Innovations for Industry
11/17/21

Broad Top Health & Wellness

Broad Top Area Medical Center: **Chronic Care Management System Requirements Document**

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Executive Summary

The Broad Top Area Medical Center (BTAMC), a Federally Qualified Health Center (FQHC), is a community-based and patient-directed organization that provides comprehensive primary health care and preventative care services. BTAMC services Huntingdon county and surrounding regions with several locations. To better serve their community and expand their client base, they would like to strengthen their organization's support for Chronic Care Management (CCM). Federal standards exist for CCM implementation, care, and billing practices that must be considered while strengthening this support.

BTAMC is engaging with the Innovations for Industry Fall 2021 class at Juniata College to help investigate and plan for a comprehensive CCM implementation. This group will steward the project to create and finalize two deliverables: a Requirements Document and a Solutions Document. The team will conduct all the research necessary to identify CCM requirements and other associated considerations on behalf of BTAMC. These will be documented in this Requirements Document. The team will also identify potential solutions that would satisfy those identified requirements and come to a conclusion on potential system solutions for BTAMC's CCM implementation. These will be documented in the Solutions Document which will be delivered by 11/17/21, the date that the Student I4I team should have also fully completed their efforts on.

Purpose and Scope

The purpose of this project is to aid BTAMC with finding Chronic Care Management (CCM) software to strengthen their CCM program. This I4I Student team will steward the project to create and finalize two deliverables: a Requirements Document and a Solutions Document. These will help identify a CCM solution that would simplify their daily work routines and provide better care to patients with chronic conditions.

In-Scope:

- Researching requirements for CCM software (technical, functional, financial, support)
- Creating a requirements and a solutions document for the given problem
- Researching Medent-compatible certified software that supports CCM
- Looking into the possibility of adding CCM functionality to Medent itself

Out-of-Scope:
The Fall 2021 I4I Student team will not be responsible for

- Implementing the chosen software

Goals

The goal of the project is to find a CCM solution for BTAMC to implement. This requires finding an effective solution as within the given time frame of the semester. We intend to complete several milestones by set deadlines, as can be seen below. This encompasses the submission of our two main deliverables: the requirements and solutions documents.

Along with meeting all time deadlines, our goal is to create these documents to be accurate, coherent, and implementable such that BTAMC team will be able to use all the documentation provided to them to implement their CCM system.

Milestones	**Estimated Completion**
Draft of Requirements Doc sent for review	10/13/2021
Finalized Requirements Doc set for approval	10/20/2021
Solutions search begins	10/27/2021
Shortlist Solutions Doc sent for review	10/27/2021
Finalized Solutions Doc submitted	11/17/2021
Project complete	11/19/2021

Target Market Overview

The Huntingdon County Community and surrounding area would be the target market. Current patients that have two or more chronic health issues would be the target audience. It would also include new patients that have two or more chronic health issues that come for care. The existing medical practice would identify those patients who would qualify for Chronic Care Management through their database or identify new patients who would also qualify.

Software Overview and Uses

CCM software is used to provide enhanced, non-face-to-face medical services to patients with two or more chronic conditions. The software will display an electronic care plan to all individuals involved in the patient's care, including the patient themselves. It will also allow medical providers to track services provided to the patient to enable appropriate billing.

The software will be used for communicating with the patient and give the patient the ability to contact a physician 24/7. The care plan can be changed/adjusted at any time by the physician using this software. Additionally, the software will have the ability to ensure appropriate billing.

More specific requirements that the CCM software will satisfy have been detailed in this document under Requirements. BTAMC will use their new CCM software to help provide services to patients with multiple chronic conditions more efficiently, even at a distance.

Requirements

Below are the specific requirements that the CCM software must meet, or the requirements that must be met before the CCM software can be used. The following section is based on the current CMS standards as of 2021, and is subject to future change. These requirements have been separated under different groupings: Technical, Functional, Financial, and Support.

Technical Requirements

The new CCM software must meet the following technical requirements:

1. EHR certified & FQHC compatible technology
   Patient records must be kept using certified Electronic Health Record (EHR) technology. This means a version of certified EHR that is acceptable under the EHR Incentive Programs as of December 31st of the calendar year preceding each Medicare PFS payment year ("CHRONIC CARE MANAGEMENT SERVICES"). (Dates: Promoting Interoperability Programs | CMS). Patient records include information recorded about a patient's:
      - Demographics
      - Problems
      - Medications
      - Medication allergies
      - Past medical history (comorbidities)
      - Surgical history
      - Family history

   Top EHR Vendor List ("Top EHRSoftware Companies"):
      - Medent
      - Epic
      - Cerner
      - Carecloud
      - Athenahealth
      - Allscripts
      - Nextgen

2. Vendor assessment
   Electronic health record (EHR) vendor assessment is a critical step when vetting potential EHR vendors. This process consists of collecting information on top vendors and narrowing the field based on those that match the client's selection criteria. The following criteria allows vendor assessment ("Top Ehr Software Companies"):
      - Outline organization's SMART goals (Specific, Measurable, Attainable, Realistic and Time Bound)

        - Note: SMART goals are for rating vendor selection that isn't Medent (which already satisfies the goals) and pertain to each care plan
    - Involve all critical stakeholders in this process.
        - Our stakeholders include: Dr. John Roth, CEO, Dr. James Hayden, CMO; Carol Black, RN, CQO; Shelly Rivello, LCSW, COO; Terry Heath, Executive Assistant/IT Coordinator; Kelly Maffia, LCSW, Director of MH/BH.
    - Identify your needs that the EHR software needs to solve.
    - Narrow the field of vendors based on their ability to meet your needs.
      Note: the following steps would be completed after this project's conclusion.
    - Issue a Request of Proposal (RFP) to all the vendors on your list. (optional)
    - Complete an in-depth vendor comparison based on the demos, documentation, and collateral that you've received.
    - Request references from the final vendors in the selection process.

3. Care plan display
   The CCM software should provide the patient and/or caregiver with a virtual copy of the care plan. A person-centered, electronic care plan is based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment, and an inventory of resources (a comprehensive plan of care for all health issues, with particular focus on the chronic conditions being managed). This should ensure that the electronic care plan is available and shared timely within and outside the billing practice to individuals involved in the patient's care. ("CHRONIC CARE MANAGEMENT SERVICES")

   A comprehensive care plan for all health issues typically includes, but is not limited to, the following elements:
    - Problem list
    - Expected outcome and prognosis
    - Measurable treatment goals
    - Symptom management
    - Planned interventions and identification of the individuals responsible for each intervention
    - Medication management
    - Community/social services ordered
    - A description of how services of agencies and specialists outside the practice are directed/coordinated
    - Schedule for periodic review and applicable revision of the care plan

For ease of use, the ideal CCM application will use radio buttons to identify the elements that apply, reducing the amount of typing necessary on the behalf of the care providers.

Care plan display information should be presented with the following characteristics:

- User-friendly
  This consideration is especially pertinent for elderly audiences, since they make up a large percentage of CCM patients.
- Clear font style
- Large font size
- Plain language
  Language should be plain or low literacy friendly around a sixth grade reading level, as opposed to language that contains complicated medical or technical jargon.

The care plan, while provided electronically, should also be accessible offline. Since the CCM audience is likely to be located in areas with poor or no internet connection, the ability to download the content and access it while offline is critical to patient ease-of-access. The care plan and any updates made to it should also be provided by BTAMC in print (physical copy).

The care plan display should be able to be reviewed and updated as appropriate for the patient's care, which will inevitably be prone to change.

4. Communication
   The CCM software should provide enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care through secure messaging, secure Internet, or other asynchronous non-face-to-face consultation methods (for example, email or secure electronic patient portal currently pending through Medent). Along the lines of communication, patients should also have the ability to notify the FQHC to discontinue CCM service if wanted ("CHRONIC CARE MANAGEMENT SERVICES").

   Contact information for care team members should be made available for communication within the care plan or CCM application itself. BTAMC's on-call number must also be displayed.
   Note: This requirement may end up being satisfied outside of the CCM software's capabilities, but is ideally met with it.

5. Billing
   The CCM Software must enable the appropriate billing of CCM services to occur. See Financial Requirements for more information on billing-specific codes. It is

presumed that this requirement is met if the CCM software allows the tracking of services in order to ensure that billing is backed by appropriate documentation of hours spent and services provided. EMR software should be able to audit and verify the documentation to ensure it is taking place and is up to standard.

6. Medent compatibility
   If the new CCM software is not branched off of Medent itself, it must be technically compatible with Medent records since this EHR that's currently being used and will be used for the foreseeable future. Additionally, this new software must be able to timestamp any documentation it produces.

Functional Requirements

The following functional requirements must be satisfied in order for the CCM software being sought to be utilized appropriately("CHRONIC CARE MANAGEMENT SERVICES"):

1. Initiating visit ("CMS in RHCs")
   There must be an initiating visit (E/M, AWV, or IPPE) within one year of starting CCM services.
   - Determine by FQHC practitioner ("FAQ")
   - Consent not required but need to be discuss and must be obtain before the start of CCM ("FAQ", "CMS in RHCs")
2. Consent ("CMS in RHCs", "FAQ")
   Patient consent to care plan (Written or Verbal) must be received. Consenting to:
   - The availability of care coordination services and applicable cost-sharing
   - Only one practitioner can furnish and bill for care coordination services during a calendar month
   - The right to stop care coordination services at any time (able to opt out at any time)
   - Permission to consult with relevant specialists
   - Document in the patient's medical record that the required information was explained and whether the patient accepted or declined the services
3. Eligibility ("CMS in RHCs", "FAQ")
   Patient eligibility for CCM services dictates that they must have two or more chronic conditions that:
   - Last at least 12 months
   - Place patient in significant risk of death
   - Include acute decompensation or functional incline

4. Service Element Requirement ("CMS in RHC"s)
   - Structure recording of patient health information

        - Includes problems, medications, allergy, medical history, demographics that inform care plan, care coordination and ongoing clinical care
    - 24/7 Access to physicians / qualified healthcare professionals
        - To provide patients/caregivers means to make contact with health care professionals to “urgent needs”
        - Continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments
    - Comprehensive care management
        - Systematic assessment of patient needs (functional, medical, and psychological)
        - System based approach of timely receipt of recommended preventive care services
        - Medical reconciliation, review of potential, and adherence interaction
        - Oversight of patient self management of medications
    - Comprehensive care plan
        - Creation, revision, and/or monitoring of an electronic care plan based on assessments and on resources and supports
        - Care plan for all health issues with focus on the chronic conditions being managed
    - Care plan information made available electronically (includes FAX) in a timely manner within and outside FQHC (as appropriate)
        - Copy of care plan given to patient and/or caregiver
    - Management of care transitions
        - Among and between health care settings and providers
        - Referral to other clinicals
        - Exchange/transmit care document(s) with other practitioners and caregivers
        - Follow up visit after emergency depart and after discharge from hospital
    - Coordination with home & community-based clinical service providers
        - Must have documentation of communication to and from home/community-based providers regarding patient’s needs
    - Enhanced opportunities
        - For patient and caregiver to communicate with practitioner despite patient care
        - Not only telephone access but secure internet, messaging or non face to face methods

Financial Requirements

Billing Requirements

The practice must have the patients written or oral consent in order to bill for CCM services. The following billing codes need to be set up/manageable in the new CCM software:

1. All documentation must be time-stamped in order to capture the total time spent. Before submission, software should flag whether a time-stamp is missing so that the provider knows to add it.
2. Encounter codes.
3. At least 20 minutes of care coordination per month must be clocked (“CMS in RHCs”, "FAQ")
    - Under the direction of FQHC or primary care physician
    - Furnished by FQHC practitioner under the general supervision
    - Note: less than 20 minutes, RHQC can’t bill ("FAQ")
4. CPT code 99490
   CCM Services, at least 20 minutes per month.
5. CPT code 99487
   Complex CCM services, 60 minutes of clinical staff time per month.
6. CPT code 99489
   Complex CCM services, each additional 30 minutes of clinical staff time per month.
7. HCPCS code G0506
   Care planning for Chronic Care Management. Billing code G0506 is an add-on code for chronic care management. It is meant to report additional work of the billing provider in personal face-to-face assessments and personal performance of CCM care planning. This code is used when the practitioner’s time and efforts exceed the usual time described in the initial visit E&M code. Code G0506 can also be billed when the initiating E&M visit addresses problems that are not related to Chronic Care Management and the CCM related work is not part of the initial visit code. G0506 is allowed to be billed only once per beneficiary during the introduction of the patient into Chronic Care Management.

8. CPT code 99091
   Collection and Interpretation of Physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified healthcare professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time.
9. CPT code G0511 (BHI)
10. G0512 for Psychiatric Care Services
    70 minutes minimum initial month and 60 minutes subsequent months

11. G0511 for General Care Management (BHI Coding)
    20 or more minutes per month, including activity previously billed on CCM(99490 or 99487)
12. CPT code 96127 (BHI Coding)
    Emotional and behavior assessment

Budget Requirements

The budget requirements for the potential CCM software proposed have not yet been identified by BTAMC. The I4I Student team will collect whatever information they can regarding the cost of potential CCM software identified as a solution. Retrievable comparisons of potential costs will be considered when identifying the best solutions.

Support Requirements

1. Vendor support
   Support for CCM itself should come through the vendor's provided services. The quality of support provided should be assessed by the team.
   Note: Medent currently has an active support team.
2. Staff training
   To use the CCM software effectively, it should be identified whether potential vendors provide training support to end users.
   Note: One of the issues with Medent's current use is that BTAMC employees did not receive appropriate training, and therefore may not be able to leverage it in the most effective way possible.

Constraints

Monetary

- The project is under monetary constraints in the sense that BTMC should spend as little amount of money as possible when implementing a new system.

Time

- The time taken for adding CCM functionality should be minimized.
- Moving from one software to another will require moving data between databases, which will require time. This time can be eliminated completely if CCM functionality is added to Medent.

Workflow

Our project is fairly linear, meaning that there is not too much work that can be done in parallel by different members of the I4I Student team. Listed below is the work breakdown structure which has the general order of things that need to be done. The I4I Student team will meet biweekly with the BTAMC team in order to discuss progress and verify that the project is on track. Additionally, the I4I Student team will meet weekly to work on the next part of the project corresponding to the work breakdown structure and the milestones, updating BTAMC via email.

Work Breakdown Structure

1.0 Research CCM to build base understanding of medical field and terminology

2.0 Create Requirements Doc
- 2.1 Initial client meeting
- 2.2 Research Federal CCM Standards
  - 2.2.1 Integration
  - 2.2.2 Tech Requirements
  - 2.2.3 Billing
- 2.3 Identify client's needs to reach federal standards

3.0 Create Solutions Doc
- 3.1 Research software solutions
- 3.2 Present client with valid options
- 3.3 Select top solutions

Evaluation Plan and Performance Metrics

We plan to evaluate which EHR software to use based on how well they satisfy the requirements. Namely, how many of the technical, functional and billing requirements each of them satisfy. One of the softwares we would be testing would be Medent itself, looking at whether CCM capabilities could be added and what those capabilities would entail. As an example, one of the performance metrics would be to consider whether a given software supports delivering a care plan that will include all the symptoms of a given patient.

In addition to these metrics, we will rate the performance of such software positively if it also includes the option of using a patient portal. The version of Medent that BTAMC is currently using does not have such capabilities, although they could possibly be added. Additional testing of the software will probably be required of the I4I Student team that will be implementing this project.

Future Work

If this project goes on to a new I4I Student team next semester, that team would possibly work with implementing the CCM software chosen. In this case, that means using the Requirements and the Solutions document deliverables from our project to make it a reality. As a group, we did the research which makes the next step of implementation possible. Implementing the CCM system that fits the Broad Top Area Medical Center would allow BTAMC to manage and document the CCM care process, and as a result, make it possible to appropriately bill for CCM services and more effectively serve patients with chronic conditions.

The next group that is assigned this project will be working on the next step for BTAMC. They would refer to the Requirements documents and Solutions documents that we provided. In this case, that group may be tweaking the software and implementing the CCM system into their current medical record system, Medent(EHR). Or implementing a CCM system that is compatible with Medent already.

BTAMC having a CCM system will be beneficial as it would make what they couldn't do possible. Their reason for having a CCM system is to make it possible to document and manage the CCM care process. The CCM system would help BTAMC save a lot of time, making their time more time efficient. With the implementation that the next I4I group will do (possibly), what BTAMC envision would become a reality.

Appendix

1. Sample Consent Form

- Dear Patient,
- As a patient with two or more chronic conditions (__ _list conditions ____), you may benefit from a new program that [name of practice] offers all Medicare patients. Our goal is to make sure you get the best care possible from everyone that is involved with your care. We can help coordinate your visits with other doctors, facilities, lab, radiology, or other testing; we can talk to you on the phone about your symptoms; we can help you with the management of your medications; and we will provide you with a comprehensive care plan. Medicare will allow us to bill for these services during any month that we have provided at least 20 minutes of non-face-to-face care of you and your conditions. You must provide your consent to participate once a year. Your assigned clinician in charge of your care is ___[insert clinician name] __. Sometimes other staff from our practice will talk to you or handle issues related to your care, but please know that your assigned clinician will supervise all care provided by our staff or clinicians who may be involved in your care. You agree and consent to the following: As needed, we will share your health information electronically with others involved in your care.· Please rest assured that we continue to comply with all laws related to the privacy and security of your health information. We will bill Medicare for this chronic care management for you once a month. The fee for this service· allowed by Medicare is ___[insert allowed fee]___, of which your portion will be ___[insert copayment amount]____. Although you may or may not come into the office every month, your account will reflect this charge and you will be responsible for payment. Our office will have a record of our time spent managing your care if you ever have a question about what we did each month. Only one physician can bill for this service for you. Therefore, if another one of your physicians has· offered to provide you with this service, you will have to choose which physician is best able to treat you and all of your conditions. Please let your physician or our staff know if you have entered into a similar agreement with another physician/practice. You have a right to: A Comprehensive Care Plan from our practice to help you understand how to care for your conditions so· that you can be as healthy as possible. Discontinue this service at any time for any reason. Because your signature is required to end your· chronic care management services, please ask any of our staff members for the CCM termination form. Our goal is to provide you with the best care possible, to keep you out of the hospital, and to minimize costs and inconvenience to you due to unnecessary visits to doctors, emergency rooms, labs, or hospitals. We know your time and your health is valuable and we hope that you will consider participation in the program with our practice. I agree to participate in the Chronic Care Management program. Yes ____ No_____ _____ _____

- Patient Signature Date
- Only one clinician can furnish and be paid for CCM services during a calendar month. Database will have to include billing physician under patient's record

- The clinician who is providing the primary care to the patient is the one who can bill. Usually this will be the primary care internist, but some specialists may be serving as the patient's primary care physician.
- Copayments (coinsurance and deductibles) DO apply, unless performed at the same time as the Annual· Wellness Visit.
- (The following codes cannot be billed during the same month as CCM CPT 99490):· (You will need to build in if CPT 99490 than no to the following codes. It will need to kick out of the billing system)
- o Transition Care Management (TCM) – CPT 99495 and 99496
- o Home Healthcare Supervision – HCPCS G0181
- o Hospice Care Supervision – HCPCS G9182 o
- Certain ESRD services – CPT 90951-90970
- If other E·&M or procedural services are provided, those services will be billed as appropriate. That time can NOT be counted toward the 20 minutes. If time, such as from a phone call, leads to an office visit resulting in an E&M charge, that time would be included in the billed office visit, NOT the CCM time. (THIS EXCEPTION NEEDS TO BE BUILT INTO SYSTEM TOO)
- DOCUMENTATION – a system of documentation will need to be in place for practice.

2. CCM Checklist

Checklist/Requirements to bill for CCM	Completed Yes	Missing No
Initiating Visit. An Evaluation Management (E/M), Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE) visit has been furnished by a FQHC employed MD, DO, NP, PA, or CNM. This is required for patients not seen within one year of the start of CMM services, or new patients (not seen within the last three years by a FQHC provider covered by Medicare). The face-to-face visit included in transitional care management (TCM) services (CPT codes 99495 and 99496) also qualifies as a "comprehensive" visit for CCM, general Behavioral Health, or Psychiatric CoCM service initiation*.		
Beneficiary Consent. Consent is obtained during or after the initiating visit and before provision of care coordination services by clinical staff. Consent can be written or verbal but must be documented in the medical record and: • Include the availability of care coordination services and applicable cost-sharing • Inform the patient that only one practitioner can furnish and be paid for care coordination services during a calendar month • Communicate the patient's right to stop care coordination services at any time (effective at the end of the calendar month) • Provide the patient with permission to consult with relevant specialists		
Patient Eligibility. A patient with multiple (two or more) chronic conditions expected to last at least 12 months or until the patient dies, or places the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline.		
Care Coordination Services. 20 or more minutes of care coordination services are documented; furnished in the calendar month (a) under the direction of the FQHC employed practitioner (i.e., MD, DO, NP, PA, CNS or CNM), and (b) by a FQHC practitioner, or by clinical personnel under general supervision. State law, licensure, and scope of practice definitions must be considered for non-primary care service providers.		
Electronic Health Record Documentation. The patient's health information has been structurally recorded with Certified EHR Technology, including: demographics, problems, medications and medication allergies that inform the care plan, care coordination, and ongoing clinical care.		
24/7 Access. The patient has 24/7 access to physicians or other qualified health care professionals or clinical staff and means to contact health care professionals in the practice to address urgent needs regardless of the time of day or day of week.		
Continuity of Care. The patient is offered continuity of care with a designated member of the care team with whom the patient can schedule successive routine appointments.		
Comprehensive Assessment. Comprehensive care management is offered, including a systematic assessment of the patient's medical, functional, and psychosocial needs.		
Preventive Care. System-based approaches are applied to ensure the patient receives all recommended preventive care services in a timely manner.		
Medication Management. Medication reconciliation includes the review of adherence, potential interactions, and oversight of the patient's self-management.		

Checklist/Requirements to bill for CCM	Completed Yes	Missing No
Comprehensive Care Plan. A comprehensive care plan is created, including the creation, revision, and/or monitoring of an electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment. The comprehensive care plan covers all health issues with particular focus on the chronic conditions being managed. This plan includes, but is not limited to, the following elements: • Problem list • Expected outcome and prognosis • Measurable treatment goals • Symptom management • Planned interventions, including responsible individuals • Medication management • Community/social services ordered • A description of how outside services/agencies are directed/coordinated • Schedule for periodic review and, where appropriate, revision of the care plan		
Resources and Support. An inventory of resources and supports are provided to the patient.		
Care Plan Sharing. Care plan information is made available electronically (including by fax) in a timely manner for internal FQHC staff and external stakeholders, as appropriate. A copy of the care plan is given to the patient and/or caregiver.		
Care Transition Management. Care transitions between and among health care providers and settings are managed, including referrals to other clinicians. Follow-up is provided after an emergency department visit, a hospital discharge, or with skilled nursing facilities and other health care facilities being utilized. The creation and exchange/transmission of continuity of care document(s) is shared with other practitioners and providers in a timely manner.		
Coordination of Care. Care is coordinated with home- and community-based clinical service providers, and communication to and from home- and community-based providers regarding the patient's psychosocial needs and functional deficits is documented in the patient's medical record.		
Electronic Communication Options. Enhanced opportunities are available for the patient and caregiver to communicate with the practitioner regarding the patient's care through telephone access, secure messaging, internet, and/or other asynchronous non-face-to-face consultation methods.		
Coding & Billing. Documentation has been made to support using G0511 for General Care Management. Payment for G0511 code may only be billed once per month per beneficiary, and cannot be billed if other care management services are billed for the same time period.		

Resources (Work Cited)

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