The Power of Primary Care Transformation

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CHESS

Our Mission:

To empower providers to make the transition to value-based medicine

Our Vision:

To be the force across the nation that builds healthy communities
by enabling coordinated and sustainable care

Our Values:

Collaboration, Innovation, Fairness, Integrity

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Innovation changes how services are delivered.

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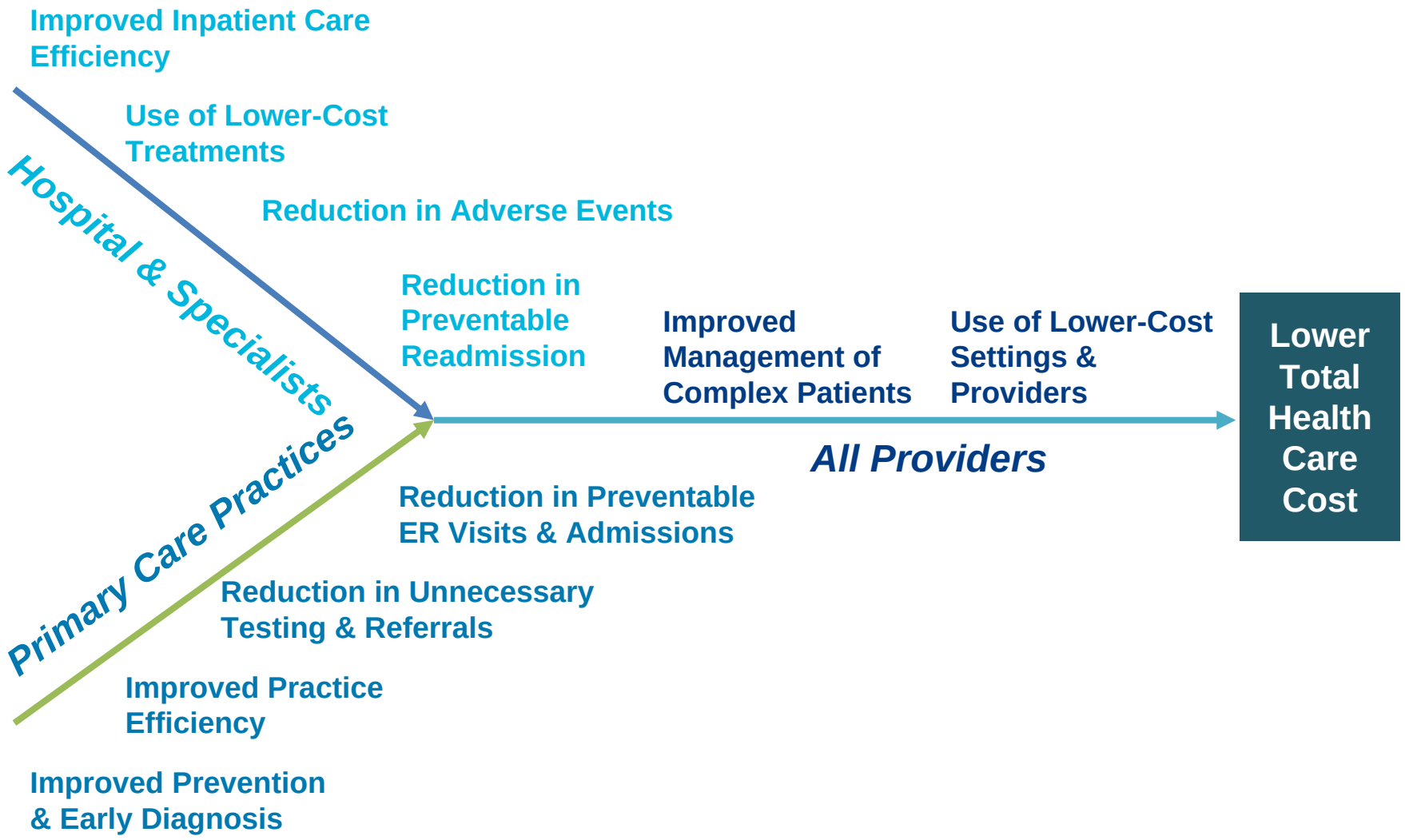
Opportunities for cost reduction and quality improvement require realignment of the health care ecosystem into a new value chain.



Mission:

To be your medical home

Vision:

To be the model for physician-led health care in America

Values:

As a physician owned and directed company, we are committed to ensuring that patient care is efficient, effective, equitable, patient centered, safe, and timely

CORNERSTONE
HEALTH CARE

Cornerstone's Timeline

1995

January
- Cornerstone Health Care formed
- CHC on EMR

2007

January
- Westchester Building built
- Extended and weekend hours now offered

2008

January
- Premier Building built
- NCQA Medical Home designations

2010

December
- CHC goes live on Humedica Mindshare
- Revised MVV

2011

March
- PCA Program launched
- Adoption of new Cornerstone Credo

July
- Service Lines implemented

October
- Shareholders vote to move to PFV

2012

January
- CHC & Oliver Wyman Redesign
- Care Pathway Redesign
- Optum & Teradata Tech partners
- VBR: Negotiating Contracts

March
- Personalized Cardiac Care Program launched

April
- Personalized Cancer Care w/ embedded Primary Care launched

June
- CHC opens its first practice in Hickory

July
- MSSP ACO Personalized Primary Care Program launched

2013

January
–Value-based compensation formula implemented

February
- Care Outreach & Life Care Clinics launched
- Transitions of Care implemented
- Launch of CHESS

November
- Rite Aid Alliance
- Labcorp Partnership
- Strategic Partnership with WFBMC & CHESS

2014

January
- 13 CHC practices earn 2011 PCMH Recognition
- COPD Model Launched

March
- FastMed partnership

April
- Cornerstone Convenience Care opened at Westchester building

July
- Shareholders approve Cornerstone Compact

December
- Gainshares paid out
- Catawba Valley Medical Center signs contract with CHESS
- Received highest quality score in NC & ranked 6th in the nation on quality

2015

January
- CHC goes full-risk
- CHESS MSSP ACO
- CHESS Select
- Lightbeam launch
- Nephrology Medical Home Launched
- Touchcare telemedicine begins
- Livongo launched

April
- Cornerstone Convenience Care opened at Premier building

October
- AMGA Acclaim Award Winner

2016

January
- CMS NextGen ACO participant

Care Model Number One:
Personalized Primary Care Program

Team:

Top 20% of patients

Health Navigation

Care Coordination and Outreach (PCAs)

Health Coaching (Rite Aid)

Patients Enrolled:

PPCP A	PPCP B
678	**539**

Readmissions:

ED% chg A
-42%

ED% chg B
-54%

Hosp% chg A
-53%

Hosp% Chg B
-54%

Estimated Savings:

A
$.5 Million

B
$2.2 Million

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Care Model Number Two:
Personalized Life Care Program

Team:

Internist with focus on chronic disease management

Health Navigation

Embedded Pharmacist

Licensed Clinical Social Work

Extended Office Visit times

Home visits

Patients Enrolled:

261

Readmissions:

ED% chg
-36%

Hosp% chg
-74%

Estimated Savings:

$1.43 Million

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Care Model Number Three:
Cornerstone Care Outreach Clinic

Team:

Medical Director
LCSW
Consultant psychiatrist (IMPACT Model)
Pharmacist

Initial focus on Dual Eligible patients

Patients Enrolled:

IMPACT Model
138

Total
>600

Clinical Impact:

ED% chg
-60%

Hosp% chg
-64%

Estimated Savings:

$1 Million

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Care Model Number Four:
Cornerstone Cancer Services

Team:

5 hematologist/oncologists
Tumor lines: breast, lung
Director of Psychosocial Oncology
Tumor line specific Health Navigators
Nutritionist
Pharmacist
Chaplain
Embedded Internist for primary care needs

Patients Enrolled:

Breast Cancer	Lung Cancer
325	**220**

Clinical Impact:

Ed % Chg
-84%

Hosp % Chg
-27%

Estimated Savings:

$1 Million

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Care Model Number Five:
Cornerstone Heart Function Clinic

Team:

Three lead physicians
Health Navigator
Nurse Practitioner
Tightly aligned psychologist
Dedicated pharmacist available remotely
Nutritionist

Patients Enrolled:

321

Clinical Impact:

Ed % Chg
-41%

Hosp % Chg
-54%

Estimated Savings:

$1.8 Million

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Care Model Number Six:
Chronic Obstructive Pulmonary Disease

Team:

Dedicated Pulmonologist

Health Navigation (RT v. RN)

Dedicated pharmacist available remotely

Emphasis on identification and management

Patients Enrolled:

Patients currently being enrolled.

Readmissions:

Reduction from 12% to 6%

Estimated Savings:

Pending

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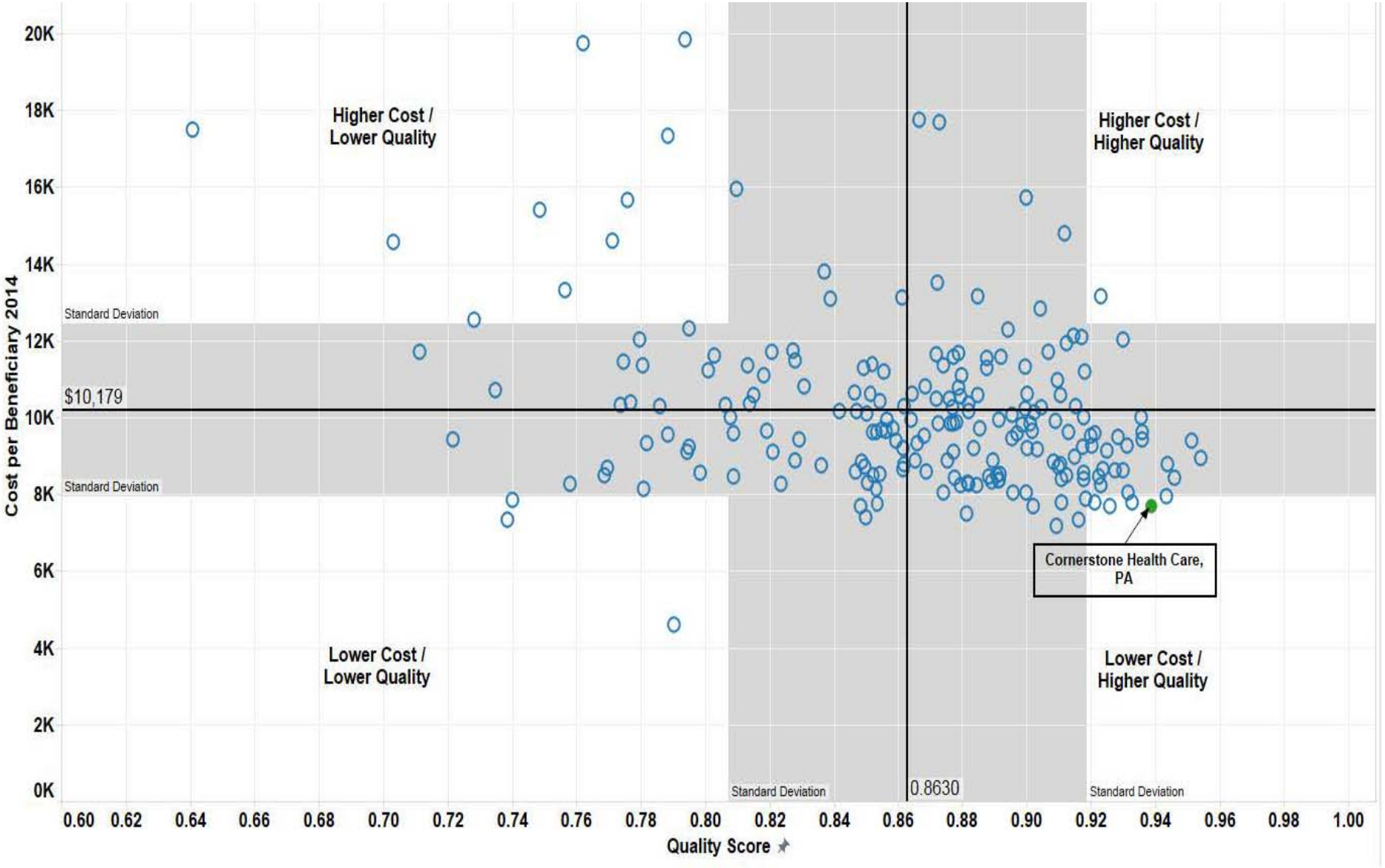
The new care models significantly altered the cost and utilization by service area.

	Cornerstone Heart Function	Cornerstone Life Care	Cornerstone Care Outreach Clinic	Cornerstone Personalized Primary Care
Overall program	-13.7%	-10.7%	-16.1%	-13.6%
Inpatient Hospital	-32.5%	-13.3%	-23.3%	-44.9%
Outpatient Hospital	16.1%	-19.1%	-26.7%	40.2%
Home Health	71.5%	-19.9%	-0.6%	18.6%
SNF	-4.2%	-28.9%	-98.1%	91.3%
Office	49.6%	17.4%	18.4%	-8.6%
ED	-24.6%	16.7%	8.1%	-28.4%
Injectable Drugs	68.0%	-33.5%	-57.0%	-50.9%
Laboratory	-8.4%	35.8%	-5.4%	-26.0%
DME	106.0%	-36.1%	38.6%	-31.8%
Adv. Imaging	-3.5%	-38.9%	-47.3%	-19.2%
ASC	4.9%	-34.7%	992.4%	-43.1%
Rehab (PT/OT)	-100.0%	-88.0%	-78.5%	-47.3%
Other	91.1%	121.5%	105.1%	209.0%

Care model program summary results:

	Heart Function Care Model	Life Care Extensivist Model	Care Outreach Dual-Eligible Care Model	Personalized Primary Care Poly-Chronic Care Model	Aggregate for Fully Implemented Programs
# of patients in study sample	21	56	25	159	**261**
Avg. per person spend in year prior to study	$40,284	$51,289	$23,616	$18,574	**$30,771**
Avg. per person spend in study year (actual)	$34,754	$45,815	$19,805	$16,051	**$26,876**
Predicted avg. per person spend in study year	$38,583	$63,374	$35,900	$26,631	**$38,224**
Aggregate spend in year prior to study	$845,957	$2,872,164	$590,403	$2,953,340	**$7,261,863**
Aggregate spend in study year (actual)	$729,840	$2,565,657	$495,130	$2,552,148	**$6,342,775**
Predicted aggregate spend in study year	$810,246	$3,548,963	$897,500	$4,246,625	**$9,503,334**
% change (prior to actual)	-13.7%	-10.7%	-16.1%	-13.6%	**-12.7%**
% change (prior to predicted)	-9.9%	-27.7%	-44.8%	-40.0%	**-33.3%**

Our performance in the Medical Shared Savings Program the first year of the care models was strong.



How do we tap the power of primary care transformation?

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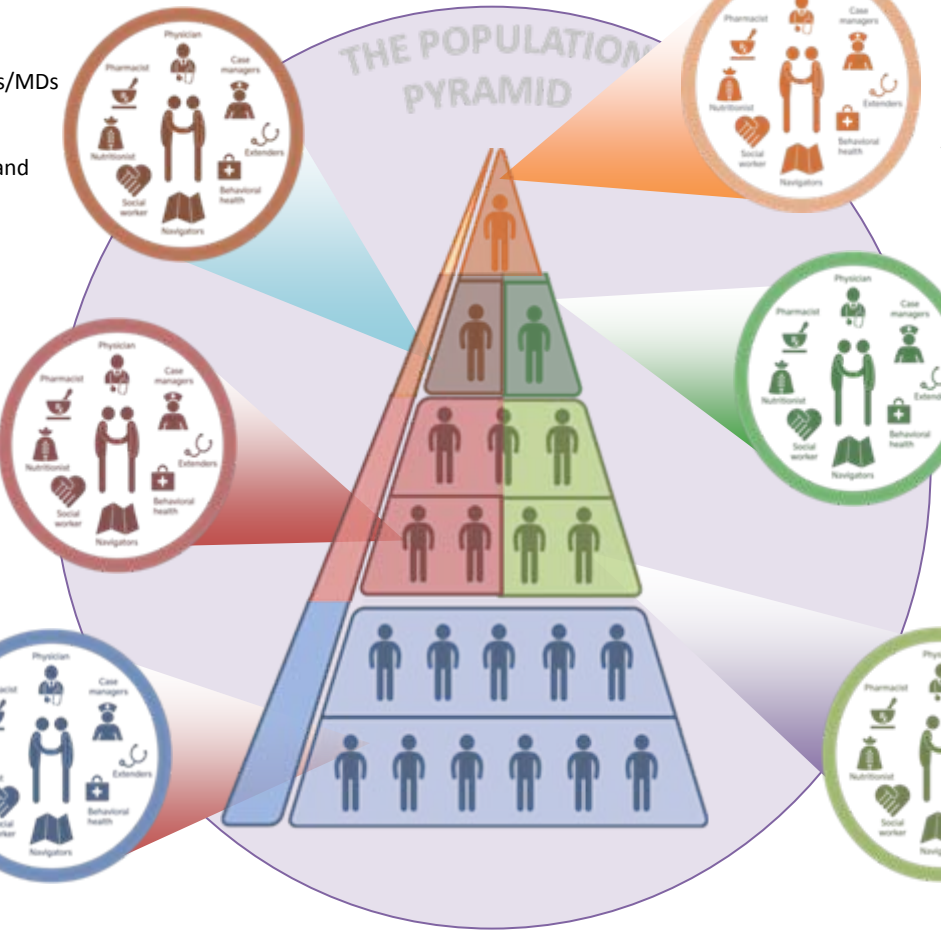
Next generation PHMs will thrive on complex adaptive systems that are highly-tailored to particular segments of the population.



Severe behavioral
- Dedicated psychiatric NPs/MDs
- Bio-monitoring of Rx adherence
- Dedicated social worker and PCP
- Etc.

Chronic with social needs
- Case worker embedded in care team
- Dedicated coach focused on nutritional and mental health needs
- Etc.

Generally healthy
- Affordable acute care options
- Rewards and incentives
- Social/mobile health tracking tools
- Etc.

End of life
- Palliative care experts
- Support for caregivers
- Hospice centers
- Legal/financial advisers for family
- Etc.

Potential Care Model Components

Poly-chronic/complex
- Dedicated "Extensivists"
- Remote monitoring
- Specialty clinics
- Integrated behavioral health
- Etc.

Early chronic/at-risk
- Dedicated health coach focused on fitness, nutrition
- Attention to behavioral health
- Rewards for meeting health goals
- Etc.

Specialized care models will be supported by new population-specific ecosystems

Begin with what we know:
Identify Patient Populations & Opportunity

Poly-chronic patients

Chronic & complex conditions

Cancer

Kidney failure

Multiple co-morbidities

Heart failure

COPD

Diabetes

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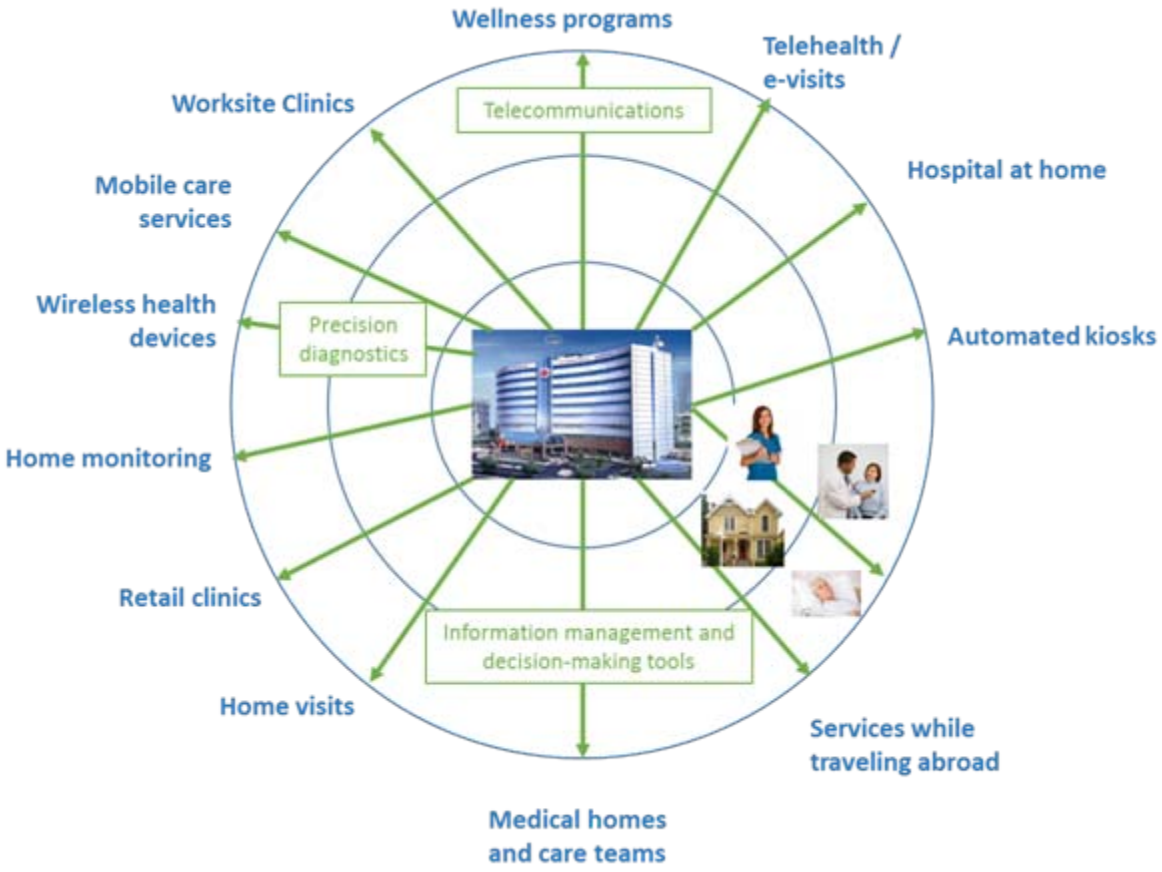
Understand that a new ecosystem of disruptive business models will arise.



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New competencies are required to support the population health management business.

- Care Coordination
- Clinical Performance Management
- Effectiveness Analysis
- Financial and Clinical Risk Management
- Patient Engagement
- Patient Safety
- Physician Development and Training
- Smart Care Teams
- Value-Based Contracting

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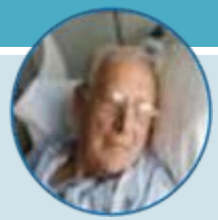
Models of care must be designed around the patient's needs, not the tyranny of the 15 minute office visit.

HEALTHY

Populations Health Segments

FRAIL

Healthy and Independent	Health Risk Factors	Early Stage Chronic Disease	Complex Conditions	Late-stage or poly-chronic
				
No chronic conditions and free of key risk factors	No major conditions with one or more risk factors	Chronic condition that is well-controlled and now substantially progressed	Systematic or otherwise complex condition	One or more chronic conditions that are uncontrolled or advanced
Normal weight Non-smoker	High cholesterol High blood pressure Smoker	Diabetes Asthma Coronary artery disease	Cancer Multiple sclerosis Cystic fibrosis	Congestive heart failure End-stage renal disease

Team based care model redesign is crucial…

…and it requires reorganization of the health care work force into SMART CARE TEAMS.

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Smart care teams are integrated across the continuum of care.

- Community Workers
- Dieticians/Nutritionists
- Extensivists
- Faith-based community
- Health Coaches
- Health Navigators
- Licensed Social Workers
- Patient Care Advocates
- Pharmacists
- Primary Care Providers
- Psychologists
- Specialists

Rite Aid Integrated Care Patient Enrollment and HIPAA Authorization Form

Consent for Participation in the Rite Aid Integrated Care Program

I,_____, consent to enroll in the Integrated Care program with my physician, and the Rite Aid Integrated Care team of pharmacists and Care Coaches. Integrated Care is a program provided at no additional cost to me aimed at achieving the best possible health outcomes and helping patients attain established health and lifestyle goals.

Authorization for Release of Health Information Pursuant to HIPAA

I,_____, hereby authorize my medical practice or physician, and other health care providers, _____, to release the following information to the Rite Aid Integrated Care team of pharmacists and Care Coaches for the purposes of reinforcing my physician's recommended care plan.

Here's what we need to do together:

- Commit to partnership that drives value further faster
  - Reduce clinical variation
  - Reduce costs for all involved
  - Strong focus on consumerism
- Build culture
  - Transparency, team work, trust, solution-focused
- Evolve economics and associated business models
- Learn together
  - Predictive analytics and micro-segmentation
  - Match clinical models and interventions

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But we are just at the starting line…

Three transformational waves are reshaping the health marketplace.

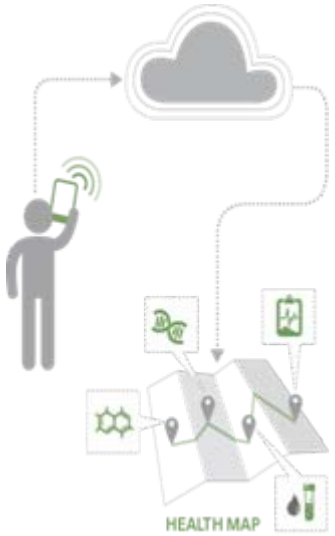
WAVE 1
PATIENT-CENTERED CARE
2010-2016

FROM	TO
Physician-centered	Patient-focused
Transactional, isolating	Care team managed
Sick-care	Health and well-being
Inaccessible	Convenient and 24/7
Patient turnover-volume	Patient health-value
Unwarranted variation	Evidence-based standard

WAVE 2
CONSUMER ENGAGEMENT
2014-2020

FROM	TO
Uninformed	Informed, shared decisions
Limited engagement	Highly engaged/empowered
Isolated individual	Socially connected
Limited consequence	Financial rewards/incentives
Bricks, office hours	Virtual, mobile, anytime
Physician opinion	Informed shared decisions

WAVE 3
SCIENCE OF PREVENTION
2018-2025



FROM	TO
Basic health management	Genome-linked life plan
Symptom treatment	Monitoring and prevention
One-size-fits-all	Personalized therapies
Limited biomarkers	100% accurate diagnostics
Big pharmaceuticals	Tailored gene/microbiome therapies
Medical competencies	Life, social, and ethics competencies

2010 → **2025**

Contact Information

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