ChronicCareIQ

Care Management Software – for you, and for your patients

ChronicCareIQ.com

Helping providers simplify care for complex patients, manage medical practices more efficiently, and generate significant monthly recurring revenue.

Maximize Reimbursements

Track 35+ codes automatically, every month, generating recurring reimbursements for work that's already performed in your EHR and on the phone.

Improve Patient Outcomes

ChronicCareIQ alerts staff about which patients have needs *now* – so they can focus on who needs help the most, significantly 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 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 technology they already use.

341,000+	29.4%	$242M+	2,379,573
Patients Enrolled	Reduction in all-cause hospitalizations	Reimbursements generated for care management activities	Hours of staff activities documented for billing

You Can Depend On ChronicCareIQ

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.

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.

Principal Care Management

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

Advanced Primary Care Management

APCM codes simplify via bundling billing for PCM, TCM, and CCM services. APCM provides a flat fee per primary care patient per month with no need to track time.

Behavioral Health/ Care Coordination

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

Transitional Care Management

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

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