



The Office of the National Coordinator for  
Health Information Technology



# Advancing Health IT Alignment Across HCBS Funded Programs

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October 11, 2017

Putting the **I** in Health **IT**  
[www.HealthIT.gov](http://www.HealthIT.gov)



# What we are going to cover today?

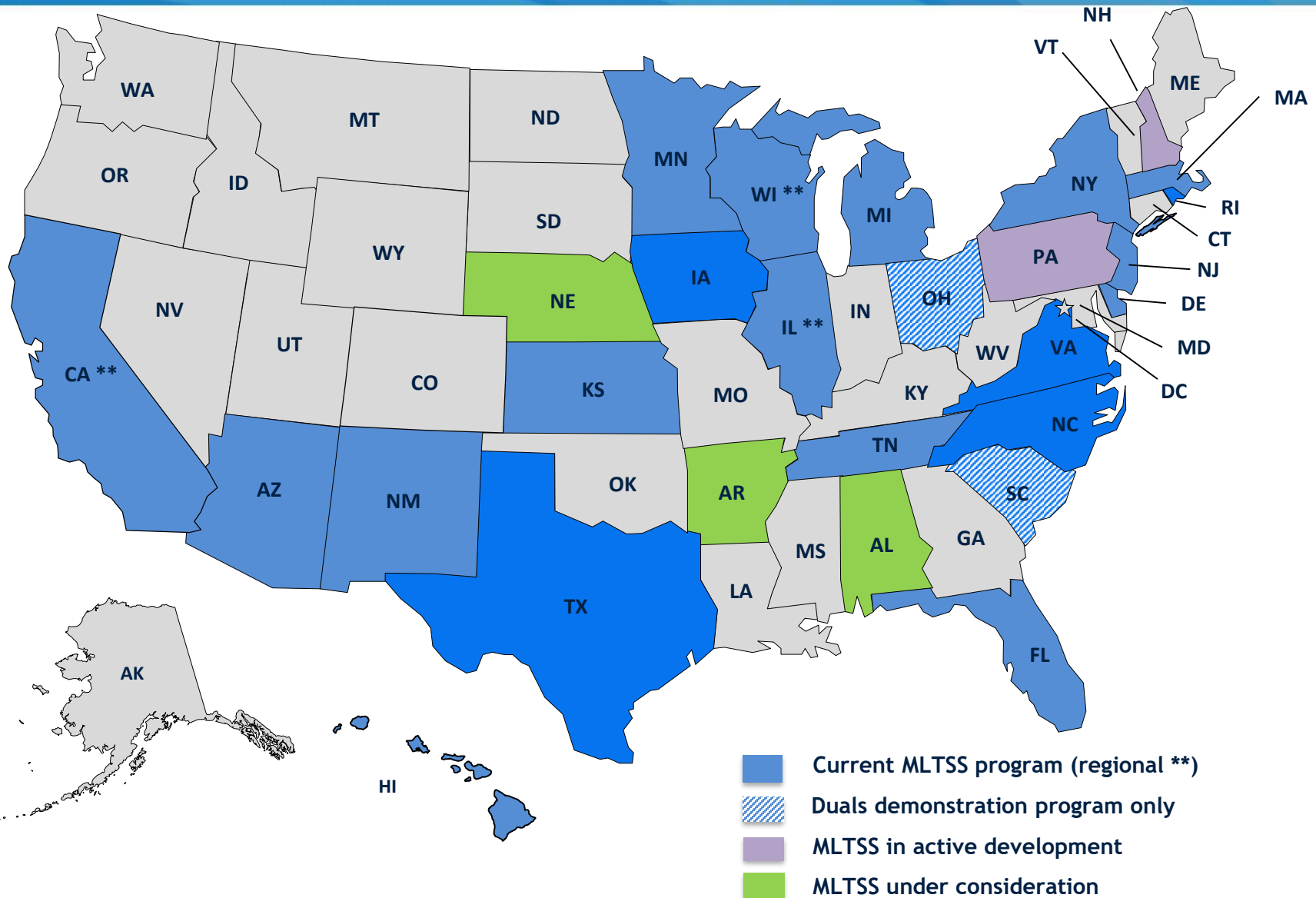


- Introductions
- Inter-relatedness of health care and human services inter-relate
- Long Term Services and Supports
- HCBS and LTSS
- The HCBS health IT toolkit
- State examples



- 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
  - However, eligibility, payment, and quality management can be fractured inside of Medicaid too
- Interoperable systems have the promise of improving coordination and keeping LTSS person-centered

# Changing Delivery Systems Impacting Services – MLTSS Programs 2017

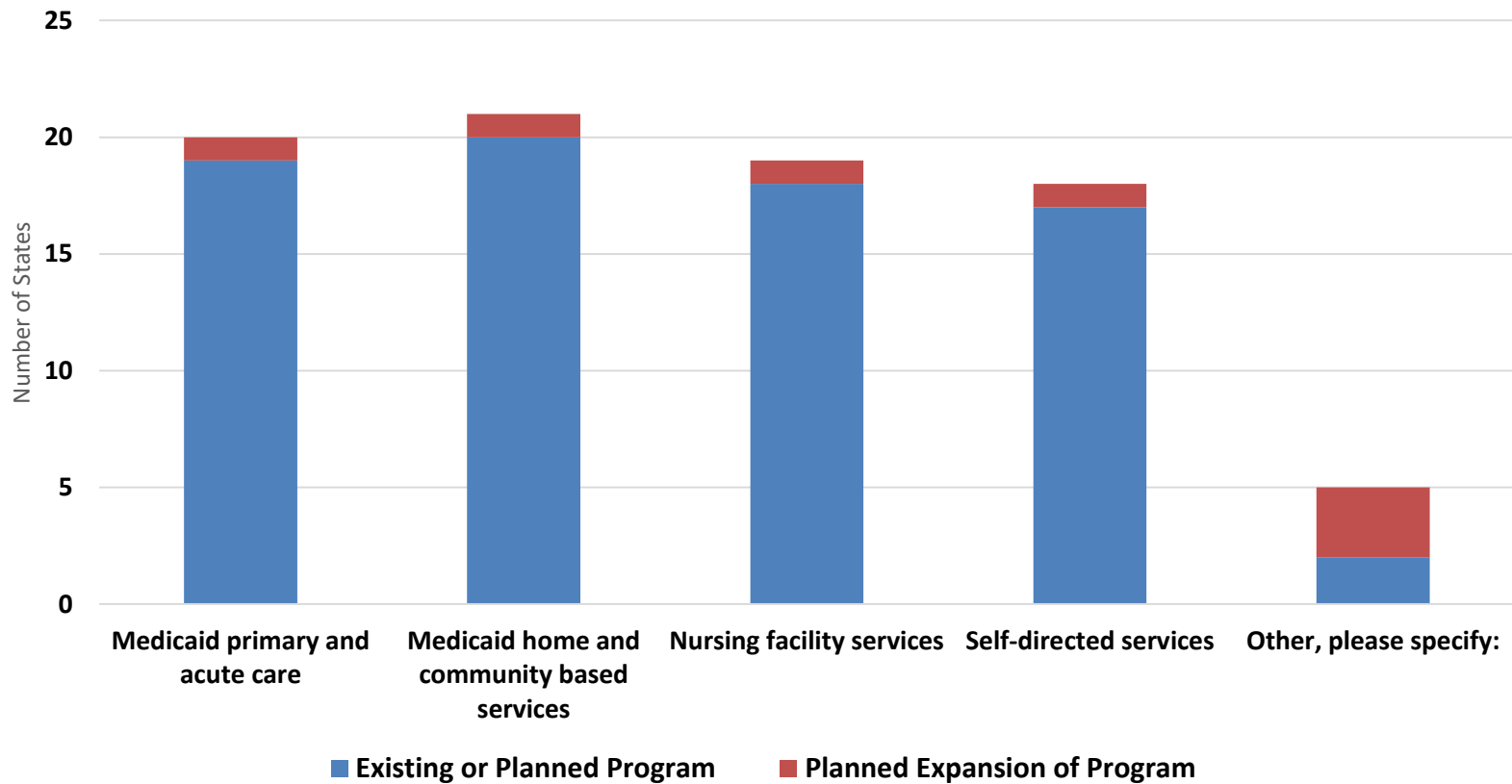


Source: NASIAD survey; CMS data

# Services Included in Planned or Existing MLTSS Programs



Services Included in Planned or Existing MLTSS Programs

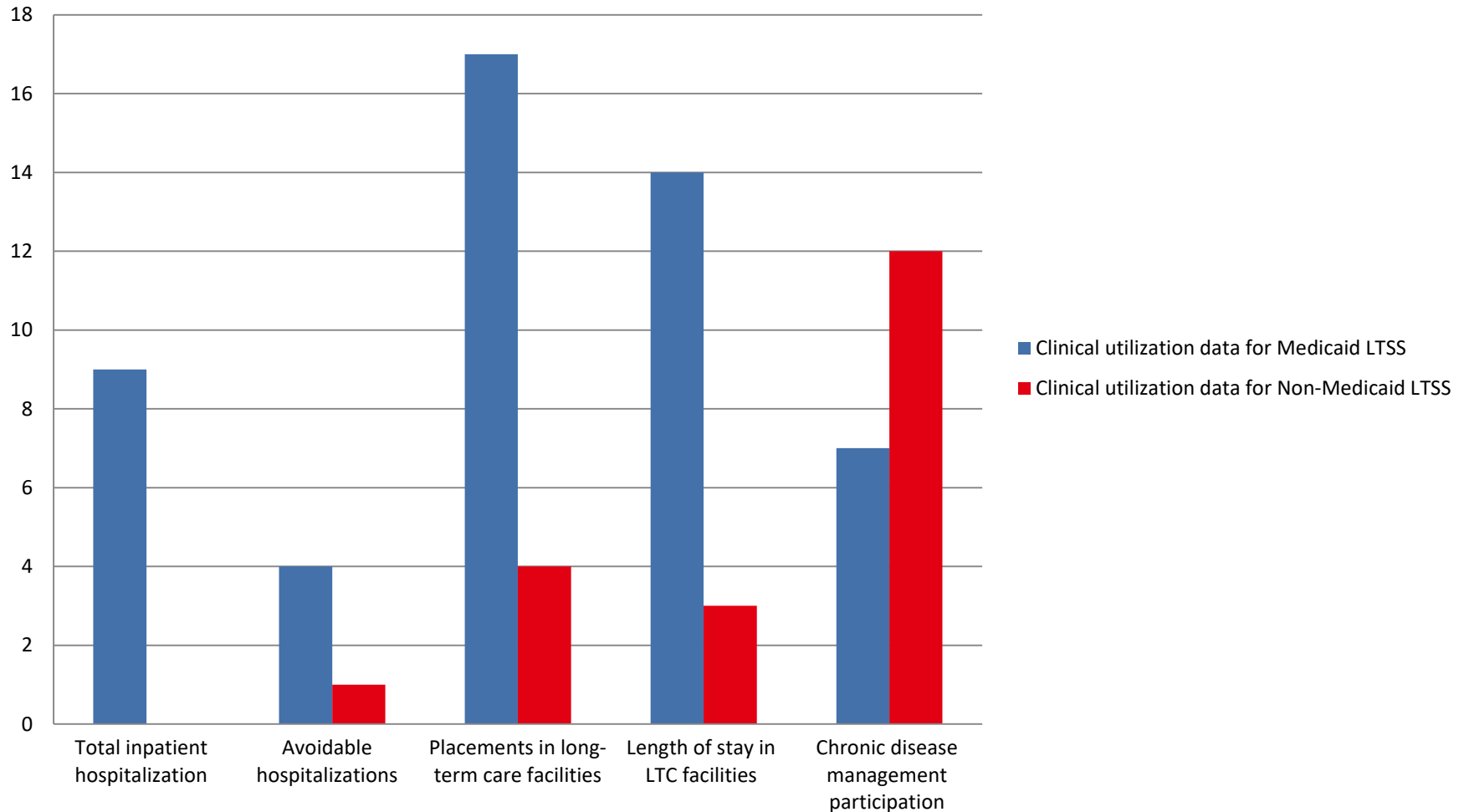


Source: NASUAD 2017 State of the States report (Published: August 2017)

# Clinical Data Collection: Survey of Aging/Disability Agencies



## Number of States Collecting Clinical Utilization Data for LTSS Participants

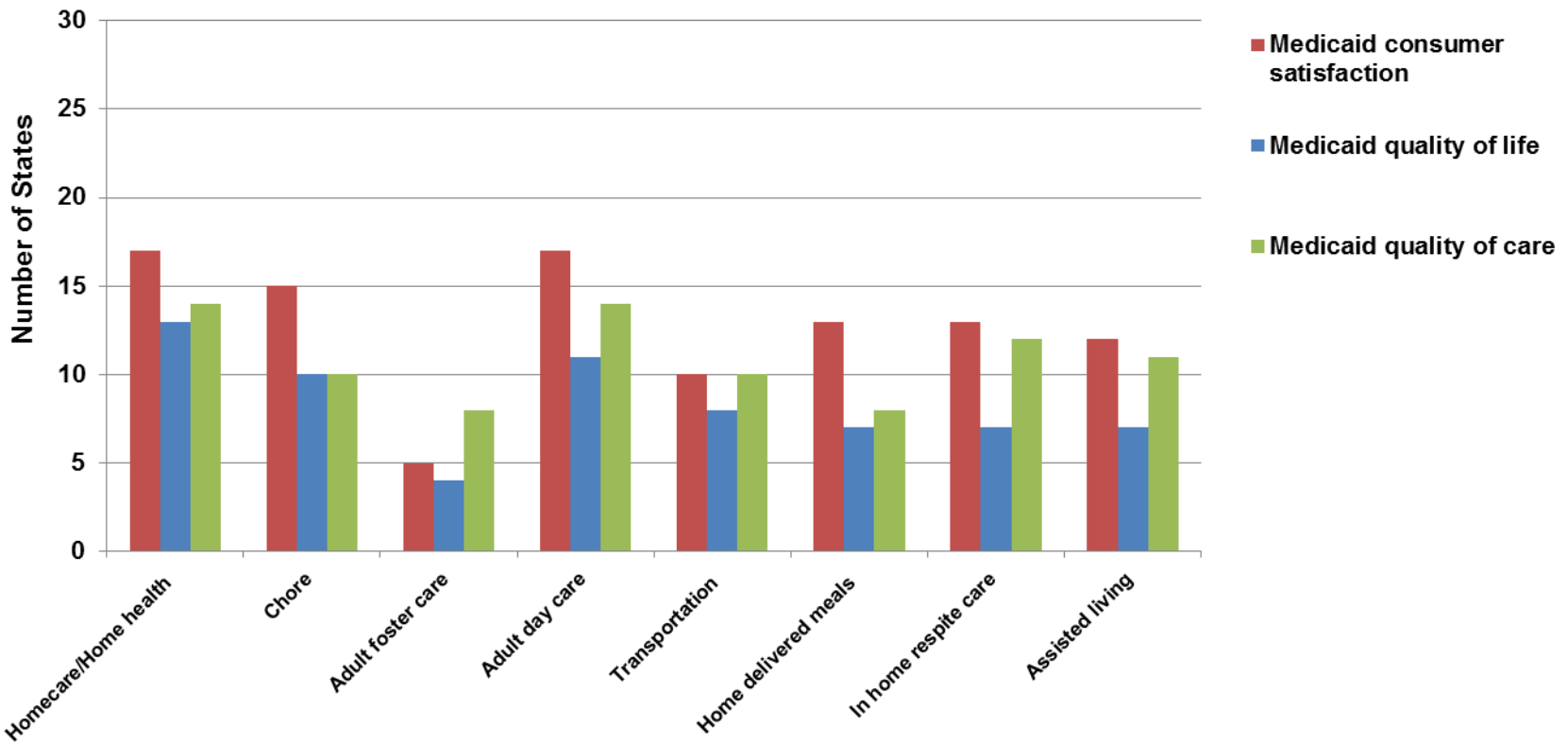


Source: NASUAD 2016 Survey of State Agencies on Outcomes and Data (n=42)

# Consumer Surveys: Medicaid Supports



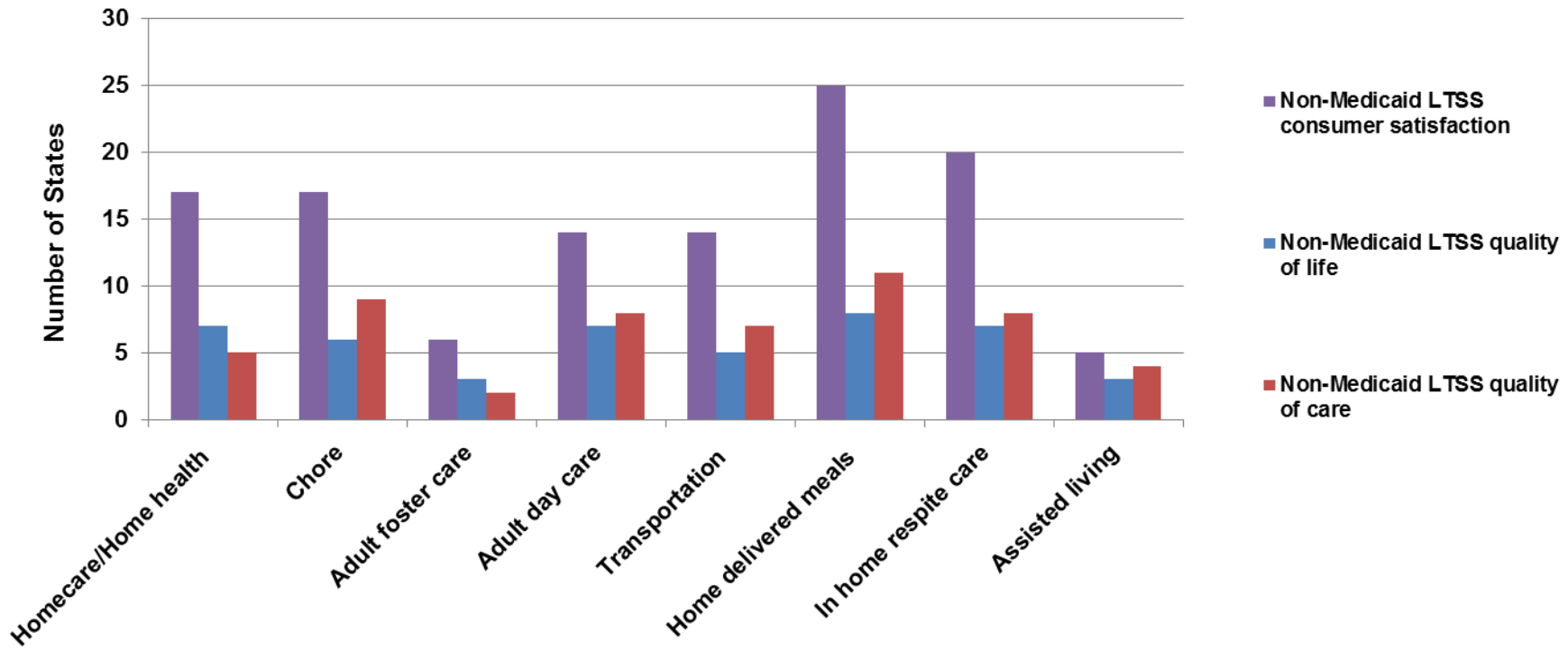
## States Collecting Data on Medicaid Consumer Satisfaction, Quality of Life, and Quality of Care by Service



Source: NASUAD 2016 Survey of State Agencies on Outcomes and Data (n=42)



## States Collecting Data on Non-Medicaid LTSS Consumer Satisfaction, Quality of Life, and Quality of Care by Service



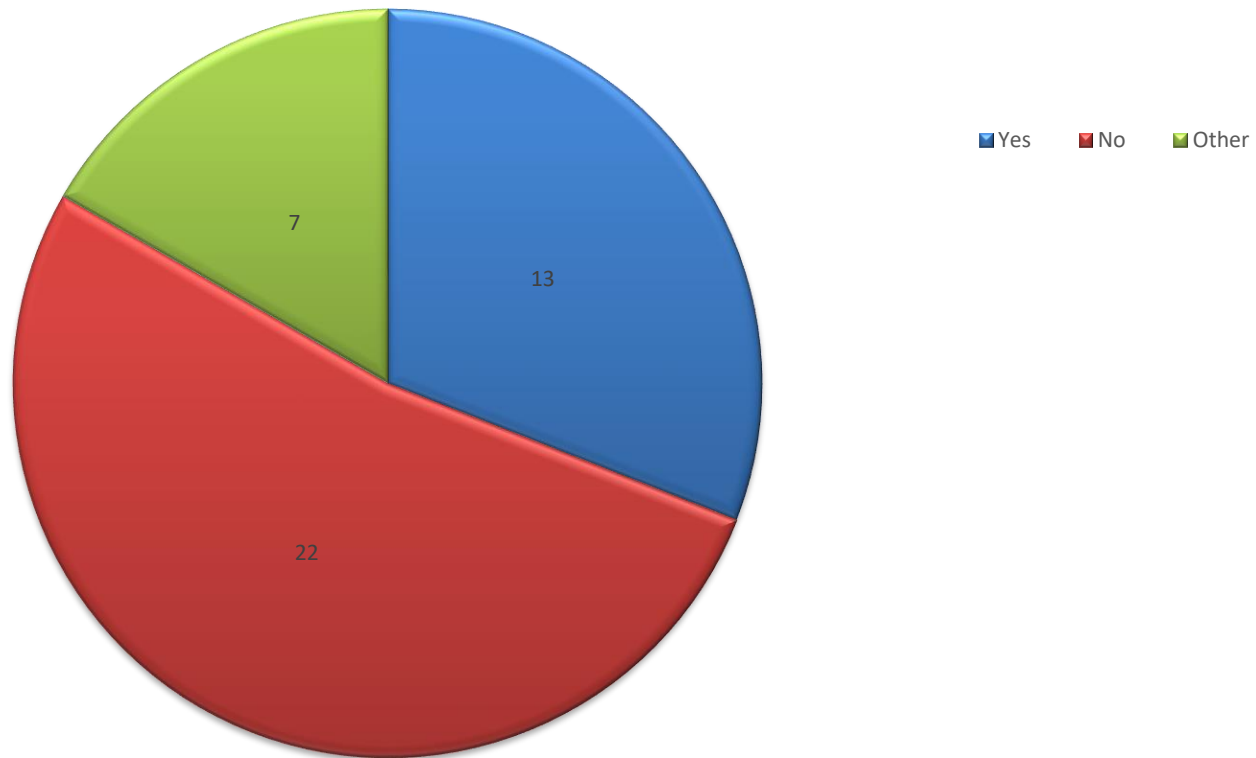
Source: NASUAD 2016 Survey of State Agencies on Outcomes and Data (n=42)



# State Aging/Disability Information Sharing



Does your information system share data with other HHS data systems?



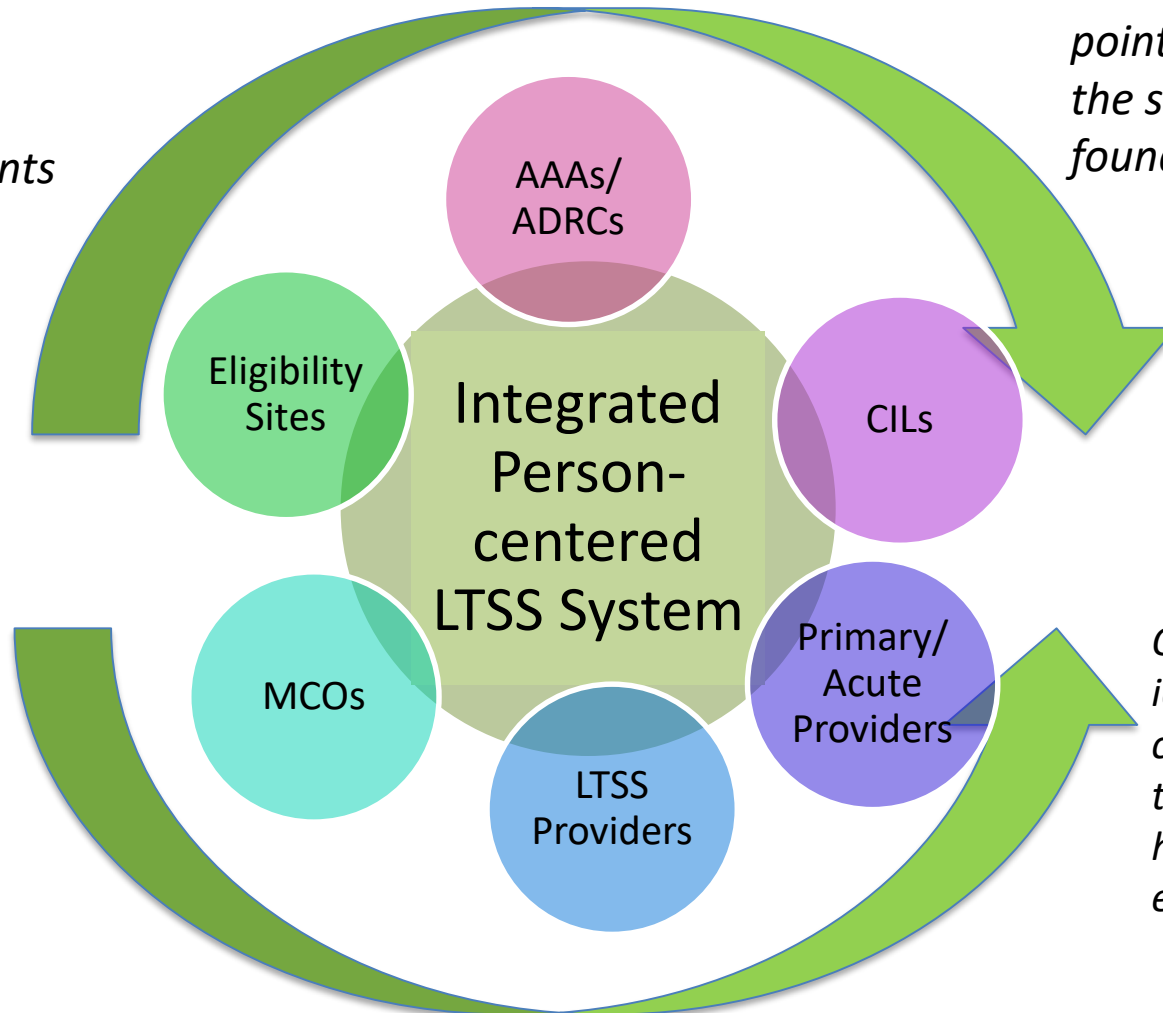
# The Goal: LTSS Integrated System



*Statewide  
database of  
services for use  
for all entry points  
regardless of  
payer*

*Multiple entry  
points, but built on  
the same  
foundation*

*Easy to  
use data  
collection  
system*



*Measuring  
quality and  
improving  
performance*

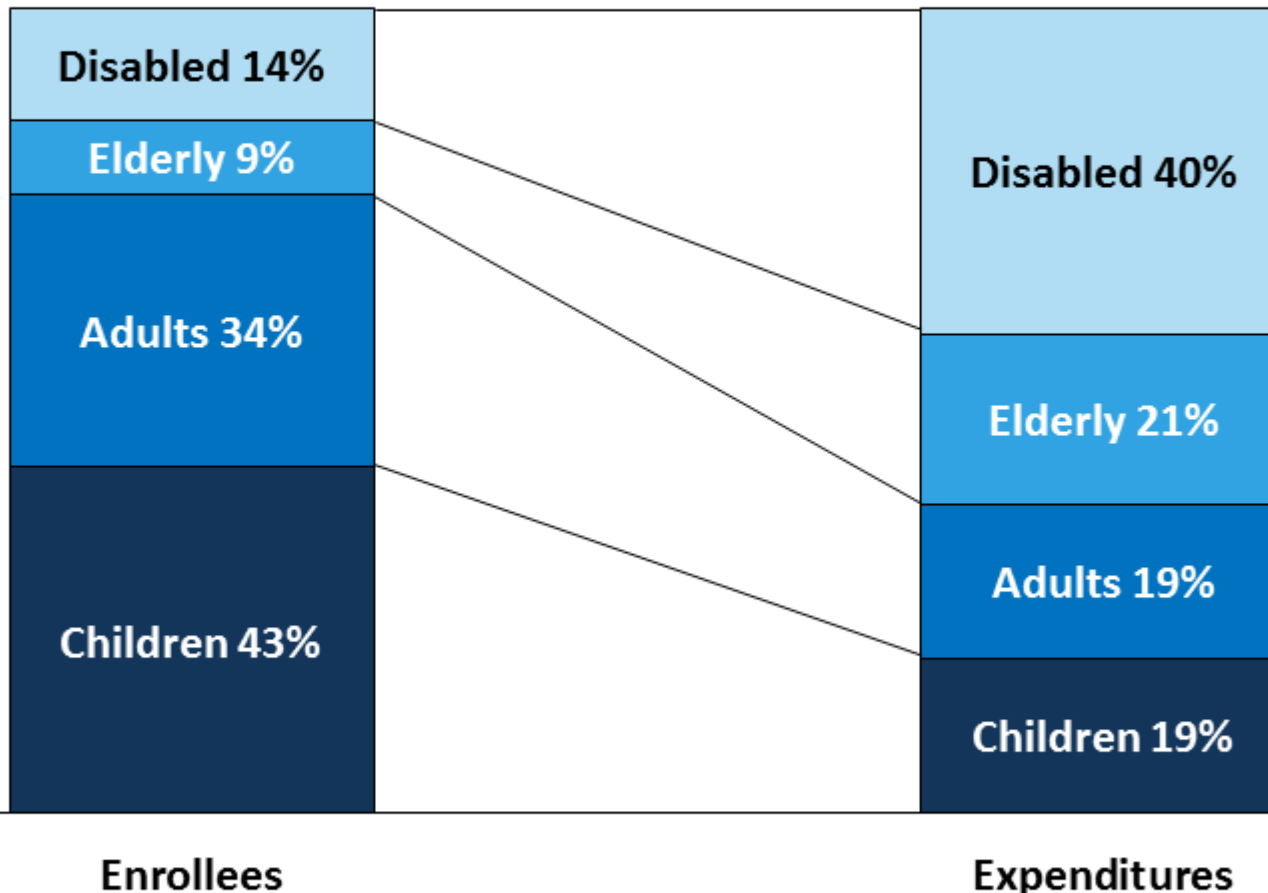
*One common  
identifier for  
consumer  
throughout  
his/her LTSS  
experience*

# Medicaid Spending Older Adults and People w/ a Disability



Figure 1

**Nearly two-thirds of Medicaid spending is for the elderly and people with disabilities, FY 2014.**





- Home and Community Based Settings
  - “Integrated in and supports full access...to the greater community, including opportunities... to engage in community life....”



- Taxonomy Category:
  - Supported Employment

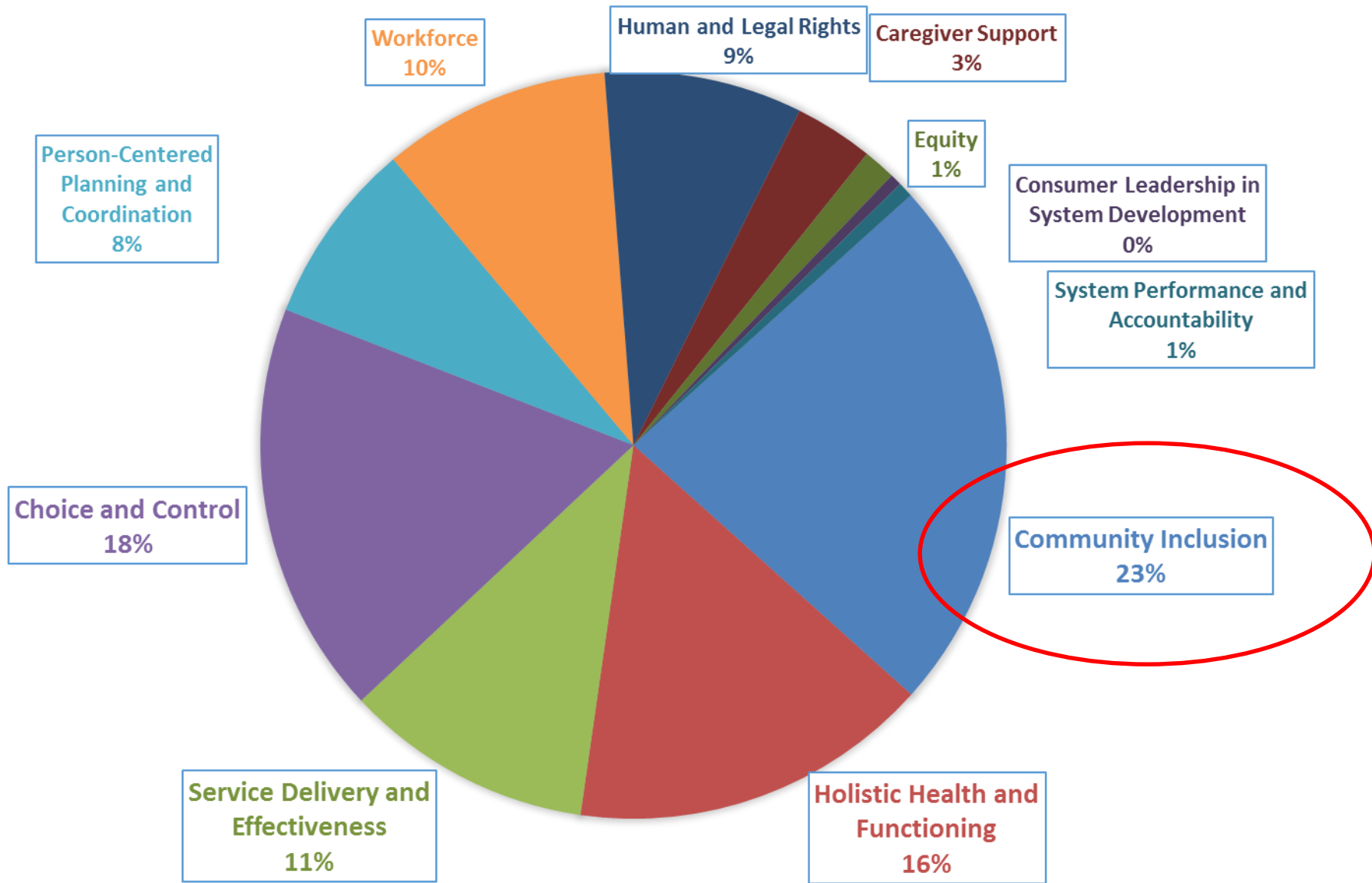
[Link HCBS Taxonomy](#)



- Institute of Medicine
  - Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors
    - Socioeconomic position
    - Race, ethnicity, and cultural context
    - Gender
    - Social Relationships
    - Residential and community context
    - Health literacy

[Institute of Medicine Social Determinants](#)

Note: Numbers represented percent of total items coded (n = 6673)





- 50 Instruments, 255 measures

Examples of Surveys with employment qs

- CQL Personal Outcome Measures (50 items)
- CAHPS HCBS (11 items)
- NCI (16 items)
- Canadian Survey on Disability (40 items)



# Opioid and Employment State Medicaid Directors Letters



- CMS SMDL# 17-003 Strategies to Address the Opioid Epidemic [SMDL #17-003](#)
- SMDL #18-002 Opportunities to Promote Work and Community Engagement among Medicaid Beneficiaries [SMDL #18-002](#)

## Work Requirements are limited in their impact



- 6% of working age adults enrolled in Medicaid who are not in the labor force would qualify for a work incentive program
- The remaining people not in the labor force are either exempted from work requirements (28%), or are caring for family, attending school, or already in a work program (14.1%)

# Big Idea



- Combine Employment and Opioid efforts in the health IT space.
- Talk to your state VR and workforce development agencies
- Consider eLTSS as a set of data elements at the individual level and scalable
  - Goals/preferences: Employment
  - Services supports: Supported Employment, VR, etc.
- Measure and incentivize at the provider level



- CMS and ONC are committed to ensuring that we are supporting states to develop a health IT infrastructure able to sustain and deliver on our shared Medicaid program objectives.
- To this end, HHS has developed a series of state facing program authority specific health IT toolkits. States can use these toolkits as they are designing their Medicaid programs.



- Use of these tool kits will help states:
  - Ensure they have the health IT capacity and infrastructure to accomplish their Medicaid program goals.
  - Identify and adopt a common set of health IT standards (where federally recognized standards exist) among states to promote information sharing (interoperability).
  - <https://www.healthit.gov/providers-professionals/advancing-interoperability-medicaid>
  - <https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html>

# Key health IT considerations to include in an HCBS health IT, HIE and interoperability toolkit



1. Care Plan Exchange
2. Real time access to Admission/Discharge/Transfer notifications
3. Inclusion of 45 CFR 170 Standards and as applicable other federally recognized standards identified in the Interoperability Standards Advisory (ISA) within RFPs for LTSS MCO contract procurements
4. Connecting LTSS Providers to local/state's HIE – requirement to send in and/ or receive information
5. HCBS (1915(c)) Quality Framework – using electronically specified measures

# How are HCBS Programs Fitting into a SMA's Larger HIT, HIE, and Interoperability framework?



1. Plan to support HCBS providers for their health IT, HIE and interoperability needs (Regional Extension Center like services)
2. Leveraging states 90-10 funding per SMD 16-003 for HCBS providers.
  - Registries
  - Funding Connections
3. SMA's Governance plan- what is the role for including HCBS services/providers? Are the HCBS programs represented in these State discussions
4. Are HCBS considerations included in the State's Master Data Management (MDM) strategy
  - Provider Directory strategy
  - Identity Management
5. Role of PHRs – Can the HCBS Medicaid program encourage/fund or support HCBS individuals access to a PHR for their human and health care services?

# Indiana – Using AAA to capture SDOH for Medicaid Bene's and Provide Services



- Aging and In-Home Services of Northeast Indiana, a federal and state designated Area Agency on Aging, the Aging and Disability Resource Center (ADRC), and the Central Indiana Council on Aging (CICOA) have leveraged technology to integrate HCBS provider data with Indiana's existing Health Information Exchanges. Use of technology has allowed both Aging and In-Home Services and CICOA to negotiate with accountable care organizations to contract for provision of HCBS services that address the social determinants of health, which in turn help achieve the triple aim.



# VISION



- “With the Area Agency on Aging network, we have a national infrastructure in place and a workforce trained and ready to deploy. The answer to how we address social determinants of health in our country just needs to be recognized and activated.”

•Connie Benton Wolfe, National Area Agency on Aging Conference, 2016

# Major Drivers of Health Care Costs



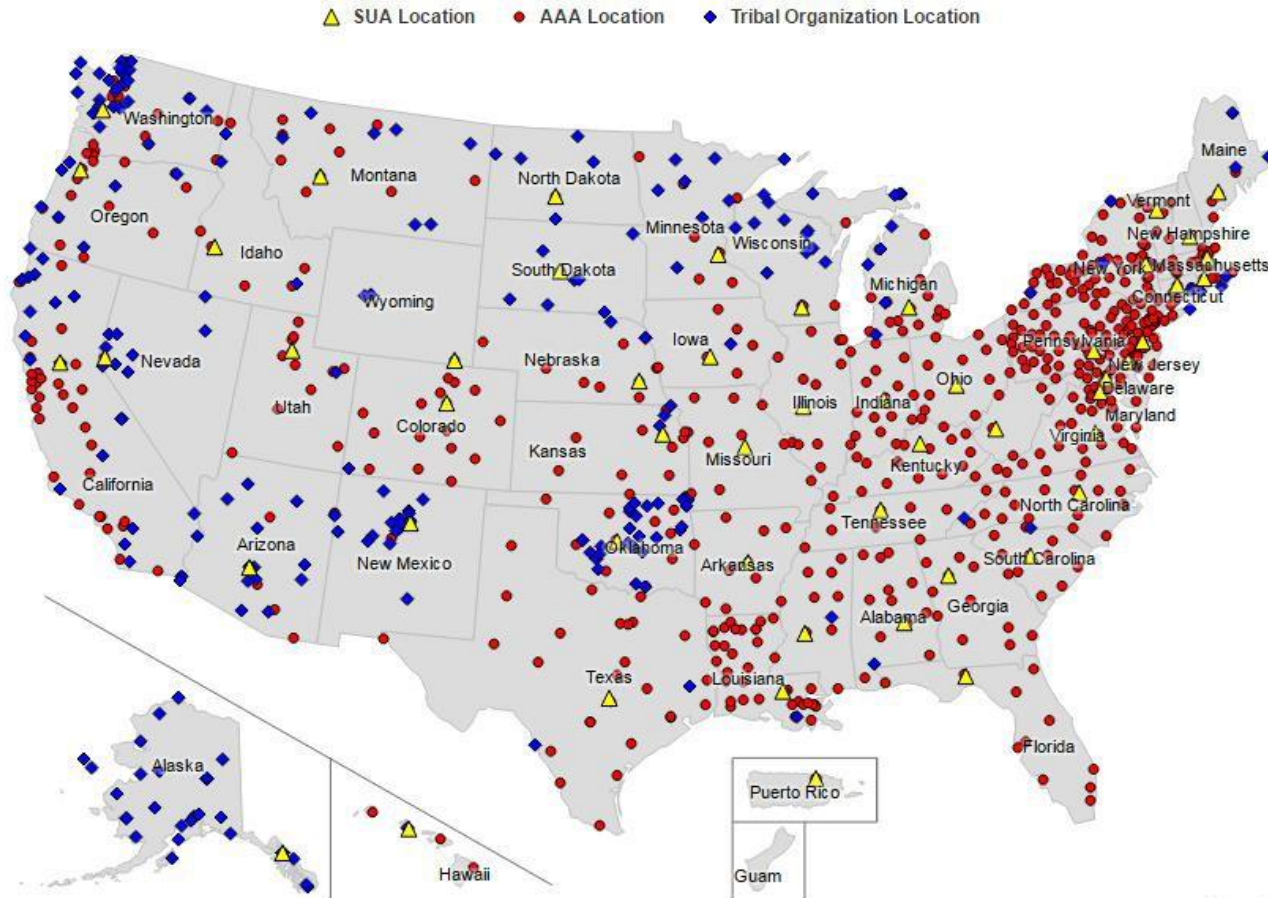
## Social Determinants of Health

Economic Stability	Neighborhood & Physical Environment	Education	Food	Community & Social Content	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expense	Safety	Early childhood education		Community engagement	Provider linguistics & cultural competency
Debt	Parks	Vocational training		Discrimination	
Medical bills	Playgrounds	Higher education			Quality of care
Support	Walkability				

### Health Outcomes

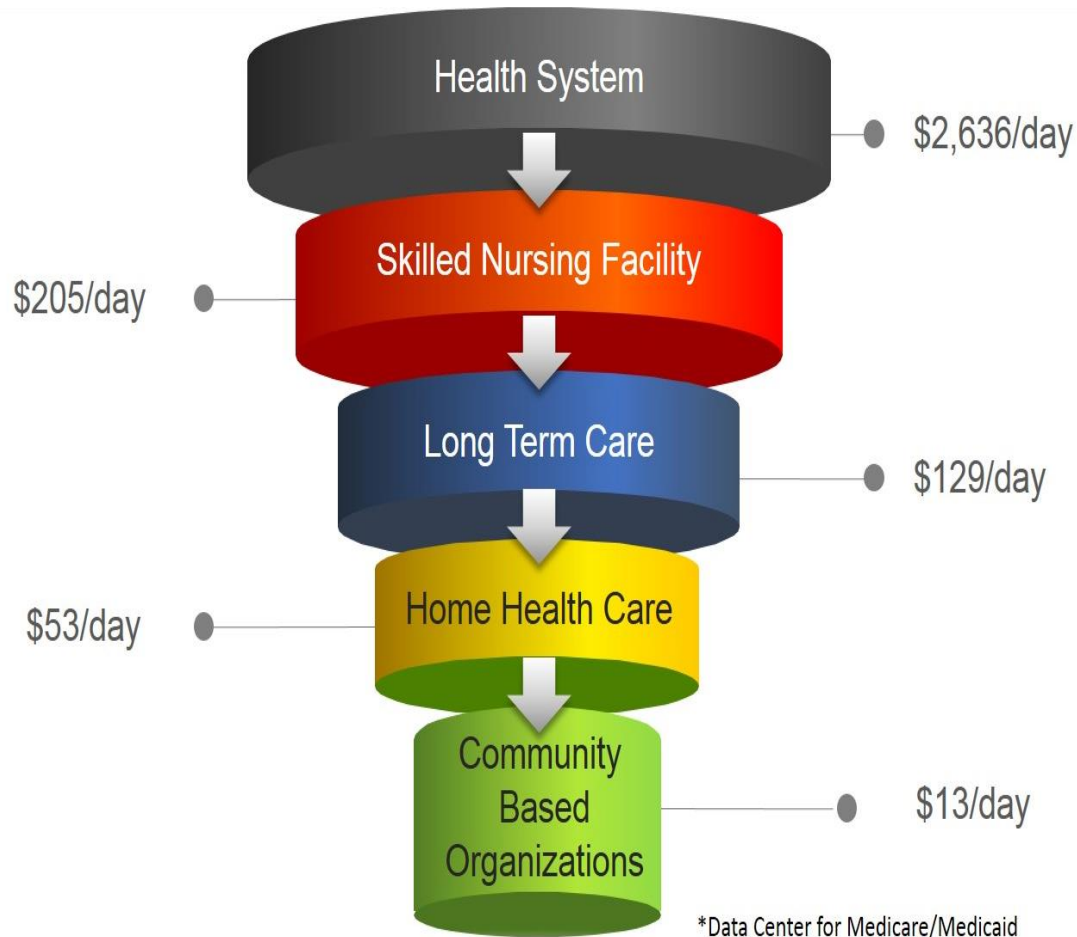
Mortality, Morbidity, Life Expectancy, Health Care Expenditure, Health Status, Functional Limitations

# Nationwide Network In Every State. In Every County.



Source: 2017 Administration for Community Living

# Average Cost/Day



# Why Rely on the AAA Experts?



- Screening for patient's health related social determinants is fundamentally different from screening for medical problems.
- Interventions must be accessed outside the health system and generally from cross-sector providers.
- Resources to pay for interventions are diverse and qualifications complex.
- Problem solving is required; Information & Referral is not sufficient.



## Portfolio:

- Screenings & Assessment
- Person & family centered planning
- Care transition support
- Care coordination
- Chronic disease management
- Behavioral health support
- Caregiver support
- Long-term service support
- Advance Care Planning





# Investing in Community-Anchored Health Care is Good Business!



# Unleash the Power of the Health Care System



## TRIPLE AIM OF HEALTHCARE





# NY Grant Program for EHR Adoption to HCBS Providers



- In order to assure that Adult Behavioral Health HCBS providers are ready for and can succeed in the transition to Medicaid Managed Care under the New York State 1115 waiver program, New York State created a Behavioral Health Information Technology Grant Program (BH-IT) to support these providers. The grants provide assistance with: Health Information Technology (HIT) scoping and vendor qualifications and initial purchase of licenses, system upgrades, and/or implementation and technical assistance for Electronic Health Records (EHR) and/or Electronic Billing Systems (EBS).

# Use of the 2015 Standards Advisory: Health Home Examples – Clinical Decision Support



Washington's Medicaid Health Home SPA targets individuals with one chronic condition and at risk for developing a second, defined as a PRISM risk score of 1.5 or greater. Chronic conditions may include cancer, dementia, Intellectual disability or disease, HIV/AIDs as well as others. The State integrates fee-for-service claims data, managed care encounter data, eligibility, and enrollment data for medical, pharmacy, mental health, substance use disorder, long term services and supports, and Medicaid and dual eligible Medicare covered services in a secure web-based clinical decision support tool called PRISM.

(the Monitoring Section)



- TEFT Grantee
- Accountable Care Arrangements
- Advanced Primary Care Arrangements
- All-Payer Claims Database Policies
- Episodes of Care Risk Sharing
- HIE Advisory Council
- Colorado Regional Health Information Organization as Colorado's Qualified State-Designated Entity
- State Privacy and Security Laws promotes exchange of behavioral health information

# Use of the Interoperable Standards Advisory: Health Home Examples – Admit, Discharge, Transfer Sets



WASHINGTON: The State has developed an HIT pilot for Health Action Plans through OneHealthPort, an entity contracted with HCA to also consult on building a statewide health information exchange. HCA has developed the Medicaid Health Profile clinical data repository, with clinical data passed through OneHealthPort HIE using the Continuity of Care Document (CCD) and the Admit/ Discharge/Transfer Document (ADT) transaction sets.

(the Monitoring Section)

# Use of the Interoperable Standards Advisory: Health Home Examples – Care Planning



MAINE: Over 24 months all BHHO will be expected to have implemented certified EHR systems. BHHO will be expected to share health information including care planning documents to and from other treating providers/organizations and across the team of BHH professionals. (the Provider Section)

IDAHO: The final standards require that designated providers use HIT for the following processes:

1. Have a systematic process to follow-up on tests, treatments, services, and referrals which is incorporated into the patient's care plan;
2. Utilize HIT allowing the patient health information and care plan to be accessible and allow for population management and identification of gaps in care including preventive services; and
3. Is required to make use of available HIT and access members' data through the IHDE to conduct all processes, as feasible. (the Provider Section)

# Use of the Interoperable Standards Advisory: Health Home Examples – Care Coordination



ALABAMA: Providers will be able to transmit a prescription electronically to the enrollee's pharmacy of choice, review laboratory data and determine medication adherence information. (the Service Section)

# Use of the Interoperable Standards Advisory: Health Home Examples – Consent



ALABAMA: The state is planning to implement use of "One Health Record" [the state's HIE] when national standards are finalized. Once One Health Record is operational the state will consider possible sharing of consent forms and encouragement of all providers types (SA, CMHCs and ADPH) to connect to One Health Record. (the Service Section)

# Example of 1115 Waiver Support for Interoperability



- NY DSRIP Waiver
  - The incentive to reduce readmissions is driving the use of interoperable health IT for performing care coordination.
  - Specific health IT usage and exchange requirements also support interoperability.
    - E.g., STCs requires Performing Provider Systems to report on “Percent of Eligible Providers with participating agreements with RHIO’s [Regional Health Information Organizations]; meeting MU Criteria and able to participate in bidirectional exchange.”



# Questions



# Using the “Get Connected Toolkit” to Address the Opioid Crisis Within the Older Adult Population

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U.S. Department of Health and Human Services

August 30, 2018



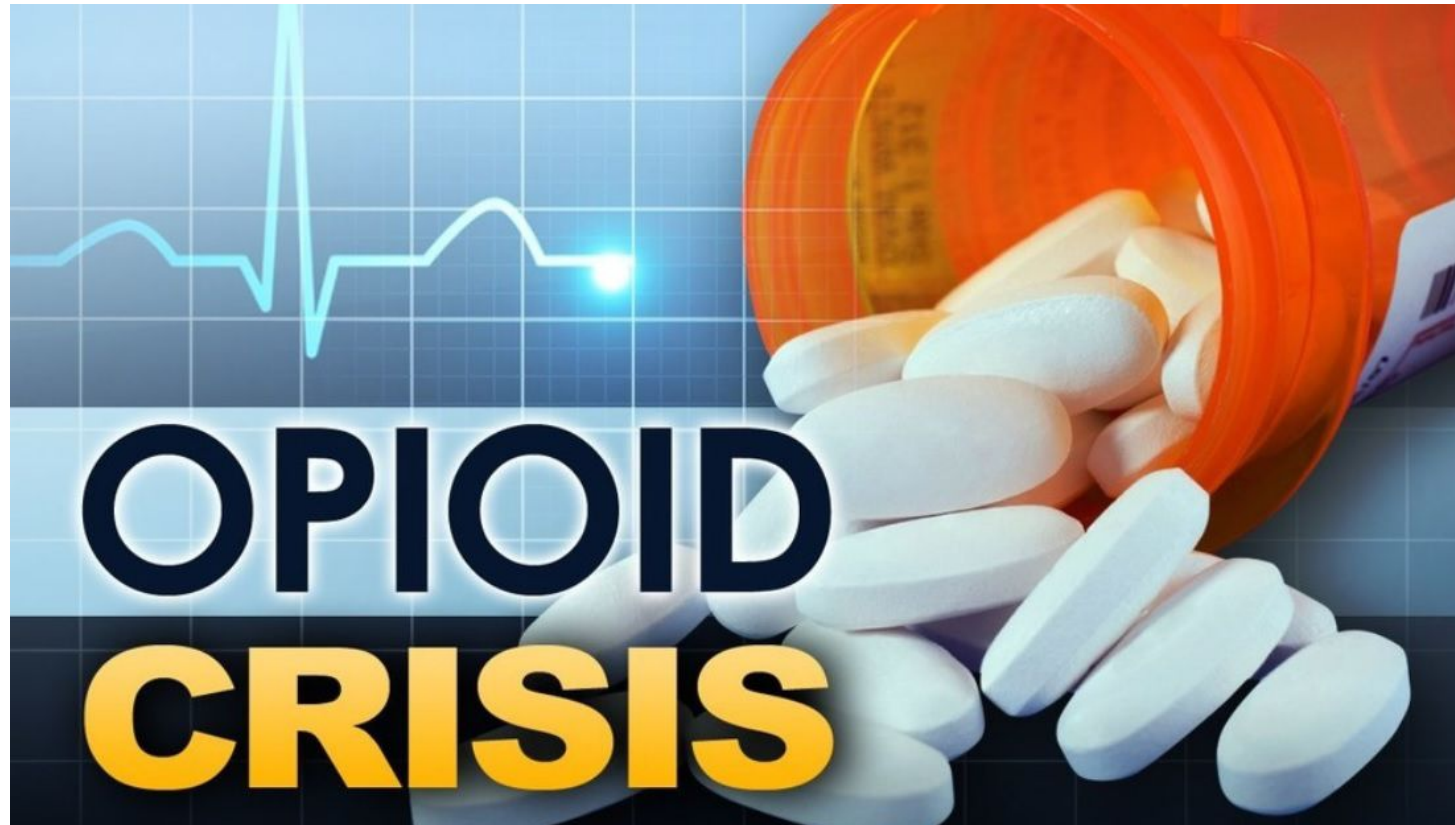
**SAMHSA**  
Substance Abuse and Mental Health  
Services Administration

# Objective

Learn how to use the *Get Connected Toolkit* to develop prevention messages and educational resources to address the impact of the opioid crisis within the older adult population.



# *Substance Misuse and Abuse Among Older Adults*



# Prevalence of Misuse and Abuse Among Older Adults

- More than 80 percent of older adults use at least one prescription on a daily basis, with 50 percent taking five or more medications and supplements daily. (SAMHSA, 2017).
- CDC's Vital Signs Report showed the number of people treated for opioid overdoses in emergency rooms over a 15-month period was up 32% for persons age 55 over. (CDC, 2018).

Substance Abuse Center for Behavioral Health Statistics and Quality. Results from the 2016 National Survey on Drug Use and Health: Detailed Tables. SAMHSA. <https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2016/NSDUH-DetTabs-2016.htm>. Published September 7, 2017. Accessed March 7, 2018.

# Signs of Substance Misuse and Abuse

- Loss of motivation
- Memory loss
- Family or marital discord
- New difficulty with activities of daily living
- Difficulty sleeping
- Drug seeking behavior
- Doctor shopping





# Opioid Prescription and Education

Its vital we educate older adults about how to take their medications, and appropriate disposal of medications. Saving medications for a later use unless directed by a physician can be very harmful.

 NATIONAL POLL ON HEALTHY AGING  
UNIVERSITY OF MICHIGAN

[HEALTHYAGINGPOLL.ORG](http://HEALTHYAGINGPOLL.ORG)

## What older adults did with leftover opioid medications\*

Among those who had a prescription for opioids in the past two years



**86%**

Saved for later use/kept at home



**13%**

Returned to approved location\*\*



**9%**

Disposed, threw in trash, or flushed down toilet

**July/August 2018 Report:** Older Adults' Experiences with Opioid Prescriptions

\*Respondents could select more than one response; \*\*Pharmacy, health care provider, law enforcement, or community takeback event

***Get Connected  
Toolkit: Linking  
Older Adults with  
Medication, Alcohol,  
and Mental Health  
Resources***





# Get Connected Toolkit



- The Get Connected Toolkit** helps communities:
- Build health promotion programs
  - Offer prevention messages and education
  - Provide screening and referral for mental health problems and misuse of alcohol and medications

[www.samhsa.gov](http://www.samhsa.gov)

It Can Happen to Anyone Coping with Life Transitions Video

<https://www.youtube.com/watch?v=FQan4-6amJk>

# Get Connected Toolkit: Goals

## Get Connected Toolkit Goals:

- Educate older adults
- Link older adults to resources
- Help provider staff understand substance use/misuse and mental health issues
- Increase staff competence and confidence
- Encourage peer support

## Who benefits from the toolkit:

- Senior Centers
- Adult Day Health Services
- Nutrition Programs
- State and Local Agencies
- Area Agencies on Aging
- Health and Social Services Providers

# What is Included in the Get Connected Toolkit

## Toolkit Contents:

- Teaching agendas, learning objectives
- Class outlines
- Required materials lists
- Exercises, activities, and discussion topics
- Tips for preparing and conducting sessions

# The Get Connected Toolkit: Curricula Topics

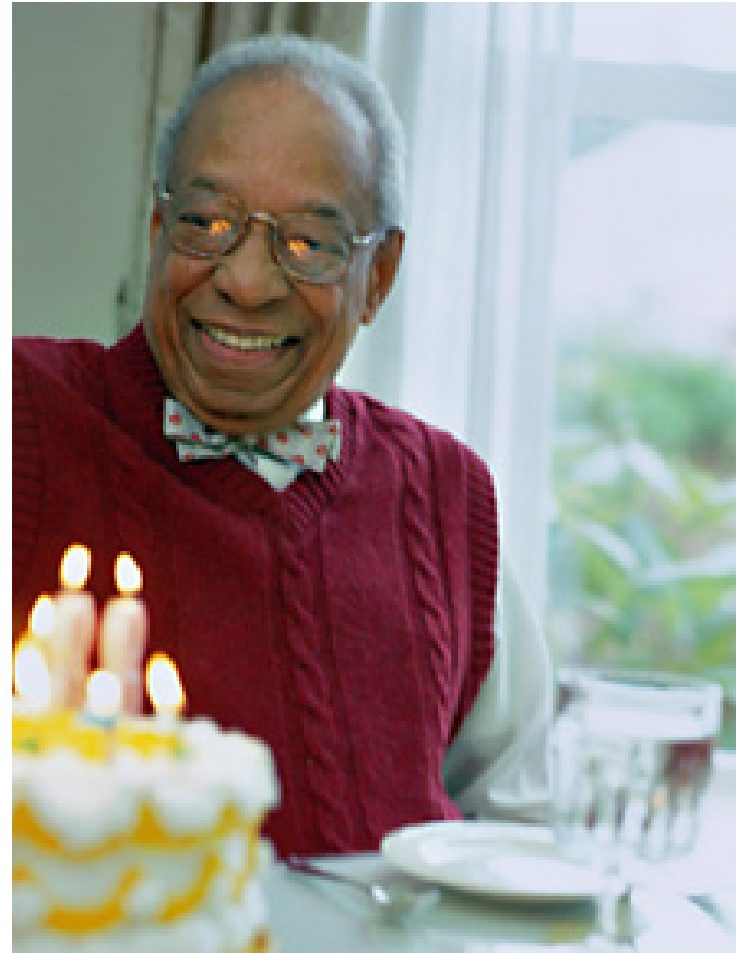
**Session One:** It Can Happen to Anyone –  
Coping with Life Transitions

**Session Two:** Using Medication Wisely

**Session Three:** Keeping a Healthy Outlook  
on Life

# Why Use the Get Connected Toolkit!

To enhance the quality of life and promote the physical and mental well-being of older Americans by reducing the risk for and incidence of substance abuse/misuse and mental health issues late in life.



SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

Jennifer Solomon, M.A.

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Center for Substance Abuse Prevention

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**[www.samhsa.gov](http://www.samhsa.gov)**

1-877-SAMHSA-7 (1-877-726-4727) • 1-800-487-4889 (TDD)