

Increasing Visibility and Productivity for Health Partner Team

MissionPoint Health Partners, 4-Hospital System, Nashville, TN

- **About:** Founded in late 2011 in Nashville, Tenn., MissionPoint Health Partners is comprised of four hospitals and 100+ outpatient locations with 1,400 clinically-integrated physicians.
- **Challenges:** To scale care management and enable rapid growth of its at-risk population, MissionPoint needed to create an effective, efficient, and technology-powered program that achieved their goals for reducing cost and improving quality of patient care, while maximizing the size of the caseload each care manager could influence.
- Lack of ready access to recent patient information—about utilization, clinical factors and psychosocial status—was a major barrier both to managing patient health effectively and to building an efficient program.
- **Solution:** By combining the capabilities of Crimson Population Risk Management and Crimson Care Management, the Health Partners are able to make efficient and accurate treatment decisions in the moment, thereby increasing their productivity and patient load.
- **Impact:** Quadrupled the load of patients per care manager.

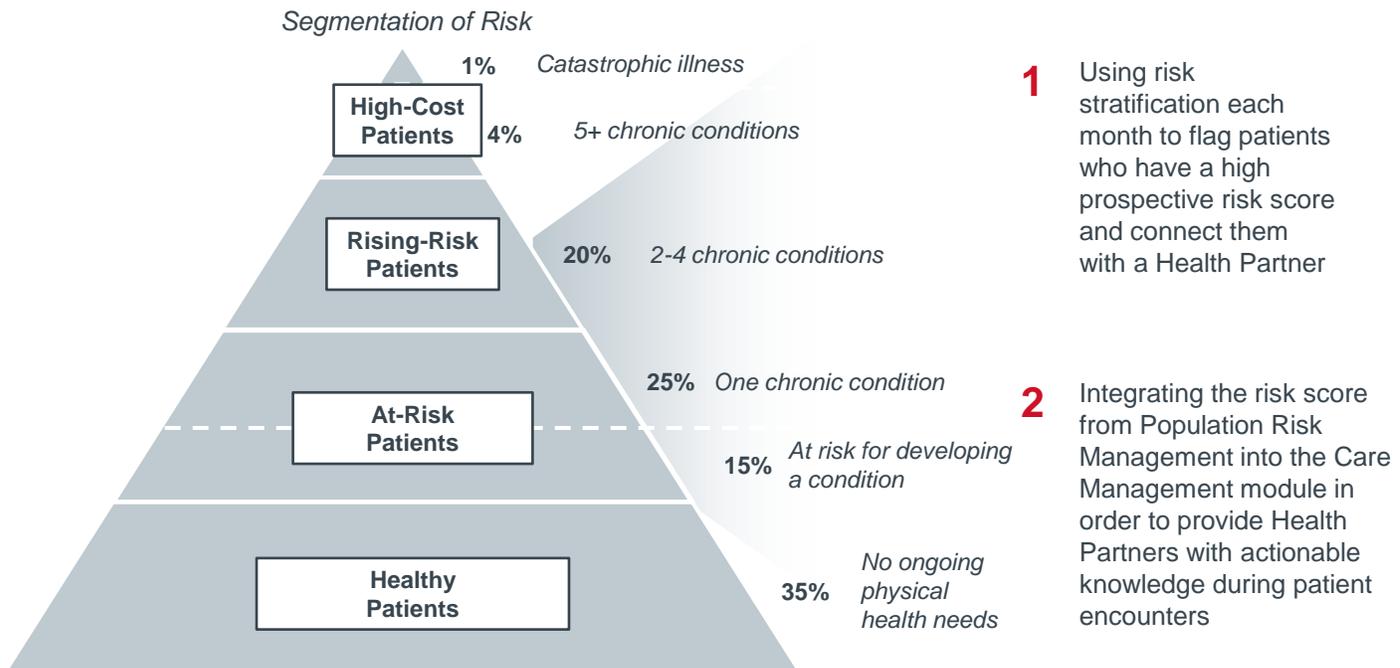


Impact Highlight

400%

Increase in patients managed per care manager

Using Crimson to Identify Rising-Risk Patients and Provide Risk Scores in the Moment



Using Crimson to Provide Comprehensive Visibility Across the Continuum



- 1 Crimson Care Management immediately captures and notifies Health Partners whenever a patient visits the ER or a Hospital within network



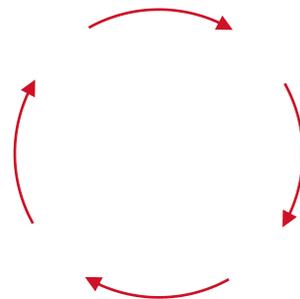
- 2 Once flagged, either the ambulatory team or transition team can follow up with the patient and ensure appropriate next steps for care will occur



- 4 At the end of each month, the MissionPoint team uses Crimson Population Risk Management to identify who received care outside of the network and connects these patients with a Health Partner



- 3 However, if a patient goes out of network, the Health Partner team is not aware and cannot follow up with the patient



Increasing Overall Reach of Health Partner Yields Significant Quality Gains

Health Partner Process Improvements



- ✓ Workflow enables efficient interactions between patients and Health Partners



- ✓ Efficient interactions allow for an increased capacity for Health Partners to engage new patients



- ✓ Health Partners using risk stratification on a monthly basis to identify new patients



Impact Highlights

37%

Reduction in 30 day readmissions

14%

Reduction in ED visits per 1,000

12.2%

Reduction in overall cost of care

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