Next-Gen AI Care Orchestration and Business Intelligence: A New Frontier for Impacting the Most Actionable Patients

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Background

- Value-based care (VBC) organizations, including Medicare and Medicaid ACOs, succeed by delivering high-quality care while keeping patients safely at home.
- Avoidable admissions and readmissions, prolonged skilled nursing facility (SNF) length of stay (LOS), and unnecessary facility post-acute stays are key, controllable cost drivers.
- Care teams cannot reach every patient. The challenge is knowing who is both high/rising-risk *and* actionable, and what to do next.

Problem and Opportunity

- Bookmark Medical provides integrated administrative and operational support to value-based primary care practices. The organization sought to reduce readmissions and SNF LOS for a multi-state population of 65,000+ MSSP members.
- Prior to the implementation of our point-of-care decision support solutions, care managers spread effort across many risk patients who were not actionable. Result: excess 30-day readmissions, SNF utilization, and prolonged SNF LOS.

Objectives

- Deploy AI care orchestration to focus care teams on the patients most likely to benefit from intervention (e.g., readmissions avoidance).
- Measure impact on 30-day readmissions, SNF LOS, and cost using business intelligence (BI) in order to drive strategic decisions.

Intervention & Methods

- **Users:** Bookmark Medical's Medical Ambulatory Care Management and Extended Care Facility Medicare teams.
- **AI care orchestration (Figure 1a):** ranks patients daily by risk, actionability, and urgency; explains why; suggests a next best action.
- **Workflow (Figure 1b):** care managers work a prioritized daily list; executives use BI to set focus.
- **Case Example (Figure 2a):** identify the highest-yield patients and coordinate an interdisciplinary care plan to drive engagement and outcomes.
- **Evaluation:** qualitative feedback from users. Quantitative results continuously tracked by BI.

Study Overview and Findings

Figure 1a. AI Care Orchestration

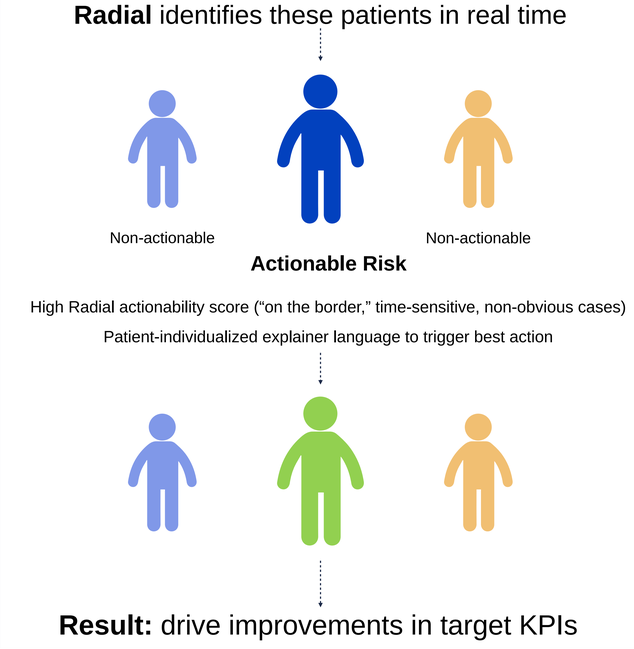
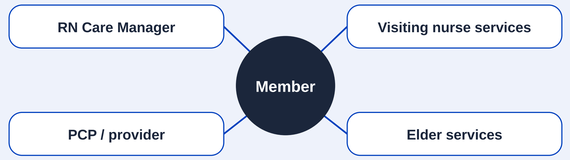


Figure 2a. Case Example

Re-engaging a hard-to-reach member with repeat readmissions

Medicare ACO member · high readmission rate · hard to engage consistently

1. **Identify** Leveraging readmission risk and utilization history (chief complaints, hospitalizations), Radial flagged him as a high-yield, actionable opportunity
2. **Coordinate** Interdisciplinary team identified the best ways to connect



3. **Outcome** Engaged consistently, accepted several offered resources, and his readmission rate went down

"Supporting them in this way helps them remain healthy, safe, and independent at home."

"It was a great example of how teamwork and persistence can lead to better support for a patient."

Edwin, Manager, Medical Ambulatory Care Management, Bookmark Medical

"I use it every day to find additional referrals to assign to my team."

"Radial always has the information I need, other platforms don't."

"I especially like the valuable insights on readmissions and each member's utilization history."

Bookmark Medical frontline users and leaders

Figure 1b. Workflow

CLINICAL EXECUTIVE · business intelligence for strategy

Find opportunities Diagnoses and facilities driving avoidable utilization → **Benchmark** ACO vs. regional and national peers on clinical and operational metrics → **Sharpen focus** Set priority diagnoses, facilities, and cohorts for care teams

Insights flow down: sharper focus for care teams

Results flow up: impact tracked in BI

CARE MANAGER · every morning

1. **Prioritize** Review worklist ranked by Radial actionability score for readmissions and SNF LOS intervention opportunity
2. **Deep dive** Review the patient's clinical, functional, and social risk factors
3. **Choose actions** Evaluate suggested next best action steps
4. **Plan engagement** Set the right touch and timing for outreach
5. **Wrap around** Arrange home services and outpatient follow-up
6. **Close the loop** Touch base with patient, caregivers, PCP, and specialists

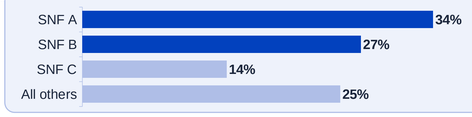
Figure 2b. Next-Gen Business Intelligence

What makes BI **next-gen**?

Traditional BI	Next-Gen BI
Static dashboards	**Ask questions in plain language**
Siloed, retrospective reports	**Unifies clinical, operational & cost data**
Users interpret the charts	**Explains drivers & curates next steps**
Log in to look	**Pushes insights to leaders**

From question to action *(illustrative example)*

1. **Ask** — *"Which facilities and diagnoses drive our excess SNF days?"*
2. **Synthesize** — **SNF A and SNF B drive 61% of excess SNF days;** CHF and hip fracture stays exceed benchmark LOS by 6+ days.



3. **Act** — **Recommended next steps**
   - ✓ Review LOS outliers with SNF A & B; set weekly huddles
   - ✓ Flag CHF admissions early for a home-health pathway
4. **Push** — **Weekly brief:** SNF A LOS ↑ 3 days vs. last month · 2 actions ready

Impacts

- **Timely identification:** high-yield patients surface each morning with utilization context.
- **Workflow:** one view to assign patients with high readmission actionability or SNF LOS opportunity.
- **Care team impact:** effort shifts to actionable patients; we re-engage hard-to-reach members.
- **Business intelligence:** benchmarking against national peers to target focus and measure impact.

Conclusions

- Focusing care management effort on the most *actionable* patients and urgent interventions, not just high-risk members, has been shown to reduce readmissions and avoid unnecessary SNF days.
- Explainable insights and next best actions help care managers act quickly and drive care team alignment on concrete steps.
- BI shows leaders which diagnoses, hospitals, SNFs, and providers drive avoidable utilization, linking VBC strategy to execution.

Ongoing Collaboration

- **Next-gen BI (Figure 2b):** Expansion of self-service business intelligence to clinical and operational leadership to deepen ACO/provider partnership and improve strategic decisions.
- **Avoidable admissions:** Go beyond readmissions to prioritize chronically ill, socially complex, and palliative/hospice-appropriate members for home-based care.
- **Beyond MSSP:** Medicaid ACO, value-based Medicare Advantage, and other programs.
- **Broadening impact:** Potential users include PCPs, onsite nursing staff, and social workers.

Disclosures

- Anant Vasudevan is a hospitalist at Brigham and Women's Hospital and CMO at Radial
- Haley Claflin has no disclosures



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