electronic Long-Term Services & Supports (eLTSS) Community Update

July 16, 2020

The Office of the National Coordinator for Health Information Technology

Disclaimer

- eLTSS is a joint project of the Centers for Medicare & Medicaid Services (CMS), the Office of the National Coordinator (ONC), and eLTSS community participants
- The eLTSS Initiative and this document were made possible by funding from CMS
- The contents of this document are solely the responsibility of the author(s) and do not represent the official views of CMS, ONC, or any of its affiliates

Meeting Etiquette

- Remember: If you are not speaking, **please keep your phone on mute**
- **Do not put your phone on hold.** If you need to take a call, hang up and dial in again when finished with your other call
  - Hold = Elevator Music = frustrated speakers and participants
- This meeting is being recorded
  - Another reason to keep your phone on mute when not speaking
- **Use the "Chat" feature** for questions, comments, and items you would like the moderator or other participants to know

Agenda

TOPIC	PRESENTER
Project Overview	Amber Patel @ Security Risk Solutions
eLTSS FHIR Implementation Guide Overview	Becky Angeles @ Carradora
HL7 May Connectathon Testing and Outcomes	Becky Angeles @ Carradora
Missouri's eLTSS Testing a State's Perspective and Journey	Gary Schanzmeyer, Angela Brenner, Toi Wilde @ State of Missouri
Patient-Centered Care: Implementing eLTSS in Patient*Share*	Nancy Lush @ Patient Centric Solutions
eLTSS Planning for HL7 September Connectathon	Greg White @ Security Risk Solutions
eLTSS Community Engagement	Elizabeth Palena Hall @ ONC

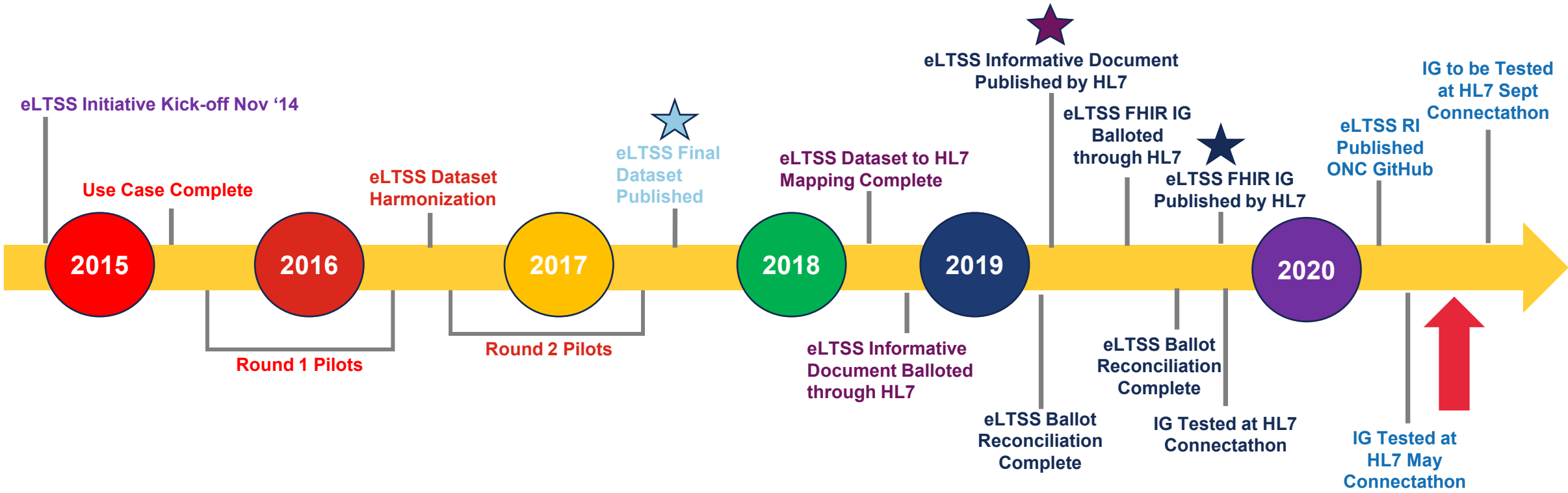
Project Overview

Review of the eLTSS Project

- Phase 1: Identified and harmonized a set of 56 data items (the eLTSS dataset) commonly found on LTSS Service Plans to facilitate the capture and exchange of person-centered LTSS service plan data
- Phase 2: Piloted, identified, and harmonized data items with TEFT grantee states and vendors to validate the eLTSS dataset
- Phase 3: Continuation of Phase 1 & Phase 2 broken into 2 Tracks
  - Track 1: Informative Document
    - The eLTSS Informative Document, officially named "HL7 Cross-Paradigm Information Sharing for Electronic Long-Term Services & Supports (eLTSS), Release 1 - US Realm" describes how the eLTSS dataset enables Home and Community Based Services (HCBS) person-centered service plans to be represented for exchange and sharing using FHIR and C-CDA. The Informative Document was balloted through HL7 and is now available as an HL7 publication.
  - Track 2: FHIR Implementation Guide (IG) and Testing
    - The eLTSS FHIR IG expands the FHIR to eLTSS mapping from the Informative Document into the HL7 FHIR IG structure (Profiles, Extensions, Capability Statements, etc.). The eLTSS FHIR IG has been published by HL7 and was tested at the HL7 September 2019 and May 2020 Connectathons.

To track and review eLTSS Artifacts please see the eLTSS wiki:
https://oncprojectracking.healthit.gov/wiki/display/TechLabSC/eLTSS+Home

eLTSS Initiative At-A-Glance



eLTSS FHIR Implementation Guide Overview

eLTSS FHIR IG Overview

- Builds on the Informative Document balloted in January 2019 by using existing FHIR Resources to provide mappings between the eLTSS dataset and existing FHIR R4 elements
- Provides implementers with guidance regarding the conformance requirements for leveraging FHIR to exchange LTSS data among beneficiaries (patients), providers, care team members, and between both non-clinical and clinical systems
- Utilizes US Core and applies other constraints (mostly through the “Must Support” flag)
- Profiles 13 Resources and provides 3 extensions
- Published by HL7 as a standard for trial use (STU) and available at: http://hl7.org/fhir/us/eltss/index.html
- Referenced in the 2020 *ONC Interoperability Standards Advisory* (ISA)
- Applied within the eLTSS FHIR IG Reference Implementation available on ONC GitHub https://github.com/onc-healthit/eLTSS-Reference-Implementation

HL7 May Connectathon Testing and Outcomes

Purpose of eLTSS Testing

- Implement and test the eLTSS FHIR IG within a variety of independently developed systems
- Exchange eLTSS care plans among disparate health IT (HIT) systems and clients, and display care plans in a consumable format for care providers, beneficiaries, and family members
- Implement the eLTSS IG in combination with other IGs and aggregate related data so that it can be accessed collectively

Test Partners

- Post-acute Care Interoperability (PACIO) Project led by MITRE
- Patient Centric Solutions
- Altarum

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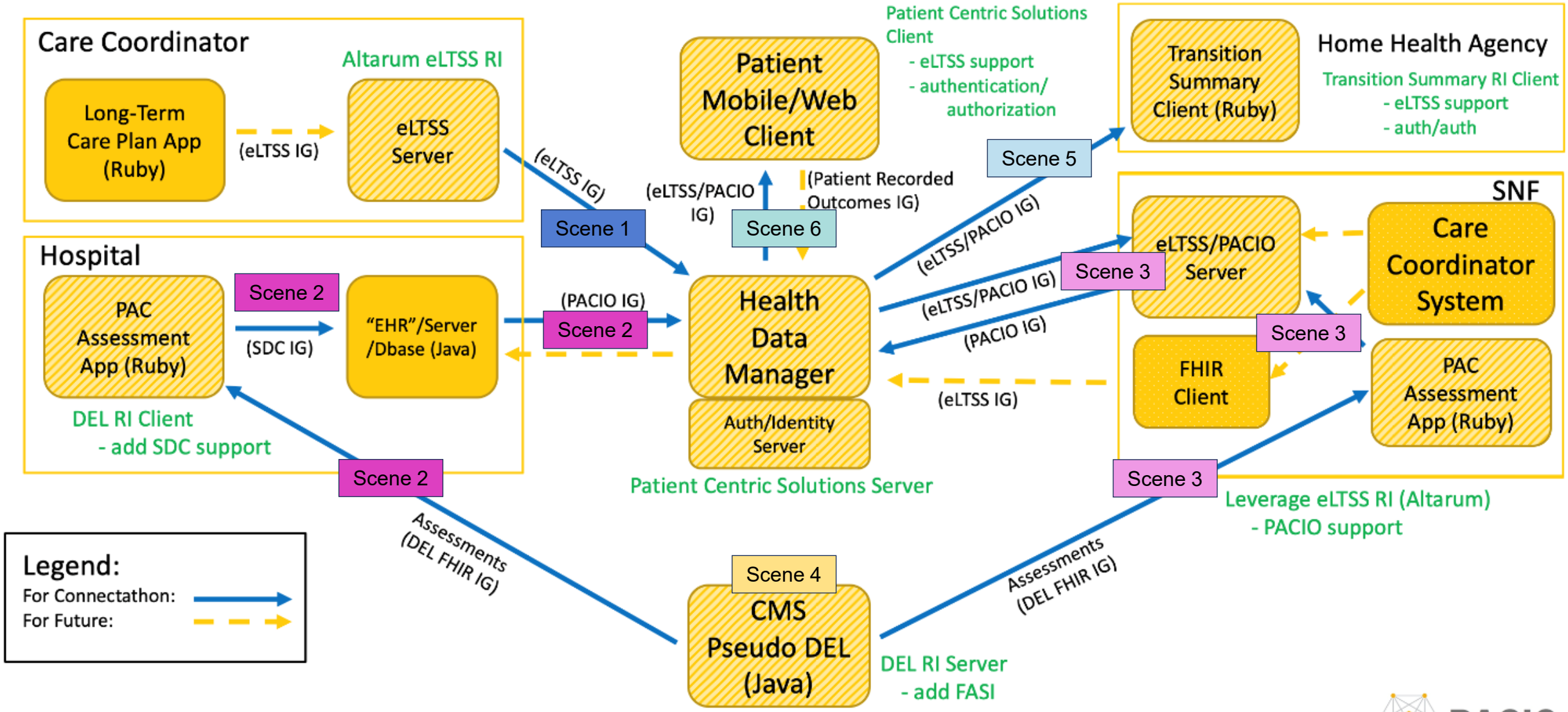
PACIO-eLTSS Track Testing Architecture



PACIO

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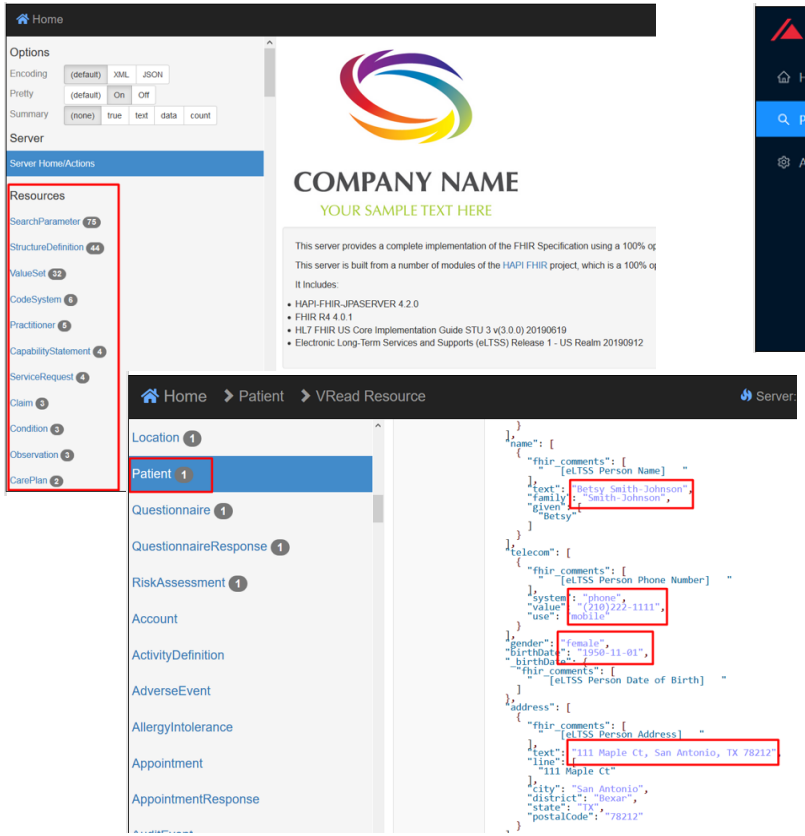
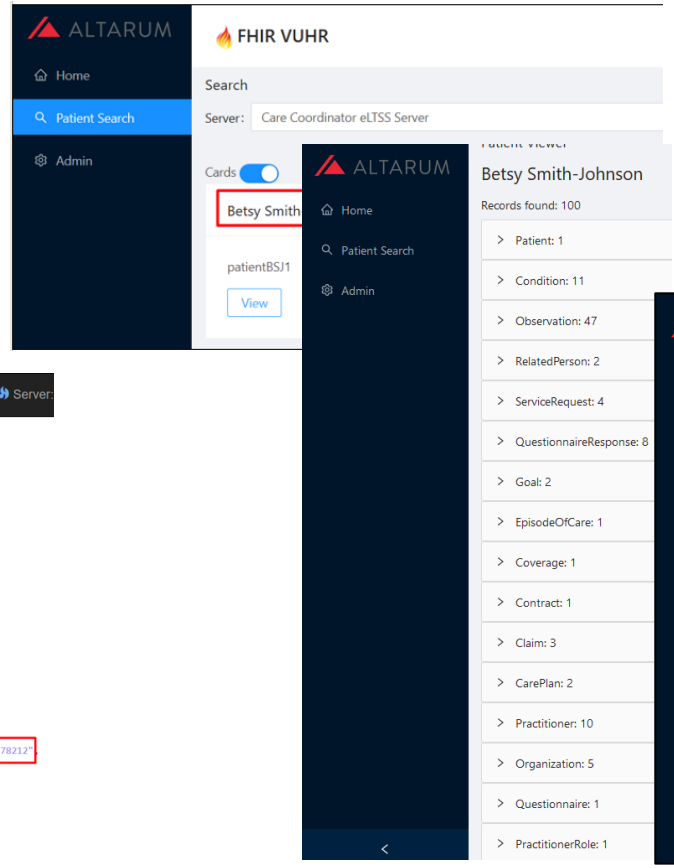
Scene 1

- Ms. Betsy Smith Johnson receives home community-based services (HCBS) services at home. A social worker documents eLTSS data including care plan and goals. eLTSS data is pushed to the Data Hub.

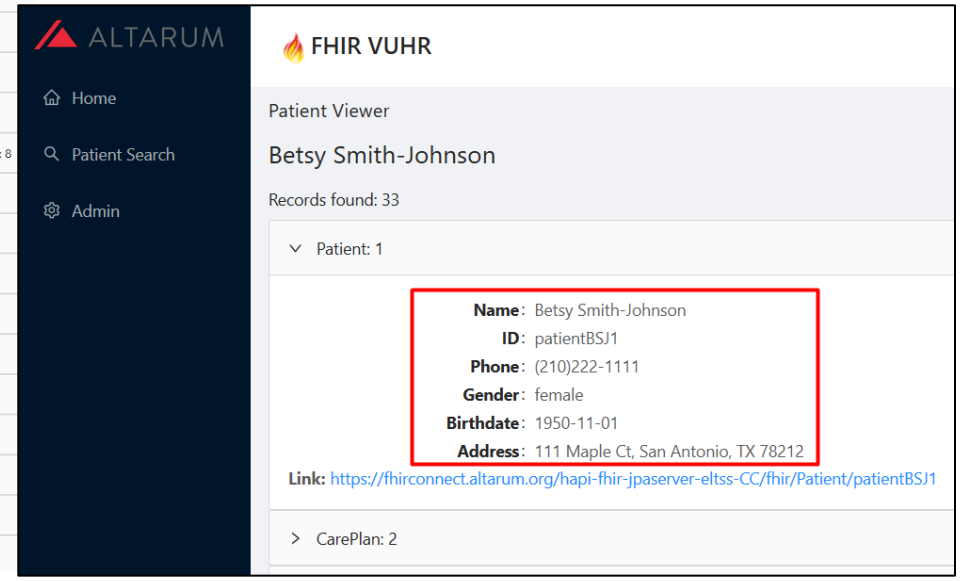
Server



Viewer

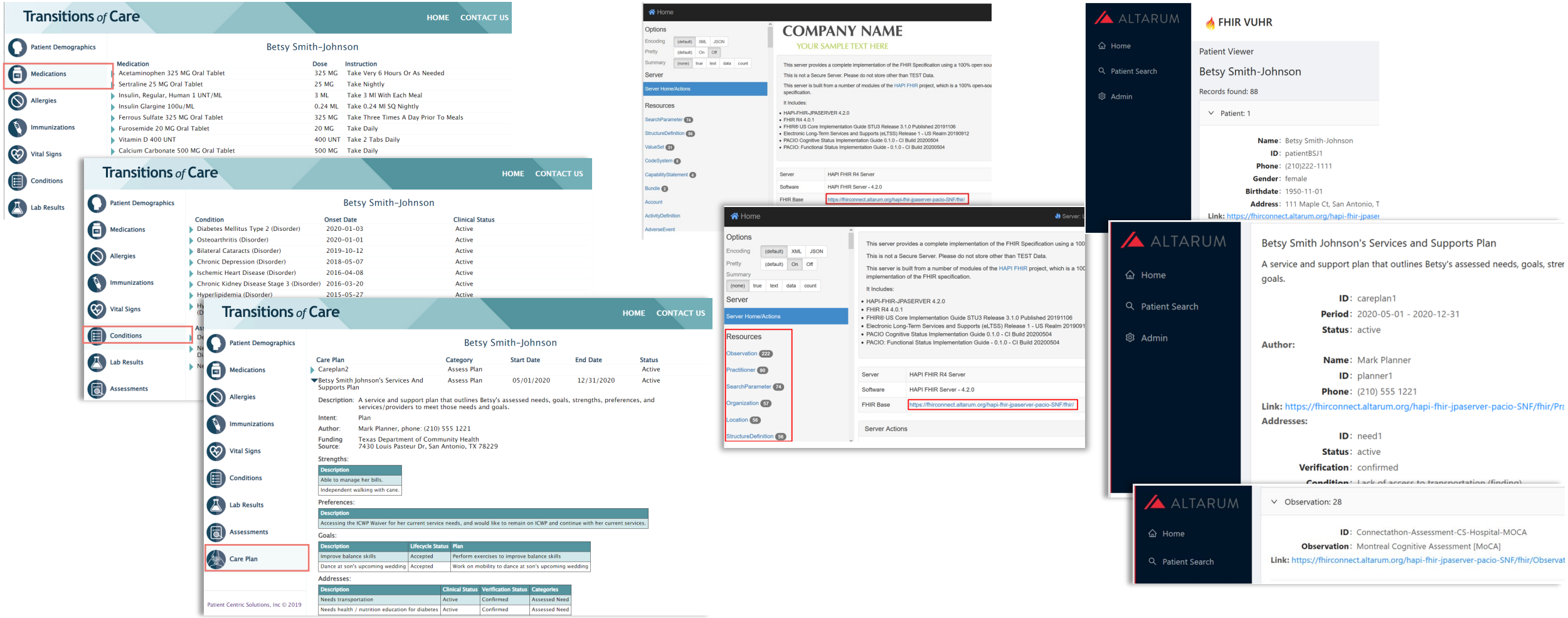


Push to Data Hub



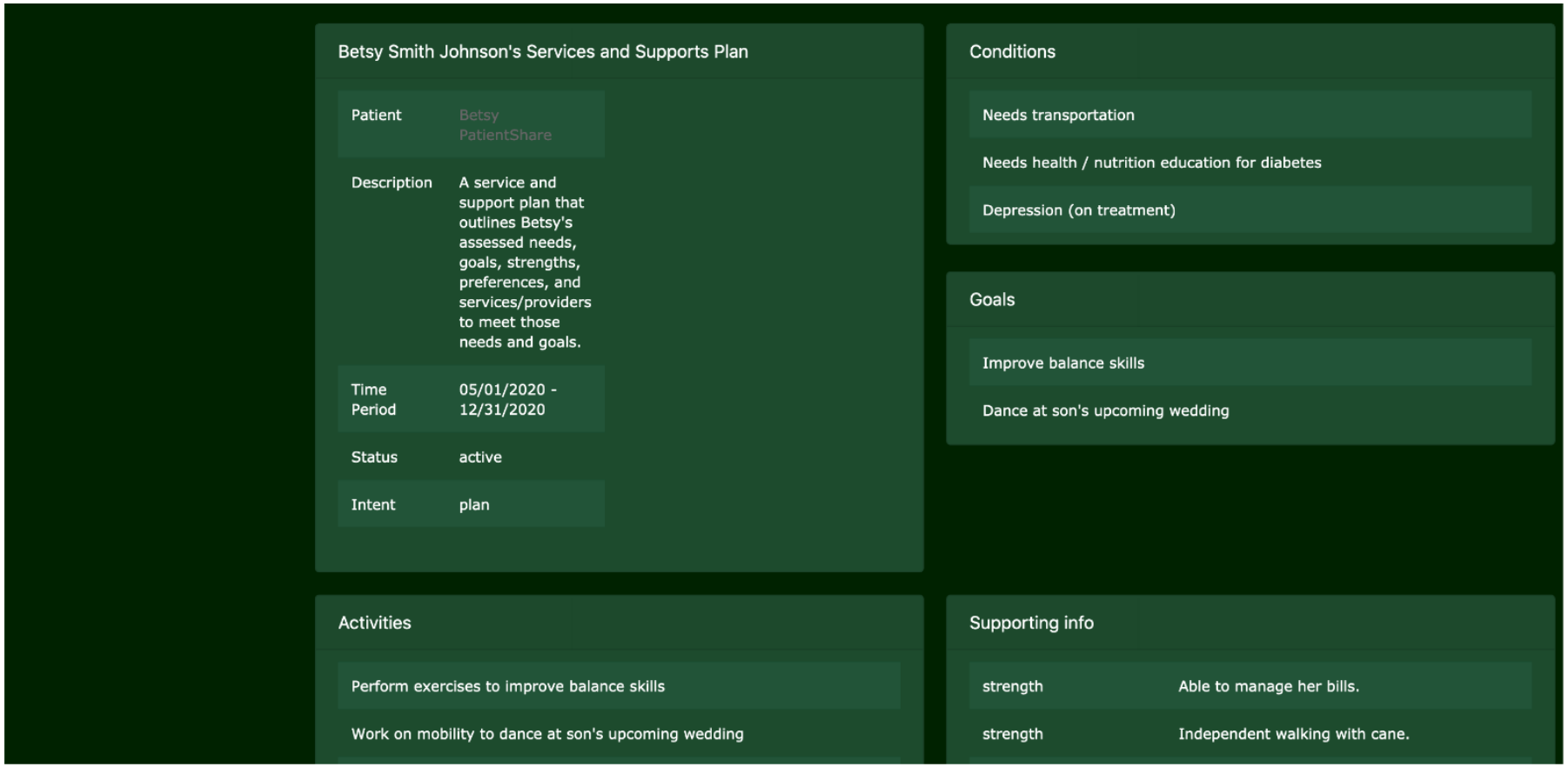
Scene 3

- Betsy is admitted to the SNF for PT/OT/SLP services for 14 days. The SNF retrieves the eLTSS data and assessment data from the Data Manager to inform her care. Functional and cognitive status is assessed on admission and discharge and pushed to the Data Hub.



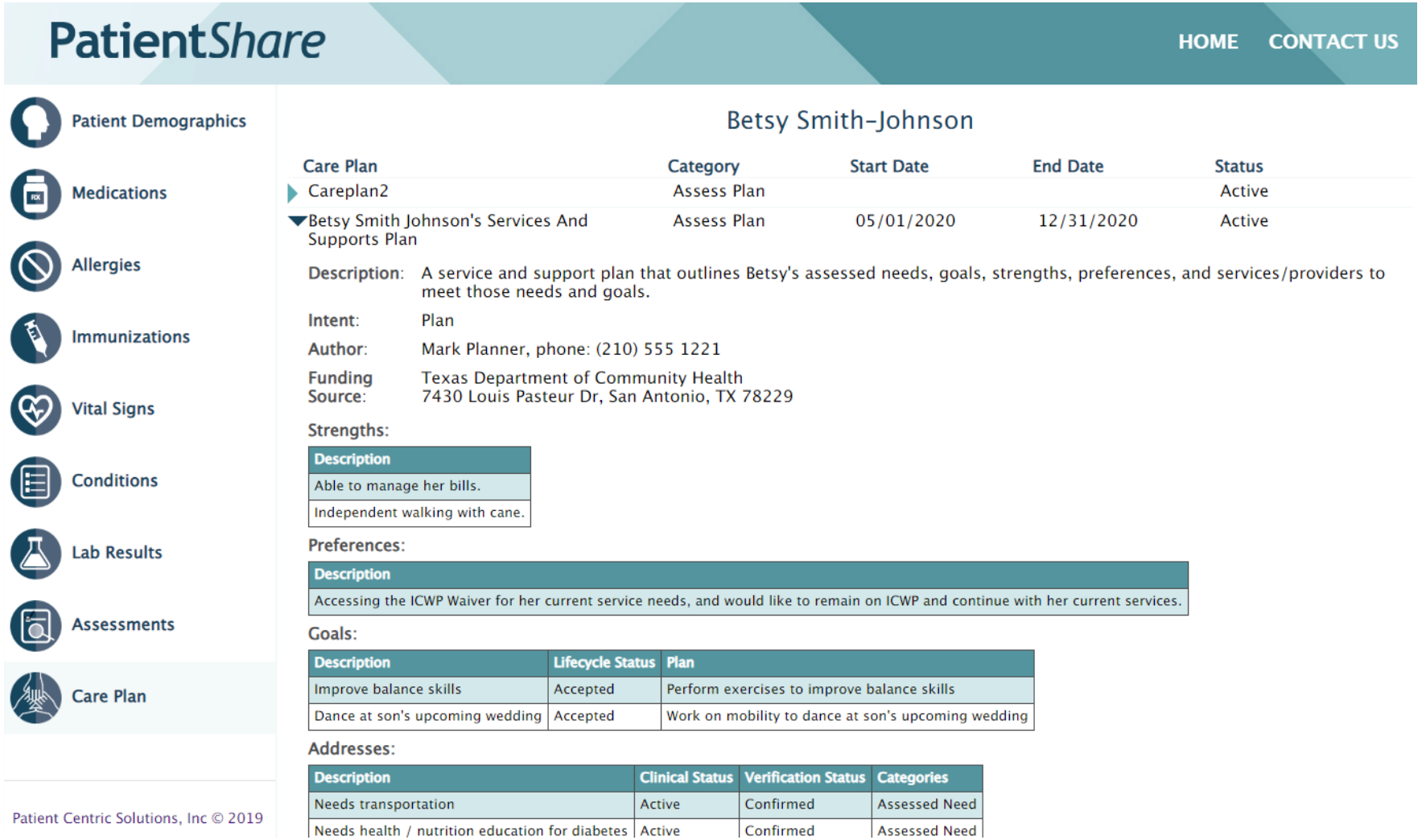
Scene 5

- After 14 days, Betsy is ready for discharge back home. The HHA agency coordinator reviews the patient's data from the Data Manager as part of the triage process.



Scene 6

- As she moves across the continuum of care, Betsy and her authorized family caregiver access the eLTSS care plan and assessment data through a patient web application.



Missouri's eLTSS Testing
A State's Perspective and Journey

Missouri Department of Mental Health – Division of Developmental Disabilities

Gary Schanzmeyer – Deputy Director for Administration

Angie Brenner – Director of Federal Programs

Toi Wilde – DD Project Director

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Missouri Division of Development Disabilities

- The Missouri Division of Developmental Disabilities is committed to improving the quality of life for individuals with developmental disabilities and their families. Offering support across the lifespan, the Division implements a statewide system of supportive services that focus on assuring health and safety, supporting access to community participation, and increasing opportunities for meaningful employment.
- The Missouri Division of Developmental Disabilities provides home and community-based services (HCBS) through Medicaid Waiver programs for more than 15,000 individuals with developmental disabilities such as:
  - Intellectual Disabilities
  - Cerebral Palsy
  - Down Syndrome
  - Autism
  - Epilepsy

Missouri's Journey

MISSOURI DIVISION OF DEVELOPMENTAL DISABILITIES

- April 2018 thru September 2019 - Medicaid Innovative Accelerator Program technical support to design Value Based Payment for HCBS strategy
- January 2019 through Current - Technical assistance with ONC
- June 2019 – Finalized Behavior Use Cases
- June 2019 – 1st Stakeholder meeting
- July 2019- Online Case Management RFP released
- August 2019 - First HIN Summit
- November 2019 – Receiving Medicaid Pre-Certification file
- November 2019 – Essence Data Meeting with Department of Health & Senior Services
- January 2020– Enhanced Supports of Service (parallel effort)
- **May 2020 – Participated in HL7 Connectathon**
- June 2020 – Applied for LEAP grant
- June 2020 – Waiver Informal Public Comment (30 days)
- August 2020 – Beginning New Case Management System Implementation Project for HCBS Services
- September 2020 – Waiver Formal Public Comment (30 days)
- January 2021 - Waiver Submission to CMS
- July 1, 2021 - Waiver Renewal Effective

What Issues Are We Trying To Solve?

- ❑Independence, decreasing the reliance on services
- ❑Improve employment, community integration, behavior supports
- ❑Improved methods of payment to incentivize positive outcomes
- ❑Increased access to preventative and acute health care services
- ❑Enhanced coordination across service providers
- ❑More…provider rates…

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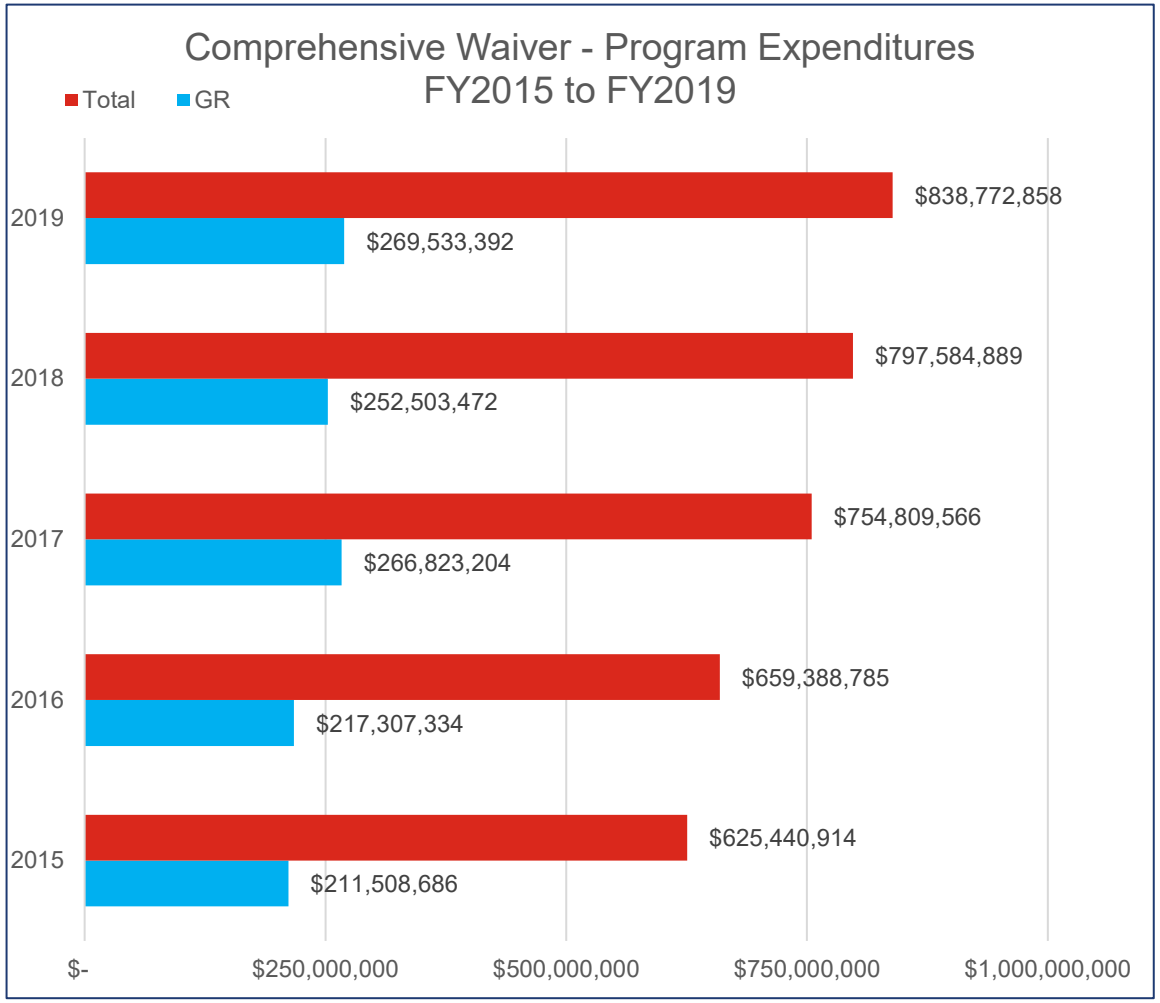
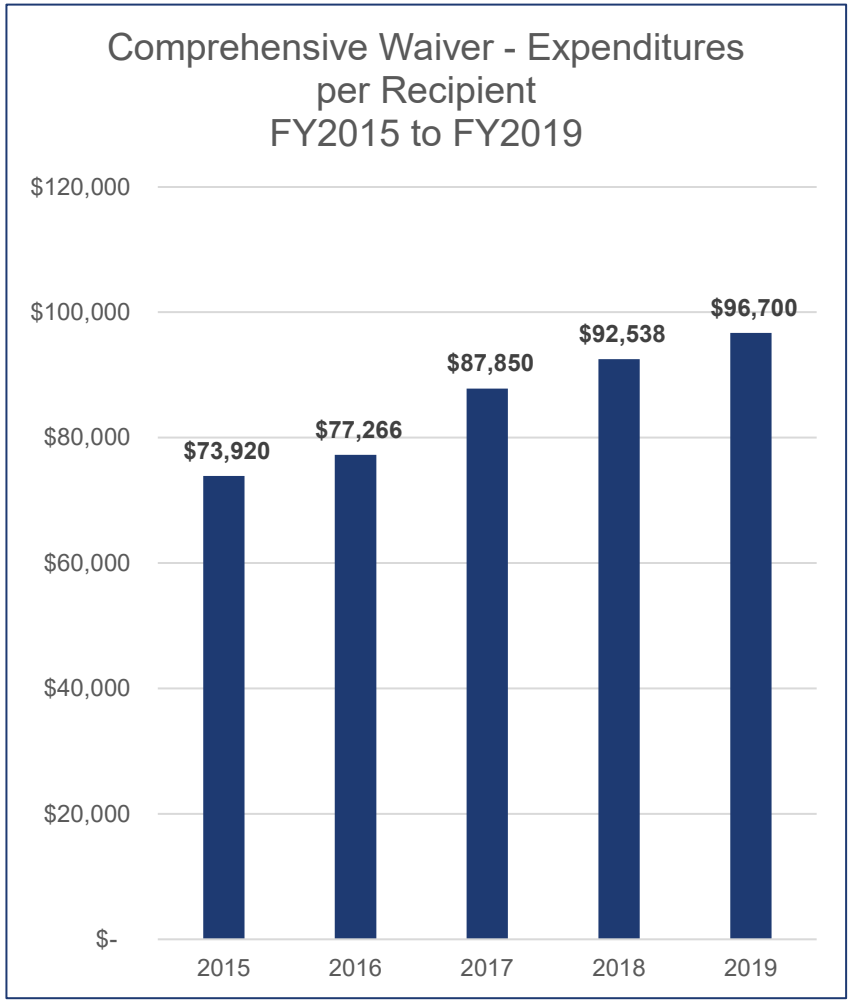
MISSOURI DIVISION OF DEVELOPMENTAL DISABILITIES

DD Comprehensive Waiver Expenditure History





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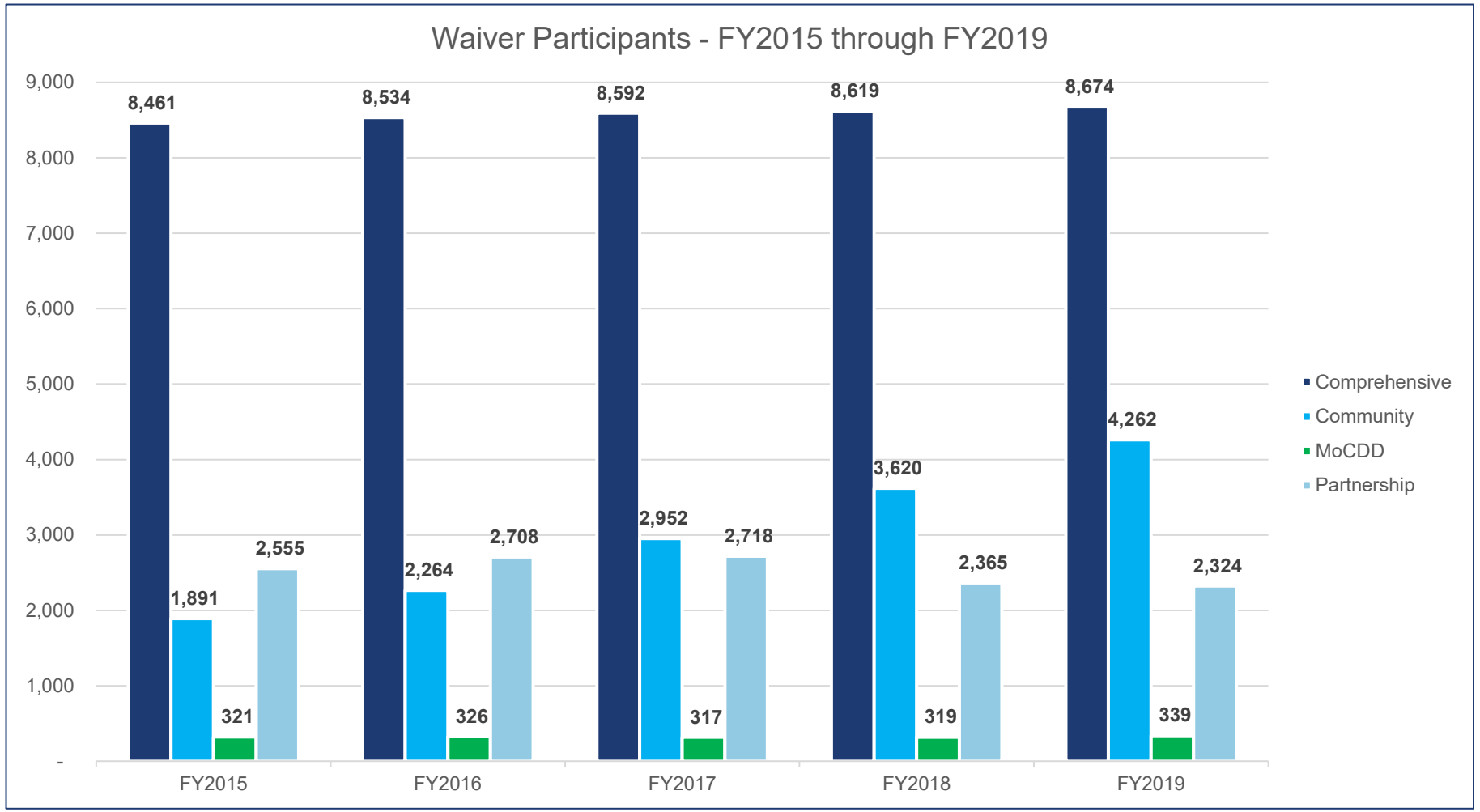
MISSOURI DIVISION OF DEVELOPMENTAL DISABILITIES

DD Waiver Participants



Our 1st HL7 Connectathon Experience!

- *Lessons Learned & Highlights:*
  - ❑ Our 1st virtual and Connectathon experience was very positive.
  - ❑ Participated in the Care Coordination Track:
    - PACIO: Functional and Cognitive Status Assessments (CMS based)
    - eLTSS: Person-Centered Social Services Planning
    - Gravity Project: Social Determinants of Health
  - ❑ HL7 Connectathon experience highlighted the push vs pull.
  - ❑ Benefited & Gained Knowledge From:
    - The live examples from start to finish and being able to see how the data flowed through an entire scenario.
    - Being able to see the use case and the movement through all the data feeds was very eye opening for our team. Also, being able visualize how our HRST and other data bases will move.
  - ❑ Knowing that we want to move to VBP, the Connectathon gave us the opportunity to visualize the data needed and movement to accomplish this, before this was a very elusive concept for us and this experience give us more of a concrete picture.

- *Opportunities:*
  - ❑ Difficult to navigate through the different virtual rooms or know what track we should be in, might be level of experience/technical expertise impacting this.
  - ❑ Slack was a really good option to have track leads support non-expertise observers but would have been helpful to have a narrator in the tracks to be able to assist observers in what is being demonstrated.
  - ❑ Difficult to apply some of the concepts demonstrated in our current landscape. More education and understanding needed at the State level.
  - ❑ Looking forward to being a participant in future Connectathons and able to demonstrate eLTSS through new Case Management System.

What Are WE Missing & Next Steps?

- DATA!

- *Approach for Sharing State Data Across Agencies:*
  - ❑ New online case management system that utilizes the Electronic Long-Term Services and Supports (eLTSS) standard and interoperability with screening and assessments;
  - ❑ Health Risk Screening Tool (HRST) and case management system interoperability;
  - ❑ Consolidated or separated care plans (clinical vs eLTSS) with aggregation and reconciliation;
  - ❑ Crosswalk Supported Employment Service Milestone/Outcomes Data with Medicaid Encounter Claims Data;
  - ❑ HRST enabled behavioral support for safety crisis plan and integration into case management;
  - ❑ Telehealth for COVID-19; and
  - ❑ Leverage these data sets for clinical quality processes.

MISSOURI DIVISION OF DEVELOPMENTAL DISABILITIES

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Patient-Centered Care: Implementing eLTSS in Patient*Share*

Secure, Private, Seamless Health Data Exchange

Nancy Lush
President, Patient Centric Solutions, Inc
www.patientcentricsolutions.com
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Transitions of Care

- We believe a complete aggregated patient record should follow patients as they move from facility to facility
- Transitions of care for a patient with multiple chronic conditions
- No longer a technology problem
- COVID-19: Save lives

Transitions of Care for Patients With Multiple Chronic Conditions

- Represents largest % of patients transitioning between healthcare settings
- Care is often fragmented
- Too often the necessary information does not flow at all
- Stories from the field
- Negative effects

Financial and Operational Impact

- Leading causes of readmission
  - Lack of coordination between hospitals and SNFs (skilled nursing facilities)
  - Poorly defined goals of care at the time of hospital discharge
  - Limited information sharing between SNF and hospital
  - 1 in 4 Medicare patients discharged from Acute Care went to a SNF. Of those, 1 in 4 will be readmitted within 30 days
- Post-acute care accounts for over $73B in annual spending
- 45% of patients require post-acute services after hospitalization
- Of those patients that require further services, 42% transitioned to home health services
- Lack of data interoperability is a key barrier to coordinated care - especially to community organizations like SNF's

PatientShare

- Infrastructure system to enable seamless, secure, dynamic data exchange
  - Enterprise FHIR-API V4 server, UMA 2 and HEART enabled
  - Patient-mediated consent system
  - Authorization server to support both organizational and patient-directed policy
  - Integrates to external Trusted Identity Server
  - Open standards based
- Integrates with any Health Care System or use case.
- Supports the USCDI data set
- Includes web-based clients to enable data sharing – accessible at any point of care

PatientShare

- Web-based clients to enable data sharing
  - Accessible at any point of care
  - Available directly or via an EMR integrated with CDS-hooks
- Data access for any authorized Care Provider
- Read/Write data repository
  - Enables patient data to follow the patient
  - Enables care collaboration
  - Enables patient collaboration
- Fast track to seamless interoperability

eLTSS Care Coordination

- Patient-focused care plan
  - Core features to represent patients with multiple chronic conditions
  - Well-defined Implementation Guide (IG)
  - Complementary to USCDI
- Enables read/write access – high impact starting point
- Combined with PACIO functional and cognitive IGs and core FHIR resources
- Viable model to promote transitions of care

DEMO

Enable FHIR-based Transitions Of Care

- No longer a technology problem
- Provide the tools to adopt today
- Demonstrate clear benefits
- Empower the patient: Include patients and their families in care collaboration
- Put patients and value at the center of our healthcare system
- Join us to enable
  - An aggregated patient record
  - A record that always follows patients even as they move from facility to facility

Patient Centric Solutions, Inc Contact Information

Nancy Lush

Office: 401-423-9111

Cell: 401-965-9347

NLush@patientcentricsolutions.com

www.PatientCentricSolutions.com

Contact us today to enable a patient record that follows the patient.

eLTSS Planning for HL7 September Connectathon

eLTSS Planning for HL7 September Virtual Connectathon (September 9 – 11)

- Testing partners for the September Connectathon include:
  - PACIO Project (MITRE)
  - Altarum
  - Patient Centric Solutions
  - FEI Systems
- FEI Systems will utilize their Blue Compass system to move Care Plan information from a case management platform into a FHIR data hub
- Patient Centric Solutions will continue to extend their data hub and transitions of care use cases
- Please contact the eLTSS project if your organization has an interest in participating

eLTSS Community Engagement

It Takes a Village! Thank You eLTSS Partners

- Administration for Community Living
- Altarum
- FASI Initiative
- FEI Systems
- Georgia Tech Research Institute
- LTCI
- Lantana Health
- Medical Micrographics
- MITRE
- PACIO Project
- Patient Centric Solutions
- SMC Partners
- State of Colorado
- State of Connecticut
- State of Georgia
- State of Kentucky
- State of Maryland
- State of Minnesota
- State of Missouri
- VorroHealth

How to Engage

- Get the eLTSS FHIR IG
  - http://hl7.org/fhir/us/eltss/
- Download the eLTSS Informative Document
  - http://www.hl7.org/implement/standards/product_brief.cfm?product_id=495
- Utilize the eLTSS Reference Implementation
  - https://github.com/onc-healthit/eLTSS-Reference-Implementation
- Join the HL7 CBCP WG weekly calls to learn more about eLTSS
  - Tuesdays 12:00 – 1:00pm ET
  - https://zoom.us/j/9883657483?pwd=QTBTODR3M3hvemllOU1NaXhGTVB0QT09
  - Meeting ID: 988 365 7483 Password: 722930 Dial-in +1 646 558 8656 US (New York) | Find your local number: https://zoom.us/u/acrouUaT6T
- Pilot the eLTSS FHIR IG
  - If you or your organization is interested in testing or piloting the eLTSS FHIR IG, please contact Johnathan Coleman at: jc@securityrs.com and Becky Angeles at: becky.angeles@carradora.com
- Visit the eLTSS Confluence Page for meeting information and relevant artifacts:
  - https://oncprojectracking.healthit.gov/wiki/display/TechLabSC/eLTSS+Home

Team eLTSS

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- Harmonization Lead
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