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
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.

Why Types of Data are Shared?

**HIE**
- Clinical data from providers
- Activity (claims) and cost data
- Pharmaceutical R&D data
- Public Health data
- Quality Reporting and other reporting

**CIE**
- SDOH from providers
- Activity (claims) and cost data
- Legal data
- Public Health data
- Quality Reporting and other reporting

Sources: [https://www.himss.org/library/health-information-exchange/FAQ](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](https://www.healthit.gov/topic/health-it-basics/hie-benefits)
State Activities Related to SDOH Data Capture
What Goes Into Your Health?

Socioeconomic Factors
- Education
- Job Status
- Family/Social Support
- Income
- Community Safety

Physical Environment

Health Behaviors
- Tobacco Use
- Diet & Exercise
- Alcohol Use
- Sexual Activity

Health Care
- Access to Care
- Quality of Care

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

![Diagram showing a flowchart for data analysis steps]

1. Identify Data Sources
2. Engage Data Partners
3. Develop Analytic Questions
4. Establish Data Sharing Agreements
5. Exchange Data and Check Data Quality
6. Match Data to Medicaid
7. Stratify Data to Identify SMI and Other Sorting Criteria

Abbreviation: SMI, serious mental illness.

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
Questions?

Arun Natarajan: Arun.Natarajan@hhs.gov

Evelyn Gallego: Evelyn.Gallego@emiadvisors.net
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
  o But many (over 2/3rd of beneficiaries in 2008) do not receive any follow-up care – leading to increased risk of overdose
  o 2 of top 10 reasons for Medicaid hospital readmissions are SUD-related
• Lack of availability of providers – widespread shortage
  o 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
  o Most spending on individuals with SUDs is on treatment for co-morbid physical conditions
  o At least one state found significant reductions in medical costs for benes receiving SUD treatment
Questions
Additional Information


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?

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

25
National Center on Advancing Person-Centered Practices and Systems

Transforming how we think, plan, and practice
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
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:

- eLTSS FHIR IG (May 2019 ballot version):

- 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://oncprojecttracking.healthit.gov/wiki/display/TechLabSC/eLTSS+Home
eLTSS Project Leads

- **ONC Project Leads**
  - Stacy Perchem ([Anastasia.perchem@hhs.gov](mailto:Anastasia.perchem@hhs.gov))
  - Elizabeth Palena-Hall ([elizabeth.palenahall@hhs.gov](mailto:elizabeth.palenahall@hhs.gov))

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

- **Program Manager**
  - Johnathan Coleman ([jc@securityrs.com](mailto:jc@securityrs.com))

- **Project Manager**
  - Amber Patel ([ayp@securityrs.com](mailto:ayp@securityrs.com))
  - Greg White ([gw@securityrs.com](mailto:gw@securityrs.com))

- **Subject Matter Expert**
  - Jamie Parker ([jamie.parker@carradora.com](mailto:jamie.parker@carradora.com))

- **Harmonization Lead**
  - Becky Angeles ([becky.angeles@carradora.com](mailto:becky.angeles@carradora.com))
Thank you for joining!
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

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

Gary Schanzmeyer, Deputy Director for Administration in the Missouri Department of Mental Health, Division of Developmental Disabilities Quality Enhancement Unit

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

AIM

Increase individual independence and quality of life by decreasing behavior related 1-on-1 staffing hours by 25% within two years

PRIMARY DRIVERS

- Individuals have fewer negative contact with law enforcement
- Individuals elope less
- Individuals experience fewer aggressive behaviors, physical altercations & emergency procedures
- Individuals have increased time without supervision
- Individuals have appropriate medical plan to address health concerns

SECONDARY DRIVERS

- Implementation of 24 hour Crisis Line (refer to DBH)
- Individual develop coping skills through appropriate services
- Individuals have appropriate staff matching
- Individuals have appropriate roommate matching
- Person-centered planning for individuals with identified needs
- Individuals access to appropriate Behavior and Behavioral Health Services
- Implementation of Behavior Support Plan
- Planning Team identify and access appropriate Assistive Technology/Remote Supports
- Individuals develop skills to use Assistive Technology/Remote Supports
- Health Risk Assessment Tool utilized to identify health concerns
Crisis Hospitalization Use Case Driver Diagram

**AIM**

- Improve individual independence and quality of life by decreasing avoidable behavioral crisis hospital utilization rate by 20% within two years

**PRIMARY DRIVERS**

- Individuals have fewer negative contact with law enforcement.
- Provider staff qualified, trained, and properly equipped.
- Primary supports to individual are informed of behavioral crisis risks and mitigation strategies.
- Individuals have appropriate medical plan to address behavior related health concerns.
- Individuals access to appropriate Behavior and Behavioral Health Services.

**SECONDARY DRIVERS**

- Implementation of 24 hour Crisis Line (refer to DBH).
- Individual develop coping skills through appropriate services.
- Recruit additional Providers to participate in Tiered Supports.
- Retain provider participation in Tiered Supports which includes continuing education component.
- Person-centered planning for individuals with identified needs.
- Provide easily readable and accessible behavior crisis plan to new staff; create “executive summary” page with key behavior indicators.
- Health Risk Screening Tool utilized to identify behavior concerns.
- Planning Team identify and access appropriate Assistive Technology/Remote Supports.
- Individuals develop skills to use Assistive Technology/Remote Supports.

The Office of the National Coordinator for Health Information Technology
AIM
Decrease avoidable Hospital/ER utilization rate by 20% within two years

PRIMARY DRIVERS
- Individuals have reduction of avoidable ER visits.
- Individuals have reduction of avoidable medical hospital admissions
- Primary supports to individual are informed of health risks and strategies to mitigate identified risk
- Individuals have increased access to preventative local health care resources
- Individuals have access to DD Health Home model
- Usable, relevant healthcare data is available

SECONDARY DRIVERS
- Individuals use telehealth as access to preventative health and medical specialist services
- Increase access and utilization of primary care services
- Educate individual on health management skills to identify and decrease health risk
- Train DSP on preventive health and risk strategies
- Health Risk Screening Tool (HRST) utilized by the individual and their support team to identify health risks
- Develop and implement Individualized Health Care Plans
- Provide easily readable and accessible healthcare plans to support team members with care coordination
- Community mapping to identify local healthcare resources by county
- Educate individuals on available local public health resources
- Individuals are supported to enhance their health literacy skills
- Individuals have access to Community Health Worker
- Access to data to support ongoing monitoring of health data at the individual, service provider and state systems level
- Access and utilization of technology to mitigate health risks
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.
Thank You

Arun Natarajan, Senior Policy Analyst, ONC
Arun.Natarajan@hhs.gov

Kristina Celentano, EMI Advisors, ONC contractor
Kristina.Celentano@emiadvisors.net

Angela Brenner, Missouri Department of Mental Health
Angela.Brenner@dmh.mo.gov
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 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
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.
## 2019 HIT Operational Plan Topic Areas

<table>
<thead>
<tr>
<th>Data and Governance</th>
<th>Master Person Index</th>
<th>Provider Directory</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payment Models and Sources</strong></td>
<td>Health Information Exchange functionality, including enhancing the Clinical Data Repository (CDR)</td>
<td>Increase Clients In and Users of the CDR</td>
</tr>
<tr>
<td>Increase functionality of and uses of the CDR (e.g., reports, query capability)</td>
<td>Develop standardized tools and templates (e.g., discharge plan, care plans, SDOH)</td>
<td>Behavioral Health Integration</td>
</tr>
<tr>
<td><strong>Substance Use Disorder (SUD) HIT (e.g., eConsent Management)</strong></td>
<td>Tribal Engagement</td>
<td>Increase Use of Registries</td>
</tr>
<tr>
<td><strong>EHR Incentive Program</strong></td>
<td>Closed loop referral and Population Health Management</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>SUD HIT Plan Tasks</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct Financial Mapping</td>
<td>Provide reports on clinician long-term opioid prescribing patterns</td>
</tr>
<tr>
<td>Establish agreements for interstate data sharing through a PDMP</td>
<td>Convene clinical EMR users to describe desired workflow for accessing the PDMP via the CDR</td>
</tr>
<tr>
<td>Support the “ease of use” of the PDMP</td>
<td>Develop a function to allow providers within the CDR clinical portal to access the DOH-operated PDMP</td>
</tr>
</tbody>
</table>
| 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/Partnership 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 assessing 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**

<table>
<thead>
<tr>
<th>Task</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Closed Loop Referrals and e-Referrals</td>
<td>Telehealth to integrate MH and primary care</td>
</tr>
<tr>
<td>Create and use Electronic Care Plans</td>
<td>Analytics</td>
</tr>
<tr>
<td>Medical Records Transition</td>
<td>Technology for care coordination</td>
</tr>
<tr>
<td>E-consent</td>
<td>Identity Management</td>
</tr>
<tr>
<td>Interoperable Intake, Assessment, and Screening tools</td>
<td></td>
</tr>
</tbody>
</table>
Questions?

Jennie Harvell  
Senior Advisor  
Health IT Section  
Health Care Authority  
Washington State  

jennie.harvell@hca.wa.gov
HCA HIT Resources

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

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

- 3.9% Washington, D.C.
- 3.7% Vermont
- 2.5% Massachusetts

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)

98%

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

<table>
<thead>
<tr>
<th><strong>Life expectancy is highly variable across the District.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ 17-year difference in lifespan: Ward 3 (86 years) and Ward 8 (69 years)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>One in ten births is preterm.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ The percentage of live preterm births decreased from 2006 to 2016 for all wards, but has remained around 10% District-wide since 2009.</td>
</tr>
<tr>
<td>➢ ~1/3 of preterm births in the District occur among women who have previously experienced a preterm birth.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Avoidable and Preventable Conditions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ 12th highest 911 call-volume in the country. Hospital emergency departments have very high rates of ambulatory care sensitive conditions (ACSs).</td>
</tr>
<tr>
<td>➢ In Wards 7 and 8, 20% of hospital discharges and 21% of ED visits are for ACS conditions.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Inappropriate Use of Acute Care</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ ~10% of District residents report they delayed medical care due to not being able to get an appointment soon enough.</td>
</tr>
<tr>
<td>➢ Ward 1 residents report the most challenges (~14%).</td>
</tr>
</tbody>
</table>
Steps Towards Managing Population Health

LAN Category 1

LAN Category 2

LAN Category 3

LAN Category 4

* 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 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
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
<table>
<thead>
<tr>
<th>Nearly 20 SDOH Domains Collected in the District</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Access to Technology</td>
</tr>
<tr>
<td>2. Adverse Childhood Events (ACEs)</td>
</tr>
<tr>
<td>3. Demographics (Race, Ethnicity, Language)</td>
</tr>
<tr>
<td>4. Education (graduation, absenteeism)</td>
</tr>
<tr>
<td>5. Employment</td>
</tr>
<tr>
<td>6. Food Insecurity</td>
</tr>
<tr>
<td>7. Health Literacy</td>
</tr>
<tr>
<td>8. Housing</td>
</tr>
<tr>
<td>9. Income</td>
</tr>
<tr>
<td>10. Information to Support Trauma-care</td>
</tr>
<tr>
<td>11. Intimate Partner Violence</td>
</tr>
<tr>
<td>12. Material Resources</td>
</tr>
<tr>
<td>13. Mental Health</td>
</tr>
<tr>
<td>14. Patient Activation</td>
</tr>
<tr>
<td>15. Public Benefits</td>
</tr>
<tr>
<td>16. Resilience</td>
</tr>
<tr>
<td>17. Social Isolation/Social Inclusion</td>
</tr>
<tr>
<td>18. Substance Use</td>
</tr>
<tr>
<td>19. Transportation</td>
</tr>
</tbody>
</table>
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
  - Referral Function allowing providers to make referrals to social service providers
  - Close-Loop Function allowing referring providers to be notified when patient has seen referred provider

*Also known as the CoRIE Planning Initiative
DHCF Contact Information and Resources

Erin Holve, Director,
Health Care Reform & Innovation Administration
Erin.Holve@dc.gov | 202-442-9090

Noah Smith, Program Manager, Health IT
Health Care Reform & Innovation Administration
Noah.Smith@dc.gov | 202-609-8929

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