# Three Keys to CCM & RPM *Without Compromise*

Prepared for clinical administrators, doctors and other healthcare professionals, in the interest of healthcare without boundaries.

# Dear Colleagues,

Integrated Chronic Care Management works. It helps mitigate the systemic drain caused by chronic illness treatment, which is 3.5 times more expensive to treat than other conditions and accounts for 90% of U.S. healthcare costs. This, according to the American Heart Association. Moreover, it works so well that reimbursements for non-face-to-face CCM have steadily increased and broadened since the introduction of CPT 99490 in 2015.

As you know, in 2020, the need for virtual health exploded. Results included the massive patient and physician adoption of platforms like Remote Patient Monitoring and telehealth—even among some of the slowest populations to change. Despite initial protests, virtual health platforms proved so efficient and safe they became an accepted, if not necessary, tool to provide quality care.

For the first time, the platforms that make the delivery of CCM and RPM most valuable are considered business-as-usual. Moreover, the paths of least resistance favor providing quality care to more patients and receiving more reimbursements— while compromising nothing.

In this guide, you will find the critical elements to provide more profitable, personalized care that complements and enhances your existing model and standards of healthcare.

Welcome to your practice without boundaries.

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## Briefly: Vital Health Links

- Providing CCM since 2016 (Inception of non-face-to-face reimbursement)
- Clinical focused Care Coordinator program is led and overseen by physicians
- Care Coordinator methodology enhances revenue growth through CCM & RPM reimbursements
- Founder/CEO Saurin Patel holds an MBA from Indiana University Kelley Business School
- Coordinated care platforms integrate with practice workflows and care standards
- CCM and RPM platforms are turn-key and require virtually no up-front investment such as in personnel, technology, or additional infrastructure

## How It Works

Vital Health Links was founded by a practicing physician with an MBA, dedicated to making "your practice without boundaries" a reality. Since 2016, we have continued to help practices and systems overcome barriers to healthcare without boundaries through our clinical, profitable, and personalized chronic illness care support methods.

From being led by your doctors' directives to our end-to-end clinical approach, Vital Health Links' methodology is different from most CCM or RPM providers. As a result, you experience the benefits of clinically-trained Care Coordinators who are dedicated to your practice or system's unique healthcare needs...

- Are trained by physicians to provide clinically-based coordinated care and responsiveness
- Are dedicated to your patient panels to provide consistent extended care that feels personal
- Provide care that integrates completely with your care quality, EMR, operations and workflows
- Feel like your care, extended, providing attentive monitoring of chronic conditions and social determinants, as well as screenings and assessments.

## Your Standards

Our pathways support you and your patients with organized clinical-care processes on your behalf, regardless of location or hour.

Our clinical processes are built to carry out the directives of the attending doctor, along with standardized, evidence-based guidelines of the American Medical Association and American Health Association, for responsive, customizable care.

## The Extra Mile

Bridging gaps in clinical care and social-determinants are just a part of VHL Care Coordinators' dedication to you, resulting in stronger engagement, increased compliance, and lengthening enrollment in the program. True end-to-end chronic care management includes identifying and addressing obstacles to care, including depression, domestic issues, and food insecurity— which are some of the most common obstacles that define chronic illness outcomes for patients.

Know your extended healthcare, CCM & RPM options before you have to—from the physicians who direct our programs.

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# Final Thought

CCM, RPM, and other extended patient care services help practices generate revenue beyond what CPT codes provide. When done correctly, remote patient care provides contextual engagement with patients, collects important between-visit data, and can help spot potential concerns early.

**"It is critical to the success of achieving the "Triple Aim" of providing better care, lower costs, and improved health."**

This relationship-based, proactive approach to care helps encourage preventive care making your patients' next visit more encouraging than the last.

Additionally, with the industry's latest reimbursement models, there is tremendous value in how CCM & RPM can improve patient satisfaction and health, leading to better quality and performance scores.

CCM and RPM are two significant pieces of coordinated care. However, there are still others, including Annual Wellness Visits and Transitional Care Management.

Additionally, having success with MACRA (MIPS or Advanced APM path) and CPC+ are part of a larger goal—the proactive management of chronic conditions before they become a more significant threat to patient and population health and its additional costly impact on the U.S. economy.

It is a complete care coordination strategy that Medicare has been advancing year after year. It is critical to achieving the "Triple Aim" of providing better care, lower costs, and improved health.

**10,000 baby boomers will turn 65 every day for the next 8 years, a growing patient base that is prone to developing multiple chronic conditions.**

Know your CCM/RPM options before you have to. Speak with one of our physicians:
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