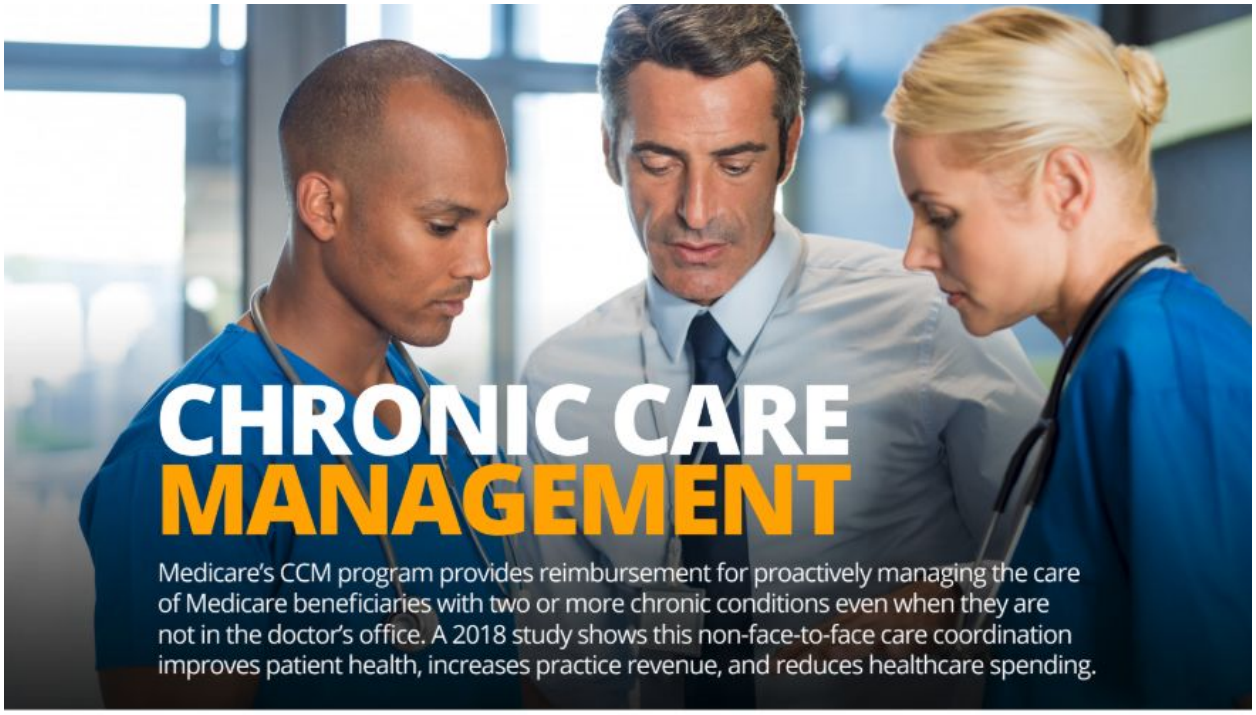
Kaerrie Hall - Samples from CareSync
kaerrie.wixsite.com/portfolio



Put yourself in the best possible position to deliver CCM with minimal demand on available resources and maximum reimbursement by choosing CareSync to implement your CCM program. Count on us to become a clinical extension of your practice, following your preferences and protocols to deliver between-visit care coordination to patients on your behalf.

- Give patients access to CareSync Health Assistants 24/7/365
- Generate recurring revenue for your healthcare organization
- Provide a wider range of valuable services and expanded access to care

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At CareSync, we believe CCM is more than just fulfilling a list of Medicare's requirements. You can count on us to treat your patients with respect, follow your preferences and protocols, and work hard to resolve issues that stand between your patients and better health.

CareSync is amazing and I want to thank you. You've helped me through two years of cancer and I know you've played a good part in my still being here.
- CareSync Member

My husband is alive thanks to the CareSync team calling and checking in on us.
- CareSync Member

I love the fact that we are in a position to help people and show them they matter.
- CareSync Health Assistant

CCM makes it possible to deliver the type of care I've always wanted to provide.
- CareSync Client


Clinical support for your patients 24/7/365


Medical records requested from all providers


Seamless integration with your certified EHR


Medication management support


Reporting on key quality metrics and identification of potential risk measures


Flexible enrollment options, including our Remote Enrollment Program


Customized training, billing consultation, and implementation support


The staff, capability, and scalability to deliver what we promise


Care coordination solutions that include support for Annual Wellness Visits, Advance Care Planning, Transitional Care Management, CPC+, and MACRA

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THE LEADER IN CHRONIC CARE MANAGEMENT
800-501-2984 • caresync.com

Did You Know?

Medicare provides 100% coverage for an annual wellness assessment for all individuals enrolled in Medicare plans. This valuable benefit is designed to keep you healthy, and doing the things you love to do. Best of all, it is available at no cost to you!

An Ounce of **Prevention...**

Making time now for preventive healthcare can help you avoid illnesses that rob you of days, weeks, months, or even years.

caresync

Call to schedule this important appointment.

855-336-7080

Monday - Friday 9am - 4pm EST

Be **Active** By Being **Proactive!**

FREE MEDICARE ANNUAL WELLNESS VISITS

- ✓ **It's FREE**
- ✓ **No Copay**
- ✓ **No Deductible**

Health Promotion and **Disease Prevention**

The Annual Wellness Visit is designed to create a prevention plan based on your personal health, lifestyle, and potential risk factors, and then update that plan year after year so you can get and stay as healthy as possible.

Annual Wellness Visit Benefits

- Health Risk Assessment
- Personalized preventive plan
- No copay or deductible

What To Expect At Your **First AWV**

During your first AWV, you and your healthcare provider will develop a strategy for managing your health, along with a prevention plan for how you'll accomplish your health goals. Your provider will:

- Complete a Health Risk Assessment
- Review your medical and family history
- Make a list of your current healthcare providers, as well as the medications, vitamins, and supplements you take
- Create a written 5 to 10 year preventive screening schedule or checklist
- Identify medical and mental health conditions and risk factors
- Check your height, weight, blood pressure, and body mass index
- Screen for cognitive impairment and hearing impairment, and determine risk for falls, depression, and inability to perform activities of daily living
- Provide appropriate health advice, referrals, health education resources, or preventive counseling services

What to Expect at **Future AWVs**

For future AWVs, your healthcare provider will update the information in your preventive care plan and determine any new health risks, screenings, or treatments needed.

COORDINATED CARE IS BETTER CARE

Improve patient health and increase revenue with care coordination solutions from CareSync™

Chronic Care Management

When you choose CareSync to implement and deliver your CCM program, our knowledgeable care coordination staff is available to your patients 24/7/365. We act as a true extension of your practice, following your preferences and protocols to deliver quality between-visit care to patients on your behalf. Our CCM services include support for CCM, Complex CCM, the G0506 add-on code for CCM enrollment, and the new general care management code G0511 for RHCs and FQHCs.

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CARESYNC PROVIDES CCM AND OTHER CARE COORDINATION SOLUTIONS

Annual Wellness Visits (AWVs)

We identify preventive care opportunities (over 25 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.

Comprehensive Primary Care Plus (CPC+)

Our customizable care coordination services 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.

Advance Care Planning

Help patients make important decisions about the type of care they receive and when they receive it. Bring ACP into your practice with our turnkey program. ACP codes are free from service or specialty limitations, may be added to existing patient visits (ideally an AWV visit), and can be accomplished without placing additional burdens on physicians.

MACRA (MIPS or Advanced APM Path)

CareSync assists with reporting on MACRA measures, 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).

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.

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 CareSync Scribe to send verbal instructions to the CareSync clinical 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 TCM.

Bring Advance Care Planning Into Your Practice

With Our Turnkey Program

Help patients make important decisions about the type of care they receive and when they receive it. Advance Care Planning codes 99497 and 99498 are free from service or specialty limitations, may be added to existing patient visits, and can be accomplished without placing additional burdens on physicians.

How Advance Care Planning works in your practice

Before Visit

Add an advance care planning session to patient visit, ideally an AWV visit

During Visit

Conduct the advance care planning session and answer any patient questions

After Visit

Collect reimbursement for session $85*/first 30 min, $75*/next 30 min

Ongoing

Add additional appointments as needed (no limit to the number of sessions per year)

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800-501-2984
sales@caresync.com
www.caresync.com

In **2016,** CMS reimbursed **$43 million** for Advance Care Planning discussions. Are you missing out? Use our turnkey program to add ACP services for fast, easy implementation, and yield great returns for you and your patients!

- Training for you and your staff to guide service delivery and maximize patient engagement and outcomes
- Session documentation and billing support for successful reimbursement
- A fully-featured, easy-to-use, HIPAA-compliant online app with planning tools, patient educational materials, legal advance directives for all U.S. states and territories, and 24/7 online access to completed plans
- The ability to leverage existing visits, ideally delivering with an Annual Wellness Visit (there is no patient responsibility when ACP is administered with the AWV)
- In-app guidance and legal forms
- Additional appointments can be billed as needed
- ACP codes allow for a team-based approach under the order and medical management of the treating physician

Advance Care Planning Codes 99497 and 99498

$85*/first 30 min, $75*/next 30 min as many times as needed

**National average reimbursement, actual amount varies by region*

1,000 Medicare patients yield roughly **$85,000** with a better than 40% return

CareSync Advance Care Planning powered by Honor My Decisions

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800-501-2984
sales@caresync.com
www.caresync.com

Questions CPC+ Practices Are Asking

- I've committed to a 5-year program. How do I put a sustainable program in place... one I can scale for years to come?
- The practice is busy. How do I go from seeing patients a few times a year to coordinating care for my patient population every single month?
- There is so much documentation required. Am I confident I'll be prepared for an audit?
- How do I build a care coordination program to follow up with my at-risk patients or allocate resources to support them outside of the office?
- How do I improve practice performance for patient experience of care, clinical quality, and utilization measures?
- I've seen a lot of technology solutions. Who can provide a people solution that will integrate with my practice workflows?
- How do I allocate and reconcile how I spend my care management fees?
- How can you help me meet the care delivery requirements while working hand-in-hand with my practice?

Set Your Doctors Up For Success, Not the Status Quo

Medicare is counting on this program to change the way primary care is delivered and reduce the financial burden on the healthcare system. You signed on because you want to be on the frontlines in delivering on that goal. Count on CareSync and our full suite of care coordination solutions to help you maximize your CPC+ program.

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Did You Know?

CMS requires this:	CareSync supports you by doing this:
Provide targeted, proactive, relationship-based (longitudinal) care management to all patients identified at increased risk.	We have the people, technology, and services in place to provide care coordination 24/7/365 to your patient population, no matter how it is risk stratified.
CPC+ practices can't bill CCM for their CPC+ attributed beneficiaries, but are free to bill CCM for any non-attributed beneficiary, which may result in future attribution.	We can supply full-service CCM services to eligible Medicare beneficiaries who are not currently in your attributed list, laying the groundwork for future attribution.
Practices that serve more high-risk beneficiaries are expected to provide more intensive care management and practice support.	We communicate with patients and family members to assess and monitor changes in health conditions and adherence to treatment regimens, while providing timely feedback to your practice.
CPC+ practices must meet or exceed the requirements for their performance-based incentive payments or risk having to repay all or some of the payment CMS has advanced.	We provide a focused, patient-centric approach to address the quality and utilization measures you have selected.
Track 2 practices are expected to increasingly provide services that are not billable to Medicare.	We help you instantly expand the breadth and depth of services you offer, including identifying and addressing patient behavior and needs, such as medication compliance, transportation assistance, and community resources.

Let's Connect

For more information and to learn how we can customize care coordination solutions to meet the specific needs of your CPC+ practice, please call 800-501-2984 or email sales@caresync.com.

How We Support the Practice

When you partner with CareSync™ to provide Chronic Care Management and other care coordination services on your behalf, we instantly become an additional resource for your patients. This helps reduce the burden on practice staff, results in fewer calls to the office and fewer requests for test results and copies of medical records, and saves every member of the practice team time and energy to achieve their highest and best use.

What We Do Benefits You

Acting as a true extension of your practice, we:

- Answer healthcare questions 24/7/365
- Drive patients back to the practice for preventive care
- Increase revenue to help sustain and grow the practice
- Follow-up with patients about doctor's instructions and tests
- Reconcile medication lists and encourage medication adherence
- Field requests from caregivers and family members
- Improve patient satisfaction and encourage patient compliance
- Exchange health information with other practitioners
- Provide self-management education and support
- Schedule appointments and provide reminders
- Share copies of a patient's care plan and medical records
- Help patients avoid hospitalizations and ER visits
- Improve management of care transitions and referrals
- Coordinate care among home- and community- based providers
- Support more productive, efficient office visits
- Provide important between-visit data to the doctor

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Coordinated Care Is Better Care™

Every day, our clinical services team provides members with personalized, compassionate care coordination that fits their doctor's preferences and protocols. Here are a few stories that highlight how we've recently helped members.

A Family Affair

The benefits of care coordination extend beyond the provider and patient, providing value and support to caregivers and family members as well. As one member told us, "I want you to know how much I appreciate the program... what you have done is absolutely fantastic! I have never seen any program in my life that has met the requirements of the 'non-primary' user as well."

Removing Barriers

Going the extra mile for patients includes helping to remove barriers to care. When one Health Assistant learned a member wasn't taking her medication because it wasn't covered by her insurance and she couldn't afford to pay for it on her own, she researched discount medication programs. The lowest price she could find was $240. Not one to give up, the Health Assistant worked with the member's pharmacist and doctor until an alternative was found that would only cost $1.20 out of pocket. The member told the Health Assistant without that solution, she would have simply skipped the medication because of cost.

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Knowledge is Power

A member called just to say thank you for the compassion our team showed when she was recently diagnosed with type 2 diabetes. She explained how much she appreciated the support and being sent information from the American Diabetes Association and other helpful resources. "I was overwhelmed and confused," she said, "but the information you sent got me back on track! Thank you!"

Quick Thinking

When a member called and stated he had been feeling tired, his Health Assistant asked questions that led her to believe he needed to get in with his doctor right away. She arranged the appointment quickly and the member ended up being sent directly to the hospital from the appointment because of an extremely low Hemoglobin level. At the hospital, he received a blood transfusion. Once he was feeling better, the member called the Health Assistant to say, "Thank you for making the appointment and saving my life."

Medication Refills

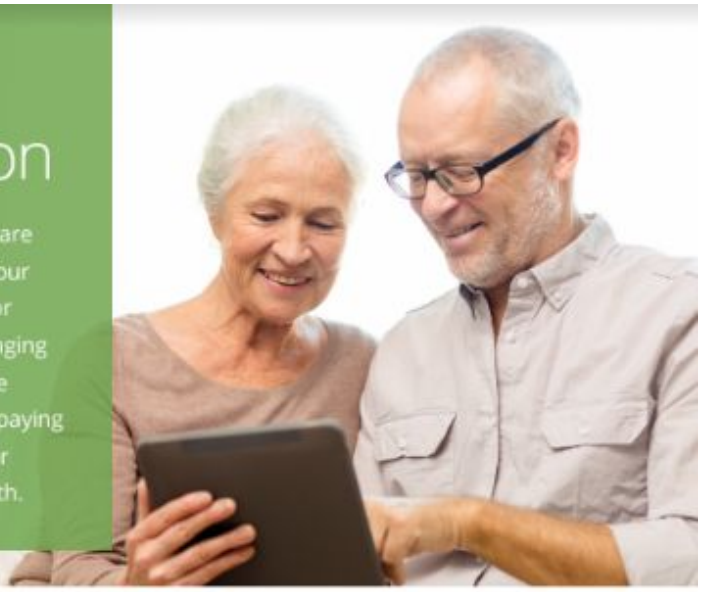
During a care call, a Health Assistant learned a member was out of his medication. The member had decided that, rather than contact his doctor for a refill, he'd wait for an upcoming appointment to mention it. The Health Assistant explained how critical it was to follow the doctor's medication instructions and not stop taking them suddenly. She then worked quickly to coordinate with his doctor's office, the pharmacy, and the member to get the medications filled.

Ramp Up

The daughter of a member told us her mother needed to have a ramp installed at her home so she could keep her independence and stay out of a nursing facility. The Health Assistant called the member's local Council on Aging to inquire about a volunteer ramp building program they had and gave them the member's information. Within three days, 14 volunteers came to the house and built a ramp. The daughter called to express her gratitude, saying the entire family was thankful that we would take the time to make something like that happen.

Get to Know Care Coordination

If you've been hearing a lot about chronic care management, care coordination, or even your doctor wanting to prescribe one of these for you, there is good reason. Medicare is changing the way they pay doctors, giving them more reasons to focus on quality of service, and paying for health benefits like care coordination, or between-visit care, to improve patient health.



This is all really great news for you! Here's why.

Care coordination is a huge part of the move toward improving healthcare by making it more proactive, personal, and patient-focused. Care coordination involves having someone in your corner, doing everything possible to make sure all your doctors and any caregivers or family members you choose get on the same page about your health.

This requires getting all your medical records together and making them available to your healthcare providers. It includes someone advocating on your behalf to get you the care you need, answering your questions day or night, and helping you follow up on your doctor's orders. And it means saving you time, money, and stress by helping you avoid medical errors, duplicate tests, expensive treatments, emergency room visits, and hospital stays.

While this is important for everyone to have, it can be especially important if you have chronic conditions such as diabetes, high blood pressure, heart disease, arthritis, or cancer, or if you have multiple health concerns. You may be seeing many different types of doctors or taking several medications. You may have caregivers involved or family members who are helping you recover from illnesses, manage conditions, or reach your health goals.

For every medication you take, it's important to know how it reacts with other medications. For every doctor you see, there are test results or other health data that could be **valuable information for your other doctors to have**.

With care coordination services, all your medications, medical records, doctor's instructions, allergies, appointments, test results, and more can be put in one place with **someone looking out for your best interests 24/7/365**. When your doctor prescribes it for you, it's like he or she is saying, "I want you to be taken care of the way you deserve, even when you're not in my office. This is how I can make sure that happens."

INTRODUCING

Chronic Care Management

Our practice is offering chronic care management (CCM) services, a program created by Medicare to help improve patient health and reduce healthcare spending. We have chosen CareSync to provide these services and help you manage your chronic conditions between office visits. CareSync's team of nurses will:

- Coordinate the care you receive from all your healthcare providers
- Answer your questions and address your urgent needs 24/7/365
- Schedule doctor appointments and make sure you receive timely preventive care
- Closely monitor your medication lists and help you avoid drug interactions and other complications

THINGS TO KNOW:

- CCM services are "non face-to-face" services your care team does for you outside of our office
- Standard coinsurance, copays, and deductibles apply so you may be billed for these services up to once per month
- CCM services are covered by Medicare Part B
- Supplemental insurance may cover the copay; check with your insurance carrier for details
- Only one provider can sponsor CCM services during a calendar month, so please let us know if someone is already providing these services for you
- You can cancel CCM services at any time, effective at the end of that calendar month, by contacting CareSync

I will be happy to answer any questions you have about CCM and how it can help you achieve better health.

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Introducing Our Care Coordination Program

Powered by caresync

Your health and well-being is always top of mind for us. That's why we now offer a care coordination program with services designed to proactively support your health, manage your care between office visits, and help you get and stay healthier longer. We have chosen CareSync to provide you with these care coordination services on our behalf.

Here are just some of the ways CareSync Health Assistants have helped others:

- Get answers to their healthcare questions
- Secure medical supplies and assistive devices
- Arrange transportation to medical appointments
- Connect with programs for diet, nutrition, and exercise support
- Locate discounts for prescribed medications
- Avoid duplicate tests, ER visits, and hospital stays
- Prevent serious medication interactions

Access to Health Assistants 24/7/365

When you join our program, you will have phone and online access to CareSync Health Assistants 24/7/365. The CareSync team provides us with valuable information about your health and progress between office visits, while supporting your healthcare needs day and night.

We believe coordinating your care is key to helping you achieve your best possible health. Ask us today if you qualify for our care coordination program.

Success With An Onsite Program Coordinator

True care coordination takes time to scale. We are here to help!

We believe that in order to be a true extension of your practice, we need to truly understand your unique workflows. That's where the **Onsite Program Coordinator (OPC)** comes in.

The **OPC** is an onsite CareSync representative who integrates with your workflows, understands the needs of your patients, and supports your care coordination program by educating and enrolling patients, and providing timely feedback on the results.

CCM enrollment taking place right in your office for true continuity of care

With an OPC, you benefit from:

- A proven way to increase practice revenue, while decreasing the enrollment workload/burden on your staff
- Real-time, face-to-face access to a CareSync representative who is focused on your practice and your patients
- An onsite resource to handle patient and caregiver questions about CCM and your program for instant patient satisfaction
- Expertise in the most up-to-date best practices for true care coordination success

Experience the difference an OPC makes for your practice

- Showcases the value of your care coordination program with in-office enrollments
- Sets the stage to roll out additional revenue-generating programs with onsite support already in place
- Fast-tracks enrollments and creates a steady enrollment strategy
- Serves as a knowledge source and liaison between your practice and CareSync
- Provides patient onboarding materials to increase patient satisfaction and program retention

How to get started

The **OPC** will work with you and your staff to create the best workflow for identifying eligible patients on the schedule with intention to enroll them into your care coordination program.

CareSync will provide training, supplies and ongoing support in order to make this program as **simple** and **successful** as possible.

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The Chronic Care Management Opportunity

With new codes and more reimbursement for 2017, CMS has made it easier and more profitable than ever to enroll patients in Chronic Care Management (CCM). With care coordination services from CareSync, you're in the best possible position to provide quality between-visit care for your patients and capture revenue from:

CPT Code 99490
This code reimburses providers an average of $43.66 per patient per month for 20 minutes of non face-to-face care coordination for eligible Medicare patients with two or more chronic conditions.

Add-On Code for Enrollment
Add-on code G0506 is a one-time code that reimburses providers an average of $65.34 for the extra time it takes to create a personalized care plan and initiate CCM services.

Complex CCM Codes
For complex CCM that requires more care coordination time, CPT Code 99487 reimburses approximately $96.13 for 60 minutes and 99489 reimburses approximately $48.25 for each additional 30 minutes (only with 99487).

Other Value-Based Initiatives
Beyond CCM, we also help practices with Annual Wellness Visits, Transitional Care Management, CPC+, commercial patient care coordination, quality measure programs, and MACRA consulting.

CCM That Exceeds Medicare's Requirements

When you choose CareSync to implement and deliver your care coordination program, we act as a nursing extension of your practice, coordinating care for your patients 24/7/365.

- Your instructions are turned into action. We reach out to the patient to expedite follow-up and encourage patient and caregiver engagement. Appointments are scheduled, medications are obtained, labs are drawn, and data is shared.
- Barriers are removed. I don't have a ride. I can't afford these medications. I need more supplies, but haven't received the insurance authorization yet. We work around the clock to help identify and remove the roadblocks that keep patients from adhering to your plan of care.
- Information is in the right hands at the right time. We help strengthen your referral network and close the feedback loop, giving specialists the information they need to take the best care of your patients and ensuring you get data back from other providers.

Your Voice Becomes Our Action™

We also offer innovative healthcare solutions, such as CareSync Scribe™, a simple, single-button app for iOS and Android that's like having a personal scribe with you wherever you go. This isn't just transcription or Voice-to-Text functionality. Scribe is Voice-to-Text-to-ACTION (VTA) technology. With Scribe, an audio file of your instructions is sent directly to your CareSync Health Assistant who hears your recording (avoiding the usual dictation woes like a computer auto-correcting your words), transcribes your instructions, and turns them into action items.

Leverage Scribe to enroll a patient in CCM and we can help you meet the documentation requirements for the G0506 code for care planning and explaining CCM. Use it to send verbal instructions to the CareSync nursing team for us to follow-up on, such as requesting records from a community provider, getting a note to a hospitalist taking care of your patient, and ensuring patients get access to the resources they need.

The Most Complete Care Coordination Solution

CareSync combines people, technology, special programs, and proven patient engagement tools to educate and build trust with patients and their caregivers, and effectively deliver Chronic Care Management services. Contact CareSync today at **800-587-5227**, or at **sales@caresync.com**, to learn more.

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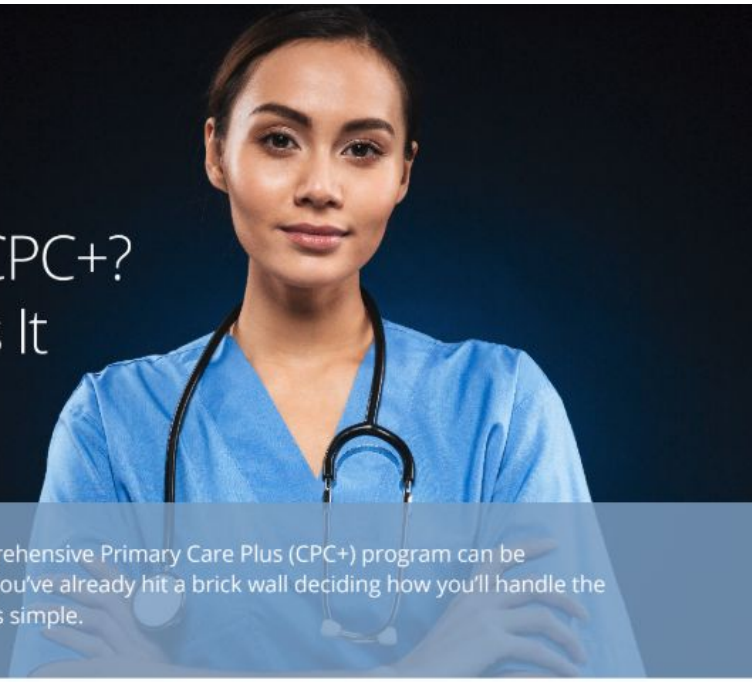
Participating in CPC+? CareSync Makes It Easy to Excel



A five-year commitment to the Comprehensive Primary Care Plus (CPC+) program can be overwhelming and you may feel like you've already hit a brick wall deciding how you'll handle the potential workload. But the solution is simple.

Let the care coordination experts at CareSync help you deliver a successful CPC+ program

With experience providing care coordination for patients across 43 states and more than 1,000 contracted physicians, CareSync has the quality measures behind CPC+ down to a science. Whether you're participating in Track 1 or Track 2, we have specific clinical protocols to manage most CPC+ measures, certified technology that integrates with all EMRs, and solutions that support your efforts to:

- Provide patients with 24/7/365 access to clinical assistance
- Improve health outcomes and use healthcare resources efficiently
- Coordinate care among all clinicians and hospitals
- Ensure medication reconciliation and care plan follow-through
- Provide continuity of care and documentation for reporting
- Perform patient assessments and provide Transitional Care Management
- Achieve CPC+ quality measures no matter how patients are risk stratified
- Honor collaborative care agreements between your practice and specialists

Create a superior experience for your providers, patients, and their caregivers

With the people, technology, and clinical services to succeed already in place, you can trust CareSync to help you maximize your CPC+ efforts and ensure patients on your attribution list get connected with the right CPC+ measures.

For more information and to learn how we can customize care coordination solutions to meet your individual needs, please call 800-501-2984 or email sales@caresync.com.

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We Are Tampa-Based and Proud Of It

We have been technologists building successful companies in Tampa Bay for two decades. We've been turned away by venture capitalists specifically because we weren't willing to move headquarters to a "tech" city.

We've never let that slow us down, and don't plan to now. We're passionate about the Tampa Bay technology ecosystem and are working to show the world that you can build successful technology companies in zip codes other than those in California, Massachusetts, and DC.

CareSync Headquarters: Hidden River Corporate Park, Tampa, FL

Chronic Care Management

CMS Study Shows Savings and Health Benefits

CCM Benefits Providers, Payers, and Patients

PROVIDERS

Generate an additional **$636** per member per year in revenue*

PAYERS

Save an average of **$888** per member per year*

PATIENTS

See an average savings of **$200** per year*

CCM Manages Chronic Disease Costs

Patients are redirected to primary care and community services

Savings are net of CMS payment of the CCM code

CCM Gets More Effective Over Time

Beneficiaries *with* CCM:

- Experience better management of end-of-life care
- Take greater advantage of healthcare benefits, such as advance care planning
- Spent an average of $203 less in the first six months of 2016 than they did in the first six months of 2015

Source: The results of a 2018 study published by the Centers for Medicare and Medicaid Services (CMS) and focused on data from the first two years of the Medicare CCM program.

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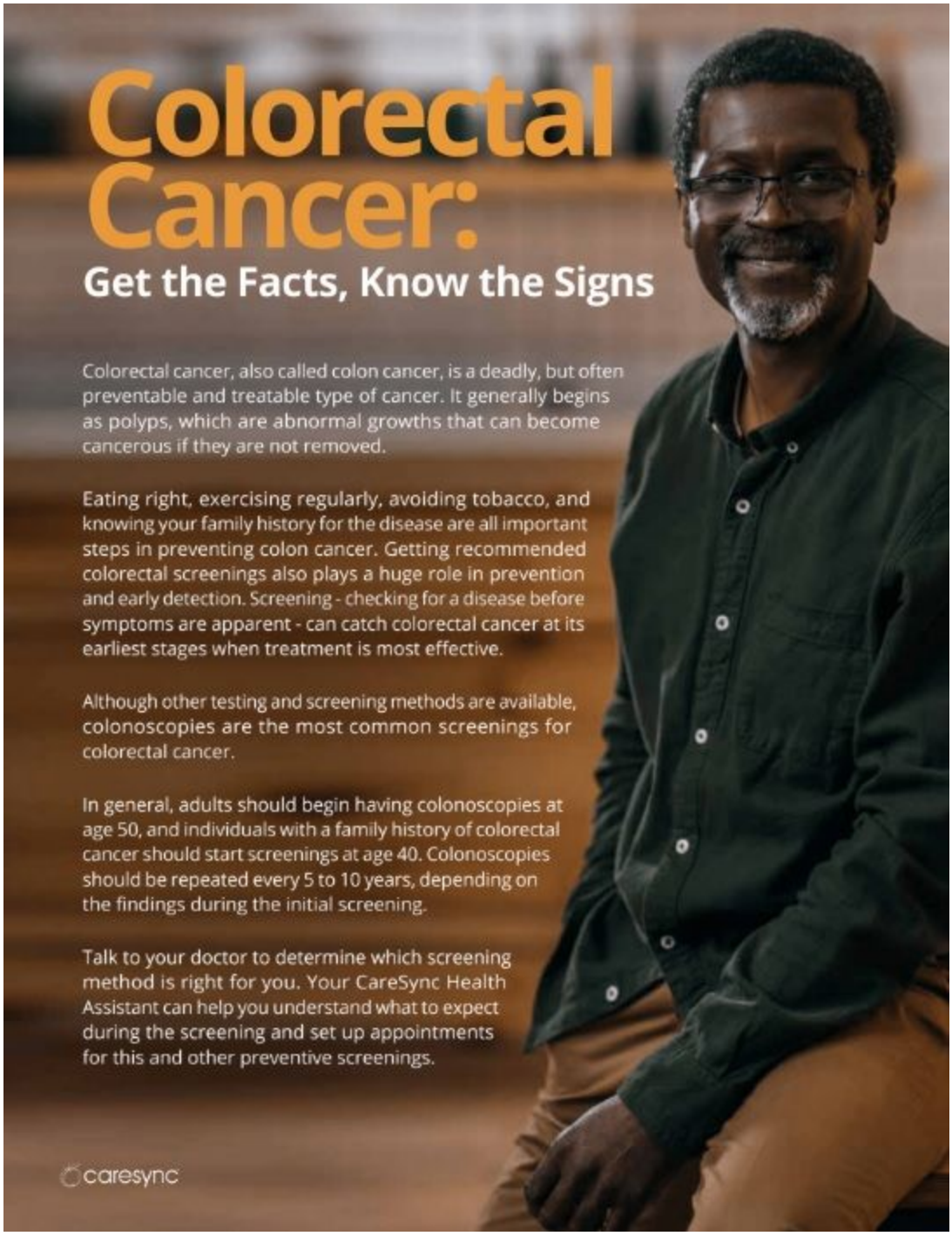
According to the American Heart Association, you should be eating omega-3 rich foods like salmon at least twice a week for good heart health.

Get Hooked On Healthy Fish

Beyond powerful omega-3s, salmon also supplies you with vitamins B12, D, B6, and B5, as well as phosphorus, niacin, protein, choline, biotin, potassium, and selenium. All of these work together to:

- Keep you from becoming tired or weak
- Help strengthen your bones, hair, and skin
- Aid your digestive system and nervous system
- Help prevent cellular damage
- Fight liver disease
- Help create red blood cells
- Lower your triglyceride levels (high levels can increase your risk of heart disease)

Other fish high in omega-3s include tuna, lake trout, herring, mackerel, anchovies, Alaskan halibut, and sardines. And getting 2 to 3 cups per day of dark green vegetables like kale, spinach, and Brussels sprouts in your diet will also help you increase your intake of the good fats.


Colorectal Cancer:
Get the Facts, Know the Signs
Colorectal cancer, also called colon cancer, is a deadly, but often preventable and treatable type of cancer. It generally begins as polyps, which are abnormal growths that can become cancerous if they are not removed.
Eating right, exercising regularly, avoiding tobacco, and knowing your family history for the disease are all important steps in preventing colon cancer. Getting recommended colorectal screenings also plays a huge role in prevention and early detection. Screening - checking for a disease before symptoms are apparent - can catch colorectal cancer at its earliest stages when treatment is most effective.
Although other testing and screening methods are available, colonoscopies are the most common screenings for colorectal cancer.
In general, adults should begin having colonoscopies at age 50, and individuals with a family history of colorectal cancer should start screenings at age 40. Colonoscopies should be repeated every 5 to 10 years, depending on the findings during the initial screening.
Talk to your doctor to determine which screening method is right for you. Your CareSync Health Assistant can help you understand what to expect during the screening and set up appointments for this and other preventive screenings.
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CHRONIC CARE MANAGEMENT FOR RHCs and FQHCs

NEW CODE G0511 REIMBURSES **RHC AND FQHC** PRACTITIONERS **$62.28 PER MEMBER PER MONTH** FOR PROVIDING **NON-FACE-TO-FACE** CARE COORDINATION SERVICES TO MEDICARE BENEFICIARIES WITH **2+ CHRONIC CONDITIONS**

AS MANY AS **3 OUT OF 4** PERSONS AGE **65** AND OLDER HAVE **MULTIPLE CHRONIC** CONDITIONS

PROVIDERS

Generate an additional **$636** per member per year in revenue*

PAYERS

Save an average of **$888** per member per year*

PATIENTS

See an average savings of **$200** per year*

- PROVIDE **PATIENT-CENTERED** CARE MANAGEMENT AND OVERSIGHT
- DELIVER **20 MINUTES MINIMUM** MONTHLY CARE COORDINATION
- BUILD AND MAINTAIN A **COMPREHENSIVE CARE PLAN**
- SCHEDULE **ROUTINE AND REFERRAL** MEDICAL APPOINTMENTS
- **RECONCILE MEDICATION LISTS** AND REVIEW FOR **POTENTIAL INTERACTIONS**
- MAKE CLINICAL STAFF **ACCESSIBLE 24/7** TO ADDRESS URGENT NEEDS
- ENSURE **TIMELY SHARING** AND USE OF **HEALTH INFORMATION**
- **MANAGE CARE TRANSITIONS** BETWEEN HEALTHCARE PROVIDERS AND SETTINGS

IMPROVE PATIENT HEALTH

INCREASE PRACTICE REVENUE

LEVERAGE BETWEEN-VISIT DATA

* Averages reflecting data culled from a CCM assessment report released by CMS in 2018

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COORDINATED CARE IS BETTER CARE

TRAVIS BOND, FOUNDER AND CEO, CARESYNC

But what about solutions? If we envision greater efficiency and effectiveness in healthcare, how do we get there?

Close Gaps In Care

Even when as many as 3 out of 4 persons age 65 and older have multiple chronic conditions and 7 out of 10 deaths each year in the U.S. are from chronic diseases, our aging population frequently identifies itself as "not sick."

Seeing chronic illness in a more accurate light, Medicare created programs like Chronic Care Management (CCM) to help patients achieve better health outcomes. How? By filling in the gaps between doctor visits with care coordination.

Care coordination, which has tremendous value for individuals of all ages, gives patients access to clinical services 24/7, helps them manage chronic conditions like diabetes and heart disease, encourages them to follow through on their doctor's plan of care, and gets vital between-visit data back to the doctor.

Reduce ER Visits, Hospitalizations, and Readmissions

Similar to recognizing it's a lot cheaper to regularly change the oil in your car than it is to replace the engine, care coordination is about managing or, to some degree, containing a disease by proactively treating it with a maintenance program versus reactively attacking an acute scenario.

Encourage Cost Control

Fear, uncertainty, and doubt often lead individuals to go directly to the ER when a reassuring phone call from a provider, accompanied by an appointment within 12 hours at their office, is far more efficient and effective.

Acute specialty points of care are more costly than adhering to what has already been prescribed. With greater access to their physicians and 24/7 clinical support, patients can make more appropriate and affordable choices about when, how, and where they seek care.

Where To Next?

Care coordination solutions are relatively new, but my hope is that five years from now, patients will be familiar and comfortable with them, and eager to take advantage of their benefits.

Travis Bond - Founder and CEO, CareSync

Travis is a healthcare technology disruptor, a passionate entrepreneur, and a charismatic leader. Leveraging his diverse educational background in business, finance, and medicine, Travis creates products and services that have dramatically enhanced the way people do business and the way patients experience healthcare.

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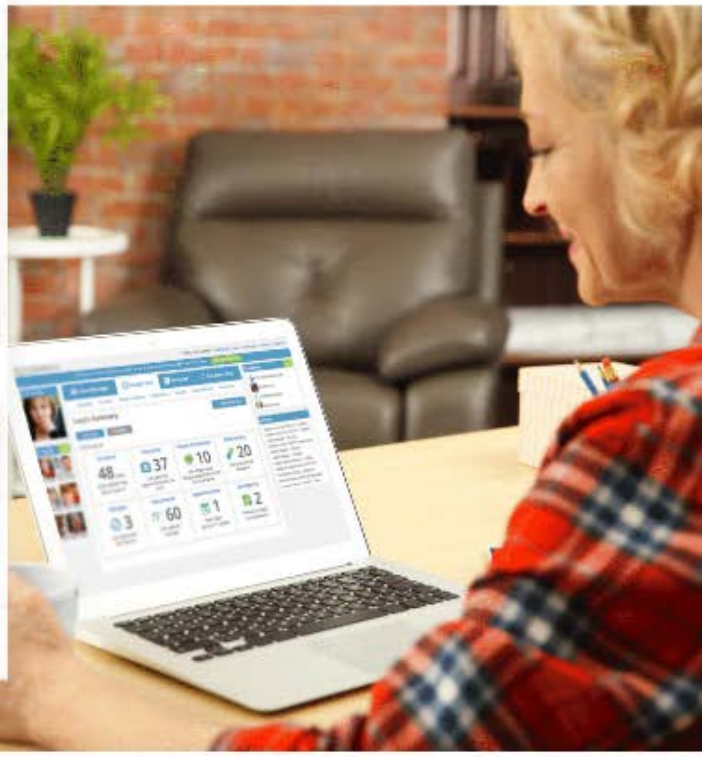
caresync | THE LEADER IN CHRONIC CARE MANAGEMENT

Unapologetically Patient-Centered

We want CareSync to be the place where an individual's healthcare information is not just stored, but made useful and actionable to improve their health and make a real difference in their lives.

– Travis Bond, CEO and founder of CareSync

Founded in 2011, CareSync is the leading provider of software and services for Chronic Care Management, combining technology, data, and 24/7 clinical services to facilitate care coordination among patients, family and caregivers, and all healthcare providers.



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RHCS and FQHCS CCM

Chronic Care Management for RHCs and FQHCs is now reimbursed under a new code created exclusively for these practices:

G0511 for General Care Management

With G0511, RHCs and FQHCs benefit from streamlined reporting of care management services and earn a higher reimbursement rate for CCM-related services than they did with the base CCM 99490.

$62.28 pmpm vs. approx. $42 pmpm

With these positive changes and the right to choose a third party to deliver CCM on your behalf, there are more reasons than ever to implement CCM and leverage solutions from CareSync to do it successfully.

- Give patients access to CareSync Health Assistants 24/7/365
- Offer between-visit care that can improve patient health
- Generate recurring revenue for the practice
- Bring a wider range of valuable services to the community

G0511 for General Care Management

Put yourself in the best possible position to deliver CCM with minimal demand on available resources and maximum reimbursement with support from the CCM experts at CareSync.

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At CareSync, we believe CCM is more than just fulfilling a list of Medicare's requirements. You can count on us to treat your patients with respect, follow your preferences and protocols, and work hard to resolve issues that stand between your patients and better health.

CareSync is amazing and I want to thank you. You've helped me through two years of cancer and I know you've played a good part in my still being here.
- CareSync Member

My husband is alive thanks to the CareSync team calling and checking in on us.
- CareSync Member

I love the fact that we are in a position to help people and show them they matter.
- CareSync Health Assistant

CCM makes it possible to deliver the type of care I've always wanted to provide.
- CareSync Client

- Clinical support for your patients 24/7/365
- Medical records requested from all providers
- Seamless integration with your certified EHR
- Medication reconciliation and adherence
- Care plans are specific to the patient, not templated or one-size-fits-all
- Reporting on key quality metrics and identification of potential risk measures
- Flexible enrollment options, including our Remote Enrollment Program
- Services that support G0511, including AWV and TCM
- Customized training, billing consultation, and implementation support
- The staff, capability, and scalability to deliver what we promise

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THE MEDICARE ANNUAL DEDUCTIBLE FOR 2018

At the beginning of every calendar year, your Medicare annual deductible "resets" and you must pay your healthcare costs up to the deductible amount before Medicare kicks in. The deductible for Medicare Part B in 2018 is $183. While it can be frustrating to receive those first bills each year from providers and have to pay out-of-pocket against that deductible, it is the patient's responsibility to do so and the nature of health insurance plans.

"Sometimes patients with Medicare will feel caught off guard - getting a bill they have to pay from a doctor they saw all of last year 'for free.' But that's not the case and certainly not a fault of the doctor," said Jason Wilson, RN, BSN, Vice President of Nursing and Clinical Affairs at CareSync. "That doctor just happened to be one of the first to bill them in the year, and had to by virtue of the physician and the patient being Medicare participants."

Of course, how much you pay and who you pay will be based on who you saw first and who billed you first in the year, as well as how much the charge was.

As an example: In 2018, if you were to have an appointment in January with Dr. Joe, who billed you right away for a Medicare-approved service that cost $183, you will receive a bill from Dr. Joe for $183 and be responsible for paying it. You will have met your deductible for the entire year with that one bill. But if you saw Dr. Joe in January and Dr. Sue in February, and each charged you $91.50, you would pay both those doctors those amounts, meeting your deductible after two bills.

After your deductible is met, you may still have to pay copayments and coinsurance depending on the plans you have chosen. With Part B, you will typically pay 20 percent of the Medicare-approved amount for most doctor services, outpatient therapy, and durable medical equipment. If you have a paying secondary or supplemental insurance, it may pay the other 20 percent.