COACHCARE | 2026 STRATEGY REPORT

Heart & Vascular Center of West Tennessee

Cardiovascular Service Line Performance & Optimization

A Remote Care Service Line (TCM + RPM + CCM + PCM) as the operating spine

Purpose of this report

To give the physician and administrative leadership of Heart & Vascular Center of West Tennessee a data-grounded view of how a managed Remote Care Service Line — transitional care management, remote physiologic monitoring, chronic care management, and principal care management, delivered as one program — creates a margin-positive recurring service line for the practice, extends daily cardiovascular coverage across its five West Tennessee locations, and strengthens the practice's referral and hospital relationships.

All modeled figures in this report are illustrative, modeled — verify against practice data. Public facts are date-stamped to their source vintage (July 2026 unless noted).

Prepared by CoachCare · July 2026

Confidential — prepared for practice leadership discussion

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Executive Summary

Heart & Vascular Center of West Tennessee is an independent, physician-owned cardiovascular group headquartered in Jackson, Tennessee, serving one of the most rural cardiology catchments in the state. Six physicians — spanning interventional cardiology, electrophysiology, and structural heart — and eight advanced practice providers care for patients across five locations: the Jackson hub plus satellite clinics in Lexington, Dyersburg, McKenzie, and Ripley. The practice operates its own ACR-accredited cardiac PET/CT and nuclear imaging, a vascular lab, external counterpulsation, and a clinical trials program, and performs WATCHMAN left atrial appendage closure. It admits and performs procedures through its affiliated hospitals in Jackson and Dyersburg. (Practice website and NPPES, July 2026.)

Two facts about this practice frame the opportunity. First, **the buy-versus-build question is already answered:** the practice runs its cardiac device clinic on an outsourced remote-monitoring partnership — evidence that leadership prefers proven external infrastructure over hiring and building in-house. Second, **everything beyond the device clinic is whitespace:** the practice's public materials show no remote physiologic monitoring, no chronic care management, and no principal care management program for its heart failure and multi-chronic panel. That combination — demonstrated willingness to partner, and an unbuilt service line sitting on a heavy heart failure and interventional panel — is rare.

Geography sharpens it. Satellite clinics in McKenzie (staffed one day per week) and Ripley (one day per month) mean most patients in Carroll and Lauderdale counties have cardiology access measured in days-until-the-next-clinic-day. A remote care service line converts those gaps into covered days: connected cellular devices, 24/7 alert and triage, and nurse outreach operate every day the clinic doors are closed.

The central argument

One managed Remote Care Service Line — TCM at discharge, RPM for physiologic monitoring, CCM for the multi-chronic panel, PCM for principal-condition heart failure management — creates value two ways at once:

1. **Standalone value.** Recurring, subscription-like professional-fee revenue at top-of-license staffing. Modeled on this practice's estimated Medicare panel: $1.95M net reimbursement and $820,843 practice profit over 24 months at a 42.1% margin — margin-positive from month two, before any value-based dollar.
2. **Connective tissue.** The same enrollment, device, triage, and billing engine powers the heart failure pathway, extends daily coverage across all five sites, defends referral relationships with regional PCPs and hospital partners, and supports procedural growth in structural heart and — as coverage matures — renal denervation.

The practice currently has no mandatory model exposure — pure-upside timing, and prepared if selection maps change.

The 2026 payment environment is a tailwind: the CY2026 Medicare Physician Fee Schedule added short-window RPM codes (99445 for 2–15 days of readings; 99470 for the first 10 minutes of management), which make post-discharge and post-procedure monitoring windows billable that

previously were not. And the practice's October 2025 move to Epic — with MyChart live on a hospital partner's Epic environment — lands at exactly the right moment: CoachCare's bi-directional Epic integration lets the entire program run inside the EMR the practice just adopted, while workflows are still being formed.

2026–2027 priority recommendations

1. **Stand up the heart failure pathway first.** PCM plus RPM for the HF cohort, with guideline-directed medical therapy (GDMT) titration run as a managed production process out of the Jackson hub.
2. **Layer CCM onto the multi-chronic panel.** Hypertension, coronary disease, diabetes, and kidney disease cluster in this panel; CCM is the longitudinal wrapper for patients whose burden is broader than one principal condition.
3. **Use remote care to cover the satellite-day gaps.** Enroll McKenzie and Ripley patients on clinic days; monitor them daily between visits. Distance stops determining touch frequency.
4. **Capture TCM at every discharge.** A two-business-day contact and structured follow-up for practice patients discharged from the affiliated Jackson and Dyersburg hospitals — the front door into RPM enrollment.
5. **Deploy inside Epic from the start.** Enrollment flags, discrete vitals, documentation, and automated claim generation in the practice's new EMR environment; exact instance configuration is confirmed during contracting.
6. **Validate the panel in discovery.** The 2,250-patient Medicare panel estimate (plausible range 2,000–2,300) is derived from third-party Medicare allowed-amount data, not a chart count; a CoachCare-funded on-site enrollment specialist is included in the model at no cost to the practice.

1. Practice Footprint & Operating Model

1.1 Five locations, one hub

The practice operates a classic rural hub-and-spoke model: a full-service Jackson headquarters and four satellites reaching west and north across West Tennessee. Site cadence varies sharply — two satellites run full weekday schedules, while two are staffed one day per week or one day per month. (Practice website, July 2026.)

Location	County	Schedule	Role
Jackson (HQ) — 17 Centre Plaza Dr.	Madison	Monday–Friday	Hub: imaging, vascular lab, procedures workup, admin
Lexington — 9486 Hwy 412 W	Henderson	Monday–Friday	Full-week satellite
Dyersburg — 350 E Parkview St.	Dyer	Monday–Friday	Full-week satellite; interventional physician based on-site
McKenzie — 205 Hospital Dr.	Carroll	Mondays only	One-day-per-week satellite
Ripley — 319 Ashbury Ave.	Lauderdale	One day per month	One-day-per-month satellite

The Jackson, TN metropolitan area (Madison, Chester, Crockett, and Gibson counties) holds roughly 186,000 residents (2025 estimate), and the satellite counties are more rural still. Tennessee's Medicare Advantage penetration was approximately 53% statewide as of September 2024 — the traditional-Medicare versus MA mix of the practice's own panel is a discovery item that directly shapes program economics.

1.2 Clinical breadth

For an independent group of its size, the practice's capability set is unusually deep: interventional cardiology (cardiac catheterization and coronary intervention through its affiliated hospitals), electrophysiology including pacemaker and defibrillator management, WATCHMAN left atrial appendage closure, ACR-accredited cardiac PET/CT and nuclear imaging, a vascular laboratory, external counterpulsation for refractory angina, and an active clinical trials program. Ancillary lines in primary care, endocrinology and diabetes, and medical weight management round out the panel. (Practice website, July 2026.)

1.3 Remote care today: one program outsourced, the rest unbuilt

The practice already trusts remote infrastructure where it has adopted it: pacemaker and defibrillator patients are followed through an outsourced remote home device-monitoring partnership. That is the entire remote footprint. There is no RPM program for blood pressure, weight, or heart failure symptoms; no CCM program for the multi-chronic panel; no PCM pathway; and no TCM capture at discharge visible in the practice's public materials (July 2026). The device clinic proves the operating model works here — the service line this report describes extends the same partnership logic to the rest of the panel, with the revenue accruing to the practice.

1.4 Design principles for the service line

Principle	What it means at this practice
Longitudinal by default	Care between visits is the product: daily physiologic data and monthly clinical touches, not visit-by-visit encounters alone
Hub-and-spoke with daily digital coverage	Jackson anchors the clinical oversight; connected devices and telephonic outreach cover all five sites every day, regardless of clinic schedule
One front door	Every discharge, every referral, every satellite visit is an enrollment opportunity captured through one workflow in Epic
Digital as care, not documentation	Device readings trigger triage and titration actions — the data works, it does not just accumulate
A single scorecard	Census, capture rate, revenue per patient per month, and clinical outcomes reviewed on one dashboard by practice leadership

2. The Remote Care Service Line — The Spine

2.1 What it is: the specialty billing stack

The service line is four Medicare care-management programs run as one operation on shared infrastructure. Each has its own eligibility, cadence, and billing logic; together they cover a cardiovascular patient from hospital discharge through long-term chronic management.

Program	Who qualifies	What it delivers	Billing cadence
TCM — Transitional Care Management	Any practice patient discharged from hospital or facility	Contact within 2 business days; medication reconciliation; face-to-face visit within 7–14 days	Once per discharge (99495/99496)
RPM — Remote Physiologic Monitoring	Patients whose condition warrants device monitoring (HF, hypertension, post-procedure)	Cellular blood pressure cuff, scale, or pulse oximeter; daily readings; 24/7 alert and triage; monthly clinical management time	Monthly (99453 setup; 99454/99445 supply; 99457/99470/99458 management)
CCM — Chronic Care Management	Two or more chronic conditions expected to last 12+ months	Monthly care coordination, care plan maintenance, medication and appointment management across conditions	Monthly (99490/99439 staff; 99491/99437 physician; 99487/99489 complex)
PCM — Principal Care Management	One high-risk principal condition — heart failure is the archetype	Condition-specific monthly management: GDMT titration support, symptom surveillance, escalation	Monthly (99424–99427)

The coordination rule (one wrapper per patient)

Each enrolled patient carries **one longitudinal wrapper** per month — CCM for the multi-chronic patient, or PCM where a single principal condition (heart failure) dominates — never both in the same month. **RPM stacks with either.** TCM is captured at discharge with documented time separation from the monthly programs. The practice sets one attribution policy up front, and the billing engine enforces it — no double-billing exposure, no leakage.

2.2 Standalone value: the four value layers

1. **Direct recurring professional-fee revenue — the lead layer.** Care-management revenue behaves like a subscription: census × per-patient monthly billing, recurring every month a patient stays enrolled. On this practice's estimated panel the model reaches a steady state of approximately $110,900 in monthly net reimbursement (Section 3). Every dollar is ordinary Medicare Part B professional-fee revenue — no value-based contract required. Margin-positive before any value-based dollar.
2. **Avoided cost and referral-relationship defense.** Nationally, roughly one in five Medicare heart failure discharges is readmitted within 30 days, and hospitals carry readmission-penalty exposure on exactly the patients this practice manages. A cardiology group that demonstrably

keeps its heart failure patients out of the hospital — with data to show it — becomes structurally more valuable to its affiliated hospitals and to every referring primary care physician in a five-county radius. The model projects 52 avoided hospitalizations over 24 months (illustrative, modeled).

3. **Procedural throughput and program growth.** Remote monitoring tightens post-procedure follow-up for WATCHMAN and interventional patients, supports earlier and safer discharge patterns, and builds the documented-hypertension infrastructure that renal denervation coverage now expects (Section 5).
4. **Strategic durability.** A recurring revenue line diversifies the practice's income beyond procedural and imaging volume, strengthens physician recruiting with a modern care model, and reinforces the practice's independence — the service line is an asset the practice owns, on infrastructure a partner operates.

The CY2026 billing stack (illustrative)

Service / code	Type	~CY2026 magnitude	Notes
TCM 99495 / 99496	Per discharge	~$200 / ~$280	Moderate / high complexity; contact within 2 business days
RPM 99453	One-time setup	~$20	Device setup and patient education
RPM 99454	Monthly	~$52	Device supply, 16–30 days of readings
RPM 99445 — new for 2026	Short window	~$52	2–15 days of readings — makes short post-discharge and post-procedure windows billable
RPM 99457	Monthly	~$52	First 20 minutes of management time
RPM 99470 — new for 2026	Monthly	~$26	First 10 minutes — captures lighter-touch months
RPM 99458	Monthly	~$41	Each additional 20 minutes
PCM 99426 / 99427	Monthly	~$60 / ~$50	Clinical staff time, first 30 min / each additional 30 min
CCM 99490 / 99439	Monthly	~$60 / ~$47	Clinical staff time, first 20 min / each additional 20 min

Amounts are illustrative national non-facility magnitudes; actual payment is locality-adjusted and set by the regional Medicare Administrative Contractor for Tennessee (Palmetto GBA, Jurisdiction J). Verify against the CY2026 Physician Fee Schedule before financial planning. The Value Analysis in Section 3 applies Tennessee locality rates.

Recurring-revenue mechanics

Visit revenue must be re-earned every day; care-management revenue persists. Once a patient is enrolled, monthly billing recurs for as long as the patient benefits — the model's enrolled census ramps for roughly 21 months and then sustains. The practice adds no staff: CoachCare provides telephonic enrollment, an on-site enrollment specialist, health coaching, cellular devices, 24/7 monitoring, and automated claim generation as part of the program.

2.3 Connective tissue: one engine, every lever

The deeper argument for building the service line as one program — rather than a code-by-code experiment — is that a single shared engine (enrollment, cellular devices, alert and triage, nurse navigation, titration support, billing capture, analytics) powers every strategic lever the practice cares about at once.

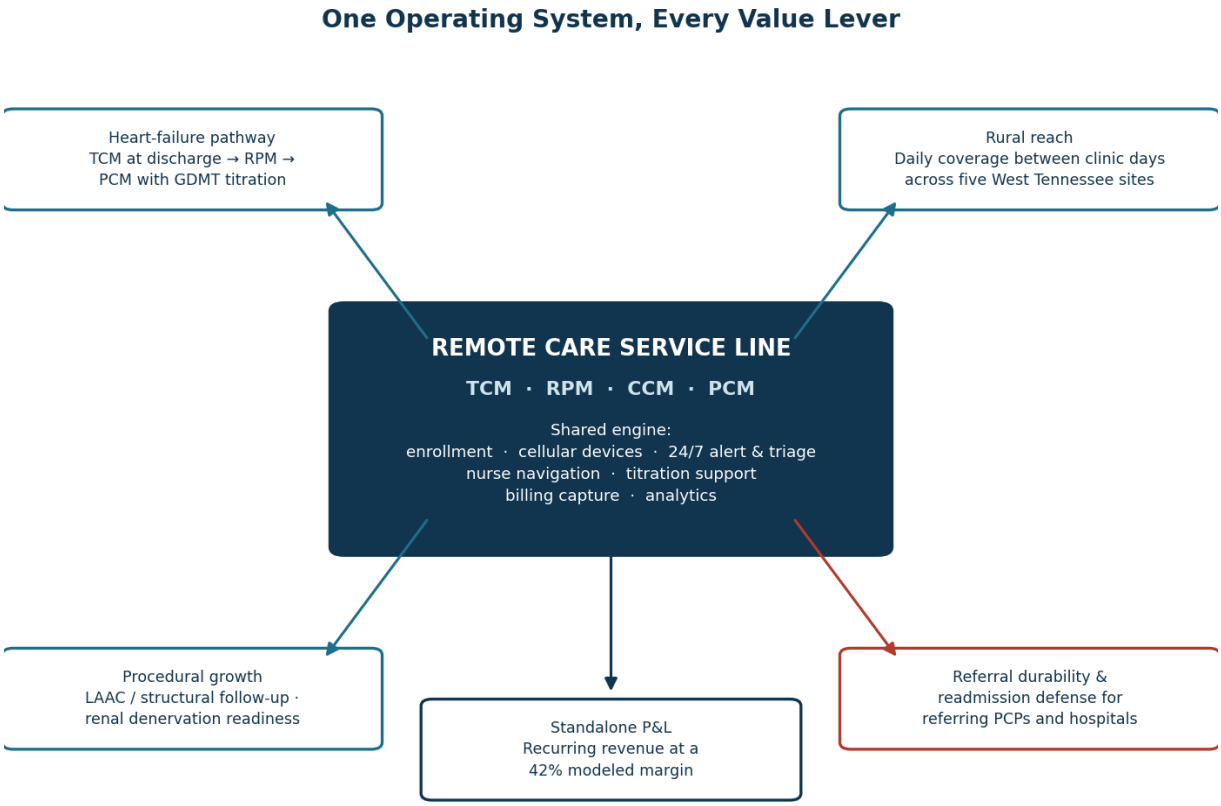

Figure 1. *One shared remote-care engine powers the heart failure pathway, rural reach, procedural growth, referral durability, and a standalone P&L.*

Strategic lever	What the shared engine contributes
Heart failure pathway	TCM at discharge → RPM (daily weight/BP) → PCM with GDMT titration; 24/7 triage intercepts decompensation between visits
Rural reach across five sites	McKenzie and Ripley patients are monitored daily between clinic days; satellite cadence stops limiting care frequency

Strategic lever	What the shared engine contributes
Procedural growth	Post-WATCHMAN and post-intervention monitoring windows (now billable via 99445); documented-hypertension registry feeds renal denervation evaluation
Referral durability & readmission defense	Referring PCPs and affiliated hospitals see documented between-visit management and fewer avoidable admissions
Device-clinic synergy	The practice already operates one remote pathway; enrollment conversations, patient expectations, and workflows extend naturally
Standalone P&L	Every lever above rides on infrastructure that pays for itself — 42.1% modeled practice margin (Section 3)

3. Standalone Economics: The 2026 Value Analysis

CoachCare's Value Analysis models the service line on this practice's estimated Medicare panel, using Tennessee locality reimbursement rates, program-specific eligibility and conversion assumptions, and CoachCare's full-service delivery model. **All figures in this section are illustrative, modeled — verify against practice data.**

3.1 Model inputs and the panel estimate

Input	Value	Basis
Medicare panel	2,250 patients (range 2,000–2,300)	Estimate: ~$2.94M annual practice Medicare allowed amount (third-party claims data) ÷ $1,300 per beneficiary-year, a cardiology-calibrated divisor. Not a chart count — validate in discovery
Programs modeled	RPM + CCM + PCM (+ TCM workflow)	Cardiology specialty configuration
Eligibility	RPM 60% · CCM 70% · PCM 70%	Cardiology panel benchmarks
Conversion of eligible	RPM 30% · CCM 25% · PCM 25%	CoachCare program benchmarks
Enrollment engine	1 on-site enrollment specialist (~80 enrollments/month) + telephonic enrollment	Staffed and funded by CoachCare — embedded value, not a practice expense
Reimbursement locality	Tennessee (Palmetto GBA)	Locality-adjusted rates in the model
Program pricing	18% multi-program discount off CoachCare's fee schedule	Tennessee reimbursement-locality precedent; lifts practice margin from ~29.9% at list to 42.1%
Providers	14 (6 physicians + 8 APPs)	Practice website, July 2026

About the panel estimate

The 2,250-patient figure is an estimate derived from the practice's Medicare allowed-amount profile, not from its charts. The plausible range is 2,000–2,300. Discovery should validate three things: the actual active Medicare panel, the traditional-Medicare versus Medicare Advantage mix, and the heart failure cohort size. Economics scale approximately linearly with the validated panel.

3.2 Headline results

	Year 1	Year 2	24-month total
Net reimbursement to practice	$670,760	$1,277,347	**$1,948,108**
CoachCare program fees	$397,561	$729,703	$1,127,264
Practice profit	$273,199	$547,644	**$820,843**
Practice margin (profit ÷ net reimbursement)			**42.1%**

Program (24-month)	Net reimbursement	Practice profit
RPM	$708,494	$284,913
CCM	$773,865	$369,306
PCM	$465,749	$209,136

Month 1 is modeled at −$5,134 as one-time implementation and EMR-integration fees land; the program is **margin-positive from month two** (+$3,941) and reaches **cumulative breakeven in month three**. At saturation the service line sustains approximately $110,900 in monthly net reimbursement and $47,700 in monthly practice profit.

3.3 Ramp, ceilings, and monthly economics

Enrollment ramps program by program. Each program's census ceiling is panel × eligibility × conversion: RPM 405 patients (binds around month 10), CCM ~394 (around month 11), and PCM ~394 (around month 21, on a slower ramp). Total concurrent program enrollments reach approximately 1,193 by month 21 — program enrollments, not unique patients, since RPM stacks with CCM or PCM for many patients.

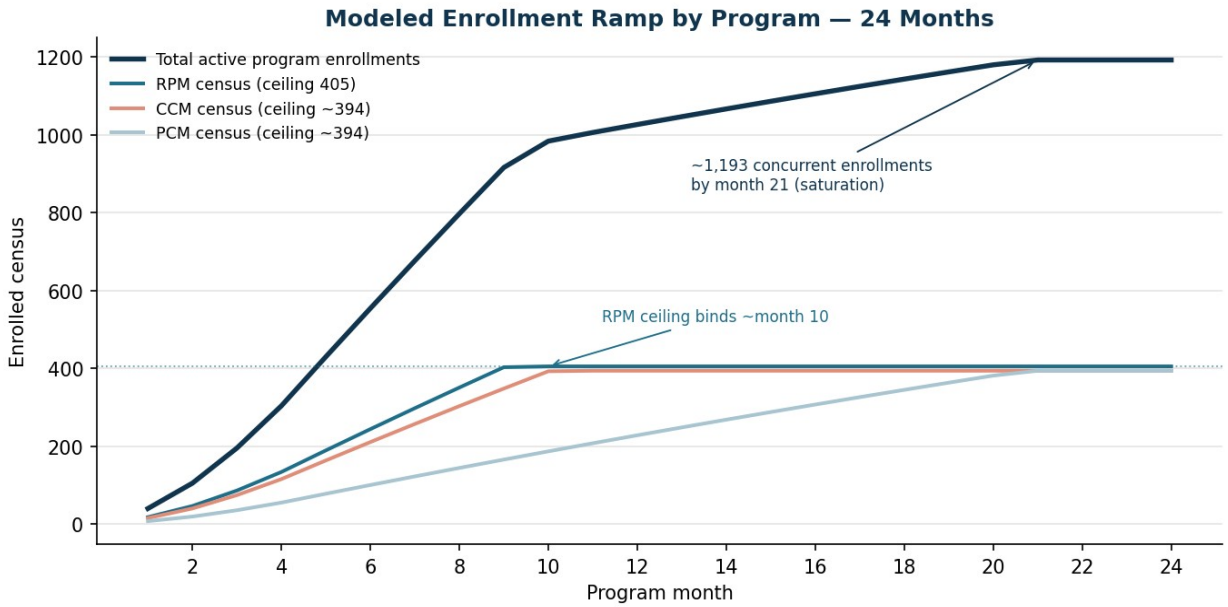

Figure 2. *Modeled enrollment ramp by program over 24 months. Illustrative, modeled — verify against practice data.*

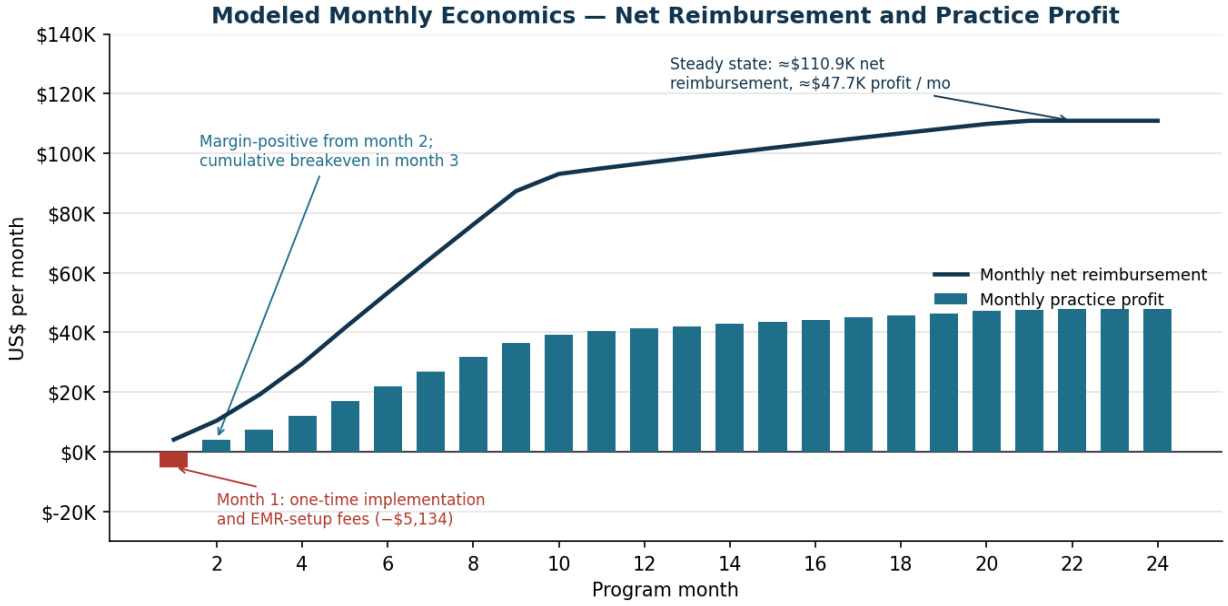

Figure 3. *Modeled monthly net reimbursement and practice profit. Month 1 reflects one-time setup fees; margin-positive from month two. Illustrative, modeled.*

3.4 Clinical and operational value

The same census that generates the P&L generates clinical work product and staff leverage — CoachCare's care staff absorb the monitoring and outreach load that would otherwise fall on practice nurses and APPs.

Measure (modeled)	Year 1	24 months
Billable claims / units generated	13,470	38,432

Measure (modeled)	Year 1	24 months
Physiologic readings captured	31,306	82,336
Hospitalizations avoided	19.9	52.3
Care-staff hours absorbed by CoachCare	6,345	19,016
FTE-equivalent staffing leverage	3.05	9.14

Hospitalizations-avoided and hours-saved figures are modeled from program benchmarks applied to this census — illustrative, modeled; verify against practice data.

4. Powering the Heart Failure Pathway

4.1 Why heart failure is the wedge

Heart failure is where an interventional- and EP-heavy panel concentrates its risk: it is the highest-readmission chronic cardiovascular condition, the costliest to hospital partners, and the condition where between-visit management most directly changes outcomes. Nationally, roughly one in five Medicare heart failure discharges returns to the hospital within 30 days, at a mean cost per readmission in the low five figures (AHRQ/HCUP national statistics) — and hospital readmission-penalty programs keep that exposure permanently on the agenda of the hospitals this practice admits to. A cardiology group that runs a visible, data-producing heart failure management pathway is the partner every hospital and every referring PCP in the region wants.

4.2 GDMT titration as a production process

The clinical core of the pathway is guideline-directed medical therapy run as a managed process rather than an intention. National registry data show how large the gap is — in the CHAMP-HF registry, only about 1% of eligible heart failure patients were receiving target doses of all three then-recommended therapy classes. Titration fails for operational reasons: no blood pressure and weight data between visits, no one watching for the window when a dose step is safe, and quarterly visit cadence that turns a four-step titration into a two-year project.

The service line industrializes it:

- **Daily physiologic surveillance.** Cellular scale and blood pressure cuff transmit daily; weight-gain and hypotension alerts route to 24/7 triage.
- **Protocolized titration support.** Standing-order titration ladders let CoachCare's clinical staff surface every safe up-titration opportunity to the supervising provider, visit or no visit.
- **Monthly PCM management.** A dedicated monthly clinical touch for the principal condition — symptoms, adherence, labs due, escalation — documented and billed.
- **TCM at every discharge.** Contact within two business days of discharge from the affiliated Jackson or Dyersburg hospitals, medication reconciliation, and a scheduled follow-up — then straight into RPM enrollment while the readmission window is still open.

4.3 The satellite-coverage effect

The pathway matters most where the practice is present least. A heart failure patient in Ripley sees cardiology one day per month; a McKenzie patient, one day per week. Under the service line, those patients transmit weight and blood pressure every day, and a decompensation signal on a Tuesday in Ripley gets a same-day nurse call and a titration or diuretic adjustment decision — not a three-week wait or an emergency department default. For referring primary care physicians in Henderson, Carroll, Dyer, and Lauderdale counties, that between-visit coverage is a concrete, differentiating reason to keep referrals with this practice.

What the hospital partners see

Fewer avoidable heart failure returns (52 modeled avoided hospitalizations over 24 months), documented post-discharge contact on every practice patient, and a cardiology group whose management footprint extends into the home. The practice becomes easier to admit with, easier to discharge to, and harder to replace.

5. Powering Procedural Growth: Structural Heart & Renal Denervation

5.1 Structural heart: tighter follow-up, stronger program

The practice's WATCHMAN left atrial appendage closure program is a genuine differentiator for an independent group. Remote monitoring strengthens it at both ends: pre-procedure, enrolled patients arrive with months of physiologic history and managed comorbidities; post-procedure, the new 2026 short-window RPM code (99445) makes the first days after implant billable monitoring — vitals surveillance during anticoagulation transitions, early symptom capture, and structured follow-up that supports confident discharge patterns. The same logic covers post-intervention patients across the cath-lab caseload.

5.2 Renal denervation: policy-aligned whitespace

Medicare established national coverage for renal denervation in uncontrolled hypertension effective October 28, 2025 (NCD 20.40), under Coverage with Evidence Development, with two FDA-approved device systems on the market. The practice does not currently advertise a renal denervation program (July 2026) — which makes the timing useful rather than late: the procedure's coverage pathway is built on exactly what an RPM program produces.

- **Candidate identification.** A blood-pressure RPM cohort is a living registry of patients with documented uncontrolled hypertension despite medication management — the eligibility substrate for referral or future program development.
- **Evidence requirements.** Coverage with Evidence Development expects structured longitudinal blood pressure data; an RPM program generates it as a byproduct.
- **Either path wins.** Whether the practice ultimately builds a renal denervation service with its hospital partners or refers candidates out, the hypertension monitoring cohort creates the option — and bills on its own in the meantime.

The strategic point is symmetry with the device clinic: the practice has already shown it will adopt the right delivery partner when a clinical program requires always-on infrastructure. Hypertension and heart failure monitoring are the same decision with a larger panel and a revenue line attached.

6. Epic Integration: The Program Lives in the EMR

The practice transitioned to Epic in October 2025 — MyChart went live for patients on October 3, 2025, hosted on a hospital partner's Epic environment, replacing the legacy FollowMyHealth portal (practice website, July 2026). The exact instance arrangement and integration pathway are confirmed during contracting, but the vendor fact is what matters: **CoachCare maintains a direct, bi-directional Epic integration**, so the entire service line runs inside the system the practice's staff are learning right now — no parallel portal, no swivel-chair workflow.

6.1 Five integration pillars

Pillar	What it does
Integrated enrollment	Enrollment flags and trigger ordering inside the clinical workflow; CoachCare enrolls qualified Medicare patients on the practice's behalf; status visible in Epic in real time
Health-history exchange	Bi-directional exchange at intake — no re-keying of problem lists or medications
Discrete vitals	Device readings land as discrete vitals in the chart, not PDF attachments — trendable, chartable, actionable
Compliance documentation	Audit-ready care summaries and time documentation in the record
Automated claim generation	The CoachCare billing engine creates claims automatically — no manual claim step per patient per month

Patients begin receiving CCM and RPM services in under five days from the enrollment flag, and CoachCare is the only care-management platform integrated with Epic that provides automated claims creation — the difference between a program the billing office tolerates and one it never has to think about.

Why the timing is favorable

An EMR transition is when workflows are rewritten. Adding remote-care enrollment flags, standing orders, and vitals flowsheets while the Epic build is young means the service line becomes part of how the practice uses Epic — not a retrofit onto established habits. The October 2025 go-live makes 2026 the natural program-launch window.

“Key to achieving a program that is efficient, effective and sustainable, is creating a seamless, intuitive user experience for the patient and provider, and that's what our integration with Epic accomplishes.”

7. Operating System & KPI Scorecard

A service line earns permanence by being managed like one. CoachCare's analytics feed a single monthly scorecard for practice leadership; the recommended structure blends clinical, operational, and financial measures.

Domain	Key measures	Cadence
Remote care service line	Enrolled census by program · time-to-first-billable-enrollment · billing capture rate · revenue per patient per month	Monthly
Heart failure pathway	HF cohort enrolled % · GDMT titration steps completed · alert response time · 30-day post-discharge contact rate	Monthly
Rural reach	Satellite-county enrollment share · covered days between clinic days · device adherence (days transmitting)	Monthly
Referral & partner health	TCM capture rate on affiliated-hospital discharges · referral volume by county · PCP-facing reporting sent	Quarterly
Financial	Net reimbursement vs. model · practice profit vs. model · panel validation progress vs. 2,000–2,300 range	Monthly

Two disciplines matter most in the first two quarters: **time-to-first-billable-enrollment** (the model assumes enrollment begins in month one — every week of drift moves the breakeven month) and **capture rate** (enrolled patients whose monthly services are actually documented and billed — the difference between modeled and realized revenue).

8. Implementation Playbook & 12-Month Roadmap

8.1 Scope and target populations

Cohort	Program assignment	Entry point
Heart failure patients	PCM + RPM (daily weight/BP)	HF registry pull in Epic; discharge follow-up; clinic visits
Multi-chronic patients (HTN + CAD, diabetes, kidney disease)	CCM (+ RPM where monitoring is indicated)	Panel query; satellite clinic days; annual visits
Uncontrolled hypertension	RPM (BP cuff)	Clinic BP readings; medication-change visits; renal denervation evaluation funnel
Every hospital discharge	TCM, then program enrollment	Discharge feeds from affiliated hospitals
Post-procedure (WATCHMAN, interventional)	Short-window RPM (99445), then longitudinal programs as indicated	Procedure scheduling workflow

8.2 Who does what

- **CoachCare provides:** telephonic enrollment plus one on-site enrollment specialist (~80 enrollments/month, CoachCare-funded), cellular connected devices shipped and provisioned, 24/7 monitoring and alert triage, dedicated health coaches, GDMT titration support under practice protocols, Epic integration, automated claim generation, and program analytics.
- **The practice provides:** supervising providers and standing orders (general-supervision model), the clinical escalation pathway, cohort sign-off, and a monthly leadership review. No new practice hires are required.

8.3 Twelve-month roadmap

Phase	Milestones	Model checkpoints
Months 0–1 · Foundation	Contracting; Epic integration configuration; standing orders and titration protocols; HF and multi-chronic registry pulls; enrollment specialist onboarded	One-time setup fees land in month 1 (modeled −$5,134)
Months 2–3 · HF first	HF cohort enrollment (PCM + RPM); TCM workflow live on Jackson-hospital discharges; first titration cycles	Margin-positive month 2; cumulative breakeven month 3
Months 4–6 · Broaden	CCM enrollment across the multi-chronic panel; Lexington and Dyersburg satellites fully integrated; Dyersburg-hospital TCM feed	~554 active enrollments by month 6
Months 7–9 · Rural reach	McKenzie and Ripley enrollment on clinic days; between-visit coverage running in all five counties; first PCP-facing outcome reports	~916 active enrollments by month 9

Phase	Milestones	Model checkpoints
Months 10–12 · Saturate & review	RPM census reaches ceiling (~month 10), CCM (~month 11); PCM continues ramping into Year 2; Year-1 review against scorecard	~$96,700 net reimbursement in month 12; Year-1 profit $273,199

8.4 Expected impact

On the modeled panel, Year 1 delivers $670,760 in net reimbursement and $273,199 in practice profit; the 24-month view reaches $1,948,108 and $820,843 at a 42.1% margin, alongside 52 modeled avoided hospitalizations and roughly 19,000 care-staff hours absorbed by CoachCare's clinical operation. Beyond the P&L, the practice exits Year 1 with a running heart failure pathway, daily coverage in its most remote counties, tighter hospital and referral relationships, and a documented-hypertension cohort feeding its procedural future. **All figures are illustrative, modeled — verify against practice data.**

Immediate next steps

1. Discovery working session: validate the Medicare panel (2,000–2,300 range), the traditional-Medicare/MA mix, and the HF cohort size.
2. Epic integration scoping: confirm the instance arrangement and integration pathway with the practice's IT and hospital-partner contacts.
3. Clinical protocol review: titration ladders, alert thresholds, and escalation pathways with the physician leadership.
4. Contract and launch: month-one foundation phase begins on signature; first enrollments within the first program month.

References & Data Sources

- Heart & Vascular Center of West Tennessee website — home, services, providers, about, contact, and patient-portal pages (heartvascular.net; fetched July 2026).
- NPPES NPI Registry — organizational and provider records for the practice's entities and physicians (npiregistry.cms.hhs.gov; queried July 2026).
- CMS CY2026 Medicare Physician Fee Schedule — care-management and remote-monitoring code values (illustrative national non-facility magnitudes; Tennessee locality rates set by Palmetto GBA, Jurisdiction J).
- CMS National Coverage Determination 20.40 — Renal Denervation for Uncontrolled Hypertension, effective October 28, 2025 (Coverage with Evidence Development).
- Third-party Medicare allowed-amount data (Definitive Healthcare) — basis of the panel estimate (~$2.94M annual Medicare allowed; accessed July 2026).
- Jackson, TN metropolitan area population estimate (~186,000, 2025) — U.S. Census-based compilations.
- Tennessee Medicare Advantage penetration (~53% of Medicare beneficiaries, September 2024) — healthinsurance.org compilation of CMS enrollment data.
- National 30-day heart failure readmission and cost statistics — CMS readmission measures and AHRQ Healthcare Cost and Utilization Project (HCUP).
- CHAMP-HF registry — GDMT utilization and target-dose rates (Journal of the American College of Cardiology, 2018).
- CoachCare platform statistics — 500,000+ patients managed across 400+ conditions; 10,000+ providers; 1,000+ implementations; 5M+ claims generated; 100M+ vitals recorded (coachcare.com, 2026).
- CoachCare Value Analysis workbook for Heart & Vascular Center of West Tennessee (July 2026) — all modeled economics in Section 3.

Global caveat

This report combines public information (date-stamped to its source vintage) with modeled program economics. All modeled figures are illustrative, modeled — verify against practice data. Reimbursement values are locality-adjusted estimates — verify against the CY2026 Physician Fee Schedule and the practice's Medicare Administrative Contractor. Panel size, payer mix, and cohort sizes are estimates to be validated in discovery. Nothing in this report is billing, coding, legal, or clinical advice.