Monthly Workflows and Best Practices for Care Managers

ChronicCare | HealthArc EMR | CCM-Only Training Module

This training provides **guidance** on the monthly responsibilities of Care Managers, emphasizing **care quality, documentation accuracy, patient engagement**, and **platform efficiency** using **HealthArc** for Chronic Care Management (CCM) documentation.

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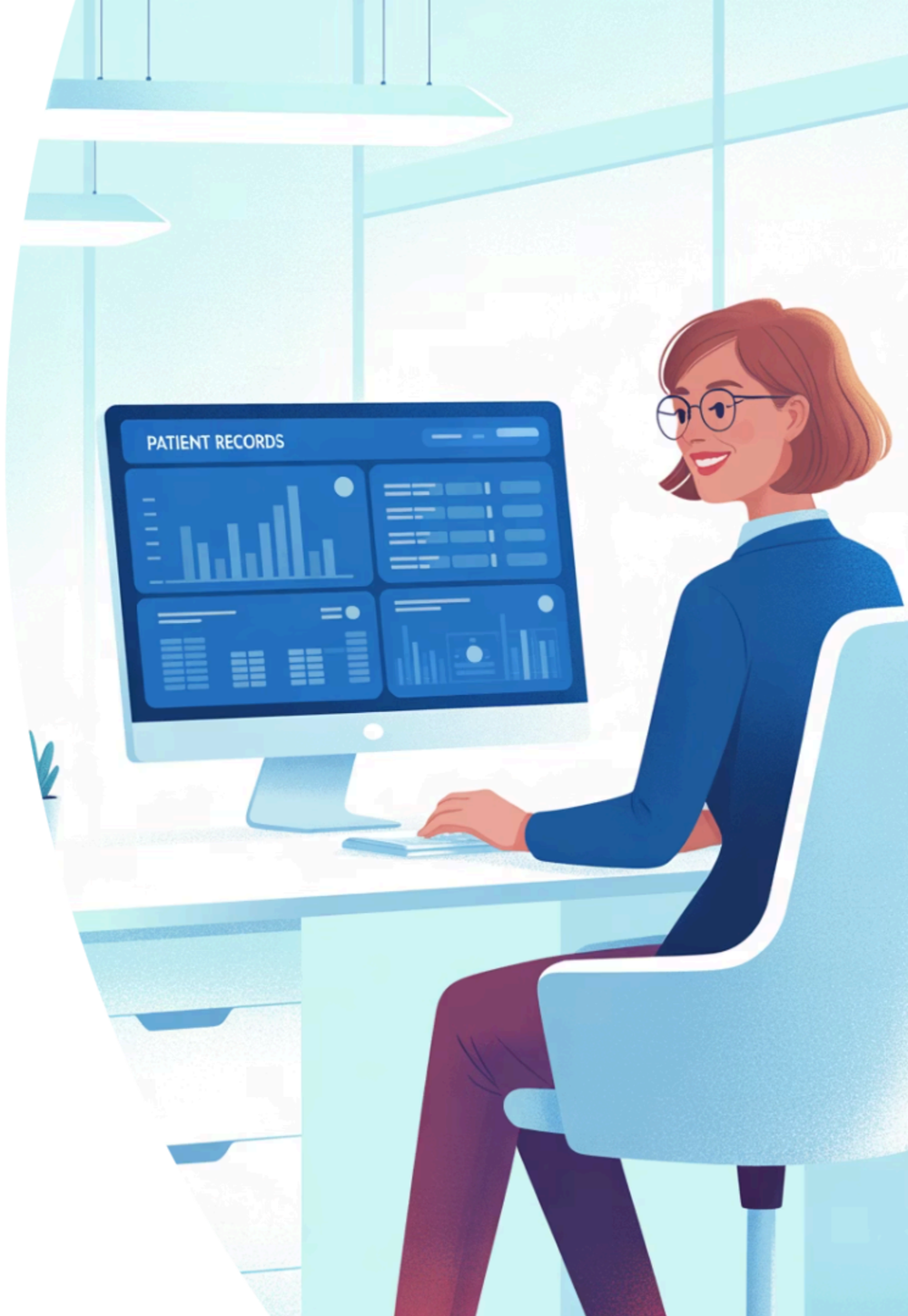
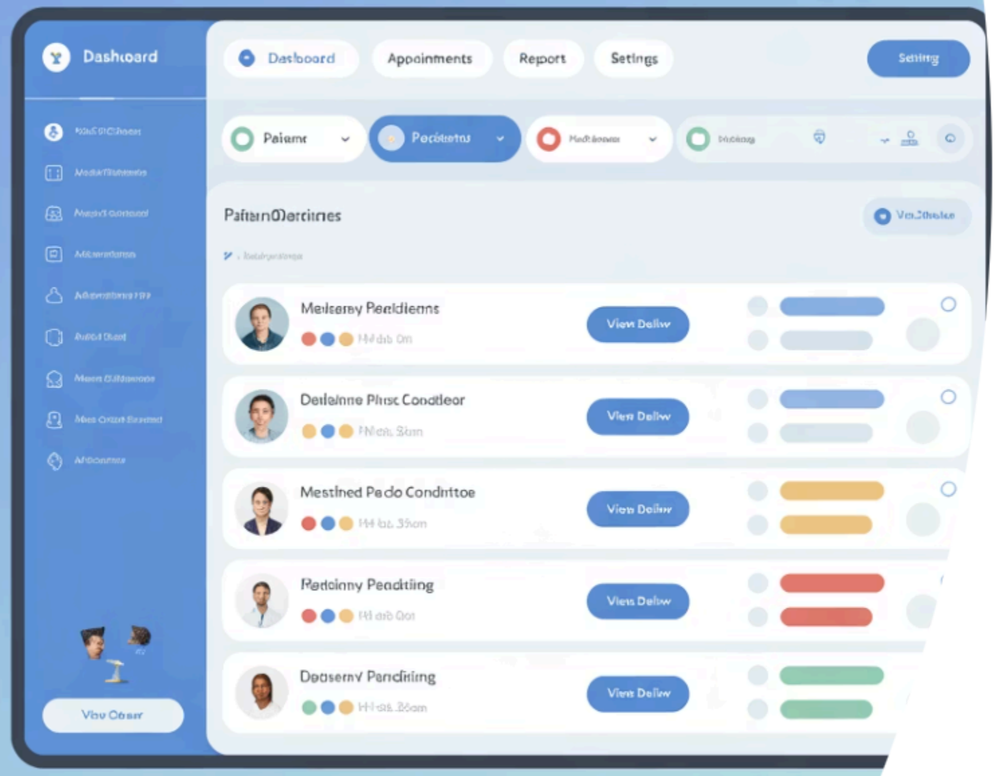




Patient Identification & Prioritization (Days 1–5)

Purpose

Confirm and organize the list of patients due for monthly CCM engagement.

HealthArc Navigation

Log into **HealthArc** and navigate to your **Assigned Patients dashboard**. Use filters to display **patients due this month**.

Prioritization Criteria

Recent discharges or acute episodes, High-medication burden or frequent care gaps, Newly enrolled patients, Previous missed contacts

Example: You notice that Ms. Benjamin, a patient with hypertension and diabetes, missed last month's call. She is marked as "overdue." You move her to the top of your call list and schedule outreach within 48 hours.

Monthly Patient Outreach & Documentation (Days 5–15)

1

Confirm Identity

Confirm identity and review last month's discussion

2

Ask Guided Questions

"Have there been any changes in your health or medications?" "Have you had any recent doctor or hospital visits?" "Are you facing any difficulties with eating, mobility, or mood?"

3

Review Care Plan Goals

Discuss what's going well and identify areas of concern

4

Provide Education

Reinforce medication understanding, diet, or activity goals

5

Update Care Plan

Update the care plan as needed based on discussion

Purpose: Deliver CCM services through structured non-face-to-face engagement.

Minimum Requirement: Document at least **20 minutes of clinical staff time** over the course of the calendar month.

HealthArc Documentation Requirements

Required Documentation Elements

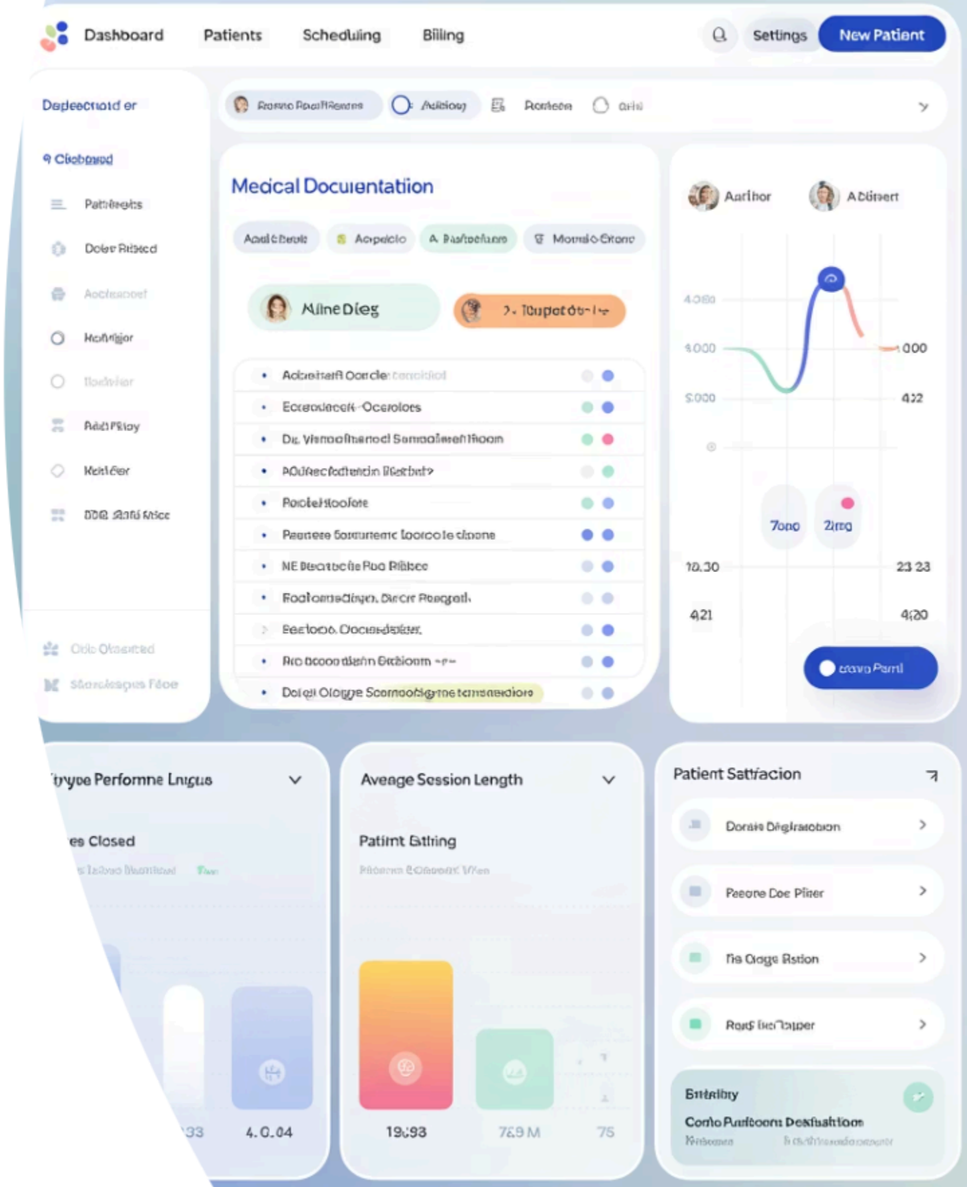
Enter detailed case notes, including: Start and end time, Topics discussed, Interventions or recommendations, Education provided, Changes made to the care plan

Standardization Tools

Use dropdowns and templates to standardize input

Real-Time Example

During your 22-minute call with Mr. Thompson, you discover he's been skipping his blood pressure meds due to dizziness. You explain how to safely manage side effects and recommend follow-up with his PCP. You update his care plan, note the barrier, and add a reminder for follow-up next month.



Care Coordination & Escalation (Days 10–20)

1 Identify Escalation Needs

Escalate concerning symptoms or complications to the RN or PCP

2 Contact Clinical Team

Contact the clinic if: The patient reports a change in condition needing evaluation, There are medication issues or missed appointments

3 Document Coordination

Update **HealthArc care plan** with notes on coordination, including names, dates, and outcomes

4 Use Internal Messaging

Notify appropriate team members (e.g., "Patient reports worsening leg swelling. PCP referral recommended.") Keep a **timestamped communication trail** in the record

Purpose: Address issues beyond your scope and coordinate with the clinical team.

Care Coordination Example Case

Initial Discovery

You call Ms. Douglas and learn she had a fall last week. She refused to go to the ER but has persistent back pain.

Team Notification

You notify the RN, who speaks to her and schedules a follow-up.

Complete Documentation

You document the entire chain of communication and add a note to revisit the fall risk plan next month.

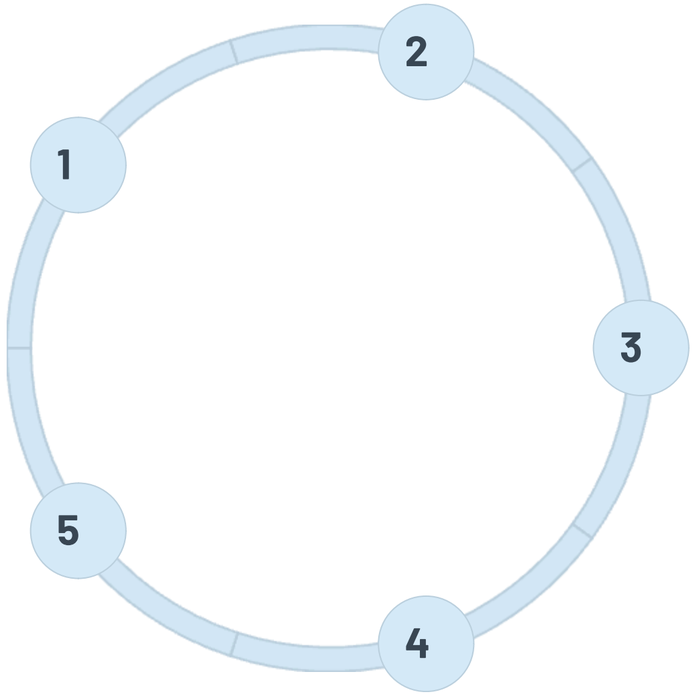
End-of-Month Review & Compliance (Days 25–30)

Time Compliance

≥ 20 minutes of non-face-to-face care logged

Entries Finalized

All time entries finalized in HealthArc



Documentation Complete

Monthly interaction documented with clear summary

Care Plan Updated

Care plan reviewed or updated

Follow-ups Tracked

Follow-ups or referrals completed or documented

Purpose: Ensure each assigned patient's CCM activity meets CMS compliance standards and internal protocols.

Use HealthArc Reports: View "Incomplete" or "Below Time" patients, Confirm which cases need attention before the month ends

Best Practices for Documentation and Patient Interaction

Document in Real-Time

Use HealthArc's built-in stopwatch or timer tools. Avoid end-of-month bulk logging, which increases errors and risks noncompliance. **Best Practice:** Log every call, message, or task as it happens—even short interactions count when clinically relevant.

Be Purpose-Driven

Each conversation should tie back to a care plan goal. Reinforce education, track progress, and modify strategies based on patient feedback. **Example Questions:** "Have you been walking three times a week like we discussed?" "What's getting in the way of taking your medication daily?"

Practice Motivational Interviewing

Support behavior change using open-ended, non-judgmental dialogue. **Examples:** "Tell me what's been most difficult about managing your blood sugar." "What do you feel ready to work on this month?"

Care Plan Management and Time Tracking

Standardize Care Plan Review

Make it part of every monthly touchpoint. Use HealthArc's care plan tab to walk through: Current problems and goals, Education provided, Pending tasks or referrals

Tip: Mark completed goals and update any barriers or new priorities as they arise.

Track Time with Purpose

Billable time includes: Patient calls and care plan reviews, Documentation, Referral coordination, Patient/caregiver education

Do not include non-clinical admin time (e.g., scheduling unless it relates to clinical coordination).

End-of-Month Review Guide

5

Essential Checkpoints

Complete monthly review items

20+

Minutes Required

Documented clinical time per patient

100%

Compliance Target

All patients meeting requirements

Final Notes for Care Managers:

- Patient contact complete
- 20+ minutes documented
- Care plan reviewed or modified
- Time tracker finalized
- Escalations followed through