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

<table>
<thead>
<tr>
<th>Topic Area</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome</td>
<td>Kerry Lida (CMS)</td>
</tr>
<tr>
<td>eLTSS Final Dataset Review and Next Steps</td>
<td>Evelyn Gallego (EMI Advisors LLC)</td>
</tr>
</tbody>
</table>
| Advancing the Interoperability of Social Determinants of Health | Sam Meklir (ONC)  
Liz Palena-Hall (ONC)  
Al Taylor (ONC)                                  |
| Federal Partner Discussion                           | All                                                |
| Next Steps                                           | Evelyn Gallego (EMI Advisors LLC)                  |
Welcome & Introductions
eLTSS Final Dataset Review & Next Steps
eLTSS Initiative At-A-Glance
eLTSS Results

• Successful completion of **two rounds** of testing (pilots)
  » Pilots included **6** TEFT grantees and **12** non-TEFT grantees
  » **Round 1 results:** **692 total data elements** narrowed down to **47 core data elements**
  » **Round 2 results:** Over **270 comments received** and request for **114 new data elements**; narrowed down to **56 core data elements** and **36 non-core data elements**

• Broad public engagement and contribution to eLTSS dataset
  » Increased from **200 to 339** members over 2 years
  » Members include non-TEFT participants across HCBS, government, health and technology industries

• Outreach and Education
  » **+130** different organizations contacted over course of initiative
  » **5** Federal Partner Webinars
  » **27** public outreach presentations
eLTSS Dataset Development Approach

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.

Round 2 Harmonization Approach

• Data elements identified for harmonization, and thereby included for discussion with eLTSS community, needed to meet following criteria:
  » Used by 4 or more Pilots in their existing plans
  » Not used as intended on plan
  » Suggestions for changes/edits to name, definition or format

• All comments and feedback were consolidated into a spreadsheet and were scheduled for review as part of weekly public calls
  » Consolidated harmonization spreadsheet with dispositions made available at: https://oncprojecttracking.healthit.gov/wiki/display/TechLabSC/eLTSS+Home
### Harmonization Example: Plan Funding Source

<table>
<thead>
<tr>
<th>Included in Pilot’s Plan?</th>
<th>CO</th>
<th>CT</th>
<th>GA</th>
<th>KY</th>
<th>MD</th>
<th>MN</th>
<th>FEi</th>
<th>MoW</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>4</td>
</tr>
</tbody>
</table>

**Definition:** The source(s) of payment for the plan.

**Common themes in provider feedback (5 comments total)**
- There are many different payer sources.
- Does not need to be included in plans

**PROPOSAL:** Remove Plan Funding Source from the core eLTSS Dataset
### eLTSS Final Dataset

- **Total Number of Elements:** 56

<table>
<thead>
<tr>
<th>Beneficiary Demographics: 10 Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person Name</td>
</tr>
<tr>
<td>Person Identifier</td>
</tr>
<tr>
<td>Person Identifier Type</td>
</tr>
<tr>
<td>Person Date of Birth</td>
</tr>
<tr>
<td>Person Phone Number</td>
</tr>
<tr>
<td>Person Address</td>
</tr>
<tr>
<td>Emergency Contact Name</td>
</tr>
<tr>
<td>Emergency Contact Relationship</td>
</tr>
<tr>
<td>Emergency Contact Phone Number</td>
</tr>
<tr>
<td>Emergency Backup Plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Person Centered Planning: 11 Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessed Need</td>
</tr>
<tr>
<td>Preference</td>
</tr>
<tr>
<td>Person Setting Choice Indicator</td>
</tr>
<tr>
<td>Person Setting Choice Options</td>
</tr>
<tr>
<td>Service Options Given Indicator</td>
</tr>
<tr>
<td>Service Selection Indicator</td>
</tr>
<tr>
<td>Service Provider Options Given Indicator</td>
</tr>
<tr>
<td>Service Provider Selection Agreement Indicator</td>
</tr>
<tr>
<td>Service Plan Agreement Indicator</td>
</tr>
<tr>
<td>Plan Monitor Name</td>
</tr>
<tr>
<td>Plan Monitor Phone Number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan Information: 1 Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Effective Date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan Signatures: 12 Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person Signature</td>
</tr>
<tr>
<td>Person Printed Name</td>
</tr>
<tr>
<td>Person Signature Date</td>
</tr>
<tr>
<td>Guardian/Legal Representative Signature</td>
</tr>
<tr>
<td>Guardian/Legal Representative Printed Name</td>
</tr>
<tr>
<td>Guardian/Legal Representative Signature Date</td>
</tr>
<tr>
<td>Support Planner Signature</td>
</tr>
<tr>
<td>Support Planner Printed Name</td>
</tr>
<tr>
<td>Support Planner Signature Date</td>
</tr>
<tr>
<td>Service Provider Signature</td>
</tr>
<tr>
<td>Service Provider Printed Name</td>
</tr>
<tr>
<td>Service Provider Signature Date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risks: 2 Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identified Risk</td>
</tr>
<tr>
<td>Risk Management Plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Information: 12 Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Name</td>
</tr>
<tr>
<td>Self-Directed Service Indicator</td>
</tr>
<tr>
<td>Service Start Date</td>
</tr>
<tr>
<td>Service End Date</td>
</tr>
<tr>
<td>Service Delivery Address</td>
</tr>
<tr>
<td>Service Comment</td>
</tr>
<tr>
<td>Service Funding Source</td>
</tr>
<tr>
<td>Service Unit Quantity</td>
</tr>
<tr>
<td>Unit of Service Type</td>
</tr>
<tr>
<td>Service Unit Quantity Interval</td>
</tr>
<tr>
<td>Service Rate per Unit</td>
</tr>
<tr>
<td>Total Cost of Service</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Provider Information: 5 Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support Planner Name</td>
</tr>
<tr>
<td>Support Planner Phone Number</td>
</tr>
<tr>
<td>Service Provider Name</td>
</tr>
<tr>
<td>Service Provider Phone Number</td>
</tr>
<tr>
<td>Non-Paid Provider Relationship</td>
</tr>
</tbody>
</table>

Final Dataset available at: [https://oncprojecttracking.healthit.gov/wiki/display/TechLabSC/eLTSS+Home](https://oncprojecttracking.healthit.gov/wiki/display/TechLabSC/eLTSS+Home)
Why standardize Data Elements?

**Standardization at the data level, not IT system level.** Information can be captured in different IT systems to include EHRs, PHRs, care coordination systems, HCBS/LTSS systems.
What are Common Industry Data Element Standards?
What is a Health & Human Services IT Standard?

An IT standard provides the fundamental *definitions for* and *structures of* the data that can be communicated electronically across a wide variety of healthcare use cases.

They refer to agreed-upon FILE formats for *electronic documents, messages*, and other healthcare related *data elements*.

They permit two or more disparate entities to work in some cooperative way to share information in a secure and seamless way.

Why are Standards Important for Health & Human Services Industries?

• Need common approach for representing and exchanging health and human services data:
  » Those who collect it from outside sources
  » Those who enter it into electronic format
  » Those who analyze it
  » Those who verify the findings
  » Those that communicate the information for interventions (health, public health and services related)

Source: Public Health Informatics http://slideplayer.com/slide/7341838/
## What are Types of IT Standards?

<table>
<thead>
<tr>
<th>STANDARD TYPE</th>
<th>FUNCTIONS OF STANDARDS</th>
<th>REAL WORLD EXAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>VOCABULARY &amp; TERMINOLOGY</td>
<td>Information is universally understood</td>
<td>Specific words and language used in a letter/package</td>
</tr>
<tr>
<td>FORMAT, CONTENT &amp; STRUCTURE</td>
<td>Information is in the appropriate format</td>
<td>Structure and specific type of information in the letter/package</td>
</tr>
<tr>
<td>TRANSPORT</td>
<td>Information moves from point A to point B</td>
<td>Method used to move letter/package from one address to another</td>
</tr>
<tr>
<td>SECURITY</td>
<td>Information is securely accessed and moved</td>
<td>Sealing the envelope or package</td>
</tr>
<tr>
<td>SERVICES</td>
<td>Support the exchange of information</td>
<td>Delivering to intended recipient, finding address, insuring package for delivery</td>
</tr>
</tbody>
</table>

---

*The Office of the National Coordinator for Health Information Technology*
Vocabulary & Terminology Standards

• These are the “words” you choose to use to communicate information so you are clearly understood

• In health & human services, these can be tables of codes that describe things:
  » Numbers as county codes (FIPS)
  » Reportable diseases as number codes
  » ICD-9, ICD-9 CM, ICD-10 codes for underlying cause of death

• These codes are represented as **data element attributes**

• Common code standards include:
  » LOINC (e.g. code for activities of daily living score is 72095-3)
  » SNOMED CT (e.g. code for current every day smoker is 449868002)
  » RxNorm (e.g. code for Ibuprofen is 5640)
Content Standards

Define the structure of the building blocks which can be used to contain a multitude of data elements that can be captured, stored, accessed, displayed and transmitted electronically for use and reuse in many formats.

THE WAY YOU PUT WORDS TOGETHER
eLTSS Dataset can be incorporated into various programs and health/wellness IT systems.

For interoperability, eLTSS dataset needs to be represented using nationally recognized vocabularies and content standards.
eLTSS Dataset Standardization

- eLTSS dataset has been “harmonized” so it can be easily understood across “human” end-users
- Next level of harmonization involves standardization so dataset is machine readable and thereby “interoperable” across multiple systems
  » Need to identify applicable *vocabulary, content* and *transport* standards
- A few of *vocabulary standards* exist for eLTSS elements that are commonly collected in clinical systems
  » E.g. person demographics, goals, preferences
- Most of eLTSS dataset consists of elements that do not have existing vocabulary standard available for machine readability
- *Content standards* such as C-CDA and FHIR will need to be updated if used to support eLTSS dataset exchange
## Example: Existing Vocabulary Standards and Gaps

<table>
<thead>
<tr>
<th>eLTSS Data Element</th>
<th>Definition</th>
<th>Datatype/Format</th>
<th>Applicable Code Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal</td>
<td>A statement of a desired result that the person wants to achieve</td>
<td>String/ Free text</td>
<td>LOINC Goals Narrative (61146-7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Goals Achievement value set: Goal achieved Goal not achieved Goal not attainable, No progress toward goal</td>
</tr>
<tr>
<td>Assessed Need</td>
<td>The clinical and/or community based necessity or desire as identified through an assessment that should be addressed by a service.</td>
<td>String/ Free text</td>
<td>Not available</td>
</tr>
</tbody>
</table>
eLTSS Standardization: Next Steps

• One of the TEFT Grantees, GA, provided supplemental funding to advance the standardization of the eLTSS dataset through HL7

• HL7 will provide guidance on best available standards and revisions needed to update the dataset so it can be included in a standard

  » For dataset to be incorporated into an electronic LTSS system and be interoperable with other systems, it needs to be formatted using nationally recognized health IT standards

• GA will develop concept whitepaper and reference data model to:

  » identify existing standards gaps with the eLTSS dataset

  » describe how eLTSS dataset can be incorporated into existing content standards (C-CDA and FHIR)
Advancing the Interoperability of Social Determinants of Health
ONC Health IT Certification Program Criterion: Social, Psychological, and Behavioral Data

45 CFR 170.315(a)(15): Enable a user to record, change, and access the following patient social, psychological, and behavioral data:

- (i) Financial resource strain
- (ii) Education
- (iii) Stress
- (iv) Depression
- (v) Physical activity
- (vi) Alcohol use
- (vii) Social connection and isolation
- (viii) Exposure to violence (intimate partner violence)

Specifics on Criteria:


» Test Procedure for SDOH provides information to EHR developers on the testing procedures employed by the Authorized Testing Labs to validate compliance with regulation on SDOH: [https://www.healthit.gov/sites/default/files/170_315a15_social_behavioral_data_v1.1.pdf](https://www.healthit.gov/sites/default/files/170_315a15_social_behavioral_data_v1.1.pdf)
Interoperability in Action: Advancing Interoperable Social Determinants of Health (SDOH)

July 25 2017: ONC hosted webinar to discuss current state of interoperability of social determinants of health (SDOH) screening and assessment tools in care delivery. Webinar highlighted:

• efforts and available resources to increase the interoperability of SDOH tools, concepts and data elements
• how health IT can be leveraged to support the use of SDOH in clinical practice and to improve clinical decision support and quality measurement, care coordination, and population health management
• specific “health IT enabled” exemplars (such as Health Leads, Socially Determined, NACHC/AAPCHO/OCHIN and PRAPARE tool)
• content to support future playbook as informed by NLM and Regenstrief Institute

Access Slides/Recording Here
Interoperability in Action: Advancing Interoperable Social Determinants of Health (SDOH)

Action Day Spotlights:

• **76% of participants** were interested in exchanging social needs data with community based organizations

• Stakeholders such as Social Interventions Research & Evaluation Network (SIREN) working to inventory available codes representing different SDOH domains across screening tools

• NACHC/AAPCHO developing Common Data Model and looking to link social risk assessment data with interventions data and facilitate EHR integration

• Growing research base (OCHIN) on EHR/portal integration to support data collection and referrals to community services to meet social needs; standardizing SDOH data collection and presentation in EHRs could lead to improved patient and population health outcomes

• Considerations for standardization prioritization include: consensus, instrument validity and ease of use, available interventions, business value (program requirements, reimbursement for interventions and outcomes)

• Best Practices for developing terminology and codes when users request additions

• Assessment tools use validated and standardized questions and answers with flexibility in administration
Interoperability in Action: Informing Next Steps

• Call upon various stakeholders to commit to adopting health IT to enable SDOH tools
  » social determinant assessment tool developers, end users, EHR developers, payers, researchers

• Identification of best practices/best tools for further development
  » SIREN (https://sirenetwork.ucsf.edu/tools-resources/metrics-measures-instruments)

• Identification of available resources to assist the community in health IT enabling these tools
  » ONC Interoperability Standards Advisory- https://www.healthit.gov/isa/
  » National Library of Medicine
    – Value Set Authority Center (VSAC)- https://vsac.nlm.nih.gov/

• Supporting communities with technical assistance and facilitating connections with non-governmental resources to advance progress
ONC and Standards Related /Other Resources for Social, Psychological, and Behavioral Data (SPB)


- Certification Companion Guide for SDH and Test Procedures provides technical explanations and clarifications to the regulation text and provides links to resources to facilitate adoption:

- ONC’s Tech Lab is a platform for ONC’s standards and technology work and houses The Interoperability Proving Ground (IPG) https://www.healthit.gov/techlab/ipg/

- ONC (via HITPC workgroup) has explored the issues of what health IT policies are needed to support advanced health models’ capabilities to address the holistic health of individuals and communities that they serve. See: https://www.healthit.gov/FACAS/health-it-policy-committee/health-it-policy-committee-recommendations-national-coordinator-health-it for August 11, 2015 Transmittal Letter

## How does current eLTSS dataset support SDOH?

<table>
<thead>
<tr>
<th>Element</th>
<th>Definition</th>
<th>Relevant SDOH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Name</td>
<td>Identifies the paid and/or non-paid service provided to a person. Include the code and display name plus any modifiers when a coding system (e.g., Healthcare Common Procedure Coding System (HCPCS), Home Health Revenue Codes) is used.</td>
<td>Services can be identified to address SDOH related needs such as education, behavioral health, physical activity, housing, social connections.</td>
</tr>
<tr>
<td>Identified Risk</td>
<td>An aspect of a person’s life, behavior, environmental exposure, personal characteristic, or barrier that increases the likelihood of disease, condition, injury to self or others, or interaction with the criminal justice system.</td>
<td>ALL 8 ONC recognized social, psychological, and behavioral data</td>
</tr>
<tr>
<td>Non-paid service provider relationship type</td>
<td>The relationship (e.g., spouse, neighbor, guardian, daughter) of the individual providing a non-paid service or support to the person.</td>
<td>• Social connection and isolation</td>
</tr>
</tbody>
</table>
How does current eLTSS dataset support SDOH?

<table>
<thead>
<tr>
<th>Element</th>
<th>Definition</th>
<th>Relevant SDOH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengths</td>
<td>A favorable attribute of oneself, his/her support network, environment and/or elements of his/her life as depicted by the person</td>
<td>• Education</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Physical Activity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Social connection and isolation</td>
</tr>
<tr>
<td>Assessed Needs</td>
<td>The clinical and/or community-based necessity or desire as identified through an assessment that should be addressed by a service.</td>
<td>• Education</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Physical activity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Social connection and isolation</td>
</tr>
<tr>
<td>Goal</td>
<td>A statement of a desired result that the person wants to achieve.</td>
<td>• Education</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Physical activity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Social connection and isolation</td>
</tr>
<tr>
<td>Step or Action</td>
<td>A planned measurable step or action that needs to be taken to accomplish a goal identified by the person.</td>
<td>• Education</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Physical activity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Social connection and isolation</td>
</tr>
</tbody>
</table>
How can eLTSS dataset evolve to further support SDOH?

• Incorporate additional elements into existing eLTSS groupings:
  
  » **Beneficiary Demographics**: e.g. education level, language and literacy, enrollment in higher education
  
  » **Financial Information**: e.g. financial resource strain, employment, food insecurity, housing instability
  
  » **Service Information**: e.g. civic participation, access to services that support independent living, quality of housing
  
• Create new grouping to capture:
  
  » **Issues and barriers**: Poverty, social cohesion, stress, depression, alcohol use, discrimination, incarceration, crime and violence
  
  » **Neighborhood and built environment**: e.g. access to services to support independent living, quality of housing
Federal Partner Discussion
Key Asks:
Opportunities for Broader Federal Partner Engagement

• Are there other Federal Partner Projects focused on use of IT to capture SDOH?
• 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 **January 2018**
  » Upcoming Meetings:
    – April 2018

• Identify additional organizations that can contribute to testing and validating of eLTSS dataset
eLTSS Initiative Contacts

• ONC Leadership
  » Ali Massihi (ali.massihi@hhs.gov)
  » Caroline Coy (caroline.coy@hhs.gov)
  » Elizabeth Palena-Hall (elizabeth.palenahall@hhs.gov)

• CMS Leadership
  » 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
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

Key Inputs to Person-Centered Plan: Person-Centered Profile

WHAT IS IMPORTANT TO ROBERT
- Having a straw to hold
- Looking sharp
- Using my iPad apps
- Drinking water
- Out and about
- Eating out
- Swimming
- Church
- Music
- Family
- Healthy food
- Recreation, sports
- Volunteer, Job

WHAT PEOPLE LIKE AND ADMIRE ABOUT ROBERT
- Say what I want, decisive
- Good memory
- Like everyone
- Handsome and polite
- High energy, adventurous
- Love my family
- Deep thinker
- Nice dresser
- Mellow
- Funny
- Like to "chill"

PEOPLE WHO HELP ROBERT BEST
- Tell me when I do well
- Cheerful and outgoing
- Assist me to do things for myself
- Help me do what I like to do
- Use positive language (not “don’t...”)
- Tell me the plan
- Keep my house clean and neat
- Communicate and keep my mom in the loop
- Minimize waiting for things to happen
- Know I may have a seizure
- Identify fun activities
- Professional
- Stay with me
- Think ahead
- Safe driver
- Engage me
- Are on time

SUPPORTS ROBERT NEEDS TO BE HAPPY, HEALTHY, AND SAFE
- Medication on time
- Careful in parking lots
- Help in bathroom
- Seat belt on
- Wear ID bracelet
- Use bathroom a lot
- Call Mom if problem or question(s) 410.733.9539
- Deep breaths if agitated
- Safe seizures
- Suntan lotion
- Food cut up
- Teeth clean
- No balcony use
- Nurse Lara: 443.677.7130

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