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From Conversation to Coordinated Care.

Gia by Scienza for home-based care, clinical accountability and payment design

David Kaiser · Scienza Health · November 2026

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The opportunity

A conversation with a patient creates value when the right information reaches the right person and leads to an appropriate next step. For organizations caring for people at home, that means connecting outreach, clinical context, documentation and follow-up within a workflow that staff can manage.

Gia by Scienza brings together conversational patient engagement and clinician-facing tools. Its implemented workflows include telephone and video interactions, template-based check-ins, dated assessment history, AI-assisted clinical notes, care-plan drafting and EHR integration. Availability depends on the contracted scope and verification in each customer environment. These capabilities provide a basis for supporting ACOs, health systems and medical practices around a visit.

Scienza proposes using Gia alongside an organization's existing care teams and technology. The aim is to connect patient interactions with clinical review and follow-through, while the responsible medical practice retains clinical decision-making.

THE CENTRAL QUESTION

Can Gia help a participating care team move from patient contact to a reviewed, documented and completed next step with less avoidable administrative work?

This paper maps Gia's platform to that question, outlines a bounded evaluation and separates the technology purchase from the payment rules governing care. It proposes a practical starting point: one participating practice, one patient group and one defined between-visit workflow.

SCOPE OF THIS PAPER

This paper describes Gia capabilities and proposes how care organizations could apply and evaluate them. The proposed workflow requires customer-specific configuration and operational verification. Clinical effectiveness and financial value must be established for the intended population and use.

Connect engagement to the clinical workflow

1

Patient contact with a defined purpose

Gia implements template-based intake, follow-up and check-in calls. Follow-up templates can draw on selected prior context. Scheduling code supports one-time and recurring calls, organization-specific calling windows and bounded retries.

For an evaluation, a participating practice could specify a narrow call purpose, such as gathering updates before a planned visit. The team would decide the questions, permitted context, contact cadence and response process. Patient preferences, consent, language and accessibility requirements would be confirmed before use.

> **MEASURE**
>
> Eligible patients, attempted contacts, completed exchanges and contacts requiring human follow-up. A successfully initiated call is not proof of a completed conversation or a resolved need.

A patient view that supports review over time

Gia's clinical interface includes patient information, medications and conditions, encounter history, dated assessment results and trends. Its review logic distinguishes recent findings from older information and can surface changes between assessments.

The proposed value is better preparation: a clinician can review available history alongside a new interaction. Completeness depends on the connected sources and the data actually received. Missing information must remain visible as missing.

> **MEASURE**
>
> Availability and freshness of required context, preparation time and clinician-rated usefulness. A screening result or change in a displayed risk tier requires clinical interpretation; it does not establish a diagnosis or a validated forecast of deterioration.

How Gia could fit a delivery organization

The organization's existing engagement system could remain responsible for population selection and program orchestration. Gia could support an agreed interaction and clinical-documentation workflow. The parties would first map their systems, select the record of authority and specify how information moves between them. This is a proposed division of work, not an existing technical connection.

The same approach can be adapted to an ACO's participating practices or a health system's care teams. The organization assigning work must also name who reviews it and records the next action.

Turn clinical information into reviewed documentation

2

Notes grounded in the encounter

Gia's scribe workflow supports audio capture, transcription, draft clinical notes, transcript-linked citations and clinician sign-off. Multiple note formats are implemented. The encounter queue distinguishes drafts requiring attention, work in review and signed notes.

The evaluation would examine documentation accuracy and efficiency. Citation links support checking a draft against its source; they do not guarantee correctness.

MEASURE

Total documentation time, correction burden, missing information, time to sign-off and the accuracy of a clinician-reviewed sample. Include review and correction time when calculating any time saving.

Care plans with clinician ownership

Gia can draft narrative care-plan sections using encounter material and prior assessment context. The drafting instructions address documented active conditions, functional concerns and caregiver context where present. They reserve clinical attestations and standardized instrument scores for the clinician.

The signing workflow requires acknowledgment when a care plan is present and blocks signing when required AI-drafted fields remain unverified. The signing workflow records the signer's role; it does not itself enforce clinician-only authorization. Before use, the practice must verify authorized signers, access controls and staffing. Clinicians retain responsibility for the plan and care decisions.

MEASURE

Clinician edits, verification completion, plan-sharing documentation and follow-up completion. Sharing and follow-up are pilot responsibilities to demonstrate, not assumed consequences of generating a plan.

EHR connection and delivery

Gia includes EHR integration code for patient and clinical information. Assessment-report and signed-note PDF delivery is implemented for specific EHR paths. Each target environment needs configuration, permissions and end-to-end verification; these paths do not establish universal write-back support.

MEASURE

Correct patient matching, required fields received, delivery receipts, failed transfers and recovery. Signing a note and successfully delivering it to an EHR are separate events. Neither EHR connectivity nor a signed document establishes billing eligibility or payment.

Define the service and responsibilities

3

A proposed between-visit workflow

1. **Select.** A participating practice identifies an appropriate patient group and agrees on the information it needs before a scheduled review. Confirm patient preferences, consent and an alternative way to reach the team.
2. **Engage.** Gia conducts the configured interaction. The operating process distinguishes no answer, incomplete contact and completed contact. Staff receive unresolved items through a workflow verified before enrollment.
3. **Review.** The responsible clinician or qualified team member examines the available interaction, history and assessment context. The practice determines the response and any clinical assessment needed.
4. **Document.** Where a clinical encounter occurs, Gia can support note and care-plan drafting. The clinician reviews, corrects and signs applicable documentation. Staff verify any required EHR delivery.
5. **Follow through.** The team records the next action, its owner and whether it occurred. Pilot reporting reconciles the contact record, clinical documentation and follow-up disposition so an unfinished task remains visible.

Establish the boundaries before enrollment

The workflow needs an operating agreement covering staff availability, response times, urgent concerns, unanswered contacts, outages and handoffs. Patients should understand the role of automation and how to reach human help. Gia must not be presented as continuous human monitoring or an emergency-response service.

Some rounds, triage and monitoring functions are gated or pilot-stage. An automated escalation process and durable task closure must therefore be demonstrated for the selected workflow before reliance. The initial evaluation can use the practice's established work queue if that is the verified handoff destination.

Device monitoring or an additional predictive model would require a separate scope and evidence review. The scope and intended use of Scienza's separate cohort-analytics offering remain distinct.

> **PROPOSED RESPONSIBILITY SPLIT**
>
> The participating practice owns clinical decisions and clinical documentation. The delivery organization and practice agree on operational coordination. Scienza supplies the contracted technology and technical support. The parties assign every handoff explicitly before participant use.

Align payment with the service 4

Start with the buyer and the care arrangement

For an ACO, health system or practice, Gia may be purchased as technology supporting an existing care program. The business case would identify the budget owner, contracted functions and full delivery cost. A software purchase does not itself create a payable clinical service or guarantee shared savings.

Medicare and Medicaid pathways require separate analysis. CMS describes ACO REACH participants as serving Original Medicare beneficiaries, including some people who are also eligible for Medicaid. **[1]** Medicaid HCBS service authorization remains a distinct question, even when the same person receives both programs' benefits.

Medicaid HCBS requires a program-specific fit

Section 1915(c) waivers allow states to tailor eligible populations and services, with requirements concerning health and welfare, provider standards, individualized planning and program cost neutrality. **[2]** A potential Gia-supported arrangement must be mapped to the relevant state's actual service definition, provider qualifications, documentation and payment rules.

For example, Ohio's remote-support rule applies to specified developmental-disability waivers. It includes awake staff, live two-way communication capability, service planning, consent, backup arrangements and documentation requirements. **[3]** That example does not establish Gia's eligibility or approval. An automated interaction alone would not satisfy the described human-support service.

Federal requirements for Medicaid managed-care in-lieu-of services address defined substitutes, eligible populations, medical appropriateness, cost effectiveness, encounter reporting and oversight. **[4]** They do not create a general software reimbursement route.

A practical commercial approach

Scienza proposes separating implementation and integration costs, recurring technology charges and the practice's human-service costs. The agreement would define what each charge purchases, the usage unit and how failed or incomplete interactions are treated. A per-member or usage-based supplier price is a negotiated commercial term, not an assumed Medicaid billing unit.

Gia provides usage metering and clinician-selected candidate codes for operational review. These functions do not establish claim submission, coverage approval or reimbursement. Billable services remain subject to payer and program requirements.

Evaluate value before expansion 5

Select one workflow and define success

Before launch, the parties should specify the population, participating practice, operating hours, duration, spending limit and criteria for expansion or stopping. Confirm the EHR configuration and demonstrate the complete handoff with synthetic scenarios, including unanswered calls, incorrect identity, ambiguous information, unavailable staff and failed document delivery.

The following measures connect the platform to a purchasing decision:

Gia capability	Proposed value to test	Evidence to collect
Purpose-specific calls	More useful contact before review	Attempts, completions, unresolved needs and patient experience
Patient and assessment history	Better preparation for the encounter	Data freshness, missing context and preparation time
Scribe and care-plan drafting	More efficient, accurate documentation	Total staff time, corrections and verified sign-off
EHR integration	Reliable information transfer	Patient-match checks, delivery receipts and failed-transfer recovery
Agreed staff handoff	Follow-through on identified needs	Named owner, response time, disposition and unresolved backlog

These are proposed measures, not results already achieved. Some require additional reporting or manual audit beyond current product instrumentation.

Measure the full cost

The evaluation budget should include setup, integration, training, technology, communication use, support and human review. Count each cost once. Show temporary discounts separately, and distinguish cash savings from staff capacity that is redeployed.

Compare equivalent workflows and patient groups. Predefine outcome definitions, observation periods and missing-data treatment. Report unsuccessful contacts and withdrawals alongside successful use. A short pilot can establish workflow feasibility; clinical outcomes or total-cost effects may require a longer study and an appropriate comparison design.

Expansion should depend on useful patient contact, trustworthy documentation, reliable handoffs and acceptable full-workflow cost. Gia's effect on hospital use, falls, institutional placement or shared savings remains a question for evaluation. No such benefit is claimed here.

Sources and discussion scope

Primary sources

[1] Centers for Medicare & Medicaid Services. **ACO REACH Model.** Model design and participant types. Accessed November 3, 2026. https://www.cms.gov/priorities/innovation/innovation-models/aco-reach

[2] Centers for Medicare & Medicaid Services. **Home & Community-Based Services 1915(c).** Program basics and state flexibility. Accessed November 3, 2026. https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915c

[3] Ohio Administrative Code. **Rule 5123-9-35: Remote support under specified developmental-disability waivers.** Effective July 1, 2026; paragraphs (B)-(F). Accessed November 3, 2026. https://codes.ohio.gov/ohio-administrative-code/rule-5123-9-35

[4] **42 CFR 438.16: In lieu of services and settings requirements.** Paragraphs (b), (d), (e) and (f). eCFR display current through October 30, 2026; accessed November 3, 2026. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.16

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About this paper

This white paper by David Kaiser, published by Scienza Health, presents a proposed application of Gia by Scienza for ACOs, health systems and medical practices. The workflow, evaluation and commercial approach are Scienza proposals. Government references support the specific program descriptions; they do not imply endorsement.

Product capabilities reflect Scienza's November 2026 technical review. Availability depends on the contracted scope and customer configuration. Clinical effectiveness and program-specific reimbursement require their own evidence. This paper is not a coverage determination, actuarial certification or clinical peer review.

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