The Office of the National Coordinator for Health Information Technology

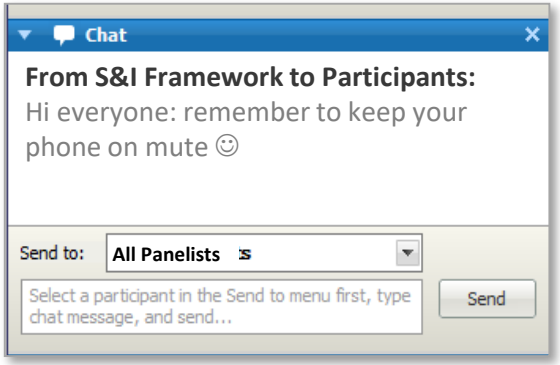
Electronic Long-Term Services & Supports (eLTSS)

FEDERAL PARTNER WEBINAR

Date: November 4, 2016

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.
  - » **Send comments to All Panelists** so they can be addressed publically in the chat, or discussed in the meeting (as appropriate).



Agenda

Topic Area	Presenter
Welcome	Mike Smith (CMS) Kerry Lida (CMS)
IMPACT Act of 2014 Data Element Harmonization Overview	Stace Mandl (CMS)
FASI Overview	Barbara Gage (GWU)
eLTSS Round 2 Pilot Update	Evelyn Gallego (EMI Advisors LLC)
Federal Partner Discussion	All
Next Steps	Evelyn Gallego (EMI Advisors LLC)

Welcome & Introductions

Data Element Uniformity, Assessment Domain Standardization & The IMPACT Act of 2014

Stella Mandl RN, BSN, BSW, PHN
Deputy Division Director for Chronic and Post-Acute Care (DCPAC)
Centers for Medicare & Medicaid Services (CMS)

Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

- **Bipartisan bill passed on September 18, 2014 and signed into law by President Obama on October 6, 2014**

- **Requires Standardized Patient Assessment Data that will enable:**
  - Data Element uniformity
  - Quality care and improved outcomes
  - Comparison of quality and data across post-acute care (PAC) settings
  - Improved discharge planning
  - Exchangeability of data
  - Coordinated care

Requirements for Standardized Assessment Data

- IMPACT Act added new section 1899(B) to Title XVIII of the Social Security Act (SSA)
- Post-Acute Care (PAC) providers must report:
  - Standardized assessment data
  - Data on quality measures
  - Data on resource use and other measures
- The data must be standardized and interoperable to allow for the:
  - Exchange of data using common standards and definitions
  - Facilitation of care coordination
  - Improvement of Medicare beneficiary outcomes
- PAC assessment instruments must be modified to:
  - Enable the submission of standardized data
  - Compare data across all applicable providers

Driving Forces of the IMPACT Act

- **Purposes Include:**
  - Improvement of Medicare beneficiary outcomes
  - Provider access to longitudinal information to facilitate coordinated care
  - Enable comparable data and quality across PAC settings
  - Improve hospital discharge planning
  - Research

- **Why the attention on Post-Acute Care:**
  - Escalating costs associated with PAC
  - Lack of data standards/interoperability across PAC settings
  - Goal of establishing payment rates according to the individual characteristics of the patient, not the care setting

Definitions

- Applicable PAC settings and Prospective Payment Systems (PPS):
  - Home health agencies (HHA) under section 1895
  - Skilled nursing facilities (SNF) under section 1888(e)
  - Inpatient rehabilitation facilities (IRF) under section 1886(j)
  - Long-term care hospitals (LTCH) under section 1886(m)

Definitions (continued)

- Applicable PAC assessment instruments
  - HHA: Outcome and Assessment Information Set (OASIS) or any successor regulation
  - SNF: assessment specified under section 1819(b)(3)
  - IRF: any Medicare beneficiary assessment instrument established by the Secretary for purposes of section 1886(j)
  - LTCH: any Medicare beneficiary assessment instrument used to collect data elements to calculate quality measures, including for purposes of section 1886(m)(5)(C)

Legislative Background: Data Standardization

- **Benefits Improvement & Protection Act (BIPA) of 2000**
  - Required the Secretary to report to Congress on standardized assessment items across PAC settings
- **Deficit Reduction Act (DRA) of 2005**
  - Required the standardization of assessment items used at discharge from an acute care setting and at admission to a post acute care setting
  - Established the Post-Acute Care Payment Reform Demonstration (PAC-PRD) to harmonize payments for similar settings in PAC settings
  - Resulted in the Continuity Assessment Record and Evaluation (CARE) tool, a component to test the reliability of the standardized items when used in each Medicare setting
- **PAC Reform Demonstration requirement of 2006**
  - Data to meet federal Health Information Technology (HIT) interoperability standards

PAC-PRD & the CARE Tool:
Goals and Guiding Principles

Goals

- ✓ Fosters seamless care transitions
- ✓ Measures that can follow the patient
- ✓ Evaluation of longitudinal outcomes for patients that traverse settings
- ✓ Assessment of quality across settings
- ✓ Improved outcomes, and efficiency
- ✓ Reduction in provider burden

Guiding Principles

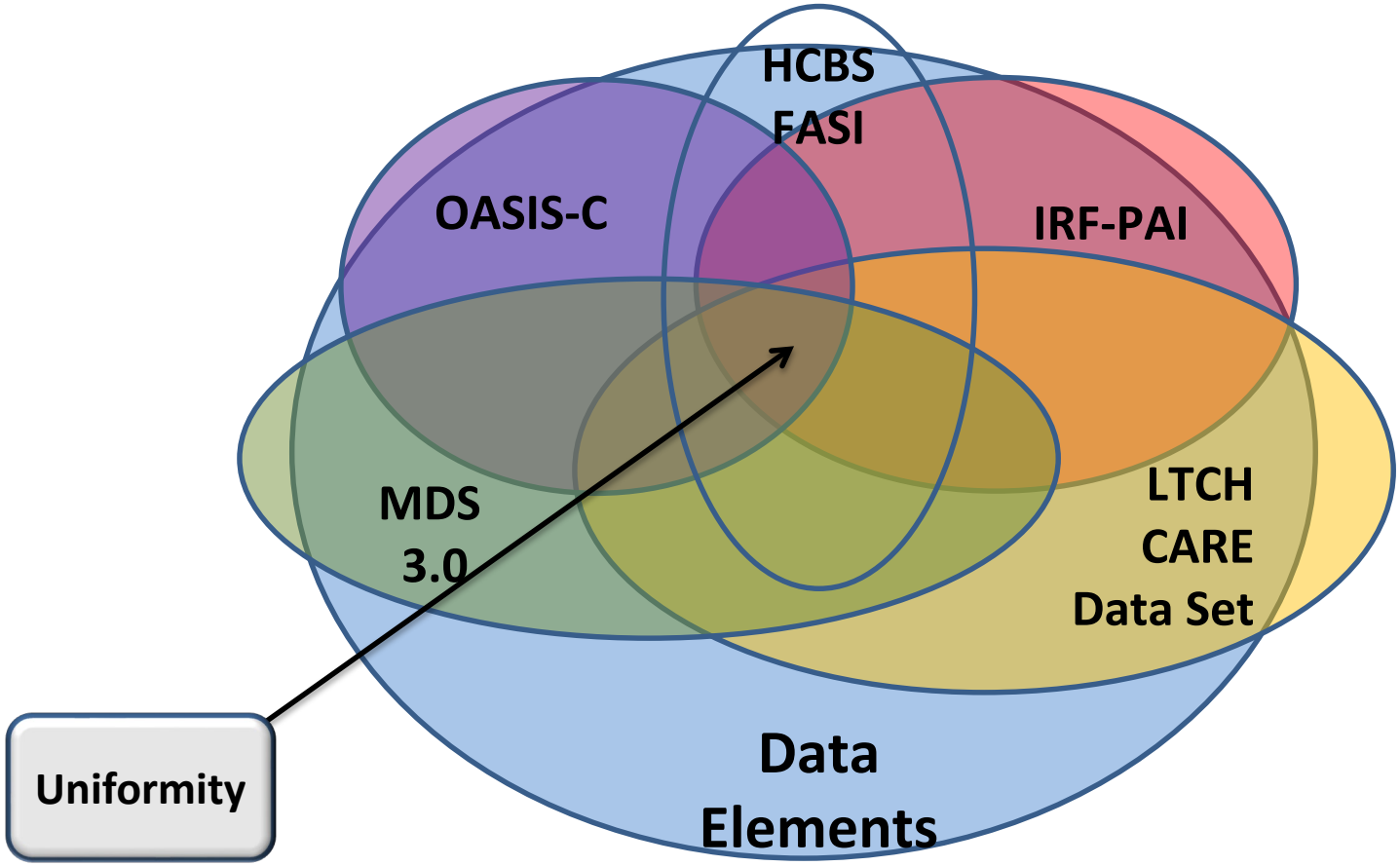
Data Uniformity

- ✓ Reusable
- ✓ Informative
- ✓ Increases Reliability/validity
- ✓ Facilitates patient care coordination

Interoperability

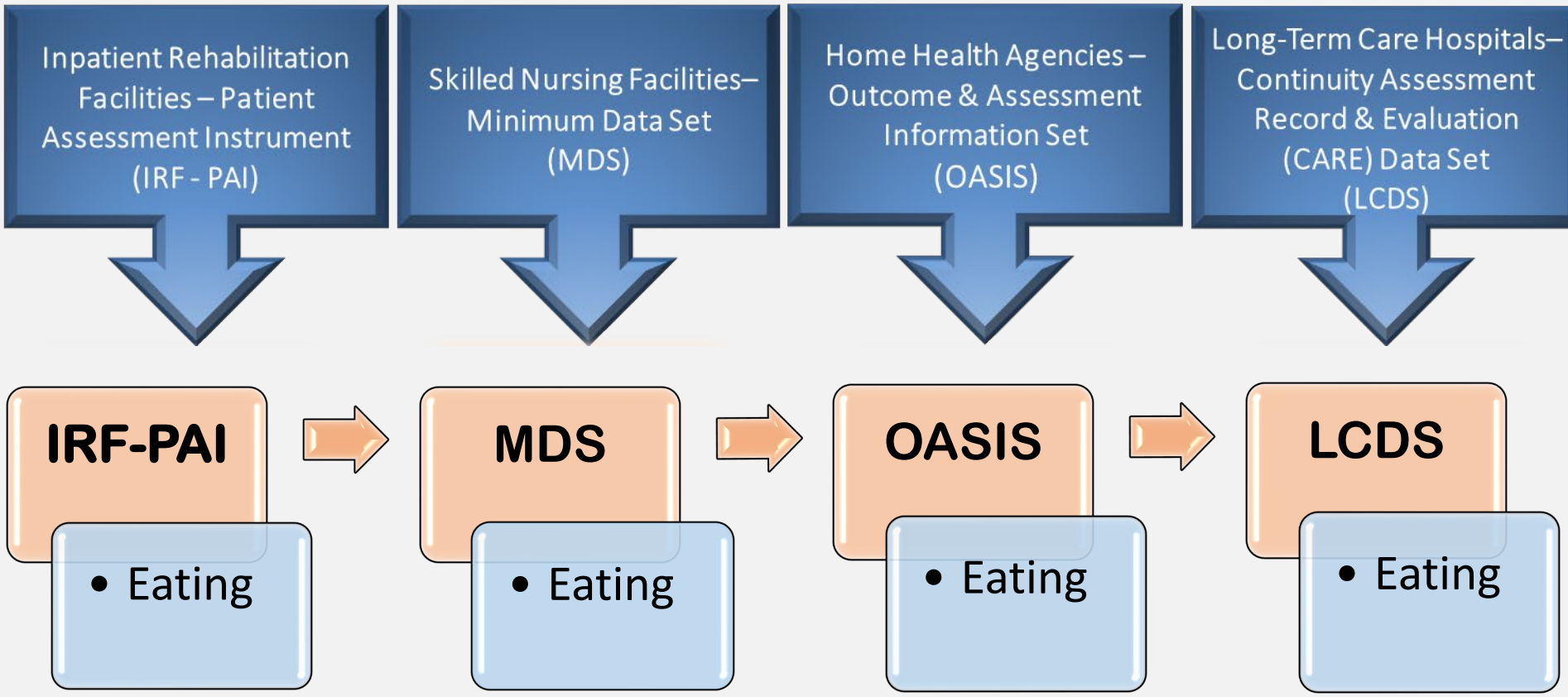
- ✓ Data that can communicate in the same language across settings
- ✓ Data that can be transferable forward and backward to facilitate care coordination
- ✓ Follows the individual

Data Elements: Standardization



What is Standardization?

Standardizing Function at the Item Level



Standardized Assessment Data Elements

One Question: Much to Say → One Response: Many Uses

GG0160. Functional Mobility
(Complete during the 3-day assessment period.)

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

CODING:
Safety and **Quality of Performance** - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

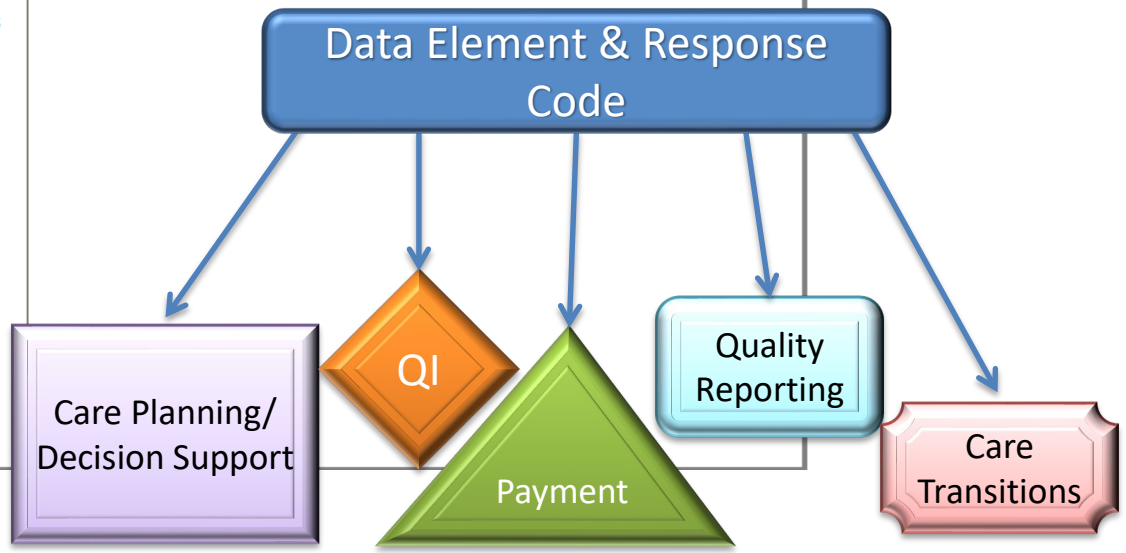
06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/ STEADYING 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.

07. **Patient refused**
09. **Not applicable**

If activity was not attempted, code:
88. Not attempted due to **medical condition or safety concerns**

↓ **Enter Codes in Boxes**

☐☐	**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.



Standardizing Across Settings

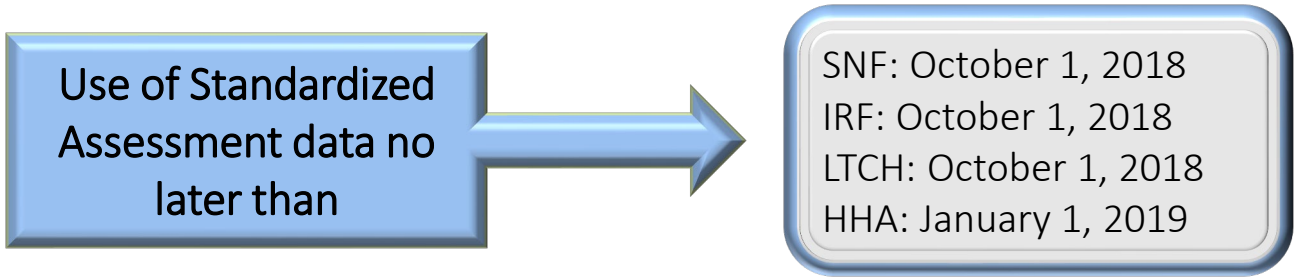
Item	Item Description	Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) v1.4	Minimum Data Set (MDS) 3.0	Long-Term Care Hospital CARE Data Set v3.00
SELF-CARE GG0130				
A	Eating	✓	✓	✓
B	Oral hygiene	✓	✓	✓
C	Toileting hygiene	✓	✓	✓
D	Wash upper body	—	—	✓
E	Shower/bathe self	✓	—	—
F	Upper body dressing	✓	—	—
G	Lower body dressing	✓	—	—
H	Putting on/taking off footwear	✓	—	—

Standardizing Across Settings (continued)

Item	Item Description	Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) v1.4	Minimum Data Set (MDS) 3.0	Long-Term Care Hospital CARE Data Set v3.00
MOBILITY GG0170				
A	Roll left and right	✓	—	✓
B	Sit to lying	✓	✓	✓
C	Lying to sitting on side of bed	✓	✓	✓
D	Sit to stand	✓	✓	✓
E	Chair/bed-to-chair transfer	✓	✓	✓
F	Toilet transfer	✓	✓	✓
G	Car transfer	✓	—	—
I	Walk 10 feet	✓	—	✓
J	Walk 50 feet with two turns	✓	✓	✓
K	Walk 150 feet	✓	✓	✓
L	Walking 10 feet on uneven surface	✓	—	—
M	1 step (curb)	✓	—	—
N	4 steps	✓	—	—
O	12 steps	✓	—	—
P	Picking up object	✓	—	—
R	Wheel 50 feet with two turns	✓	✓	✓
S	Wheel 150 feet	✓	✓	✓

IMPACT Act: Standardized Patient Assessment Data

- **Requirements for reporting assessment data:**
  - Providers must submit standardized assessment data through PAC assessment instruments under applicable reporting provisions

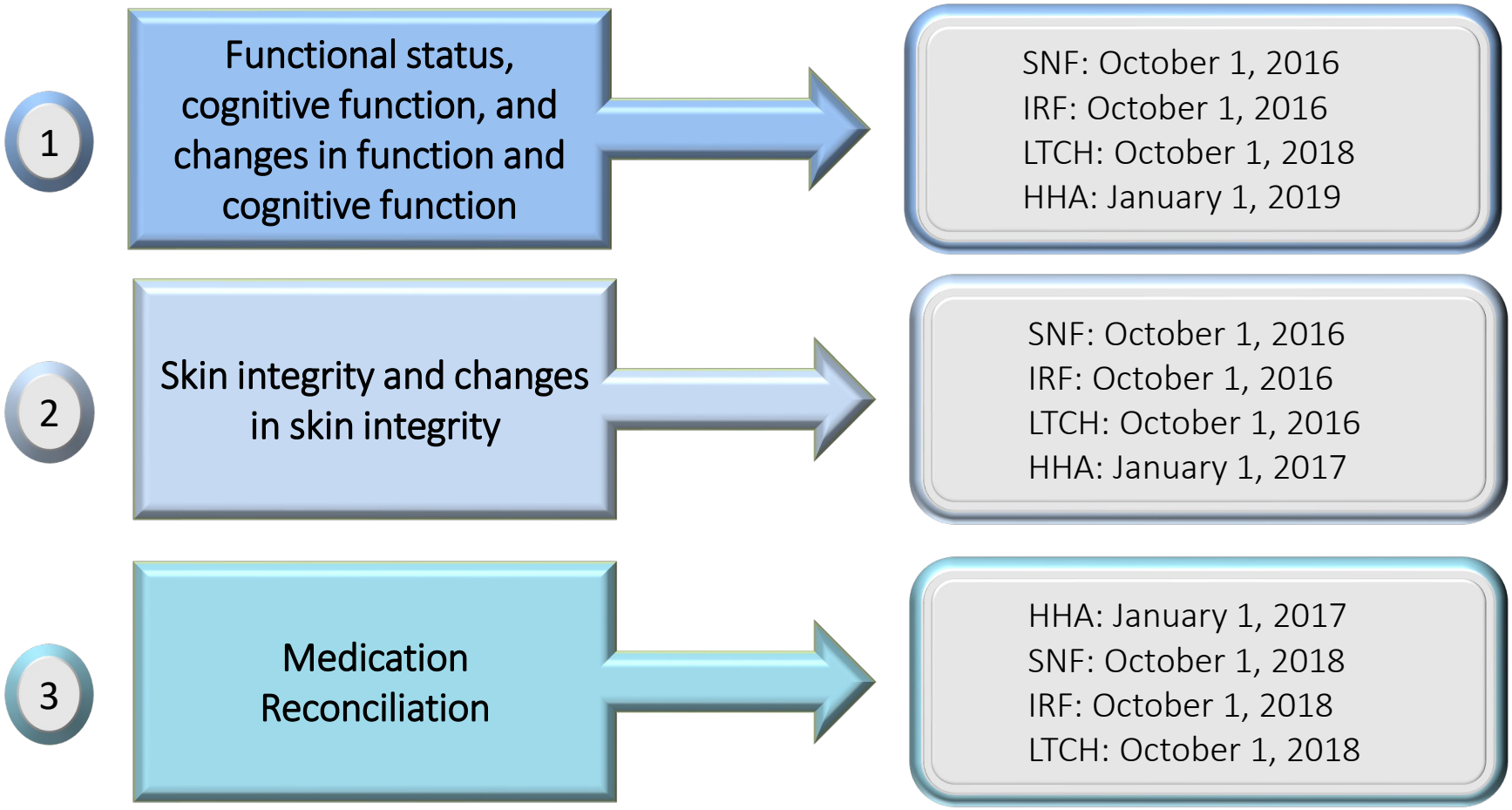


  - The data must be submitted with respect to admission and discharge for each patient, or more frequently as required

- **Data categories:**

•Functional status •Cognitive function and mental status •Special services, treatments, and interventions •Medical conditions and co-morbidities •Impairments •Other categories required by the Secretary

IMPACT Act: Quality Measure Domains & Timelines



IMPACT Act: Quality Measure Domains & Timelines (continued)

4 — Incidence of Major Falls

- SNF: October 1, 2016
- IRF: October 1, 2016
- LTCH: October 1, 2016
- HHA: January 1, 2019

5 — Communicating the existence of and providing for the transfer of health information and care preferences

- SNF: October 1, 2018
- IRF: October 1, 2018
- LTCH: October 1, 2018
- HHA: January 1, 2019

Resource use and other measures will be specified for reporting

- ✓ Total estimated Medicare spending per beneficiary
- ✓ Discharge to community
- ✓ Measures to reflect all-condition risk-adjusted potentially preventable hospital readmission rates

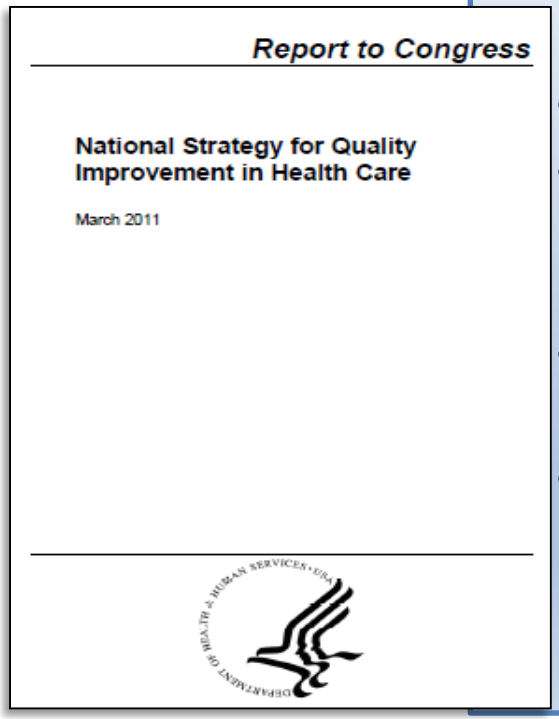
- SNF: October 1, 2016
- IRF: October 1, 2016
- LTCH: October 1, 2016
- HH January 1, 2017

National Quality Strategy Promotes Better Health, Healthcare, and Lower Cost

The strategy is to concurrently pursue three aims:

Better Care	Improve overall quality by making health care more patient-centered, reliable, accessible, and safe
Healthy People / Healthy Communities	Improve population health by supporting proven interventions to address behavioral, social and environmental determinants of health, in addition to delivering higher-quality care
Affordable Care	Reduce the cost of quality healthcare for individuals, families, employers and government

NQS Promotes Better Health, Better Healthcare, and Lower Costs Through:

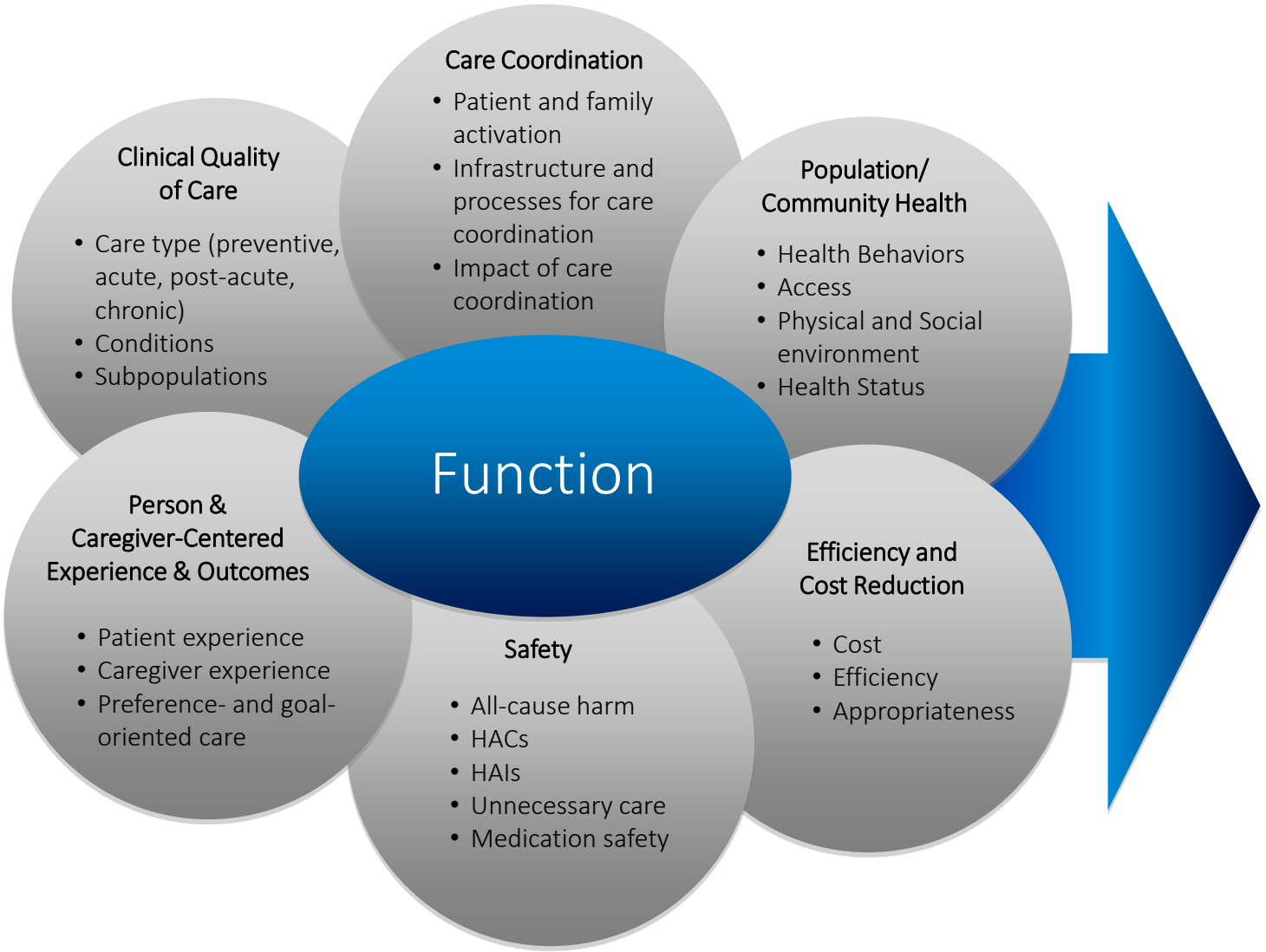


Six Priorities

- Make care safer by reducing harm caused in the delivery of care
- Ensure that each person and family are engaged as partners in their care
- Promote effective communication and coordination of care
- Promote effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease
- Work with communities to promote wide use of best practices to enable healthy living
- Make quality care more affordable for individuals, families, employers, and governments by developing and spreading new healthcare delivery models

The Six Priorities Have Become the Goals for the CMS Quality Strategy

CMS Framework for Measurement



- Measures should be patient-centered and outcome-oriented whenever possible
- Measure concepts in each of the six domains that are common across providers and settings can form a core set of measures

Addressing Critical Gaps
IMPACT Act & Opportunity

The Act provides an opportunity to address all goals within the CMS Quality Strategy:

IMPACT Act: Measurement Implementation Phases

1) Measurement Implementation Phases

(A) Initial Implementation Phase –

(i) Measure specification

(ii) Data collection

(B) Second Implementation Phase –

Feedback reports to PAC providers

(C) Third Implementation Phase –

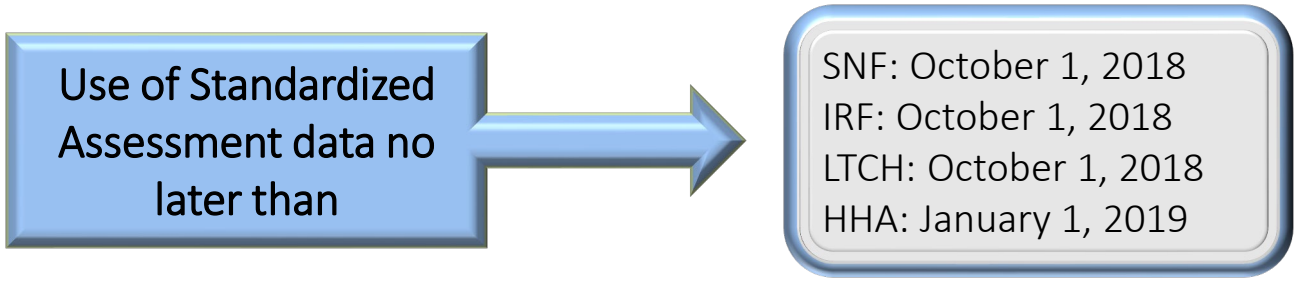
Public reporting of PAC providers' performance

2) Consensus-based Entity Endorsement Evaluation

3) Treatment of Application of Pre-Rulemaking Process

IMPACT Act: Standardized Patient Assessment Data

- **Requirements for reporting assessment data:**
  - Providers must submit standardized assessment data through PAC assessment instruments under applicable reporting provisions



  - The data must be submitted with respect to admission and discharge for each patient, or more frequently as required

- **Data categories:**

•Functional status •Cognitive function and mental status •Special services, treatments, and interventions •Medical conditions and co-morbidities •Impairments •Other categories required by the Secretary

Overarching Principles

The Mission: To transform and modernize the health care system; promoting effective, efficient, high quality care for beneficiaries, through the use of standardized, reusable data so as to:

- Facilitate rapid, accurate exchange of critical patient information to reduce errors, prevent adverse events and improve care
- Allow for the measurement and reporting of comparable quality across providers and provider types
- Enable person-centered decision making using comparable data
- Enable payment reform

Guiding Principles I

We believe that certain principles should be applied in the work related to data standardization and that the data should:

- Allow for reusable data:
  - Data to serve multiple purposes: ***collect once***, use multiple times
- Create a common spoken and IT language
  - Enable Interoperability
  - Facilitate care coordination through standardized communication
- Be usable across the continuum of care, and beyond the healthcare system

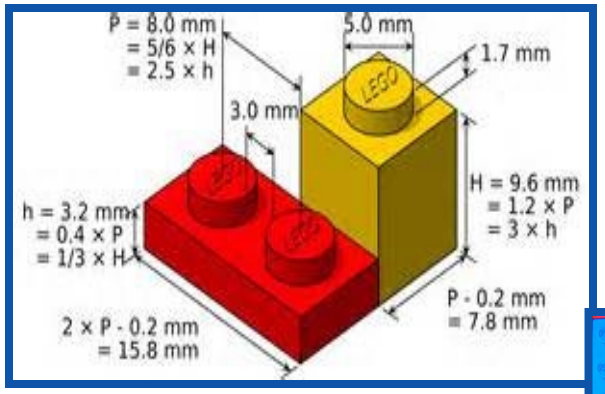
Guiding Principles II

Assessment instrument item development shall take into account these essential principles:

- The data elements selected for use shall reside in the public domain
- Item development shall occur through a consensus-based development process
- Application of current science
- Adherence to the statutory requirements under the IMPACT Act of 2014

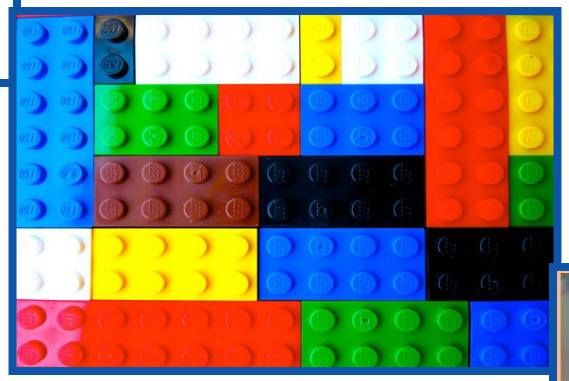
CMS Data Element Library: HIT Exchange Standards

Please Pass the Legos:

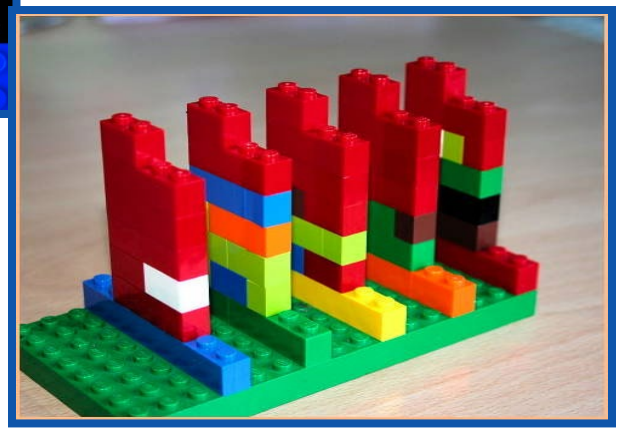


Standardized

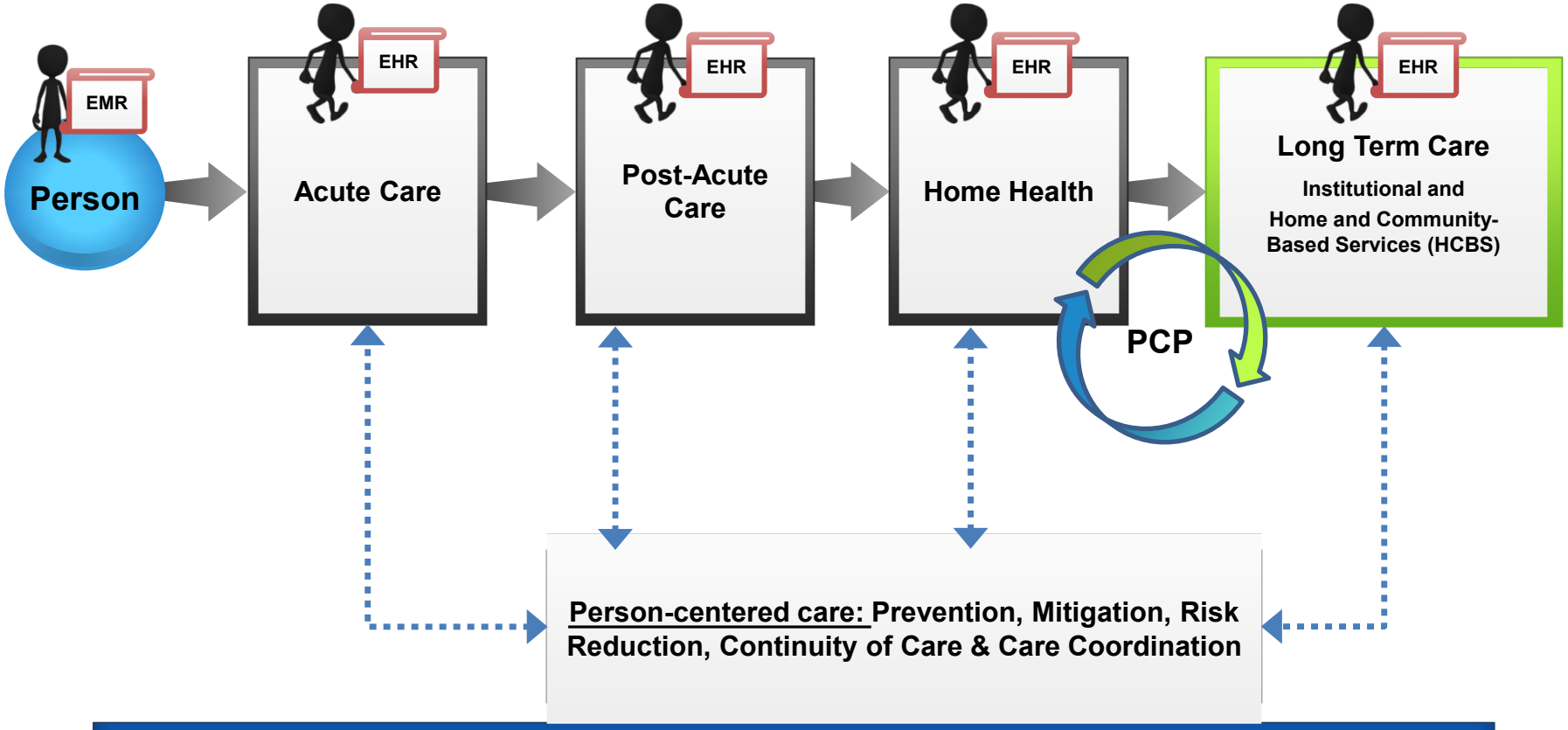
Detailed



Reusable

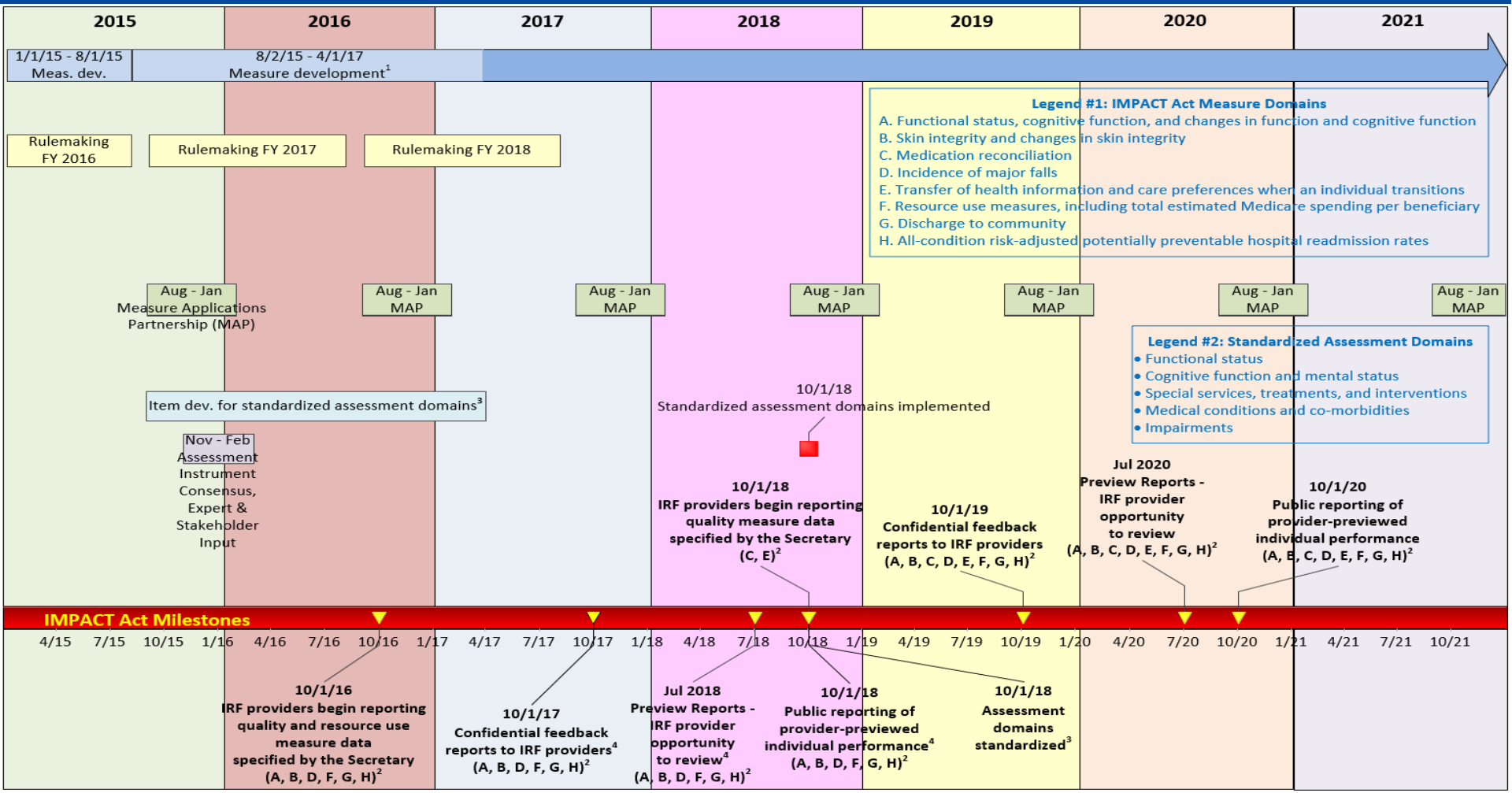


Standardization: Ideal State



Information Follows the Person

PAC QRP IRF Estimated Timelines/Milestones to Meet the IMPACT Act of 2014 Timeline Requirements



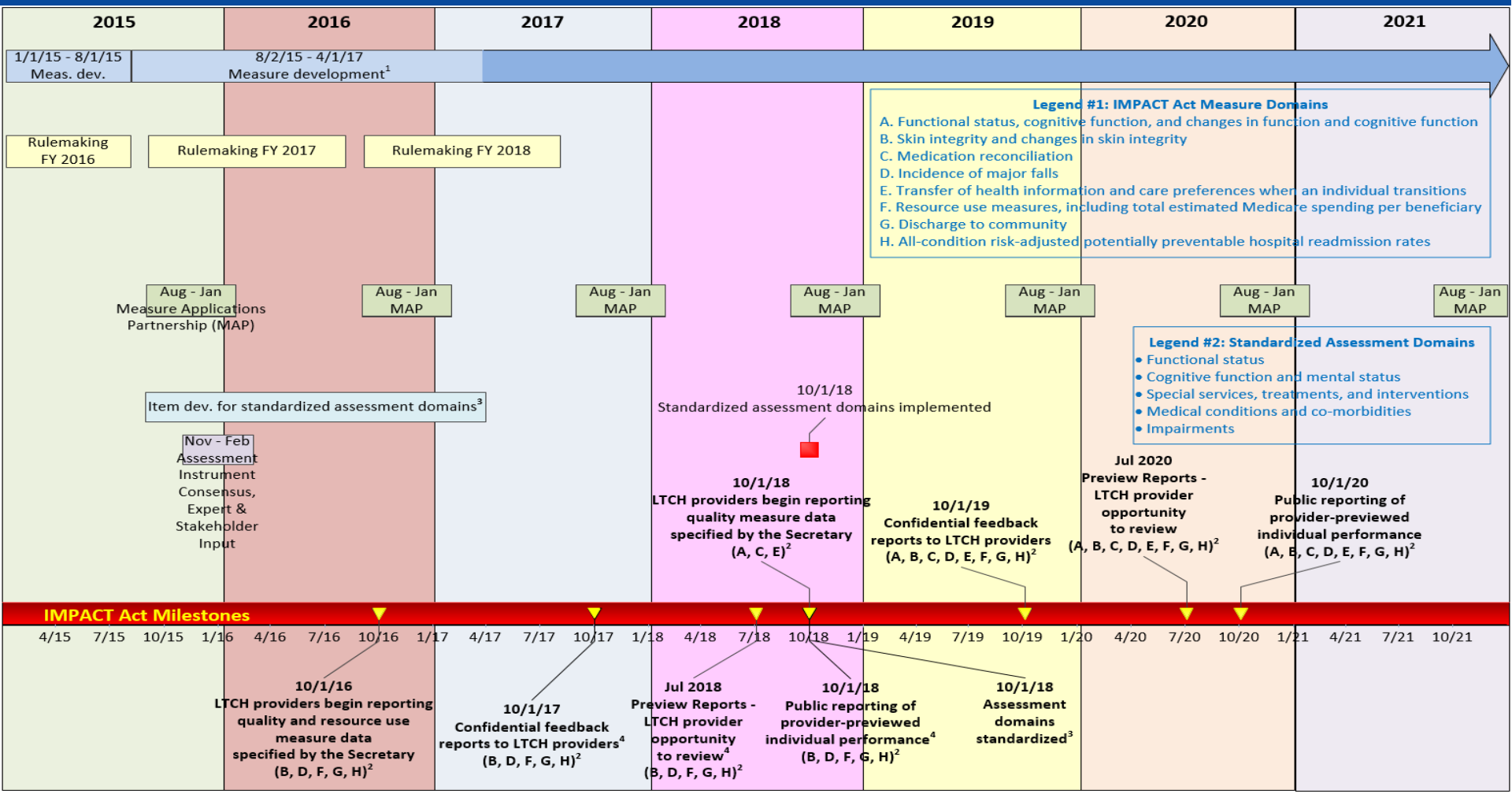
[1] Quality measure development requires six months to two years and includes public input, stakeholder input, and the MAP process

[2] IMPACT Act measure domains are defined in legend #1 above

[3] IMPACT Act assessment domains are defined in legend #2 above

[4] Provider feedback and preview reports and publicly reported data are refreshed at regular intervals after starting

PAC QRP LTCH Estimated Timelines/Milestones to Meet the IMPACT Act of 2014 Timeline Requirements



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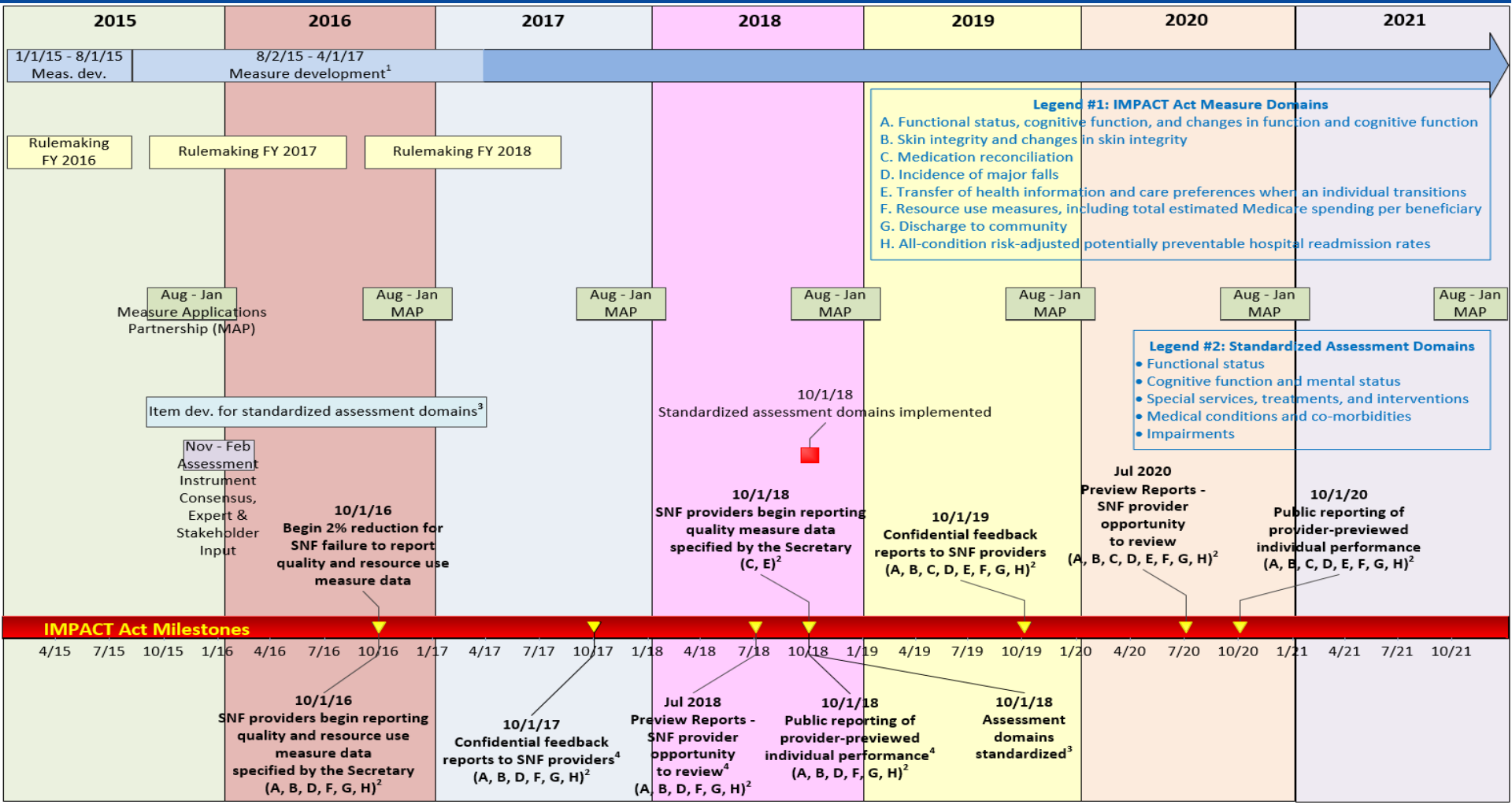
PAC QRP SNF Estimated Timelines/Milestones to Meet the IMPACT Act of 2014 Timeline Requirements



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[3] IMPACT Act assessment domains are defined in legend #2 above

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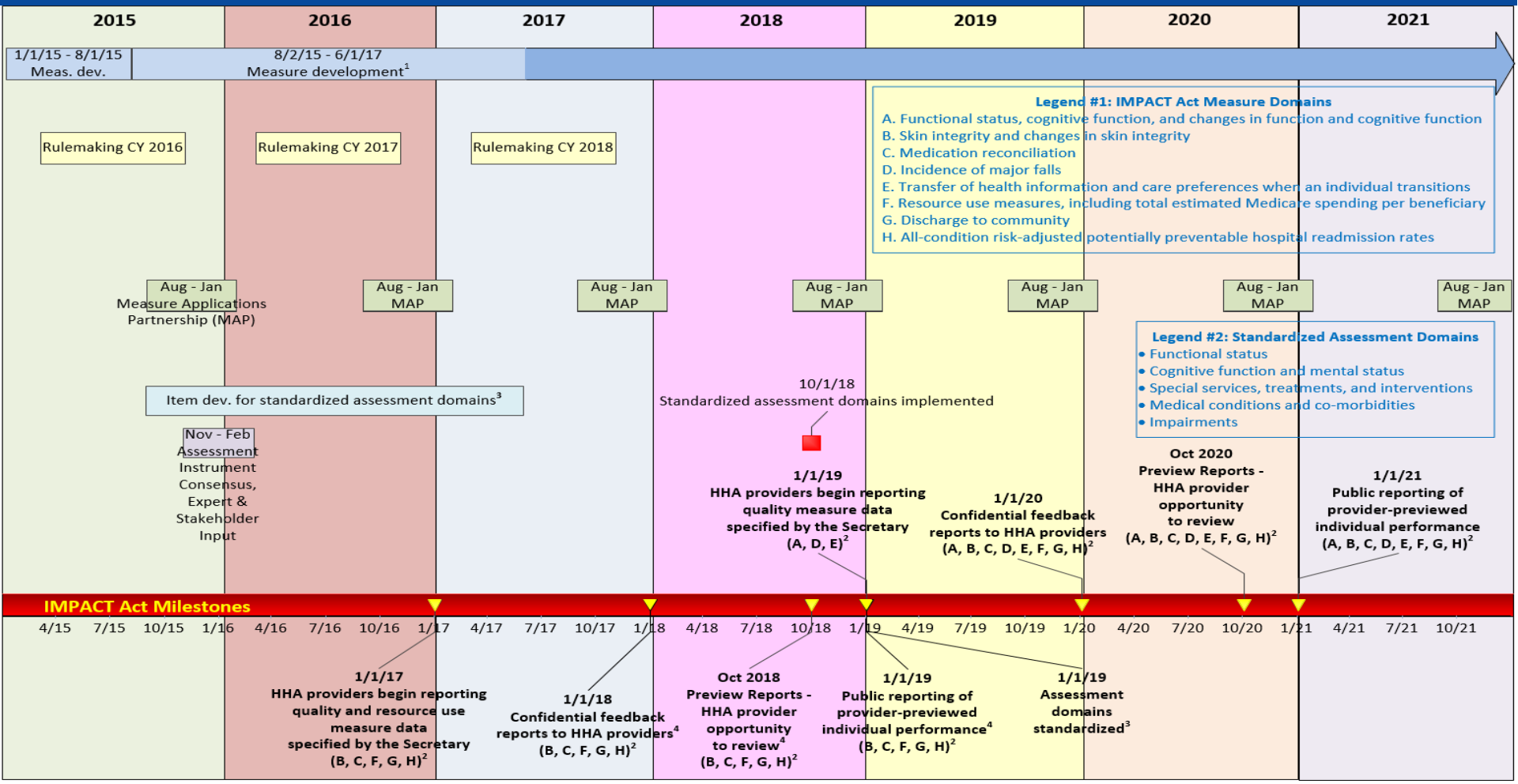
PAC QRP HHA Estimated Timelines/Milestones to Meet the IMPACT Act of 2014 Timeline Requirements



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[3] IMPACT Act assessment domains are defined in legend #2 above
[4] Provider feedback and preview reports and publicly reported data are refreshed at regular intervals after starting

Home and Community Based Services Testing Experience Function Tools (TEFT) Functional Assessment Standardized Items (FASI)

Barbara Gage, PhD
Co-Director for IMPACT Act & FASI Task Lead
George Washington University, Contractor to CMS

TEFT COMPONENTS

CROSS- DISABILITY EXPERIENCE OF CARE (EoC) SURVEY

* Field Test: 2014-2015
* Grantee implementation: 2016-2018
* Submission for CAHPS Trademark : 2015
* NQF submission for endorsement of EoC-derived measures: 2016

FUNCTIONAL ASSESSMENT STANDARDIZED ITEMS (FASI)

* Field Test: 2016
* Grantee implementation: 2017-2018
* NQF submission for endorsement of FASI measures: 2017

eLTSS PLAN STANDARD

* Participation in solution plan development & consensus activities with ONC: 2014-2015
* Phase I Pilot execution: 2015-2016
* Phase II Pilot execution: 2016-2017

PERSONAL HEALTH RECORD (PHR)

* Development/procurement: 2014-2016
* Grantee implementation: 2016–2018

TRUVEN HEALTH ANALYTICS™
an IBM Company

WHAT IS FASI?

- Person-centered measures of functional ability and need for caregiver assistance
- Aligned with Federally standardized items (ADL & Mobility) with additional items (IADLs, Caregiver assistance needs)
- Identifies personal goals related to functioning and caregiver assistance

5 HCBS POPULATIONS

- Individuals who are Frail Elderly (FE)
- Individuals with Brain Injury (BI)
- Individuals with Intellectual or Developmental Disabilities (ID/DD)
- Individuals with Physical Disabilities (PD)
- Individuals with Severe Mental Illness (SMI)

*** These 5 population groups are participating in FASI Round 1 data collection.**

OVERVIEW OF FASI ITEM DOMAINS

- Self-Care such as eating, dressing.
- Mobility activities such as bed mobility and transfers, ambulation, wheelchair use.
- Instrumental Activities of Daily Living (IADLs) such as making a light meal, answering the telephone.
- Use or need for assistive devices
- Living arrangements and presence of paid/unpaid assistance
- Personal goals for each area

Identifier (Assessor ID# / Recipient #) _____

Section B	Functional Abilities and Goals

Self-Care

Form Instructions:

Code the person's **usual** performance during the **past 3 days** using the 6-point scale in **Column A**. If the person's performance **changed** during the **past month**, also code their **most dependent** performance in **Column B**. If the person's self-care performance was **unchanged** during the **past month**, column B should be coded the same as column A. *If the activity was not attempted*, code the reason.

Please complete the Self-Care Priorities section at the bottom of this page.

CODING:

Safety and Quality of Performance – If helper assistance is required because person's performance is unsafe or of poor quality score according to amount of assistance provided. *Activities may be completed with or without assistive devices.*

06. **Independent** – Person completes the activity by him/herself with no assistance from a helper.
05. **Setup or cleanup assistance** – Helper SETS UP or CLEANS UP; person completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** – Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as person 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.

Performance Level Enter Codes in Boxes		
A Usual	B Most Dependent	
☐☐	☐☐	**6a. Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.
☐☐	☐☐	**6b. Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]
☐☐	☐☐	**6c. Toileting hygiene:** The ability to maintain perineal/feminine hygiene, adjust clothes before and after using the toilet, commode, bedpan or urinal. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	☐☐	**6d. Wash upper body:** The ability to wash, rinse, and dry the face, hands, chest, and arms while sitting in a chair or bed.

TEFT FASI OVERVIEW

FASI Personal Priorities

Self-Care Priorities: Please indicate your top two priorities in the area of self-care for the next six months.
1. _____
2. _____

FASI GOALS

Align and standardize core HCBS functional assessment items with corresponding items within Medicare Program

Integrate FASI into CMS' data element library or item bank on assessment items

Seek NQF endorsement for quality measures based on FASI

PROGRESS TO DATE

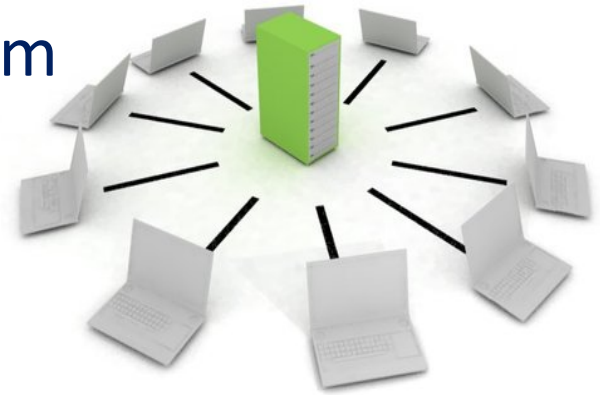
- October 2015:
  - Input from Technical Expert Panel
- December 2015:
  - Pilot-Tested items in Connecticut to evaluate usability
- February 2016:
  - Revised FASI set for Round 1 testing
- May 2, 2016:
  - FASI published in Federal Register for public comment

NEXT STEPS

- Fall 2016:
  - Online FASI training Go-Live
  - Round 1 Data Collection Begins
- November-March 2016:
  - Data Collection/Analysis
  - FASI revisions
- March 2016:
  - State-specific reports
  - Round 2 State Data Collection

HOW CAN STATES USE FASI?

- Determine eligibility Medicaid HCBS programs
- Develop person-centered service plans
- Monitor quality and measure program impact
- Report across multiple programs within a state especially rebalancing initiatives
- Update systems to reflect national standards
- Create exchangeable data platform



PERSON-CENTERED CARE PLANNING

- The Medicaid HCBS rules require states practice person-centered care planning
- Person's voice as the driver of the decision-making

UPDATE STATE IT SYSTEMS

- States can benefit from federally-funded information technology efforts
- Exchangeable data formats exist for existing function items
  - These are being developed for FASI
- TEFT e-LTSS provides "envelopes" for exchanging FASI
- FASI code is in the public domain
  - Available through the CMS website

Thank YOU!

- Additional Information on TEFT and FASI may be found at:

https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/grant-programs/teft-program.html

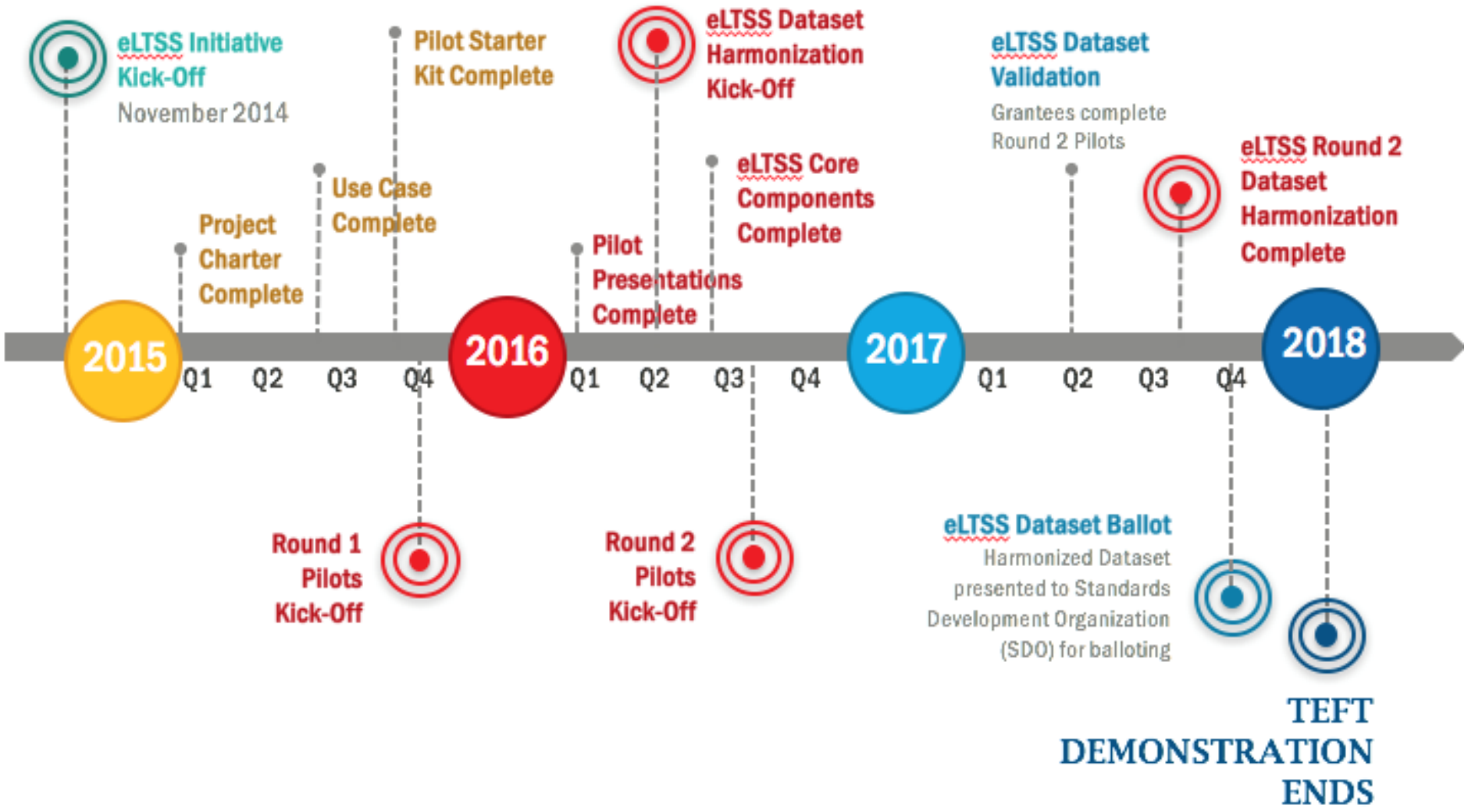
More Information:

- Barbara Gage, PhD
- Research Faculty
- George Washington University
- School of Medicine
- Center for Healthcare Innovation and Policy Research
- bgage@gwu.edu

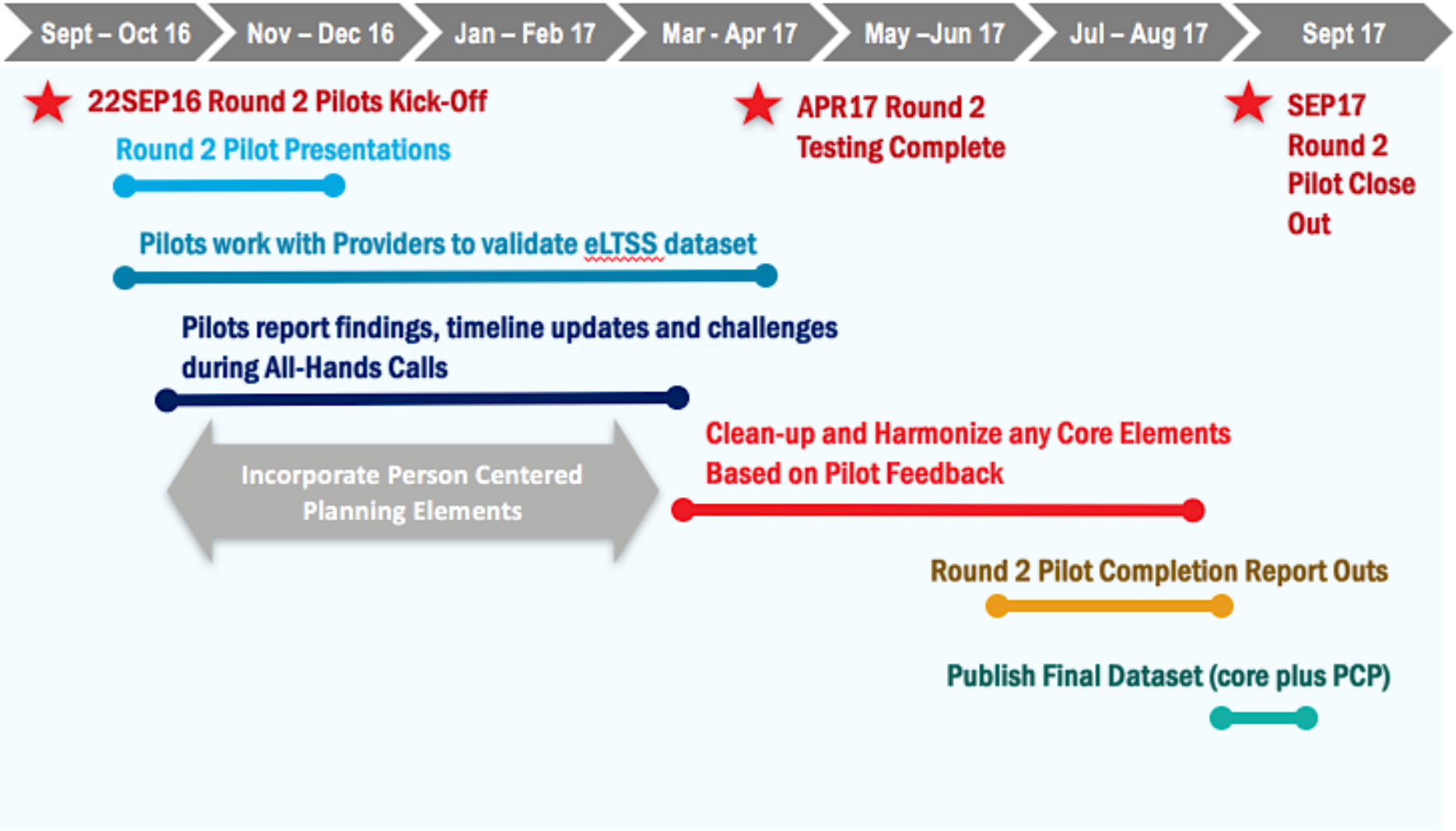
eLTSS Round 2 Pilot Status

Evelyn Gallego, MBA, MPH, CPHIMS
eLTSS Initiative Coordinator
EMI Advisors LLC, Contractor to ONC

eLTSS Initiative At-A-Glance



Round 2 Pilots Timeline



eLTSS Round 2 Pilots

- Kicked off on September 22, 2016
- Round 2 pilots consist of testing the agreed upon ”Core” Plan elements identified by eLTSS Community as part of Round 1 Pilot activities
- Piloting can include:
  - » Updating the Pilot organization’s current Service Plan to include the eLTSS Core data elements
  - » Mapping the existing organization’s Service Plan to the eLTSS Core data elements
- Piloting MUST include sending the Plan to multiple provider groups
  - » Plan can be sent electronically using secure email and/or fax
- Providers ‘receiving’ the plan must provide feedback on the eLTSS Core data elements

eLTSS Round 2 Pilots: Focus on LTSS Providers

- Providers that 'receive' the plan must validate the plan meets their information needs—*does the information in the plan contain everything the Provider needs to know to provide the best and required service to the individual?*
- Need to confirm what information in the plan works, what does not work, and what is missing
  - » Information or elements that are 'missing' will be evaluated as either being 'core' to the plan or 'optional'
- Need to confirm whether the Provider can electronically receive, view and accept the Plan

Grantee Pilot Sites encouraged to identify **3** to **4** different types of providers to work with where at least one of these requires most of the information in the plan to deliver and/or coordinate service.

What is being Piloted? eLTSS Core Dataset

- Pilots must test at least 80% or 38 elements from dataset
- Total Number of Elements: 47

Risk: 1 Element
Identified Risk

Plan Period/Plan Effective Dates: 1 Element
Plan Effective Date

Service Preferences: 2 Elements
Person Service Agreement Indicator
Person Service Provider Choice Indicator

Goals & Strengths: 4 Elements
Assessed Needs
Goal
Step or Action
Strengths

Financial Information: 4 Elements
Plan Funding Source
Program Name
Total Plan Budget
Total Plan Cost

Emergency Backup Plan: 4 Elements
Emergency Backup Name
Non-Paid Emergency Backup Relationship Type
Emergency Backup Phone Number
Emergency Backup Plan Text

Service Provider Name & Other Identifiers: 5 Elements
Support Planner Name
Support Planner Phone Number
Service Provider Name
Non-Paid Service Provider Relationship Type
Service Provider Phone Number

Beneficiary Demographic: 6 Elements
Person Name
Person Identifier
Person Identifier Type
Person Date of Birth
Person Phone Number
Person Address

Plan Signatures: 9 Elements
Person Signature
Person Printed Name
Person Signature Date
Guardian / Legal Representative Signature
Guardian / Legal Representative Printed Name
Guardian / Legal Representative Signature Date
Support Planner Signature
Support Planner Printed Name
Support Planner Signature Date

Service Information: 11 Elements
Service Name
Service Start Date
Service End Date
Service Comment
Service Funding Source
Service Unit Quantity
Unit of Service Type
Service Unit Quantity Interval
Service Rate per Unit
Service Total Units
Total Cost of Service

eLTSS Round 2 Pilot Organizations

TEFT Organization	User Story To Be Tested
CO: Dept. of Health Care Policy & Financing	User Story 1: LTSS Eligibility, eLTSS Plan Creation and Approval
CT: Dept. of Social Services Division of Health Services	User Story 2: Sharing a Person-Centered eLTSS Plan
GA: Dept. of Community Health	User Story 1: LTSS Eligibility, eLTSS Plan Creation and Approval
KY: Office of Administrative & Technology Services	User Story 1: LTSS Eligibility, eLTSS Plan Creation and Approval User Story 2: Sharing a Person-Centered eLTSS Plan
MD: Dept. of Health & Mental Hygiene	User Story 2: Sharing a Person-Centered eLTSS Plan
MN: Dept. of Human Service	User Story 2: Sharing a Person-Centered eLTSS Plan

Detailed presentations from each of the Pilot Sites available here:
http://oncprojectracking.healthit.gov/wiki/display/TechLabSC/eLTSS+Pilots#eLTSSPilots-Round2PilotPlanPresentations

****eLTSS Pilots are open to all participants regardless of participating grant program**

Other Education/Outreach activities: Engagement with HL7

- In September 2016, ONC Team introduced the eLTSS Initiative at the HL7 September Working Group Meeting in Baltimore, MD
- Presentations to two HL7 Working Groups:
  - **Community-Based Collaborative Care (CBCC):** facilitate development and use of HL7 standards that support and integrate the provision of health and human services in community and non-acute care residential settings (e.g. Data Provenance, Data Segmentation for Privacy, Data Access Consent)
  - **Patient Care (PC):** define the technical requirements and solutions to support the needs of communicating information related to the creation, management, execution and quality of care provision (e.g. Care Plan, Care Team, Diet and Nutrition Orders, representation of vital signs)
- Purpose was to bring awareness of the eLTSS Initiative and emerging dataset, and to inquire about existing standards development projects that can inform or be informed by the eLTSS Initiative

Health Level Seven (HL7) is a not-for-profit standards development organization that provides a comprehensive framework and related standards for the exchange, integration, sharing, and retrieval of electronic health information that supports clinical practice and the management, delivery and evaluation of health services: www.hl7.org

Federal Partner Discussion

Key Asks:
Opportunities for Broader Federal Partner Engagement

- Are there other Federal Partner Projects focused on use of data elements similar to those for IMPACT and FASI?
- Which Federal Partners are currently working with SDOs to include HL7, Integrating the Health Enterprise (IHE) International, International Health Terminology Standards Development Organization (IHTSDO) and Regenstrief Institute?
  - » Is there opportunity to collaborate amongst the Federal Partner Projects?

Next Steps for Federal Partner Engagement

- Participate in eLTSS Quarterly Meetings:
  - Seeking other Federal Partner Project presentations
  - Next one to be scheduled for **March 3, 2017**
  - Upcoming Meetings:
    - May 2017
    - Aug 2017
    - Nov 2017
- Identify additional organizations that can contribute to testing and validating of eLTSS dataset

eLTSS Initiative Contacts

- ONC Leadership
  - Caroline Coy (caroline.coy@hhs.gov)
  - Elizabeth Palena-Hall (elizabeth.palenahall@hhs.gov)
- CMS Leadership
  - Mike Smith (Michael.Smith1@cms.hhs.gov)
  - Kerry Lida (Kerry.Lida@cms.hhs.gov)
- Federal Partner Leadership
  - Shawn Terrell (shawnterrell@acl.hhs.gov)
  - Caroline Ryan (caroline.ryan@acl.hhs.gov)
  - Marisa Scala-Foley (marisa.scala-foley@acl.hhs.gov)
- Initiative Coordinator
  - Evelyn Gallego (evelyn.gallego@emiadvisors.net)

Back-Up

CMS 2014 Medicaid HCBS Rule

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 eLTSS Plan Input: Person-Centered Profile

- **Introductory Information: strengths/preferences, positive reputation, etc.**

~ Ruth's One Page Description (at home)~

What People Like and Admire about Ruth

- Such a "grandmother"
- A true lady
- Has the gift of gab ~ can hold a conversation with anyone!
- Always dressed so nice ~ everything always matches, right down to socks and earrings
- Very liberal thinker for her age

What is Important to Ruth

- Living with granddaughter and grandson-in-law
- Being warm and feeling safe with caregivers
- Having "a little pour" before bed (rum and tea)
- Being a part of whatever is going on at home ~ being in the middle of it!
- Sweets during the day!

Supports Ruth Needs to be Happy, Healthy and Safe

- Needs people to ask frequently if she is warm enough and help her put on sweater/sweatshirt if she is not (she'll be cold when you're not)
- Must have assistance with her medications ~ knows them by color but you need to dole them out and keep track of times
- Needs assistance with bathing and dressing ~ will tell you what clothes she wants to wear for the day/event
- When bathing, no water on face ~ she will wash with cloth
- Must talk with daughter 2-3 times a week on the phone ~ will need you to dial for her
- Must see her doctor right away if she has cough, fever or is "off balance" ~ indications of systemic infection that will grow quickly!

People Who Support her Best

- Like to chit chat
- Are timely and stay busy
- Polite and mannerly
- Have a witty and dry sense of humor
- Can be reassuring and help Ruth feel safe

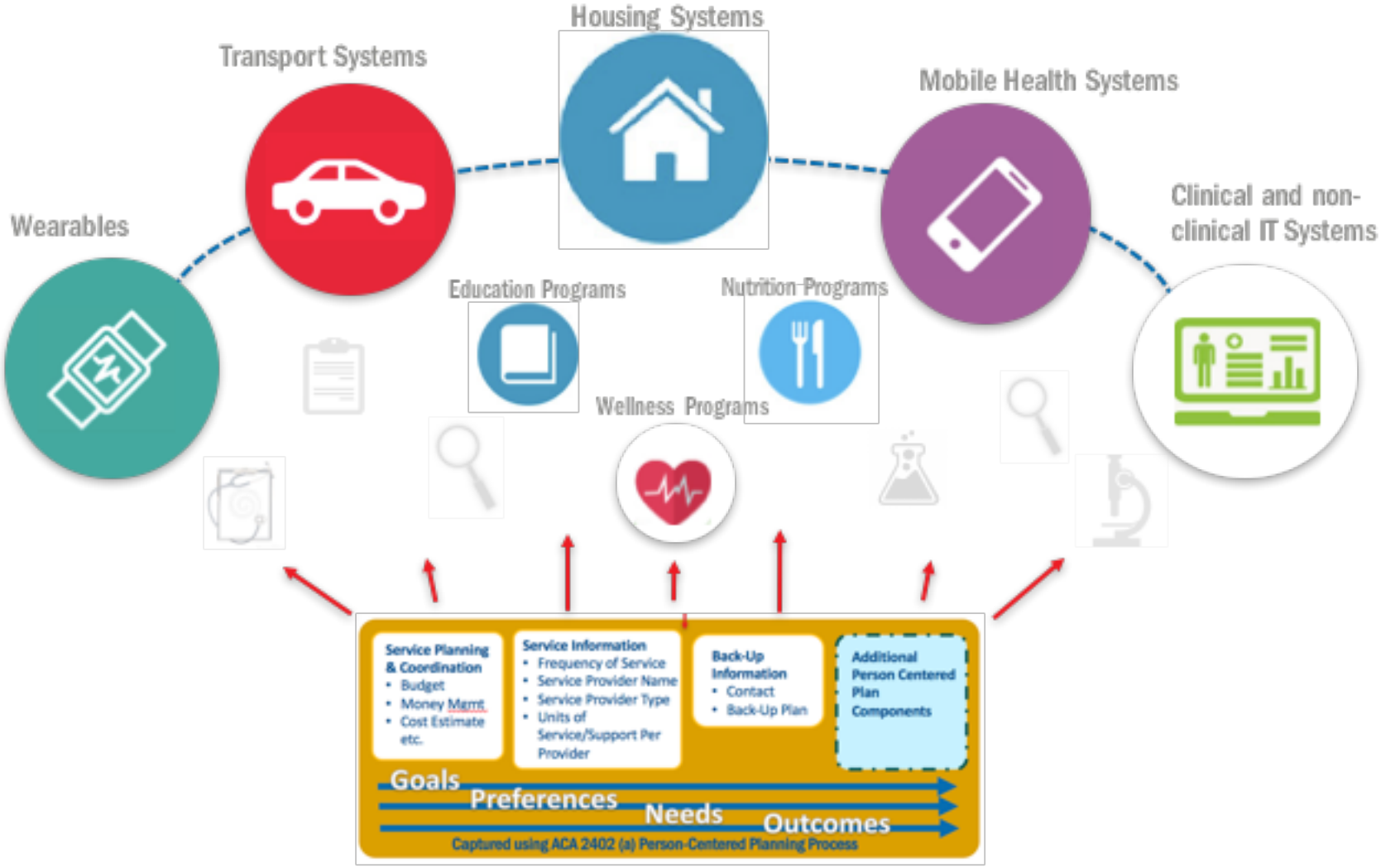
Who participates in the eLTSS Initiative?

321 Total Members

- 96 Committed Members
- 225 Other Interested Party
- 289 Not Registered (attended 1+ meeting)

Stakeholder Group Type/ Total Participants			
Beacon Community, Quality Improvement Organizations, or similar organization	4	Research Organization	15
Consumer / Patient Advocate	11	Standards Organization	4
Contractor / Consultant	31	Service Provider (community-based)	12
Federal, State, Local Agency	141	Service Provider Professional (community-based)	11
Health Information Exchange (HIE) / Health Information Organization (HIO)	10	Other System IT Vendor (Community-Based IT Vendor or Other)	20
Health IT Vendor (EHR, EMR, PHR, HIE)	44	Other	46
Health Professional (DO, MD, DDS, RN, Tech, etc.)	9	Unknown	171
Healthcare Payer/Purchaser or Payer Contractor	5	TEFT Leadership / TA	33
Licensing / Certification Organization	2	ONC Staff / Contractor	26
Provider Organization (institution / clinically based)	9		

Vision for eLTSS Dataset Integration



eLTSS Plan Dataset can be incorporated into various programs and health/wellness IT systems