Chronic Care Management Toolkit

Sample CCM Care Team Flow

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

HQIN
Health Quality Innovation Network

Certified EHR

- Demographics
- Problem List
- Medications/Medication Allergies
- Beneficiary written consent
- Documentation of communications to/from home and community-based providers

CMS

- Billed Monthly

Licensed Clinical Staff

- Coordinate referrals
- Identify appropriate providers
- Capable of sharing electronic care plan and electronic summary care record
- Medication reconciliation
- Communicate to/from community-based providers

Care Plan

- Electronic
- Updated at least annually

Practitioner

- Conduct initial Preventative Physical Exam
- Conduct Annual Wellness Visit OR
- Conduct Evaluation and Management Visit (billed separately)

Care Team

- ≥ 20 minutes CCM/month
- 24/7 access for urgent needs
- Telephone and asynchronous consultation
- Post-discharge TCM (if appropriate)
- ER follow-up

Beneficiary

- Access to successive, routine appointments

Educate → **Written Consent** → **Beneficiary** ← **Other Providers**

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