The Office of the National Coordinator for Health Information Technology

Addressing Social Determinants of Health (SDOH) via Community Information Exchange (CIE)

Evelyn Gallego, MBA, MPH, CPHIMS
EMI Advisors LLC

August 22, 2019

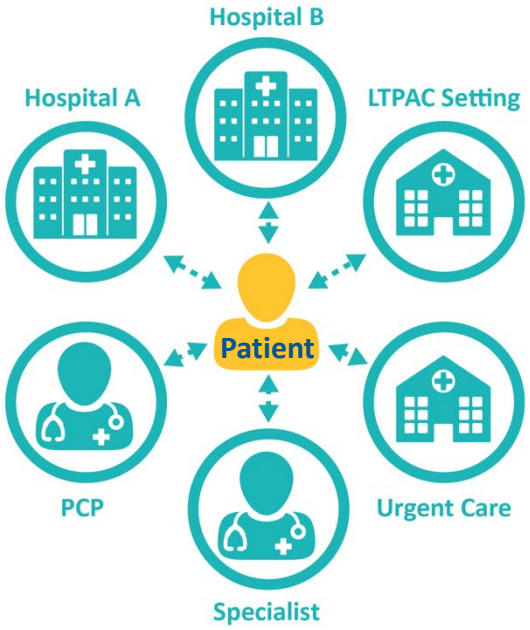
Agenda

- Setting the Stage: Interoperability & Value Based Payment
- Health Information Exchange & Community Information Exchange
- State Activities Related to SDOH Data Capture

INTEROPERABILITY & VALUE BASED PAYMENT

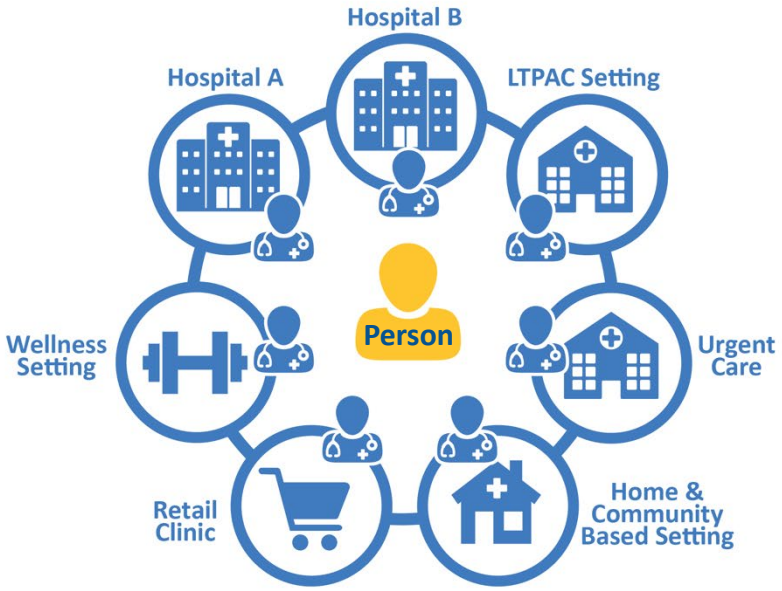
Business Case for Interoperability: Delivery System Reform & Value Based Care

Clinician and Institution Centered Models



- ✓ Provider Centric Fee-for-Service Model
- ✓ Siloed Delivery of Care
- ✓ Limited Information Sharing and integration across settings (paper and electronic)
- ✓ Reactive vs Proactive Care

Person-Centered and Community-Based Models



- ✓ Person Centric Value-Based Care Model
- ✓ Providers Paid for outcomes, not volume of services
- ✓ Care Team includes patient and all allied providers
- ✓ Emphasis on wellness, prevention and population health management
- ✓ **Emphasis on use of technology to integrate care and share information**
- ✓ Proactive vs Reactive Care

Delivery System Reform: Focus Areas

"Improving the way providers are incentivized, the way care is delivered, and the way information is distributed will help provide better care at lower cost across the health care system…"

Pay Providers

- Promote value-based payment systems
- Bring proven payment models to scale

Deliver Care

- Encourage the integration and coordination of clinical and non clinical care services
- Improve population health
- Promote patient engagement through shared decision making

Distribute Information

- Create transparency on cost and quality information
- Bring electronic health information to the point of care for meaningful use

Source: Burwell SM. Setting Value-Based Payment Goals – HHS Efforts to Improve U.S. Health Care. NEJM 2015 Jan 26; published online first.

Health Information Exchange (HIE) & Community Information Exchange (CIE)

What is Health Information Exchange (HIE)?

AS A VERB Health information exchange (HIE) is the process of securely accessing and exchanging an individual's health information across and between health stakeholder groups (e.g., providers, individuals, payers and other accountable entities)

AS A NOUN An organization that facilitates the information exchange within a network of facilities, community, state, or region (also referred to as Health Information Network or Organization HIN/HIO)

Three forms of exchange:

Directed Exchange: ability to send and receive secure information electronically between providers and individuals to support care

Query-based Exchange: ability for providers to find and/or request information on a patient from other providers, often used for unplanned care

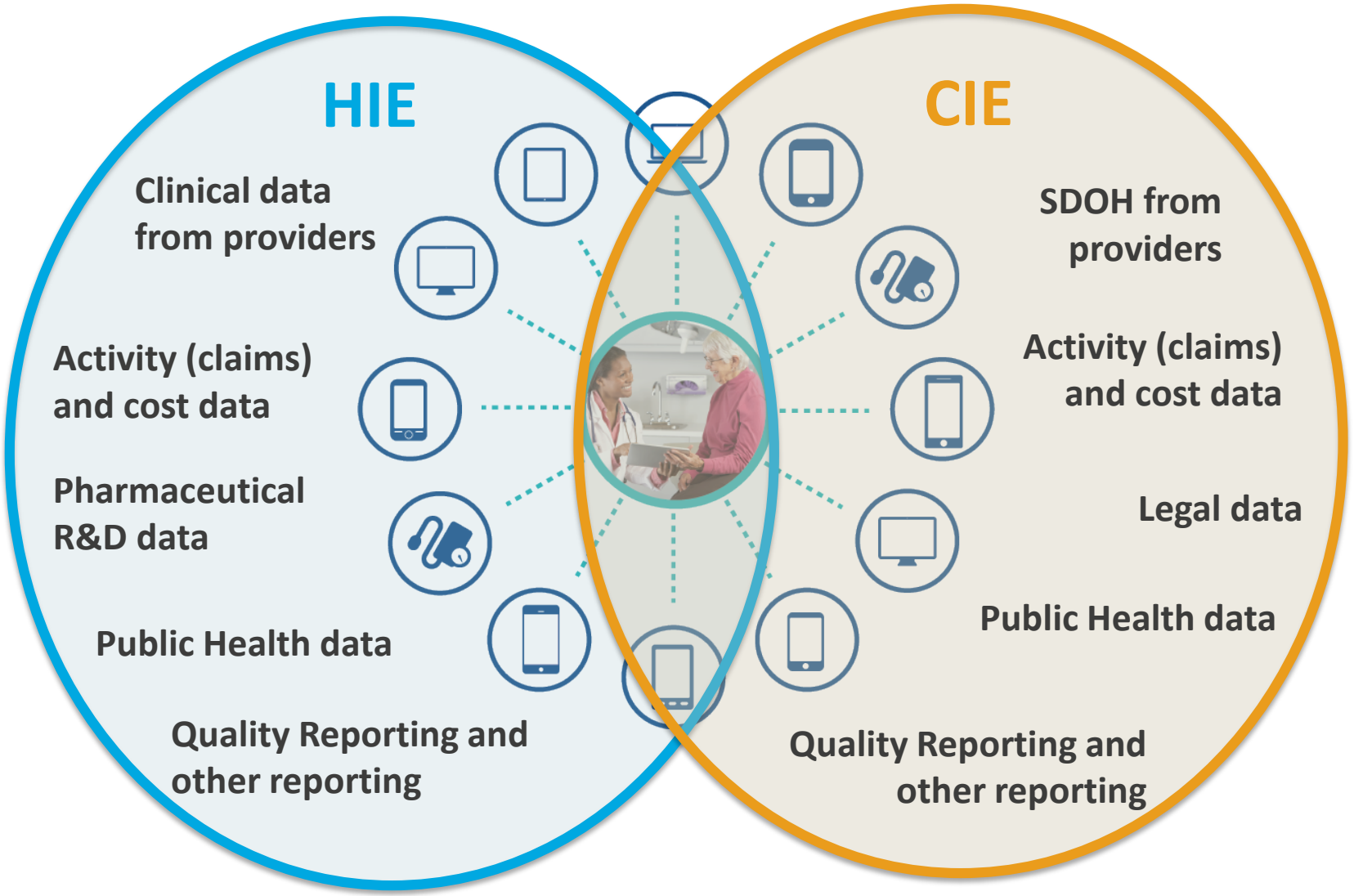
Consumer Mediated Exchange: ability for patients to aggregate and control the use of their health information among providers

What is Community Information Exchange (CIE) ?

AS A NOUN An ecosystem of multidisciplinary network partners that use and share data across non-clinical settings to deliver enhanced community care planning

http://ciesandiego.org/wp-content/uploads/2019/05/Driving-Collaboration-and-Cross-Sector-Data-Sharing-With-CIE.pdf

Why Types of Data are Shared?



Sources: https://www.himss.org/library/health-information-exchange/FAQ

Why is HIE/CIE Important for Medicaid?

If a state has coordination of care as a goal, HIE/CIE can help…

Facilitate effective care and treatment by multidisciplinary care team members

Reduce duplicative and redundant testing

Avoid costly mistakes associated with medical errors

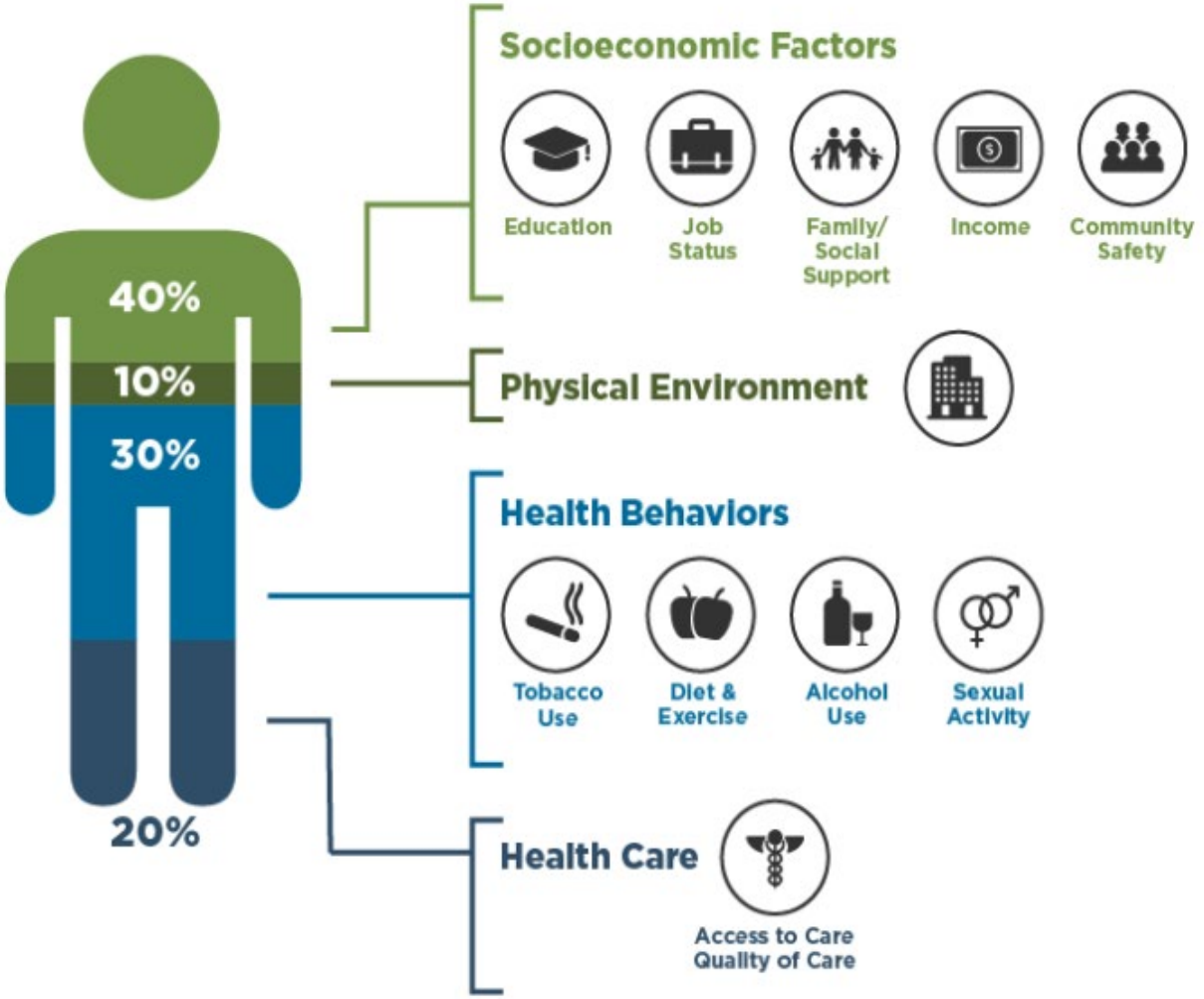
HIE/CIE is necessary to advance ONC & CMS Strategic Goals

- Patients over Paperwork
- Eliminating Opioid Overdoses and Misuse
- Interoperability—putting data in the hands of patients
- Tackling Information Blocking

Additional HIE Benefits available at: https://www.healthit.gov/topic/health-it-basics/hie-benefits

State Activities Related to SDOH Data Capture

What Goes Into Your Health?



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

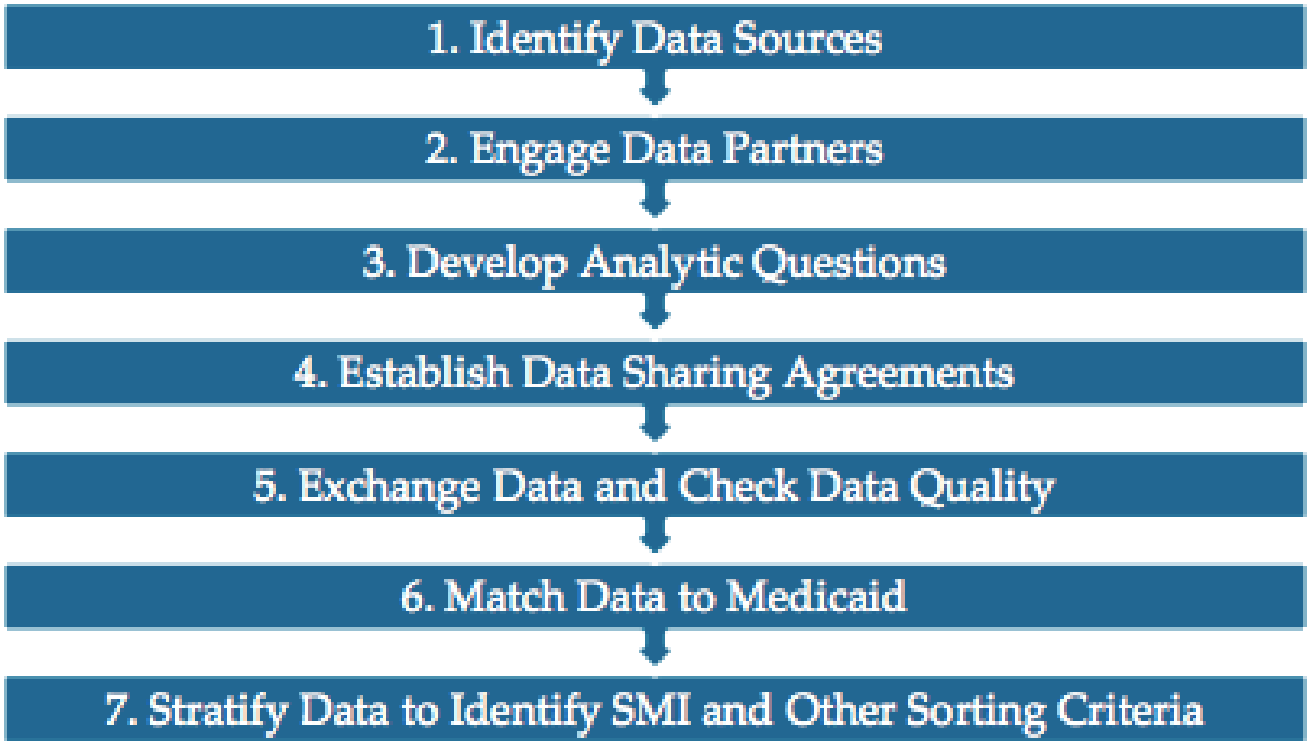
Adapted from The Bridgespan Group

Building the Business Case for SDOH Data

- Avoidable hospitalizations – business case
- Reduce emergency room visits – business case
- Improve management of chronic conditions – business case
- Reduce in behavioral health costs – business case
- Reduce in psychiatric hospitalizations – business case
- Quality measurement – operational
- Health and human service data exchange at time of transition – operational
- Shared savings across home and community-based service providers and clinical providers – payment model

Framework for Approaching Analysis

FIGURE D.1 – FRAMEWORK FOR APPROACHING ANALYSIS



Abbreviation: SMI, serious mental illness.

https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/program-areas/data-analytics-smi-2.pdf

States and SDOH Data

- Growing recognition that non-clinical factors influence health and outcomes
- SDOH strategies are flourishing under value based purchasing models
- States are in a unique position to identify and address social determinants
- SDOH data collection underpins efforts to address unmet needs, improve health outcomes, and lower costs
- States can institute policy changes to drive consistent collection and use of SDOH data

SDOH Domains of Interest to States

- Housing
- Family and social support
- Education and/or literacy
- Food security
- Employment
- Transportation
- Criminal justice involvement
- Intimate partner violence

The Office of the National Coordinator for Health Information Technology

Questions?

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Understanding Health IT, HIE and Interoperability within Section 1115(a) Demonstrations

Adam Goldman, CMS
Technical Director

Arun Natarajan, ONC
Sr. Program Analyst

Background

CMS in coordination with the Office of the National Coordinator for Health IT (ONC) has created Health IT toolkits focused on health information exchange, health IT, and interoperability for use in Medicaid program design.

- Health Home State Plan Amendment
- 1115 Demonstrations (general)
- SUD 1115 Demos
- SMI SPMI 1115 Demos
- HCBS Waivers

Health IT Plans in SUD Demonstrations: Primary Focus on PDMP Interoperability

In SUD HIT plans, each state describes its **ability to leverage Health IT**, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals. Key areas include:

1. Prescription Drug Monitoring Program (PDMP) Functionalities
2. Current and Future PDMP Query Capabilities
3. Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes
4. Master Patient Index / Identity Management
5. Overall Objective for Enhancing PDMP Functionality & Interoperability

Health IT Plans in SMI/SED Demonstrations: Primary Focus on Care Coordination

- Following acute care for withdrawal management, engaging in outpatient treatment within 14 days has been shown to reduce readmissions
  - But many (over 2/3rd of beneficiaries in 2008) do not receive any follow-up care – leading to increased risk of overdose
  - 2 of top 10 reasons for Medicaid hospital readmissions are SUD-related
- Lack of availability of providers – widespread shortage
  - 40% of US counties did not have a single outpatient SUD treatment provider that accepted Medicaid in 2009
- People with SUDs often have serious co-morbid conditions
  - Most spending on individuals with SUDs is on treatment for co-morbid physical conditions
  - At least one state found significant reductions in medical costs for benes receiving SUD treatment

Questions

Additional Information

- Health IT, HIE and Interoperability within Section 1115(a) Demonstrations: https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html

- The SUD SMD Letter is posted here: https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf

- The SUD SMD Letter is posted here: https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf

For more about Health IT and section 1115(a) demonstrations, please contact Adam.Goldman@cms.hhs.gov and/or Arun.Natarajan@hhs.gov

What is the Administration for Community Living?

The Administration for Community Living (ACL) is committed to one fundamental principle—that people with disabilities and older adults should be able to live where they choose, with the people they choose, and fully participate in their communities. In working toward that vision, the ACL oversees and administers programs and activities that support older adults, persons with disabilities, and family caregivers across the lifespan.

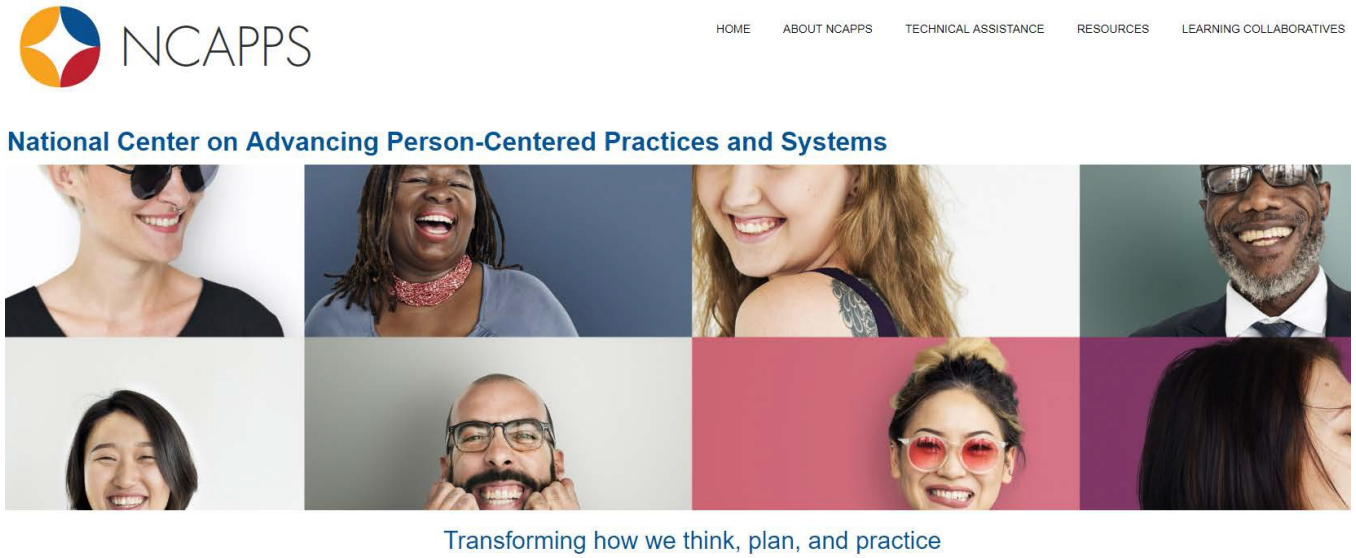
- Programs for Older Adults
- Programs for People with Disabilities
- Combined Aging and Disability Programs
- Research Initiatives

What is the Administration for Community Living?

Programs for Older Adults	Programs for People with Disabilities	Combined Aging and Disability Programs	Research Initiatives
• 56 State Units on Aging • 56 Long Term Care Ombudsman Programs • 629 Area Agencies on Aging • 239 Tribal organizations • 2 Native Hawaiian organizations • 29,000 local service providers • Elder Rights Services • Health Prevention and Wellness Programs • National Clearinghouse for Long-Term Care Information • National Family Caregiver Support • Nutrition Services • Support Services	• 56 State Councils on Developmental Disabilities • 68 University Centers for Excellence in Developmental Disabilities • 57 Protection and Advocacy programs • 54 State Independent Living Councils • 354+ Centers for Independent Living • 56 Statewide Assistive Technology Programs • Help America Vote Act • Paralysis Resource Center • Limb Loss Resource Center • Traumatic Brain Injury Program	• Aging and Disability Resource Centers/No Wrong Door Systems • Evidence Based Care Transitions • Veterans Directed Home and Community Based Services • Business Acumen for Community Based Organizations • Policy Analysis and Development • Duals Demonstration Ombudsman • State Health Insurance Assistance Program • Senior Medicare Patrol • Medicare Improvements for Patients and Providers	• Disability and Rehabilitation Research • Rehabilitation Research and Training Centers • Rehabilitation Engineering Research Centers • Research Fellowship Program • Field Initiated Program • Model Spinal Cord Injury Systems • Advanced Rehabilitation Research and Training Program • Small Business Innovation Research Program • Disability Business and Technical Assistance Centers

Our Website

ncapps.acl.gov



National Center for Advancing Person-Centered Practices and Systems (NCAPPS)

- Central clearinghouse for all stakeholders to access useful information through a centralized website.
- Provide effective TA to states on the full spectrum of needs related to implementing person-centered thinking, planning, and practices in their systems
- Assist states in creating the organizational culture, processes, payment incentives, policy, and practices at all levels of state systems to support Person-centered planning.
- Support state-to-state E-Learning collaboratives to facilitate the development and sharing of best practices across state systems.

National Quality Forum: Person-Centered Planning Project

- Refine the current definition(s) for PCP;
- Develop a set of core competencies for performing PCP facilitation;
- Make recommendations to HHS on systems characteristics that support person-centered thinking, planning, and practice;
- Develop a conceptual framework for PCP measurement; and
- Conduct an environmental scan including the historical development of person-centered planning in LTSS systems to include a research agenda for future PCP research
- http://www.qualityforum.org/ProjectMaterials.aspx?projectID=89422

The Office of the National Coordinator for Health Information Technology

electronic Long-Term Services & Supports (eLTSS) Project Overview

August 22, 2019
Security Risk Solutions, Inc.

eLTSS is a joint project of The Centers for Medicare & Medicaid Services (CMS), The Office of the National Coordinator (ONC), the Testing Experience and Functional Tools (TEFT) Grantee states (CO, CT, GA, KY, MD, MN), and eLTSS community participants made possible by CMS funding.

Agenda

- The Need for Interoperability in Long Term Services and Support (LTSS)
- eLTSS Project Overview
  - Phases
  - Current Activity
- eLTSS Links and Resources
- eLTSS Project Leads

The Need for Interoperability in Long Term Services and Support (LTSS)

- Especially for older adults, there is a significant overlap between primary/acute care and LTSS:
  - Hospitalization (example: broken hip) -> post-acute rehabilitation -> personal care and chore services
- Fractured eligibility & payment systems, particularly Medicare and Medicaid, can lead to disconnects between settings of care, treatment goals, and desired health/social outcomes
- Interoperable systems have the promise of improving coordination and keeping LTSS person-centered

eLTSS Project Overview: Phases

- Phase 1: Identified and harmonized a set of data items commonly found on LTSS Service Plans to facilitate the capture and exchange of person-centered LTSS service plan data
- Phase 2: Piloted data items with TEFT grantee states and vendors to validate the dataset
- Phase 3: Continuation of Phase 1 & Phase 2 broken into two Tracks
  - Track 1: Informative Document
    - Balloted and published through HL7, the eLTSS Informative Document describes how the eLTSS dataset, consisting of 56 data elements, enables home and community-based services (HCBS) person-centered service plans to be represented for exchange and sharing using FHIR and C-CDA
  - Track 2: FHIR Implementation Guide (IG) and Testing
    - The eLTSS FHIR IG expands the FHIR to eLTSS mapping from the Informative Document into the HL7 FHIR IG structure (Profiles, Extensions, Capability Statements, etc.). IG content will be tested and piloted in coordination with interested organizations

eLTSS Project Overview: Current Activity

- The mappings published in the eLTSS Informative Document were formalized into an eLTSS Standard for Trial Use (STU) FHIR IG.
- The eLTSS FHIR IG:
  - Uses existing FHIR resources to provide mappings between the eLTSS data set and existing FHIR elements
  - Utilizes US Core and applies other constraints (mostly through the "Must Support" flag)
- The May 2019 HL7 Ballot Cycle approved the STU eLTSS FHIR IG
- The eLTSS Project team via the HL7 CBCP WG has reconciled the ballot comments and updated the IG accordingly. The IG in now advancing through the HL7 publication process
- Planning is underway to test the eLTSS IG at HL7's September Connectathon. Test participants include Altarum, LTCI, and FEI Systems
- The eLTSS Project team is interested in developing relationships with organizations to explore future piloting opportunities

eLTSS Links and Resources

- eLTSS Informative Document, balloted by HL7: http://www.hl7.org/implement/standards/product_brief.cfm?product_id=495
- eLTSS FHIR IG (May 2019 ballot version): http://hl7.org/fhir/us/eltss/2019May/index.html
- eLTSS FHIR IG Build Site (version being advanced for publication) http://build.fhir.org/ig/HL7/eLTSS/index.html
- eLTSS Page on ONC Techlab: https://oncprojectracking.healthit.gov/wiki/display/TechLabSC/eLTSS+Home

eLTSS Project Leads

- ONC Project Leads
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  - Elizabeth Palena-Hall (elizabeth.palenahall@hhs.gov)
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  - Becky Angeles (becky.angeles@carradora.com)

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Thank you for joining!

@ONC_HealthIT @HHSONC HealthIT.gov

The Office of the National Coordinator for Health Information Technology

Missouri's Value-Based Payment Model to Improve Intellectually and Developmentally Disabled Beneficiary Outcomes

Krissy Celentano, EMI Advisors, ONC contractor

Acknowledgements

Val Hunh, Division Director, Missouri Department of Mental Health, Division of Developmental Disabilities

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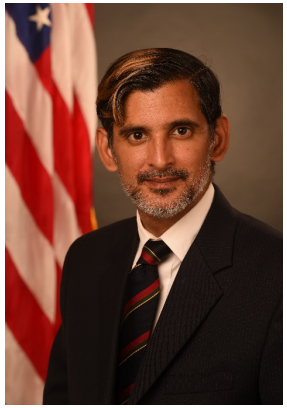
Angela Brenner, Director of Federal Programs, Missouri Department of Mental Health, Division of Developmental Disabilities

Donna Siebeneck, Director of Medicaid and Reimbursements, Missouri Department of Mental Health, Division of Developmental Disabilities



Arun Natarajan, Senior Policy Analyst, ONC

Approach to Developing MO's VBP Roadmap

1. Establish policy objectives
   - Develop aim statement
   - Develop a driver diagram
   - Develop a technical support plan
2. Engage stakeholders
3. Develop a VBP strategy measurement system
   - Select HCBS outcomes/quality measures
   - Determine accountable entities
   - Identify target population and population attribution methods
4. Collect and analyze baseline data
5. Develop the financial model
6. Measure performance
7. Monitor and make adjustments

Alison: 22 Years Old, Multiple Quarters on the High Risk List

- Female who loves her Curious George doll, shopping and eating out
- Placed in children's division custody at age 9
- History of in patient psychiatric services since she was 16 – self harm, property destruction, elopement and aggression
- Current placement since 2011 with multiple hospitalizations and ER visits
- Has behavior analyst services and support plan, has been reviewed by the Regional Behavior Support Committee
- Has two to one staffing since 2016 and multiple psychotropic medications, restrictions in plan include locking the yard gate when she gets upset, plexi glass enclosure for T.V.
- Needs prompts and reminders to plan for and complete daily tasks
- Goes to day program to learn skills towards independence in the community

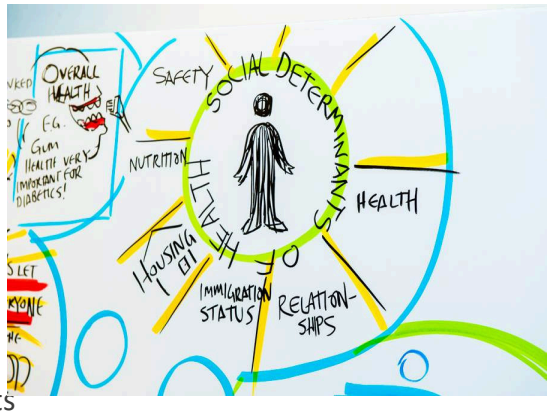
Model For Sharing State Data Across MO Agencies

Multi-Sector Data Drives Improved Outcomes

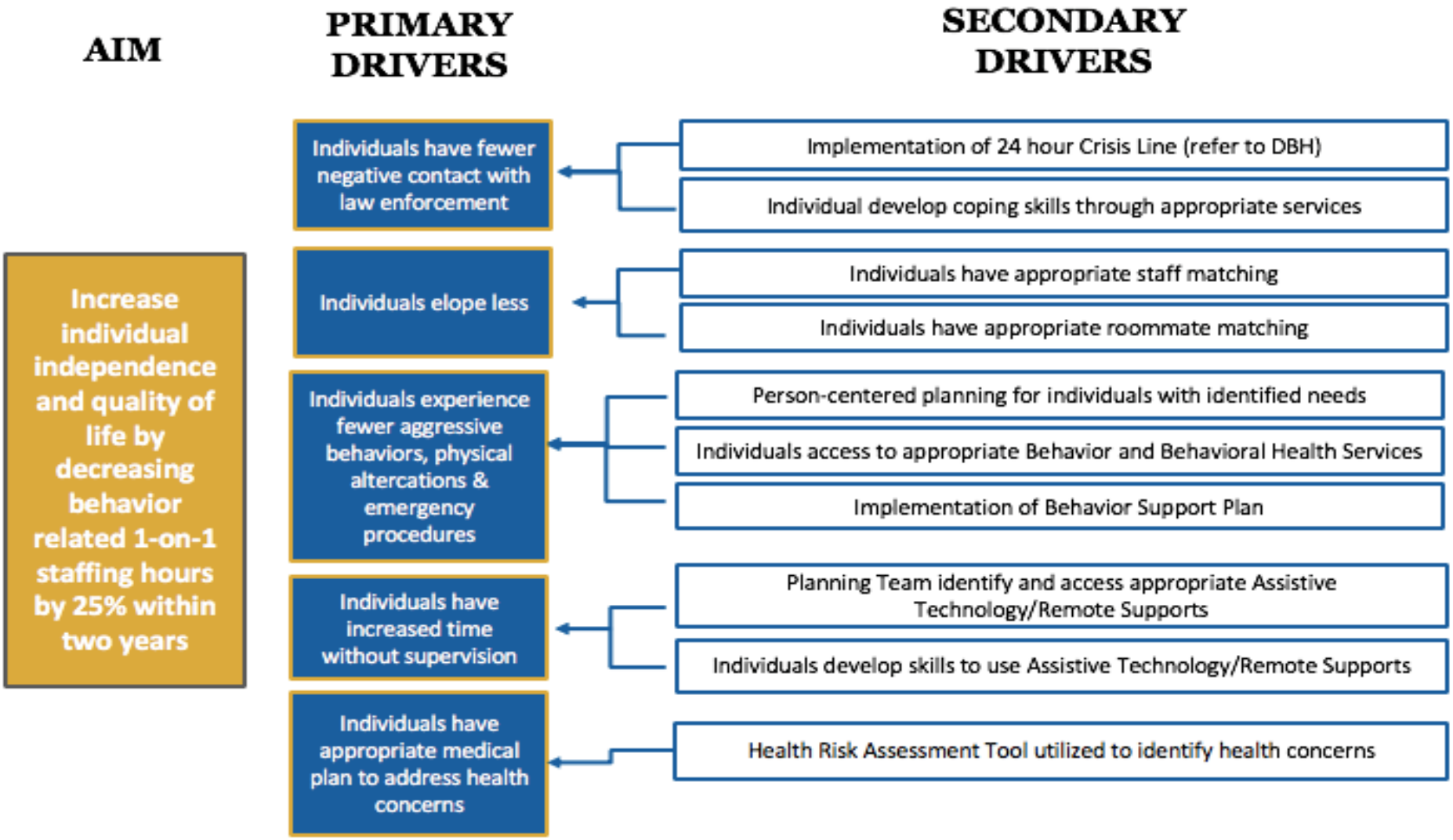
Integrate Medicaid claims (including ER and hospitalization), case management, and staffing authorizations and billing data

Increase independence by decreasing 1:1 staffing and decreasing hospitalization/ER utilization

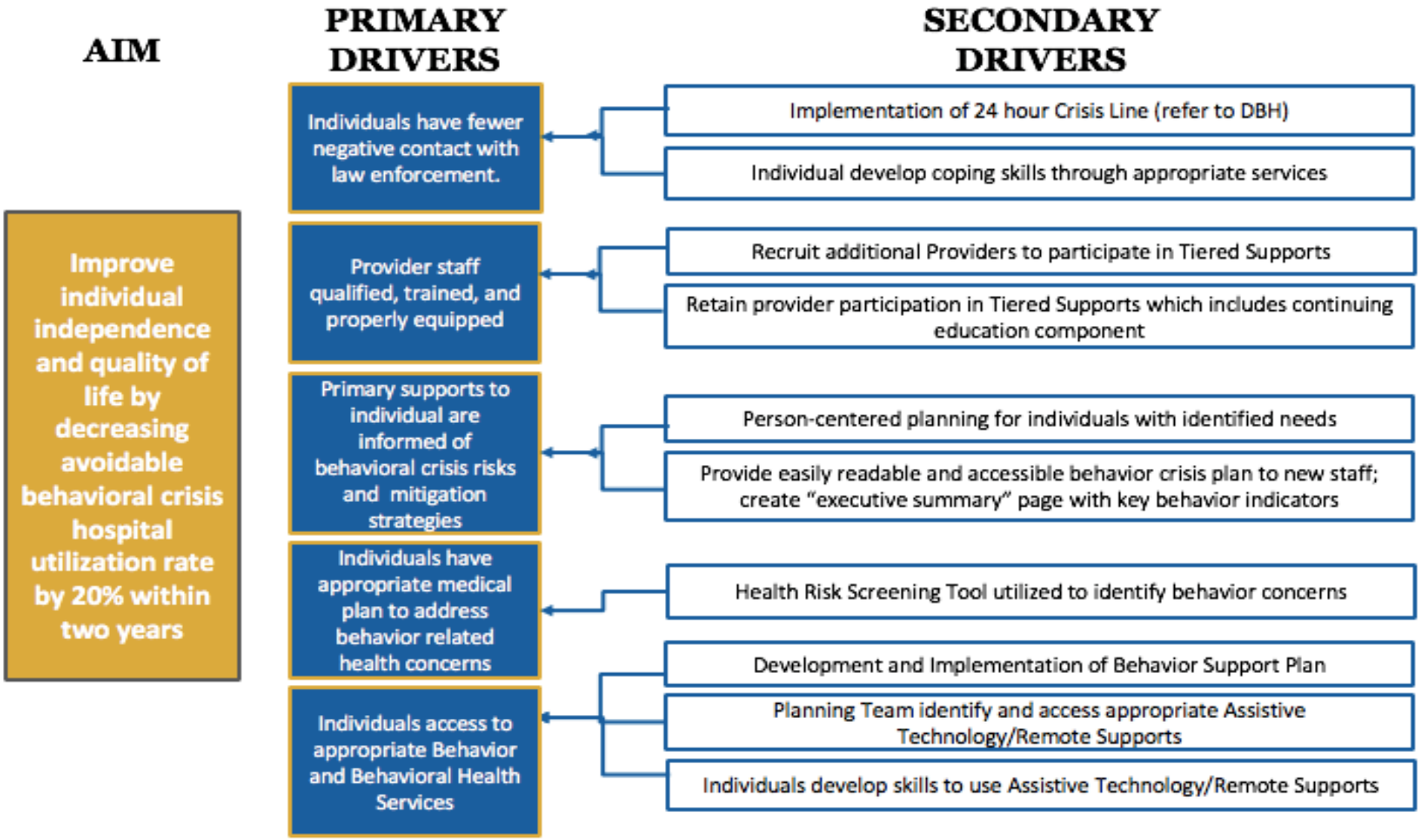
Improve I/DD beneficiary outcomes and decrease costs



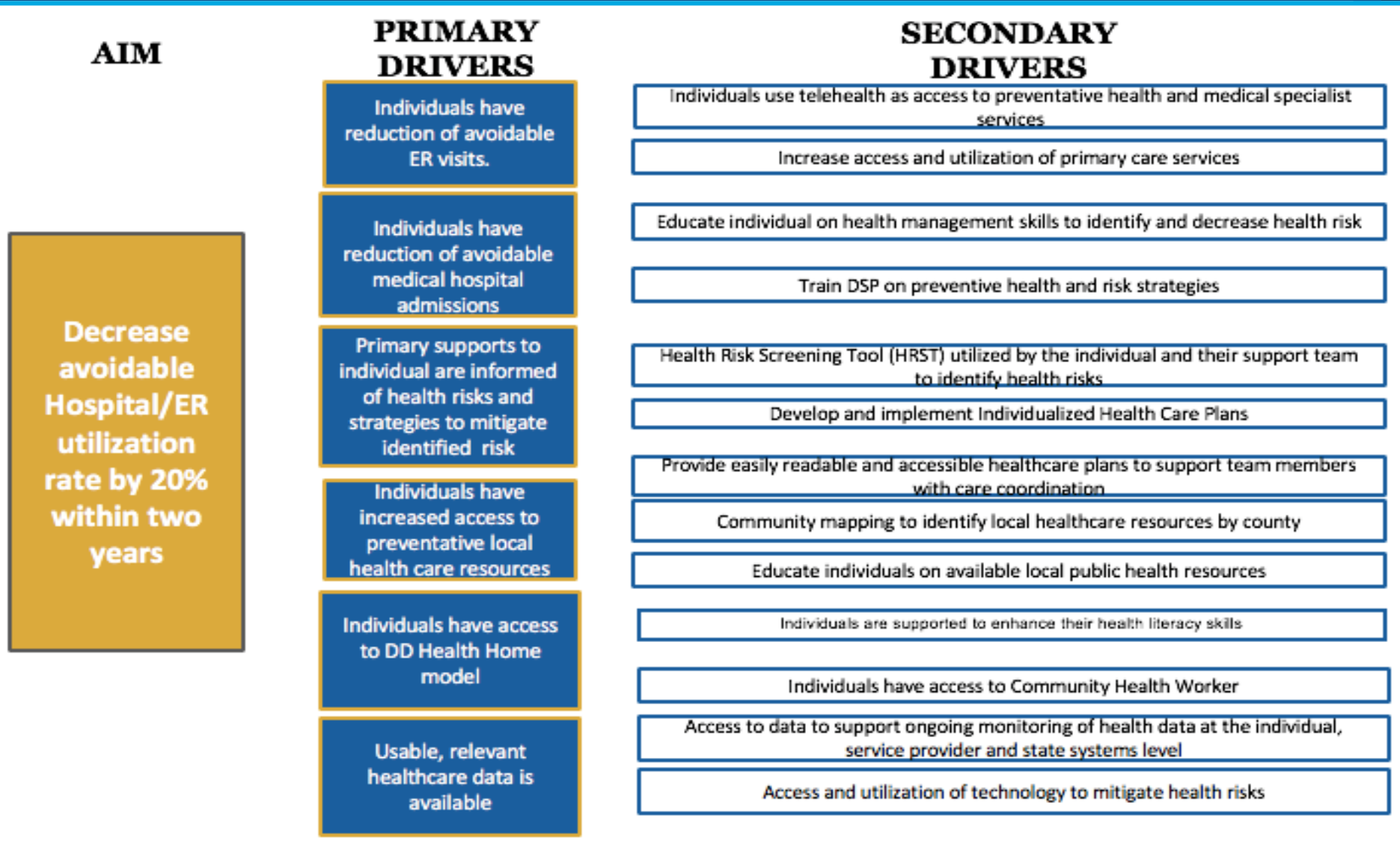
Behavioral Health Use Case Driver Diagram



Crisis Hospitalization Use Case Driver Diagram



Medical Utilization Use Case Driver Diagram



Summary of What is Needed

- **Effective governance and decision making:** Requires all state agencies buy-in and support to make a 2021 VBP model achievable. Also requires education and buy-in of providers for the goals of the VBP model.
- **Health IT and technical capabilities:** Requires ADT notifications to the state, enhanced capacity to CIMOR, and HIE support and coordination.
- **Key challenges:** Enhanced CIMOR functionality needed, legal constraints on sharing ADT notifications with providers through a state portal and associated costs. HIEs not effectively coordinating.

The Office of the National Coordinator for Health Information Technology

Thank You

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Washington State Health Care Authority

ONC's 3rd Interoperability Forum
August 21-22, 2019

Washington State

Health Care Authority

Health IT Section

Jennie Harvell

Agenda

Washington State

- Medicaid Transformation Program: Health IT Requirements
  - Strategic Roadmap
  - Operational Plan
- SUD IMD Waiver: Health IT Requirements
- MH IMD Waiver: Health IT Requirements

Washington State Health Care Authority

Washington State Medicaid Transformation Program Health IT Plan

Medicaid Transformation Program

- 2018 Washington State began implementing the Medicaid Transformation Program (MTP), a five-year agreement between the Health Care Authority (HCA) and the Centers for Medicare & Medicaid Services (CMS) to invest in and transform healthcare at the regional level

- Nine Accountable Communities of Health (ACHs) are pursuing transformation projects focused on three domains:

  - Domain 1 — Health systems capacity building
  - Domain 2 — Care delivery redesign
  - Domain 3 — Prevention and health promotion

Washington State Health Care Authority

MTP HIT Activities

- MTP requires the use of Health Information Technology (Health IT) to:
  - Coordinate and align Health IT activities currently underway
  - Link services and core providers across the continuum of care to the greatest extent possible

- HCA coordinates Health IT activities with ACHs, Managed Care Organizations (MCOs), Providers, State Agencies, Tribal Governments, and Justice System

- The MTP requires that Health IT activities be coordinated through an:
  - Health IT Roadmap; and
  - Operational Plan

Health IT Strategic Roadmap and Operational Plan

- Health IT Strategic Roadmap and HIT Operational Plan identify the vision, broad activities, tasks, and timelines to advance the use of interoperable Health IT and health information exchange to support the MTP

- Strategic Roadmap submitted to CMS September 1, 2017

- Health IT Operational Plan is an annual document.

Washington State Health Care Authority

2019 HIT Operational Plan Topic Areas

Data and Governance	Master Person Index	Provider Directory
Payment Models and Sources	Health Information Exchange functionality, including enhancing the Clinical Data Repository (CDR)	Increase Clients In and Users of the CDR
Increase functionality of and uses of the CDR (e.g., reports, query capability)	Develop standardized tools and templates (e.g., discharge plan, care plans, SDOH)	Behavioral Health Integration
Substance Use Disorder (SUD) HIT (e.g., eConsent Management)	Tribal Engagement	Increase Use of Registries
EHR Incentive Program	Closed loop referral and Population Health Management	
Each topic area includes Tasks. HCA coordinates with other participants in the execution of Tasks.		

SUD IMD Waiver: Health IT Plan

SUD IMD Waiver

- July 2018 Washington State was granted an 1115 waiver amendment to its MTP for SUD IMD facilities
- This IMD Waiver permits Medicaid coverage of SUD services in IMDs
- The MTP/ SUD IMD Waiver requires:
  - reporting milestones; and
  - SUD HIT Plan
- HCA modified the MTP Health IT Operational Plan to include the SUD HIT Plan requirements

SUD IMD Waiver HIT Plan

- SUD IMD HIT Plan identifies tasks to achieve activities identified by CMS
- HCA added Financial Mapping Task and made all other Tasks contingent on funding

SUD HIT Plan Tasks	
Conduct Financial Mapping	Provide reports on clinician long-term opioid prescribing patterns
Establish agreements for interstate data sharing through a PDMP	Convene clinical EMR users to describe desired workflow for accessing the PDMP via the CDR
Support the "ease of use" of the PDMP	Develop a function to allow providers within the CDR clinical portal to access the DOH-operated PDMP
Enhanced connectivity between the state's PDMP and HIE-organizations	Work with the HHS multi-agency Enterprise Governance process (e.g., HCA, DoH, DSHS, DCYF, HBE) on: • master patient index (MPI) strategy for PDMP query • Patient/provider matching

- Significant overlap in the SUD IMD Waiver HIT Plan and the "Qualified PDMP" in Section 5042 of the SUPPORT Act

SUPPORT/Partnership Act: Section 5042

- Section 5042 of the SUPPORT/Partnerhship Act:
  - Requires States to implement a “Qualified PDMP” by October 1, 2021
  - Makes available 100% FMAP from 10/2018 to 9/2020 to States to design, develop, or implement enhancements for a Qualified PDMP if the State has agreements with all contiguous states to enable covered providers in all such contiguous States to access certain information through the PDMP

Qualified PDMP – Funding Request

- HCA, in collaboration with the DoH, submitted a funding request to CMS to access the 100% federal funds for:
  - a PDMP solution
  - technical assistance to assist providers with integrating PDMP data into the workflow of their EHR systems
  - interoperable HIT to support the integration of the PDMP and CDR:
    - electronic consent management,
    - availability of additional clinical data sources, and
    - reporting for clinical and case management.

- CMS approved HCA's request for 100% FMAP for Section 5042

MH IMD Waiver: Health IT Plan

MH IMD Waiver

- Washington State is applying for an 1115 waiver amendment to its MTP for MH IMD facilities
- This IMD Waiver permits Medicaid coverage of MH services in IMDs
- The MTP/ MH IMD Waiver requires:
  - reporting milestones; and
  - MH HIT Plan

MH IMD Waiver / HIT Plan

- CMS requires the following assurances and tasks in the HIT Plan:

Assurances:

1. **The state has (or will have) sufficient health IT infrastructure at every appropriate level (i.e., state, delivery system, MCO and provider level) to achieve demonstration goals.**
2. **The state commits to aligning its HIT Plans.**
3. **The state commits to assess the applicability and inclusion of certain national standards in MMCO contracts, including at a minimum, standards for: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management**

MH Waiver HIT Plan	
Closed Loop Referrals and e-Referrals	Telehealth to integrate MH and primary care
Create and use Electronic Care Plans	Analytics
Medical Records Transition	Technology for care coordination
E-consent	Identity Management
Interoperable Intake, Assessment, and Screening tools	

Washington State Health Care Authority

Questions?

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Washington State Health Care Authority

HCA HIT Resources

Health IT Strategic Roadmap, Operational Plans, and other materials available at the HCA/HIT website:

https://www.hca.wa.gov/about-hca/health-information-technology/washington-state-medicaid-hit-plan

Achieving Interoperability for Our Providers and Patients:

Bridging the Divide Between Physical, Behavioral, LTSS and Social Service Providers

Government of the District of Columbia, Department of Health Care Finance Discussion

ONC Interoperability Forum

August 22, 2019

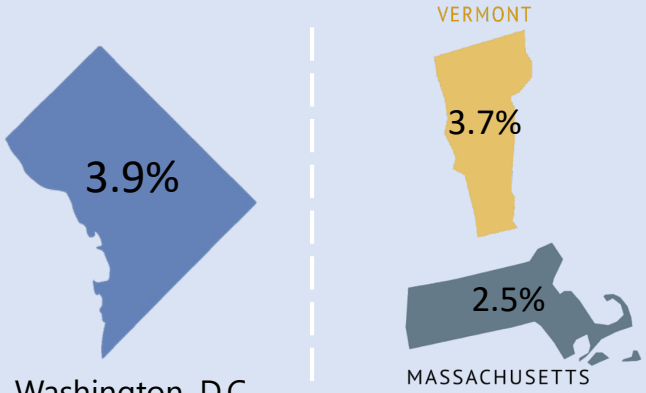
A Brief Tour of Current Efforts to Promote Interoperability in the District

- Medicaid is the Largest Payer of Health Services in the District
- The District's is Aligning Stakeholder-engaged VBP with Health IT Investments
- Ongoing efforts to integrate all domains of health information for District Residents
  - Physical
  - LTSS
  - Behavioral
  - SDOH

DC Medicaid by the Numbers

Near Universal Coverage

DC has the third lowest uninsured rate

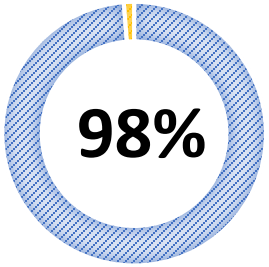


DC Medicaid covers approximately 260,000 individuals

4 out of 10 District residents

7 out of 10 Children

DC Health Care Alliance provides insurance to **15,000 residents** who are not eligible for Medicaid



Of all eligible DC children are enrolled in Medicaid (highest rate in the US)

DC Medicaid has a **$3 billion annual budget**, most of which is spent on payments to providers (like doctors, hospitals, etc.)

70% FFP "Match"

94% Annual budget spent on provider payments

Despite High Coverage Rates & Services, Health Challenges Persist

Life expectancy is highly variable across the District.

- 17-year difference in lifespan: Ward 3 (86 years) and Ward 8 (69 years)

One in ten births is preterm.

- The percentage of live preterm births decreased from 2006 to 2016 for all wards, but has remained around 10% District-wide since 2009.
- ~1/3 of preterm births in the District occur among women who have previously experienced a preterm birth.

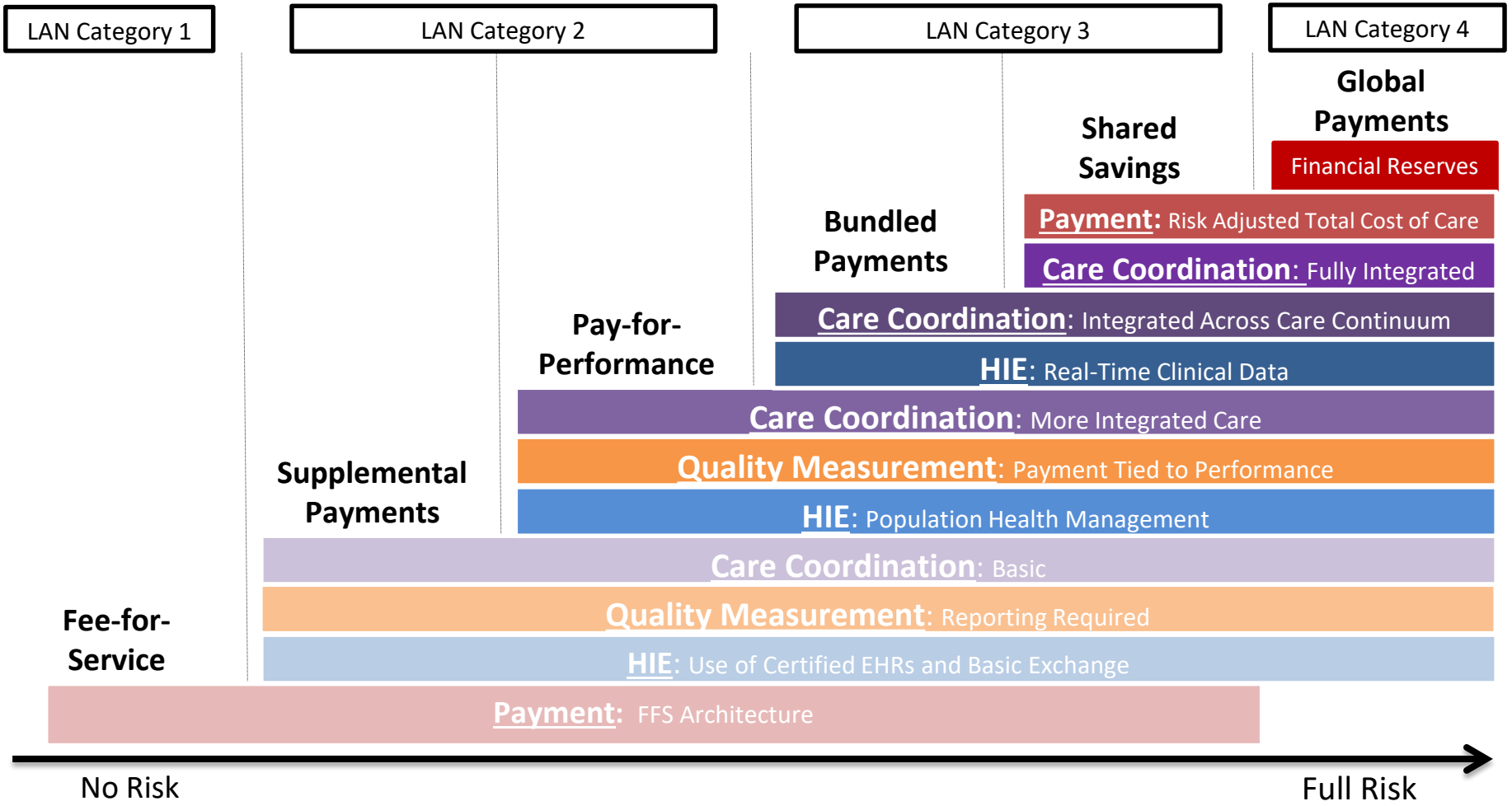
Avoidable and Preventable Conditions

- 12th highest 911 call-volume in the country. Hospital emergency departments have very high rates of ambulatory care sensitive conditions (ACSs).
- In Wards 7 and 8, 20% of hospital discharges and 21% of ED visits are for ACS conditions.

Inappropriate Use of Acute Care

- ~10% of District residents report they delayed medical care due to not being able to get an appointment soon enough.
- Ward 1 residents report the most challenges (~14%).

Steps Towards Managing Population Health

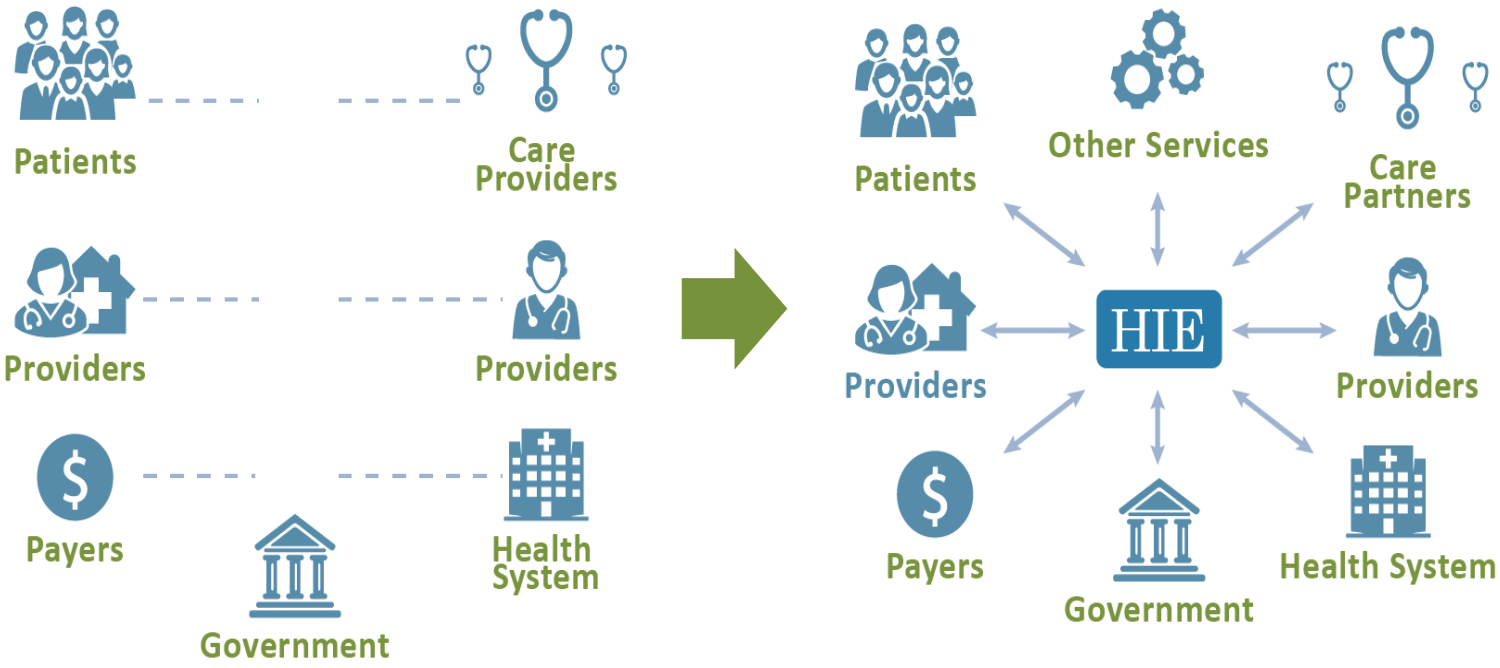


* Alternative Payment Model (APM) categories are based on the 2017 Update to the Health Care Payment Learning and Action Network Framework. (LAN). In essence, category 1 is fee for service (FFS) with no link to quality; category 2 is FFS with a link to quality such as pay for reporting or a bonus payment for quality outcomes; category 3 is an an APM built on a fee for service architecture (e.g. shared savings, or shared savings with downside risk; and category 4 is population-based payment for populations or conditions.

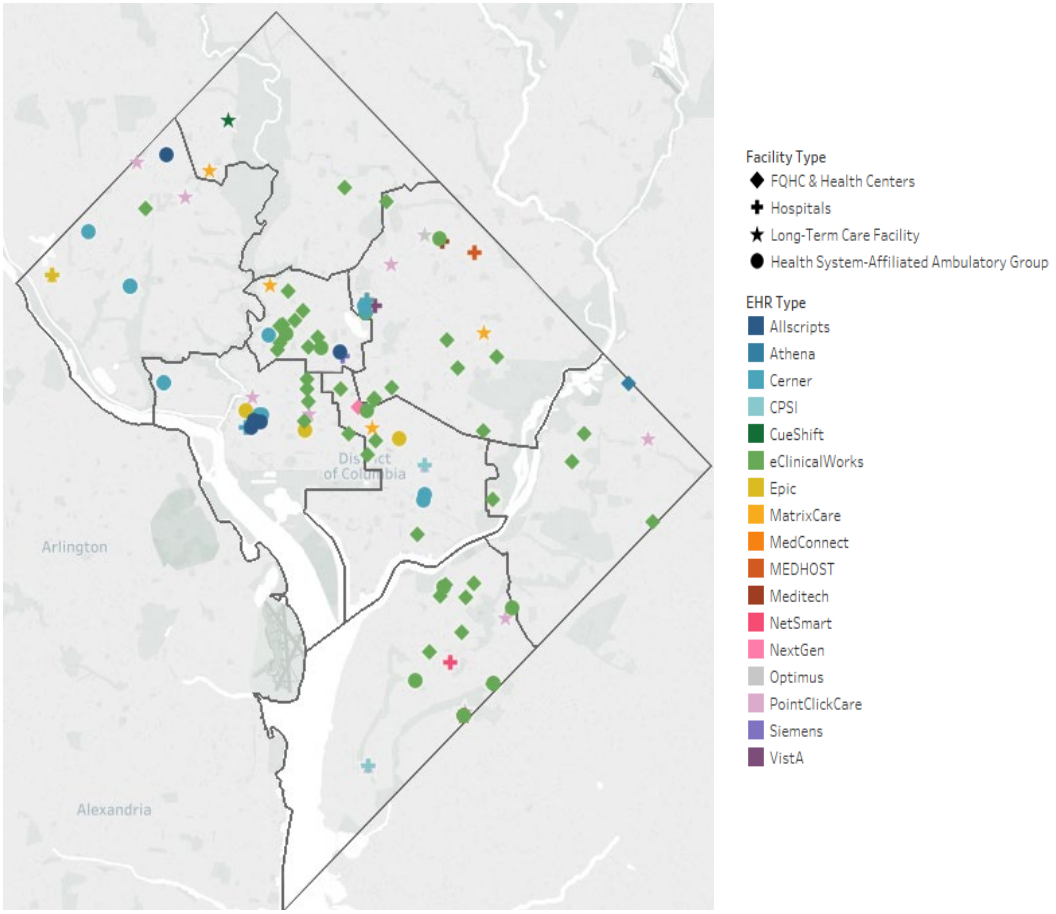
Source: Edmunds, Hass, Holve (eds.),*Consumer Informatics and Digital Health*
https://www.springer.com/us/book/9783319969046

The District's State Medicaid Health IT Plan is the Roadmap for Connecting a Disconnected Health System

HIE tools can connect health system partners and give providers *the right information at the right time in the right place*.



Vast Majority of District Providers (89%) Have Technology to Enable Information Exchange…



**No dominant EMR, suggesting HIE is important to resolve current challenges

…connecting patients with their providers

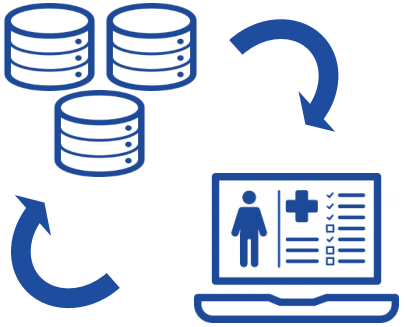
…ensuring providers communicate and refer to other providers electronically

…reduce the time payers spend chasing medical records using fax and phone

The DC HIE's Five Core HIE Capabilities for Providers

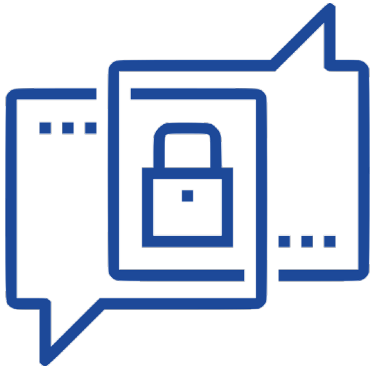
Clinical Patient Lookup

Electronic Clinical Quality Measures (eCQM) Calculation and Review



Specialized Registry Submission through EHRs

Advanced Analytics for Population Health Management



Simple and Secure Digital Communications Among Providers

IAP VBP Engagement with ONC – Helping DC Use All our Policy Levers

- The Problem: LTSS have historically operated in information siloes, resulting in opportunities to improve care coordination and transitions
  - New electronic case management system is big improvement, but not integrated with broader system

- IAP allowing DHCF to narrow down solutions
  - Create personas and real-life use cases
  - Understand how providers use information everyday
  - Expand access to person-centered care plans
  - Utilize HIE as the backbone for provider communication citywide

District Efforts to Align Infrastructure and Incentives for Health IT and HIE in LTSS

- 100% of Nursing Facilities have an EHR and accessing information from the HIE
  - DC Nursing Facility Quality program offered incentives for HIE connectivity.
- LTSS is a priority for new 3-year grant to assist Medicaid providers to access and send data via HIE
- DSNP contracts incentivize participation in the DC HIE

- DHCF's LTC Administration getting connected to CRISP DC tools for quality improvement projects
- Utilizing ONC T/A to integrate DC's electronic case management system with HIE

DC's Joint 1115 SUD and SMI/SED Demonstration Waiver: Health IT Implementation Plans for Integrated Care

- SUD HIT Plan focused on PDMP
  - Developed with DC Health
  - July 2019: All District providers must use the PDMP
  - Planned integration with EHRs in the District
- SMI/SED HIT Plan envisions a sophisticated future state, including:
  - Closed loop referrals
  - Comprehensive care plans
  - e-Consent
  - Interoperability of data assessment
  - Telehealth
  - Alerting/Analytics
  - Identity management

SMI/SED HIT Plan Reflects Ongoing HIT Projects that will Support Demonstration's Success

- *HIE Connectivity Grant:* Will facilitate St. Elizabeth's connection to CRISP DC
- *DCHA E-Referral Grant:* DHCF grant will promote "eReferral" and discharge planning improvements
- *DCPCA TA Contract:* DHCF technical assistance contract to support Health IT adoption and meaningful use
- *DC Mental Health Information Act Policy Work:* Ongoing DHCF policy work to broaden exchange of mental health information consistent with updates to the DC Mental Health Information Act
- *CoRIE Project:* Community Resource Information Exchange project focused on social needs

MAP Summit - Largest District Cross-sector Convening on SDOH

Nearly 20 SDOH Domains Collected in the District

1. Access to Technology
2. Adverse Childhood Events (ACEs)
3. Demographics (Race, Ethnicity, Language)
4. Education (graduation, absenteeism)
5. Employment
6. Food Insecurity
7. Health Literacy
8. Housing
9. Income
10. Information to Support Trauma-care
11. Intimate Partner Violence
12. Material Resources
13. Mental Health
14. Patient Activation
15. Public Benefits
16. Resilience
17. Social Isolation/Social Inclusion
18. Substance Use
19. Transportation

Two Grants Comprise the Community Resource Information Exchange (CoRIE) Project

Phase 1: CRI

*Community Resource Inventory Needs Assessment and Design Grant**

- Develop **Standardized Screening Tool**
- Design and Develop **Community Resource Inventory**
- Gather Technical Requirements for **Community Resource Information Exchange Technical Solution**

Phase 2: CoRIE

Community Resource Information Exchange Technical Solution Development Grant (HITECH Funds)

Develop and Implement **Community Resource Information Exchange Technical Solution with the following possible capabilities:**

- Implement **Standardized Screening Tool** to address individual or family social needs
- **Utility to exchange screening results** with other providers
- Utilize **Community Resource Inventory**
- **Referral Function** allowing providers to make referrals to social service providers
- **Close-Loop Function** allowing referring providers to be notified patient has seen referred provider

*Also known as the CoRIE Planning Initiative

DHCF Contact Information and Resources

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State Medicaid Health IT Plan (SMHP) and Roadmap
https://dhcf.dc.gov/hitroadmap