Pennsylvania eHealth Partnership Program

Inpatient Hospital/Facility and Outpatient Practice or Other Outpatient Provider Onboarding Grant

Onboarding Completion Attestation and Survey

To be completed by the Health Information Organization (HIO):

Health Information Organization Name: _____

Onboarded Organization Name: _____

Date of Onboarding Completion: _____

To be completed by the Onboarded Organization:

1. Please identify which of the following functions your HIO has enabled for your organization (check all that apply):

   # Clinical/Quality Event Reporting to Public Health Registries

   # Send Discharge Summaries

   # Query for Discharge Summaries

   # Query for Historical Lists (Medications, Allergies, etc.)

   # Query for Longitudinal Medical Record

   # Meaningful Use Analysis and Reporting

   # Patient Portal

   # Provider-to-Provider Clinical Messaging

   # Provider-to-Patient Clinical Messaging

   # Exchange in Support of Referrals or Consultations

   # Query for Diagnostic Results

   # Other (please describe):

   _____

   _____

2. Approximate number of individuals within your organization who have access to the functions described above: _____

Continued on Reverse

3. Please rate the integration into your workflows of the functions enabled by your HIO:

   # Excellent # Good # Fair # Poor

4. Please rate the quality of user documentation provided by your HIO:

   # Excellent # Good # Fair # Poor # Not Provided

5. Please rate the quality of formal training provided by your HIO:

   # Excellent # Good # Fair # Poor # Not Provided

6. Please rate the quality of in-person go-live support provided by your HIO:

   # Excellent # Good # Fair # Poor # Not Provided

7. How confident or uncertain are you that your organization is prepared to make use of the functions enabled by your HIO?

   # Very Confident # Somewhat Confident # Somewhat Uncertain # Very Uncertain

8. How confident or uncertain are you that your organization is prepared to meet HIE-related Meaningful Use Stage 2 requirements?

   # Very Confident # Somewhat Confident # Somewhat Uncertain # Very Uncertain

9. I am willing to participate in future Authority surveys to follow-up in six months and/or one year (check all that apply):

   # Yes, by phone # Yes, by email # No

10. Please use the space below to tell eHealth anything else you would like to communicate regarding your HIO Onboarding experience. You may attach additional pages if desired.

_____

_____

_____

_____

Name of Individual Completing This Form: _____

Title of Individual Completing This Form: _____

Phone Number: _____ Email Address: _____

I certify that the information on the enclosed attestation is accurate and complete as submitted.

I understand that the payment for these services will be from federal and state funds and that I may be prosecuted for false claims, statements or documents, or concealment of material facts.

Signature: _____ Date: _____

Please note that the Department of Human Services may contact you to validate that you completed this form.