We are proud to introduce our Preventative Wellness program for our Medicare patients. Effective October 1, 2018, we are urging all of our Medicare patients to enroll into our Chronic Care Management program with our program Care Coordinator. This program is designed to help us better manager your health, communicate with you in between office visits and to keep you out of the Emergency Room.

***What is Chronic Care Management CCM?***

Chronic Care Management (CCM) is defined as the non-face-to-face services provided to you who have multiple (two or more), chronic conditions. In addition to office visits, this service includes communication with you and other treating health professionals for care coordination, medication management, and other non-life-threatening services.

**You will gain a team of dedicated health care professionals who can help you plan for better health and help you stay on track.** Services such as monthly telephonic check-ins and ready access to your care team improves their care coordination, including improved communication and management of care transitions, referrals, and follow-ups.

**You will receive a comprehensive care plan developed by our Care Coordinator in conjunction with you.** The plan will help support your disease control and health management goals, including physical, mental, cognitive, psychosocial, functional, and environmental factors. You may also receive a list of suggested resources and, if available, community services.,

 **Patients who use CCM will provide the support they need between visits.** Having a regular touch point will help you think about your health and become more engaged in your care plan,

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