How can you benefit from chronic care management?

- **You will have 24/7 access to your primary care team.**
- **You will have preventive care services scheduled, many of which are covered by Medicare, and your medications will be closely monitored.**
- **You will receive a personalized, comprehensive plan of care for all of your health issues.**
- **Your care will be coordinated by your physician and staff, including care you may receive at other locations, such as specialists' offices, the hospital, other health care facilities, or your home.**

Medicare and Chronic Care Management

We enjoy and appreciate the opportunity to provide you with comprehensive primary care. Medicare has identified the care of chronic health conditions as an important goal. Chronic conditions are ongoing medical problems that must be managed effectively in a partnership between the health care team and the patient to maintain the best possible health. Examples include diabetes, high blood pressure, heart disease, depression, and others. Effective Jan. 1, 2015, federal regulations now enable Medicare to reimburse physicians for providing chronic care management services, with only a small $8 monthly co-pay to patients.

What is chronic care management?

A personalized care program your physician and primary care team will carefully monitor and provide comprehensive care for your chronic health conditions in a systematic way to supplement regular office visit care.

Patient eligibility

. Patients with multiple (two or more) chronic conditions expected to last at least 12 months or more, and that place the patient at significant risk of decline in health, acute exacerbation/decompensation, or functional decline as determined by your doctor, are eligible for the CCM service.

What do I need to do to sign up?

Talk to your primary care physician during today's visit to see if you qualify. Sign an agreement to receive chronic care management. You can discontinue CCM services at any time.

CCM Scope of Service Elements - Highlights

The CCM service is extensive, including structured recording of patient health information, an electronic care plan addressing all health issues, access to care management services, managing care transitions, and coordinating and sharing patient information with practitioners and providers outside the practice. Some of the CCM Scope of Service elements require the use of a certified EHR or other electronic technology.

- Chronic care management services, Provide at least 20 minutes of non-face to face clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: ` Multiple (two or more) chronic conditions expected to last at least 12 months, or more, and that place the patient at significant risk of decline in health, Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, ` Comprehensive care plan established, implemented, and monitored.
- Contact Us

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