CASE STUDY

Moving the Needle on Chronic Care Coordination

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OBJECTIVES

A Clinically Integrated Network (CIN) with multiple value-based contracts sought to:

1. Understand resource utilization in order to provide services in the most cost-effective setting of care possible, and
2. To proactively manage illness to avoid hospital admissions.

CHALLENGES

- **240+ Physicians Using Multiple EHRs**
- **No Single Source of Truth for Data**
- **Inability to Close Care Gaps**
- **High Non-Emergent ED Utilization**
- **Few Patients with a PCP Relationship**

SOLUTION

Using HealthEC's CareConnect care coordination and risk stratification model that weighs patient health based on diagnosis, co-morbidities, demographics, and health expenditures, the CIN targeted high-risk and rising-risk patients who warrant closer medical attention. The CIN took advantage of CareConnect's powerful analytics to identify and rectify gaps in evidence-based care such as specialist consults for disease management, laboratory monitoring, and delayed follow-up appointments. The CIN has successfully optimized the utilization of limited resources to manage diabetic and other patient populations while meeting operational and cost targets.

BENEFITS

Utilize high-quality, cost-effective lab services that provide standardized, timely lab result data.

Reduce high-cost and out-of-network lab costs for patients.

CIN Deployed HeathEC's CareConnect Data Analytics Tool

Target high and rising-risk patient populations for disease management through effective laboratory testing and annual wellness exams.

Actively manage patients with chronic conditions with care management tools, patient engagement apps, and automatic care gap closures.

RESULTS

$4.8 Million in Total Savings

15% Decrease in Inpatient Utilization

$1600 PMPM Decreased Spending by High ED Utilization Patients

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