OAK STREET HEALTH

Population Health Colloquium

The Future of Primary Care

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Population Health

Overview

- Who We Are
- Value Creation and Value Capture
- Care Model Deep Dive
- Q&A

Rebuilding Health

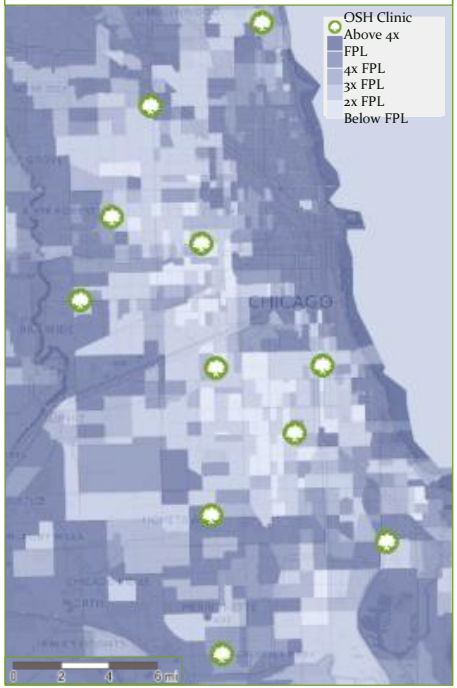
Care As It Should Be

Personal | Equitable | Accountable

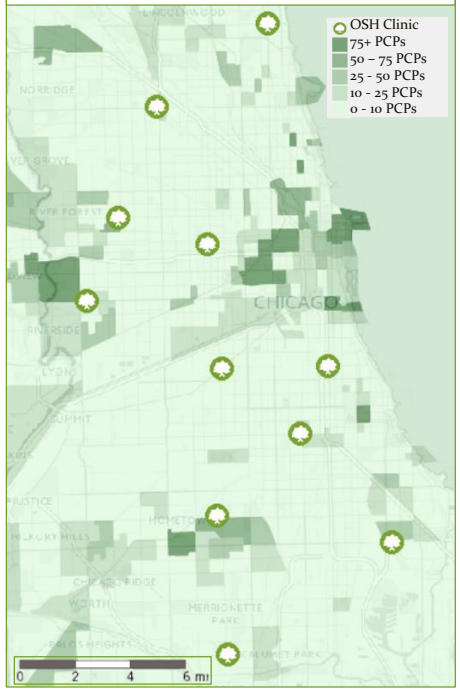
- Primary care centers for adults on Medicare
- In medically-underserved communities
  (i.e., >40% dually eligible)
- Located in high-density, low-income areas
  to create access
- Integrate primary care, care management, transportation
  among other services
- Fully “at-risk” for all cost of care

We create access where it is needed the most

Our neighborhoods face significant socioeconomic challenges…



… exacerbated by a demonstrable lack of primary care access



OSH Patient Demographics

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

Let’s watch an OSH Philadelphia commercial

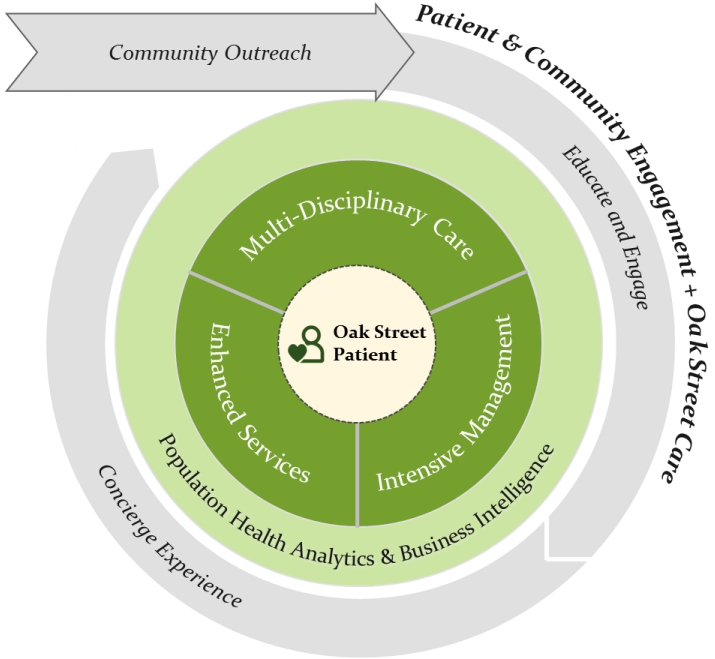
Link here

Value Creation

Value Capture

Value Creation

We cultivate a community of patients – focusing on education, engagement and experience



1. Patient and Community Engagement

2. Ongoing Oak Street Care Model

Patient and Community Engagement: We strive to elevate the primary care experience for our patients

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

Community Outreach → **Educate and Engage** → **Concierge Experience**

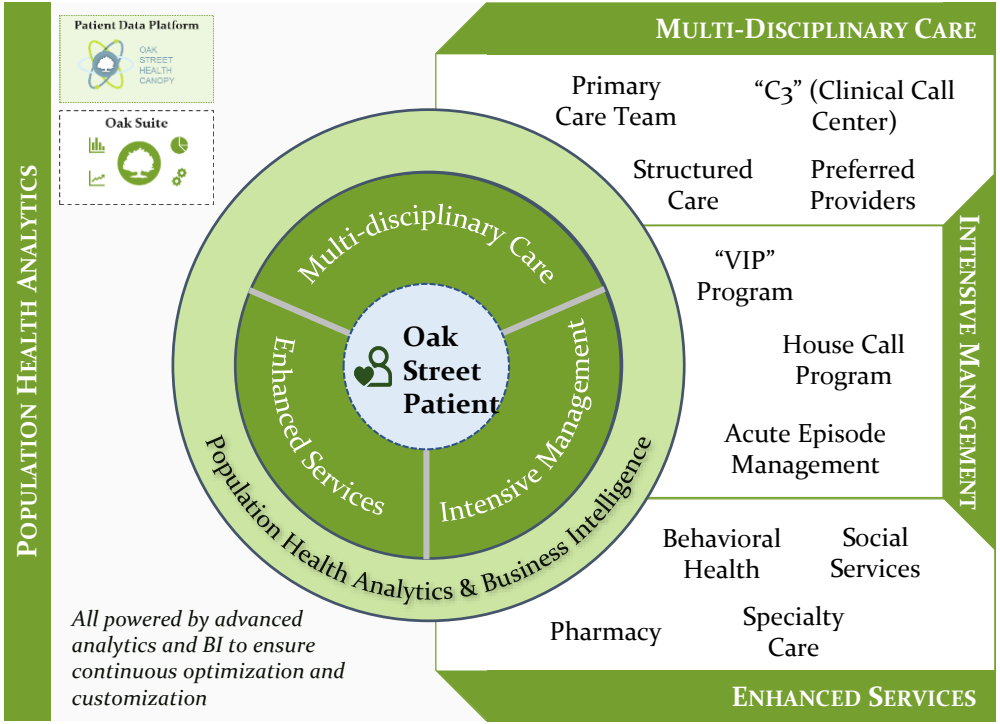
- ✓ Neighborhood Outreach and Integration
- ✓ Fully Staffed Community Center
- ✓ Complimentary Transportation
- ✓ Small Panel Sizes and Dedicated Care Team
- ✓ No Wait / Same Day Appointments
- ✓ Longer and More Frequent Care
- ✓ Multilingual Staff and Care Teams
- ✓ Onsite Patient Relations

2,000
New Patients Monthly

90%
Organic Growth

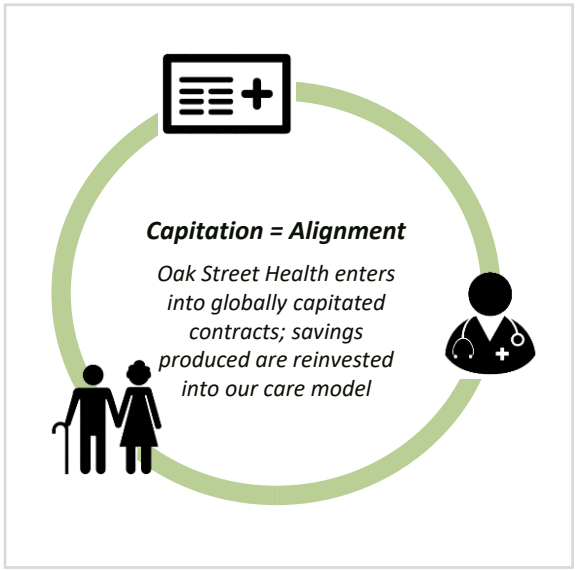
92%
Net Promoter Score

OSH Care Model: We put the patient first with wrap-around care and services



Value Capture

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

State	# Clinics	Payers	Lines of Business	
	18	Humana. BlueCross BlueShield of Illinois WellCare UnitedHealthcare CLEAR SPRING Health Cigna HealthSpring aetna Community Care Alliance of Illinois Meridian CountyCare HEALTH PLAN illinicare health.	Original Medicare	MSSP ACO
			MA MMAI ICP	Full Risk
	7	Humana. Anthem BlueCross BlueShield UnitedHealthcare aetna	Original Medicare	MSSP ACO
			MA	Full Risk
	7	hap Humana.	Original Medicare	MSSP ACO
			MA MMP	Full Risk
	3	Humana. aetna Anthem BlueCross BlueShield buckeye health plan	Original Medicare	MSSP ACO
			MA	Full Risk
	10	Cigna HealthSpring aetna HPP Humana. Clover Health Partners Plans	Original Medicare	MSSP ACO
			MA	Full Risk
	3	Blue Cross Blue Shield of Rhode Island	Original Medicare	FFS
			MA	Full Risk

Care Model Deep Dive

Oak Street Health patients are historically under-served, with a high disease burden and complex behavioral and social needs

Demographics

100% patients are on Medicare
- 42% are dual-eligible for Medicaid
- Average income <$21,000

Average Age: 68
- *<65:* 20%
- *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

Primary Care Team (Center-based)

Physician or NP	Fully employed board-certified physicians, or NP under their supervision, lead our care teams. Our patient panels are small so they can spend more time with our patients.
Nurse	R.N.s educate and manage clinical needs between visits, and provide group education on chronic disease management.
Medical Assistant	M.A.s manage clinical workflows and act as guides for a visit.
Scribe	Our "Clinical Informatics Specialists" capture structured clinical information to drive our care model.

Enhanced Clinical Services

Available at all centers

- **Behavioral Health Therapy**
- **Tele-psychiatry**
- **Social Work**
- **Podiatry**
- **On-site pharmacy (~50% of locations)**

Intensive Management

For high-risk ("VIP") patients

- **"Complex Care Team" (NP, Social Work, Pharmacist) conducts House Calls for high risk patients**
- **Transitions in Care (RN Case Manager)**

Clinical Contact Center

Central service supporting all of OSH

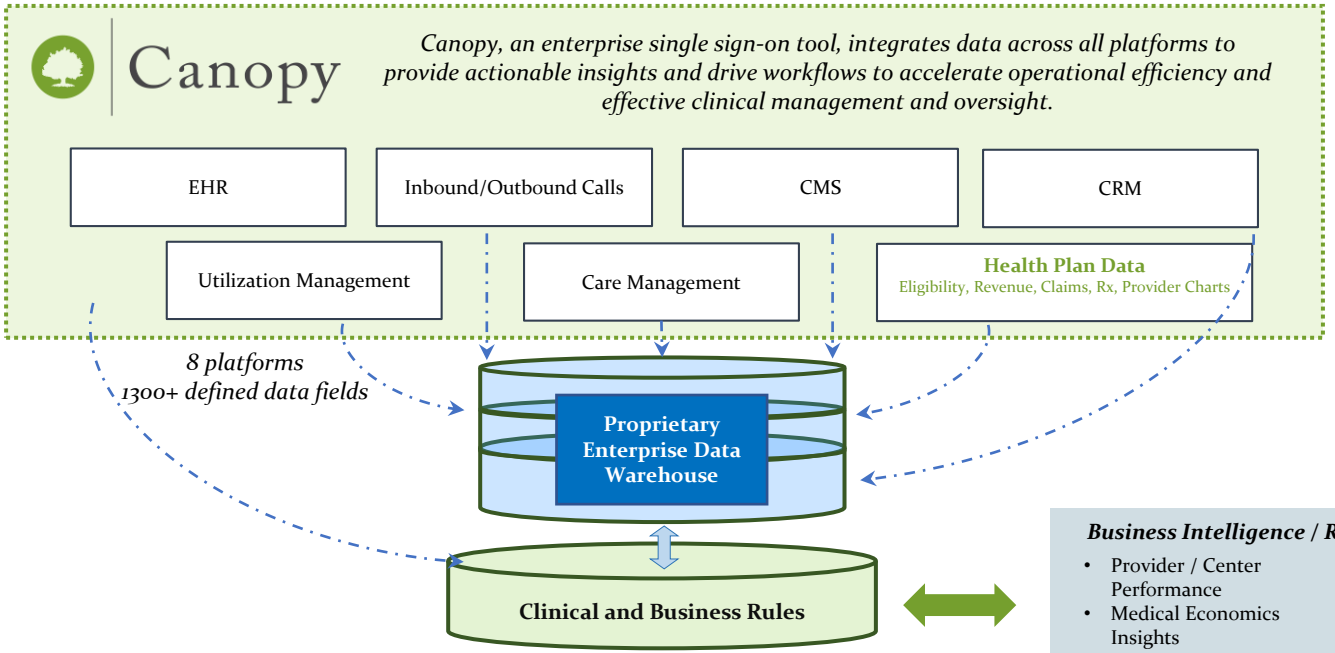
- **24/7 RN hotline, with escalation to provider**
- **Outbound Rx Interventions**
- **Patient Engagement**
- **Referral Management**

Treehouse Teams

Centrally-based *Treehouse Teams* build and support Care Teams with infrastructure data/reporting and shared services

Medical Directors	Clinical Quality	Managed Care Operations
Population Health	Medical Economics	Provider Services

Our proprietary data platform structures and monitors every element of care



Modular tech platform drives care model and business operations

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
Business / Ops Modules	Touchpoints (Patient Engagement)	Patient Check In/ Out	"My Center" (Practice mgmt.)	

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 guidelines

CARE PLAN DEVELOPMENT FOR ONGOING CARE

Ongoing Primary Care Visits <u>every month</u>
- "Visit Cadence" set by internal risk algorithm and provider judgement
- *Range from every 2 weeks to every 3 months*

Care Plan established based on Mrs. Smith's history and needs going forward
1. Uncontrolled Diabetes
2. Previous CHF exacerbation due to medication non-compliance resulting in hospitalization
3. Ongoing depression episodes due to recent loss of loved one
4. Loss of Medicaid status due to change in State forms

1. **Group Education classes in OSH Community Room**
2. **Medication reconciliation by OSH Pharm-D with ongoing medication adherence reminders**
3. **Connect with OSH Behavioral Health Specialist for counseling / therapy; tele-psychiatry as needed**
4. **Medicaid Application Review with OSH Patient Relations Manager**

Patients benefit from our Care Model Results

~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 OSH is growing

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

Q & A

Thank You!

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