04/17/2024

Discover How ChronicCareIQ Can Help Grow Your Care Management Service Company

Thought Leadership Series

ChronicCareIQ

Discover How ChronicCareIQ Can Help Grow Your Care Management Service Company

The Background

On April 17, ChronicCareIQ hosted a focused webinar for care management service providers on effectively utilizing our platform for chronic care management (CCM) and remote patient monitoring (RPM). This session was aimed at organizations currently managing or aspiring to manage chronically ill patients, highlighting how to streamline and enhance these services. ChronicCareIQ enables care management firms to handle multiple patient populations efficiently, integrate robust reporting tools, and maintain compliance with HIPAA regulations.

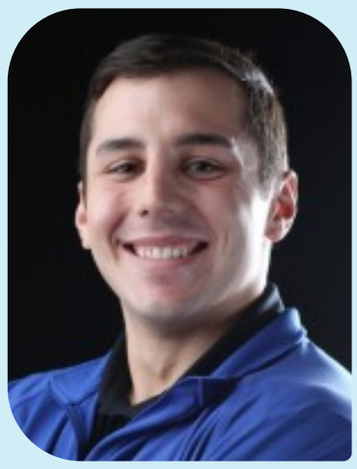
The platform's capabilities facilitate easier management of complex patients, improve care quality scores, and reduce hospitalizations by 10-30%. Moreover, providers can see an increase in reimbursement between 5-25% and boost their referral rates, simplifying the complexity of chronic care while optimizing care delivery and operational efficiency.

Our Goal

To provide insight into the crucial role of supporting efficient care management services that optimize reimbursement potential. Ensure optimal outcomes for your clients and their patients, while navigating the complexities of healthcare regulations and reimbursement strategies.

ChronicCareIQ

Justin Barnes
Barnes Advisors



Blake Whitney
ChronicCareIQ

Poonam Patel
MySeema

You'll discover how to:

1. Handle patients from various physician practices
2. Have access to an enterprise dashboard & reporting
3. Automate time tracking
4. Detail accounting of care plans & patient adherence
5. Diversify range of solutions
6. White-labeled platform to your brand
7. Uphold HIPAA compliance

ChronicCareIQ

Discover How ChronicCareIQ Can Help Grow Your Care Management Service Company

Introduction

ChronicCareIQ hosted a valuable webinar focusing on the effective management of chronic care through our platform. This discussion was specifically tailored for care management service providers who are actively involved in chronic care management (CCM) and remote patient monitoring (RPM), or those looking to adopt these practices.

Many providers invest considerable effort in managing daily non face-to-face interactions—such as monitoring digital communications and patient data—without fully capitalizing on the potential revenue. Our platform aims to transform how these essential tasks are recognized and reimbursed, ensuring that providers are rewarded for their comprehensive management efforts.

Background

Justin Barnes, is a healthcare innovation executive, corporate advisor and industry strategist. In addition, he's host of the weekly syndicated radio show "This Just In". Justin has formally addressed and/or testified before Congress as well as the last five Presidential Administrations on more than 20 occasions with statements relating to value-based care, chronic care management, virtual care, and more. As a recognized public speaker, Justin has contributed to over 3,500 media outlets, offering his expertise on a range of critical healthcare issues.

Blake Whitney brings a wealth of experience in the healthcare industry, with a robust understanding of market dynamics and a dedicated focus on enhancing patient outcomes. His career is marked by success in implementing innovative sales strategies, leading high-performing teams, and consistently surpassing revenue goals. Blake's strategic vision is focused on leveraging emerging trends to deliver value-driven solutions within the healthcare sector.

Poonam Patel, with 20 years of experience in healthcare, including three as a clinical consultant, brings a comprehensive perspective to her work in both the Provider and Payor sectors. As a Nurse Practitioner and co-founder of MySeema, she has been pivotal in offering holistic patient care and effective chronic care management. Patel's commitment to patient advocacy is at the core of her approach, ensuring that patients receive the best possible care as they navigate the complexities of the healthcare system.

CCM & VBC Update

- In 2024, more care providers are deploying chronic care management programs than ever before to augment current and future FFS reimbursement cuts

- Deploying chronic care management programs are foundational first steps for engaging value-based care

- In healthcare, with CMS and even many private payers, we've hit the the "tipping point" for these programs where the funding and investment is only increasing

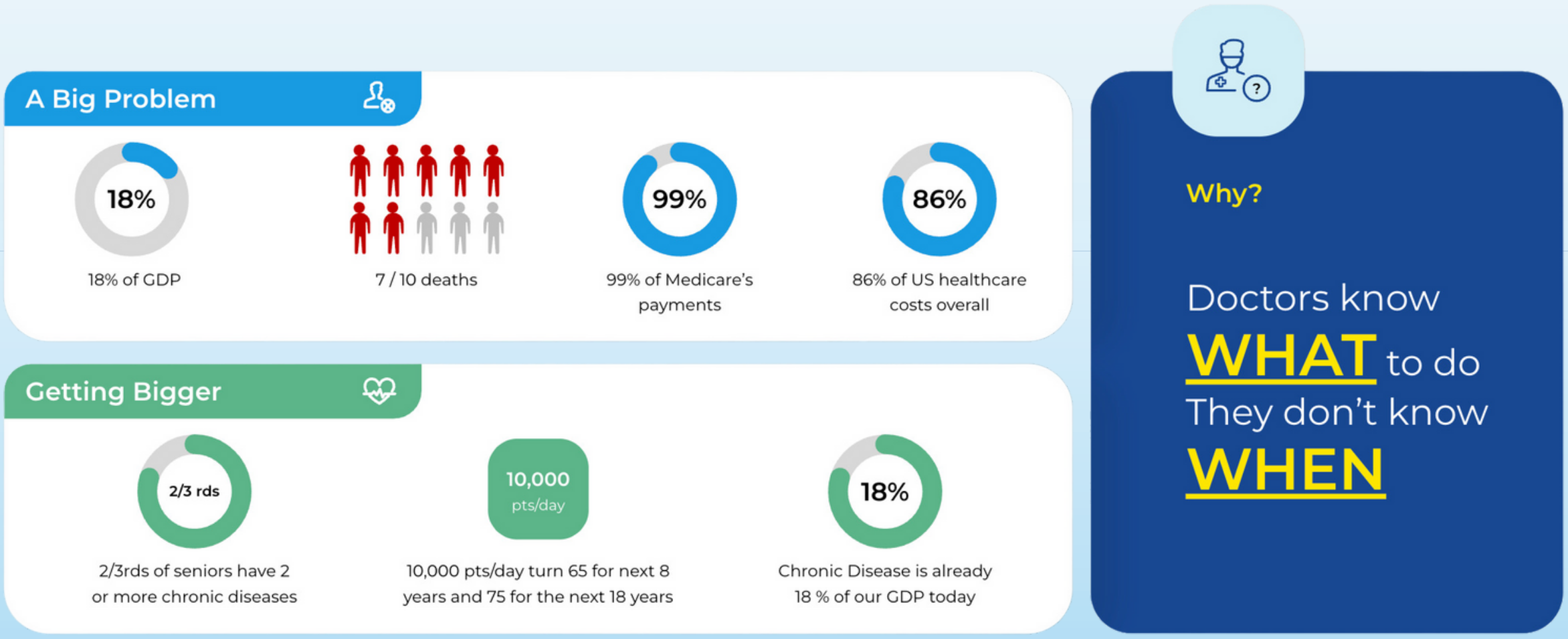
Justin has been a key figure in advocating for improved healthcare reimbursement on Capitol Hill since 2005. He successfully countered reimbursement cuts from the late 2000s through 2021. However, with ongoing cuts to fee-for-service reimbursement, Justin has focused on identifying alternative revenue streams for providers.

For Justin, this period represents an exhilarating shift as daily opportunities for new reimbursements emerge. He collaborates with practices experiencing increases in reimbursement ranging from 5% to 40% due to chronic care management—a substantial financial impact. Looking ahead to 2024, Justin anticipates a pivotal moment: an increase in the number of care providers participating in these programs, more comprehensive patient monitoring, and enhanced outcomes nationwide. A recent Sage Growth Partners study highlights this progress, with 94% of participants noting improved outcomes through remote patient monitoring and 73% reporting a positive return on investment. These practices consistently yield not only significant reimbursement gains but also reductions in unnecessary hospital visits and tangible improvements in patient outcomes, confirming the substantial return on investment in chronic care management.

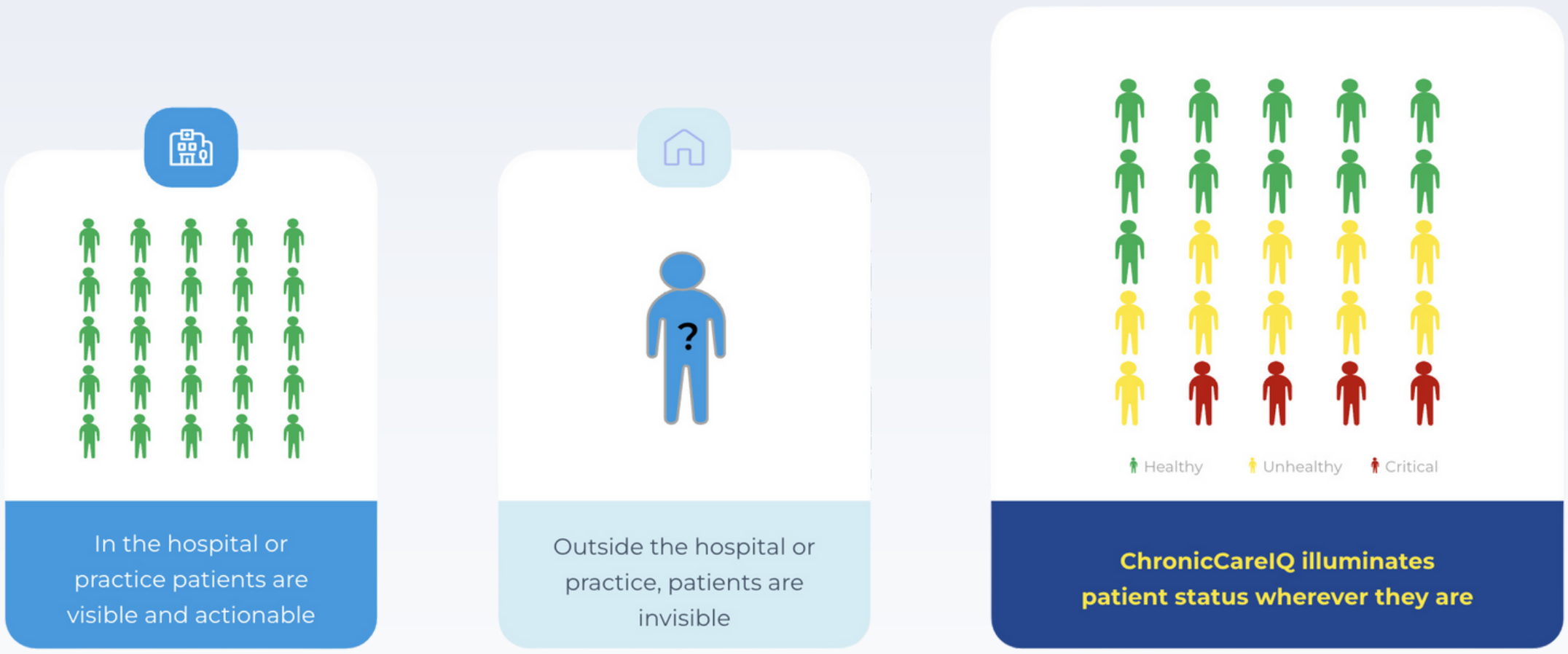
CCM/RPM by the Numbers

Blake Whitney outlined the origin and evolution of ChronicCareIQ, founded by Matt Ethington, who was diagnosed with type 1 diabetes at age 30. Despite being an active and healthy individual, Matt's unexpected diagnosis in an emergency room setting led him to a deep commitment never to be disconnected from his healthcare team. This personal experience fueled his drive to develop healthcare technology solutions, starting with SimplifyMD and subsequently founding ChronicCareIQ in 2014, initially focusing on monitoring heart failure patients post-discharge.

Blake emphasized that ChronicCareIQ, especially after the introduction of Medicare's chronic care management in 2015, is not about mere measurement but genuine care management. He highlighted the limitations of traditional healthcare models where patients check in with their providers every few months, which is hardly adequate for managing chronic conditions effectively. Chronic diseases account for **18% of America's GDP** and lead to **seven out of ten deaths**, representing **86% of U.S. healthcare costs**. The challenge, he noted, is not that doctors lack knowledge of what to do; rather, it's often a matter of timing—knowing when to act. ChronicCareIQ addresses this gap by providing continuous care and monitoring, essential in managing the increasing number of aging patients and the associated healthcare costs.



Why the Sick Keep Getting Sicker



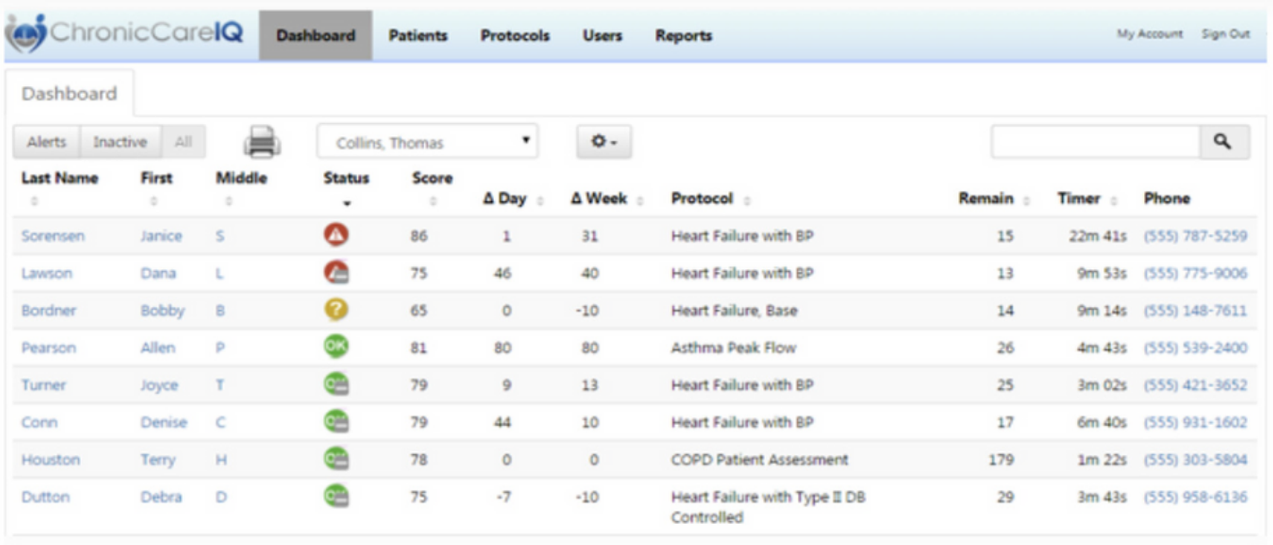
The sick keep getting sicker because they're invisible. Who hasn't left the doctor's office motivated to make changes? We all try to eat healthier, get more exercise, and practice self care but our busy schedules often get in our way and we go back to our unhealthy habits. So it's really hard to know how to manage yourself between doctor visits, if you're not communicating back and forth with your doctor.

You become invisible to your doctors, or to your hospitals, the day that you leave. The challenge is chronic diseases are medical conditions, by definition, that can't be cured. So they have to be controlled. So even if you can mitigate your type two diabetes, to the point that you don't have symptoms, you still have it, you're just non symptomatic. Even when you get your blood pressure under control, it's going to come back if you don't keep managing it. So the idea here is if a doctor knows when a patient is starting to get off course, then they can fix it early on when the patient isn’t so far off course. But if they don't see that patient for six months, and that patient’s blood sugar has been 270 every morning, it's too late. They've already damaged themselves, and they've already had significant disease progression.

ChronicCareIQ talks about how to make patients visible, and that means collecting data. When data is collected, everyone can see the patients that are in need of attention. Everyone can also see which patients need encouragement to stay on track.

Monitoring Patients

Your Dashboard Collated Patient Responses



- Situational awareness of those ‘at risk’
- For both chronic and discharged patients
- Displays patient trending speed
- Triggers text or email alerts
- Securely coordinates and incorporates relevant third parties
- Tracks required CCM & TCM billing threshold and penalty windows 30 days post-discharge

ChronicCareIQ's approach to enhancing patient care outside traditional settings was highlighted, demonstrating how the platform ensures patients remain visible and managed effectively once they leave the clinical environment. Through personalized engagement methods like secure texts, emails, mobile apps, or connected devices, ChronicCareIQ achieves impressive patient interaction, with weekly engagement rates between 85-93% and sustained active participation at 87% after one year.

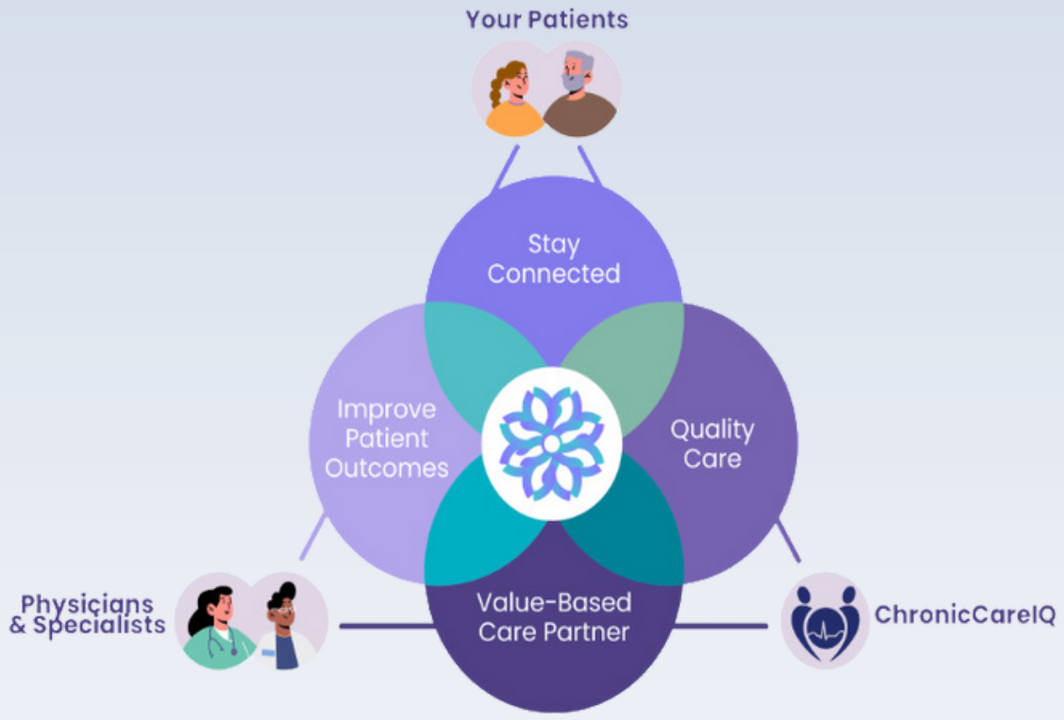
The platform's use of clinical monitoring protocols involves regularly assessing patients through a series of strategic questions. These engagements not only track patient status but also categorize responses on a color-coded dashboard. This visual tool allows care management staff to quickly identify at-risk patients, facilitating timely and precise interventions.

Financially, ChronicCareIQ leverages an expanded framework of Medicare reimbursement codes related to chronic care management, which has grown to over 25+ distinct codes across eight categories. This integration ensures that providers are compensated for the extensive non-face-to-face care they deliver. By syncing with phone systems and EMRs, the platform captures every minute of billable time, translating it into substantial reimbursement gains.

The platform also empowers care management services to efficiently scale operations across various healthcare practices. With its enterprise-ready dashboard and advanced reporting capabilities, ChronicCareIQ streamlines management tasks and broadens the scope of services offered, from chronic care management to behavioral health, under a unified system of connected care codes.

CCM Service Provider Empowerment

MySeema's Approach



ChronicCareIQ provides an enterprise-ready dashboard that allows care management service providers to handle patients from various physician practices efficiently. This dashboard offers access to sub-accounts or physician practices, each with its unique patient buckets and high-level reporting capabilities. Additionally, the platform automates time tracking with its CallerIQ technology, integrating seamlessly with the practices' EMR systems.

ChronicCareIQ offers a diversified range of solutions beyond chronic care management (CCM) and remote patient monitoring (RPM), including behavioral health (BHI) and principle care management (PCM). This comprehensive suite of connected care codes ensures that providers can manage all aspects of patient care effectively.

Handle patients from various physician practices

Have access to an enterprise dashboard & reporting

Automate your time tracking

Detail accounting of care plans & patient adherence

Diversify range of solutions

White-labeled platform to your brand

Uphold HIPAA compliance

Why CCIQ?

Poonam Patel, cofounder of **MySeema**, shared her journey to choosing ChronicCareIQ (CCIQ) driven by a blend of personal and professional motivations. She and her co-founder, inspired by personal healthcare challenges and gaps observed in the healthcare system, aimed to enhance care management with innovative solutions. Their focus centered on health advocacy, proactive outreach, and care coordination—key areas where they saw an opportunity to make a significant impact.

Poonam was drawn to CCIQ because of its user-friendly interface that allowed for efficient management of large patient volumes, crucial for scaling their operations. The platform's data visualization tools were particularly appealing, enabling her team to focus on understanding and acting on patient needs more effectively. Additionally, CCIQ's comprehensive billing and reporting tools streamlined administrative tasks, ensuring operational efficiency and compliance with CMS regulations.

The ability to quickly implement CCM with CCIQ, combined with the platform's robust support and continuous education on CMS requirements, reinforced Poonam's decision. Her choice was further validated by CCIQ’s patient-centered approach, which aligned with her goal of providing compassionate and effective care management. This synergy between Poonam’s vision and CCIQ’s capabilities highlighted a shared commitment to enhancing patient care through innovative chronic care management.

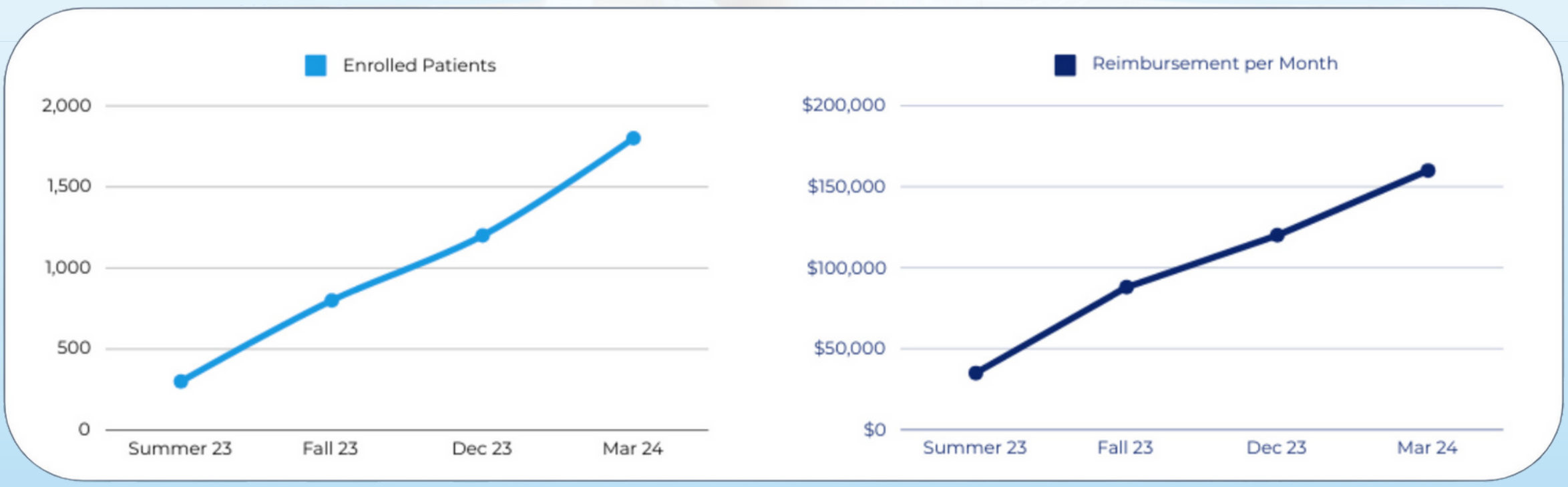
The Results

Poonam Patel shared an example of how they collaborated with a provider group using ChronicCareIQ (CCIQ) to quickly implement chronic care management (CCM). They were able to efficiently set up protocols and incrementally upload large volumes of patient data into CCIQ, facilitating rapid onboarding and integration into their system. This ease of use boosted the confidence of care navigators in managing their patient loads effectively.

The use of CCIQ's platform enabled significant improvements in patient management, such as better utilization of sick visits and the prevention of unnecessary ER visits by enabling proactive patient outreach. This not only improved patient care but also optimized appointment scheduling and resource allocation. Poonam highlighted the positive feedback from patients who felt relieved and well-cared for by the dedicated support between visits, which closed care gaps and guided them to appropriate healthcare services.

The successful integration of CCM with the provider's operations also had a noticeable impact on revenue, demonstrating a clear correlation between effective patient management and financial benefits. The provider group observed a progressive increase in both patient volume and revenue, underlining the tangible benefits of implementing CCIQ’s solutions.

Poonam concluded by expressing gratitude for the collaboration with healthcare providers and CCIQ, emphasizing the mutual goal of transforming patient care and continuously improving outcomes through effective care management programs.



Conclusion & Resources

In conclusion, the collaboration between **MySeema** and **ChronicCareIQ** exemplifies the significant benefits that care management service providers can achieve through advanced chronic care management solutions. By implementing CCIQ's intuitive platform, care management services can not only enhance patient care but also achieve substantial improvements in operational efficiency and financial performance. This successful partnership highlights how strategic use of technology can facilitate better health outcomes and streamlined processes, ultimately elevating the standard of care provided to patients.

If you are a care management service provider interested in how ChronicCareIQ can transform your operations and patient outcomes, we invite you to visit **ChronicCareIQ.com**. Explore our solutions and discover how we can help you achieve excellence in care management.

Talk To an Expert