From the Ground Up:

Designing Care to Restore Humanity and Drive Value

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Tracy Masson, Vice President, Arizona Market Operations
October 2019
Agenda

• Iora Health: Who we are and what we do
  ▪ Mission
  ▪ Value Proposition
  ▪ People, Payment, Process and Platform

• Embedding value based care in daily operations

• Q+A/Discussion
Who We Are & What We Do
“The mission of Iora Health is to restore humanity to healthcare. We transform healthcare, not by making excuses or small incremental change, but by simply building a new model of care from the ground up, solely aimed at helping patients improve their health and stay out of trouble, thus unlocking tremendous value in the US healthcare system.”

Rushika Fernandopulle, MD, MPP
Co-founder & CEO of Iora Health
Iora’s Unique Value Proposition

Human Centric Care + Value Based Care
From Transactions to Relationships

“I think the biggest problem with healthcare today is not the cost, but for all this money it’s not an expression of our humanity”

- Jonathan Bush
Defining Value = Outcomes / Cost

Results that matter to patients
- Function, quality of life, quality of death
- Avoidable hospitalizations, ER visits, low value care
- Evidence-based, preference informed decisions
- Process Measures for Quality and Prevention (HEDIS)

Total Cost
- Cost to the system
- Cost to the patient
Nearly 50 Practices
More than 500 employees
Ten states!
The Pillars of Transformation

People

Payment

Process + Platform
Payment: The Evolution to Value

Fee for Service | FFS + bonus | FFS + Case rate | Primary Care case rate | PCP Case rate + bonus | PCP case rate + shared savings | Full Risk

Throughput based models | Value based models

Retail | Employers | Medicare Advantage*
People: Building the right culture

Restoring Humanity to Healthcare

Feel **Empathy**
Bring **Creativity**
Serve with **Humility**
Act with **Passion**
Demonstrate **Courage**
People: Building the Right Team

Patient
Provider (1:500 - 1:750)
Health Coach (1:250)
Registered Nurse
Behavioral Health Specialist
Operations Assistants
Clinical Team Manager
Transitions Navigator
Process: Re-Engineering Care

Re-designed space
Daily huddle
Pre-visit planning
Shared care plans
Group visits / classes
Proactive panel rounding
Segmentation/ Stratification
E-consultation
Telepsychiatry
Preferred “Good Folks” network
Support thru transitions
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
- A platform for patients to engage
  - Shared notes
  - Text / email / web
Driving Population Health Outcomes

★ Leverage our **relationships** to embed population health in **day to day care**
★ **Empower** care teams with **accurate, real-time data** in **workflow** (Chirp)
★ **Coach Panel Managers** own screening and basic chronic disease measures, pull team together for to **plan care** for high risk patients
★ Robust **decision support** prompts gap (quality, MRA) closure in visits and drives outreach during weekly **Panel Rounding**
★ Real-time **performance tracking** of performance by coach / provider / team and by cohort with **actionable drills**
Managing Quality and MRA: Pre-Visit Planning

Visit pre-planning: daily schedule / Gaps view

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

<table>
<thead>
<tr>
<th>Appointment Time</th>
<th>Patient Name</th>
<th>Age</th>
<th>Staff (All assigned)</th>
<th>Why</th>
<th>Most Recent Provider Visit</th>
<th>Iora Priority Quality Gaps</th>
<th>All HCC Gaps</th>
<th>Flu Vaccine Status Redshift</th>
<th>Current BP Status</th>
<th>Last Text Advance Directive Value</th>
<th>Ptg2 In Last Year (Yes / No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017-11-13 10:00:00</td>
<td>Annelise Giannaria, Sheila Antony</td>
<td>59</td>
<td>Initial Visit</td>
<td></td>
<td>0</td>
<td>Mammogram: Colorectal cancer</td>
<td>0</td>
<td>Due</td>
<td>Not in Control</td>
<td>@</td>
<td>No</td>
</tr>
<tr>
<td>2017-11-13 10:30:00</td>
<td>Kristin Heider</td>
<td>84</td>
<td>Bloodwork: A1c</td>
<td></td>
<td>2017-08-02</td>
<td>Diabetic Eye: Hypertension: Mammogram</td>
<td>0</td>
<td>Up to date</td>
<td>In Control</td>
<td>counseled</td>
<td>Yes</td>
</tr>
<tr>
<td>2017-11-13 10:30:00</td>
<td>Joshua Solot, Megan Buck</td>
<td>67</td>
<td>(Rescheduled) F/U PNA (PP): made &amp; confirmed 11/11</td>
<td></td>
<td>2017-08-03</td>
<td>Diabetic Eye: Hypertension: Mammogram</td>
<td>0</td>
<td>Due</td>
<td>Not in Control</td>
<td>counseled</td>
<td>Yes</td>
</tr>
<tr>
<td>2017-11-13 10:30:00</td>
<td>Annelise Giannaria, Sheila Antony</td>
<td>64</td>
<td>Initial visit, Amy will enroll in Bounce on Nov 1</td>
<td></td>
<td>2017-08-11</td>
<td>Mammogram: Colorectal cancer</td>
<td>0</td>
<td>Due</td>
<td>Not in Control</td>
<td>@</td>
<td>No</td>
</tr>
<tr>
<td>2017-11-13 14:00:00</td>
<td>Kristin Heider</td>
<td>56</td>
<td>Flu shot</td>
<td></td>
<td>2017-08-11</td>
<td></td>
<td></td>
<td>Due</td>
<td>In Control</td>
<td>counseled</td>
<td>Yes</td>
</tr>
</tbody>
</table>
# Decision Support at the Point of Care

## Markers

<table>
<thead>
<tr>
<th>Name</th>
<th>Trend</th>
<th>Value</th>
<th>Last Updated</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>SBP</td>
<td></td>
<td>130 mmHg</td>
<td>2 months ago</td>
<td>Update</td>
</tr>
<tr>
<td>DBP</td>
<td></td>
<td>32 mmHg</td>
<td>2 months ago</td>
<td>Update</td>
</tr>
<tr>
<td>HbA1c</td>
<td>6.7%</td>
<td></td>
<td>3 months ago</td>
<td>Update</td>
</tr>
<tr>
<td>HOCC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>micro alb/cr</td>
<td></td>
<td>0 mg/g</td>
<td>2 months ago</td>
<td>Update</td>
</tr>
<tr>
<td>N/A - pt with ESRD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advance Directive</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doesn't want one</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorectal Cancer Screen</td>
<td></td>
<td>Done: Colonoscopy</td>
<td>6 years ago</td>
<td>Update</td>
</tr>
<tr>
<td>St. Francis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHQ-2</td>
<td></td>
<td></td>
<td>8 months ago</td>
<td>Update</td>
</tr>
<tr>
<td>PHQ-9</td>
<td></td>
<td></td>
<td>8 months ago</td>
<td>Update</td>
</tr>
<tr>
<td>based several answers on episodic occurrences so unclear how accurate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetic Retinopathy Screening</td>
<td></td>
<td></td>
<td>Update</td>
<td></td>
</tr>
<tr>
<td>VES-13</td>
<td></td>
<td></td>
<td></td>
<td>Update</td>
</tr>
</tbody>
</table>

## Active issues

- Prevention
- Crohn's Disease, small bowel and colon
- GERD
- Esophageal Stricture
- Panlobular emphysema
- DM 2 with neuropathy
- Anxiety
- Major depressive
- Incisional hernia
- benign hypertension with stage 3 ckd
- Hypothyroidism

## Marker status

- All markers
- Only out of range
- Only overdue
- Out of range or overdue

## Subscribed marker sets

- Check all
- Clear all
- Quality Priorities
- Congestive Heart Failure
- Diabetes
- Prevention

## Unsuscribed marker sets

- Check all
- Clear all
- Asthma
- Behavioral Health
- Chronic Kidney Disease
- Complex Care Coordination
- COPD
Panel Rounding Prompted by Worry Score

Doing well post discharge from COPD exacerbation. Plan to follow up on action plan in week.
# Live Updated Performance Tracking

## Iora Composite Quality Score for Patients Engaged > 90 Days

Click here to see Threshold and Color codes

<table>
<thead>
<tr>
<th>Health Coach</th>
<th>Percent Bp Control</th>
<th>Percent Diabetes Control (A1c&lt;9 in last 12 months)</th>
<th>Percent Diabetes Eye Exam Up to date</th>
<th>Percent Colorectal Cancer Screening</th>
<th>Percent Mammogram Up to Date</th>
<th>Percent Advanced Directives Designated</th>
<th>Percent Depression Screen/Monitoring</th>
<th>Iora Quality Score Composite 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>75.4%</td>
<td>75.8%</td>
<td>79.3%</td>
<td>72.2%</td>
<td>80.0%</td>
<td>43%</td>
<td>84%</td>
<td>3.86</td>
</tr>
<tr>
<td></td>
<td>85.1%</td>
<td>87.5%</td>
<td>84.3%</td>
<td>71.2%</td>
<td>81.2%</td>
<td>29%</td>
<td>72%</td>
<td>3.86</td>
</tr>
<tr>
<td></td>
<td>80.0%</td>
<td>75.0%</td>
<td>62.5%</td>
<td>72.7%</td>
<td>80.0%</td>
<td>83%</td>
<td>83%</td>
<td>4.14</td>
</tr>
<tr>
<td></td>
<td>87.5%</td>
<td>88.4%</td>
<td>84.6%</td>
<td>80.0%</td>
<td>84.8%</td>
<td>50%</td>
<td>81%</td>
<td>4.57</td>
</tr>
</tbody>
</table>
Questions?