

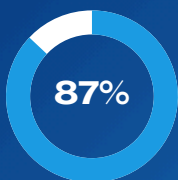


Care management made easy — for you, *and* for your patients



\$346M+

Reimbursements generated for
care management activities



Year-over-year
patient retention

376,565+

Patients enrolled



Reduction in
all-cause hospitalizations

3,229,292

Hours of staff activities
documented for billing

Leverage the work you already do, with the systems and staff you already have, to optimize your clinical, financial, and operational outcomes:



Maximize Reimbursements

- Track more than 25 codes monthly, generating recurring reimbursements for work that's already performed in your EHR and on the phone.



Improve Patient Outcomes

- Because a lot happens between office visits, the ChronicCareIQ platform alerts staff about which patients have needs — meaning they can focus on who needs help the most. That has a significant impact on reducing hospital readmissions.



Gain Visibility

- You can't manage what you can't measure. Simplify managing clinical and operational resources with real-time patient dashboards and pre-built financial reports.



Increase Staff Productivity

- ChronicCareIQ makes complex patients easier to care for by reducing inbound phone calls, slowing or halting disease progression, and preventing hospitalizations.



Enhance Patient Experience & Retention

- Enhance patient engagement, retention, and relationships by automating and simplifying communication through the technologies that they already use.



Dr. Jim Carmical
Woodside Medical, Arkansas



“ChronicCareIQ has become an indispensable ally in our mission. The platform’s impact on patient outcomes, from reducing hospital admissions to enhancing communications and achieving financial success, has exceeded our expectations.”

You can depend on **ChronicCareIQ** for



Chronic Care Management

Alert your staff so they can focus on getting the right care, to the right patient, at the right time.



Remote Patient Monitoring

Capture device-based vital signs and self-reported subjective data to help slow disease progression.



Principal Care Management

Get real-time updates on at-risk patients and auto-capture reimbursable activities.



Transitional Care Management

Prevent gaps in care when your team is informed about patients transitioning between care settings.



Remote Therapeutic Monitoring

RTM codes include non-physiologic data monitoring for areas including respiratory system status, musculoskeletal system status, medication response, medication adherence, and pain levels.



Behavioral Health/ Care Coordination

Improve patient outcomes and maximize reimbursement for care coordination between primary care providers and behavioral health professionals.



Advanced Primary Care Management Services

APCM codes simplify via bundling the billing for Principal Care Management, Transitional Care Management, and Chronic Care Management services. APCM provides a flat fee per primary care patient per month, with no need to track time.



Let's Connect

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