



Proactive, longitudinal care extends beyond the office visit. The opportunity is how effectively your team supports patients between visits.

CCM AND APCM: TWO PATHWAYS, DIFFERENT OPERATIONAL MODELS

Chronic Care Management (CCM) has established a structured pathway for patients with multiple chronic conditions. Advanced Primary Care Management (APCM) expands the model with a broader primary-care approach built around practice capabilities rather than a minimum number of minutes.

 **The issue is not whether care management matters. The question is which model fits your practice?**

CCM



Patient focus:

Patients with two or more qualifying chronic conditions.



Billing model:

Time-based; qualifying monthly time must be documented.



Core workflow:

Care plan, ongoing coordination, clinical escalation and documented time.



Best suited for:

Practices able to consistently operate time-based chronic care workflows.

APCM



Patient focus:

Broader Medicare primary-care population, with risk stratification.



Billing model:

Monthly service with no minimum monthly minutes.



Core workflow:

Comprehensive care management, continuity, transitions, enhanced communication, population management and required practice capabilities.



Best suited for:

Primary care practices ready to support a broader, capability-based care model

THE OPERATIONAL SHIFT

- CCM centers the workflow around qualifying chronic conditions and documented time.
- The care team reviews medications, referrals, results, transitions and patient needs, updates the care plan, and documents qualifying monthly work.
- The model can be highly effective when the practice has reliable time-tracking, documentation and monthly reconciliation workflows.
- APCM centers the workflow around comprehensive primary care capabilities.
- The practice must support access and continuity, comprehensive care management, an electronic care plan, transitions, enhanced communication, population-level management and performance measurement.
- The opportunity is broader – but the operational infrastructure must be in place to deliver the required elements.

BUILDING A SUSTAINABLE CARE MANAGEMENT PROGRAM

Choosing CCM or APCM is only the beginning. The real challenge is building the infrastructure behind the program – the workflows, staffing, documentation, patient engagement and clinical escalation processes that make care management sustainable.

RMS BRIDGES THE CLINICAL AND OPERATIONAL SIDES OF CARE MANAGEMENT

At Ramey Management Solutions (RMS), we help practices operationalize care management so the work supports both the patient experience and the practice's long-term sustainability.



PATIENT IDENTIFICATION

Identify eligible patients and prioritize opportunities



CARE PLAN MANAGEMENT

Create and maintain patient-centered care plans



PATIENT ENGAGEMENT

Connect with patients and caregivers between visits



CARE COORDINATION

Coordinate referrals, transitions and community resources



CLINICAL ESCALATION

Monitor and respond to changing patient needs



DOCUMENTATION

Ensure complete, accurate and compliant documentation



POPULATION MANAGEMENT

Use data to identify care gaps and target outreach



PROGRAM PERFORMANCE

Monitor activity, workflows and opportunities for improvement



The best strategy starts with the patient population, current services, staffing model, technology, documentation processes and operational capacity – not simply the code.

