Looking Forward: HCBS Quality Measures Alignment and HCBS CAHPS®

Division of Community Systems Transformation, Disabled & Elderly Health Programs Group, Center for Medicaid & CHIP Services, Centers for Medicare & Medicaid Services

Center for Clinical Standards and Quality, Centers for Medicare & Medicaid Services

Office of the National Coordinator for Health IT
Agenda

Looking Forward: HCBS Quality Measures Alignment and HCBS CAHPS®
• Jennifer Bowdoin, PhD, Division of Community Systems Transformation, Disabled and Elderly Health Programs Group

Functional Assessment and Standardized Items (FASI)
• Kerry Lida, PhD, Division of Community Systems Transformation, Disabled and Elderly Health Programs Group

CAHPS Home and Community Based Services (HCBS CAHPS®) Survey
• Kerry Lida, PhD, Division of Community Systems Transformation, Disabled and Elderly Health Programs Group

Alignment with the IMPACT Act and CMS Data Elements Library
• Tara McMullen, PhD, Center for Clinical Standards and Quality

eLTSS: Charting a forward path
• Elizabeth Palena Hall, Office of the National Coordinator for Health IT
What Is FASI?

• Functional Assessment Standardized Items (FASI)
• A set of standardized person-centered assessment items that measure functional ability and need for assistance
  – Aligned with federally standardized items for measuring function in the Medicare program and adapted for the LTSS population
    • Self-care activities (e.g., eating, dressing)
    • Mobility activities (e.g., bed mobility and transfers, ambulation, wheelchair use)
  – Additional items specific to long-term services and supports (LTSS) needs
    • Instrumental Activities of Daily Living (IADLs) (e.g., making a light meal, answering the telephone)
    • Need for caregiver assistance
    • Personal goals related to functioning
FASI Development and Testing

- Technical Expert Panels
- Pretesting in one Testing Experience & Functional Tools (TEFT) grantee state with different Medicaid LTSS populations
- Field testing in six TEFT grantee states with different LTSS populations
- Technical Expert Panel review of findings and recommendations
- Demonstration of finalized FASI in TEFT grantee states
FASI Performance Measures

• Two standardized measures to assess and compare state or program performance related to person-centered planning
  – Percentage of individuals 18 years or older who received community-based LTSS with documented needs determined by a FASI AND who have identified at least 3 personal priorities related to self-care, mobility, or IADL functional needs within the reporting period
  – Percentage of individuals 18 years or older who received community-based LTSS with documented functional needs as determined by the FASI assessment AND documentation of a comprehensive person-centered service plan that addressed identified functional needs within the reporting period
Why Standardize LTSS Assessment Items and Measures?

• Allows for comparisons across state LTSS programs
• Enables electronic exchange of LTSS data
  – Among individuals, LTSS program providers, case managers, and health care providers
  – Between LTSS caregiver partners and Medicare post acute/institutional providers
• Allows data to follow the individual
How Can the FASI Be Used by States?

• Aligns with current state approaches for assessing functional status
  – One state plans to include the FASI set as part of a new universal assessment tool that is in development
  – Other states are still in testing and assessing whether and how to integrate it into their assessments

• Represents an important component of a comprehensive person-centered assessment that could inform an individual’s eligibility for HCBS and the associated service plan
  – Could be used to support an HCBS eligibility determination depending on program criteria

• Standardized measures can be used to assess and compare performance related to person-centered planning
CMS Data Element Library

• Centralized and authoritative resource for CMS’ required Long Term and Post-Acute Care (LTPAC) assessment instrument data elements (e.g., questions, response codes)
  – Also includes information on how data elements map to health IT standards

• Goals include:
  – Facilitate the maintenance of uniformity across CMS assessments and quality measures
  – Serve as an authoritative resource for LTPAC assessment data elements
  – Promote the sharing of electronic LTPAC assessment data sets and information standards
  – Influence and support industry efforts to promote EHR interoperability and care coordination
How is the Data Element Library useful for HCBS?

- Publically available database of potential assessment questions and responses
  - Will include the FASI
  - States may reuse the standardized data elements from other areas
  - Most items have been previously tested for feasibility and reliability in post-acute care settings
The Data Elements Library is the centralized resource for CMS assessment instrument data elements (e.g., questions, responses) and their associated health information technology (IT) standards. [https://del.cms.gov/DELWeb/pubHome](https://del.cms.gov/DELWeb/pubHome)
What is the HCBS CAHPS® Survey?

• Consumer Assessment of Healthcare Providers and Systems Home- and Community-Based Services (HCBS CAHPS®) Survey
• Cross-disability consumer experience survey for eliciting feedback from beneficiaries receiving Medicaid HCBS services and supports
  – Focus on participant experience, not satisfaction
• Allows for comparisons across programs serving different target populations
  – Individuals who are frail elderly
  – Individuals with a physical disability
  – Individuals with an intellectual or developmental disability
  – Individuals with a brain injury
  – Individuals with serious mental illness
HCBS CAHPS® Survey Instruments

- Core instrument
- Supplemental employment Module
- English and Spanish versions of both
Sample Design

- Unit of analysis = HCBS program or accountable entity
- Accountable entity = operating entity responsible for managing and overseeing a specific HCBS program within a given state (e.g., managed care organization)
- Focus of analysis can vary
  - Program
  - Managed care organization
  - Case management agency
  - County
  - State
Common Services and Providers Addressed by the Survey

• Common services
  – Personal care and behavioral health care
  – Transportation
  – Home care
  – Case management
  – Employment assistance

• Common providers
  – Personal assistant and behavioral health staff
  – Medical transportation services
  – Case manager
  – Homemaker
  – Job coach
Survey Administration

- Designed to be administered by an interviewer
  - In person
  - By telephone
  - **Participant’s choice**

- 69 maximum items
  - 30 minute average due to skip patterns

- Alternate responses (for accessibility)
  - Mostly yes, mostly no (instead of four point scale)
  - Excellent, very good, good, fair, poor (instead of 1 to 10)

- Assistance and proxy respondents allowed (not a paid provider)
Key Features of HCBS CAHPS® Survey

• Person-centered
• Cross-disability
  – Ability to compare programs
  – Increased accessibility via phone mode, alternate response, and proxy
• Development aligned with CAHPS®
  – Reflects what is important to beneficiaries
  – Rigorous review of testing methods and results
  – Trademark that providers recognize
• Survey sponsor can determine frequency of use
• Available for free
Current work is underway with AHRQ to implement a CAHPS® HCBS national database

- Will offer free access to aggregated results for analysis and use

19 NQF endorsed HCBS measures (NQF#2967)

- Derived from the HCBS CAHPS® Survey
- Consist of 7 composite measures, 3 global ratings, 3 recommendation measures, and 6 single-item measures (5 unmet need and 1 physical safety)
- Fully endorsed for inclusion in the core measurement sets for Medicaid adults and for dual-eligible beneficiaries
Alignment with the IMPACT Act and CMS Data Elements Library

Tara McMullen, PhD
Center for Clinical Standards and Quality
CMS Strategic Goals

• Patients (customers) over Paperwork
• Empower customers and doctors to make decision about their health care
• Meaningful Measures
• Inter-operability – putting data in the hands of customers
• Quality Data Strategy: Re-defining quality
• Support innovative approaches to improve quality, accessibility, and affordability
• Improve the CMS customer experience
• Usher in a new era of state flexibility and local leadership
Meaningful Measures

Promote Effective Communication & Coordination of Care
Meaningful Measure Areas:
• Medication Management
• Admissions and Readmissions to Hospitals
• Transfer of Health Information and Interoperability

Strengthen Person & Family Engagement as Partners in their Care
Meaningful Measure Areas:
• Care is Personalized and Aligned with Patient’s Goals
• End of Life Care according to Preferences
• Patient’s Experience of Care
• Patient Reported Functional Outcomes

Make Care Safer by Reducing Harm Caused in the Delivery of Care
Meaningful Measure Areas:
• Healthcare-Associated Infections
• Preventable Healthcare Harm

Make Care Affordable
Meaningful Measure Areas:
• Appropriate Use of Healthcare
• Patient-focused Episode of Care
• Risk Adjusted Total Cost of Care

Promote Effective Prevention & Treatment of Chronic Disease
Meaningful Measure Areas:
• Preventive Care
• Management of Chronic Conditions
• Prevention, Treatment, and Management of Mental Health
• Prevention and Treatment of Opioid and Substance Use Disorders
• Risk Adjusted Mortality

Work with Communities to Promote Best Practices of Healthy Living
Meaningful Measure Areas:
• Equity of Care
• Community Engagement

Safeguard Public Health

Support Innovative Approaches

State Flexibility and Local Leadership

Empower Patients and Doctors

Improve Access for Rural Communities

Reduce burden

Improve CMS Customer Experience

Achieve Cost Savings

Eliminate Disparities

Track to Measurable Outcomes and Impact

*All presentation images are still under development.*
Vision for Future State

Historical state

Key characteristics
- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

Systems and Policies
- Fee-For-Service Payment Systems
- Traditional managed care

Evolving future state

Public and Private sector

Key characteristics
- Patient-centered
- Incentives for outcomes
- Sustainable
- Integrated care & Inter-operability

Systems and Policies
- Value-based purchasing
- Accountable Care Organizations
- New LTSS Options for coverage and payment
- Quality/cost transparency
The Improving Medicare Post-Acute Care Transformation Act of 2014

• Requires the use of standardized Medicare assessment data in post-acute care settings.

• Purpose:
  o Support access to longitudinal information to help inform clinical decision-making.
  o Promote coordinated care.
  o Enable comparison of data across post-acute care, including the rate-setting and payment, as well as quality of care.
  o Inform discharge planning.
  o Enable interoperability and health information exchange.
  o Outcome based decision-making to improve the beneficiary experience.
  o PAC Providers are required to submit patient assessment data to CMS via the assessment tools for multiple purposes (payment, quality measurement and survey and certification)
The IMPACT Act of 2014

Post-Acute Care Setting
- Long-Term Care Hospitals
- Skilled Nursing Facilities
- Home Health Agencies
- Inpatient Rehabilitation Facilities (IRF)
- [not included] LTSS

Assessment Instruments
- Long-term care hospital clinical data set (LCDS)
- Minimum Data Set (MDS)
- Outcome and Assessment Information Set (OASIS)
- IRF patient assessment instrument (IRF-PAI)
- [not required] Functional Assessment Instrument (FASI)
<table>
<thead>
<tr>
<th>Measure Domain</th>
<th>Measure Name</th>
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<tbody>
<tr>
<td>Functional status</td>
<td>Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)</td>
</tr>
<tr>
<td>Skin integrity</td>
<td>Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) (NQF #0678)</td>
</tr>
<tr>
<td>Medication reconciliation</td>
<td>Drug Regimen Review Conducted with Follow-Up for Identified Issues Post Acute Care (PAC)</td>
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<tr>
<td>Incidence major falls</td>
<td>Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)</td>
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<tr>
<td>Transfer of Health Information</td>
<td>Transfer of Information at Post-Acute Care Admission, Start or Resumption of Care from Other Providers/ Settings Transfer of Information at Post-Acute Care Discharge to Other Providers/Settings</td>
</tr>
<tr>
<td>Medicare Spending Per Beneficiary</td>
<td>Medicare Spending Per Beneficiary-Post Acute Care (PAC)</td>
</tr>
<tr>
<td>Discharge to Community</td>
<td>Discharge to Community-Post Acute Care (PAC)</td>
</tr>
<tr>
<td>Potentially Preventable Hospital Readmissions</td>
<td>Potentially Preventable 30-Day Post-Discharge Readmission Measure</td>
</tr>
</tbody>
</table>
Data Element Library (DEL)

- Database of CMS assessment information
- Includes:
  - Assessment questions/items
  - Assessment version
  - Item labels
  - Item status
- Designed to support
  - Data standardization
  - Sharing of CMS assessment data sets
  - Adoption of IT health technology standards
  - Industry and State efforts for interoperability
  - Care Coordination
Components of the Assessment Item Sets.

May be defined as the question/answer pair in the assessment instruments; may also be referred to as Data Items.

Consist of:
- Section
- Parent
- Question
- Answer
- Definitions
- Instruction
Section C  Cognitive Patterns

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?

Attempt to conduct interview with all residents

Enter Code

0. No (resident is rarely/never understood) → Skip to and complete C0700-C1000, Staff Assessment for Mental Status
1. Yes → Continue to C0200, Repetition of Three Words

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Ask resident: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed. Now tell me the three words."

Number of words repeated after first attempt

Enter Code

0. None
1. One
2. Two
3. Three

After the resident’s first attempt, repeat the words using cues ("sock, something to wear; blue, a color; bed, a piece of furniture"). You may repeat the words up to two more times.

C0300. Temporal Orientation (orientation to year, month, and day)

Ask resident: "Please tell me what year it is right now."

Enter Code

A. Able to report correct year

0. Missed by > 5 years or no answer
1. Missed by 2-5 years
2. Missed by 1 year
3. Correct
**One Question: Much to Say → One Response: Many Uses**

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### GG0160. Functional Mobility

*(Complete during the 3-day assessment period.)*

**Code the patient’s usual performance using the 6-point scale below.**

<table>
<thead>
<tr>
<th>CODING:</th>
<th>Enter Codes in Boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Safety and Quality of Performance</strong> - If helper assistance is required because patient’s performance is unsafe or of poor quality, score according to amount of assistance provided.</td>
<td></td>
</tr>
<tr>
<td>Activities may be completed with or without assistive devices.</td>
<td></td>
</tr>
</tbody>
</table>

06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.

05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.

04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEDYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.

03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.

02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the task.

| | A. Roll left and right: The ability to roll from lying on back to left and right side, and roll back to back. |
| | B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed. |
| | C. Lying to Sitting on Side of Bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, no back support. |

07. Patient refused

09. Not applicable

If activity was not attempted, code:

88. Not attempted due to medical condition or safety concerns
Electronic Long-Term Services & Supports (eLTSS): Charting a Path Forward

NASAUD Annual HCBS Conference
Liz Palena-Hall, LTPAC Coordinator, Office of the National Coordinator for Health IT
Date: August 30, 2018
Agenda

• Background & Scope
• eLTSS Conceptual Framework
• eLTSS Core Dataset
• Key Activities
• Value Proposition for Health Data Standardization
Background: What is the eLTSS Initiative?

- Launched in November 2014 as a **joint project** between CMS and ONC

- Driven by the requirements of the *CMS Testing Experience and Functional Tools (TEFT) in Medicaid community-based long term services & supports (LTSS) Planning and Demonstration Grant Program*
  
  » 6 of 9 TEFT grantees participate in the eLTSS component of TEFT: CO, CT, GA, KY, MD, MN

- Supports CMS Requirements for Person-Centered Service Service Plans (PCSPs) as defined within the [HCBS 1915 (c) Waiver Final Rule](https://www.medicaid.gov/medicaid/ltss/teft-program/index.html)

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What is the scope of eLTSS?

1. Identifying **components or data elements** needed for the electronic creation, sharing and exchange of person-centered service plans
   
   Data elements comprise the information needed by users of person-centered service plans; they are the units used to populate forms for electronic exchange

2. Field testing/piloting these data elements within participating organizations (pilots) respective systems (paper based and electronic)
Who Participates in eLTSS?

339 Total Members
- 100 Committed Members
- 239 Other Interested Party
- 318 Not Registered (attended 1+ meeting)

<table>
<thead>
<tr>
<th>Stakeholder Group Type/ Total Participants</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Beacon Community, Quality Improvement Organizations, or similar organization</td>
<td>4</td>
</tr>
<tr>
<td>Consumer / Patient Advocate</td>
<td>12</td>
</tr>
<tr>
<td>Contractor / Consultant</td>
<td>33</td>
</tr>
<tr>
<td>Federal, State, Local Agency</td>
<td>143</td>
</tr>
<tr>
<td>Health Information Exchange (HIE) / Health Information Organization (HIO)</td>
<td>10</td>
</tr>
<tr>
<td>Health IT Vendor (EHR, EMR, PHR, HIE)</td>
<td>45</td>
</tr>
<tr>
<td>Health Professional (DO, MD, DDS, RN, Tech, etc.)</td>
<td>15</td>
</tr>
<tr>
<td>Healthcare Payer/Purchaser or Payer Contractor</td>
<td>5</td>
</tr>
<tr>
<td>Licensing / Certification Organization</td>
<td>2</td>
</tr>
<tr>
<td>Provider Organization (institution / clinically based)</td>
<td>9</td>
</tr>
</tbody>
</table>

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<tr>
<th></th>
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<tbody>
<tr>
<td>Research Organization</td>
<td>19</td>
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<tr>
<td>Standards Organization</td>
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<tr>
<td>Service Provider (community-based)</td>
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<td>Service Provider Professional (community-based)</td>
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<td>Other</td>
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<td>Unknown</td>
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<td>TEFT Leadership / TA</td>
<td>32</td>
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<tr>
<td>ONC Staff / Contractor</td>
<td>26</td>
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</table>
TARGET **data-level interoperability** by enabling electronic creation, management and exchange of eLTSS data among all relevant users of data.
eLTSS Dataset Development and Pilot Approach

- Identified and validated through 2 rounds of public-facing pilots and harmonization activities
  - Pilots included 6 TEFT grantees and 12 non-TEFT grantees
  - After each round, dataset went through a public comment and disposition period

- Extensive education and outreach to facilitate pilots
  - +130 different organizations contacted over course of initiative
  - 5 Federal Partner Webinars
  - 27 public outreach presentations

**Harmonization (definition):** to bring into harmony, accord or agreement. When speaking of standards, relates to process of minimizing redundant or conflicting standards which may have evolved independently.

# eLTSS Core Dataset

- **Total Number of Elements: 56**

<table>
<thead>
<tr>
<th>Beneficiary Demographics: 10 Elements</th>
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<tbody>
<tr>
<td>Person Name</td>
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<td>Person Identifier</td>
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<td>Person Identifier Type</td>
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<td>Person Phone Number</td>
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<tr>
<td>Person Address</td>
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<tr>
<td>Emergency Contact Name</td>
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<tr>
<td>Emergency Contact Relationship</td>
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<tr>
<td>Emergency Contact Phone Number</td>
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<td>Emergency Backup Plan</td>
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<table>
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<th>Person Centered Planning: 11 Elements</th>
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<tr>
<td>Assessed Need</td>
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<td>Preference</td>
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<td>Person Setting Choice Indicator</td>
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<td>Person Setting Choice Options</td>
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<td>Service Options Given Indicator</td>
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<td>Service Selection Indicator</td>
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<td>Service Provider Options Given Indicator</td>
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<td>Service Provider Selection Agreement Indicator</td>
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<td>Plan Effective Date</td>
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<th>Plan Signatures: 12 Elements</th>
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<td>Guardian/Legal Representative Signature</td>
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<td>Guardian/Legal Representative Printed Name</td>
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<tr>
<td>Guardian/Legal Representative Signature Date</td>
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<tr>
<td>Support Planner Signature</td>
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<tr>
<td>Support Planner Printed Name</td>
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<tr>
<td>Support Planner Signature Date</td>
</tr>
<tr>
<td>Service Provider Signature</td>
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<tr>
<td>Service Provider Printed Name</td>
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<td>Service Provider Signature Date</td>
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<th>Risks: 2 Elements</th>
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<tr>
<td>Identified Risk</td>
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<td>Risk Management Plan</td>
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<tr>
<th>Service Information: 12 Elements</th>
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<td>Self-Directed Service Indicator</td>
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<th>Service Provider Information: 5 Elements</th>
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<tr>
<td>Service Provider Name</td>
</tr>
<tr>
<td>Service Provider Phone Number</td>
</tr>
<tr>
<td>Non-Paid Provider Relationship</td>
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</table>
Key Activities 2017-2018

• eLTSS Standard Development: Sept 2017 – Sep 2018
  » Led by The Georgia Department of Community Health – Health Information Technology Unit (DCH-HIT) supported by GTRI in coordination with participating TEFT States, ONC and CMS
  » Identification of existing nationally recognized standards to represent eLTSS Dataset: FHIR and C-CDA

• eLTSS Standard Testing: Feb 2018 – Sept 2018
  » May 2018 HL7 FHIR Connectathon (Germany)
  » June 28, 2018 FHIR mini-Connectathon Event (Atlanta, GA)
  » August 9-10, 2018 C-CDA Implementation-a-thon (Washington, DC)
  » Sept 28-29, 2018 HL7 FHIR Connectathon (Baltimore, MD)
Key Activities

- HL7 Ballot Development & Publication: April 2018 – Sept 2018
  - Outcomes from testing events informing development of eLTSS Whitepaper
  - eLTSS Whitepaper will be balloted as a comment-only ballot in the HL7 August/September 2018 Ballot Cycle

**Why Ballot through HL7 (Standards Development Organization–SDO)?**

- SDOs provide a level of legitimacy and formality to a technical innovation
- SDOs serve to identify, publish, and curate global standards for the exchange, integration, sharing and retrieval of electronic information
- HL7 is one of the SDOs whose standards are referenced by ONC in the [2015 Edition Health IT Certification Criteria](https://www.healthit.gov/certification/certification-criteria) and the [Interoperability Standards Advisory](https://www.healthit.gov/certification/standards-advisory)
June 2018 eLTSS FHIR mini-Connectathon Summary and Outcomes
eLTSS FHIR mini-Connectathon Overview

• Opportunity for community stakeholders to test the final, consensus-based eLTSS Dataset (published in September 2017) using HL7 FHIR Resources.

• The Georgia and eLTSS Project Team developed a mapping of the eLTSS Dataset to existing HL7 FHIR resources. This mapping supports our goal of identifying nationally recognized standards to support the interoperable capture, sharing and exchange of eLTSS plan information.

• Findings from the Connectathon will be used to inform the development of the eLTSS ballot materials for the HL7 August/September 2018 Ballot cycle.
Participant Organizations

- State of Georgia, Department of Community Health
- Georgia Tech Research Institute (GTRI)
- American Diabetes Association (ADA)
- Long Term Care Innovation (LTCI) Inc. / LTSS DataLink®
- Office of the National Coordinator for Health Information Technology (ONC)
- JKM Software (Contractor to Veteran’s Administration)
- Carradora Health
- EMI Advisors, LLC
- ESAC, Inc.
Participant Goals

• Identify any potential issues with the eLTSS Dataset to FHIR mapping
• Identify any gaps/additional needs (e.g. adding a code list or terminology to represent the data element)
• Test and validate the eLTSS Dataset and mapping in a FHIR-enabled environment
• Determine if eLTSS data elements can be represented in the FHIR resources selected
• Test sample LTSS service plans using the FHIR mapping
• Support eLTSS organizations and their interoperability goals
• Learn more about eLTSS goals and opportunities
Challenges and Lessons Learned

- **FHIR Server implementation nuances** appear during testing and can impact interactions with the participant applications.

- Determining the **specific workflow for interactions** would be helpful to prepare the participants prior to a connectathon event.

- **System pre-planning activities** should be executed to ensure systems are ready and can execute the different testing scenarios.

- **Face to face interactions** are helpful.

- **FHIR Server Setup FAQs** needed around FHIR server setup and how the server handles bundles.

- **Pre-Participant system to FHIR server testing** is helpful.

- Recommendation to have participants provide **sample files ahead of time** and address technical/setup issues prior to the event.

- Less feedback was received on the eLTSS FHIR Mapping due to time spent on addressing learning curves with a FHIR-enabled environment.
eLTSS Upcoming Testing Events
FHIR Testing Opportunities

• HL7 FHIR Connectathon: Care Plan Track

  » September 29 – 30, 2018 in Baltimore, MD:

  » eLTSS Use Cases and the eLTSS FHIR Mapping will be made available and tested as part of the Care Plan track:

  » Who should attend?

    – eLTSS Community Implementers who plan to use C-CDA documents

    – Individuals and organizations that use and build applications for exchange

    – Users and developers working for healthcare providers, vendors and HIEs

  » Registration Link

    – http://www.hl7.org/events/working_group_meeting/2018/09/
Stay Connected!

• Get updates and announcements regarding eLTSS:
  https://oncprojecttracking.healthit.gov/wiki/display/TechLabSC/Join+eLTSS

• eLTSS Final Dataset and Summary: https://tinyurl.com/y8xczjhp
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Questions

Thank you for attending.