CHRONIC CARE MANAGEMENT (CCM)

TAPASVI HEALTH7
CRITICAL THINKING MATTERS™

WHAT IS CCM

- Non-face to face MONTHLY follow-up care to Medicare patients
- Elderly with more than 1 chronic condition that will last at least for more than 12 months
- Places patients at the risk of death, acute exacerbation, decompensation or functional decline
- Medicare patients & MA

Revenue Potential

TRADITIONAL MODEL

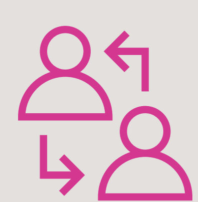
$76 $/Per visit
4X a year
= 305 $/Per patient per year

SIMPLE CCM MODEL

76/per visit + $64 Per visit
= $ 305 +$ 768
= $ 1073 per patient/year

WHY CCM

Improves patient outcomes



Increases patient engagement

Your practice already does the work but do not get reimbursed

Virtual care between visits

CCM is a way to increase your practice revenue with out increasing patients

Your Clinic does all the work already. But you do not get reimbursed. With CCM you will !

What to do

IDENTIFY THE PATIENTS

Use your EHR to search for patients that have 2 or more chronic conditions.

INVITE AND ENROLL PATIENT

Invite patients to participate . Explain how it works and that they can decline, transfer, or terminate/Transfer at any time

CREATE AND DOCUMENT A COMPREHENSIVE CARE PLAN

A systematic assessment of the patient's medical, functional, and psychosocial needs;
System-based approaches to ensure timely receipt of all recommended preventive care services AND MORE...

DOCUMENT THE TIME SPENT

Track the non-face-to-face time
Time spent coordinating care by phone or other electronic communication.
With other clinicians, facilities, community resources, and caregivers;
Prescription management/medication reconciliation.

Interested in improving your Elderly Patients Health outcomes ?

Generate Additional Revenue?

Give me a Call at **805-338-6255**
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Madhuri Gandikota, PH.D, Owner

We are eager to serve the providers serving the community in particular seniors.