Statewide EHR, EHR Lite Pilot, Waiver 2.0, Electronic Consent Management, 1477/988 Update, Advanced Directives

Health Information Technology Operational Plan Update

October 3, 2023

Washington State Health Care Authority

Agenda

- Welcome
- Statewide EHR Update
- EHR Lite Pilot
- Waiver 2.0 Overview
- Electronic Consent Management (ECM)
- 1477/988 Update
- Advanced Directive Initiative
- Closing

Washington State Health Care Authority

Statewide EHR

Jerry Britcher & Chatrina Pitsch

Washington State Health Care Authority

Topics

- Project status/overview
- Legislative direction
- Current progress
- Program next steps
- HCA project next steps
- Timeline

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Legislative direction

- Governance model
- Implementation plan
- Estimated budget and resources
- Licensing plan and procurement approach
- Recommended program structure
- List of respective state agency projects
- Process for agency funding requests
- Funds approval criteria

Current progress

- Contracted with McKinsey to support development of statewide plan
  - Facilitation of meetings with WaTech, HCA, DOC, & DSHS
  - Readiness assessment for each agency
  - Memo to legislature for status this month
  - HCA update provided to CMS - June
  - Alignment on services needed across agencies
  - Procurement strategy finalized
  - Selection of HCA as lead agency
  - Statewide plan and technology budget submitted to OFM
  - Joint supplemental decision package finalized

Program Next Steps

- Establishing program decision descriptions
- SOWs for program contract needs (i.e., OCM, QA)
- System implementer role/responsibility
  - Draft RFP
- DES to release EHR vendor RFP for statewide convenience contract
- Identify 3rd party services required for EHR and procurement strategy for each
- Planning APD update

HCA Project Next Steps

- Provider engagement
  - Consultation with tribes in platform configuration, governance, system implementation needs.
  - Gaps in current EHR functionality
  - Confirmation of services provided
  - Indian health care providers readiness for new EHR platform
  - Establish advisory groups for functional areas
- Convene steering committee
- Establish HCA project related positions

Timeline

- Q3 2023 - Delivery of final statewide plan delivery and approval
- Q4 2023 – Draft RFP for system implementor & finalization of EHR platform
- Q1 2024 – Statewide contract established with EHR platform vendor and publish RFP for implementor
- Q2 2024 – Contract with EHR vendor
- Q3 2024 – Contract with system implementor
- Q3-Q4 2024 – Initiate cycle 1 ambulatory implementation

Questions?

HCAEHR@hca.wa.gov

Chatrina Pitsch
EHR IT Project Director

chatrina.pitsch@hca.wa.gov

360.622.1301

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EHR Lite Pilot

Chris Chen & Ashley Petyak

Washington State Health Care Authority

EHR Lite Pilot Update

- OCHIN Link Use
  - Provail Adult Family Home
  - Olympic Health Recovery Services – Designated Crisis Responders
  - AADSW – Health Home Care Coordinators
- Contract renewal underway with OCHIN
- Involuntary treatment assessments
- New use case for Disease Intervention Specialists at DOH – TBD
- Staying abreast of the Statewide EHR Project and implementation of crisis system enhancements in 1477

Waiver 2.0

Chase Napier

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MTP 2.0

- The MTP demonstration ended June 30, 2023, and the renewal was approved by Centers for Medicare & Medicaid Services (CMS) that day.
  - The renewal is the Medicaid Transformation Project (MTP) 2.0: the state's Section 1115 Medicaid demonstration waiver.
  - July 1, 2023 – June 30, 2028, and adds $4B to Apple Health (Washington's Medicaid program) over the five-year renewal.
- MTP 2.0 is an agreement between HCA and CMS that allows our state to implement new policies and use federal Medicaid funds to improve Apple Health.
  - MTP 2.0 allows our state to continue to develop innovative projects, activities, and services that benefit Apple Health enrollees.

Overview of MTP 2.0 Requests and Approvals

Aims

- Ensure equitable access to whole person care, empowering people to achieve their optimal health and wellbeing in the setting of their choice.
- Build healthier, equitable communities, with communities.
- Pay for integrated health and equitable, value-based care.

Goals

- Expand coverage and access to care, ensuring people can get the care they need.
- Advance whole-person primary, preventive, and home- and community-based care.
- Accelerate care delivery and payment innovation focused on health-related social needs.

Programs

- Justice-involved reentry initiative (new)
- Continuous Apple Health enrollment (new)
- Post-partum coverage expansion (new)
- SUD and MH IMD Services (continuing)
- MAC and TSOA (continuing)
- LTSS innovations and efficiencies (new)
- Clinical integration advancements (pended)
- Services to address health-related social needs (new)
- Foundational Community Supports (continuing)
- Health equity investments (pended)

Health-Related Social Need (HRSN) Services

- Authorizes payment to support a menu of new services:
  - Nutrition supports
  - Recuperative care and short-term post hospitalization housing
  - Housing transition navigation services
  - Rent/temporary housing for up to six months
  - Stabilization centers
  - Day habilitation programs
  - Caregiver respite services
  - Environmental accessibility and remediation adaptions
  - Case management: Community Hubs and Native Hub to pay for community-based workforce
  - Community transition services: Personal care and homemaker services, and transportation services

HRSN: Community Hubs and Native Hub

- Regional community hubs managed by Accountable Communities of Health (ACHs).
- Native Hub: statewide network of IHCPs, tribal social service divisions, and Native-led, Native-serving organizations in service to whole-person care coordination.
- Role for Hubs to support reentry and connecting to community.

HRSN: Infrastructure Funding

- Approximately $270m authorized in the waiver to support:
  - Technology (including Community Information Exchange)
  - Development business or operational practices
  - Workforce development
  - Outreach, education, and stakeholder convening

Re-entry Program Summary

Eligible Population: All Medicaid-eligible individuals within 90 days of release from a state prison, jail, or youth correctional facility.

Implementation Approach: Phased services based on facility readiness.

Capacity funding: Available to support readiness (EHR, billing systems, staff and other needs).

Approved Scope of Services
Mandatory:
Case management/care coordination
Medication-assisted Treatment (MAT) pre-release
For post-release: 30-day supply of medications and durable medical equipment
Secondary:
Medications during the pre-release period (HepC)
Lab and radiology
Services by community health workers
Physical and behavioral clinical consultations (as needed)

- Winter-Spring 2024: Statewide readiness assessment
- Spring 2024: Reentry capacity building applications
- March 29, 2024: Reentry Implementation Plan submission
- Fall 2024: Reentry capacity building funding available
- July 2025: Reentry service delivery launch through first cohort

Builds off years of previous work such as Medicaid billing (P1), EHR and eligibility and enrollment systems

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Re-entry Planning and Implementation Funds

- To support the following activities:
  - Technology and IT Services
  - Hiring of Staff and Training
  - Adoption of certified EHR technology
  - Purchase of Billing Systems
  - Development of Protocols and Procedures
  - Additional Activities to Promote Collaboration
  - Planning
  - Other activities to support a milieu appropriate for provision of prerelease services

QUESTIONS?

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Electronic Consent Management

Jennifer Alvisurez

Washington State Health Care Authority

Project Objectives

- To define and deploy an electronic consent management solution that:
  - Facilitates patient-authorized exchange of sensitive data
  - Is scalable, secure, sustainable, and meets provider needs
- First use case
  - Consent to enable exchange of substance use disorder (SUD) data

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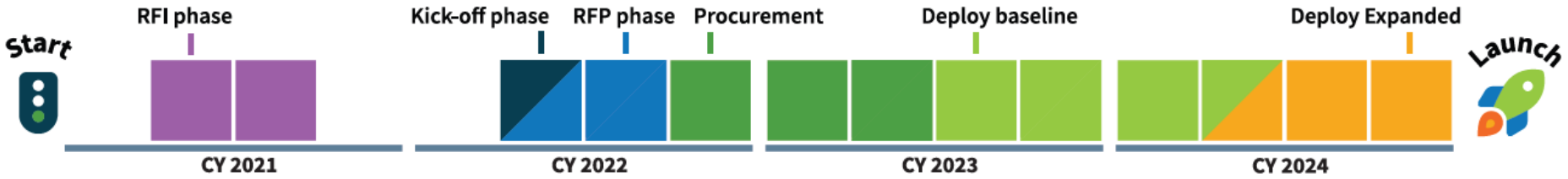
Project timeline



Timeline Milestones

1. ECM Vendor announced: Q1 2023
2. Deployment Kickoff with Vendor: Q3 2023
3. Go Live with Baseline Solution: Q2 2024
4. Expanded Solution deployment: Q3-Q4 2024

Vendor Selection

- Request for proposal
  - Stage 1: HCA received 5 proposals
  - Stage 2: Three vendors were selected for demos
- Final selection
  - Successful Bidder: CodeSmart-Midato
    - Knowledgeable of interoperability standards for required level of granularity.
    - Detailed Application Program Interface (API) documentation
    - Strong policy enforcement.
    - Optical character recognition (OCR) capabilities.
    - Familiar with existing MMIS IT systems.

Two phase approach

- Baseline solution
  - Essential functionality such as creation, modification & revocation of consents (with version history)
  - Intuitive navigation and search capability, compliance with all applicable laws, alerts, tracking
  - Reports and dashboards for HCA and providers
  - Electronic signature for client and third parties, guardians, and parents (if indicated)
  - Audit functionality (e.g., logins)
  - One to two languages other than English
  - Option for OCR scanning
  - Interoperability with one EHR instance

Two phase approach (cont.)

- Expanded solution
  - Deploy a more complete solution to address additional:
    - Use cases
    - Client populations
    - Modes of system access
    - Interoperability with other systems or functional components
  - Explore client consent self management
  - Determine priorities with providers, state agencies, solution vendor, partners, and other stakeholders

Essential technology

- A flexible architecture solution that is scalable and accommodates future state business needs
  - Cloud-based system
  - Support role-based access
  - Interoperable with many systems and solutions (e.g., EHR) using standards-based technology
  - Comply with all state, federal, and industry-standard security protocols and laws (incl data retention policies)
  - Operational reporting and analytics
  - Successful completion of OCS Security Design Review (SDR)
  - Successful completion of CMS Outcome Based Certification

Part 2 NPRM monitoring

- Notice of proposed rulemaking (NPRM) to revise 42 CFR Part 2 issued November 2022 by HHS/OCR and SAMHSA
- NPRM would implement provisions of Section 3221 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act
  - Requires HHS to bring Part 2 in greater alignment with certain aspects of HIPAA
- HCA submitted agency wide response & is monitoring

Next Steps

- Begin workflow/configuration sessions (sprints)
- Provider/Partner/Stakeholder outreach
- Continue work on Security Design Review (SDR)
- Continue preparations for the CMS Outcomes Based Certification milestones
  - Operational Readiness Review (ORR) - before go-live
  - Certification Review (CR) – 6 months after go-live

thority

Early System User Opportunity

- Quarterly Calls
- ECM solution will go live in Q2 2024
- Early System Users:
  - Possible opportunity to help with final workflow discussion and training (TBD)
- No cost to providers or other system users
- Training will be available for all system users
- Providers will work with HCA and the solution vendor for staff access

Contact econsent@hca.wa.gov for a 1:1 call

Early System User Opportunity

- Criteria to be a System User
  - Any provider type
  - May or may not have an EHR
  - Organizational leadership support
  - Attend free HCA training on system use and onboarding staff

- Baseline Participation
  - Help with workflow sessions, testing, and reviewing training
    - View only thru portal
    - Scan documents in
    - Direct data entry for consents in the portal
    - EHR interoperability pilot

Contact econsent@hca.wa.gov for a 1:1 call

Public Resources

- ECM webpage
  - www.hca.wa.gov
  - Factsheet
  - FAQ (updated Sep. 23)
- ECM email address
  - econsent@hca.wa.gov
- Substance Use Disorder Information Guide
  - www.hca.wa.gov

What is Electronic Consent Management?

Electronic consent management (ECM) is a cloud-based software solution which will house consents to share sensitive data (e.g. substance use disorder, research, sexually transmitted infection data). It is not intended to store HIPAA general consents for treatment. ECM will be free to use and is meant to replace paper-based consents or integrate with current electronic consent practices by enabling data exchange that will be compliant with 42 CFR Part 2 and other relevant statutes.

If you are interested in learning more or using the system, contact HCA at **econsent@hca.wa.gov**.

What data will be collected?

Health records will not be stored by HCA or the ECM vendor. The system will only store consents to share data, which can be updated or revoked as needed.

Why is this happening?

Providers face significant administrative challenges managing consents due to time and cost. ECM will foster more complete and coordinated care.

Who does it affect?

HCA will focus on storing consents to enable Substance Use Disorder (SUD) data exchange first. Behavioral health providers and others that serve SUD clients or exchange SUD data will benefit. In future project phases, consents to exchange other types of sensitive data will be added. HCA is prioritizing data exchange for Apple Health (Medicaid) clients. ECM is one of HCA's Tech Modernization projects.

How does this benefit me as a medical provider or health organization?

Main benefits of the ECM solution for providers and other organizations include:

- Access to client data in times of crisis which is crucial to address substance use disorder (SUD) issues.
- A reduction in provider administrative burden related to consent.
- A reduction in the number of incomplete, noncompliant, and redundant consents.
- Fewer barriers for those who provide vital services to Washington's most vulnerable residents.
- Access to a consent solution that will be adaptable and sustainable, yet flexible throughout its lifespan.
- A decrease in the time it takes to share relevant information between providers.

When is this happening?

Timeline Milestones

1. ECM Vendor announced: Q1 2023
2. Deployment Kickoff with Vendor: Q3 2023
3. Go Live with Baseline Solution: Q1 2024
4. Expanded solution deployment: Q2 2024

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1477/988 Update

Maddy Cope, Sachin Lande, & Huong Nguyen-Nabors

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Topics

- Technology Platform Request for Information (RFI) Update
  - Overview of RFI Purpose
  - Vendor RFI responses
  - Technical Requirements
  - Request for Proposals (RFP)
- Next Steps

988 Technology Platform RFI Update

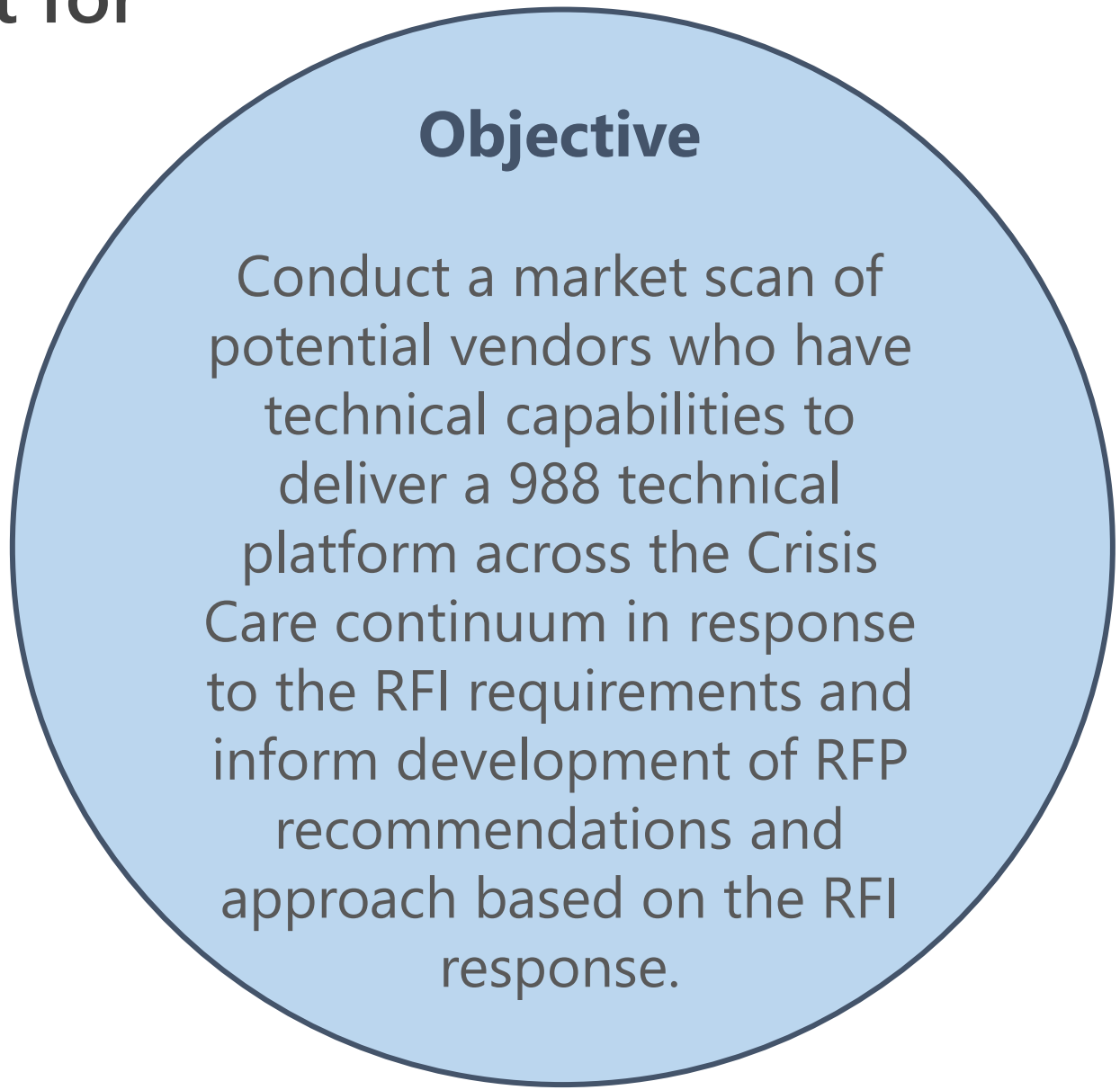
- Sachin Lande

Overview of RFI Purpose

Look at Respondents

Summary of Findings and Key Decisions

988 Request for Information



Appendix: Including 988 Eco-system Conceptual Architecture slide

RFI Overview

Functional Requirements

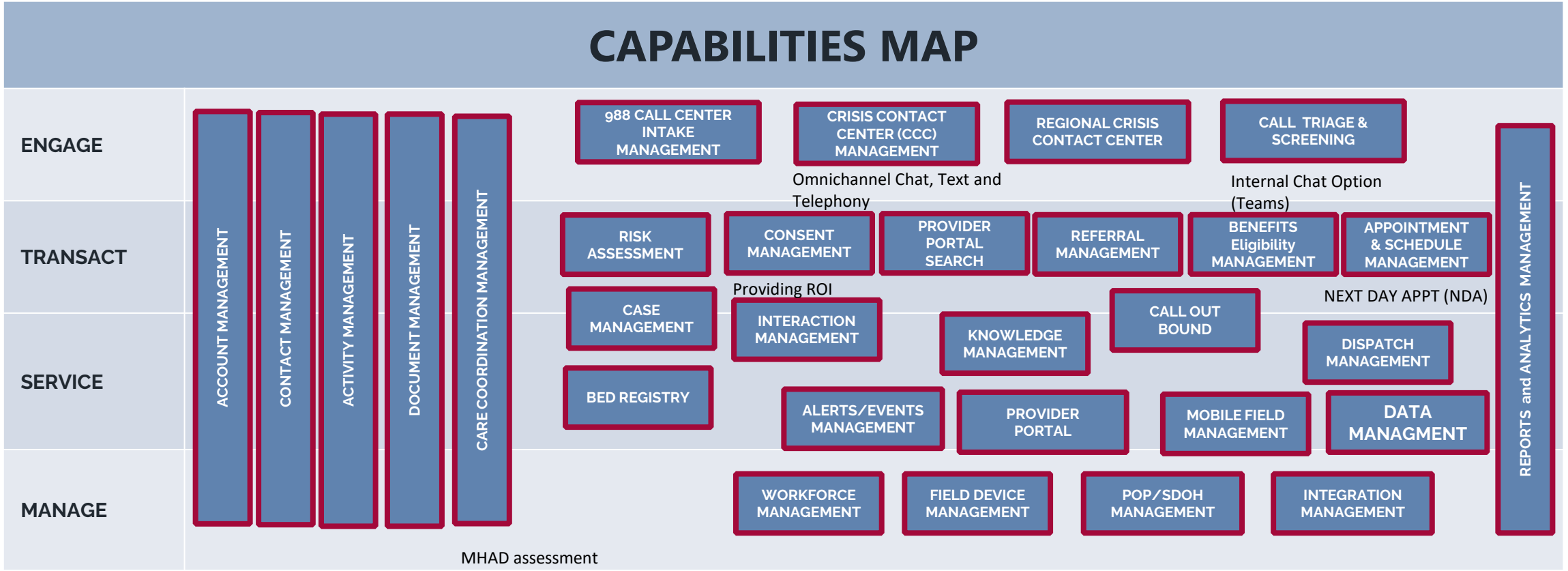
- Call Center Platform
- **Responder Dispatching**
- Resource Directory
- Provider Portal
- **Referrals and Appointments**
- Consent Management
- Electronic Documents
- **Bed Registry**
- Reporting

Technical Requirements

- Cloud-based solutions
- SaaS/Commercial Off the Shelf (COTS) solutions
- Distributed computing Architecture
- Data Governance
- Data Security and System Management
- Privacy and Protocols
- Tribal Data Sovereignty

988 CAPABILITIES MAP

A **Capability** is a collection of related activities organized into **business processes**,(**what**) executed by **people (who)** and supported with **tools (where)** to gain business insight



988 4 Quadrant – RFI Respondents Evaluation Structure

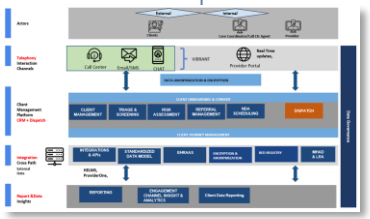
All RFI respondents were evaluated using this “4 quadrant” approach. The quadrants represent the 4 major components of the system, and each vendor was assessed based on the solution provided.

Telephony

CRM + Referral & Dispatch

Integration Cross Paths

Reports and Analytics



4 quadrant approach aligns to the model architecture:

11 total RFI Vendor respondents

988 4 Quadrant – All Vendor Coverage

	TELEPHONY	CRM + REFERRAL + DISPATCH	INTEGRATION	REPORTS & ANALYTICS	PROVIDED COST ESTIMATE
Vendor 1	✗	✓	✓	✓	Cost Estimate: $5-7 Million
Vendor 2	✗	✓	✗	✗	Cost Estimate: $2.8M implementation, $155K annually
Vendor 3	✓	✗	✗	✗	Cost Estimate: $1.2M annually
Vendor 4	✓	✓	✗	✗	Cost Estimate: $36K implementation, $26K annually
Vendor 5	✓	✗	✗	✗	Cost Estimate: $164K implementation, $26K annually
Vendor 6	✓	✓	✓	✓	Cost Estimate: $4-5 Million
Vendor 7	✓	✓	✓	✗	Cost Estimate: $4-6M, recurring $4-5M
Vendor 8	✗	✓	✗	✗	Cost estimate: Implementation $600K, annually $330K
Vendor 9	✓	✗	✗	✗	Cost Estimate: $1.2 total services + Licensing $750K + per minute rates
Vendor 10	✓	✗	✗	✗	Cost Estimate: $7.5-10 Million over 3 years
Vendor 11	✓	✗	✗	✗	Cost estimate: $2.5 Million implementation over 3-years

988 4 Quadrant – Telephony

	TELEPHONY	TELEPHONY COMMENTS
Vendor 1	✗	
Vendor 2	✗	
Vendor 3	✓	Telephony platform built on AWS Vendor is part of the Vibrant Base Package.
Vendor 4	✓	Telephony Platform
Vendor 5	✓	SaaS based, integrated with dispatch coordination tools w/ partial CRM
Vendor 6	✓	NG911 ESI Net for Telephony Carbyne Apex (Emergency Management Application)
Vendor 7	✓	Private Cloud Plexus and is built in MS Azure
Vendor 8	✗	
Vendor 9	✓	Cloud Telephony Flex Platform Technology. / IAM: Identity Access Management / RBAC : Role based access control Platform uses one single pane of glass text, SMS, telephony. Built on AWS. Configurable for telephony needs. Is a current partner with the Vibrant Basic version
Vendor 10	✓	SaaS platform. Uses Enterprise Master Patient Index to create a longitudinal record. Components include Enterprise Network Access. AWS platform multi tenanted platform. They do not support Text and SMS. Vendor is partnered with one of the NSPLs in WA state
Vendor 11	✓	Cloud based platform built on AWS, they recommend the setup of separate AWS instance. Currently Engage with WA 211

988 4 Quadrant – CRM + Referral + Dispatch

	CRM+ REFERRAL + DISPATCH	CRM + REFERRAL + DISPATCH COMMENTS
Vendor 1	✓	Solution built on health cloud Developed a dispatch console Module uses Google API for location data of dispatchers
Vendor 2	✓	Built CRM modules on Salesforce Service Cloud Current Vibrant partner
Vendor 3	✗	
Vendor 4	✓	CRM built on MS Azure
Vendor 5	✗	
Vendor 6	✓	988 Crisis response built on Salesforce Service Cloud Implementation Approach of Agile
Vendor 7	✓	Private Cloud Plexus and built in MS Azure is an CRM +EHR application
Vendor 8	✓	Dispatch Solution with GIS and GPS positioning
Vendor 9	✗	
Vendor 10	✗	
Vendor 11	✗	

988 4 Quadrant – Integration Cross Paths

	INTEGRATION	INTEGRATION CROSS PATHS COMMENTS
Vendor 1	✓	(Integration using MuleSoft and Salesforce Connector) Health Cloud is FHIR R4 compliant and HIPAA Complaint Health Cloud – Salesforce Shield for potential security Implementation
Vendor 2	✗	
Vendor 3	✗	
Vendor 4	✗	
Vendor 5	✗	
Vendor 6	✓	Integration Approach using FHIR R4
Vendor 7	✓	
Vendor 8	✗	
Vendor 9	✗	
Vendor 10	✗	
Vendor 11	✗	

988 4 Quadrant – Reports + Analytics

	REPORTS + ANALYTICS	REPORTS + ANALYTICS COMMENTS
Vendor 1	✓	Reporting based on Salesforce Health Cloud Capability. Potential to develop custom reports
Vendor 2	✓	
Vendor 3	✗	
Vendor 4	✗	
Vendor 5	✗	
Vendor 6	✓	Standard Salesforce reports
Vendor 7	✗	
Vendor 8	✗	
Vendor 9	✗	
Vendor 10	✗	
Vendor 11	✗	

Summary of Findings and RFP Recommendations

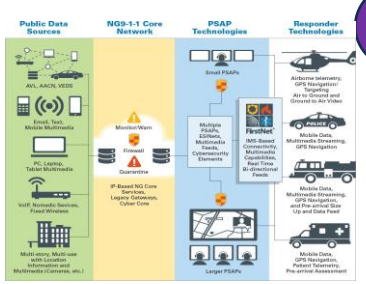
RFI Findings

- ✓ *No single RFI vendor response addressed the Crisis Care continuum platform needs in entirety*. Demos were set up with a couple vendors.
- ✓ Cost estimates were not comparable and varied. Timelines also varied, generally estimated to be 5-7 years for full implementation.

Based on the 4-quadrant evaluation framework, project staff recommend:

1. HCA & DOH are consulting with their respective contract's offices regarding the release and management of the RFP responsibilities and structure of the RFP.
2. HCA & DOH will continue to coordinate/collaborate, assigned responsibilities for systems are:
    a) Telephony - **DOH**
    b) CRM + Dispatch - **DOH**
    c) Referral & Bed Registry - **HCA**
    d) Integration Cross Paths (e.g., EHRaaS, Provider Portal, FHIR resources for Mental Health Advance Directives, LRAs, and other document types) - **HCA**
3. Next steps are for (i) HCA/DOH leadership to approve for staff to perform a *deep dive analysis* on the three architectural options below with a focus on packaged application software, strong data governance, interoperability, and private cloud infrastructure model; and (ii) provide guidance, upon completion of this analysis, on approach:
    A. Vibrant UP + CRM & Dispatch+ Integration pathways
    B. Best in Class Telephony Chat and Text + CRM & Dispatch + Integration pathways.
    C. Next Gen Emergency Services + CRM & Dispatch + Integration pathways

Architecture Approach 3 possible options - draft

	Current State	Vibrant UP (A)	Best in Class (B)	Next Gen Emergency Srvc (C)
Telephony	Vibrant Multitenant Telephony platform	Vibrant Multitenant Telephony platform	twilio GENESYS	 NENA I3
CRM + Dispatch	Crisis Conn Frontier Health VOA inContact Cisco BH- ASO (Thurston, Columbia……) Cisco	salesforce	TBD	TBD
INTEGRATION	Each NSLP has 3 different EHRD CareLogic CCP - EHR NetSmart - EHR 	PROVIDER PORTAL EHRASS, BED REGISTRY, MHAD 	PROVIDER PORTAL EHRASS BED REGISTRY MHAD 	PROVIDER PORTAL EHRASS BED REGISTRY MHAD 
REPORTING				

WA MuleSoft Structure and Re-Use

- Must support the broad scope of data integration and API management capabilities and support multiple HHS use cases (i.e., Master Person Index, Integrated Eligibility & Enrollment, 988 Crisis Hotline)
- Per agreement across the Coalition, the current MuleSoft platform will be re-used to support data integration needs for multiple critical programs/projects.
- This re-use approach will realize huge cost savings for the Coalition organizations leveraging the already established platform.
- Configuration and structure of the platform to support the individual projects or agencies is as follows:

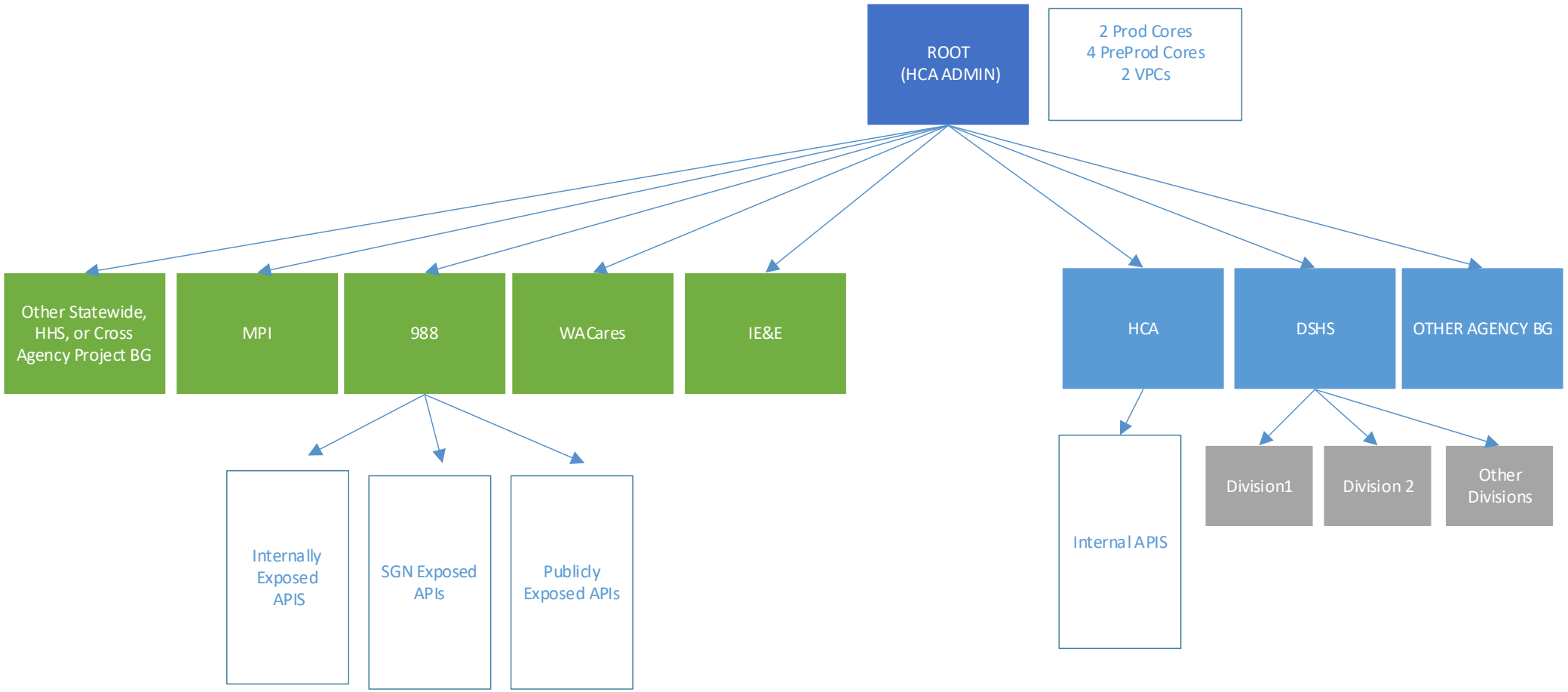
1) **Project Structure:** The project structure will be projects approved by the HHS coalition to have its own business group. These projects will commonly be large multi-agency projects.

2) **Agency Structure:** The agency structure will consist of an agency, and within the agency there are two primary models.

a. Centralized model where APIs will be managed centrally. HCA is an example of this model.

b. Divisional model, where there may be sub business groups under the agency root. DSHS is an example of this model.

MuleSoft Environment



Future Use Case for MuleSoft – 988

- The 988 system is a system of systems with these components used by NSPLs and RCLs:
  - Telephony
  - CRM
  - Referrals (Closed Loop)
  - Interoperability Platform
  - Supporting Systems
  - Reporting and Analytics
- Supporting Systems and Referrals will leverage MuleSoft Anypoint Platform using FHIR, and other standards:
  - Bed Availability
  - Provider Resource Directory
  - Sharing Information about
    - The least restrictive alternative (LRA) treatment orders
    - Mental health advance directives
    - Crisis/suicide assessments
    - Crisis plans
    - Crisis Alerts
    - EHRs (including EHRaaS), and
    - Other systems (911, 211, CIE, HIE, and others to come)

Where We Stand

- HCA/DOH staff are obtaining leadership approval for the recommendations on how to move forward with the RFP
- We are also working with OCIO as a gated funding partner to prepare for the RFP
- HCA/DOH staff are creating a series of technical specifications for the RFP based on needs that our call centers have, legislative requirements, and things we have learned from the RFI.
  - These specifications will directly affect the contents and scoring criteria of the RFP
  - Obtaining input from internal and external reviewers

Questions?

- Contact Information:
  - madeline.cope@hca.wa.gov
  - Sachin.lande@doh.wa.gov
  - Huong.Nguyen@hca.wa.gov

Advance Directive Initiative

Chris Baumgartner, Jamie Teuteberg, and Chris Chen

Washington State Health Care Authority

Advance Directive Initiative

- Health Care Authority
- Department of Health
- Department of Social and Health Services; Aging and Long-Term Support Administration

Washington State Health Care Authority

Case example #1

- Ms. Jones is an **85 year old woman with advanced heart failure** and multiple other medical issues
- She is **frequently admitted to the hospital** for heart failure exacerbations; despite intermittently having to be in the ICU on non-invasive ventilation, she has not yet talked to her two children about her goals of care because of religious beliefs that conservative medical care would equate to "giving up"
- A palliative care team is consulted during one prolonged admission, and during a **family meeting with her children**, Ms. Jones is able to share that she does not feel she is meeting her quality of life goals; she hopes to ultimately pass away at home surrounded by loved ones rather than spend a majority of her time in the hospital
- A **POLST form is filled out indicating DNR** and limited medical care including no ICU admissions; this recommended to be placed on her refrigerator at home. Hospice is also recommended, however the patient and her family prefer to participate in a Transitions program to learn more about what hospice would offer
- One month later, the patient experiences **another medical emergency** with significant difficulty breathing and calls 911. By the time medics arrive, the patient is unable to clearly express her wishes, the **POLST form is not readily available**, and family members are not available for immediate contact.
- The patient is intubated in the field by medics and **admitted to the ICU**.

Case example #2

- Mr. Smith is a **32 year old man with a history of serious mental illness (SMI)** and multiple other medical issues.
- He has required involuntary detention during previous crises, however has recently been receiving multi-modal care **from a psychiatrist** who has prescribed medications to manage his mental health condition and **weekly counseling from a licensed clinical social worker (LCSW).**
- During a counseling session, he expressed concern about what might happen to him in the event he becomes incapacitated in the future and is unable to express his preferences for care/services and the strategies that are effective for managing his crises.
- The **LCSW assists the man in completing a Mental Health Advance Directive** (MHAD) using the form at RCW 7.32.260. His psychiatrist and family members are informed that he has developed a MHAD. The MHAD indicates that he should not be hospitalized, he should receive specific medications, and his psychiatrist and LCSW should be contacted.
- One month later, the man experiences **a mental health crisis.** Someone in the community calls 988 (the crisis telephone line) and crisis responders are dispatched. By the time crisis providers arrive, the patient is unable to clearly express his preferences for treatment and his **MHAD form is not readily available.** Responders do not know who the patient's contacts are. He is restrained and medicated in the field by medics and involuntarily detained at the hospital.

Background

- What are advance directives?
  - A person's wishes in writing, regarding medical treatment
- Types of documents:
  - Living Will (Health Care Directive)– a document that details medical treatment to be executed when a person isn't able to speak for themselves (this is not a medical order)
  - Durable Power of Attorney – a legal document that gives someone else the authority to make health care decisions for another person
  - POLST – Portable Medical Orders for medically frail person
  - Mental Health Advance Directives
- WSHA/WSMA initiative – Honoring Choices Northwest
- HB1477 requires "real time information" including the means to access persons' mental health advance directives (and other types of information).

Problem

What is missing today?

- Universal electronic access to a person's advance directives does not currently exist across health systems.
- Adults may receive uncoordinated and high-cost care they do not want by not having an advance directive readily assessable.
- All people may experience conditions during which they are unable to express preferences for treatment

Why does it matter?

- Advance directives allow for patient voice to be heard
- Advance directives include:
  - a durable power of attorney to make medical decisions when a person is unable to do so;
  - Mental Health Advance Directives when a person is unable to express their care preferences.

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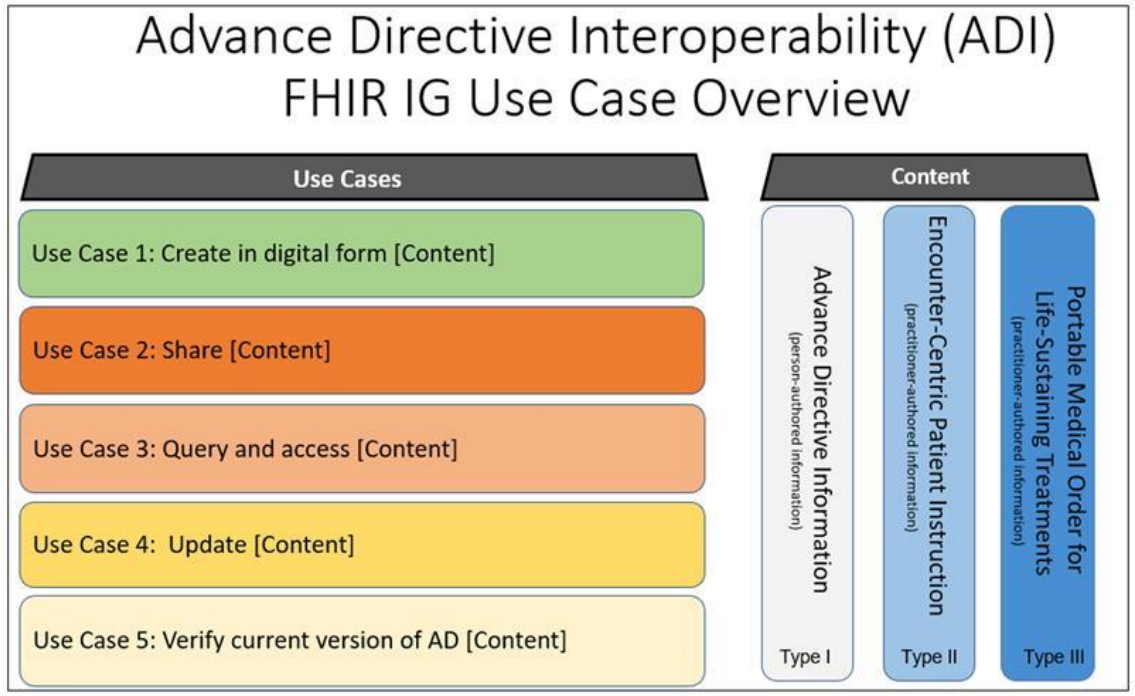
Proposed Solution



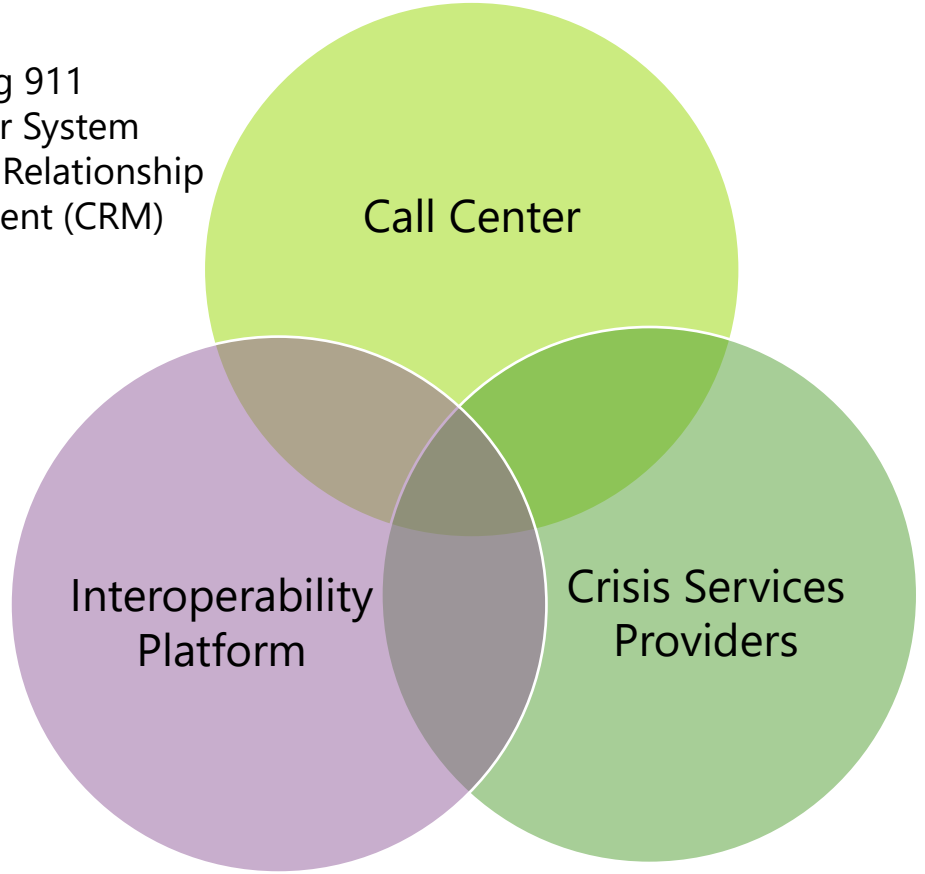
- Created patient-owned interoperable advance directive document that includes:
  - Core minimum content; and
  - Content for specific use cases
  - Leverage interoperability standards (FHIR) and privacy and security requirements
- Enable multiple methods of access, including:
  - Cell phones
  - Registry
  - Provider EMR
- Consider leveraging the state-wide HIE for hosting
- Use of National Standards
  - https://build.fhir.org/ig/HL7/fhir-pacio-functional-status/

Considerations

- Take into account requirements for advance directives
- Consider data governance and management implications of patient-owned data
- Consider workflows, feasibility and costs associated with use of registries and provider EMRs
- Understand the history of the Living Will Registry hosted by DOH
- Impact to clinical flow, especially in rural areas
- Allow for customization of advance directives
- Public awareness and education for the public, health systems, and providers will be needed for a successful launch

Interconnected work

- 988
- Leveraging 911
- Call Center System
- Customer Relationship Management (CRM)



Enabling Functionality for:

- Referrals
- Follow up appointments
- Provider communications
- HIE
- ECM
- SDOH

- Bed Registry
- EHRs, including EHRaaS
- Real-time location
- Follow up appointments
- Advance Directives
- Other document types

Timeline

- State fiscal year 2023/2024:
  - Engage in a user designed, proof of concept to support the creation of, exchange of, access to, and revocation of person-created (i) core minimum advance directive content and a sub focus on mental health advance directive content
  - Engage with stakeholders
    - Define, goals, scope and best practices
    - Understand the context, issues and potential impacts
    - Work with Standard Development Organization (HL7) to develop standards for Advanced Directives
    - Determine the focus, scope, and objectives for solutions
    - Measure of success
  - Identify funding: Federal match and IAA with coordinating State agencies.
- State fiscal year 2024:
  - Secure funds for a pilot implementation (including funding from: State agencies (HCA, DOH, DHS), Federal Government (ONC, CMS, SAMHSA), and the private sector (e.g., Microsoft, AWS)
- State fiscal year 2024/2025:
  - Conduct pilot implementations

Stakeholders

- Honoring Choices PNW
- W4A
- AARP
- 1477/CRIS Steering Committee, and Lived Experience and Technology Subcommittees
- BH-ASOs
- MCOs

Next Steps

Any questions?

Next meeting: December 5, 2023 (3:30 – 5 pm)

Washington State Health Care Authority