CARE COORDINATION SOLUTIONS

The Tools For Success, Not the Status Quo

AS THE HEALTHCARE INDUSTRY CONTINUES TO SHIFT TOWARD VALUE-BASED CARE, OPPORTUNITIES TO IMPROVE PATIENT HEALTH AND INCREASE PRACTICE REVENUE MULTIPLY. CODES ASSOCIATED WITH CHRONIC CARE MANAGEMENT ADD MONTHLY RECURRING REVENUE TO PRACTICES. SERVICES SUCH AS TRANSITIONAL CARE MANAGEMENT PROVIDE TRUE CONTINUITY OF CARE. AND NEW VALUE-BASED PROGRAMS AND CARE DELIVERY MODELS INCENTIVIZE PHYSICIANS FOR MEETING QUALITY MEASURES.

The common thread linking all these opportunities together is care coordination.

The Agency for Healthcare Research and Quality has described care coordination as "a patient- and family-centered, team-based activity designed to assess and meet the needs of patients, while helping them navigate effectively and efficiently through the healthcare system." Through care coordination, potential gaps in care are collectively addressed - from clinical and social, to behavioral and more - to help a patient achieve the best possible health.

The majority of this care takes place between doctor's visits, putting high demand on a healthcare practice's time and resources, which are already stretched thin.

That's where we come in. CareSync acts as a true nursing extension of your practice, available to your patients 24/7/365. We combine people, technology, special programs, and proven patient engagement tools to build relationships with patients and their caregivers, and effectively deliver care coordination services on your behalf.

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Chronic Disease is the Problem

130 million
Americans with chronic disease

2.5 trillion dollars
annually to treat

86%
of all healthcare spending

7 out of 10 deaths
each year in America

6 healthcare providers
on average for each chronic patient

Care Coordination is the Solution

Care coordination results in:

- 20 PERCENT — reduction in hospitalizations
- 25 PERCENT — reduction in ER visits
- 21 PERCENT — reduction in 30-day readmissions
- 16 PERCENT — fewer skilled nursing home days
- 30 PERCENT — fewer home health days

Proven CareSync outcomes:

- 64 PERCENT — of members avoided duplicate tests
- 65 PERCENT — of members said they feel more engaged and less likely to be behind
- 84 PERCENT — 84% said we helped them remember important follow-up items
- 1 IN 10 MEMBERS — Nearly 1 in 10 members have avoided serious drug interactions

Get Back to the Business of Medicine

Care coordination isn't "one size fits all." We have been providing care coordination services for over 5 years and have the people, services, technology, interoperability, and patient engagement tools to deliver on the promise of full-service care coordination. You can count on CareSync to deliver optimal between-visit care for your patients and revenue-generating opportunities for your practice.

> CareSync has made me optimistic and more in tune with my health. I know that you really care for me!
>
> *- CareSync Member*

Chronic Care Management (CCM)

- Nation's leading provider of CCM services under Medicare
- Exceeds Medicare's requirements for CPT code 99490
- Contractually indemnifies practices for its compliance with Medicare's CCM program
- Supports complex CCM codes CPT 99487 and 99489
- Supports capturing additional revenue with enrollment add-on code G0506
- Helps remove barriers to care, such as cost and transportation concerns
- 98% retention rate and 100% billable rate as of March 2017
- Offers both full-service CCM and a software-only option

Annual Wellness Visits (AWVs)

We identify preventive care opportunities (over 25 HEDIS measures may be identified by our AWV program) that result in improved health outcomes, increased patient satisfaction, and new reimbursements for your practice. We provide you with the Health Risk Assessment and the provider- and patient-facing Personalized Wellness Assessment.

Transitional Care Management (TCM)

CareSync helps you earn higher TCM fees when appropriate and provide continuity of care that reduces hospital readmissions, encourages patient follow-through, and decreases post-hospitalization no-shows. Removing the burden from practice staff, our care coordination team monitors each step to ensure deadlines are met to make the follow-up process billable.

MACRA (MIPS or Advanced APM Path)

CareSync assists with reporting on measures for MACRA (the Medicare Access and CHIP Reauthorization Act of 2015), including all of the performance categories under the Merit-based Incentive Payment System (MIPS). We also support the care coordination efforts of practices participating in an Advanced Alternative Payment Model (APM).

Comprehensive Primary Care Plus (CPC+)

Our customizable care coordination solutions support CPC+ practices in Track 1 or Track 2. We provide 24/7/365 patient access to clinical assistance, technology that integrates with your EHR, support for quality and utilization measures, and care coordination for all risk groups.

CareSync Scribe™

Featuring Voice-to-Text-to-Action technology, this single-button app for iOS and Android is like having a personal scribe with you wherever you go. Use it to send verbal instructions to the CareSync nursing team, enroll a patient in CCM (we can help you meet the documentation requirements for the G0506 code), or let us know about a patient entering Transitional Care Management.

Robust Patient, Provider, and Care Team Apps

The CareSync platform allows patients to consolidate all of their health data in one place regardless of provider, network, or health system. Additionally, CareSync allows patients to easily share any portion or all of their health data with their family, caregivers, and providers through free accounts.

Consulting Services

Consulting services can be tailored to meet individual practice needs and include: MACRA planning, quality measure selection, readiness for quality programs, quality measurement monitoring, reporting assistance, physician policy education, care coordination service opportunities, and APM strategic planning.

Why CareSync?

- 24/7/365 nursing and care coordination services
- Medical records requested from and shared among all providers
- Care plans specific to the patient, not templated or disease-specific
- CareSync Pro to access real-time data and concise patient summaries
- Customized training, billing consultation, and implementation
- Seamless integration with any certified EHR (API, HL7, Direct Message, or CareSync Data Exchange)
- Certified Direct Message Protocol via Blue Button

> I truly enjoy what I do, and I am truly thankful to be in an atmosphere that cares so much about their members.
>
> *- CareSync Health Assistant*

- Proven patient enrollment and engagement tools
- CareSync Pharmacy Discount Program
- Regular outreach and medication reconciliation
- Identification of potential risk measures and reporting of key quality metrics
- Adherence to practice and provider preferences
- Founded direct-to-consumer in 2011, and still just as patient-focused today
- We have the staff, capability, and scalability to deliver what we promise

Success Stories

HEALTHSTAR

HealthStar is a progressive client that prizes patient engagement and quality of follow-up, so CareSync's patient-centric approach was a natural fit. Our athena integration and billing integration were also "wins." But it was "an immediate impact play" early on that really solidified HealthStar's choice. CareSync demonstrated such significant value for a non-compliant patient that the physician champion was able to use the case "to engage resistant physicians," increasing the success of implementing CareSync's CCM program.

WILLAMETTE HEART AND FAMILY SERVICES

For Wayne Hurty, MD, and his wife, Sarah Hurty, PhD, partnering with CareSync was an obvious win-win. "With CareSync, we get turnkey access to reimbursements for CCM, but also to value-based reimbursements in general," Dr. Hurty explained. But the value of the relationship has been even more than expected. "We have literally had patients' lives saved because getting a complete record from another doctor revealed a potentially deadly medication interaction."

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Care Coordination: It's In Our DNA

The CareSync story is rooted in the story of Morgan Gleason, the daughter of CareSync's Chief of Staff, Amy Gleason, RN. In June 2010, when Morgan was 11 years old, she was diagnosed with a rare autoimmune disease called Juvenile Myositis. Very quickly, she went from having one pediatrician, to having 12 different providers, in three states, across six health systems and 14 portals.

Even as a nurse with a healthcare technology background, Amy struggled to coordinate care among multiple providers and keep track of all the data involved with managing a chronic condition. In the absence of a better alternative, she and her friend Travis Bond set out to create one.

The result was CareSync, established in 2011 to help others navigate a fragmented healthcare system and coordinate their care. Today, Morgan is in college and CareSync is the nation's leading provider of software and services for chronic disease management.

Improve patient health and practice revenue

To learn more about CareSync's full suite of care coordination solutions or to discuss next steps, please call us at **800-501-2984.**

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