

Improving Ohio's Health Series

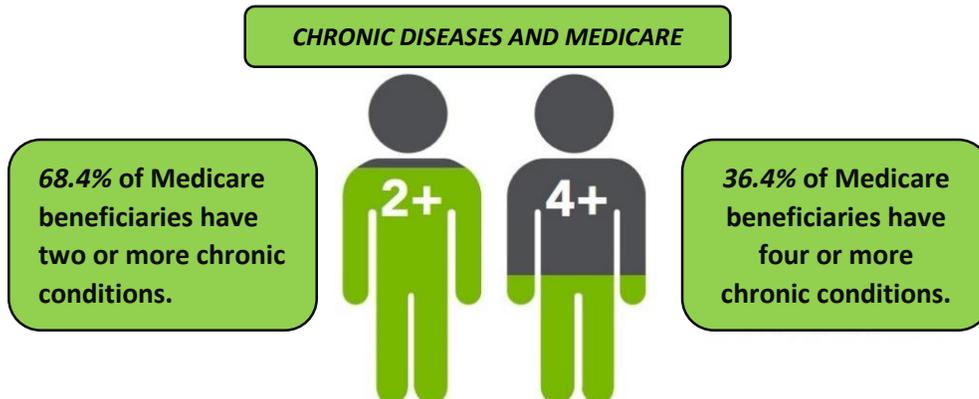
Technology to Support your Patients with Chronic Conditions – *It Doesn't Have to be Painful!*

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This article is part of a series devoted to hypertension and diabetes in Ohio and the prevalence of these chronic conditions. It explores the functionality of EHRs and other technology to meet the requirements of the Chronic Care and Transitional Care Management Programs and how best to manage patients enrolled in these programs, especially those patients with hypertension and diabetes.

In the recent past we have produced several webinars and articles outlining the Chronic Care Management (CCM) and Transitional Care Management (TCM) programs. This article will focus on the practical application of functionality in your electronic health record (EHR) to meet the requirements of CCM/TCM and to manage your patients enrolled in these programs. Many EHR vendors have not had sufficient time to provide needed functions or accommodate the most recent regulation modifying CCM that provided increased flexibility. This article addresses the program requirements of EHRs in general, although a few vendors are mentioned by name that provide specific functions.

Adoption of a CCM/TCM program in your organization is critical for improving the health of patients with two or more chronic conditions, such as hypertension and diabetes, while also providing the necessary funding to meet these goals. Studies show that approximately 68 percent of Medicare beneficiaries have two or more chronic conditions while 36 percent have four or more conditions. Ensuring that these patients receive the needed care and coaching to improve wellness necessitates services outside of regular face-to-face visits which, in turn, necessitates additional funding to provide these services. Thankfully, the CCM/TCM regulation makes additional funds available, and recent modifications to the CCM program makes documentation and technical requirements easier to meet. Also, developing strong CCM/TCM programs will build key core competencies for MACRA, CPC+ and other value-based payment programs.



The CCM program started on January 1, 2015, and requires the use of certified EHR technology. However, some of the functionality described in the CCM requirements are well beyond what is required for an EHR to gain certification. Some vendors are still struggling to provide specific functionality to meet the requirements, although the functions provided by the Meaningful Use (MU) program can be utilized in most cases. The EHR requirements for the CCM program include a practice's ability to:

1. Identify patients with multiple chronic conditions who are eligible.
2. Document that a patient has provided consent and is enrolled.
3. Capture discrete data elements including demographics, problems/conditions, medications and medication allergies.
4. Perform and record a complete medication reconciliation.
5. Document a detailed care plan.
6. Share the care plan with the patient and other providers; electronic sharing preferred although other means are acceptable.
7. Provide the patient with educational material and a self-management plan.
8. Provide timely access to the patient's electronic records and care plan.
9. Document non-face-to-face care management activities.
10. Manage referrals to specialty providers, community educational program and other support programs.
11. Provide enhanced opportunities for communication between the patient and the care team.

The capture of the discrete data items and medication reconciliation required by CCM are simple and can be performed by *any* certified EHR. The modification of the CCM program in the FY2017 Physician FFS proposed rule modified patient consent from requiring a signed document to verbal consent, which can be captured in a clinical note or other area in the EHR. The remainder of this article will focus on those functions that are not as simple or that need to be supplemented by manual workflows.

Identify Potential and Enrolled CCM Patients

During evaluation of the CCM program or the first steps of implementation, a practice must identify patients who meet the eligibility requirements. The primary eligibility requirement is the existence of two or more chronic conditions that has the propensity to last more than 12 months. There are two primary functions that can be used to identify these patients:

- ad-hoc reports, or
- patient lists.

Example of Patient List Query

Patient Lists (MENU)

Generate at least one report listing patients of the Eligible Provider with a specific condition. Please reference the MEDENT MANUAL for details on this requirement.
 To meet this Meaningful Use measure, this report must include at least one problem and be run at least once during the reporting period for each provider.

Report Criteria

Beginning Date 06/01/15 Ending 09/01/15

Doctor(s) 15

Note: Selecting All will not include NPs/PAs in the report as they are not eligible for Medicare Incentives.

Problems Essential hypertension, Diabetes mellitus

Status All

Medications

Example of Patient List Results

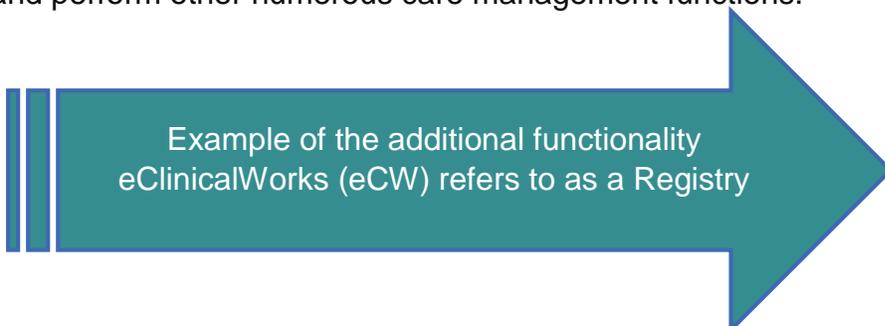
Patient Lists (MENU)

Patient	Appt Date/Time	Essential hypertension	Diabetes mellitus
C	08/07/15 - 8:00am	Yes	No
D	08/03/15 - 10:45am	Yes	No
D	08/25/15 - 11:45am	Yes	No
D	08/18/15 - 8:30am	Yes	No
F	06/08/15 - 8:00am	Yes	No
G	08/18/15 - 7:00am	Yes	No
H	06/09/15 - 8:30am	Yes	No
H	07/01/15 - 2:30pm	Yes	No
H	08/12/15 - 2:15pm	Yes	No
J	06/09/15 - 10:15am	Yes	No
M	06/02/15 - 11:30am	Yes	No
M	08/25/15 - 10:45am	Yes	No

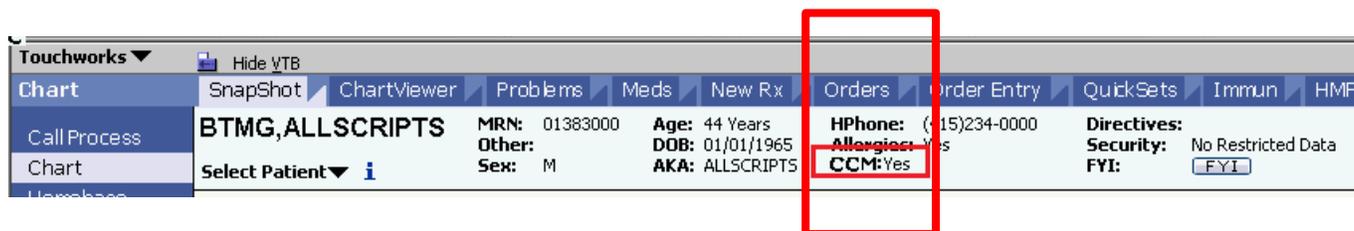
Every EHR provides an ad-hoc reporting tool, though they vary widely in the ease of use and their query tools. The MU program requires that every certified EHR have the ability to generate a patient list by one or a set of conditions for a provider or practice. There may be limitations of the patient list functionality in that the actual condition(s) must be entered or that only a limited number of conditions can be queried. For example, the MedEnt EHR provides a simple patient list interface where numerous conditions can be specified in a grid to show the presence of those conditions for each patient listed. This standard functionality meets the first requirement of the CCM program: *identification of patients eligible for enrollment in a CCM program*. This list can be utilized by the care team to manage these patients, for outreach and care management activities, and other workflows related to the CCM program.

While all EHRs can generate a patient list, only a few have additional functionality for making use of this list.

Registry functionality, available in some EHRs, can be used to identify patients with a given set of conditions and empanel them to a provider, care team or program. In some cases, this registry functionality can monitor compliance with an assigned set of clinical quality measures (CQM) and place a visual identifier on the patient record denoting that they have been empaneled with this functionality. Using this functionality, a practice could identify all patients within the practice that have both hypertension and diabetes, monitor their compliance with the quality measures NQF 0018 and NQF 0059, track which of these patients are enrolled in the CCM program and perform other numerous care management functions.



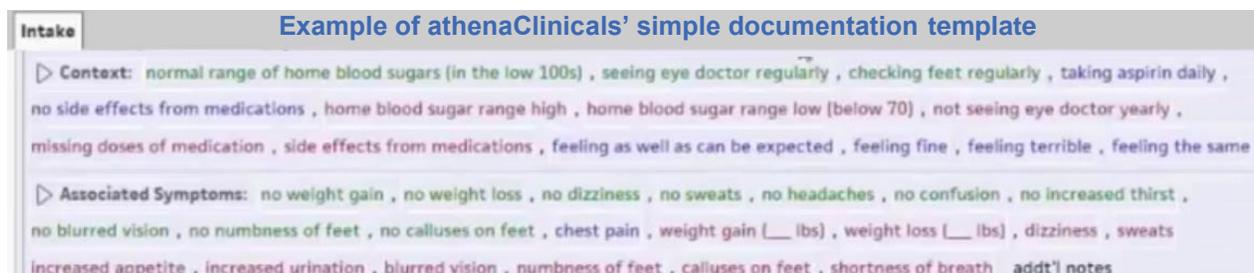
It would be useful for the care team and providers if an identifier was used to denote that a patient is eligible for or enrolled in CCM. Then, if a patient were eligible but not enrolled, any member of the care team could discuss the CCM program with the patient during the next face-to-face visit. This visual identifier could be added to the patient information ribbon that appears at the top of most EHRs. The screenshot below provides an example of a visual identifier from the Allscripts Touchworks EHR where “CCM: Yes” appears in the ribbon for patients enrolled in their CCM program.



Documenting and Sharing the Care Plan

CCM requires the care plan to be an electronic summary of physical, mental, cognitive, psychosocial, functional, and environmental assessments; recommended preventive care services; medication reconciliation with review of adherence and potential interactions and oversight of patient self-management of medications; and an inventory of clinicians, resources, and supports specific to the patient, including how the services of agencies or specialists unconnected to the designated physician’s practice will be coordinated. The assessment can be easily captured by using a detailed documentation template. Most EHRs provide document template functionality where a provider can simply answer a series of questions by simple mouse clicks.

An example of a simple documentation template functionality from the athenaClinicals EHR can be seen in the screenshot below. This functionality allows the provider to click on the appropriate items and enter an additional value. The selected items and supplied information then flow to the encounter note. The users of athenaClinicals can design a complex intake form for the CCM requirements to capture all of the required items: physical, mental, cognitive, and psychosocial assessment; treatment goals, symptom management, and planned interventions as well as the status of specific patient conditions being assessed.



The document created by this assessment can serve as the comprehensive care plan. During follow-up visits, the initial assessment can be copied into a new note, updated as appropriate

and additional information, such as referrals, can be added. Medication reconciliation, important clinical information and other information required by CCM can be added to the note as appropriate.

CCM requires that the care plan be shared with the patient and other providers of care. Since the information is captured within a single note, this can be easily printed for the patient and pushed to the patient portal. This document can also be sent to other providers of care using the Direct functionality. This document can be posted to the Community Health Record (CHR) in the CliniSync HIE making it electronically available to all potential providers of care, including the care team. Since the CHR is a web-based application that can be accessed from any location, this would meet the requirement that practices have timely access to the care plan.

Enhanced Communication Equals Patient Engagement

In a previous article, extensive information was provided on patient engagement. Some of the patient engagement tactics mentioned in that article can be used in meeting the enhanced communications requirement of CCM because the patient portal should serve as an essential tool in enhancing communication.

All patient portals that are part of a certified EHR provide functionality for the patient to send a secure message to their provider or care team, request a medication refill and access their clinical information. The care team should leverage the patient portal by providing training to all patients enrolled in CCM and encourage patients to utilize the numerous functions provided by the portal. The patient portal sends reminders for upcoming appointments, and can be utilized for sharing the comprehensive care plan, self-management plan and educational information with the patient. The care team can also make use of the secure messaging functionality, where appropriate.

The patient portal can also serve as a tool for sharing information electronically with other providers of care. For example, if a patient is referred to a specialist who has not enabled the interoperability functions within their EHR, the patient could log into their patient portal, navigate to the care plan from the most recent visit, and allow the specialist to view that document. While not ideal, it provides another avenue for ensuring the continuity of care between providers and settings.

The required care management services between patient visits are not only intended to identify patients in need of a visit but to also keep the patient engaged between visits. While a phone call may be the primary means for contacting the patient, this should be supplemented by functions of the portal, secure text messages and other patient engagement tactics.

Overcoming CCM Shortcomings in Many EHRs

There are several requirements of CCM where some EHRs fail to provide the needed functionality. In these cases, the practice must develop workarounds, sometimes manual, to compensate for the needed functionality. Earlier we discussed the patient lists in the context of identifying patients eligible for and enrolled in a CCM program. Since most EHRs do not provide extended functionality around a patient list, then the list can be exported to Excel and used by the practice to manage those patients.

Another area where EHRs may not provide the needed functions involves the recording of 20 minutes of clinical staff time each month. The majority of EHRs don't record the time a note was started and saved. While the auditing functions within all certified EHRs record the time when a document was created or edited along with who performed the action, they don't necessarily make this information available to users. As a workaround, the care team member should record the actual time he or she created or began modifying the note as one of the first entries. Then, when finished, they can record the time when work was complete and save the note.

The documentation of care management activities between visits can also require additional setup and workarounds. Some EHRs require that a note be attached to a visit or encounter. If this is the case with your EHR, then you may need to create a visit type for non-face-to-face encounters, such as the care management calls or activities. There may be some setup required to ensure that these visit types do not result in the creation of a billable event. This visit type may also simplify the creation of reports when working to ensure that the 20 minute per month requirement was met.

Managing the patient referrals to other physicians, community/social programs, educational programs or other providers of care can be a struggle with some EHRs. While an EHR may provide functionality for ordering a referral or sending information electronically via the Direct protocol, this functionality is usually limited, and showing referral activity over time may be difficult. Often external referral tools are needed to better manage the overall care of the patient. One such tool is the CliniSync referral tool, which not only tracks the status of each referral but also connects to physicians, social service agencies and other non-traditional providers of care.



Recommendations

To ensure success of your chronic care program, the best approach would be to:

1. Reach out to other practices of similar size that have already implemented a CCM program. ***(There's no need to break new ground when another practice may be able to provide some guidance that will save resources.)***

2. Develop a detailed project plan outlining the needed modifications to your EHR and the care team workflows. Create needed educational materials and other documentation.
3. Start with a manageable set of patients and conditions to be included in the list of those considered for the CCM program. Perform an analysis of your patient population to identify the top conditions, and build your program around those conditions.
4. Engage your EHR vendor for assistance with or to make recommendations for a means of building a functional patient registry, documentation templates and other functionality needed to track care management tasks and referrals.
5. Refine your workflows, documentation templates and processes as potential efficiencies or issues are identified.
6. As your program matures and the staff becomes comfortable, begin including additional conditions and patients.

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