Chronic Care Management

Chronic Care Management (CCM) is a relatively new service approved and promoted by Medicare. The goal of CCM is to help patients manage their chronic conditions, fill education gaps, ensure compliance, prevent exacerbations and hospitalization, and improve quality of life.

Patients eligible for CCM services are those that meet the following criteria:

- Medicare
- At least 2 chronic conditions (HTN, DM, etc.)
  - (Chronic is defined as a condition that is expected to last at least 12 months OR until the death of the patient)

Patients can expect to have a contact person (Care Coordinator) who will be monitoring their chronic conditions, providing education, screening for preventive services, coordinating care with other providers, ensuring that consult records have been received from other providers and creating and providing a customized care plan tailored to the patient's specific chronic conditions. Other services include reaching out to patients on a monthly, or bi-monthly basis for a status check and following medication compliance, ensuring the patient has no issues taking/receiving their medications and remains compliant with refills and follow up testing and appointments.

Think of Chronic Care Management as a VIP service for Medicare patient's. It ensures special attention to detail is paid to each patient and their overall health care needs.

For additional information regarding this program and the Medicare guidelines, please visit:
CMS.GOV