# 2026 Oregon Rural Health Conference Presentation Slides

^caret health

# Next Generation Centralized Care Coordination

AI Driven Transformation of Rural Healthcare

Dr. Riya Pulicharam



Rural Healthcare Is Facing a

# Structural Crisis



# Key Challenges

- Rising chronic disease burden
- Workforce shortages in rural communities
- Fragmented patient journeys
- Cuts to fee-for-service revenue
- Pressure from value-based care
- *Care Coordination Problem:* Difficulty meeting quality and performance metrics



# 5%

of Patients Drive Nearly of

# Half of Healthcare Costs

# The $10,000 Patient Problem

A small number of high-risk patients drive majority of costs

Fragmented care leads to preventable admissions

Poor medication coordination increases readmissions

***Better care coordination*** dramatically improves outcomes

FROM VOLUME TO VALUE

# Value Over Volume: Why Less Can Be More

## Building a sustainable value-based care model

The operating model required to turn better care into sustainable value.



# The Fundamental Shift

Value-based care requires a different definition of financial and clinical success.

## Traditional Fee-for-Service

- More encounters
- More procedures
- More utilization
- Revenue per encounter
- Reactive care
- Quality as a reporting exercise



## Value-Based Care

- Better outcomes
- Right care at the right time
- Less avoidable utilization
- Revenue per population
- Proactive care
- Quality as an operating strategy

The question changes from **“How do we generate more visits?”**
to **“How do we create more value from every patient we are responsible for?”**

# The Hidden Value of Value-Based Care

"If we reduce unnecessary utilization, aren't we reducing revenue?"

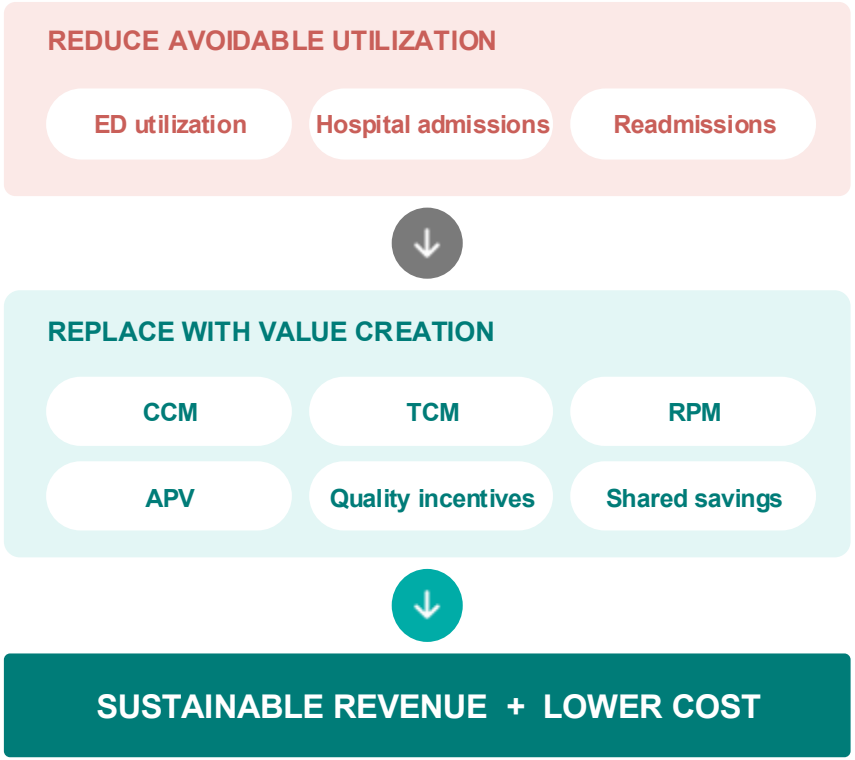
## Sometimes, in the short term.

But the strategic question is:

## What revenue is being replaced, and with what?

**VBC is not trying to eliminate revenue.**

It is trying to change the **source** of the revenue.



# Not All Admissions Are Equal

The future is not fewer admissions. The future is getting paid at every step.

**One CHF patient, one year.** ● = a payment

## Today

We get paid once, maybe twice



**Admission**
Paid once

**Readmission?**
Maybe paid twice

## Tomorrow

We get paid at every step of managing them



**APV**
Identifies risk

**CCM**
Manages condition monthly

**RPM**
Monitors weight / BP

**Admission**
Only when necessary

**TCM**
Follows discharge

**Quality**
Incentives achieved

**Shared savings**
Earned at year end

**The insurance company already won.** Payers are reducing utilization either way. We can lose it, or get paid to manage it.

**“Centralized care coordination is the digital and human bridge that ensures geography never dictates the quality of a patient's journey.”**

**Why is centralized care coordination at the core of value-based care?**

# History of Care Coordination

From social work roots to intelligent, connected care



**1900s–1970s**

## Early Origins

- Social work and public health
- Focus on vulnerable groups
- Cost and utilization tracking

**1980s–1990s**

## Demonstration Projects & Expansion

- National Long-Term Care Demonstration
- Managed care growth
- Role diversification

**2000s–Present**

## Modern Frameworks & Integration

- Patient-Centered Medical Home
- Health reform incentives
- Digital integration

**Next**

## Intelligent Care Navigation

- AI risk prediction
- Automated clinical care pathways
- One platform to consolidate work across all programs



## Fragmented Care

- Separate vendors for TCM, CCM, RPM, quality improvement, cancer care navigation, etc.
- Need to hire large teams to manage programs via spreadsheets
- Disconnected data
- Programs operate in siloes with redundant patient outreach



## Centralized Care Coordination

- One data platform
- One care plan
- One coordination team
- AI risk prioritization
- Integrated workflows to drastically save labor costs and maximize patient engagement

# The Future of Centralized Care Coordination

From a static, reactive administrative model to an intelligent, data-driven orchestration hub

## Workflow consolidation & automation

Validated clinical care pathways create each next step

## Predictive risk stratification

AI risk modeling across each patient's longitudinal journey

## Proactive prevention

Reach patients before a gap becomes an ER visit



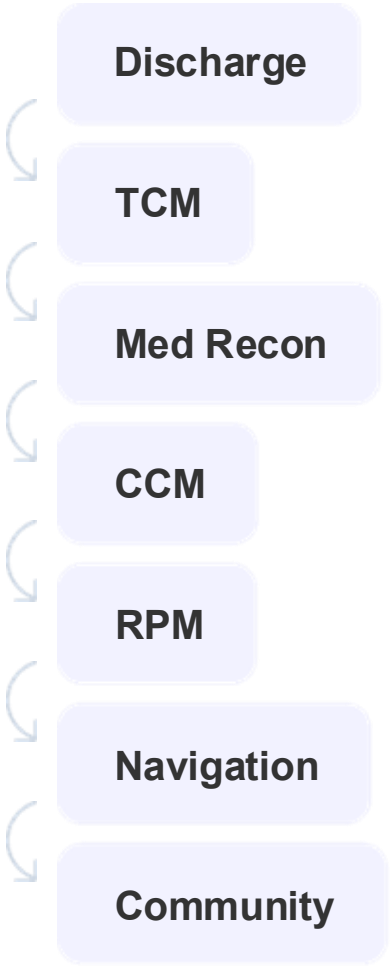
**Inside the Caret platform:** every open gap becomes a task with step-by-step pathway instructions.

**A digital platform powering intelligent care coordination for effective care navigation.**

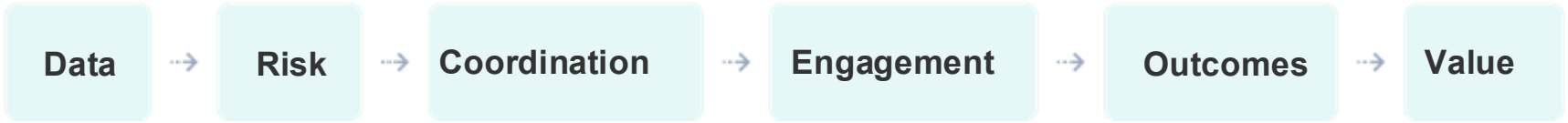
# Goal: Programs Integrated Into One Platform

1. Transitions of Care Management (TCM)
2. Medication Reconciliation
3. Chronic Care Management (CCM)
4. Remote Patient Monitoring (RPM)
5. Cancer Care Navigation
6. Social Determinants of Health

# Patient Journey Across Coordinated Care



# FROM DATA TO VALUE: HOW ONE PLATFORM DRIVES RESULTS



# Five Levers That Move Total Cost of Care

Between APVs, these five workflows keep patients stable, out of the ED, and out of the hospital.



LEVER 1

### Transitional Care Management

30 days of structured follow-up after a hospital, SNF, or facility discharge



LEVER 2

### Chronic Care Management

Year-round, monthly care coordination for patients with 2+ chronic conditions



LEVER 3

### Pharmacy Spend & Med Reconciliation

Adherence review at every encounter, our strongest lever against avoidable ED visits



LEVER 4

### ED Utilization & Readmissions

Proactive outreach and high-utilization patient identification before the next crisis



LEVER 5

### HCC Coding

Accurately reflecting patient complexity enables better risk adjustment and drives improvement

**A recent hospital discharge is one of the strongest signals to prioritize outreach.** TCM follow-up funnels patients back into primary care and CCM.

# CCM + TCM: Care Management Is Also a Revenue Engine

The work that improves care can also create legitimate, recurring fee-for-service revenue.

## CCM Chronic Care Management

For eligible patients needing ongoing chronic-care management.

- Care plans + patient outreach
- Medication management
- Coordination across settings
- Preventive / quality gap work
- Ongoing monitoring and escalation

## TCM Transitional Care Management

For qualifying transitions after discharge.

- Contact within required timeframe
- Medication reconciliation
- Follow-up visit
- Discharge plan execution
- Early identification of deterioration

**The APV can be the launch point for identifying and initiating appropriate CCM.**

# AI Enables Scalable Care Coordination

- Consolidate patient engagement workflows and remove redundancies in patient outreach
- Prioritize highest cost and highest ROI patients
- Adapt to individualized patient outreach preferences
- Predict hospitalization risk
- Automatically detect care gaps
- Trigger automated care coordination tasks
- Monitor and triage RPM alerts



# Operational Impact

- One centralized clinical team
- Automated workflows and tasking
- Real time population health dashboards
- Improved continuity of care



# Financial Impact for Rural Hospitals

- New revenue from CCM, TCM, RPM
- Reduced avoidable admissions
- Improved ACO performance
- Higher quality scores



# Revenue Is No Longer Just What Happens Inside Our Four Walls

The economic unit is increasingly the patient population and its total cost of care.



**STEP 1**

## Identify

Who are we responsible for?

**STEP 2**

## Engage

Reach the patient before risk escalates.

**STEP 3**

## Manage

Close gaps and manage chronic disease.

**STEP 4**

## Coordinate

Make transitions and handoffs work.

**STEP 5**

## Improve

Lower avoidable utilization.

**VALUE CREATION**

- Care-management revenue
- Quality incentives
- Shared savings / VBC
- Avoided cost
- Retention & payer performance

**The objective is not to bill more.** It is to manage the patient better and appropriately capture the value of doing so.

# The Value-Based Care Equation

Think about the entire financial stack, not one billing code or one quality measure.

### Care Management Revenue

- APV
- CCM
- TCM
- RPM

+

### Quality Incentives

- Payer quality
- Performance bonuses

+

### VBC Economics

- Shared savings
- Contract incentives

+

### Avoided Costs

- Lower preventable utilization

+

### Strategic Value

- Retention
- Payer performance
- Reputation

−

**PROGRAM INVESTMENT**

People • Technology • Training • Workflow redesign

=

**NET FINANCIAL IMPACT**

**Revenue created + cost avoided − investment**

**ROI = Net Financial Impact ÷ Program Investment**

# Our Partner Networks: Rough Rider & Headwaters

**What is a Clinically Integrated Network (CIN)?**

A group of independent hospitals and clinics that share data, quality goals and care coordination, and contract together with payers for value-based care, while each stays locally owned and independent.

## Rough Rider High-Value Network

North Dakota CIN · Formed 2023

| 22 | 37 | 225K+ |
|---|---|---|
| hospitals | rural clinics | patients |

Shared services, $3.5M state funding, value-based contracts

**18 hospitals live on Caret**

## Headwaters High-Value Network

Minnesota CIN · Formed 2024

| 19 | 50+ | 750K+ |
|---|---|---|
| hospitals | clinics | patients |

Shared services and joint value-based payer products

**16 hospitals live on Caret since April 2026**

**Together:** 41 hospitals and ~1M rural patients across two states, with 34 hospitals live on one platform

# RRHVN Outcomes: All 6 Quality Measures Improved

RRHVN Medicaid HMO · 2024 → 2025 final performance

### Colorectal cancer screening

**52.0%**

from 40.2% in 2024

▲ 11.8 pts

### Cervical cancer screening

**38.1%**

from 27.7% in 2024

▲ 10.4 pts

### Breast cancer screening

**50.8%**

from 40.8% in 2024

▲ 10.0 pts

### Adult preventive visits

**15.4%**

from 8.0% in 2024

▲ 7.5 pts

### Blood pressure control

**60.9%**

from 53.4% in 2024

▲ 7.5 pts

### Poor diabetes (A1c) control

**28.3%**

from 36.9% in 2024

▼ 8.6 pts (lower is better)

# Rough Rider Network: Care Coordination at Scale

18 North Dakota Rural Hospitals through 8/31

**Population**

Patients in network

**11,090**

patients

**Care Gaps**

Identified to close at start

**18,094**

current care gaps

**9,422**

**Phone**

Outbound calls

**20,187**

calls to patients

**Text**

SMS outreach

**10,466**

texts to patients

**2,459** **visits scheduled** across North Dakota

# Headwaters Network: Care Coordination at Scale

16 Minnesota Rural Hospitals through 8/31 with first hospitals launched in April 2026

**Population**

Patients in network

**14,893**

patients

**Care Gaps**

Identified to close at start

**29,157**

current care gaps

**14,722**

**Phone**

Outbound calls

**22,172**

calls to patients

**Text**

SMS outreach

**9,080**

texts to patients

**2,112** **visits scheduled** across Minnesota

# Headwaters Network: Quality Gaps Closed

YTD, all programs, Measure Year 2026 · 29,157 total gaps

**Breast cancer screening**

**85%**

of 1,972 gaps

**Colorectal cancer screening**

**78%**

of 5,329 gaps

**Cervical cancer screening**

**74%**

of 3,792 gaps

**Blood pressure control**

**61%**

of 1,661 gaps

**Diabetes eye exam**

**55%**

of 882 gaps

**Diabetes glycemic status**

**37%**

of 695 gaps

**Child well-care visits**

**18%**

of 3,611 gaps

**Adult preventive visits**

**18%**

of 11,215 gaps

Waiting on claims data for WCV and AAP as there is a 3 month delay

# Colorado, Nebraska & Wisconsin Results

4 rural hospitals across 3 new states

## Colorado

**Lincoln Health**

Medicare AWV program

Program go-live date: 05/11/26

**799**

Patients

| | |
|---|---|
| Chart scrubbing | **400 tasks** |
| Patient outreach | **726 tasks** |
| Patient calls | **2,247 calls** |
| **Total visits** | **109 AWVs** |

## Nebraska

**Memorial Health Care**

BCBS, MSSP, UHC MA quality + TCM

Program go-live date: 06/25//26

**4,288**

Patients

| | |
|---|---|
| Chart scrubbing | **4,307 tasks** |
| Patient outreach | **1,305 tasks** |
| Patient calls | **2,371 calls** |
| Text messages | **641 SMS** |
| **Total visits** | **261 visits** |

## Wisconsin

**Reedsburg Area Medical Center**

Medicare AWV Program

Program go-live date: 06/08//26

**2,173**

Patients

| | |
|---|---|
| Chart scrubbing | **1,070 tasks** |
| Patient outreach | **575 tasks** |
| Patient calls | **1,134 calls** |
| Text messages | **639 SMS** |
| **Total visits** | **498 visits** |

**7,260** patients reached · **5,752** patient calls · **868** total visits

# The Future of Rural Healthcare



AI Enabled Population Health Command Centers



All programs (CCM, TCM, RPM, Quality Improvement) under one roof



No more vendor siloes being managed through spreadsheets and manual labor

# From Fragmented Care



# Continuous Coordinated Care

# The Leadership Takeaway

Value-based care is not about doing less. It is about doing the right things earlier and supporting your teams to succeed.

PILLAR 1

## APV

Find the risk and activate the next step.

PILLAR 2

## Diabetes

Manage a high-cost chronic condition before complications escalate.

PILLAR 3

## Total Cost of Care

Reduce avoidable utilization while preserving appropriate care.

POWERED BY

CCM | TCM | RPM | Care Coordination

**Better health + lower avoidable utilization + sustainable revenue = VALUE**

***Turn the strategy into action.***



CHOLUTECA BRIDGE, HONDURAS, 1998

# Built to last. Then the river moved.

Hurricane Mitch moved the river. The bridge survived, but it no longer crossed anything.

Rural healthcare faces the same risk: fixed sites built for acute care, while patient needs shift to chronic care at home.

**Intelligent care navigation follows the patient, wherever the river goes.**