



Stop Wasting Time Chasing False Care Gaps

How Interoperability and Advanced Analytics Are Rewiring Quality Management

One out of every ten patients your team is calling already did what you asked them to. The procedures and preventive screenings were completed at outside facilities, but your team cannot see them. Focus your team on the right patients, elevate your quality score and get the quality bonus revenue you have already earned.

Because healthcare is fragmented, your staff still spends countless hours on manual work: calling patients, calling facilities and trying to pair their findings against nine different payer files in Excel. This disjointed work leads to blind spot leads, duplicative testing and frustrating patient interactions, such as reminding someone again and again to schedule a colonoscopy they already completed.

Ambiguity about outside care worsens patient care and erodes trust, causing patients to tune out reminders that matter. You are not failing at patient outreach. You are failing at data retrieval.

Key Impact Metrics

Metric	Target Impact	Operational Value
Gaps Closed	+5–10%	Identified without patient or provider outreach, driving greater quality bonus revenue based on encounters flagged externally.
Avoided Outreach	10–20%	Unnecessary patient follow-ups eliminated for patients who already completed required care.
Prep-Time Savings	50%	Reduction in pre-visit clinical record gathering.

Why Now: The Unsustainable Q4 Scramble

The annual quality season has made the status quo impossible to defend. Every year, as the final quarter arrives, ACOs and value-based care organizations enter an all-hands scramble to meet quality thresholds, often contracting expensive temporary staff to collect medical records by hand and call patients directly.

This strategy breaks down because it depends on finding a needle in a haystack, repeating work when the needle is not found. Sifting through thousands of pages of external clinical history to locate a single six-year-old colonoscopy result is not a viable operating model.

Relying on retrospective, end-of-year payer gap files makes it worse. You send your most valuable clinical resources after patients who are already adherent, instead of the patients who genuinely need intervention. Wait until year-end to catch up, and you waste clinical capacity and miss the windows to treat patients proactively.



From Manual Abstraction to Clinical Intelligence

Quality management has historically run on claims plus manual record requests. That approach rests on flawed assumptions: that the referring provider will tell you a procedure was done, and that they documented it in the exact, discrete format you need.



The reality is messier. A depression screening or a breast cancer screening is rarely an isolated event. It is one component of a broader patient encounter, and the result is almost always buried in paragraphs of unstructured text and lengthy encounter notes. The shift starts with a simple fact: broad access to outside medical records is now achievable, and AI can make sense of the messy data inside them.

Acquiring the data is only half the battle. AI can process aggregated external records and extract the procedure codes and results hidden in unstructured notes, locating, highlighting, and bolding the exact text relevant to a specific quality measure.

Providers can then take in a patient's outside care history in seconds, without skimming. Instead of depending on flawed payer gap files, your organization gains real-time visibility into outside clinical and pharmacy data. Interoperability stops being a data-sharing exercise and becomes actionable clinical intelligence, removing the manual abstraction bottleneck.

Regulatory & Network Rule Boundary: Network rules restrict how retrieved data can be used: it cannot be pulled purely for administrative purposes, so gathering records only to report quality actions is not allowed. The data must be put to active clinical use, for example to refine a patient outreach program or to inform the patient record before an upcoming appointment.

The Pragmatic Blueprint

Theoretical interoperability has to translate into operational results. Organizations can use this four-step framework to eliminate end-of-year chaos:

1. **Ingest & Segment Patient Populations**

Run your list of unknown or non-adherent patients through a technology like Connective Health.

2. **Find & Gather Outside Records Automatically**

The technology matches patients to outside activity using robust patient matching and a widespread database.

3. **Sort Patients with Clinical Algorithms & AI Sort into three clear operational groups:**

- **Completed:** With dates and results, ready to submit.
- **Likely Completed:** Billed externally with results missing, so you know exactly which facility to call.
- **Hints of Activity:** From patient or provider reports requiring quick verification.

4. **Deliver Results Directly into Workflows**

- **Completed:** deliver directly to PCPs with results before appointments and to records teams to record and submit completed activity.
- **Likely Completed:** move to the records team to source the missing data.
- **Hints of Activity:** focus your provider outreach teams to drive these to referrals or help scheduling.

The Payoff

An AI-driven, continuous interoperability model replaces the frantic Q4 scramble with a controlled, predictable workflow. Put these capabilities in place early and run them all year, and quality season stops being a crisis.

Your clinical staff stop acting as manual data miners and return to delivering proactive care. Providers walk into appointments with a complete view of each patient's outside history, so interventions happen earlier and more accurately. Your organization directs its resources to the patients who need them most.

Ready to Stop Wasting Time?

See what clinical data is hiding in your own patient population and assess your current interoperability setup.

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