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Next Generation Centralized Care Coordination

AI Driven Transformation of Rural Health Care

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Rural Health Care Is Facing a

Structural Crisis



Key Challenges

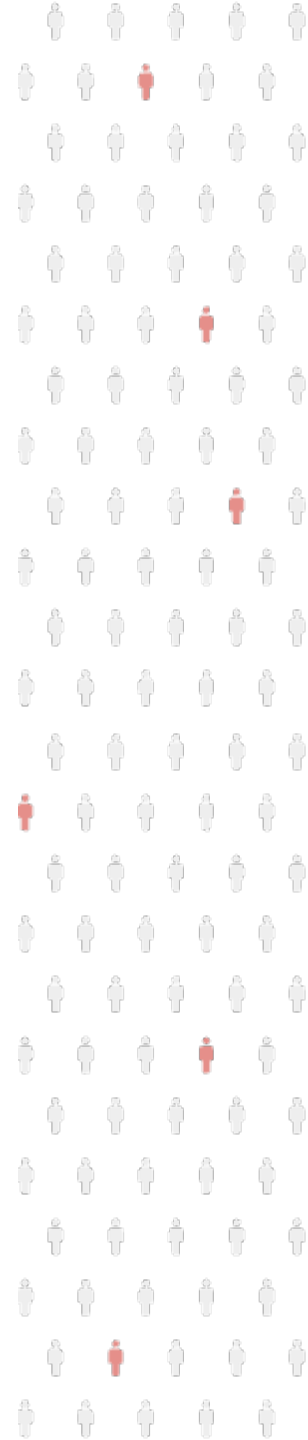
- Rising chronic disease burden
- Workforce shortages in rural communities
- Fragmented patient journeys
- Cuts to fee-for-service revenue
- Pressure from value-based care
- Care Coordination Problem: Difficulty meeting quality of care, hitting performance metrics, lowering total health care cost, and improving outcomes



5%

of Patients Drive Nearly of

Half of Health Care 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



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

Goal: Programs Integrated Into One Platform

1 Transitions of Care Management (TCM)

2 Medication Reconciliation

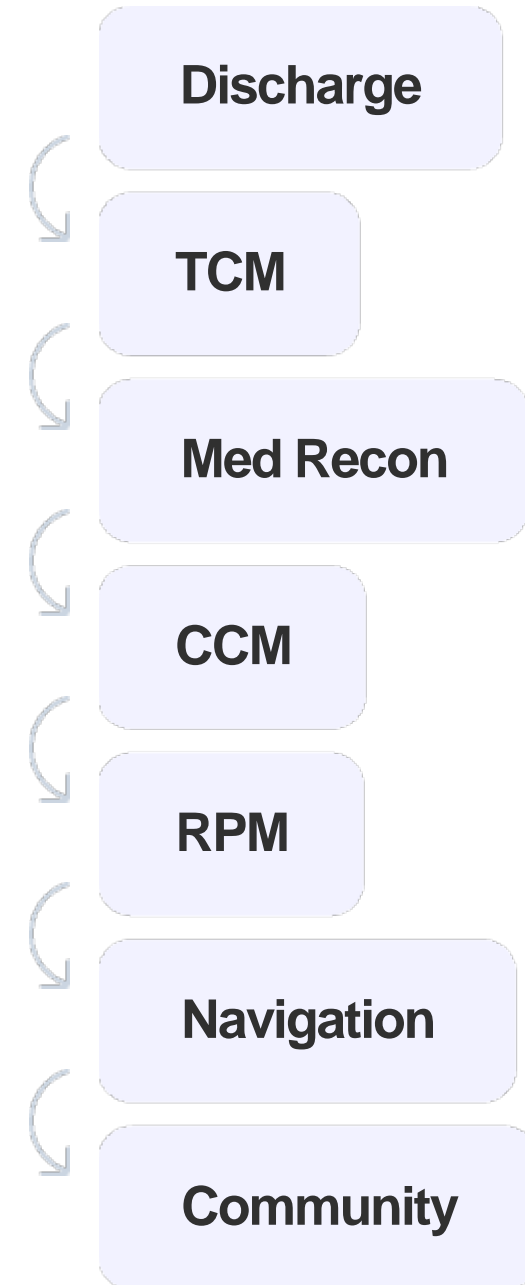
3 Chronic Care Management (CCM)

4 Remote Patient Monitoring (RPM)

5 Cancer Care Navigation

6 Social Determinants of Health

Patient Journey Across Coordinated Care

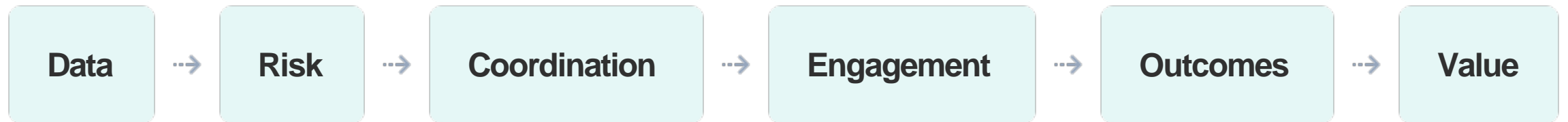


AI Enables Scalable Care Coordination

- 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



Programs Integrated Into One Platform



Operational Impact

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



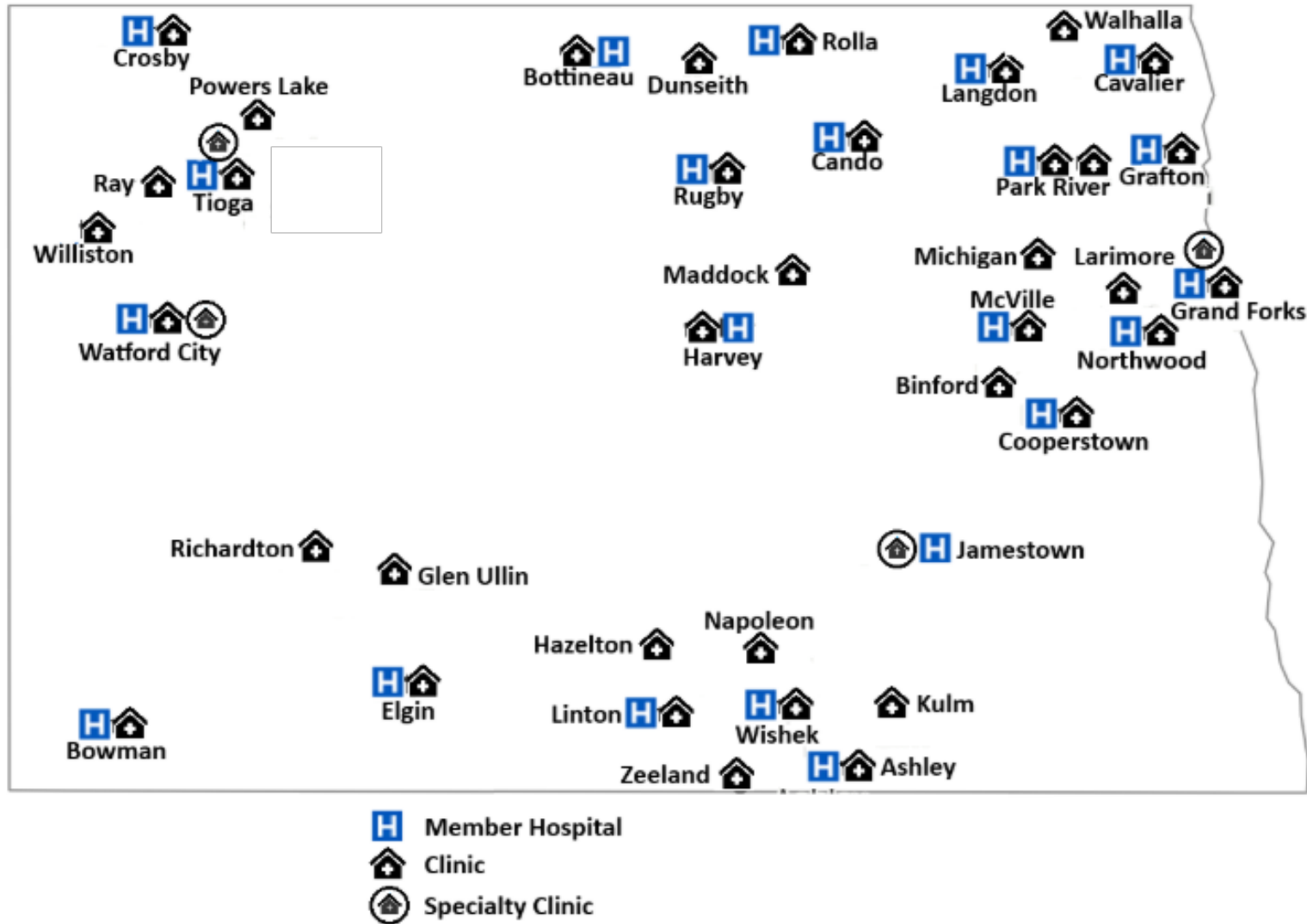
Financial Impact for Rural Hospitals

- ✔ New revenue from CCM, TCM, RPM
- ✔ Reduced avoidable ER visits, admissions, & readmissions
- ✔ Improved ACO performance
- ✔ Higher quality scores



Case Study: Deployment

Next Generation Care Coordination in North Dakota



- 23 rural North Dakota hospitals and over 40 clinics
- ~ Over 65% of North Dakota's rural population
- ~ \$1.2 Billion in net patient revenue

Next Generation Care Coordination in North Dakota

Based on Rough Rider High Value Network hospitals that have been with Caret Health for >6 months



Next-Generation Care
Coordination for Rural Health

No Additional Hiring Needed

> \$290K in Labor Cost Savings per 1,000 Patients

>\$10 PMPM of Additional Revenue from Improved
Engagement & Visits

>20% Reduction in Annual Patient Outmigration

>\$410k per 1,000 Patients of Frontend Value
(Before Shared Savings)

>50% More Care Gap Closures & Readmissions Reduction
from 16.5% -> 5%

High-Impact Clinical Outcomes

Transformative Results in a Rural Setting (St. Kateri Hospital in North Dakota)

Measure	Pre-Intervention	Post-Intervention	% Change
Breast Cancer Screening (BCS)	56.52%	74.84%	+32.41%
Cervical Cancer Screening (CCS)	3.77%	15.14%	+301.59%
Colorectal Cancer Screening (COL)	54.83%	63.89%	+16.52%

Chronic Disease Management

Hemoglobin A1c control among diabetic patients improved by **22.89%**, indicating more patients achieved healthy glucose levels through improved engagement and follow-up.

Pediatric & Adolescent Preventive Care

Well Child Visit (WCV) attendance rose by **121.88%**, from 64 to 142 visits.

Outreach targeted families with multiple children, identifying hidden risks and coordinating family-style appointment booking to maximize attendance.

Adult Patient Retention

Continuity of care increased, with a **19.75%** rise in patients returning for ambulatory visits.

Financial Impact (Frontend Only – Does Not Include Performance Bonuses)

Front-End Revenue Generation

Per 1000 patients, the increased attendance for preventive appointments led to **\$70,151.28** of additional annualized revenue.

Ancillary Service Revenue ("Halo Effect")

Per 1000 patients, ancillary services resulting from wellness visits (labs, follow-ups) yielded an annualized revenue increase of **\$51,289.68**.

Operational Efficiency – Labor Savings

Per 1000 patients, the annualized labor cost savings was **\$297,024.00** (preventing the need to hire three full-time RNs), enabling internal clinical teams to focus on higher-acuity care delivery.

Total Value Delivered

Per 1000 patients, the program has delivered **\$418,464.96** in annualized value (not including performance incentives).

On the patient level, the annualized value delivered equates to **\$28.06 PMPM**.

The Future of Rural Health Care



**AI Enabled Population Health
Command Centers**



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



**Better outcomes and no more
siloed programs managed through
spreadsheets and manual labor**

**From Fragmented
Care**



**Continuous
Coordinated Care**