The Office of the National Coordinator for Health Information Technology

electronic Long-Term Services & Supports (eLTSS) Initiative

Introduction for HITSC

November 18, 2014

Putting the I in HealthIT
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Agenda

- Background: CMS TEFT Program
- Introduction to eLTSS Initiative
- Key Challenges & Opportunities
- eLTSS Workflow
- Expected Deliverables
- eLTSS Initiative Roadmap
- Existing Efforts for Consideration
- Q&A

Background: What is LTSS?

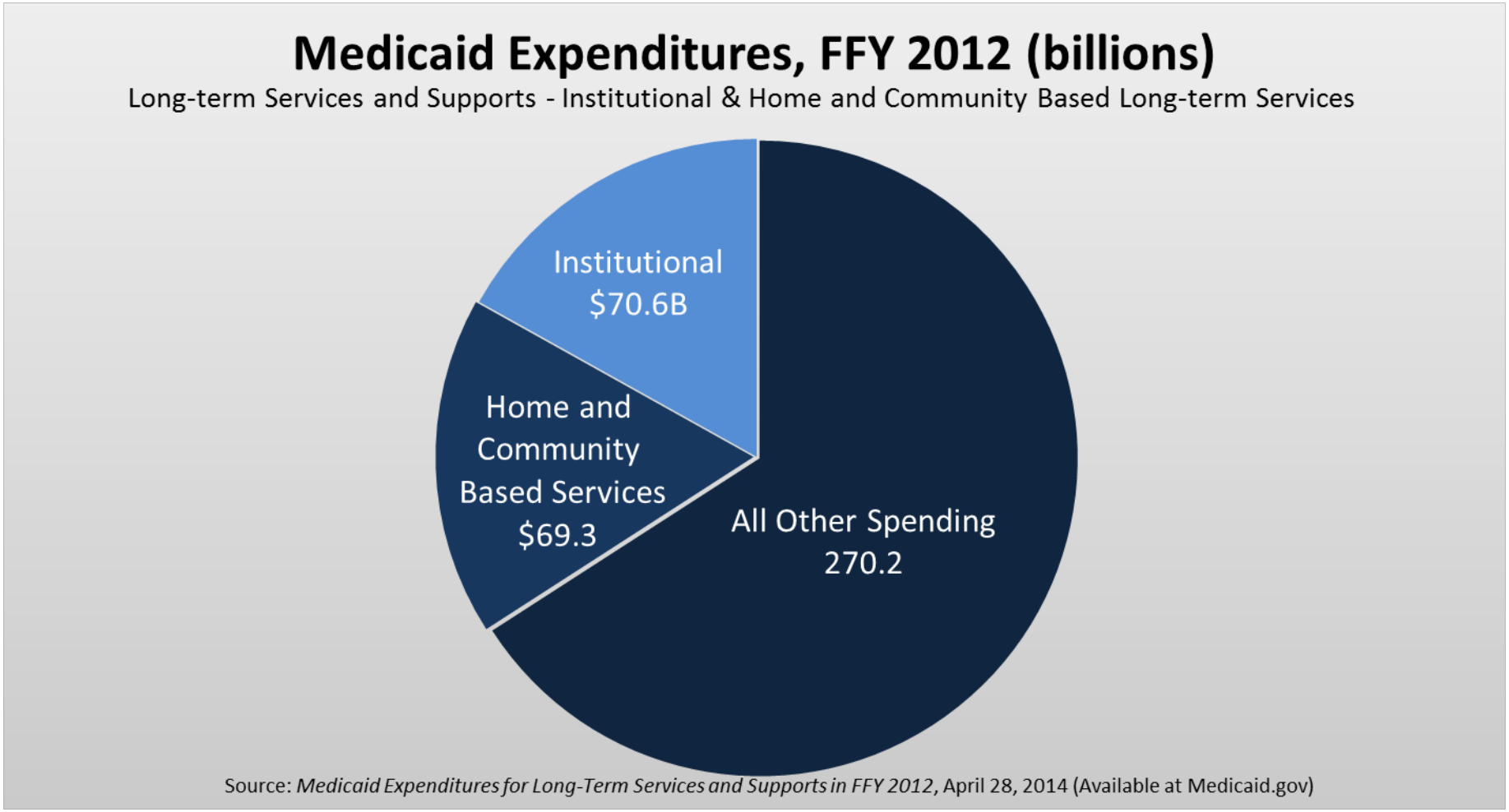
- A broad array of assistance needed by, and provided to, individuals with physical, cognitive, and/or mental impairments who never acquired, or have lost, the ability to function independently
- LTSS programs focused on providing support with daily activities and include services such as:
  - Assistance with activities of daily living (ADLs) and Instrumental ADLs
  - Adult day care
  - Care management
  - Social services
  - Assistive technologies
  - Education and training
  - Counseling
  - Other supportive services directed towards the impaired individual and their informal caregiver(s)

Why is LTSS important?

- As part of the Affordable Care Act (ACA), Congress has provided incentives to promote the use of community-based LTSS and promoted the movement from institutions to communities for people who require LTSS
  - **Money Follows the Person** (DRA and Extended through ACA, Section 2403))
  - **Community First Choice** (ACA, Section 2401)
  - **Balancing Incentives Program** (ACA, Section 10202)
  - **Person-Centered Planning and Self-Direction in Home and Community-Based Services** (ACA, Section 2402(a))
- These programs target diverse beneficiary populations, most of which are eligible for services provided by the states

Why is LTSS important? (cont'd)

One-third of Medicaid spending is for LTSS



The Need for Standardized Assessments & Tools

- Challenges in achieving standardized, comparable psychosocial data due to variance in:
  - Programs
  - Populations
  - State requirements (providers, services)
  - Assessment Instruments and Tools
  - Self-reported data
- Limitations in availability of quality measures for LTSS
- Siloed and non-integrated medical, behavioral, and LTSS service systems

To alleviate these challenges, CMS is advancing development of national, standardized items that can be applied across Community-Based LTSS (CB-LTSS)

CMS TEFT Program

- Introduced in Affordable Care Act (ACA) Section 2701
- Requirement for HHS to identify and publish initial voluntary core set of adult quality measures for adults eligible for Medicaid
- In response, CMS established *Testing Experience and Functional Tools (TEFT) in Medicaid community-based long term services & supports (LTSS) Planning and Demonstration Grant Program*
- March 2014: CMS awarded Demonstration Grants to 9 states: AZ, CO, CT, GA, KY, LA, MD, MN, NH

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/TEFT-Program-.html

CMS TEFT Components

1. Test a beneficiary experience survey within multiple CB-LTSS programs for validity and reliability
2. Test a modified set of CARE functional assessment measures for use with beneficiaries of CB-LTSS programs
3. Demonstrate use of PHR systems with beneficiaries of CB-LTSS
4. Identify, evaluate and harmonize an eLTSS standard in conjunction with the ONC S&I Framework

ONC Focus: eLTSS Standard

- Grantees who selected to work on eLTSS Component of TEFT Program will participate in eLTSS Initiative
- Once eLTSS standard is identified, Grantees will test and validate standard(s) with selected providers and beneficiaries
- Grantees who selected PHR component will also participate in eLTSS S&I process

eLTSS Initiative: Scope of Work

Identify, evaluate and harmonize Health IT standards for:

- Key client assessment domains and associated data elements to include in an electronic Long-term Services & Supports (eLTSS) plan
- The creation of a structured, longitudinal, person-centered eLTSS plan that can be exchanged electronically across and between community-based information systems, clinical care systems and personal health record systems.

We will use Health IT to establish a person-centered electronic LTSS plan, one that supports the person, makes him or her central to the process, and recognizes the person as the expert on goals and needs.*

* Source: Guidance to HHS Agencies for Implementing Principles of Section 2402(a) of the Affordable Care Act: Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs

What is a Person-Centered Service Plan?

Defined by Medicaid under **§ 441.301(c)** as part of the scope of services and supports required under the State's 1915(c) Home and Community-Based Settings (HCBS) waiver to include:

- The setting in which the individual resides is chosen by the individual
- Individual's strengths and preferences
- Clinical and support needs as identified through an assessment of functional need
- Individual's identified goals and designed outcomes
- Services and supports that will assist individual to achieve identified goals, and providers that will perform services
- Risk factors and measures in place to minimize them
- Individual and/or entity responsible for monitoring the plan
- Informed consent of the Individual
- Services the individual elects to self-direct

* Source: https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider

Key challenges for eLTSS Initiative

- Limited implementation and use of Health IT tools (i.e. EHRs) in LTSS settings
- Limitations in financial incentives for service providers to exchange LTSS information electronically
- Lack of uniformity in the terminology and definitions of data elements needed for assessments and service plans used across and between community-based information systems, clinical care systems and personal health record systems
- Lack of integration of social and behavioral determinants of health in health records regardless if paper-based or electronic
- No consensus on what a person-centered eLTSS plan is and what information should be included
  - Combination of clinical care, client assessment and service plan data

Key opportunities for eLTSS Initiative

- Leverage investments made as part of ACA, HITECH and SSA implementations:
  - ACA Balancing Incentive Program (BIP) requirements for development of a Core Standardized Assessment and LTSS Information System
  - HITECH Health Information Exchange infrastructure requirements as part of the Meaningful Use Program
  - CMS Innovation Center new payment and service delivery models
- Demonstrate how LTSS providers and beneficiaries can benefit from use of Health IT
- Demonstrate how CB-LTSS data can be shared electronically across institutionally-based and non-institutionally based settings and with individuals (beneficiaries)
- Demonstrate how Health IT can better client engagement needed to improve point of care decision-making within community-based settings

The Value of person-centered eLTSS planning

- **Standardized Data Elements** for the capture, sharing and efficient re-use of eLTSS record information
- **Improved provider workflows** through secure, single-point data entry for eLTSS record development and exchange
- **Improved timeliness for collecting and sharing LTSS information** between provider groups, between providers and beneficiaries, and between providers and payers
- **Reduced paper based and manual processes** during eLTSS information gathering and sharing
- **Enabled sending and receiving provider groups** to initiate changes for beneficiary interventions
- **Enabled beneficiaries to engage directly in decision making** regarding care and services received

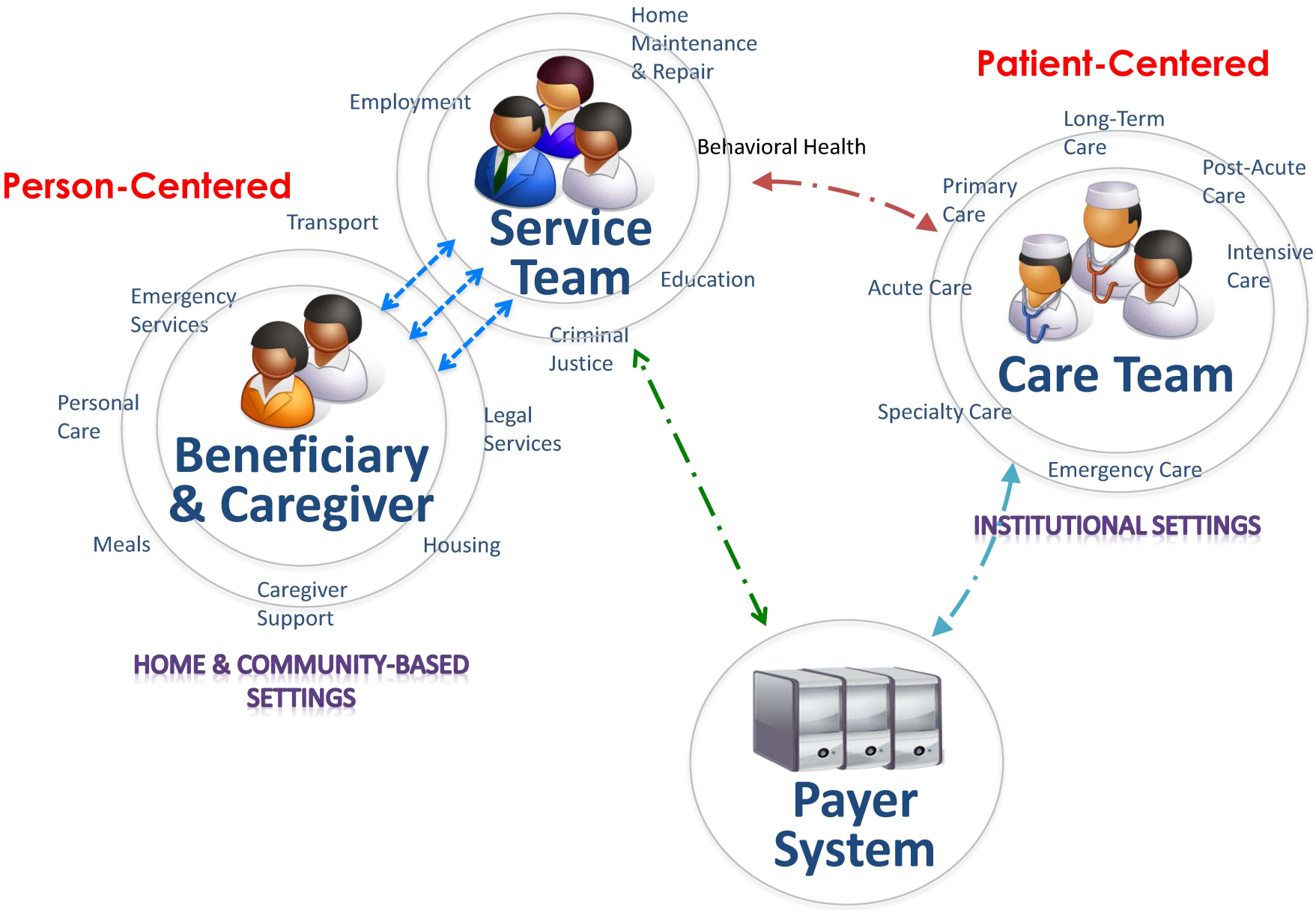
eLTSS Data Exchange Framework

Standards identified for the eLTSS plan will support interoperable exchange with various information systems to include:

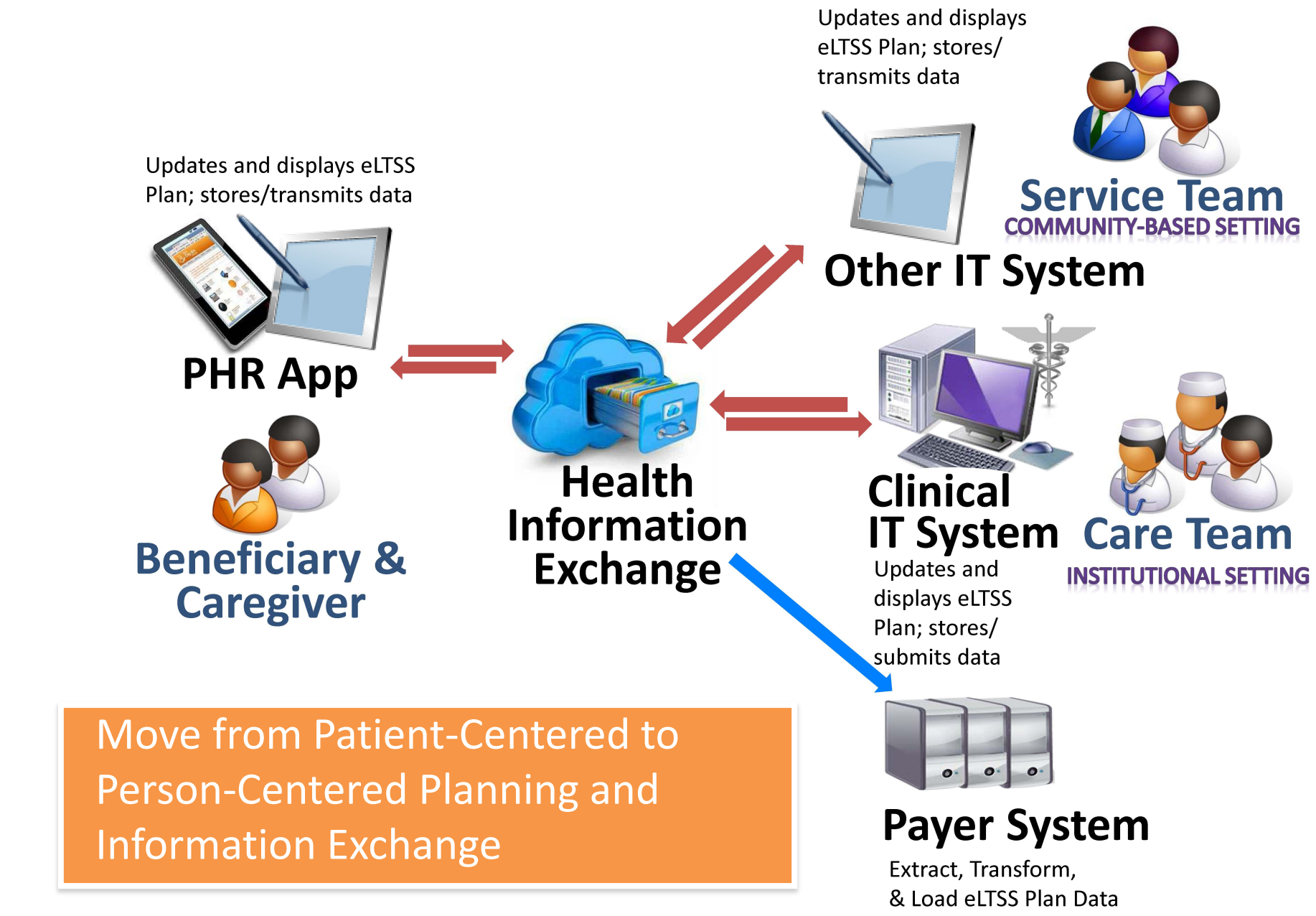
1. Community-based Information Systems
2. Clinical Information Systems (e.g. EHRs)
3. State Medicaid Systems and/or other Payer Systems
4. Health Information Exchange Systems
5. Personal Health Record Systems (PHRs)

Content or data elements of the eLTSS plan will be specific to the types of services rendered and information collected for CB-LTSS. Information collected may contain relevant clinical data needed to support the continuum of beneficiary care, support and services.

LTSS Information Sharing: As-Is Workflow



eLTSS Plan Exchange: To-Be Workflow



Move from Patient-Centered to Person-Centered Planning and Information Exchange

eLTSS Plan Exchange: To-Be Workflow

Updates and displays eLTSS Plan; stores/transmits data

PHR App

3. Receives updated eLTSS Record with new Service

Beneficiary & Caregiver

Health Information Exchange

2. Acknowledges Service Need; updates eLTSS Record

Service Team

COMMUNITY-BASED SETTING

Other IT System

1. Identifies Service Need

Clinical IT System

Updates and displays eLTSS Plan; stores/ submits data

Care Team

INSTITUTIONAL SETTING

Payer System

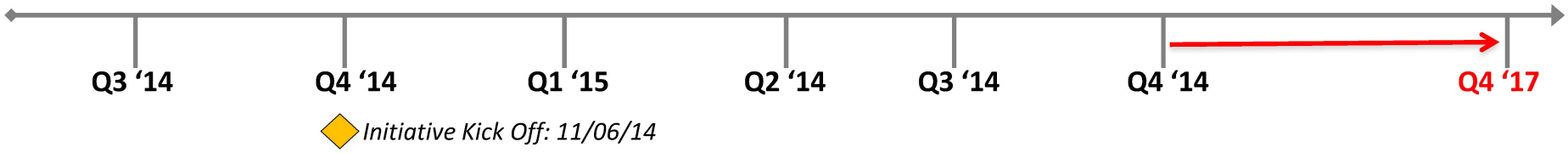
Extract, Transform, & Load eLTSS Plan Data

Move from Patient-Centered to Person-Centered Planning and Information Exchange

eLTSS Initiative: Expected Deliverables

- **Definition** for person-centered eLTSS Plan
- Identification of **key client assessment domains and associated data elements** to include in an eLTSS plan
- Development of a **Use Case** describing key conditions and business rules to enable eLTSS plan exchange while protecting privacy and confidentiality
- Development of concise **implementation guidance** to assist in testing and implementing technical requirements
- Execution of **seven TEFT grantee driven and one or more non-TEFT grantee driven pilots** to evaluate the specific use case for eLTSS plan exchange
- Identification and validation of **national standards** for eLTSS plan capture and exchange

eLTSS
S&I Phases Roadmap



Pre-Planning

- Call for Participation
- Conduct Environmental Scan
- Success Criteria
- Stakeholder Engagement

Phase 1: Pre-Discovery

- Launch initiative
- Review and Finalize Charter
- Review initial Candidate Standards

Phase 2: Use Case Development & Functional Requirements

- Develop, review, and finalize the Use Case and Functional Requirements

Phase 3: Standards & Harmonization

- Finalize Candidate Standards
- Standards Gap Analysis
- Technical & Standards Design
- Develop Requirements Traceability Matrix
- Develop Implementation Guide

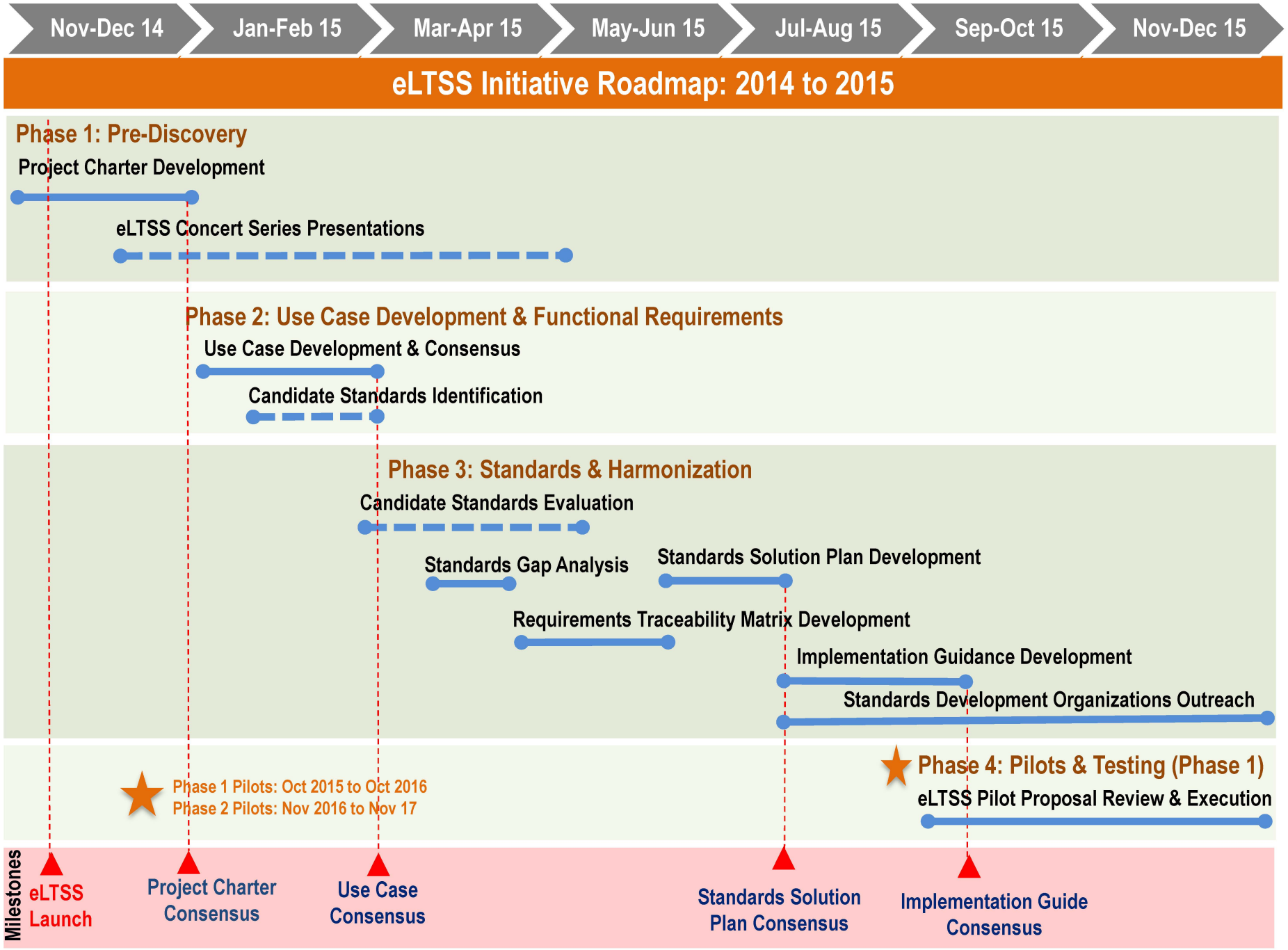
Phase 4: Pilots & Testing

- Pilot site readiness
- Implementation of solution
- Test User Stories and Scenarios
- Monitor Progress & Outcomes
- Utilize Requirements Traceability Matrix

Phase 4: Evaluation

- Evaluate outcomes against Success Metrics and Criteria
- Update Implementation Guidance

Timelines for Consideration: Two Pilot Phases, SDO Ballot Cycles


Nov-Dec 14
Jan-Feb 15
Mar-Apr 15
May-Jun 15
Jul-Aug 15
Sep-Oct 15
Nov-Dec 15
eLTSS Initiative Roadmap: 2014 to 2015
Phase 1: Pre-Discovery
Project Charter Development
eLTSS Concert Series Presentations
Phase 2: Use Case Development & Functional Requirements
Use Case Development & Consensus
Candidate Standards Identification
Phase 3: Standards & Harmonization
Candidate Standards Evaluation
Standards Gap Analysis
Standards Solution Plan Development
Requirements Traceability Matrix Development
Implementation Guidance Development
Standards Development Organizations Outreach
Phase 1 Pilots: Oct 2015 to Oct 2016
Phase 2 Pilots: Nov 2016 to Nov 17
Phase 4: Pilots & Testing (Phase 1)
eLTSS Pilot Proposal Review & Execution
Milestones
eLTSS Launch
Project Charter Consensus
Use Case Consensus
Standards Solution Plan Consensus
Implementation Guide Consensus

eLTSS Charter
Existing Efforts to Consider

- **CMS Standards & Guidance:** e.g. OASIS dataset, MDS, CARE Item Set, PACE, BIP Core Standardized Assessment Instruments, HCBS Taxonomy
- **Other Relevant Projects**:
  - CMS ACA Funded Projects: MFP, BIP, CFC, CMMI
  - HL7 Person Health Record System Functional Model Release 1
  - HL7 Consolidated Clinical Document Architecture Release 2.0
  - Terminology and Taxonomy Standards: SNOMED, LOINC, Omaha System, NANDA etc.
  - National Information Exchange Model (NIEM)
  - Openmhealth.org
  - Guided Care by Johns Hopkins University
  - Case Management Information System by Community Care of North Carolina
  - National Association of State Directors of Development Disabilities Services (NASDDDS) and Human Services Research Institute (HSRI) National Core Indicators
  - National Association of Social Workers Standards for Social Work Practice
  - Case Management Society of America (CMSA) Standards of Practice for Case Management
  - American Medical Association (AMA) and American Academy of Home Care Physicians (AAHCP) Guidelines for Uniform Assessment
  - Administration of Aging (AoA) Standardized Data Collection Tools
  - MassHealth, One Care Implementation Council, and UMass Medical School One Care Early Indicators Projects (EIP)
  - Other ONC and S&I Initiatives: e.g. Direct, LCC, BlueButton, SDC, DAF, Federal Health Information Model (FHIM)
  - IOM recommendations for Social and Behavioral Domains and Measures in EHRs

eLTSS Initiative: Project Team Leads

- ONC Leads
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- Harmonization
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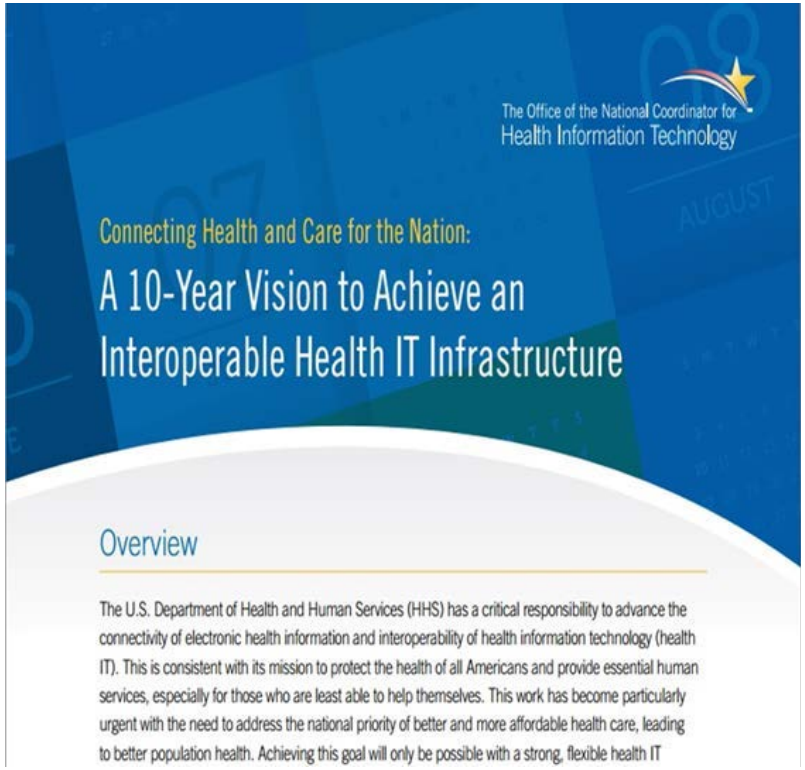
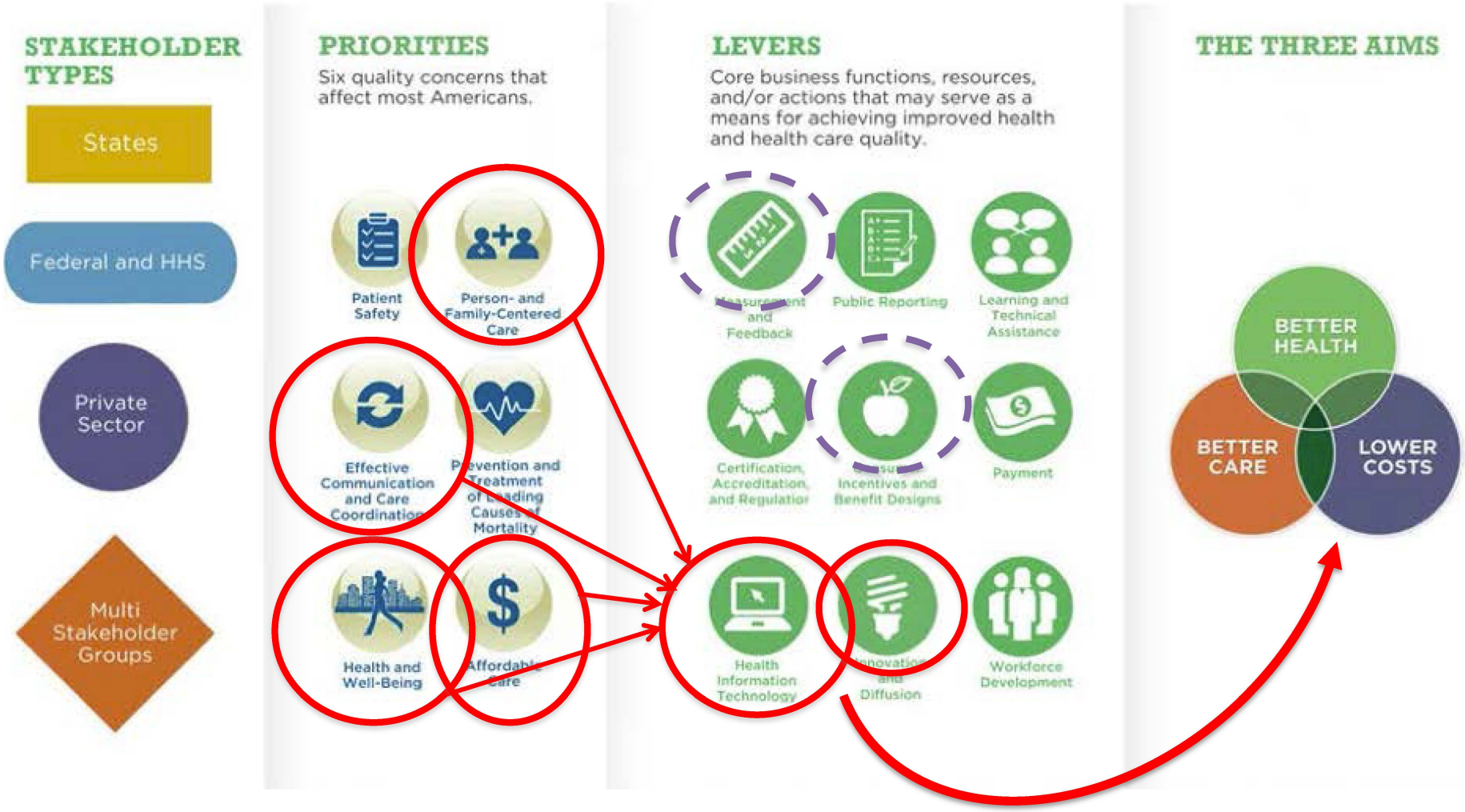
Back-up: Alignment to Interoperability & Quality Improvement Priorities

eLTSS Success Metrics: Alignment with National Interoperability Vision

- Leverage Health IT to increase health care quality, lower health care costs and improve population health
- Support health–not limited to care delivery
- Build incrementally from current technology
- Establish best minimum possible
- Create opportunities for innovation
- Empower individuals



eLTSS Success Metrics: Alignment with National Quality Strategy



Source: http://www.ahrq.gov/workingforquality/nqs/webinar051314/webinar3.pdf

CMS Medicaid Alignment with National Quality Strategy

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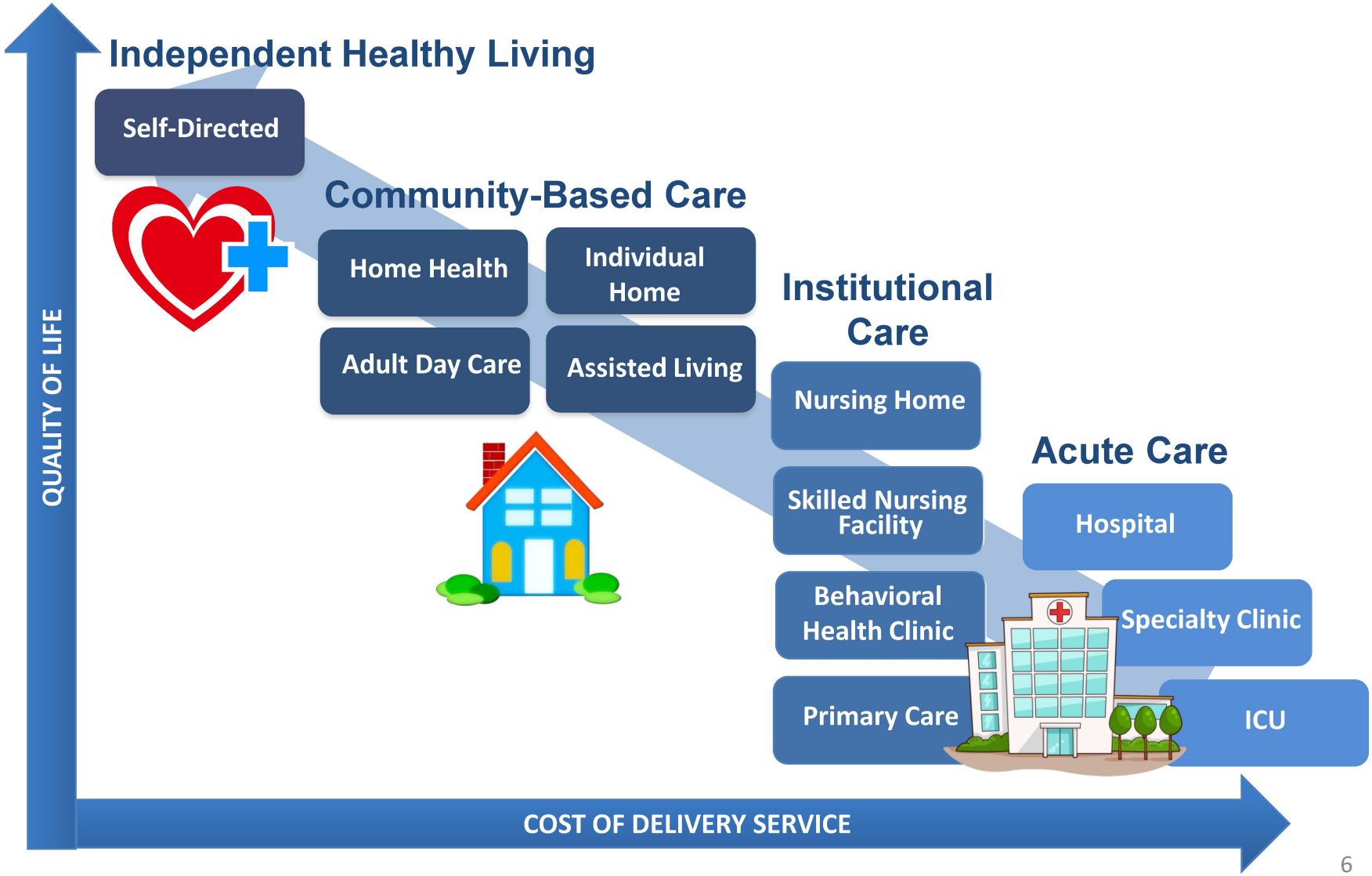

Image adapted from: http://www.marsdd.com/news-and-insights/transforming-health-decentralized-connected-care/