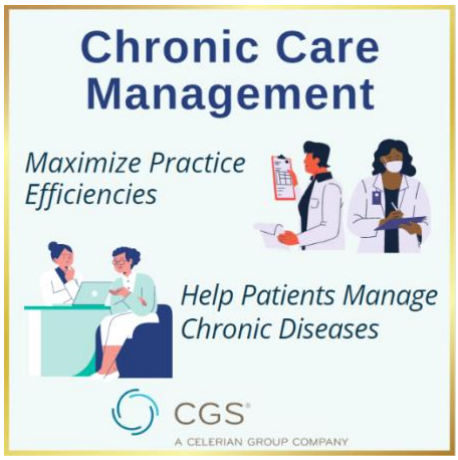
Providing Coordinated Care for Patients With Chronic Diseases



An estimated **117 million Americans have one or more chronic health conditions,** including heart disease and cancer, which are among the leading causes of death in the United States.[1] Chronic Care Management (CCM) can be part of the solution to improve the care and health of people with these conditions.

CCM is care coordination services that routinely require extra time outside of regular office visits for patients on Medicare with multiple chronic conditions. There are separate billing codes for providing these services that can help patients stay on track with their treatments. Services include providing a team of dedicated health care professionals to develop and carry out a comprehensive care plan with patients to support disease control and health management goals.

Helpful tip: Clinical staff can deliver these services under a billing provider, saving time and resources.

CCM can support your practice by:

- Improving care coordination efficiency and health outcomes
- Supporting patient compliance and helping patients feel more connected
- Sustaining and growing your practice to care for high-risk, high-needs patients

Two thirds of people on Medicare have 2+chronic conditions, which means many of your patients can benefit from CCM services. CCM can help you deliver coordinated care to your patients to improve their health and to increase satisfaction with their care.

Review this booklet for more details and information about CCM services and payment, its benefits, and how to start implementing it in your practice.

This printable flyer and provider testimony may also be helpful tools when discussing CCM with eligible patients.

[1] Centers for Disease Control and Prevention. (2022). *Leading causes of death*. https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm