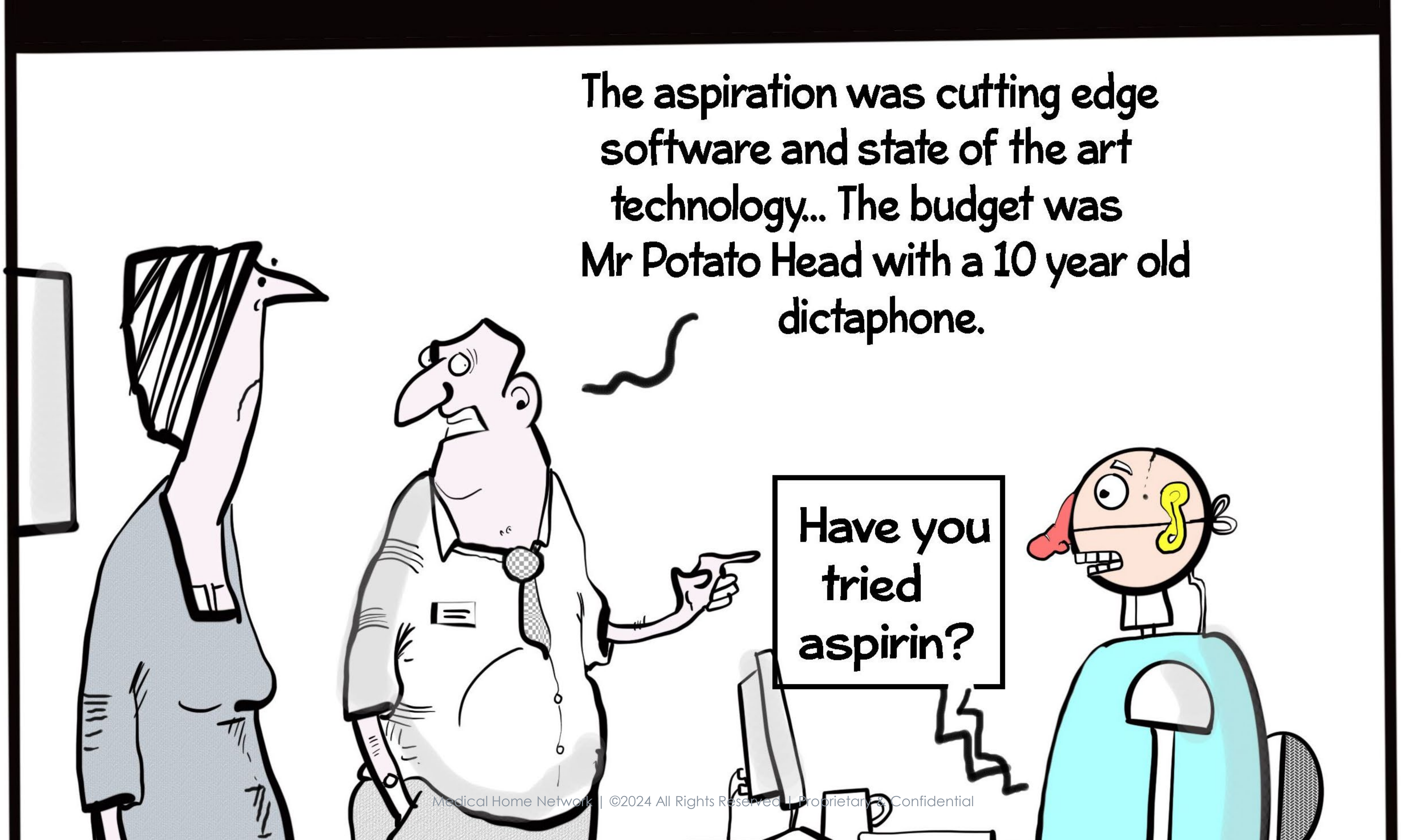
MEDICAL HOME NETWORK

Embracing AI, ML, NLP Tools for ACO

April 11, 2024

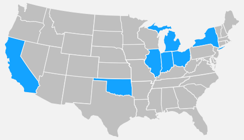

The aspiration was cutting edge software and state of the art technology... The budget was Mr Potato Head with a 10 year old dictaphone.
Have you tried aspirin?

MHN's Mission: To Transform Care and Build Healthier Communities in the Safety Net

A proven, replicable model and approach enables care transformation and success under value based care

14
Year History

Medicaid
+
ACO REACH
+
MSSP



7
States

60+
FQHCs

300,000+
Lives Impacted

$1.3B+
Medical Spend

$120M+
Shared Savings

MHN's AI Model Use Cases

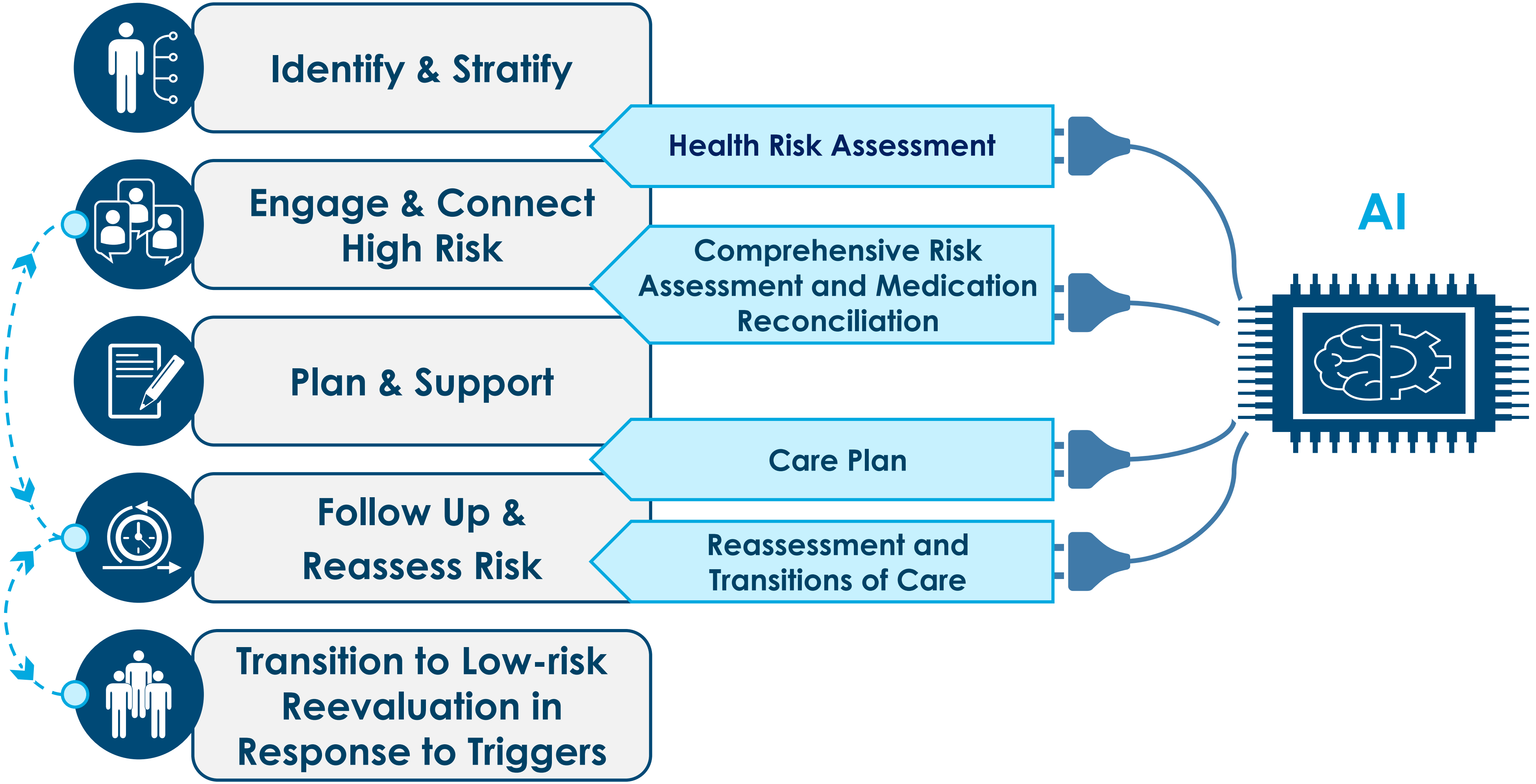
Goal:
Enable dynamic, proactive care management to improve outcomes, enhance quality and reduce total cost of care for members

How:
Leveraging all available data sources – claims, Rx, SDoH, care management, ADT, clinical data…

- ✓ SDOH powered dynamic risk stratification
- ✓ Transitions of Care – reduction of readmission risk
- ✓ Managing high cost, high risk
- ✓ Identifying the **rising risk**
- ✓ Generative AI

MHN AI Powers Dynamic, Personalized Care Management

AI Enhances Standard Workflows and Prioritizes Tasks



Identify & Stratify

Engage & Connect High Risk

Plan & Support

Follow Up & Reassess Risk

Transition to Low-risk Reevaluation in Response to Triggers

Health Risk Assessment

Comprehensive Risk Assessment and Medication Reconciliation

Care Plan

Reassessment and Transitions of Care

AI

Continual Assessment

- **Impact of the intervention**
- **Model performance over time**

MHN Predictive SDoH Powered Risk Stratification in Medicaid

Social Risk Factor Reduction of High & Medium Risk Adults

Social Risk Factor	Initial HRA	Latest HRA	% Change	Predictive of Future Cost and/or Utilization*
Total Social Factors	**11,124**	**6,963**	**-37.4%**	
Rates overall health as Fair or Poor	**2,019**	**1,578**	**-21.8%**	✓
Difficulty making appointments	685	396	-42.2%	✓
Difficulty getting to appointments or filling prescriptions	1,396	885	-36.6%	✓
Untreated Depression	1,172	511	-56.4%	
Untreated Drug/Alcohol Use	304	156	-48.7%	✓
Difficulty securing food, clothing, or housing	1,717	868	-49.4%	✓
Currently homeless or living in a shelter	126	68	-46.0%	✓
Difficulty paying for meds	1,000	270	-73.0%	✓
Does not feel physically or emotionally safe at home	213	143	-32.9%	
Refused Smoking Cessation program	607	226	-62.8%	

Results: Reduced social risk drivers that impact health by 37.4%

Member, Cost, & Utilization by Risk Level

HRA Risk Profile	Member Count	% Members Total	ER Visits / 1000	Inpatient Admits / 1000	Medical + Rx Cost PMPM	Relative Cost
Low	1,606	21%	415.3	56.66	$217.1	100%
Low-CHW	4,181	54%	620.2	96.39	$349.4	161%
Medium by Social Factors	**663**	**9%**	**742.1**	**143.29**	**$423.3**	**195%**
Medium by Utilization	320	4%	1,856.3	281.25	$479.9	221%
High by Social Factors	**127**	**2%**	**834.6**	**125.98**	**$404.7**	**186%**
High by Utilization	865	11%	1,653.2	679.77	$821.4	378%
Total	**7,762**	**100%**	**757.8**	**165.29**	**$387.2**	**178%**

** Note: This analysis includes ACA adults who were continuously enrolled for twelve months post Health Risk Assessment (7,762 observations) and their associated claims cost during that period.*

Capturing social-driven costs and utilization that would have been missed under a traditional approach

Validation to Drive Clinical Practice Adoption

Goal 1: Improve accuracy in the identification of high & medium risk members in high utilizers

Goal 2: Reduce false positives among members with low utilization that are stratified as high risk

Medicaid -ACA

45% AI correctly identifies 45% more members in the top 5% of high utilizers as high or medium risk

70% AI reduces members identified as high risk that are actually in the bottom quartile by 70%

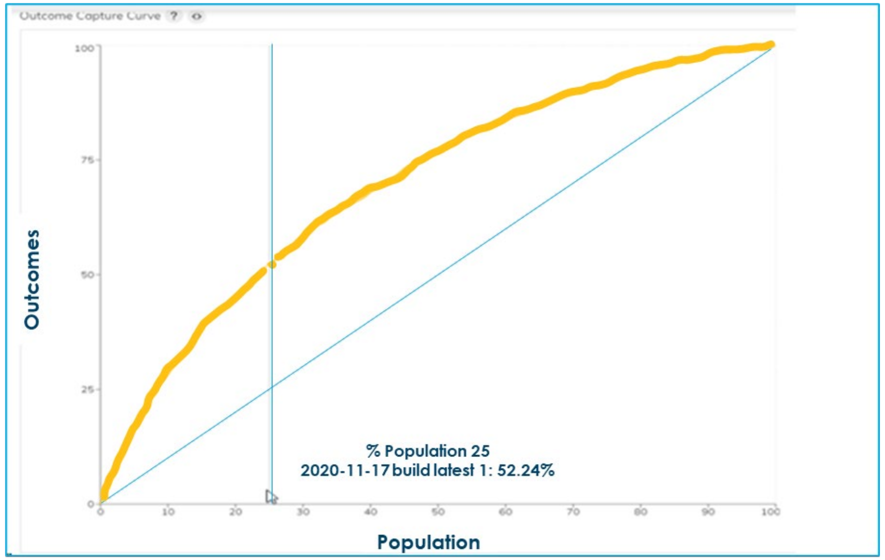
Medicaid - FHP

96% AI correctly identifies 96% more members in the top 5% of high utilizers

73% AI reduces members identified as high risk that are actually in the bottom quartile by 73%

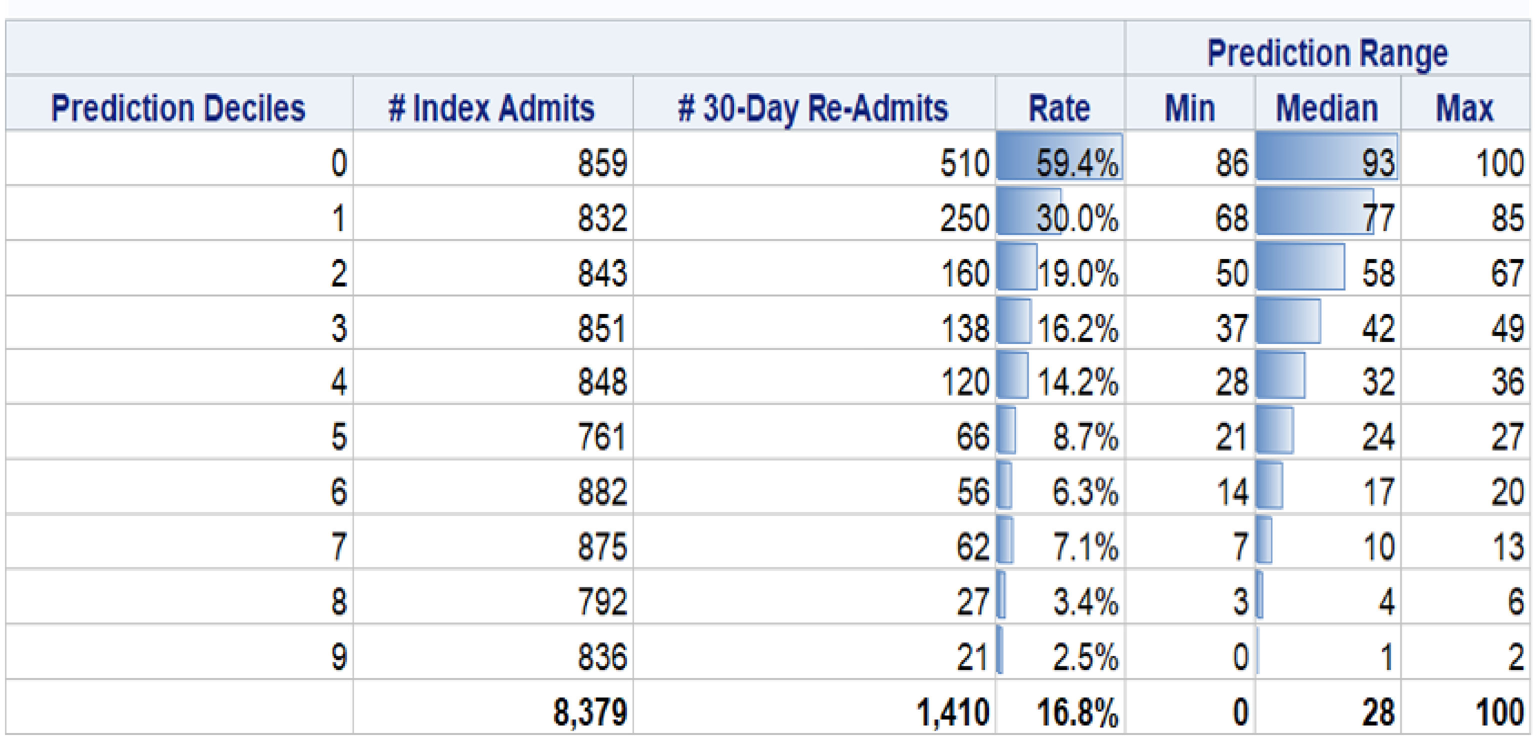
MHN AI Transitions of Care: Rate of Readmission Validation

Outcome Capture Curve for Readmission Model



Top 25% of AI risk = 52% of actual readmissions

MHN Readmission Rates by Prediction
Admissions 2022-11 to 2023- 10 paid through 2024-01

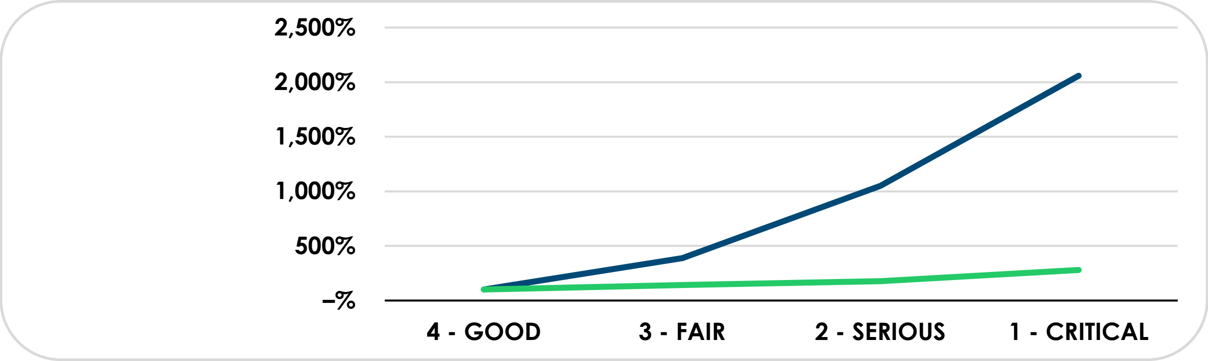


				Prediction Range		
Prediction Deciles	**# Index Admits**	**# 30-Day Re-Admits**	**Rate**	**Min**	**Median**	**Max**
0	859	510	59.4%	86	93	100
1	832	250	30.0%	68	77	85
2	843	160	19.0%	50	58	67
3	851	138	16.2%	37	42	49
4	848	120	14.2%	28	32	36
5	761	66	8.7%	21	24	27
6	882	56	6.3%	14	17	20
7	875	62	7.1%	7	10	13
8	792	27	3.4%	3	4	6
9	836	21	2.5%	0	1	2
	8,379	**1,410**	**16.8%**	**0**	**28**	**100**

MHN AI High Risk, High-Cost Opportunity

Model surfaces the most impactable patients

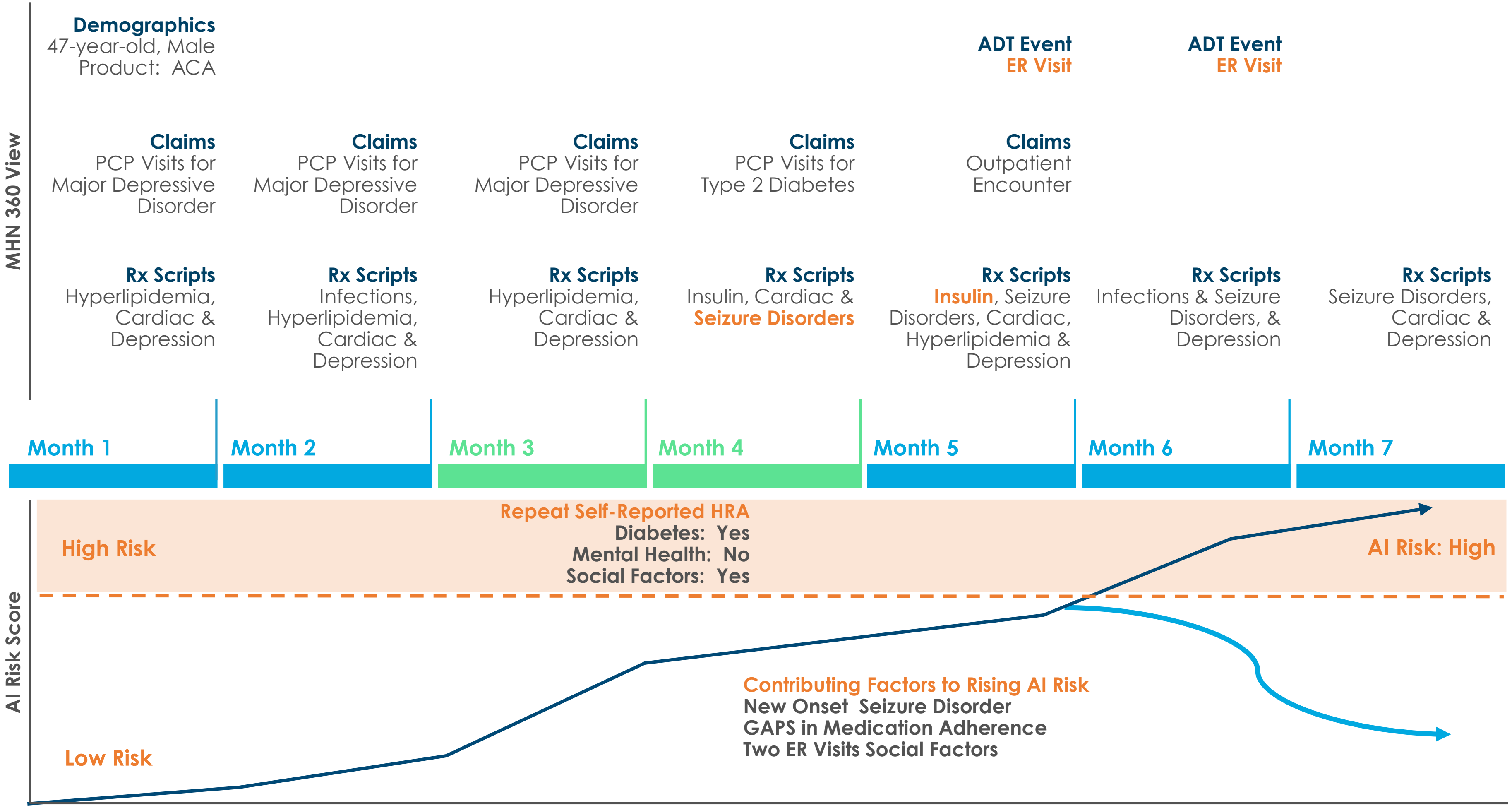
PMPM vs…



Social Determinants of Health

Chronic Conditions

MHN Proactive Care Management: Dynamic Identification of High Risk and Rising Risk



Demographics
47-year-old, Male
Product: ACA

Month 1

Claims
PCP Visits for Major Depressive Disorder

Rx Scripts
Hyperlipidemia, Cardiac & Depression

Month 2

Claims
PCP Visits for Major Depressive Disorder

Rx Scripts
Infections, Hyperlipidemia, Cardiac & Depression

Month 3

Claims
PCP Visits for Major Depressive Disorder

Rx Scripts
Hyperlipidemia, Cardiac & Depression

Month 4

Claims
PCP Visits for Type 2 Diabetes

Rx Scripts
Insulin, Cardiac & **Seizure Disorders**

Month 5

ADT Event
ER Visit

Claims
Outpatient Encounter

Rx Scripts
Insulin, Seizure Disorders, Cardiac, Hyperlipidemia & Depression

Month 6

ADT Event
ER Visit

Rx Scripts
Infections & Seizure Disorders, & Depression

Month 7

Rx Scripts
Seizure Disorders, Cardiac & Depression

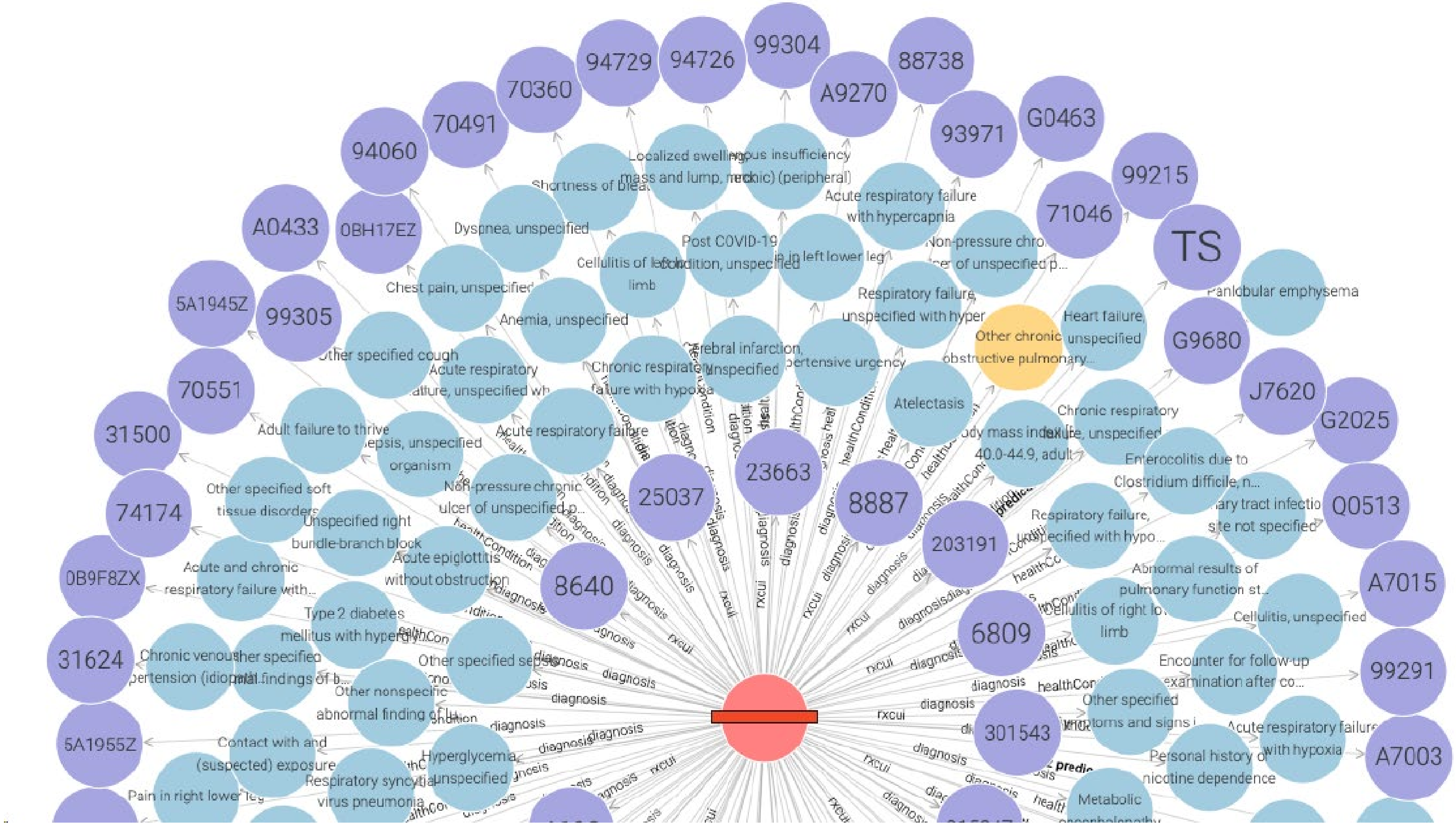
Repeat Self-Reported HRA
Diabetes: Yes
Mental Health: No
Social Factors: Yes

Contributing Factors to Rising AI Risk
New Onset Seizure Disorder
GAPS in Medication Adherence
Two ER Visits Social Factors

AI identifies trends in patient outcomes and utilization and **triggers clinical workflows** that respond to them

AI-identified rising risk clinical intervention **prevented escalation to "High"**

Generative AI: Power to Put Structured and Unstructured Data in Context for Care Planning



Generative AI: Leveraging Unstructured ADT Data to Identify Likely Reason for Admission

71% of ADT Events have no Diagnosis Data

Apply MER to free text where available

19% of ADT messages have free text to mine

Surface relevant context

e.g., inferences from medical history & medications about what is likely to result in an acute episode

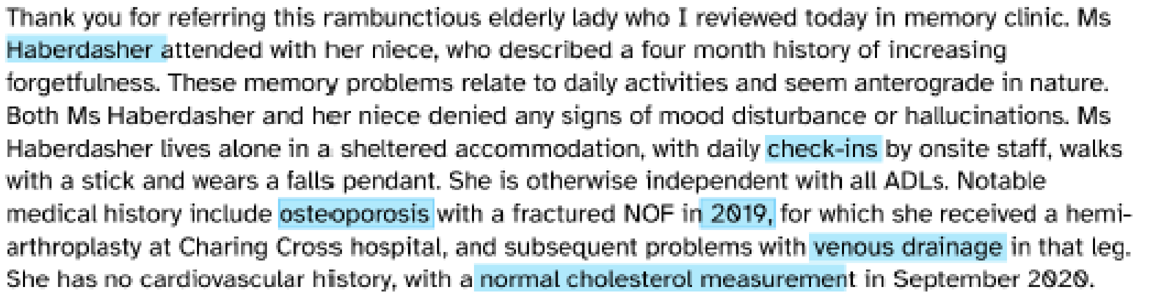
Time series analysis

Can we see exacerbations e.g., changing medication/dosages

Patient similarity

“This patient has a similar profile to other patients admitted for these reasons”

Unstructured Data Capture



Thank you for referring this rambunctious elderly lady who I reviewed today in memory clinic. Ms Haberdasher attended with her niece, who described a four month history of increasing forgetfulness. These memory problems relate to daily activities and seem anterograde in nature. Both Ms Haberdasher and her niece denied any signs of mood disturbance or hallucinations. Ms Haberdasher lives alone in a sheltered accommodation, with daily check-ins by onsite staff, walks with a stick and wears a falls pendant. She is otherwise independent with all ADLs. Notable medical history include osteoporosis with a fractured NOF in 2019, for which she received a hemi-arthroplasty at Charing Cross hospital, and subsequent problems with venous drainage in that leg. She has no cardiovascular history, with a normal cholesterol measurement in September 2020.

Considerations: What Makes a Good AI Model

Implementable	Transparent	Provable
• Clearly defined question (Y/N answer)	• Provides actionable insights	• Accurate predictions
• Addresses capacity issues / helps prioritize	• Shows what contributes to risk (explainability)	• Consistent results over time
• Availability of historical data for training	• Makes intuitive sense	
• Data timeliness		
• Ties to a workflow		

Key Takeaways: Building an Accurate AI Powered Risk Model for your Members

1 Avoid off-the-shelf predictive models

- Accuracy of an ML model drops if training population not representative of target population.
- Pre-trained models may rely on data unavailable to your organization.

2 Train models on local populations

- Each subpopulation and outcome of interest need to have their own trained model to maximize accuracy.

3 Include any/all relevant data types

- Individual-level SDoH and barriers to care can contribute substantially to predictive accuracy but are not typically captured in a standard format or system.

4 Monitor performance & retrain as necessary

- Capture true outcomes, anomalous predictions, and evidence that the population is changing ("feature drift") to retrain models and refine performance.

THANK YOU!

MEDICAL HOME NETWORK

CASTELL

Intermountain Health

Automation in a manual world

Embracing AI, ML, NLP Tools for ACOs Without Breaking the Bank

Dave Henriksen, MHA – VP Operations(Castell) COO (Trinsic)

CASTELL

Castell is Intermountain's population health company

We support the system and aligned partners in transitioning to population health and value-based care.

What does Castell do?

Helps providers enter value-based arrangements

Develop value-based contracting and programs with payers and large employers.

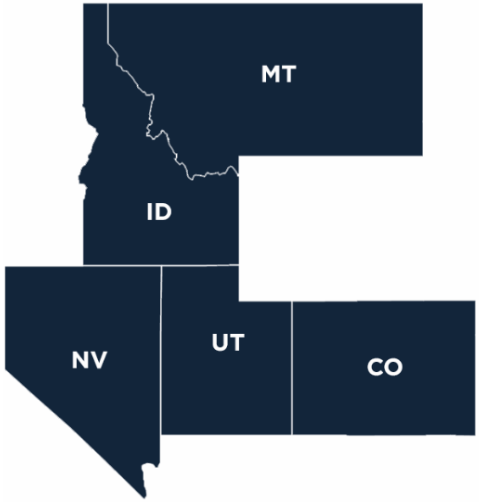
Perform in those value-based arrangements

Care processes that allow providers to focus on managing their patient panel for outcomes. State of the art technology and analytics that provide real-time information to manage patients and improve efficiencies.

Castell At A Glance

CASTELL

Intermountain Health's Population Health Platform Company



5 states

~1.2 Million
lives under management

~$5 Billion
in value-based care arrangements

600
employees

Advanced data & analytics platform

860
employed providers

840
affiliate providers

Multi payer value-based relationships

Full spectrum of value-based care arrangements

Medicare Shared Savings	Medicare Direct Contracting	Medicare Advantage	Managed Medicaid	Individual ACA	Commercial

ACO Stats

- Intermountain owns and Castell manages two ACOs.
- Castell Accountable Care participates in the ACO REACH program
  - Providers across Idaho, Utah, and Nevada
  - About 51,000 attributed beneficiaries
  - Joined MSSP in 2018 and has achieved savings every year of participation in MSSP and REACH
  - Stats for 2022:
    - $46.8M in gross savings (second highest in REACH)
    - $34.3M in shared savings received from CMS (second highest in REACH)
    - $20.6M shared with provider groups
    - Top REACH ACO on readmissions
    - Second best REACH ACO on unplanned admissions for chronic conditions

ACO Stats

- Rocky Mountain Accountable Health Network is currently in the Basic Track of MSSP
  - Providers across Colorado and Montana
  - About 26,000 attributed beneficiaries
  - Joined MSSP in 2014
  - Consistently strong quality performance
  - Working to improve savings performance

Our Journey to Value Based Care

1975
Intermountain Healthcare founded

1983
selecthealth

1988
Shift from quality control to quality improvement

1994
Intermountain
Medical Group

1997
Clinical Programs

2011
Population Health

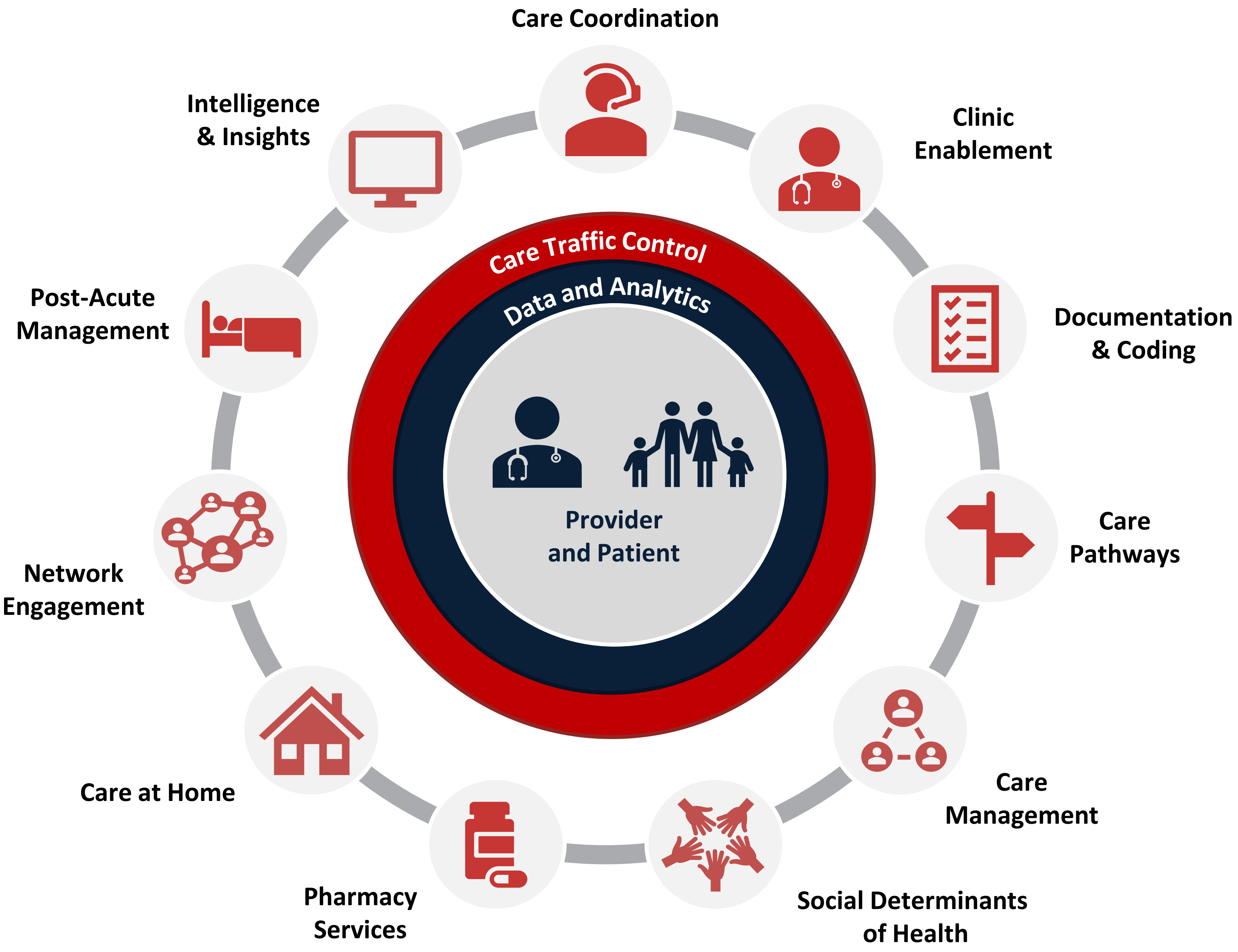
2014
New Mission:
Helping People Live the Healthiest Lives Possible

2016
New model for health delivery

2019 **Present**
CASTELL

Intermountain
Health

CASTELL



Care Traffic Control

Data and Analytics

Provider and Patient

Care Coordination

Clinic Enablement

Documentation & Coding

Care Pathways

Care Management

Social Determinants of Health

Pharmacy Services

Care at Home

Network Engagement

Post-Acute Management

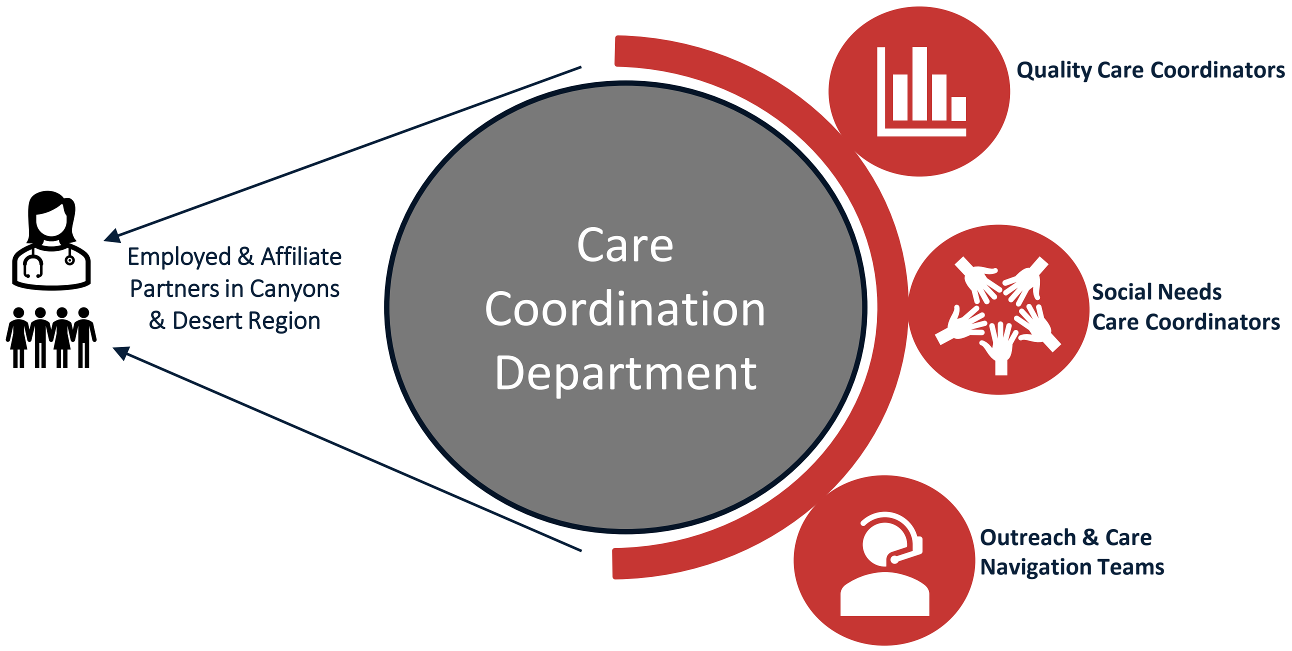
Intelligence & Insights

- Incredible resources with tremendous opportunity for automation
- Opportunities identified by shadowing

Intermountain Health

CASTELL

Care Traffic Control



Providers Served

900+

Clinics Served

225+

Weekly Care Traffic Control Department Averages

Post hospital visit follow ups (including TOC)

3,500

Patient charts pre-visit planned

14,000

Patient level huddles with PCPs

950

Care Gap Outreach Calls

13,000

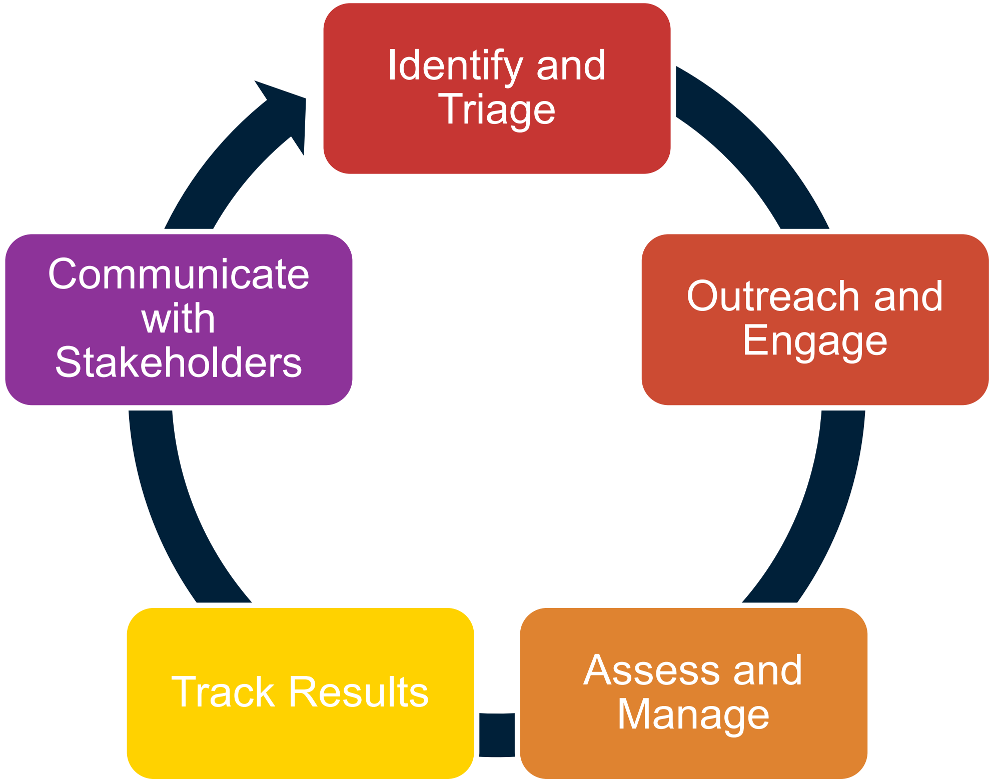
Connections to SDoH Resources

1,200

Intermountain Health

Care Management

Common Principles Across Programs



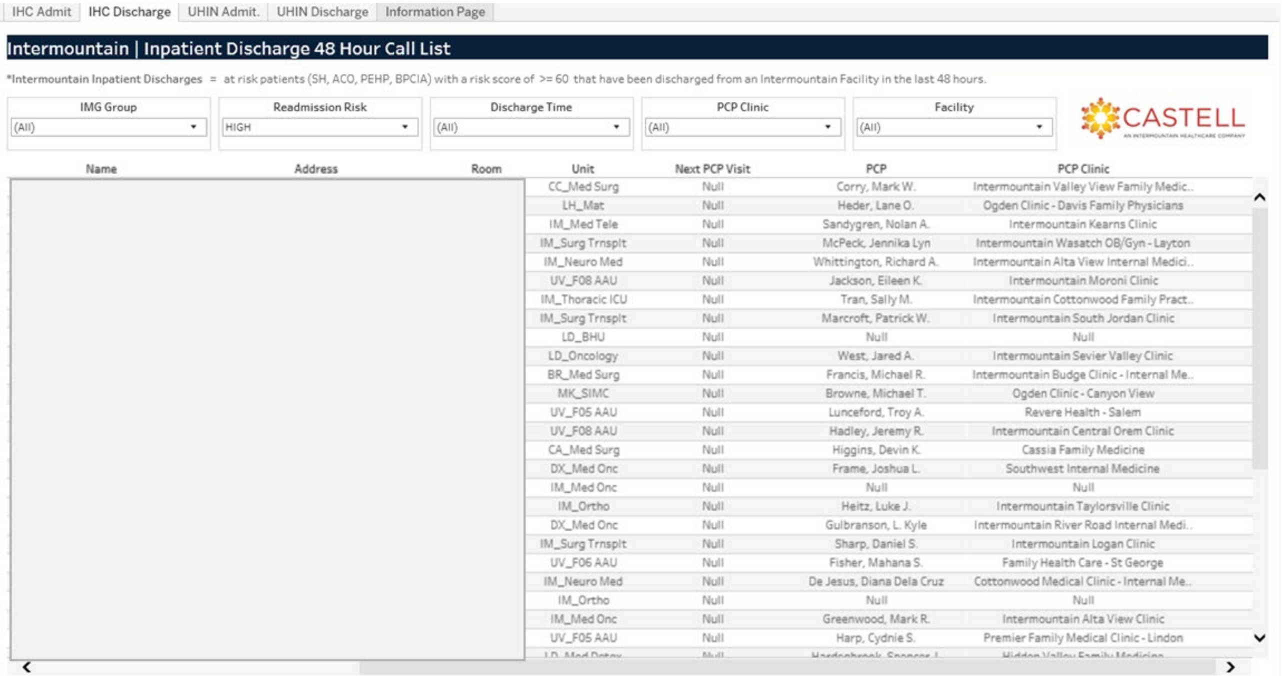
Identify and Triage

Outreach and Engage

Assess and Manage

Track Results

Communicate with Stakeholders



Intermountain | Inpatient Discharge 48 Hour Call List

*Intermountain Inpatient Discharges = at risk patients (SH, ACO, PEHP, BPCIA) with a risk score of >= 60 that have been discharged from an Intermountain Facility in the last 48 hours.

IMG Group: (All)
Readmission Risk: HIGH
Discharge Time: (All)
PCP Clinic: (All)
Facility: (All)

Name	Address	Room	Unit	Next PCP Visit	PCP	PCP Clinic
[redacted]	[redacted]	[redacted]	CC_Med Surg	Null	Corry, Mark W.	Intermountain Valley View Family Medic..
[redacted]	[redacted]	[redacted]	LH_Mat	Null	Heder, Lane O.	Ogden Clinic - Davis Family Physicians
[redacted]	[redacted]	[redacted]	IM_Med Tele	Null	Sandygren, Nolan A.	Intermountain Kearns Clinic
[redacted]	[redacted]	[redacted]	IM_Surg Trnsplt	Null	McPeck, Jennika Lyn	Intermountain Wasatch OB/Gyn - Layton
[redacted]	[redacted]	[redacted]	IM_Neuro Med	Null	Whittington, Richard A.	Intermountain Alta View Internal Medici..
[redacted]	[redacted]	[redacted]	UV_F08 AAU	Null	Jackson, Eileen K.	Intermountain Moroni Clinic
[redacted]	[redacted]	[redacted]	IM_Thoracic ICU	Null	Tran, Sally M.	Intermountain Cottonwood Family Pract..
[redacted]	[redacted]	[redacted]	IM_Surg Trnsplt	Null	Marcroft, Patrick W.	Intermountain South Jordan Clinic
[redacted]	[redacted]	[redacted]	LD_BHU	Null	Null	Null
[redacted]	[redacted]	[redacted]	LD_Oncology	Null	West, Jared A.	Intermountain Sevier Valley Clinic
[redacted]	[redacted]	[redacted]	BR_Med Surg	Null	Francis, Michael R.	Intermountain Budge Clinic - Internal Me..
[redacted]	[redacted]	[redacted]	MK_SIMC	Null	Browne, Michael T.	Ogden Clinic - Canyon View
[redacted]	[redacted]	[redacted]	UV_F05 AAU	Null	Lunceford, Troy A.	Revere Health - Salem
[redacted]	[redacted]	[redacted]	UV_F08 AAU	Null	Hadley, Jeremy R.	Intermountain Central Orem Clinic
[redacted]	[redacted]	[redacted]	CA_Med Surg	Null	Higgins, Devin K.	Cassia Family Medicine
[redacted]	[redacted]	[redacted]	DX_Med Onc	Null	Frame, Joshua L.	Southwest Internal Medicine
[redacted]	[redacted]	[redacted]	IM_Med Onc	Null	Null	Null
[redacted]	[redacted]	[redacted]	IM_Ortho	Null	Heitz, Luke J.	Intermountain Taylorsville Clinic
[redacted]	[redacted]	[redacted]	DX_Med Onc	Null	Gulbranson, L. Kyle	Intermountain River Road Internal Medi..
[redacted]	[redacted]	[redacted]	IM_Surg Trnsplt	Null	Sharp, Daniel S.	Intermountain Logan Clinic
[redacted]	[redacted]	[redacted]	UV_F06 AAU	Null	Fisher, Mahana S.	Family Health Care - St George
[redacted]	[redacted]	[redacted]	IM_Neuro Med	Null	De Jesus, Diana Dela Cruz	Cottonwood Medical Clinic - Internal Me..
[redacted]	[redacted]	[redacted]	IM_Ortho	Null	Null	Null
[redacted]	[redacted]	[redacted]	IM_Med Onc	Null	Greenwood, Mark R.	Intermountain Alta View Clinic
[redacted]	[redacted]	[redacted]	UV_F05 AAU	Null	Harp, Cydnie S.	Premier Family Medical Clinic - Lindon

Provider Referrals & Castell Analytics

A Team Approach to Care

Intermountain Health

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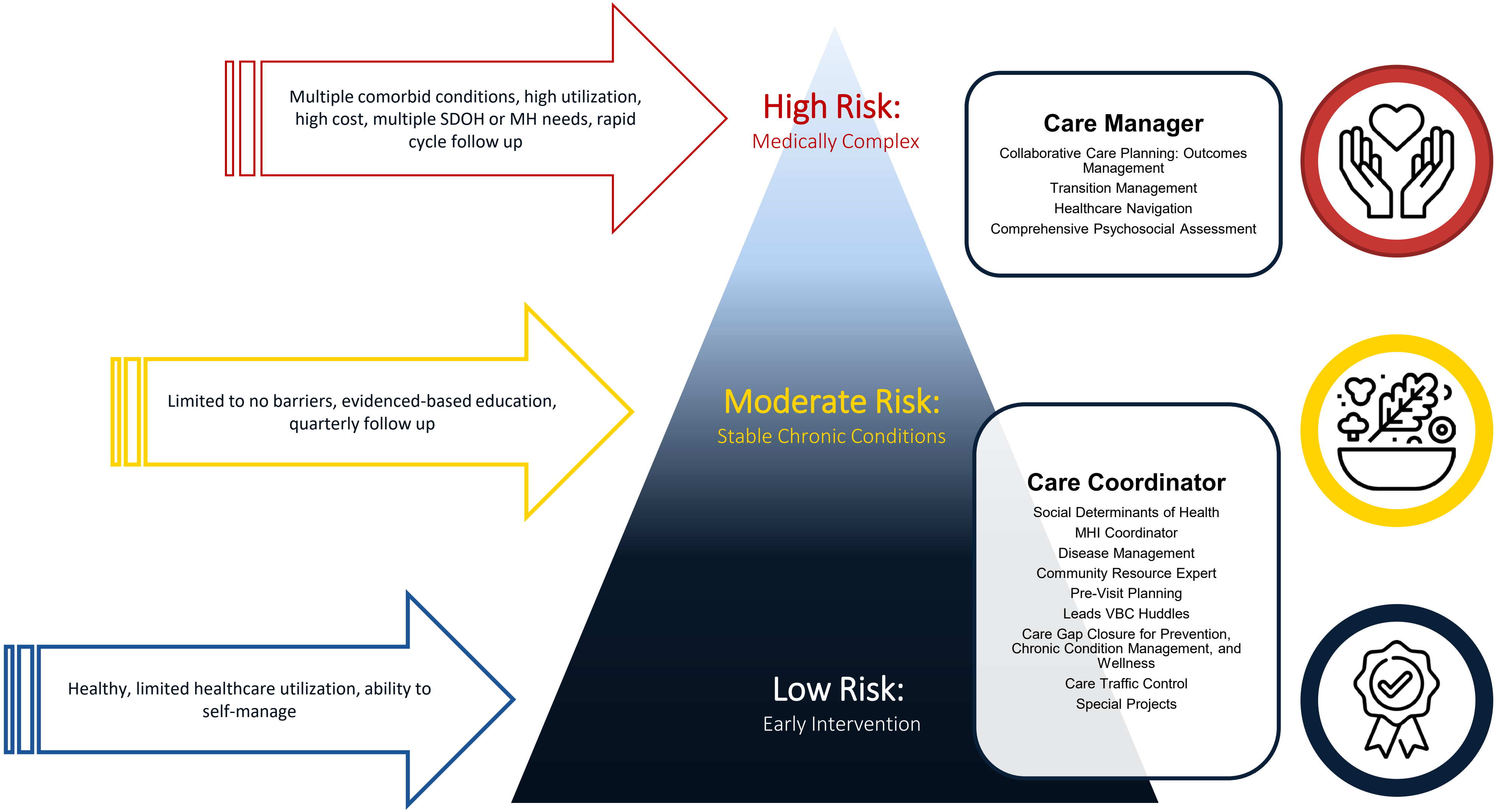


Multiple comorbid conditions, high utilization, high cost, multiple SDOH or MH needs, rapid cycle follow up

High Risk:
Medically Complex

Care Manager

Collaborative Care Planning: Outcomes Management
Transition Management
Healthcare Navigation
Comprehensive Psychosocial Assessment

Limited to no barriers, evidenced-based education, quarterly follow up

Moderate Risk:
Stable Chronic Conditions

Healthy, limited healthcare utilization, ability to self-manage

Low Risk:
Early Intervention

Care Coordinator

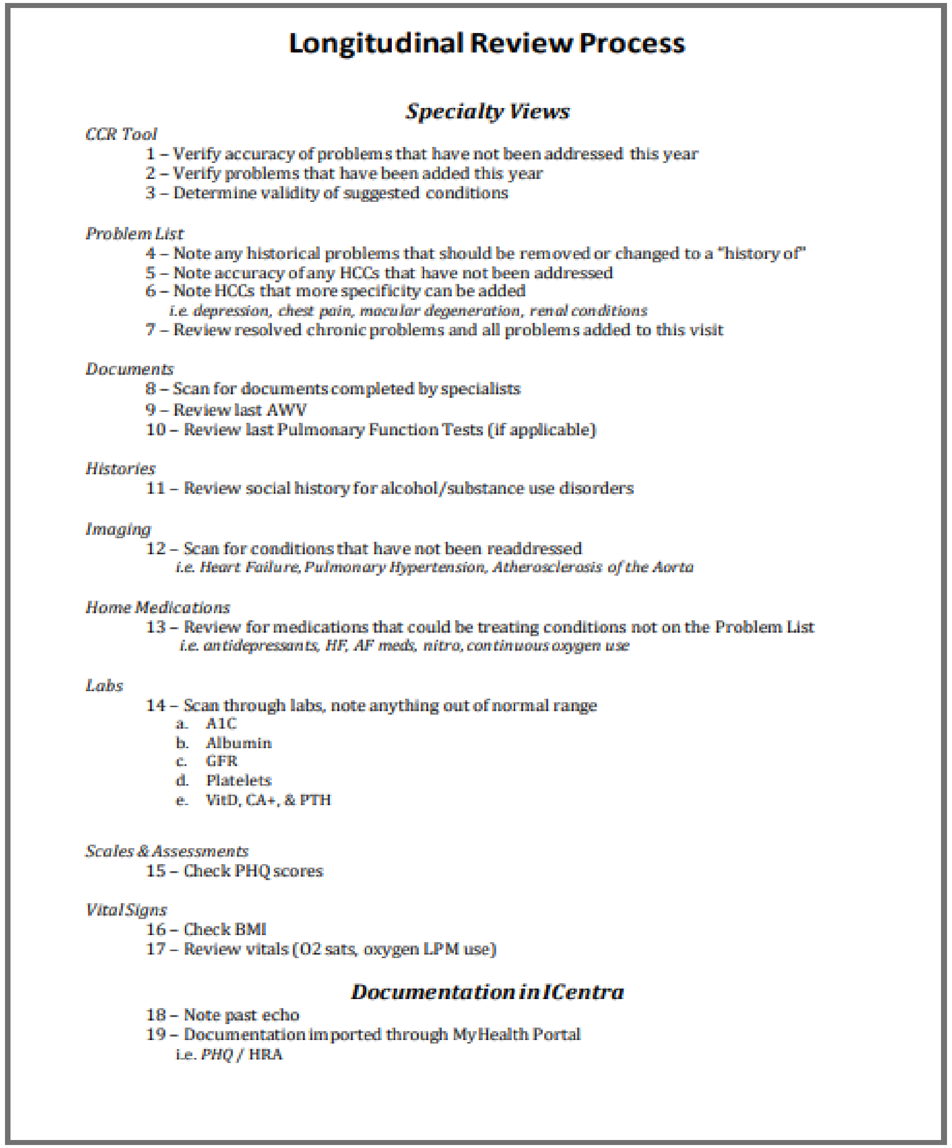
Social Determinants of Health
MHI Coordinator
Disease Management
Community Resource Expert
Pre-Visit Planning
Leads VBC Huddles
Care Gap Closure for Prevention, Chronic Condition Management, and Wellness
Care Traffic Control
Special Projects

Local care teams have access to a specific Care Coordinator and Care Management team

Clinical Documentation Support

- Clinical Documentation Specialists (CDS) provide longitudinal record reviews
  - Identify Suspect HCCs
  - Review accuracy of Persistent HCCs

- Partner with physician to support their success in coding and documentation



Longitudinal Review Process

Specialty Views

CCR Tool

1 – Verify accuracy of problems that have not been addressed this year
2 – Verify problems that have been added this year
3 – Determine validity of suggested conditions

Problem List

4 – Note any historical problems that should be removed or changed to a "history of"
5 – Note accuracy of any HCCs that have not been addressed
6 – Note HCCs that more specificity can be added
i.e. depression, chest pain, macular degeneration, renal conditions
7 – Review resolved chronic problems and all problems added to this visit

Documents

8 – Scan for documents completed by specialists
9 – Review last AWV
10 – Review last Pulmonary Function Tests (if applicable)

Histories

11 – Review social history for alcohol/substance use disorders

Imaging

12 – Scan for conditions that have not been readdressed
i.e. Heart Failure, Pulmonary Hypertension, Atherosclerosis of the Aorta

Home Medications

13 – Review for medications that could be treating conditions not on the Problem List
i.e. antidepressants, HF, AF meds, nitro, continuous oxygen use

Labs

14 – Scan through labs, note anything out of normal range
  a. A1C
  b. Albumin
  c. GFR
  d. Platelets
  e. VitD, CA+, & PTH

Scales & Assessments

15 – Check PHQ scores

Vital Signs

16 – Check BMI
17 – Review vitals (O2 sats, oxygen LPM use)

Documentation in ICentra

18 – Note past echo
19 – Documentation imported through MyHealth Portal
i.e. *PHQ* / HRA

CASTELL

Intermountain Health

Three primary goals of the Castell-Notable partnership

CASTELL

Goal 1

Improve patient outcomes across quality measures & chronic care management

Goal 2

Improve operational efficiency and up-level team to top-of-license work

Goal 3

Drive the right action for patients in and outside visits

notable

AI for healthcare operations

Notable analyzes structured and unstructured data in your EHR and other systems to deliver AI-powered personalized experiences that patients love. Enable your team to improve quality of care while driving top-of-license work.

1M+	32M+	10K+
daily automated tasks	cumulative patients served	sites live

Personalize the patient experience. Automate the work.

Simplifying clinician and provider workflows to drive quality performance & accurate risk capture

Care Gap Chart Review

Close care gaps with structured and unstructured data automating chart prep for over 470 providers

Payer Attestation

Close payer-reported open care gaps across multiple payers via automated chart review (100,000+ and growing)

HCC Suspecting

HCC chart prep integrated directly into native provider workflows for 86,000 patients

Care Management Outreach

Automate pre-visit assessment reducing 60+ minute call times for care coordinators

Care Program Enrollment

Increase Omada and CareCentra enrollment via embeds in existing patient experiences and automated outreach

2021

2022

2023

$2.8M

annual cost savings in chart review ROI alone

47 FTE

FTE capacity created

6.9%

increase in avg. care gap closure rate across five care gaps

>400

HCC captured (3x increase of weekly charts reviewed compared to manual equivalent)

96%

average patient satisfaction

3x

higher Omada enrollment rate

CASTELL

Intermountain Health

Reducing outpatient documentation burden with AI

Nathan Moore, MD
BJC ACO
St. Louis, MO
Nathan.Moore@BJC.org

BJC Medical Group

Countering Physician Burnout

- AMA’s 2022 National Report states that 51% of providers are experiencing burnout
    - Oncology rate of burnout: 69%
    - Family medicine: 59%
    - Critical care medicine: 51%
- Burnout is highest in providers that are 6-10 years post training (58%)
- Physician assistants have the highest burnout rate, followed by NPs, and then physicians

Our goal is to leverage artificial intelligence to improve your efficiency and job satisfaction to decrease your risk of burnout

Ambient Listening Note Generation

BJC Medical Group

Ambient Listening Note Generation

Generative AI creates structured summaries of patient conversations in real time

- Use your phone (Epic Haiku app or a third-party app) to allow the AI to listen to your encounter
- The generated note is then available for your review a few minutes later
- You are able to make edits directly in your note and the AI learns from your feedback

Goals:

1. Create better notes, faster
2. Providers can be more present
3. Improve provider wellbeing

Ambient Listening Note Generation

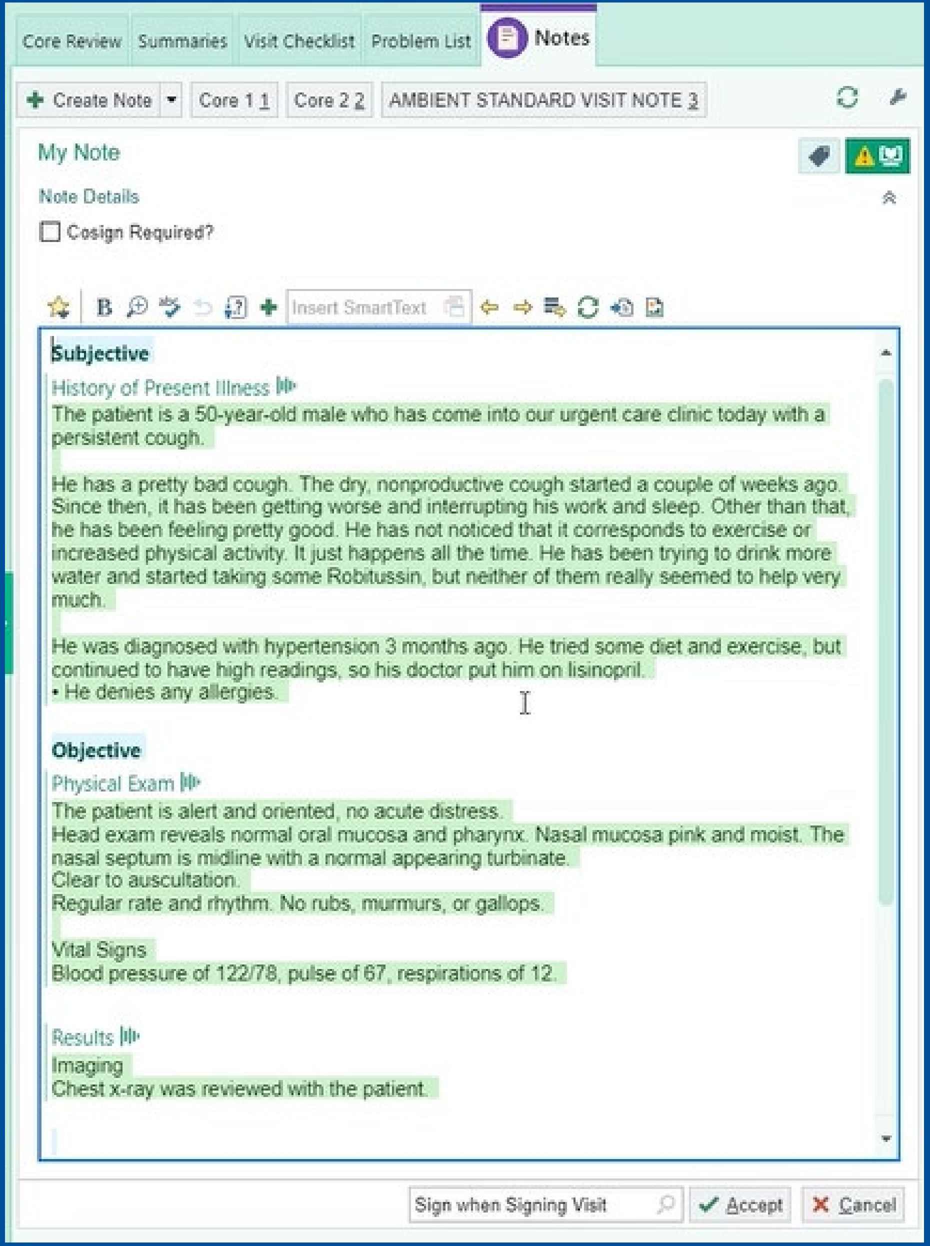
- Listens passively via smartphone app
- Large Language Model
- Not integrated into patients chart (labs, etc)
- Can include exclude HPI, physical exam, results and A/P

Ambient Listening Note Generation

- Currently will not select diagnosis codes
- Recordings are kept for 30 days for auditing purposes only
- Fairly good at not including "small talk" (non medical)
- Feedback has been generally positive, but providers say the notes are too long and sometimes it just reports what the patient says at face value.

Ambient Listening Note Generation

- Green highlight indicates text written and recognized by the AI
- You can edit this text after seeing the patient on your Desktop
- Note that once you manually edit green text, you can no longer use the AI to edit it (it becomes read only to the AI)



☐ Cosign Required?

Subjective

History of Present Illness

The patient is a 50-year-old male who has come into our urgent care clinic today with a persistent cough.

He has a pretty bad cough. The dry, nonproductive cough started a couple of weeks ago. Since then, it has been getting worse and interrupting his work and sleep. Other than that, he has been feeling pretty good. He has not noticed that it corresponds to exercise or increased physical activity. It just happens all the time. He has been trying to drink more water and started taking some Robitussin, but neither of them really seemed to help very much.

He was diagnosed with hypertension 3 months ago. He tried some diet and exercise, but continued to have high readings, so his doctor put him on lisinopril.
- He denies any allergies.

Objective

Physical Exam

The patient is alert and oriented, no acute distress.
Head exam reveals normal oral mucosa and pharynx. Nasal mucosa pink and moist. The nasal septum is midline with a normal appearing turbinate.
Clear to auscultation.
Regular rate and rhythm. No rubs, murmurs, or gallops.

Vital Signs
Blood pressure of 122/78, pulse of 67, respirations of 12.

Results

Imaging
Chest x-ray was reviewed with the patient.

In Basket Draft Response Generation

BJC Medical Group

In Basket Draft Response Generation

AI model reads messages from your patients and generates a draft response

- This AI-generated message sits in your In Basket for your review
- You can edit or delete the response prior to sending back to the patient

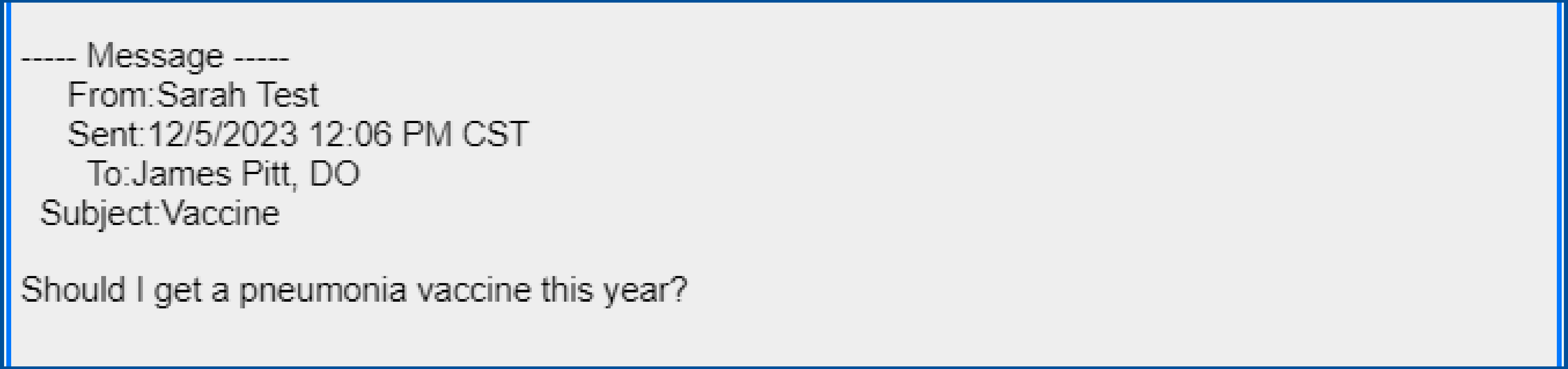
Goals:

1. Create better messages, faster
2. Provide “soft” content that patients value
3. Improve provider wellbeing

In Basket Draft Response Generation

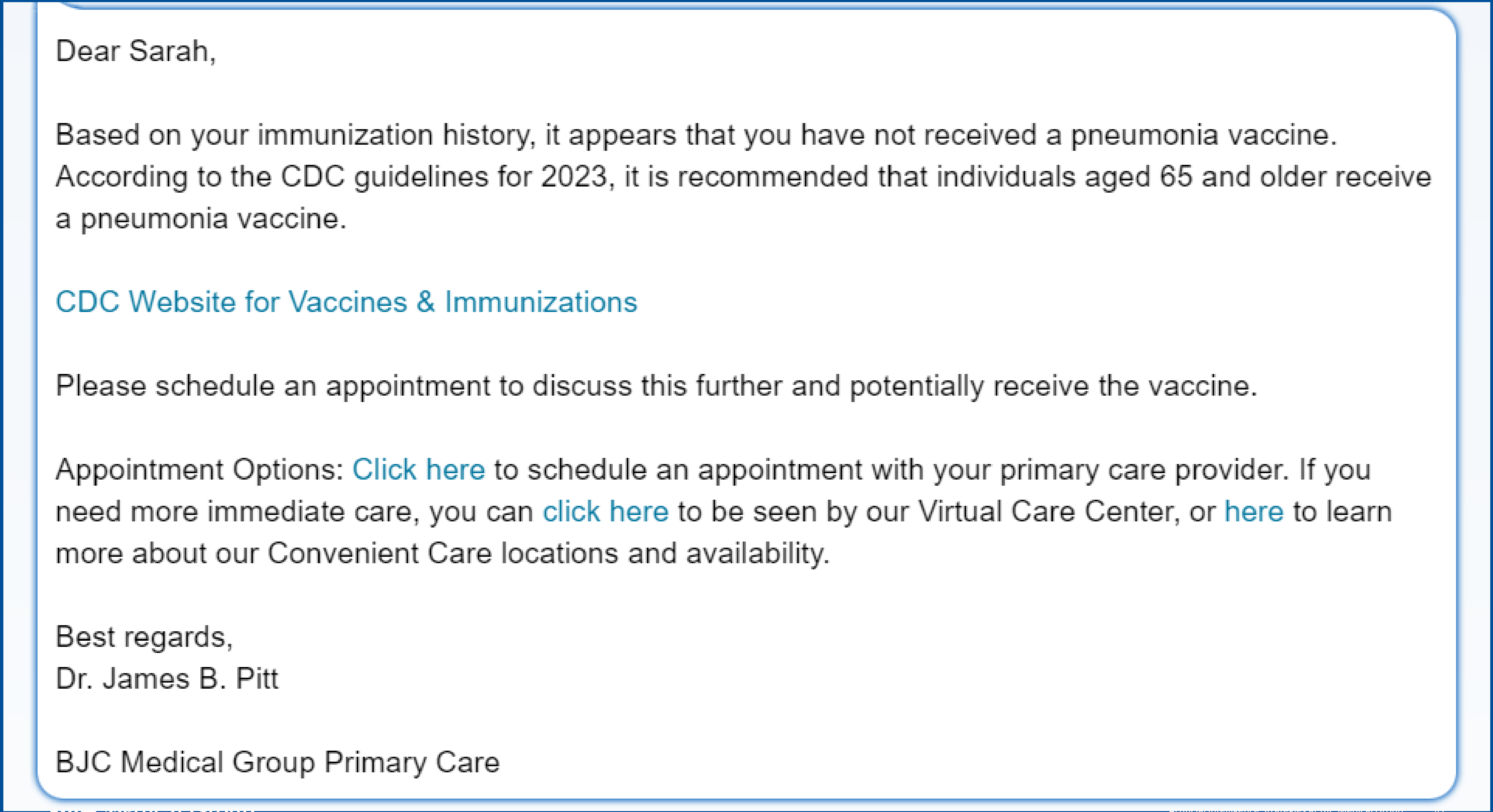
- Large Language Model
- Prompts: Meds, Results, Vaccines, General Medical
- Instructed to ignore patient demands (“I <u>need</u> an MRI")
- Chart integration for Labs, Meds, Imaging, Pharmacy
- Instructed to recognize red flag symptoms and recommend calling 911/988

In Basket Draft Response Generation



----- Message -----
From:Sarah Test
Sent:12/5/2023 12:06 PM CST
To:James Pitt, DO
Subject:Vaccine

Should I get a pneumonia vaccine this year?



Dear Sarah,

Based on your immunization history, it appears that you have not received a pneumonia vaccine. According to the CDC guidelines for 2023, it is recommended that individuals aged 65 and older receive a pneumonia vaccine.

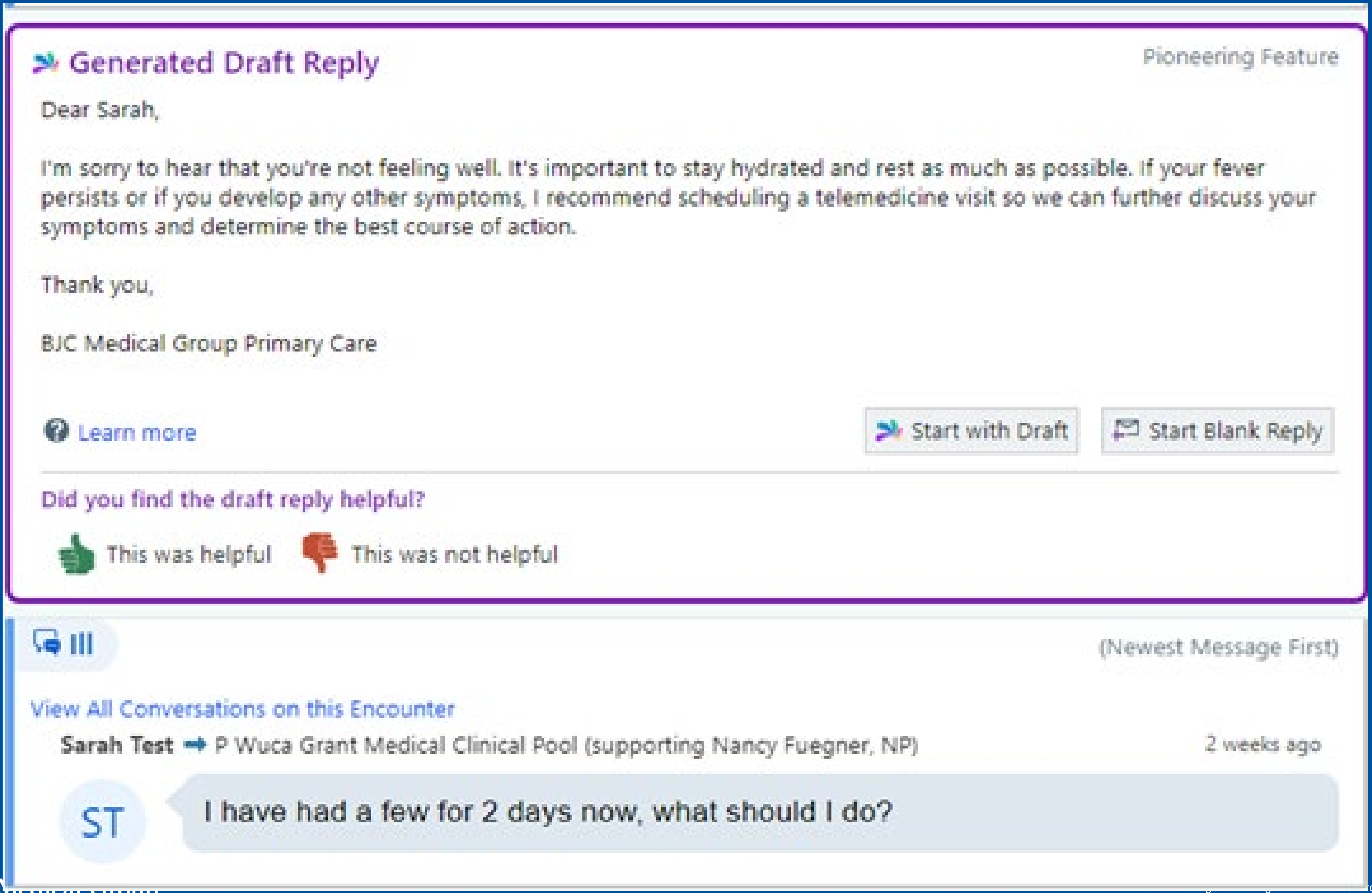
CDC Website for Vaccines & Immunizations

Please schedule an appointment to discuss this further and potentially receive the vaccine.

Appointment Options: Click here to schedule an appointment with your primary care provider. If you need more immediate care, you can click here to be seen by our Virtual Care Center, or here to learn more about our Convenient Care locations and availability.

Best regards,
Dr. James B. Pitt

BJC Medical Group Primary Care



Dear Sarah,

I'm sorry to hear that you're not feeling well. It's important to stay hydrated and rest as much as possible. If your fever persists or if you develop any other symptoms, I recommend scheduling a telemedicine visit so we can further discuss your symptoms and determine the best course of action.

Thank you,

BJC Medical Group Primary Care

Sarah Test → P Wuca Grant Medical Clinical Pool (supporting Nancy Fuegner, NP) 2 weeks ago

I have had a few for 2 days now, what should I do?

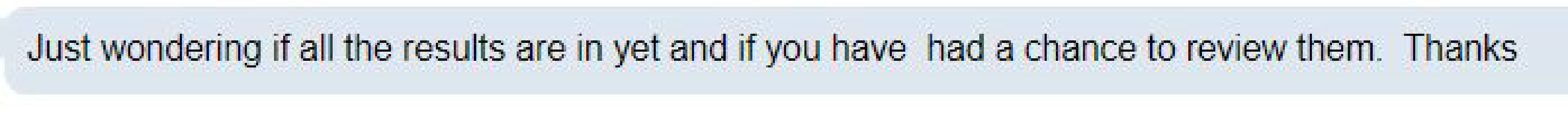
I am having problem with numb toes on the bottom of the front on both feet. I have intermittent neuropathy from the front of my knees down to my toes at night. I was going to take the Cymbalta you prescribed, however, I still take Meloxicam. Can you take Cymbalta with Meloxicam And do you think that drug will help. As you know I am not a fan of taking drugs. I also have a full tear Gluteus Minimus that I am being treated for, presently. I use to think I was a sturdy person, however, not anymore.

Dear Bev,

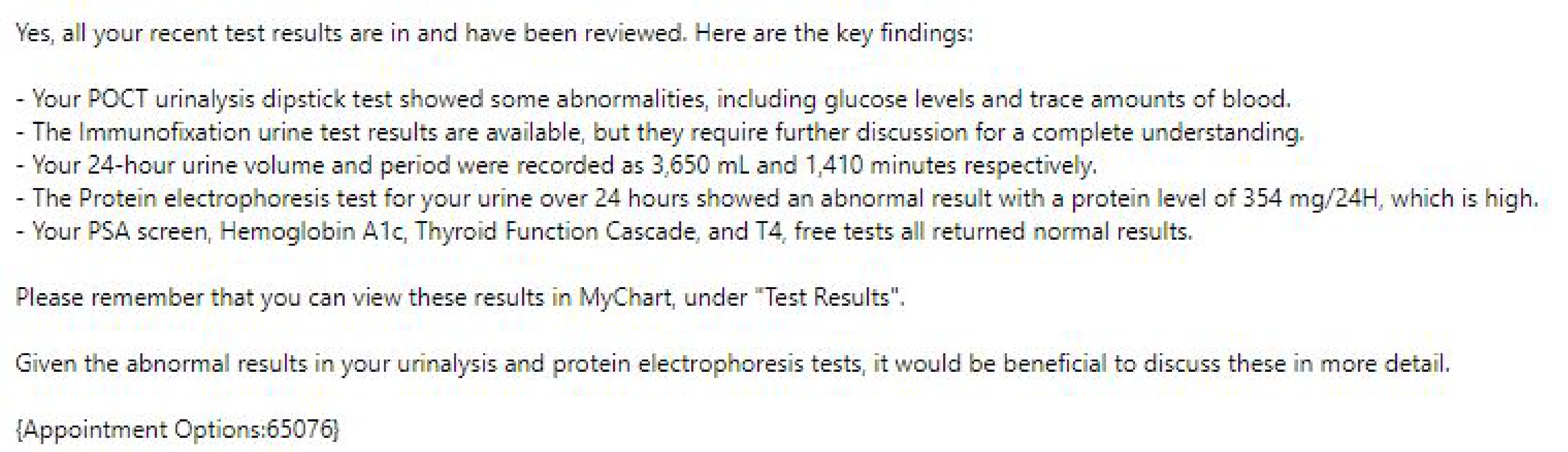
I understand your concerns about taking multiple medications. Yes, you can take Cymbalta and Meloxicam together. Cymbalta is often used to help manage neuropathy symptoms, so it may help with the numbness you're experiencing in your toes.

For your Gluteus Minimus tear, continue with the current treatment plan and follow up with the treating provider with ongoing concerns.

Remember, it's important to take care of yourself and listen to your body. You're still sturdy, Bev. We're just addressing some maintenance issues.



Just wondering if all the results are in yet and if you have had a chance to review them. Thanks



Yes, all your recent test results are in and have been reviewed. Here are the key findings:

- Your POCT urinalysis dipstick test showed some abnormalities, including glucose levels and trace amounts of blood.
- The Immunofixation urine test results are available, but they require further discussion for a complete understanding.
- Your 24-hour urine volume and period were recorded as 3,650 mL and 1,410 minutes respectively.
- The Protein electrophoresis test for your urine over 24 hours showed an abnormal result with a protein level of 354 mg/24H, which is high.
- Your PSA screen, Hemoglobin A1c, Thyroid Function Cascade, and T4, free tests all returned normal results.

Please remember that you can view these results in MyChart, under "Test Results".

Given the abnormal results in your urinalysis and protein electrophoresis tests, it would be beneficial to discuss these in more detail.

{Appointment Options:65076}

In Basket Draft Response Generation

- Feedback has been generally positive
- 35% use rate
- Limited response to <150 words
- Vaccine recs are difficult because guidelines update frequently (LLM trained on historical data)
- Not currently shown to staff

End of Life

- Created LSTM machine learning algorithm to predict likelihood of dying within 30 days (inpatient) or 1 year (outpatient) using EMR data
- Combined with provider training and clinical workflows to support advance care planning for high risk patients
- Have seen substantial increases in ACP conversations and documented code status

Future AI Enhancements

- Assistance with inpatient documentation
  - Discharge summaries
  - Hand offs
  - Daily notes

- Coding

Questions?