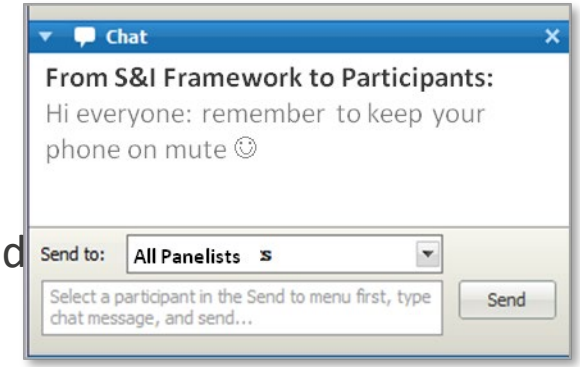
The Office of the National Coordinator for Health Information Technology

electronic Long-Term Services & Supports (eLTSS) Community Update

December 7, 2017

Meeting Etiquette

- Remember: If you are not speaking, **please keep your phone on mute**
- **Do not put your phone on hold.** If you need to take a call, hang up and dial in again when finished with your other call
  - » Hold = Elevator Music = frustrated speakers and participants
- **This meeting is being recorded**
  - » Another reason to keep your phone on mute when not speaking
- **Use the "Chat" feature** for questions, comments and items you would like the moderator or other participants to know.
  - » **Send comments to ALL PANELISTS** so they can be addressed publically in the chat, or discussed in the meeting (as appropriate).



Agenda

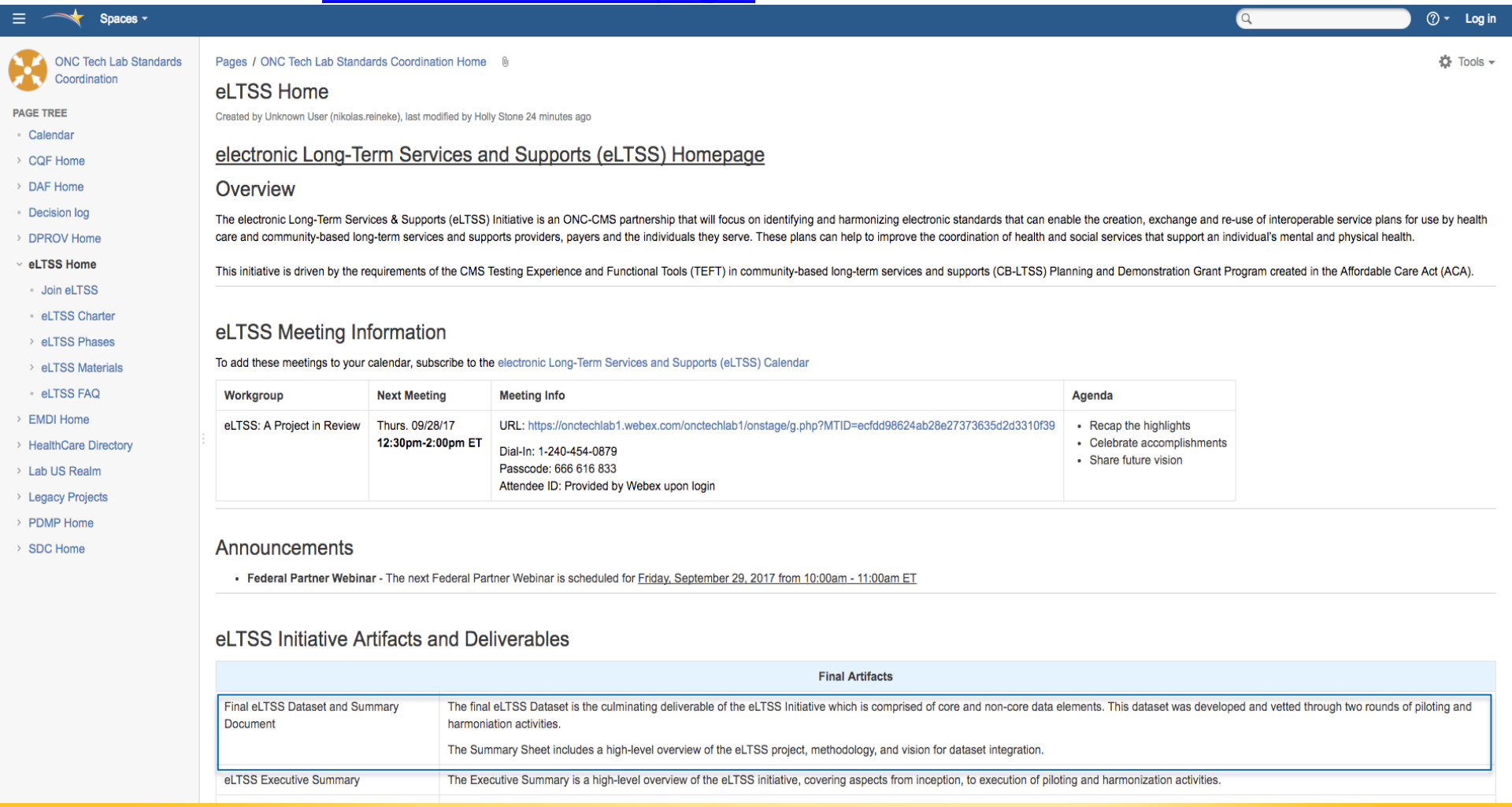
Topic	Presenter
Welcome and Introductions	Evelyn Gallego/Kerry Lida
Recap: Final eLTSS Dataset Publication	Becky Angeles
Review eLTSS Dataset Standardization Timeline	Evelyn Gallego
Status of GA Data Reference Model Project	Bonnie Young/Irina Connelly
Opportunities for broad eLTSS Community Engagement	Evelyn Gallego
Next Steps	Evelyn Gallego

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

Beneficiary Demographics: 10 Elements
Person Name
Person Identifier
Person Identifier Type
Person Date of Birth
Person Phone Number
Person Address
Emergency Contact Name
Emergency Contact Relationship
Emergency Contact Phone Number
Emergency Backup Plan

Goals & Strengths: 3 Elements
Goal
Step or Action
Strength

Person Centered Planning: 11 Elements
Assessed Need
Preference
Person Setting Choice Indicator
Person Setting Choice Options
Service Options Given Indicator
Service Selection Indicator
Service Provider Options Given Indicator
Service Provider Selection Agreement Indicator
Service Plan Agreement Indicator
Plan Monitor Name
Plan Monitor Phone Number

Plan Information: 1 Element
Plan Effective Date

Plan Signatures: 12 Elements
Person Signature
Person Printed Name
Person Signature Date
Guardian/Legal Representative Signature
Guardian/Legal Representative Printed Name
Guardian/Legal Representative Signature Date
Support Planner Signature
Support Planner Printed Name
Support Planner Signature Date
Service Provider Signature
Service Provider Printed Name
Service Provider Signature Date

Risks: 2 Elements
Identified Risk
Risk Management Plan

Service Information: 12 Elements
Service Name
Self-Directed Service Indicator
Service Start Date
Service End Date
Service Delivery Address
Service Comment
Service Funding Source
Service Unit Quantity
Unit of Service Type
Service Unit Quantity Interval
Service Rate per Unit
Total Cost of Service

Service Provider Information: 5 Elements
Support Planner Name
Support Planner Phone Number
Service Provider Name
Service Provider Phone Number
Non-Paid Provider Relationship

eLTSS Dataset Standardization Timeline

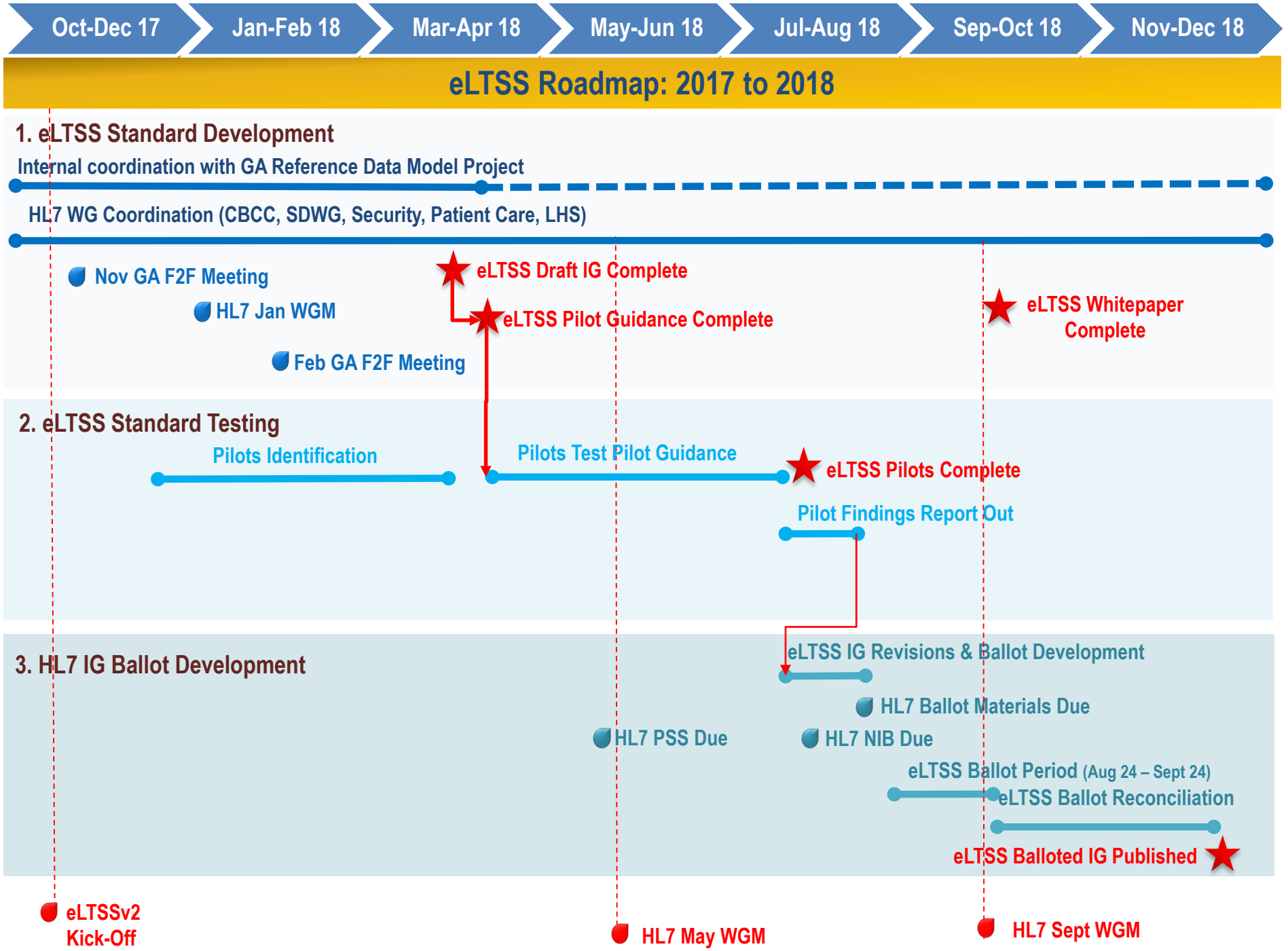
Key Activities

- 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


Oct-Dec 17
Jan-Feb 18
Mar-Apr 18
May-Jun 18
Jul-Aug 18
Sep-Oct 18
Nov-Dec 18
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 PSS 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

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	FHIR Care Plan Resource
Plan Effective Date	**Info about the plan** Id, title, description, category, status, plan period, related plans, etc.
Beneficiary Demographics Contact(s)	**Subject** aka Person aka Beneficiary aka Patient Contains identifying info for the beneficiary, as well as contact info, etc.
Support Planner	**Author** – Who is responsible for contents of the plan Can have multiple authors. May be Patient, Practitioner, Related Person, and Organization
Service Providers Support Planner Plan Monitor	**Care Team** – Who's involved in plan? Can include practitioners, organizations and related persons
Goal	**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.
Service Details (no cost info)	**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.)
Risk, Strengths, Preferences, Signatures, Choice Indicators	**Supporting Info** – Reference to any relevant information
	Note(s) – Comment about plan

Assessed Need Discussion

Goals, Strengths, Steps and Preferences: 5 Elements

- Assessed Need
- Goal
- Step or Action
- Strength
- Preference

title	Σ	0..1	string	Human-friendly name for the CarePlan
description	Σ	0..1	string	Summary of nature of plan
subject	Σ	1..1	Reference(Patient | Group)	Who care plan is for
context	Σ	0..1	Reference(Encounter | EpisodeOfCare)	Created in context of
period	Σ	0..1	Period	Time period plan covers
author	Σ	0..*	Reference(Patient | Practitioner | RelatedPerson | Organization | CareTeam)	Who is responsible for contents of the plan
careTeam		0..*	Reference(CareTeam)	Who's involved in plan?
addresses	Σ	0..*	Reference(Condition)	Health issues this plan addresses
supportingInfo		0..*	Reference(Any)	Information considered as part of plan
goal		0..*	Reference(Goal)	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

Condition	I		DomainResource	Detailed information about conditions, problems or diagnoses *+ If condition is abated, then clinicalStatus must be either inactive, resolved, or remission* *+ Condition.clinicalStatus SHALL be present if verificationStatus is not entered-in-error* Elements defined in Ancestors: id, meta, implicitRules, language, text, contained, extension, modifierExtension
identifier	Σ	0..*	Identifier	External Ids for this condition
clinicalStatus	?! Σ I	0..1	code	active | recurrence | inactive | remission | resolved Condition Clinical Status Codes (Required)
verificationStatus	?! Σ I	0..1	code	provisional | differential | confirmed | refuted | entered-in-error | unknown ConditionVerificationStatus (Required)
category		0..*	CodeableConcept	problem-list-item | encounter-diagnosis Condition Category Codes (Example)
severity		0..1	CodeableConcept	Subjective severity of condition Condition/Diagnosis Severity (Preferred)
code	Σ	0..1	CodeableConcept	Identification of the condition, problem or diagnosis Condition/Problem/Diagnosis Codes (Example)
bodySite	Σ	0..*	CodeableConcept	Anatomical location, if relevant SNOMED CT Body Structures (Example)
subject	Σ	1..1	Reference(Patient | Group)	Who has the condition?
context	Σ	0..1	Reference(Encounter | EpisodeOfCare)	Encounter or episode when condition first asserted

Condition Resource

onset[x]	Σ	0..1		Estimated or actual date, date-time, or age
onsetDateTime			dateTime	
onsetAge			Age	
onsetPeriod			Period	
onsetRange			Range	
onsetString			string	
abatement[x]	I	0..1		If/when in resolution/remission
abatementDateTime			dateTime	
abatementAge			Age	
abatementBoolean			boolean	
abatementPeriod			Period	
abatementRange			Range	
abatementString			string	
assertedDate	Σ	0..1	dateTime	Date record was believed accurate
asserter	Σ	0..1	Reference(Practitioner | Patient | RelatedPerson)	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) Condition Stage (Example)
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 Manifestation and Symptom Codes (Example)
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

☒ 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
  - 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

Next Steps & Community Updates

eLTSS Initiative: Project Team Leads

- ONC Leadership
  - Elizabeth Palena-Hall (elizabeth.palenahall@hhs.gov)
  - Caroline Coy (caroline.coy@hhs.gov)
- CMS Leadership
  - Kerry Lida (Kerry.Lida@cms.hhs.gov)
- Initiative Coordinator
  - Evelyn Gallego-Haag (evelyn.gallego@emiadvisors.net)
- Project Management
  - Lynette Elliott (lynette.elliott@esacinc.com)
- Use Case & Functional Requirements Development
  - Becky Angeles (becky.angeles@esacinc.com)
- Pilots Management
  - Jamie Parker (jamie.parker@esacinc.com)