SAMPLE DELIVERABLE

OneStone Physician Advisory Group

INDEPENDENT · PHYSICIAN-LED · PLAN ADVISORY

STRATEGIC ADVISORY REPORT

Clinical Performance & Point Solution Analysis

An independent, physician-led evaluation of the plan's care-vendor portfolio — clinical efficacy, member engagement, redundancy, and return on investment.

PREPARED FOR
Board of Directors & Plan Fiduciaries

PLAN SPONSOR (ILLUSTRATIVE)
Cornerstone Industries Employee Health Plan

REVIEW SCOPE
12 Active Point Solutions · PY2025

REPORT DATE
July 20, 2026

ABOUT THIS ENGAGEMENT

Our Role & Why a Clinical Review

OneStone Physician Advisory Group provides independent, physician-led medical guidance for complex health plan design and cost-management decisions. We hold no reseller relationships, referral arrangements, or contingent compensation with any of the point-solution vendors evaluated in this report. That matters here more than anywhere: the point-solution market is sold on engagement dashboards and self-reported ROI, and it takes an independent clinical eye to separate a vendor that genuinely improves outcomes from one that simply generates activity.

Over the past several years the Plan — like most self-funded employers — has accumulated a portfolio of digital health and care-management vendors, each added to solve a real problem. The result is a common and expensive condition the industry now calls **"point-solution fatigue":** overlapping services, low member engagement, fragmented data, and an ROI that is difficult to prove. Half of large employers now manage ten or more health vendor relationships, and four in ten say they simply have too many. This report evaluates each solution on the only questions that ultimately matter to a fiduciary: *does it work clinically, do members use it, does it duplicate something else, and is it worth what we pay?*

WHAT WE EVALUATED

- All 12 active point-solution & care-vendor contracts
- Independent clinical evidence for each solution's category
- Enrollment, engagement, and sustained-use data
- Outcome and utilization data supplied by vendors
- Contract terms, fees, and performance guarantees
- Overlap against each other and the core plan/carrier

OUR CLINICAL TEST

- **Substitute vs. supplement:** does it replace higher-cost care, or add a layer on top of it?
- Strength of independent (not vendor-funded) evidence
- Whether engagement translates to clinical outcomes
- Redundancy with existing benefits and vendors
- Value on investment (VOI) where hard ROI is thin
- Fiduciary defensibility of continuing to pay

◆ THE DISTINCTION THAT DRIVES THIS REPORT

Independent evaluations (including the Peterson Health Technology Institute's health-technology assessments) consistently find the same pattern: point solutions that *substitute* for more expensive care — for example, virtual physical therapy replacing in-person visits — can save money and match clinical outcomes, while solutions that merely *supplement* existing care often add cost without durable clinical benefit. We graded every vendor through that lens.

SECTION 1

Executive Summary

The Plan spends approximately **$1.48M per year across 12 point solutions** — a portfolio that grew one good decision at a time but has never been evaluated as a whole. Our clinical review finds a portfolio that is **over-built, under-engaged, and partially redundant.** Average sustained engagement sits near 11% of eligible members, roughly the industry norm and far below what these contracts assume. Two solutions duplicate others, two have little or no independent clinical evidence, and one of the largest line items is, by the best available evidence, cost-additive rather than cost-saving.

$1.48M	~11%	4	$480–650K
ANNUAL POINT-SOLUTION SPEND	AVG. SUSTAINED ENGAGEMENT	REDUNDANT / LOW-VALUE FLAGS	RATIONALIZATION OPPORTUNITY
12 active vendors	near industry norm	cut or consolidate	≈ ⅓ of spend

What we found

The portfolio splits cleanly into three groups. A **high-value core** — evidence-based virtual MSK, virtual primary care, expert medical opinion, and a well-run mental health platform — earns its place and, in some cases, deserves more volume. A **redundant middle** — a second MSK app, a legacy EAP, and a standalone diabetes-prevention program — duplicates capabilities the Plan already buys elsewhere. And a **low-value tail** — a general wellness/sleep app with no independent evidence, and a digital diabetes-management program whose clinical benefit the evidence does not support at its price — is difficult to defend on either outcomes or economics.

◆ PHYSICIAN'S PERSPECTIVE

Engagement is not an outcome. Several vendors report "strong engagement" that, on inspection, measures app opens rather than glycemic control, functional improvement, or avoided procedures. The right question is never "how many members touched the tool" but "what changed clinically for the members who did — and would it have changed anyway?" Judged that way, the portfolio's value is concentrated in a handful of solutions.

The opportunity

Rationalizing the portfolio yields an estimated **$480K–$650K annually — roughly one-third of point-solution spend — without reducing members' access to any evidence-based service.** Most of that comes from cutting or consolidating four solutions and renegotiating one to an outcomes-based structure; the remainder comes from steering volume toward the solutions that actually substitute for higher-cost care. Beyond the dollars, a simpler portfolio reduces administrative burden and gives members a clearer path to the right resource.

Recommended action	# Solutions	Est. Annual Impact	Rationale
Cut — redundant or no clinical evidence	2	$149,000	Duplicate MSK app; wellness/sleep app
Consolidate — fold into a stronger platform	2	$126,000	EAP → mental health; DPP → diabetes
Total identified opportunity	**—**	**$480K – $650K**	**≈ one-third of point-solution spend**

Recommended action	# Solutions	Est. Annual Impact	Rationale
Renegotiate — move to outcomes-based terms	1	$60K–$110K	Digital diabetes management program
Steer — shift volume to high-value substitutes	2	$120K–$220K	Virtual MSK & virtual primary care
Keep & monitor — earns its place	5	—	Evidence-based, non-redundant
Total identified opportunity	**—**	**$480K – $650K**	**≈ one-third of point-solution spend**

Ranges reflect contract-timing and steerage assumptions. No recommendation reduces access to a service supported by independent clinical evidence.

SECTION 2

Point-Solution Portfolio Inventory

The Plan's 12 active point solutions, with annual fees and sustained engagement (members using the solution consistently as a share of the eligible/target population). The industry benchmark for sustained engagement is approximately 10%.

#	Point solution	Clinical domain	Annual Fee	Engagement
1	Digital Diabetes Management (RPM + coaching)	Diabetes / metabolic	$186,000	22%
2	Virtual MSK — PT-guided	Musculoskeletal	$142,000	9%
3	MSK Exercise App (added 2023)	Musculoskeletal	$88,000	3%
4	Mental Health Platform (therapy + coaching)	Behavioral health	$210,000	14%
5	Legacy EAP	Behavioral health	$54,000	4%
6	Weight Management / GLP-1 Companion	Obesity / metabolic	$168,000	31%
7	Virtual Primary Care / Telehealth	Primary care / access	$132,000	19%
8	Expert Medical Opinion	Specialty navigation	$46,000	1.5%
9	Care Navigation / Advocacy	Navigation	$228,000	12%
10	Fertility / Family Building	Reproductive health	$96,000	2%
11	Sleep / General Wellness App	Wellness	$61,000	5%
12	Diabetes Prevention Program (DPP)	Diabetes / metabolic	$72,000	6%
Total annual point-solution spend			**$1,483,000**	**~11% avg**

SPEND CONCENTRATION

Four vendors — diabetes management, mental health, navigation, and the GLP-1 companion — account for **53% of point-solution spend ($792K).** Navigation is the single largest line item at $228K, yet its clinical value depends entirely on where it steers members.

THE FATIGUE PATTERN

Twelve vendors mean twelve logins, twelve support lines, and twelve data feeds. Nationally, only ~10% of employees consistently use any given point solution, and HR teams report spending roughly a third of their time managing vendor relationships rather than members.

SECTION 3

Clinical Performance Scorecard

Each solution is graded on independent clinical evidence, sustained engagement, and redundancy, producing an overall value grade and a recommended disposition. Grades reflect the strength of *independent* evidence for the solution's category and whether it substitutes for, or merely supplements, existing care.

A — Strong value B — Solid C — Marginal D — Weak F — No demonstrated value

Solution	Clinical evidence	Engage.	Redundancy	Grade	Disposition
Virtual MSK — PT-guided	Strong · substitutes for in-person PT	Fair	None	A–	KEEP & STEER
Virtual Primary Care	Good · substitutes for office/ER visits	Good	Low	B+	KEEP
Mental Health Platform	Moderate–good · access + outcomes	Good	Overlaps EAP	B	KEEP (HUB)
Expert Medical Opinion	Good · alters high-cost pathways	Very low	None	B	KEEP & PROMOTE
Fertility / Family Building	Good · guideline-based, VOI/retention	Low*	None	B	KEEP
Weight Mgmt / GLP-1 Companion	Emerging · adherence & lifestyle support	Strong	Ties to Rx	B–	KEEP & INTEGRATE
Care Navigation / Advocacy	Enabler · value = quality of steerage	Fair	Front-door overlap	C+	ELEVATE AS HUB
Legacy EAP	Mixed · low utilization model	Poor	Overlaps mental health	C–	CONSOLIDATE
Diabetes Prevention (DPP)	Moderate · benefit fades without support	Poor	Overlaps diabetes mgmt	C–	CONSOLIDATE
Digital Diabetes Management	Weak · minimal, short-term A1c effect; cost-additive	Good	Overlaps DPP	D	RENEGOTIATE / CUT
MSK Exercise App	Moderate category · duplicate here	Poor	Duplicates PT-guided MSK	D	CUT
Sleep / Wellness App	None · no independent clinical evidence	Low	Overlaps EAP/wellness	F	CUT

*Fertility engagement is low by design — a small eligible population with high per-case value; engagement rate is not the right measure of its worth.

◆ PHYSICIAN'S PERSPECTIVE

The two lowest grades tell the story of the whole portfolio. The digital diabetes program engages members well but does not meaningfully move A1c in independent evaluations, and its modest estimated savings are smaller than its fee — good engagement, wrong outcome. The virtual MSK program engages fewer members but, for those it reaches, substitutes for in-person physical therapy at materially lower cost with equivalent results. One should be paid more to reach more members; the other should be restructured or retired.

SECTION 4

Overlap & Redundancy Map

Redundancy is the most common and least visible source of point-solution waste. Mapped by clinical domain, the portfolio shows four areas where two or more vendors — often plus the core carrier — serve the same need.

Clinical domain	Vendors / benefits serving it today	Assessment & recommended structure
Musculoskeletal	Virtual MSK (PT-guided) · MSK Exercise App · carrier PT network	Duplicate digital tools. Consolidate to the evidence-based PT-guided solution; retire the exercise app.
Behavioral health	Mental Health Platform · Legacy EAP · carrier behavioral network	Overlapping front doors. Fold EAP services into the mental health platform as the single access point.
Diabetes / metabolic	Digital Diabetes Mgmt · DPP · GLP-1 companion	Fragmented across three vendors. Integrate into one metabolic-health pathway with clear clinical hand-offs.
Navigation / "front door"	Care Navigation · carrier nurse line · each vendor's own triage	Multiple entry points confuse members. Designate one navigation hub that routes to all others.

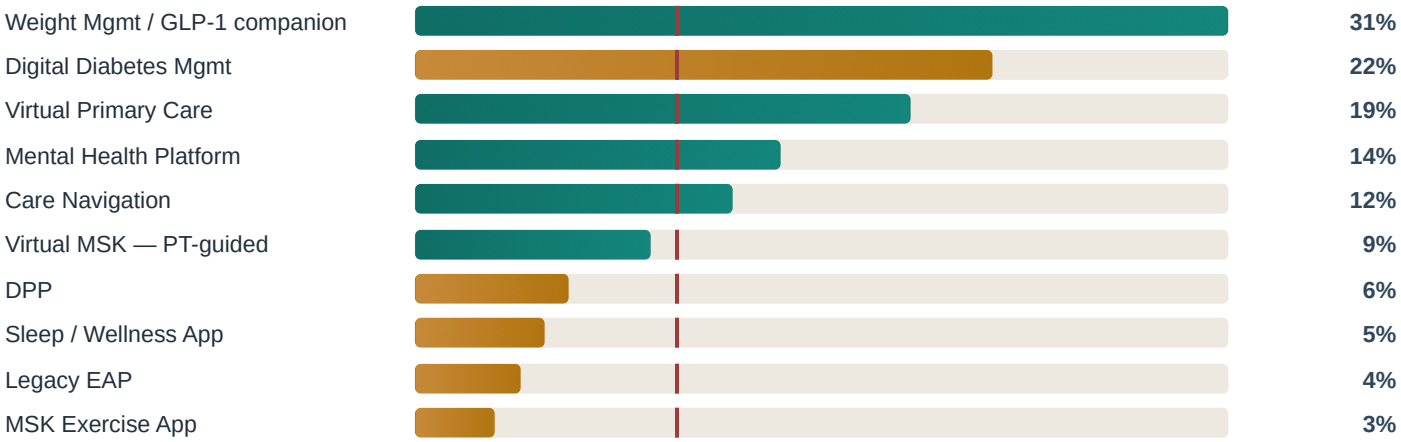
THE SINGLE-FRONT-DOOR PRINCIPLE

Members cannot navigate twelve doors, and every duplicated triage layer is paid for twice. The highest-leverage structural change is to designate **one navigation hub** — clinically informed — that routes members to the right solution, and to hold that hub accountable for steering toward the evidence-based, cost-effective options rather than the most heavily marketed ones.

SECTION 5

Engagement & Return Analysis

Sustained engagement across the portfolio, against the ~10% industry benchmark (red line). High engagement is necessary but not sufficient — it earns a solution the right to be judged on outcomes, not a pass from that judgment.



ROI vs. VOI — grade each honestly

Not every valuable benefit produces hard-dollar ROI, and that is legitimate — fertility and expert medical opinion earn their place on value-on-investment (access, retention, altered high-cost pathways) even when engagement is low. The problem is the reverse case: solutions justified on *engagement* that produce neither ROI nor a defensible VOI. We recommend the Board require each vendor to be classed as ROI-justified, VOI-justified, or unproven — and to sunset the unproven.

Justification basis	Solutions	Board standard
ROI — hard savings	Virtual MSK, Virtual Primary Care, Expert Medical Opinion	Verify savings with independent, risk-adjusted analysis.
VOI — access / experience / retention	Mental Health, Fertility, GLP-1 companion, Navigation	Define the non-financial value and measure it.
Unproven — activity without outcome	Digital Diabetes Mgmt, DPP, MSK App, Wellness/Sleep, EAP	Consolidate, renegotiate to outcomes, or exit.

◆ PHYSICIAN'S PERSPECTIVE

Ask every vendor for the same three things: the independent (non-vendor-funded) evidence for their category, the risk-adjusted outcome for *your* members, and what would have happened without them. Vendors delivering real value welcome those questions. The ones that deflect to engagement dashboards are answering a different question than the one a fiduciary must ask.

SECTION 6

Recommendations & Rationalization Roadmap

A sequenced 12-month plan that captures savings quickly from the clear-cut cases, then restructures the fragmented domains around evidence and a single front door.

MONTHS 0–3

Prune

- Exit the MSK Exercise App and the Sleep/Wellness App at the next contract dates (no evidence / duplicate).
- Issue the diabetes-management vendor an outcomes-based renewal term or notice of non-renewal.
- Freeze net-new point-solution additions pending a clinical-value gate (below).

MONTHS 3–9

Consolidate

- Fold EAP services into the mental health platform as the single behavioral front door.
- Integrate DPP, diabetes management, and the GLP-1 companion into one metabolic pathway.
- Designate one clinically informed navigation hub and route all solutions through it.

MONTHS 9–12

Optimize

- Steer volume to the evidence-based MSK and virtual-primary-care substitutes; promote expert medical opinion.
- Stand up a quarterly clinical-value scorecard with risk-adjusted outcomes for every retained vendor.
- Apply a standing "clinical-value gate" to any future point-solution request.

THE CLINICAL-VALUE GATE (FOR EVERY FUTURE VENDOR)

Before adding any point solution, require four answers: (1) independent evidence it works; (2) what existing benefit or vendor it overlaps; (3) whether it substitutes for or supplements current care; and (4) how outcomes — not engagement — will be measured. No gate, no contract.

SECTION 7

Projected Financial Impact

$480–650K	$275K	12 → 8	0
ANNUALIZED OPPORTUNITY	IMMEDIATE FEE SAVINGS	VENDOR COUNT	EVIDENCE-BASED SERVICES LOST
≈ ⅓ of PS spend	**cut + consolidate**	**simpler portfolio**	**no access reduction**

Action	Annual Impact	Type
Cut MSK Exercise App (duplicate)	$88,000	Direct fee
Cut Sleep / Wellness App (no evidence)	$61,000	Direct fee
Consolidate DPP into diabetes pathway	$72,000	Direct fee
Consolidate EAP into mental health platform	$54,000	Direct fee
Renegotiate diabetes mgmt to outcomes-based	$60,000 – $110,000	Fee / performance
Steer volume to evidence-based substitutes	$120,000 – $220,000	Avoided medical cost
Reduced vendor-management burden	$25,000 – $40,000	Operational
Total identified opportunity	**$480,000 – $650,000**	**Illustrative, conservative**

Direct fee savings ($275K) are contractual and high-confidence; renegotiation, steerage, and operational figures are ranges dependent on contract timing, member behavior, and vendor cooperation. Figures are illustrative and demonstrate the structure of a OneStone impact model, not a guarantee of savings.

Recommended next step

With the Board's direction, OneStone will execute the Phase 1 "prune" actions — the two cuts and the diabetes-management renegotiation — within the current quarter, and return at the next quarterly meeting with a clinical-value scorecard for every retained vendor and realized savings to date.

APPENDIX

Methodology, Benchmarks & Important Notices

SCORING METHODOLOGY

Each solution was assessed on three weighted dimensions: strength of independent clinical evidence for its category (weighted most heavily), sustained member engagement relative to the ~10% industry benchmark, and redundancy against other vendors and core plan benefits. Solutions were classified by whether they substitute for higher-cost care (favorable economics) or supplement existing care (cost-additive unless outcomes justify it). Letter grades (A–F) summarize overall value; dispositions (keep, steer, elevate, integrate, consolidate, renegotiate, cut) translate the grade into action. Vendor-reported outcomes were reviewed but not accepted at face value; independent evidence took precedence.

BENCHMARK SOURCES

Market and evidence context draws on published 2024–2026 sources, including the Peterson Health Technology Institute health-technology assessments of digital diabetes management (minimal, short-term glycemic benefit; cost-additive relative to fee) and virtual musculoskeletal care (PT-guided solutions matching in-person outcomes and generating savings when substituting for in-person care), and published employer benchmarks on point-solution proliferation (roughly half of large employers managing 10+ health vendors; ~10% sustained engagement per solution; significant HR administrative burden). National figures provide context; all plan-specific figures in this sample are illustrative.

INDEPENDENCE STATEMENT

OneStone Physician Advisory Group is independent and holds no reseller, referral, or contingent-compensation relationship with any vendor evaluated here. Our duty runs solely to the plan sponsor and its members.