Continuum Provider Enablement Case Study*

Cost of Care Strategy Increases Provider Revenue by 5—10%

- Delivered **17%** Lower Cost of Care
- Reduced Inpatient Admissions by **18.8%**
- Achieved **90th** Percentile of Care Quality
- Increased Ambulatory Footprint by **8-9%**

- Reduced Hospital 30-Day Readmissions to **12%**
  (National Industry Average is **18%**)  
- Reduced Emergency Department Visits by **3.2%**
- Increased Generic Drug Dispensing to Medicare Patients by **11.3%**
- Increased Provider Revenue by **5-10%** Through Value-Based Rewards

**The Challenge**

A group of internal medicine and family medicine participated in a shared savings program with a commercial payer. The population consisted of adults over the age of 18. The goal of the program was to improve quality based on specific HEDIS Metrics, improve patient satisfaction and reduce the overall cost of care. The initiative required that all practices make a commitment to becoming a NCQA recognized Patient Centered Medical Home (PCMH) within two years.

**Keys to Success**

The program utilized a centralized and scalable model of care coordination that included the services of RN's, a social worker, a pharmacist and support staff. The program was affordable to practices of every size because of this centralized approach, and the care coordination was responsive to individual practices and patients. The interactions with patients ranged from telephone communication to, "Super Visits." A Super Visit is used for patients with the greatest needs who benefit from bringing the entire care team, patient and family together to manage an individual's specific healthcare needs.

* Outlier Product Mix Adjusted Global Cost of Care vs. Peers. Results from 24-month period

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