CASE STUDY

Converging Health
Saving Money Improving Lives

How a Hospital Serving a High-Risk Medicaid Population Reduced Costs by $14 Million in Year One

THE CHALLENGE

A safety-net hospital system operates primary care clinics serving a Medicaid Managed Care population in Queens, New York. Like most safety-net systems, they faced a high-risk population with complex needs, care delivery workflows built around reactive appointments, and a capitation model that tied financial performance to total cost of care outcomes.

A core problem was that appointment slots filled on a first-call basis, with no mechanism to prioritize patients by risk. The result was a schedule that looked full but left the highest-risk members without timely access to their primary care team. Many were first seen in the emergency department.

The hospital system engaged Converging Health to implement an Advanced Primary Care model, with Whole Person Risk Score™ (WPRS) as the foundation for transforming how the system identified, scheduled, and cared for its highest-risk members.

STARTING POINT

37,318	$5,102	671
members served	per member per year	ED visits per 1,000 people

THE APPROACH

Converging Health deployed WPRS across the hospital's patient population, integrating risk data directly into the EPIC electronic health record system. WPRS stratifies risk across three dimensions: absolute clinical risk, care quality risk, and engagement and activation risk. The result is monthly risk intelligence that identifies which patients are most likely to become high-cost without proactive engagement.

That intelligence drove a fundamental change to how clinicians filled their schedules. Rather than random appointment access, each clinician reserved one to two slots per day for high-value visits with their highest-risk patients. These were extended, whole-person focused encounters (Advanced Primary Care) designed to build trust, close care gaps, address social determinants, and establish a care plan the patient would actually follow.

The hospital also restructured care teams, pairing medical assistants and care navigators with individual clinicians. Pre-visit preparation and post-visit follow-up became standard practice, increasing adherence and reducing the likelihood that a high-value visit would be a one-time event rather than the start of an ongoing relationship.

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THE RESULTS

Cost reductions and utilization declines began within three months of implementation, well ahead of the 12 to 18 month timeline the team had anticipated.

TOTAL SAVINGS	PMPY COST REDUCTION	ED UTILIZATION
$14 Million	$5,102 → $4,749	15% Reduction
Total cost savings across a population of 37,318	A 6.8% reduction from March 2023 to March 2024	ED visits dropped from 671 to 571 per 1,000 people

The speed of results points to a few specific factors:

- Risk stratification changed the composition of the schedule before anything else changed. Getting the right patients in front of clinicians is a prerequisite for everything downstream. WPRS provided ranked, actionable intelligence that clinical teams could act on immediately.
- High-value *Advanced Primary Care* visits changed the nature of the encounter. Extended time with a high-risk patient, structured around the whole person rather than a presenting complaint, produced the trust and care plan adherence that brief reactive appointments rarely achieve.
- Team-based care distributed the work. With navigators handling pre-visit preparation and post-visit follow-up, clinicians could focus on the clinical encounter itself. No-show rates dropped. Wait times improved.

Within three months of implementation, the utilization numbers were already heading in the right direction. The combination of risk stratification and high value visits changed how the teams thought about the patient outreach and scheduling priorities.

HOW IT WORKS

1. IDENTIFY	2. ACTIVATE	3. MEASURE
WPRS™	**Clinician Activation**	**WPRS™ Reporting**
Stratify the population. Flag rising-risk members before costly events appear in claims.	Primary care clinicians provide outreach, care coordination, benefits navigation, and accountability.	Track risk migration, cost trends, and care gap closure with reporting built for governance.

THE BOTTOM LINE

Identifying risk and acting on it is what changes outcomes and reduces costs. By embedding WPRS into daily workflows and prioritizing high-risk patients for proactive care, the hospital system achieved rapid, measurable improvements in cost and utilization.

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