VITAL DECISION

The Questions That Define Remote Care Success

Providers know remote care can work. The outcomes are real, the ROI is proven, and the impact on patient health is well documented.

Yet hesitation remains—and for good reason. As participation in ACOs and value-based care models continues to grow, many organizations are balancing fee-for-service performance with shared savings objectives, quality measures, and long-term risk. At the same time, concerns about vendor staying power, inflated promises, and operational complexity persist. With no shortage of RPM and CCM companies in the market, identifying a partner that can support both today's reimbursement models and tomorrow's care strategies isn't easy. Add ongoing Medicare reimbursement and service changes, and the decision only gets more complex.

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With more than 1,000 implementations and over 500,000 patients served, we've seen what actually makes remote care successful across payment models—and just as importantly, what doesn't. We've learned where programs break down at the practice level, what "success" looks like under fee-for-service versus shared savings, and why "integration" can mean very different things depending on the vendor and the EHR.

That experience led us to this guide. The questions that follow —and the candid context behind them—are designed to help you cut through the noise and make the right call for your remote care objectives, whether you're optimizing fee-for-service performance, advancing value-based care, or navigating both at once.

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Do you offer program design for my organization type? Are programs customizable for specific focus areas?

Yes—but with intent. Our program models are designed to extend existing care delivery, not replace it. We work closely with each partner to design remote care programs that align to organizational structure, patient populations, and clinical priorities—while operating seamlessly within existing provider workflows.

We don't believe in one-size-fits-all care models.

rograms are thoughtfully configured to bring patients' care plans to life across specialties and use cases, whether deployed as focused, standalone services or combined into broader care strategies as needs evolve.

Our core expertise centers on RPM and CCM. We also support adjacent programs and initiatives as part of a larger care strategy—ensuring flexibility without losing operational focus or execution quality.

Examples of care management programs we design and support include:

- Remote Patient Monitoring (RPM)
- Chronic Care Management (CCM)
- Transitional Care Management (TCM)
- Principal Care Management (PCM)
- Annual Wellness Visits (AWV)
- Value-Based Care (VBC) initiatives

Do you offer comprehensive integration with my EHR, or will I need to log in to a third-party platform?

Not all "integrations" are created equal. Requiring clinicians to log into another system slows decision-making, fragments workflows, and undermines adoption—especially at scale. We designed our integrations to avoid that problem entirely.

With CoachCare, client partners do not need to work in a separate platform. Our remote care services are embedded directly within the EHR, allowing providers to operate entirely in the environment they already use. Ordering, enrollment, tasking, real-time vitals review, documentation, and automated claims creation are all managed without leaving the EHR.

Because interoperability is foundational—not an afterthought—our integrations are built to support long-term flexibility, including EHR transitions, without disrupting care delivery or program continuity.

We've built an integration ecosystem designed for real-world clinical workflows—connecting seamlessly with leading EHRs, data systems, and devices. Our two-way integrations support daily care delivery at scale, not just data exchange. Below are examples of practice-based EHRs we integrate with today, with additional systems added as client needs evolve.

What challenges should be addressed before implementation? What's the implementation timeline?

From a technical standpoint, the primary factor that can impact implementation timelines is the completion of the EHR integration within the health system itself. Outside of that dependency, our teams are prepared to move quickly—and when resources are aligned from the outset, programs can be launched in as little as four weeks.

That said, implementation speed is a shared responsibility. While we do not require dedicated FTEs at each site, successful launches depend on having clear roles, decision ownership, and operational bandwidth established early—particularly when the individuals approving the program are not the same teams responsible for executing it.

Programs must also be thoughtfully designed from the start to ensure operational effectiveness, scalability, and alignment with outcomes goals. We work closely with partners to define these elements upfront and provide additional guidance for RHCs and FQHCs in selecting appropriate device strategies and service models that reflect the realities of their patient populations and financial constraints.

Who will enroll and market the remote care program to my patients?

We do—in partnership with your practice. Successful enrollment isn't driven by a single touch or a handoff; it depends on consistent, multi-touch patient education and reinforcement across the care journey.

Our team leads enrollment efforts using EHR-embedded workflows to identify and outreach to eligible patients, supported by trigger-based ordering and real-time visibility into enrollment status within the clinical workflow. Patient education is delivered through a combination of outreach methods designed to build understanding, trust, and readiness —not just consent.

That said, enrollment outcomes are strongest when practices actively reinforce the program during in-person and clinical interactions. When partners align around shared messaging and expectations, enrollment rates increase meaningfully.

How is device inventory and logistics managed for RPM programs?

We manage the full device lifecycle end to end. That includes storage, fulfillment, shipping, and returns—initiated through trigger-based ordering directly within the EHR. Clinic staff are not responsible for storing, distributing, cleaning, or recalibrating equipment.

Logistics, however, are only part of the equation. Before devices ever arrive, we begin patient engagement to set expectations and reduce friction. Patients are guided through the process via SMS outreach, two-way in-app messaging, and telephonic support from our U.S.-based care teams—so devices arrive with context, not confusion.

What kind of devices are available, and will my patients have to set up devices themselves?

We support a flexible, device-agnostic remote care ecosystem, led by our proprietary, preconfigured cellular devices designed for the fastest path to patient activation. These devices require no Wi-Fi, Bluetooth pairing, or setup and are supported through on-demand assistance for patients and care teams.

To ensure long-term interoperability, our platform also integrates with a wide range of cellular-enable ancillary devices, including connected blood pressure monitors, weight scales, blood glucose meters, spirometers, and pulse oximeters.

Have existing wearable devices? Our platform can connect with these, too. We'll work with your practice to determine the best device connections for your unique program, designed for long-term compliance with remote care.

COACHCARE

Who performs the work to monitor my patients' data in real-time? Who delivers CCM services?

We do. Unlike many competitors, CoachCare provides nationwide, multilingual registered nurses and medical assistants as a true extension of your practice. Our care teams operate with industry-leading clinician-to-patient ratios (approximately 1:165), allowing for proactive review of real-time vitals data and patient engagement guided by defined empathy standards—not volume-based call metrics.

For patients enrolled in CCM and RPM, we consistently deliver 20+ minutes of chronic care management services each month. Engagement happens across multiple channels, including phone, SMS, and secure in-app messaging, with interactions designed to be personal, continuous, and relationship-driven—not transactional.

All care activities are time-stamped and documented to align with Medicare billing requirements, ensuring the work being done clinically is fully reflected operationally and financially.

What if I have my own clinicians and I want them to run the program?

That can be a great fit—for the right organizations. If your team has the clinical bandwidth, operational maturity, and appetite for ownership, we offer a software-only option that provides access to the same platform our own clinicians rely on every day.

Just keep in mind: software doesn't enroll patients, monitor vitals, or course-correct workflows on its own. Practices that succeed with a software-only model are the ones prepared to actively manage the program—not simply turn it on and hope for results.

We are a health system, what levels of scale can you meet?

Scale is not a bolt-on feature in our model—it's the foundation. Our task-based care delivery system is designed for structured expansion, not chaos, allowing programs to grow without breaking workflows, clinical quality, or patient experience.

Because we run these programs ourselves, we bring proven best practices in enrollment, workflow efficiency, and care plan adherence—grounded in real-world execution, not theory. Our model is designed to scale across large, complex health systems by combining remote care programs in a way that supports growth without sacrificing consistency, accountability, or patient trust.

Can care plans and/or critical alerts be customized?

Yes. Care plans and alerts are configurable by population, condition, or individual patient—built on evidence-based clinical pathways.

Personalized care planning: Uses structured assessments across physical, cognitive, functional, psychosocial, mental health, and SDOH factors.

Smart alerts & escalation: Risk-based thresholds trigger timely triage and escalation when patient data requires attention—without alert fatigue.

Human oversight, always: Our care teams coordinate directly with practices to ensure appropriate follow-up when action is needed.

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How do you encourage program adoption and patient retention?

We design for reality—not wishful thinking. Programs that combine RPM and CCM consistently outperform standalone efforts, driving faster adoption and stronger long-term engagement.

Make it matter to patients: We connect vitals to real care. Patients learn quickly that recording their data leads to timely outreach, faster support, and fewer surprises—not just another reminder.

Relationships beat reminders: Patients engage longer when they build trust with a consistent health coach. Ongoing messaging and coaching calls create continuity, not churn.

Shared data, smarter conversations: Health coaches work from the same real-time vitals and condition data providers see in the EHR—so outreach is relevant, informed, and responsive.

Re-engagement when reality hits: When patients fall off (it happens), targeted email, text, and call campaigns bring them back—without starting over.

How do you measure program efficacy?

We measure what matters and make it actionable. Across RPM, CCM, and the broader care continuum, we turn tens of millions of data points into clear insights that support real clinical decision-making—not just reporting. Analytics are embedded across multiple points of care, enabling providers to track outcomes and improve performance without added operational burden.

In an independent study, patients enrolled in our care management programs experienced a 50% reduction in readmissions. In a separate study, targeted care management interventions resulted in a 100% elimination of first admissions within the observed population— underscoring the impact of early engagement, monitoring, and timely intervention. We work closely with providers to interpret results and apply insights that drive sustained improvements in patient outcomes.

Do you automatically generate claims in my EHR each month?

Yes—and accurately. Claims are generated automatically and directly within your EHR, eliminating the manual work of tracking time, codes, and documentation month after month. We handle the nuances of time-stamped data, service thresholds, and code adherence so billing reflects the care delivered—without creating additional administrative burden for your team. The result is cleaner claims, fewer surprises, and more time focused on patient care.

What ROI can my practice expect?

ROI looks different depending on your goals, but it's real. Independent research shows that 73% of hospital and health system leaders report positive returns from RPM, while 94% see improved patient outcomes, including reductions in ER visits and readmissions. Those results reflect more than reimbursement alone; they reflect better utilization, engagement, and continuity of care.

We'll also be candid: not all ROI calculators are created equal. Many rely on aggressive assumptions that don't hold up in real-world operations. We take a more disciplined approach, setting achievable expectations based on your Medicare population, workflows, and care model. Most partners see profitability in year one, with scale-driven efficiencies improving performance over time.

Practices can generate meaningful new revenue without adding FTEs or taking on upfront investment. When you're ready, we'll walk through a tailored value analysis grounded in how programs actually perform—not how they look in a spreadsheet.

Are you ready to get started?

The questions in this guide are meant to be asked early and answered honestly—by vendors, by leadership teams, and by the organizations responsible for delivering care. We hope this framework helps you evaluate what partnership truly means as care demands evolve.

If you'd like to explore how these principles translate into real-world results, we're happy to continue the conversation. **Get in touch:** sales@coachcare.com.

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