

AI-DRIVEN DECISION SUPPORT FOR VALUE-BASED CARE SUCCESS: CENTRALIZING MORE OF THE RIGHT CARE AT HOME

HIMSS Case Study *Beyond Boundaries: Shaping Healthcare's Digital Future* | June 5, 2025



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AGENDA

Background

Post-Acute Care

The Opportunity

Case study

Introducing Radial

Introducing BILHPN

Results

Future Directions

Panel

Q&A

Disclosures

The following faculty of this continuing education activity has no relevant financial relationships with commercial interests to disclose:

Roger Schutt, DO

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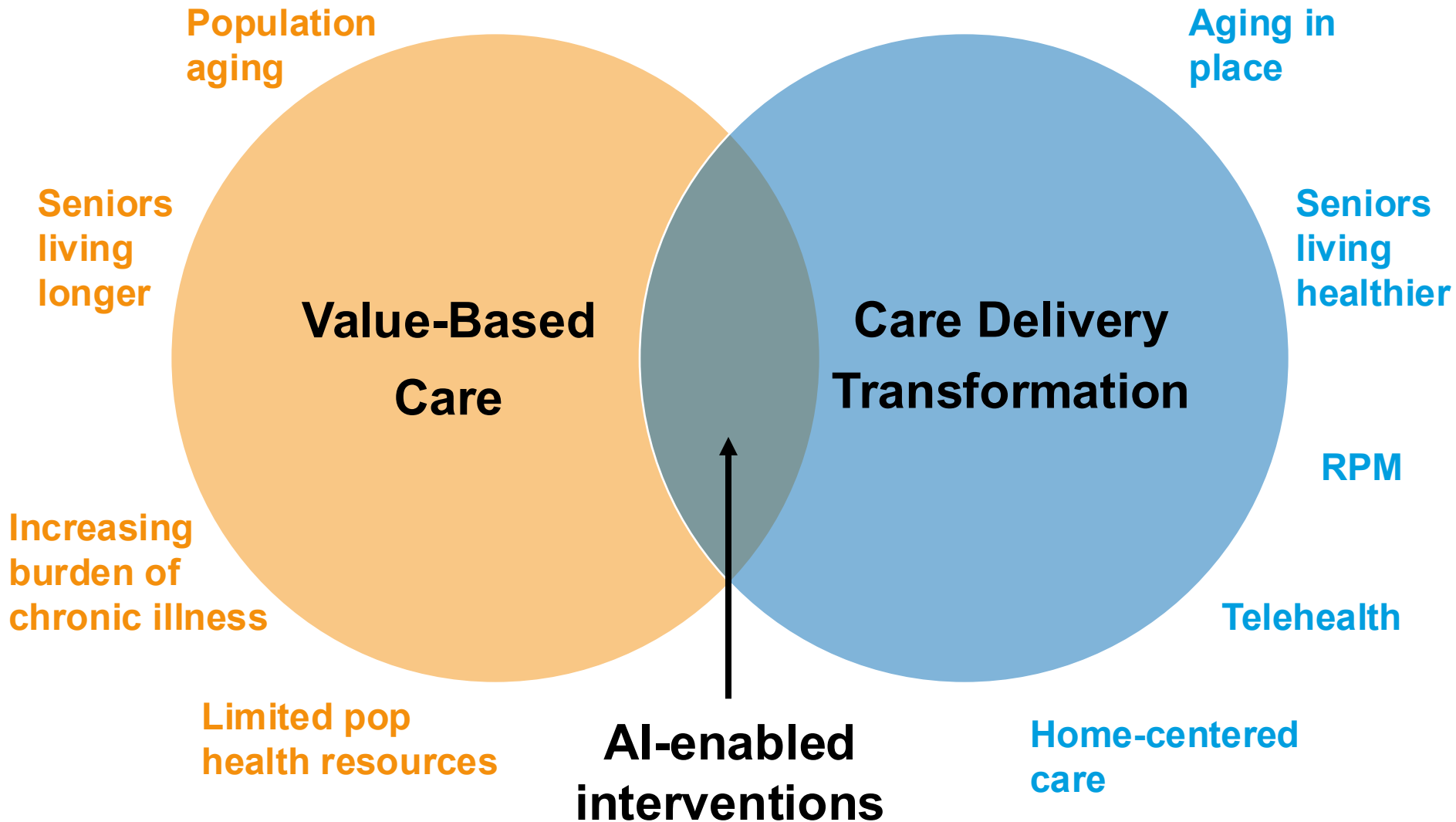
Radial: Chief Medical Officer

Kerry Son, MSN, FNP

Radial: Director of Clinical Innovation

From Volume to Value ... Faster

AI at the Intersection of Reimbursement and Redesign



Not Every Patient Needs a Bed

The Data Shows the Risks of Facility Post-Acute Care

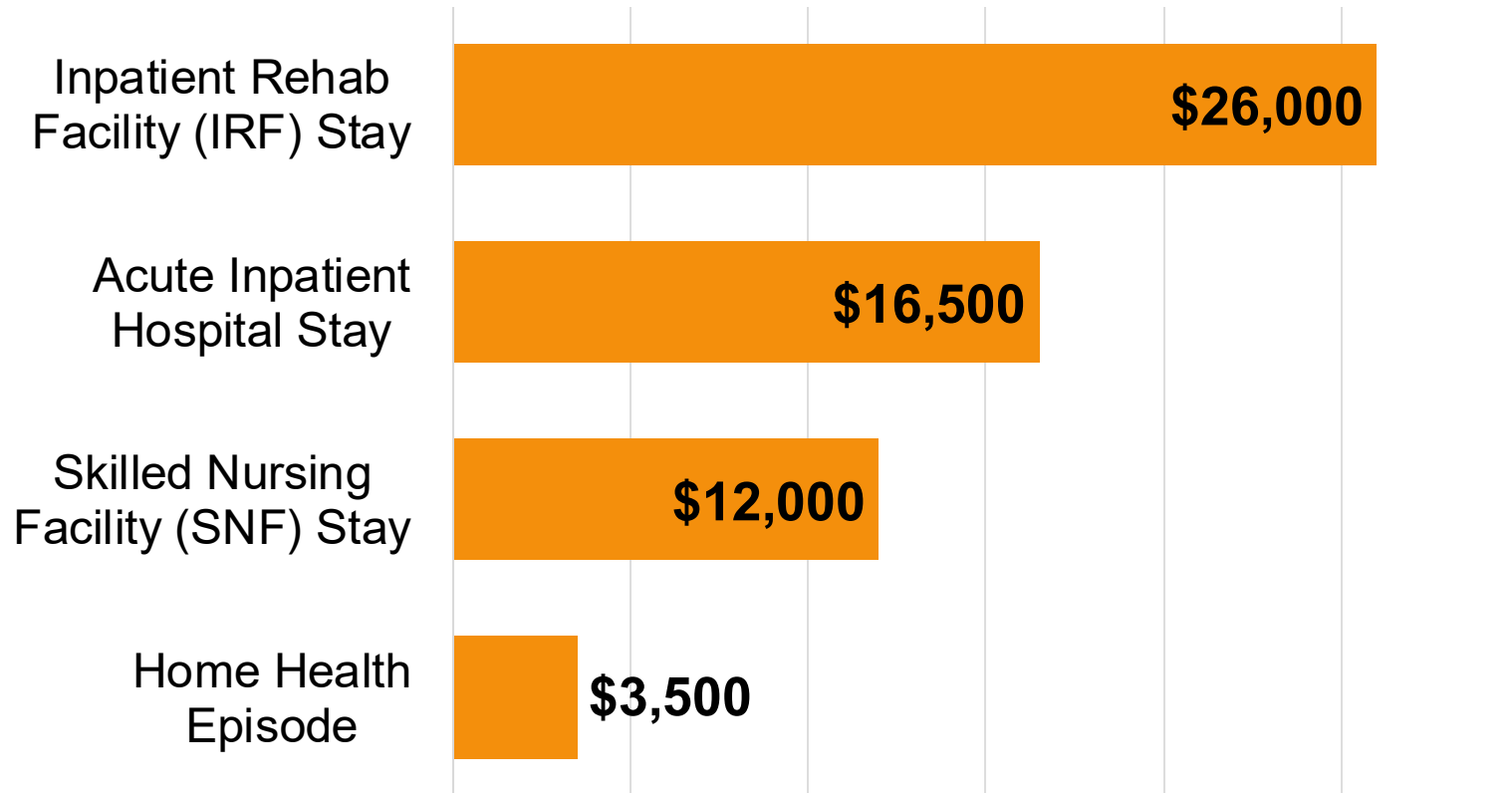
- For many common conditions, **seniors can achieve the same or better functional outcomes with homecare**^{1,2,3}
- Facility post-acute care **may be unnecessary or even harmful** – secondary infections, delirium, venous thromboembolism⁴
- Readmissions data from home health vs. skilled nursing facility is mixed - however, key subpopulations including those with dementia show **similar readmission rates**^{5,6}
- **Mortality rates are similar** at home vs. facilities^{5,6}
- **Post-acute costs and costs within 60 days of admission are significantly lower with home health vs. post-acute facility**⁵



The Cost of Recovery Varies Widely

Home Health is Best Value - When Used for the Right Patients

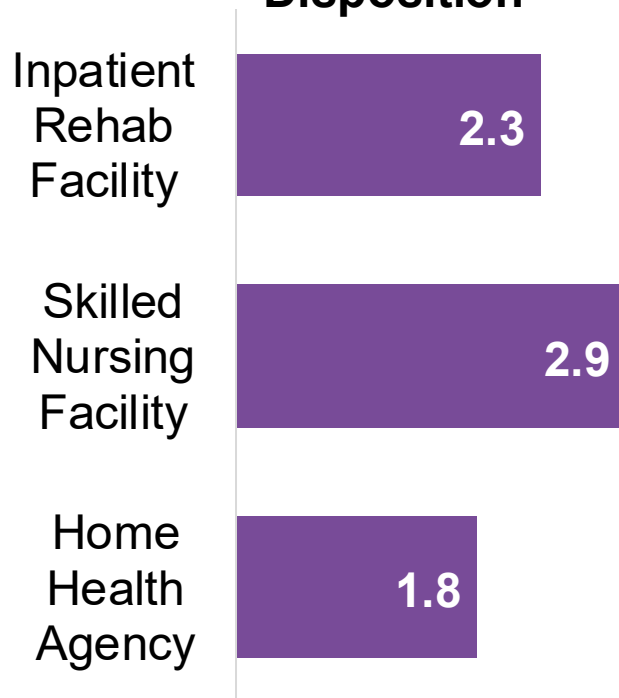
Median Cost (Medicare)



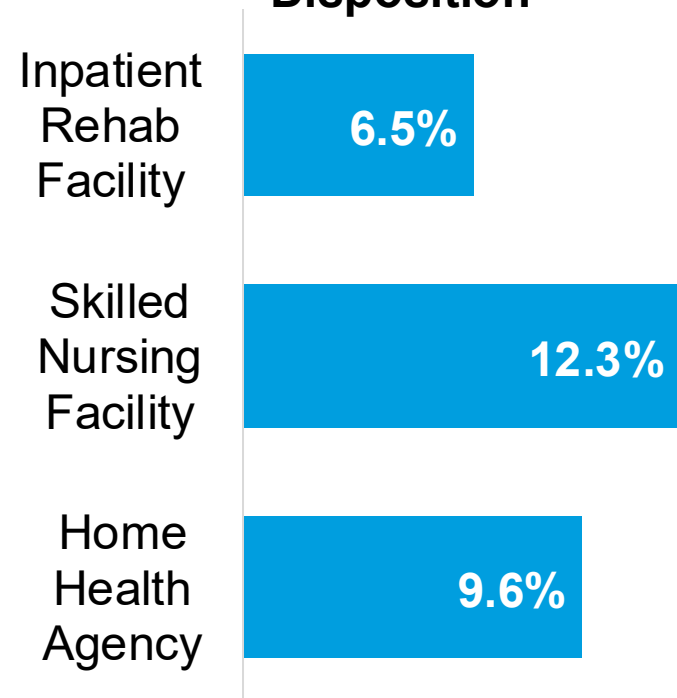
Source: BILHPN data and MedPac Data Book July 2024

Homecare Results in Shortest Hospital Length of Stay Even After Case Mix Adjustment, SNF is a Readmissions Risk

**Case Mix Adjusted
Average Hospital GMLOS
(Days) by Discharge
Disposition**



**Case Mix Adjusted 30-day
Unplanned Readmission
Rate (%) by Discharge
Disposition**



Source: BILHPN data

Smarter Hospital Stays Can Boost Home Discharge Likelihood

Two Science-Backed Inpatient Practices Are Key

Early mobilization:

- Increases likelihood of home discharge^{7,8}
- Improved functional outcomes and steady state recovery^{7,9,10,11,12}
- Reduces risk of adverse events (deconditioning⁷, clots¹¹, pneumonia,¹² etc.)
- Reduces inpatient length of stay^{8,9}, 30-day readmission rates⁸

Individually tailored discharge planning:^{13,14}

- Reduces inpatient length of stay and readmissions for older patients with at least one comorbidity, improves satisfaction and emotional well-being



Key Question: How can AI help supercharge these interventions?

Introducing Radial

AI Decision Support



AI With a Mission: Helping our Customers Succeed Wherever They Are on Their Volume-to-Value Journey

Funded in part by National
Science Foundation and NIH

We build AI-enabled
interventions and workflows to:

- Standardize evidence-based care
- Drive holistic, high-value interventions
- Centralize more of the right care at home
- Support the shift to value-based care



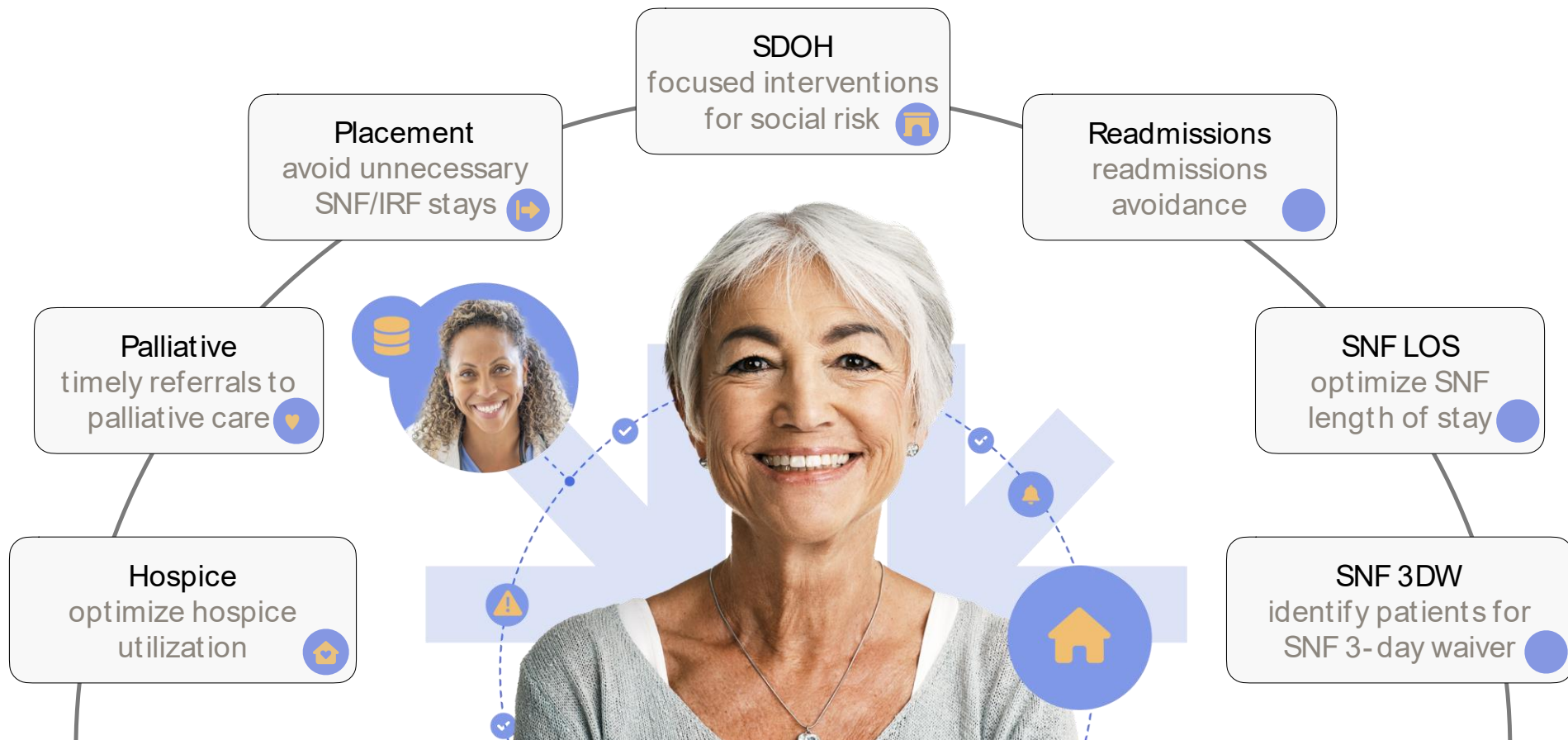
National Institutes
of Health



National
Science
Foundation

Radial Care: One Platform, Many Use Cases

AI Decision Support that Drives Impact for What Matters Most



Radial Care: One Platform, Many Use Cases

AI Decision Support that Drives Impact for What Matters Most



Radial Placement: AI-Supported Real-Time Risk Stratification To Avoid Unnecessary Stays at SNF and IRF

Radial automatically identifies these patients on hospital day one



“No uncertainty”
Skilled Nursing Facility
or Inpatient Rehab



“On the border”
At risk of unnecessary
facility-based post-acute
stay



“No uncertainty”
Home with Skilled Nursing
and/or PT services

Radial Placement: AI-Supported Real-Time Risk Stratification To Avoid Unnecessary Stays at SNF and IRF

Result: safely shift discharge dispositions in favor of homecare, reducing readmissions, hospital length of stay, and total cost of care



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Skilled Nursing Facility
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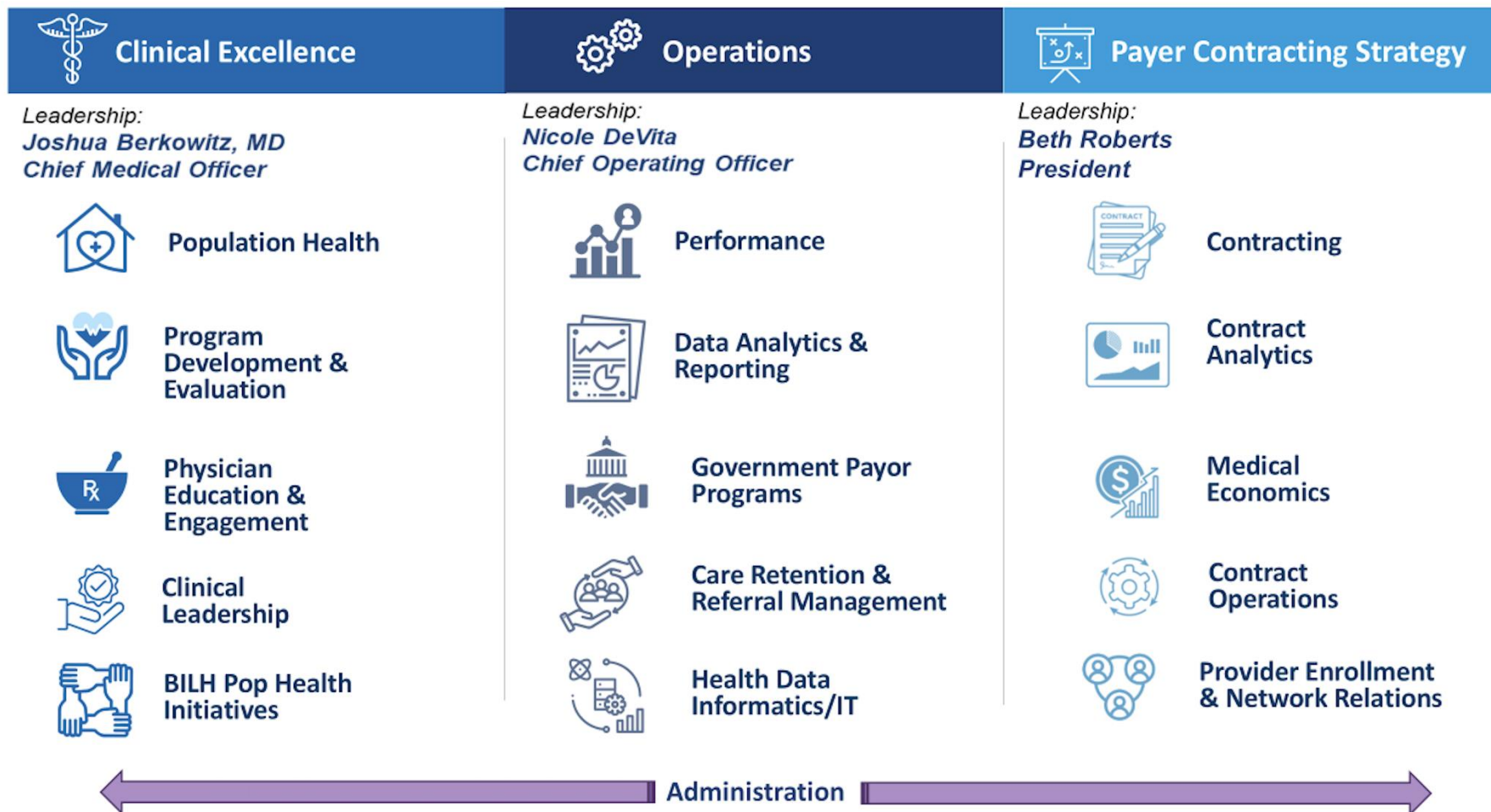
“No uncertainty”
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Introducing BILHPN

The Clinically Integrated Network of BILH

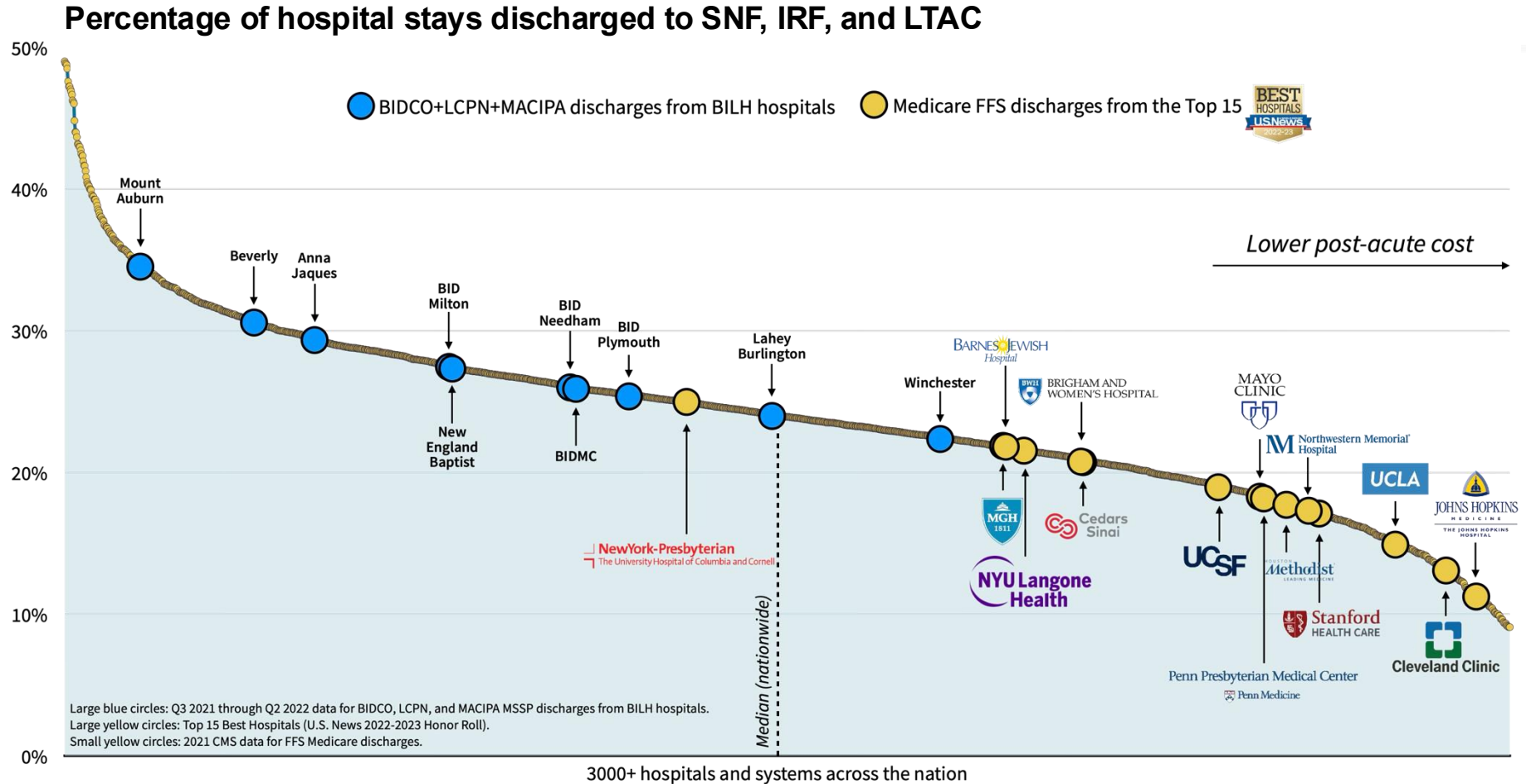
BILH Performance Network (BILHPN)

Functions and Responsibilities



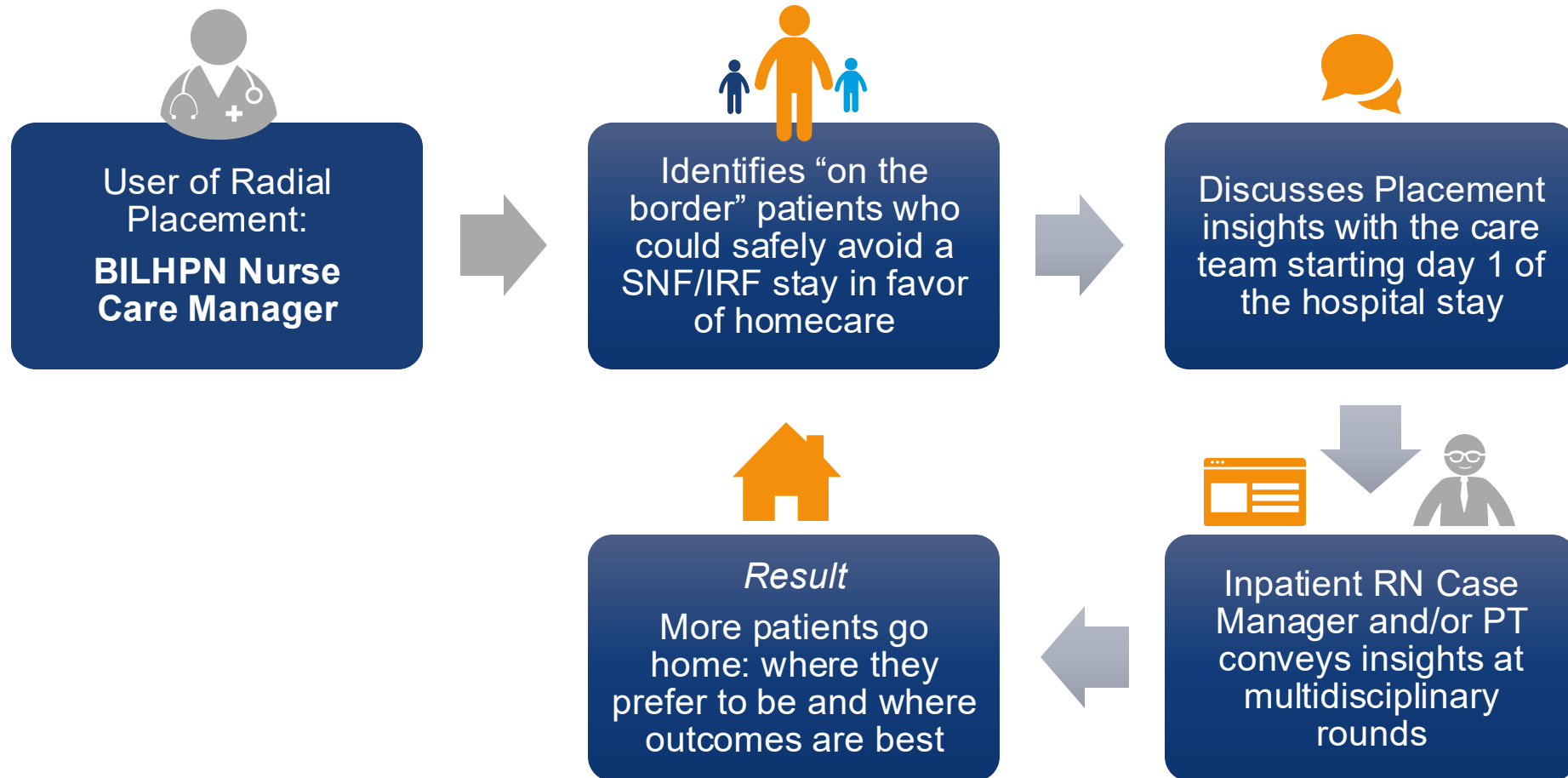
Before Radial:

Most BILH Hospitals Overutilized Facility Post-Acute Care



Our Radial Placement Workflow

Promoting Day One Collaboration Between Stakeholders



A Real Patient Story

Beth Israel Deaconess Medical Center



A Borderline Case — Made Clearer by AI

Placement Insights Uncovered a Safer, Lower-Cost Alternative



90+ y.o. male with PMH significant for CHF, chronic kidney disease, atrial fibrillation, admitted to BIDMC with a CHF flare



Hospital day 1: Radial Placement flagged him as “on the border” - a great candidate to avoid an unnecessary SNF/IRF stay in favor of robust homecare

Radial Placement automatically-generated insights:



- This hospitalization is a 30-day readmission. Consider how home services and/or wrap-around services can mitigate readmission risk.



- Patient history shows previous discharges to facility post-acute care, but they occurred after hospitalizations with higher acuity diagnoses.



- Patient has seen a cardiologist twice in the past 12 months, suggesting high likelihood of post-discharge follow-up.

Right Discussions, Right Actions, Right Outcome

Coordinated Discharge Planning Helped Avoid SNF



The BILHPN Care Manager (CM) proactively engaged the BIDMC care team to collaboratively discuss discharge plans:



- Inpatient team **agreed with plan for early mobilization**



- **Goal was discharge to homecare**, once volume status stabilized



- Hospital day 4: **patient cleared for discharge to home with services**, to be followed for 30d post-discharge by BILHPN CM



Care Beyond the Hospital Walls

Proactive Outreach Identified Risk and Prevented a Setback



After discharge home, BILHPN CM called patient and found he **did not understand need for a follow-up appointment** in the Heart Failure clinic to have his sodium levels monitored



BILHPN CM helped him schedule the appointment but also **noted a 7lb weight loss in the 7d** since discharge, and was concerned that a diuretic dose adjustment may be needed



BILHPN CM **contacted patient's PCP** to place an order for a blood draw, and to obtain clarification regarding diuretic dose



PCP adjusted the diuretic dose, patient's weight stabilized



Additionally, the BILHPN CM called the home health agency and **arranged for blood draw at home**



Results

BIDMC, Lahey, and Mount Auburn

Strong and Growing ROI, Multiple Paths to Value

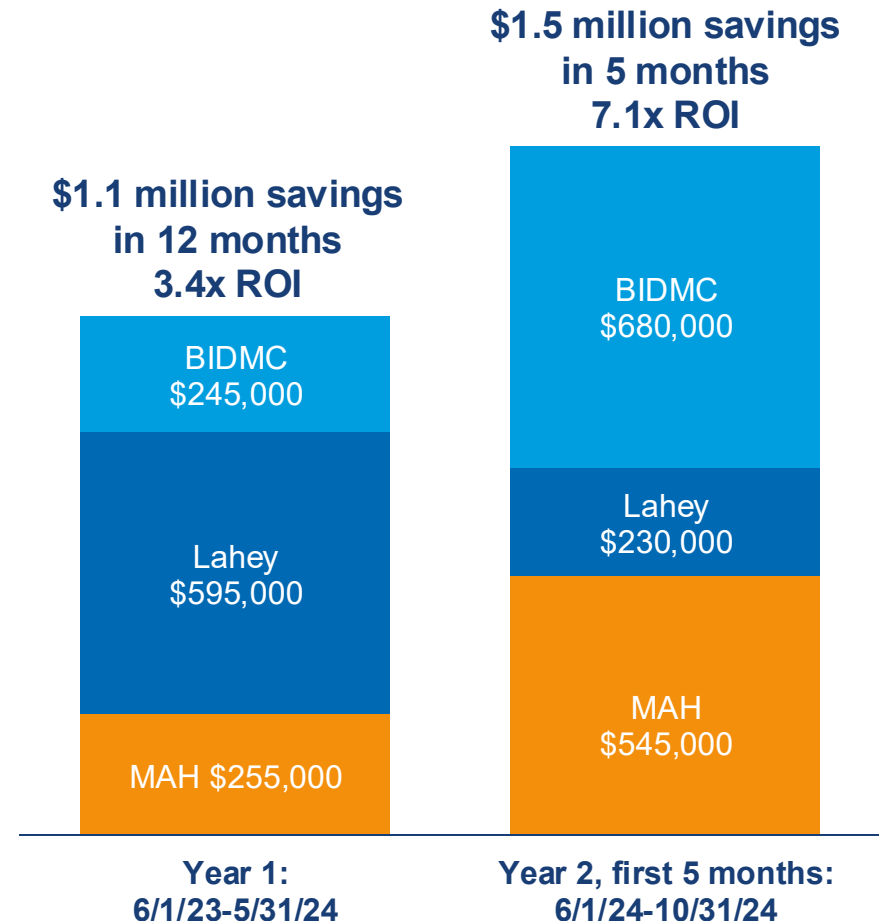
Addressing Both IRF Overutilization and SNF Overutilization

Three hospitals, three different primary opportunities:

- BIDMC: Avoid unnecessary **SNF** stays in favor of homecare.
- Lahey: Avoid unnecessary **IRF** stays in favor of SNF and/or homecare.
- Mount Auburn Hospital: Avoid unnecessary **SNF and IRF** stays

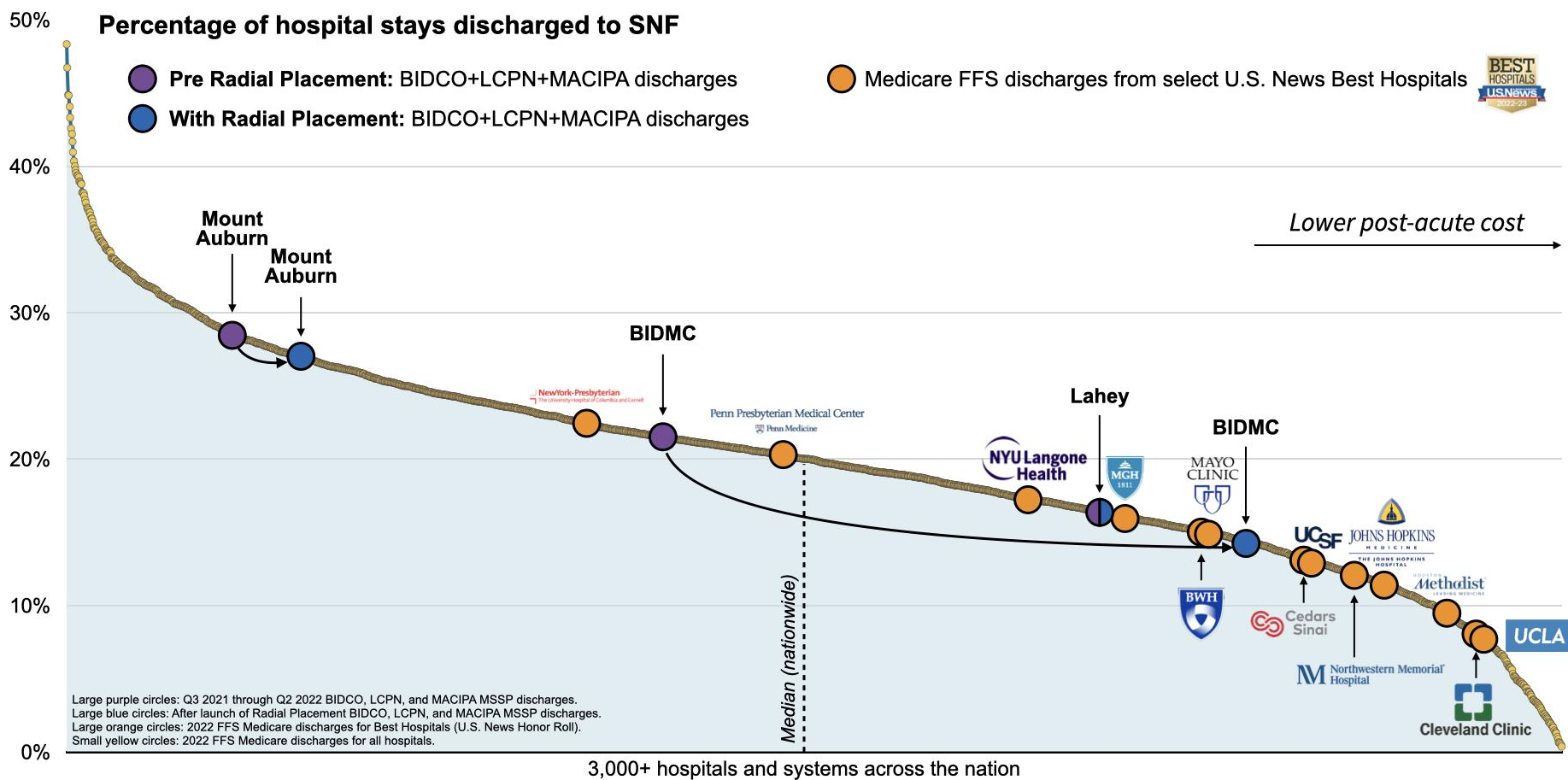
7.1x ratio of savings to fee paid for the Radial Placement initiative in Year 2 (was 3.4x in Year 1).

Savings with Radial Placement

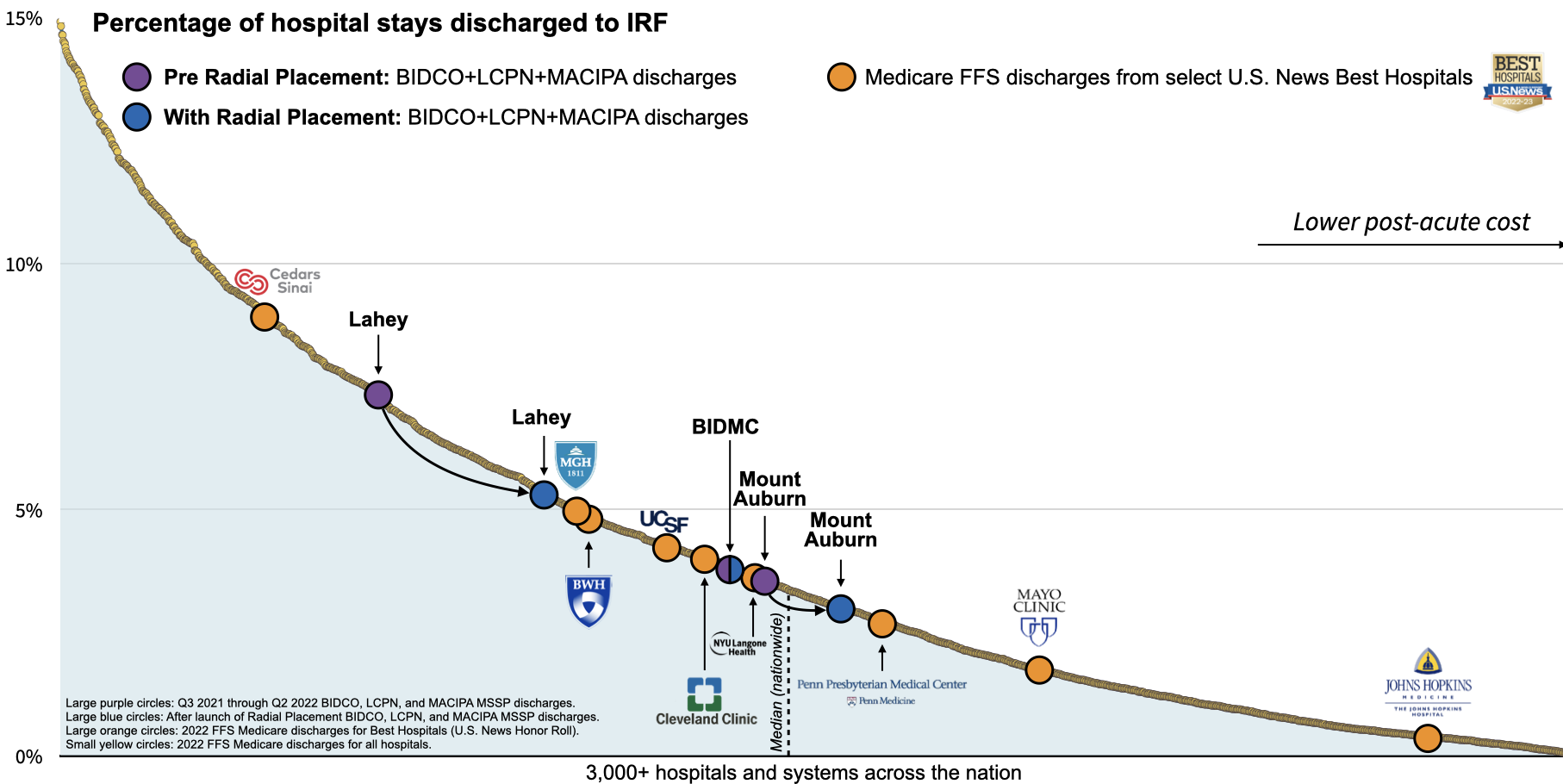


SNF Utilization: BIDMC now rivals nation's top hospitals

Mount Auburn Hospital also seeing reduction in SNF stays



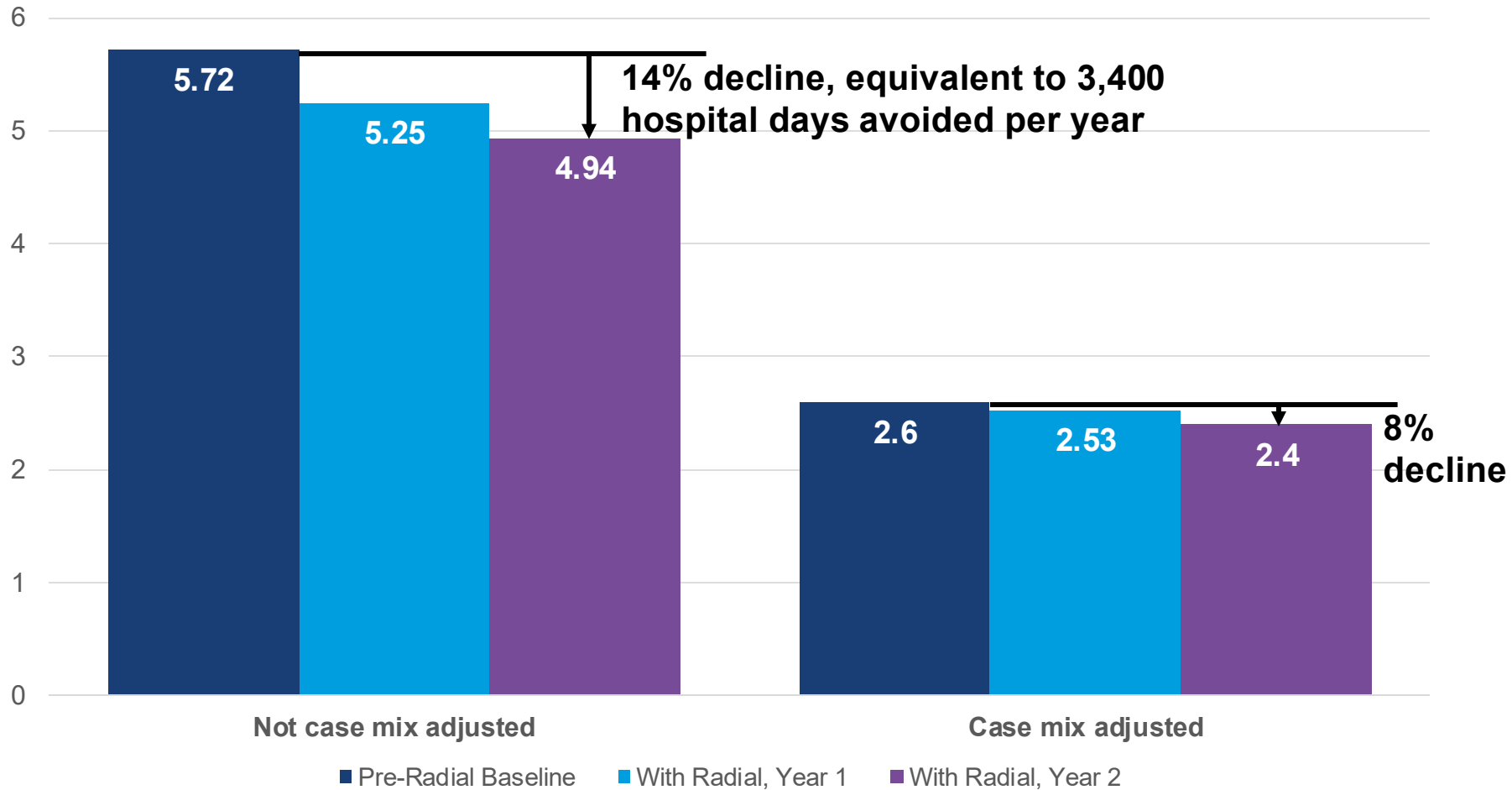
IRF Utilization: Significant Reductions at Lahey and MAH Further Opportunity Remains



BIDMC Spotlight: Hospital LOS Reduction

Saving 3,400 Hospital Days Annually By Avoiding SNF Stays

Average GMLOS (Days) For MSSP ACO Patients Admitted to BIDMC



Future Directions

More Areas of Impact, More Sites of Care, More Populations



Additional areas of opportunity

- End of life care
- Social risk mitigation
- Downstream post-acute optimization



Additional sites of care

- Home-based services including palliative care
- Outpatient providers/primary care



More populations

- CMS TEAM (Jan 2026)
- Medicare Advantage
- MassHealth



Panel Discussion

And Q&A

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