SAMPLE CHRONIC CARE MANAGEMENT NOTE

T2DM + HTN + HFPEF + CKD — COMPLEX CCM

Questions? Visit us at
www.marvix.ai

1 Patient Information

1 PATIENT DETAILS

Name
Margaret A. Holloway

Date of Service / Care Period
05/06/2026 — April 2026 CCM Period

DOB
03/22/1965

Provider
Dr. Patricia Kim, MD — Internal Medicine

Age / Sex
61 / Female

MRN
CCM-2026-0178

Care Manager / Clinical Staff
RN Care Manager: Linda Chen, BSN, CCM

Primary Care Provider
Dr. Patricia Kim, MD

Care Setting
Primary Care — Telehealth CCM Contact (monthly)

RN Reason for CCM Enrollment

2 CCM ENROLLMENT RATIONALE

Mrs. Holloway is enrolled in the Chronic Care Management (CCM) program for management of multiple complex chronic conditions — Type 2 diabetes mellitus, hypertension, heart failure with preserved ejection fraction (HFpEF), CKD stage 3a, and major depressive disorder. She has had 4 ED visits in the past 12 months (2 for hypertensive urgency, 1 for HFpEF decompensation with fluid overload, 1 for hypoglycemic episode) — indicating inadequate disease control and high risk for further acute events. CCM provides structured monthly care coordination, medication management, self-monitoring support, and coordination with multiple specialists (cardiology, nephrology, endocrinology, psychiatry).

AC Active Chronic Conditions

3 CHRONIC DIAGNOSES

1. TYPE 2 DIABETES MELLITUS — HbA1c 9.4% at last check (02/2026). On metformin 1000 mg BID + empagliflozin 10 mg daily + insulin glargine 20 units QHS. Suboptimally controlled. 2. HYPERTENSION — BP 158/96 mmHg at last visit (04/20/2026). On lisinopril 20 mg + amlodipine 5 mg + chlorthalidone 25 mg. 2 ED visits for hypertensive urgency in past year. 3. HEART FAILURE WITH PRESERVED EJECTION FRACTION (HFpEF) — EF 55% on echo (01/2026). On furosemide 40 mg QD + spironolactone 25 mg + empagliflozin. 1 admission for decompensated HFpEF (03/2026 — 4-day stay) secondary to salt and fluid non-adherence. 4. CHRONIC KIDNEY DISEASE STAGE 3a — eGFR 48 (04/2026). Baseline creatinine 1.6. CKD complicates diabetes and HF medication management. Nephrology follow-up q6 months. 5. MAJOR DEPRESSIVE DISORDER — PHQ-9: 14 (moderate-severe at last assessment 04/2026). On sertraline 100 mg. Under care of psychiatrist Dr. Karen Walsh quarterly. Depression significantly contributing to medication non-adherence and self-care deficits.

IH Interval History

4 UPDATES SINCE LAST CCM CONTACT

LAST CCM CONTACT: 04/01/2026 (telephone, 22 minutes with RN care manager Linda Chen). INTERVAL EVENTS: (1) HOSPITALIZATIONS: HFpEF decompensation hospitalization 03/12–03/16/2026 (4 days) — developed dyspnea and bilateral lower extremity edema after 'a very salty week' (patient's words: went to a wedding and ate buffet food for 3 days). Responded to IV furosemide; discharged on increased oral furosemide 40 mg QD (was 20 mg). (2) MEDICATION CHANGES SINCE LAST CONTACT: Furosemide increased to 40 mg QD (post-discharge). No other changes this period. (3) HOME BLOOD PRESSURE READINGS: Patient purchased automated cuff after last CCM contact. BP log submitted (emailed): readings range 152–172/88–102 mmHg — all elevated. Average home BP past 30 days: 162/94 mmHg. Consistent morning hypertension pattern. (4) HOME GLUCOSE READINGS: Fasting glucose log: range 128–224 mg/dL (average 168 mg/dL). Evening readings consistently 180–220s. Overnight hypoglycemia episode x1 (04/18/2026 — glucose 62 mg/dL at 2 AM, managed with juice). (5) MOOD: Patient reports depression worsening over past 2 weeks — 'I feel like I can't do anything right with all of these medicines.' Increased tearfulness. PHQ-9 administered today: 16 (moderate-severe — worsening from 14 at last contact). (6) NEW SYMPTOMS: Bilateral ankle edema returning per patient — 'My ankles are puffy again.' Weight up 4 lbs from baseline (home scale). NO chest pain, NO dyspnea at rest. (7) APPOINTMENTS ATTENDED: Nephrology (04/08/2026, Dr. Patel) — eGFR 48,

stable; continue current medications. Psychiatry (04/22/2026, Dr. Walsh) — sertraline continued, therapy recommended. Cardiology (04/15/2026, Dr. Chen) — uptitration of spironolactone deferred pending eGFR improvement.

MR Medication Review

5 MEDICATION RECONCILIATION & ADHERENCE

CURRENT MEDICATIONS REVIEWED via patient report and pharmacy refill records: (1) Metformin 1000 mg PO BID — adherence POOR: pharmacy refill data shows 60% fill rate. Patient reports missing doses 'when my stomach hurts.' (2) Empagliflozin 10 mg PO daily — adherence GOOD: 90% fill rate. No side effects reported. (3) Insulin glargine 20 units SC QHS — adherence FAIR: patient skips injection 'sometimes when I'm too tired.' Overnight hypoglycemia episode 04/18 likely related to inconsistent dosing pattern. (4) Lisinopril 20 mg PO daily — adherence FAIR: 75% fill rate. 'I forget the morning medicines.' (5) Amlodipine 5 mg PO daily — adherence FAIR: 75% fill rate (taken with lisinopril; when she misses one, she misses both). (6) Chlorthalidone 25 mg PO daily — adherence POOR: 55% fill rate. 'I don't like taking the water pill because I can't make it to the bathroom in time at work.' (7) Furosemide 40 mg PO daily — adherence POOR: 50% fill rate post-discharge. Same concern as chlorthalidone — workplace bathroom access. (8) Spironolactone 25 mg PO daily — adherence FAIR: 70% fill rate. (9) Sertraline 100 mg PO daily — adherence GOOD: 88% fill rate. Tolerating well. INTERVENTIONS THIS CONTACT: Bladder urgency with diuretics discussed — counseled on taking diuretics in early morning at home before work to reduce urgency at workplace. Pillbox system recommended. Pill organization and reminder strategies discussed. Dr. Kim notified of non-adherence patterns.

SM Self-Management Assessment

6 PATIENT SELF-MANAGEMENT

Symptom Monitoring at Home
BP: Home cuff purchased — logs emailed. Average 162/94 mmHg past 30 days. Glucose: Using fingerstick glucometer — logs maintained, shared via patient portal. Weight: Weighing daily per HF protocol — 4 lb increase from baseline this week.

Diet
High-sodium diet continues to be challenge (wedding event = decompensation). Reports difficulty following low-sodium diet at restaurants and social events. Daily home cooking: better-controlled. Fluid: 48 oz/day (less than recommended 64 oz clear fluid — restricted fluid due to HF concern; needs clarification.

Exercise
Walking 15–20 minutes 3 days/week since hospitalization. Improvement from sedentary. Reports feeling better after walks but 'too tired' other days.

Tobacco / Alcohol
Non-smoker. Alcohol: social, 1 glass wine/week. No cannabis.

Medical Equipment
Automated BP cuff (Omron): using correctly. Glucometer: using correctly. Weight scale: home scale accurate within 2 lbs of clinic scale.

Patient Confidence
Patient states: 'I want to be healthier but all of these medicines and rules are overwhelming. I feel like I'm failing.' This statement reflects significant health literacy challenge and depression's impact on self-efficacy. Motivational counseling provided.

CC Care Coordination Activities

7 COORDINATION THIS MONTH

(1) Reviewed and reconciled records from nephrology (04/08), psychiatry (04/22), and cardiology (04/15) visits — summaries added to care management record. (2) Communicated with Dr. Kim (PCP) today regarding: (a) worsening depression (PHQ-9 16 — request for sertraline dose increase or alternative; Dr. Kim to review and respond), (b) persistent hypertension despite triple therapy (request to consider amlodipine uptitration to 10 mg; Dr. Kim agreed — prescription sent), (c) diuretic non-adherence — patient education completed today; plan reviewed with Dr. Kim. (3) Called cardiology (Dr. Chen's office) — spironolactone uptitration deferred pending stable eGFR; next cardiology appointment confirmed 07/15/2026. (4) Confirmed nephrology follow-up: 10/2026 (per Dr. Patel's 6-month schedule). (5) Referred patient to social work for assistance with workplace accommodation for bathroom access (to support diuretic adherence). Social work appointment: 05/14/2026. (6) Patient portal: reviewed portal messages — patient had sent 2 portal messages this month about glucose confusion; responded same day with instructions. (7) Pharmacy coordination: pillbox packaging requested — CVS Pharmacy confirmed they offer compliance packaging; patient educated on how to request.

CD Clinical Data Reviewed

8 REVIEWED DATA

Recent Labs
eGFR 48 (04/2026, stable). Na 138, K 4.2, Cr 1.6 — stable electrolytes on diuretics. Glucose 168 (fasting, 04/2026 routine). HbA1c 9.4%

Home Monitoring Data

(02/2026 — due for recheck in June 2026). TSH 2.1 (WNL). Lipid panel (02/2026): LDL 88 (on rosuvastatin — at goal <100).

BP log: average 162/94 mmHg (30 days). Glucose log: fasting average 168 mg/dL, evening average 198 mg/dL. Weight: 4 lb increase from 148 lbs baseline to 152 lbs this week.

Specialist Notes

Nephrology (04/08): eGFR stable; continue ACEi; monitor K. Cardiology (04/15): Spironolactone uptitration deferred; empagliflozin continued. Psychiatry (04/22): Sertraline 100 mg continued; therapy recommended.

Preventive Care Status

Mammogram: due (last 2022 — overdue). Colonoscopy: up to date (2023). Annual eye exam: completed (02/2026, mild NPDR noted by ophthalmology). Flu and pneumonia vaccines: up to date.

A Assessment

9 CHRONIC CARE STATUS INTERPRETATION

Mrs. Holloway is a 61-year-old female with multiple complex chronic conditions demonstrating suboptimal disease control across several domains, driven primarily by medication non-adherence and depression. Current assessment by condition: (1) T2DM: POORLY CONTROLLED — HbA1c 9.4%, fasting glucose average 168 mg/dL, evening glucoses in 180–220s. Insulin glargine timing and adherence concerns. Overnight hypoglycemia episode 04/18 — safety concern. (2) HYPERTENSION: UNCONTROLLED — Home average 162/94 mmHg despite triple antihypertensive therapy; poor adherence to chlorthalidone. Amlodipine uptitration ordered today. (3) HFpEF: AT RISK for re-decompensation — 4 lb weight gain this week, ankle edema returning, poor furosemide adherence. Closely monitoring. (4) CKD 3a: STABLE — eGFR 48, electrolytes stable. (5) DEPRESSION: WORSENING — PHQ-9 16 (from 14 last month). Significantly impacting adherence and self-management. Sertraline dose increase request submitted to Dr. Kim. KEY RISKS: Re-hospitalization for HFpEF decompensation is highest-risk near-term concern given 4 lb weight gain, poor diuretic adherence, and returning edema.

CP Care Plan / Plan of Care

10 CCM MANAGEMENT PLAN

1. HFpEF: Patient instructed to call clinic same day if weight increases >3 lbs from 148 lbs baseline. Today's 4 lb gain warrants phone assessment by Dr. Kim today (Linda notifying Dr. Kim after this call). Reinforce furosemide adherence — taking early morning strategy counseled. Salt restriction reinforced — patient given low-sodium restaurant guide. 2. HYPERTENSION: Amlodipine increased to 10 mg (Dr. Kim approved today). Continue monitoring home BP log — target <130/80. Repeat home BP log in 2 weeks. 3. T2DM: HbA1c recheck scheduled for June 2026. Insulin glargine counseling — consistency of timing and dose; overnight hypoglycemia prevention (no skipping, snack before bed if glucose <120). Metformin GI tolerability — trial of extended-release formulation (metformin ER 1000 mg BID) to reduce GI side effects; Dr. Kim to prescribe. 4. DEPRESSION: PHQ-9 16 reported to Dr. Kim today — awaiting sertraline dose increase or referral update. Psychiatry appointment already scheduled (next in July 2026 — may need to be moved up if PHQ-9 not improving). 5. PREVENTIVE CARE: Overdue mammogram — referral placed today for screening mammogram at radiology. 6. SOCIAL WORK: Workplace bathroom accommodation referral placed 05/14/2026.

PE Patient Education

11 EDUCATION PROVIDED

1. DAILY WEIGHT MONITORING: Reinforced 'weigh every morning, call if +3 lbs' rule with explanation of why it matters for HF management. Patient verbalized understanding. 2. LOW-SODIUM DIET: Restaurant low-sodium dining tips provided (written handout emailed to patient). Wedding/event strategies: select grilled not fried, skip sauces, request no added salt. 3. MORNING DIURETIC STRATEGY: Take furosemide + chlorthalidone together at 6 AM before leaving for work (bathroom access at home for first 2 hours of diuretic effect). Patient states this is feasible. 4. INSULIN SAFETY: Overnight hypoglycemia prevention — bedtime snack if glucose <120 before injection; emergency glucagon kit location reviewed with husband (telephone). 5. DEPRESSION & ADHERENCE CONNECTION: Validated patient's feelings of being overwhelmed. Explained that depression makes self-care harder and that this is a medical problem, not a personal failure. Motivated by framing: 'Every pill you take is keeping you out of the hospital.' 6. MAMMOGRAM: Importance discussed; patient agreed to schedule.

FU Follow-Up

12 NEXT CCM CONTACT

Next Care Management Contact

05/20/2026 (2 weeks) — due to HFpEF weight gain concern and new amlodipine dose; closer monitoring interval

Items to Reassess

Daily weights and edema (HFpEF trend). Home BP on new amlodipine 10 mg. Glucose log review. Diuretic adherence. PHQ-9 follow-up (depression). Metformin ER tolerance if prescribed. Social work appointment completed?

Upcoming Appointments

Dr. Kim PCP: 06/10/2026. Mammogram referral: pending scheduling. Social work: 05/14/2026. Psychiatry: 07/2026 (considering pulling forward per PHQ-9 16).

TIME DOCUMENTATION & BILLING (CCM)

Total CCM Time April 2026
42 minutes this contact + 18 minutes prior contacts in April = 60 minutes total this calendar month

Provider Time
20 minutes — Dr. Kim (medication changes, reviewing alerts)

CPT Code(s)
99490 — CCM, first 20 min, clinical staff. 99439 — each additional 20 min (x2 this month)

Clinical Staff Time
40 minutes — RN care manager Linda Chen

Basis for Billing
Non-face-to-face CCM time — calendar month ≥20 min. Two additional 20-min increments billed (99439 x2)

Primary ICD-10 Code
E11.9 — Type 2 DM without complications

Secondary ICD-10 Code(s)
I10 — Hypertension; I50.32 — HFpEF chronic; N18.3 — CKD stage 3a; F32.2 — MDD, severe without psychotic features

PROVIDER / CARE MANAGER	CREDENTIALS	DATE	TIME
Linda Chen, BSN, CCM	RN — Certified Case Manager | Internal Medicine CCM	05/06/2026	10:45 AM