electronic Long-Term Services and Supports (eLTSS) Plan

Creation and Sharing of an eLTSS Plan

11/5/2015

DISCLAIMER: This Use Case document was developed solely for informational and decisional purposes in the identification of standards for the creation and sharing of an eLTSS Plan within the S&I Framework. This document is not policy binding, does not recommend policy directions nor provide policy guidance.

Table of Contents

List of Figures:

List of Tables:

1.0 Preface and Introduction

To fully realize the benefits of Health Information Technology (Health IT) for community-based long-term services and supports (CB-LTSS), the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare and Medicaid Services (CMS) have partnered to facilitate the development of a Use Case for person-centered service planning. This Use Case defines the interoperability requirements for high priority LTSS data exchange that maximizes efficiency, encourages rapid learning, and protects beneficiaries[1,] privacy in an interoperable environment. The electronic Long-term Services and Supports (eLTSS) Use Case addresses the requirements of a broad range of Communities of Interests including but not limited to: beneficiaries, beneficiary advocates/legal representatives, CB-LTSS providers, clinical and institutional-based providers, healthcare payers, accountable entities, vendors, standards organizations, public health organizations, and government agencies.

The eLTSS Use Case describes the following:

- The operational context for the sharing and exchange of LTSS data
- The stakeholders with an interest in the Use Case
- The information flows that must be supported by the data exchange
- The types of data and their specifications required in the data exchange

The eLTSS Use Case serves as the foundation for identifying and specifying the standards required to support the data exchange and developing reference implementations and tools to ensure consistent and reliable adoption of the data exchange standards.

2.0 Initiative Overview

This initiative will identify key domains that will inform the creation of a structured, longitudinal, person-centered, electronic long-term services and supports (eLTSS) plan for community-based (CB-LTSS) beneficiaries[2]. The eLTSS plan will be designed in such a way that it can be shared electronically, with beneficiary approval, across multiple CB-LTSS settings (e.g., the homes of beneficiaries receiving services, adult day services, schools, group homes, foster homes, assisted living, employment sites, supportive housing, home health, and hospice), institutional settings (e.g. hospitals, nursing facilities, primary care, post-acute care) and with individuals receiving services 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.[3] The standards identified for the eLTSS plan will support consistent data collection and interoperable sharing with various information systems to include clinical information systems, State Medicaid and other Accountable Entity systems, Health Information Exchange (HIE) systems, Personal Health Record (PHR) systems, and other information systems (e.g. case management, legal, justice,

[1] For the purpose of the eLTSS Initiative, beneficiary will refer to all individuals who are eligible for and receive LTSS benefits to include those paid by Medicaid. These beneficiaries are also referred to as recipients, consumers, persons, participants, clients and individuals. The beneficiary may also include other individuals like a legal representative or advocate to participate in his or her care.

[2] CB-LTSS (as with home and community-based services (HCBS)) is defined by CMS for this project as "assistance with activities of daily living and instrumental activities of daily living provided to beneficiaries that cannot perform these activities on their own due to a physical, cognitive, or chronic health condition."

[3] The eLTSS plan can be directed by the person or facilitated by a coordinator or other person chosen by the person. The process of developing the plan is responsive to the priorities and preferences of the person.

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 timely revisions to the eLTSS plan as the beneficiary receives services consistent with CMS final regulations §441.301(c) (1) and (2) regarding Person-Centered Planning Process/Person-Centered Service Plan.

The Affordable Care Act and other legislative statutes introduce 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 and policies include the Money Follows the Person demonstration program (included in the Deficit Reduction Act (DRA) and Extended through ACA, Section 2403), the Community First Choice (ACA, Section 2401) State Plan option, the Balancing Incentives Program (ACA, Section 10202) Aging and Disability Resource Center (ACA, Section 2405) and directives to develop additional oversight and assessment of the administration of HCBS. (ACA, Section 2402(a)). These programs and policies target diverse beneficiary populations[4], 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, the administration of home and community-based services, and person-centered planning. In 2014 The Secretary HHS issued guidance to HHS operating division regarding self-direction, and person-centered planning[5]. In addition, the IMPACT Act of 2014 requires the use of standardized data to: 1) enable interoperable, longitudinal person-centered goals, preferences and outcomes and 2) promote quality measurement regardless of the person's transition of care placement (institutional or HCBS).[6]

2.1 Initiative Challenge Statement

The Initiative Challenge Statement describes how a standards and interoperability challenge currently limits the achievement of a national health goal. The eLTSS Project Charter[7] defines the challenge statement as:

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; and lack of consensus on the inter-relationships between a beneficiary's plan across care, services and supports settings; and lack of evidence and understanding of how Health IT may benefit the beneficiary and encourage their adoption and use of Health IT.

[4] Sample populations identified by the TEFT Program include: Aged, Disabled, Developmentally disabled, Brain Injury, Serious Mental Illness.
[5] http://www.acl.gov/Programs/CDAP/OIP/docs/2402-a-Guidance.pdf
[6] http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014-and-Cross-Setting-Measures.html
[7] The Consensus-Approved eLTSS Project Charter is available at: http://wiki.siframework.org/electronic+Long-Term+Services+and+Supports+%28eLTSS%29+Charter

3.0 Use Case Scope

The scope of this Use Case is to define the necessary requirements that will drive the identification and harmonization of standards needed for the creation, sharing, use and re-use of:

- key domains and associated data elements of CB-LTSS assessment, person-centered planning, and services
- Interoperable, accessible, person-centered service plans for use by beneficiaries, beneficiary advocates, providers, accountable entities, and payers

The person-centered eLTSS plan will be led by the beneficiary and includes individuals chosen by the beneficiary to participate in his or her services and supports. The eLTSS plan will be specific to LTSS information collected for home and community-based services; however the eLTSS plan may contain relevant clinical data needed to support the full continuum of beneficiary care, supports and services across all provider types and settings of care.

3.2 In Scope

The following list outlines what is in scope for the Use Case to include the type of transactions, the information/data to be exchanged, and specific aspects that need to be in place to enable the eLTSS plan content to be shared and understood by all entities involved in the transactions:

- Identify key domains and associated data elements of CB-LTSS assessment, person-centered planning, and services that will support consistent data collection and interoperable sharing with various information systems to include clinical information systems, State Medicaid and Accountable Entity systems, Health Information Exchange (HIE) systems, Personal Health Record (PHR) systems, and other information systems (e.g. case management, legal, justice, education, protective services, etc.)
- Identify eLTSS plan content and data elements that are specific to the types of services rendered and information collected for CB-LTSS
- Define the "actors" and/or entities contributing to the development, sharing and exchange of an eLTSS plan where the beneficiary, as an actor, will contribute and request corrections, changes and additions to his or her eLTSS plan.
- Identify domains of the eLTSS plan to be shared electronically across multiple CB-LTSS settings (e.g., the homes of beneficiaries receiving services, adult day services, schools, group homes, foster homes, assisted living, employment sites, supportive housing, home health, and hospice), institutional settings (e.g. hospitals, nursing homes, primary care, post-acute care) and with beneficiaries, payers and accountable entities
- Identify transactions to support timely revisions to the eLTSS plan
- Identify data elements that will enable interoperable, longitudinal person-centered goals, preferences and outcomes regardless of the person's transition of care placement (institutional or HCBS)

3.3 Out of Scope

The following list outlines what is out of scope for the Use Case. These points may highlight dependencies on the feasibility, implementability, and usability that result in limitations of the Use Case. At a high level, whatever is not declared "In Scope," is by definition, "Out of Scope." Note: Some of the items listed are out of scope for the Use Case, but may be in scope for later phases of the eLTSS initiative, such as the Standards Harmonization phase. Also, there may be some items that are out of scope for the Use Case and Functional Requirements Development, as well as the Standards Harmonization activities, that can be included as part of a pilot.

- Harmonization[8] of state and setting-specific assessment templates, person-centered planning methodologies, tools and proprietary instruments and data items
- Resolve potential gaps in beneficiary assessment content collected between and across states
- Harmonization of assessment domains and data elements that do not directly drive care and service planning (e.g., functionality eligibility, rate setting, budgeting, etc.)
- Harmonization or integration of various plans and components within these plans (Care Plans, Plan of Treatment, etc.) with the components of the eLTSS plan. However, the eLTSS plan will include relevant domains across those plans.
- Full integration[9] of eLTSS plan into an EHR or other clinical IT system (e.g., eLTSS plan is part of the EHR)
- Full integration of eLTSS plan into a PHR system
- Transmission protocols describing the most efficient means of transport of eLTSS plan information from sender to receiver
- The process and workflow by which eLTSS plan components are assembled into an eLTSS plan
- The packaging of eLTSS data elements into a specified form or template for submission from one EHR system to another Health Information system
- Standardization of data elements to be included in all queries for clinical health information, and to be used to link clinical health information from disparate systems
- Standardization of plan format or requirements
- Identification of privacy and security consent standards
- Configuration of systems to alert providers to the presence of new or relevant information from other sources and make it conveniently available to the provider(s)
- Process by which states and/or payers authorize, access, approve and pay for service delivery (pre-condition)
- Development of state-autonomous policy to support interoperability
- Process by which states and/or payers validate data and ensure data integrity
- Identification of eLTSS Record information (non-planned data)

3.4 Communities of Interest

Communities of Interest are relevant stakeholders who are directly involved in the business process, in the development and use of interoperable implementation guides, and/or in actual implementation. Communities of Interest may directly participate in the exchange; that is, they are business actors or are affected indirectly through the results of the improved business process.

MEMBER OF COMMUNITIES OF INTEREST	DEFINITION
Beneficiary	Individual who is eligible for and receives LTSS benefits to include those provided by Medicaid and Medicare. Also referred to as recipient, consumer, person, client, participant, and individual.
Beneficiary Advocate/Legal Representative	Individual who speaks on the behalf of the beneficiary who can be either legally appointed or simply engaged with the individual. This individual may or may not be paid to provide support to the beneficiary. (e.g., representative and/or delegate, designee, caregiver, family member, healthcare agent and other advocates).

[8] The Harmonization Process provides detailed analysis of candidate standards to determine "fitness for use" in support of Initiative functional requirements.
[9] Integration is defined as: the physical or functional combining and/or linking of separate parts or elements to act as a coordinated whole

MEMBER OF COMMUNITIES OF INTEREST	DEFINITION
CB-LTSS Provider	A provider of an authorized service which assists in maintaining and enabling the beneficiary to continue living in his or her home and community (e.g., social worker, in-home supportive service provider, direct-care worker/personal care aide, adult day care provider, multipurpose older adult service program provider, case manager, personal care provider, registered dietitian/nutritionist, meal and transportation service provider, home care agency, hospice care agency, job development and supported employment, equipment and technology, peer specialist, community integration, support broker, fiscal intermediary, and others who provide assistance in support of participant direction, etc.).
Clinical and Institutional-based Provider	Provider of medical or health service and any other person or organization that furnishes, bills, or is paid for health care services in the normal course of business. This includes a licensed/certified and/or credentialed person who provides health care, who is authorized to implement a portion of the plan and who has care responsibilities (e.g., physician, advanced practice nurse, physician assistant, nurse, nurse practitioner, nurse care manager, psychologist, therapist, pharmacist, dietitian/nutritionist, specialist, dentist, emergency department provider, etc.). This also includes an organization including, but not limited to a hospital including short-term acute care hospital and specialty hospital (e.g., long-term care hospital, rehabilitation facility, and psychiatric hospital, etc.), ambulatory surgery center, provider practice, and nursing home.
Informaticist	Individual who may analyze, design, implement, and evaluate healthcare information and communication systems that enhance individual and population health outcomes, improve care, and strengthen the clinician-beneficiary relationship.
Government Agency	Organization within the government that delivers, regulates, or provides funding for health care, long-term care, and/or human services. For example: • Centers for Medicare & Medicaid Services (CMS) • HHS Office of the National Coordinator for Health IT (ONC) • HHS Office of the Assistant Secretary for Planning & Evaluation (ASPE) • HHS Office of the Assistant Secretary for Health (ASH) • HHS Agency for Healthcare Research & Quality (AHRQ) • HHS Administration of Community Living (ACL) • 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 Labor Office of Disability Employment Policy • Department of Housing and Urban Development (HUD) • Department of Transportation • National Institutes of Health (NIH) • Social Security Administration (SSA) • Veterans Health Administration (VHA) • Indian Health Service • Department of Defense (DoD) • National Council on Disability • Centers for Disease Control and Prevention (CDC) • State Medicaid Offices, State Departments of Health and Public Health, and State Health Information Exchange Organizations • Local Government Organizations

MEMBER OF COMMUNITIES OF INTEREST	DEFINITION
Vendor	Provider of technology solution such as software application and software service. May include developer, provider, reseller, operator, and others that may provide these or a similar capability. (e.g., EHR system, PHR system, mobile health system and application, health information exchange system, and community-based service information system (e.g., HCBS case management system, and "No Wrong Door" system IT infrastructure, digital health technology, device manufacturer, data warehouse / data mart, etc.).
National Association of Area Agencies on Aging (n4a)	A 501c(3) membership association established under the Older American's Act that represents America's national network of 618 Area Agencies on Aging (AAAs) and provides representation in the nation's capital for the 246 Title VI Native American aging programs.
National Associations representing State Agencies	Entities that were created to represent state agencies that manage state Medicaid funding. (e.g., National Association of States United for Aging and Disabilities (NASUAD), National Association of State Directors of Developmental Disabilities Services (NASDDDS), National Association of Medicaid Directors (NAMD), National Association of Head Injury Administrators (NASHIA), National Association of State Mental Health Program Directors (NASMHPD), National Association of State Alcohol and Drug Abuse Directors (NASADAD), etc.).
National Quality Forum (NQF)	A consensus-building nonprofit organization that works to improve health and healthcare by endorsing and encouraging the use of the best measures of quality.
Standards Organization	Organization whose purpose is to define, harmonize and integrate standards that will meet clinical, business, and vocabulary/terminology needs for sharing information among organizations and systems.
Healthcare Payer	Any private or public entity that finances heath care delivery or organizes health financing. This includes commercial for-profit health insurers; non-profit health insurers; ERISA self-insured; and public state, federal and local departments and agencies that oversee health services delivery.
Accountable Entity	The health care professional, team, organization, or person that is primarily responsible for key delivery activities to a HCBS consumer including care transitions, and is responsible for success and failures in the aspects(s) of care for which it is accountable. Under certain circumstances the consumer or proxy is an accountable entity. An Accountable Care Organization could be an accountable entity.
Provider Professional Association	Organization that is dedicated to ensuring sustainable provider practices that result in better outcomes for those individuals receiving services. These organizations advocate that provider service practices are provider-led, advance the provider-beneficiary relationship and ensure that care costs can be prudently managed. Examples include: American Medical Association, Association for Community-Based Service Providers, American Nurses Association, Service Providers Association for Developmental Disabilities.
Privacy and Security Professional	An entity that focuses on the use and governance of personal data (privacy) and protecting data from malicious attacks and the exploitation of stolen data for profit (security).

Table 1. Communities of Interest

4.0 Value Statement

The eLTSS Initiative, as driven by the requirements of the CMS TEFT Program and other HHS Initiatives (e.g. National Quality Forum work on HCBS Quality Measurement), 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[10], the

[10] 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

Improving Post-Acute Care Transformation Act of 2014 (IMPACT), and the Medicare Access and CHIP Authorization Act of 2015, which requires that beneficiary information include the care preferences of the person, the family caregiver, and providers of services whenever the person transitions between any setting of care. 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.[11] The required Core Dataset domains for assessments include clinical and non-clinical data.[12] 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, the beneficiary's caregivers, in facilitating the development of the beneficiary's person-centered 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 Veteran's Health Administration, 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.[13]

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 states to demonstrate how CB-LTSS providers and beneficiaries can benefit from the use of Health IT, but 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, beneficiaries, payers and accountable entities by:

- Identifying an agreed upon core 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
- Designing and identifying beneficiary priorities, preferences, and goals for the CB-LTSS setting
- 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, accountable entities, and other stakeholders

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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)

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

[12] (Mission Anayltics 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.

[13] There are over 350 HCBS 1915 (c), 1915(i) and 1915(k) programs nationwide that are required to implement person centered planning per the CMS HCBS final rule.

- Reducing data collection burden processes (e.g. paper based, manual and/or other electronic) placed on providers/beneficiaries/payers/accountable entities 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, circumstances, and goals change
- Enabling sending and receiving between provider types to initiate prompt changes for beneficiary interventions
- Enabling beneficiaries to lead decision making regarding desired and appropriate care and services to be received[14]
- Initiating or 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 between settings of care, and with accountable entities and other parties
- Enhancing the capacity of state agencies and other payers to monitor the quality of services
- Increasing Caregiver involvement in both contributing to the plan and the beneficiary's care
- Improving quality of caregiver support as a result of timely access to the plan
- Ability for Payers to analyze data to evaluate the quality and effectiveness of services

5.0 Use Case Assumptions

Use Case Assumptions outlines what needs to be in place to meet or realize the requirements of the Use Case (e.g. the necessary privacy and security framework). These points are more functional in nature and state the broad overarching concepts related to the Initiative. The Use Case assumptions will serve as a starting point for subsequent harmonization activities.

The Assumptions for this Use Case are the following:

- The eLTSS plan is longitudinal and dynamic in nature – beneficiaries are able to update information as needed, whenever needed
- Beneficiary populations (e.g. ID/DD, elderly, persons with mental illness, children, pregnant women) will be able to access the eLTSS plan through their main beneficiary system, including the option of a state-identified PHR
- 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)
- Beneficiary is approved to receive LTSS benefits
- Beneficiary leads and/or directly engages in the creation of their eLTSS plan and can opt-out/terminate the plan at any time
- Beneficiary has ability to grant consent to eLTSS plan for selected care team members
- Beneficiary has ability to define notifications and designate notification recipients
- Send and receipt of notifications depend on the capability of the beneficiary's system, service providers, managed care/LTSS system, and other clinical IT system (e.g. Electronic Health Record system)

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

- Change in service needs need to be communicated from service provider system to beneficiary system
- There will be an individual assigned as the eLTSS plan facilitator/steward who is responsible for reviewing and reconciling all proposed modifications (with consensus and approval from beneficiary) to the eLTSS plan. The review process includes a discussion of proposed services and changes to these services.
- The beneficiary can directly modify eLTSS plan components (e.g., preferences, goals, outcomes, person-centered profile, etc.) that do not affect LTSS resource allocation
- Components of the plan may involve information from the eligibility determination forms, brief person-centered profile and other relevant sources
- State and/or Payer may vary in the process or order of steps required for the creation, approval and sharing of an eLTSS plan
- State and/or Payer may identify additional domains and elements to capture in the eLTSS plan in addition to the core domains and data elements
- eLTSS Information Sharing Resource foundation(s) are operational with the capability of allowing users to view, download and transmit the eLTSS plan
- All interested parties approved by the beneficiary are capable of providing input toward the eLTSS plan
- eLTSS standards are compliant with Americans with Disabilities Act (ADA) accessibility standards
- Relevant participants (may include the beneficiary, immediate caregivers, case manager, plan coordinator, etc.) assemble the person-centered eLTSS plan
- Providers approve services/care delivery based on their designation or authorization by the payer and/or accountable entity (always consistent with engaging the beneficiary at every level)
- The user interface and specific person-centered planning methodologies are determined at the State, program, and or practice levels

6.0 Pre-Conditions

Pre-conditions are those conditions that must exist for the implementation of the eLTSS plan interoperability information sharing. These conditions describe the state of the system, from a technical perspective, that must be true before an operation, process, activity or task can be executed. It lists what needs to be in place before executing the information sharing as described by the Functional Requirements and Dataset suggestions.

- Beneficiary's eligibility determination forms have been completed, submitted and approved
- PHR and/or other relevant systems for data sharing are in place
- The system to coordinate and provide LTSS services must be capable of sharing data electronically with other IT systems such as EHRs, PHRs, HIEs and other accountable entity systems.
- The beneficiary, advocates and providers establish the eLTSS Information Sharing resource[15]
- Consent is established to govern information sharing of the eLTSS plan

[15] The eLTSS Information Sharing Resource (see Appendix C) is a tool organizations can use to inform their workflow when planning for the creation and sharing of an eLTSS plan within their system environment. This resource is meant to be used as a guide to help implementers of the eLTSS Planning process identify who could be involved, what interactions need to be in place and what activities could be performed when setting up the eLTSS plan environment.

- A system-determined way to establish and verify identity for all persons and entities involved in the sharing of the eLTSS plan needs to be in place to facilitate sharing of information across individuals and entities and to maintain a reliable record of each user's access
- The eLTSS plan is generated in a state and/or payer defined LTSS system that has enabled the capture of structured eLTSS domains and associated data elements

7.0 Post Conditions

Post Conditions describe the state of the system, from a technical perspective, that will result after the execution of the operation, process activity or task.

- The eLTSS plan specifically captures the goals, priorities, preferences, outcomes, service and formal /informal support needs, etc. of the beneficiary and is stored electronically in a format that can support interoperable exchange
- The eLTSS plan may be used to provide the beneficiary/advocate with information on available service providers and assistance with selecting from available provider(s), and making referrals
- Ongoing updates to the plan are made with the beneficiary's oversight and approval
- In addition to serving as the basis for service delivery, the plan can be used for other monitoring and quality improvement activities (e.g. beneficiary outcomes, community inclusion outcomes, risk adjustment, etc.)
- The eLTSS plan is successfully shared and can be exchanged with the beneficiary, providers, accountable entities and payers
- eLTSS plan information is displayed in a human readable format and is compliant with ADA accessibility standards
- Sending and Receiving Entity Systems have the capability to receive, view, modify, process, incorporate, download and share structured eLTSS plan content

8.0 Use Case Diagram

The Use Case diagram conceptually represents the Actors interacting with the eLTSS Plan within the context of the Use Case and the User Stories. This diagram characterizes the types of interactions that an actor has with a specific system. The context diagram below shows the inputs and outputs to provide a pictorial representation of the environment, both internal and external where data sharing takes place.

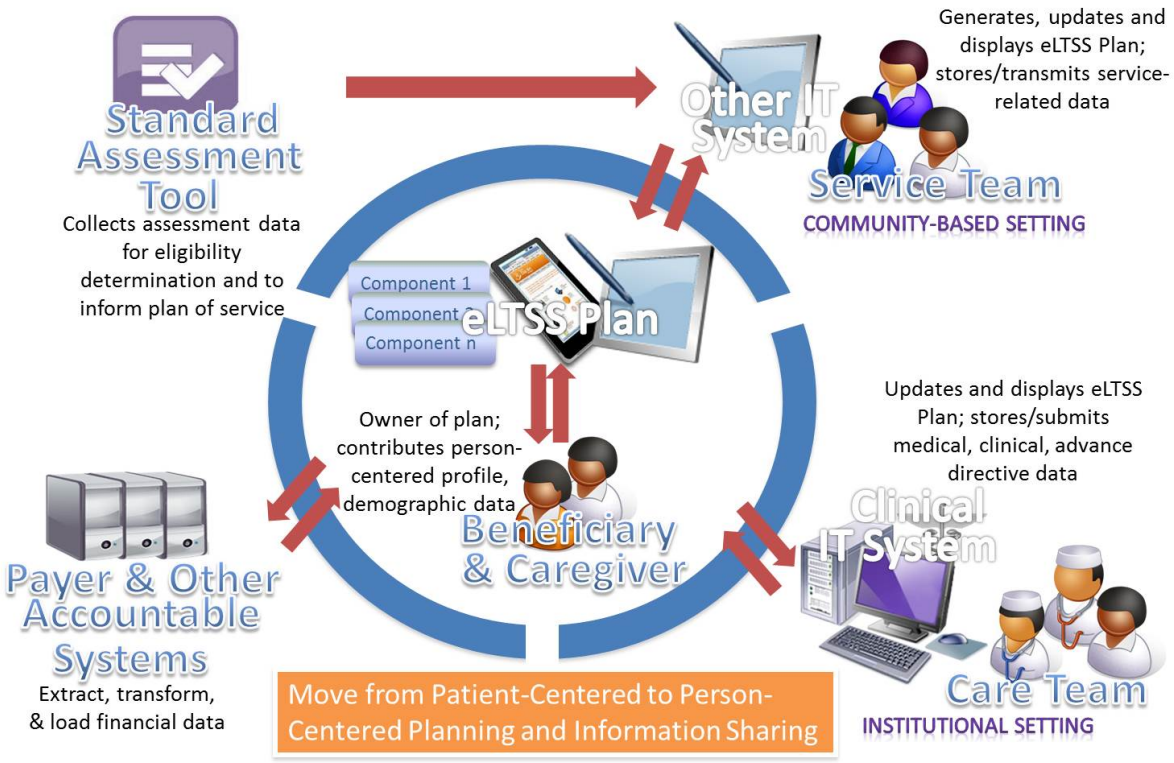

Figure 1. eLTSS Plan Sharing Context Diagram

9.0 User Stories

User stories summarize the interactions between the actors of the Use Case, and specify what information is captured, shared and exchanged from a contextual perspective. User Stories serve to illustrate an example of a real world application of the technical solution.[16]

Elements of the User Story that include functions not directly in the scope of the Use Case will be indicated in the following sections with *italicized, blue text*.

Elements of the User Story that include functions that provide context or further explanation or examples needed to frame the User Story are indicated with *italicized, gray text.*

Summary of User Stories

1. Story 1: LTSS Eligibility Determination, eLTSS Plan Creation and Approval
2. Story 2: Sharing a Person-Centered eLTSS Plan

9.1 User Story 1: LTSS Eligibility Determination, eLTSS Plan Creation and Approval

Following the admission of a beneficiary with developmental disabilities to a hospital, it is determined by the beneficiary advocates and hospital-based care team that an eLTSS plan will need to be in place at

[16] Each state and/or payer may vary in the process or order of steps required for the creation, sharing and exchange of an eLTSS plan

discharge to manage the various services needed by the beneficiary and advocates at home.[17] *The beneficiary needs to be approved for long-term services and supports (LTSS) coverage, create a brief person-centered profile and work with his/her service team to establish an eLTSS information sharing resource.*

An eligibility determination form submitter is assigned to the beneficiary who, with his/her consent, completes and submits the eligibility determination forms electronically to the payer system for community-based long-term services and supports. The payer receives, reviews and approves (as applicable) the eligibility determination forms. The payer defines the boundaries of cost/services that the payer is responsible for which may not be all services included in the plan. The payer system transmits the boundary information to the beneficiary and plan developer.

The beneficiary develops his or her brief person-centered profile, with the assistance of individuals he/she selects. The brief person-centered profile is a summary of what the beneficiary/advocate wants his/her service providers to know about them as an individual, regardless of the services the individual needs. The beneficiary defines the relationships that they are seeking with service providers, what his/her personal goals are, and what people and activities matter most and are most important.

The eLTSS plan developer then works with the beneficiary and his/her advocates, and service providers to establish an eLTSS information sharing resource. The eLTSS information sharing resource contains a set of request and response activities that must be established for the beneficiary/advocate and providers to share eLTSS information. The steps and process on establishing the eLTSS information sharing resource will vary between states and other payers. Some states can and may have multiple information sharing resources. An example set of activities performed to establish the information sharing resource can be found in Appendix C (Actors and Activities table).

The eLTSS plan developer meets with the beneficiary and advocates and together they assemble the person-centered eLTSS plan within the case manager's information system. Information from the eligibility determination forms, brief person-centered profile and eLTSS information sharing resource is used as input for the comprehensive eLTSS plan. The eLTSS plan also captures the goals, preferences, priorities, outcomes, service and formal /informal support needs, etc. of the beneficiary electronically. The eLTSS plan developer provides the beneficiary/advocate with information on available community resources and service providers, and/or service delivery modes (e.g. self-direction, managed care, etc.). The beneficiary/advocate selects from available provider(s) and/or a self-directed service delivery model with assistance from the plan developer as needed. The plan developer then makes a referral to the community resource(s) or provider(s), or refers the beneficiary to necessary information sources to establish self-directed service delivery. The plan developer updates the plan as providers are finalized. The beneficiary reviews and approves the eLTSS plan. The plan developer submits elements of the person-centered eLTSS plan to the LTSS payer agency for service authorization. Once services are authorized by the payer agency, the eLTSS plan is updated in the case manager's information system.

The eLTSS plan is sent to the beneficiary's system. *Depending on the specific beneficiary information system, the beneficiary and/or advocate may receive a notification to access the system as there is new information available*.

[17] There are certain activities that need to accompany the creation of an eLTSS plan. These activities may occur at any time and in any order within the process of creating an eLTSS plan.

The eLTSS plan exchange message is received into the beneficiary's system. The beneficiary/advocate accesses the system to view the eLTSS plan.

9.1.1 Actors and Activities - User Story 1

The following table describes the Actors who are participants in the information exchange requirements for User Story 1. Each actor performs a set of activities to support the transactions of the user story. These transactions can be instantiated by an IT system that the Actor uses in the capture, exchange and sharing of data. For the purpose of this user story, a Plan Developer is defined as the individual who assists the beneficiary and beneficiary-selected individuals in creation of the eLTSS Plan. As stated in the CMS Rule and HHS Guidance for the Person-Centered Planning Process, "Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process."

ACTOR	ACTIVITY	SYSTEM
Beneficiary	*- Complete eligibility determination form(s)* *- Create brief person-centered profile* *- Create eLTSS information sharing resource* - Provide eLTSS plan information - Select providers *- Receive notification* - Review and Approve eLTSS plan - Access eLTSS plan	*- State Eligibility Determination System (e.g., No Wrong Door System)* - LTSS/Case Management Information System - Beneficiary System
Beneficiary Advocate	*- Complete eligibility determination form(s)* *- Contribute to brief person-centered profile* *- Create eLTSS information sharing resource* - Create/Contribute to eLTSS plan *- Receive notification* - Access eLTSS plan	*- State Eligibility Determination System* - LTSS/Case Management Information System - Beneficiary System
Eligibility Determination Form Submitter	*- Submit eligibility determination form(s)*	*- State Eligibility Determination System*
eLTSS Plan Developer	*- Establish eLTSS information sharing resource* - Assemble eLTSS plan based on beneficiary input - Provide beneficiary/advocate with available service provider information - Submit referrals to providers - Update plan with selected provider information and authorized services - Submit elements of the eLTSS plan for service authorization - Send eLTSS plan *- Receive notification* - Receive eLTSS plan	- LTSS/Case Management Information System
Payer	*- Receive eligibility determination form(s)* *- Approve eligibility* *- Assign eLTSS plan developer* *- Define and transmit cost/service boundaries* - Receive and review eLTSS plan - Authorize services within eLTSS plan *- Send notification*	- Payer System - LTSS/Case Management Information System

Table 2. Actors and Activities - User Story 1

9.1.2 Base Flow - User Story 1

The following table lists the step-by-step event activities presented in the user story by actor and highlights relevant inputs and outputs.

STEP	ACTOR	ROLE	EVENT/ DESCRIPTION	INPUT(S)	OUTPUT(S)
1	Beneficiary / Advocate	*Form completer*	*Complete eligibility determination form(s)*		*Eligibility determination form(s)*
2	Eligibility Determination Form Submitter	*Form sender*	*Submit eligibility determination form(s)*		*Eligibility determination form(s)*
3	Payer	*Form receiver*	*Receive, review and approve eligibility determination form(s)*	*Eligibility determination form(s)*	*Approved eligibility determination form(s)*
4	Payer	*Service Boundary Information Submitter*	*Define boundaries of cost/services that the payer is responsible for; transmits the boundary information to the beneficiary and plan developer*	*Approved eligibility determination form(s)*	*Service Boundary Information*
5	Beneficiary / Advocate	*Brief person-centered profile and eLTSS information sharing resource creator*	*Develop the brief person-centered profile and collaborate with the eLTSS plan developer to establish the eLTSS information sharing resource*	*Eligibility form data; beneficiary goals, preferences, etc.*	*1. Brief person-centered profile 2. eLTSS information sharing resource*
6	eLTSS Plan Developer	*eLTSS information sharing resource developer*	*Establish the eLTSS information sharing resource*	*Eligibility form data; beneficiary goals, preferences, etc.*	*1. Brief person-centered profile 2. eLTSS information sharing resource*
7	Beneficiary / Advocate	eLTSS plan creator	Provide necessary eLTSS plan information	Eligibility form data; brief person-centered profile; beneficiary goals, preferences, daily plan, service and formal/informal support needs, etc.	Draft eLTSS plan
8	eLTSS Plan Developer	eLTSS plan developer	Assemble eLTSS plan based on beneficiary's input	Eligibility form data; brief person-centered profile; beneficiary goals, preferences, daily plan, service and formal/informal support needs, etc.	Draft eLTSS plan
9	eLTSS Plan Developer	eLTSS plan developer	Provide beneficiary/advocate with available service providers	eLTSS Information Sharing Resource	Draft eLTSS plan
10	Beneficiary / Advocate	eLTSS plan creator	Select from available providers	Draft eLTSS plan	Draft eLTSS plan

STEP	ACTOR	ROLE	EVENT/ DESCRIPTION	INPUT(S)	OUTPUT(S)
11	eLTSS Plan Developer	eLTSS plan developer	Submit referrals to providers and update plan with selected provider information	Draft eLTSS plan	Draft eLTSS plan
12	Beneficiary / Advocate	eLTSS plan approver	Review and approve eLTSS plan	Draft eLTSS plan	Approved eLTSS plan
13	eLTSS Plan Developer	eLTSS plan sender	Submit elements of eLTSS plan to LTSS payer agency for service authorization	Approved eLTSS plan	Approved eLTSS plan
14	Payer	eLTSS plan receiver	Review elements of eLTSS plan and authorize services	Approved eLTSS plan	Authorized eLTSS plan
15	eLTSS Plan Developer	eLTSS plan developer	Update authorized eLTSS services in case manager's information system	Authorized eLTSS plan	Authorized eLTSS plan
16	eLTSS Plan Developer	eLTSS plan sender	Send eLTSS plan to beneficiary	Authorized eLTSS plan	Authorized eLTSS plan
17	Beneficiary / Advocate	eLTSS plan receiver / access	*Receive notification about eLTSS plan* and access eLTSS plan	*Available plan message*	eLTSS plan

Table 3. Base Flow - User Story 1

9.1.3 Activity Diagram - User Story 1

The Activity Diagram illustrates the flow of events and information between the Actors for User Story 1. This diagram also displays the main events/actions that are required for the data sharing activity and the role of each system in supporting the exchange.

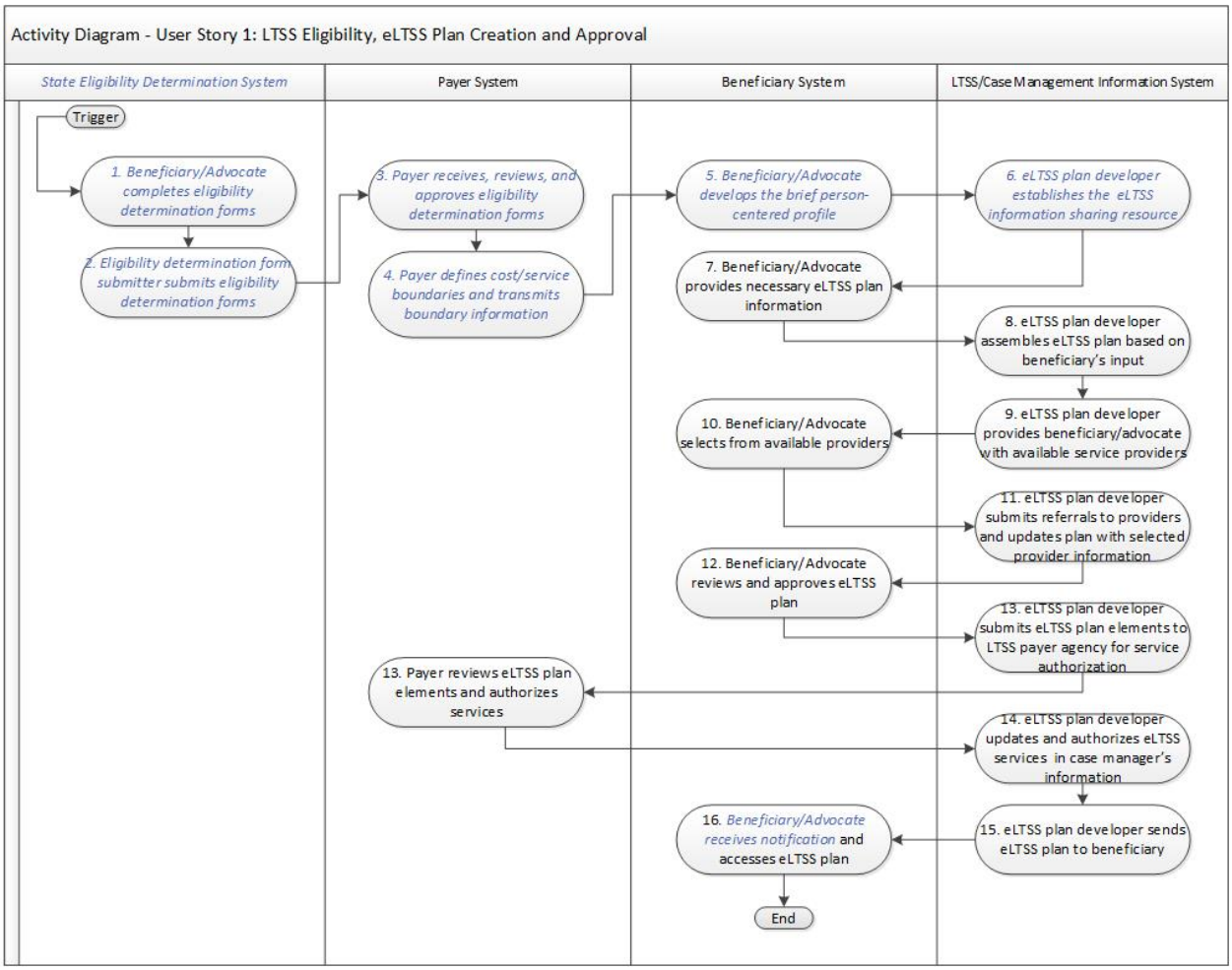

Figure 2. Activity Diagram - User Story 1

9.1.4 Information Interchange Requirements - User Story 1

The Information Interchange Requirements define the system's name and role. They also specify the actions associated with the actual transport of content from the sending system to the receiving system.

INITIATING SYSTEM	ACTION	INFORMATION INTERCHANGE REQUIREMENT NAME	ACTION	RECEIVING SYSTEM
State Eligibility Determination System	*Send*	*Eligibility Determination Form(s)*	*Receive*	*Payer System*
Payer System	*Send*	*Cost/service boundary information and eLTSS service authorization message*	*Receive*	*LTSS/Case Management Information System and Beneficiary System*
LTSS/Case Management Information System	*Send*	*eLTSS service availability notification*	*Receive*	*Beneficiary System*
State Eligibility Determination System (No Wrong Door System)	*Send*	*Brief Person-Centered Profile*	*Receive*	*State Eligibility Determination System (No Wrong Door System)*
LTSS/Case Management Information System	Send	Draft eLTSS plan	Receive	LTSS/Case Management Information System
LTSS/Case Management Information System	Send	Draft eLTSS plan	Receive	Payer System

Table 4. Information Interchange Requirements - User Story 1

9.1.5 System Requirements - User Story 1

The System Requirements section lists the requirements internal to the system necessary to participate successfully in the sharing of data. System requirements may also detail a required workflow that is essential to the Use Case.

SYSTEM	SYSTEM REQUIREMENT
LTSS/Case Management Information System	Access, Create, Store, Modify, Publish eLTSS Plan Share eLTSS Plan with Information System or Application (Beneficiary System, EHR System, LTSS Service Provider System, Payer/Accountable Entity System)
Payer System	Receive, Store, Access, Modify eLTSS Plan Authorize Services *Receive eligibility determination forms* *Share eLTSS Plan with State-defined LTSS/Case Management Information System* *Share Cost/Service Boundary Information*
State Eligibility Determination System	*Submit eligibility determination forms* *Create Brief Person-Centered Profile*

Table 5. System Requirements - User Story 1

9.1.6 Sequence Diagram - User Story 1

A Sequence Diagram represents the interactions between objects in the sequential order that they occur in the User Story. This representation can make it easy to communicate how the exchange works by displaying how the different components interact. The primary use of the diagram is in the transition from requirements expressed as use cases to the next and more formal level of refinement. Note: Horizontal lines are used to identify the specific activity between the systems.

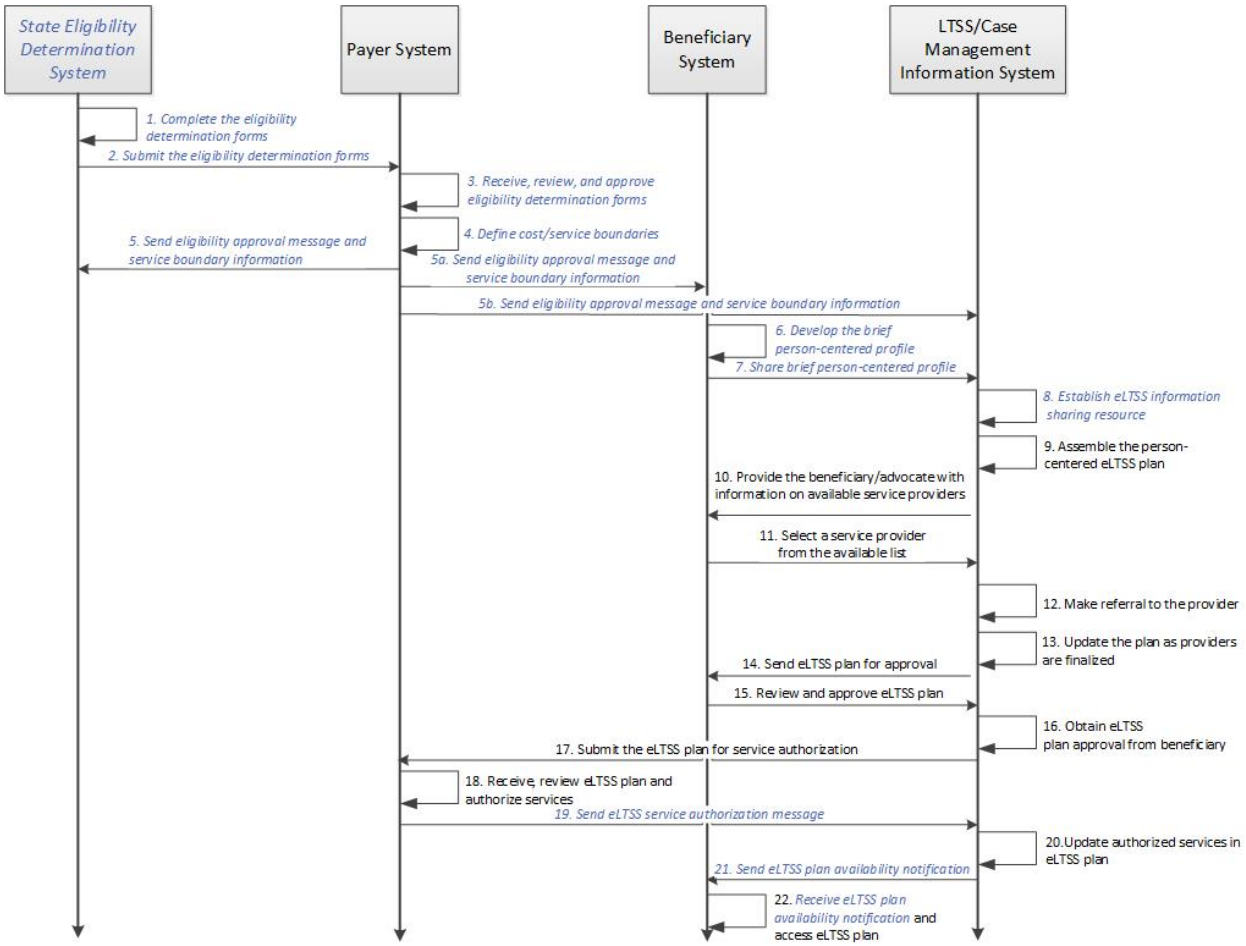

Figure 3. Sequence Diagram - User Story 1

9.2 User Story 2: Sharing a Person-Centered eLTSS Plan

A beneficiary has an eLTSS plan that represents her goals, preferences, priorities, outcomes, daily plan and formal and informal support systems to help provide a successful home life within her community. The eLTSS plan also states that the beneficiary must see a doctor immediately upon any sign of fever, cough, or abnormal balance due to a causal relationship with a rapid-spreading systemic infection. The beneficiary's daily plan includes a scheduled phone call every day at 11:00 am with her daughter, who serves as her advocate. The beneficiary requires assistance from the assigned home care assistant (HCA) to dial the phone. The beneficiary participates in a self-directed service delivery system and has selected the home health agency that is providing care. The beneficiary has a specified budget amount for personal care services and has been working with her plan facilitator to recruit candidates to spend time with her during the day (social support). In the interim until a qualified paid staff is hired, her daughter has been fulfilling the role through telephone oversight.

While meeting with the beneficiary and her daughter, the plan facilitator notices that the beneficiary seems agitated and looks somewhat unkempt. During the conversation the beneficiary states that she does not like and is dissatisfied with her current agency provided home care assistant (HCA). She feels that the HCA tends to rush when helping her with dressing, bathing, etc. and does not take time to talk to her or focus on what is important to her. She also notes that the HCA is not allowing her to perform

self-help activities on her own, when she can. The beneficiary also states that she would prefer more assistance and company in the evening.

The beneficiary's daughter admits that she has not been able to call the beneficiary every day at 11:00 am and knows this in part contributes to the beneficiary feeling depressed. The daughter states that she would be more able to make these daily calls if they were scheduled for after 8:00 pm, as she works during the day.

After further discussion, the beneficiary states that her neighbor has recently retired and may be willing to support her with some daily living tasks. The beneficiary provides contact details for her neighbor. The process by which the neighbor is vetted as a caregiver is determined at the state and/or payer level.

After the meeting, the plan facilitator documents an overview of the meeting in the beneficiary's contact notes. The beneficiary and her advocate update her daily plan to reflect the change in the preferred call time and notes the preference changes for what she feels are important to her, and what is manageable for her daughter. Since these are purely functional changes the plan is not shared with the payer for authorization. *Alerts of the updates are sent to the beneficiary, beneficiary, daughter, plan facilitator and the agency providing daily living services. All recipients have the ability to acknowledge that they have seen and agree to the changes.* The updated plan is also shared with the beneficiary's primary care provider (PCP) so he can be referenced as needed in the ongoing medical care of the beneficiary.

At a follow-up meeting, the beneficiary, daughter (via phone), plan facilitator, and the neighbor discuss the planned changes to the beneficiary's supports. The neighbor has agreed to spend one hour each evening with the beneficiary on an unpaid basis to assist her with her daily living activities and will also stop by once each morning. *The team discusses that as soon as her background check, training, and other qualifications are verified, the neighbor will be hired as a direct support worker under the self-directed personal assistance model, with the beneficiary signing off on time sheets with the assistance of her plan facilitator, and developing schedules and other management and administrative strategies with her advocate's assistance as necessary. The beneficiary's payer will pay the neighbor and calculate applicable taxes and insurances, and send summaries to the beneficiary. The beneficiary will also be provided a different HCA, and the agency will give the beneficiary the choice of at least three people prior to sending a new HCA. The agency provider will work with the beneficiary to establish a new protocol for ensuring the HCA understands and adheres to the beneficiary's preferences as documented in her eLTSS plan.* To help ensure her health and safety during the afternoon (and overnight) the plan facilitator recommends that a PERS (Personal Emergency Response System) be placed in the home and the beneficiary agrees to wear a pendant monitor. *Depending on the PERS information system and pendant monitor selected, alerts from the PERS can be transmitted to the eLTSS plan*.

The plan facilitator updates the beneficiary's eLTSS plan to note the changes in services, caregiver and the details around why these changes are being made and how they support the beneficiary's preferences and her health and wellness. Access to the functional components of the beneficiary's plan is granted to the neighbor and, after some discussion with the beneficiary and her advocate, the neighbor is given access to medical information as well. All changes are reviewed with the team at the conclusion of the meeting and the beneficiary's approval is documented.

The plan facilitator submits the updated elements of the plan to the beneficiary's payer for review and service authorization. The payer reviews the changes and the detail related to the reasons for the changes and confirms that they support what is important to the beneficiary while accounting for her health, safety, and welfare. The changes are also reviewed to ensure that they meet the payer's fiscal standards. The services are authorized and *alerts are sent to the beneficiary, beneficiary advocate, the neighbor, and the agency provider of daily living services. All recipients have the ability to acknowledge that they have seen and agree to the changes.* Alternatively, the payer could question a service (not authorize) and send modified plan elements back to the plan facilitator for review. The plan facilitator discusses the changes with patient and provider (when applicable) and resends the modified proposal back to the payer. The payer reviews and then authorizes service elements. The changes are also shared with the beneficiary's PCP so that they can be referenced in her ongoing medical care.

A few days later while visiting the beneficiary, the HCA recognizes a fever and upon reviewing the eLTSS plan, schedules a visit with the PCP immediately. The HCA schedules transportation services through a volunteer organization for the beneficiary to get to the doctor's office. The beneficiary also has a certain amount of taxi funds available through her self-directed budget for such occasions if a volunteer driver is not available.

The beneficiary sees the PCP, who performs an exam and prescribes new medication. The PCP reviews relevant eLTSS plan components with the beneficiary and recommends additional assistance be provided to the beneficiary for her meal preparation and medication administration. The beneficiary agrees with the PCP recommendation and the PCP adds proposed modifications to the beneficiary's clinical documentation within their EHR system. *The PCPs EHR System sends the relevant portion of the beneficiary's medical record containing the notes pertaining to proposed modifications to the eLTSS plan to the eLTSS plan facilitator's information system*.

The eLTSS plan facilitator receives the proposed modifications and makes updates to the beneficiary's eLTSS plan. The plan facilitator sends the updated plan to the beneficiary for approval. If the plan is not approved by the beneficiary, the plan facilitator notifies the PCP of the disapproval. The PCP may have to revise his/her recommendations and re-send the plan to the plan facilitator for further update, using the same process as outlined previously. If the plan is approved by the beneficiary, the plan facilitator sends the modified eLTSS plan to the payer, which receives, reviews, and authorizes the modified eLTSS services. *Notifications of the modifications are sent to affected parties.* In preparation for the next visit, the HCA accesses the beneficiary's modified eLTSS plan to review the list of new medications/administration and reminder instructions as well as changes in assisting with meal preparation duties.

9.2.1 Actors and Activities - User Story 2

The following table describes the Actors who are participants in the information exchange requirements for User Story 2. Each actor performs a set of activities to support the transactions of the user story. These transactions can be instantiated by an IT system that the Actor uses in the capture, exchange and sharing of data. For the purpose of this user story, a Plan Facilitator/Steward refers to the role of the individual who oversees and manages the resources of an eLTSS plan. This individual may or may not be the person involved in delivering the service to the individual.

ACTOR	ACTIVITY	SYSTEM
Beneficiary / Advocate (daughter)	- Access eLTSS plan - Authorize eLTSS plan access - Modify "non-regulated"/functional sections of eLTSS plan[18] - Approve modifications/updates to eLTSS plan	- Beneficiary System
eLTSS Plan Facilitator / Steward	- Send eLTSS plan *- Receive proposed modified clinical record reflecting proposed changes to eLTSS plan* - Receive eLTSS plan - Modify/Update eLTSS plan - Submit eLTSS plan elements for payer review and service authorization	- Case Management System
CB-LTSS Provider	- Receive eLTSS plan - View eLTSS plan - Execute eLTSS plan services and supports	- LTSS/Service Provider System
Clinical and Institutional-based Provider	- Receive eLTSS plan - Propose modifications - Review eLTSS plan components *- Send modified clinical record reflecting proposed changes to eLTSS plan* *- Receive notification*	- EHR System
Payer	- Receive and review eLTSS plan - Authorize updated services within eLTSS plan *- Send notification*	- Payer System - LTSS/Case Management Information System

Table 6. Actors and Activities - User Story 2

9.2.2 Base Flow - User Story 2

The following table lists the step-by-step event activities presented in the user story by actor and highlights relevant inputs and outputs.

STEP	ACTOR	ROLE	EVENT/ DESCRIPTION	INPUT(S)	OUTPUT(S)
1	Beneficiary / Advocate	Plan Access	Access plan	eLTSS plan	eLTSS plan
2	Beneficiary / Advocate	Plan Modifier	Modify "non-regulated"/ functional section of plan	eLTSS plan	Modified eLTSS plan
3	eLTSS Plan Facilitator / Steward	Plan Modifier	Modify plan services and access control with beneficiary approval	eLTSS plan	Modified eLTSS plan
4	eLTSS Plan Facilitator / Steward	Plan Sender	Submit/share updated plan elements for review & service authorization	Modified eLTSS plan	Modified eLTSS plan
5	Payer	Plan Access, Review	Receive and review modified eLTSS plan elements	Modified eLTSS plan	Modified eLTSS plan
6	Payer	Plan Service Authorization	Authorize service modifications *and send notification of authorization*	Modified eLTSS plan	Modified eLTSS plan
7	CB-LTSS Provider	Plan Viewer	View plan, provide service(s) based on plan	Modified eLTSS plan	Modified eLTSS plan
8	Clinical and Institutional-based Provider	Plan Access and Review	Review relevant eLTSS components with beneficiary	Beneficiary Electronic Health Record	Beneficiary Electronic Health Record

[18] These sections of the eLTSS plan (e.g., goals, outcomes, priorities, preferences, etc.) do not require payer authorization.

STEP	ACTOR	ROLE	EVENT/ DESCRIPTION	INPUT(S)	OUTPUT(S)
9	Clinical and Institutional-based Provider	Propose Modifications to Plan, *Send Proposed Modifications*	*Generate and send proposed modifications based on healthcare status*	Beneficiary Electronic Health Record	Beneficiary Electronic Health Record
10	eLTSS Plan Facilitator / Steward	Plan Access and Modification Integrator	Receive proposed modifications, integrate proposed modifications	Proposed modifications to eLTSS plan	Proposed integration of eLTSS plan modifications
11	eLTSS Plan Facilitator / Steward	Plan Sender	Sends modified plan for beneficiary approval	Proposed integration of eLTSS plan modifications	Proposed modified eLTSS plan
12	Beneficiary / Advocate	1. Plan Access 2. Proposed Plan Modification Reviewer	Provides approval or disapproval for proposed modifications	Proposed modified eLTSS plan	Approval or disapproval of modifications
13	eLTSS Plan Facilitator / Steward	1. Plan Access 2. Plan Modification	Receives approval, receives comments towards disapproval	Approval or disapproval of modifications	Approval or disapproval of modifications
14	eLTSS Plan Facilitator / Steward	Plan Sender	Finalizes and shares plan	Approval or disapproval of modifications	Finalized modified eLTSS plan
15	Payer	1. Plan Access 2. Plan Reviewer 3. Service Authorization	Receives finalized modified elements of the plan, reviews and authorizes services	Finalized modified eLTSS plan	Executed eLTSS plan
16	CB-LTSS Provider	Plan Viewer	View plan, provide service(s) based on plan	*Updated plan notification*	eLTSS plan

Table 7. Base Flow - User Story 2

9.2.3 Activity Diagram - User Story 2

The Activity Diagram illustrates the flow of events and information between the Actors for User Story 2. This diagram also displays the main events/actions that are required for the data sharing activity and the role of each system in supporting the exchange.

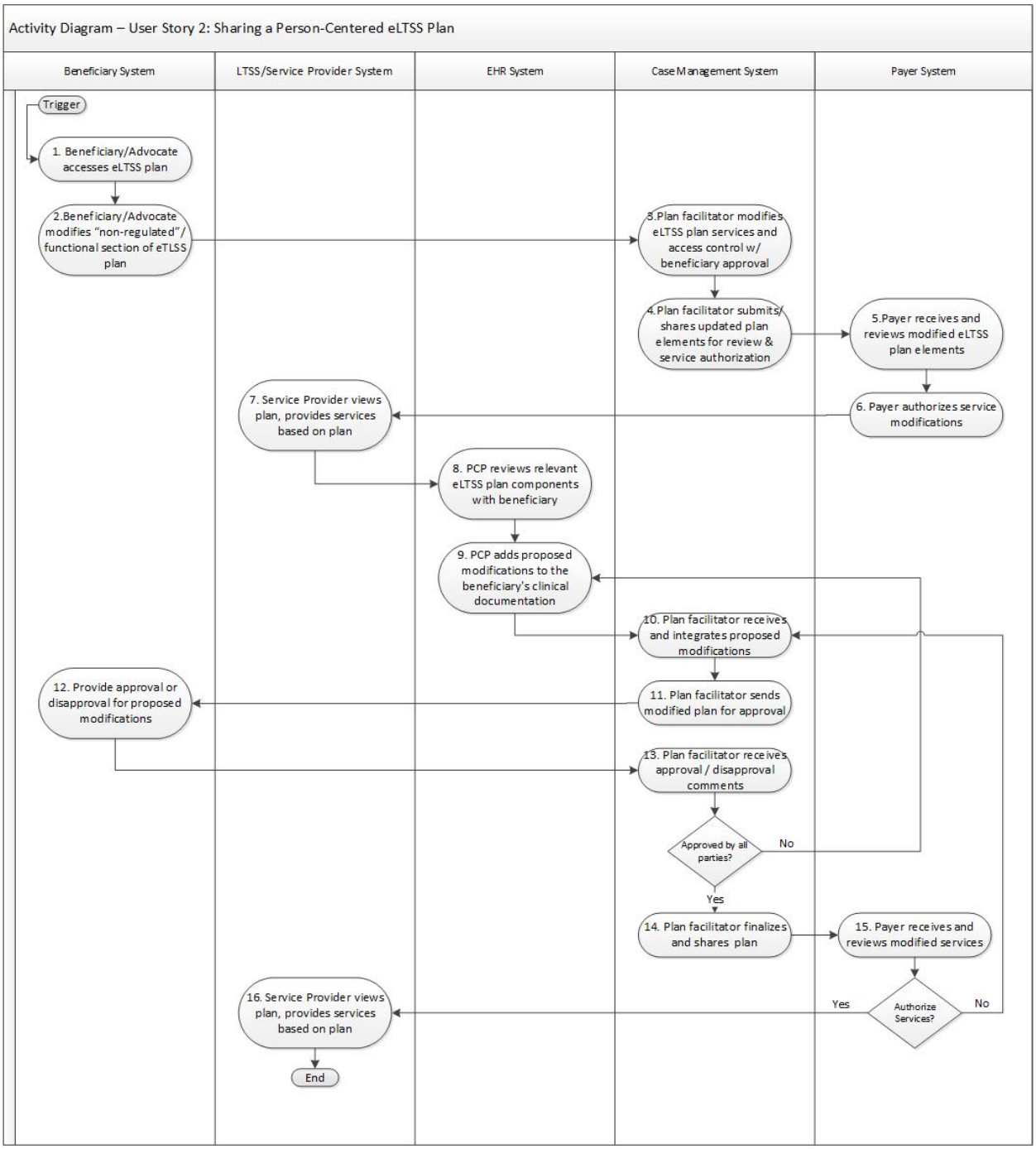

Figure 4. Activity Diagram - User Story 2

9.2.4 Information Interchange Requirements - User Story 2

The Information Interchange Requirements define the system's name and role. They also specify the actions associated with the actual transport of content from the sending system to the receiving system.

INITIATING SYSTEM	ACTION	INFORMATION INTERCHANGE REQUIREMENT NAME	ACTION	RECEIVING SYSTEM
Beneficiary System	Access	"Non-regulated" sections of eLTSS plan	Modify Approve	Beneficiary System
LTSS Service Provider System	Send	Proposed eLTSS plan modifications	Receive	LTSS/Case Management Information System
EHR System	Send	Proposed eLTSS plan modifications	Receive	LTSS/Case Management Information System
LTSS/Case Management Information System	Modify	Modified eLTSS plan	Receive	LTSS/Case Management Information System
LTSS/Case Management Information System	Send	Modified eLTSS plan	Receive	Beneficiary System EHR System LTSS Service Provider System Accountable Entity System

Table 8. Information Interchange Requirements - User Story 2

9.2.5 System Requirements - User Story 2

The System Requirements section lists the requirements internal to the system necessary to participate successfully in the sharing of data. System requirements may also detail a required workflow that is essential to the Use Case.

SYSTEM	SYSTEM REQUIREMENT
Receiving Entity Information System – Beneficiary System	Receive, Store, Access, View, Modify ("non-regulated" sections) eLTSS Plan Approve/Disapprove proposed eLTSS Plan modifications
Receiving Entity Information System – LTSS Service Provider System	Access, View eLTSS Plan Generate, Publish and Share proposed modifications to eLTSS Plan
Receiving Entity Information System – EHR System	Access, View eLTSS Plan Generate, Publish and Share proposed modifications to eLTSS Plan
LTSS/Case Management Information System	Access, Create, Store, Modify, Publish eLTSS Plan Receive, Approve proposed eLTSS Plan service modifications Share eLTSS Plan with Information System or Application (Beneficiary System, EHR System, LTSS Service Provider System, Accountable Entity System)
Accountable Entity System	Receive, Access, View eLTSS Plan

Table 9. System Requirements - User Story 2

9.2.6 Sequence Diagram - User Story 2

A Sequence Diagram represents the interactions between objects in the sequential order that they occur in the User Story. This representation can make it easy to communicate how the exchange works by displaying how the different components interact. The primary use of the diagram is in the transition from requirements expressed as use cases to the next and more formal level of refinement. Note: Horizontal lines are used to identify the specific activity between the systems.

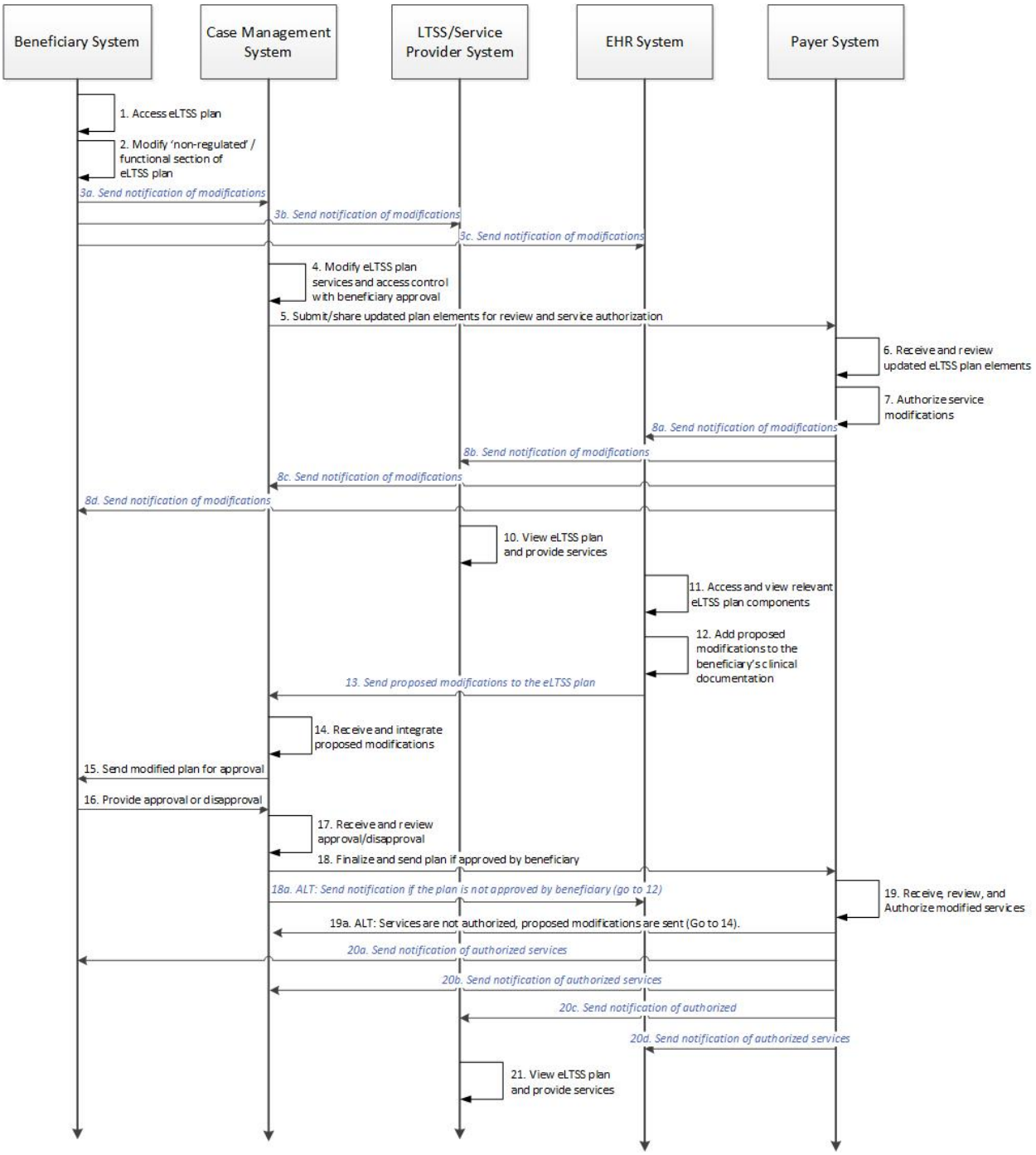

Figure 5. Sequence Diagram - User Story 2

10.0 Risks, Issues and Obstacles

In general, the absence of the pre-conditions or failure to meet the assumptions described earlier in this document presents risks, issues, obstacles and barriers to implementation of this Use Case.

Additional risks, issues, obstacles and barriers for this use care include but are not limited to:

- 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 an appropriate and effective person-centered planning and assessment process, and implementation of this process
- Failure to train administrative staff at all levels of system in person centered thinking
- 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 and nationwide interoperability roadmap requirements
- Insufficient funding and/or financial incentives to implement eLTSS standard and supporting policies, services, delivery systems, and programs
- Insufficient engagement and participation by vendor communities
- Lack of IT system vendor adoption
- Insufficient engagement and participation by beneficiary populations
- Limited adoption of beneficiary IT solutions by beneficiaries, advocates and providers
- Insufficient focus by stakeholders on the care and service planning goals and preferences of beneficiaries
- Insufficient equipment and/or awareness of the beneficiary in how to procure, use, and access cost-friendly electronic options (e.g. used computer and tablet equipment, budget internet service, etc.)
- Insufficient IT infrastructure regarding PHR, EHR, and other relevant data platforms, particularly with respect to availability, use, and sharing/interoperability
- 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, the definition of an eLTSS plan, and the components 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
- Standard and solutions may not scale to self-directed service delivery models
- 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. beneficiary 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
- The eLTSS standard identified may not be applicable to all LTSS populations
- Harmonization and timing of quality measures and other regulatory items that affect both eLTSS and other providers

11.0 Dataset Suggestions

The eLTSS Initiative formed an eLTSS Plan Content Sub-Workgroup (SWG) made up of TEFT Grantees and community members to identify an agreed upon set of domain, sub-domains and exemplar question/answer sets for each sub-domain to be used for the capture and sharing of eLTSS Plan content. This section lists the work of that SWG along with sample coded elements for exemplar question/answers where available.

11.1 eLTSS Domains and Sub-domains Overview

The SWG identified a set of five domains with a corresponding total of 27 sub-domains. These domains and sub-domains were gleaned from TEFT Grantee experience and the existing work of the National Core Indicators (NCI) Domains and sub-domains. The group also pulled information from the Institute of Medicine (IOM) Social and Behavioral Domains, CMS Balancing Incentive Program (BIP) Core Data Set (CDS), and ACL Person Centered Counseling artifacts, resulting in the data shown below.

The following table depicts the domains, sub-domains, and definitions of the sub-domains of sample information/content to be included in an eLTSS Plan as identified by the TEFT Grantee States and community members of the eLTSS Plan Content SWG.

Domain	Sub-domain	Sub-domain Definition
Person Information	Work	Contains the beneficiary's employment information, including the beneficiary's related goals regarding employment and volunteerism.
Person Information	Residence	Refers to information about the beneficiary's residence and living situation, including what home modifications are present and/or needed and what home-based equipment and supplies are currently available and/or needed in the beneficiary's home to ensure safe and optimum functioning.
Person Information	Community Inclusion	Describes the beneficiary's social functioning for community engagement, including access to any publicly-funded community services that are readily available to the beneficiary. This sub-domain also includes any support the beneficiary receives in becoming integrated within the community so that he or she has uninhibited community integration.
Person Information	Choice & Decision Making	Captures information around the choices and decisions the beneficiary makes about their lives and/or treatment e.g. by hiring and firing members of their service team, control and management of personal resources, including approved personal service budget; where the person lives, whether or not they are seeking competitive employment, etc. around personal control and choice.

Domain	Sub-domain	Sub-domain Definition
Person Information	Relationships	Lists attributes about the beneficiary's social life, including relationships with friends and family members.
Person Information	Self-Direction	Refers to information on the beneficiary's ability to direct and manage their own services.
Person Information	Demographics	Contains the beneficiary's core administrative information such as name, birthdate, sex, ID numbers, etc. which allow for person identification and categorization.
Person Information	Person-Centered Profile	A short "person-centered profile" (one-page) that summarizes what is important to someone and how they want to be supported. It describes the beneficiary's Interests, goals, preferences, and priorities written by the beneficiary in their own words. The profile is a document that can be used by others to provide the beneficiary with more person-centered care and support.
Health, Wellness and Rights	Health	Serves as the primary medical and health related sub-domain describing the beneficiary's clinical information related to the beneficiary's health. The data elements for this sub-domain may be incorporated from the beneficiary's medical health record and other health assessment information.
Health, Wellness and Rights	Medications	Captures information describing the purpose of all current over the counter and prescribed medications as well as supplements for the beneficiary, including drug name, drug type, dosage, frequency, etc.
Health, Wellness and Rights	ADLs/IADLs	Refers to basic tasks of everyday life, e.g. eating, bathing, dressing, toileting, and transferring as well as complex skills that are needed to successfully live independently.
Health, Wellness and Rights	Safety	Precautions are in place to ensure the beneficiary is safe from abuse, exploitation, neglect, fraud, and injury in the home and community. Additionally, this contains emergency contact information and emergency back-up plan information for the beneficiary. Personal risk management plans are also included here to address risks remaining when a beneficiary chooses no service, in addition to risks associated with maltreatment.
Health, Wellness and Rights	Wellness	Contains the beneficiary's nutrition, physical activity, and other wellness information, including use of physical fitness facilities, dieticians and nutritionists, meditation and group therapy and other supports to ensure the beneficiary is maintaining healthy habits.
Health, Wellness and Rights	Psychological Well-Being	Contains information related to the mood, behavior, and mental health needs of the beneficiary, including any interventions past, present, or recommended.
Health, Wellness and Rights	Restrictions	Any modifications or restrictive interventions e.g. with respect to goals, specific choices, roommates, access to food, physical restraints, seclusion, location restraints, elevated supervision etc.

Domain	Sub-domain	Sub-domain Definition
Service Planning and Coordination	Service Coordination	Describes how providers and the beneficiary will coordinate services to ensure all beneficiary needs are satisfied and contains contact information for service providers.
Service Planning and Coordination	Personal Finance Information	Includes the beneficiary's individual or household income (including wages, benefits, and other income) and money management goals for the beneficiary.
Service Planning and Coordination	Service Information	Represents items that are important for the authorization, payment, and provision of services, such as service type, number of units, frequency, provider, start/end dates, schedule, payer, and cost estimate. Also contains information related to signatures and dates including when and by whom the eLTSS Plan has been signed/acknowledged (e.g. beneficiary/legal representative, plan creator, others as appropriate, etc.).
Family and Caregiver Information	Family Information	Includes information on family caregivers (related or non-related), their background and contact information, and the ways in which the beneficiary plans to maintain connections with family members not living at home.
Family and Caregiver Information	Community Connections	Contains information on what integrated community services and activities the beneficiary has chosen to participate in with assistance from a friend, family member, or caregiver within the community.
Family and Caregiver Information	Access & Support Delivery	Captures information on how, by whom, and where the beneficiary and/or family members can obtain the services and supports they need.
Family and Caregiver Information	Information & Planning	Provides a place for confirmation by the beneficiary that they have received the proper materials, that they have participated in the planning process for their eLTSS Plan, and that family members also have the information and support necessary to plan for the beneficiary's services and supports.
Cross-Cutting Sub-Domains	Goals	A defined outcome or condition to be achieved in the process of person-centered care. Includes beneficiary defined Goals (e.g., longevity, function, comfort) and service provider specific Goals to achieve desired and agreed upon outcomes.
Cross-Cutting Sub-Domains	Units of Service	Any individual, organization, or community given long term services and supports provided to the beneficiary or family member in time increments such as 15 minutes, 1 hour, 1 day, etc.
Cross-Cutting Sub-Domains	Priorities	Actions or objectives established in order of importance or urgency to the welfare or purposes of the beneficiary at a given time. This could be short versus long term goals.
Cross-Cutting Sub-Domains	Issues	The likely course of action for the beneficiaries care. This also includes the concerns, status, risks, barriers, and their associated interventions, identified in order to increase the likelihood of the beneficiary achieving the Goals.

Domain	Sub-domain	Sub-domain Definition
Cross-Cutting Sub-Domains	Interventions (Technology)	Actions taken and interventions implemented to maximize the chances of achieving the Goals, including the removal of barriers to success. Instructions and the performance of monitoring are subsets of Interventions.

Table 10. eLTSS Plan Content Domains, Sub-domains and Definitions

11.2 Sub-domain Coded Element Recommendations

For each sub-domain, the TEFT Grantee States and community members of the eLTSS Plan Content SWG identified exemplar questions and answer sets for the collection of desired plan content information. The tables below represent that information along with recommended terminology sources for coded elements to use for those questions and answers where available. It is expected since eLTSS Plan development has traditionally been performed in a paper-based format and custom (single use) settings, many questions/answers will not have coded elements available.

11.2.1 Person Information Domain

The Person Information Domain contains the following sub-domains: Work, Residence, Community Inclusion, Choice & Decision Making, Relationships, Self-Direction, Demographics, and Person-Centered Profile. Refer to the sub-sections below for recommended coded elements for these sub-domains.

11.2.1.1 Work Sub-domain Coded Elements

The Work sub-domain contains the beneficiary's employment information, including the beneficiary's related goals regarding employment and volunteerism.

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Work	Employment Status	Employment status	LOINC	Select from List	SNOMED CT	
Work	If Not Employed, Would you like to be employed? (ISSUE/GOAL)			Y/N		
Work	Do you receive sick leave?	Employment Benefits Indicator	NCI caDSR	Y/N	NCI caDSR	
Work	Number of Months Employed	Length of time in job		Free Text	SNOMED CT	
Work	Wages (Weekly/ Biweekly/ Monthly)	Income paid weekly Income paid monthly		Free Text	SNOMED CT	
Work	Number of Hours Worked (Weekly)	Work hours per week	LOINC	Free Text		

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Work	Number of Hours Worked (Biweekly)			Free Text		
Work	Number of Hours Worked (Monthly)			Free Text		
Work	Do you earn at or above state minimum wage?			Y/N		
Work	Do you participate in volunteer work?	Voluntary worker		Y/N	SNOMED CT	
Work	Do you attend day program?			Y/N		

Table 11. Work Sub-domain Coded Elements

11.2.1.2 Residence Sub-domain Coded Elements

The Residence sub-domain refers to information about the beneficiary's residence and living situation, including what home modifications are present and/or needed and what home-based equipment and supplies are currently available and/or needed in the beneficiary's home to ensure safe and optimum functioning.

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Residence	Living Situation (Own/ Rent/Stay with Family)	Person Residence Ownership Demographics Status Housing ownership and tenure - finding	NCI caDSR	Select from List	NCI caDSR SNOMED CT	
Residence	N/A	Type of Residence	HMIS Data Standards	Select from List	Emergency shelter, including hotel or motel paid for with emergency shelter voucher Foster care home or foster care group home Hospital or other residential non-psychiatric medical facility Hotel or motel paid for without emergency shelter voucher Jail, prison or juvenile detention facility	2014 HMIS Data Standards

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
					Long-term care facility or nursing home Owned by client, no ongoing housing subsidy Owned by client, with ongoing housing subsidy Permanent housing for formerly homeless persons (such as: CoC project, HUD legacy programs, or HOPWA PH) Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) Psychiatric hospital or other psychiatric facility Rental by client, no ongoing housing subsidy Rental by client, with VASH subsidy Rental by client, with GPD TIP subsidy Rental by client, with other ongoing housing subsidy Residential project or halfway house with no homeless criteria Safe Haven Staying or living in a family member's room, apartment or house Staying or living in a friend's room, apartment or house Substance abuse treatment facility or detox center Transitional housing for homeless persons (including homeless youth) Other Client doesn't know	
Residence	N/A	HUD-assigned CoC	HMIS Data	Free Text	*Response categories must correlate to the responses provided to Project*	2014 HMIS Data

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
		Code	Standards		*Descriptor Data Element 2.3 Continuum of Care Code*	Standards
Residence	N/A	Homeless and At-Risk of Homelessness Status	HMIS Data Standards	Select from List	Category 1 – Homeless Category 2 – At imminent risk of losing housing Category 3 – Homeless only under other federal statutes Category 4 – Fleeing domestic violence At-risk of homelessness Stably housed Client doesn't know Client refused	2014 HMIS Data Standards
Residence	Who do you live with?	Person Shared Residence Type Household composition - finding	NCI caDSR	Select from List	NCI caDSR SNOMED CT	
Residence	Do you have home or environmental modifications?			Y/N		
Residence	What are your home modifications?	Access modification		Select from List	SNOMED CT	
Residence	What home modifications are required?	Access modification		Select from List	SNOMED CT	
Residence	Do you have home equipment and supplies?			Y/N		

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Residence	What are your home equipment and supplies?	Aids or devices usually used for dressing and grooming, arising, eating, AndOr walking Aids or devices usually used for hygiene, reach, grip, AndOr activities Devices and restraints Set Mobility devices Device	LOINC	Select from List	SNOMED CT	
Residence	What home equipment and supplies are required?	Mobility Devices and Aids Needed Device	LOINC	Select from List	SNOMED CT	
Residence	Assistive Technology	Assistive equipment		Select from List	SNOMED CT	

Table 12. Residence Sub-domain Coded Elements

11.2.1.3 Community Inclusion Sub-domain Coded Elements

The Community Inclusion sub-domain describes the beneficiary's social functioning for community engagement, including access to any publicly-funded community services that are readily available to the beneficiary. This sub-domain also includes any support the beneficiary receives in becoming integrated within the community so that he or she has uninhibited community integration.

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Community Inclusion	Are you involved in your community?	Do you belong to any clubs or organizations such as church groups unions, fraternal or athletic groups, or school groups	LOINC	Y/N	LOINC	
Community Inclusion	- If Y, What do you do?	Older adult activities	LOINC	Free Text		
Community Inclusion	- If N, Would you like to be involved in the community? (GOAL)			Y/N		
Community Inclusion	- If N, why? (ISSUE)			Free Text		
Community Inclusion	Do you have freedom to participate in community activities?			Y/N		
Community Inclusion	- If Y, What are they?	Older adult activities	LOINC	Select from List	LOINC	
Community Inclusion	- If Y, how often do you participate?	Time frame		Select from List	SNOMED CT	
Community Inclusion	- If Y, how do you get there?	Current ability: transportation	LOINC		LOINC	
Community Inclusion	- If N, why not (ISSUE)	Communication with community resources		Select from List	SNOMED CT	
Community Inclusion	- If N, how can it be improved? (GOAL)					
Community Inclusion	Excluding those who live with you, do you interact with non-paid individuals in your community?			Y/N		

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Community Inclusion	- If Y, who? (E.g. best buddies, church members, choir group etc.)			Free Text		
Community Inclusion	N/A	**76506-5 Social connection and isolation panel** Are you now married, widowed, divorced, separated, never married or living with a partner? In a typical week, how many times do you talk on the telephone with family, friends, or neighbors? How often do you get together with friends or relatives? How often do you attend church or religious services? Do you belong to any clubs or organizations such as church groups unions, fraternal or athletic groups, or school groups?	LOINC 76506-5 LOINC 63503-7 LOINC 76508-1 LOINC 76509-9 LOINC 76510-7 LOINC 76511-5 LOINC 76512-3	Select from List Free Text Y/N	N/A LOINC LL1068-7 UCUM Version 1.9 UCUM Version 1.9 UCUM Version 1.9 LOINC LL963-0 UCUM Version 1.9	ONC 2015 Edition Health IT Certification Rule *Comments from VA STS Domain Team: For questions not related to married or living with someone; the social hx and demographic teams recommend using a normative answer list from LOINC such as LL2181-7 (Never, Less than monthly, Monthly, Weekly, Daily or Almost Daily)*

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
		Social isolation score [NHANES]				

Table 13. Community Inclusion Sub-domain Coded Elements

11.2.1.4 Choice & Decision Making Sub-domain Coded Elements

The Choice & Decision Making sub-domain captures information around the choices and decisions the beneficiary makes about their lives and/or treatment e.g. by hiring and firing members of their service team, control and management of personal resources, including approved personal service budget; where the person lives, whether or not they are seeking competitive employment, etc. around personal control and choice.

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Choice & Decision Making	Do you choose your daily schedule?			Y/N		
Choice & Decision Making	Do you choose how to spend free time?			Y/N		
Choice & Decision Making	Did you choose the staff members on your care team?			Y/N		
Choice & Decision Making	Did you choose your case manager/care coordinator?			Y/N		
Choice & Decision Making	Did you choose your housing arrangement?			Y/N		
Choice & Decision Making	Did you choose your roommate?			Y/N		

Table 14. Choice & Decision Making Sub-domain Coded Elements

11.2.1.5 Relationships Sub-domain Coded Elements

The Relationships sub-domain lists attributes about the beneficiary's social life, including relationships with friends and family members.

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Relationships	Are you lonely?	Emotional state finding		Select from List	SNOMED CT	
Relationships	Why do you feel lonely?			Free Text		
Relationships	Marital/relationship status	Marital status	LOINC	Select from List	HL7 V3	
Relationships	Do you have a close friend outside of your care team?			Y/N		
Relationships	Would you like to have a close friend outside of your care team? (GOAL)			Y/N		
Relationships	Can you see/contact friends/family members when you want to?	Daily contact with relatives/close friends Can you find companionship when you want it?	LOINC LOINC	Y/N Select from List		
Relationships	Why are you unable to see/contact friends/ family members when you want to? (ISSUE)			Free Text		
Relationships	How can you improve your ability to see/contact friends/ family members when you want to? (GOAL)			Free Text		

Table 15. Relationships Sub-domain Coded Elements

11.2.1.6 Self-Direction Sub-domain Coded Elements

The Self-Direction sub-domain refers to information on the beneficiary's ability to direct and manage their own services.

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Self-Direction	Are you comfortable directing/managing the			Y/N		

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
	services you receive?					
Self-Direction	What kind of assistance do you need in managing your services?			Free Text		
Self-Direction	Do you have a choice on who your fiscal intermediary is?			Y/N		
Self-Direction	What meetings do you have with your care team?			Free Text		
Self-Direction	How often do you meet with your care team?			Free Text		
Self-Direction	Do you have the support and information needed to hire and fire members of your service/care team?			Y/N		
Self-Direction	- If Y, how do you find and hire staff?			Free Text		
Self-Direction	Service Provider Name			Free Text		
Self-Direction	Services Schedule			Free Text		
Self-Direction	Do you have the supports needed to control and manage your personal resource?			Y/N		
Self-Direction	- If N, what kind of supports do you need?	A person to help you: Tools to help you: Information to help you better understand:		Select from List	Financial Coach, Conservator appointed by law, Representative payee for your benefits Financial Health Assessment Financial Education	National Disability Institute (NDI) Banking Status, Financial Behaviors and Financial Capability of Adults with Disabilities

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Self-Direction	Do you have a conservator, or someone who manages your personal resource?			Y/N		
Self-Direction	- If Y, who helps you manage your personal finances?			Select from List	Financial Coach, Conservator, Representative Payee, Family member, Paid staff person from agency, Trusted friend, Guardian, Local bank employee	National Disability Institute (NDI) Banking Status, Financial Behaviors and Financial Capability of Adults with Disabilities
Self-Direction	- If Y, Does the conservator support your ability to direct and manage your own services?			Y/N		
Self-Direction	- If N, Why not? (ISSUE)			Free Text		
Self-Direction	- If N, would you like to be able to? (GOAL)			Y/N		
Self-Direction	Did/do you have a choice about where you live and who lives with you?			Y/N		
Self-Direction	Does a fiscal intermediary allocate/handle how care plan funds are used?	Financial durable power attorney	LOINC	Y/N		

Table 16. Self-Direction Sub-domain Coded Elements

11.2.1.7 Demographics Sub-domain Coded Elements

The Demographics sub-domain contains the beneficiary's core administrative information such as name, birthdate, sex, ID numbers, etc. which allow for person identification and categorization.

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Demographics	Name	Name Prefix First Name Middle Name Last Name Name Suffix	NA LOINC 45392-8 LOINC 52461-1 LOINC 45394-4 LOINC 45395-1	Free Text		Common Clinical Data Set / ONC 2015 Edition Health IT Certification Rule
Demographics	Individual Identifier/MRN	Medical Record Number	LOINC	Free Text	LOINC	
Demographics	N/A	Gender Identity		Select from List	IHTSDO SNOMED CT®, U.S. Edition, September 2015 Release HL7 Version 3 Standard, Value Sets for AdministrativeGender and NullFlavor Male. 446151000124109 Female. 446141000124107 Female-to-Male (FTM)/Transgender Male/Trans Man. 407377005 Male-to-Female (MTF)/Transgender Female/Trans Woman. 407376001 Genderqueer, neither exclusively male nor female. 446131000124102 Additional gender category or other, please specify. nullFlavor OTH Choose not to disclose. nullFlavor ASKU	ONC 2015 Edition Health IT Certification Rule
Demographics	Administrative Gender	Sex [HL7.v3]	LOINC 72143-1	Select from List	HL7 V3 Normative Edition, 2015, AdministrativeGender Value Set and NullFlavor Male. M Female. F Unknown. UNK	Common Clinical Data Set / ONC 2015 Edition Health IT Certification Rule

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Demographics	N/A	Sexual Orientation		Select from List	IHTSDO SNOMED CT®, U.S. Edition, September 2015 Release HL7 Version 3 Standard, Value Sets for AdministrativeGender and NullFlavor Lesbian, gay or homosexual. 38628009 Straight or heterosexual. 20730005 Bisexual. 42035005 Don't know. nullFlavor UNK Choose not to disclose. nullFlavor ASKU	ONC 2015 Edition Health IT Certification Rule
Demographics	Race	Race OMB.1997	LOINC 72826-1	Select from List	The Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, Statistical Policy Directive No. 15, as revised, October 30, 1997 CDC Race and Ethnicity Code Set Version 1.0 (March 2000) Value Set OID: 2.16.840.1.113883.3.2074.1.1.3	Common Clinical Data Set / ONC 2015 Edition Health IT Certification Rule
Demographics	Ethnicity	Ethnicity OMB.1997	LOINC 69490-1	Select from List	The Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, Statistical Policy Directive No. 15, as revised, October 30, 1997	Common Clinical Data Set / ONC 2015 Edition Health IT Certification Rule

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
					CDC Race and Ethnicity Code Set Version 1.0 (March 2000) Value Set OID: 2.16.840.1.114222.4.11.837	
Demographics	Address Line 1	Address	HL7v3	Free Text		
Demographics	Address Line 2	Address	HL7v3	Free Text		
Demographics	Address City	City of residence		Free Text	SNOMED CT	
Demographics	Address State	Region of United States of America		Select from List	SNOMED CT	
Demographics	Address ZIP Code	PostalCode		Free Text	HITSP	
Demographics	Home Telephone	Telephone	ITU-T E.123, Series E ITU-T E.164, Series E	Free Text		ONC 2015 Edition Health IT Certification Rule
Demographics	Mobile Telephone	Patient mobile telephone number		Free Text		
Demographics	Date of Birth	Birth date	LOINC 21112-8	Free Text		Common Clinical Data Set / ONC 2015 Edition Health IT Certification Rule
Demographics	Highest education level attained	What is the highest grade or level of school you have completed or	LOINC 63504-5	Select from List	LOINC LL1069-5	ONC 2015 Edition Health IT Certification Rule

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
		the highest degree you have received				
Demographics	Number of years spent in school	Education year count		Free Text		
Demographics	Preferred Language	Language.preferred	LOINC 54899-0	Select from List	Internet Engineering Task Force (IETF) Request for Comments (RFC) 5646 Value Set OID: 2.16.840.1.113883.11.20.9.64	Common Clinical Data Set / ONC 2015 Edition Health IT Certification Rule
Demographics	Language(s) spoken			Select from List	Internet Engineering Task Force (IETF) Request for Comments (RFC) 5646 Value Set OID: 2.16.840.1.113883.11.20.9.64	
Demographics	Language(s) proficiency	Language ability proficiency		Select from List	HL7v3	
Demographics	Do you have a language(s) barrier?	Language barrier		Y/N	SNOMED CT	
Demographics	In what language do you have a barrier?			Select from List	Internet Engineering Task Force (IETF) Request for Comments (RFC) 5646 Value Set OID:	

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
					2.16.840.1.113883.11.20.9.64	
Demographics	Do you want to improve your skill in the language that you have a barrier? (GOAL)			Y/N		

Table 17. Demographics Sub-domain Coded Elements

11.2.1.8 Person-Centered Profile Sub-domain Coded Elements

The Person-Centered Profile sub-domain describes the beneficiary's Interests, goals, preferences, and priorities written by the beneficiary in their own words. The profile is a document that can be used by others to provide the beneficiary with more person-centered care and support.

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Person-Centered Profile	Interests (what is important to me)			Free Text		
Person-Centered Profile	Strengths and Weaknesses			Free Text		
Person-Centered Profile	Likes/Dislikes			Free Text		
Person-Centered Profile	What do people like and admire about me?			Free Text		
Person-Centered Profile	Preferences and Priorities for Services (How to support me)			Free Text		
Person-Centered Profile	Characteristics of people who support me best	Character trait finding		Select from List	SNOMED CT	
Person-Centered Profile	First Name			Free Text		
Person-Centered Profile	Last Name			Free Text		
Person-Centered Profile	Photo Image			N/A		
Person-Centered Profile	Education related goal			Free Text		

Table 18. Person-Centered Profile Sub-domain Coded Elements

11.2.2 Health, Wellness and Rights Domain

The Health, Wellness and Rights Domain contains the following sub-domains: Health, Medications, ADLs/IADLs, Safety, Wellness, Psychological Well-Being, and Restrictions. Refer to the sub-sections below for recommended coded elements for these sub-domains.

11.2.2.1 Health Sub-domain Coded Elements

The Health sub-domain serves as the primary medical and health related sub-domain describing the beneficiary's clinical information related to the beneficiary's health. The data elements for this sub-domain may be incorporated from the beneficiary's medical health record and other health assessment information.

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Health	Diagnoses	Active Disease Diagnosis		Select from List	LOINC SNOMED CT ICD-10-CM	
Health	Vaccines	Immunizations		Select from List	HL7 Standard Code Set CVX—Vaccines Administered, updates through August 17, 2015: http://www2a.cdc.gov/vaccines/iis/iisstandards/vaccines.asp?rpt=cvx National Drug Code Directory (NDC) – Vaccine NDC Linker, updates through August 17, 2015: http://www2a.cdc.gov/vaccines/iis/iisstandards/ndc_tableaccess.asp	Common Clinical Data Set / ONC 2015 Edition Health IT Certification Rule
Health	Current Treatment Plan	Assessment and Plan of Treatment		Free Text	HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes, Draft Standard for Trial Use, Release 2.1.	Common Clinical Data Set / ONC 2015 Edition Health IT Certification Rule
Health	Name of Primary Care Provider	Primary Care Provider	LOINC	Free Text		
Health	Dental exam in last year?			Y/N		

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Health	Auditory exam in last year?			Y/N		
Health	Vision exam in last year?			Y/N		
Health	If female, mammogram in past two years?	Date of last mammogram		Free Text	SNOMED CT	
Health	Physical exam in past year?			Y/N		
Health	Flu vaccine in past year?			Y/N		
Health	Recent falls?	Fall history on admission		Select from List	LOINC	
Health	Pregnant?	Are you currently pregnant		Select from List	LOINC	
Health	Feeding problems?			Y/N		
Health	Allergies			Select from List		
Health	Laboratory Test	Lab Result Name		Select from List	Logical Observation Identifiers Names and Codes (LOINC®) Database version 2.52: OID 2.16.840.1.113883.6.1	Common Clinical Data Set / ONC 2015 Edition Health IT Certification Rule
Health	Laboratory Test	Lab Result Date and Time		Free Text		
Health	Laboratory Test results	Lab Result Value		Free Text		Common Clinical Data Set / ONC 2015 Edition Health IT Certification Rule

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Health	Laboratory Test results	Lab Result Units		Select from List	UCUM v1.9 OID2.16.840.1.113883.6.8	
Health	Radiology Test results	Radiology Study Observation Radiologic finding		Free Text	LOINC SNOMED CT	
Health	Procedure Name	Procedure Name	LOINC 29300-1	Select from List	IHTSDO SNOMED CT®, U.S. Edition, September 2015 Release Health Care Financing Administration Common Procedure Coding System (HCPCS) Current Procedural Terminology, Fourth Edition (CPT–4) American Dental Association CDT: Code on Dental Procedures and Nomenclature	Common Clinical Data Set / ONC 2015 Edition Health IT Certification Rule
Health	N/A	Functional status		Select from List	IHTSDO SNOMED CT®, U.S. Edition, September 2015 Release	ONC 2015 Edition Health IT Certification Rule *IMPACT Act*
Health	N/A	Cognitive function / status		Select from List	IHTSDO SNOMED CT®, U.S. Edition, September 2015 Release	ONC 2015 Edition Health IT Certification Rule *IMPACT Act*

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Health	N/A	Unique Device Identifier		Free Text	"Product Instance" in the "Procedure Activity Procedure Section" of the HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes, Draft Standard for Trial Use, Release 2.1.	Common Clinical Data Set / ONC 2015 Edition Health IT Certification Rule
Health	N/A	Problem Name Problem Type Problem Onset Date Problem End Date	LOINC 75326-9 N/A LOINC 11368-8 LOINC 77976-9	Select from List Select from List Free Text Free Text	IHTSDO SNOMED CT®, U.S. Edition, September 2015 Release Value Set OID: 2.16.840.1.113883.3.88.12.3221.7.4 LOINC v2.52 Value Set OID: 2.16.840.1.113883.3.88.12.3221.7.2 N/A N/A	Common Clinical Data Set / ONC 2015 Edition Health IT Certification Rule

Table 19. Health Sub-domain Coded Elements

11.2.2.2 Medications Sub-domain Coded Elements

The Medications sub-domain captures information describing the purpose of all current over the counter and prescribed medications as well as supplements for the beneficiary, including drug name, drug type, dosage, frequency, etc.

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Medications	Medication Indication	Indication for each drug checked		Free Text	SNOMED CT	

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Medications	Medication Types	ProductTypeName		Select from List	FDA NDC National Drug File Reference Terminology (NDF-RT)	
Medications	N/A	Medication Generic Code and Name Medication Brand Code and Name Medication Dose Medication Dose Units	LOINC 74062-1 LOINC 74060-5 LOINC 18817-7 SNOMED CT 408103002	Select from List Select from List Free Text Free Text	RxNorm, September 8, 2015 Release Value Set OID: 2.16.840.1.113883.3.88.12.80.17 RxNorm, September 8, 2015 Release Value Set OID: 2.16.840.1.113762.1.4.1010.5 N/A UCUM	Common Clinical Data Set / ONC 2015 Edition Health IT Certification Rule
Medications	Medication Frequencies	Current medication, Frequency	LOINC	Select from List		
Medications	Medication for mood?	Indication for each drug checked		Free Text	SNOMED CT	
Medications	Medication for anxiety?	Indication for each drug checked		Free Text	SNOMED CT	
Medications	Medication for behavior problems?	Indication for each drug checked		Free Text	SNOMED CT	
Medications	Medication for psychotic disorders?	Indication for each drug checked		Free Text	SNOMED CT	
Medications	Medication Allergies	Allergen Code		Select	RxNorm, September	Common Clinical Data Set /

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
				from List	8, 2015 Release Medication Drug Class (2.16.840.1.113883.3.88.12.80.18) (NDFRT drug class codes) Clinical Drug Ingredient (2.16.840.1.113762.1.4.1010.7) (RxNORM ingredient codes) Unique Ingredient Identifier - Complete Set (2.16.840.1.113883.3.88.12.80.20) (UNII ingredient codes) Substance Other Than Clinical Drug (2.16.840.1.113762.1.4.1010.9) (SNOMED CT substance codes)	ONC 2015 Edition Health IT Certification Rule
Medications	Medication administered by?			Free Text		
Medications	Medication management support needed?	Prior medication management	LOINC	Select from List		
Medications	Units of Service			Free Text		

Table 20. Medications Sub-domain Coded Elements

11.2.2.3 ADLs/IADLs Sub-domain Coded Elements

The ADLs/IADLs sub-domain refers to basic tasks of everyday life, e.g. eating, bathing, dressing, toileting, and transferring as well as complex skills that are needed to successfully live independently.

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
ADLs/IADLs	Toilet Use	Toileting	LOINC	Select from List		
ADLs/IADLs	Mobility in the Home			Select from List		
ADLs/IADLs	Mobility in the Community			Select from List		
ADLs/IADLs	Telephone Use	Current ability: telephone use	LOINC	Select from List		
ADLs/IADLs	Bathing	Bathing	LOINC	Select from List		*Could leverage HIT codes being identified for the CMS Data Element Library (DEL)*
ADLs/IADLs	Grooming	Current ability: grooming	LOINC	Select from List		
ADLs/IADLs	Shopping	Current ability: shopping	LOINC	Select from List		
ADLs/IADLs	Units of Service			Free Text		
ADLs/IADLs	Bowel Continence	Bowel continence	LOINC	Select from List		*Could leverage HIT codes being identified for the CMS Data Element Library (DEL)*
ADLs/IADLs	Bladder Continence	Bladder continence	LOINC	Select from List		*Could leverage HIT codes being identified for the CMS Data Element Library (DEL)*
ADLs/IADLs	Dressing	Dressing	LOINC	Select from List		*Could leverage HIT codes being identified for the CMS Data Element Library (DEL)*
ADLs/IADLs	Transferring	Transferring	LOINC	Select from List		*Could leverage HIT codes being identified for the CMS Data Element Library (DEL)*
ADLs/IADLs	Eating	Feeding or Eating	LOINC	Select from List		*Could leverage HIT codes being identified for the CMS Data Element Library (DEL)*
ADLs/IADLs	Meal Preparation	Current ability: prepare	LOINC	Select from List		

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
		light meals				
ADLs/IADLs	Positioning			Select from List		
ADLs/IADLs	Laundry	Current ability: laundry	LOINC	Select from List		
ADLs/IADLs	Using Transportation	Current ability: transportation	LOINC	Select from List		
ADLs/IADLs	Housework and Basic Home Maintenance	Household tasks	LOINC	Select from List		

Table 21. ADLs/IADLs Sub-domain Coded Elements

11.2.2.4 Safety Sub-domain Coded Elements

The Safety sub-domain contains information to ensure the beneficiary is safe from abuse, exploitation, neglect, fraud, and injury in the home and community. Additionally, this contains emergency contact information and emergency back-up plan information for the beneficiary. Personal risk management plans are also included here to address risks remaining when a beneficiary chooses no service, in addition to risks associated with maltreatment.

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Safety	Do you have someone to seek for help when afraid?			Y/N		
Safety	- If Y, Who?	Emergency contact information	LOINC	Free Text		
Safety	- If N, Why not? (ISSUE)			Free Text		
Safety	Do you feel safe?	Feeling safe		Y/N	SNOMED CT	
Safety	- If N, Why? (ISSUE)			Free Text		
Safety	- If N, How can it be improved? (GOAL)			Free Text		
Safety	Victim of crime in past year?	Humiliation, Afraid, Rape, and Kick questionnaire [HARK] Within the last year, have you been humiliated or emotionally	LOINC 76499-3 LOINC 76500-8 LOINC 76501-6	Y/N	N/A LOINC LL963-0 LOINC LL963-0	ONC 2015 Edition Health IT Certification Rule

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
		abused in other ways by your partner or expartner? Within the last year, have you been afraid of your partner or ex-partner? Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner? Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner? Total score [HARK]	LOINC 76502-4 LOINC 76503-2 LOINC 76504-0		LOINC LL963-0 LOINC LL963-0 N/A	
Safety	- If Y, what happened? (ISSUE)			Free Text		
Safety	Do you feel safe within your current relationship(s) with family members and/or friends?			Y/N		
Safety	- If N, Why not? (ISSUE)			Free Text		
Safety	- If N, How can it be improved? (GOAL)			Free Text		
Safety	Do you use a Personal Emergency Response System (PERS)?			Y/N		

Table 22. Safety Sub-domain Coded Elements

11.2.2.5 Wellness Sub-domain Coded Elements

The Wellness sub-domain contains the beneficiary's nutrition, physical activity, and other wellness information, including use of physical fitness facilities, dieticians and nutritionists, meditation and group therapy and other supports to ensure the beneficiary is maintaining healthy habits.

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Wellness	Vital Signs	Systolic Blood Pressure Diastolic Blood Pressure Body Weight Body Height Heart Rate Respiratory Rate Body Temperature Head Circumference Pulse Oximetry Inhaled Oxygen Concentration	LOINC 8480-6 LOINC 8462-4 LOINC 29463-7 LOINC 8302-2 LOINC 8867-4 LOINC 9279-1 LOINC 8310-5 LOINC 8287-5 LOINC 44616-1 LOINC 3150-0	Free Text	Unified Code of Units of Measure, Revision 1.9	Common Clinical Data Set / ONC 2015 Edition Health IT Certification Rule *Could leverage HIT codes being identified for the CMS Data Element Library (DEL)*
Wellness	Do you exercise regularly?	How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days? On those days that you engage in moderate to strenuous exercise, how many minutes, on average, do you exercise?	LOINC 68515-6 LOINC 68516-4	Free Text	The Unified Code of Units of Measure, Revision 1.9 The Unified Code of Units of Measure, Revision 1.9	ONC 2015 Edition Health IT Certification Rule
Wellness	- If N, What barriers prevent you from exercising? (ISSUE)			Free Text		
Wellness	- If N, Do you plan to? (GOAL)			Free Text		

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Wellness	Smoke/chew tobacco? - If Y, How often?	Smoking Status	LOINC 72166-2	Select from List	IHTSDO SNOMED CT®, U.S. Edition, September 2015 Release Value Set OID: 2.16.840.1.113883.11.20.9.38 Current every day smoker SNOMED CT 449868002 Current some day smoker SNOMED CT 428041000124106 Former smoker SNOMED CT 8517006 Never smoker SNOMED CT 266919005 Smoker, current status unknown SNOMED CT 77176002 Unknown if ever smoked SNOMED CT 266927001 Heavy tobacco smoker SNOMED CT 428071000124103 Light tobacco smoker SNOMED CT 428061000124105	Common Clinical Data Set / ONC 2015 Edition Health IT Certification Rule *Could leverage HIT codes being identified for the CMS Data Element Library (DEL)*
Wellness	- If Y, Do you want to quit? (GOAL)			Y/N		
Wellness	Unprescribed or illegal drug use status	Drug Use Frequency of drug misuse	LOINC	Select from List	LOINC SNOMED CT	

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Wellness	Alcohol use status	Alcohol Use Disorder Identification Test – Consumption [AUDIT-C] How often do you have a drink containing alcohol? How many standard drinks containing alcohol do you have on a typical day? How often do you have six or more drinks on one occasion? [Total score [AUDIT-C]] *Drinking habits*	LOINC 72109-2 LOINC 68518-0 LOINC 68519-8 LOINC 68520-6 LOINC 75626-2 *N/A*	Select from List	N/A LOINC LL2179-1 LOINC LL2180-9 LOINC LL2181-7 N/A *SNOMED CT*	ONC 2015 Edition Health IT Certification Rule
Wellness	Do you follow a special diet? - If Y, What kind?	Dietary finding		Select from List	SNOMED CT	*Could leverage HIT codes being identified for the CMS Data Element Library (DEL)*
Wellness	- If Y, Who helps you with the diet?			Free Text		
Wellness	- Do you have a dietician? (GOAL)			Y/N		
Wellness	Do you prepare your own meals?	Current ability: prepare light meals	LOINC	Select from List	LOINC	
Wellness	- If N, Why not? (ISSUE)			Free Text		
Wellness	Additional wellness/			Y/N		

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
	health practices?					

Table 23. Wellness Sub-domain Coded Elements

11.2.2.6 Psychological Well-Being Sub-domain Coded Elements

The psychological Well-Being sub-domain contains information related to the mood, behavior, and mental health needs of the beneficiary, including any interventions past, present, or recommended.

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Psychological Well-Being	Do you attend counseling to improve your mental health?			Y/N		
Psychological Well-Being	- If Y, How often?			Free Text		
Psychological Well-Being	- If Y, From whom?	Person counseled by		Select from List	SNOMED CT	
Psychological Well-Being	- If N why not? (ISSUE)			Free Text		
Psychological Well-Being	- If N, Would you like to? (GOAL)			Free Text		
Psychological Well-Being	N/A	Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions	LOINC 69858-9	Select from List	LOINC LL361-7	HHS Affordable Care Act (ACA) Section 4302 - Disability Information and Assistance Needed Panel
Psychological Well-Being	N/A	Because of a physical, mental, or emotional condition, do you have difficulty doing errands such as visiting a doctor's office	LOINC 75253-5	Select from List	LOINC LL361-7	HHS Affordable Care Act (ACA) Section 4302 - Disability Information and Assistance Needed Panel

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
		or shopping				
Psychological Well-Being	N/A	[Patient Health Questionnaire 2 item (PHQ-2) [Reported]] Little interest or pleasure in doing things in last 2 weeks Feeling down, depressed or hopeless in last 2 weeks [Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]]	LOINC 55757-9 LOINC 44250-9 LOINC 44255-8 LOINC 55758-7	Select from List	N/A LOINC LL358-3 LOINC LL358-3 N/A	ONC 2015 Edition Health IT Certification Rule
Psychological Well-Being	N/A	Stress	LOINC 76542-0	Select from List	LOINC LL3267-3	ONC 2015 Edition Health IT Certification Rule

Table 24. Psychological Well-Being Sub-domain Coded Elements

11.2.2.7 Restrictions Sub-domain Coded Elements

The Restrictions sub-domain includes any modifications or restrictive interventions e.g. with respect to goals, specific choices, roommates, access to food, physical restraints, seclusion, location restraints, elevated supervision etc.

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Restrictions	Do you require modifications in daily living due to restrictions?	Does your problem significantly restrict your participation in social activities such as going out to dinner, the movies, dancing or to parties	LOINC	Select from List	LOINC	

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Restrictions	- If Y, What are they?			Free Text		
Restrictions	- If Y, Why? (ISSUE)			Free Text		
Restrictions	Do you have access to food?			Y/N		
Restrictions	- If N Why not? (ISSUE)			Free Text		
Restrictions	- If N, How can it be improved? (GOAL)			Free Text		
Restrictions	Date restrictions last reviewed			Free Text		
Restrictions	Frequency of restriction review (days / weeks / months)			Free Text		
Restrictions	Restrictions last reviewed by?			Free Text		
Restrictions	Restriction Management Information			Free Text		

Table 25. Restrictions Sub-domain Coded Elements

11.2.3 Service Planning and Coordination Domain

The Service Planning and Coordination Domain contains the following sub-domains: Service Coordination, Personal Finance Information, and Service Information. Refer to the sub-sections below for recommended coded elements for these sub-domains.

11.2.3.1 Service Coordination Sub-domain Coded Elements

The Service Coordination sub-domain describes how providers and the beneficiary will coordinate services to ensure all beneficiary needs are satisfied and contains contact information for service providers.

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Service Coordination	Service team member name			Free Text		
Service Coordination	Service team member daytime telephone			Free Text		
Service Coordination	Service team member evening telephone			Free Text		
Service Coordination	Service team member address			Free Text		
Service Coordination	How would you like to coordinate the services that you receive?			Free Text		

Table 26. Service Coordination Sub-domain Coded Elements

11.2.3.2 Personal Finance Information Sub-domain Coded Elements

The Personal Finance Information sub-domain includes the beneficiary's individual or household income (including wages, benefits, and other income) and money management goals for the beneficiary.

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Personal Finance Information	Do you control part or all of own personal finances?			Y/N		
Personal Finance Information	- If N, Why not? (ISSUE)			Free Text		
Personal Finance Information	- Does someone assist you?	Could you get a friend or family member to help you with your finances if you need it	LOINC	Y/N	LOINC	
Personal Finance Information	- Would you like to be in control? (GOAL)			Y/N		
Personal Finance Information	N/A	Financial Resource Strain: How hard is it for you to pay for the very basics like food, housing, medical care, and heating	LOINC 76513-1	Select from List	LOINC LL3266-5 NDI Data Values: 1-I have all the basics I need; 2- I don't have some of the basics (food, housing medical care, heating, electricity, phone, medications) because I don't know how to get these basics; 3- I can't afford some of the basics (food, housing,	ONC 2015 Edition Health IT Certification Rule National Disability Institute (NDI)

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
					medical care, heating, electricity, phone, medications - check off which ones so a referral to appropriate resource can be generated; 4- I don't have money to pay for most or any of these basics (food, housing, medical care, heating, electricity, phone, medications)	
Personal Finance Information	Where do you receive money from and how often and how much?	Income		Select from List	NDI Data Values: SSI, Social Security Disability, Earnings, Private Trust, Family, Savings, Other	National Disability Institute (NDI) Banking Status, Financial Behaviors and Financial Capability of Adults with Disabilities
Personal Finance Information	Do you have a bank account?	Banked status		Y/N		National Disability Institute (NDI) Banking Status, Financial Behaviors and Financial Capability of Adults with Disabilities
Personal Finance Information	- If Y, what type of account and what type savings business?	Type of account and where banked		Select from List	NDI Data Values: Savings, Checking, Both (followed by) Bank, Credit Union, Other	National Disability Institute (NDI) Banking Status, Financial Behaviors and Financial Capability of Adults with Disabilities
Personal Finance Information	Do you have a goal to save money for something?	Savings		Y/N		National Disability Institute (NDI) Banking Status, Financial Behaviors and Financial Capability of Adults with Disabilities

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Personal Finance Information	- If Y, how are you saving? (goal)	how and goal $ amount		Select from List	NDI Data Values: Savings, Investments, Special Needs Trust, ABLE Account, Combination, Other	National Disability Institute (NDI) Banking Status, Financial Behaviors and Financial Capability of Adults with Disabilities
Personal Finance Information	- If N, do you want to be saving money for something? (goal)	how and goal $ amount		Free Text		National Disability Institute (NDI) Banking Status, Financial Behaviors and Financial Capability of Adults with Disabilities
Personal Finance Information	Have you ever borrowed money from someone or some place?	Credit behavior		Y/N		National Disability Institute (NDI) Banking Status, Financial Behaviors and Financial Capability of Adults with Disabilities
Personal Finance Information	- If Y, from who or where?			Select from List	NDI Data Values: Family, Friends, Payday Lender, Check Cashing Store	National Disability Institute (NDI) Banking Status, Financial Behaviors and Financial Capability of Adults with Disabilities
Personal Finance Information	Have you or do you own a credit card to buy things?	Credit behavior		Y/N		National Disability Institute (NDI) Banking Status, Financial Behaviors and Financial Capability of Adults with Disabilities
Personal Finance Information	Do you owe anyone money now?	Credit behavior		Y/N		National Disability Institute (NDI) Banking Status, Financial Behaviors and Financial Capability of Adults with Disabilities

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Personal Finance Information	- If Y, the amount (goal repair credit)	Credit behavior		Free Text		National Disability Institute (NDI) Banking Status, Financial Behaviors and Financial Capability of Adults with Disabilities
Personal Finance Information	Have you ever seen your credit report?	Credit behavior		Y/N		National Disability Institute (NDI) Banking Status, Financial Behaviors and Financial Capability of Adults with Disabilities
Personal Finance Information	Do you want/need to improve your credit score? (goal)	Credit behavior		Y/N		National Disability Institute (NDI) Banking Status, Financial Behaviors and Financial Capability of Adults with Disabilities
Personal Finance Information	Do you have someone else to help you with your money?	Money management		Y/N		National Disability Institute (NDI) Banking Status, Financial Behaviors and Financial Capability of Adults with Disabilities
Personal Finance Information	- If Y, who?			Select from List	NDI Data Values: Family, Paid Support Staff, Rep Payee, Certified Benefits Advisor, Financial Coach	National Disability Institute (NDI) Banking Status, Financial Behaviors and Financial Capability of Adults with Disabilities
Personal Finance Information	- If N, do you want someone to help you with your money? (Goal)			Y/N		National Disability Institute (NDI) Banking Status, Financial Behaviors and Financial Capability of Adults with Disabilities

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Personal Finance Information	Are you interested in learning more about your money?	Financial Literacy		Y/N		National Disability Institute (NDI) Banking Status, Financial Behaviors and Financial Capability of Adults with Disabilities
Personal Finance Information	- If Y, what would you like to learn (Goal)?	Financial Literacy		Select from List	NDI Data Values: Financial class, Make and keep a budget, Paying bills, Retirement	National Disability Institute (NDI) Banking Status, Financial Behaviors and Financial Capability of Adults with Disabilities

Table 27. Personal Finance Information Sub-domain Coded Elements

11.2.3.3 Service Information Sub-domain Coded Elements

The Service Information sub-domain represents items that are important for the authorization, payment, and provision of services, such as service type, number of units, frequency, provider, start/end dates, schedule, payer, and cost estimate. Also contains information related to signatures and dates including when and by whom the eLTSS Plan has been signed/acknowledged (e.g. beneficiary/legal representative, plan creator, others as appropriate, etc.).

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Service Information	Do you live in a facility?	Current residence	LOINC	Select from List	LOINC	
Service Information	- If Y, What type of facility?	Care setting Facility [NHCS] Site of care	LOINC	Select from List	LOINC SNOMED CT	
Service Information	- Number of units			Free Text		
Service Information	- Do you have a roommate?	Lives with roommate		Y/N	SNOMED CT	
Service Information	- If Y, how many roommates?	Number in household		Free Text	SNOMED CT	

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Service Information	Plan start date			Free Text		
Service Information	Plan end date			Free Text		
Service Information	Plan signatures (beneficiary/ legal representative, plan creator, others)			Free Text		
Service Information	Plan cost estimate			Free Text		
Service Information	Units of service			Free Text		
Service Information	Service Schedule			Free Text		
Service Information	N/A	Finding related to care and support circumstances and networks			SNOMED CT 365483002	

Table 28. Service Information Sub-domain Coded Elements

11.2.4 Family and Caregiver Information Domain

The Family and Caregiver Information Domain contains the following sub-domains: Family Information, Community Connections, Access & Support Delivery, and Information & Planning. Refer to the sub-sections below for recommended coded elements for these sub-domains.

11.2.4.1 Family Information Sub-domain Coded Elements

The Family Information sub-domain includes information on family caregivers (related or non-related), their background and contact information, and the ways in which the beneficiary plans to maintain connections with family members not living at home.

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Family Information	Family Member Name	Name family member	LOINC	Free Text		

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Family Information	Relationship to Family Member	Details of informal carer Caregiver patient relationship Relative Personal And Legal Relationship Role Type Family Member		Select from List	SNOMED CT SNOMED CT SNOMED CT HL7 HL7	
Family Information	Do you live with family members at home?	Lives with family		Y/N	SNOMED CT	
Family Information	- If N, Do you engage with family members outside of the home?	No contact with family Maintains contact with family		Y/N	SNOMED CT SNOMED CT	
Family Information	- If Y, How?			Free Text		
Family Information	- If N, Why not? (ISSUE)			Free Text		
Family Information	- Do you want to engage with family members outside of the home in the future? (GOAL)			Y/N		

Table 29. Family Information Sub-domain Coded Elements

11.2.4.2 Community Connections Sub-domain Coded Elements

The Community Connections sub-domain contains information on what integrated community services and activities the beneficiary has chosen to participate in with assistance from a friend, family member, or caregiver within the community.

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Community Connections	Do you or your family participate in community activities?			Y/N		
Community Connections	- If Y, What are they?			Free Text		
Community Connections	- If Y, What family members do you participate in them with?			Free Text		
Community Connections	- If N, Why not? (ISSUE)			Free Text		
Community Connections	- If N, Do you want to in the future? (GOAL)			Y/N		
Community Connections	Do you or your family attend church?			Y/N		
Community Connections	Do you or your family attend other community events?			Y/N		
Community Connections	- If Y, What type of events?			Free Text		
Community Connections	- If N, Why not? (ISSUE)			Free Text		
Community Connections	- If N, Do you want to in the future? (GOAL)			Y/N		
Community Connections	Are there barriers preventing you and your family attending community events?			Y/N		

Table 30. Community Connections Sub-domain Coded Elements

11.2.4.3 Access & Support Delivery Sub-domain Coded Elements

The Access & Support Delivery sub-domain captures information on how, by whom, and where the beneficiary and/or family members can obtain the services and supports they need.

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Access & Support Delivery	Do services in your service plan			Y/N		

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
	meet you and your family's needs?					
Access & Support Delivery	- If N, Why not? (ISSUE)			Free Text		
Access & Support Delivery	- If N, How can they meet your needs? (GOAL)			Free Text		
Access & Support Delivery	Do you and your family have support in the case of a crisis?			Y/N		
Access & Support Delivery	Are services delivered to you and your family in a safe manner?			Y/N		

Table 31. Access & Support Delivery Sub-domain Coded Elements

11.2.4.4 Information & Planning Sub-domain Coded Elements

The Information & Planning sub-domain provides a place for confirmation by the beneficiary that they have received the proper materials, that they have participated in the planning process for their eLTSS Plan, and that family members also have the information and support necessary to plan for the beneficiary's services and supports.

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Information & Planning	Have you and your family participated in the planning process for your eLTSS plan?			Y/N		
Information & Planning	- If Y With whom?			Free Text		
Information & Planning	- If N, Why not? (ISSUE)			Free Text		
Information & Planning	- If N, Would you like to in the future? (GOAL)			Y/N		
Information & Planning	Are you and your family informed about community resources and services available to you?			Y/N		
Information & Planning	Do you and your family members have all information available to skillfully plan for your services and supports?			Y/N		

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Information & Planning	N/A	Advance directives panel	LOINC 75772-4			ADVault

Table 32. Information & Planning Sub-domain Coded Elements

11.2.5 Cross-Cutting Sub-domains Coded Elements

The Cross-Cutting Sub-domain contains elements that may be used in and across other sub-domains.

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
Goals	N/A	Goals	LOINC 61146-7		"Goals Section" of HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes, Draft Standard for Trial Use, Release 2.1.	Common Clinical Data Set / ONC 2015 Edition Health IT Certification Rule
Units of Service	N/A					
Priorities	N/A					
Issues	N/A					
Interventions (Technology)	N/A	Procedure Name Procedure Date Procedure Priority	LOINC 29300-1 SNOMED CT 439272007 N/A		IHTSDO SNOMED CT®, U.S. Edition, September 2015 Release Health Care Financing Administration Common Procedure Coding System (HCPCS) Current Procedural Terminology, Fourth Edition (CPT–4)	Common Clinical Data Set / ONC 2015 Edition Health IT Certification Rule

Sub-domain	Exemplar Question	Coded Element Name	Element Vocabulary	Answer Type	Answer Vocabulary / Suggested Values	Regulation(s) or Suggested Standard(s)
					American Dental Association CDT: Code on Dental Procedures and Nomenclature Procedure Priority Value Set OID: 2.16.840.1.113883.1.11.16866	

Table 33. Cross-Cutting Sub-domains Coded Elements

Appendices

Appendix A: Related Use Cases

- ONC S&I Longitudinal Coordination of Care (LCC) Care Plan Exchange Use Case
- Blue Button Plus
- ONC S&I Data Segmentation for Privacy (DS4P)
- ONC S&I Data Provenance
- ONC S&I Structured Data Capture
- ONC S&I Data Access Framework

Appendix B: Previous Work Efforts

- CMS Medicaid Money Follows the Person (MFP) Rebalancing Demonstration Grant
- CMS Medicaid Community First Choice Option
- CMS Medicaid Balancing Incentives Program
- Institute of Medicine (IOM) Capturing Social and Behavioral Domains in Electronic Health Records
- The Improving Medicare Post-Acute Care Transformation Act of 2014
- National Core Indicators (NCI)
- Administration for Community Living (ACL), Centers for Medicare & Medicaid Services (CMS), Veterans Health Administration (VHA) Transforming State LTSS Access Programs and Functions into A No Wrong Door System for All Populations and All Payers
- National Quality Forum (NQF) Patient Reported Outcomes (PROs) in Performance Measurement
- National Quality Forum (NQF) HCBS Quality Measures Project
- ONC Direct Project
- Institute of Medicine's Committee on Approaching Death: Key End-of-Life Issues
- 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)
- 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
- HL7 Personal Health Record System Functional Model Release 1
- HL7 Implementation Guide for CDA Release 2: Patient Generated Document Header Template
- 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 Planning (ELP)
  - PACER
  - Wraparound Child and Family Planning
  - Mental Health Recovery Plans
  - Wellness Recover Action Plans
  - Life Course Planning
- 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
- International Classification of Functioning, Disability, and Health (WHO)
- Standard Terminologies and Taxonomies adopted by ONC: SNOMED CT, LOINC
  - HITSP Nursing Terminology Overlap Resolution

Appendix C: Actors and Activities for establishing eLTSS Information Sharing Resource

The eLTSS information sharing resource contains a set of Actors and request and response Activities that must be established for the beneficiary/advocate and providers to share eLTSS information. The steps and process on establishing the eLTSS information sharing resource will vary between states and other payers. Some states can and may have multiple information sharing resources. An example set of activities performed to establish the information sharing resource can be found in the table below[19].

eLTSS Plan Creation and Sharing Actors and Activities		**ACTORS**	**Beneficiary/Legal Representative**	**Beneficiary Advocate**	**eLTSS Plan Developer**	**eLTSS Plan Facilitator/Steward**	**CB-LTSS Provider**	**Clinical and Institutional-based Provider**	**Accountable Entity / Payer**
Set up the eLTSS Information Sharing Resource	**Description**								
Grant Approval to Share Information	The beneficiary indicates whether and to what extent identification, personal preferences and personal health information can be shared with service providers and accountable entities								

[19] The full Appendix C Actors and Activities for establishing eLTSS Information Sharing Resource is available for download

eLTSS Plan Creation and Sharing Actors and Activities		**ACTORS**	**Beneficiary/Legal Representative**	**Beneficiary Advocate**	**eLTSS Plan Developer**	**eLTSS Plan Facilitator/Steward**	**CB-LTSS Provider**	**Clinical and Institutional-based Provider**	**Accountable Entity / Payer**
Create Summary "Brief Person-Centered Profile"	High-level summary of what the beneficiary or the beneficiary advocate wants the service provider to know about the beneficiary such as things, people, and activities that matter most to the beneficiary. It lists the beneficiary's priorities and goals.								
Create Addendum to "Brief Person-Centered Profile"	A statement that expands, amplifies and/or corrects the beneficiary's profile								
Request for Service Providers to Identify Themselves	A request for a response from any provider that can provide the requested service								
Response from Service Provider to Request to Identify Themselves	Acknowledgement of ability to provide requested services in a specific location								
Request for Additional Information	Response to referring entity with a request from proposed service provider for additional information								

eLTSS Plan Creation and Sharing Actors and Activities		ACTORS	Beneficiary/Legal Representative	Beneficiary Advocate	eLTSS Plan Developer	eLTSS Plan Facilitator/Steward	CB-LTSS Provider	Clinical and Institutional-based Provider	Accountable Entity / Payer
	needed to provide requested services								
Request to Share Information	Request to share information made by providers to the beneficiary, advocate and other providers. Confirm that an agreement by the beneficiary (or proxy) to share the information is in place, to be followed by a request for specific information.								
Request Documentation to Share Information	Proposed provider requests a copy of the beneficiary's agreement to share information								
Request for Service from a Specific Provider	A request from an beneficiary or provider for services from a specific third party								
Request for Statement of Engagement with Beneficiary	Response to a request from other service providers to indicate that you are providing a service to this								

eLTSS Plan Creation and Sharing Actors and Activities		ACTORS	Beneficiary/Legal Representative	Beneficiary Advocate	eLTSS Plan Developer	eLTSS Plan Facilitator/Steward	CB-LTSS Provider	Clinical and Institutional-based Provider	Accountable Entity / Payer
	beneficiary								
Request for "Brief Person-Centered Profile"	A service provider asks the beneficiary for the information to guide how services should be delivered and what personal information the beneficiary wants the service provider to know.								
Statement of Termination with Beneficiary	Announcement to other engaged service providers that provider no longer has a relationship with the beneficiary								
Request List of all Engaged Service Providers	Request to all potential service providers for their list of current service providers								
Request List of all Active Issues being Addressed by Service Provider	Request to a service provider for a list of the issues they are aware of (medical, behavioral, functional, environmental)								

eLTSS Plan Creation and Sharing Actors and Activities		**ACTORS**	**Beneficiary/Legal Representative**	**Beneficiary Advocate**	**eLTSS Plan Developer**	**eLTSS Plan Facilitator/Steward**	**CB-LTSS Provider**	**Clinical and Institutional-based Provider**	**Accountable Entity / Payer**
Request for Notification of Change in Status (admission, discharge from ED, facility or service)	Hospital, facility or hospice notifies service providers that beneficiary has been (or is about to be) discharged								
Request for List of Issues that Might Pose a Safety Threat to In-Home Staff	Assessment of risks to home visiting staff (dogs, guns, violent residents)								
Request for Results of a Standardized Assessment	A request for OASIS results from HHAs, MDS from ECFs and SNFs, and IRF PAI from IRFs and for specific assessments for function, cognitive assessment, depression, fall risk, skin breakdown risk and other standardized assessments								
Assemble Aggregate List of Active Health Concerns (medical, behavioral, functional, environmental)	Compile list of currently active problems and issues from all engaged service providers								
Assemble Aggregate List of all Current Interventions	Reports from all providers engaged in the care of this beneficiary indicating services, issues and projected outcomes								

eLTSS Plan Creation and Sharing Actors and Activities		**ACTORS**	**Beneficiary/Legal Representative**	**Beneficiary Advocate**	**eLTSS Plan Developer**	**eLTSS Plan Facilitator/Steward**	**CB-LTSS Provider**	**Clinical and Institutional-based Provider**	**Accountable Entity / Payer**
Analysis of Unmet Needs	Difference between identified issues and interventions								
Request Outcomes of Interventions and Services	Report degree to which interventions and services are effective, partially effective or ineffective								
Request Observations of Family Dynamics, Information on Social Functioning	Compilation of observations made by service providers								
eLTSS Plan Creation and Sharing Activities									
Determine who will assist the Beneficiary in the eLTSS Planning Process (Person-Centered Planning Requirement)									
Invite People to Assist in eLTSS Planning Process									
Create/Contribute to eLTSS Plan (Person-Centered Planning Requirement)									
Develop eLTSS Plan									
Submit eLTSS Plan for Approval									
Review eLTSS Plan for Approval									
Approve eLTSS Plan									
Grant Consent to Share eLTSS Plan									

eLTSS Plan Creation and Sharing Actors and Activities		**ACTORS**	**Beneficiary/Legal Representative**	**Beneficiary Advocate**	**eLTSS Plan Developer**	**eLTSS Plan Facilitator/Steward**	**CB-LTSS Provider**	**Clinical and Institutional-based Provider**	**Accountable Entity / Payer**
Grant Access to eLTSS Plan									
Host eLTSS Plan									
Maintain eLTSS Plan									
Reconcile eLTSS Plan									
Access eLTSS Plan									
Update eLTSS Plan									
Monitor Plan									
Manage eLTSS Plan Utilization									
Send eLTSS Plan									
Receive eLTSS Plan									
Send Notification									
Receive Notification									
Out of Scope for Use Case Activities									
Complete Eligibility Determination Forms (Pre-condition)									
Receive LTSS Benefits (Assumption)									
Lead eLTSS Plan creation (Assumption)									
Submit Eligibility Determination Form(s)(Pre-condition)									

eLTSS Plan Creation and Sharing Actors and Activities		**ACTORS**	**Beneficiary/Legal Representative**	**Beneficiary Advocate**	**eLTSS Plan Developer**	**eLTSS Plan Facilitator/Steward**	**CB-LTSS Provider**	**Clinical and Institutional-based Provider**	**Accountable Entity / Payer**
Schedule Services									
Manage Incident and Risk for Beneficiary, as well as at the provider level									
Facilitate regular review (and update if needed) of eLTSS Plan									
Assist Beneficiary in selecting provider(s) for new service(s)									
Assist Beneficiary in electing and implementing self-directed services									
Monitor Plan Implementation and Beneficiary's health and welfare									
Manage Incident and Risk for Beneficiary									
Conduct a Monitoring/Inspection Visit									
Submit Service Change Request									
Approve Service Request									
Manage Services									
Coordinate Care									
Quality Assurance and Quality Management for MCO area									
Receive Eligibility Determination Form(s)									

eLTSS Plan Creation and Sharing Actors and Activities		**ACTORS**	**Beneficiary/Legal Representative**	**Beneficiary Advocate**	**eLTSS Plan Developer**	**eLTSS Plan Facilitator/Steward**	**CB-LTSS Provider**	**Clinical and Institutional-based Provider**	**Accountable Entity / Payer**
Approve Eligibility									
Assign Support Coordinator/Case Manager									
Assure Needs are Assessed (Person-Centered Planning Requirement)									
Ensure Plan Addresses Needs(Person-Centered Planning Requirement)									
Monitor Services Delivered									
Monitor Service Providers and MCOs									
Authorize Certain Services									
Establish eLTSS plan Policies, Procedures									
Establish/Maintain eLTSS System									
Quality Assurance and Quality Management									

Appendix D: References

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