CCMCN

January 2023

Rural Connectivity Quarterly Newsletter

Issue #2

What Is Rural Connectivity?

The Rural Connectivity Program was implemented to increase access to health information technology (HIT) resources and analytics for Colorado's Rural Health Clinics (RHCs) and Critical Access Hospitals (CAHs). CCMCN makes available a Community Analytics Platform (CAP) that provides a comprehensive suite of analytics. By accessing the analytics provided through the CAP, providers are better supported with initiatives that address the following:

- Developing programs
- Understanding costs
- Refining workflows
- Population health strategies

In partnership with:

Colorado Rural Health Center — Celebrating 30 Years 1991-2021 — The State Office of Rural Health

OeHI — Office of eHealth Innovation

Mark your calendars

Rural Connectivity User Group

Thank you to those who took the time to attend our November User Group. CCMCN and CRHC will continue to host quarterly user group meetings on the **2nd Tuesday of every quarter at 10am**, with the next meeting on **Tuesday, February 14th , 10am - 11am MST.**

The objectives of these meetings will be to:

- ✓ Increase awareness of the Community Analytics Platform (CAP) and available reports
- ✓ Collaborate on new reporting ideas
- ✓ Increase utilization and comprehension of the CAP
- ✓ Gather feedback from users for enhancements to the platform
- ✓ Understand how organizations are using the CAP

Join us for our next Rural Connectivity User Group!

Click here to join the meeting

40% of RHCs are participating in the Rural Connectivity Project

61% of CAHs are participating in the Rural Connectivity Project

Emergency Department Visits

"Potential overuse or inappropriate use of emergency departments (EDs) for non-emergent care has been a concern for many years. "[3]

Emergency Department Visits in the U.S.

In 2017, aggregate ED visit costs totaled $76.3 billion across 144.8 million ED visits, with an average cost per visit of $530. [2]

Individuals 65 years or older accounted for 26.4%(20.2 Billion) of cost, but only 20.2%(29.2 Million) of visits. [2]

Medicaid accounted for the majority of ED visits at 31.5%(45.6 Million), but only 25%(19.1 Billion) of cost, with an average visit cost of $420. Medicare accounted for 30.1%(23.0 Billion) of cost, with an average visit cost of $660, and 24.1%(34.9 Million) of ED visits. [2]

Females accounted for 55.9% (42.6 Billion) of total cost. Females represented the majority of costs and number of visits for all age groups, except for children ages 0-17. [2]

80.8% of ED visits resulted in routine discharge. [2]

Rural patients had the highest cost per visit at $560 and accounted for 6.8%(9.8 Million) of ED visits. Rural patients accounted for 7.2%(5.5 Billion) of ED costs. [2]

For more information on ED visits in the U.S., please view the Agency for Healthcare Research and Quality Statistical Brief #268

Emergency Department Visits in Colorado

For 2020, The Colorado Hospital Association reported a total of 1,642,979 ED visits that did not turn into inpatient stays.[1]

Health First Colorado ED 2022 Report
March 2019 – March 2021

- Statewide ED rate was 634.9 per 1000 members. RAE 7 had the highest ED rate, 723.9 per 1000 members
- 4% of members frequented the ED 6 or more times accounting for more than 20% of total ED visits
- Primary Diagnosis for ED visits before and after COVID was Abdominal Pain (7.7 -7.8%)

Click here for full report

1. Colorado Hospital and Community Data and reports. (n.d.). Retrieved November 30, 2022, from https://cha.com/center-for-health-information-and-data-analytics/data-reports/
2. Moore BJ (IBM Watson Health), Liang L (AHRQ). Costs of Emergency Department Visits in the United States, 2017. HCUP Statistical Brief #268. December 2020. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports/statbriefs/sb268-ED-Costs-2017.pdf.
3. Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services. Trends in the Utilization of Emergency Department Services, 2009-2018. 2021. https://aspe.hhs.gov/pdf-report/utilization-emergency-department-services

How can the CAP help you monitor ED Visits?

Evidence suggests that a lack of continuity between ED care and outpatient care can lead to unnecessary and duplicative care, conflicting care plans and less effective preventive care and chronic disease management. Follow-up after ED discharge can promote positive outcomes by ensuring that chronic diseases are managed appropriately and that the primary complaint prompting the ED visit has not worsened. This evidence has led to the endorsement of timely follow-up after ED discharge to reduce readmissions and negative outcomes by multiple agencies and programs, including the Hospital Transformation Program.[1,2]

The **ADT Summary Report** allows users to visualize Admits, Discharges, and Transfers over time for their respective organizations to aid in the continuity of care. Users can:

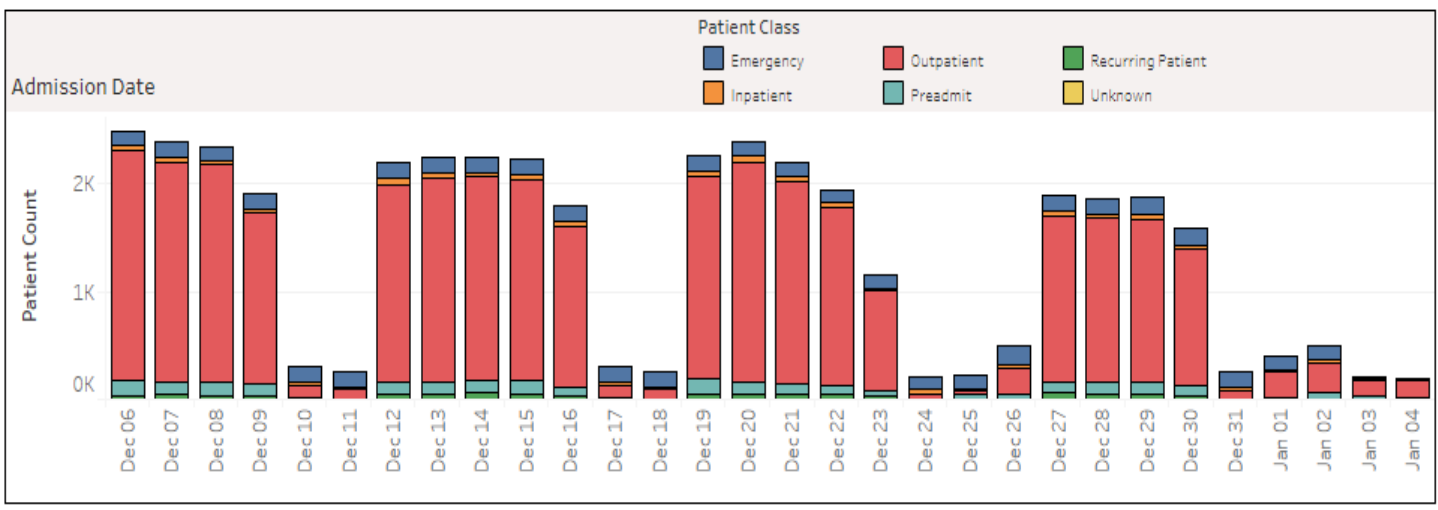
- ✓ View ADT messages over the last 24 hours, 3 days and 30 days.
- ✓ View the primary diagnosis/presenting complaint for visits
- ✓ View and filter by the sending facility, discharge and mortality disposition
- ✓ View demographic characteristics of patients admitted
- ✓ Search for patients who are frequent ED users

The ADT report aids in:

- ✓ Identifying patients with a recent ED visit for follow–up or outreach
- ✓ Identifying and managing high utilizers of the ED
- ✓ Identifying trends in recent ED visits, i.e., surges in visits for respiratory illnesses, and more.

In the last 30 days

There were **132,656** ADT Messages for **24,436** unique patients.



Research has shown disparities in ED utilization by multiple factors including age, race, gender, ethnicity, income, and insurer. "To fairly address the issue of unnecessary use of ED, it is prudent to assess if overuse is concentrated to a particular race or to a particular age group or a particular gender" [1,2,3]

59.9% on patients with ADT messages in the last 30 days were female.

48.8% of patients with ADT messages in the last 30 days were 60 years and older.

7.2% of patients with ADT messages in the last 30 days were Hispanic or Latino.

1. Carmel AS, Steel P, Tanouye R, Novikov A, Clark S, Sinha S, Tung J. Rapid Primary Care Follow-up from the ED to Reduce Avoidable Hospital Admissions. West J Emerg Med. 2017 Aug;18(5):870-877. doi: 10.5811/westjem.2017.5.33593. Epub 2017 Jul 14. PMID: 28874939; PMCID: PMC5576623.
2. Lin MP, Burke RC, Orav EJ, Friend TH, Burke LG. Ambulatory Follow-up and Outcomes Among Medicare Beneficiaries After Emergency Department Discharge. JAMA Netw Open. 2020;3(10):e2019878. doi:10.1001/jamanetworkopen.2020.19878
3. Sarkar, S., DeVito, A., Lespinasse, E., & Khosa, F. (2020). Gender and racial disparity for hospital emergency service usage in USA: a quantitative analysis for various age groups during 2010–2017. Journal Of Public Health And Emergency, 4. doi:10.21037/jphe-20-47

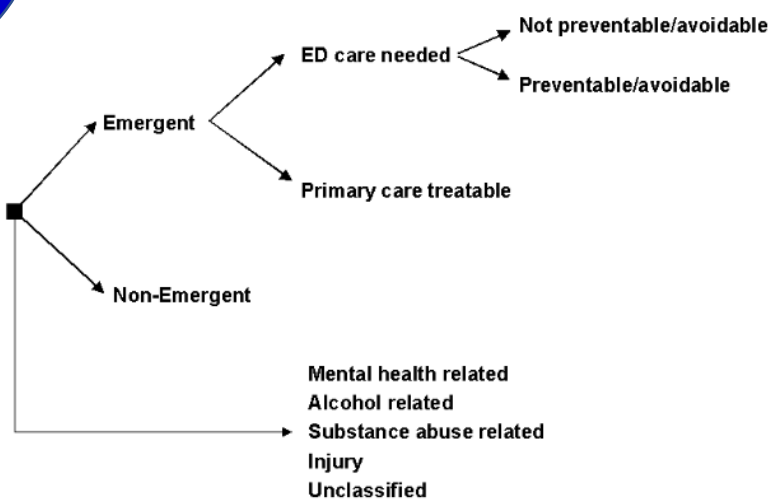
How can the CAP help you monitor ED Visits?

ER Visits Report

In 2021, there were **12,804** total ER visits by patients attributed to participating rural providers, accounting for **$8,062,404** in expenditures.

30.9% of the 2021 ER visits were avoidable

Avoidable visits are characterized by the NYU Emergency Room Algorithm.



ED Care Needed Preventable/Avoidable
Emergency department care was required based on the complaint or procedures performed/resources used, but the emergent nature of the condition was potentially preventable/avoidable if timely and effective ambulatory care had been received during the episode of illness (e.g., the flare-ups of asthma, diabetes, congestive heart failure, etc.)

For more information on the NYU Algorithm, please view the links below:

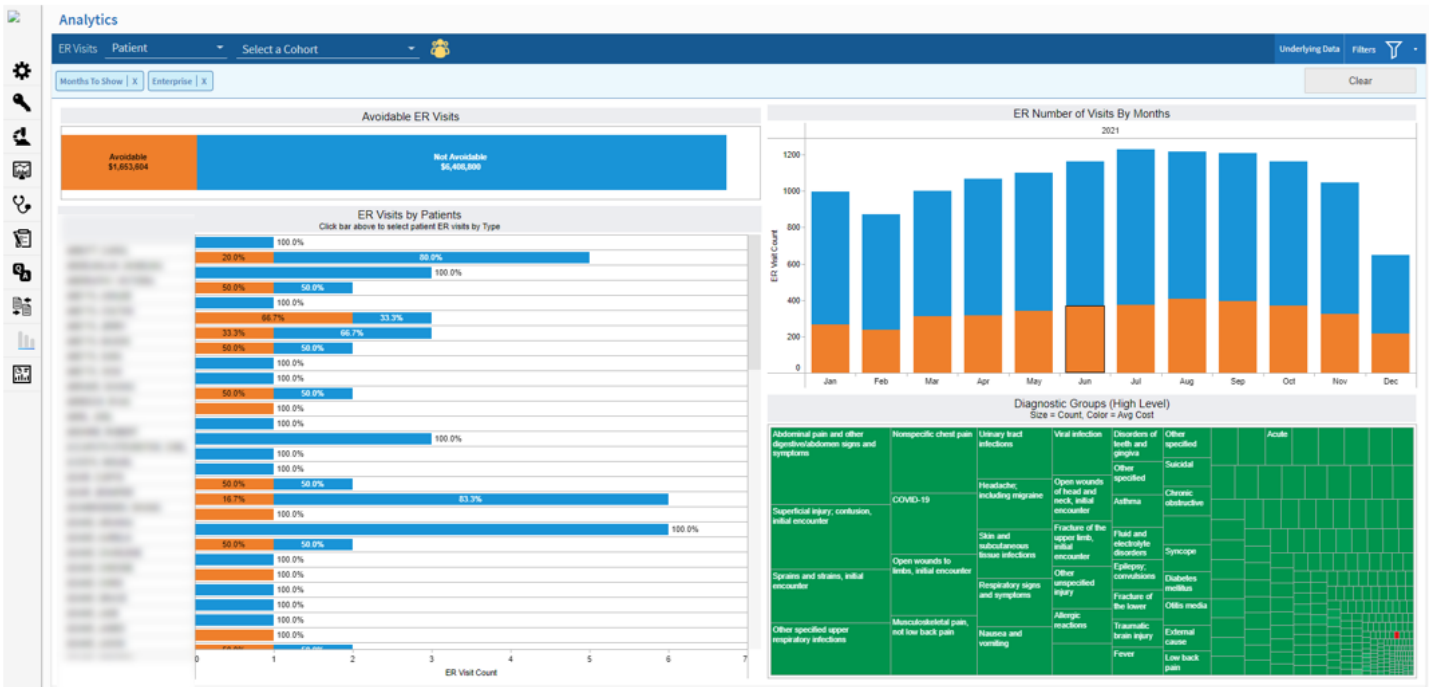
- NYU Background/Introduction
- HDMS NYU ER Algorithm PDF

The ER Visits Report allows for users to review ER visits over time to identify high utilizers, ED trends and develop interventions.

Metrics are a representation of Medicaid-attributed patients of participating rural providers only. Incurred but not yet reported (IBNR) claims are not represented. Please note the analysis may not include data pertaining to substance use disorders or other patient records protected by confidentiality rules

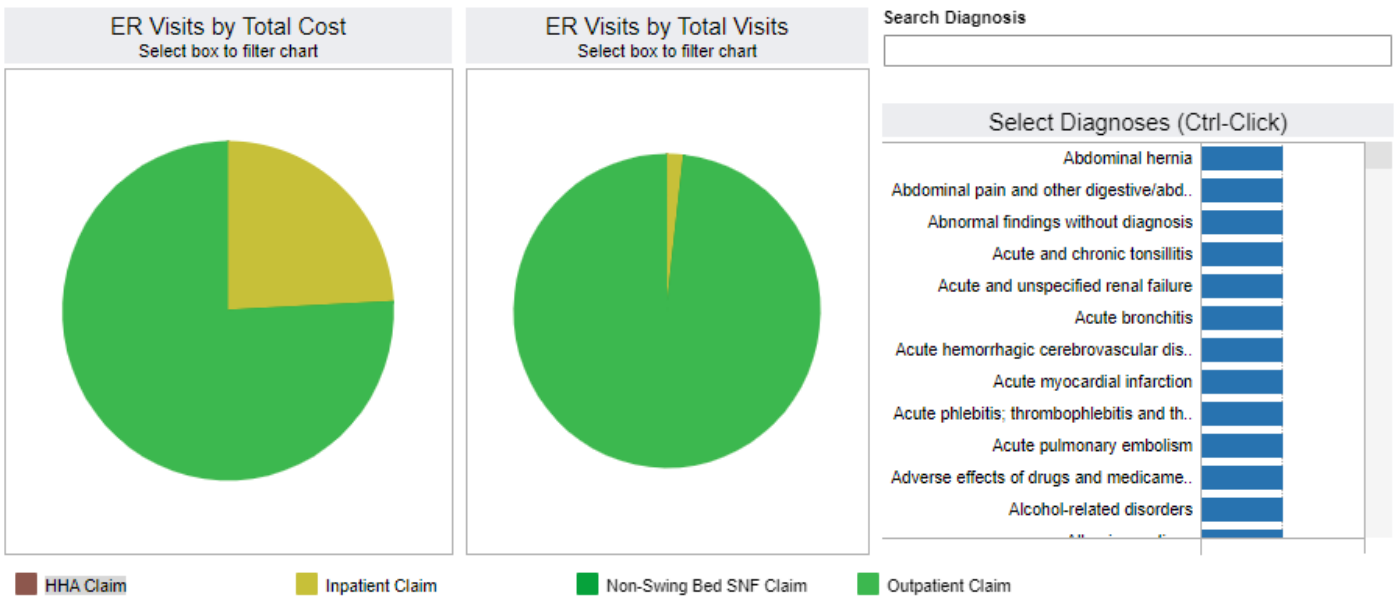
How can the CAP help you monitor ED Visits?

ER Visits Report



Community Analytics Platform ER Visits Report- Patient Level View

In the Organization level view, users can search ER Visits by diagnoses and view the disposition of the ER visit. Additional pie-chart details can be seen by hovering over visual in the CAP.



Community Analytics Platform ER Visits Report- Organization Level View

97.5% of ER visits were Outpatient Claims accounting for **$6,112,878** in costs in 2021.

1.8% of ER visits were Inpatient Claims accounting for **$1,947,617** in costs in 2021.

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How can the CAP help you monitor ED Visits?

ER Visits Report

Avoidable Visits View allows users to View the Top 50 Avoidable Visits by most recent visit, facility, patients and diagnosis.

Top 50 Members with Avoidable ED Visits

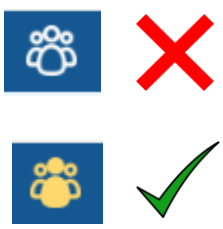
Patient Name	Attributed Provider	Avoidable Visits
[redacted]	[redacted]	19
[redacted]	[redacted]	13
[redacted]	[redacted]	11
[redacted]	[redacted]	9
[redacted]	[redacted]	9
[redacted]	[redacted]	9
[redacted]	[redacted]	8
[redacted]	[redacted]	8
[redacted]	[redacted]	8
[redacted]	[redacted]	7
[redacted]	[redacted]	7
[redacted]	[redacted]	7
[redacted]	[redacted]	7
[redacted]	[redacted]	6
[redacted]	[redacted]	6
[redacted]	[redacted]	5

Top 50 Avoidable ED Visits by Diagnosis

Diagnosis Description	Avoidable Visits	Share of Total Visits
Acute upper respiratory infecti..	317	8.07%
Nausea with vomiting, unspeci..	194	4.94%
Urinary tract infection, site not ..	174	4.43%
Noninfective gastroenteritis an..	106	2.70%
Acute pharyngitis, unspecified	96	2.44%
Low back pain	84	2.14%
Chronic obstructive pulmonary..	79	2.01%
Migraine, unsp, not intractable..	78	1.99%
Streptococcal pharyngitis	70	1.78%
Unspecified asthma with (acut..	69	1.76%
Diarrhea, unspecified	67	1.71%
Periapical abscess without sin..	62	1.58%
Dizziness and giddiness	59	1.50%
Cellulitis of left lower limb	52	1.32%
Cough	51	1.30%
Pneumonia, unspecified organ..	50	1.27%

In 2021, 'Acute Upper Respiratory Infections, Unspecified' accounted for the most Avoidable ER Visits by Diagnosis with **317 (8.1%)** visits, accounting for **5.8%** of cost with an average paid amount of **$302.**

To view patient level and underlying data be sure that the Detail-Level Icon is selected and turned gold.



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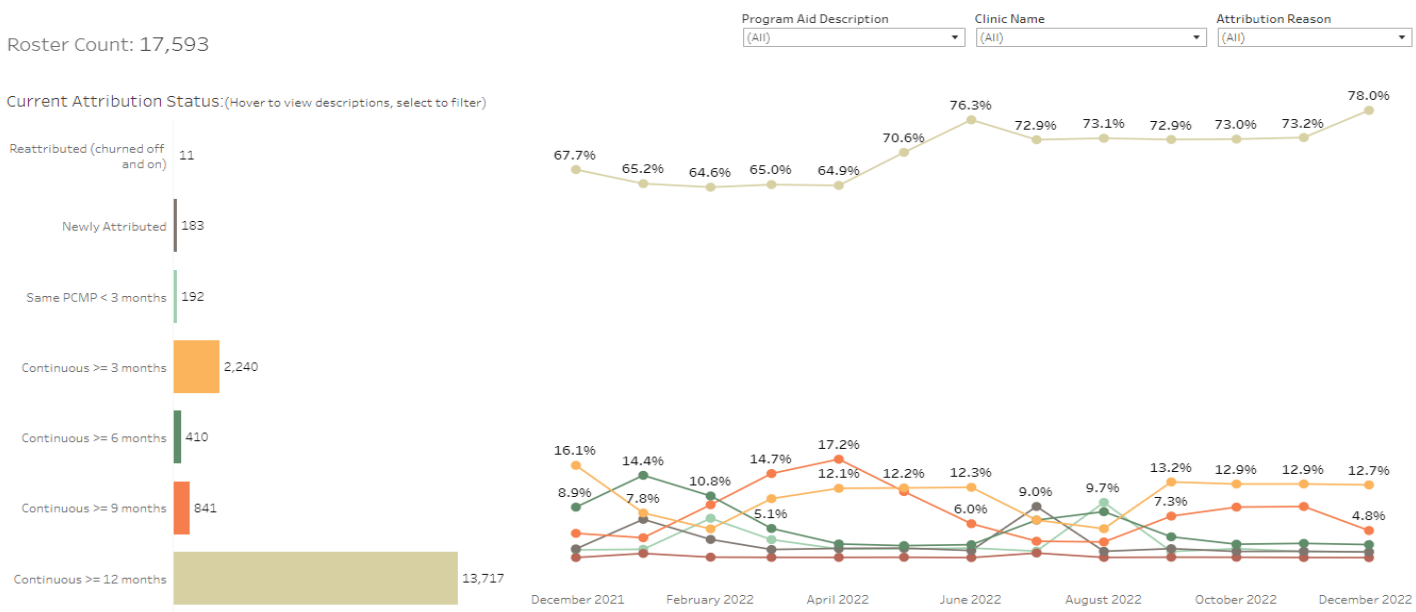
Current and Historical Attribution

The Families First Coronavirus Response Act (FFCRA) was implemented at the start of the pandemic. It required Medicaid Programs to keep members continuously enrolled through the end of the month in which the COVID-19 Public Health Emergency (PHE) ends. With the current PHE set to end on January 11, 2023, and with increased enrollment since the start of the pandemic, many members could lose their coverage. [1]

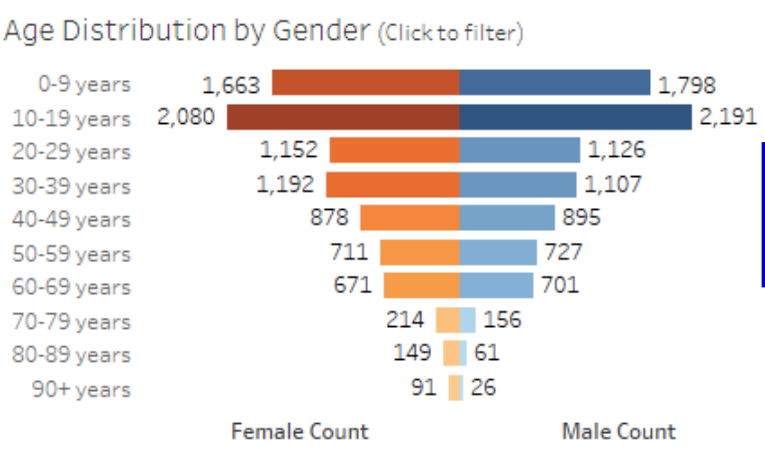
Note: There will be a 60-day notice prior to the end of the PHE, which has not yet been administered nor confirmed.

Users can utilize the Current and Historical Attribution Report to view their current member population and help eliminate the administrative barrier to prevent churn due to the ending of the PHE. Continue to view newsletters to stay informed on the impending end of the PHE.



Community Analytics Platform Current and Historical Attribution Report- Monthly Enrollment Churn

As of December 2022, **78.0%** of attributed members have been continuously insured by Medicaid for 12 months or more. This number could drop significantly after the Public Health Emergency ends



Users can also view attribution for additional clinic locations and distributed by age, gender and other demographic characteristics

To view your organization's current Medicaid attribution and monitor churn, your organization must provide CCMCN with Trading Partner(TP) authorization to receive roster files from HCPF. Metrics above only represents rural providers with TP authorization.

1. Text - H.R.6201 - 116th Congress (2019-2020): Families First Coronavirus Response Act. (2020, March 18). https://www.congress.gov/bill/116th-congress/house-bill/6201/text

Rural Health Today

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- Factors Predicting Swing Bed Versus Skilled Nursing Facility Use
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- The Impact of the COVID-19 Pandemic on Rural Health Clinics' Operations and Cancer Prevention and Control Efforts

To learn more about claims analytics and its functionality, be sure to review our quarterly analytic newsletter and participate in our quarterly user group meetings

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Request a Demo

If you are interested in receiving an in-depth demonstration of the CAP and all it has to offer, please contact Demetria Flowers at demetria@ccmcn.com

Topics of Interest

Are you interested in learning more about a topic that has not yet been covered in the quarterly newsletter or CAP user group meeting? Submit any questions or topics to Demetria Flowers at demetria@ccmcn.com

Demographic Files and Trading Partner Authorization

Want to view data for your organization in the CAP? If you would like to begin submitting demographic files to CCMCN or allow CCMCN Trading Partner Authorization, please reach out to Jessica Whiting at jessica.whiting@ccmcn.com

Next Rural Connectivity Quarterly Newsletter: April 2023.