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Educational Webinar Series

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Leveraging AI-Enabled Remote Patient Management for Preventative Care in the Fight Against Diabetes

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1 PM EST

Speakers:

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INTRODUCTION: TODAY'S SPEAKERS

Kevin McQueen
Vice President
Business Development

- 30+ years in professional services
- AI certified from MIT with 10+ years of AI experience
- Patent award winner

Rob Pittroff
Vice President
Business Development

- 20+ years of experience working in healthcare
- Proven success in developing strategic vision and programs with measurable success for partners
- Vast experience in diagnostics, imaging, POCT, and SaaS (GE Healthcare/Abbott Labs)

AGENDA

1. Diabetes by the Numbers
2. What is AI-Enabled Remote Patient Monitoring
3. Setting Up Your Solution
4. Expected Outcomes
5. Questions

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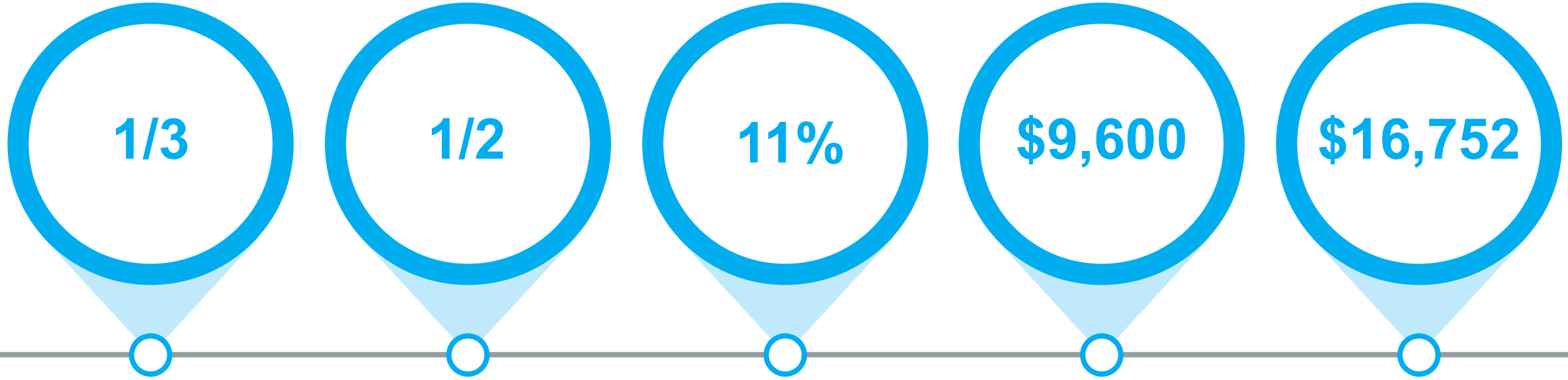
DIABETES BY THE NUMBERS

ADA statistics in the US



US Population is Prediabetic

US ~88M individuals

Prediabetic Population are Unaware

Annual Progression from Prediabetic to Type 2

Diabetes the 7th leading cause of death

Annual Direct Cost of Diabetes per Person

Annual Total Cost of Diabetes per Person

(Direct and Indirect costs)

$327B cost of diagnosed diabetes (2017)

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REMOTE PATIENT MONITORING

Evolution From Isolated Technology to Holistic Solutions

Remote Patient Monitoring

Remote Patient Monitoring in a traditional sense is an isolated solution involving:

- Connected Device
- Data Collection
- Regular Monitoring

When leveraging other capabilities within a more comprehensive solution, RPM can be taken from monitoring to true patient management for better outcomes.

Remote Patient Management

Remote Patient Management leverages an omnichannel approach to take things a step further, enabling:

- Proactive outreach based on patient preference for better activation and engagement
- Continuous learning for increased personalization and real-time interventions
- Automated and manual treatment plan revisions based on collected data
- Easy data sharing for better care coordination

PRESCRIPTIVE ANALYTICS: AI ENGINE DATA COLLECTION

From Client

- Claims/Billing
- Enrollment/Care Management

Augmented Intelligence

- Behavioral
- Environmental
- Lifestyle
- Transportation

U.S. Census
Updated every 10 years. Last census 2010.

U.S. Department of Agriculture
Retrospectively updated every 1-3 years.

U.S. Department of Housing & Urban Development
Updated yearly. Last update 2018.

Weather/Air Pollution Source
Updated yearly. Last update 2019.

3rd Party Purchased
Updated weekly – monthly. Non-transactional.

4500+
factors analyzed per patient

Readily available data can provide meaningful correlations between disparate data sources to help understand disparities, barriers to health & wellness, and accelerating risk.

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AI-ENABLED REMOTE PATIENT MANAGEMENT

Prescriptive Analytics & RPM By Definition

Prescriptive Analytics: risk stratification of a cohort via AI, then individual consideration for the entire care journey. Population to patient (ex. SDOH)

Remote Patient Management: enables highly personalized solutions utilizing RPM devices and virtual care technology for better outcomes

Why?

- Preventative Health for At-Risk Populations
- Improve Care Coordination
- Lower Overall Healthcare Costs

PRESCRIPTIVE ANALYTICS: GETTING MORE GRANULAR

Social Vulnerability Intelligence

Population Insights

- Vulnerability Category
- Vulnerability Score
- Vulnerability Percentile

Patient Insights

- Vulnerability Ranking
- Top 5 Drivers of Social Vulnerability

MRN	First Name	Last Name	Vulnerability Category	Vulnerability Score	Vulnerability Percentile	Driver 1	Driver 2	Driver 3	Driver 4	Driver 5
12345	Susan	Smith	Moderate	3	67.3	Short residence length	Education likely includes some college	Above average particulate matter contributing to air quality	Likely to be digitally fluent	Lack of other adults in household

Choose visualization

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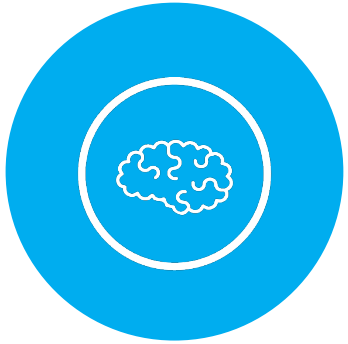
AI-ENABLED REMOTE PATIENT MANAGEMENT

How to set up a solution to prevent the progression of your **prediabetic population**

Identify



Data Collection & Analysis

Assess

Prescriptive AI Recommendations

Intervene

Personalized RPM Solution

IDENTIFY

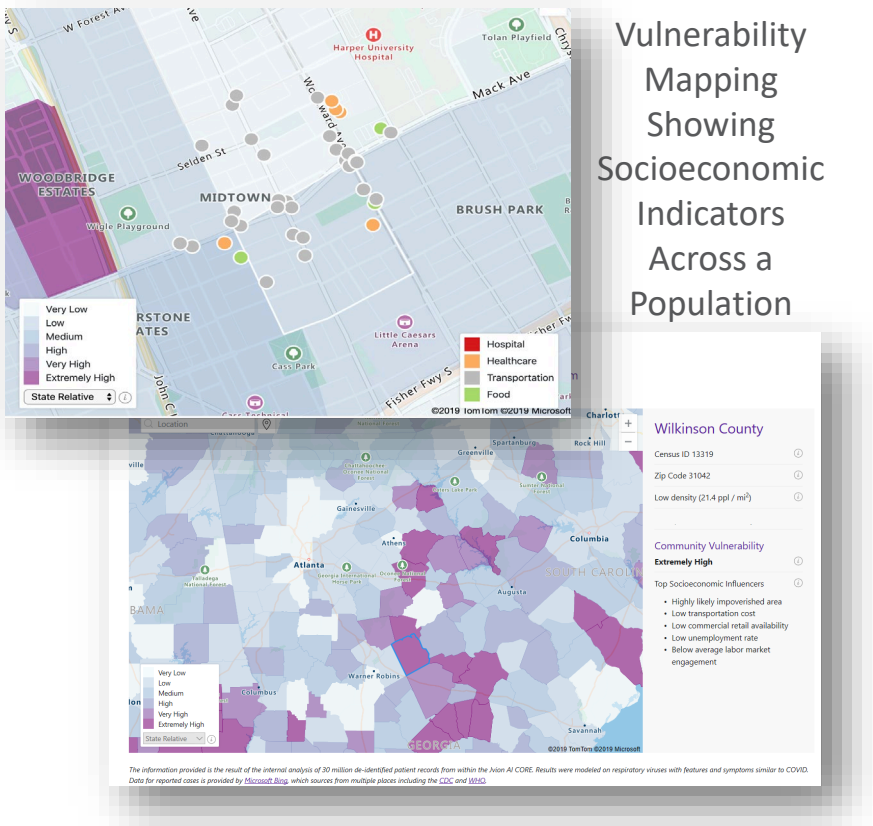
Identify the Pre-Diabetic Population At-Risk for Progression

Clinical Factors (Claims & ADT Data)

- Medical history
- Diagnoses
- Test results
- Vitals data
- Prescription information
- Previous admissions
- ADT data

Socioeconomic Factors (Outside Data)

- Education
- Income
- Food desert
- Transportation
- Digital fluency
- Purchasing preferences



Vulnerability Mapping Showing Socioeconomic Indicators Across a Population

Key indicators that you've identified a pre-diabetic population at-risk for disease progression could include findings like:

- High rates of obesity within the community
- Low income leading to reduced access to healthy food and fitness facilities
- Lack of health literacy indicating less education on how to prevent disease progression

ASSESS

Drill Down to the Individual Level and Make the Collected Data Actionable

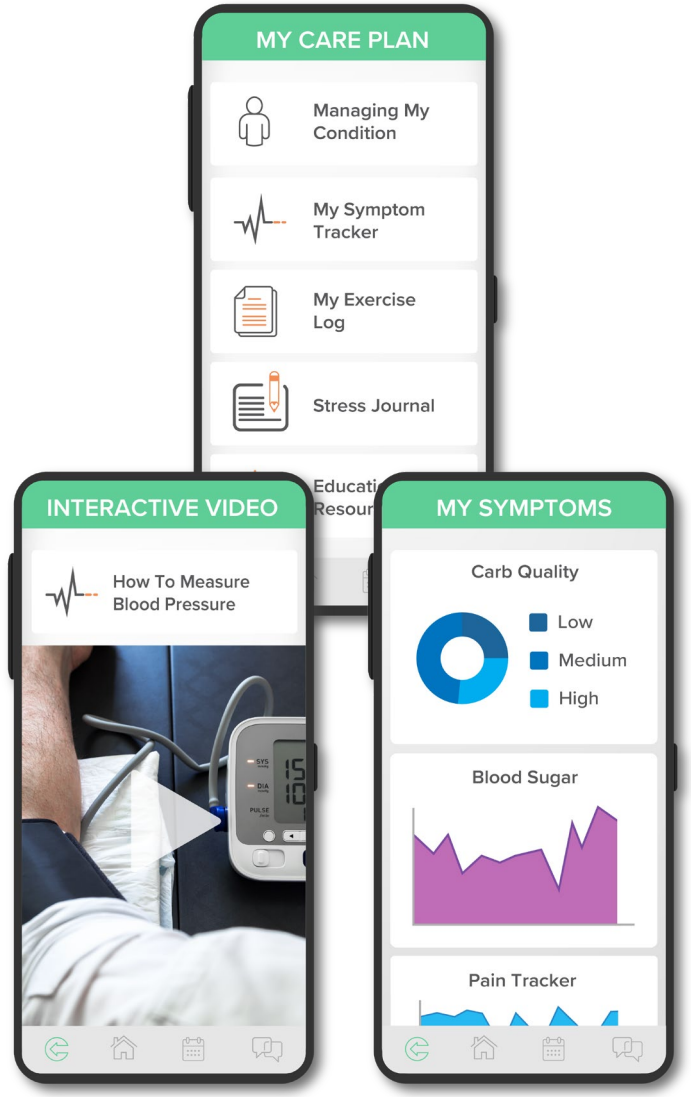
Individual Info: A 35-year-old male who is pre-diabetic has been identified as at-risk for progression to Type II Diabetes

Identified Risk Factors:

- Overweight
- Low Health Literacy
- High-Stress Job
- History of Depression

Recommended Actions:

- Consider dietician consult
- Remotely monitor blood glucose and weight
- Consider psychotherapy referral
- Provide educational content on risk factors in disease progression



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INTERVENE

Deliver a Personalized RPM Solution to Change Behavior

RPM for Continuous Glucose Monitoring:

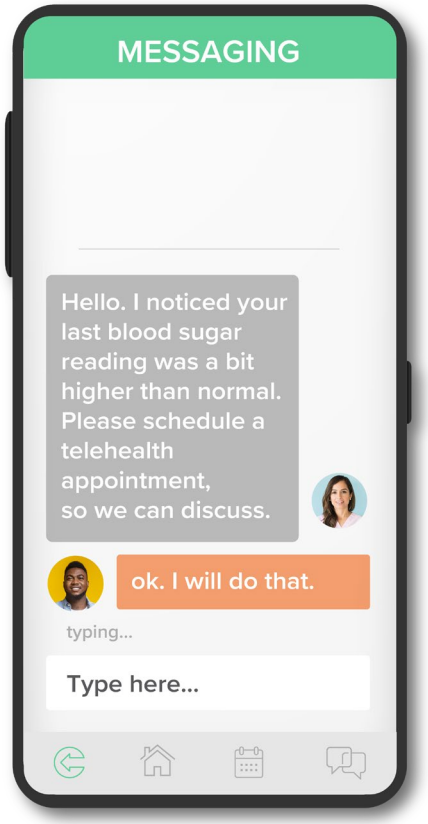
- Reminders to take blood sugar readings
- Educational prompts on how to use the device
- Patient dashboards for progress tracking

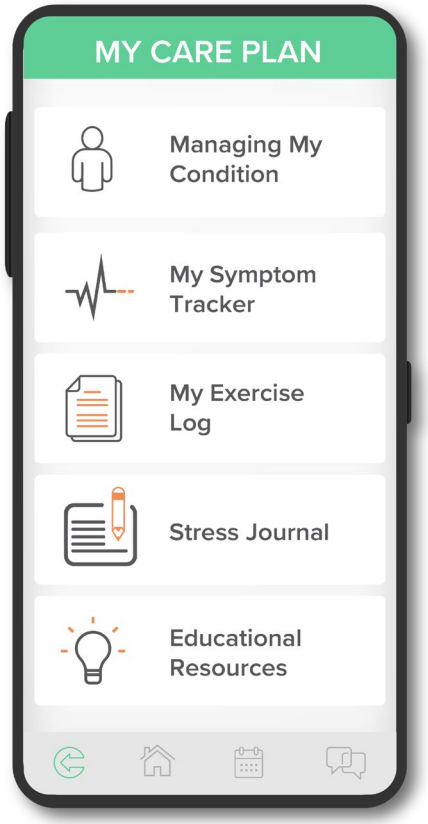
INTERVENE

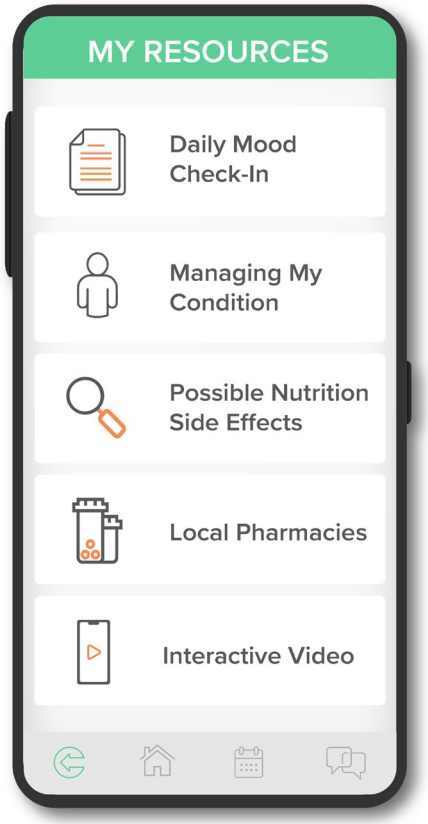
Deliver a Personalized RPM Solution to Change Behavior

RPM for Continuous Glucose Monitoring:

- Secure bi-directional messaging between patients and providers
- Digitized care plans for increased engagement and adherence
- Educational resources to improve health literacy and increase awareness of local resources



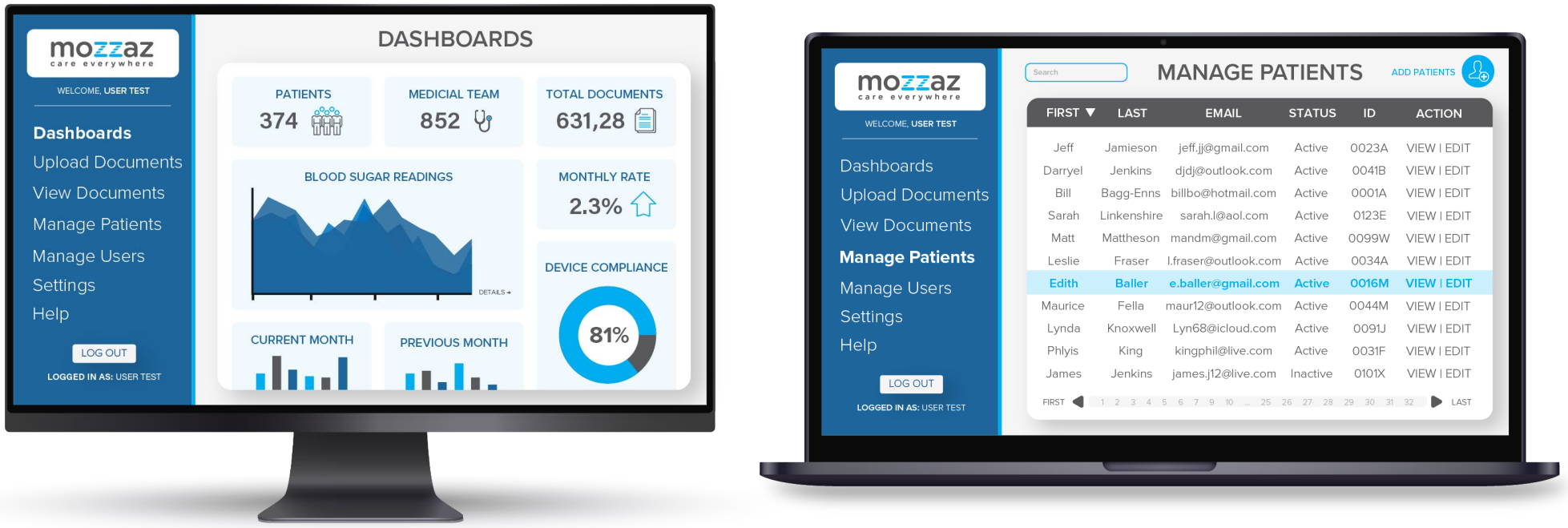




INTERVENE

Deliver a Personalized RPM Solution to Change Behavior

RPM for Continuous Glucose Monitoring Dashboards & Reporting for Providers:

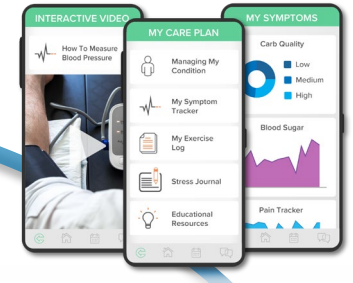


AI-ENABLED RPM AS A WHOLE

AI & RPM Work Together to Change Behavior and Prevent Disease Progression

AI Driven Identification & Assessment

RPM Platform



RPM Patient Solution

RPM Platform

REAL-WORLD BUSINESS CASE EXAMPLE

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"Customer ABC" Benefit Projection

Projected Savings:	$19,072,152
Projected Additional Revenue:	$26,777,520
Total Projected Gross Benefit:	**$45,849,672**

Monthly Cost for Diabetes per patient

Total Cost of Diabetes	$1,396
Total Direct Diabetes Cost	$800
Indirect cost, ie other disease	$596

Population Health Annual Savings (Payer / ACO / Captivated Models)

Total Population of pre-Diabetes cohort	690,000
Annual Prediabetic progression to Type II	11%
Annual Population Growth of prediabetic	75,900
Projected Cost without Preventative	$1,271,476,800
Projected Adoption rate (very conservative)	15%
Adoption Rate Population	11,385
Aversion/Prevention Rate (very conservative)	10%
Aversion/Prevention Population	1,139
Total Projected Savings from Aversion/Prevention Population	**$19,072,152**

Revenue CPT codes (Provider)

RPM revenue (one time monthly)	**$120**
Virtual Care revenue (one time monthly)	**$76**
Adoption Rate Population	11,385
Total Potential Opportunity (based on adoption population only)	**$26,777,520**

DIABETES FINANCIAL OPPORTUNITY

Estimated Cost Savings for One Large Payer

1

Prediabetic Population

= 866,500

2

Annual Cost per Diabetes Patient = $9,600

With Indirect Cost = $16,752

3

Total Opportunity for savings Annually =

+ $915M *

**Prediabetic population = 866,500 x 11% (annual progression to Type 2) = 95,315*

86,650 x 9,600.00 = $915,024,000 (Direct cost ONLY)

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APPLYING THIS MODEL ACROSS OTHER POPULATIONS

Cost & Utilization Management

- 6 mo. Deterioration
- Avoidable Admission
- Avoidable ED Visit
- Avoidable Utilization
- Disease specific
- Community Sepsis
- ED High Utilizers

Population Health

- Social Determinants of Health Vulnerability

Activation & Engagement

- Activation Score
- Engagement Preference
- Medication Adherence

Behavioral Health

- Substance Abuse
- Suicide Risk / Self Harm
- Depression Risk
- Opioid Misuse

Chronic Disease Management

- Diabetes
- COPD
- Cancer
- Heart Disease
- Chronic Lung Disease
- Stroke
- Alzheimer's Disease
- Kidney Disease
- & More

WHY DOES IT WORK?

Key to a Successful RPM Program: Identifying the Problem, Providing the Solution

Leverage AI Powered Insights to:

- ✓ Identify patients at risk with a holistic approach
- ✓ Accurately identify individuals NOT high risk today, but on a rapid trajectory to become high risk
- ✓ Understand unique drivers of risk for each patient
- ✓ Align and prioritize interventions based on individual risk factors gleaned from clinical and socioeconomic data

Implement a Remote Patient Management Solution to:

- ✓ Digitally tether patients to their care team
- ✓ Change patient behavior and improve outcomes
- ✓ Remotely monitor patient's conditions
- ✓ Close care gaps, reduce readmissions, & lower ED utilization for cost savings

QUESTIONS?

For a deeper discussion, please email us:

info@mozzaz.com

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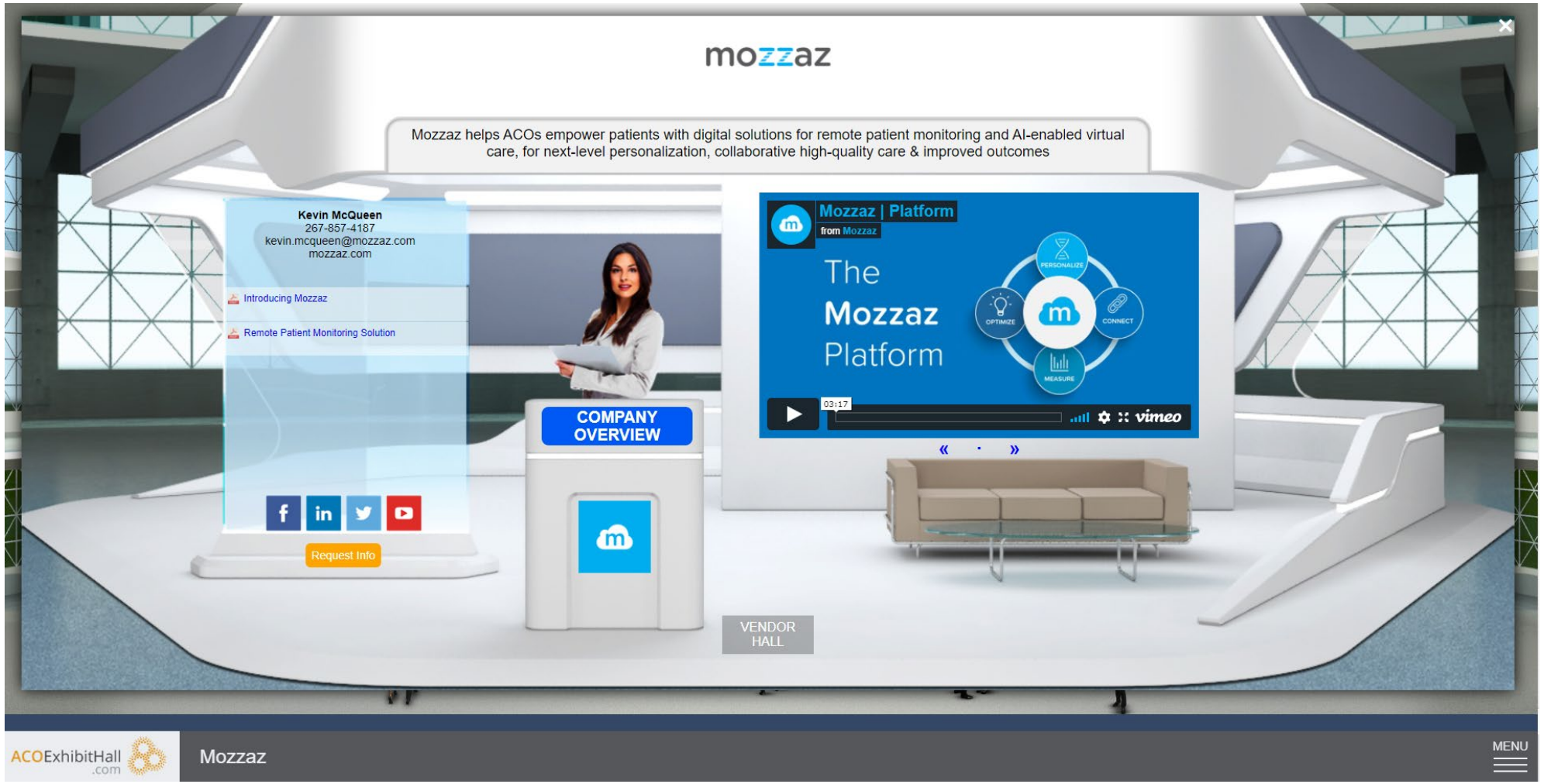

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THANK YOU!

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