Meeting Etiquette

• Remember: If you are not speaking, please keep your phone on mute

• Do not put your phone on hold. If you need to take a call, hang up and dial in again when finished with your other call
  » Hold = Elevator Music = frustrated speakers and participants

• This meeting is being recorded
  » Another reason to keep your phone on mute when not speaking

• Use the “Chat” feature for questions, comments and items you would like the moderator or other participants to know.
  » Send comments to ALL PANELISTS so they can be addressed publically in the chat, or discussed in the meeting (as appropriate).
<table>
<thead>
<tr>
<th>Topic</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome and Introductions</td>
<td>Evelyn Gallego/Kerry Lida</td>
</tr>
<tr>
<td>Recap: Final eLTSS Dataset Publication</td>
<td>Becky Angeles</td>
</tr>
<tr>
<td>Review eLTSS Dataset Standardization Timeline</td>
<td>Evelyn Gallego</td>
</tr>
<tr>
<td>Status of GA Data Reference Model Project</td>
<td>Bonnie Young/Irina Connelly</td>
</tr>
<tr>
<td>Opportunities for broad eLTSS Community Engagement</td>
<td>Evelyn Gallego</td>
</tr>
<tr>
<td>Next Steps</td>
<td>Evelyn Gallego</td>
</tr>
</tbody>
</table>
Welcome & Introductions
Recap: Final eLTSS Dataset Publication
Published eLTSS Dataset

A downloadable PDF version of the eLTSS Dataset complete with a high-level overview of the project, dataset definitions, list of values, and format is available on the eLTSS confluence page.
### eLTSS Final Dataset

- **Total Number of Elements:** 56

<table>
<thead>
<tr>
<th>Beneficiary Demographics: 10 Elements</th>
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<tbody>
<tr>
<td>Person Name</td>
</tr>
<tr>
<td>Person Identifier</td>
</tr>
<tr>
<td>Person Identifier Type</td>
</tr>
<tr>
<td>Person Date of Birth</td>
</tr>
<tr>
<td>Person Phone Number</td>
</tr>
<tr>
<td>Person Address</td>
</tr>
<tr>
<td>Emergency Contact Name</td>
</tr>
<tr>
<td>Emergency Contact Relationship</td>
</tr>
<tr>
<td>Emergency Contact Phone Number</td>
</tr>
<tr>
<td>Emergency Backup Plan</td>
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<table>
<thead>
<tr>
<th>Person Centered Planning: 11 Elements</th>
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<tbody>
<tr>
<td>Assessed Need</td>
</tr>
<tr>
<td>Preference</td>
</tr>
<tr>
<td>Person Setting Choice Indicator</td>
</tr>
<tr>
<td>Person Setting Choice Options</td>
</tr>
<tr>
<td>Service Options Given Indicator</td>
</tr>
<tr>
<td>Service Selection Indicator</td>
</tr>
<tr>
<td>Service Provider Options Given Indicator</td>
</tr>
<tr>
<td>Service Provider Selection Agreement Indicator</td>
</tr>
<tr>
<td>Service Plan Agreement Indicator</td>
</tr>
<tr>
<td>Plan Monitor Name</td>
</tr>
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<td>Plan Monitor Phone Number</td>
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<table>
<thead>
<tr>
<th>Plan Information: 1 Element</th>
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<tbody>
<tr>
<td>Plan Effective Date</td>
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</table>

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

<table>
<thead>
<tr>
<th>Risks: 2 Elements</th>
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<tbody>
<tr>
<td>Identified Risk</td>
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<tr>
<td>Risk Management Plan</td>
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<table>
<thead>
<tr>
<th>Service Provider Information: 5 Elements</th>
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</thead>
<tbody>
<tr>
<td>Support Planner Name</td>
</tr>
<tr>
<td>Support Planner Phone Number</td>
</tr>
<tr>
<td>Service Provider Name</td>
</tr>
<tr>
<td>Service Provider Phone Number</td>
</tr>
<tr>
<td>Non-Paid Provider Relationship</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Goals &amp; Strengths: 3 Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal</td>
</tr>
<tr>
<td>Step or Action</td>
</tr>
<tr>
<td>Strength</td>
</tr>
</tbody>
</table>

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

• **eLTSS Standard Development: Sept 2017 – Sep 2018**
  
  » Led by The Georgia Department of Community Health – Health Information Technology Unit (DCH-HIT) supported by GTRI in coordination with participating TEFT States, ONC and CMS
  
  » Continuation of eLTSS Initiative work on developing a national solution for sharing HCBS Service Plan data. Primary HL7 WG Sponsor: Community Based Care & Privacy Collaborative (CBCP)

• **eLTSS Standard Testing: Feb 2018 – June 2018**
  
  » Led by ONC Support Team in collaboration with HL7
  
  » Pilots will test eLTSS HL7 artifacts as they are developed (AGILE development; SPRINT testing)
  
  » Call for participation (Nov 2017 to Feb 2018); first tests to be scheduled February and March; pilots will inform eLTSS HL7 artifacts

*Contingent of approval of a No-Cost Extension*
Key Activities

• **HL7 IG Ballot Development & Publication: April 2018 – Dec 2018**
  
  » Outcomes from sprint pilots will inform development of eLTSS IG
  
  » DCH-HIT, GTRI and ONC Support Team will develop HL7 artifacts for Aug-Sept Ballot: Project Scope Statement (due May); Notice of Intent to Bid (due July); Ballot Package (due August)
  
  » eLTSS Community will be engaged to review, revise and vote on the eLTSS IG
    
    – Note: Non-HL7 members can vote on HL7 ballot

• **eLTSS Community Engagement (Dec 2017 – Sept 2018)**
  
  » ONC will facilitate monthly eLTSS Community updates to inform broad eLTSS Community on status of above activities
eLTSS Roadmap: 2017 to 2018

1. eLTSS Standard Development
   - Internal coordination with GA Reference Data Model Project
   - HL7 WG Coordination (CBCC, SDWG, Security, Patient Care, LHS)

   - Nov GA F2F Meeting
   - HL7 Jan WGM
   - Feb GA F2F Meeting

   - eLTSS Draft IG Complete
   - eLTSS Pilot Guidance Complete
   - eLTSS Whitepaper Complete

2. eLTSS Standard Testing
   - Pilots Identification
   - Pilots Test Pilot Guidance

   - eLTSS Pilots Complete
   - Pilot Findings Report Out

3. HL7 IG Ballot Development

   - eLTSS IG Revisions & Ballot Development
     - HL7 Ballot Materials Due
     - HL7 NIB Due

   - eLTSS Ballot Period (Aug 24 – Sept 24)
   - eLTSS Ballot Reconciliation
   - eLTSS Balloted IG Published

- eLTSSv2 Kick-Off
- HL7 May WGM
- HL7 Sept WGM

Oct-Dec 17  |  Jan-Feb 18  |  Mar-Apr 18  |  May-Jun 18  |  Jul-Aug 18  |  Sep-Oct 18  |  Nov-Dec 18
Georgia Data Reference Model
Goals and Objectives

Our Overarching Goal:

Enable data-level electronic exchange of LTSS Service Plan data using Health Information Technology (HIT) data standards.

GA Supplemental Outcome and Deliverables:

*Straightforward and precise specifications and implementer guidance for how to exchange LTSS Core Dataset data.*
Approach

**Step 1:** Identify what information is important to exchange for the HCBS community. Identify and document the why (e.g. use cases).

We started with a focus on HCBS Service Plans.

We identified a list of common data elements and published those into the eLTSS Core Dataset.

**Step 2:** Determine how the HIT standards can be used to support the exchange of information identified in Step 1.

Document the findings:

- How-To for the items that are covered well by standards
- Any gaps and potential ways to address them

**Step 3:** Work with the SDO (e.g. HL7, etc.) to address the gaps and publish our artifacts.
Approach – Resulting Artifacts

Step 1 Outcomes and Deliverables:
- eLTSS Core Dataset
- Other data items including:
  - non-core items
  - exemplar data items
  - items collected by states during Round 1

Step 2 Outcomes and Deliverables:
- Documentation on how to use HIT standards to exchange eLTSS Core Dataset data
- Documentation on any gaps / deficiencies and strategies on how to address them

Step 3 Outcomes and Deliverables:
- SDO ratified documentation on how to use HIT standards to exchange eLTSS Core Dataset data
Collaborative Approach

• Thank you MN, CT and CO for your continued participation and input

• KY, MD – We will continue to include you in our communications and opportunities to provide input

• eLTSS Broader Community

If you would like to be included on email distributions related to this effort please contact Bonnie Young bonnie.young@dch.ga.gov
Atlanta F2F Debrief

• Held in Atlanta, November 29 – 30, 2017

• Facilitated by DCH-HIT and GTRI

• **Purpose:** Review Georgia Team’s findings to-date. Discuss, brainstorm approached for items where mapping was not ideal, compile items to discuss and seek guidance from HL7 on

• **Participants:**

  » TEFT States Medicaid: GA, CO, CT, MN

  » ESAC (ONC Support Team)

  » Lewin (CMS Support Team)
Summary of FHIR Mapping topics discussed

1. Support Planer vs Plan Monitor – vs. CarePlan author, Care Team participant roles etc.

2. Assessed Needs – Does FHIR Condition resource fit?

3. Strength(s), Preference(s) – How do we want to capture this data?

4. HCBS Services – What resources can we use for HCBS Service data?

5. Step or Action – What exactly does this element hold?
   • Specifically, do we need an ability to specify more granular steps under a specific Service or Activity

6. Risks – Risk Assessment or Observation?

7. Cost Information – Not typically mixed in with clinical data. How to ensure the structures FHIR includes are sufficient for our needs
eLTSS Data Set vs FHIR Care Plan at a glance

**eLTSS Core Dataset**

- **Plan Effective Date**
- **Beneficiary Demographics**
  - Contact(s)
- **Support Planner**
- **Service Providers**
  - Support Planner
  - Plan Monitor
- **Goal**
- **Service Details**
  - (no cost info)
  - Risk, Strengths, Preferences, Signatures, Choice Indicators

**FHIR Care Plan Resource**

- **Info about the plan**
  - Id, title, description, category, status, plan period, related plans, etc.
- **Subject**
  - aka Person aka Beneficiary aka Patient
  - Contains identifying info for the beneficiary, as well as contact info, etc.
- **Author**
  - Who is responsible for contents of the plan
  - Can have multiple authors. May be Patient, Practitioner, Related Person, and Organization
- **Care Team**
  - Who’s involved in plan?
  - Can include practitioners, organizations and related persons
- **Goal(s)**
  - Desired outcome of plan
  - Goal resource contains id, status, category, priority, description, subject (aka patient), target, target outcome, status+date, related condition(s), note(s), outcome code(s), etc.
- **Activity(ies)**
  - Action to occur as part of plan
  - Lost of info here. Varies a bit depending on what is used to specify e.g. References (Appointment, Device Request, Medication Request, Nutrition Order, Task, Procedure Request, etc.)
- **Supporting Info**
  - Reference to any relevant information
- **Note(s)**
  - Comment about plan
### Assessed Need Discussion

#### Goals, Strengths, Steps and Preferences: 5 Elements

<table>
<thead>
<tr>
<th>Assessed Need</th>
<th>Goal</th>
<th>Step or Action</th>
<th>Strength</th>
<th>Preference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessed Need</strong></td>
<td><strong>Goal</strong></td>
<td><strong>Step or Action</strong></td>
<td><strong>Strength</strong></td>
<td><strong>Preference</strong></td>
</tr>
<tr>
<td>- title</td>
<td>- description</td>
<td>- subject</td>
<td>- context</td>
<td>- period</td>
</tr>
<tr>
<td>- careTeam</td>
<td>- addresses</td>
<td>- supportingInfo</td>
<td>- goal</td>
<td></td>
</tr>
<tr>
<td>Σ 0..1 string</td>
<td>Σ 0..1 string</td>
<td>Σ 1..1 Reference(Patient</td>
<td>Group)</td>
<td>Σ 0..1 Reference(Encounter</td>
</tr>
<tr>
<td>Σ 0..* Reference(Patient</td>
<td>Practitioner</td>
<td>RelatedPerson</td>
<td>Organization</td>
<td>CareTeam)</td>
</tr>
<tr>
<td>Σ 0..* Reference(Patient</td>
<td>Practitioner</td>
<td>RelatedPerson</td>
<td>Organization</td>
<td>CareTeam)</td>
</tr>
<tr>
<td>Σ 0..* Reference(Condition)</td>
<td>Σ 0..* Reference(Any)</td>
<td>Σ 0..* Reference(Goal)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Care Plan Category (content): Human-friendly name for the CarePlan
- Summary of nature of plan
- Who care plan is for
- Created in context of
- Time period plan covers
- Who is responsible for contents of the plan
- Who's involved in plan?
- Health issues this plan addresses
- Information considered as part of plan
- Desired outcome of plan
Assessed Need vs. Condition

eLTSS Assessed Need - The clinical and/or community-based necessity or desire as identified through an assessment that should be addressed by a service.

**FHIR Condition Description:**

This resource is used to record detailed information about a condition, problem, diagnosis, or other event, situation, issue, or clinical concept that has risen to a level of concern.

The condition resource may be used to record a certain health state of a patient which does not normally present a negative outcome, e.g. pregnancy. The condition resource may be used to record a condition following a procedure, such as the condition of Amputee-BKA following an amputation procedure.

While conditions are frequently a result of a clinician's assessment and assertion of a particular aspect of a patient's state of health, conditions can also be expressed by the patient, related person, or any care team member.

**Some example conditions:**

- Unemployed
- Without transportation (or other barriers)
- Susceptibility to falls
- Exposure to communicable disease
- Family History of cardiovascular disease
- Fear of cancer
- Cardiac pacemaker
- Amputee-BKA
- Risk of Zika virus following travel to a country
- Former smoker
- Travel to a country planned (that warrants immunizations)
- Motor Vehicle Accident
- Patient has had coronary bypass graft
Assessed Need vs. Condition

**MN** take on Condition and Assessed Need semantics

**Condition**: a state of health (read this broad, not just medical)

**Assessed Need**: Functional limitations and other conditions identified during an activity intended to evaluate functional capacity. For HCBS, this evaluation is across a broad range of functional domains.

**Question:**

- Would you agree that Assessed Need is essentially a category of Conditions, and would be semantically appropriate to represent using the Condition resource?

- Ask: please provide a snippet of your Service Plan showing the Assessed Need field, and some sample data it may typically hold
Condition Resource

<table>
<thead>
<tr>
<th>Element</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition</td>
<td>Detailed information about conditions, problems or diagnoses.</td>
</tr>
<tr>
<td></td>
<td>+ If condition is abated, then clinicalStatus must be either inactive, resolved, or remission</td>
</tr>
<tr>
<td></td>
<td>+ Condition.clinicalStatus SHALL be present if verificationStatus is not entered-in-error</td>
</tr>
<tr>
<td></td>
<td>Elements defined in Ancestors: id, meta, implicitRules, language, text, contained, extension, modifierExtension</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>identifier</td>
<td>External Ids for this condition</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>clinicalStatus</td>
<td>active</td>
</tr>
<tr>
<td></td>
<td>Condition Clinical Status Codes (Required)</td>
</tr>
<tr>
<td>verificationStatus</td>
<td>provisional</td>
</tr>
<tr>
<td></td>
<td>ConditionVerificationStatus (Required)</td>
</tr>
<tr>
<td>category</td>
<td>problem-list-item</td>
</tr>
<tr>
<td></td>
<td>Condition Category Codes (Example)</td>
</tr>
<tr>
<td>severity</td>
<td>Subjective severity of condition</td>
</tr>
<tr>
<td></td>
<td>Condition/Diagnosis Severity (Preferred)</td>
</tr>
<tr>
<td></td>
<td>Identification of the condition, problem or diagnosis</td>
</tr>
<tr>
<td>code</td>
<td>Anatomical location, if relevant</td>
</tr>
<tr>
<td></td>
<td>SNOMED CT Body Structures (Example)</td>
</tr>
<tr>
<td>bodySite</td>
<td>Who has the condition?</td>
</tr>
<tr>
<td>subject</td>
<td>Encounter or episode when condition first asserted</td>
</tr>
<tr>
<td>context</td>
<td></td>
</tr>
</tbody>
</table>

The Office of the National Coordinator for Health Information Technology
Condition Resource

- **onset[x]**
  - **onsetDateTime** (dateTime)
  - **onsetAge** (Age)
  - **onsetPeriod** (Period)
  - **onsetRange** (Range)
  - **onsetString** (string)

- **abatement[x]**
  - **abatementDateTime** (dateTime)
  - **abatementAge** (Age)
  - **abatementBoolean** (boolean)
  - **abatementPeriod** (Period)
  - **abatementRange** (Range)
  - **abatementString** (string)

- **assertedDate**
  - **dateTime**

- **asserter**
  - **Reference(Practitioner | Patient | RelatedPerson)**

- Estimated or actual date, date-time, or age
- If/when in resolution/remission
- Date record was believed accurate
- Person who asserts this condition
**Condition Resource**

- **stage**
  - I 0..1 BackboneElement
  - Stage/grade, usually assessed formally
    + Stage SHALL have summary or assessment

- **summary**
  - I 0..1 CodeableConcept
  - Simple summary (disease specific)

- **assessment**
  - I 0..* Reference(ClinicalImpression | DiagnosticReport | Observation)
  - Formal record of assessment

- **evidence**
  - I 0..* BackboneElement
  - Supporting evidence
    + evidence SHALL have code or details

- **code**
  - Σ I 0..* CodeableConcept
  - Manifestation/symptom

- **detail**
  - Σ I 0..* Reference(Any)
  - Supporting information found elsewhere

- **note**
  - 0..* Annotation
  - Additional information about the Condition
MN Sample for Assessed Need(s)

Support Options and Strengths

**Personal Assistance**
- X Dressing
- Grooming
- Toileting
- Bathing
- Eating
- Positioning
- Transferring
- Walking
- Wheeling
- Other
- N/A – Does not apply

**Description of need**

**Supports and strengths used to meet this need** (Include items such as informal/formal services and supports, referrals to be made or additional evaluations)

**Health Related/Medical**
- Clinical monitoring
- Special treatment
- Medication management
- Diagnosis
- Falls
- ER visits
- Nursing home stays
- Preventative health care
- Other
- N/A – Does not apply

**Home Management**
- Shopping
- Light housekeeping
- Heavy housekeeping
- Laundry
- Money management
- Preparing meals
- Other
- N/A – Does not apply

**Training/Skill Building**
- Adult day services
- Employment
- Habilitation/training
- Skill building
- Training
- Other
- N/A – Does not apply

**Communication**
- Telephone answering
- Telephone calling
- Hearing
- Vision
- Communication
- Other
- N/A – Does not apply

**Supportive Services**
- Socialization
- Transportation
- Caregiver services
- Housing/living arrangements
- Community living
- Leisure and recreation
- Other
- N/A – Does not apply

**Caregiver/Parent Support**
- Education/coaching
- Respite
- Other
- N/A – Does not apply

**Cognitive and Behavior Supports**
- Behavior
- Mental status exam
- Self-preservation
- Orientation
- N/A – Does not apply
Next Steps after Atlanta F2F

• Summary of discussion and outcomes for the topics discussed

• A list of items / questions to discuss with respective HL7 working groups
  » Will approach this collaboratively with ESAC
  » Will work to schedule briefings and discussions during the HL7 F2F in Jan 2018

• Follow-up with TEFT States and review outcomes once we receive some guidance from HL7 on our proposals and questions
eLTSS Engagement
How can broader eLTSS Community engage?

• Participate in monthly eLTSS Community Update Meetings

• Follow engagement with HL7 CBCP Workgroup:
  » [https://www.hl7.org/Special/committees/homehealth/index.cfm](https://www.hl7.org/Special/committees/homehealth/index.cfm)
  » Weekly calls scheduled Tuesdays 12 to 1pm ET
  » GTRI will provide periodic brief status updates

• Sign up to pilot draft eLTSS standardized materials
  » Contact: Jamie Parker [jamie.parker@esacinc.com](mailto:jamie.parker@esacinc.com)
Next Steps & Community Updates
eLTSS Initiative: Project Team Leads

- **ONC Leadership**
  - Elizabeth Palena-Hall ([elizabeth.palena hall@hhs.gov](mailto:elizabeth.palena hall@hhs.gov))
  - Caroline Coy ([caroline.coy@hhs.gov](mailto:caroline.coy@hhs.gov))

- **CMS Leadership**
  - Kerry Lida ([Kerry.Lida@cms.hhs.gov](mailto:Kerry.Lida@cms.hhs.gov))

- **Initiative Coordinator**
  - Evelyn Gallego-Haag ([evelyn.gallego@emiadvisors.net](mailto:evelyn.gallego@emiadvisors.net))

- **Project Management**
  - Lynette Elliott ([lynette.elliott@esacinc.com](mailto:lynette.elliott@esacinc.com))

- **Use Case & Functional Requirements Development**
  - Becky Angeles ([becky.angeles@esacinc.com](mailto:becky.angeles@esacinc.com))

- **Pilots Management**
  - Jamie Parker ([jamie.parker@esacinc.com](mailto:jamie.parker@esacinc.com))