INFERSCIENCE

AI at the Point of Care:

Best Practices for Evaluating AI Solutions in Value-Based Care

Dr. Sunil Nihalani & Subbu Ramalingam

VBCExhibitHall.com

Educational Webinar Series

Your Speakers Today

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Healthcare AI and Value Based Care Leader

What You'll Walk Away With Today

1. **Why this matters** right now
2. **What "good" looks** like from both the provider and payer side
3. An ideal AI experience in a **real patient walkthrough**, from exam room to payer
4. **A simple framework** for evaluating any point-of-care AI solution: “does this platform help, or will it **just add noise**?”
5. Three things you can act on **right now,** regardless of which platform you buy

AUDIENCE POLL

What's the biggest barrier to adopting point-of-care AI in your organization?

A. Physician workflow disruption

B. Don’t know where to start

C. Cost and ROI

D. EHR integration & data connectivity

E. Other

Why This Matters Right Now

If You're Still Planning, You're Behind

Accurate quality and risk capture now depends on decisions made in the exam room, and the rules are tightening in 2027.

THE TENSION FOR PROVIDER GROUPS

- Physicians didn’t train to be coders, and don’t have time to become coders.
- But accurate quality and risk capture increasingly depends on what they document at the visit.
- The gap between the two is where revenue and compliance risk both live.

THE BROADER ENVIRONMENT

- Risk adjustment pressure and RADV audit exposure
- Quality gaps documented inconsistently, all over the place
- Disjointed EHR systems that don't talk to each other

SECTION I

WHAT GOOD AI LOOKS LIKE
(AND WHEN IT'S JUST MORE NOISE)

Two Jobs, One Visit

Care Delivery and Clinical Coding Are Not the Same Job

JOB 1: Caring for the patient in the room
JOB 2: Administrative documentation after the visit

2 hours

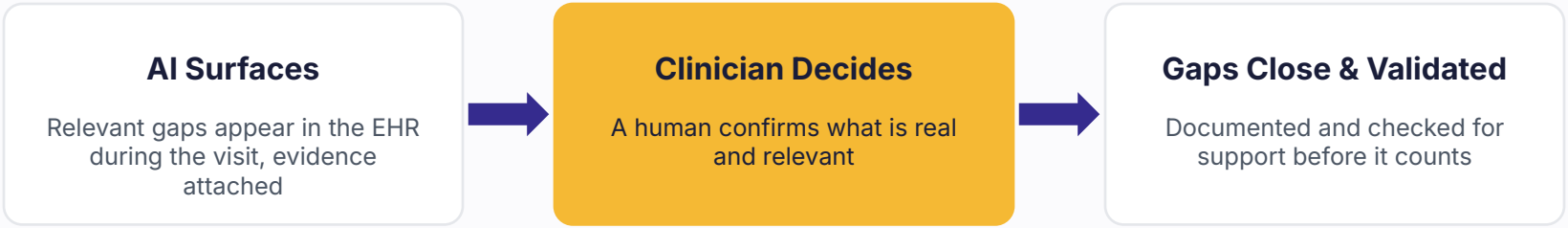
Hours of admin and EHR work for every hour of direct patient care

~42 percent

Percentage of physicians report burnout symptoms, with documentation cited as the top driver

What Good Point-of-Care AI Actually Looks Like

Inside the workflow. Evidence attached. A human makes the decision.



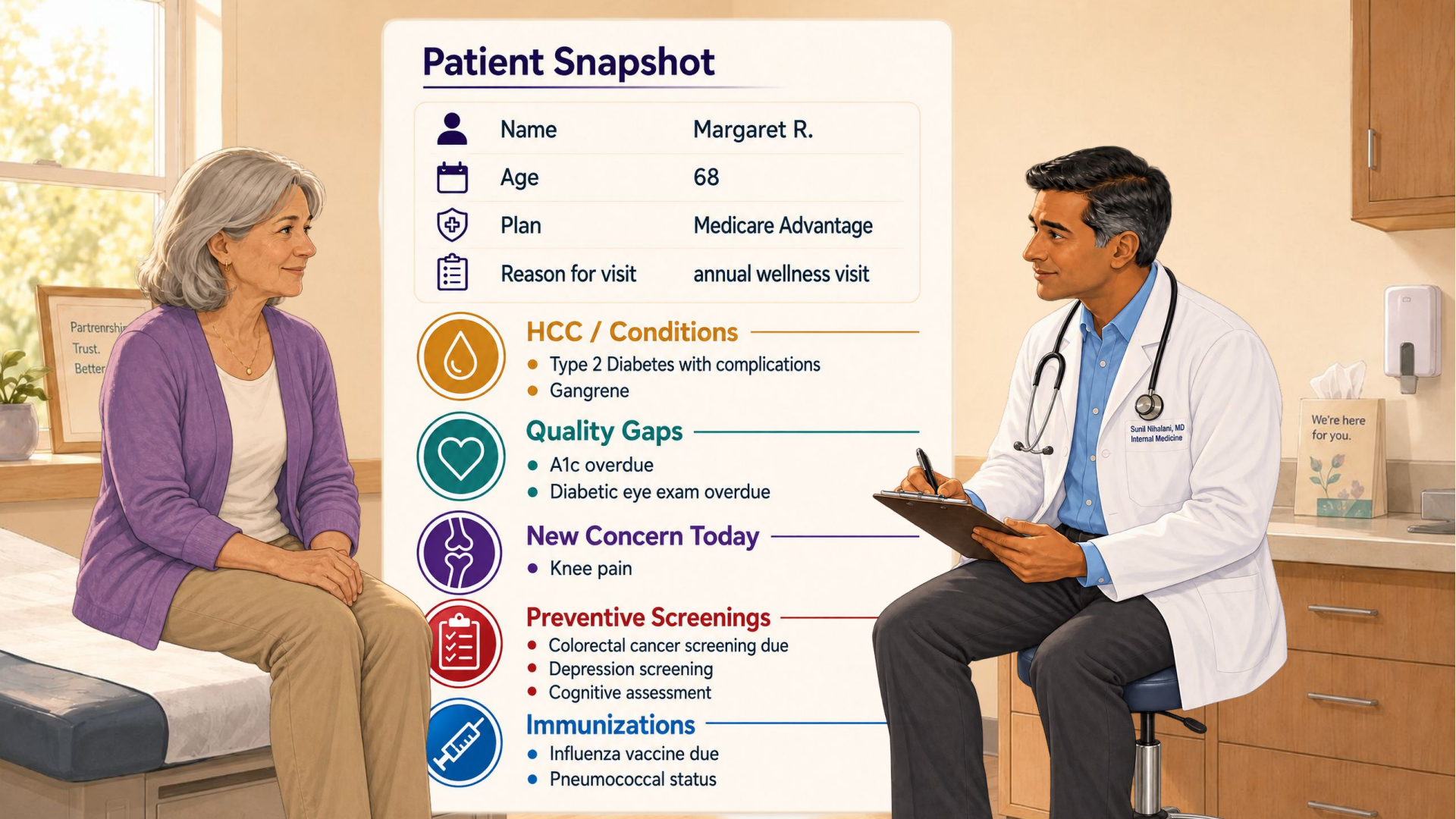
The clinician stays in the loop at every step.

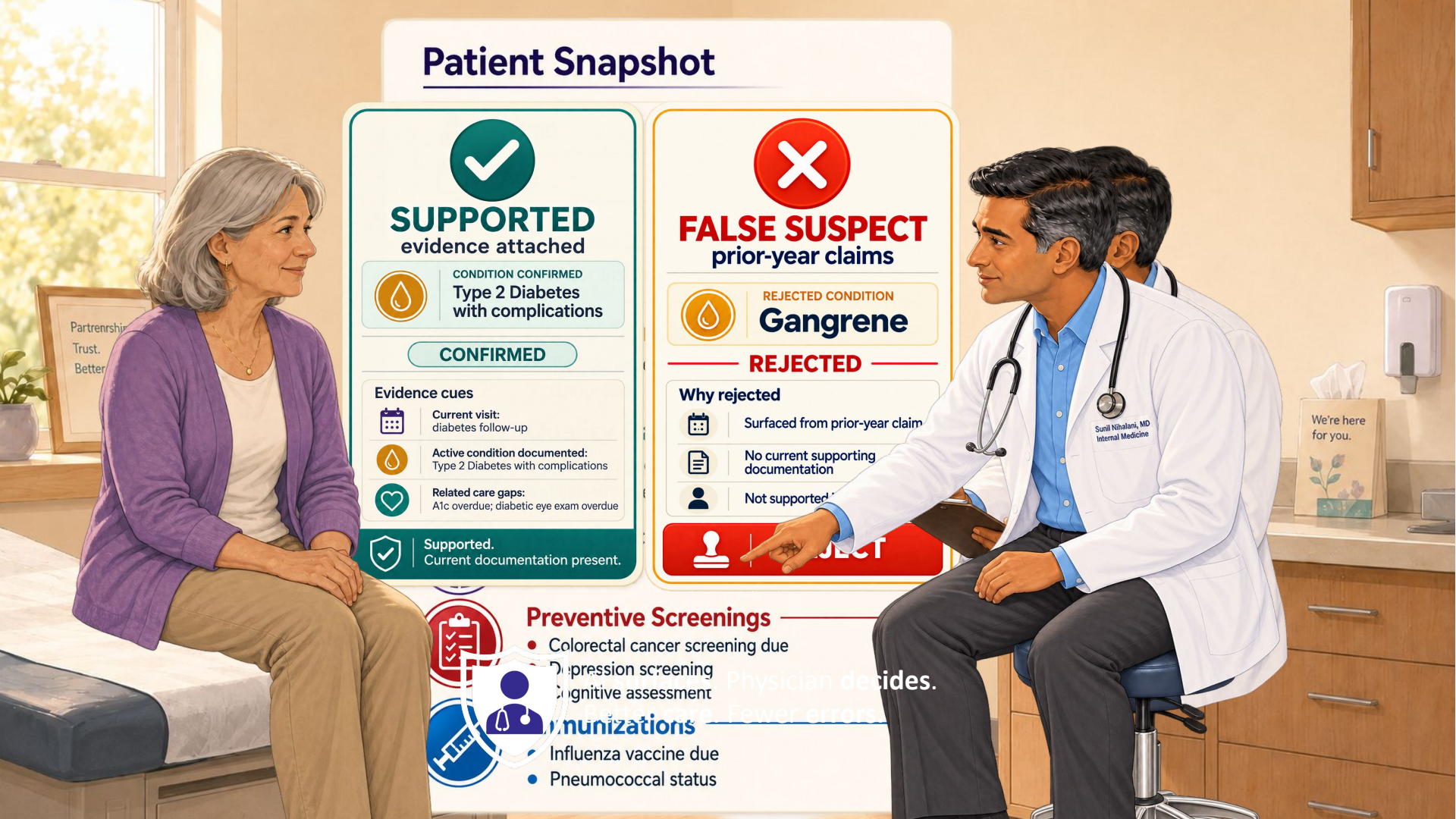
Providers: Less cleanup after the visit

Payers: More complete, supportable encounter data

SECTION II

WHERE AI FITS INTO THE PATIENT JOURNEY


Patient Snapshot
Name
Margaret R.
Age
68
Plan
Medicare Advantage
Reason for visit
annual wellness visit
HCC / Conditions
Type 2 Diabetes with complications
Gangrene
Quality Gaps
A1c overdue
Diabetic eye exam overdue
New Concern Today
Knee pain
Preventive Screenings
Colorectal cancer screening due
Depression screening
Cognitive assessment
Immunizations
Influenza vaccine due
Pneumococcal status
Sunil Nihalani, MD
Internal Medicine
We're here for you.


Patient Snapshot
SUPPORTED
evidence attached
CONDITION CONFIRMED
Type 2 Diabetes with complications
CONFIRMED
Evidence cues
Current visit: diabetes follow-up
Active condition documented: Type 2 Diabetes with complications
Related care gaps: A1c overdue; diabetic eye exam overdue
Supported. Current documentation present.
FALSE SUSPECT
prior-year claims
REJECTED CONDITION
Gangrene
REJECTED
Why rejected
Surfaced from prior-year claim
No current supporting documentation
Not supported
Preventive Screenings
Colorectal cancer screening due
Depression screening
Cognitive assessment
Immunizations
Influenza vaccine due
Pneumococcal status
Physician decides.
Fewer errors.
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Unsupported codes caught **before submission** . Not **in an audit** two years later.

	CONFIRMED Evidence found in clinical record	**VALIDATED** Meets coding rules and clinical criteria	**ADDRESSED** Administered or referred	**SUBMITTED** Ready for downstream systems & payment
Type 2 diabetes	✓	✓		✓
Gangrene	✗	✗		
Hyperlipidemia	✓	✓		✓
A1C			✓	
Eye exam			✓	
Knee pain			✓	
Screenings			✓	
Immunizations			✓	


Margaret R.
Member ID: 1234567890
Plan: MA PPO
PCP: Sunil Nihalani, MD
Visit Summary
Date of Service May 12, 2025
Provider Sunil Nihalani, MD
Setting Primary Care Office
Encounter Type Office Visit
Documentation Complete
COMPLETE
HCC gaps closed
quality gaps/star measures addressed
PAID
nual wellness visit
specialist referral placed
Complete, accurate, and actionable.
Driving quality. Reducing risk.
Improving outcomes.
NOT CAPTURED / NOT VALIDATED
gap reopens
audit risk grows
time lost due to back and forth
Incomplete data leads to missed value and more rework.

AUDIENCE POLL

How much of your risk and quality gap closure still happens after the visit?

A. Most of it

B. About half

C. A little

D. All of it happens at the encounter

SECTION III

HOW TO EVALUATE AI FOR YOUR PRACTICE

Evaluating Point-of-Care AI: A 6-Part Framework

1. Clinical Data Integration

Are data integrated correctly?

Is the right member attributed to the right physician?

2. EHR Connectivity

Can it integrate directly?

Does the vendor have a proven integration track record?

3. Security & Compliance

PHI/HIPAA compliance, comprehensive data security, LLM use and handling.

4. Governance & Accountability

Who owns performance and reviews it weekly/monthly?

Don't treat AI as "set-it-and-forget-it."

5. Burnout Impact

Are you actually measuring clinician and physician burden before and after implementation?

6. Flexibility

Can it support more than risk adjustment: quality measures, referrals, and other workflows?

Fits the workflow. Shows the evidence. Keeps a human in the loop.

Three Things to Do Next

Start Here, Regardless of Which Platform You Buy

1

Start at the Encounter

Move gap identification into the visit, not after it.

2

Keep a Human in the Loop

AI surfaces. A clinician confirms. Every time.

3

Evaluate on Workflow Fit

If it creates another login outside the EHR, it will not survive a clinic day.

Q&A

Stop By Our VBC Exhibit Hall Booth

VBCExhibitHall.com

More Information

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Get in touch with the Inferscience team to learn how AI at the point of care can close HCC gaps without adding to your physicians' workload.

Appendix: Supporting Detail for Three Things to Do Right Now

This Quarter

- Audit how much of your capture still depends on unlinked chart reviews
- Move suspect review upstream so the physician sees a curated list at the visit
- Brief physicians on the handful of conditions that drive the most miscoding

Before 2027

- Make point-of-care capture the default, with post-visit review as the safety net
- If you use AI, confirm there is a human gate before anything is submitted
- Build internal QA that mirrors how an auditor reads a chart