Electronic Long-Term Services & Supports Initiative GLOSSARY

Term/ Title	Description	Source
Section 1915c of the Social Security Act: Home and Community-Based Services Waivers **Final Rule CMS 2249-F and CMS 2296-F: State Plan Home and Community-Based Services**	Authorizes the Secretary to waive certain requirements in Medicaid Law in order for states to provide home and community-based services (HCBS) to meet the needs of individuals who choose to receive their long-term care services and supports in their home or community, rather than in institutional settings. The final rule establishes requirements for HCBS settings under the 1915(c), 1915(i) and 1915(k) Medicaid Authorities, and conflict of interest and person-centered planning requirements for Medicaid HCBS participants under 1915(c) and 1915(i). This rule offers states new flexibilities in providing necessary and appropriate services to elderly and disabled populations. This rule also describes Medicaid coverage of the optional state plan benefit to furnish home and community based-services and draw federal matching funds.	http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/1915c-fact-sheet.pdf 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
Section 2402(a) of the Affordable Care Act: Guidance for Implementing Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs	Requires Secretary to ensure all states receiving federal funds develop service systems that are responsive to the needs and choices of beneficiaries receiving home and community-based long-term services (HCBS), maximize independence and self-direction, provide support coordination to assist with a community-supported life, and achieve a more consistent and coordinated approach to the administration of policies and procedures across public programs providing HCBS.	http://www.acl.gov/Programs/CDAP/OIP/docs/2402-a-Guidance.pdf
Long-Term Services & Supports (LTSS)	Assistance with activities of daily living and instrumental activities of daily living provided to older people and adults with disabilities that cannot perform these activities on their own due to a physical, cognitive, or chronic health conditions. LTSS may provide care, case management, and service coordination to people who live in their own home, a residential setting, a nursing facility, or other institutional setting. LTSS also include supports provided to family members and other unpaid caregivers. LTSS may be provided in institutional and community settings.	http://www.acl.gov/Programs/CDAP/OIP/docs/2402-a-Guidance.pdf

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Home and Community-Based Services (HCBS)	Services and supports that assist older adults and people with disabilities (including mental health and substance use disorders) to live with dignity and independence in community settings. HCBS complement medical and other traditional health services, and help people to maintain and improve health and quality of life in their chosen community settings. *NOTE: National Quality Forum (NQF), under contract with HHS, is creating a conceptual framework for measurement of HCBS to include a definition for HCBS.	http://www.acl.gov/Programs/CDAP/OIP/docs/2402-a-Guidance.pdf
State Plan HCBS	Needed long-term care services for Medicaid beneficiaries. These services will be provided in the home or alternative living arrangements in the community, which is of benefit to the beneficiary, than institutional care. HCBS may be available to assist individuals to transition from an institution to the community.	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#h-30
Person-Centered Planning (Administration of Community Living)	Process directed by the person with LTSS needs. It may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP approach identifies the person's strengths, goals, preferences, needs (medical and HCBS), and desired outcomes. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.	http://www.acl.gov/Programs/CDAP/OIP/docs/2402-a-Guidance.pdf
Person-Centered Planning (Institute of Medicine)	A highly individualized comprehensive approach to assessment and services that is founded on an understanding of the person's history, strengths, needs, and vision of his or her own recovery and includes attention to issues of culture, spirituality, trauma, and other factors	http://iom.edu/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf

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Person-Centered Planning Process (Administration of Community Living)	PCP must be implemented in manner that supports the person, makes him or her central to the process, and recognized the person as the expert on goals and needs. Process elements include: • Person/Representative must have control over who is included in the planning process • Process is timely and occurs at times and locations of convenience to the person • Necessary information and support is provided to ensure the person is central to the process • A strengths-based approach to identifying the positive attributes of the person must be used, including an assessment of the person's strengths and needs • Personal preferences are used to develop goals and meet person's HCBS needs including cultural preferences	http://www.acl.gov/Programs/CDAP/OIP/docs/2402-a-Guidance.pdf
Medicaid funded HCBS Person-Centered Planning Process	§ 441.301 Contents of request for a waiver. In addition to being led by the individual receiving services, the person-centered planning process: • Includes people chosen by the individual. • Provides necessary support to ensure that the individual has a meaningful role in directing the process. • Occurs at times and locations of convenience to the individual. • Reflects cultural considerations of the individual. • Includes strategies for solving conflict or disagreement within the process, including any conflict of interest concerns. • Offers choices to the individual regarding the services and supports they receive and from whom. • Includes a method for the individual to request updates to the plan as needed.	https://www.federalregister.gov/articles/2011/04/15/2011-9116/medicaid-program-home-and-community-based-services-hcbs-waivers#h-22

Term/ Title	Description	Source
Person-Centered Service Plan	Identifies the services and supports that are necessary to meet the person's identified needs, preferences and quality of life goals. PCP must be consistent with statutory and regulatory provisions and consist of following attributes: • Setting where person resides as chosen by the person • Be prepared in person-first singular language and be understandable by the person • Positive attributes of the person. These must be documented at the beginning of the plan. • Risks and measures available to reduce risks or identify alternative ways to achieve personal goals • Goals documented in person's own words • Services and supports that will be necessary and specify what HCBS are to be provided through various resources including natural supports, to meet the goals in the PCP. • Specific person or persons, and/or provider agency or other entity providing services and supports and monitoring services and supports • Signatures of everyone with responsibility for its implementation including the person and/or representative, his or her case manager, the support broker/agent (where applicable), and a timeline for review. • Emergency back-up plan must be documented that encompasses a range of circumstances (e.g. weather, housing, staff). • Address elements of self-direction (e.g. fiscal intermediary, support broker/agent, alternative services) whenever a self-directed service delivery system is chosen	http://www.acl.gov/Programs/CDAP/OIP/docs/2402-a-Guidance.pdf
Self-Direction	Refers to a consumer-controlled method of selecting and using services and supports that allow the person maximum control over his or her HCBS including the amount, duration, and scope of services and supports as well as choice of provider(s).	http://www.acl.gov/Programs/CDAP/OIP/docs/2402-a-Guidance.pdf

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Medicaid funded HCBS Person-Centered Plan	The person-centered plan must reflect the services that are important for the individual to meet individual services and support needs as assessed through a person-centered functional assessment as well as what is important to the person with regard to preferences for the delivery of such supports. Commensurate with the level of need of the individual, the plan must: 1. Reflect individuals strengths and preferences 2. Reflect clinical and support needs as identified through a person-centered functional assessment 3. Included individually identified goals, which may include, as desired by the individual, items related to relationships, community living, community participation, employment, income and savings, health care and wellness, education, and others 4. Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals and the providers of those services and supports 5. Reflect risk factors and measures 6. Be signed by all individuals and providers 7. Be understandable to the individual receiving services and individuals important in supporting him or her 8. Include a timeline for review 9. Identify the individual and/or entity responsible for monitoring the plan 10. Be distributed to everyone involved in the plan 11. Be directly integrated into self-direction where individual budgets are used 12. Prevent the provision of unnecessary or inappropriate care	https://www.federalregister.gov/articles/2011/04/15/2011-9116/medicaid-program-home-and-community-based-services-hcbs-waivers#h-22
Institutional Long Term Care	Medicaid covers certain inpatient, comprehensive services as institutional benefits. The word "institutional" has several meanings in common use, but a particular meaning in federal Medicaid requirements. In Medicaid coverage, institutional services refer to specific benefits authorized in the Social Security Act. These are hospital services, Intermediate Care Facilities for People with mental Retardation, Nursing Facility, Inpatient Psychiatric Services for Individuals under 21, and Services for individuals age 65 or older in an institution for mental diseases. Institutions are residential facilities, and assume total care of the individuals who are admitted to include room and board.	http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/long-term-services-and-supports.html
Community-Based Long-Term Services & Supports (CB-LTSS)	As part of Medicaid coverage, refers to a sustainable, person-driven long-term support system in which people with disabilities and chronic conditions have choice, control and access to a full array of quality services that assure optimal outcomes, such as independence, health and quality of life. The system must be: person-driven, inclusive, effective and accountable, sustainable and efficient, coordinated and transparent, and cultural competent.	http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/long-term-services-and-supports.html

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No-Wrong Door/ Single Point of Entry (NWD/SEP) Plan of Care	The plan of care must offer each individual all of the LTSS that are covered by the State that the individual qualifies for, and that are demonstrated to be necessary through the evaluation and assessment process. The plan of care must be based only on medical necessity (for example, needs-based criteria), not on available funding. The Plan is informed by the individual's functional assessment.	http://www.balancingincentiveprogram.org/sites/default/files/Balancing_Incentive_Program_Manual_2.0.pdf
PROPOSED. Electronic Long-Term Services and Supports (eLTSS) Plan	Electronic version of ACL and CMS defined Person-Centered Service Plan. Structured, longitudinal person-centered service plan that can be exchanged electronically across multiple community-based LTSS settings, institutional settings, and with beneficiaries and payers. The content or data elements of the eLTSS Plan is specific to the types of services rendered and information collected for CB-LTSS.	http://wiki.siframework.org/electronic+Long-Term+Services+and+Supports+%28eLTSS%29+Charter
PROPOSED. eLTSS Record	An electronic Long-Term Services and Supports Record is a digital version of the services and supports a person receives in his or her community. The record contains service and supports data collected for LTSS and can be inclusive of a broader view of a service eligibility, determination, payment, service planning and service monitoring. An eLTSS Record can contain a person's service and supports history, financial and functional eligibility for such services and supports, and service plan (eLTSS plan). For Medicaid, the eLTSS record must document the person-centered process and exceptions to HCB Settings as required under 42 CFR 301 parts (6)(c)(1)and (6)(c)(2)	Similar to EHR definition from healthit.gov; build from ACL LTSS definition and BIP NWD Implementation Manual
Care Plan	A consensus-driven dynamic plan that represents all of a patient's and Care Team Members' prioritized concerns, goals, and planned interventions. It serves as a blueprint shared by all Care Team Members, including the patient, to guide the patient's care. A Care Plan integrates multiple interventions Care Team Members (including Patients, their caregivers, providers and clinicians) proposed by multiple providers and disciplines for multiple conditions. A Care Plan represents one or more Plan(s) of Care and serves to reconcile and resolve conflicts between the various Plans of Care developed during the continuum of care for a specific patient. Unlike the Plan of Care, a Care Plan includes the patient's life goals and enables Care Team Members to prioritize interventions. The Care Plan also serves to enable longitudinal coordination of care. Care Plan Components are: Health Concern, Goal, Instructions, Interventions, Outcomes, Care Team Member This is the definition included in the HL7 Consolidated Clinical Document Architecture (C-CDA) Release 2.0 Care Plan Document.	ONC S&I LCC Initiative: http://wiki.siframework.org/file/view/LCC%20Care%20Plan%20Exchange%20Use%20Case%20Final.pdf/442230840/LCC%20Care%20Plan%20Exchange%20Use%20Case%20Final.pdf

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Care Plan (Stage 2 Final Rule)	We do not intend to limit the inclusion of the care plan to a single field. Therefore, we are amending the language to "Care plan field(s), including goals and instructions" in our list of required elements below. However, we decline to provide an alternate definition that would limit the information in the care plan. We believe that the definition we proposed in the proposed rule is sufficient to allow for the inclusion of a variety of care plans in the clinical summary. For purposes of the clinical summary, we define a care plan as the structure used to define the management actions for the various conditions, problems, or issues. A care plan must include at a minimum the following components: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome).	Electronic Health Record Incentive Program Stage 2 Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf
Care Plan for Chronic Care Management (Medicare Physician Fee Schedule)	In consultation with the patient, any caregiver and other key practitioners treating the patient, the practitioner furnishing CCM services must create a patient-centered care plan document to assure that care is provided in a way that is congruent with patient choices and values. The care plan is based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports. It is a comprehensive plan of care for all health issues, and typically includes, but is not limited to, the following elements: problem list, expected outcome and prognosis, measurable treatment goals, symptom management, planned interventions, medication management, community/social services ordered, how the services of agencies and specialists unconnected to the billing practice will be directed/coordinated, identify the individuals responsible for each intervention, requirements for periodic review and, when applicable, revision of the care plan. A full list of problems, medications and medication allergies in the EHR must inform the care plan, care coordination and ongoing clinical care.	Medicare Physician Fee Schedule (MPFS) Final Rule: https://www.federalregister.gov/articles/2014/11/13/2014-26183/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-clinical-laboratory
Plan of Care (LCC)	A clinician driven plan that focuses on a specific health concern or closely related concern. It represents a specific set of related conditions that are managed or authorized by a clinician or provider or certified by a clinician or provider. The Plan of Care represents a single set of information that is generally developed independently. When two or more Plans of Care exist, these plans are reconciled into a Care Plan. Examples: Home Health Plan of Care	
Treatment Plan (LCC)	A domain-specific plan managed by a single discipline focusing on a specific treatment or intervention. Examples: Physical Therapy Treatment Plan, Nutrition Treatment Plan, Invasive Line Treatment Plan	
Beneficiary	For the purpose of the eLTSS Initiative, the term 'beneficiary' will refer to all individuals who are eligible for and receive LTSS benefits to include Medicaid. These beneficiaries are also referred to as recipients, consumers, persons, clients, and individuals.	

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Consumer Engagement with Health Information	Engaging healthcare consumers while maintaining their own health as well as while they are caring for others	http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_050578.hcsp?dDocName=bok1_050578
Consumer Mediated Exchange	Ability for patients to aggregate and control the use of their health information among providers. While in control of their own health information, patients can actively participate in their care coordination by: 1) providing other providers with their health information; 2) Identifying and correcting wrong or missing health information; 3) Identifying and correcting incorrect billing information; and 4) Tracking and monitoring their own health.	http://www.healthit.gov/providers-professionals/health-information-exchange/what-hie
Exchange (i.e. eLTSS Plan Exchange)	Implies the data is sent or transferred somewhere else	
Sharing (i.e. eLTSS Plan Sharing)	Digital technology definition: the practice of giving specific users access to digital documents or other online content. Sharing implies the data is made available for access by other parties/multiple parties.	
Social Functioning	The ability of the beneficiary to interact in a normal or usual way in society; can be used as a measure of quality of care.	
Community Engagement	The process by which the beneficiary builds ongoing relationships with community organizations and successfully participates in community based activities.	