Rebuilding healthcare as it should be.

Integrated Physician Practice Section
June 7th 2019

David Buchanan M.D., M.S.
Chief Clinical Officer
Rebuilding healthcare as it should be.

Overview

→ Who We Are

→ Improving Outcomes and Capturing Value

→ Care Model Deep Dive

→ Q&A
Rebuilding Health
Care As It Should Be
Personal  |  Equitable  |  Accountable

- Primary care centers for adults on Medicare
- In medically-underserved communities (i.e., >50% dually eligible)
- Located in high-density, low-income areas to create access
- Integrate primary care, care management, transportation among other services
- Fully “at-risk” for all cost of care
We create access where it is needed the most

Our neighborhoods face significant socioeconomic challenges...

... exacerbated by a demonstrable lack of primary care access

Oak Street’s centers are located in medically underserved communities where primary care access is limited

We open our centers “de novo”, growing organically through community integration and patient education

The neighborhoods we serve tend to be lower income, and in fact nearly half of our patients are dual eligible

Each center has capacity for 3,500 patients, the majority of whom live within the radius of our transportation service

Every Oak Street employee shares a common passion to have positive impact in the communities we serve
40
CENTERS
(53 by August)

5
STATES
(7 by August)

11
HEALTH
PLAN PARTNERS

1,500
OAKIES

170
PROVIDERS

6
YEARS

>55,000
PATIENTS
Improving Outcomes

Capturing Value
Improving Outcomes
We cultivate a community of patients – focusing on education, engagement and experience

1. Patient and Community Engagement
   - A multifaceted engagement approach
   - Partnerships with local organizations
   - Beautiful community centers at each location with daily events
   - Concierge patient experience

2. Oak Street Care Model
   - Integrated clinical teams
   - Intensive management programs for high-risk/high-need patients
   - Enhanced services to fill “traditional system” gaps
   - Enterprise analytics platform to enable proactive population management
Patient and Community Engagement

Each Oak Street center is built to create primary care access for the neighborhood... and is designed with a retail look-and-feel to bolster a differentiated patient experience... and staffed to provide each patient the unparalleled care and experience they deserve.

- Neighborhood Outreach and Integration
- Fully Staffed Community Center
- Complimentary Transportation
- Small Panel Sizes and Dedicated Care Team
- No Wait / Same Day Appointments
- Longer and More Frequent Care
- Multilingual Staff and Care Teams
- Onsite Patient Relations

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<th>2,000</th>
<th>90%</th>
<th>92%</th>
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<td>New Patients Monthly</td>
<td>Organic Growth</td>
<td>Net Promoter Score</td>
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Oak Street Health Care Model

All powered by advanced analytics and BI to ensure continuous optimization and customization.
Capturing Value
Patient health is the shared goal in a value-based ecosystem

**Insurance Plans**
- Globally capitated arrangements shift “risk” to Oak Street Health
- Medicare-only focus ensures high level of engagement with MA plan
- Differentiated in-network independent primary care offering for members
- Results-oriented group: patient engagement, quality, and management

**Primary Care Providers**
- Rapid and visible positive impact on in-need patient population
- Care model focused on outcomes, not volume
- Tools, analytics, and resources to enable true population health
- Ongoing emphasis on provider engagement and development

**Medicare Patients**
- Curated and concierge-level experience
- Access to care that focuses on eliminating barriers
- Meaningful and lasting relationships with Care Team
- Community orientation with opportunities to socialize and learn

Medicare Advantage creates natural alignment between payers, providers, and patients to focus on quality and prevention
Capitated risk agreements align our incentives to outcomes

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<th>Lines of Business</th>
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Care Model Deep Dive
Oak Street Health patients are historically underserved, with a high disease burden and complex behavioral and social needs.

### Demographics

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<th>100% patients are on Medicare</th>
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<td>• 42% are dual-eligible for Medicaid</td>
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<tr>
<td>• Average income &lt;$21,000</td>
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**Average Age: 68**

| 65 – 74: 52% |
| 75 – 84: 23% |
| ≥85+: 5% |

>92% live within 5 miles of their OSH center

### Disease Burden

**Average of 4+ chronic conditions**

- ~75% Hypertension
- ~40% Diabetes
- ~20% CHF
- ~20% COPD
- ~5% CKD IV / V
- ~5% Cancer

**Average of 7.2 medications**

5% of patients drive >50% of the total medical costs (“OSH VIPs”)

### Behavioral and Social Needs

>35% with Depression

>20% with Substance Abuse / Dependence

Majority of patients with 1 or more social needs related to:

- Housing / Shelter
- Food
- Isolation / Loneliness
Team based primary care coupled with enhanced clinical services and intensive interventions for highest risk patients

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<th>Primary Care Team (Center-based)</th>
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<td><strong>Physician or NP</strong></td>
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<td><strong>Nurse</strong></td>
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<td><strong>Medical Assistant</strong></td>
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<td><strong>Scribe</strong></td>
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<th>Enhanced Clinical Services</th>
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<td>Available at all centers</td>
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<tr>
<td>• Behavioral Health Therapy</td>
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<td>• Tele-psychiatry</td>
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<tr>
<td>• Social Work</td>
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<td>• Podiatry</td>
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<tr>
<td>• On-site pharmacy (~50% of locations)</td>
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<th>Intensive Management</th>
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<td>For high-risk (VIP) patients</td>
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<td>• “Complex Care Team” (NP, Social Work, Pharmacist) conducts House Calls for high risk patients</td>
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<td>• Transitions in Care (RN Case Manager)</td>
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<th>Clinical Contact Center</th>
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<td>Central service supporting all of OSH</td>
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<tr>
<td>• 24/7 RN hotline, with escalation to provider</td>
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<tr>
<td>• Outbound Rx Interventions</td>
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<tr>
<td>• Patient Engagement</td>
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<td>• Referral Management</td>
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<th>Treehouse Teams</th>
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<td>Centrally-based <em>Treehouse Teams</em> build and support Care Teams with infrastructure data/reporting and shared services</td>
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<tr>
<td>Medical Director</td>
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<td>Population Health</td>
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Our proprietary data platform structures and monitors every element of care

Canopy, an enterprise single sign-on tool, integrates data across all platforms to provide actionable insights and drive workflows to accelerate operational efficiency and effective clinical management and oversight.

**Proprietary Enterprise Data Warehouse**
- 8 platforms
- 1300+ defined data fields

**Clinical and Business Rules**

**Care Model Modules**
- Inpatient Review
- High Risk Patient Panel
- Care Report (HCC)
- Consults (Rx, BH)
- Huddle Form (Daily Gap Closure)
- Blue Button / Med. Records
- STARS Registry (Quality)
- Patient Rooming
- Care Report (HCC)
- Consults (Rx, BH)

**Business / Ops Modules**
- Touchpoints (Patient Engagement)
- Patient Check In/Out
- “My Center” (Practice mgmt.)
- Inpatient Review
- High Risk Patient Panel
- Care Report (HCC)
- Consults (Rx, BH)
- Huddle Form (Daily Gap Closure)
- Blue Button / Med. Records
- STARS Registry (Quality)
- Patient Rooming
- Care Report (HCC)
- Consults (Rx, BH)

**Business Intelligence / Reporting**
- Provider / Center Performance
- Med Econ Insights
- KPIs
A patient’s journey with OSH is personalized based on an individualized care plan

**Mrs. Smith**
- Hasn’t seen a PCP in 18 months
- Signs up for an initial Oak Street Health visit with free transportation at an Oak Street community event at local housing center

**INTAKE**
- Welcome Visit
  - Meet your Care Team
  - How to work with Oak Street
  - 3 weeks later
- Wellness Review Visit
  - Full H&P
  - Medical Record Synthesis
  - CMS AWV aspects

**CARE PLAN DEVELOPMENT FOR ONGOING CARE**
- Ongoing Primary Care Visits
  - Visit Frequency set by internal risk algorithm and provider judgement
- Care Plan established based on full patient need
  1. Uncontrolled Diabetes
  2. Previous CHF exacerbation resulting in hospitalization due to medication non-compliance
  3. Ongoing depression episodes due to recent loss of loved one
  4. Loss of Medicaid status 6 months prior due to change in state forms

**FOR ONGOING CARE**
- Medication reconciliation by OSH Pharm-D with ongoing medication adherence reminders
- Connect with Behavioral Health Specialist for counseling / therapy; tele-psychiatry as needed
- Medicaid Application Review with OSH Patient Relations Manager

**Group Education classes in OSH Community Room**
- Group Education classes in OSH Community Room
Patients benefit from our Care Model: Results to date

- ~45% reduction in Hospital Admissions
- ~52% reduction in ED Visits
- ~35% reduction in 30-day readmission rate
- 5 Star on HEDIS measures
- 92% Net Promoter Score
- >90% Retention Rate
Where Oak Street is growing

- Geographies (existing and new)
- Patients
- Enhanced Services and Patient Experience