ASTP Assistant Secretary for Technology Policy

Person-Centered Care Planning and Social Care Referrals: FHIR Real World Implementation, Policy, and Technical Resources

ASTP Annual Meeting

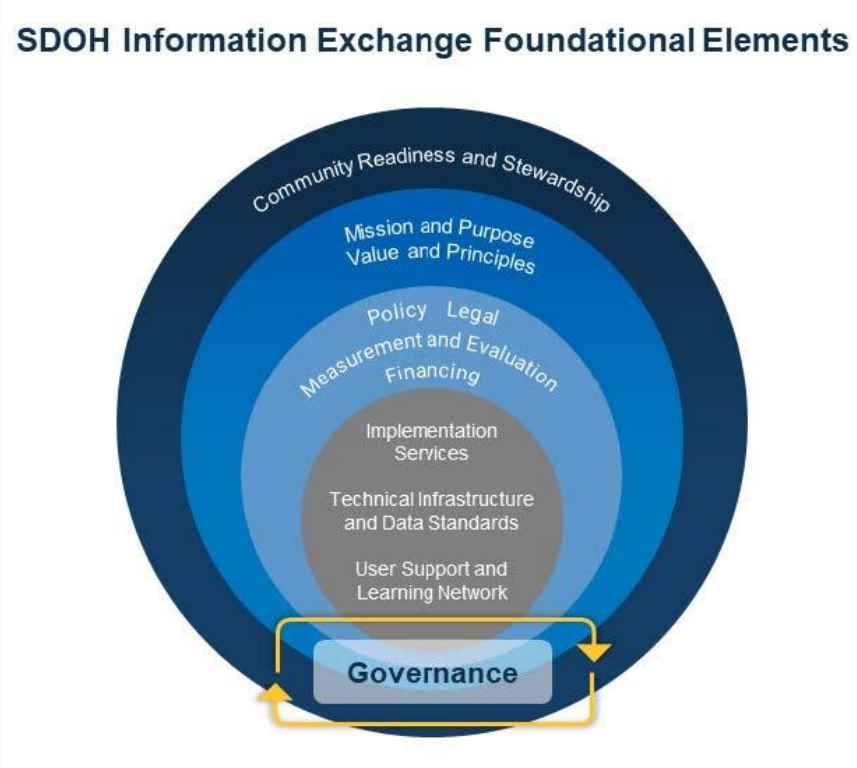
December 5, 2024

Social Determinants of Health Information Exchange Toolkit

Meley Gebresellassie

SDOH Information Exchange Toolkit

- Developed by ASTP/ONC with support from EMI Advisors and a panel of technical experts convened in 2020.
- Provides information on the **SDOH information exchange landscape** to stakeholders of all experience levels.
- **Identifies approaches to advance SDOH information exchange** goals through the 'foundational elements' framework.
- Provides **examples of common challenges and promising approaches**.
- Shares **guiding questions and resources** to support implementers.
- Available here: [Social Determinants of Health (SDOH) Information Exchange Toolkit]



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Learning Forum Webinar Series

DESCRIPTION	Meeting Date	Materials Link
Phase I Webinars		
Introduction to SDOH Information Exchange and the Learning Forum	March 2022	View past meeting materials and recordings here
Vision, Purpose, and Community Engagement	April 2022	
Governance	May 2022	
Technical Infrastructure and Interoperability	June 2022	
Policy and Funding	July 2022	
Phase II Webinars		
Community-level Governance	February 2023	View past meeting materials and recordings here
Values, Principles, and Privacy	March 2023	
Implementation, Measurement, and Evaluation	May 2023	
SDOH Information Exchange Learning Forum Summary	June 2023	

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Social Determinants of Health Information Exchange Technical Integration and Implementation Framework

“SDOH Technical Framework”

Brenda Akinnagbe

SDOH Technical Framework

- Complements the SDOH Information Exchange Toolkit (the Toolkit) by using the Toolkit's foundational elements, along with real world lessons and partner input to create a step-by-step framework of the phases of a SDOH integration project.
- The SDOH Technical Framework is a document designed for both technical and non-technical partners to collaborate throughout the various phases of an SDOH data integration project.
- Additional appendices include four documents targeting technical implementers. (Future release date).
- The SDOH Technical Framework includes phases that reflect what implementers adopting electronic data integration or advancing to interoperable information exchange need to implement a health IT solution.

Phases

1 **Planning**
View

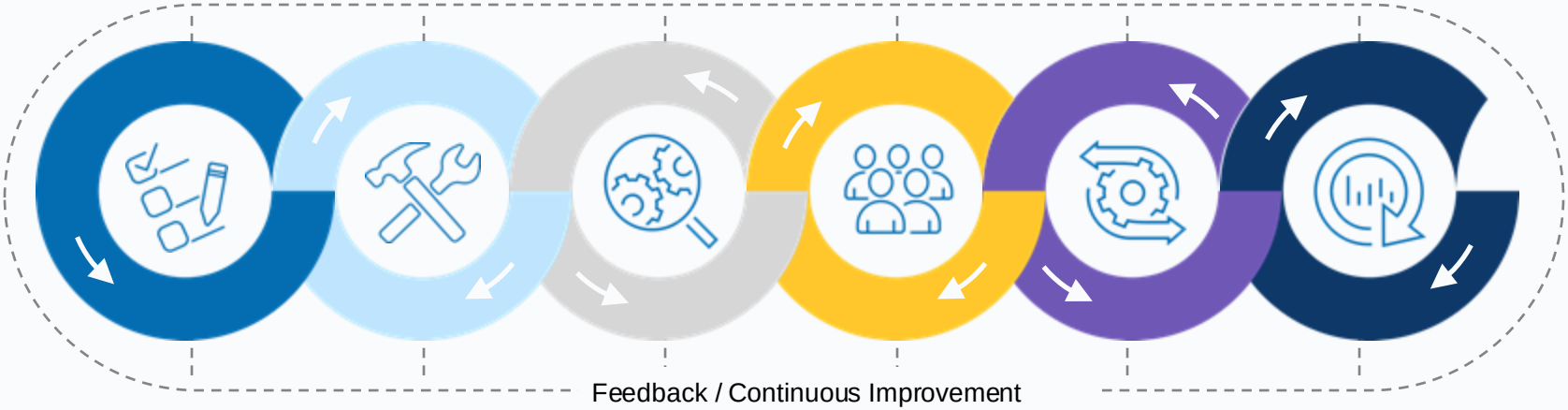
2 **Development**
View

3 **Testing**
View

4 **Training**
View

5 **Go-Live**
View

6 **Ongoing Activities**
Technical Maintenance, Usage Auditing, and Reporting
View



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Reach out via phone or web

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Improving lives THROUGH supports and services THAT FOSTER self-determination.

FHIR-ed Up *for* INTEROPERABILITY

The Missouri eLTSS Project

ASTP Annual Meeting 2024

December 5, 2024

Introduction and Objectives

Toi Wilde, RN, BSN, MBA, CPHQ, LSSGB

Director of Strategic IT Initiatives
Missouri Department of Mental Health - Division of Developmental Disabilities

- Describe the current state of care plan data exchange for Individuals with Intellectual or Developmental Disabilities in Missouri.
- Demonstrate a solution to a data exchange challenge using partnership with HINs and developing a FHIR API.
- Describe how eLTSS care plan data exchange is beneficial to caring for individuals with IDD.

Intellectual and Developmental Disabilities (IDD)

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- Cerebral Palsy
- Epilepsy
- Head Injury
- Autism
- Mental/Physical Impairment
- Brain dysfunction

Caring for Individuals with IDD

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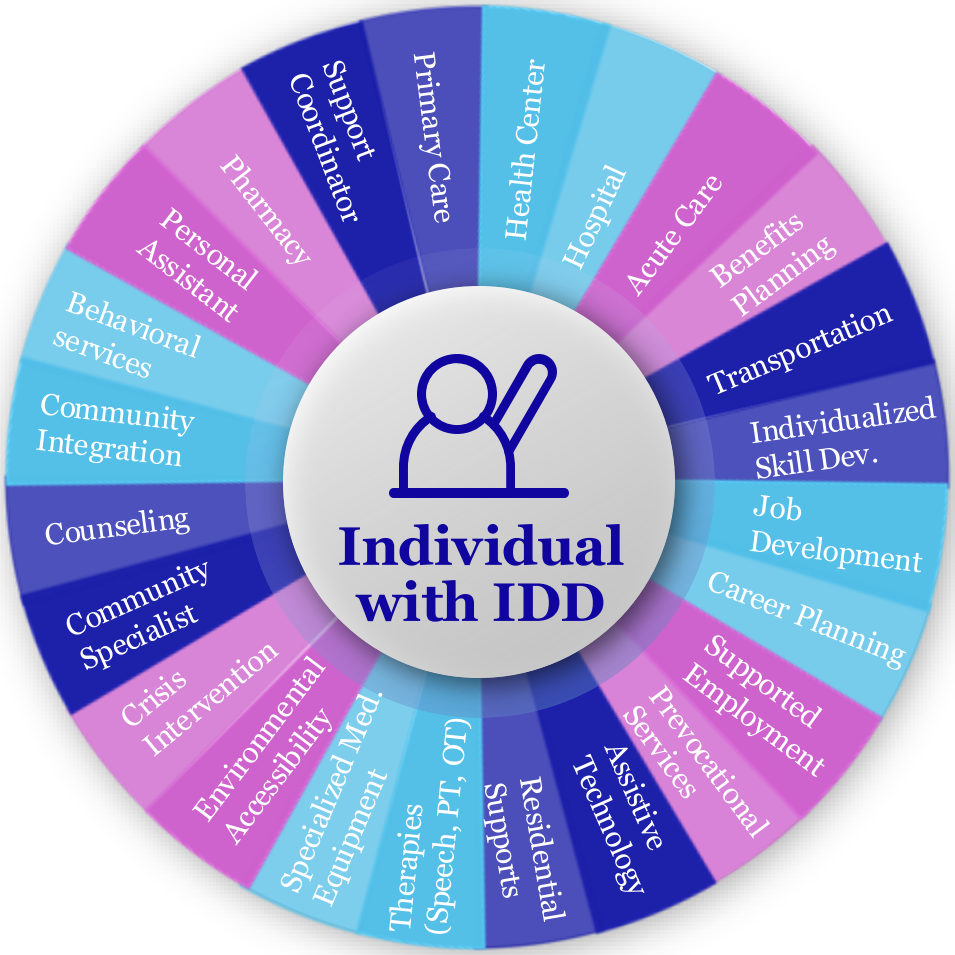

Division of Developmental Disabilities

MISSOURI DIVISION OF DEVELOPMENTAL DISABILITIES

MO contracts with **over 600 home and community-based services (HCBS) providers** for HCBS Medicaid waiver services.

- HCBS provide person-centered care in the home and community to individuals with IDD who require support with daily tasks.
- HCBS programs generally fall into two categories:
  - health services
  - social services

Examples of HCBS providers in Missouri

- State-operated regional offices
- Habilitation centers
- Community services programs
- Residential and non-residential support services

Sources: Centers for Medicare and Medicaid Services

A Disconnected Health and Social Care IT Ecosystem

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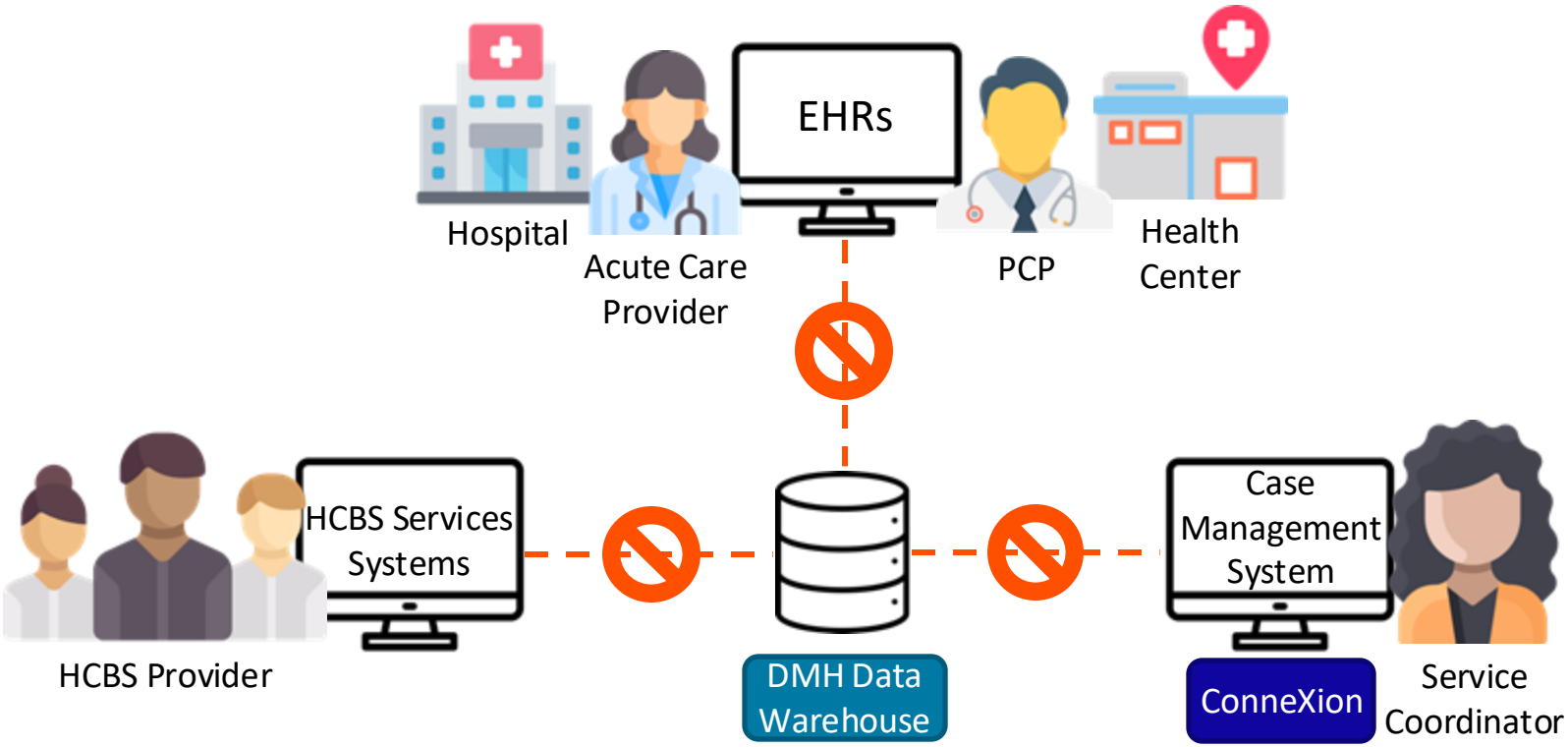
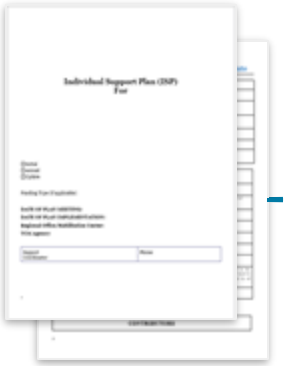


Current State of eLTSS Care Plan Exchange

Annual Meeting

DMH Person Centered Service Plan



Paper-based Person-Centered Service Plan

- ✗ Time-intensive
- ✗ Inconsistent
- ✗ Risk for errors
- ✗ Limited scalability

- Primary Care
- HCBS Provider
- Hospital
- Specialist

External Providers

Vision: Seamless Data Sharing Across The Individual's Care Team

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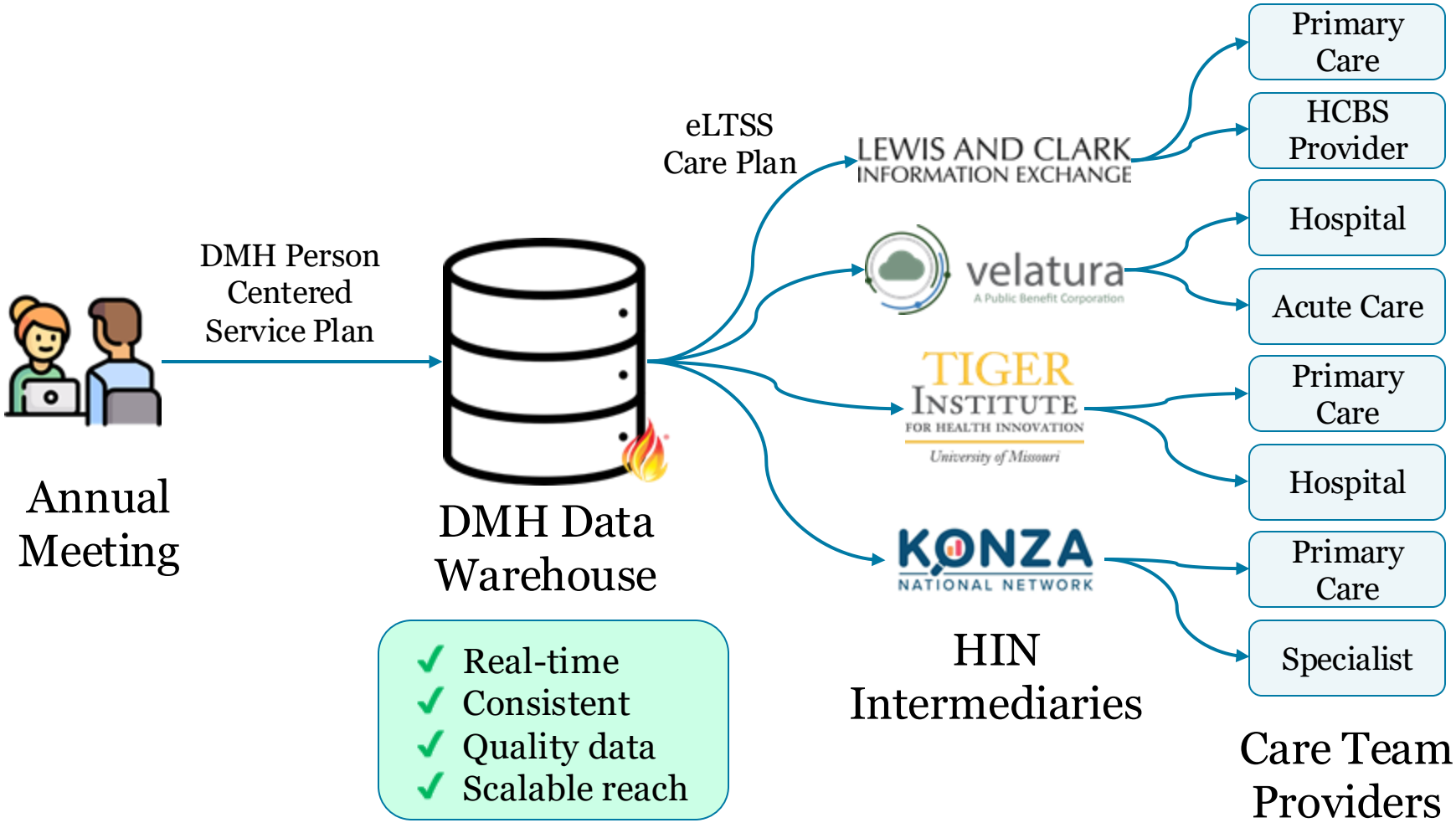

Missouri's Technical Solution for Exchanging Care Plan Data

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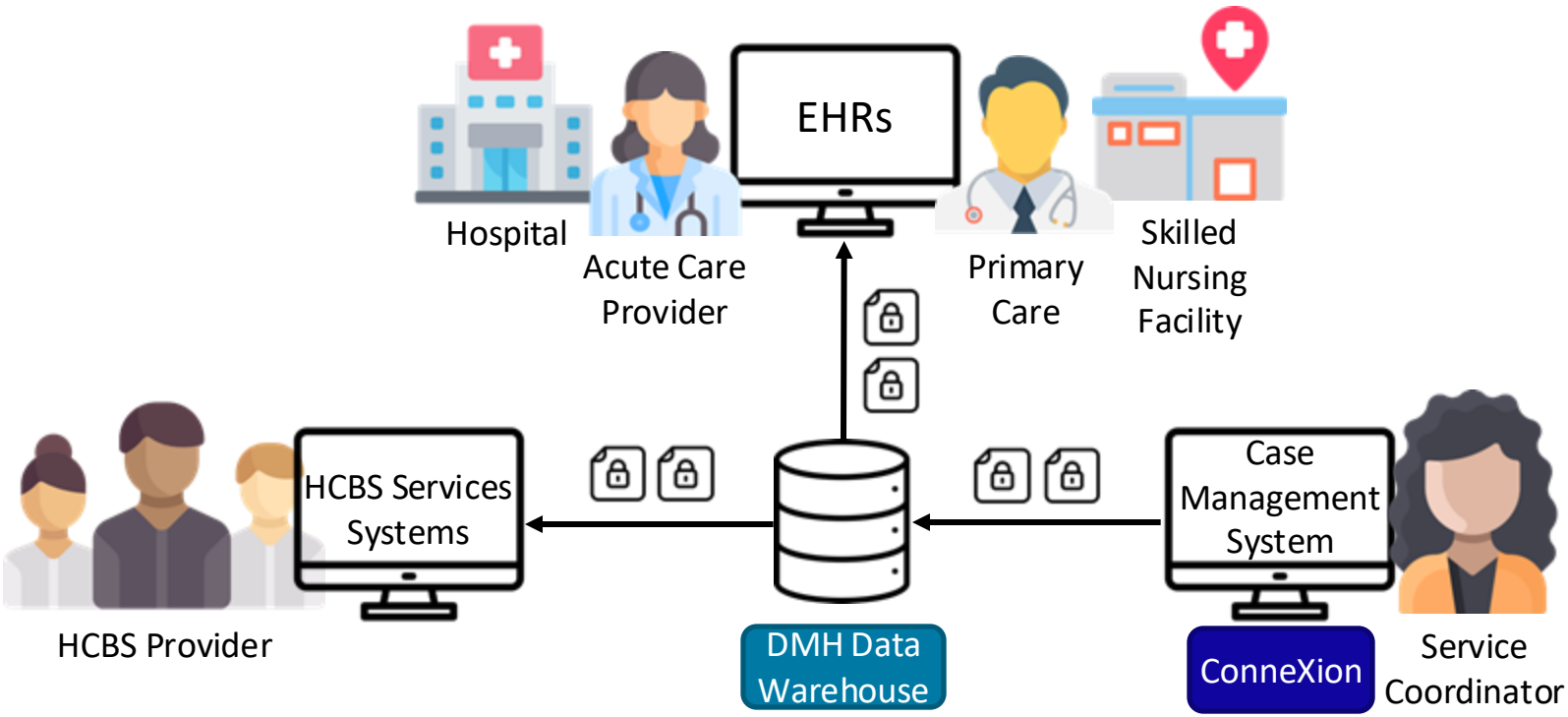

An integrated health and social care ecosystem to exchange person-centered service plan (PCSP) data supported by the standards-based electronic long term services and supports (eLTSS) dataset.

Legend

- eLTSS care plan data
- FHIR API via HIN intermediary
- IT system

Alignment to National Interoperability Objectives

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HHS Data Strategy:

HHS strategy to enhance data accessibility, governance, sharing, and security across healthcare systems.

Federal Health IT Strategic Plan:

ASTP/ONC Plan to modernize healthcare systems through interoperability and digital transformation.

Federal FHIR Action Plan:

ASTP/ONC plan to promote FHIR adoption for seamless data exchange and system interoperability.

HHS Health IT Alignment Policy:

HHS/ASTP policy to align health IT standards to improve national healthcare data interoperability.

eLTSS Health Data Exchange Project Objective

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FHIR-ed Up for INTEROPERABILITY

The objective of this project is to **bridge the gap for individuals with IDD** receiving HCBS Waiver services and their care providers **by providing the ability to receive and access current person-centered care plan* data** to support the provision of quality care and services.

Learn more: dmh.mo.gov/dev-disabilities/eltss

**Federal regulations require a person-centered plan for HCBS, whether provided through the State, Medicaid plan, or a waiver process.*

Two Methods for Digital eLTSS Care Plan Data Exchange

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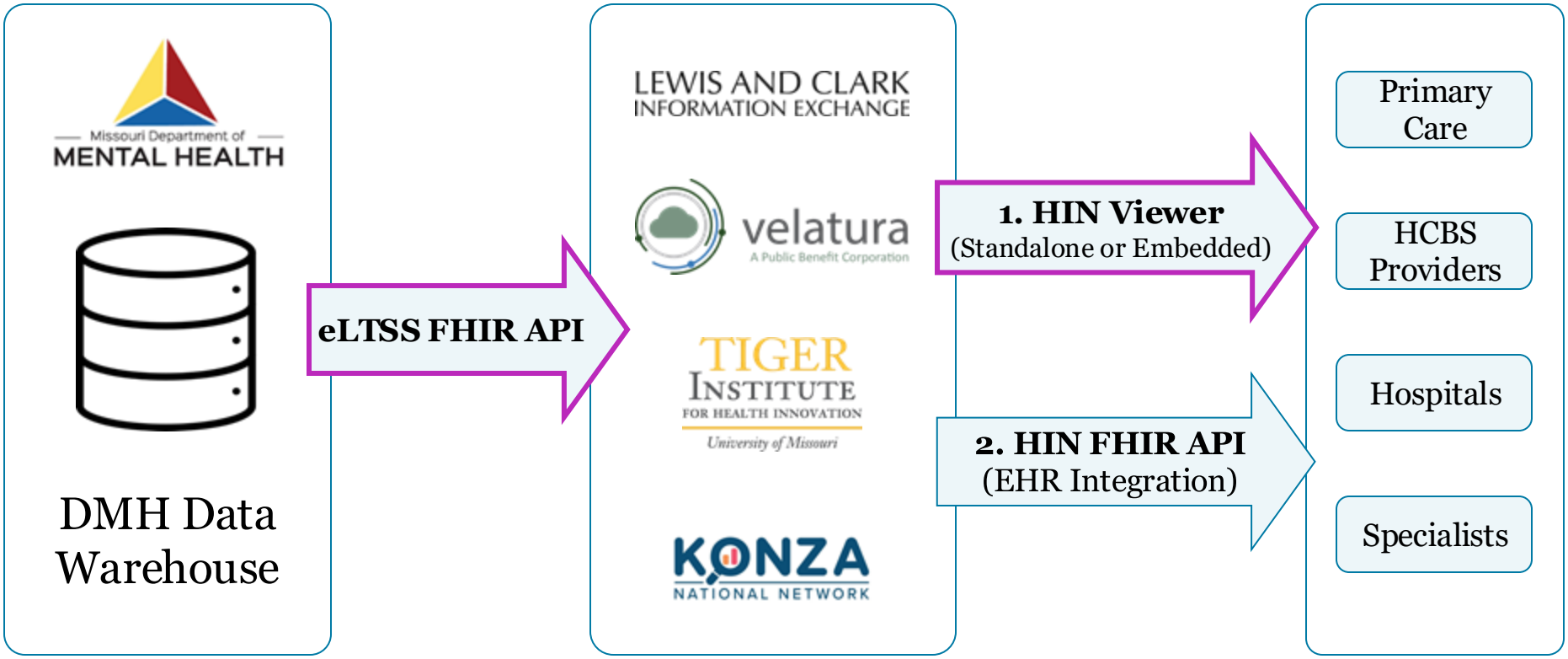

= Addressed in Phase 1

eLTSS Project Phase 1 Final Milestone: Testing Event

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Testing Event Objectives

1. Demonstrate the intermediary system actor's ability to **query care plan data** from the State Data Warehouse through a **FHIR R4 API**.

2. Evaluate the extent to which system actors can ingest and make eLTSS data available for end users.

Participants

Facilitators

emi ADVISORS

MettaHealth Partners

PatientCentricSolutions

Observers

Missouri Department of MENTAL HEALTH

ASTP

MoHealthNet

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

dss Missouri Department of Social Services

NCQA Measuring quality. Improving health care.

Actors

State Data Warehouse

itsd State of Missouri - Office of Administration Information Technology Services Division

infocrossing™

Intermediaries

LEWIS AND CLARK INFORMATION EXCHANGE

TIGER INSTITUTE FOR HEALTH INNOVATION University of Missouri

velatura A Public Benefit Corporation

EHR Actor

StationMD

eLTSS Health Data Exchange Phase 2 Success Outcome

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FHIR-ed Up *for* INTEROPERABILITY

Phase 2 Success Outcome: Produce a **live, in-production implementation** of the eLTSS FHIR IG so care team end users can access the eLTSS care plan for individuals with IDD through the HIN viewer and/or through an EHR connection to an outbound HIN FHIR API.

Steps for SDOH Data Integration

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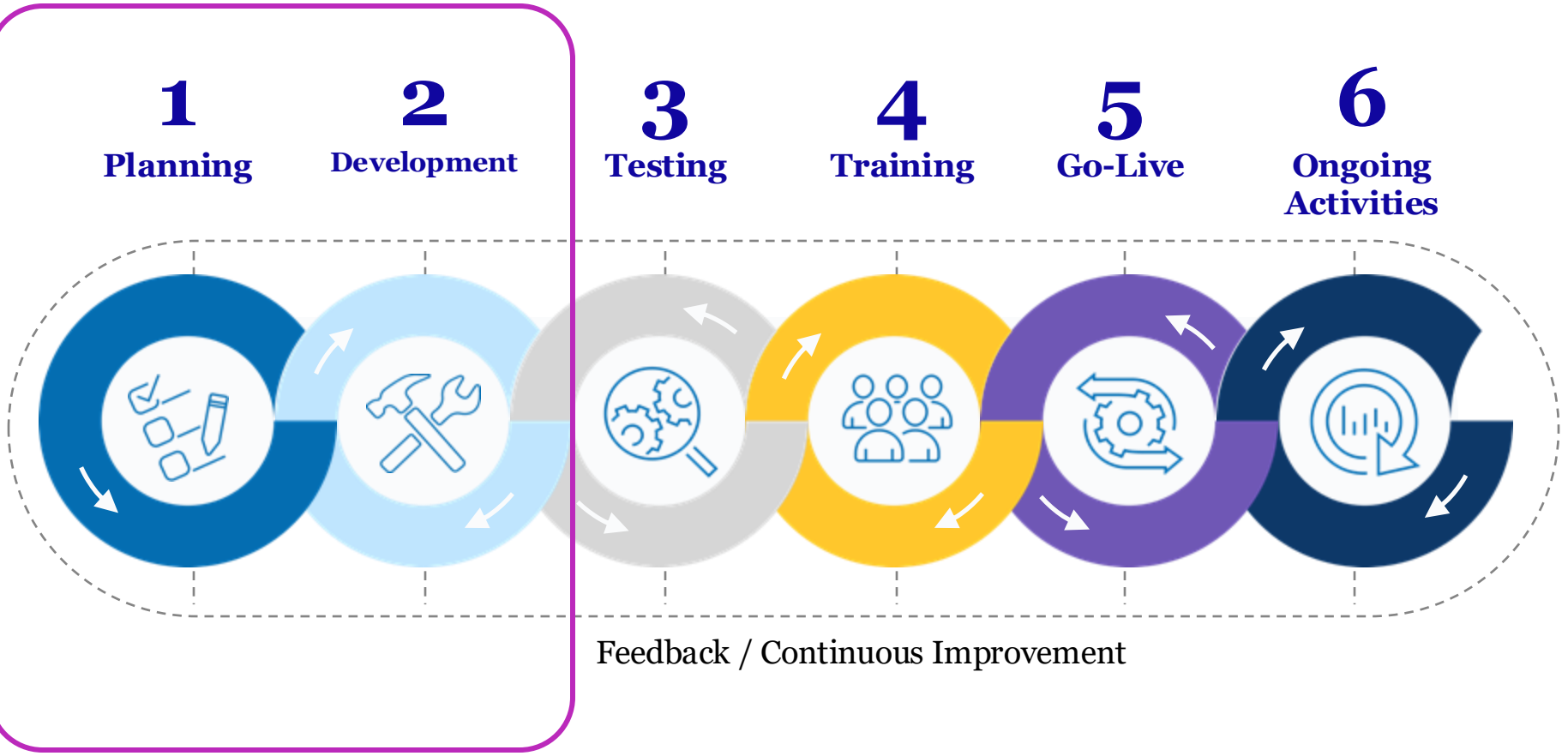
We are here:



DMH-DD Interoperability Initiatives

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Case Management System

ConneXion
Division of Developmental Disabilities

Home and Community Based Services Provider Onboarding Program

Department of Mental Health
HIE Onboarding

DMH Electronic Health Records (EHR) System

ORACLE Cerner

eLTSS Health Information Data Exchange Project

FHIR-ed Up for INTEROPERABILITY

Interoperability is Foundational to Improving Care

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Improving lives THROUGH supports and services THAT FOSTER self-determination.

Toi Wilde

Director of Strategic IT Initiatives,
Division of Developmental Disabilities

toi.wilde@dmh.mo.gov

Appendices

Method 1: HIN Viewer

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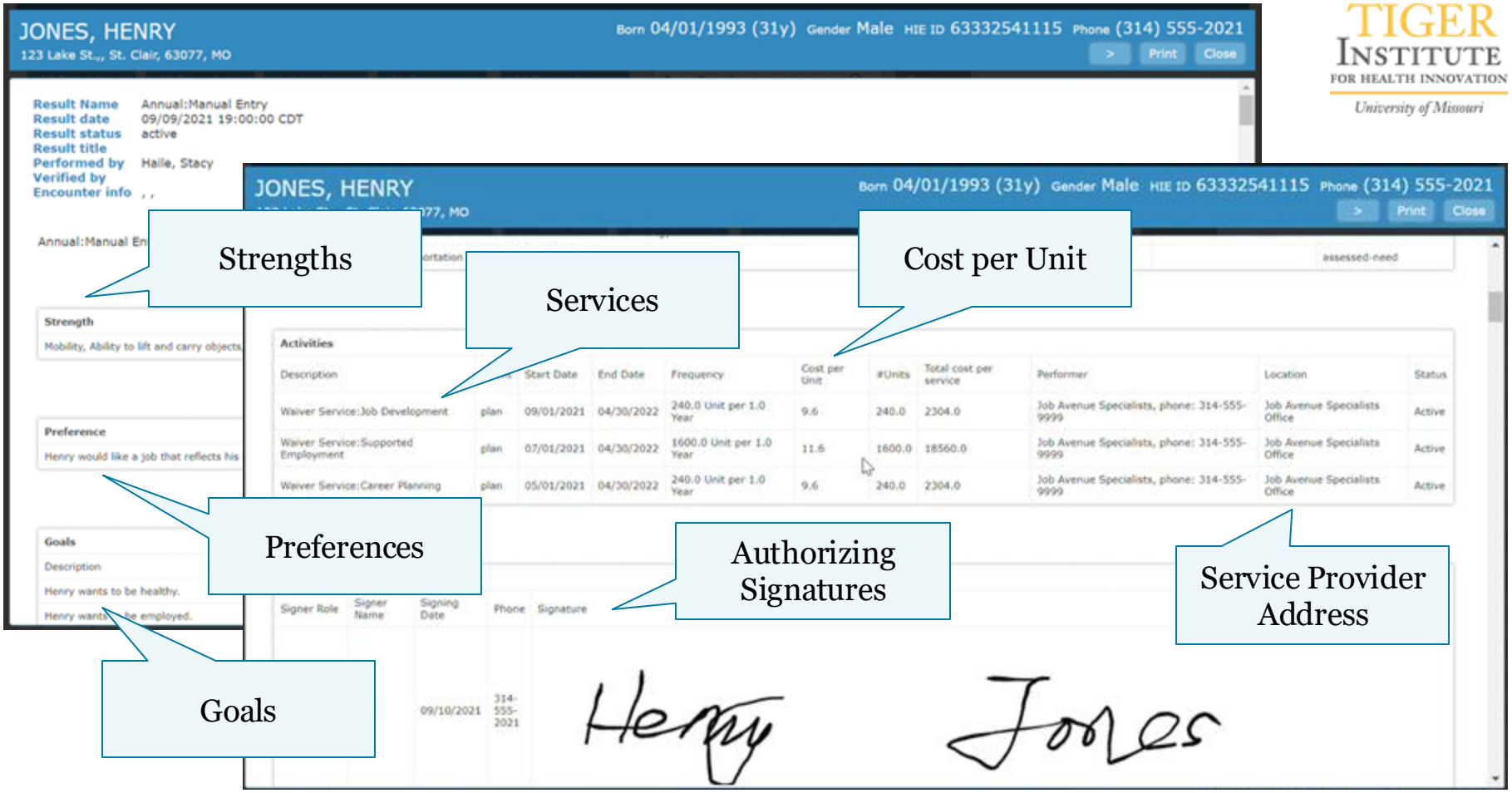
TIGER INSTITUTE FOR HEALTH INNOVATION
University of Missouri



Method 2: Outbound FHIR API

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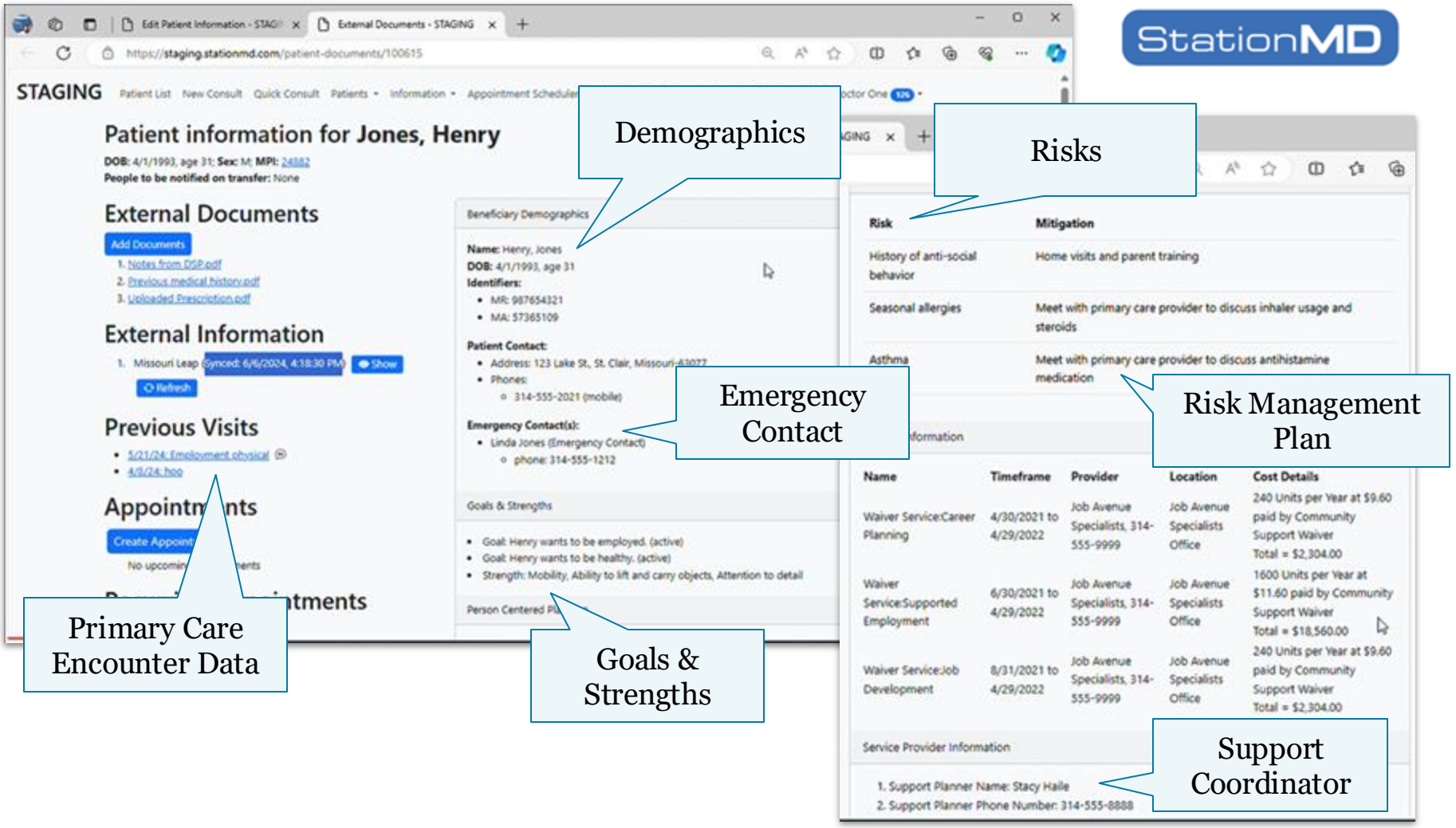
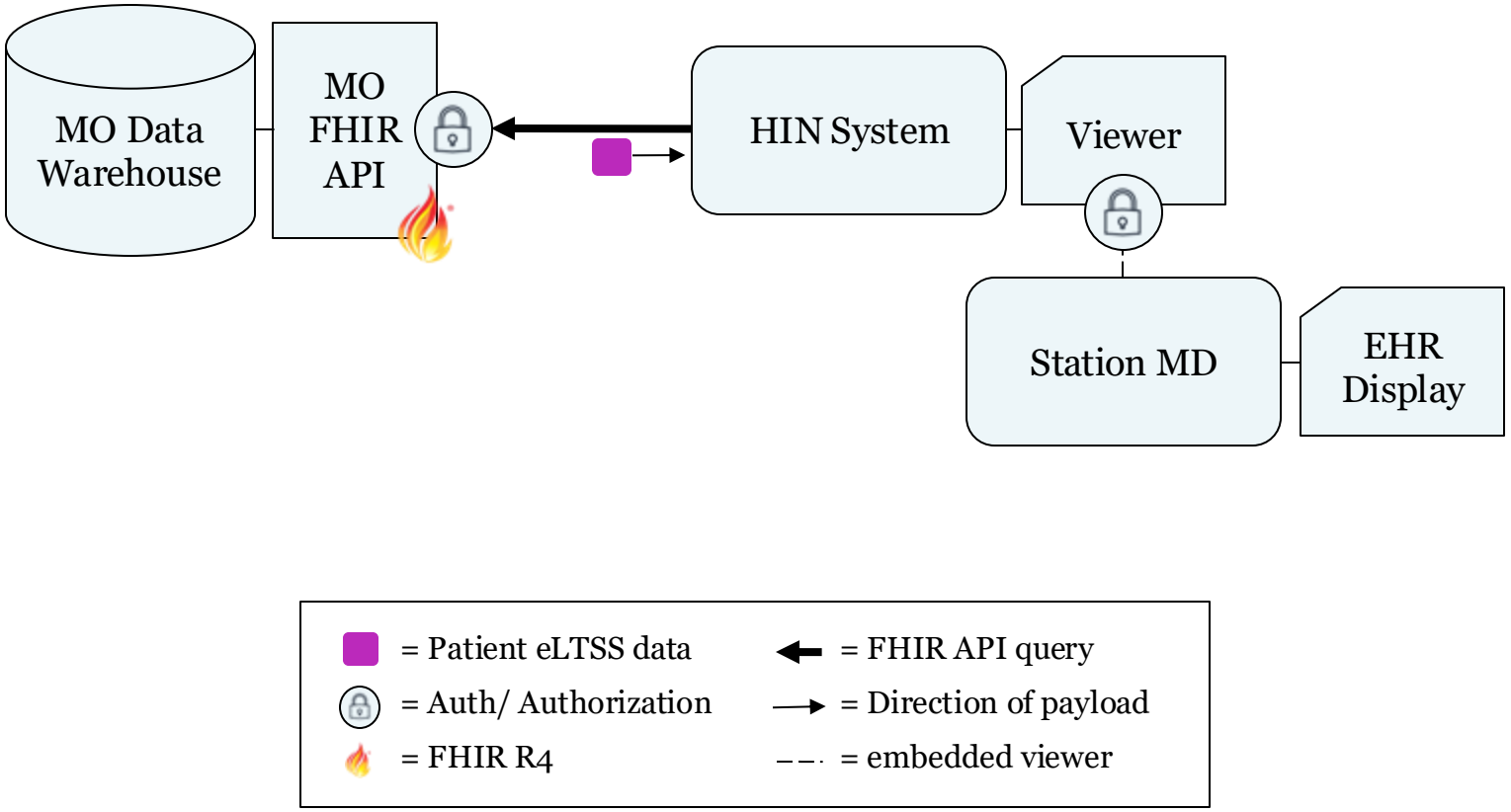
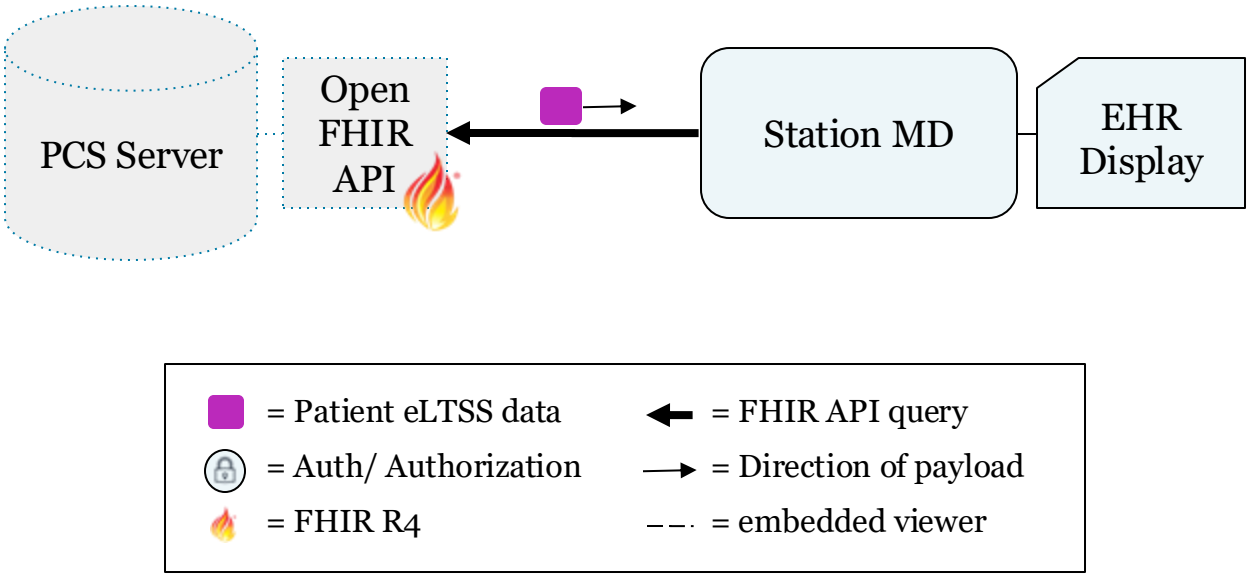


eLTSS Phase 1 Test Plan



eLTSS Phase 1 Test Plan

MISSOURI DIVISION OF DEVELOPMENTAL DISABILITIES



SHIN-NY Implementation Using Gravity SDOH Standards

Lindsay Ferris, DrPH, Technical Implementation Lead | NYeC SHIN-NY
James Shalaby, PharmD, FAMIA | Gravity Project | Elimu Informatics,Inc

December 5, 2024

Agenda

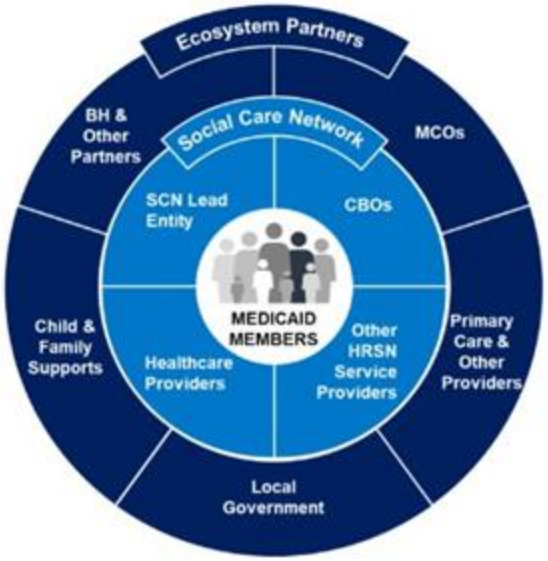
- NYHER 1115 Waiver Overview
- SHIN-NY Responsibilities
- Gravity SDOH standards: Fit for purpose
- Demo
- Q/A

Medicaid 1115 Waiver Amendment - New York Health Equity Reform (NYHER) Overview

CMS approved in January 2024 to address health disparities and systemic health care delivery issues highlighted and intensified by the COVID-19 pandemic.

Social care ecosystem

SCN Lead Entities will work closely with their Networks to identify and address HRSNs among Medicaid Members in each region, as well as work with a broader set of partners to help address the needs of Members.



Roles of entities within the social care ecosystem

Social Care Network

- **SCN Lead Entity:** Coordinate SCN to conduct HRSN screening and deliver services to ensure Member HRSNs are addressed
- **CBOs & other HRSN service providers:** Conduct HRSN screening, navigate Members to HRSN services, and deliver HRSN services
- **Healthcare (physical and behavioral health) providers:** Conduct HRSN screening and navigate Members to HRSN services

Ecosystem Partners

- **MCOs:** Refer Members to SCN and work with SCN to ensure all Members are screened for HRSNs
- **Other ecosystem partners**: Refer Members to SCN and coordinate with SCN on service navigation and delivery

NEW YORK STATE Department of Health

1115 Waiver SHIN-NY Support Responsibilities

Health-Related Social Needs (HRSN): "Up to $3.673 billion for building HRSN infrastructure, including the creation of new Social Care Networks (SCNs), and reimbursing for an array of HRSN services through the Medicaid program."[1]

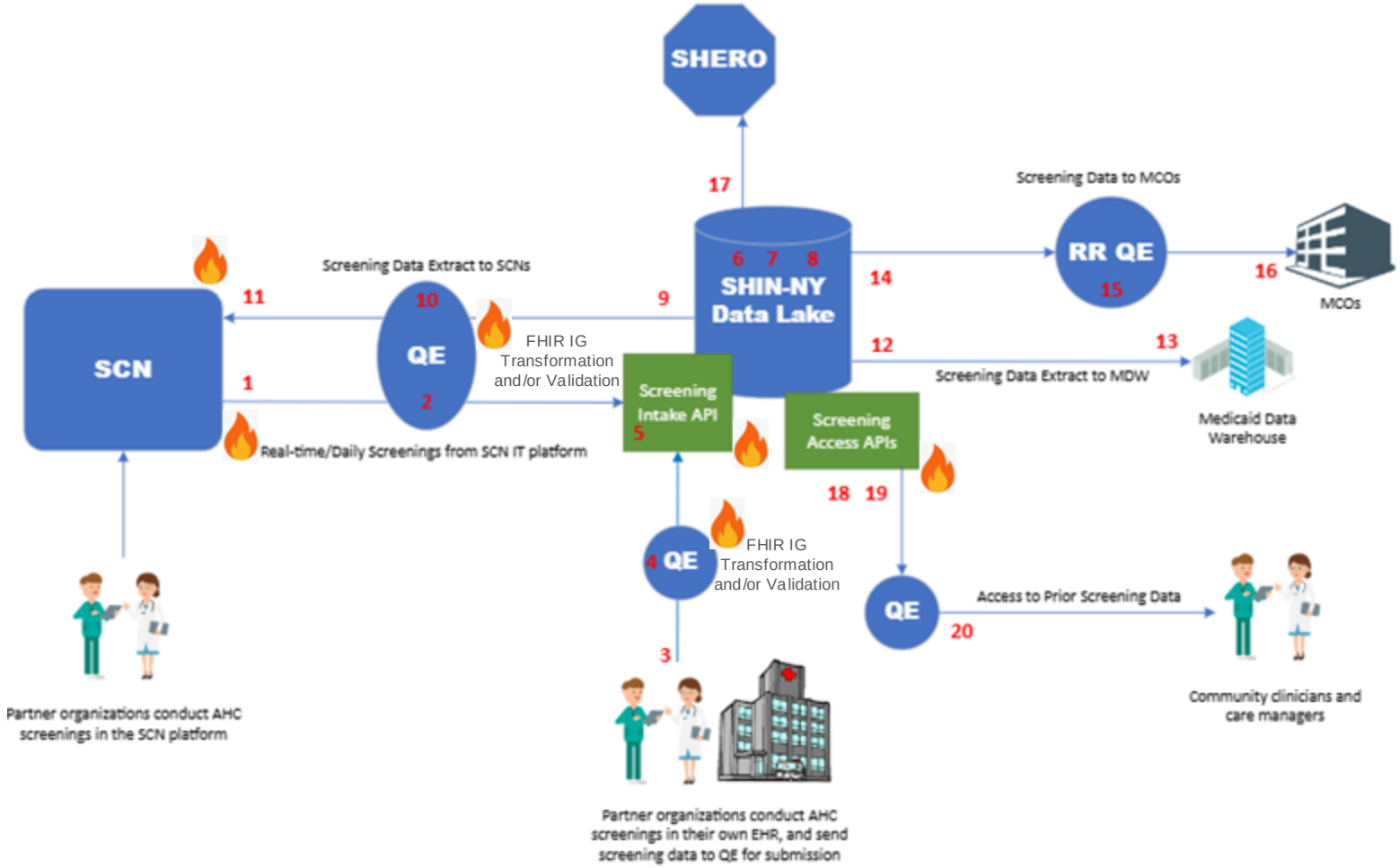
HRSN Screening, Assessment and Referrals Copies

1. **Aggregate screenings, referrals and other HRSN data into a statewide registry**
2. **Enhance screenings, referrals and other HRSN data with better demographics and chronic conditions flags**
3. **Send extracts where they are needed (Medicaid Data Warehouse, SCNs, MCOs, HERO)**
4. **Deliver screening, assessment, and referral data to point of care**
5. **Apply SHIN-NY Policies and Procedures to data use**

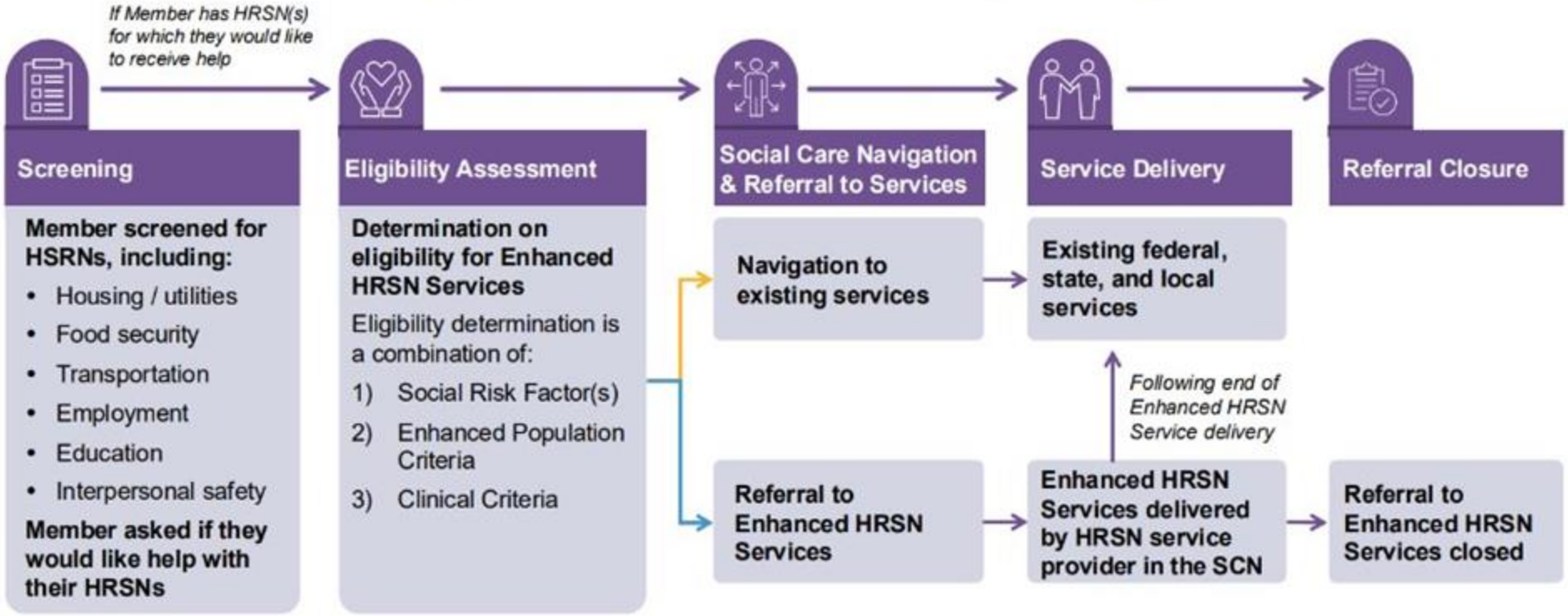
[1]https://www.health.ny.gov/health_care/medicaid/redesign/med_waiver_1115/docs/2022-09-02_final_amend_request.pdf

Draft

HRSN Screenings Infrastructure



HRSN screening and services: Member journey



Leveraging Gravity FHIR Standards: Fit-For-Purpose

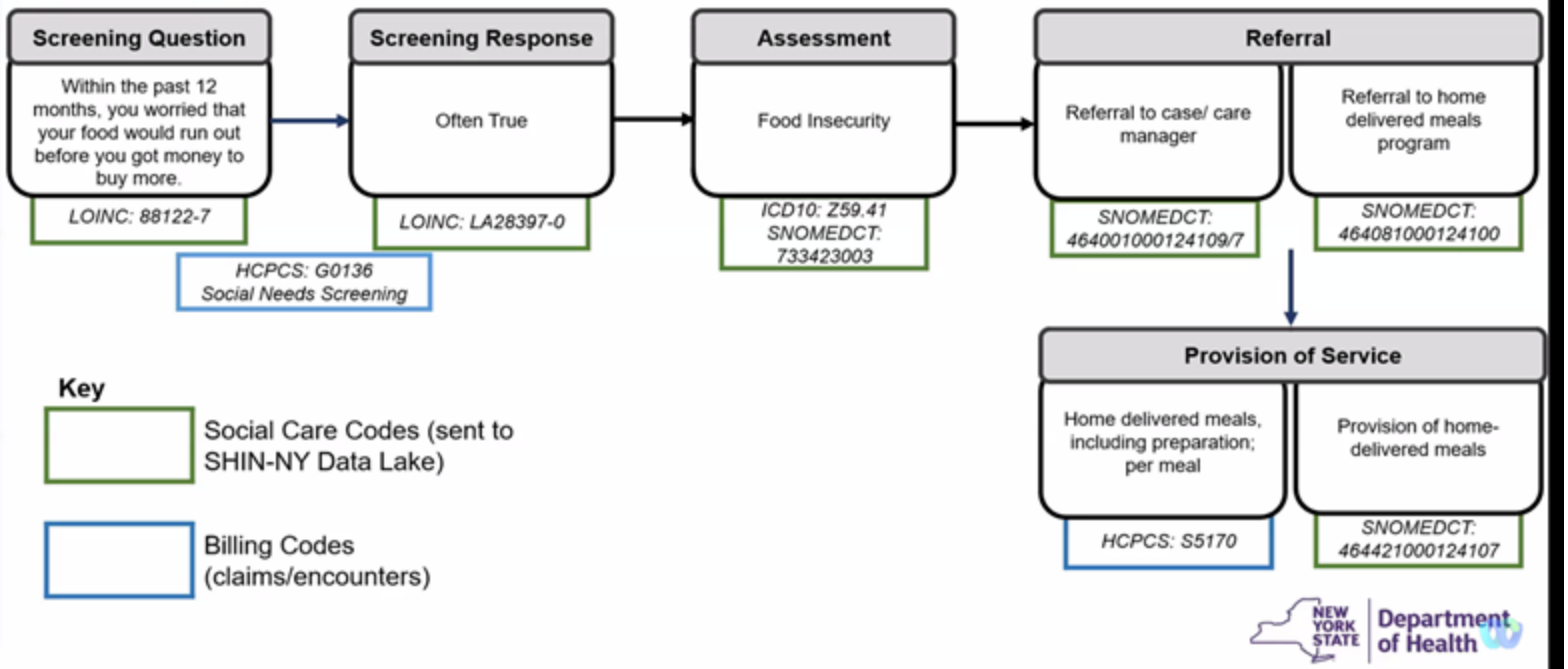
1. Terminology Standards
2. FHIR messaging standards to support:

Requirement	Gravity FHIR Resources
Screening/Assessments	Questionnaire/QuestionnaireResponse/Observation/Condition/Goal
Referral	ServiceRequest/Task
Provision of Services	Procedure/Task

1. FHIR Gravity model as the basis for standardizing SHIN-NY data lake and DOH access for population level outcomes reporting
2. Standards "Funnel": Mixed messaging support → QEs → SHIN-NY → data consumers (e.g., DOH, QEs, SCNs)

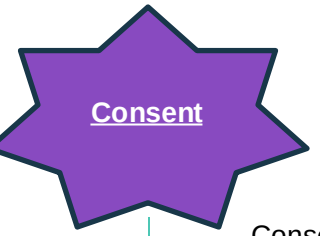
Example Mapping: Screening to HRSN Service

food insecurity



HRSN Data FHIR Resources

Subject to change as we learn more about the Waiver/SCNs.



Consent Resource with "permits"

Screening

The act of a patient filling out AHC HRSN questions.

- Bundle
- Patient
- Encounter
- Organization
- **Observation** or QuestionnaireResponse/Questionnaire

Permit/Deny Services Resource: **Observation**

Assessment

An individual will discuss any positive risks further to diagnose a condition. Eligibility for Level 2 services will be determined.

- Bundle
- Patient
- Encounter
- Organization
- Practitioner
- Observation and/or QuestionnaireResponse/ Questionnaire
- Condition(s)
- Goal (potentially)

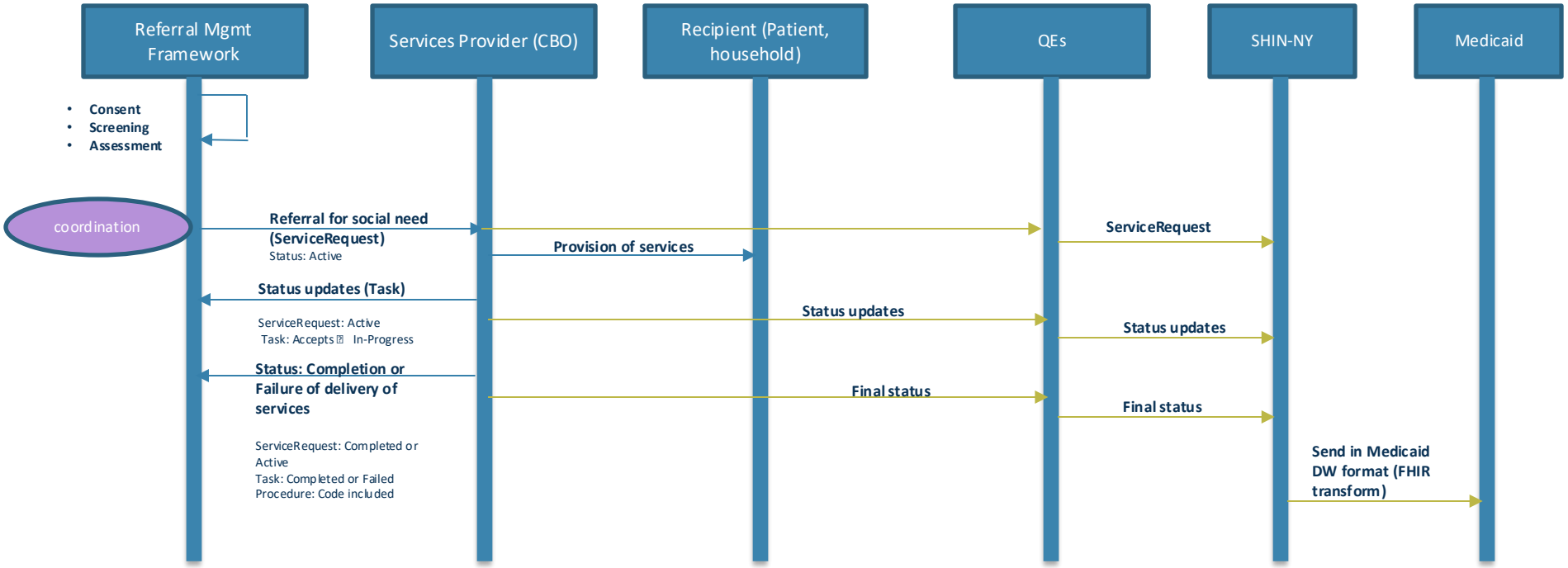
Permit/Deny Services Resource: **Observation**

Referral

Individual is referred to Level 2 services.

- Bundle
- Patient
- Encounter
- Organization
- Practitioner
- ServiceRequest
- Task "Fulfillment Request"
- Procedure or Procedure code on Task

Workflow Diagram For Referrals



Demo

Questions?