+ Take Control of Your Health

CHRONIC CARE MANAGEMENT for Medicare Patients

Comprehensive Care Through Coordinated Communication.

Organizing and coordinating your healthcare when you have two or more chronic conditions can be challenging and requires constant attention. That's where **Chronic Care Management (CCM)** can help. CCM organizes patients into groups based on conditions like diabetes or hypertension. For each condition a coordinated healthcare plan has been developed that includes scheduling of appointments, labs and medications. The Veranda Care Coordination Team is here to help you manage that plan. We help by offering direct communication with you on your condition and treatment. In addition, we help coordinate doctor visits, lab reports, and medications. Simply--we serve as your health coach & personal assistant.

To Qualify for the Chronic Care Management (CCM) Service:

- You must have at least **2 chronic conditions** that are expected to last at least 12 months or until the death of the patient.
- Only one physician can be designated as your CCM provider during a calendar month.
- You simply give your verbal consent for these services and can decline at any time by contacting our office.
- Your Medicare plan **will be** charged a fee only IF….. our care coordination team spends at least 20 minutes **(NON FACE-TO-FACE)** during a month working with you and your chronic condition, or working on your behalf to manage your chronic condition. Important to note, some months you may not need this service at all or 20 minutes is not provided. If this is the case, your Medicare plan will not billed.

EXAMPLES OF NON FACE-TO-FACE SERVICES

- Referral initiation and follow up
- Working hospital reports for Veranda patients that present to PPMH ER, admitted or discharged
- Identifying patients through Greenway Community cohorts – Ex: Diabetic, Hypertensive, High Utilization, Behavioral Health conditions, etc.

SERVICES COVERED

- Allows our team to provide education and assistance in daily management of their chronic conditions through telephone outreach.
- Medication reconciliation to review adherance and potential interactions.
- Coordination between all health care providers to provide continuity of care and timely information sharing.
- Cost savings for the patient with the decrease in duplication of services like labs, imaging and other tests.

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Ask for the Care Coordination Department

TheVeranda.org