



CHRONIC CARE MANAGEMENT BEHAVIORAL HEALTH INTEGRATION

WHAT IS CCM?

CCM or Chronic Care Management is a program through Medicare. The goal of CCM is to offer individuals with two or more chronic conditions support throughout their life and during their involvement in the program. The care coordinator is available to all participants for coordination support with their PCP office, specialists', community resources, family and caregiver support and advanced care planning.

HOW IT WORKS

- A patient, who meets insurance eligibility, is introduced to the program by their PCP or Care Coordinator
- Patient consents to engage in the program
- Patient and Care Coordinator develop health goals and ways to work towards these goals
- Patient and Care Coordinator meet, in person or via phone, at least once a month to check in on goals and follow-up if other needs arise.

HOW CAN LIV HELP?

Our Care Coordinators will help patients engage more in their treatment plans.

Example: by becoming more conscious of taking medications, managing fall risks, and other self-management tasks. Our team can help encourage patients to stay on track managing different transitions of care.

- Communicate frequently with PCP or Specialist teams, to keep the patient's primary care involved and up to date on what is going on with their patients when they aren't in the office.
- We can provide check-in visits and assist with virtual visits with providers.
- We can integrate our behavioral health providers into their practice.
- Our behavioral health team can meet with providers regularly to make recommendations, develop treatment plans, and treat patients with mental illness.
- Together, we can help improve outcomes, provide a more supportive, and overall better quality model of care.

WHAT IS A CHRONIC CONDITION?

- A condition that last 1 year or more
- Requires ongoing medical attention
- Can limit ability to do daily activities
- If not addressed can cause functional decline



WHO TO CONTACT WITH QUESTIONS?

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