OREGON OFFICE of RURAL HEALTH

OPPORTUNITY Just knock.

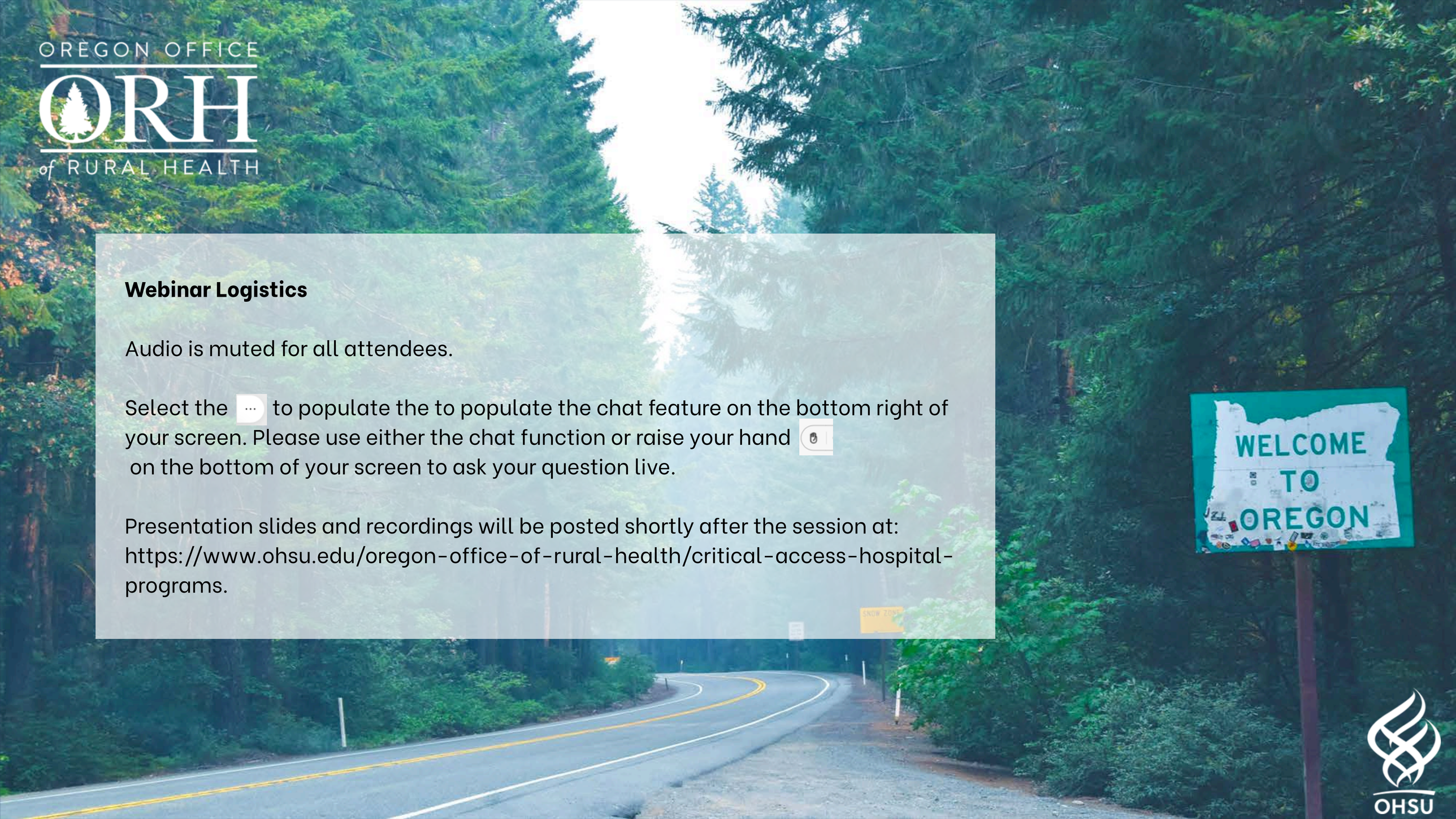
Critical Access Hospital Finance and Operations Webinar Series

Value-Based Care & Clinical Risk Stratification for CAHs
January 27, 2026

The mission of the Oregon Office of Rural Health is to improve the quality, availability and accessibility of health care for rural Oregonians.

The Oregon Office of Rural Health's vision statement is to serve as a state leader in providing resources, developing innovative strategies and cultivating collaborative partnerships to support Oregon rural communities in achieving optimal health and well-being.

OHSU



OREGON OFFICE of RURAL HEALTH

Webinar Logistics

Audio is muted for all attendees.

Select the ··· to populate the to populate the chat feature on the bottom right of your screen. Please use either the chat function or raise your hand on the bottom of your screen to ask your question live.

Presentation slides and recordings will be posted shortly after the session at: https://www.ohsu.edu/oregon-office-of-rural-health/critical-access-hospital-programs.

OHSU

Claire Adams is the Vice President of Healthcare Analytics at REDi Health, with over 10 years of experience delivering data-driven solutions to health care organizations. She specializes in building scalable analytic processes for small hospital systems, Accountable Care Organizations (ACOs), and physician practices. Claire is passionate about using data to identify health care disparities and improve processes across the care continuum. Her expertise in process development, data engineering and stakeholder engagement supports REDi Health's mission to improve health care outcomes for underserved communities.

Marnell Bradfield, MS is the Executive Director, Community Care Alliance. She is a dynamic health care executive with over 30 years of experience in the industry. As the executive director of CCA, she is at the forefront of transforming rural health care. Under her leadership, CCA is diversifying to include new payer partnerships and member recruitment strategies, data analytics, direct care coordination, innovative alternative payment models and services to optimize revenue cycle integrity.

Before her current role, Marnell held leadership and clinical positions in acute care and population health. Her extensive experience spans health care operations and population health strategies. She has overseen inpatient and outpatient hospital departments, quality improvement, risk management and emergency management. Marnell's unique perspective on patient care, gained from her experience as a registered respiratory therapist, enhances her understanding of health care on a personal level. She has also worked for a commercial payer, Rocky Mountain Health Plans.

OHSU

REDi Health

Value-Based Care & Clinical Risk Stratification for CAHs

A Plan of Action for Preparing for Value-Based Care

Learning Objectives Value-Based Care

Understand how to:

1) Transition to a Value-Based Care mindset

2) Create a pathway for action (PCP Panel Attribution)

3) Prioritize outreach for your population (Risk Stratification)

4) Get credit for the work you are doing (AWV and CCM)

5) Proactively manage care (preventive care, quality measures)

6) Transition insights into a planning tool

Poll Question

What is your current involvement in Value-Based Care?

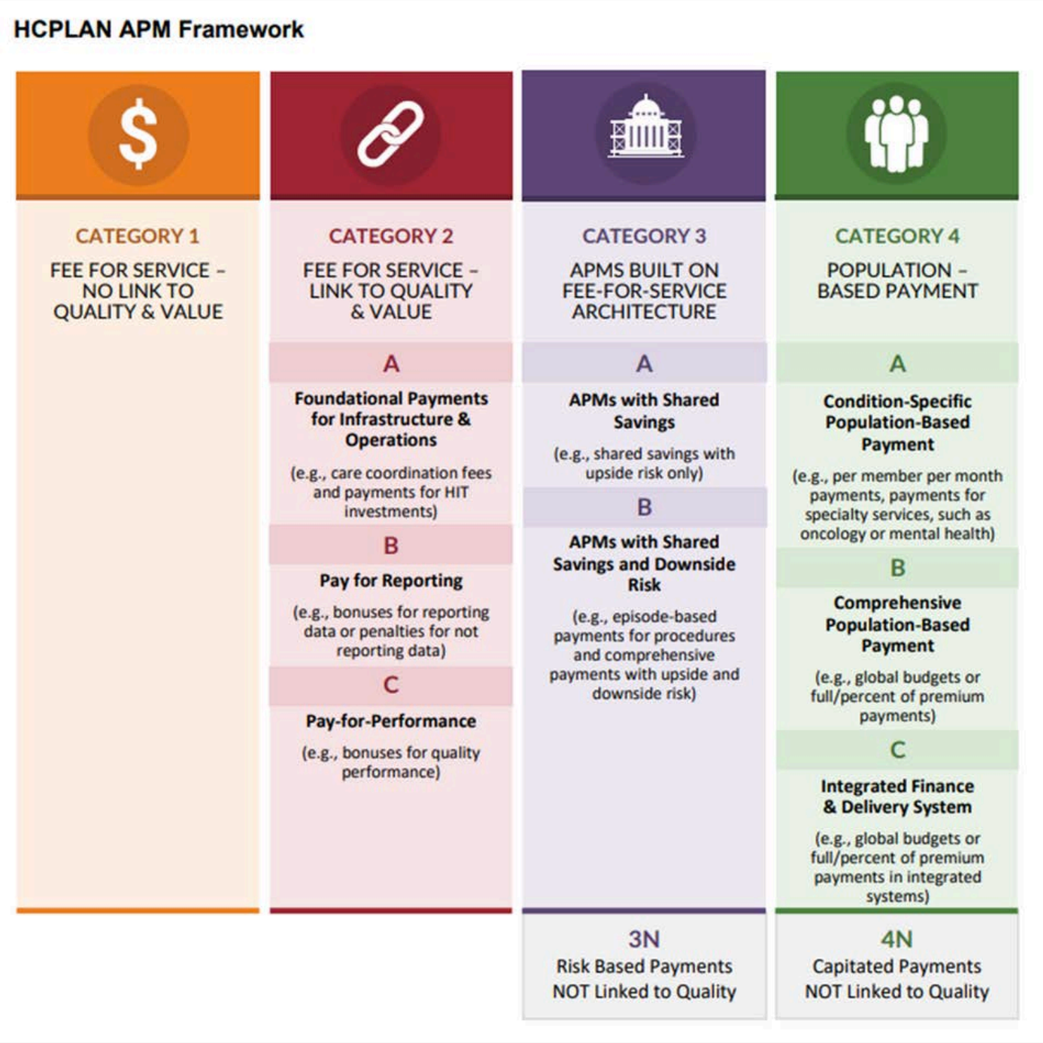
a. Still learning what is involved in Value-Based Care

b. Practicing elements of Value-Based Care, but not in any formal contracts

c. Actively seeking a Value-Based arrangement that fits our organization

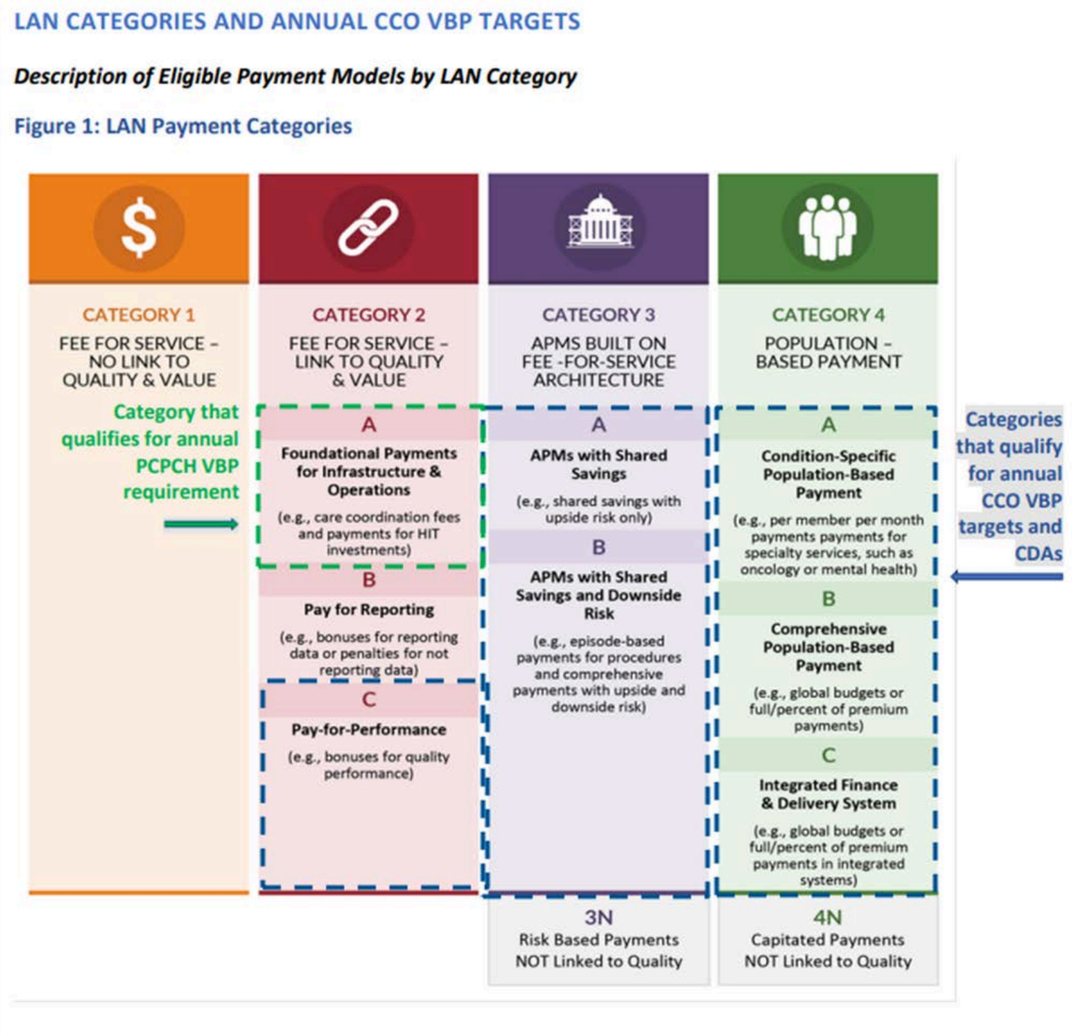
d. Participating in Pay for Performance or a Shared Savings arrangement

What types of VBC arrangements exist?



https://hcp-lan.org/apm-framework/

How do these arrangements exist in Oregon?



https://www.oregon.gov/oha/HPA/dsi-tc/Documents/VBP-Technical-Guide-for-CCOs.pdf

Transition Mindset from FFS to VBC

Where do we start?

We’re already struggling to capture revenue, how can we take on risk for an alternative payment model?

How can we know if we are set up for success prior to entering a VBC?

How can we start to make small steps towards preparing for VBC?

How do we know what type of VBC arrangement will work best for our organization?

Elements needed to progress to VBC

PCP Attribution to create a mechanism for patient outreach

Risk Stratification to prioritize outreach

Proactive Patient care facilitated through care coordination

- Methods to measure and evaluate how you are doing

CIN involvement can help mobilize around these areas

Provider Attribution aligns a Patient with a Provider

- Formal Methods
  - Voluntary Alignment
  - Claims based or primary care service based attribution
  - EMR based Registry
- Informal Methods
  - Clinician Knowledge
  - Manual lists or spreadsheets

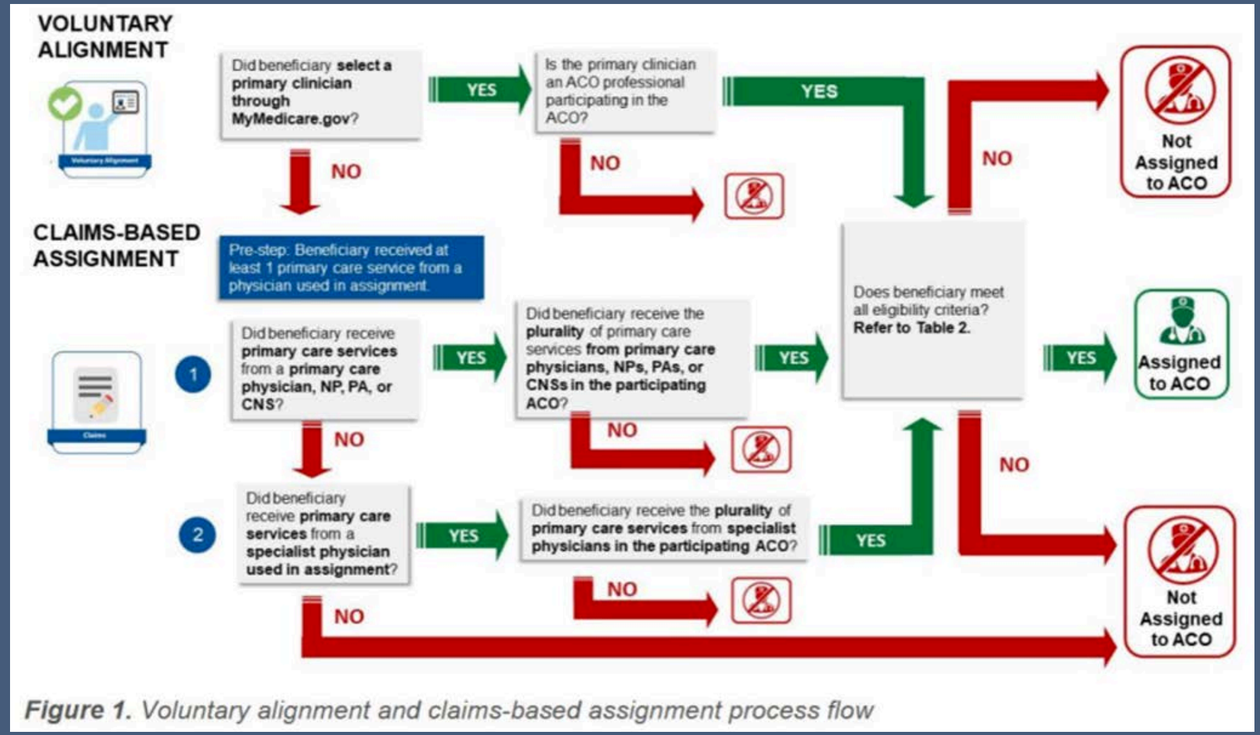
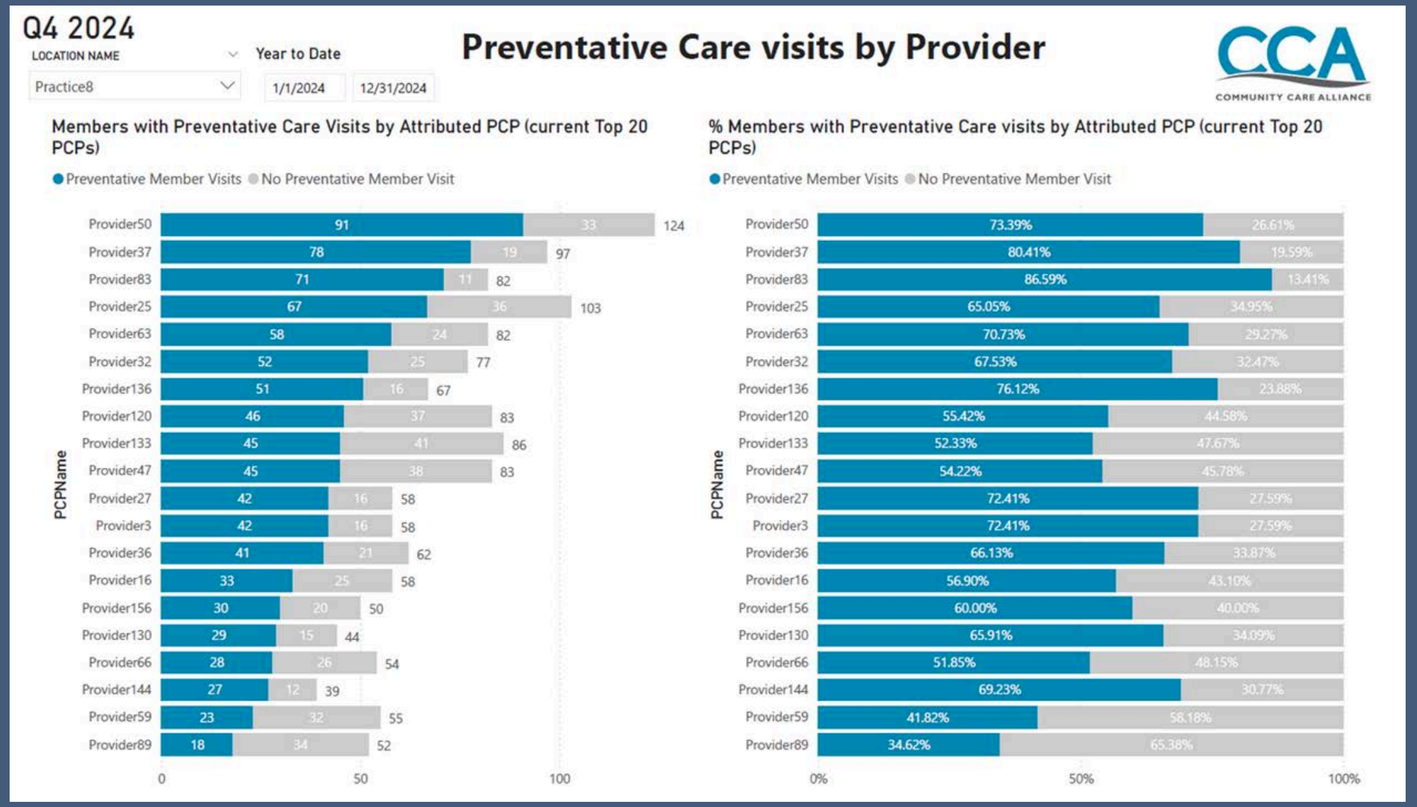


Figure 1. *Voluntary alignment and claims-based assignment process flow*

Why is Attribution Important?

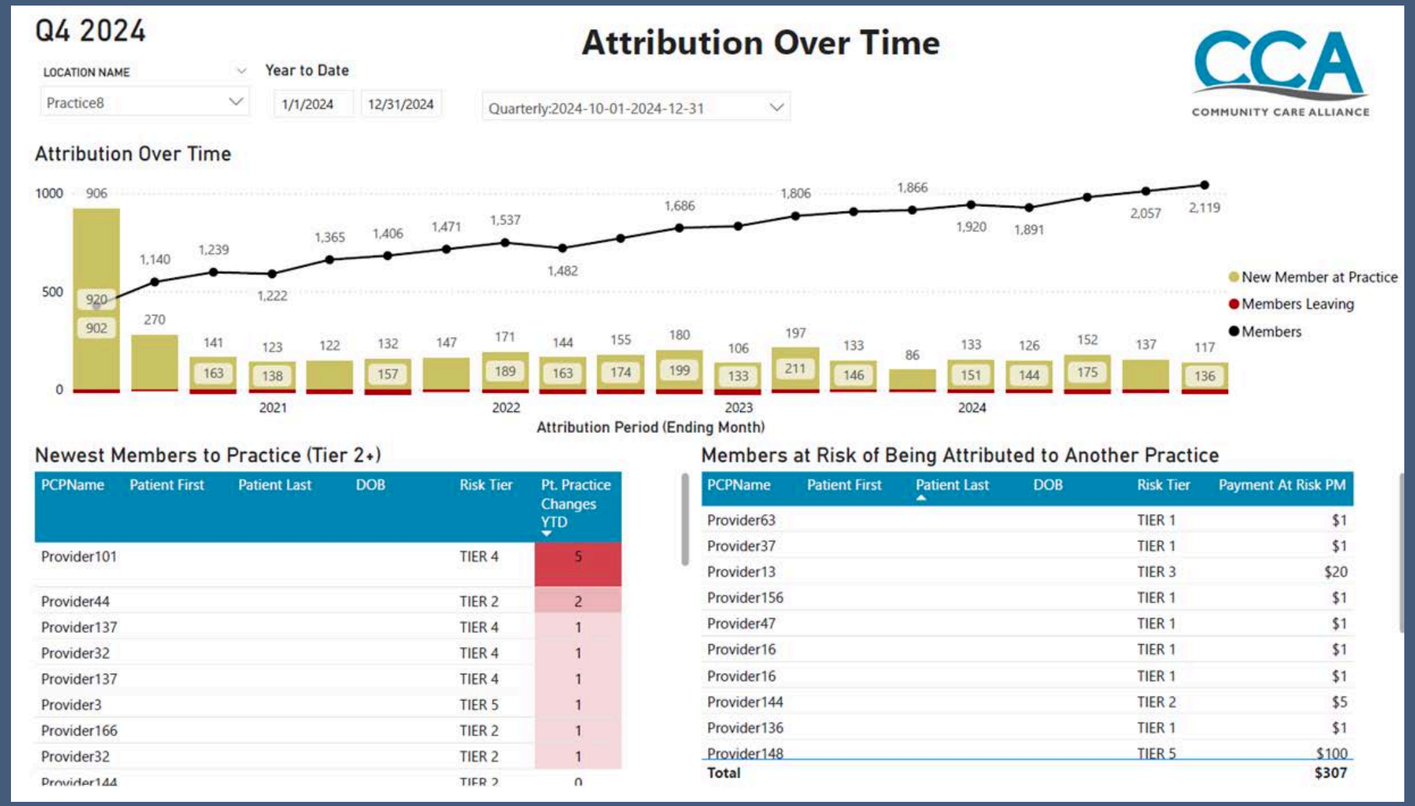
Becomes a method to align measures and success to a workflow



What insights can be derived?

Leakage: Where are patients on our panels going for primary and specialty care

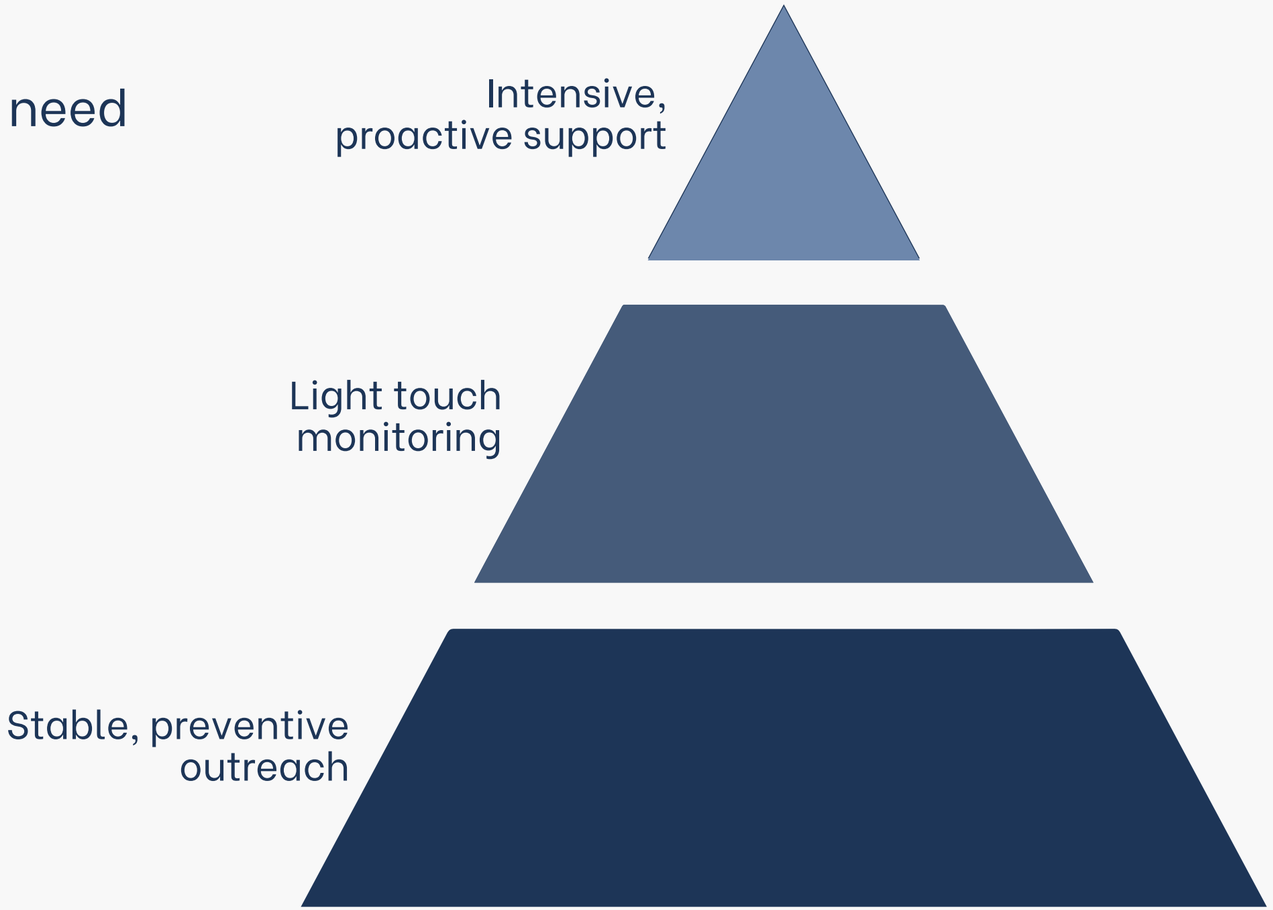
What does the composition of a panel look like?



Risk Stratification

The process of grouping patients by level of need

- Chronic Conditions
- Recent Utilization
- Functional or social complexity
- Clinician judgement

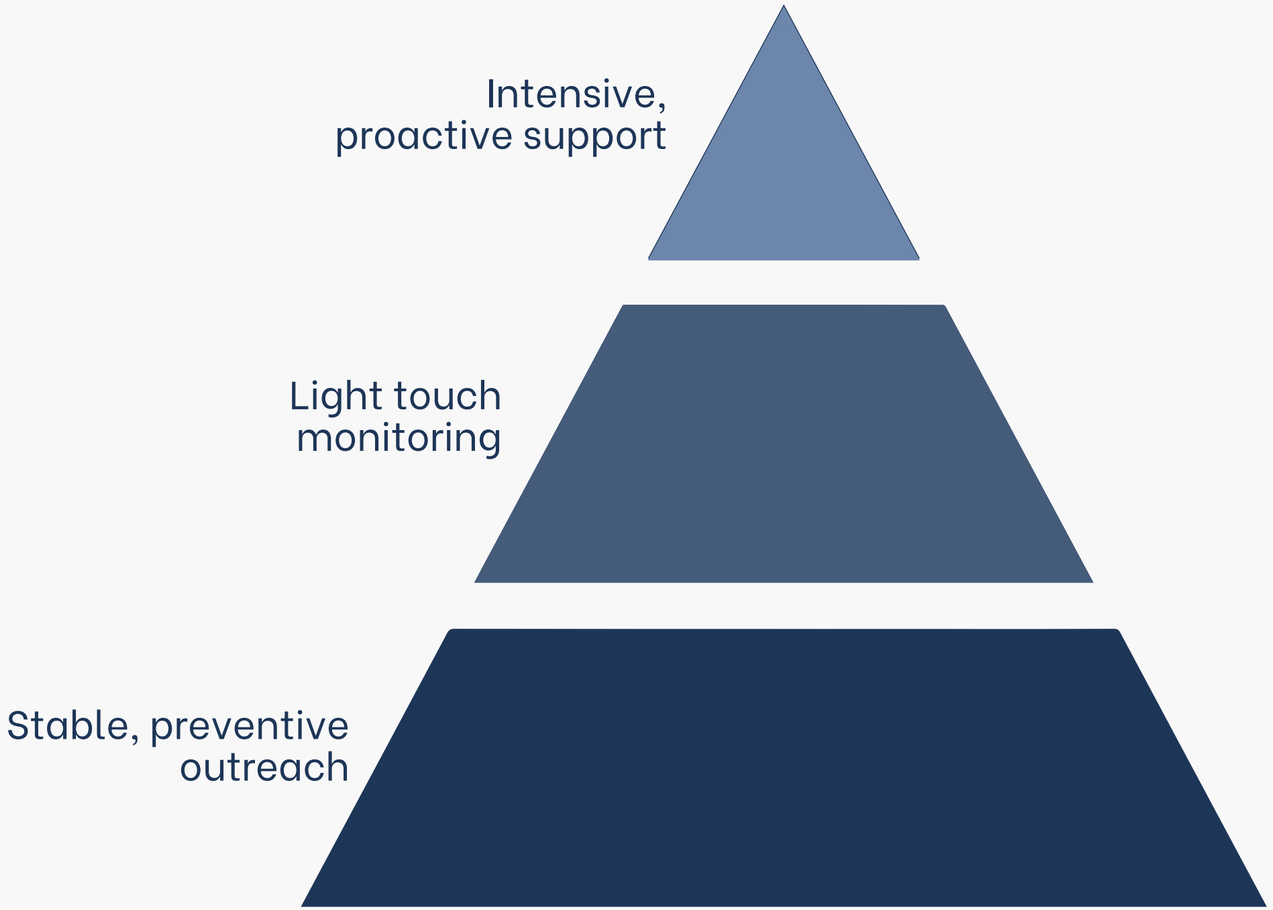


What are the benefits?

Allows workforce to work at the top of their scope/license

Prioritized outreach can minimize burden on providers and reduce burnout

Important to keep an eye on quick movement between levels



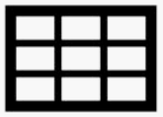
How to Risk Stratify?

Methods by level of effort

- Clinician Knowledge
- Care team huddles
- Manual lists/spreadsheets
- EMR-based registry
- Claims cost and utilization
- CMS HCC Risk adjustment
- Johns Hopkins ACG

CMS.gov Centers for Medicare & Medicaid Services

Johns Hopkins ACG® System

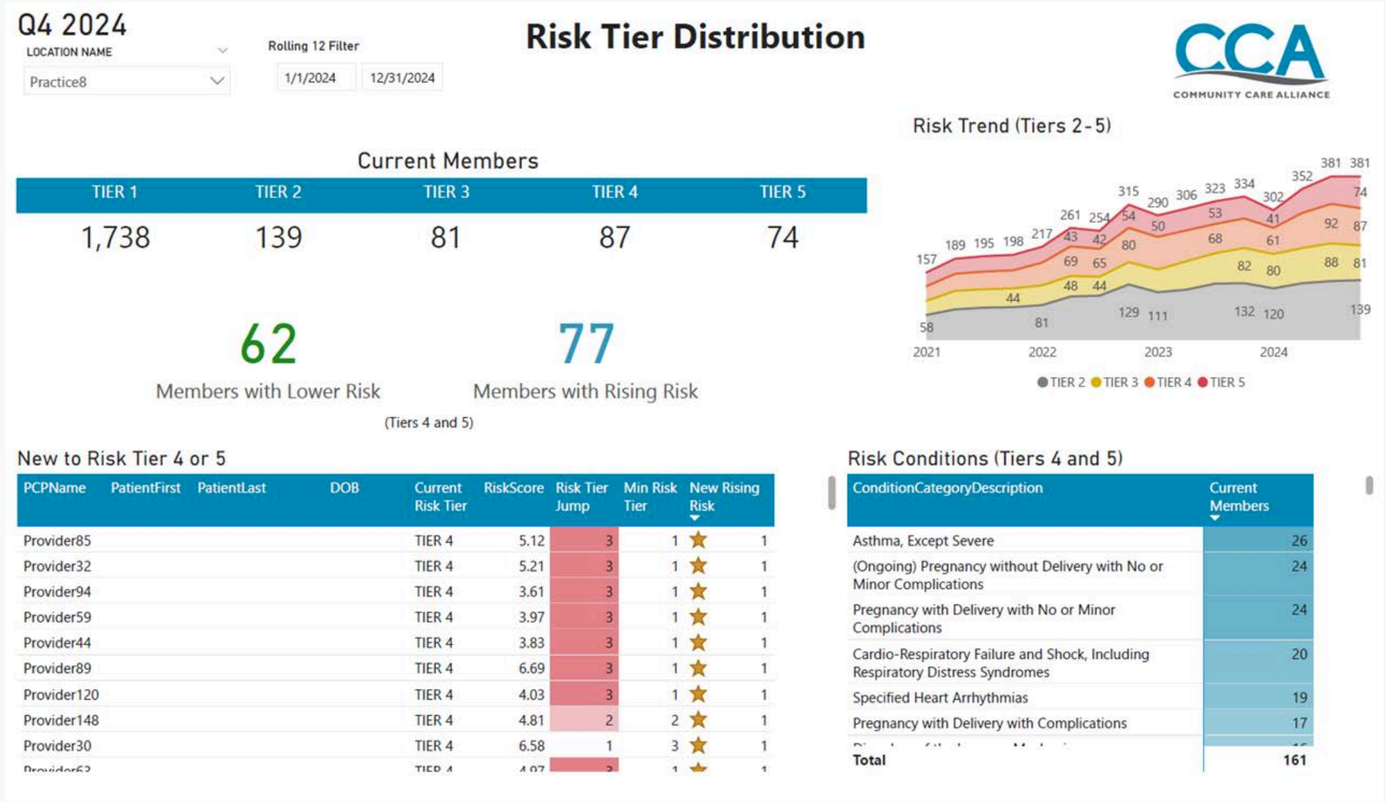


How to prioritize outreach?

Define an “impactable patient”

- Risk level
- Utilization
- Cost
- Risk score

Proactive outreach based on list



Poll Question

Which of these workflows are you proactively working on?

a. Annual Wellness Visits/Primary Care Visits

b. Chronic Condition Management

c. Transitional Care Management

d. One or more of the above

e. None of the above

Care Coordination services

Annual Wellness Visits:

Visit to develop or update a personalized prevention plan & perform a health risk assessment

Covered once every 12 months

Chronic Condition Management:

A continuous patient relationship with a chosen care team member

Based on time per calendar month

Transitional Care Management:

Supporting a patient's transition toa community setting

Conducted within 30 days post discharge

Advance Care Planning:

Voluntary, face-to-face discussion between you and your patient & their family members to discuss the patient's health care wishes if they become unable to make their own medical decisions

Behavioral Health management

Transforming Rural Healthcare through Care Coordination

Patient & Community Values

- Improved Outcomes & Satisfaction
- Fosters Patient Engagement & Responsibility
- Feels More Connected to Care Team
- Personal Connection in Managing Discharge Tasks
- Sense of Relief to Have Assistance Navigating Health Care Systems

Provider Benefits

- Outcomes Improve & Shown Through Data
- Re-admission Rates Decrease
- Opens Opportunity for Chronic Care Management Conversation
- Opportunity to Ensure Completion of Annual Wellness Visit & HCC Recapture Completed
- Emphasizes Communication & Coordination

Primary Care Visits for Current Members

Q4 2024

LOCATION NAME: Practice8

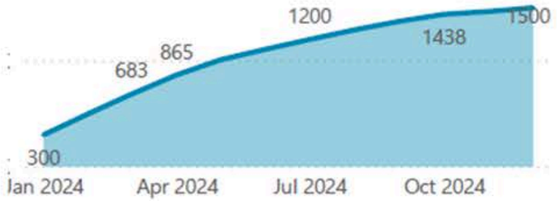
Year to Date: 1/1/2024 – 12/31/2024

COMMUNITY CARE ALLIANCE

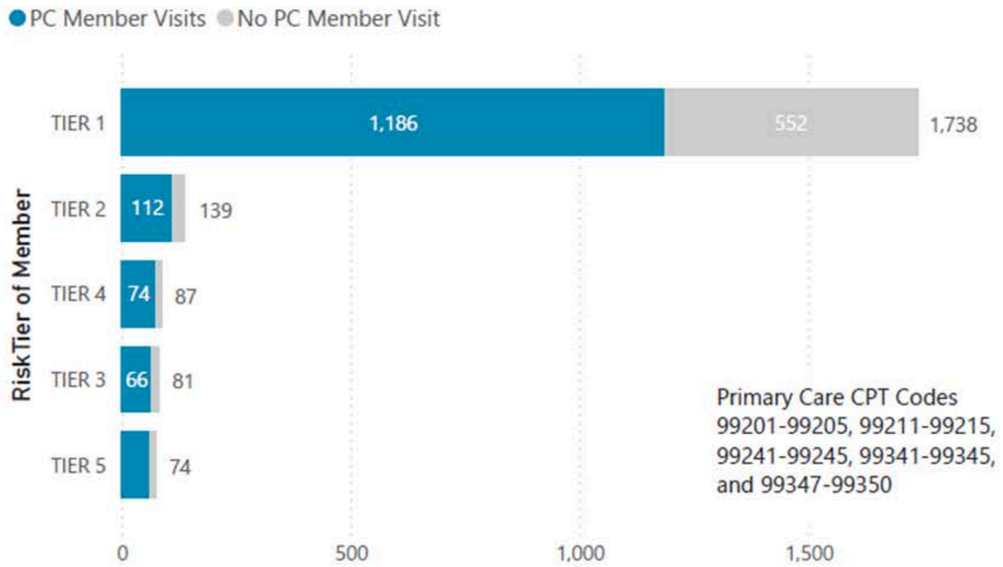
Volume

Members with Primary Care Visits

Members with Primary Care Visits over me



PC Visits by Risk Tier (current)



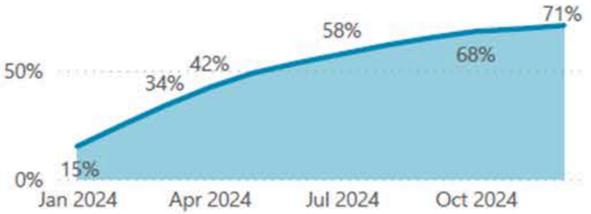
Primary Care CPT Codes
99201-99205, 99211-99215, 99241-99245, 99341-99345, and 99347-99350

% Percentage

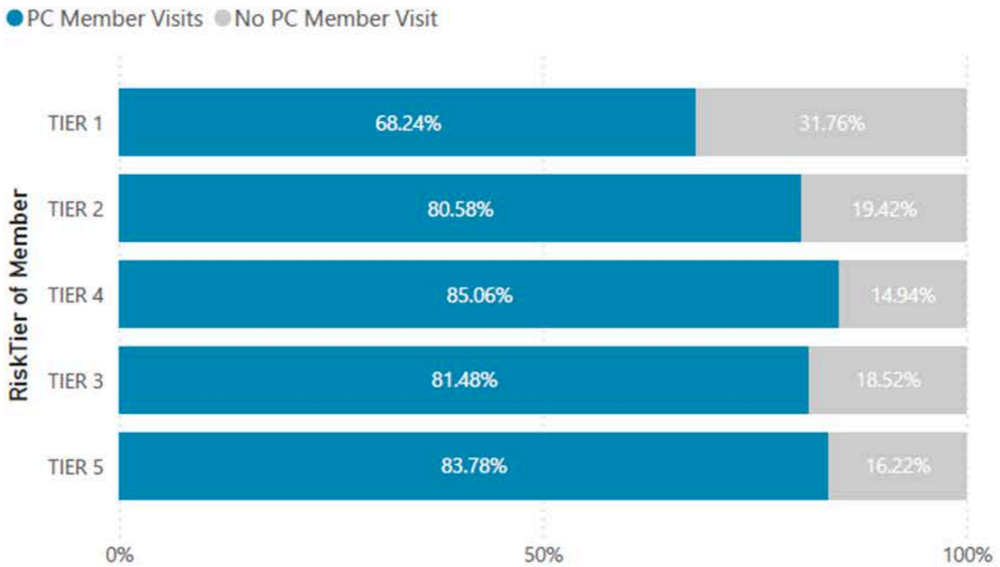
% Primary Care Member Visits

Prior % Primary Care Member Visits YTD

% Members with Primary Care Visits over time



% PC Visits by Risk Tier (current)



Q4 2024

Primary Care Conditions

LOCATION NAME

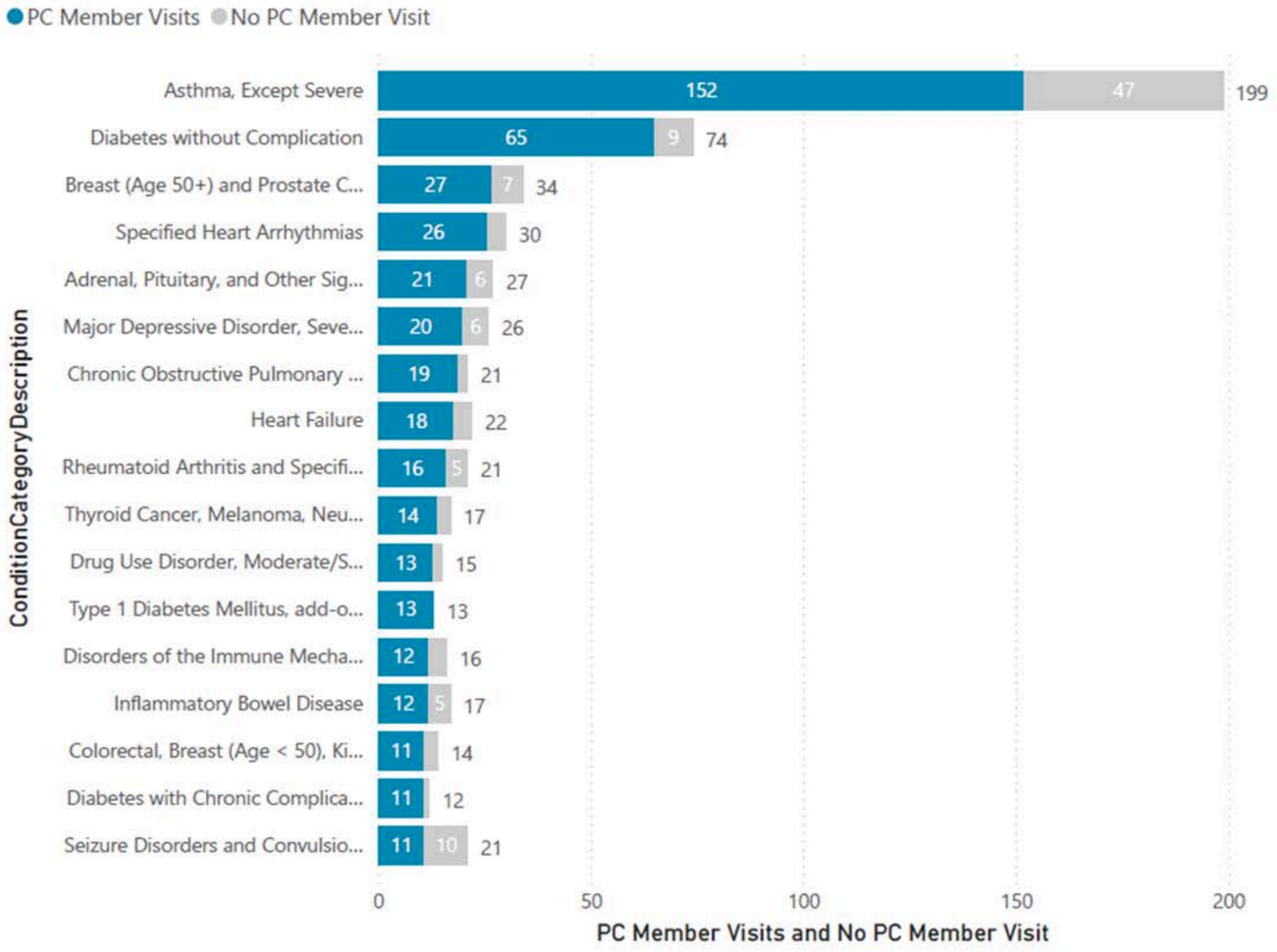
Practice8

Year to Date

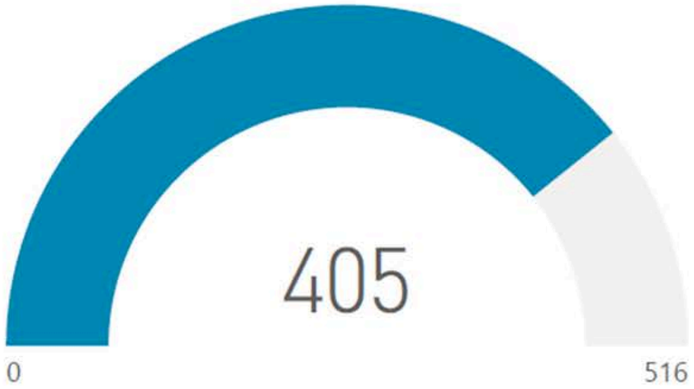
1/1/2024 12/31/2024

COMMUNITY CARE ALLIANCE

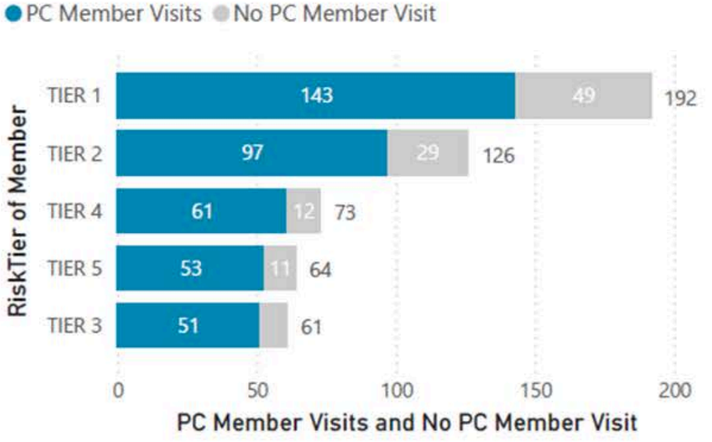
PC Member Visits and No PC Member Visit by ConditionCategoryDescription- Chronic



Current Members with Chronic Conditions that have had Primary Care Visit



PC Member Visits and No PC Member Visit by ConditionCategoryDescription- Chronic



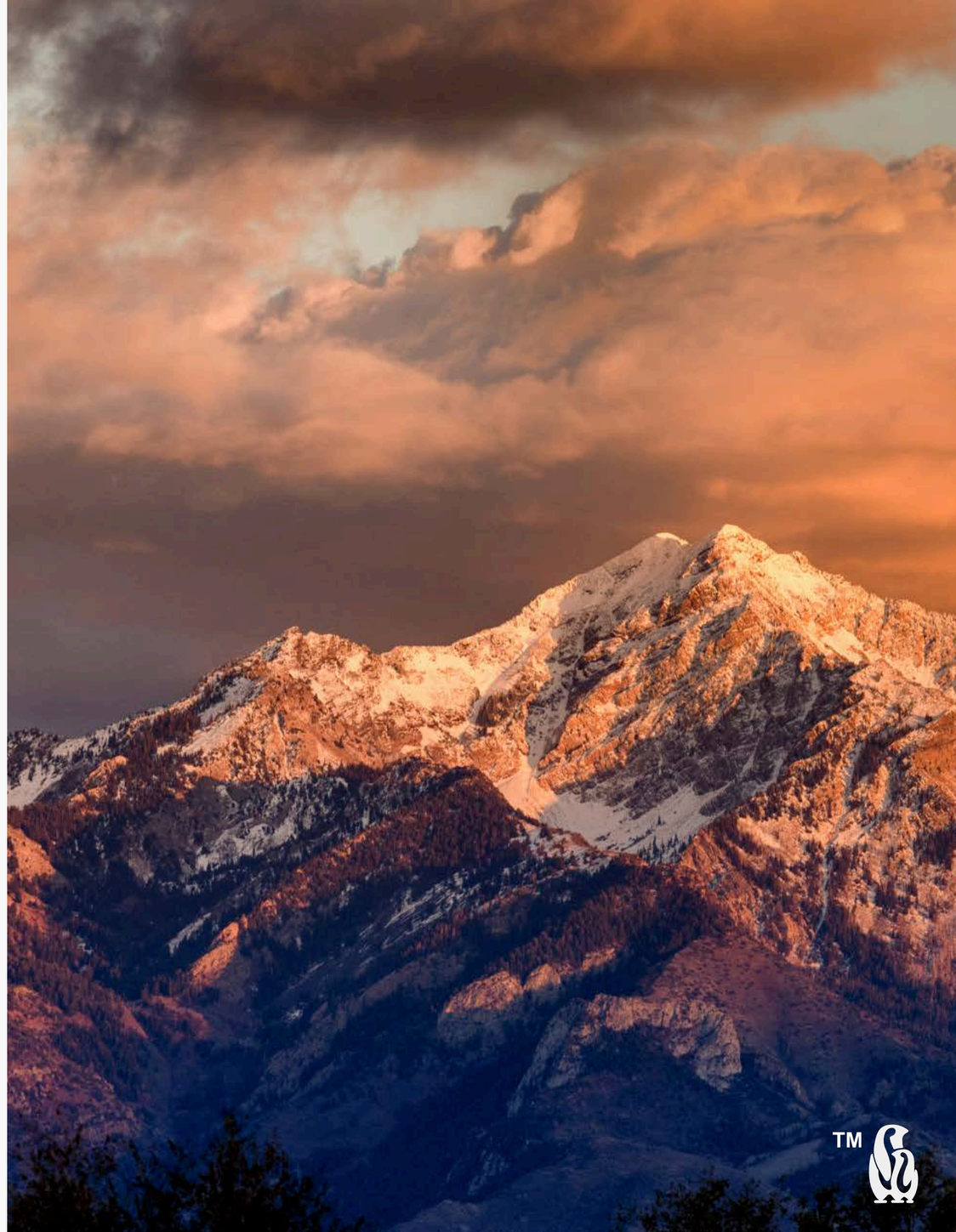
Proactively Managing Patients

Quality measures can help ensure patients are proactively managing conditions

- A better way to provide healthcare

Managing quality measures well can result in value-based payments

- Aligns outcomes with financial incentive



LOCATION NAME

Practice8

Year to Date

1/1/2024 12/31/2024

Commercial Scorecard

Measure Source	Measure	Numerator	Denominator	Rate	Target	Measure Met	Prior Year Rate	% Change
HEDIS	Breast Cancer Screening	233	281	82.9%	50%	33%	83.1%	-0.1%
HEDIS	Cervical Cancer Screening	556	849	65.5%	28%	37%	66.0%	-0.5%
HEDIS	Child and Adolescent Well-Care Visits	412	575	71.7%	40%	32%	61.3%	10.4%
HEDIS	Childhood Immunization Status	27	60	45.0%	24%	21%	57.1%	-12.1%
HEDIS	Colon Cancer Screening	431	680	63.4%	60%	3%	56.5%	6.9%
HEDIS	Immunizations for Adolescents	33	62	53.2%	30%	23%	44.6%	8.6%
HEDIS	Well-Child Visits in the First 30 Months of Life	64	73	87.7%	40%	48%	91.5%	-3.9%
VHA	Avoidable ED Visits	145		71.0		-27%	56.1	26.5%
VHA	ED Visit Follow Up	163	348	46.8%	75%	-28%	35.8%	11.1%
VHA	Preventive Care	1,376	2,119	64.9%	40%	25%	55.9%	9.0%
VHA	Transitions of Care	46	80	57.5%	75%	-18%	63.5%	-6.0%
Total								

Q4 2024

Preventative Visits for Current Members

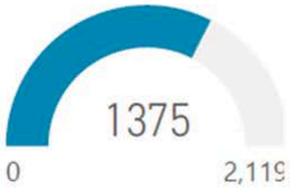
LOCATION NAME: Practice8

Year to Date: 1/1/2024 – 12/31/2024

COMMUNITY CARE ALLIANCE

Volume

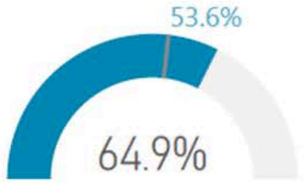
Members with Preventative Visits



Members with Preventative Visits over time

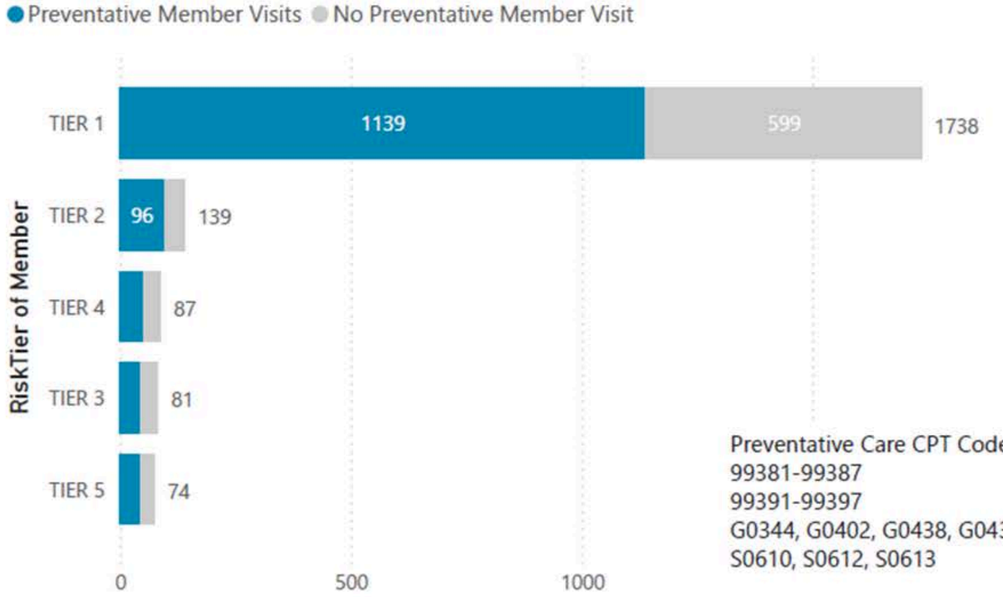
% Percentage

% Preventative Member Visits YTD



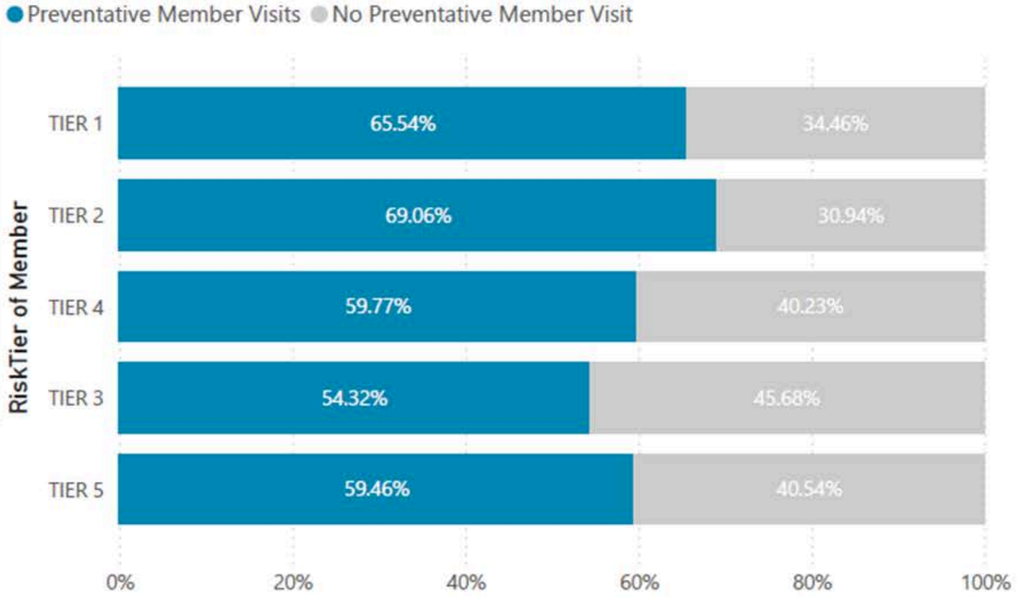
% Members with Preventative Visits over time

Preventative Visits by Risk Tier (current)



Preventative Care CPT Codes
99381-99387
99391-99397
G0344, G0402, G0438, G0439,
S0610, S0612, S0613

% Preventative Visits by Risk Tier (current)



LOCATION NAME

Practice8

YTD Date Range

1/1/2024 12/31/2024

Readmissions

CCA COMMUNITY CARE ALLIANCE

National Average % Readmissions Rate

13.9%

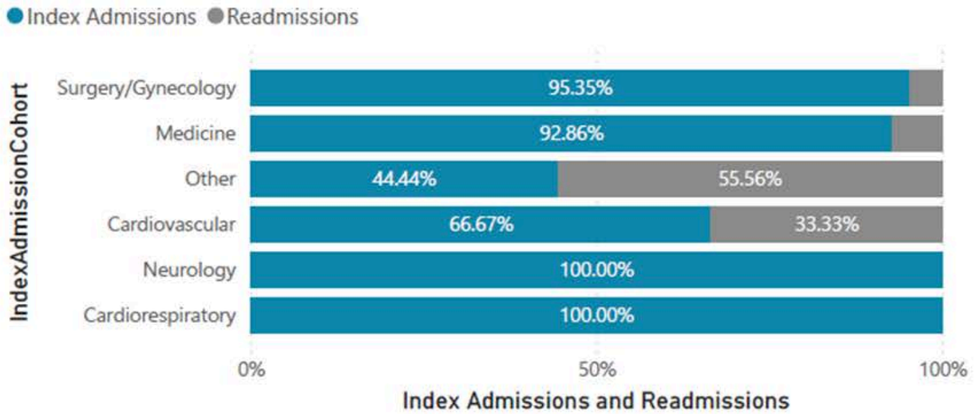
https://hcup-us.ahrq.gov/reports/statbriefs/sb304-readmissions-2016-2020.jsp

Readmission Rate for Rolling 12

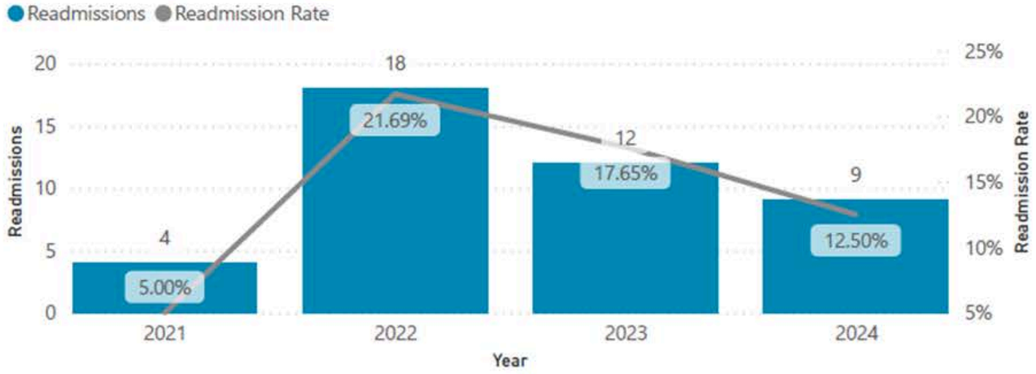
Readmissions Rate

Year	IndexAdmissions	Readmissions	Readmission Rate
2021	80	4	5.00%
2022	83	18	21.69%
2023	68	12	17.65%
2024	72	9	12.50%
Total	**303**	**43**	**14.19%**

Index Admissions and Readmissions by IndexAdmissionCohort for Rolling 12



Volume of Readmissions by Year and Quarter



Index Admission: An initial hospitalization that qualifies to be included in the readmission measure. Hospitalizations that are not included are: Planned hospitalizations, cancer, rehab, and mental health admissions, death before discharge, transfers, and discharge against medical advice.

Readmission Visit: A readmissions to a hospital visit that can be attributed to a previous hospital admission within a 30 day timeframe.

Patient Lists with Care Gaps

Loca	PatientAge	Gender	AttributionMethod	PreventiveCareNumerator	PreventiveCareDenominator	ChildAdolWellVisitNumerator	ChildAdolWellVisitDenominator	CervicalScreenNumerator	Cervi
ASPI	18	M	Claims Based Assignmer	Not Met	Denominator	Not Met	Denominator	N/A	N/A
ASPI	11	M	Claims Based Assignmer	Not Met	Denominator	Not Met	Denominator	N/A	N/A
ASPI	18	F	Claims Based Assignmer	Not Met	Denominator	Not Met	Denominator	N/A	N/A
ASPI	10	M	Claims Based Assignmer	Not Met	Denominator	Not Met	Denominator	N/A	N/A
ASPI	18	M	Claims Based Assignmer	Met	Denominator	Met	Denominator	N/A	N/A
ASPI	20	F	Claims Based Assignmer	Not Met	Denominator	Not Met	Denominator	N/A	N/A
ASPI	22	M	Claims Based Assignmer	Met	Denominator	Met	Denominator	N/A	N/A
ASPI	36	F	Claims Based Assignmer	Not Met	Denominator	N/A	N/A	Met	Denc
ASPI	6	M	Claims Based Assignmer	Met	Denominator	Met	Denominator	N/A	N/A
ASPI	3	M	Claims Based Assignmer	Met	Denominator	Met	Denominator	N/A	N/A
ASPI	10	M	Claims Based Assignmer	Not Met	Denominator	Not Met	Denominator	N/A	N/A
ASPI	13	M	Claims Based Assignmer	Met	Denominator	Met	Denominator	N/A	N/A
ASPI	9	M	Claims Based Assignmer	Met	Denominator	Met	Denominator	N/A	N/A
ASPI	7	F	Claims Based Assignmer	Met	Denominator	Met	Denominator	N/A	N/A
ASPI	5	M	Claims Based Assignmer	Met	Denominator	Met	Denominator	N/A	N/A
ASPI	3	M	Claims Based Assignmer	Met	Denominator	Met	Denominator	N/A	N/A
ASPI	0	M	Claims Based Assignmer	Met	Denominator	N/A	N/A	N/A	N/A
ASPI	17	M	Claims Based Assignmer	Met	Denominator	Met	Denominator	N/A	N/A

Tying it all together

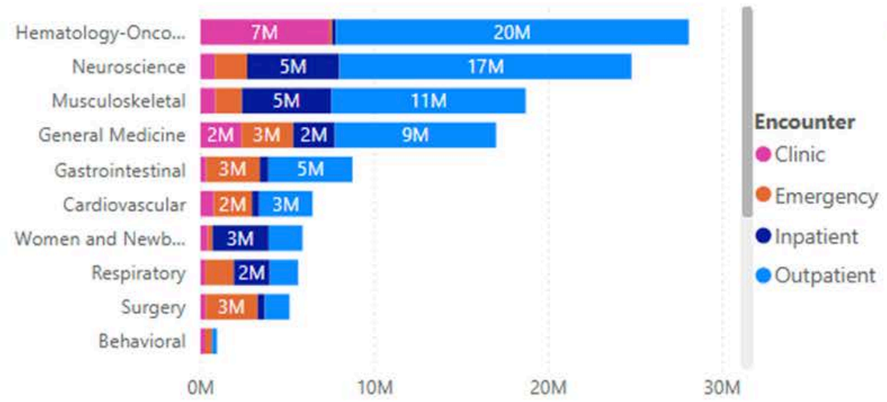
- Identify gaps in preventive care (e.g., diabetes, cancer screening, vaccinations)
- Understand future demand for services
- Inform staffing, clinic flow, and service line decisions
- Panel insight turns population health from an abstract concept into a planning tool
- For example - If 30% of a panel has uncontrolled diabetes, that’s not just a clinical issue – it’s an operational signal.”

Patient Lists with Care Gaps

REDiHealth
Life is better with data

Quantitative Assessment
Volume Analysis

Pareto Metric: Charges
Date: 1/1/2024 – 11/30/2024
Outlier Category: All
Encounter Type: All



CareProcessNM	Selected Year	Prior Year	% Change	% Trend
Back and neck pain	19,021,075.64	17,433,352.58	9.11%	1.42%
Cancer therapeutic procedures	12,594,621.24	6,104,043.24	106.33%	5.82%
Osteoarthritis	5,615,608.15	5,709,818.36	-1.65%	-0.08%
General examination	5,493,411.53	4,836,874.19	13.57%	0.59%
Myelodysplastic syndromes	3,070,212.32	744,029.75	312.65%	2.09%
Soft tissue disorders	2,445,523.38	2,779,976.83	-12.03%	-0.30%
Other general medicine findings and anomalies	2,371,865.02	1,883,216.37	25.95%	0.44%
Lymphoid and hematopoietic neoplasms	2,162,927.47	2,725,260.84	-20.63%	-0.50%
Abdominal and pelvic pain, tenderness and rigidity	2,124,648.92	1,767,477.06	20.21%	0.32%
Total	**122,849,234.73**	**111,533,161.02**	**10.15%**	**10.15%**

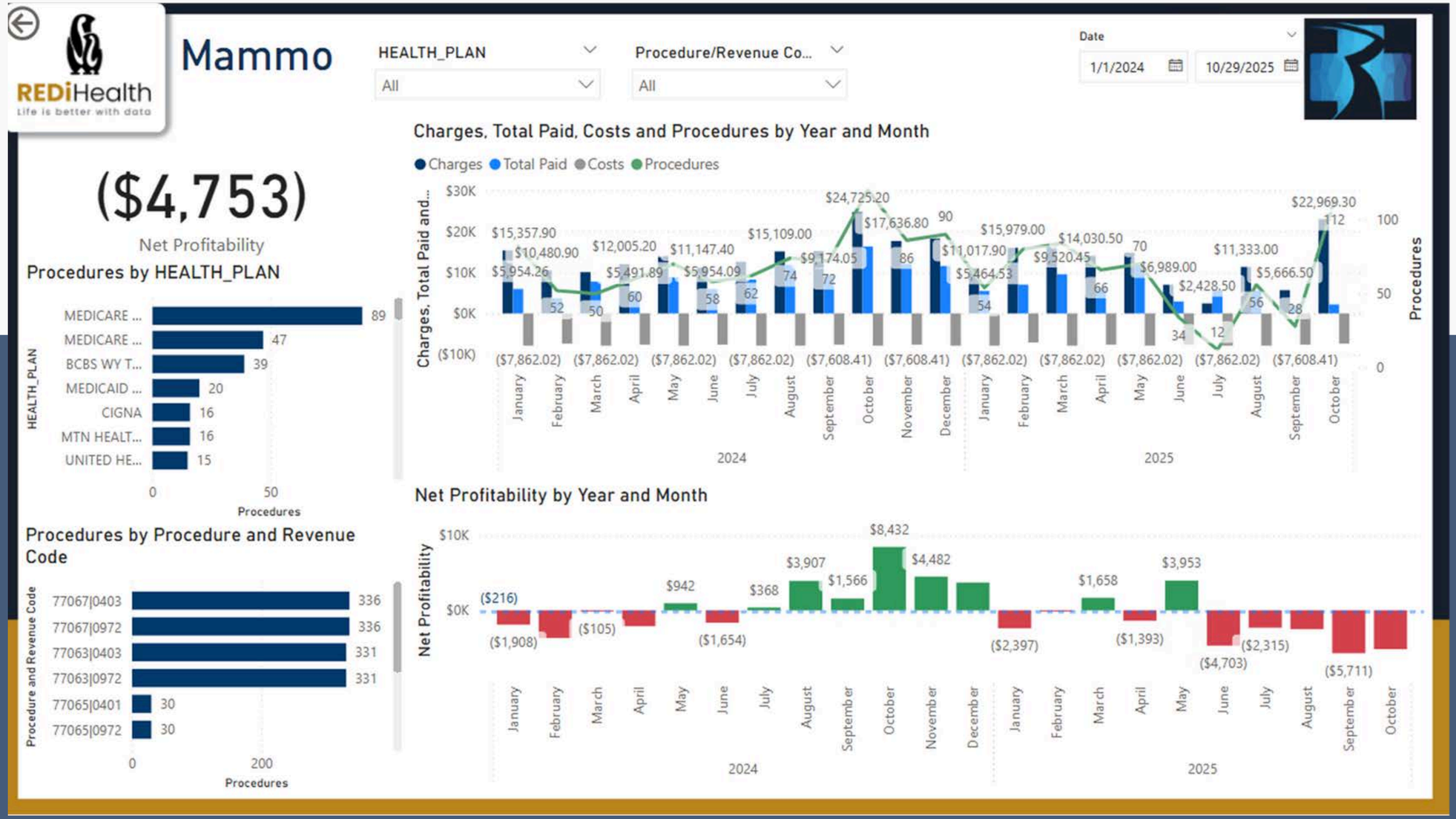
CareProcessFamilyNM	Discharges	Charges	Avg. Charge	Net Revenue	Collection %
⊞ **Neoplasms**	**3,335**	**$21,573,623.97**	**$6,468.85**	**$11,809,446.60**	**54.74%**
⊟ **Dorsopathies**	**4,374**	**$19,347,327.13**	**$4,423.26**	**$7,299,095.86**	**37.73%**
⊟ **Back and neck pain**	**4,359**	**$19,021,075.64**	**$4,363.63**	**$7,223,166.73**	**37.97%**
⊞ M47.896 - Other spondylosis, lumbar region	549	$5,136,255.37	$9,355.66	$1,672,972.97	32.57%
⊞ M54.16 - Radiculopathy, lumbar region	694	$2,021,547.14	$2,912.89	$792,827.93	39.22%
⊞ M43.16 - Spondylolisthesis, lumbar region	29	$1,892,951.56	$65,274.19	$825,205.41	43.59%
⊞ M47.892 - Other spondylosis, cervical region	117	$897,286.32	$7,669.11	$345,285.92	38.48%
⊞ M47.26 - Other spondylosis with radiculopathy, lumbar region	73	$828,284.23	$11,346.36	$375,520.66	45.34%
⊞ M54.59 - Other low back pain	565	$802,749.40	$1,420.80	$348,106.35	43.36%
⊞ M48.062 - Spinal stenosis, lumbar region with neurogenic claudication	28	$732,785.21	$26,170.90	$212,205.96	28.96%
⊞ M54.12 - Radiculopathy, cervical region	278	$656,081.97	$2,360.01	$276,363.28	42.12%
Total	**49,614**	**$122,849,234.73**	**$2,476.10**	**$61,447,350.33**	**50.02%**

Data Through: 02/20/2025

Clinic | Hospital

Version: 0.1.0

Patient Lists with Care Gaps



The Role of a CIN

Centralized Data Analytics

Support for Care Coordination (The “Human Link” Between Data & Outcomes)

Integrated Pharmacy Strategy

Locally Led Improvement

Questions or Comments?

Get In Touch!

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ORH Announcements

- **Next CAH Finance and Operations Webinar:**
  - **Feb. 3 at 12 p.m. | Revenue Integrity with ChargeMaster (CDM) Use Case** (*Register here*)
- **Next ORH Community Conversations** (*Register here*):
  - **Jan. 29 at 12 p.m.** | Oregon Legislative Update
  - **March 19 at 12 p.m.** | Rural Health Transformation Program Updates
- **May 14-15, 2026 Virtual | 3rd Annual Forum on Rural Population Health** (*More information here*)
- **Oct. 7-9, Bend, OR | 43rd Annual Oregon Rural Health Conference** (*More information here*)

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OPPORTUNITY Just knock.

Thank you!

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