Chronic Care Management The Role of Care Managers

Chronic Care Management (CCM) is a comprehensive, proactive service provided to patients with two or more chronic health conditions.

At ChronicCare, our CCM program is powered by dedicated Care Managers who deliver non-face-to-face services that complement clinical care.
This presentation outlines what CCM entails, the specific responsibilities of Care Managers, and how they contribute to better health outcomes while maintaining compliance with CMS (The Centers

for Medicare and Medicaid) standards.

by Natasha Jackson RN

Understanding Chronic Care Management

What is CCM?

A care coordination service introduced by CMS designed to provide support to patients between office visits.
It was designed for patients with
two or more chronic conditions.
It focuses on continuous communication between the patient and their provider, coordinated care, and patient empowerment.

Eligibility Criteria

Two or more chronic conditions expected to last at least 12 months that place the patient at significant risk.

Patient must provide verbal or written consent to participate.

Billing Requirements

Minimum of 20 minutes of clinical staff time per month, delivered under provider supervision. Comprehensive care plan must be established and documented in a certified EHR.
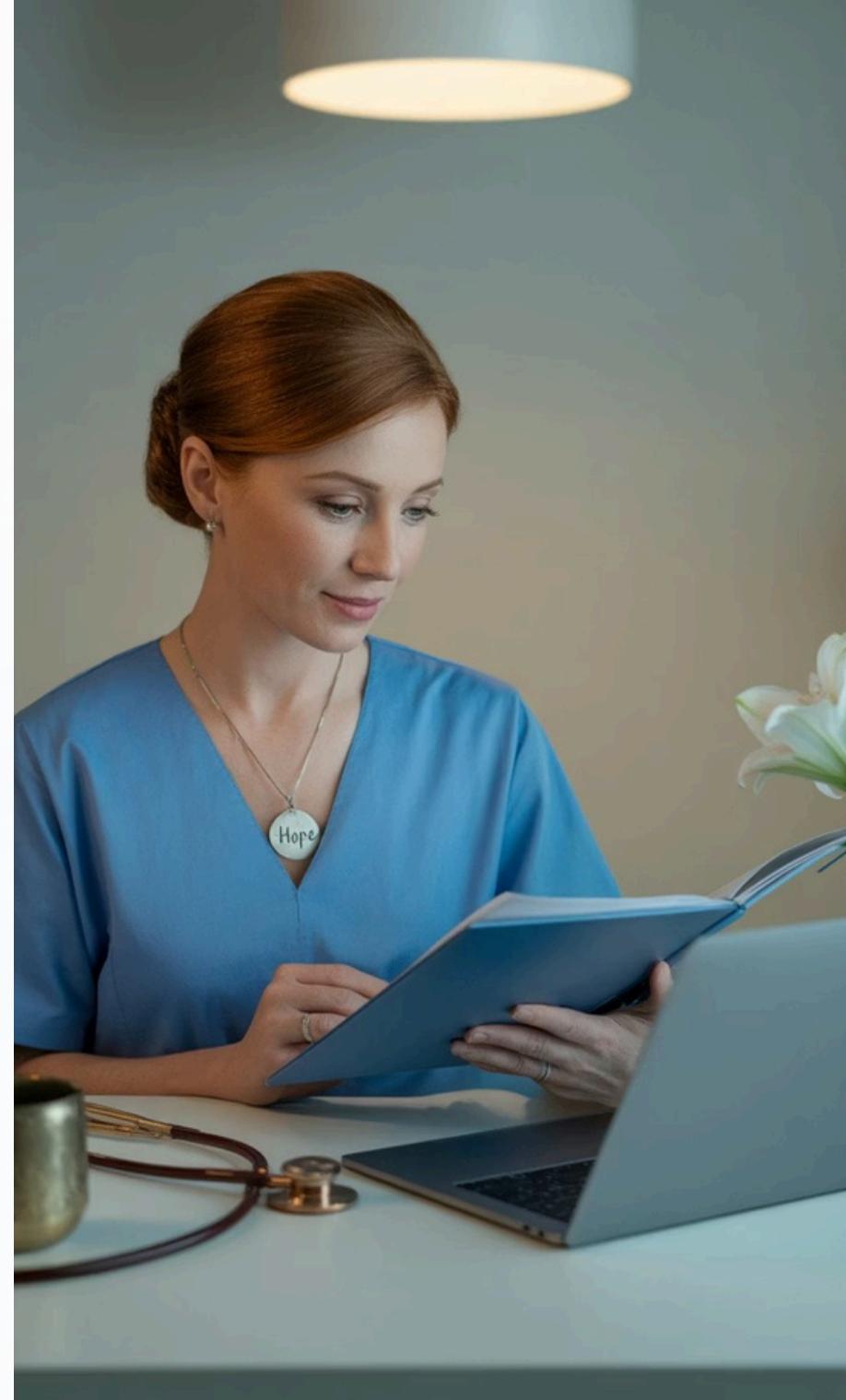
Qualifying Chronic Conditions

Cardiovascular

- Hyper tension Chronic
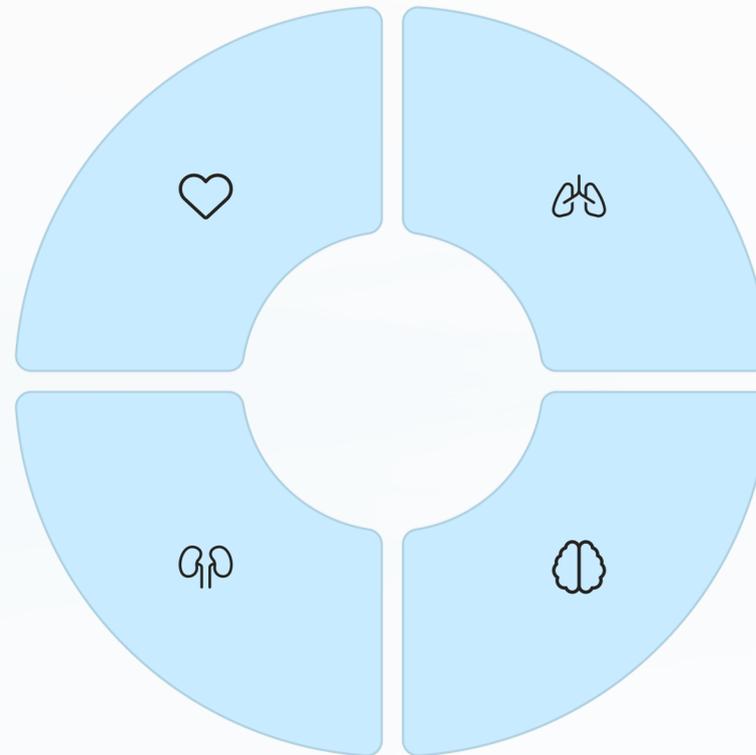- heart failure (CHF)
- Hyperlipidemia

Metabolic

- Diabetes mellitus Obesity
- Chronic kidney disease (CKD)
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Respiratory

- Chronic obstructive pulmonary disease (COPD)
- Asthma

Neurological

- Stroke or TIA history
- Depression or anxiety disorders

Initial Assessment and Enrollment

Contact and Consent
Reach out to eligible patients, explain the CCM program benefits, and obtain their formal consent to participate in ongoing care management.

Document and Initiate
Record chronic conditions and begin developing the personalized care plan that will guide the patient's ongoing management.

Review Medical Records

Examine patient history, social factors, and identify care gaps to establish a baseline understanding of the patient's health status and needs.

Example: Ms. T has hypertension and diabetes and struggles with medication adherence. The Care Manager explains CCM services and sets initial goals for glucose control and daily medication reminders.

Creating and Maintaining the Care Plan

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Comprehensive Documentation

Develop a personalized care plan in HealthArc that includes chronic conditions, current medications, functional limitations, social supports, and health goals.

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Regular Updates

Review and revise the care plan monthly or when new health events occur to ensure it remains relevant to the patient's changing needs.

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Collaborative Approach

Involve patients in care planning to increase engagement and ensure goals align with their preferences and capabilities.

Example: After a patient develops vision changes from diabetic retinopathy, the Care Manager updates the care plan and adds a new specialist referral.
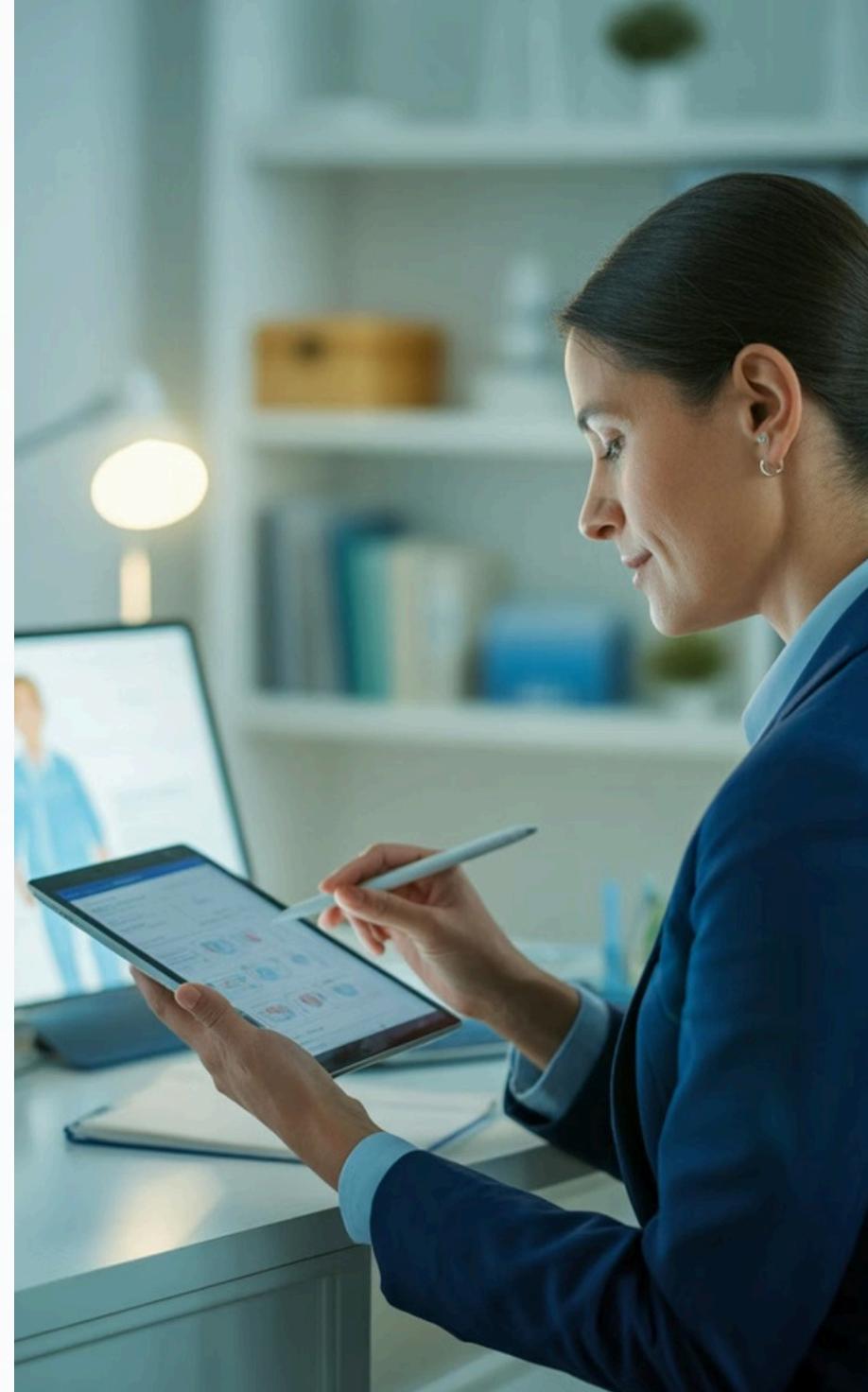
Monthly Monitoring and Communication

Regular Check-ins
Conduct monthly outreach calls or video check-ins to assess patient status and address emerging concerns.

Health Monitoring
Track symptoms, medication side effects, lab results, and daily vitals (if on Remote Patient Monitoring).
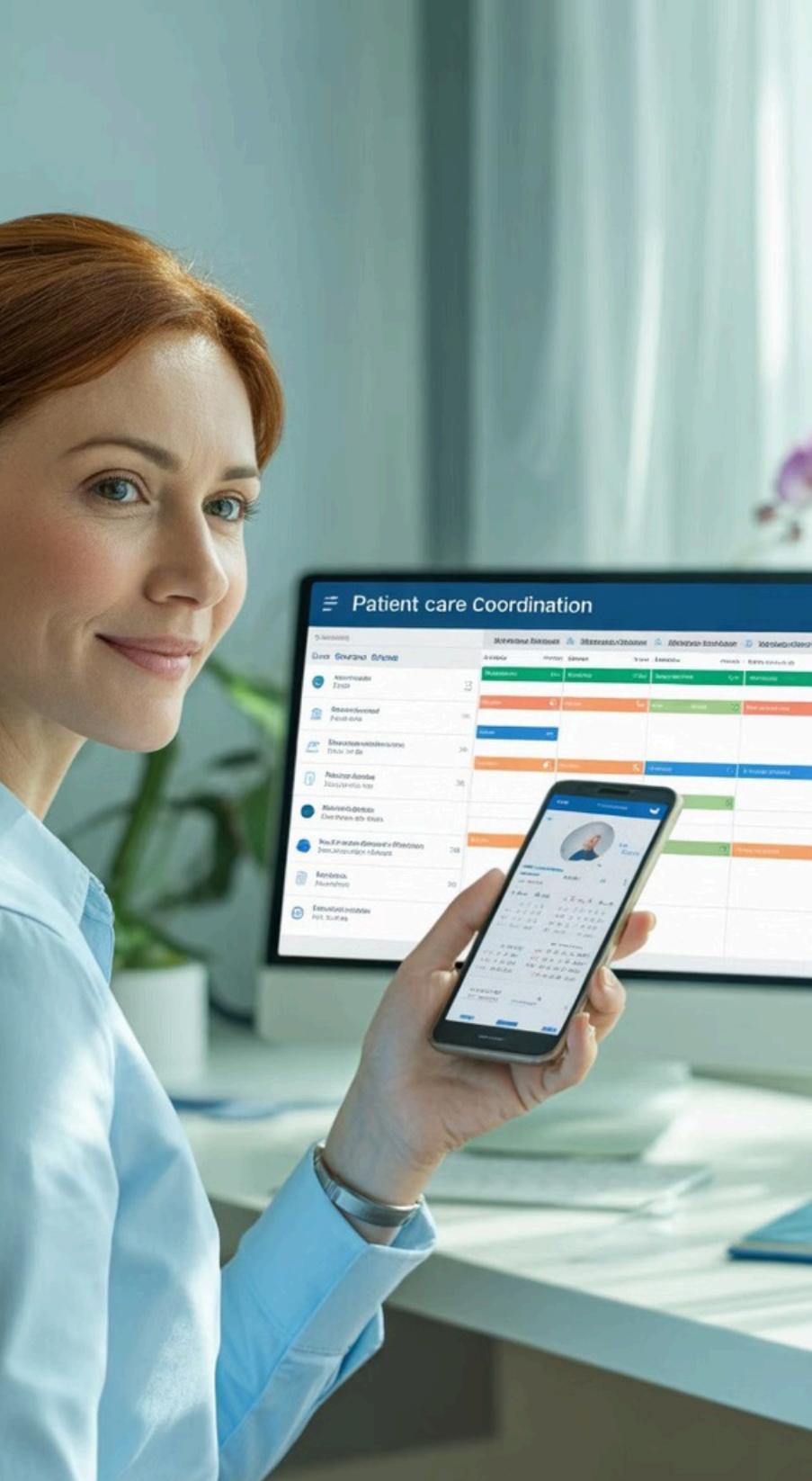
Patient Education
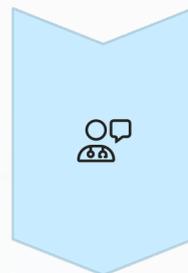Provide information on disease management and coping strategies to empower patients in self-care.

Issue Escalation
Identify concerning changes and promptly communicate with healthcare providers when intervention is needed.

Coordination of Care

Provider Liaison
Serve as a connection between primary care, specialists, and ancillary services.

Appointment Facilitation
Schedule and confirm medical appointments, tests, and procedures.

Referral Management
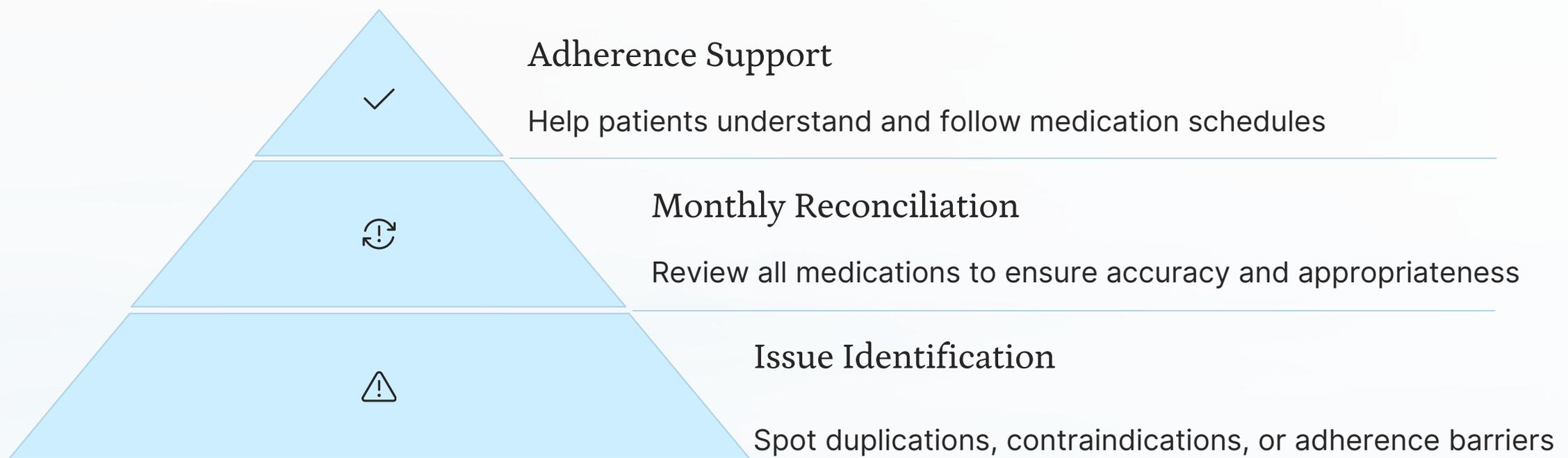Coordinate referrals to specialists and therapy services as needed.

Documentation
Record all coordination efforts in the patient's electronic health record.

Example: A Care Manager schedules a nutritionist appointment for a patient newly diagnosed with high cholesterol and confirms with the PCP to ensure coordinated care.

Medication Management

Adherence Support
Help patients understand and follow medication schedules

Monthly Reconciliation
Review all medications to ensure accuracy and appropriateness

Issue Identification

Spot duplications, contraindications, or adherence barriers

Medication management is a critical component of CCM. Care Managers help patients understand the purpose and timing of each medication, identify potential issues, and work with providers to resolve problems.

Example: A patient takes three blood pressure medications simultaneously, causing dizziness. The Care Manager consults with the provider to adjust the timing and resolve the adverse effects.

Addressing Barriers to Care

$ Financial Hardship
Connect patients with prescription assistance programs, insurance navigation support, and financial counseling services.

Transportation Issues
Help patients access transportation services, coordinate ride-sharing options, or arrange telehealth alternatives when appropriate.

Food Insecurity
Provide referrals to food banks, meal delivery services, and nutrition assistance programs to ensure patients maintain proper nutrition.

Social Isolation
Connect patients with community support groups, senior centers, and social services to combat loneliness and improve mental health.

Example: A patient repeatedly misses appointments due to lack of transportation. The Care Manager helps enroll them in a transportation assistance program, improving care access and adherence.

Promoting Self-Management

SMART Goal Setting
Collaborate on Specific, Measurable, Achievable, Relevant, Time-bound goals

Progress Tracking
Monitor advancement toward health objectives and adjust as needed

Success Celebration
Acknowledge achievements to reinforce positive behavior changes

Effective self-management is crucial for long-term health improvement. Care Managers work with patients to develop realistic goals and build confidence in managing their conditions independently.

Example: A patient with diabetes sets a goal to walk 20 minutes a day, five days a week.

The Care Manager tracks their progress monthly and helps adjust the goal as fitness improves.

Documentation and Compliance
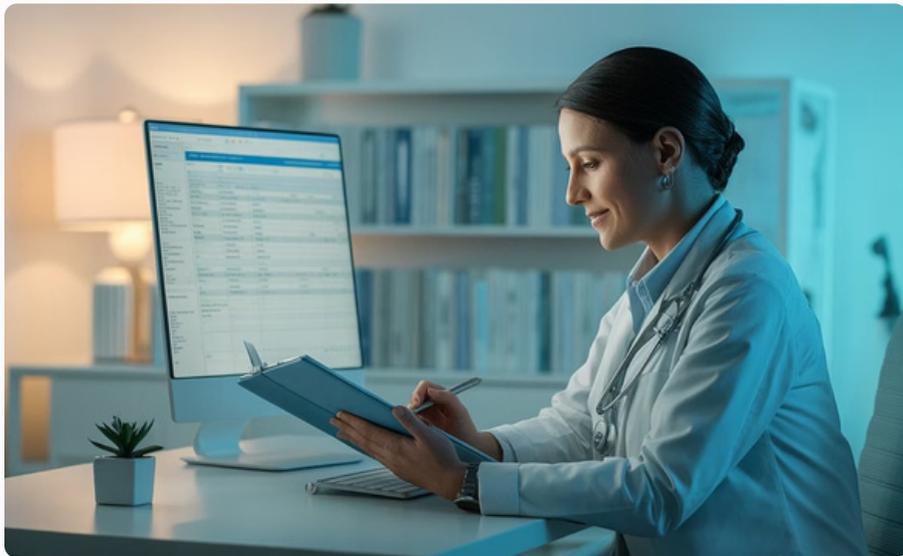
Thorough Record-Keeping

Record every patient interaction, update, and coordination task in HealthArc to maintain comprehensive care records and support continuity of care.

Time Tracking

Accurately document time spent on CCM activities, ensuring the minimum 20 minutes per month required for billing while capturing all valuable patient care time.

Audit Readiness

Ensure all notes are clear, complete, and structured to meet compliance requirements and withstand potential audits from regulatory bodies.

Best Practice: Document as you go to avoid missed details. Use structured fields and drop-down menus in HealthArc to maintain consistency and completeness.
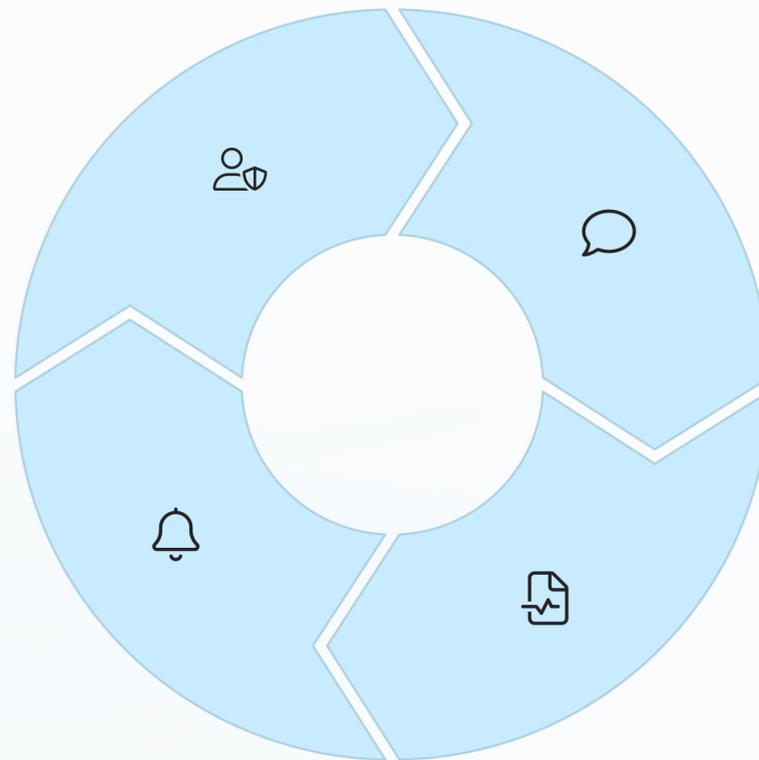
Best Practices for Effective CCM

Risk Stratification

Prioritize high-risk patients and those with frequent ER/hospital visits to focus resources where they can have the greatest impact

Open Communication

Maintain clear channels with providers and clinical staff to ensure coordinated care delivery

Prompt Escalation

Quickly alert providers to abnormal findings or concerning changes in patient status

Comprehensive Documentation

Include summaries of interventions, barriers, goals, and outcomes in each patient note

As a Care Manager, you're not just checking boxes you're changing lives through education, coordination, compassion, and consistency.
Your work ensures patients stay engaged, goals are met, and complications are prevented.

Need help or guidance? Reach out to your Clinical Supervisor or the ChronicCare Support Team anytime for clarification, feedback, or additional resources.