

Health IT Policy Committee - Use Case Prioritization Template for Presentation 4/7/15

			I. Impact		
			Rating: 1 (Minimal impact on goal); 2 (Moderate impact on goal); 3 (Major impact on goal)		
ID	Vision Statement	Exemplar Use Case	Health	Care	Cost
	The Vision Statement represents a broad future-oriented goal for how participants will utilize information to support the health of individuals.	The Exemplar Use Case (UC) describes one specific interaction between participants/systems under the Vision Statement, the data exchanged by the participants, and the outcome/purpose of the interaction.	UC supports proven interventions to address determinants of health.	UC makes health care more pt-centered, reliable, accessible, and safe.	UC reduces cost of quality care for individual, employer, govt, etc.
1.1	All members of a person's health team (including the individual and family caregivers) have appropriate, real-time access to comprehensive, longitudinal, cross-organizational information to support informed clinical decision making and care coordination.	A healthcare professional accesses and imports elements of a common clinical dataset on an individual they are treating from the EHRs of other providers who have cared for the same patient, in order to improve coordination of care across settings.	<u>2.38</u>	<u>2.88</u>	<u>2.63</u>
1.2	(Same as above)	An individual queries for a common clinical dataset from all of their healthcare providers and receives this data as a single aggregated record to support better self-management.	1.88	<u>2.50</u>	1.75
2.1	Individuals can appropriately access, interpret, and engage in bidirectional exchange of information (including person-originated data) about their health status with members of their health team to enable effective engagement, self-	An individual (or their family member/personal caregiver) sends person-generated data automatically from home-based medical devices (e.g., BP cuffs, glucometers and scales) to the individual's health record.	1.13	1.50	1.38
2.2	(Same as above)	A health professional's system automatically sends alerts to an individual regarding reminders for preventative screenings, care and medication regimens based on the individual's own care history, to increase adherence to recommended preventive care.	1.86	<u>2.14</u>	2.00
3.1	Health team members appropriately share information across the continuum (including the home), noting care transitions, identifying gaps, and supporting care coordination.	A primary care provider sends a specialist a basic set of patient information consisting of structured data and free electronic text to support more effective care coordination.	1.57	<u>2.29</u>	2.00
3.2	(Same as above)	A specialist sends a primary care provider a basic set of patient information consisting of structured data and free electronic text, including the findings of a consultation or determination that no consult is needed, to support more effective care coordination.	1.63	<u>2.50</u>	<u>2.13</u>
4.1	De-identified clinical, claims and other health data (e.g. public-health sources, social determinants of health) are linked and matched from multiple sources with robust identity management to use for research, public health, and quality improvement.	A payer links clinical quality data from providers with administrative cost data to support more accurate assessment of value in value-based payment bidirectional models.	1.63	1.63	1.88
5.1	Providers report and receive public health data routinely as a byproduct of using the EHR to provide care and use public health data to guide patient specific clinical decisions and interventions.	Providers automatically send syndromic surveillance data (including de-identified data) to public health departments to improve public health monitoring.	1.75	1.25	1.13

			II. Programmatic Needs							
			Rating: 0 (Not relevant to need); 1 (Moderately supportive of need); 2 (Strongly supportive of need)							
ID	Vision Statement	Exemplar Use Case	NQS: Safer	NQS: Pt Eng	NQS: Care Coord	NQS: Prevention	NQS: Community	NQS: Afford	2015 - 2017	2018
	The Vision Statement represents a broad future-oriented goal for how participants will utilize information to support the health of individuals.	The Exemplar Use Case (UC) describes one specific interaction between participants/systems under the Vision Statement, the data exchanged by the participants, and the outcome/purpose of the interaction.	To what degree does UC support safer care/reduce harm?	To what degree does UC ensure each person and family is engaged?	To what degree does UC promote effective coordination of care?	To what degree does UC promote prevention and effective treatment?	To what degree does UC support communities to enable healthy living?	To what degree does UC make care more affordable/support new delivery models?	To what degree is UC needed to help providers and individuals send/find/receive a common clinical data set by 2017?	To what degree is UC needed for success in alt. payment models (50% of Medicare payments by 2018)?
1.1	1. All members of a person's health team (including the individual and family caregivers) have appropriate, real-time access to comprehensive, longitudinal, cross-organizational information to support informed clinical decision making and care coordination.	A healthcare professional accesses and imports elements of a common clinical dataset on an individual they are treating from the EHRs of other providers who have cared for the same patient, in order to improve coordination of care across settings.	<u>2.00</u>	<u>1.00</u>	<u>1.88</u>	<u>1.75</u>	<u>0.50</u>	<u>1.50</u>	<u>2.00</u>	<u>1.63</u>
1.2	1. Same as above.	An individual queries for a common clinical dataset from all of their healthcare providers and receives this data as a single aggregated record to support better self-management.	<u>1.25</u>	<u>1.88</u>	<u>1.25</u>	<u>1.38</u>	<u>0.88</u>	<u>1.25</u>	<u>1.75</u>	<u>1.13</u>
2.1	2. Individuals can appropriately access, interpret, and engage in bidirectional exchange of information (including person-originated data) about their health status with members of their health team to enable effective engagement, self-management, and shared decision making.	An individual (or their family member/personal caregiver) sends person-generated data automatically from home-based medical devices (e.g., BP cuffs, glucometers and scales) to the individual's health record.	<u>1.25</u>	<u>1.50</u>	<u>1.00</u>	<u>1.25</u>	<u>0.75</u>	<u>1.00</u>	<u>0.63</u>	<u>1.25</u>
2.2	2. (Same as above)	A health professional's system automatically sends alerts to an individual regarding reminders for preventative screenings, care and medication regimens based on the individual's own care history, to increase adherence to recommended preventive care.	<u>1.57</u>	<u>1.71</u>	<u>1.14</u>	<u>1.86</u>	<u>0.71</u>	<u>1.43</u>	<u>0.43</u>	<u>1.57</u>
3.1	3. Health team members appropriately share information across the continuum (including the home), noting care transitions, identifying gaps, and supporting care coordination.	A primary care provider sends a specialist a basic set of patient information consisting of structured data and free electronic text to support more effective care coordination.	<u>1.86</u>	<u>0.43</u>	<u>2.00</u>	<u>1.29</u>	<u>0.14</u>	<u>1.00</u>	<u>1.57</u>	<u>1.71</u>

II. Programmatic Needs, continued										
Rating: 0 (Not relevant to need); 1 (Moderately supportive of need); 2 (Strongly supportive of need)										
ID	Vision Statement	Exemplar Use Case	NQS: Safer	NQS: Pt Eng	NQS: Care Coord	NQS: Prevention	NQS: Community	NQS: Afford	2015 - 2017	2018
	The Vision Statement represents a broad future-oriented goal for how participants will utilize information to support the health of individuals.	The Exemplar Use Case (UC) describes one specific interaction between participants/systems under the Vision Statement, the data exchanged by the participants, and the outcome/purpose of the interaction.	To what degree does UC support safer care/reduce harm?	To what degree does UC ensure each person and family is engaged?	To what degree does UC promote effective coordination of care?	To what degree does UC promote prevention and effective treatment?	To what degree does UC support communities to enable healthy living?	To what degree does UC make care more affordable/support new delivery models?	To what degree is UC needed to help providers and individuals send/find/receive a common clinical data set by 2017?	To what degree is UC needed for success in alt. payment models (50% of Medicare payments by 2018)?
3.2	3. Health team members appropriately share information across the continuum (including the home), noting care transitions, identifying gaps, and supporting care coordination.	A specialist sends a primary care provider a basic set of patient information consisting of structured data and free electronic text, including the findings of a consultation or determination that no consult is needed, to support more effective care coordination.	<u>1.88</u>	0.50	2.00	<u>1.25</u>	0.13	<u>1.13</u>	<u>1.63</u>	<u>1.75</u>
4	De-identified clinical, claims and other health data (e.g. public-health sources, social determinants of health) are linked and matched from multiple sources with robust identity management to use for research, public health, and quality improvement.	A payer links clinical quality data from providers with administrative cost data to support more accurate assessment of value in value-based payment bidirectional models.	0.88	0.25	0.75	<u>1.13</u>	1.00	<u>1.63</u>	0.50	<u>1.50</u>
5.1	5 Providers report and receive public health data routinely as a byproduct of using the EHR to provide care and use public health data to guide patient specific clinical decisions and interventions.	Providers automatically send syndromic surveillance data (including de-identified data) to public health departments to improve public health monitoring.	<u>1.38</u>	0.00	0.50	<u>1.63</u>	<u>1.88</u>	0.88	0.38	0.75

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			III. Operational Readiness			
			Rating: -2 (Factor very adverse); -1 (Factor moderately adverse); 0 (Factor not relevant);			
ID	Vision Statement	Exemplar Use Case	Bus. and Cultural	Tech. Environment	Stakeholder Effort	Policy Environment
	The Vision Statement represents a broad future-oriented goal for how participants will utilize information to support the health of individuals.	The Exemplar Use Case (UC) describes one specific interaction between participants/systems under the Vision Statement, the data exchanged by the participants, and the outcome/purpose of the interaction.	To what degree are business and cultural factors supportive of UC adoption?	To what degree is the technical environment (e.g. available, mature standards) supportive of UC adoption?	How significant is the \$\$/operational burden on stakeholders implementing the UC ? (2=minimal burden; -2=significant burden)	To what degree is the state/local/federal policy environment supportive of adoption?
1.1	1. All members of a person's health team (including the individual and family caregivers) have appropriate, real-time access to comprehensive, longitudinal, cross-organizational information to support informed clinical decision making and care coordination.	A healthcare professional accesses and imports elements of a common clinical dataset on an individual they are treating from the EHRs of other providers who have cared for the same patient, in order to improve coordination of care across settings.	<u>0.63</u>	-0.63	-0.88	<u>0.25</u>
1.2	1. (same as above)	An individual queries for a common clinical dataset from all of their healthcare providers and receives this data as a single aggregated record to support better self-management.	-0.25	-0.63	-1.13	<u>0.25</u>
2.1	2. Individuals can appropriately access, interpret, and engage in bidirectional exchange of information (including person-originated data) about their health status with members of their health team to enable effective engagement, self-management, and shared decision making.	An individual (or their family member/personal caregiver) sends person-generated data automatically from home-based medical devices (e.g., BP cuffs, glucometers and scales) to the individual's health record.	<u>0.38</u>	-0.50	-0.50	<u>0.13</u>
2.2	2. (same as above)	A health professional's system automatically sends alerts to an individual regarding reminders for preventative screenings, care and medication regimens based on the individual's own care history, to increase adherence to recommended preventative care.	<u>1.14</u>	<u>1.29</u>	<u>0.43</u>	<u>0.43</u>
3.1	3. Health team members appropriately share information across the continuum (including the home), noting care transitions, identifying gaps, and supporting care coordination.	A primary care provider sends a specialist a basic set of patient information consisting of structured data and free electronic text to support more effective care coordination.	<u>0.57</u>	<u>0.29</u>	-0.14	<u>0.43</u>

			III. Operational Readiness, continued			
			Rating: -2 (Factor very adverse); -1 (Factor moderately adverse); 0 (Factor not relevant);			
ID	Vision Statement	Exemplar Use Case	Bus. and Cultural	Tech. Environment	Stakeholder Effort	Policy Environment
	The Vision Statement represents a broad future-oriented goal for how participants will utilize information to support the health of individuals.	The Exemplar Use Case (UC) describes one specific interaction between participants/systems under the Vision Statement, the data exchanged by the participants, and the outcome/purpose of the interaction.	To what degree are business and cultural factors supportive of UC adoption?	To what degree is the technical environment (e.g. available, mature standards) supportive of UC adoption?	How significant is the \$\$/operational burden on stakeholders implementing the UC ? (2=minimal burden; -2=significant burden)	To what degree is the state/local/federal policy environment supportive of adoption?
3.2	3. Health team members appropriately share information across the continuum (including the home), noting care transitions, identifying gaps, and supporting care coordination.	A specialist sends a primary care provider a basic set of patient information consisting of structured data and free electronic text, including the findings of a consultation or determination that no consult is needed, to support more effective care coordination.	<u>0.25</u>	<u>0.13</u>	-0.38	<u>0.38</u>
4.1	4. De-identified clinical, claims and other health data (e.g. public-health sources, social determinants of health) are linked and matched from multiple sources with robust identity management to use for research, public health, and quality improvement.	A payer links clinical quality data from providers with administrative cost data to support more accurate assessment of value in value-based payment bidirectional models.	<u>0.13</u>	-0.25	-0.63	-0.25
5.1	5. Providers report and receive public health data routinely as a byproduct of using the EHR to provide care and use public health data to guide patient specific clinical decisions and interventions.	Providers automatically send syndromic surveillance data (including de-identified data) to public health departments to improve public health monitoring.	<u>0.25</u>	-0.38	-0.50	<u>0.25</u>

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			IV. Beneficiary Net Impact					
			Rating: -2 (Very negative net impact); -1 (Moderately negative net impact); 0 (No Impact); 1 (Moderately positive net impact); 2 (Very positive net impact)					
ID	Vision Statement	Exemplar Use Case	1. Individual	2. Community	3. Health Professional	4. Public Health	5. Research	6. Payer
	The Vision Statement represents a broad future-oriented goal for how participants will utilize information to support the health of individuals.	The Exemplar Use Case (UC) describes one specific interaction between participants/systems under the Vision Statement, the data exchanged by the participants, and the outcome/purpose of the interaction.						
1.1	1. All members of a person's health team (including the individual and family caregivers) have appropriate, real-time access to comprehensive, longitudinal, cross-organizational information to support informed clinical decision making and care coordination.	A healthcare professional accesses and imports elements of a common clinical dataset on an individual they are treating from the EHRs of other providers who have cared for the same patient, in order to improve coordination of care across settings.	<u>1.63</u>	0.88	<u>1.63</u>	0.63	0.63	0.88
1.2	1. Same as above	An individual queries for a common clinical dataset from all of their healthcare providers and receives this data as a single aggregated record to support better self-management.	<u>1.63</u>	0.63	0.88	0.38	0.00	0.38
2.1	2. Individuals can appropriately access, interpret, and engage in bidirectional exchange of information (including person-originated data) about their health status with members of their health team to enable effective engagement, self-management, and shared decision making.	An individual (or their family member/personal caregiver) sends person-generated data automatically from home-based medical devices (e.g., BP cuffs, glucometers and scales) to the individual's health record.	<u>1.50</u>	0.38	0.75	0.25	0.25	0.63
2.2	2. (same as above)	A health professional's system automatically sends alerts to an individual regarding reminders for preventative screenings, care and medication regimens based on the individual's own care history, to increase adherence to recommended preventive care.	<u>1.43</u>	0.43	<u>1.43</u>	0.86	0.14	<u>1.14</u>
3.1	3. Health team members appropriately share information across the continuum (including the home), noting care transitions, identifying gaps, and supporting care coordination.	A primary care provider sends a specialist a basic set of patient information consisting of structured data and free electronic text to support more effective care coordination.	<u>1.29</u>	0.14	<u>1.29</u>	0.14	0.14	<u>1.14</u>

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			IV. Beneficiary Net Impact, continued					
			Rating: -2 (Very negative net impact); -1 (Moderately negative net impact); 0 (No Impact); 1 (Moderately positive net impact); 2 (Very positive net impact)					
ID	Vision Statement	Exemplar Use Case	1. Individual	2. Community	3. Health Professionals	4. Public Health	5. Research	6. Payer
	The Vision Statement represents a broad future-oriented goal for how participants will utilize information to support the health of individuals.	The Exemplar Use Case (UC) describes one specific interaction between participants/systems under the Vision Statement, the data exchanged by the participants, and the outcome/purpose of the interaction.						
3.2	3. Health team members appropriately share information across the continuum (including the home), noting care transitions, identifying gaps, and supporting care coordination.	A specialist sends a primary care provider a basic set of patient information consisting of structured data and free electronic text, including the findings of a consultation or determination that no consult is needed, to support more effective care coordination.	<u>1.50</u>	0.13	<u>1.63</u>	0.13	0.25	<u>1.38</u>
4.1	4. De-identified clinical, claims and other health data (e.g. public-health sources, social determinants of health) are linked and matched from multiple sources with robust identity management to use for research, public health, and quality improvement.	A payer links clinical quality data from providers with administrative cost data to support more accurate assessment of value in value-based payment bidirectional models.	0.88	1.00	<u>1.38</u>	<u>1.13</u>	1.00	<u>1.75</u>
5.1	5. Providers report and receive public health data routinely as a byproduct of using the EHR to provide care and use public health data to guide patient specific clinical decisions and interventions.	Providers automatically send syndromic surveillance data (including de-identified data) to public health departments to improve public health monitoring.	0.75	<u>1.63</u>	0.88	<u>1.75</u>	0.50	0.75