

How Primary Partners Alliance Reduced Healthcare Costs by Nearly \$70 PMPM Through Proactive Population Health Management



Primary Partners Alliance (PPA) believes that improving health starts with making comprehensive, coordinated primary care easy to access. By engaging patients early and helping them stay connected to care, PPA aims to improve outcomes before health issues become more complex. As a participant in MSSP and ACO REACH, PPA is committed to helping patients stay well through proactive engagement, coordinated care, and earlier intervention.

Like many organizations advancing to value-based care, PPA faced a common challenge: how do you identify patient needs earlier, close care gaps, strengthen documentation, and connect patients with the right support before preventable utilization occurs?

Results

Compared with patients who did not complete an Annual Wellness Visit (AWV), AWV-compliant patients demonstrated:

\$70

Lower PMPM healthcare costs
(\$947 vs. \$1,014)

14K

Lower emergency department utilization
(272/K vs. 286/K)

44%

Lower readmission rates (9% vs. 16%)

13%

Higher HCC recapture (70% vs. 57%)

With Lightbeam supporting patient identification, performance visibility, and care management workflows, PPA transformed Annual Wellness Visits (AWVs) into the front door of its population health strategy—using each visit to identify risk earlier, strengthen documentation, close care gaps, and connect patients to ongoing care management before health issues escalated.

In 2025, patients who completed an AWV consistently demonstrated better clinical and financial outcomes than those who did not, reinforcing the value of AWVs as the entry point to PPA's broader care management strategy.

The Challenge

"You don't know what you don't know," as PPA's Dr. Memory Crowley, Chief Medical Administrative and Development Officer often says. Success in value-based care depends on identifying patient needs before they become preventable complications. AWVs gave PPA a structured opportunity to better understand each patient's health, identify emerging risks, and guide earlier interventions. Achieving this required timely visibility into which patients needed attention, allowing care teams to prioritize outreach before opportunities for intervention were missed.

For PPA, AWVs have become an opportunity to better understand each patient, strengthen relationships, close care gaps, improve documentation, and connect patients with additional care management services when needed.

While AWVs served as the entry point, the broader value came from the coordinated care management activities that followed. Rather than demonstrating that the visit itself caused better outcomes, the analysis highlights how proactive engagement enabled care teams to identify needs earlier and connect patients with the appropriate clinical resources.



"We have seen physicians who were ready to walk away because they did not know how to keep going. With better visibility and support, they can focus on providing quality care, understanding where each patient is, and connecting them with the right resources. It allows them to do the job they wanted to do—help patients—while keeping their practices running."

Lisa Bloder

Executive Director of Population Health at Primary Partners Alliance

From Preventive Visit to Population Health Strategy

With Lightbeam supporting population health analytics, patient outreach, and performance visibility, PPA integrated AWWs into its broader value-based care workflows.

Before the visit, practices can use Lightbeam patient-level information to review open care gaps, chronic conditions that may need recapture, specialist involvement, and preventive questions.

Every AWW became an opportunity to:

- Review preventive care gaps
- Capture chronic conditions and improve HCC documentation
- Identify unmet clinical and social needs
- Determine whether additional care management support was appropriate



Improved documentation helped ensure patient complexity was more accurately captured, allowing providers to receive appropriate credit for the care they were already delivering. Better visibility also allowed providers to spend less time searching for information and more time focusing on patient care.

For PPA's network of 251 providers, this initiative directly advances Primary Partners' mission of making comprehensive, coordinated primary care more accessible. It empowers independent practices to thrive in value-based care by providing greater transparency, actionable insights, and the resources needed to remain strong, sustainable, and independent while delivering high-quality patient care.

When an AWW or another point of contact identifies a need, the practice sends a referral and demographic information to PPA's care management team. The referral is reviewed within 24 hours, and the appropriate team member begins outreach. Assessments and follow-up activity are documented in Lightbeam, then shared back with the primary care practice to maintain a closed communication loop.



Patient Story: One Outreach Call Changed the Outcome

During a biweekly outreach call, a patient reported several weeks of shortness of breath, chest pain, and pressure. Although an earlier emergency department evaluation had not identified a cardiac issue, the community health worker recognized the ongoing concern and contacted the patient's primary care office to request an earlier appointment. The office moved the visit forward, and the patient was admitted from that appointment. A heart catheterization revealed a severe heart attack and significant arterial blockages, leading to stent placement and additional treatment.

Provider relations teams also use Lightbeam to build targeted cohorts and translate performance gaps into actionable patient lists for each practice. ADT insights surface admissions, discharges, high-cost patients, and frequent utilizers, enabling timely follow-up for post-discharge and other high-risk patients. Together, these capabilities give care teams a single view of patient needs, allowing them to prioritize interventions, coordinate follow-up, and measure performance over time. Shared documentation allows any available team member to understand what has happened with a patient and continue the next step without losing context. Combined with round-the-clock access to community health workers and the after-hours care team, this continuity helps patients reach someone when support is needed. Rather than viewing AWWs as a compliance activity, PPA leveraged them as the front door to proactive population health management.



"Now, the alerts in Lightbeam show us an admission and then a discharge. We have the insight we did not have before through the interfaces, and it is so much different."

Carla Williams

Provider Relations Manager at Primary Partners Alliance

The Impact

Compared with patients who did not complete an AWW, AWW-compliant patients demonstrated:

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Together, these outcomes demonstrate how proactive engagement at the beginning of the patient journey can translate into measurable improvements across cost, utilization, documentation, and patient care.



“For me, it is being able to see the patient as a whole person—to understand what they need from every aspect and see how these interventions affect their lives.”

Catalina Ramchandani

Clinical Operations Manager for the Alliance for Community Health

Beyond cost savings, AWWs created an important point of engagement for patients and care teams. Improved HCC recapture—the outcome most directly associated with the visit itself—helped ensure patient complexity was more accurately documented, supporting both clinical decision-making and risk-adjusted reimbursement. Although the AWW marked the beginning of the patient journey, the downstream improvements in emergency department utilization, readmissions, and overall cost likely reflect the coordinated care management activities that followed, including Transitional Care Management (TCM), medication reconciliation, chronic disease management, social determinants of health (SDOH) support, and ongoing patient outreach. Together, these interventions helped patients receive earlier, more coordinated care before health issues escalated.

This shift gave PPA's teams a timelier view of the patient journey. Instead of interpreting repeated admissions as isolated entries on delayed paper reports, care teams can see admission and discharge activity in sequence, understand what happened, and direct follow-up based on current information. That visibility supports faster intervention and helps translate the stronger outcomes associated with PPA's AWW and care management strategy into a repeatable daily workflow.

The Bottom Line ---

Primary Partners Alliance demonstrates that Annual Wellness Visits are most valuable when they serve as the beginning—not the end—of proactive population health management. By combining early patient engagement with coordinated care management and timely performance visibility, PPA translated routine preventive visits into measurable improvements across cost, utilization, documentation, and patient outcomes.

With Lightbeam providing the analytics, workflows, and care coordination infrastructure behind that strategy, PPA built a scalable, repeatable model for proactive value-based care.

Methodology: Analysis included PPA's Vytalize MSSP and ACO REACH population from January–December 2025 (AWV-compliant: ~6,535; non-compliant: ~1,474). This observational analysis did not include risk adjustment or normalization; findings demonstrate an association between AWV completion and improved outcomes and should not be interpreted as evidence that AWV completion alone caused the observed results.