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2024 Forum on
Rural Population Health & Health Equity

OHSU

Using Population Data to Drive Care Management Program Development

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- Audio has been muted for all participants upon entry
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- Sessions will be recorded and available to attendees
- Please take the session surveys!

TODAY'S DISCUSSION

As the healthcare system continues to evolve from the traditional fee-for-service model into a population-based health system, the need for improving care management processes within communities is becoming increasingly important.

Now is the time to leverage data at the local level to begin to develop interventions to improve health and reduce cost.

For today we will address the following:

IMPORTANCE OF POPULATION HEALTH DATA TO DRIVE STRATEGY

COMPONENTS OF A CARE MANAGEMENT PROGRAM

STRATEGIES TO LEVERAGE POPULATION HEALTH DATA TO DEVELOP A CARE MANAGEMENT PROGRAM

THE PREMISE

FINANCE → FUNCTION → FORM

Macro-economic Payment System

- Government Payers
  - Changing from FFS to PBPS
- Private Payers
  - Follow Government payers
  - Steerage to lower cost providers

Provider Imperatives

- F-F-S
  - Management of price, utilization, and costs
- PBPS
  - Management of care for defined population
  - Providers assume insurance risk

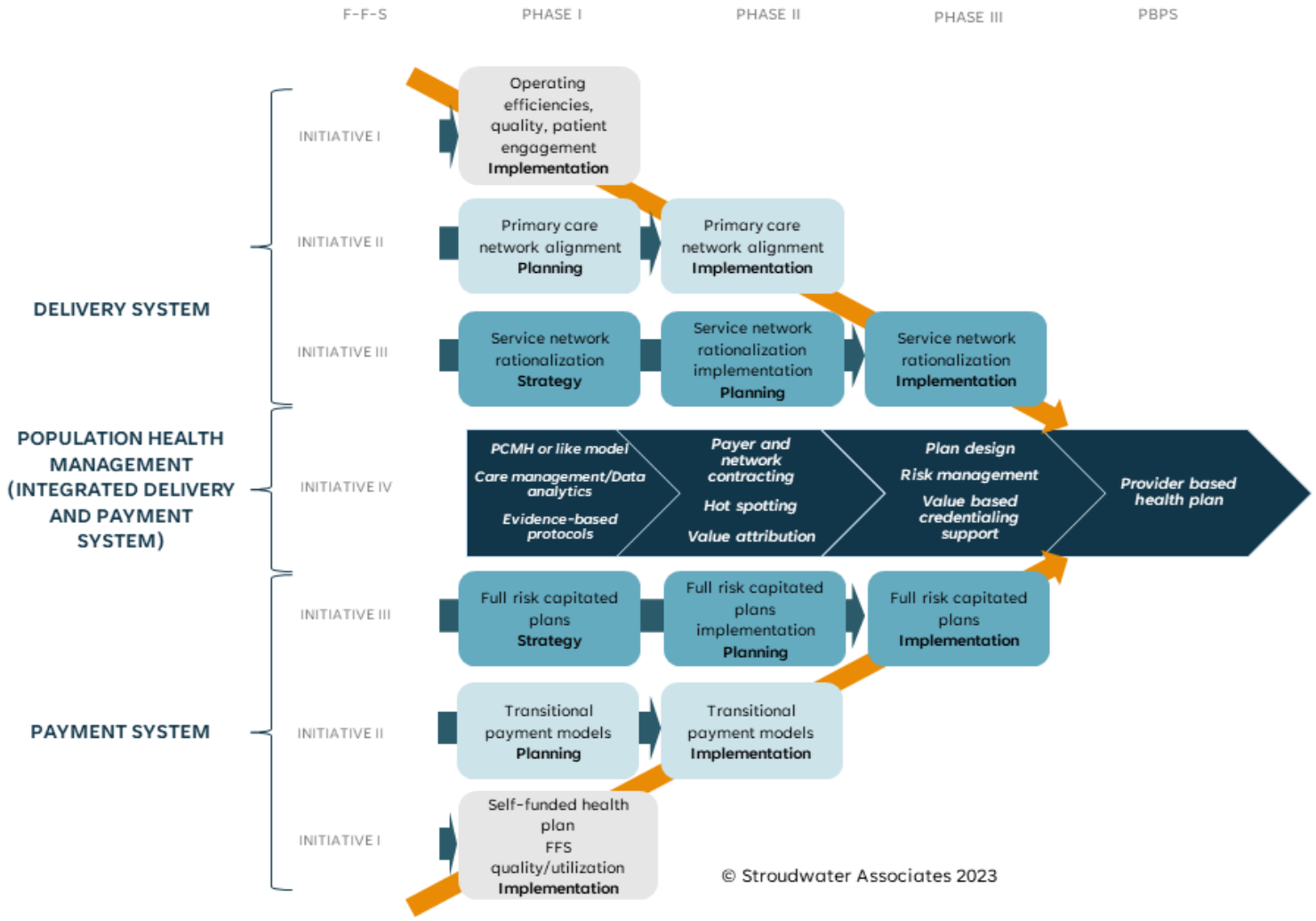
Provider Organization

- Evolution from
  - Independent organizations competing for market share based on volume
  - To aligned organizations competing with other aligned organizations for covered lives based on quality and value

Network and Care Management Organization

- New competencies required
  - Network development
  - Care management
  - Risk contracting
  - Risk management

TRANSITION FRAMEWORK



LEVERAGING POPULATION HEALTH DATA

IMPORTANCE OF POPULATION HEALTH DATA

- Understanding population health data is essential to fulfilling the mission of the IHI's Triple Aim:
  - Improving the patient experience of care (including quality and satisfaction);
  - Improving the health of populations; and
  - Reducing the per capita cost of healthcare
- Hospitals and health systems need the right data and analytics to inform their initiatives in fulfilling the Triple Aim
- For healthcare organizations to understand the need and manage the care of the population they must seek and leverage population health data

Source: "CMSA's Standards of Practice for Case Management, 2016." P. 36

BARRIERS TO POPULATION HEALTH DATA

- System-level and patient-level barriers to population health data include:
  - Data quality and completeness
  - Resource constraints – limited capacity to collect, manage, and analyze
  - Information technology limitations
  - Lack of standardized data formats/systems
  - Patient privacy concerns
  - Data literacy and skills gap

Tolera A, Firdisa D, Roba HS, Motuma A, Kitesa M, Abaerei AA. Barriers to healthcare data quality and recommendations in public health facilities in Dire Dawa city administration, eastern Ethiopia: a qualitative study. Front Digit Health. 2024 Mar 14;6:1261031. doi: 10.3389/fdgth.2024.1261031. PMID: 38550717; PMCID: PMC10972939.

DATA INFRASTRUCTURE/ANALYTICS

A strong data infrastructure requires leadership support to promote and share data across the organization

- Increasingly, hospitals are developing Business Intelligence as a key strategic focus
  - The top 5 healthcare-specific business intelligence functions sought by organizations are: enterprise analytics, predictive analytics, ACO analytics, data warehousing/integration, and population health data

Provide staff training and support in obtaining accurate data

- To stratify, characterize, and assess data, organizations must first develop a data collection plan; it is necessary to train and support staff in consistently interacting with patients to collect data

Assess the accuracy of your data

- As with any data item, organizations need data quality assurance to ensure that categories indicated in the data records accurately match patient choices

Characterize missing data

Articulate the reasons for stratifying data

Source: https://www.ihi.org/communities/blogs/create-the-data-infrastructure-to-improve-health-equity

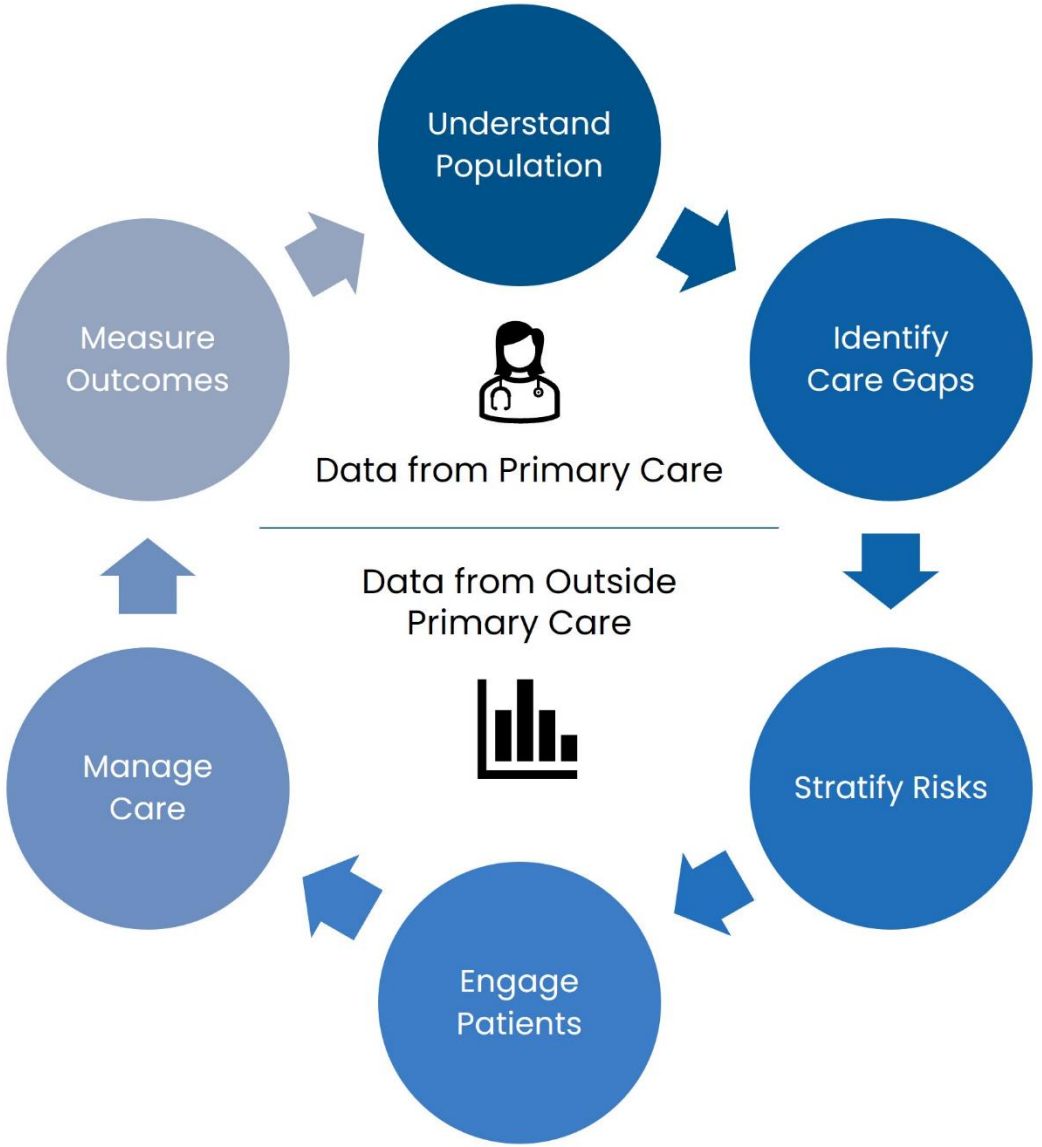
DATA SETS

Internal Data

- Referral information
- Utilization
- Clinical outcomes
- SDOH (food security, housing, employment)

External Data

- Health information exchanges (HIEs)
- State & Federal data sets
- Claims data



Data source: https://publications.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=18633&lid=3

STATE HEALTH INFORMATION EXCHANGE (HIE) DATA

MAP Dashboard
Member Profile

Attribution Type
Default

Attribution Level
Facility

Attribution Entity
Bagsmon Doewga Darewbon Bagsam

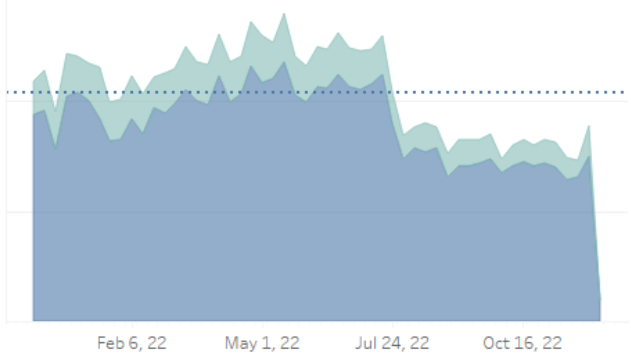
Medicaid ID
All

Active Program
All

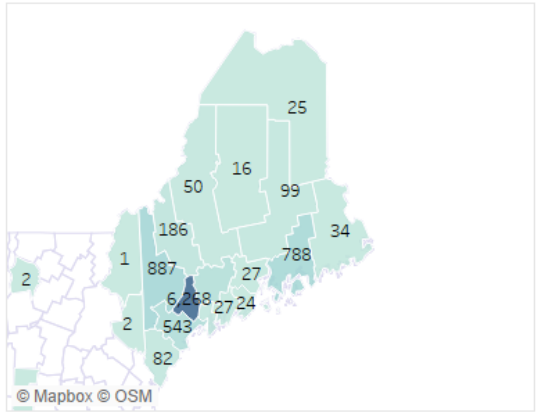
Primary Insurance Indicator
All

HIE data includes detailed demographic information

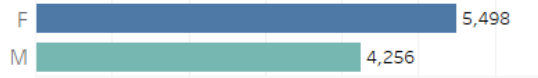
Population 9,754
Population With Encounters 8,120



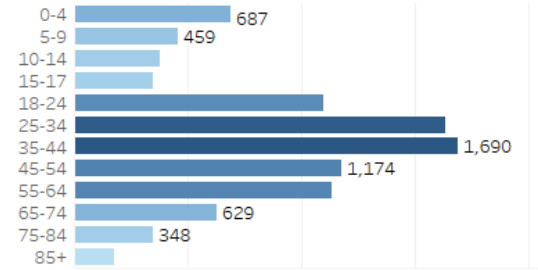
County Distribution



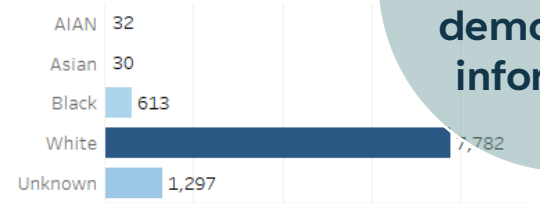
Sex Distribution



Age Distribution



Race Distribution



Ethnicity Distribution

Member Profile Table

Medicaid ID	Member Name	DOB	Sex	Race	Ethnicity	Street Address	City/Town	State	ZIP Code	Telephone Number	PCP Name
0a0a0bata	Bfewmewga Idom	10/14/1998	F	Black	Non-Hispanic	247 Tappam Oja Ohs 2	LEWISTON	ME	04240-6122	4074049993	Null
0a0aads0a	Kodaw Lmogs	4/5/1983	M	White	Non-Hispanic	5 W Ogr N Toy	BUCKSPORT	ME	044164951	4073963997	DANIEL HAMMOND
0a0adct0a	Sodyo Bomsam	7/28/1978	F	White	Non-Hispanic	241 A Fomrwbmoppna Mr	AUBURN	ME	04210-8894	4077908033	DALLAS MARQUIS
0a0ag0yya	Rajewg Lmiww	7/28/1989	M	Unknown	Non-Hispanic	304 Inr Biugsy Mr	SEDGWICK	ME	046762836	4076303998	Anthony Fusco
0a0atsbya	Mewbfomr Jaewnnauz, Km	3/12/1990	M	White	Non-Hispanic	142 Binnala Wsmaas	LEWISTON	ME	04240	4079400739	PROVIDER UNKNOWN
0a0bccyya	Vewamwsag Tewgl	4/24/1986	F	White	Non-Hispanic	182 Ponr Fewnn Mr Smnm A4	NEW GLOUCESTER	ME	042603273	4079407434	MANJU HILARY
0a0bd0yta	Gewbfinow Minnewgl	3/25/1992	M	Black	Non-Hispanic	Hi Piz 752	SABATTUS	ME	042800752	4073338790	. NO LMD
0a0bfbb0a	Miwadomewa Dowig-Tonvam	4/15/1966	F	White	Non-Hispanic	250 Newga Mior	Greene	ME	04236	4074049490	KIMBERLY PETTENGILL
0a0bgasta	Rawsigewa Riuewg	3/20/2012	F	White	Non-Hispanic	28 Lmija Ws	AUBURN	ME	042106029	4073449339	ANGELA CASTONGUAY
0a0bgdc0a	Ardugr Apams, Ewj	3/10/1983	M	White	Non-Hispanic	20 Wsimdy Pmiiva Ng Ohs 1	SEBAGO	ME	040293267	4076903800	ANDREA MALONEY
0a0btatta	Nodewbfoan Lewnramwnaaja	9/20/1982	M	Black	Non-Hispanic	176 Hewga Ws Ohs 1	LEWISTON	ME	04240	4074044899	Clinic Mmc
0a0byycta	Lnimewo Wog Harmi	2/8/2004	F	Unknown	Non-Hispanic	30 Niuewwa Ws	AUBURN	ME	042105524	4073460939	Null

Source: HealthInfoNet

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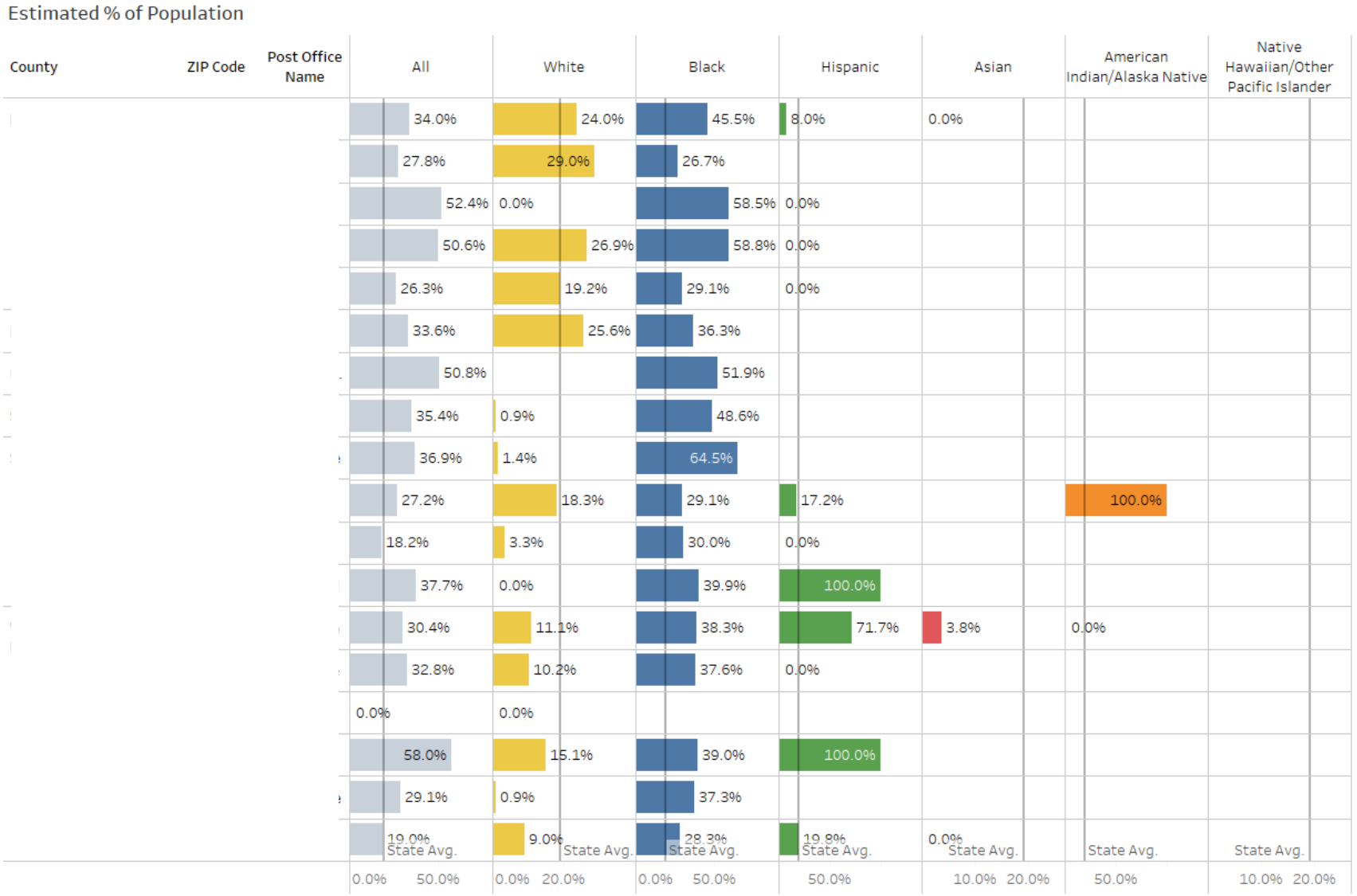
USING ICD-10 DATA TO IDENTIFY COMMUNITY NEEDS

- Every hospital/healthcare provider has access to their community's health data through the medical coding system ICD-10, which they must use to submit claims to payers
- In ICD-10, Social Determinants of Health (SDOH codes) are found in categories Z55-Z65:
  - **Z55, Problems related to education and literacy**
  - **Z56, Problems related to employment and unemployment**
  - **Z57, Occupational exposure to risk factors**
  - **Z58, Problems related to physical environment**
  - **Z59, Problems related to housing and economic circumstances**
  - **Z60, Problems related to social environment**
  - **Z62, Problems related to upbringing**
  - **Z63, Other problems related to primary support group, including family circumstances**
  - **Z64, Problems related to certain psychosocial circumstances**
  - **Z65, Problems related to other psychosocial circumstances**

Understand how SDOH data can be gathered and tracked using ICD-10 Z codes

SOCIAL DETERMINANTS OF HEALTH



Source: Decennial Census and American Community Survey (ACS), 2018-2022

Percent of the population in poverty by ZIP code and race/ethnicity

USING DATA TO IDENTIFY PRIORITY POPULATIONS: QUERY EXAMPLES

PROCESS query examples (treatment, procedure, encounter)	OUTCOME query examples
• Percentage breakdown by race of female patients who were screened for breast cancer • Percentage of male patients who had a colonoscopy, by ethnicity • Percentage of patients with chronic health conditions who filled prescriptions, by ZIP code	• Breakdown of readmitted patients by insurance status • Ethnicity breakdown of patients who suffered a fall during an inpatient stay • Breakdown of Hispanic patients hospitalized for COVID-19, by English-speaking and non-English-speaking

https://www.aha.org/system/files/media/file/2021/03/Market_Insights_Disparities_Data.pdf

POPULATION HEALTH MANAGEMENT

What is Population Health Management? Population Health Management proactively identifies and addresses the needs of populations of people rather than focusing episodically on individual patients when they seek or access health care services.

Developing the infrastructure and capabilities to focus on population health management is essential in a risk-based or value-based reimbursement environment

- Registries are an important tool to enable the identification, monitoring, and tracking of sub-populations of patients within and across practices to identify and proactively address gaps in care, support chronic disease management, and promote timely preventive health screenings and services
- Examples include:
  - Addressing due/past due diabetes care for all known pre-diabetics within a selected sub-population
  - Sending out mammogram and colonoscopy reminders to members based on age and gender criteria, per agreed-upon evidence-based clinical practice guidelines
- Proactive outreach to identified sub-populations can be done via targeted mailings, email blasts, and other communication methods

https://www.thehaugengroup.com/2022-guidelines-for-reporting-social-determinants-of-health/

RISK-STRATIFYING THE POPULATION

- What is risk stratifying? The process of categorizing individuals and populations according to their likelihood of experiencing adverse outcomes, e.g., high risk for hospitalization
- Hospitals and providers committed to improving patient outcomes must develop or procure the capability to risk-stratify their patient population by including:
  - Selection of risk stratification criteria and a methodology to classify members into identified risk categories - for example, low-moderate/rising-risk/high-risk categories
    - Selected risk stratification criteria should reflect the population served by the organization
  - Generally, risk criteria include inpatient hospital and ED cost and utilization data, pharmacy cost and utilization data, pertinent diagnosis and clinical conditions data, and increasingly, key social determinants of health (SDOH) data for that population
  - Both claims data and EHR data are important data sources in the risk stratification process, as available
- The identified risk categories can then be correlated with defined levels of intensity of care management services offered to the respective risk levels

Source: "CMSA's Standards of Practice for Case Management, 2016." P. 36

EXAMPLE OF RISK STRATIFICATION

MAP Dashboard
Member Predicted Risk

Attribution Type	Attribution Level	Attribution Entity	Model Name	Risk Class	90D Risk Change
Default	Facility	Bagsmon Doewga Darewbon Bagsa..	All	All	All

Medicaid ID	Sex	Age Group	Race	Ethnicity
All	All	All	All	All

Medicaid ID	Member Name	Alzheimer's	Asthma Exacerbation	Acute Myocardial Infarction	Lung Cancer	Cardiac Dysrhythmias	Congestive Heart Failure	Chronic Kidney Disease	COPD	Cerebrovascular Accident	Type II Diabetes	ED Visit	Hip/Spine/Pelvic Fracture (Elderly)	Hypertension	IP Admission	Mortality	ESRD
0a0a0bata	Bfewmewga Idom	L	L	L	L	L	L	L	L	L	L	M	L	L	L	L	L
0a0aads0a	Kodaw Lmogs	L	M	L	L	L	L	M	L	L	L	M	M	P	M	M	L
0a0adct0a	Sodyo Bomsam	L	M	L	L	L	L	L	L	L	L	V	M	L	M	L	L
0a0ag0yya	Rajewg Lmiww	L	M	L	L	L	L	L	L	L	L	M	L	P	L	L	L
0a0atsbya	Mewbfomr Jaewnnauz, Km	L	M	L	L	L	L	L	L	L	L	H	M	L	L	L	L
0a0bccyya	Vewamwsag Tewgl	L	H	L	L	L	M	M	L	L	L	H	M	L	M	M	L
0a0bd0yta	Gewbfinow Minnewgl	L	M	L	L	L	L	M	L	L	L	H	L	P	L	L	L
0a0bfbb0a	Miwadomewa Dowig-Tonvam	L	L	L	L	L	L	M	L	L	L	M	L	M	L	L	L
0a0bgasta	Rawsigewa Riuewg	L	H	L	L	L	L	L	L	L	L	H	M	L	L	L	L
0a0bgdc0a	Ardugr Apams, Ewj	L	L	L	L	P	M	V	M	L	M	M	L	M	H	V	M
0a0btatta	Nodewbfoan Lewnramwnaaja	L	M	L	L	L	L	L	L	L	L	M	M	P	L	L	L
0a0byycta	Lnimewo Wog Harmi	L	L	L	L	L	L	L	L	L	L	M	L	L	L	L	L
0a0c0cbya	Kodewa Jomgay	L	L	L	L	L	L	L	L	L	L	M	L	L	L	L	L
0a0cadf0a	Hosmewbewo Fiy	L	M	M	L	L	M	M	P	M	P	H	M	P	M	M	L
0a0cbcd0a	Pippy Tonsig	L	M	L	L	L	L	L	L	L	L	M	M	L	M	L	L
0a0dasata	Pmiivnyg Newppy	L	M	L	L	L	L	L	L	L	L	M	M	L	L	L	L
0a0dd0yta	Wsahfag Homvam	L	M	L	L	L	L	L	L	L	L	H	M	L	L	L	L
0a0ddaa0a	Sewdisfy Piujewam	L	H	L	L	L	L	L	L	L	L	H	M	L	L	L	L
0a0dgcbta	Smewwsog Onwsig	L	M	L	L	L	L	L	L	L	L	M	L	L	L	L	L
0a0dsbgta	Oprew Onew	M	L	M	L	H	M	H	M	M	M	M	M	H	M	M	L
0a0ffsdya	Bimmewa Womlags	L	M	L	L	L	L	L	L	L	L	H	L	L	M	L	L
0a0gb0sya	Kog Pumgay	L	M	L	L	L	L	L	L	L	L	V	M	P	M	L	L
0a0sfcc0a	Nyrewo Noxomiu	L	M	L	L	L	L	L	L	L	L	M	L	L	L	L	L
0a0sgdyya	Moydigr Wsaomgw	L	M	M	L	P	H	M	M	L	P	H	M	M	H	M	L
0a0t0ffta	Kogewa Fagrmewbvw	L	M	L	L	L	L	L	L	L	L	M	M	L	M	L	L
0a0thcfva	Myog Oupa	L	M	L	L	L	L	L	L	L	L	H	L	L	L	L	L

90-Day Risk Change: Decrease | Increase | No Change

Source: HealthInfoNet

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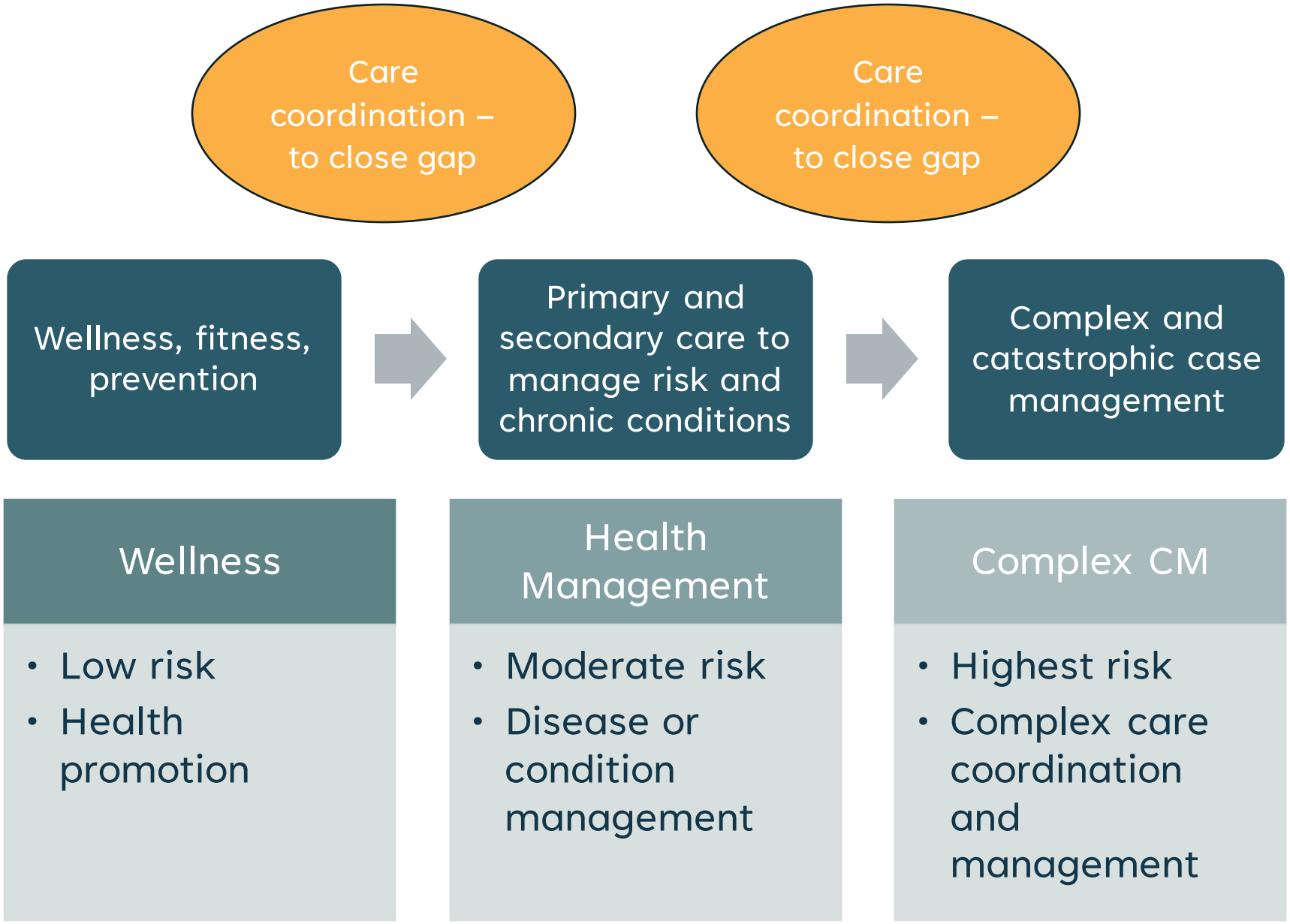


Care coordination across the continuum for population health management

IDENTIFYING PATIENTS WHO NEED ONGOING CARE MANAGEMENT

- Individuals with complex medical, behavioral health/substance use disorder and/or social determinants of health needs may benefit from ongoing, longitudinal care management
- Completion of care needs screening tools and comprehensive assessment tools, analysis of patient/member health care utilization and cost data, and patient/member risk stratification scores are utilized to identify individuals who would potentially benefit from ongoing care management services and support
    - PHQ-2, PHQ-9, Alcohol and drug use screening tool, SDOH screening tool

KEY TAKEAWAYS FOR POPULATION HEALTH DATA

- Identify populations or cohorts of interest
- Obtain health outcomes data for the cohorts (such as mortality, disease burden and injury, and behavioral factors)
- Examine experience of care
- Determine per capita cost (total cost of care, and hospital and emergency department utilization rate and/or cost)
- Examining these integrated data points, allows organizations to craft and deliver tailored services that enhance care, promote population health, and reduce per capita cost

Source: https://www.healthcatalyst.com/wp-content/uploads/2021/05/Care-Management-A-Critical-Component-of-Effective-Population-Health-Management.pdf

CARE MANAGEMENT

WHAT IS CARE MANAGEMENT AND WHY IS IT IMPORTANT?

Care Management utilizes systems, science, incentives and information to:

- Improve medical practice
- Assist consumers and their support system to become engaged
- Provide a collaborative process designed to manage medical/social/mental health conditions effectively

The overall goal is to achieve an optimal level of wellness and improve coordination of care while providing cost-effective, non-duplicative services

Care Management is crucial to guiding and educating patients with complex healthcare needs through a complex healthcare delivery system

Source: "Care Management Definition and Framework." Center for Health Care Strategies. December 28, 2016. Accessed July 01, 2019. http://www.chcs.org/resource/care-management-definition-and-framework/

CARE MANAGEMENT FRAMEWORK

- Outlines and defines the key components of a comprehensive care management program and provides examples of tools and strategies that can be utilized to effectively meet the needs of patients with complex and special needs

Care Management Components	Definition	Tools / Strategies
Identification **Stratification** **Prioritization**	Identification, stratification, and prioritization should be used to identify consumers at the highest risk who offer the greatest potential for improvements in health outcomes. Programs should incorporate clinical and non-clinical sources of information to identify consumers who will most benefit from care management.	▪ Health risk assessments ▪ Predictive models (algorithm–driven model that uses multiple inputs to predict high-risk opportunities for care management) ▪ Surveys (e.g., Patient Health Questionnaire 9, Short Form 12) ▪ Case finding (e.g., chart reviews, surveys) ▪ Referrals (from member, provider, community)
Intervention	Interventions should be tailored to meet individual consumer need, respecting the role of the consumer to be a decision maker in the care planning process. Interventions should be designed to best serve the consumer, be multi-faceted, improve quality and cost effectiveness, and ensure coordination of care.	▪ Evidence-based practices ▪ Interactive care plan, developed based on consumer-set priorities ▪ Multidisciplinary care teams ▪ "Go to" person ▪ Medical home ▪ Physical/behavioral health integration ▪ Specialized patient engagement (e.g., self-management training)
Evaluation	Evaluation should include systematic measurement, testing, and analysis to ensure that tailored interventions improve quality, efficiency, and effectiveness. Careful and consistent evaluation will build the evidence base in terms of what works for complex and special need populations.	▪ Program evaluations ▪ Rapid-cycle micro experiments (e.g., continuous quality improvement, testing, and program adjustments) ▪ Representative measures of quality (e.g., HEDIS, CAHPS) ▪ Representative measures of cost (e.g., ROI calculations)
Payment/Financing	Payment/financing should be aligned to support improvements in care management by rewarding consumers and providers for participating in interventions/evaluations and establishing accountability for quality and cost.	▪ Pay for performance at multiple levels (e.g., health plan, provider, and consumer level) ▪ Share in program savings (gainsharing) ▪ Case management/medical home payments

Source: "Care Management Definition and Framework." Center for Health Care Strategies. December 28, 2016. Accessed July 01, 2019. http://www.chcs.org/resource/care-management-definition-and-framework/

HOW DOES CARE MANAGEMENT BENEFIT PATIENTS?

- In a practice panel of 1,000 patients, there will likely be about 200 patients who could benefit from an increased level of support. According to The Commonwealth Fund, this 20% of the population accounts for 80% of the total healthcare spending in the United States, with the very highest medical costs concentrated in the top 1%.
- Data-driven care management programs that target high risk and rising risk patients can achieve impressive results, including:
  - 20% lower rates of hospitalization in mature care management programs
  - Lower rates of ED utilization
  - Decreased costs

Sources:
https://www.aafp.org/family-physician/practice-and-career/delivery-payment-models/medical-home/care-management.html
https://www.healthcatalyst.com/wp-content/uploads/2021/05/Care-Management-A-Critical-Component-of-Effective-Population-Health-Management.pdf

BUILDING A CARE MANAGEMENT PROGRAM

Developing, implementing, and/or managing a comprehensive care management program are essential activities for any healthcare organization

According to the Agency for Healthcare Research and Quality (AHRQ), care management has emerged as a leading strategy to manage the health of populations. “Care management is organized around the principle that appropriate interventions for individuals within a given population will reduce health risks and decrease the cost of care.”

Source: Care Management: Implications for Medical Practice, Health Policy, and Health Services Research. Content last reviewed August 2018. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/caremanagement/index.html

BUILDING A CARE MANAGEMENT PROGRAM (CONT.)

- Key strategic and tactical decisions to consider when developing a care management program include:
  - "Buy versus build" decisions, such as contracting with a third party for CM services versus building a program internally
  - Determination of Care Management model, including:
    - Creation of centralized Care Management staff versus embedding care managers within individual Primary Care practices or Primary Care clinics or a hybrid model
    - Telephonic Care Management services versus face-to-face services or a combination
  - Determination of Care Management program goals and objectives and key performance metrics
  - Determination of the Care Management organizational structure and composition of Care Management staff
  - Selection of a Care Management electronic platform to house and manage care management-related assignments and documentation

CARE MANAGEMENT CORE RESPONSIBILITIES

Identify and engage ACO members in active Care Management via referrals to CM and via pro-active outreach to identified high- and rising-risk members with modifiable risk

Perform a *Comprehensive Assessment* using standardized screening and comprehensive assessment tools

- Utilize effective communication skills including active listening, motivational interviewing, and use of open-ended questions

Prepare a member-centric *Case Management Plan of Care* in collaboration with member and their family/caregiver(s) and other members of the interdisciplinary care team

Monitor and periodically follow-up with members receiving Care Management services, per established policies and procedures

- Assist member to identify and address any barriers and update Care Management *Plan of Care*, as indicated

Work with member and their family/caregiver(s) to determine appropriate timing of completion of Care Management services, per established case closure criteria and processes

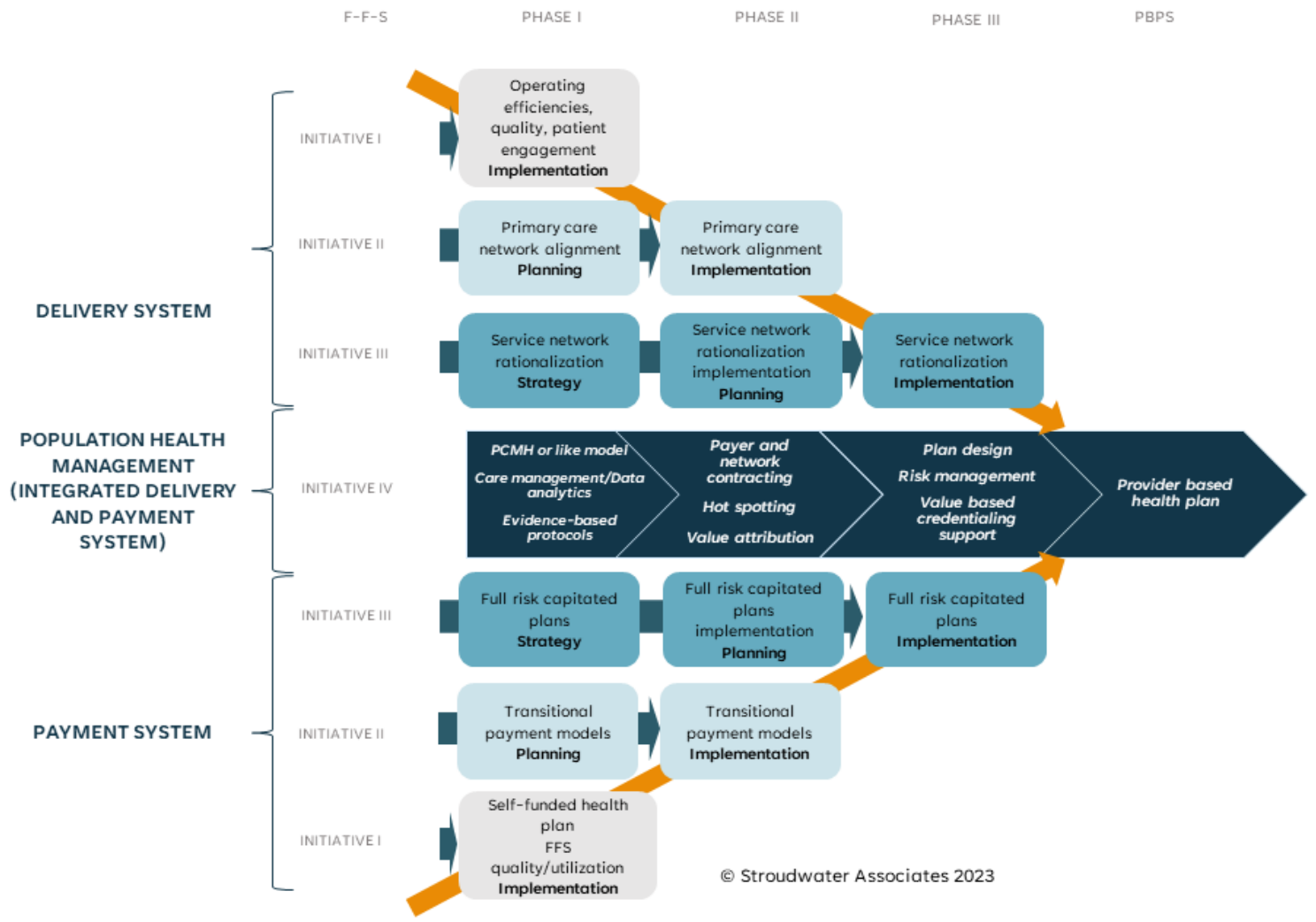
Assist with/perform care coordination and facilitate transitions of care, when members access care across multiple providers and/or across the ACO care continuum

- Develop and implement standardized processes, workflows, and tools across the ACO entity to maximize efficient, timely coordination of care/transitions of care and to minimize gaps or duplication of services

Source: Case Management Society of America. Standards of Practice for Case Management; Section VII. Components of the Case Management Process. Little Rock, AK. Revised 2016; accessed at cmsa.org

KEY RECOMMENDATIONS

TRANSITION FRAMEWORK



FFS QUALITY AND UTILIZATION INCENTIVES

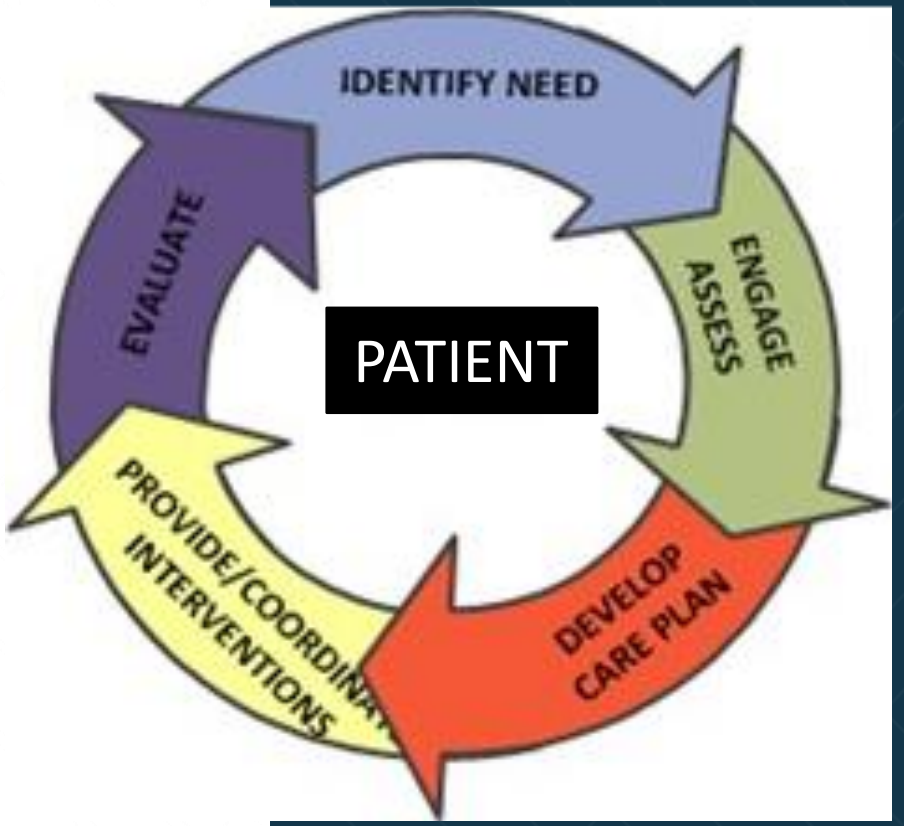
Maximize FFS incentives for improving quality or reducing inappropriate utilization

Common opportunities include:

- Annual Well visits (AWV), Chronic Care Management (CCM), Transitional Care Management (TCM), and Behavioral Health FFS payments
- Maximize MIPS incentive payments
- Value-based purchasing program
- Submitting quality information to commercial insurers
- Emergency room reduction incentive payments (commercial insurers)
- Patient Centered Medical Home enhanced FFS payments
- Etc.

CARE MANAGEMENT INITIATIVES

- Medicare Care Management Programs
  - Chronic Care Management (CCM), Principal Care Management (PCM), Transitional Care Management (TCM), etc.
  - Annual wellness visits
- Care management programs that target high-risk and rising-risk patients
  - Readmissions, high ED utilization
  - Collaborative Care Model (CoCM)
- Discharge planning and transitions of care
- Pre-visit planning
- **THIS IS WHERE DATA AND DATA ANALYTICS COME IN!**



PATIENT CENTERED MEDICAL HOME/TEAM-BASED CARE

Patient Centered Medical Home (PCMH) - team-based, comprehensive model of primary care that is centered around the patient and has the following characteristics:

- Patient-centered
- Comprehensive
- Coordinated
- Accessible
- Committed to quality and safety

Opportunity for formal recognition through the National Committee for Quality Assurance (NCQA)

- Potentially creating opportunities for increased reimbursement

Team-based care – collaborative system focused around high-quality and efficient patient care, which includes PCPs, nurses, medical assistants, administrative staff and other support services

As determined by the Primary Care Collaborative (PCC) https://www.pcpcc.org/about/medical-home
See AMA framework and introduction at https://edhub.ama-assn.org/steps-forward/module/2702513

EVIDENCE-BASED PROTOCOLS

Use of evidence-based protocols leads to better informed decisions, improved health outcomes and quality of care, standardization for diagnosis/treatment pathways

- Benefits include reduction in unnecessary testing/treatment and reduced cost

Use of evidence-based protocols and order sets considered best practice for the monitoring and measurement of vital signs, clinical assessments, and treatment plans

- COPD
- CHF
- Pneumonia
- COVID-19
- Sepsis
- UTI
- Etc.

Collaboration with Medical Staff and periodic review of order sets are essential

ACO PARTICIPATION GENERATES SHARED SAVINGS

- Consider opportunities to understand what ACO participation and the generation of population health could mean for not only the organization financially, but for the community
- Consider development of a pro-forma to understand the potential shared savings of optimizing ACO participation versus the current state

Summary	Baseline	Pro Forma - Status Quo					Baseline	Pro Forma - Joining ACO					Cumulative Impact of Joining ACO vs. Status Quo
	Base Year	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Base Year	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	
Hospital P&L													
Total Net Patient Revenue													
Medicare	$ 5,444,597	$ 5,664,246	$ 5,893,586	$ 6,133,079	$ 6,383,209	$ 6,644,487	$ 5,444,597	$ 5,727,018	$ 6,026,045	$ 6,342,712	$ 6,678,116	$ 7,033,426	$ 1,088,711
Medicaid	$ 605,502	$ 621,259	$ 637,432	$ 654,031	$ 671,068	$ 688,555	$ 605,502	$ 632,182	$ 659,798	$ 688,381	$ 717,960	$ 748,568	$ 174,544
All Other	$ 11,665,330	$ 11,827,680	$ 11,992,290	$ 12,159,191	$ 12,328,415	$ 12,499,994	$ 11,665,330	$ 12,149,912	$ 12,645,722	$ 13,152,980	$ 13,671,908	$ 14,202,733	$ 5,015,685
Total Patient Revenue	$ 17,715,429	$ 18,113,186	$ 18,523,308	$ 18,946,301	$ 19,382,692	$ 19,833,035	$ 17,715,429	$ 18,509,111	$ 19,331,566	$ 20,184,073	$ 21,067,985	$ 21,984,727	$ 6,278,940
Other Revenue (excl. COVID)	$ 3,859,260	$ 3,936,445	$ 4,015,174	$ 4,095,478	$ 4,177,387	$ 4,260,935	$ 3,859,260	$ 3,936,445	$ 4,015,174	$ 4,095,478	$ 4,177,387	$ 4,260,935	$ -
Total Revenue	$ 21,574,689	$ 22,049,631	$ 22,538,482	$ 23,041,779	$ 23,560,079	$ 24,093,970	$ 21,574,689	$ 22,445,557	$ 23,346,740	$ 24,279,551	$ 25,245,372	$ 26,245,662	$ 6,278,940
Expenses													
Expenses	$ 19,362,934	$ 19,955,035	$ 20,566,926	$ 21,199,343	$ 21,853,059	$ 22,528,874	$ 19,362,934	$ 20,210,913	$ 21,094,810	$ 22,016,265	$ 22,977,002	$ 23,978,832	$ 4,174,583
Total Operating Expenses	$ 19,362,934	$ 19,955,035	$ 20,566,926	$ 21,199,343	$ 21,853,059	$ 22,528,874	$ 19,362,934	$ 20,210,913	$ 21,094,810	$ 22,016,265	$ 22,977,002	$ 23,978,832	$ 4,174,583
Operating Margin	$ 2,211,755	$ 2,094,596	$ 1,971,557	$ 1,842,435	$ 1,707,020	$ 1,565,096	$ 2,211,755	$ 2,234,644	$ 2,251,930	$ 2,263,286	$ 2,268,370	$ 2,266,830	$ 2,104,357
% of Net Revenue	10.3%	9.5%	8.7%	8.0%	7.2%	6.5%	10.3%	10.0%	9.6%	9.3%	9.0%	8.6%	
Hospital Volume													
Days	4,043	4,068	4,094	4,121	4,149	4,178	4,043	4,204	4,367	4,533	4,702	4,875	2,070
Visits	171,527	171,620	171,740	171,886	172,061	172,263	171,527	175,911	180,327	184,778	189,267	193,796	64,508
Physician Group - P&L													
Total Net Patient Revenue													
Medicare	$ 852,804	$ 881,470	$ 911,166	$ 941,932	$ 973,810	$ 1,006,844	$ 852,804	$ 883,091	$ 914,586	$ 947,344	$ 981,424	$ 1,016,885	$ 28,107
Medicaid	$ 959,827	$ 1,472,490	$ 1,515,771	$ 1,560,329	$ 1,606,202	$ 1,653,429	$ 959,827	$ 1,474,308	$ 1,519,495	$ 1,566,048	$ 1,614,010	$ 1,663,422	$ 29,063
All Other	$ 1,911,589	$ 1,938,193	$ 1,926,635	$ 1,915,146	$ 1,903,725	$ 1,892,373	$ 1,911,589	$ 1,962,421	$ 1,974,801	$ 1,986,964	$ 1,998,912	$ 2,010,646	$ 357,671
Total Patient Revenue	$ 3,724,220	$ 4,292,153	$ 4,353,572	$ 4,417,407	$ 4,483,737	$ 4,552,645	$ 3,724,220	$ 4,319,820	$ 4,408,882	$ 4,500,357	$ 4,594,345	$ 4,690,952	$ 414,840
Total Operating Expense	$ 5,550,280	$ 5,717,239	$ 5,889,313	$ 6,066,664	$ 6,249,459	$ 6,437,870	$ 5,550,280	$ 5,724,343	$ 5,903,962	$ 6,089,323	$ 6,280,617	$ 6,478,043	$ 115,743
Operating Margin	$ (1,826,060)	$ (1,425,085)	$ (1,535,740)	$ (1,649,257)	$ (1,765,722)	$ (1,885,225)	$ (1,826,060)	$ (1,404,523)	$ (1,495,080)	$ (1,588,966)	$ (1,686,272)	$ (1,787,091)	$ 299,097
% of Net Revenue	-49.0%	-33.2%	-35.3%	-37.3%	-39.4%	-41.4%	-49.0%	-32.5%	-33.9%	-35.3%	-36.7%	-38.1%	
Physician Group - Visits													
Total Visits	22,055	22,072	22,093	22,118	22,146	22,178	22,055	22,348	22,646	22,948	23,254	23,564	4,151

CONCLUSION

THROUGH THE STRATEGIC USE OF DATA, POPULATION HEALTH INITIATIVES CAN ACHIEVE THE GOAL OF IMPROVING HEALTH OUTCOMES AND REDUCING DISPARITIES, DEMONSTRATING THE CRUCIAL ROLE OF DATA-DRIVEN DECISION-MAKING IN ADDRESSING THE COMPLEX HEALTH CHALLENGES FACED BY DIVERSE POPULATIONS.

QUESTIONS?

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COMMITTED TO INCREASING THE IMPACT OF RURAL AND COMMUNITY HEALTHCARE.

Our team of rural and community healthcare experts support the leadership of hospitals, health systems with a rural footprint, and the groups and clinics that form an essential care network across the 97% of the US that is defined as rural.

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