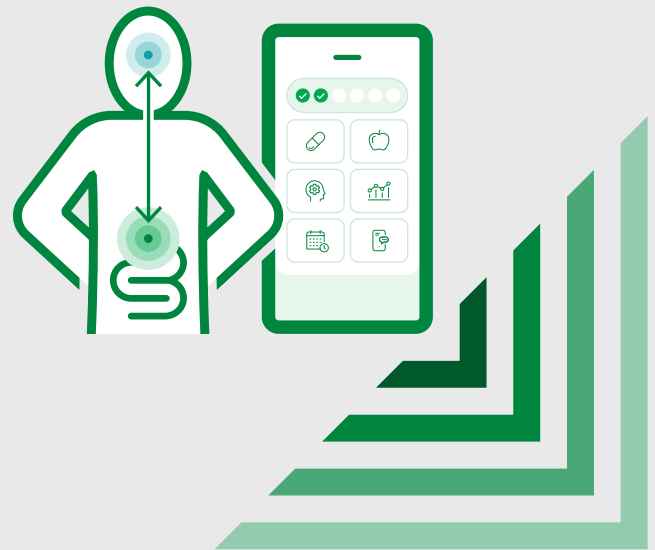


Virtual Gastrointestinal Care Solutions

PURCHASING GUIDE | AUGUST 2026



Gastrointestinal (GI) conditions impact one in five adults in the United States, causing symptoms that negatively affect patients' quality of life, productivity, and mental health. These disorders account for \$112 billion in total healthcare spending per year—driven by diagnostic imaging, scoping, specialty medications, emergency department visits, and hospitalizations.¹ Access to effective GI care is also limited, with specialist shortages, long wait times, and fragmented care delivery compounding the challenges for both providers and patients. PHTI's [assessment on virtual GI care solutions](#) focuses on irritable bowel syndrome (IBS) and inflammatory bowel disease (IBD) as representative conditions, given their high prevalence and cost burden, respectively.

Virtual GI care solutions are designed to address cost, symptom, and access challenges, and the evidence suggests that they can deliver meaningful clinical benefits and reduce spending. These solutions are designed to replicate a multidisciplinary GI care experience for patients by providing a suite of support services, including nutrition counseling, behavioral health support, care navigation, and symptom tracking.

Clinician-led solutions function as a specialty care provider—delivering direct, comprehensive GI care that includes medication prescribing—and are typically structured as an in-network solution integrated into the medical benefit. Clinician-led solutions are particularly valuable for patients in geographic areas where access to gastroenterologists is limited. PHTI estimates that these solutions substantially reduce net healthcare spending across all payer types for both patients

with IBS and IBD and are especially economically beneficial when targeted to patients with moderate-to-severe IBD. To maximize their economic benefits, these solutions should be targeted to patients with more complex GI conditions and high annual spending.

Wraparound solutions take a different approach, augmenting a patient's existing provider network with wraparound support, delivered virtually, that provide support services, as well as engagement with coaches, dietitians, and mental health providers. Wraparound solutions are well suited for employers and health plans with adequate GI network coverage that are interested in supplementing their medical benefit. PHTI estimates that these solutions substantially decrease net healthcare spending for patients with IBS in the commercial market.

¹ Anne F. Peery, Caitlin C. Murphy, Chelsea Anderson, et al., "Burden and Cost of Gastrointestinal, Liver, and Pancreatic Diseases in the United States: Update 2024," *Gastroenterology* 168, no. 5 (2025): 1000–1024. <https://doi.org/10.1053/j.gastro.2024.12.029>.

The assessment examined five solutions across the two distinct categories of virtual GI solutions. PHTI found that the magnitude of savings depends on solution type and population: wraparound solutions save roughly \$1,900 per IBS patient per year, while clinician-led solutions, at a higher price point, can save an estimated \$2,900 per patient per year when targeted to patients with moderate-to-severe IBD alongside IBS.

When selecting a virtual GI solution, PHTI recommends that purchasers should evaluate companies on the basis of how they integrate with the broader benefit design, including network access and integration, benefit structure and operations, and budget.

Purchasers should also consider their own ability to target and enroll specific populations. The ability to identify and enroll higher-acuity patients has direct implications

for economic outcomes. Clinician-led solutions carry a higher price point that may be justified by the savings generated in patients with moderate-to-severe IBD. However, when those solutions are deployed primarily to patients with IBS, purchasers pay a higher cost without the savings opportunity the solution was priced to capture. The potential value for clinician-led solutions depends on a purchaser's ability to both find and route the right patients to the solution, not only on offering the solution itself.

Given the strength of outcomes, some purchasers, particularly large, self-insured employers or health plans with a substantial GI population, may find value in offering both solution types. However, this can be operationally complex, confusing to patients, and some vendors may be unwilling to contract for only a portion of the population (e.g., patients with IBD and high annual GI-spend).

CHARACTERISTICS THAT MAY INFLUENCE AN EMPLOYER'S DECISION TO SELECT VIRTUAL GI SOLUTION TYPE OVER ANOTHER:

	WRAPAROUND SOLUTIONS	CLINICIAN-LED SOLUTIONS
Enrollment		
PATIENT TARGETING	Prefer broad eligibility; a formal diagnosis is not required to participate	Formal diagnosis is not required but greatest value when paired with the ability to identify members with moderate-to-severe IBD through claims data or care management programs
Network Access and Integration Considerations		
GI SPECIALTY ACCESS	Have strong network access to gastroenterologists without long wait times	Membership is geographically dispersed, rural, or in areas with limited GI specialty access; members often encounter long wait times for gastroenterologists
ROLE OF THE SOLUTION	Want a solution that complements existing GI care relationships	Prefer the solution functions as a primary GI access point for some members
Benefit Structure and Operations		
BENEFIT PLACEMENT	Want to offer this as a wellness benefit, supplemental benefit, or buy-up option outside the medical benefit	Prefer to integrate the solution into the existing medical benefit as an in-network provider
COST-SHARE DESIGN	Want to offer a solution at no added cost to participants	Are comfortable with standard in-network cost-sharing, or are able to waive cost-share
Budget		
PRICE AND ROI	Lower price point; lower savings relative to clinician-led solutions	Higher price point; higher estimated net savings (particularly for moderate-to-severe patients)

Action Steps for Purchasers

Based on PHTI's review of the evidence and the strong clinical and economic impact of these solutions, we recommend considering the following when selecting a GI solution.

1 Purchasers who do not currently offer a virtual GI solution should consider adding one.

Access to specialized GI care in the United States is limited by specialist shortages, long wait times, and care delivery that remains concentrated in academic medical centers. Virtual GI solutions are designed to close this gap by delivering guideline-recommended components of multidisciplinary care to patients who would otherwise go without coordinated treatment. PHTI's evaluation finds that these solutions improve clinical outcomes and reduce net healthcare spending, making them one of the highest-value additions available to purchasers in the digital health market today.

2 Purchasers should match solution type and incentives to their population's needs and organization's structure.

Before choosing between a clinician-led and wraparound solution, purchasers should think through their ability to target specific patients. This matters most if a clinician-led solution is selected, where targeting moderate-to-severe patients or targeting those with high costs can drive additional savings. Targeting patients can be operationally challenging and purchasers should weigh the effort each approach requires against their own capacity and capabilities.

3 Purchasers should consider implementing a performance-based contract to optimize outcomes.

Tie contractual payments to clinically validated outcomes (e.g., change in IBS-SSS or IBDQ scores) and demonstrated reductions in avoidable utilization. Consider vendor incentives to encourage them to target patients with moderate-to-severe GI conditions by structuring performance guarantees around moderate-to-severe populations or by requiring that a minimum proportion of engaged members meet an acuity threshold.

Considerations for Performance-Based Contracting for Virtual GI solutions

Performance-based contracts are an important tool for ensuring that vendor payments reflect the value delivered to members and to the plan. A few things are worth knowing before entering contract negotiations in this space.

Structure payment as a case rate plus a performance payment. Given the episodic nature of GI care, PHTI recommends a case-rate structure, covering all services delivered to a member over a defined episode of care and period of time, rather than a flat per-member-per-month arrangement. PHTI recommends tying approximately 70% of contract value to the case rate and 30% to a performance payment.

Defining member engagement is critical to overall success. Members who do not meaningfully engage with a virtual GI solution will not improve.

Contracts should establish the definition of a program start on the basis of:

1. A completed intake or initial clinician intake visit;
2. Require baseline-validated symptom severity-level measurement captured by a physician or member within a pre-defined period after program start; and
3. Define ongoing monthly engagement as at least one interaction, such as a synchronous telehealth visit, a nutrition counseling or gut-brain behavioral health session, pre-specified number of days of symptom and trigger logging, or two-way asynchronous messaging with the care team.

Expect measurement challenges across GI disorder types.

GI conditions span a wide range of disorders with distinct symptom profiles, making it difficult to measure clinical improvement with a single instrument across a mixed population. Some vendors have developed proprietary scales to address this, which can be pragmatic but may make it more challenging to compare performance across vendors or determine whether reported improvements are clinically meaningful. To improve assessment, contracts should specify which instruments will be used and what threshold of improvement constitutes performance.

PHTI developed a Performance-Based Contracting Toolkit specifically for virtual GI solutions with detailed guidance on payment model structure, engagement definitions, performance metrics, and data sharing terms. The GI toolkit can be found [here](#).

Virtual GI Care Solutions: Suggested RFP Questions

As purchasers explore implementing a virtual GI care solution, below are questions to consider including in future RFPs:

Solution-Specific Questions

Q1

What GI conditions does your solution address?

Q2

Does your solution provide direct clinical care (i.e., licensed clinicians delivering diagnosis, prescribing, treatment, or ongoing management) or does it primarily provide care to augment in-person providers?

- Are all provider types available to all members, or are some tiered by acuity or condition?
- How does your solution handle medication management, including initiation, optimization, or deprescribing? Are prescribing clinicians on staff, and what clinical oversight governs prescribing decisions?
- How does your solution coordinate with a member's existing PCP or in-network gastroenterologist?

Q3

What is the care pathway for a member who requires in-person evaluation or testing?

- Who is responsible for facilitating that transition?
- Is the solution provider making recommendations or a referral? To whom? How is that provider identified?
- Who is responsible for payment?

Q4

How does your solution address the gut-brain connection? Is behavioral health treatment (e.g., cognitive behavioral therapy, gut-directed hypnotherapy) offered? How is this type of treatment delivered?

Solution Strategy and Contracting Questions

Q1

Do you target outreach to specific members on the basis of: GI diagnosis, GI-related claims and total healthcare spending, or other criteria?

Q2

What are the primary clinical outcomes demonstrated by your solution for each major GI condition (IBS, IBD, GERD, others)? Examples may include validated symptom score improvement, reduction in ER visits or hospitalizations, etc.

- What instruments do you use to measure symptom change?
- Are these instruments validated?
- What constitutes a clinically meaningful change?
- How do outcomes vary by population?

Q3

What is your typical member engagement rate among identified eligible members? How do you define "engaged"? How do you measure engagement over time?

Q4

How do you calculate cost savings? Please describe your methodology in detail, including how the comparator or control group is constructed, what data sources are used, and what assumptions are embedded in the model.

Q5

Describe your pricing model and how performance guarantees align with GI outcomes for engaged members (e.g., PMPM, per engaged member, outcomes-based, or hybrid).

Virtual Gastrointestinal Care Solutions: Company Profiles

Full details on PHTI’s evidence criteria, assessment methods, and review process can be found in the [assessment](#) and [appendices](#).

Summary of Findings

PHTI RATINGS FOR VIRTUAL GASTROINTESTINAL CARE SOLUTIONS BY CATEGORY

● Positive ● Moderate ● Negative
● Higher Clinical Evidence Certainty ○ Lower Clinical Evidence Certainty

Category of Solution	Clinical Effectiveness ^a	Economic Impact	Summary Rating ^b
Wraparound Solutions Cylinder Health Digbi Health	● Results: Clinically meaningful improvements in symptoms and quality of life for patients with IBS compared with usual care No evidence of clinical benefit for patients with IBD only Evidence Certainty: Higher (for IBS)	● Decreases net spending for patients with IBS	● Evidence supports broader adoption for patients with IBS; patients with IBD require clinician-led interventions
Clinician-Led Solutions Ayble Health Oshi Health Salvo Health	○ Results: Improvements in symptoms and quality of life for patients with IBS and/or IBD compared with usual care Evidence Certainty: Lower	● Decreases net spending for patients with IBS and/or IBD, with the highest savings for patients with moderate-to-severe IBD	● Evidence supports broader adoption for patients with IBS and/or IBD, particularly those with moderate-to-severe IBD

Source: PHTI, Virtual Gastrointestinal Care Solutions, March 2026. See [PHTI.org](#) for complete report, methods, and recommendations.
Notes: ^aNot all solutions have clinical data that meet the inclusion standards for this report. ^bSummary rating reflects the combination of clinical and economic results. Some solutions are evolving their business models to offer products in multiple categories.

Inclusion Criteria

Solutions considered for this assessment were identified through a market scan, a search of published literature, and company-by-company research. The final list of included companies was informed by company meetings; detailed company research and input from a broad set of stakeholders, including health plans, employers, clinicians, and virtual health experts.

All of the solutions included in this report:

- Are sold by companies that have clinical evidence of treating GI conditions or indicate they target people with GI conditions;
- Offer a combination of clinician-based GI care, behavioral health support, nutrition counseling, care navigation, and symptom tracking;
- Are sold in the United States;
- Are sold to employers, payers, or health systems/providers; and
- Are sold by companies that have raised at least \$10M in funding via private investors.

Virtual GI care solutions are evolving their business models and product design. For instance, some clinician-led solutions are developing wraparound-only offerings that work with gastroenterologists external to the platform, and some wraparound solutions are incorporating clinician-led services into their platforms. The company categorizations above represent the historic, dominant approach for each company, many of which are actively spreading into other models.

The findings and recommendations contained within this document represent the opinions of PHTI based on the information considered in the assessment. The findings are current as of the date of publication. Readers should be aware that new evidence may emerge following the publication of the report that could influence the results.

These findings are based on the criteria set forth in the ICER-PHTI Assessment Framework and the currently available evidence. Please see the [full PHTI report](#) and [appendices](#), and [online data supplement](#) for complete assessment, methods, and recommendations. Find more information on our website [PHTI.org](#).

Clinician-Led Solutions

Clinician-led solutions offer comprehensive GI care that includes gastroenterologists and other clinicians integrated with a suite of support services, to deliver a virtual multidisciplinary care model.

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Ayble Health

10

Oshi Health

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Salvo Health

Ayble Health

ayblehealth.com

Company Description

Ayble Health provides virtual access to gastroenterologists who design and oversee care plans that include medication prescribing and support services such as nutrition counseling, behavioral health support, symptom tracking, and care navigation. Patients have access to a broad multidisciplinary care team of providers including clinical pharmacists, registered dietitians, behavioral health teams, and health coaches.

Solution Category

Ayble Health is in the clinician-led solutions category, which are designed to offer comprehensive GI care that includes gastroenterologists and other clinicians integrated with a suite of support services, to deliver a virtual multidisciplinary care model. The solutions rely on clinical teams to develop and modify treatment plans, including prescribing and adjusting medications, and directly oversee nutrition, behavioral health, and other support services.

Contracting

Ayble Health sells to employers and health plans. Ayble is typically reimbursed by health plans as in-network providers, that bill directly for visits and other services. Ayble offers performance guarantees based on clinical and financial outcomes.

Pricing

Based on available market data, **clinician-led solutions** are estimated at a price of \$1,025 in all markets, based on vendor-supplied pricing information. This information is an annual estimated cost based on published economic studies and vendor-supplied pricing. Actual vendor costs will vary.

Features	AYBLE HEALTH
TYPES OF PROFESSIONALS GUIDING TREATMENT	
Gastroenterologist serving as a patient's primary GI provider with the ability to oversee and prescribe medications	●
Gastroenterologist serving as adjunct to patient's primary GI	●
Licensed mental health provider	●
Registered dietitian	●
Clinical pharmacist	●
Human coach	●
SERVICES OFFERED	
Nutrition counseling (e.g., personalized nutrition plans)	●
Behavioral health support (e.g., gut-directed hypnotherapy, CBT guidance)	●
Care navigation	●
Symptom tracking	●
Diagnostic tests to support diagnosis and disease monitoring	●
INTEGRATION	
Provider responsible for care plan uses the digital solution as a tool to deliver and coordinate care. Platform is embedded in care workflow.	●
PATIENT MANAGEMENT	
Digital solution enables data sharing and communication with an external provider (e.g., patient's provider responsible for care plan). Primary clinical responsibility remains with external provider.	●
PURCHASERS	
Providers/health systems	
Health plans (in-network provider)	●
Health plans (as a buy-up)	●
Employers	●

Notes: CBT = cognitive behavioral therapy.

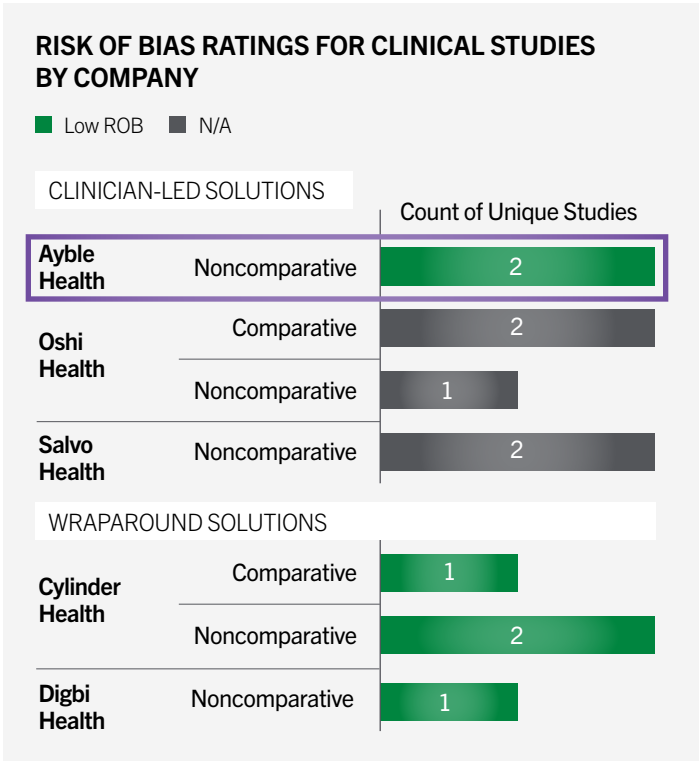
Source: Public information (e.g., websites, marketing materials, company-provided public information).

Ayble Clinical and Economic Data Summary

Ayble had two single-arm, low risk of bias, studies that both showed statistically significant and clinically meaningful improvements in IBS symptoms, measured on the IBS-SSS.

One study found that patients with IBS who engaged with one or more of Ayble’s care pathways—multidisciplinary care, nutrition programs, or gut-brain interventions—experienced a statistically significant and clinically meaningful 140-point decrease in IBS-SSS scores, on average.^{1–3} When stratified by care pathway(s) selected, those who selected two or more care pathways experienced significantly greater symptom improvement than those who selected only one. A second study found that patients with IBS and patients with comorbid IBS/IBD using Ayble experienced statistically significant improvements in symptoms as measured via condition-appropriate scales (IBS-SSS for patients with IBS; P-SCCAI or mHI-CD for patients with dual IBS/ulcerative colitis or dual IBS/Crohn’s disease).^{4–6} No studies reported on the impact of Ayble on costs or HCRU.

One single-arm study of clinician-led, multidisciplinary care (that included virtual components) for patients with IBD reported statistically significant improvements in disease activity and quality of life, as well as reductions in inpatient hospitalizations and emergency department visits over a 12-month period.⁷ Ayble Health has exclusively licensed the clinical protocols evaluated in this study.



Notes: N/A = not applicable. N/A means that studies could not be rated. Risk of bias is assessed for studies, not articles. For ease of interpretation across risk of bias ratings, “Low” refers to original ratings of “Low Risk of Bias” (RoB2) or “Good Study Quality” (NOS), “Moderate” refers to original ratings of “Some Risk of Bias” (RoB2) or “Fair Study Quality” (NOS), and “High” refers to original ratings of “High Risk of Bias” (RoB2) or “Poor Study Quality” (NOS). See Appendix C-1 and C-2 for more detail on risk of bias ratings.

Ayble submitted two additional articles that did not meet the inclusion criteria for this assessment. A complete list of references supporting the clinical and economic evidence summaries is provided in the Appendices of the assessment (Appendix B).

Company-Specific References

- ¹ Stephen E. Lupe, Joseph M. Olson, Kendra Kamp, et al., “First Real-World Evidence of an AI-Enhanced Digital Collaborative Care Model to Improve IBS Symptoms,” *Neurogastroenterology & Motility* 37, no. 11 (2025): e70144.
<https://doi.org/10.1111/nmo.70144>
- ² Stephen Lupe, Joseph Olson, Tiffany Taft, et al., “First Real-World Evidence of an AI-Enhanced Digital Collaborative Care Model to Improve IBS Symptoms,” abstract presented at Digestive Disease Week, San Diego, CA, May 3, 2025.
- ³ Stephen Lupe, Joseph Olson, Tiffany Taft, et al., “42: First Real-World Evidence of an AI-Enhanced Digital Collaborative Care Model to Improve IBS Symptoms,” *Gastroenterology* 169, no. 1 suppl. (2025): S-16–S-17.
[https://doi.org/10.1016/S0016-5085\(25\)01003-0](https://doi.org/10.1016/S0016-5085(25)01003-0)
- ⁴ Samuel N. Jactel, Joseph M. Olson, Kathleen Y. Wolin, et al., “Efficacy of a Digital Personalized Elimination Diet for the Self-Management of Irritable Bowel Syndrome and Comorbid Irritable Bowel Syndrome and Inflammatory Bowel Disease,” *Clinical and Translational Gastroenterology* 14, no. 1 (2023): e00545.
<https://doi.org/10.14309/ctg.0000000000000545>
- ⁵ Samuel N. Jactel, Joseph M. Olson, Jordan Brown, et al., “Efficacy of a Digitally Delivered Personalized Elimination Diet for the Self-Management of Inflammatory Bowel Disease and Irritable Bowel Syndrome,” *Gastroenterology* 162, no. 3 suppl. (2021): S25.
[https://www.gastrojournal.org/article/S0016-5085\(21\)03871-3/fulltext](https://www.gastrojournal.org/article/S0016-5085(21)03871-3/fulltext)
- ⁶ Samuel Jactel et al., “Efficacy of a Digitally Delivered Personalized Elimination Diet for the Self-Management of Inflammatory Bowel Disease and Irritable Bowel Syndrome,” *Inflammatory Bowel Diseases* 28, no. 1 suppl. (2022): S25.
<https://doi.org/10.1093/ibd/izac015.039>
- ⁷ Miguel Regueiro, Benjamin Click, Alyce Anderson, et al., “Reduced Unplanned Care and Disease Activity and Increased Quality of Life After Patient Enrollment in an Inflammatory Bowel Disease Medical Home,” *Clinical Gastroenterology and Hepatology* 16, no. 11 (2018): 1777–1785.
<https://doi.org/10.1016/j.cgh.2018.04.007>

Oshi Health

oshihealth.com

Company Description

Oshi Health is a virtual specialty clinic that provides multidisciplinary support services for a range of digestive conditions. Care plans are designed and overseen by gastroenterologists. Oshi's platform includes prescribing, medication management, nutrition counseling, behavioral health support, symptom tracking, care navigation, and access to Oshi Health clinicians through messaging or virtual visits. Oshi also connects with in-person GI care when needed for services such as infusions, imaging, and endoscopies.

Solution Category

Oshi Health is in the clinician-led solutions category, which are designed to offer comprehensive GI care that includes gastroenterologists and other clinicians integrated with a suite of support services, to deliver a virtual multidisciplinary care model. The solutions rely on clinical teams to develop and modify treatment plans, including prescribing and adjusting medications, and directly oversee nutrition, behavioral health, and other support services.

Contracting

Oshi Health sells to employers and health plans. Oshi is typically reimbursed by health plans as in-network providers that bill directly for visits and other services. In late 2025, Oshi announced that it plans to make their multidisciplinary services available to external providers and health systems as a wraparound solution. Oshi receives payment for care coordination and support services through a bundled case rate. Oshi offers performance guarantees based on total cost of care.

Pricing

Based on available market data, **clinician-led solutions** are estimated at a price of \$1,025 in all markets, based on vendor-supplied pricing information. This information is an annual estimated cost based on published economic studies and vendor-supplied pricing. Actual vendor costs will vary.

Features	OSHI HEALTH
TYPES OF PROFESSIONALS GUIDING TREATMENT	
Gastroenterologist serving as a patient's primary GI provider with the ability to oversee and prescribe medications	●
Gastroenterologist serving as adjunct to patient's primary GI	●
Licensed mental health provider	●
Registered dietitian	●
Clinical pharmacist	
Human coach	
SERVICES OFFERED	
Nutrition counseling (e.g., personalized nutrition plans)	●
Behavioral health support (e.g., gut-directed hypnotherapy, CBT guidance)	●
Care navigation	●
Symptom tracking	●
Diagnostic tests to support diagnosis and disease monitoring	●
INTEGRATION	
Provider responsible for care plan uses the digital solution as a tool to deliver and coordinate care. Platform is embedded in care workflow.	●
PATIENT MANAGEMENT	
Digital solution enables data sharing and communication with an external provider (e.g., patient's provider responsible for care plan). Primary clinical responsibility remains with external provider.	●
PURCHASERS	
Providers/health systems	●
Health plans (in-network provider)	●
Health plans (as a buy-up)	●
Employers	●

Notes: CBT = cognitive behavioral therapy.

Source: Public information (e.g., websites, marketing materials, company-provided public information).

Oshi Clinical and Economic Data Summary

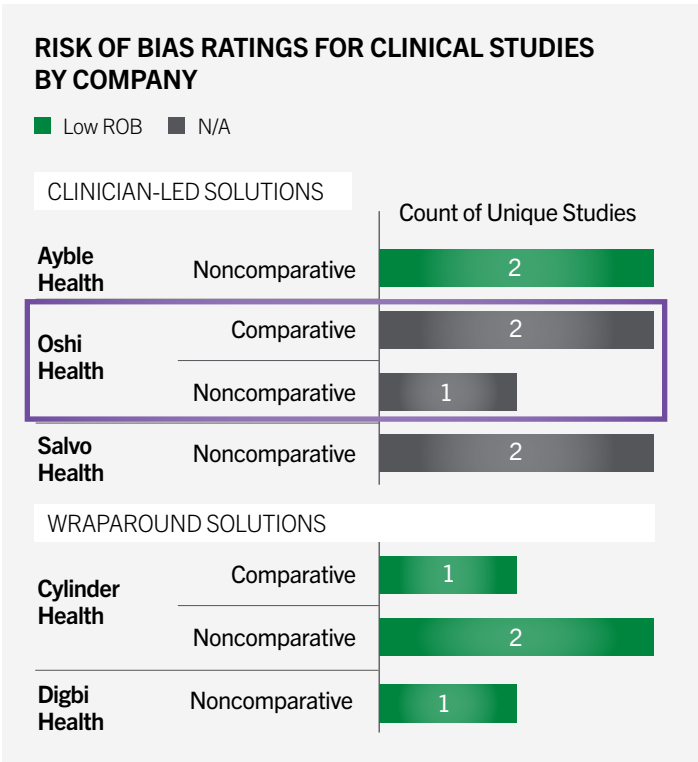
Oshi had three unique studies, two comparative and one single-arm, none of which could be rated for risk of bias because all were published only as abstracts or posters. All three found symptom improvement, one of which was statistically significant and one of which was clinically meaningful (IBS-SSS). The comparative studies also found reductions in healthcare resource utilization, including fewer ED visits and GI-related services.

The two comparative studies examined HCRU (via claims) for Oshi users and a matched control group, and symptom severity (IBS-SSS) and quality of life (self-report) for the Oshi user group only.^{1–13} Among patients with general GI conditions, Oshi participants experienced significant reductions, including 68% fewer ED visits and 52% fewer inpatient admissions over nine months. Oshi participants also had lower annual all-cause costs—resulting in an overall difference-in-difference gross savings of \$6,081, or \$507 per member per month.¹⁴ The study also reported statistically significant improvements in symptom severity and symptom control (measured using a nonvalidated custom scale) among Oshi users. Cost savings were even greater for patients with IBD, with Oshi users seeing annual all-cause gross savings of \$16,751, or \$1,396 per member per month. This was driven by utilization reductions including 76% fewer ED visits and 48% fewer inpatient admissions over nine months.^{15, 16}

A separate study evaluated changes in costs, utilization, and symptoms among Oshi users with IBS, functional GI disorders, or related signs and symptoms. Three difference-in-difference analyses using varying index dates showed six-month, all-cause, gross savings ranging from \$3,483 to \$10,292, or \$581 to \$1,715 per member per month.¹⁷ While reductions in HCRU varied by index date, statistically significant decreases in endoscopies, imaging, and GI-related services were consistently observed. In contrast, reductions in GI-related inpatient admissions and other cost categories were mixed. The study also reported clinically meaningful improvements in symptom severity among Oshi users, with an average 70-point decrease on the IBS-SSS after two or more months—a clinically meaningful change, per the MCID. Additionally, 92% of Oshi users reported overall symptom improvement.

The single-arm study of patients diagnosed with disorders of the gut-brain interaction (including IBS) found that 81.2% of Oshi users reported symptom improvement after an average of 4–5 weeks.^{18, 19}

*Of note, Oshi Health’s study reports high average annual healthcare spending for their IBD enrollees, suggesting they are disproportionately enrolling more complex patients. The study reports annual, all-cause spending for their enrollees of \$50,000, compared with approximately \$25,000 for the average patient with IBD.



Notes: N/A = not applicable. N/A means that studies could not be rated. Risk of bias is assessed for studies, not articles. For ease of interpretation across risk of bias ratings, “Low” refers to original ratings of “Low Risk of Bias” (RoB2) or “Good Study Quality” (NOS), “Moderate” refers to original ratings of “Some Risk of Bias” (RoB2) or “Fair Study Quality” (NOS), and “High” refers to original ratings of “High Risk of Bias” (RoB2) or “Poor Study Quality” (NOS). See Appendix C-1 and C-2 for more detail on risk of bias ratings.

Oshi submitted nine additional articles that did not meet the inclusion criteria for this assessment. A complete list of references supporting the clinical and economic evidence summaries is provided in the Appendices of the assessment (Appendix B).

Company-Specific References

- ¹ Sameer K. Berry, Jeffrey Berinstein, David J. Cook, et al., “S635 A Virtual Integrated Care Program Improves Patient Outcomes, Engagement, and Satisfaction at Reduced Costs: A Prospective Trial,” *American Journal of Gastroenterology* 118, no. 10 suppl. (2023): S465–S466.
<https://doi.org/10.14309/01.ajg.0000952180.47006.f3>
- ² Sameer K. Berry, Jeffrey A. Berinstein, David J. Cook, et al., “Virtual Integrated Care Improves Patient Outcomes at Lower Costs: Prospective Pilot Study on GI Care,” poster presented at the Institute for Healthcare Improvement Forum, Orlando, FL, December 4–7, 2022.
- ³ Sameer K. Berry, Sanskriti Varma, Chamara Basnayake, et al., “Virtual Multidisciplinary GI Clinic Improves Patient Engagement, Satisfaction, and Symptoms at Reduced Costs and Healthcare Utilization: A Propensity-Matched Prospective Observational Study,” *The American Journal of Gastroenterology* 120, no. 10S2 (October 2025): S635–S635.
<https://doi.org/10.14309/01.ajg.0001139268.02765.79>
- ⁴ Sameer Berry, Jahnvi Curlin, Jeffrey Berinstein, et al., “Reduced ED Utilization in Patients Enrolled in a Provider-Integrated Digital Health Platform: Results from a Prospective Study,” abstract presented at the American Public Health Association Annual Meeting and Expo, Atlanta, GA, November 12–15, 2023.
- ⁵ Sameer K. Berry, Sanskriti Varma, Chamara Basnayake, et al., “Virtual Multidisciplinary Clinic Improves IBD Patient Engagement, Satisfaction, and Symptoms at Reduced Costs and Healthcare Utilization: A Propensity-Matched Prospective Observational Study,” poster presented at the American College of Gastroenterology Annual Scientific Meeting, Phoenix, AZ, October 24–29, 2025.
- ⁶ Sameer Berry, Sanskriti Varma, Chamara Basnayake, et al., “S2482 Transforming Liver Care: Patient-Reported Outcomes from a Virtual Multidisciplinary Gastrointestinal Clinic,” *American Journal of Gastroenterology* 120, no. 10 suppl. 2 (2025): S533.
<https://doi.org/10.14309/01.ajg.0001137388.06934.83>
- ⁷ Sameer K. Berry, Sanskriti Varma, Chamara Basnayake, et al., “Virtual Multidisciplinary GI Clinic Improves Outcomes in Medicare-Aged Patients with Gastrointestinal Conditions,” poster presented at the American College of Gastroenterology Annual Scientific Meeting, Phoenix, AZ, October 24–29, 2025.
- ⁸ Sameer K. Berry, Sanskriti Varma, Lyndsay Solimine, et al., “Outcomes of a Multidisciplinary Care Delivery Model for Gastrointestinal Disorders,” poster presented at the American Telemedicine Association, New Orleans, LA, May 3–6, 2025.
- ⁹ Sameer Berry, Jeffrey Berinstein, David Cook, et al., “A Virtual Integrated Care Program Improves Patient Outcomes, Engagement, and Satisfaction at Reduced Costs: A Prospective Trial,” abstract presented at the American Telemedicine Association Annual Conference & Expo, San Antonio, TX, March 4–6, 2023.
- ¹⁰ Sameer K. Berry, Jeffrey A. Berinstein, David J. Cook, et al., “A Virtual Integrated Care Program Improves Patient Outcomes, Engagement, and Satisfaction at Reduced Costs: A Prospective Trial,” poster presented at the American College of Gastroenterology (ACG) Annual Meeting, Vancouver, Canada, October 20–25, 2023.
- ¹¹ Sameer K. Berry, Sanskriti Varma, Chamara Basnayake, et al., “Virtual Multidisciplinary Clinic Improves IBD Patient Engagement, Satisfaction, and Symptoms at Reduced Costs and Healthcare Utilization: A Propensity-Matched Prospective Observational Study,” *The American Journal of Gastroenterology* 120, no. 10S2 (October 2025): S342.
<https://doi.org/10.14309/01.ajg.0001133824.17131.72>
- ¹² Sameer K. Berry, Sanskriti Varma, Chamara Basnayake, et al., “Virtual Multidisciplinary GI Clinic Improves Outcomes in Medicare-Aged Patients with Gastrointestinal Conditions,” *The American Journal of Gastroenterology* 120, no. 10S2 (October 2025): S639–S640.
<https://doi.org/10.14309/01.ajg.0001139356.20270.ed>
- ¹³ Sameer K. Berry, Sanskriti Varma, Jeffrey Berinstein, et al., “Transforming Liver Care: Patient-Reported Outcomes From a Virtual Multidisciplinary Gastrointestinal Clinic,” poster presented at the American College of Gastroenterology Annual Scientific Meeting, Phoenix, AZ, October 24–29, 2025.

- ¹⁴ Berry et al., “Virtual Multidisciplinary GI,” S635–S635.
- ¹⁵ Berry et al., “Virtual Multidisciplinary Clinic Improves IBD,” 2025.
- ¹⁶ Berry et al., “Virtual Multidisciplinary Clinic Improves IBD,” S342.
- ¹⁷ Berry et al., “Virtual Integrated Care,” 2022.
- ¹⁸ Madeline Berschback, Treta Purohit, Sanskriti Varma, et al., “S1166 Predictors of Improvement Among Patients with Disorders of Gut-Brain Interaction in a Virtual Multidisciplinary Care Model,” *American Journal of Gastroenterology* 120, no. 10 suppl. 2 (2025): S251.
<https://doi.org/10.14309/01.aig.0001132124.76594.5b>
- ¹⁹ Madeline Berschback, Treta Purohit, Sanskriti Varma, et al., “Predictors of Improvement Among Patients with Disorders of Gut-Brain Interaction in a Virtual Multidisciplinary Care Model,” poster presented at the American College of Gastroenterology Annual Scientific Meeting, Phoenix, AZ, October 24–29, 2025.

Salvo Health

salvohealth.com

Company Description

Salvo Health supplements in-person care for chronic digestive and metabolic GI conditions by offering virtual multidisciplinary care support services such as nutrition counseling, behavioral health support, care navigation, and symptom tracking to in-person GI practices. Patients access Salvo's virtual multidisciplinary care team, including registered dietitians, nurses, and behavioral health specialists, while remaining under their primary GI physician's supervision.

Solution Category

Salvo Health is in the clinician-led solutions category, which are designed to offer comprehensive GI care that includes gastroenterologists and other clinicians integrated with a suite of support services, to deliver a virtual multidisciplinary care model. The solutions rely on clinical teams to develop and modify treatment plans, including prescribing and adjusting medications, and directly oversee nutrition, behavioral health, and other support services.

Contracting

Salvo Health sells directly to health systems and provider practices who want to offer virtual support services to deliver multidisciplinary care for their patients. Salvo is purchased by providers who then bill insurers using chronic care management, remote patient monitoring, or behavioral health integration codes.

Pricing

Based on available market data, **clinician-led solutions** are estimated at a price of \$1,025 in all markets, based on vendor-supplied pricing information. This information is an annual estimated cost based on published economic studies and vendor-supplied pricing. Actual vendor costs will vary.

Features	SALVO HEALTH ^a
TYPES OF PROFESSIONALS GUIDING TREATMENT	
Gastroenterologist serving as a patient's primary GI provider with the ability to oversee and prescribe medications	
Gastroenterologist serving as adjunct to patient's primary GI	
Licensed mental health provider	●
Registered dietitian	●
Clinical pharmacist	
Human coach	
SERVICES OFFERED	
Nutrition counseling (e.g., personalized nutrition plans)	●
Behavioral health support (e.g., gut-directed hypnotherapy, CBT guidance)	●
Care navigation	●
Symptom tracking	●
Diagnostic tests to support diagnosis and disease monitoring	
INTEGRATION	
Provider responsible for care plan uses the digital solution as a tool to deliver and coordinate care. Platform is embedded in care workflow.	●
PATIENT MANAGEMENT	
Digital solution enables data sharing and communication with an external provider (e.g., patient's provider responsible for care plan). Primary clinical responsibility remains with external provider.	●
PURCHASERS	
Providers/health systems	●
Health plans (in-network provider)	
Health plans (as a buy-up)	
Employers	

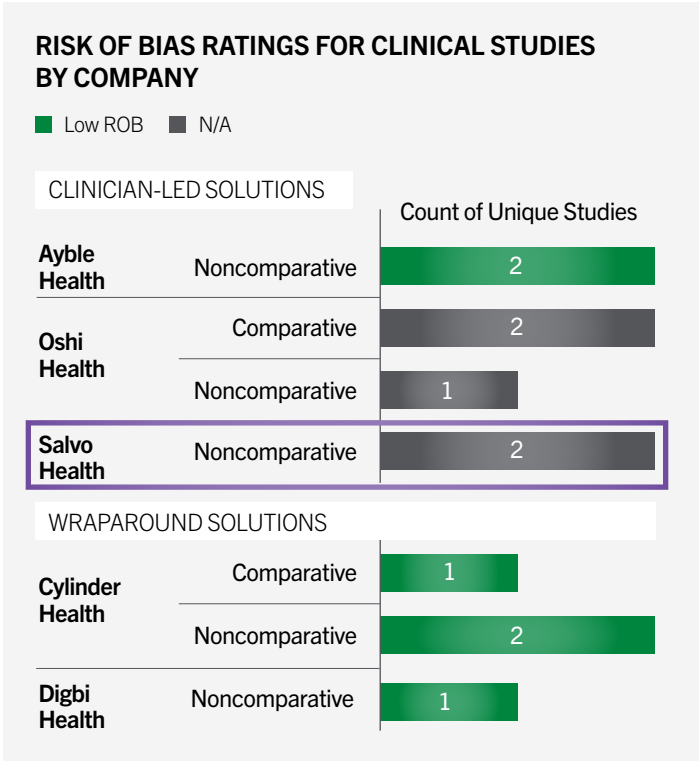
Notes: CBT = cognitive behavioral therapy. ^aSalvo Health provides multidisciplinary support services through GI clinicians, who serve as the patient's primary provider.

Source: Public information (e.g., websites, marketing materials, company-provided public information).

Salvo Clinical and Economic Data Summary

Salvo Health had two single-arm studies that could not be rated for risk of bias, both assessing symptoms and quality of life among patients with IBS. One found statistically significant improvement on a composite symptom and quality of life scale.

One study found that 57% of patients experienced improvements on a composite symptom and quality of life score after 30 days.^{1,2} The study also reported statistically significant improvements for the overall population at both 30 and 60 days. The second study measured the proportion of patients who reported reduced avoidance of responsibilities, reduced GI-related anxiety, and improved symptom control, ranked on a scale from 1 to 5. The study reported that less than half of participants showed improvements across these measures; statistical significance was not reported.³⁻⁶ No studies assessed Salvo’s impact on cost or HCRU.



Notes: N/A = not applicable. N/A means that studies could not be rated. Risk of bias is assessed for studies, not articles. For ease of interpretation across risk of bias ratings, “Low” refers to original ratings of “Low Risk of Bias” (RoB2) or “Good Study Quality” (NOS), “Moderate” refers to original ratings of “Some Risk of Bias” (RoB2) or “Fair Study Quality” (NOS), and “High” refers to original ratings of “High Risk of Bias” (RoB2) or “Poor Study Quality” (NOS). See Appendix C-1 and C-2 for more detail on risk of bias ratings.

Salvo submitted eight additional articles that did not meet the inclusion criteria for this assessment. A complete list of references supporting the clinical and economic evidence summaries is provided in the Appendices of the assessment (Appendix B).

Company-Specific References

- ¹ Partha Nandi, Naresh T. Gunaratnam, Frank G. Gress, et al., “The Use of Telehealth and Digital Technology In the Multidisciplinary Treatment of Irritable Bowel Syndrome In Patients Within Traditional Gastroenterology Practices,” poster presented at Digestive Disease Week.
- ² Partha Nandi, Naresh T. Gunaratnam, Frank G. Gress, et al., “The Use of Telehealth and Digital Technology in the Multidisciplinary Treatment of Irritable Bowel Syndrome in Patients Within Traditional Gastroenterology Practices,” *Gastroenterology* 169, no. 1 (2025): S1068–S1069.
[https://doi.org/10.1016/S0016-5085\(25\)03364-5](https://doi.org/10.1016/S0016-5085(25)03364-5)
- ³ Amit Sachdev, Peter H.R. Green, Alyssa Guberman, et al., “S657 The Use of Telehealth and Digital Technology in the Multidisciplinary Treatment of Irritable Bowel Syndrome,” *American Journal of Gastroenterology* 118, no. 10 suppl. (2023): S480–481.
<https://doi.org/10.14309/01.ajg.0000952268.79111.8b>
- ⁴ Max Pitman, Erin Hendriks, and Alyssa Guberman, “A Modified Low-FODMAP Diet for the Treatment of Irritable Bowel Syndrome,” poster presented at the Institute for Functional Medicine Annual International Conference, Orlando, FL, June 1–3, 2023.
- ⁵ Amit Sachdev, Peter H. R. Green, Alyssa Guberman, et al., “The Use of Telehealth and Digital Technology in the Multidisciplinary Treatment of Irritable Bowel Syndrome,” poster presented at the American College of Gastroenterology (ACG), Vancouver, BC, October 20–25, 2023.
- ⁶ Max Pitman, Alyssa Guberman, and Erin Hendriks, “A Modified Low-FODMAP Diet for the Treatment of Irritable Bowel Syndrome (IBS),” abstract presented at American College of Lifestyle Medicine, Boulder, CO, October 29, 2023.

Wraparound Solutions

Wraparound solutions complement patients' existing GI treatment by offering them a virtual program that includes support services, as well as engagement with coaches, dietitians, and mental health providers.

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Cylinder Health

21

Digbi Health

Cylinder Health*

cylinderhealth.com

Company Description

Cylinder Health's core program offers a virtual platform that delivers support services such as nutrition counseling, behavioral health support, symptom tracking, and care navigation with engagement from registered dietitians, behavioral health teams, and health coaches. Cylinder has expanded its solution options to include configurations that offer virtual visits with clinicians, including gastroenterologists who can provide medication management. Cylinder facilitates referrals to external providers when patients require in-person testing and services.

Solution Category

Cylinder Health is in the wraparound solutions category, which complement patients' existing GI treatment by offering them a virtual program that includes support services, as well as engagement with coaches, dietitians, and mental health providers. These solutions generally operate independently of patients' GI specialist, primary care provider, or other clinicians. Wraparound solutions may employ physicians such as gastroenterologists as part of their solution, but providing one-on-one patient care is not their primary function.

Contracting

Cylinder Health sells to health plans and employers typically for a flat rate per engaged member, and patients enroll directly in these wraparound solutions. Cylinder offers performance guarantees based on financial outcomes, member satisfaction, and clinical outcomes.

Pricing

Based on available market data, **wraparound solution** price is estimated at \$825 per engaged member per year based on information from published economic studies and vendor-supplied pricing, with no variation across plan type.¹ This information is an annual estimated cost based on published economic studies and vendor-supplied pricing. Actual vendor costs will vary.

¹On August 4, 2026, Hinge Health announced plans to acquire Cylinder Health.

● Standard Feature ○ Optional Feature

Features	CYLINDER HEALTH ^a
TYPES OF PROFESSIONALS GUIDING TREATMENT	
Gastroenterologist serving as a patient's primary GI provider with the ability to oversee and prescribe medications	○
Gastroenterologist serving as adjunct to patient's primary GI	●
Licensed mental health provider	●
Registered dietitian	●
Clinical pharmacist	
Human coach	●
SERVICES OFFERED	
Nutrition counseling (e.g., personalized nutrition plans)	●
Behavioral health support (e.g., gut-directed hypnotherapy, CBT guidance)	●
Care navigation	●
Symptom tracking	●
Diagnostic tests to support diagnosis and disease monitoring	●
INTEGRATION	
Provider responsible for care plan uses the digital solution as a tool to deliver and coordinate care. Platform is embedded in care workflow.	○
PATIENT MANAGEMENT	
Digital solution enables data sharing and communication with an external provider (e.g., patient's provider responsible for care plan). Primary clinical responsibility remains with external provider.	●
PURCHASERS	
Providers/health systems	
Health plans (in-network provider)	●
Health plans (as a buy-up)	●
Employers	●

Notes: CBT = cognitive behavioral therapy. ^aCylinder Health provides a gastroenterologist who can serve as the primary GI when clinically appropriate, oversee medication management, and the platform is integrated into the care workflow as of January 2026.

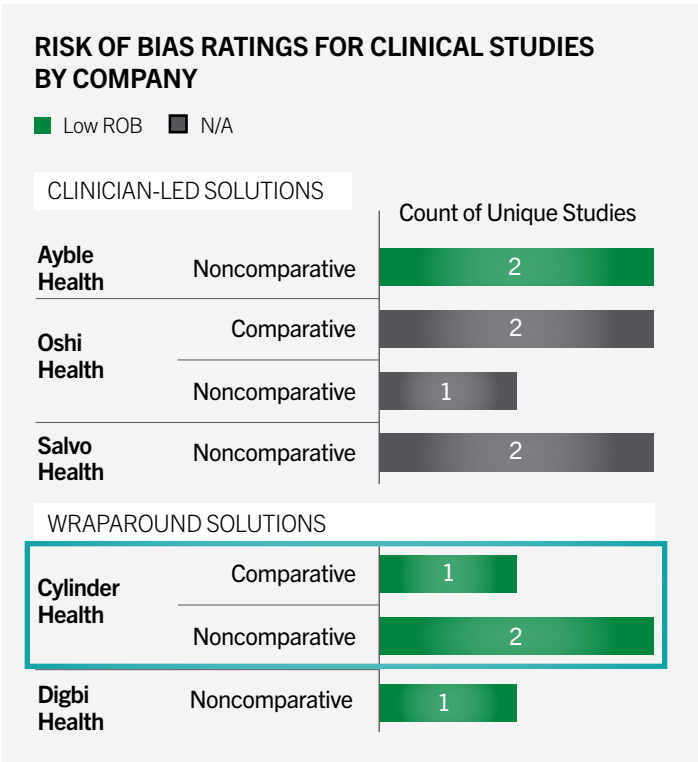
Source: Public information (e.g., websites, marketing materials, company-provided public information).

Cylinder Clinical and Economic Data Summary

Cylinder Health had three low risk of bias studies assessing symptom severity on a custom Cylinder scale. Two single-arm studies found statistically significant improvements in symptom severity from baseline, and a stratified analysis from a comparative study found significantly fewer sick days among employees aged 50 years or older.

All of Cylinder’s studies used a custom scale to assess changes in symptom severity. The comparative study assessed absenteeism and symptom improvement among a cohort of adult employees offered a digital digestive care program as part of their health benefits, and found improvements in symptoms that were not reported to be statistically significant.² However, a stratified analysis showed that employees aged 50 years or older who participated in the program had significantly fewer sick days compared to nonparticipants. The two single-arm studies followed Cylinder participants for three months. Both studies measured outcomes on the Cylinder scale and reported statistically significant improvements in symptom severity, demonstrating a 4.7-point (61%) decrease in symptom severity from baseline.^{3–11}

One study assessed cost and HCRU outcomes for a retrospective claims-based cohort study of employees, comparing Cylinder participants versus nonparticipants using a difference-in-difference analysis. The study evaluated total healthcare spending of employees in a large public school system, comparing participants with any GI diagnosis to propensity-matched controls in the 12 months before and after Cylinder’s program launch. For participants enrolled in Cylinder, the study reported \$169 per member per month in gross savings, costs of \$29 per member per month, and net savings of \$140 per member per month. Savings were driven by reductions in inpatient admissions and emergency care spending that offset increases in outpatient and prescription drug spending.¹²



Notes: N/A = not applicable. N/A means that studies could not be rated. Risk of bias is assessed for studies, not articles. For ease of interpretation across risk of bias ratings, “Low” refers to original ratings of “Low Risk of Bias” (RoB2) or “Good Study Quality” (NOS), “Moderate” refers to original ratings of “Some Risk of Bias” (RoB2) or “Fair Study Quality” (NOS), and “High” refers to original ratings of “High Risk of Bias” (RoB2) or “Poor Study Quality” (NOS). See Appendix C-1 and C-2 for more detail on risk of bias ratings.

Cylinder submitted 11 additional articles that did not meet the inclusion criteria for this assessment. A complete list of references supporting the clinical and economic evidence summaries is provided in the Appendices of the assessment (Appendix B).

Company-Specific References

- ¹ Martha Shepherd, Pen-Che Ho, David Hines, et al., “A Health Economic Evaluation of Digital Digestive Care Management,” *American Journal of Managed Care* 32, no. 1 (2026): e5–e10.
<https://doi.org/10.37765/ajmc.2026.89872>
- ² Martha Shepherd, Pen-Che Ho, Jon Harris-Shapiro, et al., “The Effects of a Digital Digestive Care Management Program on Employee Absenteeism: A Case-Control Study,” *Journal of Occupational & Environmental Medicine* 67, no. 9 (2025): e612–e615.
<https://doi.org/10.1097/JOM.0000000000003441>
- ³ Dena M. Bravata, Hau Liu, Meghan M. Colosimo, et al., “Improvements in Digestive Symptoms After Participation in an App-Based Chronic Digestive Disease Management Program: A Prospective Cohort Evaluation,” *Cureus* 16, no. 8 (2024): e66941.
<https://doi.org/10.7759/cureus.66941>
- ⁴ Dena Bravata, Hau Liu, Meghan M Colosimo, et al., “Digital Disease Management Programme Reduces Chronic Gastrointestinal Symptoms Among Racially and Socially Vulnerable Populations,” *BMJ Open Gastroenterology* 11, no. 1 (2024): e001463.
<https://doi.org/10.1136/bmjgast-2024-001463>
- ⁵ Sanskriti Varma, Alicen Black, Erin Commons, et al., “The Impact of a Digital Digestive Health Program and Telehealth Visits in Socially Vulnerable Populations: Cohort Evaluation,” *JMIR Formative Research* 9 (September 2025): e70748.
<https://doi.org/10.2196/70748>
- ⁶ Erin Commons, Alicen Black, Pen-Che Ho, and Hau Liu, “Addressing Health Inequities in Gastroenterology: The Impact of a Digital Digestive Health Program with Virtual Dietitian and Health Coach Support for Socially Vulnerable Populations,” poster presented at 2024 Food & Nutrition Conference & Expo, Minneapolis, MN, October 5–8, 2024.
<https://cylinderhealth.com/wp-content/uploads/Cylinder-FNCE2024-poster-addressing-health-inequities-in-GI.pdf>
- ⁷ Hau Liu, Meghan M. Colosimo, Alex Bullock, et al., “P1236 Improvements in Digestive Symptoms After Participation in a Digital Digestive Chronic Care Program,” poster presented at the American College of Gastroenterology Annual Scientific Meeting, Vancouver, BC, October 20–25, 2023.
- ⁸ Erin Commons, Hau Liu, and Rachel Sepulveda, “Deployment and Evaluation of an Integrated Digital Digestive Solution Deploying App-Based Telenutrition Services for a Commercially-Insured Population with Chronic Digestive Conditions,” *Journal of the Academy of Nutrition and Dietetics* 123, no. 9 (2023): A81.
<https://doi.org/10.1016/j.jand.2023.06.008>
- ⁹ Dena Bravata, Hau Liu, Alex Bullock, et al., “696 Participation in a Digital Digestive Chronic Care Program Improves Health Outcomes in Demographically Diverse and Socially Vulnerable Populations,” *Gastroenterology* 166, no. 5 suppl. (2024): S-162.
[https://doi.org/10.1016/S0016-5085\(24\)00865-5](https://doi.org/10.1016/S0016-5085(24)00865-5)
- ¹⁰ Hau Liu, Meghan Colosimo, Alex Bullock, et al., “S1731 Improvements in Digestive Symptoms After Participation in a Digital Digestive Chronic Care Program,” *American Journal of Gastroenterology* 118, no. 10 suppl. (2023): S1290.
<https://doi.org/10.14309/01.ajg.0000956564.98996.92>
- ¹¹ Erin Commons, Alicen Black, Pen-Che Ho, and Hau Liu, “Addressing Health Inequities in Gastroenterology: The Impact of a Digital Digestive Health Program with Virtual Dietitian and Health Coach Support for Socially Vulnerable Populations,” *Journal of the Academy of Nutrition and Dietetics* 124, no. 10 (2024): A63.
<https://doi.org/10.1016/j.jand.2024.07.092>
- ¹² Shepherd et al., “A Health Economic Evaluation,” e5–e10.

Digbi Health

digbihealth.ai

Company Description

Digbi Health offers virtual support services alongside access to biological testing and follow-up care for digestive health conditions. Digbi's platform includes genetic testing, gut microbiome analysis, nutrition counseling supported by registered dietitians, behavioral health support, symptom tracking, and medication management. Patients access care teams including health coaches via online chat.

Solution Category

Digbi Health is in the wraparound solutions category, which complement patients' existing GI treatment by offering a virtual program that includes support services, as well as engagement with coaches, dietitians, and mental health providers. These solutions generally operate independently of patients' GI specialist, primary care provider, or other clinicians. Wraparound solutions may employ physicians such as gastroenterologists as part of their solution, but providing one-on-one patient care is not their primary function.

Contracting

Digbi Health sells to health plans and employers typically for a flat rate per engaged member, and patients enroll directly in these wraparound solutions. Digbi offers performance guarantees based on reduction in claims.

Pricing

Based on available market data, **wraparound solution** price is estimated at \$825 per engaged member per year based on information from published economic studies and vendor-supplied pricing, with no variation across plan type.¹ This information is an annual estimated cost based on published economic studies and vendor-supplied pricing. Actual vendor costs will vary.

	DIGBI HEALTH
Features	
TYPES OF PROFESSIONALS GUIDING TREATMENT	
Gastroenterologist serving as a patient's primary GI provider with the ability to oversee and prescribe medications	
Gastroenterologist serving as adjunct to patient's primary GI	●
Licensed mental health provider	
Registered dietitian	●
Clinical pharmacist	
Human coach	●
SERVICES OFFERED	
Nutrition counseling (e.g., personalized nutrition plans)	●
Behavioral health support (e.g., gut-directed hypnotherapy, CBT guidance)	●
Care navigation	
Symptom tracking	●
Diagnostic tests to support diagnosis and disease monitoring	
INTEGRATION	
Provider responsible for care plan uses the digital solution as a tool to deliver and coordinate care. Platform is embedded in care workflow.	
PATIENT MANAGEMENT	
Digital solution enables data sharing and communication with an external provider (e.g., patient's provider responsible for care plan). Primary clinical responsibility remains with external provider.	●
PURCHASERS	
Providers/health systems	
Health plans (in-network provider)	
Health plans (as a buy-up)	●
Employers	●

Notes: CBT = cognitive behavioral therapy.

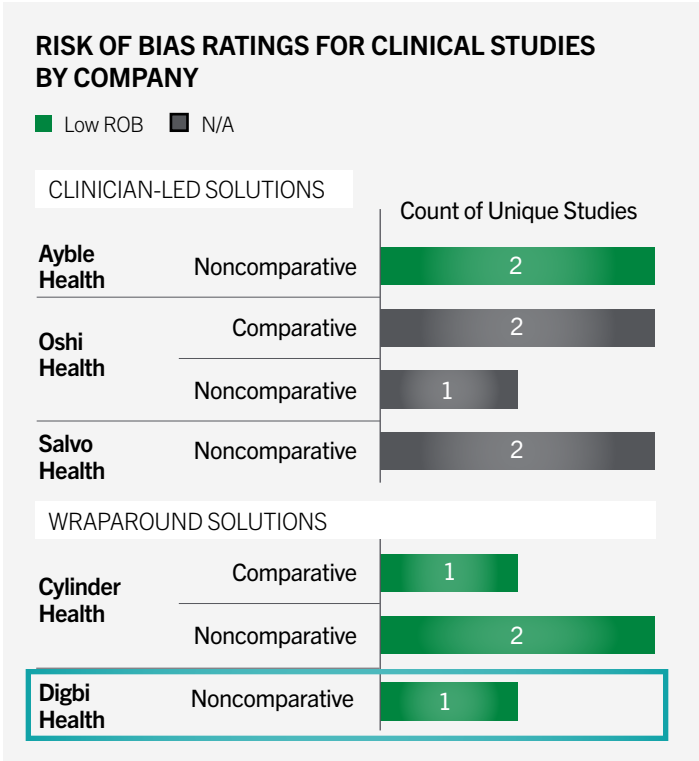
Source: Public information (e.g., websites, marketing materials, company-provided public information).

Digbi Clinical and Economic Data Summary

Digbi Health had one single-arm study with low risk of bias, which found that the majority of participants self-reported symptom improvements on a custom scale.

One Digbi study—a retrospective analysis of participants who achieved 5% or more body weight loss when enrolled in the Digbi program—found that 89% of participants with functional GI disorders experienced symptom improvements measured by a custom scale in which patients self-reported symptom severity.^{2,3}

A separate economics-focused study presented cost savings, but not HCRU outcomes, using claims data that compared medical spending between participants enrolled in Digbi and nonenrolled matched controls.⁴ For participants enrolled in Digbi, the study reported gross savings of \$770 per member per month in medical spending among a small subgroup of 18 patients with digestive disorders. Reductions in medical nutrition therapy spending accounted for \$283 per member per month in gross savings. Because the program was designed to treat individuals with multiple co-occurring conditions, observed savings in the digestive subgroup likely reflect combined improvements across multiple conditions rather than costs attributable solely to direct dietary impacts on GI health. The study notes that these results should not be interpreted to suggest that nutrition-based interventions can reverse the economic burden of digestive conditions.



Notes: N/A = not applicable. N/A means that studies could not be rated. Risk of bias is assessed for studies, not articles. For ease of interpretation across risk of bias ratings, “Low” refers to original ratings of “Low Risk of Bias” (RoB2) or “Good Study Quality” (NOS), “Moderate” refers to original ratings of “Some Risk of Bias” (RoB2) or “Fair Study Quality” (NOS), and “High” refers to original ratings of “High Risk of Bias” (RoB2) or “Poor Study Quality” (NOS). See Appendix C-1 and C-2 for more detail on risk of bias ratings.

Digbi submitted nine additional articles that did not meet the inclusion criteria for this assessment. A complete list of references supporting the clinical and economic evidence summaries is provided in the Appendices of the assessment (Appendix B).

Company-Specific References

- ¹ Martha Shepherd, Pen-Che Ho, David Hines, et al., “A Health Economic Evaluation of Digital Digestive Care Management,” *American Journal of Managed Care* 32, no. 1 (2026): e5–e10.
<https://doi.org/10.37765/ajmc.2026.89872>
- ² Shreyas V. Kumbhare, Patricia A. Francis-Lyon, Dashyanng Kachru, et al., “Digital Therapeutics Care Utilizing Genetic and Gut Microbiome Signals for the Management of Functional Gastrointestinal Disorders: Results from a Preliminary Retrospective,” *Frontiers in Microbiology* 13 (March 2022): 826916. <https://doi.org/10.3389/fmicb.2022.826916>
- ³ Daniel E. Almonacid, Shreyas V. Kumbhare, Patricia Francis-Lyon, et al., “Digital Therapeutics Care Utilizing Genetic and Gut Microbiome Signals for the Management of Functional Gastrointestinal Disorders: Results From a Preliminary Retrospective Study,” *Gastroenterology* 162, no. 7 (2022): S1010.
<https://dx.doi.org/10.1016/S0016-5085%2822%2962398-9>
- ⁴ Inti Pedroso, Santosh Kumar Saravanan, Shreyas Vivek Kumbhare, et al., “Economic Impact of a Precision Nutrition Digital Therapeutic on Employer Health Costs: A Multi-Employer and Multi-Year Claims Analysis,” *Healthcare* 13, no. 23 (2025): 3147.
<https://doi.org/10.3390/healthcare13233147>