

Greenway Care Coordination Services

Zachary Blunt Product Management

Agenda

- Overview of Chronic Care Management Services
- Prime Suite and Intergy Integration
- How we drive outcomes
- Clinical results
- Your bottom line



Poll question

What's your specialty?

- a) Family practice
- b) Internal medicine
- c) Cardiology
- d) Pulmonology
- e) Multispecialty or other



CHRONIC CARE MANAGEMENT **SERVICES OVERVIEW**

Taking the first step is hard





Sharing data is complex

Obtaining patient consent

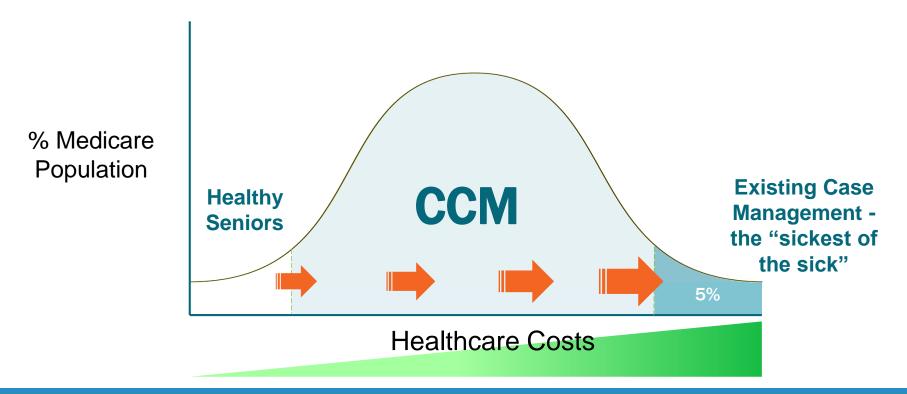
MACRA, MIPS CPIA

CCM

PCMH



Population Health — Where CCM Fits



Manage disease in ~70% of Medicare patients who are at moderate risk Prevent the progression of chronic disease Avoid unnecessary ED visits/hospital admissions



CCM Code 99490 Benefits

Clinical:

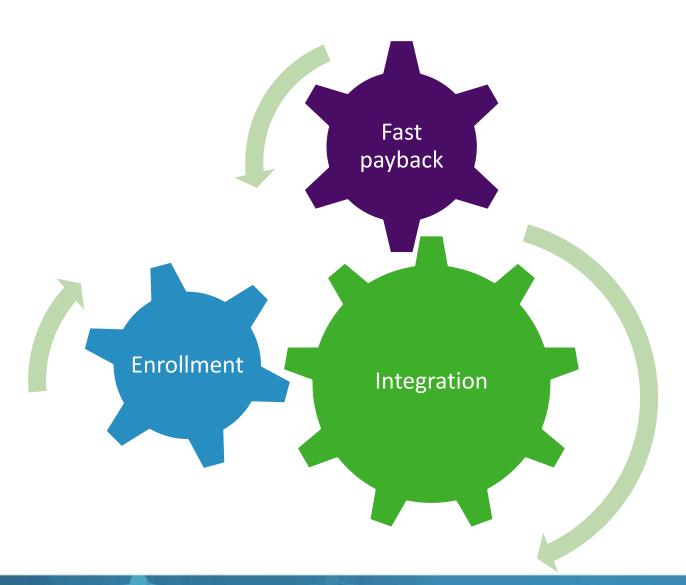
- Increased Access to Care
- Extension of the practice
- Greater patient engagement
- Improved outcomes

Financial

- Represents a reimbursement bridge for providers as they move from fee-for-service towards value-based medicine
 payments (new meaningful use)
- First of many population health reimbursement codes



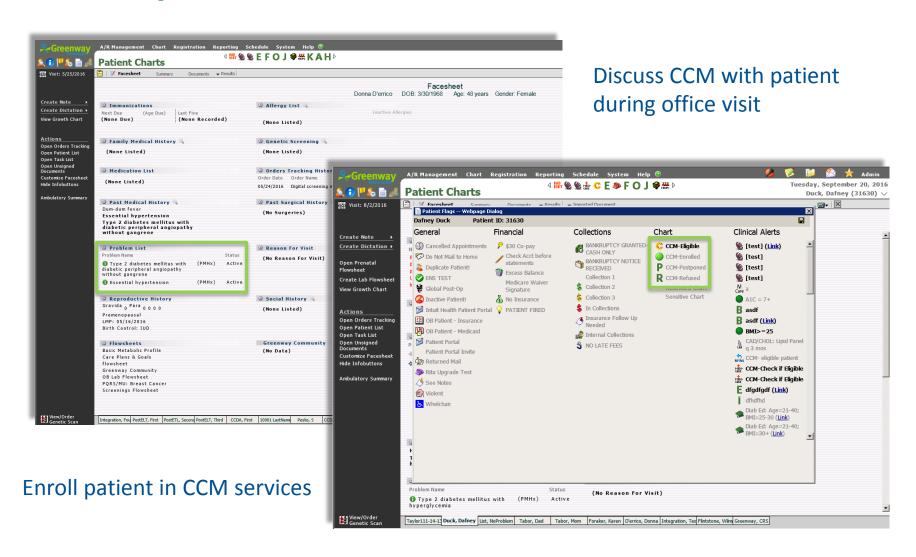
Integration makes getting started easy







Identify & Enroll





CCM services model

Practice

Enroll patients:

- 2+ chronic conditions
- Eligible payer
- Consent form signed
- · Flag as CCM-Enrolled

Patient enrolled

Service

Patient enrollment validated

CCD extracted for diagnoses and goals

CCM Services provided during month

Patient Documents:

- Care plan
- Evidence of care
- Patient reported vitals

Billing:

Process claims
Check patient out for visit
Collect patient copayment

Documentation sent

Charges posted

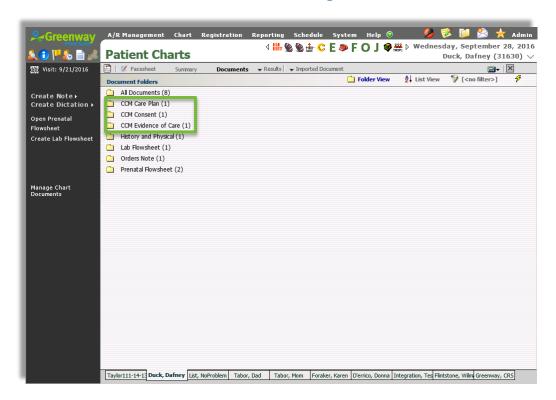
Documents updated

- RevUp care plan
- Evidence of care
- Patient reported vitals

Patient CCM minutes, diagnosis codes, CPT codes aggregated

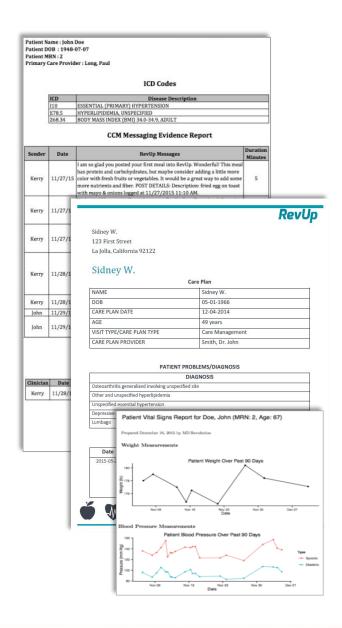


Documentation updates

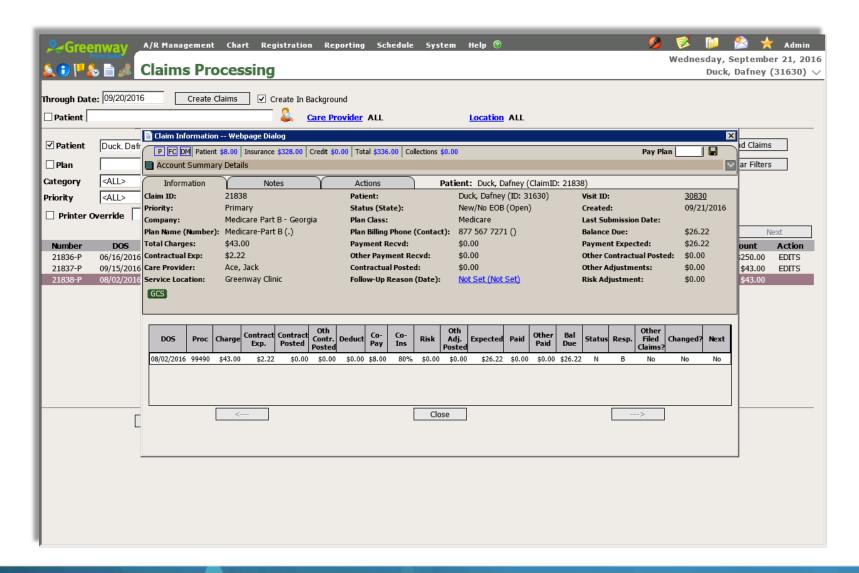


Documents linked to patient chart:

- Evidence of care
- Care plan
- Patient generated vitals



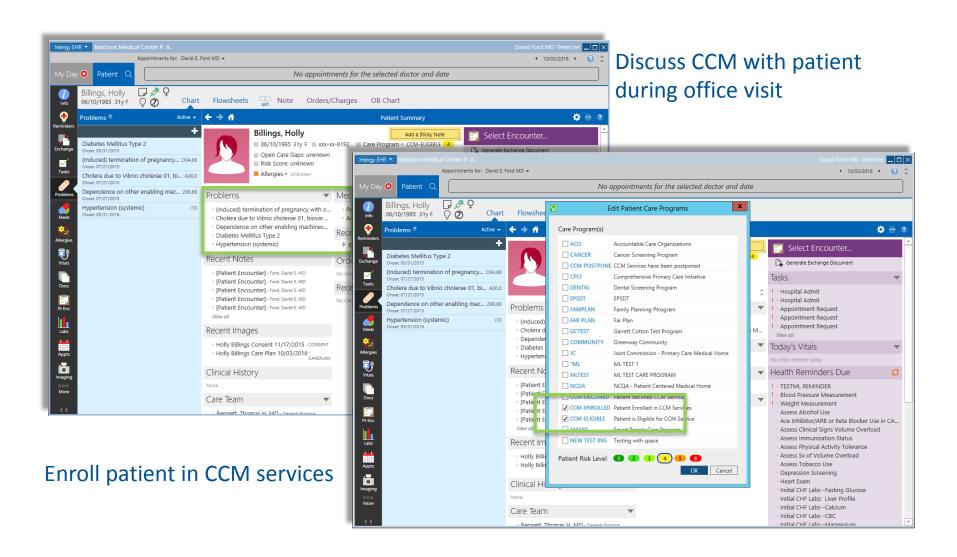
Billing







Identify & Enroll





CCM services model

Practice

Enroll patients:

- 2+ chronic conditions
- Eligible payer
- · Consent form signed
- Assign Care Program of CCM-Enrolled

Patient enrolled

Service

Patient enrollment validated

CCD extracted for diagnoses and goals

CCM Services of provided during month

Patient Imaging:

- Care plan
- Evidence of care
- Patient reported vitals

Billing:

Process claims
Collect patient copayment

Documentation sent

Billing information sent

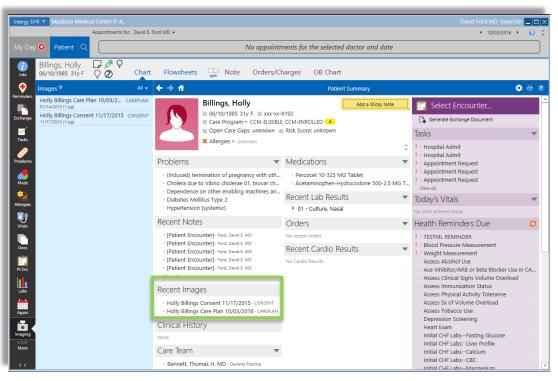
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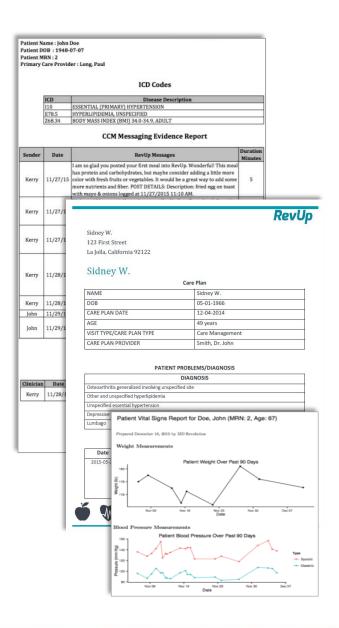


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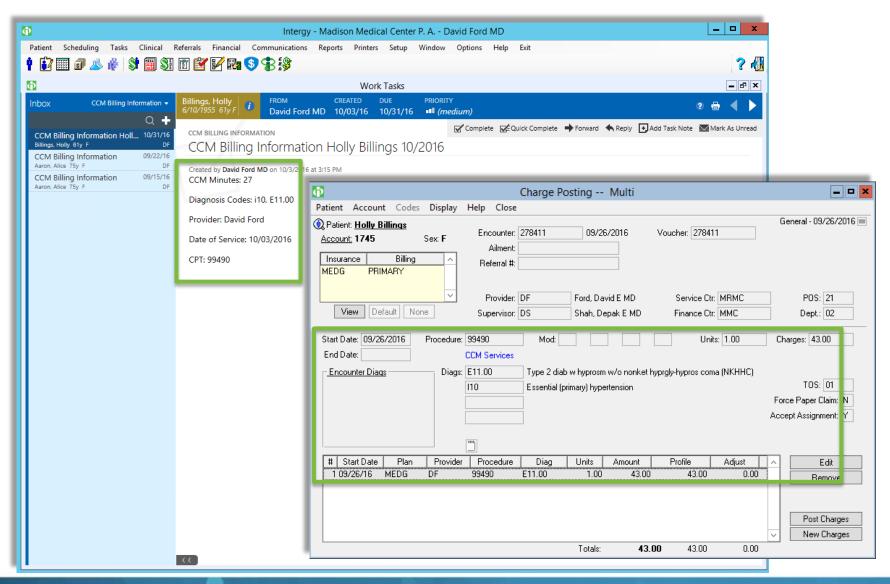


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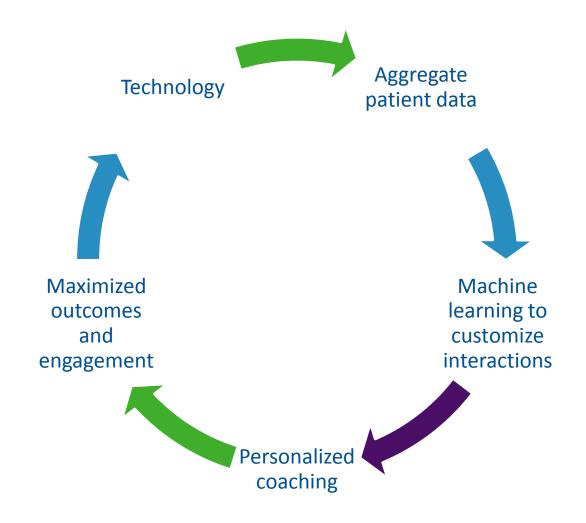
Billing





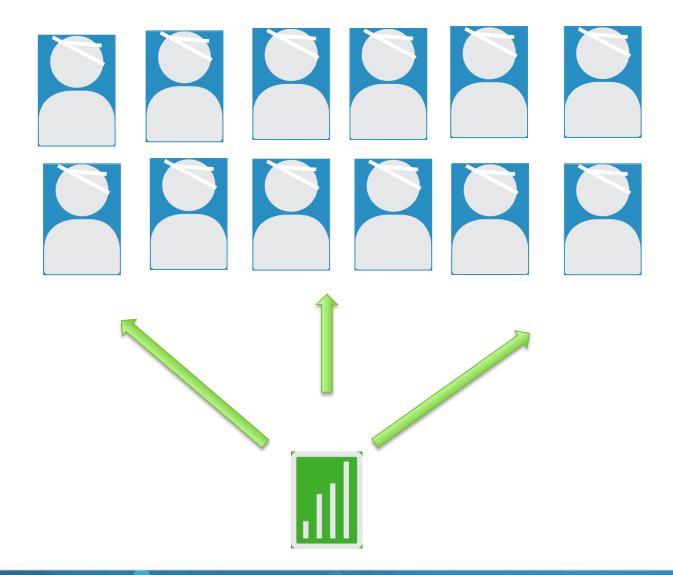


Technology and engagement driving outcomes



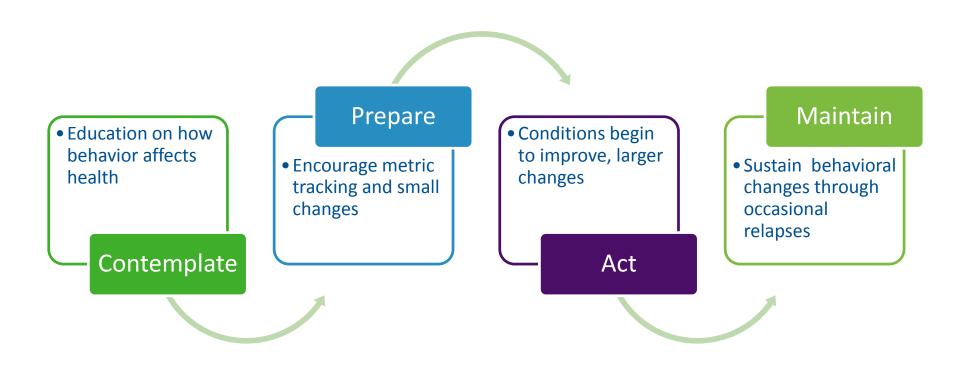


More care in twenty minutes



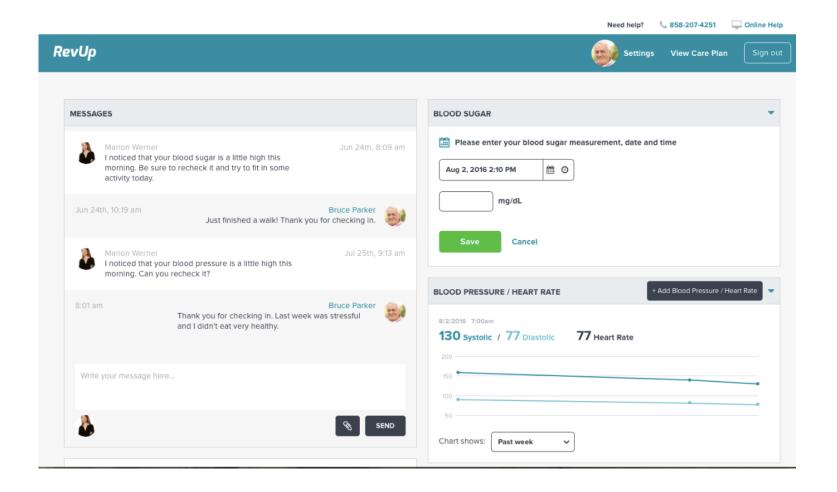


How we coordinate care



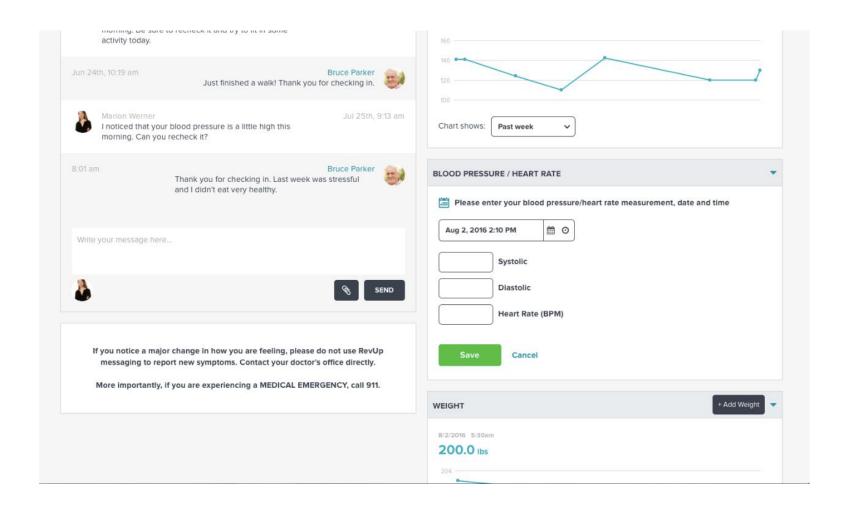


Patient-facing platform



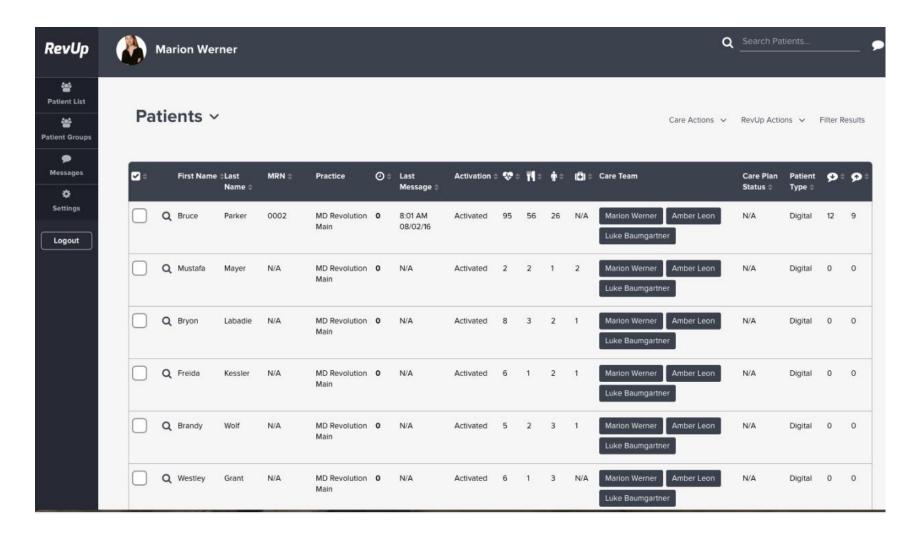


Patient-facing platform



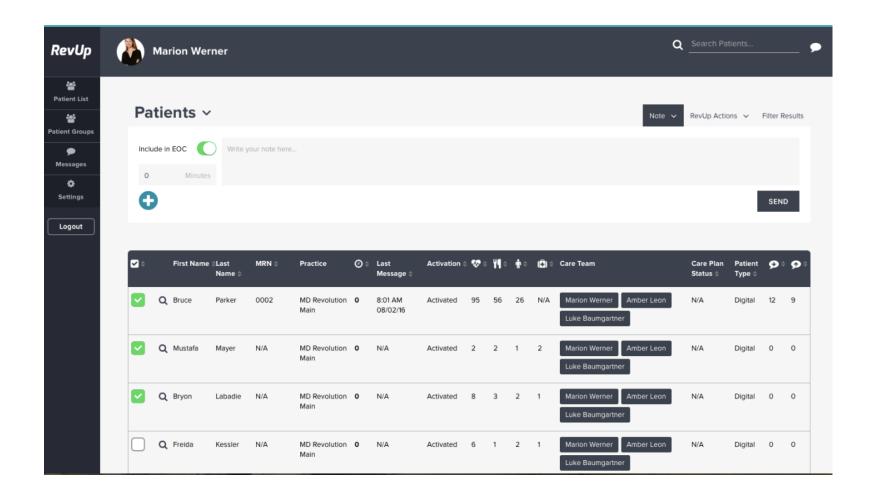


Clinician-facing platform





Clinician-facing platform



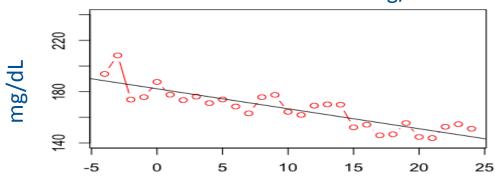




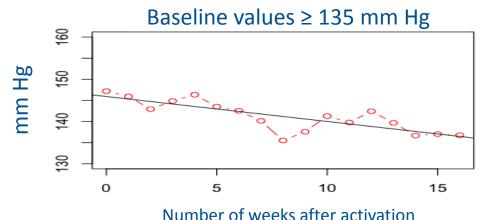
Trends over time support the role of engagement in generating clinical outcomes

Blood Glucose

Baseline values ≥ 140 mg/dL



Systolic Blood Pressure





Medicare unplanned re-admission rate: RevUp CCM patients vs. all Medicare

<u>Specific Readmission Measures:</u> Acute Myocardial Infarction, Chronic Obstructive Pulmonary Disease, Heart Failure, Pneumonia, Stroke, Coronary Artery Bypass Graft, Total Hip and/or Total Knee Surgery

Memorial Hospital at Gulfport

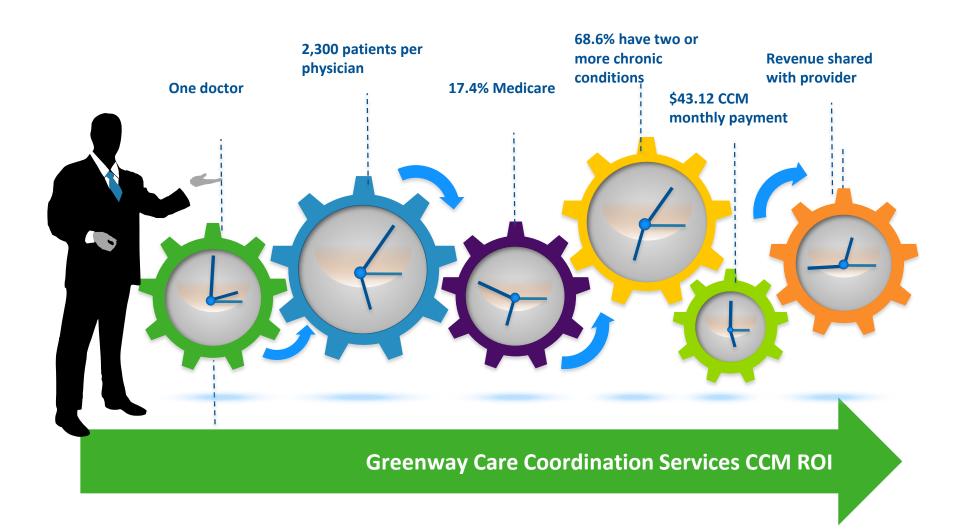
	CCM Patients	All Medicare
# of Patients	3529	~12,000
# of Admissions	444	3080
%	12.60%	25.70%
# Re- Admissions	34	468
%	7.66%	15.19%

Note: All Medicare column as filed with Medicare by Gulfport - 2014





How you earn by partnering with Greenway Care Coordination Services





Succeeding in reimbursement reform





Poll question

Would you like to a sales representative to contact you to learn more about Greenway Care Coordination Services?

- a) Yes
- b) No



