2015 Grant Makers in Aging Conference
Building Business Skills in Community Organizations: It Takes a Village

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The Office of the National Coordinator for Health IT (ONC) is the lead federal agency charged with: formulating the federal government’s health IT strategy and coordinating federal health IT policies, standards, programs, and investments.
“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
  - Test new alternative payment models
  - Increase linkage of Medicaid, Medicare FFS, and other payments to value
- Bring proven payment models to scale

Deliver Care

- Encourage the integration and coordination of 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.
Delivery System Reform Efforts and Evolving Future State

- HHS Departmental Initiative
- **Goal**: Better Care, Smarter Spending, Healthier People

**Historical state**

**Key characteristics**
- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

**Systems and Policies**
- Fee-For-Service Payment Systems

**Evolving future state**

**Key characteristics**
- Patient-centered
- Incentives for outcomes
- Sustainable
- Coordinated care

**Systems and Policies**
- Value-based purchasing
- Accountable Care Organizations
- Episode-based payments
- Medical Homes
- Quality/cost transparency
HHS goals for Medicare value-based payments

**Medicare Fee-for-Service**

**GOAL 1:** 30%

Medicare payments are tied to quality or value through *alternative payment models (categories 3-4)* by the end of 2016, and 50% by the end of 2018

**GOAL 2:** 85%

Medicare fee-for-service payments are *tied to quality or value (categories 2-4)* by the end of 2016, and 90% by the end of 2018

**STAKEHOLDERS:**

Consumers | Businesses
Payers | Providers
State Partners

**NEXT STEPS:**

Testing of new models and expansion of existing models will be critical to reaching incentive goals

Creation of a Health Care Payment Learning and Action Network to align incentives for payers
## Implementing Delivery System Reform: CMS CMMI Models

### Pay Providers

**Test and expand alternative payment models**
- **Accountable Care**
  - Pioneer ACO Model
  - Medicare Shared Savings Program (housed in Center for Medicare)
  - Advance Payment ACO Model
  - Comprehensive ERSD Care Initiative
- **Primary Care Transformation**
  - Comprehensive Primary Care Initiative (CPC)
  - Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration
  - Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
  - Independence at Home Demonstration
  - Graduate Nurse Education Demonstration
- **Bundled Payment for Care Improvement**
  - Model 1: Retrospective Acute Care
  - Model 2: Retrospective Acute Care Episode & Post Acute
  - Model 3: Retrospective Post Acute Care
  - Model 4: Prospective Acute Care
- **Initiatives Focused on the Medicaid**
  - Medicaid Emergency Psychiatric Demonstration
  - Medicaid Incentives for Prevention of Chronic Diseases
  - Strong Start Initiative
  - Medicaid Innovation Accelerator Program
- **Dual Eligible (Medicare-Medicaid Enrollees)**
  - Financial Alignment Initiative
  - Reduce Hospitalizations among Nursing Facility Residents

### Deliver Care

**Support providers and states to improve the delivery of care**
- **Learning and Diffusion**
  - Partnership for Patients
  - Transforming Clinical Practice
  - Community-Based Care Transitions
- **Health Care Innovation Awards**
- **State Innovation Models Initiative**
  - SIM Round 1
  - SIM Round 2
  - Maryland All-Payer Model
- **Million Hearts Initiative**

### Distribute Information

**Increase information available for effective informed decision-making by consumers and providers**
- **Information to providers in CMMI models**
- **Certified HIT requirements or performance reward**
- **Shared decision-making required by many models**

* Many CMMI programs test innovations across multiple focus areas
• Published by ONC in October 2015 to guide the nation towards meeting the goal of sharing information more broadly across providers, consumers and others.

• Defines how the government in collaboration with the private sector should approach sharing electronic health information and addresses the collaborative impact of all stakeholders in advancing interoperable health information.
Goals:

2015-2017: Send, receive, find and use priority data domains to improve health care quality and outcomes.

2018-2020: Expand data sources and users in the interoperable health IT ecosystem to improve health and lower cost.

2021-2024: Achieve nationwide interoperability to enable a learning health system, with the person at the center of a system that can continuously improve care, public health, and science through real-time data access.
ONC 2015 Edition Final Rule
Health IT Goals

- Improve Interoperability
- Facilitate Data Access and Exchange
- Ensure Privacy and Security Capabilities
- Improve Patient Safety
- Reduce Health Disparities
- Improve the Reliability and Transparency of Certified Health IT
- Use the ONC Health IT Certification Program to Support the Care Continuum
- Support Stage 3 of the EHR Incentive Programs
On June 2nd, 2015, the Advanced Health Models (AHMs) and Meaningful Use Workgroup of the Health IT Policy Committee conducted a hearing bringing together a diverse set of stakeholders from across the country to describe key opportunities and barriers to accelerate the design, evaluation, and adoption of advanced health models that promise to impact individual health and overall community health.

– The workgroup has sought to describe a range of emerging, community-level interventions that pragmatically utilize a mix of clinical, social, psychological, and behavioral data to improve and to coordinate health across settings for individuals.

– Accelerating AHMs through better information systems requires recognizing a broad ecosystem of technology solutions beyond the traditional electronic health records system used in clinical care.

– AHMs that bring together these disparate systems frequently rely on an additional layer of information management that can match, normalize and aggregate data to support individuals and inform targeted service provider decision-making.
Community organizations are integral partners to advanced health models and are highly motivated to share data, but sharing across clinical settings and social services is not standardized and poorly incentivized.

Advanced health models are making substantial progress by making existing data actionable in new ways, but stakeholders need seamless access to analytics capabilities to make this data useful.

Some advanced health models are responding to interoperability challenges by granting community organizations with access to a single platform, rather than realizing true interoperability across different systems.

Advanced health models will need a data infrastructure that goes beyond EHRs.

Mapping patient identities across data sets is very challenging without consistent patient identifiers.
There are many advanced health model use cases that require only limited information about an individual, not the complete record; stakeholders need tools that allow them to filter information so that only actionable information is transmitted, to avoid overwhelming the data recipient and to avoid unnecessary privacy and security risks.

Lack of clarity around privacy and security issues raised by sharing information with non-HIPAA covered community-based organizations impedes data sharing and raises concerns about adequate protection of PHI.

A shared longitudinal care plan is a critical concept for managing an individual’s health across a continuum that includes both clinical and nonclinical settings.

Community service organizations have varying levels of data support with their internal systems.

Lack of standards for human social services impedes their use and integration with clinical systems.
• Integrating social determinants data into existing health information exchange (HIE) organizations with clinical stakeholders presents governance and privacy and security challenges.

• Innovative approaches to community resource directories are addressing new ways to meet individual needs.

• Advanced health models have recognized the importance of caregivers and individuals being able to access, use, and contribute to their health data to actively support and promote individual shared care planning and shared decision making.

• AHMs are still at an early stage of developing effective patient engagement strategies.

• Global budgeting and tracking total cost of care across settings are major enablers of advanced health models and will further align incentives to encourage investments across settings and stakeholders.
CORHIO’s Grant Implementation (Colorado)

Three principal components:

1. Encourage LTPAC provider participation in community-based HIE

   ✔ Goal: Pilot HIE with 125 providers in 5 communities

2. Define and implement community goals, processes and protocols for LTPAC transitions; integrate with Clinical Advisory Committees

3. Develop statewide template and standards for improving LTPAC transitions, using HIE as integral tool

Workflow Improvement

<table>
<thead>
<tr>
<th>Average Time Spent Locating Patient Health Records</th>
<th>Average Time Pre-HIE</th>
<th>Average Time 30 days Post-HIE</th>
<th>Average Time 60 days Post-HIE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>29 hours 46 minutes</td>
<td>11 minutes 42 seconds</td>
<td>6 minutes 30 seconds</td>
</tr>
</tbody>
</table>

Source: Colorado Regional Health Information Organization (CORHIO)
AltaMed Health Services Corporation (California)
  o Will collaborate with OCPRHIO, Southern California’s leading HIE, to assist 150 providers, including skilled nursing facilities, acute rehabilitation facilities, behavioral health and specialty physician providers, to facilitate transitions of care using open source tools that allow the secure exchange of continuity of care documents (CCDs) regardless of whether or not providers use an EHR system.

Community Health Center Network, Inc. (California)
  o Will support the Community Health Center Network to provide Direct secure email addresses to a targeted number of behavioral health providers without an EHR system in Alameda County, connect them to the network, and train them on how to access data and send/receive information back to primary care providers for a more holistic view of the patients.

Georgia Health Information Network (Georgia)
  o Georgia Health Information Network (GaHIN), the Georgia statewide HIE, will leverage its recent connection with the Georgia Partnership for TeleHealth (GPT) to provide Appling and Atkinson County school nurses and the individuals (the parents/guardians and students) they serve with education, training and access to Georgia Connected Care, a robust query-based exchange.

National Healthy Start Association (District of Columbia based with a focus on South Carolina)
  o The National Healthy Start Association (NHSA) will deploy a web-based software application that will connect non-eligible health, social service, and educational organizations to South Carolina's Health Information Exchange (SCHIEx) and Centers for Medicare & Medicaid Services’s Virtual Research Data Center (VRDC), which affords access to a de-identified Medicaid/Medicare data stream. The objective of this project is to improve the health and wellness of a specific vulnerable population, served in seven (7) rural counties Pee Dee South Carolina.
Nevada Department of Health and Human Services (Nevada)
- The State of Nevada currently uses Netsmart’s Avatar, a vendor system for **behavioral health** (mental health and substance use) medical records. Nevada has proposed to connect Avatar to HealthHIE Nevada, the sole health information exchange organization.

Peninsula Community Health Services (Washington)
- Peninsula Community Health Services (PCHS) proposes to share **behavioral health** information between Kitsap Mental Health Services (KMHS), PCHS and Washington’s State Health Information Exchange—OneHealthPort. This project will utilize Consent2Share, an open source tool for consent management and data segmentation that is designed to integrate with existing EHR and HIE systems. In addition, Consent2Share will also provide a patient portal that will allow patients the ability to access their own medical records.

Rhode Island Quality Institute (Rhode Island)
- The Rhode Island Quality Institute (RIQI) will leverage its operational infrastructure, statewide Health Information Exchange (HIE) “CurrentCare”, and established relationships to include **behavioral health care providers** in the network of stakeholders who electronically send, receive, find, and use health information. RIQI will engage non-­eligible providers at Butler Hospital, the state’s only non-­profit, free-standing psychiatric hospital serving adults, seniors, and adolescents and Rhode Island’s eight community mental health organizations (CMHO) to close information gaps.
New Community Interoperability and HIE Cooperative Agreement Program

Utah Department of Health (Utah)
- The Utah Department of Health (UDOH), Utah Health Information Network (UHIN), and Intermountain Healthcare (Intermountain) will jointly implement this project to expand uses of the existing state designated, secure, interoperable clinical Health Information Exchange (cHIE) to improve the care coordination for newborn hearing screening and follow-up in the state of Utah.

UW Health/University of Wisconsin-Madison (Wisconsin)
- UW Health/University of Wisconsin-Madison proposes a project that will increase health information exchange (HIE) between the Madison Metropolitan School District (MMSD) School Nurses and UW Health/UW Hospital and Clinics. Specifically, EHR access (via Epic Care Link) will be extended to MMSD elementary school nurses to utilize the EHR to view health information, receive EMR generated Asthma Action Plans (AAP), medication authorization forms, and release of information forms.

Washtenaw County—Community Support and Treatment Services (Michigan)
- Washtenaw County Support and Treatment Services (CSTS) is partnering with Altarum Institute and the Michigan Center for Effective IT Adoption (M-CEITA), Michigan’s health IT Regional Extension Center, to extend participation in electronic Consent (eConsent) for sharing of behavioral health and physical health information to key community service partners in Washtenaw County, Michigan.
eLTSS Initiative Introduction
What is the eLTSS Initiative?

- Launched as an S&I Initiative in November 2014 in partnership with Centers for Medicare & Medicaid Services (CMS)
- 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*
  - Introduced in Affordable Care Act (ACA) Section 2701
  - March 2014: CMS awarded Demonstration Grants to 9 states: AZ, CO, CT, GA, KY, LA, MD, MN, NH

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/TEFT-Program-.html
Identify, evaluate and harmonize standards needed for the creation, exchange and re-use of:

- Key domains and associated data elements of Community Based-Long Term Services and Support (CB-LTSS) person-centered planning; and
- Accessible person-centered service plans that are interoperable and used by providers, beneficiaries, accountable entities and payers.

The standard(s) identified will support the creation of a person-centered electronic LTSS plan, one that supports the person, makes him or her central to the process, and recognizes the person as the expert on goals and needs.*

* Source: Guidance to HHS Agencies for Implementing Principles of Section 2402(a) of the Affordable Care Act: Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs
What is in an eLTSS Plan?

Domains
- Person Information
  - Work
  - Residence
  - Community Inclusion
  - Choice & Decision Making
  - Relationships
  - Self-Direction
  - Demographics
  - Person-Centered Profile

- Health, Wellness, and Rights
  - Health
  - Medications
  - ADLs/ IADLs
  - Safety
  - Wellness
  - Behavioral Needs
  - Restrictions

- Service Planning and Coordination
  - Service Coordination
  - Personal Finance Information
  - Service Information

- Family
  - Family Information
  - Community Connections
  - Access & Support Delivery
  - Information & Planning

Sub-domains

Cross-cutting Domains
- Goals
- Priorities
- Issues
- Interventions
- Units of Service
Future: eLTSS Plan Conceptual Framework

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

- **Service Team**
  - Updates and displays eLTSS Plan; stores/transmits data
- **Beneficiary & Caregiver**
  - Updates and displays eLTSS Plan; stores/transmits data
- **Payer & Other Accountable Systems**
  - Extract, Transform, & Load eLTSS Plan Data
- **Care Team**
  - Updates and displays eLTSS Plan; stores/submits data

**Other IT System**
- Displays eLTSS Plan
- Ancillary Team
  - Other Service Setting
    - e.g. education system, legal system
- Clinical IT System
  - Institutional Setting
    - e.g. hospital, nursing home, primary care practice

**eLTSS Plan Groupings**
- Create Plan
- Approve Services
- Send/Receive Plan
- Access/View Plan
- Update Plan

**Move from Patient-Centered to Person-Centered Planning**
The success of the eLTSS Initiative relies on the participation of a wide range stakeholders including Health IT vendors, health systems, implementers, standards development organizations, consumer/individual advocates and the general public. Any interested party is invited to participate, and can choose to either participate as an Initiative Committed Member, or Other Interested Party.

- The Initiative meets every Thursday from **12:30 to 1:30pm Eastern**
- Meeting information can be found on the wiki: [http://wiki.siframework.org/electronic+Long-Term+Services+and+Supports+%28eLTSS%29](http://wiki.siframework.org/electronic+Long-Term+Services+and+Supports+%28eLTSS%29)
Resource Links

- Shared Nationwide Interoperability Roadmap - Final Version 1.0
  https://www.healthit.gov/policy-researchers-implementers/interoperability
- Federal Health IT Strategic Plan 2015-2020
  https://www.healthit.gov/policy-researchers-implementers/health-it-strategic-planning
- ONC 2015 Edition Final Rule and Supplemental Materials
- Improving Transitions of Care in LTPAC: An Update from the Theme 2 Challenge Grant Awardees (2013)
Stay Connected, Communicate, and Collaborate

• Browse the ONC website at: [HealthIT.gov](http://HealthIT.gov)

• Signup for email updates: [public.govdelivery.com/accounts/USHHSONC/subscriber/new?](public.govdelivery.com/accounts/USHHSONC/subscriber/new?)

• Visit the Health IT Dashboard: [dashboard.healthit.gov](dashboard.healthit.gov)

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**Health IT and Electronic Health Record**

Office of the National Coordinator for Health Information Technology

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