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A Harris Healthcare Company

Expect Amazing Results

Population Health

Key Benefits

Better Outcomes:
Better care coordination and increased patient involvement leads to better health outcomes, and that is something all practices strive to achieve.

Reimbursement:
Practices receive reimbursement for providing a minimum of 20 minutes of CCM services per patient in a given month.

Patient Involvement:
Encouraging patients to use CCM services gives them the support and motivation they need to follow good health habits between visits to the office.

Increased Compliance:
Using a digital program to gather and provide quality metrics makes it much easier to communicate with third party reimbursement entities such as CMS or insurance companies.

Reduced Emergency Care:
Patients with better control over chronic conditions can decrease emergency room visits and hospital stays, thereby reducing costs for their insurance providers.

Assured Revenue Stream:
CCM provides another method of sustaining and growing your practice without adding additional facilities or an accompanying increase in necessary

Chronic Care Management

The federal government is moving ahead with changing the way it provides reimbursement for care of patients with chronic conditions. In 2015, The Centers for Medicare & Medicaid Services, or CMS, recognized Chronic Care Management – CCM - as a critical component of primary care. The Centers believe that an integrated approach to chronic care will contribute to better health - especially among the elder population.

The Centers subsequently took steps to adjust the Medicare Physician Fee Schedule (PFS) to encourage medical practices to provide more management services to Medicare patients with multiple chronic conditions. In addition to the in-office patient care and visits, Chronic Care Management covers non-face-to-face services which practices use to provide supplemental educational information, follow-up on health-related activities, and actively engage patients in pursuing improved health goals.

"An estimated **117 million adults** have one or more chronic health conditions, and one in four adults have **two or more** chronic health conditions."
- Centers for Medicare and Medicaid Services

Chronic Care Management, or CCM, is the coordination of care services which are furnished outside of regular office visits. The target population is patients with two or more chronic conditions which are expected to last twelve months or longer, or until the patient's death. These conditions often place the patient at significant risk of death or functional decline, increase the likelihood of multiple hospitalizations, and involve a high level of medical care and follow-up. Certain behaviors on the patient's part, however, may lead to an enhanced quality of life or a delayed reduction in decline. Sample chronic conditions include:

- Addictions
- Alzheimer's
- Arthritis
- Asthma
- Atrial Fibrillation
- Autism
- Cancer

- Cardiovascular
- COPD - Chronic • Diabetes
- Hypertension
- Infectious Diseases
- Obesity
- Stroke/Neurological Condition

Talk to us about your Patient CCM needs.
Contact us: 877.634.2727 or visit www.amazingcharts.com