

Looking Forward: HCBS Quality Measures Alignment and HCBS CAHPS®



*Division of Community Systems
Transformation, Disabled & Elderly
Health Programs Group, Center for
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*Center for Clinical Standards and
Quality, Centers for Medicare &
Medicaid Services*

*Office of the National
Coordinator for Health IT*

Agenda

Looking Forward: HCBS Quality Measures Alignment and HCBS CAHPS®

- Jennifer Bowdoin, PhD, Division of Community Systems Transformation, Disabled and Elderly Health Programs Group

Functional Assessment and Standardized Items (FASI)

- Kerry Lida, PhD, Division of Community Systems Transformation, Disabled and Elderly Health Programs Group

CAHPS Home and Community Based Services (HCBS CAHPS®) Survey

- Kerry Lida, PhD, Division of Community Systems Transformation, Disabled and Elderly Health Programs Group

Alignment with the IMPACT Act and CMS Data Elements Library

- Tara McMullen, PhD, Center for Clinical Standards and Quality

eLTSS: Charting a forward path

- Elizabeth Palena Hall, Office of the National Coordinator for Health IT

What Is FASI?

- Functional Assessment Standardized Items (FASI)
- A set of standardized person-centered assessment items that measure functional ability and need for assistance
 - Aligned with federally standardized items for measuring function in the Medicare program and adapted for the LTSS population
 - Self-care activities (e.g., eating, dressing)
 - Mobility activities (e.g., bed mobility and transfers, ambulation, wheelchair use)
 - Additional items specific to long-term services and supports (LTSS) needs
 - Instrumental Activities of Daily Living (IADLs) (e.g., making a light meal, answering the telephone)
 - Need for caregiver assistance
 - Personal goals related to functioning

FASI Development and Testing

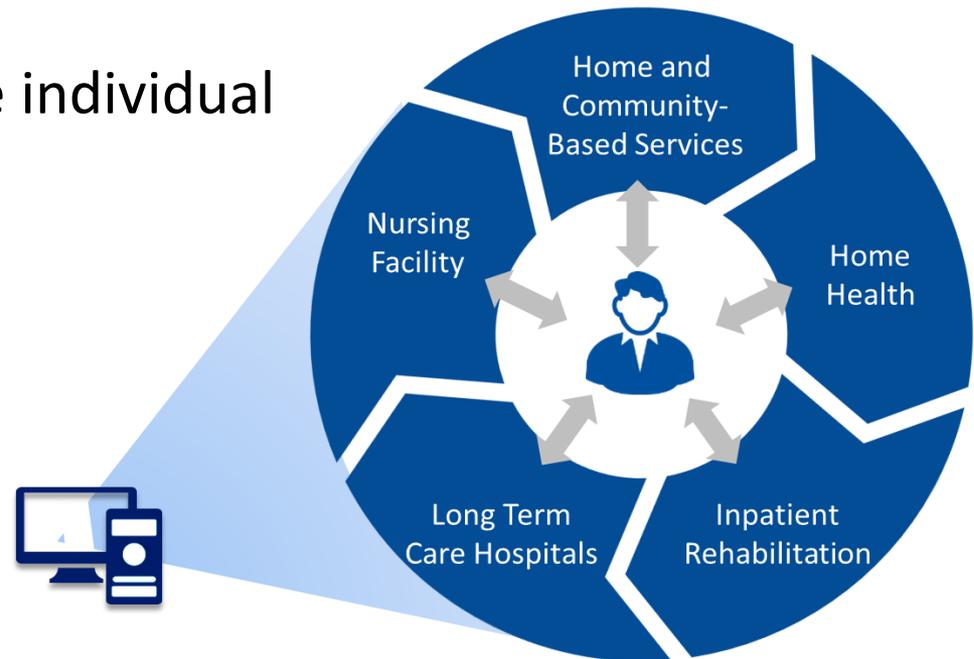
- Technical Expert Panels
- Pretesting in one Testing Experience & Functional Tools (TEFT) grantee state with different Medicaid LTSS populations
- Field testing in six TEFT grantee states with different LTSS populations
- Technical Expert Panel review of findings and recommendations
- Demonstration of finalized FASI in TEFT grantee states

FASI Performance Measures

- Two standardized measures to assess and compare state or program performance related to person-centered planning
 - Percentage of individuals **18 years or older** who received community-based LTSS with **documented needs determined by a FASI** AND who have **identified at least 3 personal priorities** related to self-care, mobility, or IADL functional needs within the reporting period
 - Percentage of individuals **18 years or older** who received community-based LTSS with **documented functional needs as determined by the FASI assessment** AND documentation of a **comprehensive person-centered service plan that addressed identified functional needs** within the reporting period

Why Standardize LTSS Assessment Items and Measures?

- Allows for comparisons across state LTSS programs
- Enables electronic exchange of LTSS data
 - Among individuals, LTSS program providers, case managers, and health care providers
 - Between LTSS caregiver partners and Medicare post acute/institutional providers
- Allows data to follow the individual



How Can the FASI Be Used by States?

- Aligns with current state approaches for assessing functional status
 - One state plans to include the FASI set as part of a new universal assessment tool that is in development
 - Other states are still in testing and assessing whether and how to integrate it into their assessments
- Represents an important component of a comprehensive person-centered assessment that could inform an individual's eligibility for HCBS and the associated service plan
 - Could be used to support an HCBS eligibility determination depending on program criteria
- Standardized measures can be used to assess and compare performance related to person-centered planning

CMS Data Element Library

- Centralized and authoritative resource for CMS' required Long Term and Post- Acute Care (LTPAC) assessment instrument data elements (e.g., questions, response codes)
 - Also includes information on how data elements map to health IT standards
- Goals include:
 - Facilitate the maintenance of uniformity across CMS assessments and quality measures
 - Serve as an authoritative resource for LTPAC assessment data elements
 - Promote the sharing of electronic LTPAC assessment data sets and information standards
 - Influence and support industry efforts to promote EHR interoperability and care coordination

How is the Data Element Library useful for HCBS?

- Publically available database of potential assessment questions and responses
 - Will include the FASI
 - States may reuse the standardized data elements from other areas
 - Most items have been previously tested for feasibility and reliability in post-acute care settings

A1000. Race/Ethnicity		BB0700. Expression of Ideas and Wants (3-day assessment period)	
↓ Check all that apply		Enter Code	Expression of ideas and wants (consider both verbal and non-verbal expression and excluding language barriers)
<input type="checkbox"/>	A. American Indian or Alaska Native	<input type="checkbox"/>	4. Expresses complex messages without difficulty and with speech that is clear and easy to understand
<input type="checkbox"/>	B. Asian		3. Exhibits some difficulty with expressing needs and ideas (e.g., some words or finishing thoughts) or speech is not clear
<input type="checkbox"/>	C. Black or African American		2. Frequently exhibits difficulty with expressing needs and ideas
<input type="checkbox"/>	D. Hispanic or Latino		1. Rarely/Never expresses self or speech is very difficult to understand
<input type="checkbox"/>	E. Native Hawaiian or Other Pacific Islander	BB0800. Understanding Verbal and Non-Verbal Content (3-day assessment period)	
<input type="checkbox"/>	F. White	Enter Code	Understanding Verbal and Non-Verbal Content (with hearing aid or device, if used, and excluding language barriers)
		<input type="checkbox"/>	4. Understands: Clear comprehension without cues or repetitions
			3. Usually Understands: Understands most conversations, but misses some part/intent of message. Requires cues at times to understand
			2. Sometimes Understands: Understands only basic conversations or simple, direct phrases. Frequently requires cues to understand
			1. Rarely/Never Understands

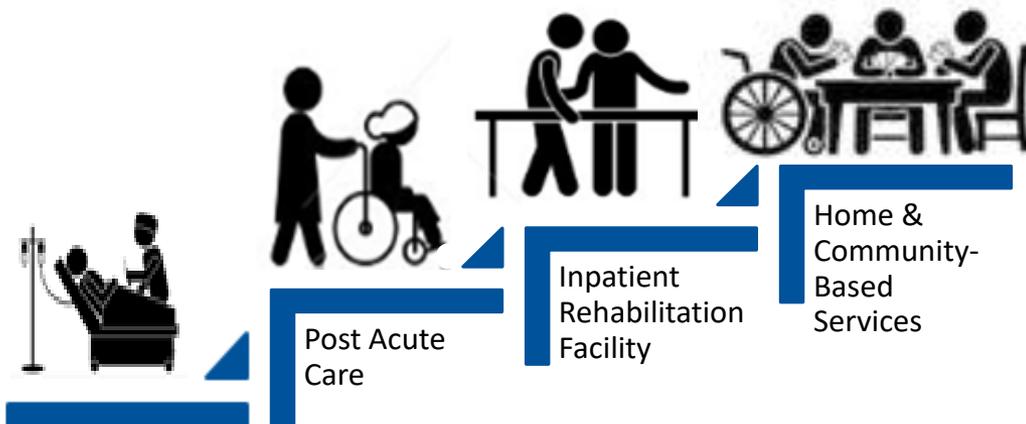
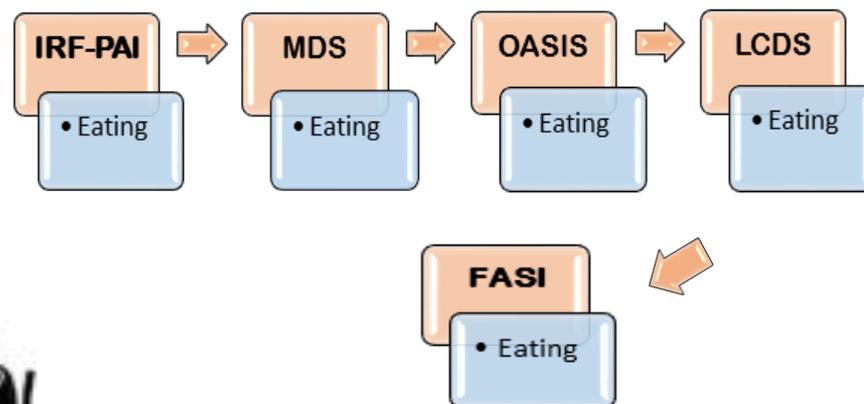
FASI USE CASE The Data Elements Library

Standardization and Interoperability

Standardized, Interoperable, Reusable EHR Data: Supports CMS and Multiple Other Users' Needs

The Data Elements Library is the centralized resource for CMS assessment instrument data elements (e.g., questions, responses) and their associated health information technology (IT) standards.

<https://del.cms.gov/DELWeb/pubHome>



Performance Level Enter Codes in Boxes		
A Usual	B Most Dependent	
<input type="checkbox"/>	<input type="checkbox"/>	6a. Eating: The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.
<input type="checkbox"/>	<input type="checkbox"/>	6b. Oral hygiene: The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]

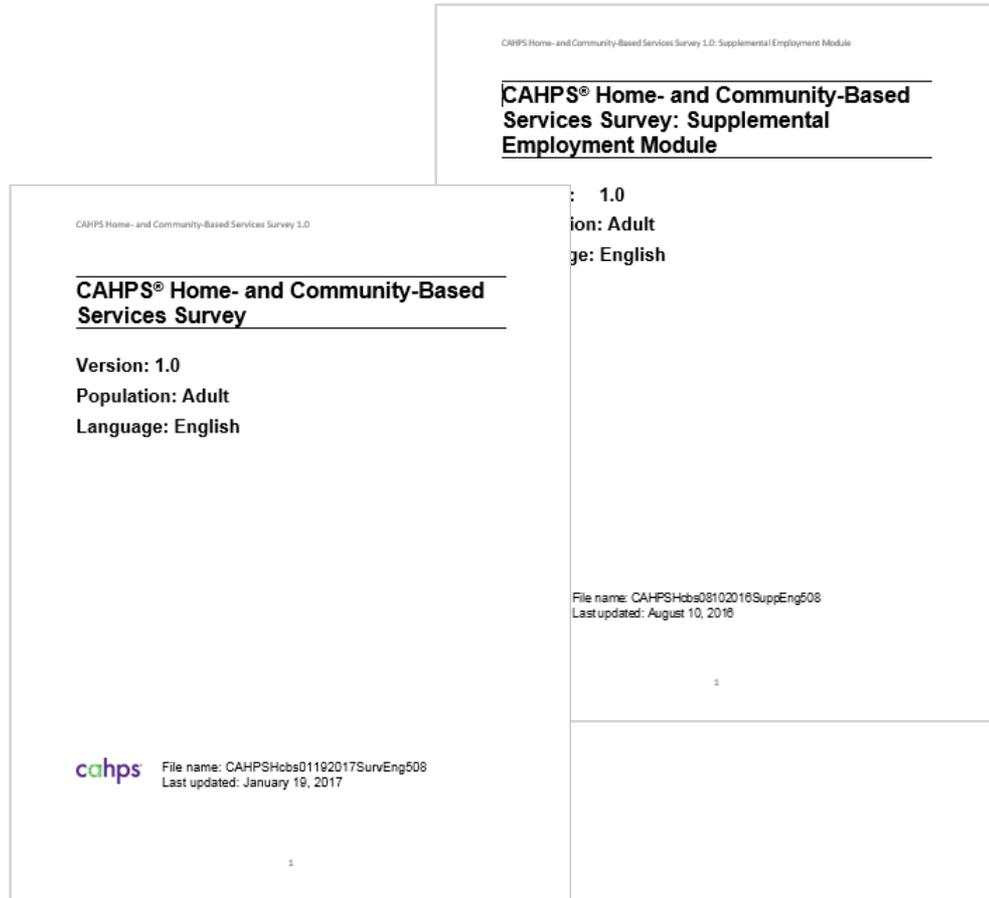
Data Follows the Person

What is the HCBS CAHPS® Survey?

- Consumer Assessment of Healthcare Providers and Systems Home- and Community-Based Services (HCBS CAHPS®) Survey
- Cross-disability consumer experience survey for eliciting feedback from beneficiaries receiving Medicaid HCBS services and supports
 - Focus on participant experience, not satisfaction
- Allows for comparisons across programs serving different target populations
 - Individuals who are frail elderly
 - Individuals with a physical disability
 - Individuals with an intellectual or developmental disability
 - Individuals with a brain injury
 - Individuals with serious mental illness

HCBS CAHPS® Survey Instruments

- Core instrument
- Supplemental employment Module
- English and Spanish versions of both



Sample Design

- Unit of analysis = HCBS program or accountable entity
- Accountable entity = operating entity responsible for managing and overseeing a specific HCBS program within a given state (e.g., managed care organization)
- Focus of analysis can vary
 - Program
 - Managed care organization
 - Case management agency
 - County
 - State

Common Services and Providers Addressed by the Survey

- Common services
 - Personal care and behavioral health care
 - Transportation
 - Home care
 - Case management
 - Employment assistance
- Common providers
 - Personal assistant and behavioral health staff
 - Medical transportation services
 - Case manager
 - Homemaker
 - Job coach

HCBS CAHPS® Survey Domains



Survey Administration

- Designed to be administered by an interviewer
 - In person
 - By telephone
 - ****Participant's choice****
- 69 maximum items
 - 30 minute average due to skip patterns
- Alternate responses (for accessibility)
 - Mostly yes, mostly no (instead of four point scale)
 - Excellent, very good, good, fair, poor (instead of 1 to 10)
- Assistance and proxy respondents allowed (not a paid provider)

Key Features of HCBS CAHPS® Survey

- Person-centered
- Cross-disability
 - Ability to compare programs
 - Increased accessibility via phone mode, alternate response, and proxy
- Development aligned with CAHPS®
 - Reflects what is important to beneficiaries
 - Rigorous review of testing methods and results
 - Trademark that providers recognize
- Survey sponsor can determine frequency of use
- Available for free

Other Important Considerations

- Current work is underway with AHRQ to implement a CAHPS® HCBS national database
 - Will offer free access to aggregated results for analysis and use
- 19 NQF endorsed HCBS measures (NQF#2967)
 - Derived from the HCBS CAHPS® Survey
 - Consist of 7 composite measures, 3 global ratings, 3 recommendation measures, and 6 single-item measures (5 unmet need and 1 physical safety)
 - Fully endorsed for inclusion in the core measurement sets for Medicaid adults and for dual-eligible beneficiaries

Alignment with the IMPACT Act and CMS Data Elements Library

Tara McMullen, PhD

Center for Clinical Standards and Quality

CMS Strategic Goals



- **Patients (customers) over Paperwork**
- **Empower customers and doctors to make decision about their health care**
- **Meaningful Measures**
- **Inter-operability – putting data in the hands of customers**
- **Quality Data Strategy: Re-defining quality**
- **Support innovative approaches to improve quality, accessibility, and affordability**
- **Improve the CMS customer experience**
- **Usher in a new era of state flexibility and local leadership**

Meaningful Measures

Promote Effective Communication & Coordination of Care

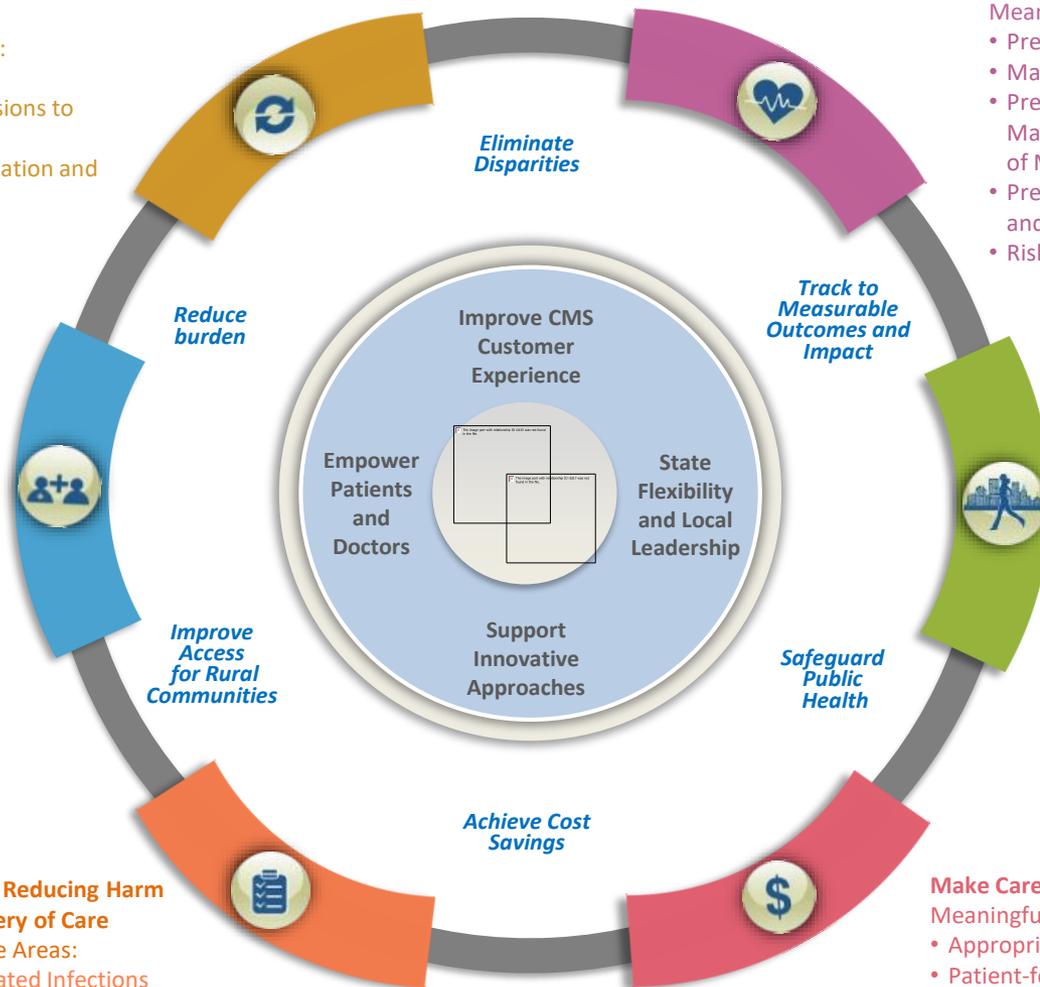
- Meaningful Measure Areas:
- Medication Management
 - Admissions and Readmissions to Hospitals
 - Transfer of Health Information and Interoperability

Strengthen Person & Family Engagement as Partners in their Care

- Meaningful Measure Areas:
- Care is Personalized and Aligned with Patient's Goals
 - End of Life Care according to Preferences
 - Patient's Experience of Care
 - Patient Reported Functional Outcomes

Make Care Safer by Reducing Harm Caused in the Delivery of Care

- Meaningful Measure Areas:
- Healthcare-Associated Infections
 - Preventable Healthcare Harm



Promote Effective Prevention & Treatment of Chronic Disease

- Meaningful Measure Areas:
- Preventive Care
 - Management of Chronic Conditions
 - Prevention, Treatment, and Management of Mental Health
 - Prevention and Treatment of Opioid and Substance Use Disorders
 - Risk Adjusted Mortality

Work with Communities to Promote Best Practices of Healthy Living

- Meaningful Measure Areas:
- Equity of Care
 - Community Engagement

Make Care Affordable

- Meaningful Measure Areas:
- Appropriate Use of Healthcare
 - Patient-focused Episode of Care
 - Risk Adjusted Total Cost of Care

****All presentation images are still under development.***

Vision for Future State



Historical state

Evolving future state

Public and Private sector

Key characteristics

- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

Systems and Policies

- Fee-For-Service Payment Systems
- Traditional managed care

Key characteristics

- Patient-centered
- Incentives for outcomes
- Sustainable
- Integrated care & Inter-operability

Systems and Policies

- Value-based purchasing
- Accountable Care Organizations
- New LTSS Options for coverage and payment
- Quality/cost transparency



The Improving Medicare Post-Acute Care Transformation Act of 2014



- Requires the use of standardized Medicare assessment data in post-acute care settings.
- Purpose:
 - Support access to longitudinal information to help inform clinical decision-making.
 - Promote coordinated care.
 - Enable comparison of data across post-acute care, including the rate-setting and payment, as well as quality of care.
 - Inform discharge planning.
 - Enable interoperability and health information exchange.
 - Outcome based decision-making to improve the beneficiary experience.
 - PAC Providers are required to submit patient assessment data to CMS via the assessment tools for multiple purposes (payment, quality measurement and survey and certification)

The IMPACT Act of 2014



Post-Acute Care Setting

- Long-Term Care Hospitals
- Skilled Nursing Facilities
- Home Health Agencies
- Inpatient Rehabilitation Facilities (IRF)
- [not included] LTSS

Assessment Instruments

- Long-term care hospital clinical data set (LCDS)
- Minimum Data Set (MDS)
- Outcome and Assessment Information Set (OASIS)
- IRF patient assessment instrument (IRF-PAI)
- [not required] Functional Assessment Instrument (FAI)

Measure Domain	Measure Name
Functional status	Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)
Skin integrity	Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) (NQF #0678)
Medication reconciliation	Drug Regimen Review Conducted with Follow-Up for Identified Issues Post Acute Care (PAC)
Incidence major falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)
Transfer of Health Information	Transfer of Information at Post-Acute Care Admission, Start or Resumption of Care from Other Providers/ Settings Transfer of Information at Post-Acute Care Discharge to Other Providers/Settings
Medicare Spending Per Beneficiary	Medicare Spending Per Beneficiary-Post Acute Care (PAC)
Discharge to Community	Discharge to Community-Post Acute Care (PAC)
Potentially Preventable Hospital Readmissions	Potentially Preventable 30-Day Post-Discharge Readmission Measure

Data Element Library (DEL)



- Database of CMS assessment information
- Includes:
 - Assessment questions/items
 - Assessment version
 - Item labels
 - Item status
- Designed to support
 - Data standardization
 - Sharing of CMS assessment data sets
 - Adoption of IT health technology standards
 - Industry and State efforts for interoperability
 - Care Coordination

Data Element Library (DEL)



- Components of the Assessment Item Sets.
- May be defined as the question/answer pair in the assessment instruments; may also be referred to as Data Items.
- Consist of:
 - Section
 - Parent
 - Question
 - Answer
 - Definitions
 - Instruction

Section C

Cognitive Patterns

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?

Attempt to conduct interview with all residents

Enter Code

0. No (resident is rarely/never understood) → Skip to and complete C0700-C1000, Staff Assessment for Mental Status
1. Yes → Continue to C0200, Repetition of Three Words

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Enter Code

Ask resident: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed. Now tell me the three words."

Number of words repeated after first attempt

0. None
1. One
2. Two
3. Three

After the resident's first attempt, repeat the words using cues ("sock, something to wear; blue, a color; bed, a piece of furniture"). You may repeat the words up to two more times.

C0300. Temporal Orientation (orientation to year, month, and day)

Enter Code

Ask resident: "Please tell me what year it is right now."

A. Able to report correct year

0. Missed by > 5 years or no answer
1. Missed by 2-5 years
2. Missed by 1 year
3. Correct

One Question: Much to Say → One Response: Many Uses

GG0160. Functional Mobility (Complete during the 3-day assessment period.)							
Code the patient's usual performance using the 6-point scale below.							
<p>CODING: Safety and Quality of Performance - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided. <i>Activities may be completed with or without assistive devices.</i></p> <p>06. Independent - Patient completes the activity by him/herself with no assistance from a helper.</p> <p>05. Setup or clean-up assistance - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.</p> <p>04. Supervision or touching assistance - Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.</p> <p>03. Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.</p> <p>02. Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.</p> <p>01. Dependent - Helper does ALL of the effort. Patient does none of the effort to complete the task.</p> <p>07. Patient refused 09. Not applicable If activity was not attempted, code: 88. Not attempted due to medical condition or safety concerns</p>	<p style="text-align: center;">↓ Enter Codes in Boxes</p> <table border="1"> <tr> <td style="text-align: center; width: 50px; height: 30px;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </td> <td style="padding-left: 10px;"> A. Roll left and right: The ability to roll from lying on back to left and right side, and roll back to back. </td> </tr> <tr> <td style="text-align: center; height: 30px;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </td> <td style="padding-left: 10px;"> B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed. </td> </tr> <tr> <td style="text-align: center; height: 30px;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </td> <td style="padding-left: 10px;"> C. Lying to Sitting on Side of Bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, no back support. </td> </tr> </table>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	A. Roll left and right: The ability to roll from lying on back to left and right side, and roll back to back.	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	C. Lying to Sitting on Side of Bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, no back support.
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The Office of the National Coordinator for
Health Information Technology

Electronic Long-Term Services & Supports (eLTSS): Charting a Path Forward

NASAUD Annual HCBS Conference

Liz Palena-Hall, LTPAC Coordinator, Office of the National Coordinator for
Health IT

Date: August 30, 2018



Agenda

- Background & Scope
- eLTSS Conceptual Framework
- eLTSS Core Dataset
- Key Activities
- Value Proposition for Health Data Standardization

Background: What is the eLTSS Initiative?

- Launched in November 2014 as a **joint project** between CMS and ONC
- Driven by the requirements of the *CMS Testing Experience and Functional Tools (TEFT) in Medicaid community-based long term services & supports (LTSS) Planning and Demonstration Grant Program*
 - » **6 of 9** TEFT grantees participate in the eLTSS component of TEFT: CO, CT, GA, KY, MD, MN
- Supports CMS Requirements for Person-Centered Service Plans (PCSPs) as defined within the [HCBS 1915 \(c\) Waiver Final Rule](#)

What is the scope of eLTSS?

1. Identifying **components or data elements** needed for the electronic creation, sharing and exchange of person-centered service plans
 - » Data elements comprise the information needed by **users** of person-centered service plans; they are the units used to populate forms for electronic exchange
2. Field testing/piloting these data elements within participating organizations (pilots) respective systems (paper based and electronic)

Who Participates in eLTSS?

339 Total Members

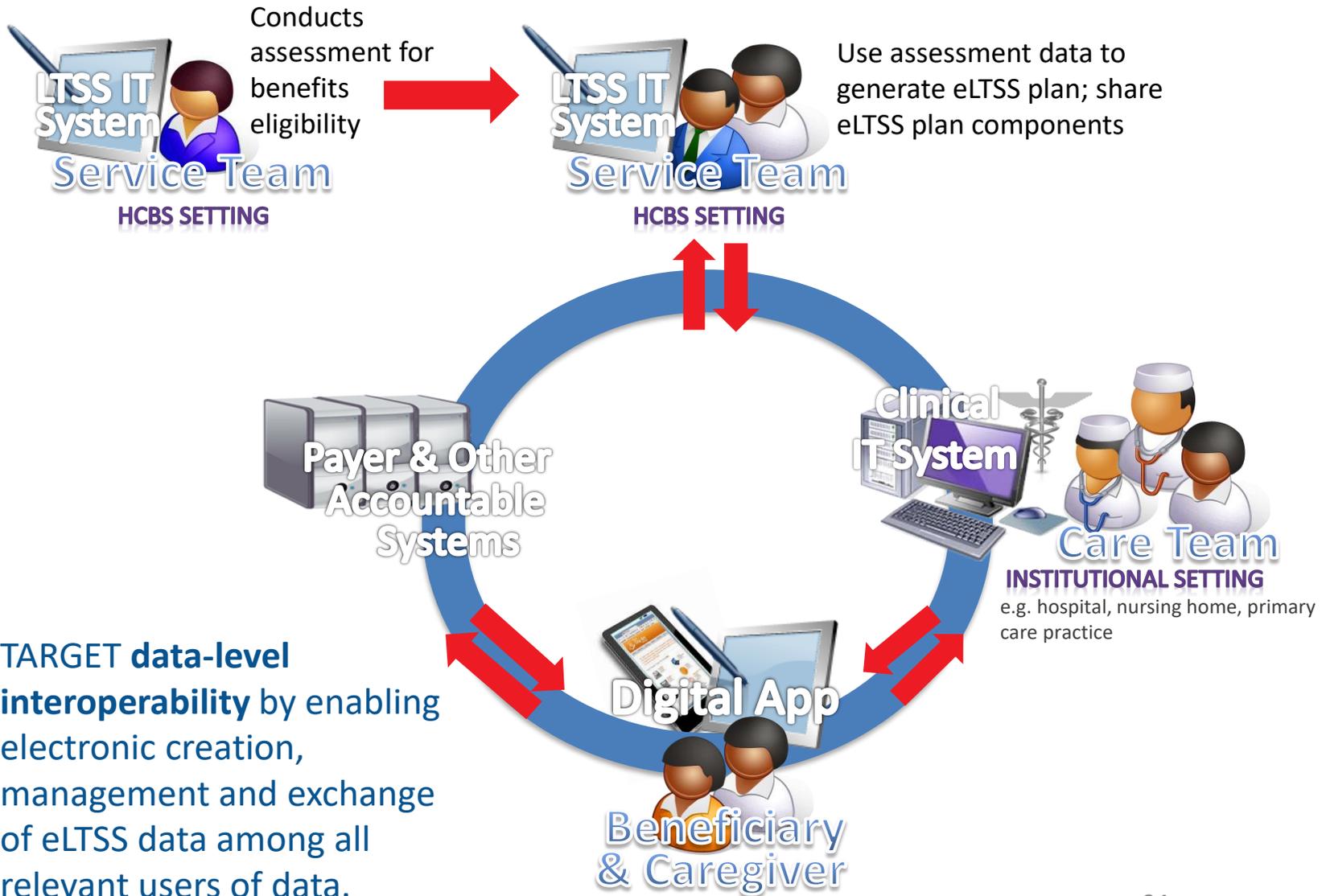
- **100 Committed Members**
- **239 Other Interested Party**
- **318 Not Registered** (attended 1+ meeting)

Stakeholder Group Type/ Total Participants

Stakeholder Group Type/ Total Participants			
Beacon Community, Quality Improvement Organizations, or similar organization	4	Research Organization	19
Consumer / Patient Advocate	12	Standards Organization	4
Contractor / Consultant	33	Service Provider (community-based)	13
Federal, State, Local Agency	143	Service Provider Professional (community-based)	11
Health Information Exchange (HIE) / Health Information Organization (HIO)	10	Other System IT Vendor (Community-Based IT Vendor or Other)	21
Health IT Vendor (EHR, EMR, PHR, HIE)	45	Other	49
Health Professional (DO, MD, DDS, RN, Tech, etc.)	15	Unknown	198
Healthcare Payer/Purchaser or Payer Contractor	5	TEFT Leadership / TA	32
Licensing / Certification Organization	2	ONC Staff / Contractor	26
Provider Organization (institution / clinically based)	9		

eLTSS Conceptual Framework

Move from Patient-Centered to Person-Centered Planning and Information Exchange



TARGET data-level interoperability by enabling electronic creation, management and exchange of eLTSS data among all relevant users of data.

eLTSS Dataset Development and Pilot Approach

- Identified and validated through **2** rounds of public-facing pilots and harmonization activities
 - » Pilots included **6** TEFT grantees and **12** non-TEFT grantees
 - » After each round, dataset went through a public comment and disposition period
- Extensive education and outreach to facilitate pilots
 - » **+130** different organizations contacted over course of initiative
 - » **5** Federal Partner Webinars
 - » **27** public outreach presentations

Harmonization (definition): *to bring into harmony, accord or agreement*
When speaking of standards, relates to process of minimizing redundant or conflicting standards which may have evolved independently.

Source: <http://ulstandards.ul.com/about/harmonizing-standards/>

eLTSS Core Dataset

- Total Number of Elements: 56

Beneficiary Demographics: 10 Elements

Person Name
Person Identifier
Person Identifier Type
Person Date of Birth
Person Phone Number
Person Address
Emergency Contact Name
Emergency Contact Relationship
Emergency Contact Phone Number
Emergency Backup Plan

Goals & Strengths: 3 Elements

Goal
Step or Action
Strength

Person Centered Planning: 11 Elements

Assessed Need
Preference
Person Setting Choice Indicator
Person Setting Choice Options
Service Options Given Indicator
Service Selection Indicator
Service Provider Options Given Indicator
Service Provider Selection Agreement Indicator
Service Plan Agreement Indicator
Plan Monitor Name
Plan Monitor Phone Number

Plan Information: 1 Element

Plan Effective Date

Plan Signatures: 12 Elements

Person Signature
Person Printed Name
Person Signature Date
Guardian/Legal Representative Signature
Guardian/Legal Representative Printed Name
Guardian/Legal Representative Signature Date
Support Planner Signature
Support Planner Printed Name
Support Planner Signature Date
Service Provider Signature
Service Provider Printed Name
Service Provider Signature Date

Risks: 2 Elements

Identified Risk
Risk Management Plan

Service Information: 12 Elements

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

Service Provider Information: 5 Elements

Support Planner Name
Support Planner Phone Number
Service Provider Name
Service Provider Phone Number
Non-Paid Provider Relationship

Key Activities 2017-2018

- **eLTSS Standard Development: Sept 2017 – Sep 2018**
 - » Led by The Georgia Department of Community Health – Health Information Technology Unit (DCH-HIT) supported by GTRI in coordination with participating TEFT States, ONC and CMS
 - » Identification of existing nationally recognized standards to represent eLTSS Dataset: FHIR and C-CDA
- **eLTSS Standard Testing: Feb 2018 – Sept 2018**
 - » May 2018 HL7 FHIR Connectathon (Germany)
 - » June 28, 2018 FHIR mini-Connectathon Event (Atlanta, GA)
 - » August 9-10, 2018 C-CDA Implementation-a-thon (Washington, DC)
 - » Sept 28-29, 2018 HL7 FHIR Connectathon (Baltimore, MD)

Key Activities

- HL7 Ballot Development & Publication: April 2018 – Sept 2018
 - » Outcomes from testing events informing development of eLTSS Whitepaper
 - » eLTSS Whitepaper will be balloted as a comment-only ballot in the HL7 August/September 2018 Ballot Cycle

Why Ballot through HL7 (Standards Development Organization-SDO)?

- SDOs provide a level of legitimacy and formality to a technical innovation
- SDOs serve to identify, publish, and curate global standards for the exchange, integration, sharing and retrieval of electronic information
- HL7 is one of the SDOs whose standards are referenced by ONC in the [2015 Edition Health IT Certification Criteria](#) and the [Interoperability Standards Advisory](#)

June 2018 eLTSS FHIR mini-Connectathon Summary and Outcomes

eLTSS FHIR mini-Connectathon Overview

- Opportunity for community stakeholders to test the final, consensus-based eLTSS Dataset (published in September 2017) using HL7 FHIR Resources.
- The Georgia and eLTSS Project Team developed a mapping of the eLTSS Dataset to existing HL7 FHIR resources. This mapping supports our goal of identifying nationally recognized standards to support the interoperable capture, sharing and exchange of eLTSS plan information.
- Findings from the Connectathon will be used to inform the development of the eLTSS ballot materials for the HL7 August/September 2018 Ballot cycle.

Participant Organizations

- State of Georgia, Department of Community Health
- Georgia Tech Research Institute (GTRI)
- American Diabetes Association (ADA)
- Long Term Care Innovation (LTCI) Inc. / LTSS DataLink®
- Office of the National Coordinator for Health Information Technology (ONC)
- JKM Software (Contractor to Veteran's Administration)
- Carradora Health
- EMI Advisors, LLC
- ESAC, Inc.

Participant Goals

- Identify any potential issues with the eLTSS Dataset to FHIR mapping
- Identify any gaps/additional needs (e.g. adding a code list or terminology to represent the data element)
- Test and validate the eLTSS Dataset and mapping in a FHIR-enabled environment
- Determine if eLTSS data elements can be represented in the FHIR resources selected
- Test sample LTSS service plans using the FHIR mapping
- Support eLTSS organizations and their interoperability goals
- Learn more about eLTSS goals and opportunities

Challenges and Lessons Learned

- **FHIR Server implementation nuances** appear during testing and can impact interactions with the participant applications.
- Determining the **specific workflow for interactions** would be helpful to prepare the participants prior to a connectathon event.
- **System pre-planning activities** should be executed to ensure systems are ready and can execute the different testing scenarios.
- **Face to face interactions** are helpful.
- **FHIR Server Setup FAQs** needed around FHIR server setup and how the server handles bundles.
- **Pre-Participant system to FHIR server testing** is helpful.
- Recommendation to have participants provide **sample files ahead of time** and address technical/setup issues prior to the event.
- **Less feedback was received on the eLTSS FHIR Mapping due to time spent on addressing learning curves with a FHIR-enabled environment.**

eLTSS Upcoming Testing Events

FHIR Testing Opportunities

- HL7 FHIR Connectathon: Care Plan Track
 - » September 29 – 30, 2018 in Baltimore, MD:
 - » eLTSS Use Cases and the eLTSS FHIR Mapping will be made available and tested as part of the Care Plan track:
http://wiki.hl7.org/index.php?title=201809_Care_Plan
 - » Who should attend?
 - eLTSS Community Implementers who plan to use C-CDA documents
 - Individuals and organizations that use and build applications for exchange
 - Users and developers working for healthcare providers, vendors and HIEs
 - » Registration Link
 - http://www.hl7.org/events/working_group_meeting/2018/09/

Stay Connected!

- Get updates and announcements regarding eLTSS:
<https://oncprojecttracking.healthit.gov/wiki/display/TechLabSC/Join+eLTSS>
- eLTSS Final Dataset and Summary: <https://tinyurl.com/y8xczjhp>

eLTSS Initiative Contacts

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Questions

Thank you for attending.