Foresight Health Solutions

&

VIVYO Group

AI-Driven Analytics
Driving Innovation in a Value-Based World

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Huzefa Dossaji

Poll Question

- Value based contracts are NOT part of your strategic plan?
- Value based contracts are part of your strategic plan?
- Value based contracts are part of your strategic plan and you are currently engaging in VBC?

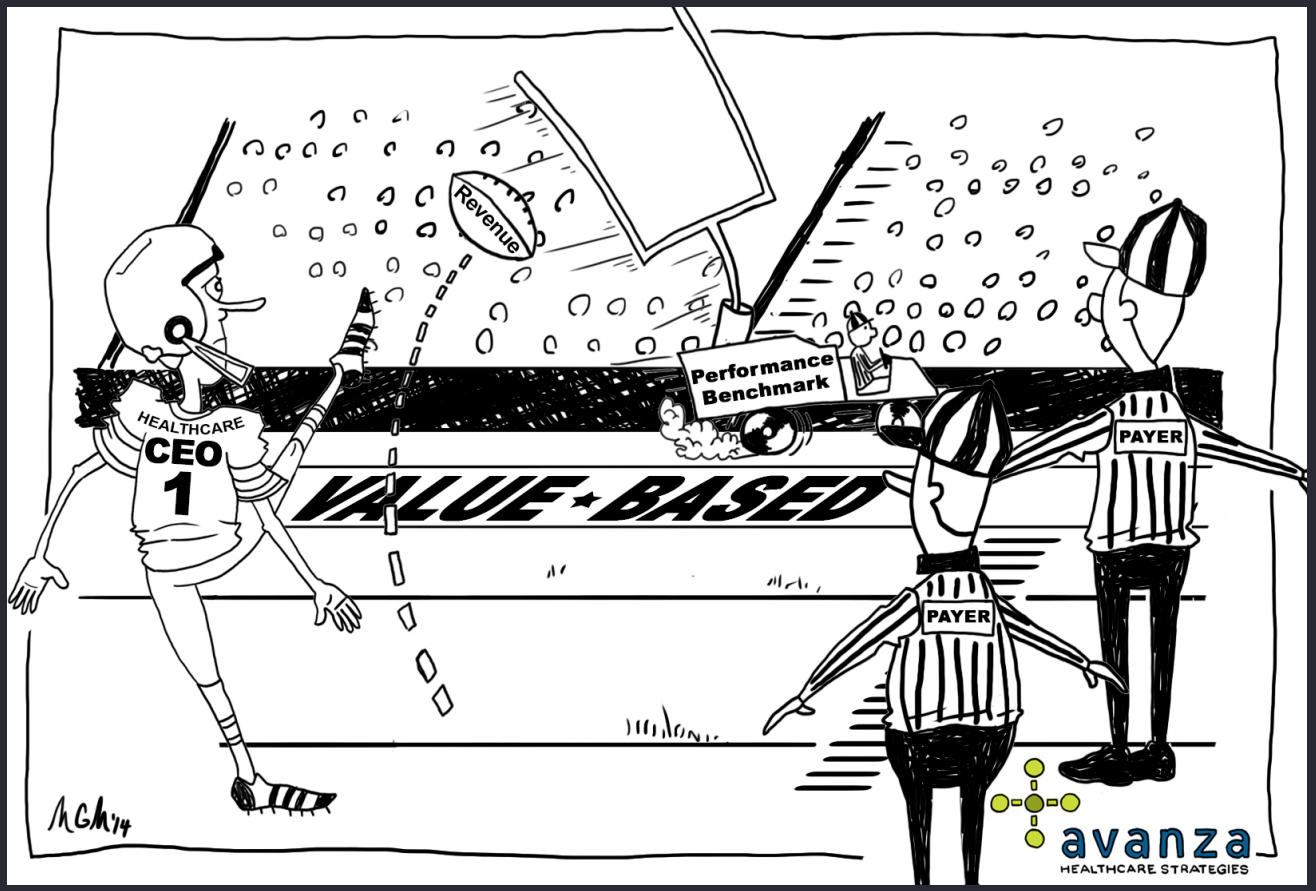
FQHCs

Largest Primary Care Network

Primary Care Providers of Choice NOT Last Resort

Charging Up for Value Based Care

- Use of SDOH and Population Health Data
- Care Management & Enabling Services
- Telehealth & Remote Patient Monitoring
- Understanding Gaps in Care


Revenue
Performance Benchmark
HEALTHCARE
CEO
1
VALUE-BASED
PAYER
PAYER
avanza
HEALTHCARE STRATEGIES

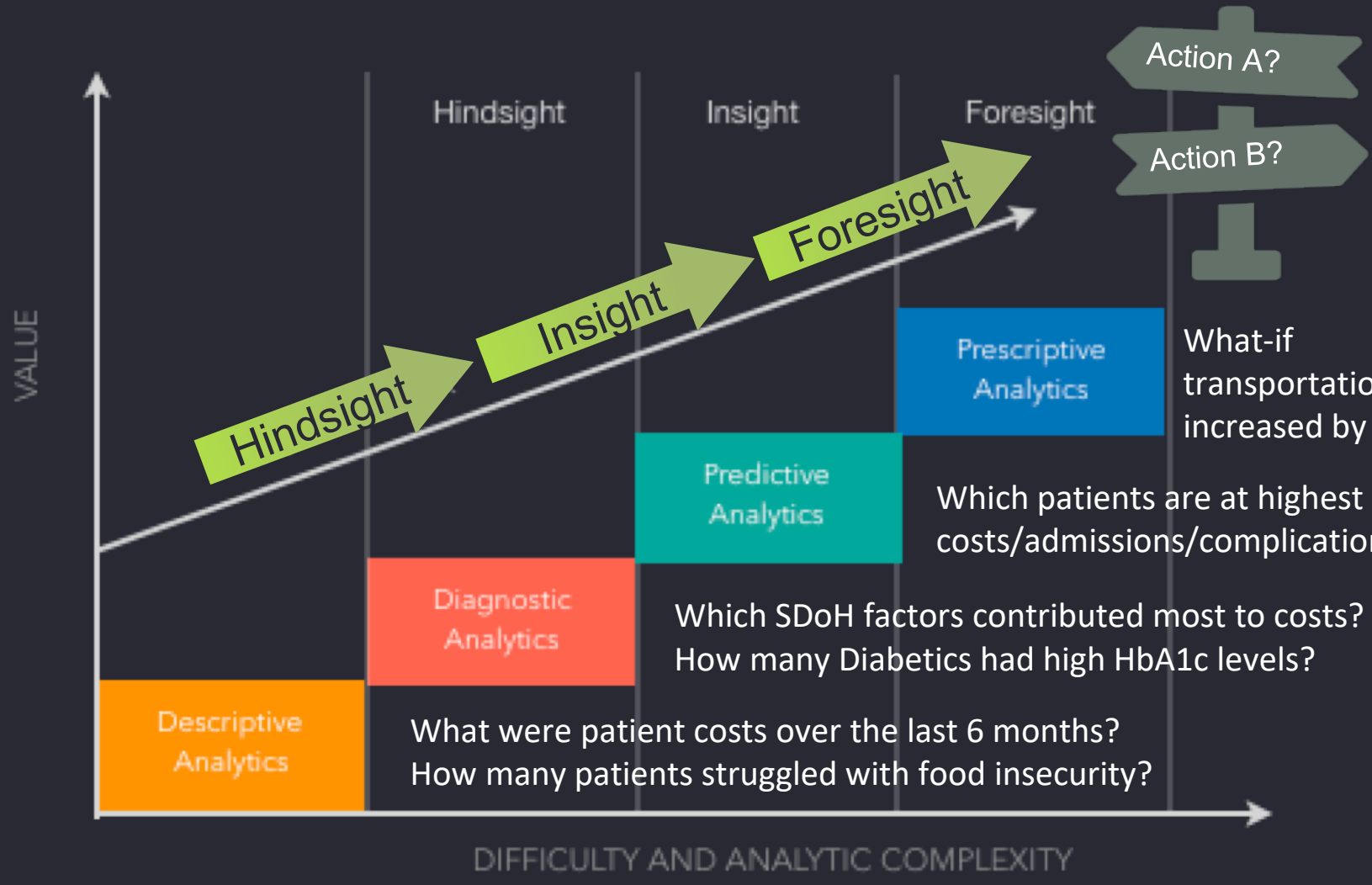
DRIP, DRIP, DRIP….

- Healthcare is…
- Data Rich Information Poor

“When automated data and decision-making tools are not built to expressly dismantle structural inequities, their speed and scale will intensify them.”

Virginia Eubank

AI within the Analytics Continuum



AI Analytics for Current Clients

- Quantify the true risk levels of clients served by FQHCs – demographic, medical, behavioral and SDoH risks
- Develop value based contracts that incentivize the successful management of diverse risks
- Quantify the impact of care management services on risk and on cost savings
- Assist care coordinators/CHWs in identifying enabling services most likely to reduce risk and costs
- COVID patient risk tracking through AI-based remote monitoring

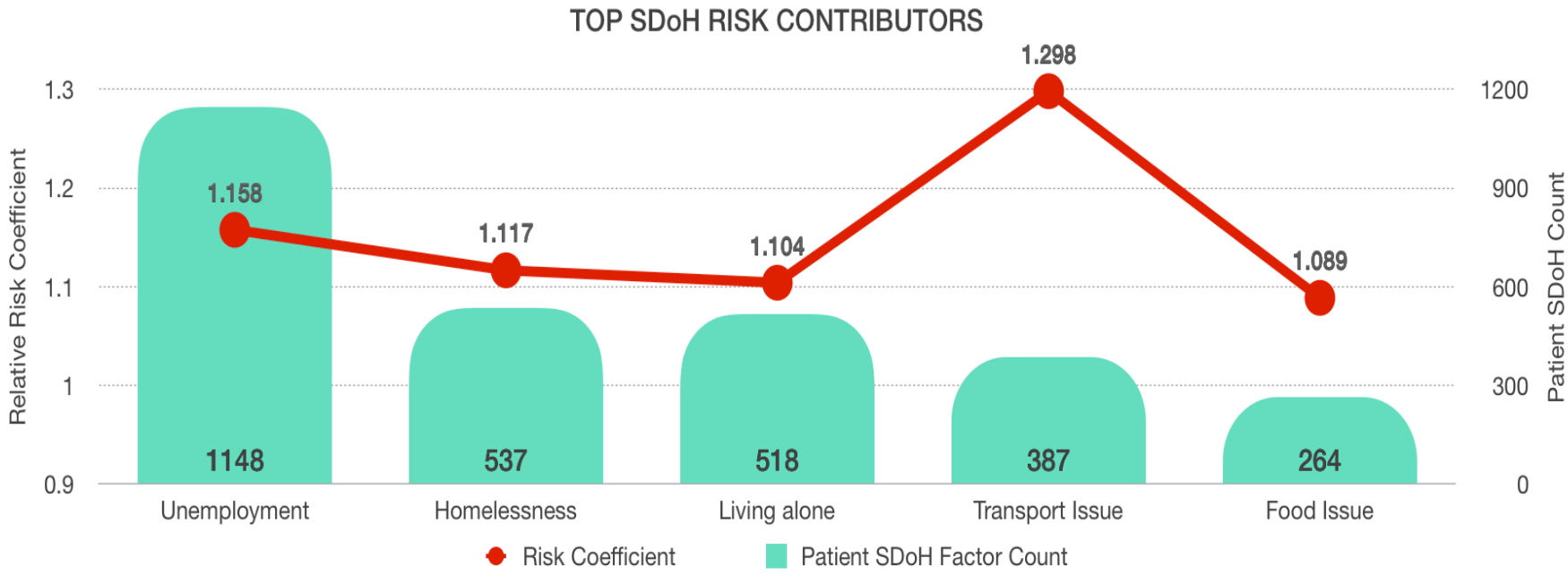
FQHC-Payer Partnership Model

- Collect and use SDoH, diagnostic and demographic data to develop a comprehensive risk and impact score for all patients
- Use this AI-based risk model to collaboratively identify a cohort for high-risk care coordination
- Develop PPS + value-based contracts with financial incentives for clinics to address social inequities, medical risks and reduce costs

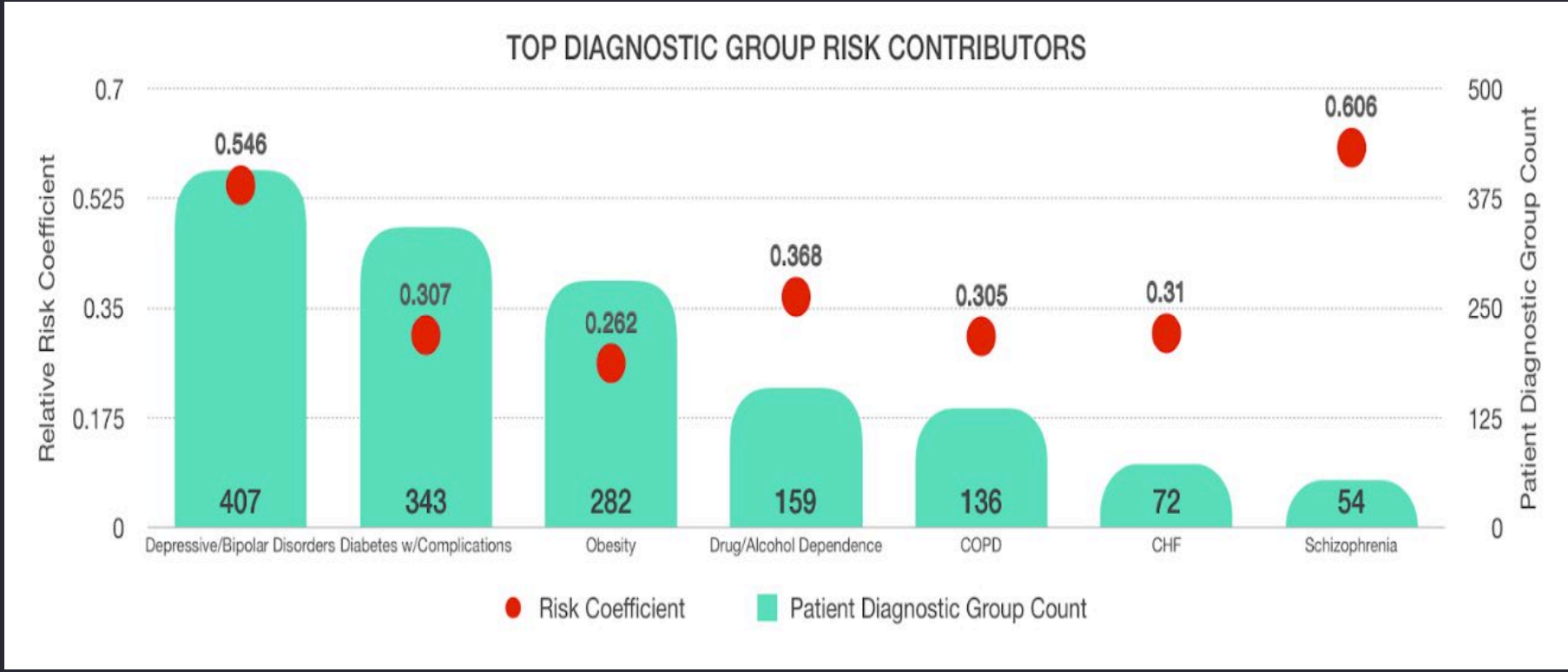
Value-Based Contract – 4 Features

- Address **Fragmentation**: Manage medical, behavioral and social needs in an integrated care model
- **Fairness**: Ensure equity within vulnerable, marginalized patients by addressing those with significant social risks
- **Funding:** Build adequate financial incentives for addressing complex care and support needs of high risk patients
- **Focus:** Targeted focus on marginalized communities and effective and impactful care enabling services

SDOH risk contributors



Medical risk contributors



SDoH + Diagnoses-Based AI Model

- True risk prediction needs both SDoH data and clinical data
- Best AI model combined 120 SDoH and 79 diagnosis groups

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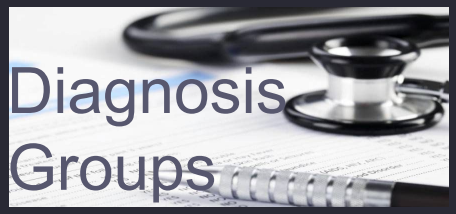
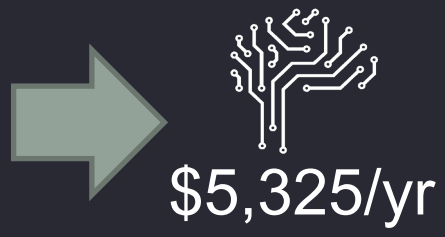


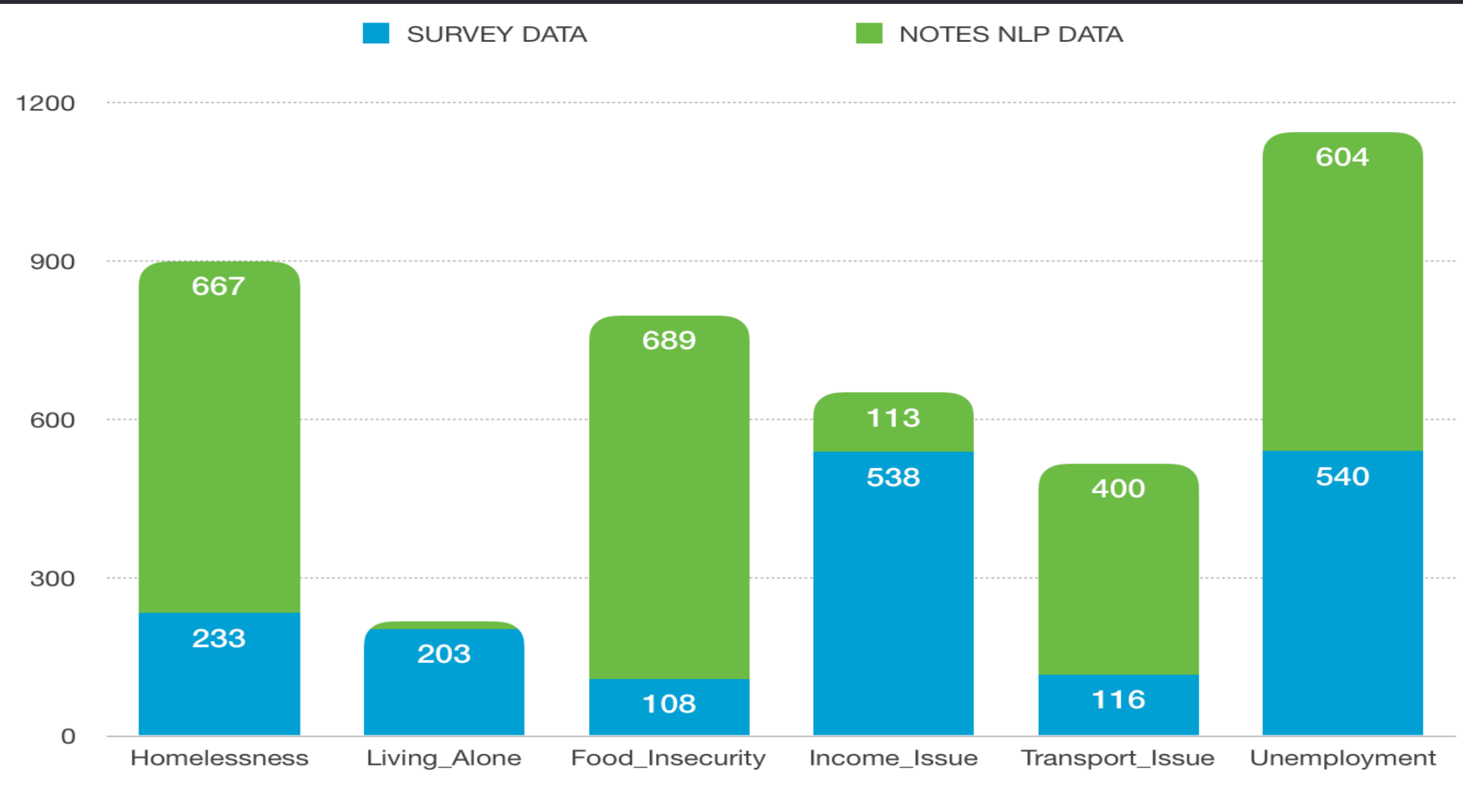


Prediction accuracy within 6.9% *of actual, observed costs*

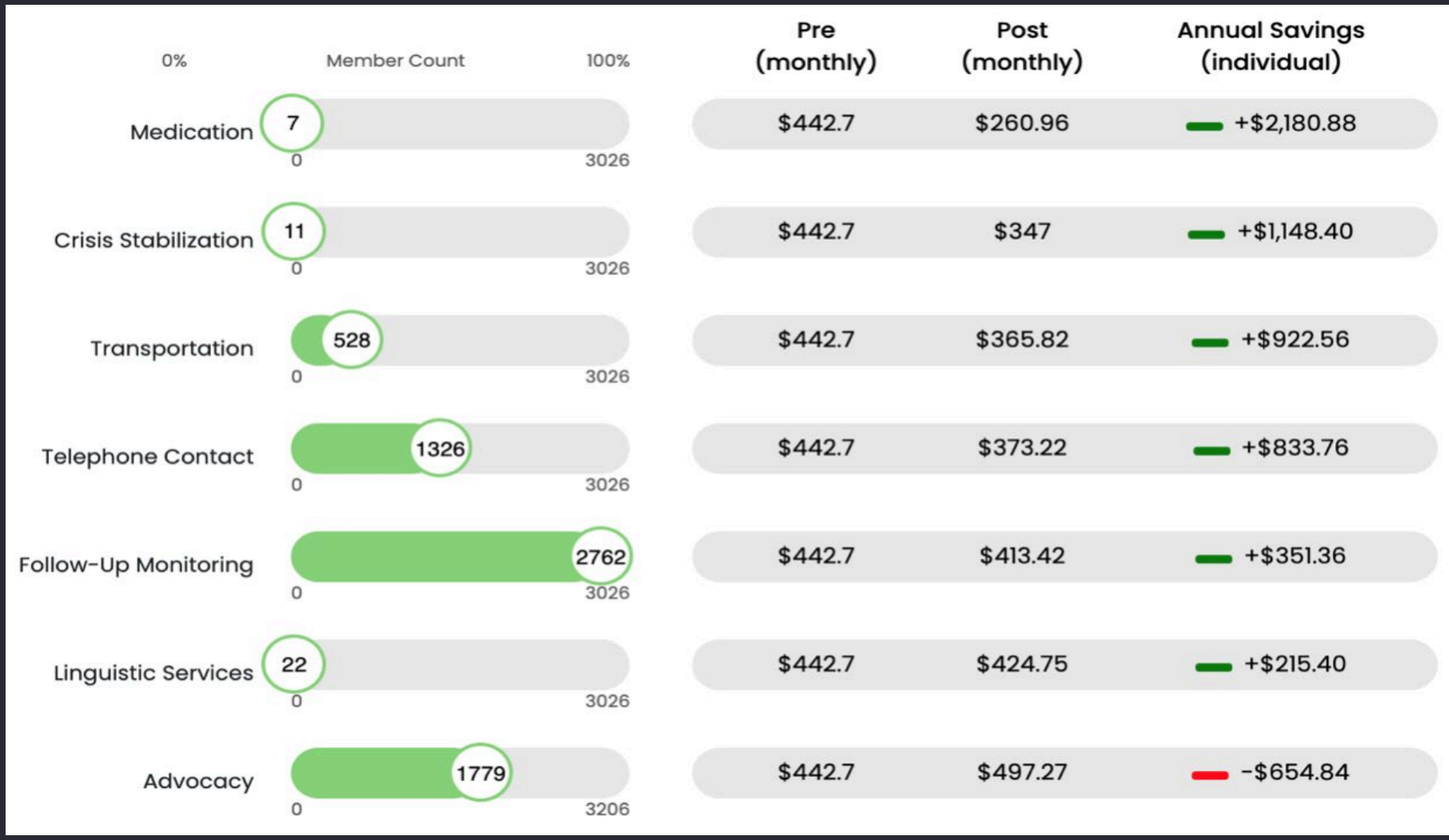
- Combining SDoH data and Diagnosis groups, with claims data, increased complexity of the model - 54% more input variables (200+)
- Higher validity of this model but larger amount of training data needed to handle higher count of inputs

… all models trained require careful validation

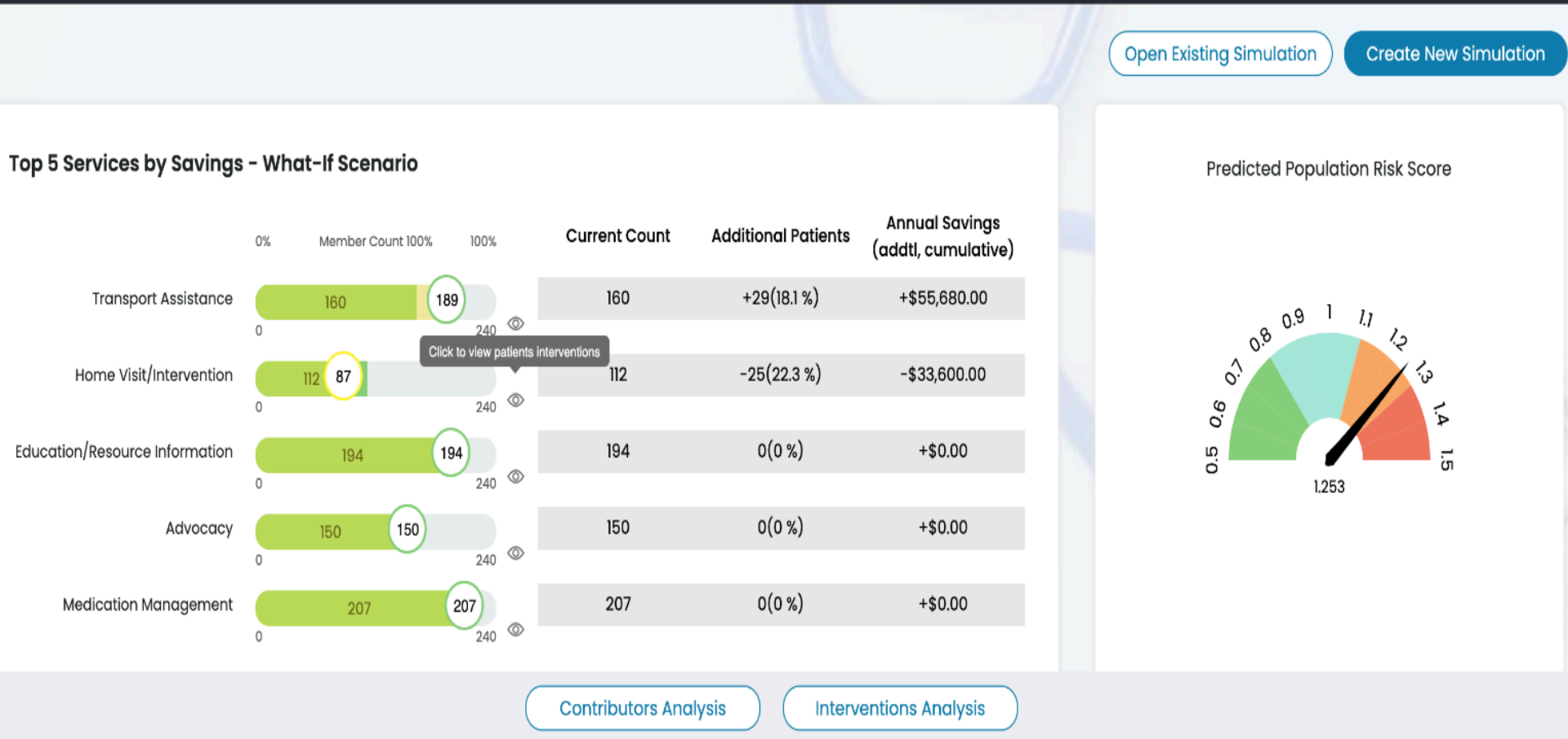
Data Gathering – SDoH Data through NLP



Impact of enabling services



Interventions “What If” Simulations



Value-Based Contract Case Study

- Value-based contracts implemented with 2 Health Plans on March 1, 2021
- Cohort populations of identified for each Health Plan
- Baseline risk levels and cost measured for cohorts for 2020
- Monthly claims combined with EMR data analyzed monthly to guide care coordination teams and monitor progress

Value-Based Contract Result

Baseline

Cohort size

- Total Attributed Health Plan A Members – 15,069
- Health Plan A – Value-Based Cohort – 891
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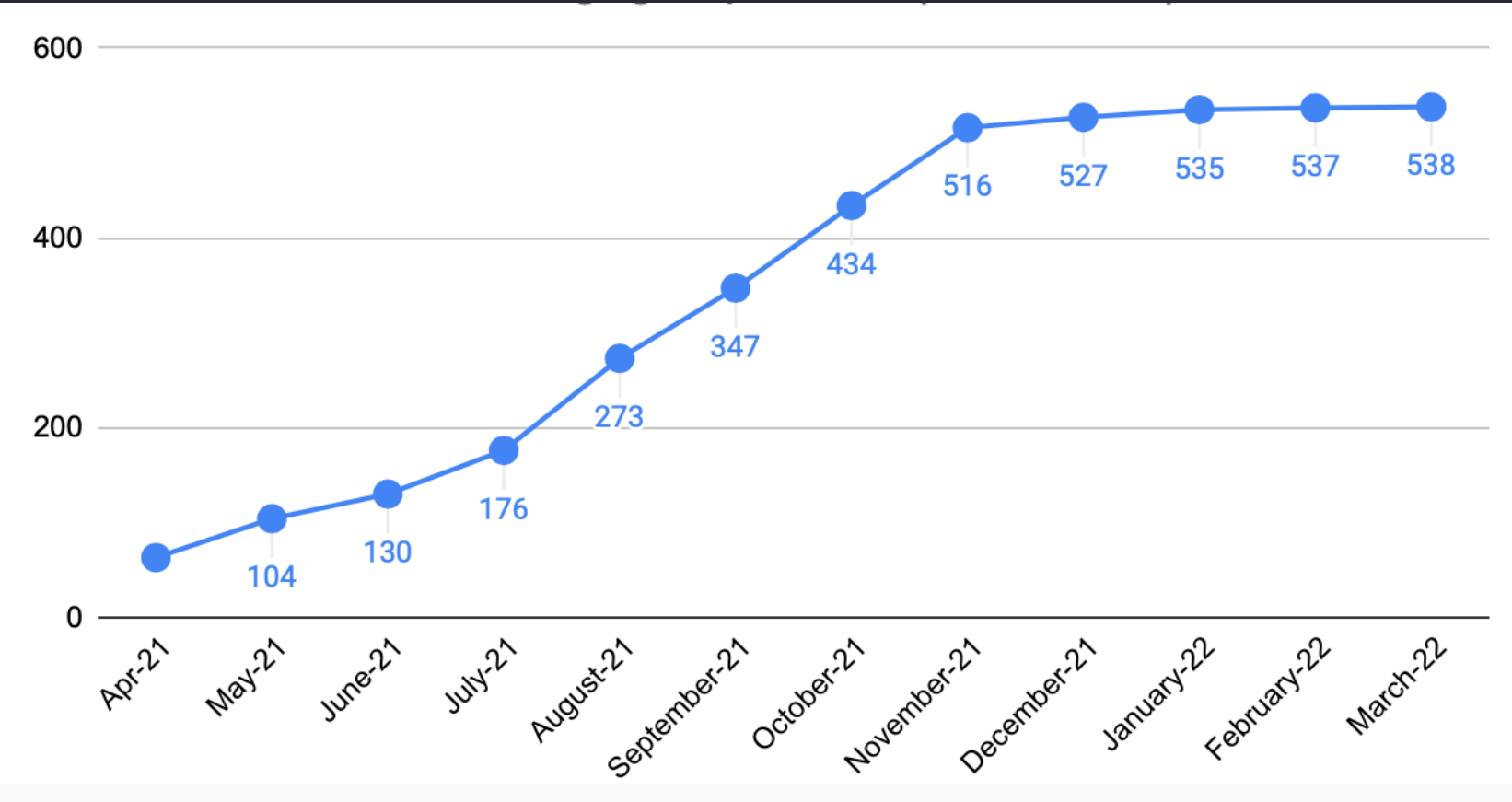
Baseline costs in 2020

- Health Plan A – Total Annual Cost – $13,353,669
- Health Plan A – PMPM cost – $1,248.9

(Cost results based on claims data provided monthly by health plans with health plan-specific IBN adjustments)

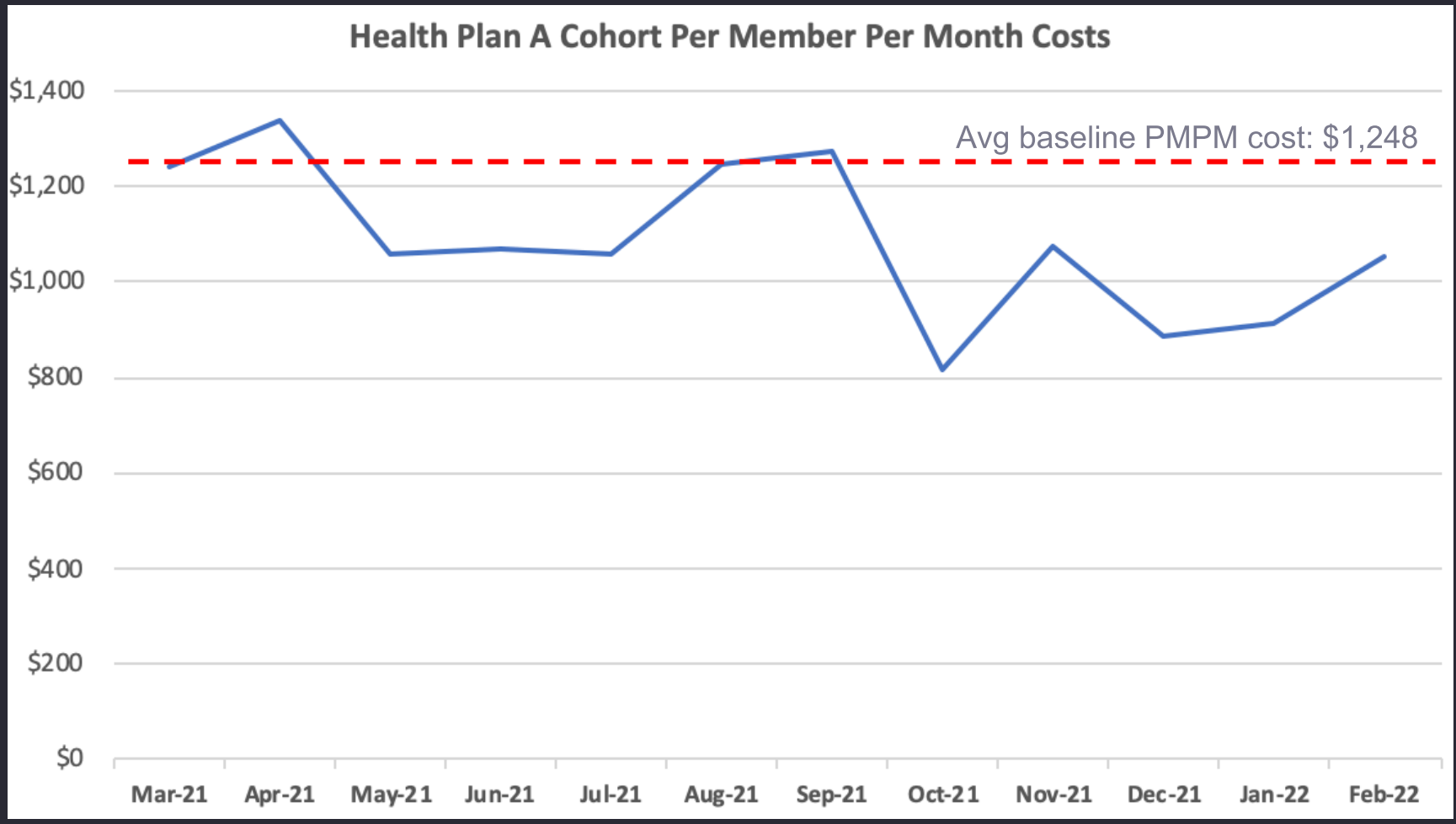
Patient Engagement – Health Plan A

Patient Engagement Rate: 60.4% (538 out of 891)



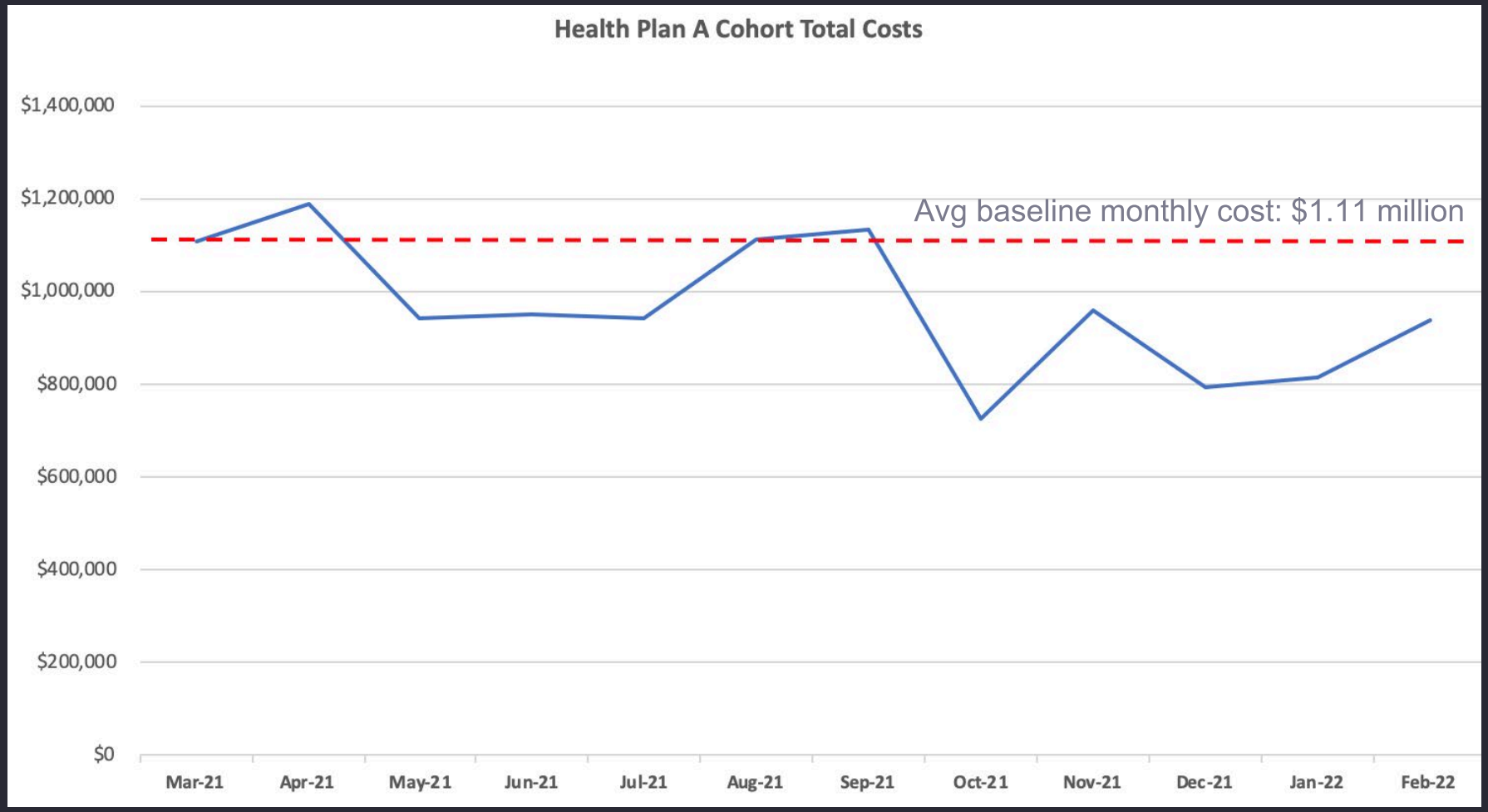
Cohort PMPM Costs– Health Plan A

Baseline Period: Calendar Year 2020
Measurement Period: March 2021 – February 2022

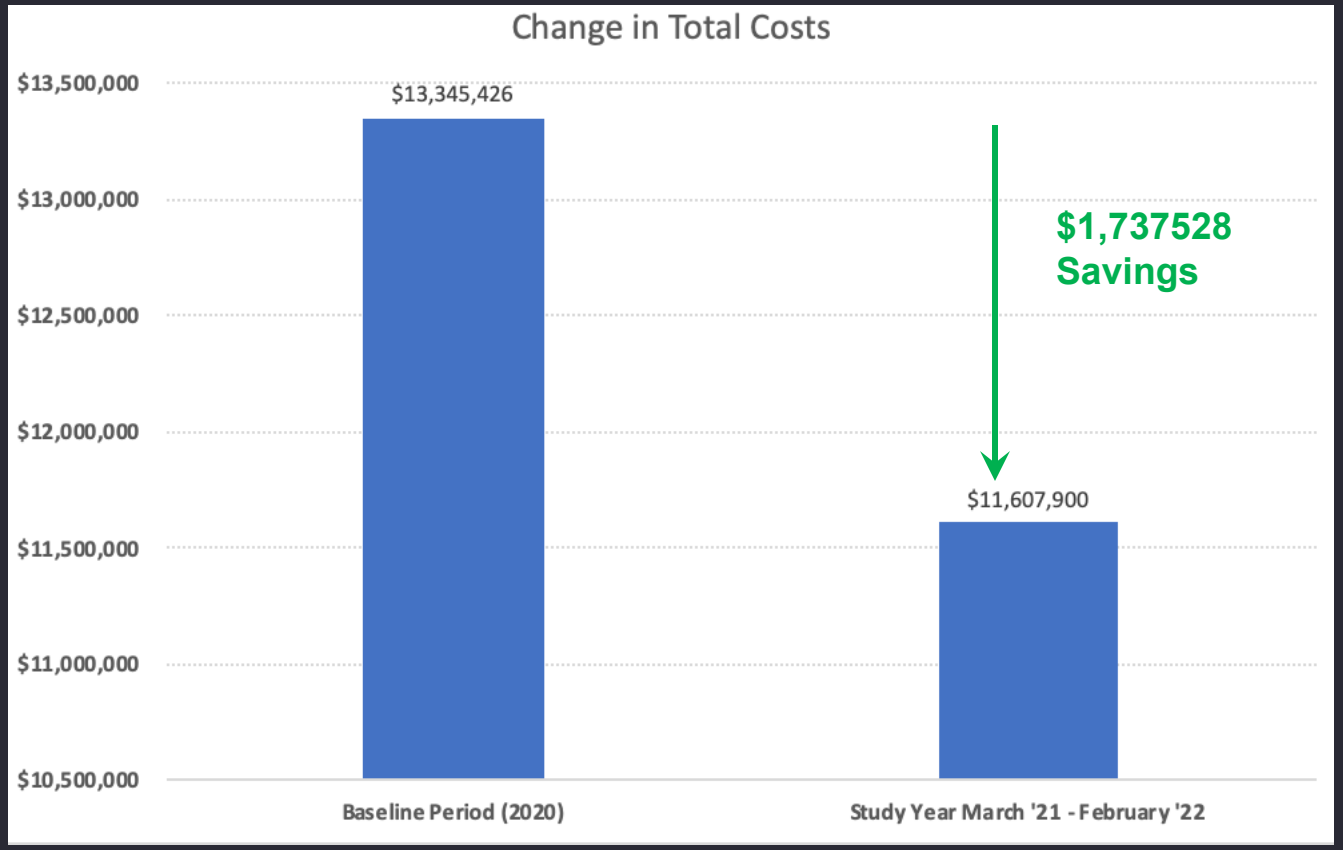


Cohort Total Costs - Health Plan A

Baseline Period: Calendar Year 2020
Measurement Period: March 2021 – February 2022



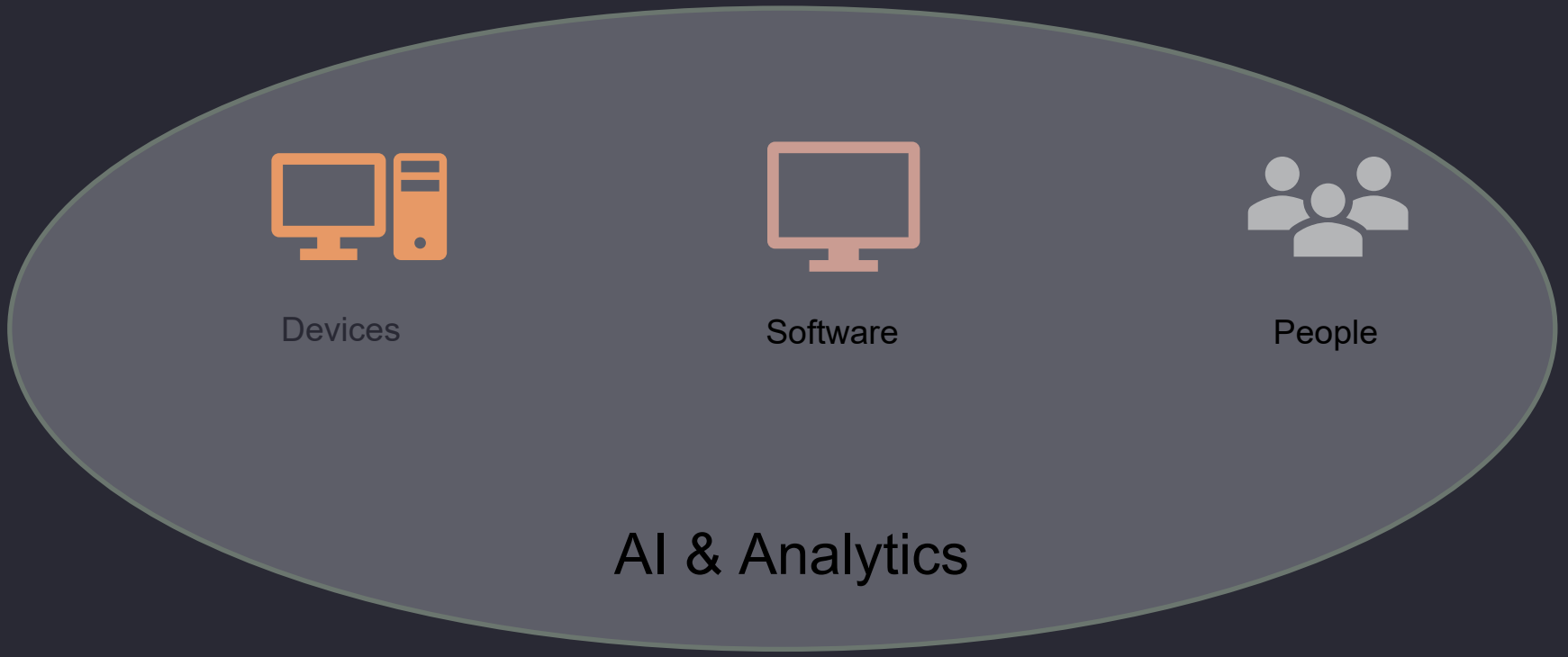
Cost Savings Health Plan A



Health Plan A: High Impact Services

Key Enabling Services	Total Count
Advocacy	962
Crisis Stabilization	305
Follow-Up Monitoring	1728
Medication Assistance	190
Telephone Contact	3065
Transportation	106
Grand Total	**6357**

The RPM “Fantastic Four”



AI Analytics in Remote Patient Monitoring

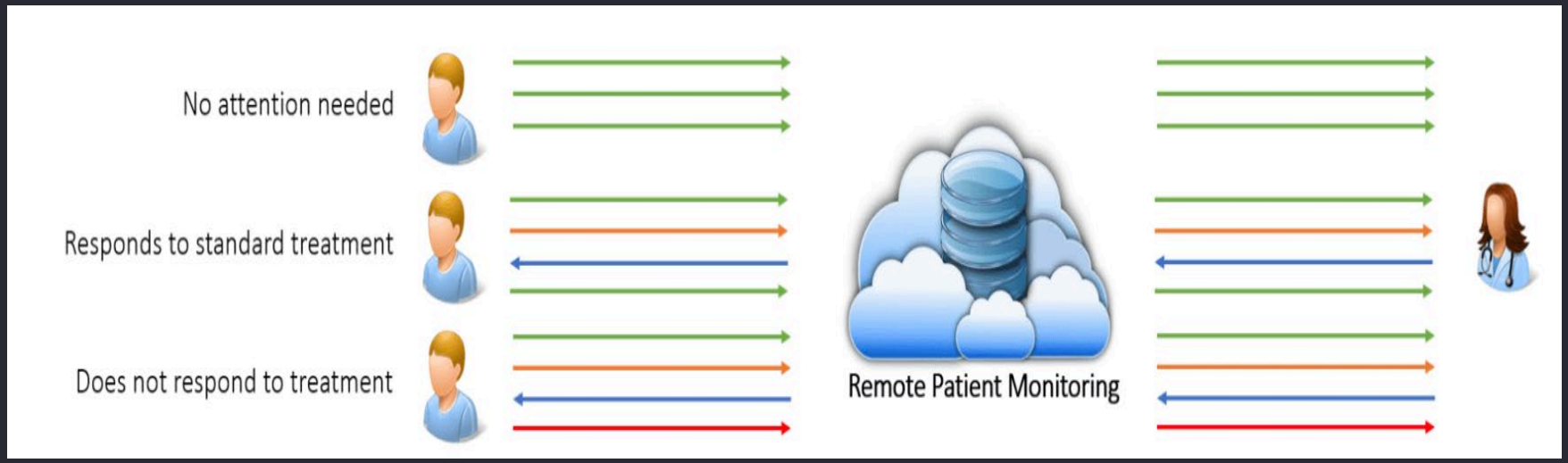
Accurate risk prediction and early warning metrics of rising risk

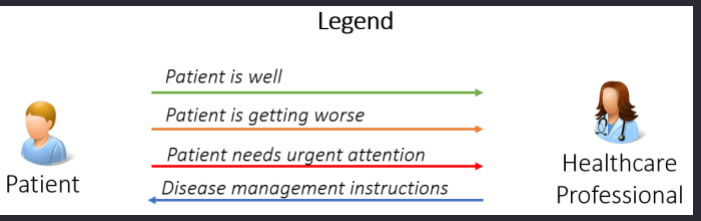
Reduced physician and nursing time requesting and reviewing health status information

Algorithms and models that recognize risk patterns in large data sets

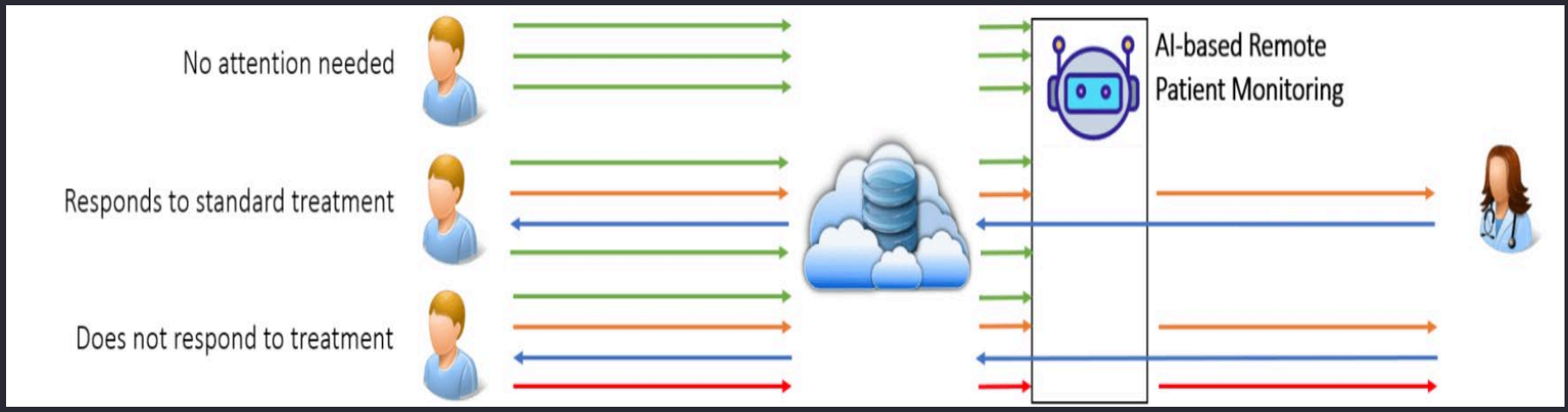
Increases engagement of patients in their own care and outcomes

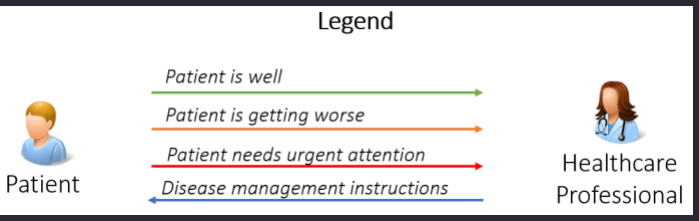
Current RPM Models – Provider review intensive





Reducing provider burden through AI-driven RPM





Charged Up for Full Risk

- Ability to use both medical, SDOH & RPM to predict & manage risk
- Use NLP to better identify key risk drivers and unstructured EMR notes data
- Impact Analysis: Ability to identify services that have the best impact
- AI/Analytics driving more effective and efficient RPM Programs

Questions?

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