Electronic Long Term Services and Supports (eLTSS) Project Charter

Background

Section 2701 of the Patient Protection and Affordable Care Act (ACA) of 2010 calls for the Secretary of the Department of Health and Human Services (DHHS) to identify and publish an initial voluntary core set of health care quality measures for adults eligible for Medicaid. In response to this provision, the Centers for Medicare and Medicaid Services (CMS) recognized that a significant quality measurement gap exists in the ability to collect standardized information about the experience and outcomes of care for individual receiving community-based long-term services and supports (CB-LTSS). CMS established the Testing Experience and Functional Tools (TEFT) in community based long-term services and supports Planning and Demonstration Grant Program to support selected, eligible State applicants to accomplish the following:

1. Test and evaluate new measures of functional capacity and individual experience for populations receiving CB-LTSS;
2. Identify and harmonize the use of health information technology (Health IT); and
3. Identify and harmonize electronic LTSS (e-LTSS) standards.[1]

Health Information Technology (Health IT), which includes the meaningful use of Electronic Health Records (EHRs), is increasingly being recognized as a tool with the highest potential to provide timely and relevant data in a form that is quickly usable for research, public health, quality improvement and consumer engagement[2]. However, EHR implementation and integration into service delivery has been limited for CB-LTSS. CB-LTSS is defined by CMS as "assistance with activities of daily living and instrumental activities of daily living provided to beneficiaries (elderly and adults with disabilities) that cannot perform these activities on their own due to a physical, cognitive, or chronic health condition."[3] The limited use of Health IT and EHRs to access and capture data for these services is partly due to the fact that incentives put in place through the American Recovery and Reinvestment Act of 2009 (ARRA) target "eligible professionals and hospitals" for using electronic health technology. These eligible groups do not include CB-LTSS providers or accountable entities. Similarly the value proposition for exchanging electronic information between institutional and non-institutional providers is not well understood by providers or beneficiaries[4]. The integration of clinical care and/or institutional care with CB-LTSS service data is also compounded by the fact that social and behavioral determinants of health and quality of life indicators are often not included in a beneficiary's health record regardless of whether it is paper-based or electronic. There is no consensus on what information should be included in a beneficiary's LTSS record, even though the record itself may contain a combination of clinical care, client assessment, service plan data and other information.

The Affordable Care Act introduces approaches to health care delivery that encourage the formation of more coordinated systems and person-centered planning, many of which can be supported by Health IT. Relevant Affordable Care Act programs include Money Follows the Person (included in the Deficit

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[1] (Centers for Medicare & Medicaid Services, 2013)
[2] (Friedman, 2013)
[3] (Centers for Medicare & Medicaid Services, 2013)
[4] For the purpose of the eLTSS Initiative, 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.

Reduction Act (DRA) and Extended through ACA, Section 2403), Community First Choice (ACA, Section 2401), the Balancing Incentives Program (ACA, Section 10202) and Oversight and Assessment of the Administration of Home and Community-Based Services. (ACA, Section 2402(a)). These programs target diverse beneficiary populations[5], some of which are eligible for Medicaid-funded CB-LTSS provided by the states. In addition, recent changes to the regulations governing Medicaid-funded LTSS provide increased clarity related to the characteristics and requirements of LTSS and person-centered planning.

Challenge Statement

The adoption and use of Health IT and quality measurement for community-based long-term services and supports is limited. Limitations include: insufficient business and/or financial incentives for service providers to acquire and use Health IT to support coordination of services; minimal national standards for quality measurement in LTSS outcomes; lack of uniformity in the terminology and definitions of data elements, including those important to the beneficiary, needed for assessments and service plans used across and between community-based information systems, clinical care systems and personal health record systems; lack of consensus on the inter-relationships between a beneficiary's plans across care, services and supports; and lack of evidence and understanding of how Health IT may benefit the beneficiary and encourage their adoption and use of Health IT.

Scope Statement

To identify, evaluate and harmonize standards needed for the creation, exchange and re-use of: (i) key domains and associated data elements of CB-LTSS person-centered planning, assessment and services; and (ii) interoperable, accessible person-centered service plans for use by providers and beneficiaries, accountable entities and payers.

This initiative will identify key assessment domains that will inform the creation of a structured, longitudinal, person-centered electronic LTSS plan for CB-LTSS beneficiaries. The eLTSS plan will be designed in such a way that it can be exchanged electronically across multiple CB-LTSS settings (e.g., adult day services, beneficiary homes, group homes, foster homes, assisted living, supportive housing, home health and hospice), institutional settings (e.g. hospitals, nursing facilities, primary care, post-acute care) and with beneficiaries and payers. The person-centered eLTSS plan is led by the beneficiary and includes individuals chosen by the beneficiary to participate in his or her care. The standards identified for the eLTSS plan will support consistent data collection and interoperable exchange with various information systems to include clinical information systems, State Medicaid and Health Information Exchange (HIE) systems, Personal Health Record (PHR) systems, and other information systems (e.g. case management, legal, justice, education, protective services, etc.). Information will be shared and accessed in compliance with policy, regulation, and Patient Consent Directives (e.g., 42 C.F.R Part 2 Confidentiality of alcohol and drug abuse patient records; and 38 USC § 7332-Confidentiality of certain medical records, Section 508 of the Rehabilitation Act). These standards will also support revisions to the eLTSS plan as the beneficiary receives services.

The content or data elements of the eLTSS plan will be specific to the types of services rendered and information collected for CB-LTSS, including person-centered quality of life goals, social determinants, and other relevant information essential to person-centered planning and quality CB-LTSS delivery.

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[5] Sample populations identified by the TEFT Program include: Aged, Disabled, Developmentally disabled, Brain Injury, Serious Mental Illness.

Beneficiary populations will be able to access the eLTSS plan through a supported PHR system, including the option of a state-identified PHR.

For the purposes of this initiative, the eLTSS plan will center on LTSS information collected for community-based services. The eLTSS plan may contain relevant clinical data needed to support the continuum of beneficiary care, support and services.

Out of Scope

This initiative will not focus on harmonizing state assessment templates per se, including resolving potential gaps in client assessment content collected across states. Nor will it harmonize assessment domains and data elements that do not directly drive care and service planning (e.g. functionality eligibility, rate setting or budgeting). However, standardizing the domains and elements of an eLTSS plan will provide the states the opportunity outside of this initiative to further evaluate and standardize their data needs, including assessment templates, to align with the eLTSS plan.

Value Statement

The eLTSS Initiative, as driven by the requirements of the CMS TEFT Program and other HHS Initiatives (e.g. National Quality Forum HCBS Quality Measures), provides an opportunity for states to leverage and integrate initiatives available under the Affordable Care Act, the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), the Social Security Act[6] and the Improving Post-Acute Care Transformation Act of 2014 (IMPACT). The Affordable Care Act Balancing Incentive Program, in particular, includes requirements for the development of a Core Standardized Assessment (CSA) that generates a beneficiary service plan based on assessment data.[7] The required Core Dataset domains for assessments include clinical and non-clinical data.[8] In addition, through the No Wrong Door (NWD) System requirement, participating states must develop a coordinated and streamlined eligibility determination and program enrollment process, where data on functional and financial assessments are shared across participating agencies. The NWD system approach entails engaging the beneficiary and, as appropriate, their caregivers, in facilitating the development of the beneficiary's person-centered service plan. The CSA and NWD System requirements provide a foundation for how states can access, capture, and share longitudinal LTSS data (institutional and community-based) across provider types and accountable entities. For example, the Administration of Community Living (ACL) investments with ACA funding, in partnership with CMS and the VHA, are building person-centered planning into Aging and Disability Resource Centers (ADRC) that function as a NWD of access to LTSS for all populations and all Payers.

States may maximize the use of health information technology by leveraging existing health information exchange (HIE) infrastructure to collect and share eLTSS plan data across CB-LTSS providers—who are not eligible for Meaningful Use (MU) incentives—CB-LTSS beneficiaries and other institutional based or clinical provider types (to include those eligible for MU incentives). This initiative will not only enable

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[6] The Social Security Act authorized CMS Innovation Center is testing new payment and service delivery models that integrate community resources with the state health system to drive broad health transformation. These models will evaluate the use of health IT to enable delivery systems connectivity and the associated challenges presented by the new data sharing agreements. (Centers for Medicare & Medicaid Services (CMS), 2014)

[7] (Centers for Medicare & Medicaid Services (CMS), 2014)

[8] (Mission Analytics Group, 2013). The Core Dataset consists of five domains: activities of daily living (ADLs), instrumental activities of daily living (IADLs), medical conditions/diagnosis, cognitive functioning/memory, and behavior concerns.

states to demonstrate how CB-LTSS providers and beneficiaries can benefit from the use of Health IT, but it will also ensure data captured for LTSS can be shared electronically with other clinically and institutionally-based provider types as the beneficiary chooses to share such information.

The identification and harmonization of standards for an eLTSS plan will improve efficiencies and promote collaboration across provider groups and beneficiaries by:

- Identifying an agreed upon set of data elements for the capture and sharing of eLTSS plan information
- Improving provider workflows by enabling secure, single-point data entry for eLTSS plan development and exchange including authentication and tracking of changes and approvals
- Integrating beneficiary priorities, preferences and goals identified in the CB-LTSS setting with those goals and outcomes included in the beneficiary care plan generated in a clinical/institutional setting
- Improving timeliness for collecting and sharing LTSS information between provider types, between providers and beneficiaries, and between providers and State Medicaid Agencies and/or payers, and other entities
- Reducing data collection burden processes (e.g. paper based, manual and/or other electronic) placed on providers/beneficiaries/payers by enabling the reuse of previously collected data
- Supporting the timely transition of relevant eLTSS plan information at the start of care and service delivery and as the beneficiary's preferences and goals change
- Enabling sending and receiving provider types to initiate changes for beneficiary interventions more promptly
- Enabling beneficiaries to lead decision making regarding appropriate care and services to be received[9]
- Increasing beneficiary engagement in preventative services and wellness activities
- Identifying critical gaps and unnecessary overlaps in the care and services needed and delivered to a beneficiary
- Enabling beneficiaries to exchange important care and service plan information across provider groups and with accountable entities and other parties

Target Outcomes & Expected Deliverables

The eLTSS Initiative will provide a framework to standardize the exchange of the eLTSS plan across and between institutionally-based and community-based information systems. In the short term, the initiative will introduce the concept of the eLTSS plan to the public, define the information model necessary to support its adoption, and inform future efforts to integrate institutional LTSS data with CB-LTSS data. In the longer term, specification of standards for the eLTSS plan will support and spur development and implementation of software and pilots that will inform refinement of these standards prior to their consideration for inclusion in future Federal regulations, which include Health IT certification requirements.

The value of this initiative will be measured through the attainment of the following outcomes:

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[9] As reflected in CMS final regulations §441.301(c) (1) and (2) regarding Person-Centered Planning Process/Person-Centered Service Plan.

Immediate

1. Identification of key assessment domains and associated data elements to include in an eLTSS plan
2. Identification of standards in nationwide health IT infrastructure for eLTSS plan data elements
3. Identification of functional requirements from **Use Cases** describing key conditions and business rules to enable eLTSS plan exchange while protecting privacy and confidentiality. These will include at a minimum required components of person-centered plans as defined by CMS (e.g. individual goals, priorities and concerns).
4. Development of concise **implementation guidance** using easy-to-understand documentation, user-friendly tooling and formal models to assist providers, software vendors and others in applying technical requirements for interoperable exchange of eLTSS plan. This will include identification of meta-standards for system capabilities regarding the development and sharing of the eLTSS plan.
5. Execution of seven TEFT grantee driven and one or more non-TEFT grantee driven **pilots** to evaluate the specific use cases for eLTSS plan exchange across provider information systems and with beneficiary PHR systems. This will include evaluation of the business case (cost-benefits analysis) for eLTSS plan exchange.
6. Identification and validation of new national **standards** for eLTSS plan capture and exchange to include an agreed upon set of data elements that can be accessed in CB and institutional LTSS, and other clinical electronic information systems

Long-Term Outcomes

1. Alignment and integration with other state defined health information systems as applicable
2. Maintain alignment with the standards identified for the nationwide Health IT infrastructure as specified in the Health IT Strategic Plan and Interoperability Roadmap
3. Engagement of the beneficiary or his/her designee to lead and to make changes whenever possible in decision-making regarding types of care and services needed and received
4. Accountability of providers in honoring beneficiary goals and preferences
5. Utilization of eLTSS plan data to accelerate quality improvement, population health and research initiatives
6. Improvement in provider experience and workflow when using Health IT systems for CB-LTSS
7. Improved health and healthcare treatment outcomes relative to beneficiary's goals, priorities and concerns as identified in their person-centered plan

Standards and Other Reference Materials

The eLTSS Initiative will leverage standardization efforts established by other projects, which may include but not be limited to the following:

- Standards identified through the 2015 Interoperability Standards Advisory to include the HL7 Consolidated Clinical Document Architecture (C-CDA) Release 2.0 Implementation Guide as updated through the S&I Longitudinal Coordination of Care (LCC) Initiative, Data Provenance, Data Segmentation for Privacy (DS4P), BlueButton Plus, and the emerging HL7 FHIR Profile Implementation Guides for Structured Data Capture (SDC) and Data Access Framework (DAF)
- ONC Direct Project (as a transport standard)
- Other HHS Guidance: Health IT Strategic Plan and Interoperability Roadmap
- HHS funded National Quality Forum (NQF) HCBS Quality Measures Project

- Substance Abuse and Mental Health Services Administration (SAMHSA) and Veterans Administration (VA) Joint Pilot under S&I Data Segmentation For Privacy Initiative
- Standards identified through the National Information Exchange Model (NIEM) Human Services Domain
- Institute of Medicine's Committee on Recommended Social and Behavioral Domains and Measures for Electronic Health Records
- Institute of Medicine's Committee on Approaching Death: Key End-of-Life Issues
- HHS funded National Quality Forum (NQF) HCBS Quality Measures Project
- HL7 Personal Health Record System Functional Model Release 1
- HL7 Implementation Guide for CDA Release 2: Patient Generated Document Header Template
- International Classification of Functioning, Disability, and Health (WHO)
- Standard Terminologies and Taxonomies adopted by ONC: SNOMED CT, LOINC
  - HITSP Nursing Terminology Overlap Resolution
- HIMSS Healthstory Project
- Openmhealth.org
- Centers for Medicare & Medicaid (CMS) Standards and Guidance:
  - Outcome and Assessment Information Set (OASIS) dataset for use in Home Health Agencies (HHAs)
  - Minimum Data Set (MDS) dataset for use in Nursing Homes
  - Continuity Assessment Record and Evaluation (CARE) Item Set
  - Program for All-Inclusive Care for the Elderly (PACE) Assessment and Care Planning Tools
  - Balancing Incentive Program
  - Home and Community-Based Services (HCBS) Taxonomy
  - Person-Centered Planning Tools
  - Post-Acute Care (PAC) Data Element Library
- Administration for Community Living
  - The Aging and Disability Resource Center Program/No Wrong Door System for All Populations and All Payers Initiative
  - Guidance to implement Person-Centered Planning
- Other projects using assessment tools (for example):
  - Guided Care by Johns Hopkins University
  - Case Management Information System by Community Care of North Carolina
  - Community Health Needs Assessment by Eastern Maine Healthcare Systems
  - Ohio Person Centered Planning Technology Tools
- Person-Centered Planning Tools
  - PATH
  - Making Action Plans (MAPS)
  - Essential Lifestyle Learning (ELP)
  - PACER
  - Wraparound Service
- National Association of State Directors of Developmental Disabilities Services (NASDDDS) and Human Services Research Institute (HSRI) National Core Indicators
- National Association of Social Workers (NASW) Standards for Social Work Practice
- Case Management Society of America (CMSA) Standards of Practice for Case Management
- American Medical Association (AMA) and American Academy of Home Care Physicians (AAHCP) Guidelines for Uniform Assessment

- MassHealth, One Care Implementation Council, and UMass Medical School One Care Early Indicators Projects (EIP)
- Standards of Practice for Registered Dietitians

Stakeholders and Other Interested Parties

Stakeholders and interested Parties include but are not limited to the following:

- Providers
  - CB-LTSS Providers (e.g. Social Workers, In-home supportive service providers, direct-care workers/personal care aides, CB-Adult Day Care providers, multipurpose Senior Service Program providers, Case Managers, Personal Care providers, Registered Dieticians, Meal and Transportation Service providers, Home Care Agencies, Hospice Care Agencies and any other approved state specific services which assist in diverting and/or transitioning individuals from institutional settings into their homes and community)
  - Clinical and Institutional based Providers (e.g. Primary Care Physicians, Nurses, Nurse Practitioners, Specialists, Pharmacists, Skilled Nursing Facilities, Nursing Homes, Chiropractors, Dentists, Emergency Department Providers, etc.)
  - Clinical Informaticists
- Beneficiaries
- Beneficiary Advocates: Beneficiary Representatives and/or Delegates, Caregivers, Family Members, and other Advocates
- Government Agencies:
  - CMS: Center for Medicaid and CHIP Services (CMCS), Medicare-Medicaid Coordination Office (MMCO), Center for Clinical Standards and Quality (CCSQ), Center for Medicare and Medicaid Innovation (CMMI)
  - HHS Office of the National Coordinator for Health IT (ONC)
  - HHS Office of the Assistant Secretary for Planning & Evaluation (ASPE)
  - HHS Agency for Healthcare Research & Quality (AHRQ)
  - HHS Administration of Community Living (ACL): National Institute on Disability, Independent Living, and Rehabilitation Research
  - HHS Administration of Children and Families
  - Substance Abuse and Mental Health Services Administration (SAMHSA)
  - Health Resources and Services Administration (HRSA)
  - Department of Labor (DoL)
  - Department of Education (DoE)
  - Department of Housing and Urban Development (HuD)
  - Department of Transportation
  - National Institutes of Health (NIH): Office of Minority Health and Health Disparities
  - Social Security Administration (SSA)
  - Veterans Health Administration (VHA)
  - Indian Health Service
  - Department of Defense (DoD)
  - National Council on Disability
  - National Information Exchange Model (NIEM)
  - CDC office and National Center for Health Statistics

- o   State Medicaid Offices, State Departments of Health and Public Health, and State Health Information Exchange Organizations
- Vendors:
  - o   EHR Systems, PHR Systems, Mobile Health Systems and Apps, Health Information Exchange Systems, and Community-Based Service Information Systems (e.g. HCBS Case Management Systems, and NWD System IT Infrastructure)
  - o   Digital Health Technologies
  - o   Device Manufacturers
  - o   Data Warehouse/Data Mart
- National Association of Area Agencies on Aging (n4a)
- National Association of States United for Aging and Disabilities (NASAUD)
- National Association of State Directors of Developmental Disabilities Services (NASDDS)
- Standards-Related Organizations: Standards Development Organizations (SDOs), vocabulary/terminology organizations
- Private Healthcare Payers
- Provider Professional Associations
- Privacy and Security Professionals

Potential Risks

- Failure to engage key stakeholders in contributing to, learning from, and committing to the eLTSS process in an accessible, productive, efficient manner early in the eLTSS process
- Failure to adequately train staff on appropriate and effective person-centered assessment collection process
- Content models for standards that overlap or compete with existing or developing models
- Identification and implementation of eLTSS standards that are misaligned with the nationwide health IT infrastructure standards
- Insufficient funding and/or financial incentives to implement eLTSS standard and supporting policies and programs
- Insufficient engagement and participation by vendor communities; lack of product adoption
- Insufficient engagement and participation by beneficiary populations; lack of PHR adoption
- Insufficient focus by stakeholders on the care and service planning goals and preferences of beneficiaries
- Insufficient participation by various vendors and organizations (including non-TEFT state grantees) in eLTSS Pilots
- Lack of consensus from non-participating groups on eLTSS key assessment domains and the definition of an eLTSS plan
- Solutions for eLTSS plan data capture and reporting may vary; one standard solution may not apply
- Standard and solutions may not scale to small vendors and service providers, including those in rural areas
- Proposed project timeline may not reflect actual deadlines in relevant standards or regulatory bodies
- Proposed project timeline may not reflect readiness of participating pilots (exchange entities and solution providers) to support implementation of standard

- Lack of clarity around legal issues (e.g. patient consent, data sharing, etc.) surrounding the new eLTSS plan and associated new data types may cause significant implementation delays for organizations that have not already addressed these issues internally.

Proposed Timeline

This timeline represents notional estimates of planned activities and will be adjusted as work moves forward through the initiative phases.

- Pre-Discovery: November 2014 to January 2015
  - o Project Charter Development and Consensus
- Discovery: January 2015 to March 2015
  - o Use Case Development and Consensus
- Implementation: April 2015 to October 2015
  - o Standards Solution Plan Development and Consensus
  - o eLTSS Implementation Guide Development and Consensus
- Pilot Execution (Phase 1): October 2015 to April 2016 (minimum 6 month pilot period)
  - o Pilot Proposal Development and Execution
- Pilot Evaluation (Phase 1): May 2016 to October 2016
  - o Pilot Evaluation Execution
  - o Implementation Guidance updates based on pilot evaluation
- Pilot Execution (Phase 2): November 2016 to November 2017
  - o Implementation Guidance Balloting with Standards Development Organization
  - o Implementation Guidance Publication (national standard) and piloting

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