Chronic care management success

How to overcome electronic health record limitations

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By Ken Terry

At first glance, Medicare's new chronic care management (CCM) billing code, which became available January 1, looks like a major opportunity for primary care practices. But many practices will find it difficult to meet the requirements for billing the code, and a major reason is the limitations of today's electronic health record (EHR) systems. The Centers for Medicare and Medicaid Services (CMS) will pay physicians roughly $40 per patient per month to provide enhanced care management and care coordination to fee-for-service Medicare beneficiaries with two or more chronic conditions. Patient-centered medical homes (PCMHs) are in a good position to take advantage of this offer, experts say, because they have already changed their workflows to improve care coordination.

However, practices must use certified EHRs to bill the CCM code (CPT code 99490) and the latest systems include features that can support chronic care management. But EHRs are not designed for non-visit care or for collaboration among providers caring for the same patient. Moreover, they lack the data analysis and automation functions that practices need to deliver chronic disease care efficiently.

So even if your practice is PCMH-recognized by the National Committee on Quality Assurance (NCQA), you'll probably need to do some EHR workarounds and customization, and you may

require some additional software to bill CCM. If your practice has not achieved medical home recognition, you'll face the same technical problems and will have to re-engineer your work processes to take advantage of the code. Only you and your colleagues can decide if doing so is worthwhile.

CCM basics

CMS will pay eligible providers—who include primary care physicians, some specialists, nurse practitioners and physician assistants—an average of $41.92 per month for each eligible patient for whom they provide the required services. But 20% of that is a copayment that practices must collect from patients.

To be eligible for CCM billing, a patient must have multiple chronic conditions expected to last for at least 12 months. Physicians and other providers must obtain written consent from the patient to be his or her CCM provider, including authorization for sharing data with other providers. Only one eligible provider can bill CMS for CCM services provided to an individual patient in any given month.

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Any certified healthcare professional can provide CCM services, and services are expected to be provided by teams. Direct physician supervision of clinicians is not needed for this program.

The required CCM services include non-face-to-face care management and care coordination with other providers. Care teams must spend a total of at least 20 minutes per patient per month on these activities, and each team member must document what they did and for how long.

Specifically, practices must provide:

- continuity of care with a particular provider or care team member,
- enhanced ability for patients and caregivers to communicate with providers,
- 24/7 access to care management services
- care management that includes an assessment of the patient's medical, functional, and psychosocial needs; preventive care, medication reconciliation, and oversight of the patient's medication self-management,
- a comprehensive, patient-centered care plan,
- electronic capture and sharing of care plan information, and
- management of care transitions, including referrals and follow-up after hospital discharges and ER visits.

NEXT: Care plans

Care plans

The comprehensive care plan for CCM must include an assessment of the physical, mental, cognitive, psychosocial, functional and environmental needs of the patient. It must contain a record of preventive care services, medication reconciliation, a review of adherence and potential drug interactions, and oversight of patient self-management of medications. In addition, it must list the clinicians and the community resources involved in the patient's care and explain how the care will be coordinated.

The care plan must be available at all times to care team members and to treating providers in other practices.

EHRs aren't designed to create this kind of care plan, but the templates in their assessment and plan section can be modified to accommodate CMS' requirements. If your practice doesn't have the technical expertise needed to do this, you can create a form outside of the EHR or use one provided by the American Academy of Family Physicians (AAFP), which can be accessed by AAFP members. The American College of Physicians also has a CCM tool kit that provides resources for physicians. But you must store the care plan in the EHR to share it among your care team members.

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Sharing the plan with outside providers is going to be a bigger challenge. Practices will have to cope with the same lack of interoperability that impedes the exchange of care summaries for Meaningful Use. Direct messaging is fine where it's available; but many providers don't yet accept Direct, so the care plans may have to be faxed.

Edward Gold, MD, an internist with a 59-physician group based in Emerson, New Jersey, said his group is modifying its EHR to create CCM care plans. As part of the practice's preparation to become a NCQA-recognized level 3 PCMH, he adds, it built additional care plan templates for such things as patients' compliance and understanding of their conditions, he said.

As for sharing the care plan with specialists, he'll include it in the visit notes he sends as part of referrals.

Documenting non-visit care

Of course, that isn't the same as having a care plan that's available to all providers at all times. The idea of a longitudinal care plan that goes across care settings is still more of a vision than a reality, noted a recent study in the *Journal of the American Medical Informatics Association*. In fact, EHRs have only a limited ability to support the work of care teams within practices, another study found.

EHRs replicate the visit-oriented model of paper records, in which a provider has to document everything that can be used to justify billing, points out Steve Waldren, MD, director of the AAFP's Alliance for eHealth Innovation. The EHR vendors did not build the systems to document care team activities, he notes. "They were building it for a single physician to do everything."

That makes it problematic to document the care coordination and non-visit care required by CCM.

"Most of that is being done in the messaging section of these EHRs: taking the telephone message, which is a non-visit encounter, and letting the docs enter the information in a particular area," Waldren points out. "It's mostly how you document it from a medico-legal standpoint, not how do you support and facilitate that type of collaboration [among care team members]."

Internist Kenneth Kubitschek, MD, belongs to a nine-doctor group in Asheville, N.C. that encourages non-visit encounters with patients, both as a recognized PCMH and as part of its use of Medicare's Transitional Care Management (TCM) billing codes.

In most cases, he says, these non-visit encounters are documented as free text messages. However, the EHR allows the practice to keep care management messages separate from other phone or email messages.

Gold's group also uses the messaging function of its EHR to document and respond to non-visit care. The practice is already using care coordinators hired by the accountable care organization (ACO) it belongs to. When one of these nurses needs to alert a physician about something concerning a patient, says Gold, she sends a "task" to the doctor in the EHR's messaging system, and the physician has to respond to the care coordinator and/or take some other action.

After the practice begins providing care billed under the CCM code, these care "navigators" also will document their activities in the EHR, he notes.

NEXT: Transitions of care

Transitions of care

Given the fragmentation of healthcare, the CCM criteria for transitions of care are among the hardest to meet. Your EHR might be able to help you here, but it depends on what kind of EHR you have.

Referral modules, for example, can list the referrals that were sent out, but they can't tell you whether the patient made an appointment with the specialist, notes Margalit Gur-Arie, a founder and health IT consultant with BizMed Solutions. "The best referral modules will list referrals, when they were sent out, and a time period in which you expect the visit to the specialist to be made," she says. "If you don't get anything back in that time, it pings someone on the staff, who can call the specialist to find out what happened. But it's still a largely manual process."

Gold's practice gets information on hospital admissions, discharges and transfers and emergency department visits from the ACO, which has a connection with its main hospital's admission, discharge and transfer (ADT) system. When one of Gold's patients is admitted or discharged, an ACO care coordinator sends him a message about that event in the "tasks" section of his EHR.

This direct link to a hospital ADT system is unusual. But Kubitschek's group has worked out its own arrangement with its hospital, which notifies the practice of admissions and discharges via fax.

To meet the TCM requirements, the practice has its nurses call the patients to make office appointments within 48 hours after their discharge. They use a customized EHR template to document their interactions.

Some nursing homes are better than others about communicating with patients' primary care physicians, Kubitschek says. Getting information from these facilities and from home health providers is more about relationships than about technology at this point, because few post-acute-care providers are online with ambulatory care clinics.

Timekeeping

EHRs are not designed to track the time that providers or other care team members spend on particular tasks. While people can free-text that information when they document a non-visit encounter, for example, there is no way to locate the various amounts of time recorded so that a practice can determine whether they add up to 20 minutes of CCM activity, notes Gur-Arie.

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One solution to this problem, she suggests, is to develop a spreadsheet that shows a list of CCM patients, what was done for each patient, and how long it took. The AAFP provides a free Excel spreadsheet for this purpose.

Spreadsheets make sense for documenting time, says Mark Anderson, a health IT consultant in Montgomery, Texas. The drawback is that the spreadsheet won't be integrated with the EHR, which means it requires manual data entry. And, unlike sophisticated registry programs, spreadsheets can't be used for care management, he says.

Practices can also adapt time management software of the kind used by attorneys and consultants, notes Gur-Arie. This can't be integrated with EHRs, either, but at least it's designed for recording the time spent on tasks.

NEXT: Care coordination software

Care coordination software

In the context of meeting CCM billing requirements, Waldren says, the biggest drawback of EHRs is their lack of robust registries that can be used to manage population health within the clinical workflow.

Registries, which show problems, lab results, and when patients last received recommended services, are used for everything from stratifying patients by their health risks to identifying care gaps to helping care managers prioritize their case loads. They can be used to support chronically ill patients between visits and to ensure these patients receive the services they need.

Because EHRs are deficient in this area, many groups have purchased outside population health management software. This kind of software, which can interface with EHRs, typically includes a registry and a range of applications designed for such functions as point-of-care reminders, patient outreach and education, and care management of high-risk patients.

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All of this would seem tailor-made for CCM, except for one thing: It's too expensive for most small practices. A 40-doctor group for whom Anderson consults paid between $75,000 and $100,000 to install population health management software and "pull the data together," he points out. No practice of fewer than 20 doctors, in his opinion, could afford this type of IT solution.

Gold says that not even his fairly large group can afford population health management software on its own. Its ACO spent approximately $1 million to buy and implement such a solution on a large scale, he points out. The organization is now considering whether to offer its analytic services to non-member practices for a fee.

Kubitschek, too, knows that his practice can't justify purchasing this kind of system. In fact, the group's physicians doubt that it makes financial sense to hire a full-time care coordinator so that they can pursue CCM. They're waiting to see what a brand-new ACO that the group belongs to might be able to offer its members, he says. For now, the group has not decided to take on CCM.

Conclusion

Observers are divided on how advanced or how large a practice must be to take advantage of CCM. Gur-Arie maintains that nearly any level 3 PCMH could take it on with a little guts and ingenuity. Anderson believes CCM is suitable only for groups of 20 or more physicians, although some smaller PCMHs might consider tackling it.

Waldren points out that PCMHs already are doing most of what CCM requires. And many practices that haven't gone the medical home route have at least implemented an EHR and met the Meaningful Use criteria.

"Maybe now they can use the CCM program to get further into population health management and care management and move toward becoming a medical home," he says.

NEXT: How to implement chronic care management

How to implement chronic care management (CCM) codes

- Identify patients

Physicians can bill for CCM codes for Medicare patients diagnosed with two or more chronic conditions that will last at least a year. The first step, then, is to identify the patients in your practice who qualify. This can be done by searching your EHR records.

- Invite patients to participate

Physicians must obtain an eligible patient's written consent to participate in CCM, along with authorization to share the patient's records electronically with other providers. The physician should explain how the program works, the patient's obligations for payment and how to terminate the arrangement.

- Build a care plan

A care plan must be created for each patient that includes an assessment of the patient's medical, functional and psychosocial needs, consistent with the patient's choices and values.

- Document

All of the above information, from patient consent through the care plan, must be documented in the patient's electronic health record. When in doubt, document it.

- Termination considerations

Patients can only participate in CCM with one primary care provider, and they can opt out at any time. Physicians must document patients who cancel CCM services.

EHRs and chronic care management: Questions to ask your vendor

Most electronic health record (EHR) systems will not support the requirements of the new chronic care management CPT code without modifications or additions to the basic system. So before you start billing for chronic care management services here are 5 important questions to ask your EHR vendor:

Q: Is the EHR system certified to 2011 or later standards (a requirement for billing the code)?

Q: Does the EHR support documentation of team care and/or care outside of an office visit? If not, what add-ons and modifications would be needed, and how much would they cost?

Q: Does the EHR enable providers to document the time spent on each patient encounter and track that time on a monthly basis?

Q: Does the EHR system include capabilities for developing and a plan of care for patients with chronic diseases or conditions, and sharing the plan with other providers and the patient? If not, what add-ons or modifications would be needed, and how much would they cost?

Q: Does the EHR include a referral module, and if so, what elements are included in it (date referral was made, alert when report comes from the specialist, etc.)? If not, how much would it cost to add a referral module?