Alaga
HEALTHCARE GROUP

Optimizing your health at home.

CHRONIC CARE MANAGEMENT

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Chronic care management:

A benefit that allows you to have a healthcare team managing and optimizing your complex chronic conditions at the comforts of your home.

A comprehensive care plan will be developed that will then be implemented in your home without needing you to come in the office each month. Your practitioner will still see you for your regularly scheduled office visits either in home or office.

Diseases such as:

Heart Failure, COPD, Diabetes, Hypertension, Coronary Artery Disease, high cholesterol.

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You will have your personal healthcare team consisting of:

1. Practitioner,
2. Nurse Care Manager
3. Support staff such as a pharmacist, PT/OT/SLP/RD, CNAs and more.

They will:

1. Manage your health problems in your home through continuing care management as frequently as every week, or more, depending on your care needs.
2. Monitor your condition and follow through your care plans and adjusting the same as your condition changes under the supervision of your provider.

   e.g. adjust your medications as your conditions change on a daily basis. Monitor blood levels, vitals signs and progression and adjust careplans to suit your condition and optimize your health.

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They will also perform:

1. Medication management such as refills and if needed, coordinate with your provider to adjust dosing.
2. Coordinate with pharmacist make sure your medications are appropriate and will not have poly pharmacy.

Best Perks:

1. Provide 24/7 access for urgent care needs such as if you develop fever, symptoms of UTI, and other conditions and your RN care manager will reach out to your assigned provider for recommendations.
2. CCM basically becomes your urgent care.

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What we do in your home:

1. Basic lab tests like CBC and chemistry, UA,
2. Vaccinations
3. IV hydrations,
4. EKG, Vital signs monitoring.
5. We also do medication reconciliation, prepare med-sets.
6. Coumadin or blood thinner dose monitoring.
7. Do post hospitalization coordination.

And:

1. **Your assigned RN care manager will also coordinate you with a social worker to navigate different resources in the healthcare community.**

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How much will it cost you?

Chronic Care Management or CCM is covered under Medicare Benefits and other insurance payers, with co-pay as low as $15.00 per month up to a maximum of $45.00 per month depending on the complexity of your condition.

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How Chronic Care Management Works:

1. The CCM program starts with a face-to-face visit with your healthcare professional—with Alaga healthcare, you will be assessed by a nurse practitioner with a critical care (ICU) training and experience.
2. The goal is to provide continuity of care and address your medical, functional, and psychosocial needs to keep your health optimized.

Example:

1. If you have heart failure and hypertension, the CCM team manages you on a weekly basis by measuring your weight, adjusting water pills if your weight changes, taper it if are getting dehydrated and prevent kidney injury. Monitor your vital signs and change your blood pressure medication if needed to prevent heart failure from worsening. This prevents you from having heart failure exacerbation and needing hospitalization because of respiratory distress.

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How Chronic Care Management Works:

1. This could mean making sure you have equipment and services available at home,
2. Arranging transportation to make sure you get to all your medical appointments
3. Setting you up with community resources to address any social determinants of health

CCM is also available 24/7 for urgent care needs.

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Benefits of participating in a CCM program:

People who participate in the Chronic Care Management program were statistically less likely to need emergency room or observation care in the hospital. Their risk for inpatient hospitalization decreased by 4.7%.[7]

Specifically, hospitalizations related to congestive heart failure, dehydration, diabetes, and urinary tract infections were statistically reduced. People also reported being more satisfied with their care

Allow us to care for you closely.

Contact Us

Office is in Prescott Gateway Mall
3250 Gateway Blvd, Ste 110
Prescott, AZ, 86303
928-350 7900
admin@alagahealthcare.com
AlagaHealthcare.com

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ALAGA HEALTHCARE GROUP
CHRONIC CARE MANAGEMENT
A Medicare Benefit

"Alaga" is a Filipino word that means to care as if one is family.

Who we are

Alaga Healthcare is a group of practitioners that practiced in critical care. Alaga Healthcare was started by a critical care nurse who became a nurse practitioner, who has seen gaps in care as a leading cause for patients becoming acutely ill and needing hospital care. Alaga Healthcare's goal is to optimize your health at home and lower your risk of getting acutely ill and needing hospitalization.

"Alaga" is a Filipino word meaning to care for one as if they are family.

Contact Us

Office is in Gateway Mall Prescott:
3250 Gateway Blvd, Ste 110
Prescott, AZ, 86303
Tel: 928-350-7900
Fax: 866-584-6065
admin@alagahealthcare.com
AlagaHealthcare.com

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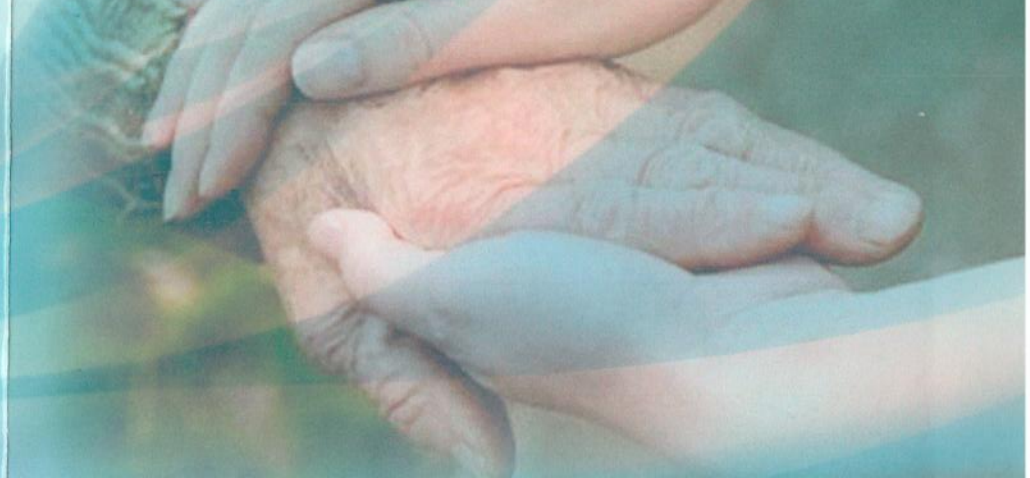
ALAGA HEALTHCARE GROUP CHRONIC CARE MANAGEMENT

A Medicare Benefit



Allow us to help you make your health better and optimized.

You will have your personal healthcare team consisting of a Practitioner, a Nurse Care Manager and Support staff that you might need depending on your condition, such as a pharmacist, PT/OT/SLP/RD, CNAs and more.

They will:

- Manage your health problems through continuing care management as frequently as every week, or more, depending on your care needs.

Our provider will prepare the care plan for you or your caregiver.

Your assigned RN Care Manager will work with you in:

- Monitoring your condition and following through your care plans and adjusting the same as your condition changes under the supervision of your provider.
- Medication management such as refills and if needed, coordinate with your provider to adjust dosing.
- Provide 24/7 access for urgent care needs such as if you develop fever, symptoms of UTI, and other conditions and your RN care manager will reach out to your assigned provider for recommendations.

How much will it cost you?

Chronic Care Management or CCM is covered under Medicare Benefits, with co-pay as low as $15.00 per month up to a maximum of $45.00 per month depending on the complexity of your condition.

What we do in your home?

Basic lab tests like CBC and chemistry, UA, Vaccinations and IV hydrations, EKG, Vital signs monitoring. We also do medication reconciliation, prepare med-sets. We can also do Coumadin or blood thinner dose monitoring. We can do post hospitalization coordination.

Your assigned RN Care Manager will also help you navigate and coordinate with different resources in the healthcare community.

RN Care Managers via phone calls will: Coordinate with health care providers to optimize your care plan. Review under the supervision of the provider, your test results and medications with you and caregiver. Coordinate with pharmacists and optimize your medications together with your provider.

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