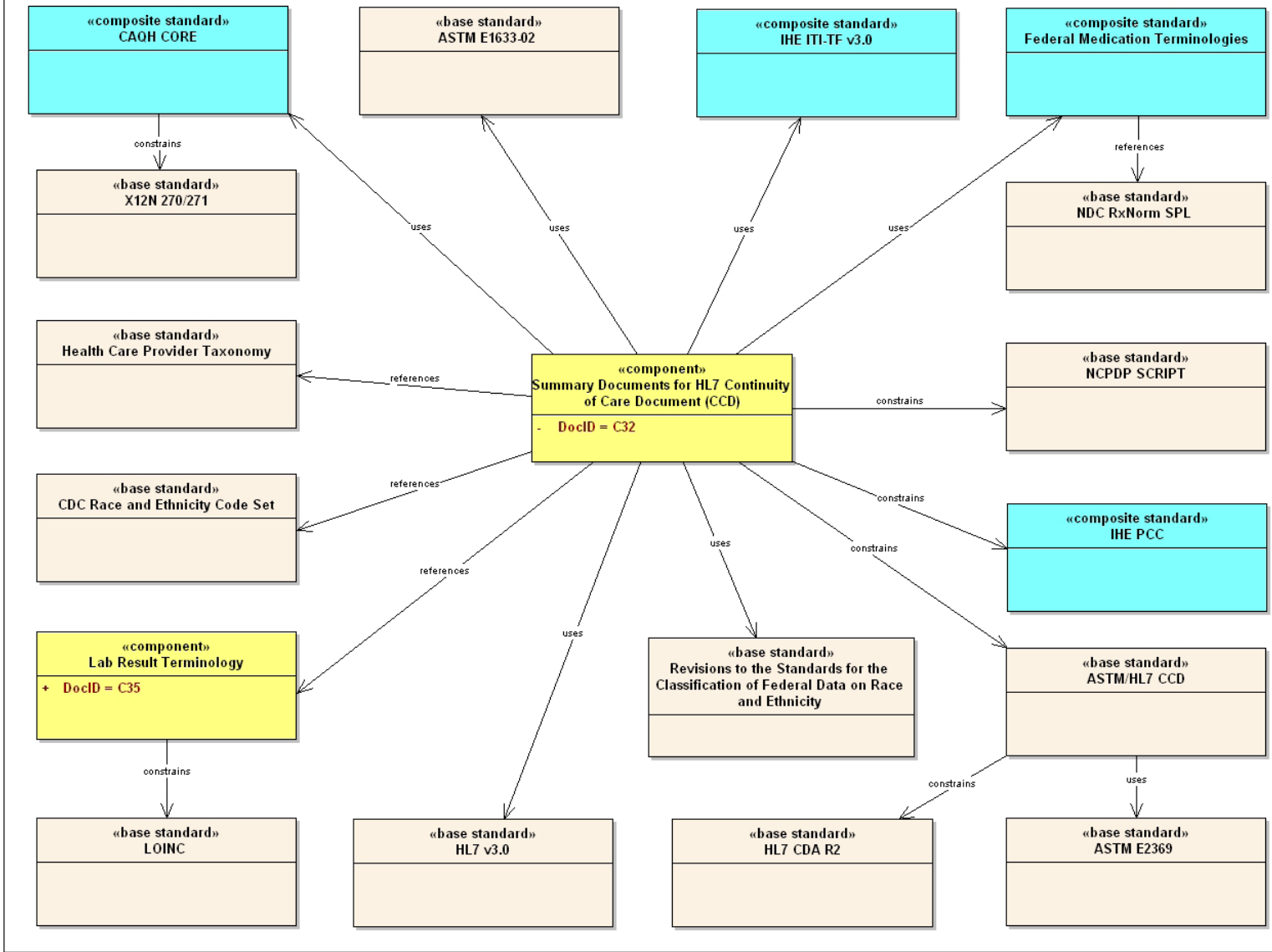
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class Summary Documents for HL7 Continuity of Care Document (CCD) Component Roadmap

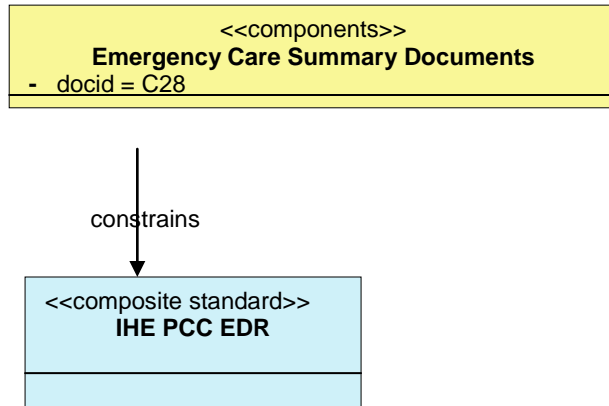




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HITSP/C28



The text for the PCC-TF specification begins here:
 The ED Encounter Record is a folder in XDS that defines a collection of documents. Separate content profiles must be created for the various kinds of documents that might be generated during an ED encounter. These content profiles include (existing and new):

- Triage Note
- Nursing Note
- ED Physician Note
- Pre-hospital Care Report
- Diagnostic Imaging Reports
- Laboratory Reports
- Consultation Reports
- Patient Consents for Treatment and Procedures
- Transfer Summary
- Summary of Death

It is important to understand that the standards selected here are within the context of the specific Use Case requirements and do not necessarily reflect selection in other contexts. The following standards are used to implement this Component specification:

Table 2.3-1 List of Standards

Standard

Integrating the Healthcare Enterprise (IHE) Patient Care Coordination (PCC) - Emergency Department Encounter Record (EDER), Technical Framework Supplement, Volume I, Revision 2.0, 2006-2007.

Description

The IHE Patient Care Coordination Technical Framework (PCC TF) defines specific implementations (called Integration Profiles) of established standards to deal with integration issues that cross providers, patient problems or time. The Emergency Department Encounter Record (EDER) enables the sharing of emergency department summary information between enterprises of a regional health network, and further describes how to map content in a CDA medical document into registry metadata. In the registry, healthcare providers publish pointers to documents stored in distributed repositories. Other healthcare providers may search and retrieve these and other documents.

Visit www.ihe.net for more information.

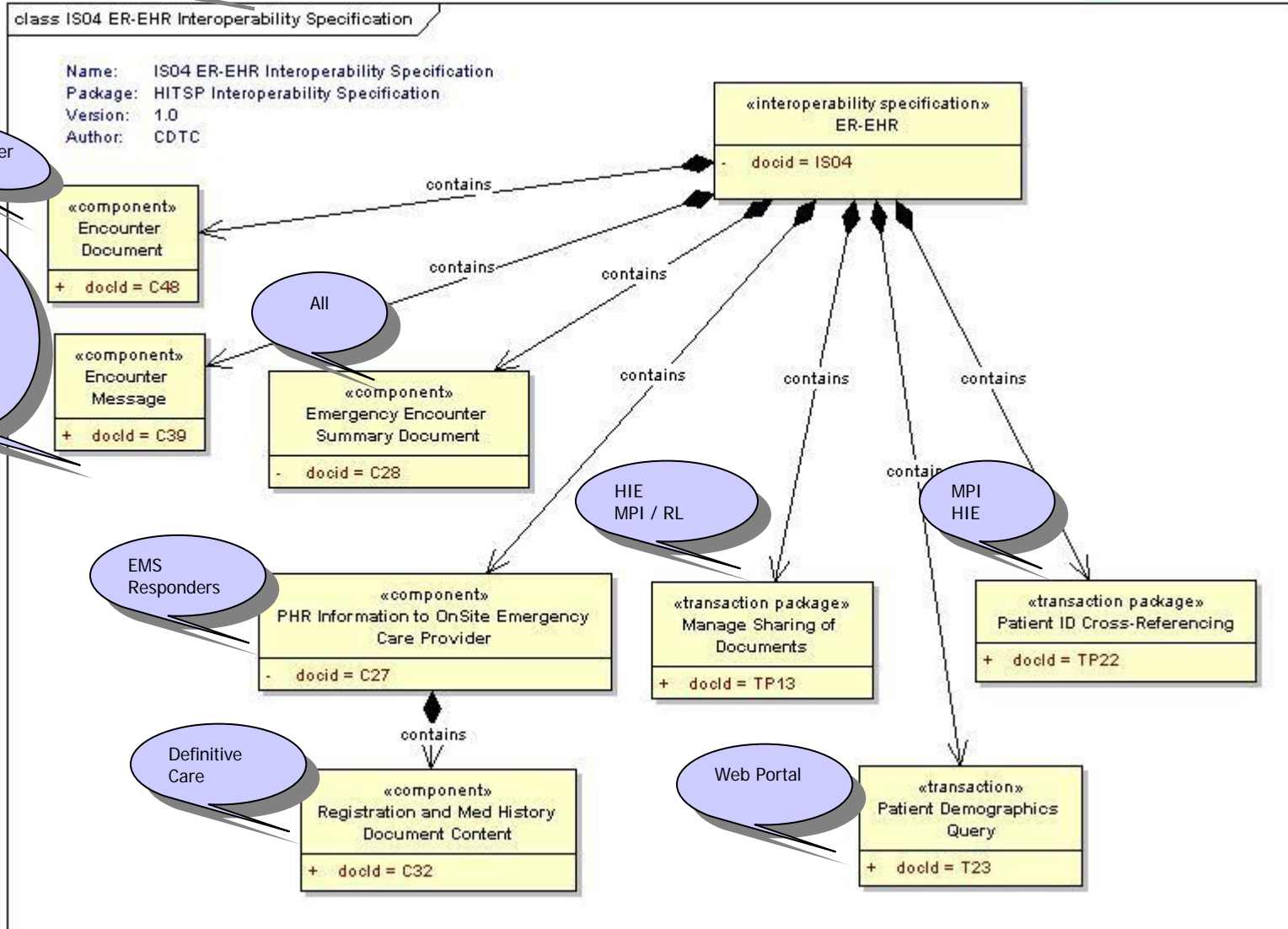
See the above IHE Technical Framework for standards



**FUTURE
INTRA-HIE NMHIC**

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In the "Perfect World" Of providing quality health care and patient safety in any emergency situation, weather large or small, we are working towards having the interoperability to carry forward all items listed in this diagram. It can happen!

