



Case Study

Executive Summary

The client is a value based healthcare delivery organization serving a high-risk Medicare Advantage population who partnered with Stability Health to address one of its most persistent cost and quality challenges: patients with poorly controlled diabetes and multiple cardiometabolic comorbidities. Despite mature value-based infrastructure, this complex population was driving disproportionate hospital utilization and financial risk.

Stability Health was white labeled and embedded in existing workflows to extend primary care capabilities with a virtual, technology-enabled system that combined culturally aligned health coaching, diabetes education, nutrition support, and specialist oversight. Powered by a proprietary platform, Stability Health created personalized care plans for patients and supported PCPs with real-time, evidence-based clinical recommendations—between office visits, where most care gaps occur.

The impact was rapid and durable. Within months, enrolled patients experienced meaningful improvements in glycemic control and engagement. Over time, hospital admissions fell dramatically: patients enrolled for more than six months had nearly 60% fewer admissions than comparable non-enrolled patients. For the client, this translated into a strong financial return, with one hospital admission avoided annually for every two patients enrolled for six months or longer.

Background

The client is an independent primary care medical practice that was created to serve the senior Hispanic population in the area and was an early adopter of creating a value-based care physician culture. They had invested in many operational processes to support their practices to succeed in value-based care: workflows to accurately represent the health status of their population to ensure adequate revenue capture; smaller panels of 450-500 patients; and enhanced access to ensure patients were seen at least every quarter. They even provided transportation to patients for visits to remove barriers to care.

As the world emerged from the Covid 19 pandemic, the leaders were focused on medical utilization in their patient population. Diabetes stood out as a primary driver of excess medical cost. However, there was a segment of the diabetes population that had even higher cost: those whose control was sub-optimal and who had other co-morbidities, primarily other cardiometabolic conditions. The client noted that this population was 125% MLR on value-based contracts, largely due to excess hospital utilization.

Furthermore, this was also the population frontline clinicians (MD/DO and Advanced Practice Clinicians, collectively “PCPs”) felt needed additional resources for education to better self-manage their condition. The leadership also saw that there was variation in the comfort level of PCPs to manage complex chronic disease and adhere to current best practice guidelines. They decided to look for a solution to better manage their most challenging full risk Medicare Advantage patients with diabetes. After evaluating several companies, they chose Stability Health because of its unique system of care that supports both patients and frontline clinicians.

The Stability Health Intervention

Stability Health provides an integrated set of technology enabled services to primary care practices to support an advanced system of care for the high cost, high need segment of their diabetes population. Stability Health’s clinical team consists of health coaches, Registered Dietitians (RD), Certified Diabetes Education and Care Specialists (CDCES), and Diabetologists. They operate as an extension of the primary care practice and were white labeled as such.

Once enrolled in the program, patients are paired with a human coach using whatever technology a patient finds most easy for them: phone, video chat, e-mail, or text. Stability Health provides health coaches matched to the culture and language of each patient. Coaches use motivational interviewing to assess readiness for change and help patients set SMART goals for what matters most to them. Patients also have access to Registered Dietitians and Certified Diabetes Education and Care Specialists (CDCES) when their coach identifies the need for more complex support.

Stability Health was rolled out to all of the client’s practices sequentially in three waves over two months. Implementation of practices was face to face to facilitate relationship building between the client and Stability Health teams. Patients who engaged with coaches started to have improvement of glucose control almost immediately. Patients remarked that they felt heard and appreciated the support from working with a coach.

Patient Vignette: The Power of Support for Lifestyle Changes

Rosario is a 74-year-old woman with uncontrolled diabetes who had been reluctant to take new medications her PCP recommended. She worked with the Stability Health team to make healthier food choices while still enjoying pizza and learned how to adapt her medications when she practiced religious fasts. She started to exercise and her diabetes control improved without the addition of medications. When she went on a trip to visit family and gained weight, she found that with the support from her coach, she was motivated to easily resume her healthy routines.

The tight connection between the client and Stability Health is driven by Stability Health’s proprietary platform that facilitates the incorporation of data from the client’s electronic health record, and patients’ devices: glucometers, continuous glucose monitors, or insulin pumps. Data is homogenized into a registry and ingested by a rules engine that proactively identifies patients for enrollment and re-engagement. The data is also used to generate

personalized care plans for patients and for their PCPs. Care plans for patients emphasize lifestyle goals. Care plans for physicians emphasize evidence-based standards of care for Diabetes and recommend patient specific tactical changes to improve diabetes control and outcomes. Monitoring by Stability Health's platform alerts the Stability Health team when more timely action is needed. Stability Health communicates with client PCPs through their existing workflows by connecting into their electronic health record with recommended actions to avoid adverse events that could lead patients to an ED or hospital admission.

Patient Vignette: Supporting PCPs and their patients

Maria is a 72-year-old woman with uncontrolled diabetes and multiple cardiometabolic comorbidities including heart disease, chronic kidney disease, metabolic liver disease. She was experiencing both high and low blood sugar readings. The Stability Health team recommended to her PCP several medication changes to help stabilize her diabetes. At the same time, her coach worked with her to make incremental changes in what she ate and also helped her incorporate more walking into her weekly routines. As a result, she lost 21 lbs. and her A1C decreased from over 9% to less than 7%. Her PCP also received guidance to gradually reduce medications as Maria's diabetes improved to avoid over correction of her blood sugar.

As part of Stability Health's ongoing collaboration, the team periodically meets in person with practices. The strategy for physician engagement is similar to "academic detailing" with one-to-one discussion of cases for learning and relationship building. Stability Health also provided noontime "Lunch and Learn" sessions on various topics related to diabetes such as use of insulin, use of new GLP-1RA and SGLT-2i medications, hypoglycemia, and cardiovascular risk reduction.

Vignette: A virtual visit to client Practice

The Stability Health team met virtually with two PCPs for 30 minutes before morning appointments. We reviewed a small roster of shared patients together.

The conversation started with a win: a patient who had struggled over the past year was now doing well, with diabetes under good control. We then shifted to a more complex case—a gentleman with highly variable blood sugars and significant insulin resistance. The discussion focused on adherence challenges with long-acting insulin and the pros and cons of sliding-scale versus basal-bolus regimens. Stability Health agreed to follow up with specific basal-bolus dosing recommendations.

Before signing off, one PCP requested enrollment of another patient who was struggling with medication adherence, reflecting the practical, in-the-moment collaboration of the visit.

Results:

Total population enrolled = 3130; 44% male, 56% female; 80% over 65. At any one time, Stability Health actively served approximately 30-40% of the eligible population.

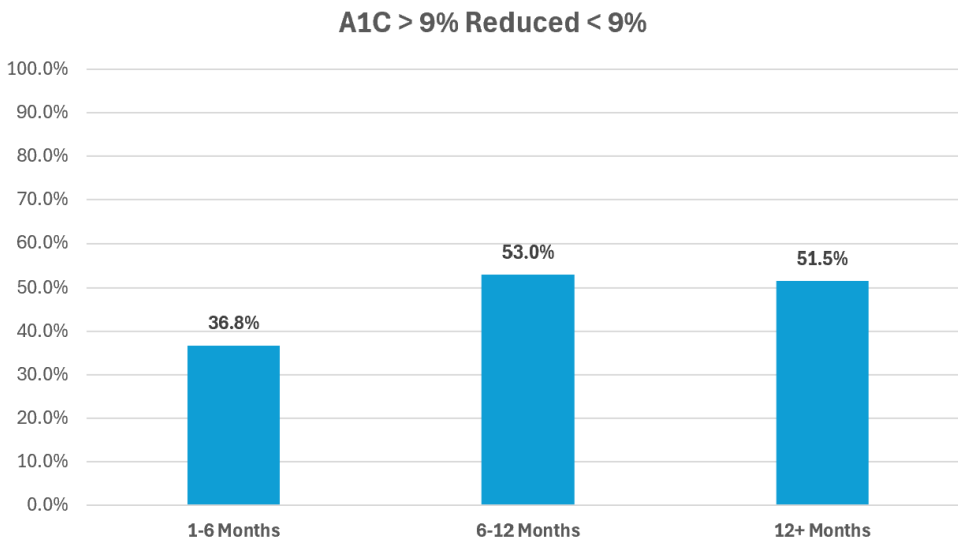
Nine months after the start of the program, Stability Health and the client reviewed utilization and financial results. They compared patients in the program to patients who were eligible for the program (i.e. similar medical conditions) but never enrolled.

	Reduction Admit/K	
	9 month Result	18 month Result
Enrolled < 6 mo	21%	14%
Enrolled > 6 mo	41%	59%
Disenrolled	35%	37%

Patients in the program for less than 6 months had 21% lower admit/K and those in the program longer than six months had 41% lower admit/K compared to those who were never enrolled.

As expected, there was turnover in the population: patients moved or passed away, patients' insurance or PCP changed, and patients sometimes needed a break from constantly working on goals to improve their health. To accommodate the expected turnover, Stability Health's system tracks patients who had dropped out but were still eligible to reengage them. The data showed that even patients who had been in the program in the past but not currently in the program had lower admit/K compared to those never in the program. The results were even better after 18 months of collaboration: patients in the program more than six months had 59% lower admit/K and those who had dropped out continued to sustain reductions in admit/K. The number of saved admissions translated into a very positive ROI. Analysis by the client concluded that for every 2 patients enrolled in the program for six months or more, 1 admission annually was avoided, resulting in savings of \$14,000 per avoided admission.

HEDIS A1C Control at 18 months of collaboration:



Conclusions and Next Steps

Despite an orientation towards value-based care and an advanced primary care structure specifically aimed at a Medicare Advantage population, the client still struggled with a

complex, high need patient population. This ongoing challenge is not surprising since most value-based care delivery systems still reside in a legacy mindset that values the office visit as the unit of ideal care rather than a more holistic population based delivery design that incorporates care away from the practice. Incorporating Stability Health's virtual system of care with existing location-based care allowed the client organization to scale additional support to patients and frontline clinical care teams between office visits that was cost effective and led to improved financial performance. A key to success was embedding Stability Health into operations on a "white label" basis and integrating workflows between practices and Stability Health.

The principles of the collaboration between a value based care healthcare delivery organizations and Stability Health would hold true for other chronic populations that are high cost, high need. There is opportunity to leverage what has been built for complex diabetes to other populations, and the two organizations are currently exploring this opportunity.