The Grove

Bamboo Health

Quality, Disparities + Equity: How Does Value-Based Care Bridge the Gap?

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Leadership Summit

OAK STREET HEALTH

Problems with the U.S. healthcare system are well-documented:

Expensive [1,2]

$4.1 tn
US annual healthcare spend

+267%
US per-capita healthcare spend vs OECD average

Poor Outcomes [1]

-2 years
US life expectancy vs OECD average

+52%
US diabetes hospital admits vs OECD average

Negative Experience [3,4]

>40%
US Physician Burnout rate

-1.2
Average Net Promoter Score for primary care physicians

High costs and poor outcomes are concentrated in older adults, who tend to be the sickest patients. Today, 96% of Medicare spend relates to chronic disease [2]

1. Source: OECD
2. Source: Centers for Medicare and Medicaid Services (CMS.gov) 2020 data
3. Source: Medscape National Physician Burnout and Suicide Report
4. Source: The Advisory Board, 2019

Note: All OECD comparisons are from 2019 or earlier to remove any uneven impact of COVID19

For certain communities, those challenges are even more stark:

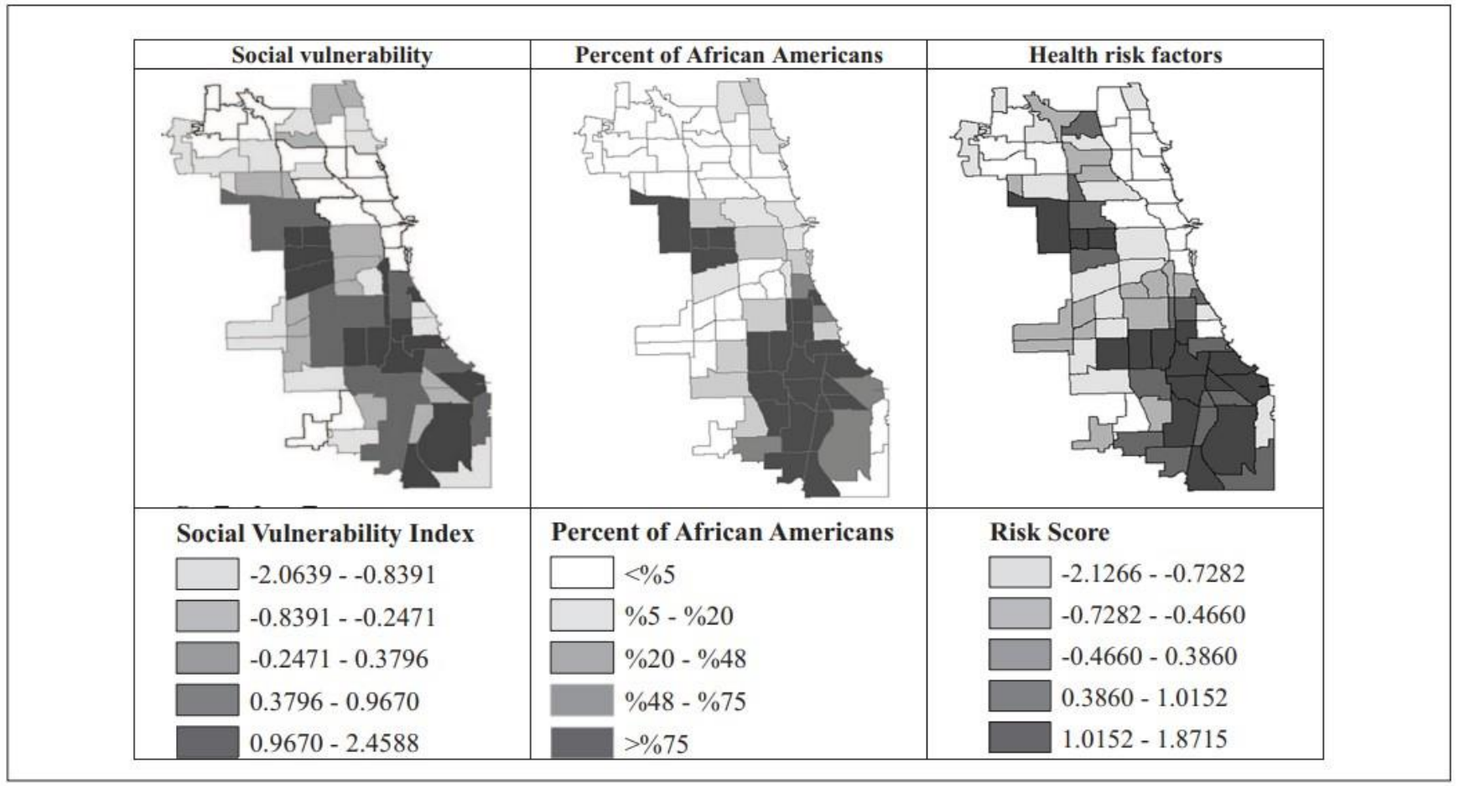


Figure 2. The spatial distributions of social vulnerability, health risk factors, and the percentage of African American residents in Chicago Community Areas.
Note. Social vulnerability index ranged from −2.0640 to 2.4859; Risk Score ranged from −2.1266 to 1.8715.

Communities with higher rates of poverty and unemployment, among other factors, suffer higher-risk health outcomes.[1]

13.4%

Proportion of Black Americans in US population[2]

40%

Proportion of Black Americans among COVID-19 hospitalizations

~3.1x

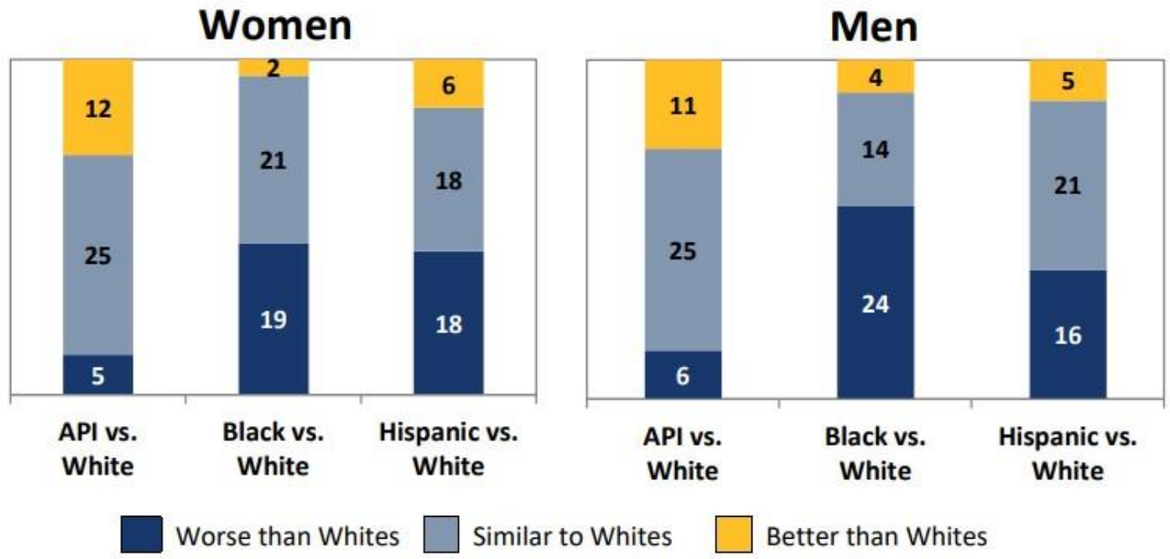
Rate of Black American hospitalizations for COVID-19, relative to population size

1. Source: Kim and Bostwick, "Social Vulnerability and Racial Inequality in COVID-19 Deaths in Chicago." Health Education and Behavior. 2020
2. Source: Centers for Disease Control and Prevention; Gaynor and Wilson, "Social Vulnerability and Equity: The Disproportionate Impact of COVID-19.".Public Administration Review. 2021.

When we examine the care we deliver, further equity gaps emerge:

Figure 5. Racial and Ethnic Disparities in Care by Gender: All Clinical Care Measures

Number of clinical care measures (out of 42) for which women/men of selected racial and ethnic minority groups experienced care that was worse than, similar to, or better than the care experienced by White women/men in 2018



SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2018 from MA plans nationwide.
NOTES: API = Asian or Pacific Islander. Racial groups such as Blacks and Whites are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

While patient-reported rates of care delivery are often equivalent across racial categories, outcome measures tell a different story.[1]

~9-10% lower

Likelihood that Black + Hispanic patients had adequately controlled high blood pressure, relative to Whites

~11-12% lower

Likelihood that Black + Hispanic patients had adequately treated depression episodes with continuous antidepressant use, relative to Whites

1. Source: Martino et al, "Racial, Ethnic and Gender Disparities in Health Care in Medicare Advantage." CMS Office of Minority Health/RAND. 2021.

Enter: Oak Street Health

We are…

A patient-centric network of primary care centers for Medicare-eligible patients

We leverage…

The Oak Street Health platform to provide comprehensive care for our patient population

We improve…

Experiences and outcomes for our patients

We reduce…

Hospitalizations by over 50% and retain the savings generated by our care model

160	Oak Street owned and operated centers
20	States currently covered
114.5k	At-risk patients receiving our care
$1.43b	Total 2021 revenue , 62% annual revenue growth
~4,800	Team members, all aligned with our mission & vision, including ~500 primary care providers

Note: Centers and states as of 03/16/2022; remaining data as of 12/31/2021

Oak Street Health locations

Currently serving 175,000+ Medicare beneficiaries and growing.

- About 45% of Oak Street patients are dually eligible for Medicare and Medicaid

Alabama	2	New Mexico	4
Arizona	10	New York	10
Georgia	5	North Carolina	8
Illinois	27	Ohio	11
Indiana	8	Oklahoma	5
Kentucky	1	Pennsylvania	10
Louisiana	5	Rhode Island	4
Michigan	11	South Carolina	3
Mississippi	2	Tennessee	4
Missouri	4	Texas	17

Why: complex patients require multi-dimensional care model – and time

68 average age

86% of patients have one or more chronic conditions

7+ average number of medications

>50% of patients identify as African American, Latino, or Indigenous

42% of patients are dually eligible for Medicare and Medicaid

~50% of patients have a housing, food, or isolation risk factor

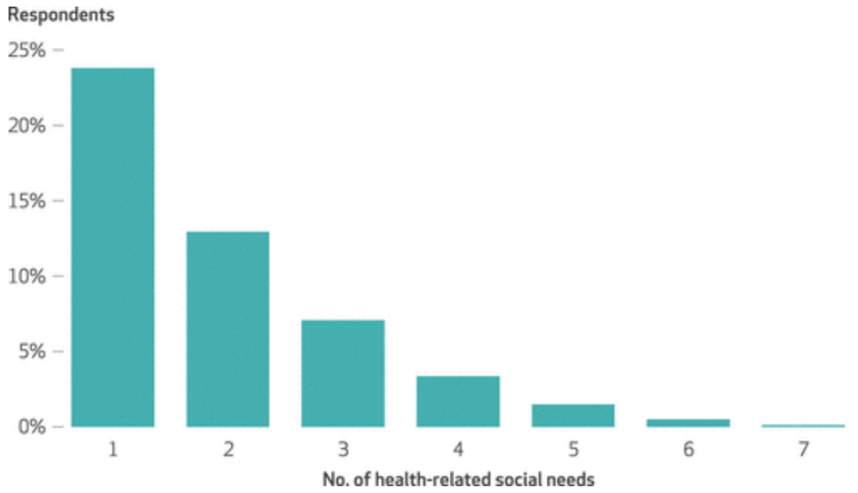
All too often, resource limitations stymie progress in health outcomes

Exhibit 1 Prevalence of health-related social needs among older adults enrolled in Medicare Advantage, 2019–20

HealthAffairs

SOURCE Authors' analysis of Humana survey data, 2019–20. NOTES Sample limited to respondents who answered all survey questions (n=51,201). Prevalence estimates are weighted for nonresponse and national age and sex distribution. Health-related social needs are not mutually exclusive, and respondents could be counted in more than one category.

Exhibit 2 Distribution of health-related social need burden among older adults enrolled in Medicare Advantage, 2019–20



1. Source: Long et al. "Health-related social needs among older adults enrolled in Medicare Advantage." Health Affairs. 2022.

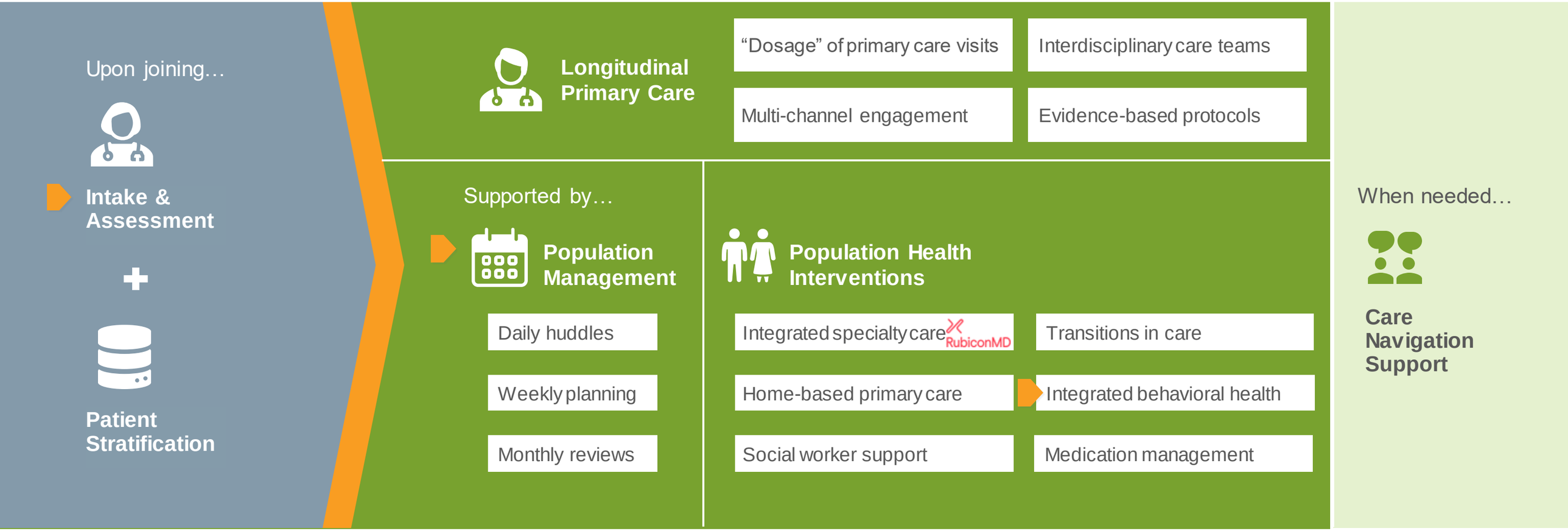
Value-based models invest upfront to keep patients happy, healthy, and out of the hospital

Challenges in Primary Care Settings	Fee For Service	Value-Based Practices (Medicare, Medicaid)
Not enough time with patients	**2,000+** Avg doctor panel[1]	**~400-800** Patient panel
No patient specialization	Accepts all ages	Medicare-eligibles focused (most often); Medicaid-eligibles focused (less common – Cityblock, CareMore, Waymark)
No non-facing patient time	No time to plan for care outside the exam room	**>1/3** Provider/nursing time used to **communicate**, coordinate care, close care gaps + proactively plan
No support beyond primary care	Minimal focus on social determinants of health	Behavioral health, pharmacy, home-based support, well-being programs + social worker/community health worker assistance within **large care teams**
Limited technology integration	Limited EMR use focused on billing & record-keeping; no time to engage with population health overlays	**4 hrs/day** Average time that clinical staff use technology platforms optimized to provide an integrated clinical and care plan – *single source of truth for teams*

1. Source: Journal of General Internal Medicine

Value-based models leverage a deep understanding of our patients, leading to coordinated and holistic support

Oak Street Health Care Model



To be discussed in further detail

Value-based models yield better quality care delivery for patients – and, in doing so, close gaps in health inequity

5-Star HEDIS Level Performance [1]:

85%
Diabetic patients with well-controlled diabetes (Hemoglobin A1C of <9)
+6% above industry 5-star benchmark

87%
Patients with a breast cancer screening
+12% above industry 5-star benchmark

88%
Patients with colorectal cancer screening
+14% above industry 5-star benchmark

1. For patients that completed a 2021 wellness review visit

Care Model Deep-Dive: Integrated Behavioral Health
Taking care of our patients' population health needs

Mental Health in the US[1]

1 in 5

US adults who experienced a mental illness in 2020

>17 million

US adults who experienced delays or cancellations in mental health appointments

At Oak Street Health

All patients

screened for behavioral health at initial visit and annually

All centers

provide access to behavioral health care

Collaborative care

Behavioral health is not stigmatized or siloed; it is a part of whole-person care at OSH

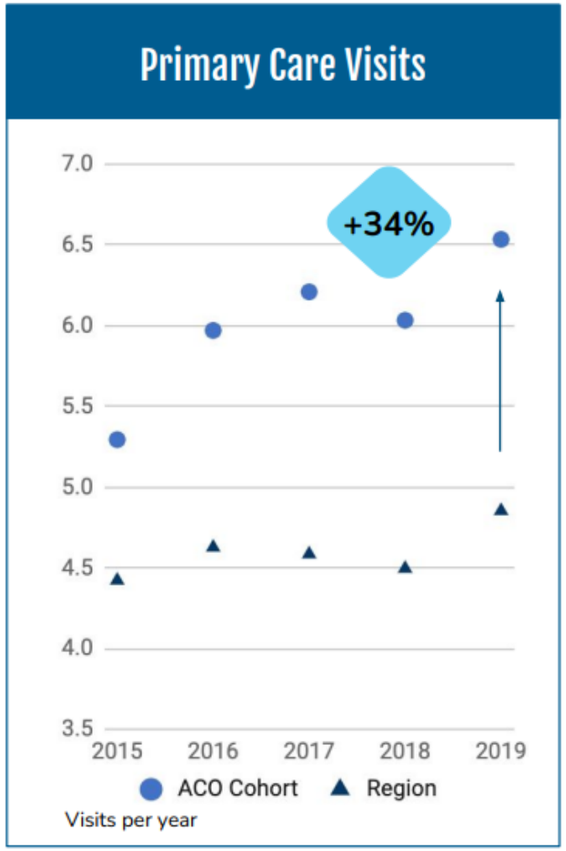
73%

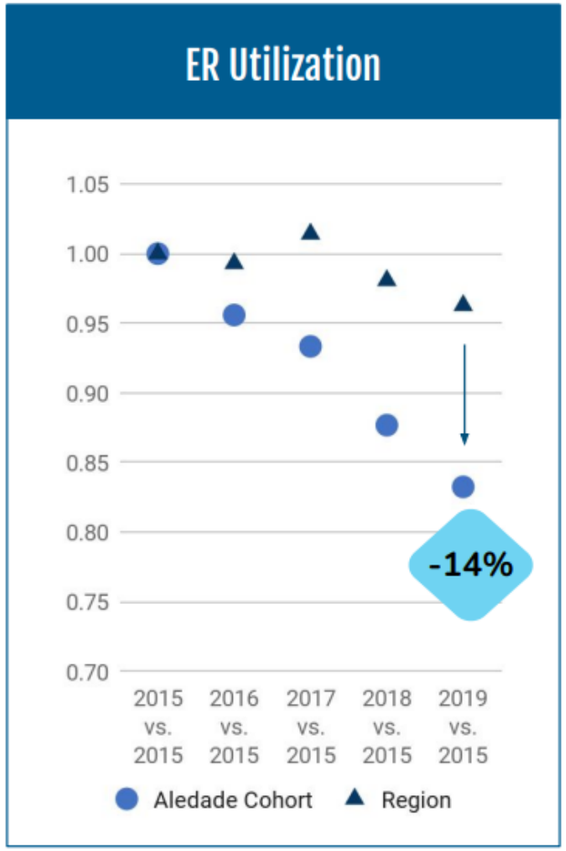
OSH patients seeing a significant reduction in depressive symptoms through Oak Street collaborative behavioral health care model[2]

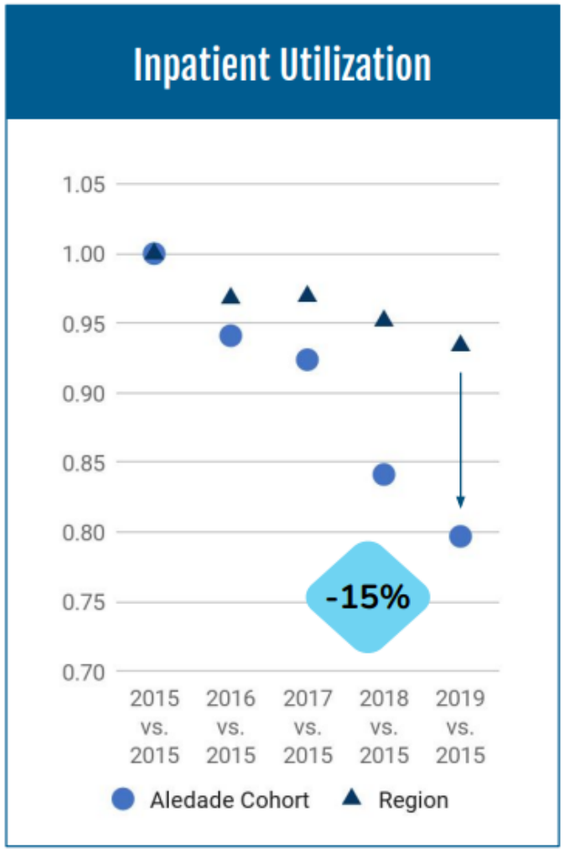
vs 19% of patients in traditional behavioral health care model[3]

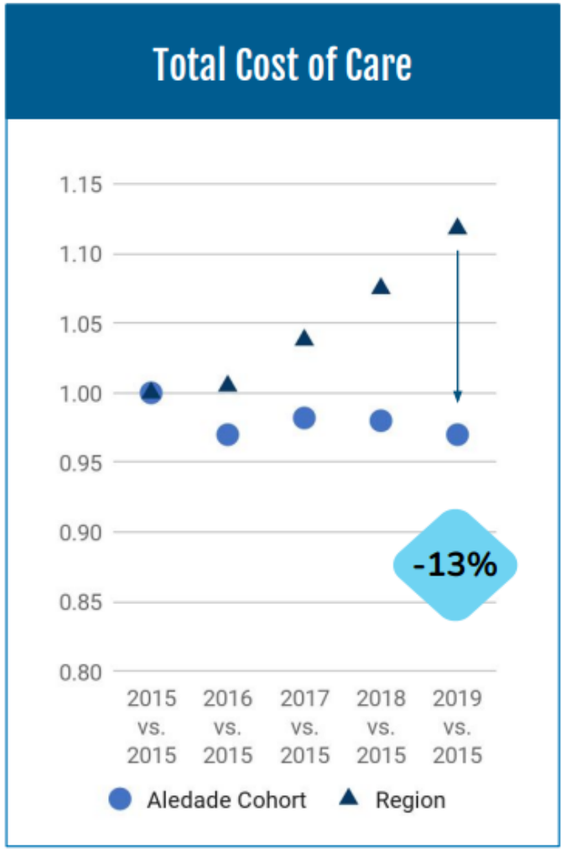
1. National Alliance on Mental Illness, 2020 data
2. Oak Street Health patient data following 6-month study, May 2021
3 JAMA 2002, "Collaborative Care Management of late-life depression in the primary care setting"; Primary Care: Clinics in Office Practice 2012

Value-based care allows for critical investment in primary care









VBC models demonstrate improved quality and lower cost across plan types (HMO, PPO, Open Access, SNP, MMP) and programs (MA, MSSP, DC and Medicaid)

1. Source: Aledade analysis of the CMS Virtual Research Data Center, containing 100% of Medicare claims nationally. More primary care, fewer ER visits, and hospitalization means lower cost over time. Primary Care Visits ER Utilization Inpatient Utilization Total Cost of Care https://www.ajmc.com/view/more-than-beating-the-benchmark-5-medicare-acos-2015-2019

Value-based care allows for critical investment in primary care

!

In 2018, hospitalizations were >60% of Medicare expenditures [1]…

…while Primary Care spend accounted for only ~3%

51% reduction in hospital admissions [2]

42% reduction in 30-day readmission rate[2]

51% reduction in ED visits vs. Medicare FFS benchmark [2]

NPS of 90[2]

VBC models invest in proactive primary care, spending more than 3x the average[3]. We remove reactive and more-expensive costs from the system

VBC models demonstrate improved quality and lower cost across plan types (HMO, PPO, Open Access, SNP, MMP) and programs (MA, MSSP, DC and Medicaid)

1. Source: CMS and Kaiser Family Foundation
2. Please see our S1, filed 2/8/2021, for information on how these statistics are calculated
3. Based on our 2021 spend (please see our 10K, filed 2/28/2022) vs industry average (sourced from Kaiser Family Foundation)

Case Study: Acorn ACO demonstrates ability to drive medical cost savings across Medicare[1]

4th

highest savings rate of all 513 ACOs

~17%

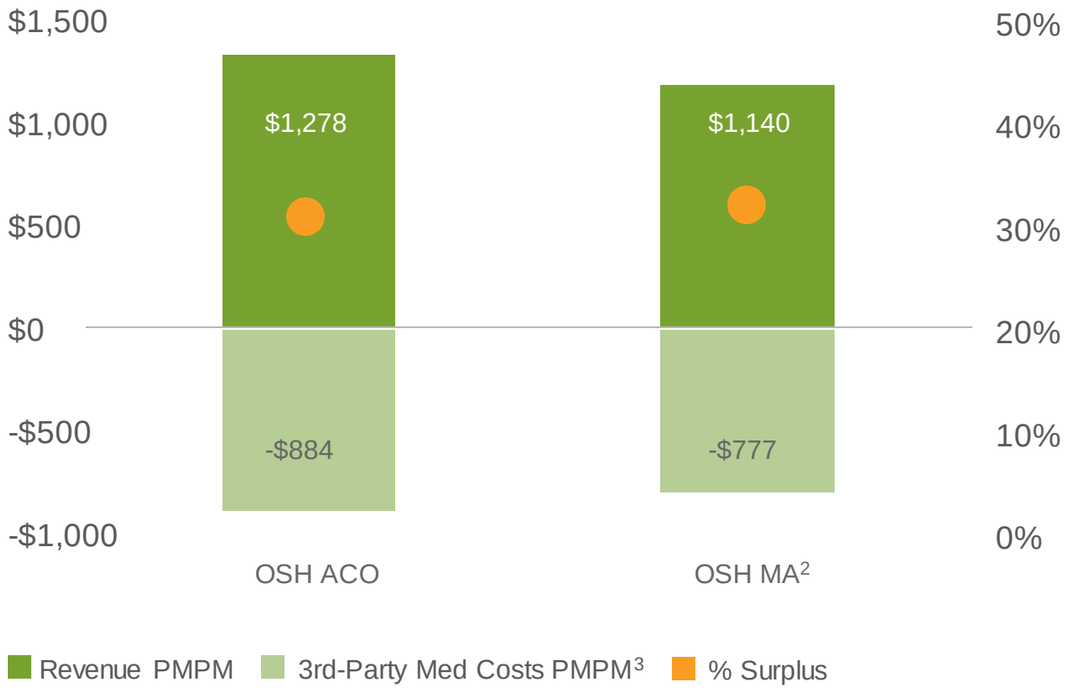
Savings rate compared to 4% average

IL, MI, IN

Only ACO in the top 10 to operate in these states

~$1.2K

Average annual taxpayer savings per patient vs CMS target[4]



Value-based care models produces consistent results across both MA and ACO populations

1. CMS 2020 data
2. Reflects OSH MA economics for 2020 for Part C revenue and medical costs (comparable to ACO economics)
3. External costs only, excludes the costs of Oak Street's primary care model which would reduce the savings retained by Oak Street Health
4. Based upon CMS' calculation of savings; not derived from the data on this slide

A growing consensus emerges: value drives better quality, particularly for those who need it most

JAMA Network Open

Results

In a study population of 489 796 MA beneficiaries, value-based payment was significantly associated with lower acute care use (Table). Compared with FFS, beneficiaries cared for under 2-sided risk models had lower rates of hospitalizations, observation stays, and ED visits. For example, the adjusted rate of ED visits per 1000 patients for 2-sided risk models was 375.8 (95% CI, 370.9-380.7) compared with 434.1 (95% CI, 426.5-441.9) for FFS. For all outcomes, there was no significant difference in acute care use between beneficiaries cared for under upside-only risk models and FFS.

The association between value-based payment and decreased acute care use was most pronounced for measures of avoidable acute care use. Compared with FFS, 2-sided risk models were associated with a 15.6% (95% CI, 14.2%-17.0%) relative reduction in avoidable hospitalizations, compared with 4.2% (3.4%-4.9%) for all-cause hospitalizations (Figure).

AJMC

RESULTS: Compared with patients randomized to usual care, patients randomized to complex care management had lower TME (adjusted difference, –$7732 per member per year [PMPY]; 95% CI, –$14,914 to –$550; *P* = .036), fewer IP bed days (adjusted difference, –3.46 PMPY; 95% CI, –4.03 to –2.89; *P* <.001), fewer IP admissions (adjusted difference, –0.32 PMPY; 95% CI, –0.54 to –0.11; *P* = .014), and fewer specialist visits (adjusted difference, –1.35 PMPY; 95% CI, –1.98 to –0.73; *P* <.001). There was no significant impact on care center or ED visits.

CONCLUSIONS: Carefully designed and targeted complex care management programs may be an effective approach to caring for high-need, high-cost Medicaid patients.

***Am J Manag Care*. 2020;26(2):e57-e63**

1. Source: Gondi et al. "Analysis of value-based payment and acute care use among Medicare beneficiaries." JAMA Network Open. 2022.
2. Source: Powers et al. "Impact of complex care management on spending and utilization for high-cost, high-need Medicaid patients." AJMC. 2020.

A growing consensus emerges: value drives better quality, particularly for those who need it most

NEJM Catalyst | Innovations in Care Delivery

Health Equity Measure Development Steps

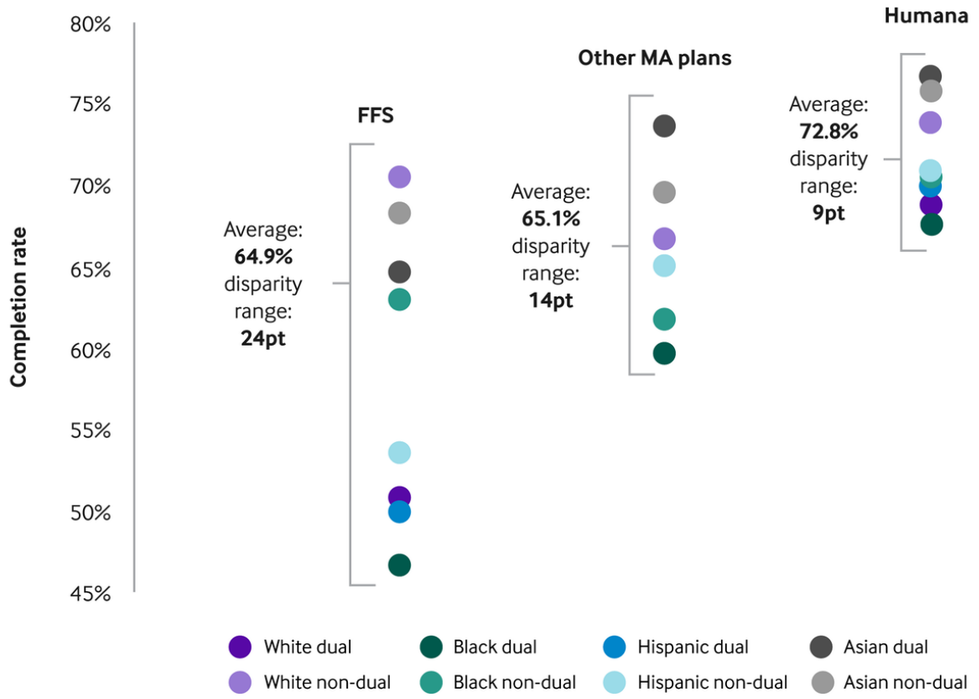
We developed this novel health equity measure in several steps. Specifically, we (1) selected eight health behavior measures, (2) calculated the rate of engagement in each applicable health behavior for each of our Medicare Advantage members and then combined the individual rates into a composite score, (3) stratified the composite rate by racial- and dual-status subgroups, and (4) calculated summary scores representing between- and within-group disparities.

1. Selection of individual measures	2. Calculation of composite measure	3. Stratification by subgroups	4. Calculation of Health Equity Scores
• 1 or more PCP Visit/Year • Influenza Vaccination • Three Medication Adherence Measures • Diabetes Eye Exam • Breast Cancer Screening • Colorectal Cancer Screening	Rate of engaging in recommended health behavior (calculated on member-level and then combined)	Rate is stratified by racial- and dual status-specific groups	Between-group disparities: sum of differences between each subgroup compared to reference group Within-group disparities: sum of standard deviations of rate within each subgroup

Source: The authors

Health Equity Measure Performance in Three Populations: Humana MA, Other MA plans, and FFS Medicare

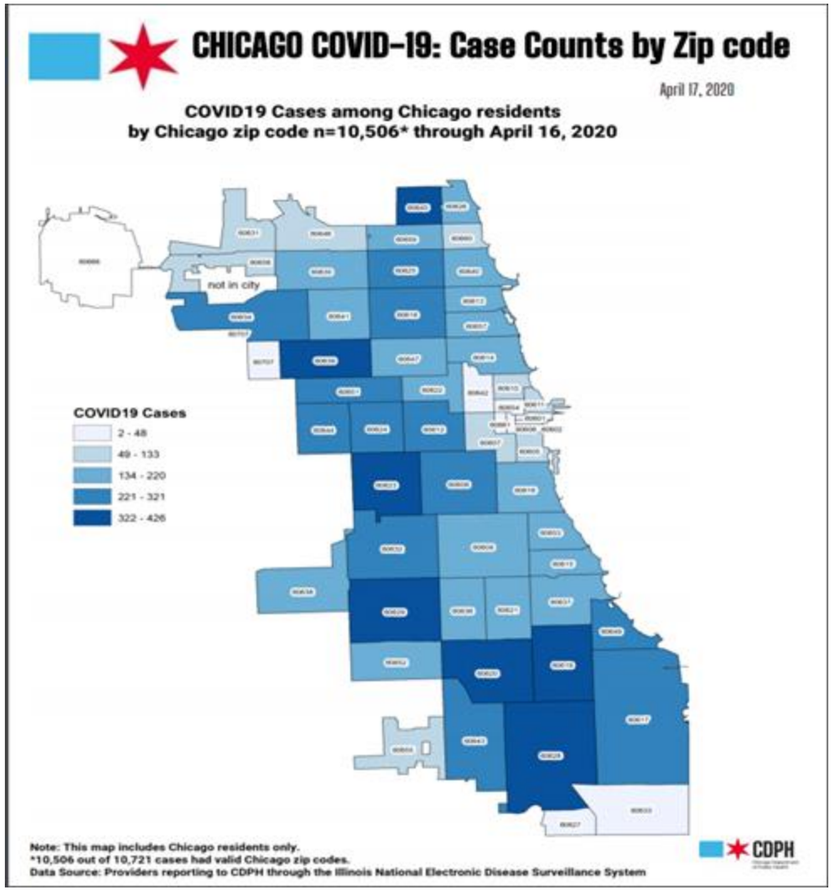
We calculated Humana's performance on the health equity measure in 2019 and benchmarked to fee-for-service (FFS) Medicare and other MA plans using 2019 data from the Inovalon MORE2 Registry. Overall, Humana members engaged in approximately 73% of applicable health behaviors and the difference between the highest-performing and lowest-performing subgroups at Humana was 9 percentage points.

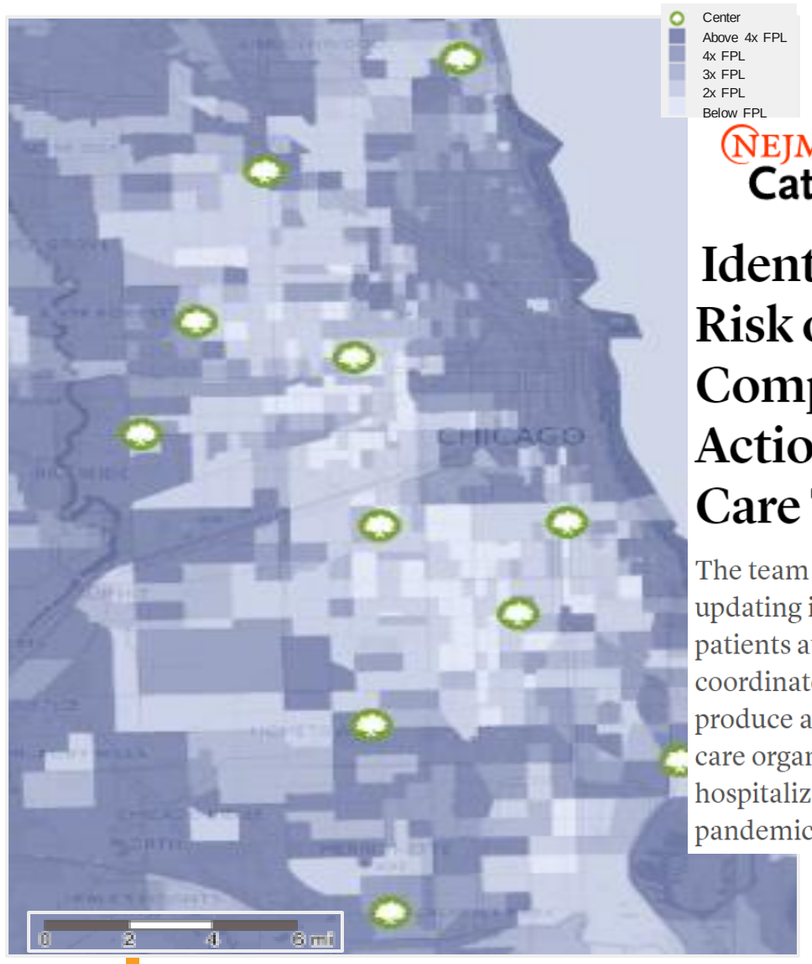


Source: The authors

1. Source: Russell et al. "Building the foundation for reducing disparities in Medicare Advantage." NEJM Catalyst. 2022.

Case Studies: Value-based care and COVID-19 inequity





NEJM Catalyst | Innovations in Care Delivery

Identifying Patients with Increased Risk of Severe Covid-19 Complications: Building an Actionable Rules-Based Model for Care Teams

The team at Cityblock Health is building, expanding, and regularly updating its rules-based, adaptable model to identify Covid-19 patients at highest risk. Recognizing the importance of a coordinated response and shared learnings, they wanted to produce an open-source tool to help other providers and health care organizations identify their patients at highest risk of hospitalization, ICU use, and death from the coronavirus pandemic.

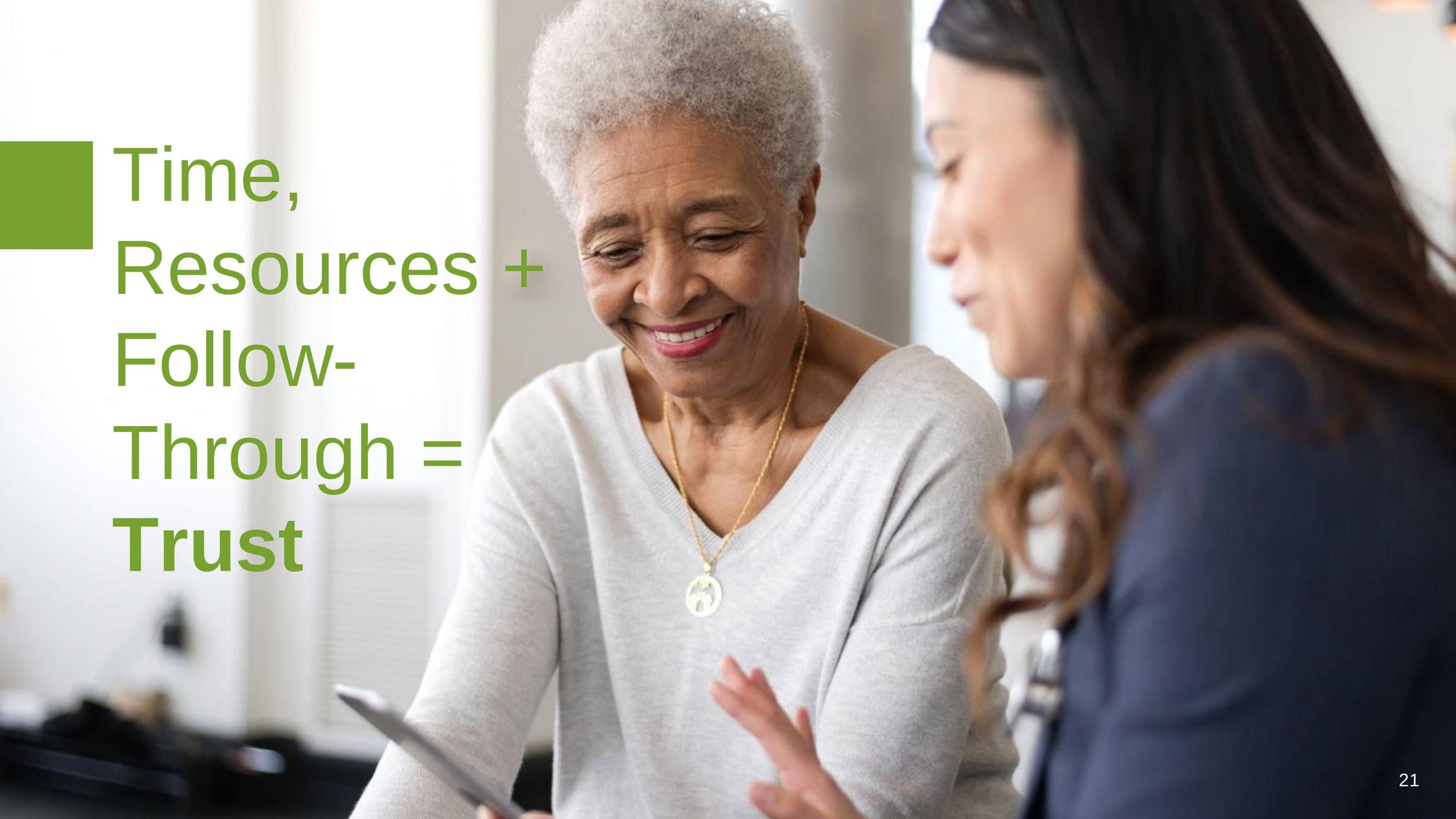
Decoupling payment from in-person visit volume incentivizes proactive outreach, home-based care and upfront investments in community protections

1. Source: Schnake-Mahl et al. "Identifying patients with increased risk of severe Covid-19 complications: building an
2. actionable rules-based model for care teams. NEJM Catalyst. 2020.

Despite progress in quality + equity, the value journey is adolescent

- **Incentive Design**: Future expansion of Medicare-led payment models to more deeply link payment reform, quality + equity in equal measure (MA STARs, ACO REACH)
- **Scalability**: Moving beyond ~1-10% of Medicare beneficiaries; application to high-risk commercial models, expansion of Medicaid services/scope
- **Clinical Excellence**: Ongoing evaluation of clinical outcomes + patient-reported outcome measures; collaborative benchmarking

Time, Resources + Follow-Through = **Trust**



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Thank you. Questions?

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