Sentara Health Plans

# Chronic Care Management Program

Sentara Health Plans has developed the new Chronic Care Management (CCM) program. Our program, which is managed by registered nurses, helps your patient understand and manage their conditions. It also outlines any factors that can have an impact on their health. The CCM program is designed to reinforce your treatment plan for your patient. Participation in the program is voluntary.

## We're here to partner with you.

Patients are automatically enrolled into the CCM program when Sentara Health Plans identifies them as having this condition. However, patients may opt out of the program at any time.

**The CCM program will supply the following services:**

- Educational materials to assist the patient in self-management
- 24-hour Nurse Advice Line
- Support from our nurses and other care staff
- Community education classes
- Communication with you on their plan of care

If you have any questions or your patient wishes to stop participating, please call us toll-free at **1-866-243-0937 (TTY 711)**. We are available Monday through Friday, 8 a.m. to 5 p.m., except holidays.

We welcome your feedback. If you would like to enroll patients who are members of Sentara Health Plans and have not been identified for the program, please let us know.

The Centers for Medicare & Medicaid Services (CMS) estimates that approximately **one in four adults** have two or more chronic conditions, qualifying them to receive CCM services.

Consultative CCM is a patient-centered approach to care that proactively manages the health of patients with chronic conditions. Sentara Health Plans' CCM program currently includes diabetes, hypertension, chronic obstructive pulmonary disease, asthma (both adult and pediatric), congestive heart failure, oncology, and end-stage renal disease (ESRD). Human immunodeficiency virus (HIV) will soon be added to the CCM program.

**For more information, please visit the link below:**

**chartspan.com**

## Facts About CCM and Chronic Illness

- Living with chronic illnesses creates a mental, physical, and financial burden for patients and leads to higher costs and complexity for their providers.
- According to the CDC, chronic disease is the leading cause of death and disability and the leading driver of $4.1 trillion in annual healthcare costs in the U.S.
- CCM aims to improve patients' quality of life, assist in managing symptoms, prevent complications, and promote patient self-management across healthcare and community settings.
- CCM programs have demonstrated positive health outcomes for enrolled patients. By offering a structured and coordinated approach to care, these programs not only enhance the patient experience but also lead to **reduced hospital readmissions**, fewer emergency room visits, and better chronic disease management.
- The collaborative nature of CCM ensures that patients and healthcare providers are aligned in their goals, driving overall improvements in the healthcare landscape.
- Chronic conditions typically last for a lifetime and may not have a cure. People with chronic illnesses often need ongoing medical care to manage their symptoms and slow down the progression of the disease. Chronic Care Management emphasizes preventive measures to proactively address chronic conditions and prevent exacerbation and subsequent health issues in between regular office visits.


*Figure 1: greenwayhealth.com (Best Practices Site)*

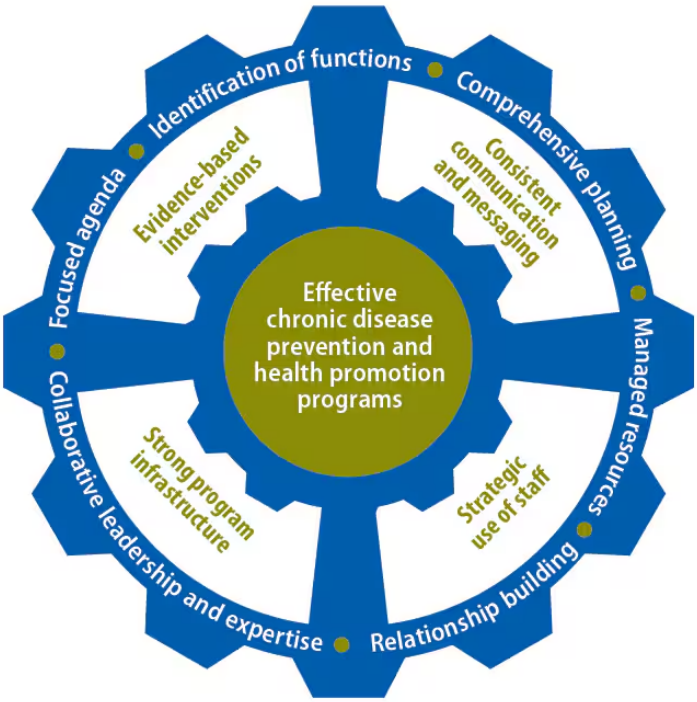


*Figure 2: A Customizable Model for Chronic Disease Coordination: Lessons Learned From the Coordinated Chronic Disease Program (cdc.gov)*

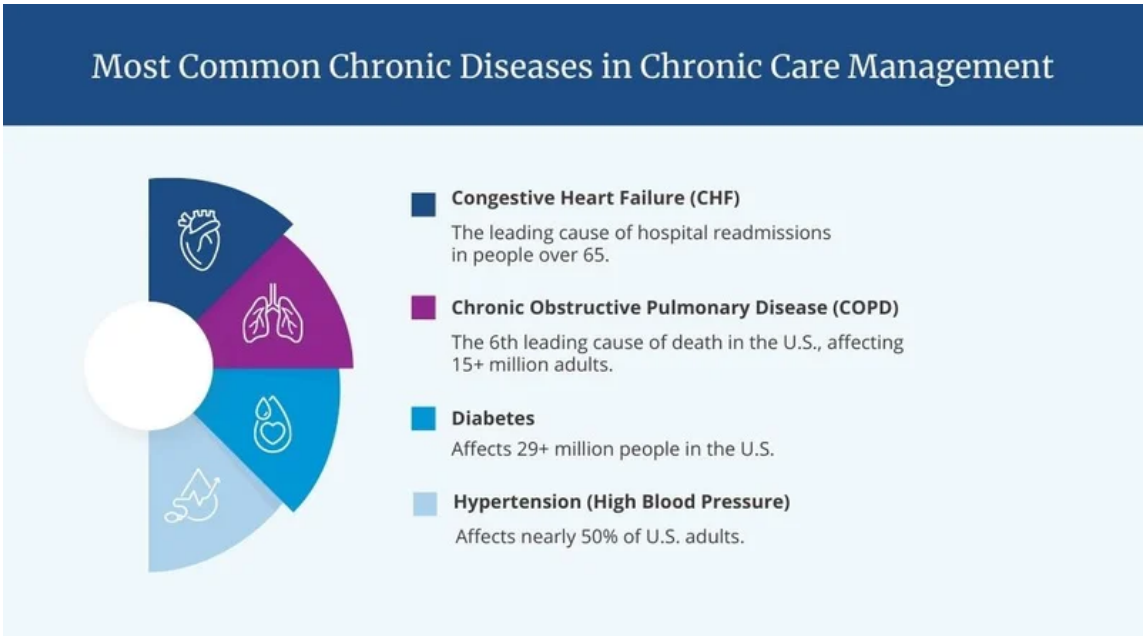


*Figure 3: The Complete Guide to Chronic Care Management (healthrecoverysolutions.com)*

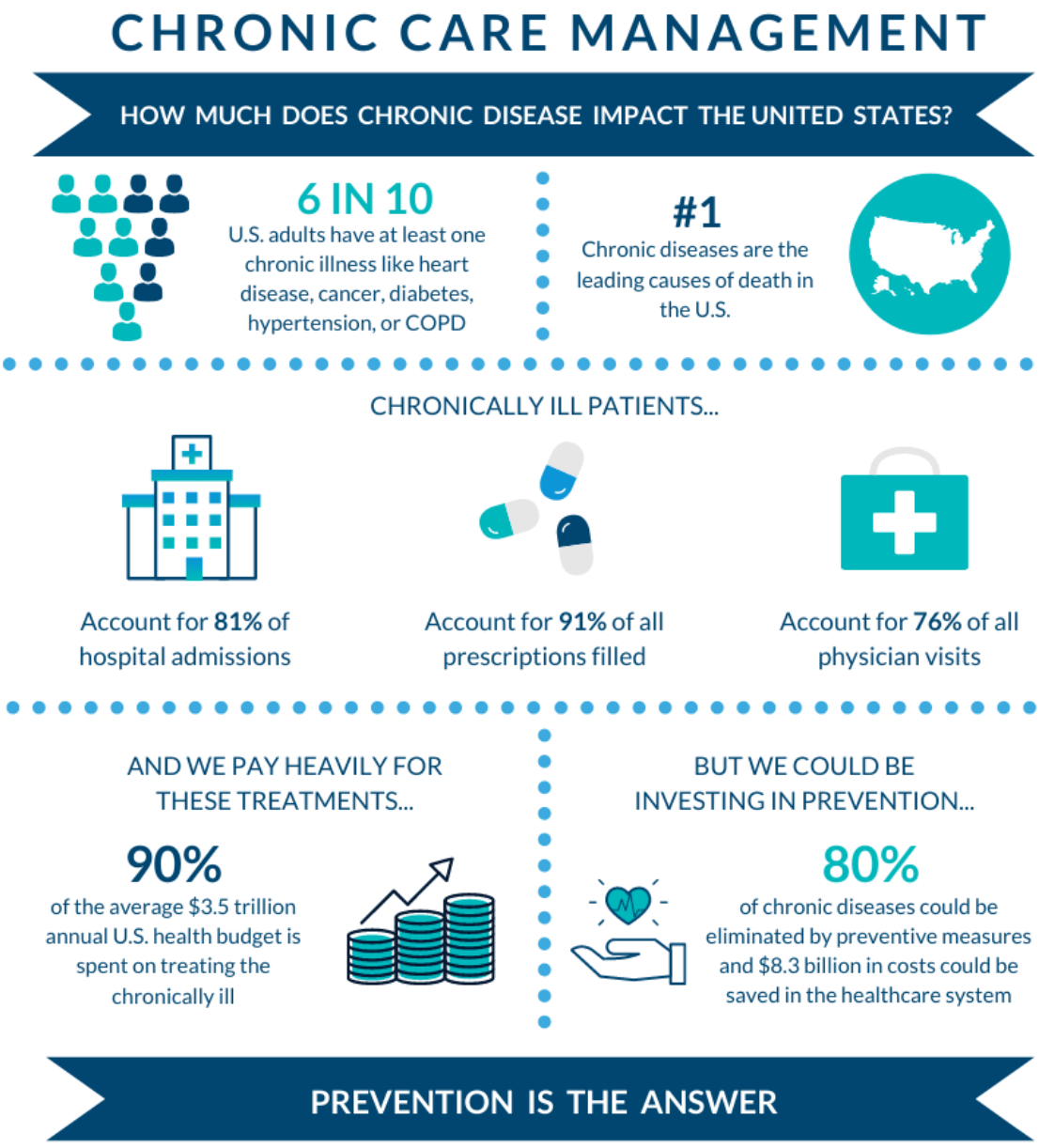


*Figure 4: 16 Facts You Should Know About Chronic Care Management - Wellbox*
*Pulls the data from*
*Fast Facts: Health and Economic Costs of Chronic Conditions | Chronic Disease | CDC*