What if Pop Health was the Main Course?

March 2018

Iora Health

Pure-play Consumer-centric, Value-based, Digitally-Enabled De-novo Provider Group

Primary Care is the Right Attachment Point

Primary Care is uniquely positioned to be the chassis for population management

Improve Health

- Food
- Exercise
- Stress
- Relationships

Population Management

Improve Navigation

- Coordinate with specialists
- Co-manage in hospital
- Streamline pharmacy

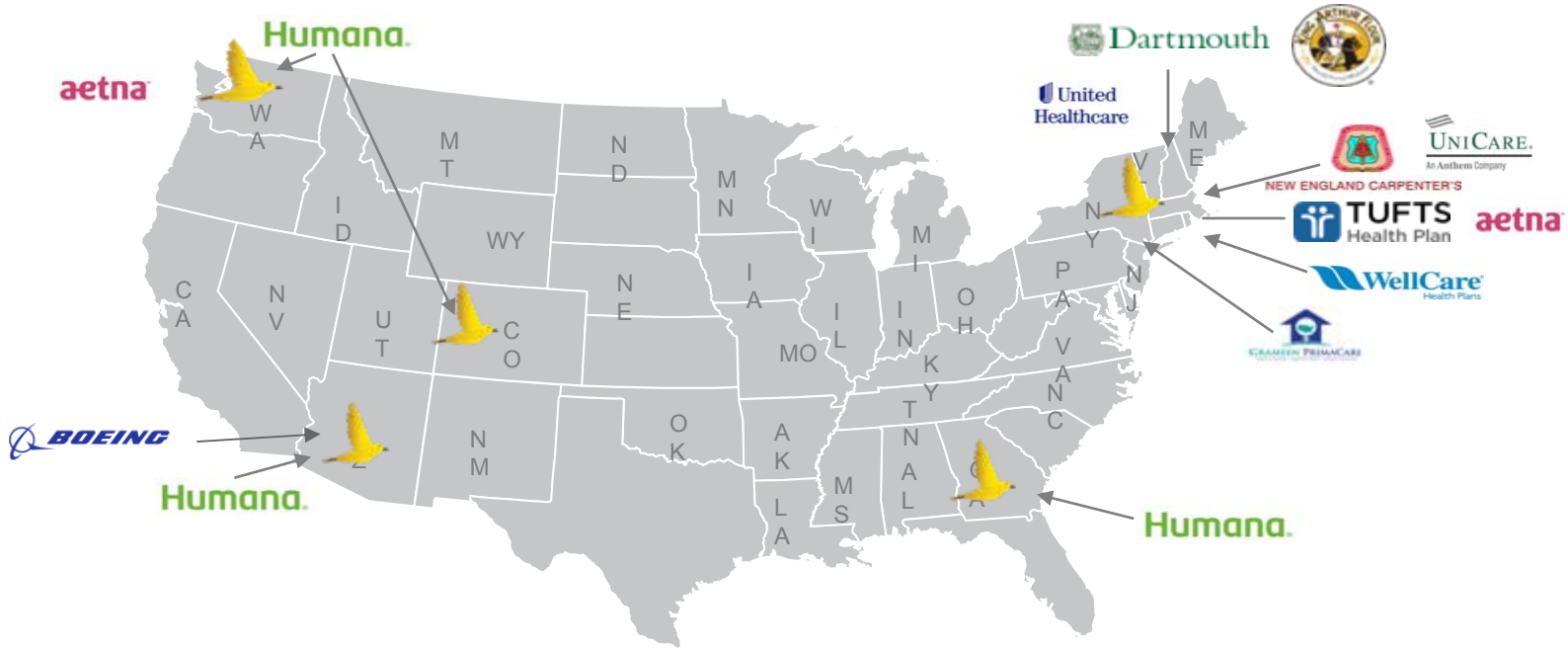
From Transactions to Relationships

"I think the biggest problem with healthcare today is not the cost, but for all this money its not an expression of our humanity"

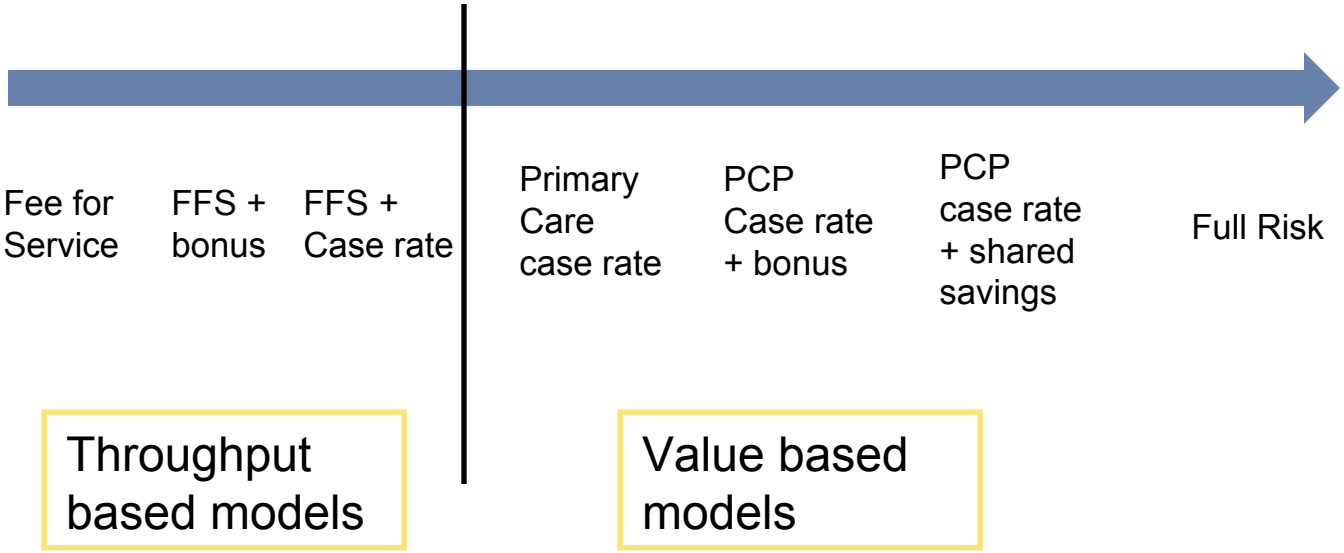
- Jonathan Bush

Working with Sponsors

- Contract with Progressive Employers and Insurers for purely value based contracts
- **By the end of 2018, Iora will serve about 30,000 patients in 36 locations nationally**



Change the Business Model



Built for purpose practices

The Team

iorahealth

Morning Huddle

Redesigned Visits

Integrated Mental Health

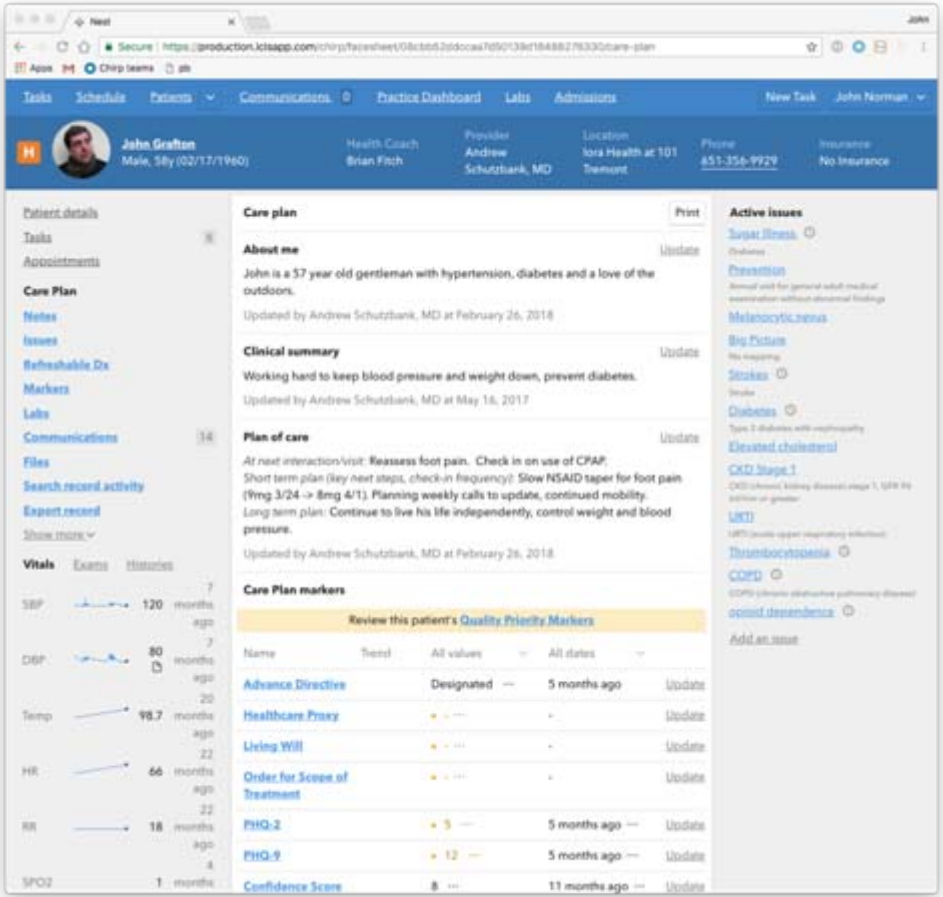
Clubs

Doing whatever it takes

Chirp

(for staff)

- Iora's Collaborative Care Platform
- Web-based, Available Anywhere
- Built for Iora's Care Model
  - Care Teams & Patients
  - Caring for a Population
  - Winning in Value-based care
- Data at the point of care
- Clinical & Engineering together



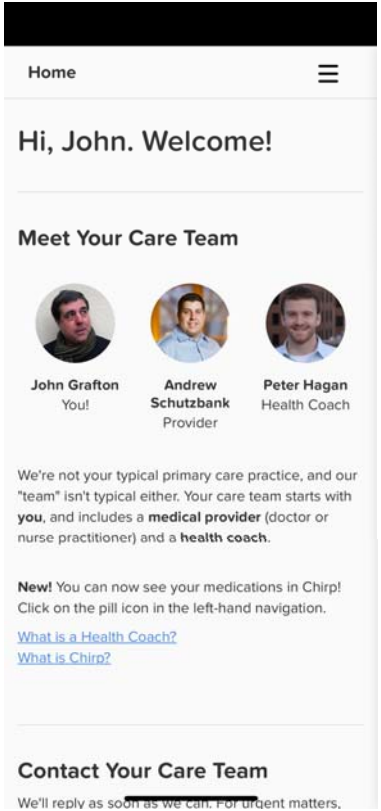
Small agile team

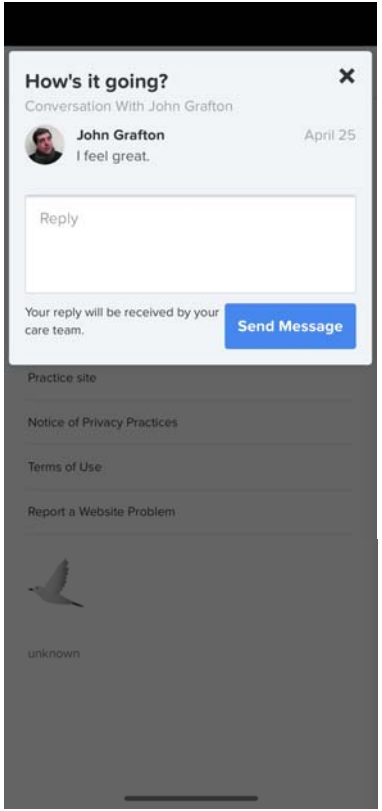
We don't (and should not) do everything . . .

Chirp

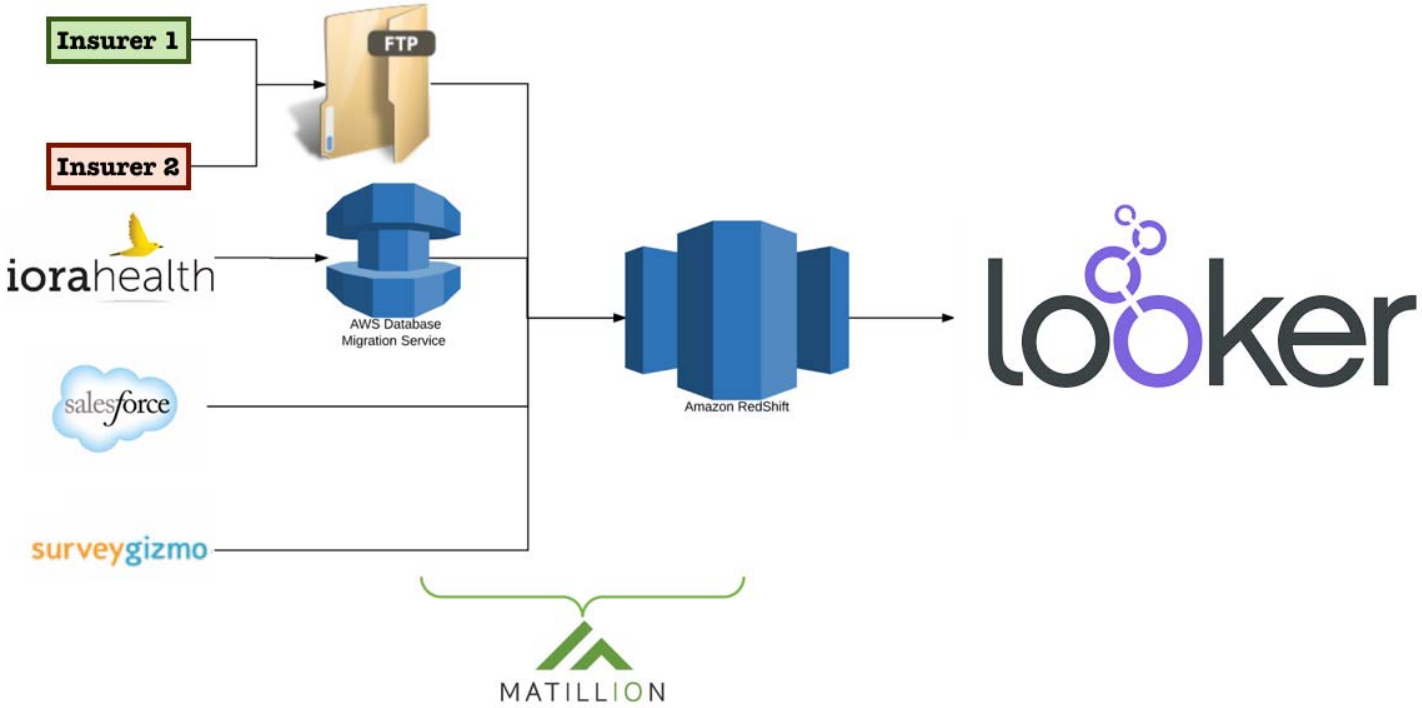
(for patients)

- Care Team Communication
- Information
  - Lab Results
  - Shared Notes
  - Documentations
- Online Scheduling
- Send data
- Web-based, any Device





Data infrastructure



Shared Care Plans

Tasks | Schedule | Patients | Communications | Practice Dashboard | Labs | Admissions

Documentation | Labs | Communications 0 | Medications | Files | Wide Lens | Appts | Tasks

Samuel Thomas

74Y/M: Add Headline

Basic info Copy

Patient demographics are incomplete.

DOB	05-11-1943
Gender	Male
Phone	396-261-6255
Email	Send email
Patient App	Declined
Insurance	N/A
Health Coach	Dave Garrett
Provider	Ellie Hastings

Vitals Exams | Histories

SBP	140	130d
DBP	90	130d
Temp	98.6	130d
HR	82	130d

Care plan

About me Update

What matters to you most in your life? Independence
What do you want your health for? Enjoying life without having to worry about illness
What are some things you want to accomplish? Go to Haiti next year for my family reunion
Who provides support to you? Caretaker, Sandra, is a main point of contact and will join me during my visits.
What prevents you from achieving your goals? I don't get around as much these days because of my foot pain.

Updated by Peter Hagan at August 14, 2017

Clinical summary Update

One-line clinical snapshot: Samuel's medical conditions include cirrhosis decompensated by ascites, anemia, atrial fibrillation, chronic hypoxemia.
Reason for current concern: More recently foot pain, joint stiffness, and mobility have been an issue, with probable diagnosis of polymyalgia rheumatica, improving with trial of steroids.
Barriers to care: Speaks Haitian Creole, caretaker Sandra translates for Samuel
Extended care team/Key specialists:
Cardiology - Dr. Sadhair Matak 245-241-2782, Dr. Antony in regular touch with
Hepatology - Dr. Terese Quinn 245-261-3562

Updated by Peter Hagan at August 14, 2017

Plan of care Update

At next interaction/visit: Reassess foot pain, oxygen. Check in on use of CPAP.
Short term plan (key next steps, check-in frequency): Slow steroid taper for PMR (9mg 3/24 -> 8mg 4/1). Planning weekly calls from Samuel/Sandra to update, continued mobility
Long term plan: Continue to live his life independently, control ascites with medications (successful thus far with last paracentesis ~9/2016). Samuel continues to want to avoid aggressive medical care. He is open to ER/hospital visits, but would prefer to avoid them if at all possible -- try DispatchHealth or office visit first. Were he to worsen in his health, he would want to be made comfortable. He wants Sandra to be his M-POA.

Personalized Markers

Diabetes Markers

Priority | All

Core markers	Value	Date	Goal	
BMI	23.1 kg/m²	6 days ago	18.5 < x < 25.0	
SBP	92 mmHg	6 days ago at 11:25am	<140	
DBP	58 mmHg	6 days ago at 11:25am	<90	
• LDL (Direct)	--		<100	
LDL (Calculated)	79 mg/dL	157 days ago	<100	
HbA1c	6.6 %	48 days ago	<7.0	

Labs	Value	Date	Goal	
• HDL	81 mg/dL	447 days ago	>40	view history
• microalb/cr	7 mg/g	451 days ago	<30	view history
• Fasting Glucose	--		<100	

Exams & Screenings	Value	Date	Goal	
• Eye exam	Done	365 days ago	Done	view history

The Daily Huddle

Huddle Agenda

5 min — Kickoff
- Visitors

5 min — Announcements
- Practice Ops
- Newsletter Updates
- Other

15 min — Concerned List
- Hospitalized & ER patients
- Overnight Calls & Voicemails
- Who Needs Us Most

5 min — Today's Schedule
- Chirp Schedule
- Self-Scheduled Patients
- Access (Plan for Urgent Visits)
- Front Desk Coverage
- Tomorrow's Schedule

5-10 min — Teaching Topic

5 min — Close Huddle
- Small Victories

Visit pre-planning: daily schedule / Gaps view

and returning). New patients will show up as having gaps based on their age range, as nothing is yet documented in Chirp.

Why	Most Recent Provider Visit	Iora Priority Quality Gaps	All HCC Gaps	Flu Vaccine Status Redshift	Current BP Status	Last Text Advance Directive Value	Phq2 In Last Year (Yes / No)
Initial Vist	∅	Mammogram; Colorectal cancer	∅	Due	Not in Control	∅	No
Bloodwork: A1c	2017-08-02		∅	Up to date	In Control	counseled	Yes
[Rescheduled] F/U PNA (PP; made & confirmed 11/10)	2017-08-03	Diabetic Eye; Hypertension; Mammogram	∅	Due	Not in Control	counseled	Yes
[redacted] - Initial visit, Amy will enroll in Bouncah on Nov 1	∅	Mammogram; Colorectal cancer	∅	Due	Not in Control	∅	No
Flu shot	2017-08-11		∅	Due	In Control	counseled	Yes

Embedding Population Health

Core Approach to Quality

- "Markers" prompt and capture Stars data
- Coach follows up as panel/population health manager
- Review real-time performance data
- Transmitted via supplemental file to health plan

L Low Complexity Healthy *Review every 6 mos*	**M** Medium Complexity Controlled Chronic Illness *Review every 3 mos*
H High Complexity Uncontrolled Chronic Illness *Review every 30 days*	**E** Emergent In Crisis *Monitor daily*

Panel Rounding to Plan Care and Outreach

- ~3 hrs blocked time per coach per week
- Guided by Iora Worry Score
  - Team Review for High Worry Score
  - Coach Quality Review for Low / Medium Worry Score
- Integrate multiple data sources
  - Claims, markers, psychosocial

Close Coordination of Complex Patients

Admissions Add admission

Currently admitted

	Patient	Admitted	Discharged	Duration
Abrazo Central				
Pain Left leg		Mar 4, 2018		1 day

TN Contact Hospital Team: UNENGAGED, Peoria **DOB 12/31/1951**
EMR Review: Negative DVT. Fever, UTI, cystogram before removing foley
Care Team Contact Patient/Family:
Anticipated Discharge Date:
Med Rec(TN/MD/RN):
IPC Appt:
Next Steps/Owner- Teresa to follow

Charlotte Gurule, MD Teresa Harvey, RN

	Patient	Admitted	Discharged	Duration
Choice Rehab				
s/p Sepsis, afib		Mar 3, 2018		2 days

DOB: 10/15/1931
TN Contact Hospital Team:
EMR Review:
Care Team Contact Patient/Family: 3/5: Spoke with wife and patient
Anticipated Discharge Date: TBD
Med Rec(TN/MD/RN): TBD
IPC Appt: TBD
Next Steps/Owner: Follow rehab stay

Admission type
- (•) All admissions
- ( ) Inpatient hospitalization
- ( ) Skilled nursing facility
- ( ) Observation
- ( ) Emergency room
- ( ) Other (LTAC, acute rehab, etc.)

Admission status
- ( ) All admissions
- (•) Currently admitted
- ( ) Discharged in last 3 days
- ( ) Discharged in last 30 days
- ( ) Future admissions

Iora staff and specialists
× Teresa Harvey, RN
× Joshua Reischer, MD

Key Activity Metrics

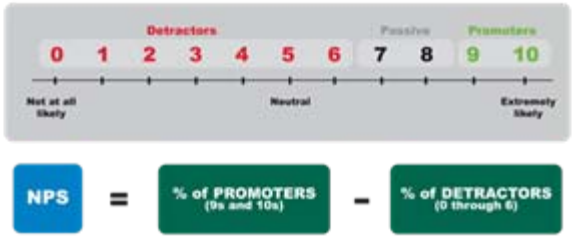
Every practice manager and market leader is accountable for managing against ~15 key operational and clinical metrics on daily / weekly / monthly basis

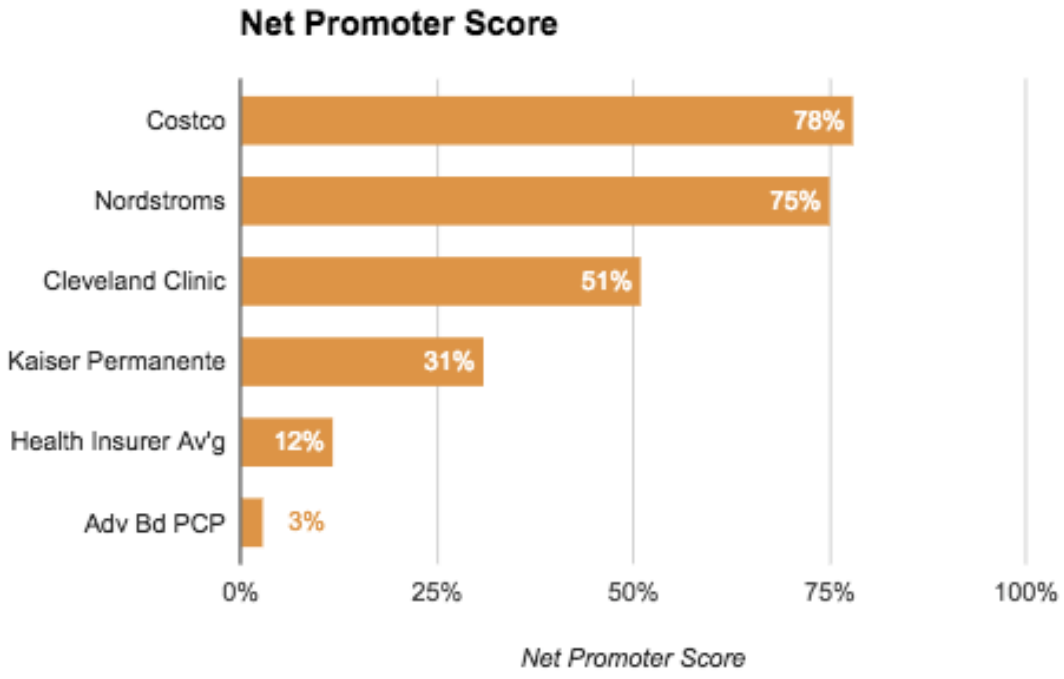
Examples of Metrics

- ❑% of High Worry Score patients with an updated care plan in last 30 days
- ❑% of High Worry Score patients with advanced directives designated.
- ❑Review of clinical suspects discussed with Market Medical Director
- ❑% of established patients with at least one provider visit
- ❑% of admitted patients with medication reconciliation by RN/Provider within 30 days of discharge
- ❑% of new patients fully onboarded within 60 days of assignment

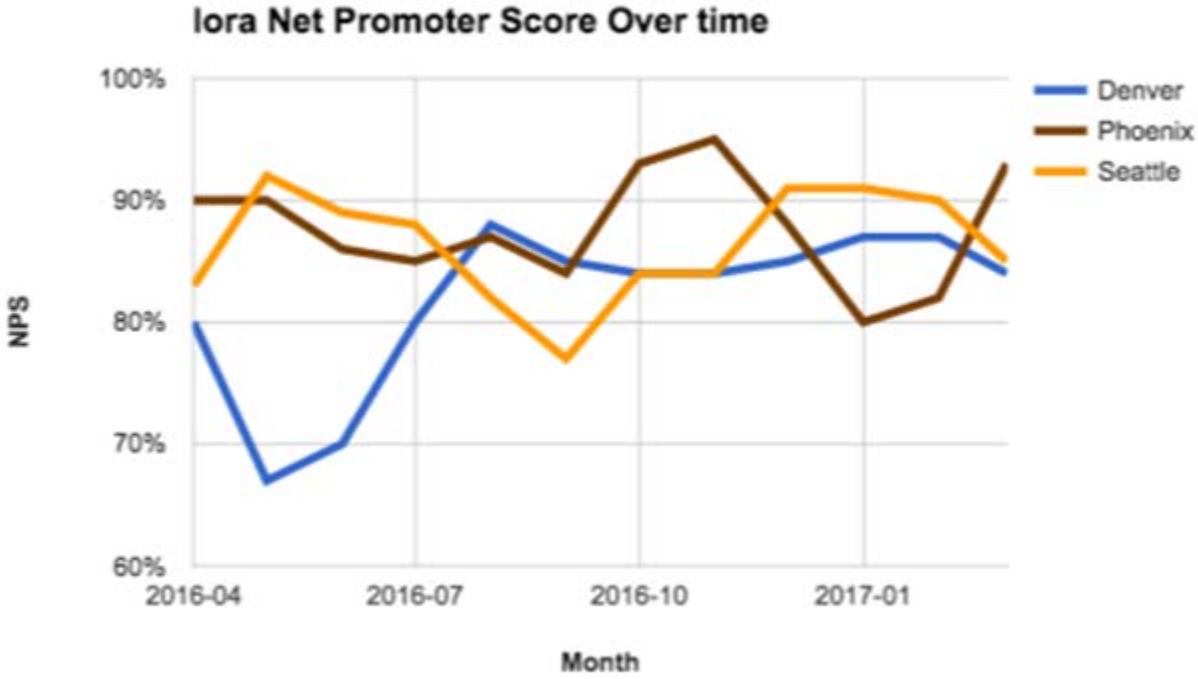
Net Promoter Scores

How likely are you to refer this to a friend of colleague? (0-10 scale)

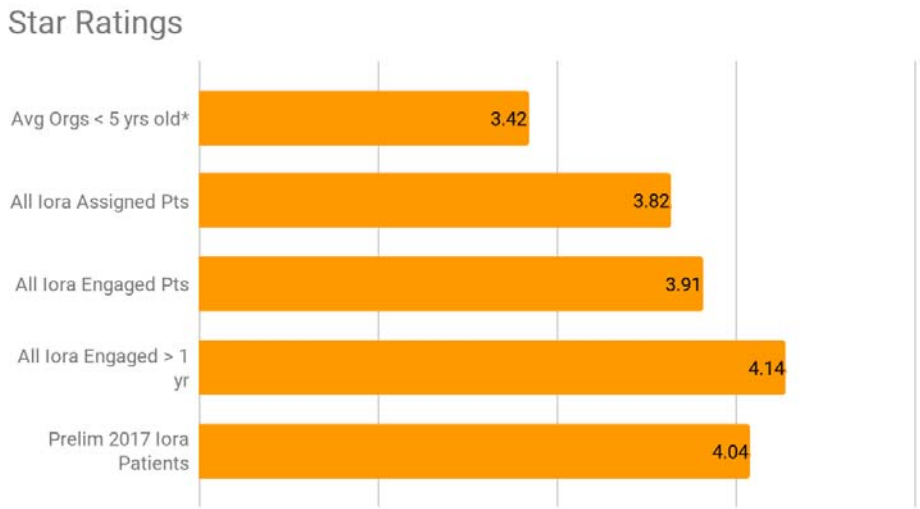




Iora Net Promoter Scores



Strong and Improving Quality

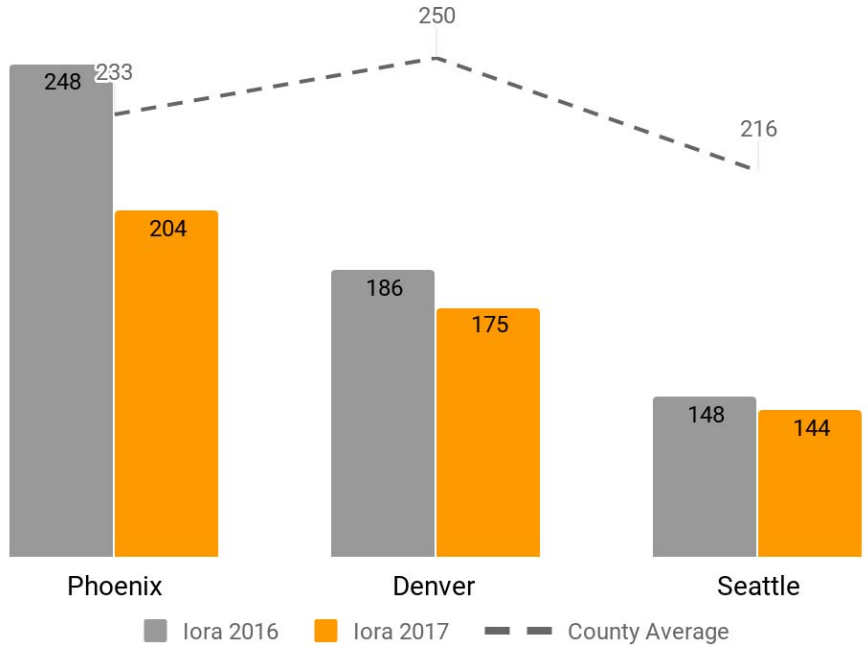


Preliminary Data 2017 Patients: **Star ratings 4.04**

*http://healthcare.mckinsey.com/assessing-2017-medicare-advantage-star-ratings

Reducing Hospital Admission

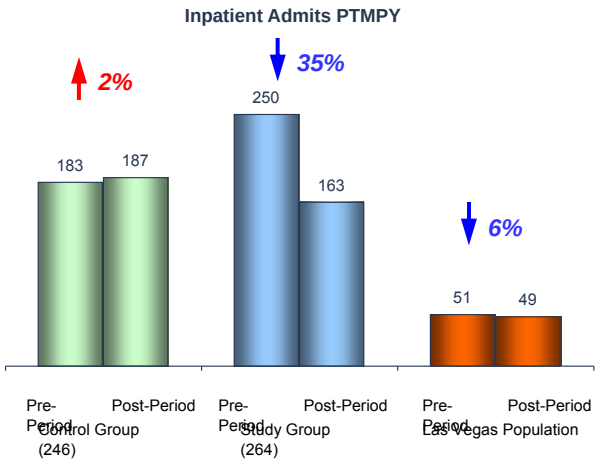
2016 and 2017 Inpatient Hospital Admissions per 1000

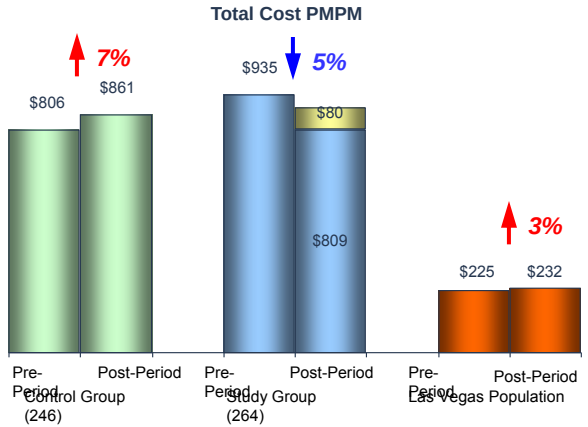


Iora significantly outperforms county Medicare benchmarks.

Rigorous analysis shows large economic value creation even after just 1 year, especially with sicker populations

In an analysis done by the Culinary Fund, inpatients admits were down 37% and total spend down 12% relative to matched controls after 1 year



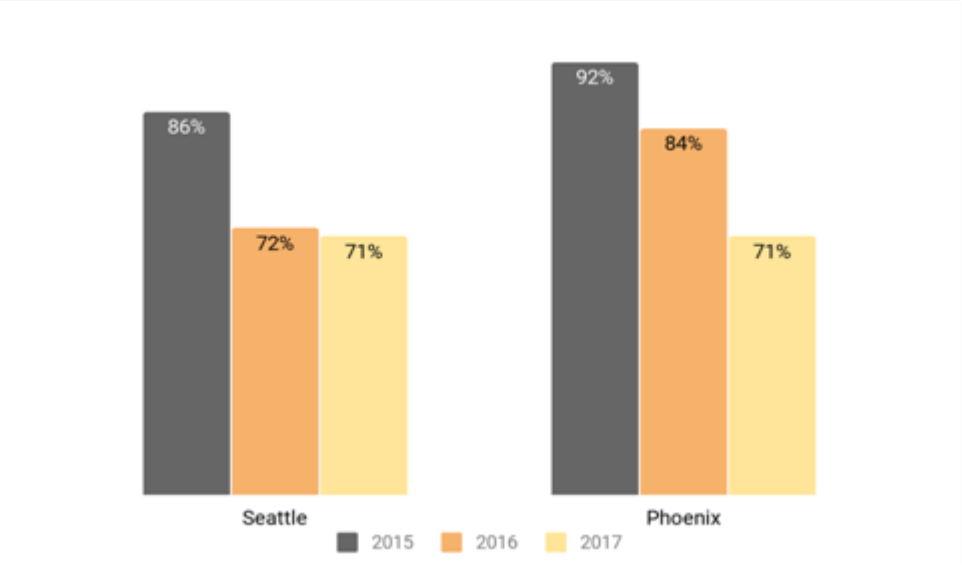


This does not even yet capture the economics of better health

Data Source: LV Claims Database

MER Performance Over Time

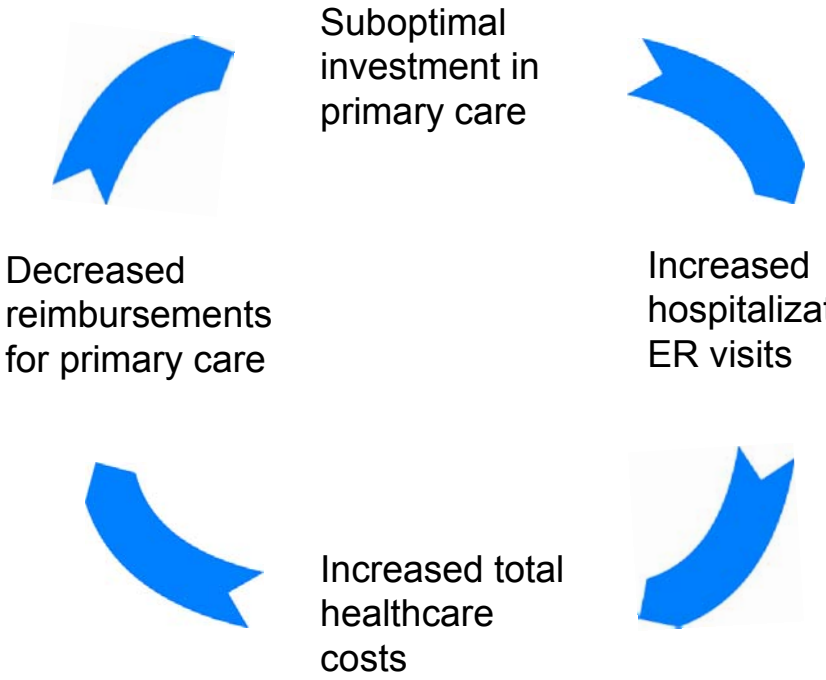
MER Trend for 2015 Cohort Assigned Patients



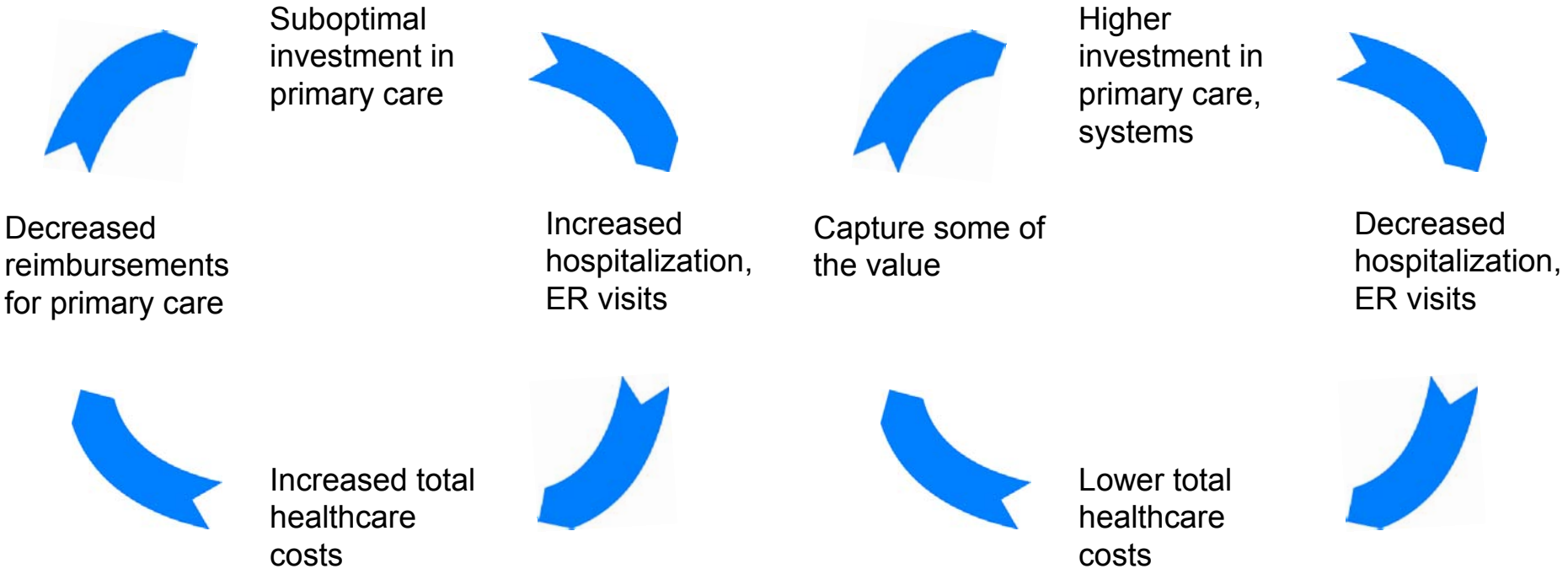
Over 20 percentage points MER improvement

Initial patients realize dramatic improvements in MER over time.

Setting up the right cycle



Setting up the right cycle

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