OSANA

Health Reimagined

A New Model of Primary Care

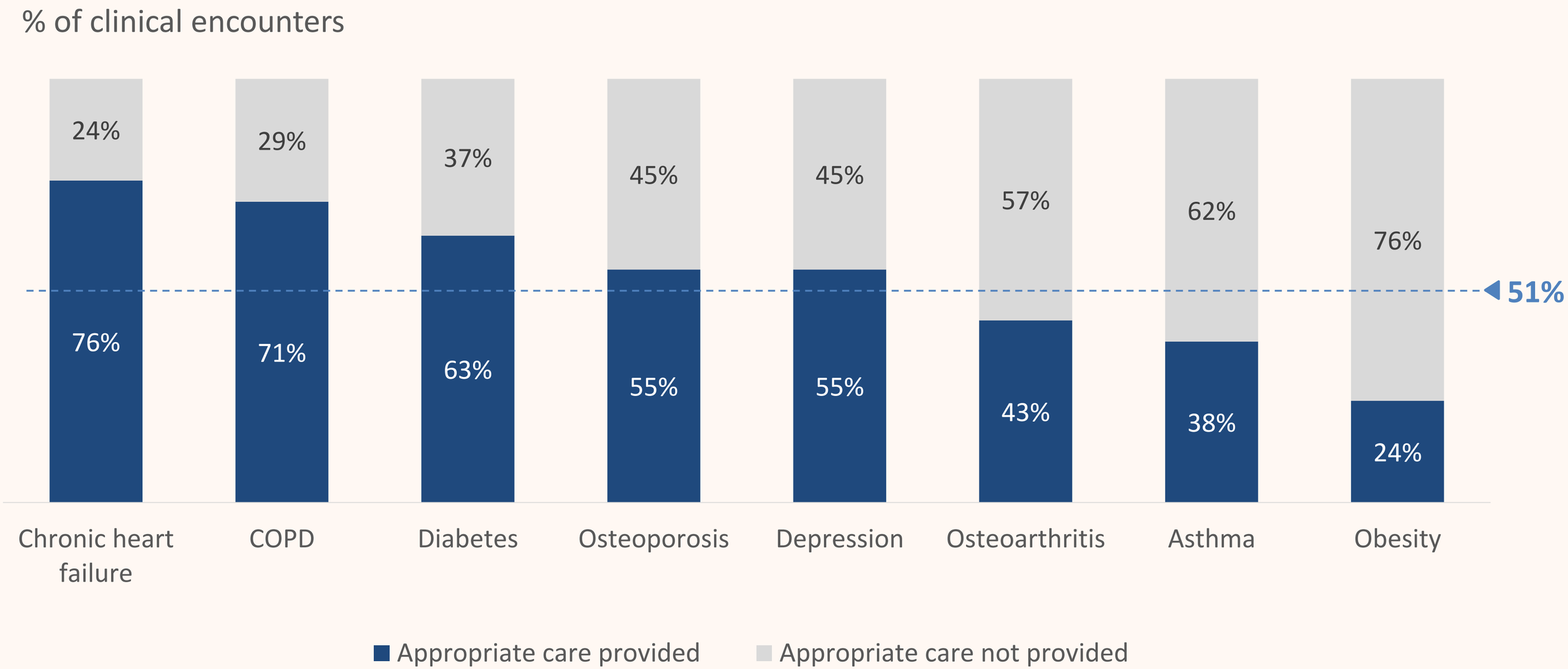
MAR, 2022

PROBLEM STATEMENT

1. **INCREASING COST**
   Ageing population & rise in chronic disease
2. **MISSED OPPORTUNITY**
   Many cases of cardiovascular disease, diabetes and cancers are preventable
3. **REACTIVE HEALTHCARE**
   System pays for activity, when people get sick
4. **INADEQUATE INVESTMENT UPSTREAM**
   Health spends 1.5% on prevention & 7% on GPs (but 40% in hospitals)
5. **GAPS IN CARE**
   50% of chronic diseases not well managed, 50-70% clinical markers do not meet target
6. **FRAGMENTATION**
   Multiple payers & jurisdictions result in diluted efforts, short term focus & limitations in innovation

OPPORTUNITY

CHRONIC DISEASE GAPS



SOURCE: CARETRACK: ASSESSING THE APPROPRIATENESS OF HEALTH CARE DELIVERY IN AUSTRALIA (MJA 2012); MEDICARE STATISTICS

OPPORTUNITY

PREVENTATIVE CARE WORKS

Integrated care

90+% of cost | **5-10% of cost**

Value chain:

Prevention and wellness	**Clinical treatments and decisions**	**Delivery of care**	**Reimbursing care**
Public health professionals	Physicians, Administrators	Hospitals, clinics	Insurers Payers

Reimburse care that is claimed

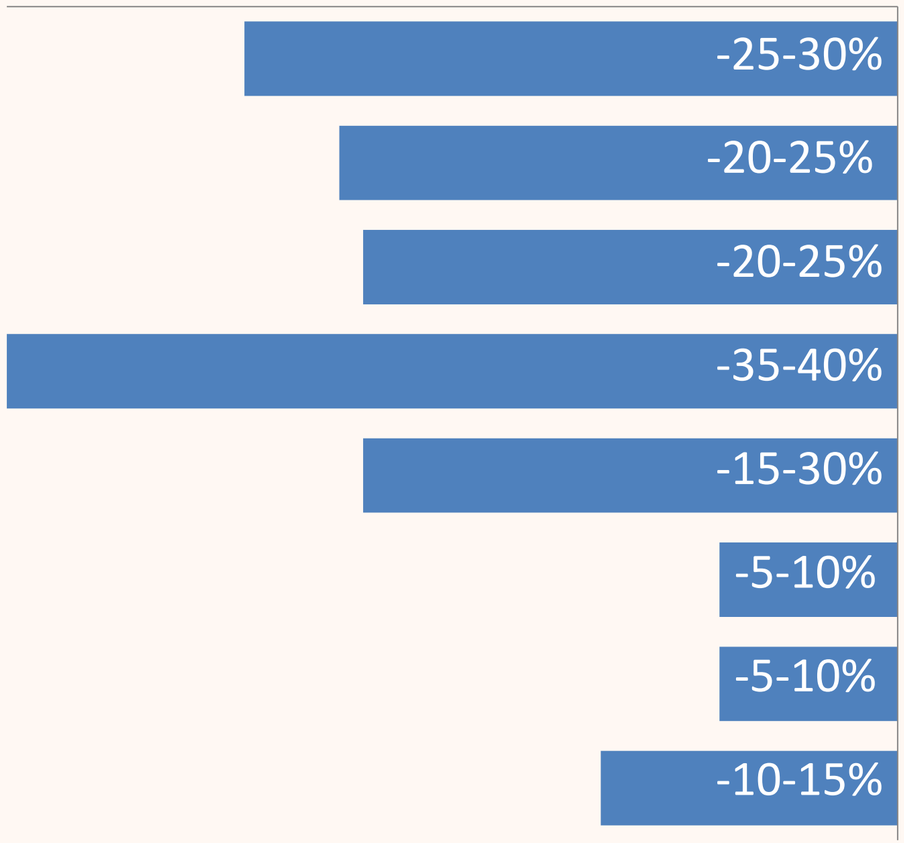
'Doing things right'
Ensuring high quality and efficiency of care delivery

'Doing the right things'
Ensuring that the right treatment choices are made for a given condition

'Preventing the need to treat'
Preventing diseases / complaints (and thereby care needed) as much as possible

SOURCE: JANCHOR AND BCG ANALYSIS

REDUCING HOSPITAL VISITS IS POSSIBLE



Levers

- **Self-management**
- **Health coaching**
- **Care planning**
- **Care navigation**
- **MDT case review**
- **Remote monitoring**
- **Rapid response team**
- **Discharge services**

Examples

neuro Montreal Neurological Institute

iorahealth

CM+ care management plus

TOWER HAMLETS TOGETHER *Delivering better health through partnership*

Project ECHO®

CSIRO

essex cares® promoting independence

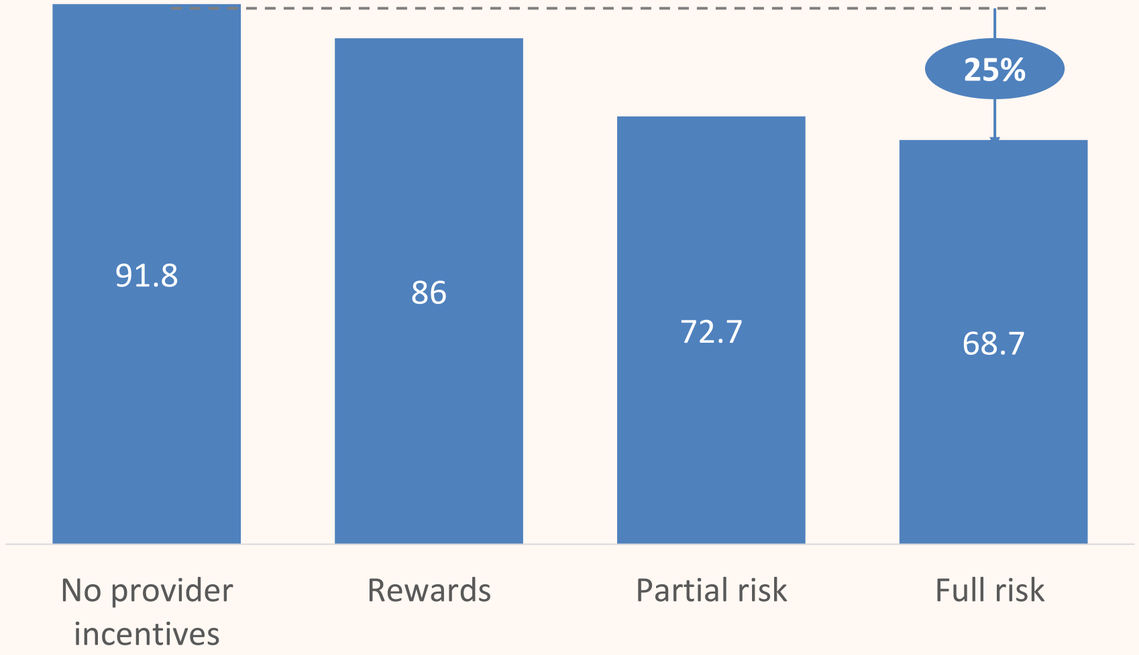
Future hospital: Caring for medical patients

SOURCE: LITERATURE REVIEW; CASE STUDIES

WHAT HAPPENS WHEN YOU SHARE WITH RISKS WITH GPS

Single year patient mortality %

Total cost vs Medicare benchmark



NOTE FFS=FEE FOR SERVICE; PPO-PREFERRED PROVIDER ORGANIZATION; HMO- HEALTH MAINTENANCE ORGANISATION; CAP-CAPITATED NETWORK
PCP – PRIMARY CARE PHYSICIAN (I.E. GP) SOURCE- BCG ANALYSIS, BASED ON DATA FROM 2013 (PRIOR TO AFFORDABLE CARE ACT)

PRIMARY CARE INNOVATIONS

PATIENT ENGAGEMENT

Health coaches to activate patients - 40% less hospital admissions and 20% lower total health care costs

Clinics designed like community centres to engage patients when they're well – 33% lower total health care costs

Community involvement and customer owners in clinical service delivery – 36% less hospital bed days and 58% less specialist visits

POPULATION HEALTH APPROACH

Digital prevention with care managers – 30% lower diabetes risk, 13% lower stroke/heart attack risk, 6 month ROI

Prevention health plans and coaching – over 50% reduction in medication costs

Team-base care with medical assistants and specialist input – 67% less hospital readmissions

VALUE BASED CULTURE

Integrated primary care and hospital service looking after a population – 25% less total health care costs

Direct, personalised primary care – 20% less total health care costs

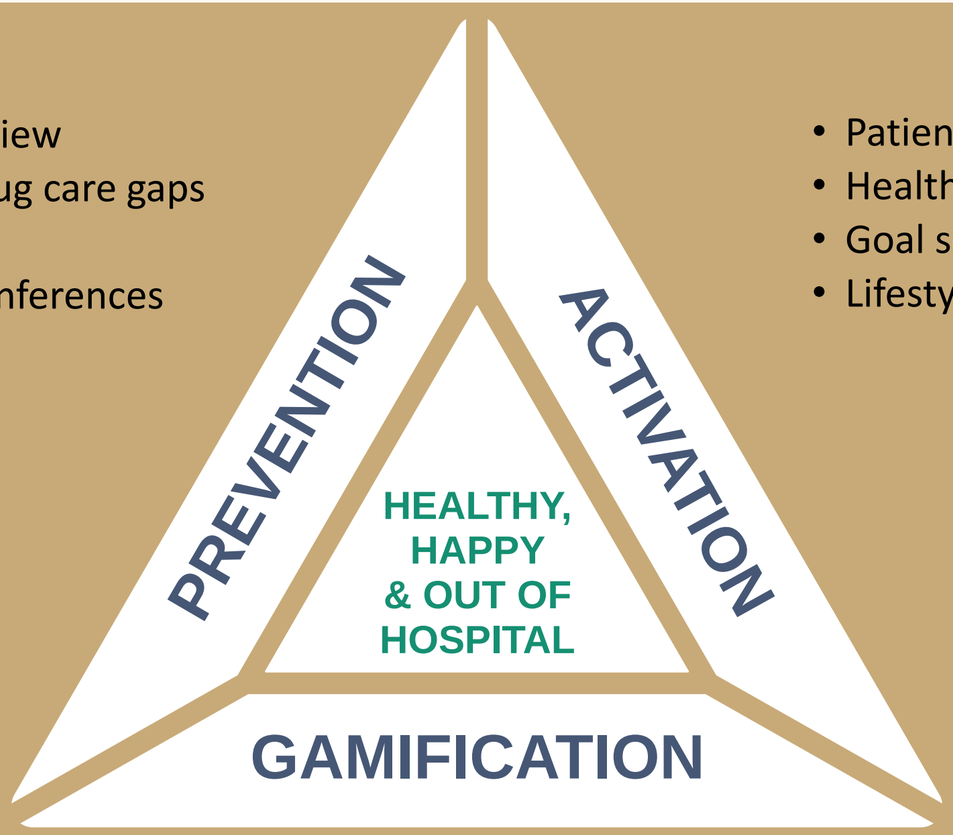
Outcomes focused, more time with less patients – 34% less ED presentations and 28% less hospital admissions

SOURCE: LITERATURE REVIEW, INTERVIEWS & WEBSITES

INNOVATION

OSANA PILOT

- Risk stratification, proactive review
- Chronic disease checklists to plug care gaps
- Slow medicine, GPs on salary
- Multi-disciplinary team case conferences



- Patient membership
- Health Assistant support
- Goal setting, health planning
- Lifestyle programs, health coaching

- Clinical dashboards linked to KPIs
- Scrubbing, huddles & quality improvement
- Staff bonuses based on results
- Patient rewards

PROUDLY

Certified B Corporation
This company meets the highest standards of social and environmental impact

AGPAL
Proudly AGPAL Accredited
Our commitment to your safety and care

OUR JOURNEY

1

2017

Secured $13m social investment funding

2

2018

Opened 3 pilot clinics in Sydney

3

2019

Signed up over 5000 members & implemented model

4

2020

Delivered results - PAM, hospital avoidance & NPS

5

2021 1H

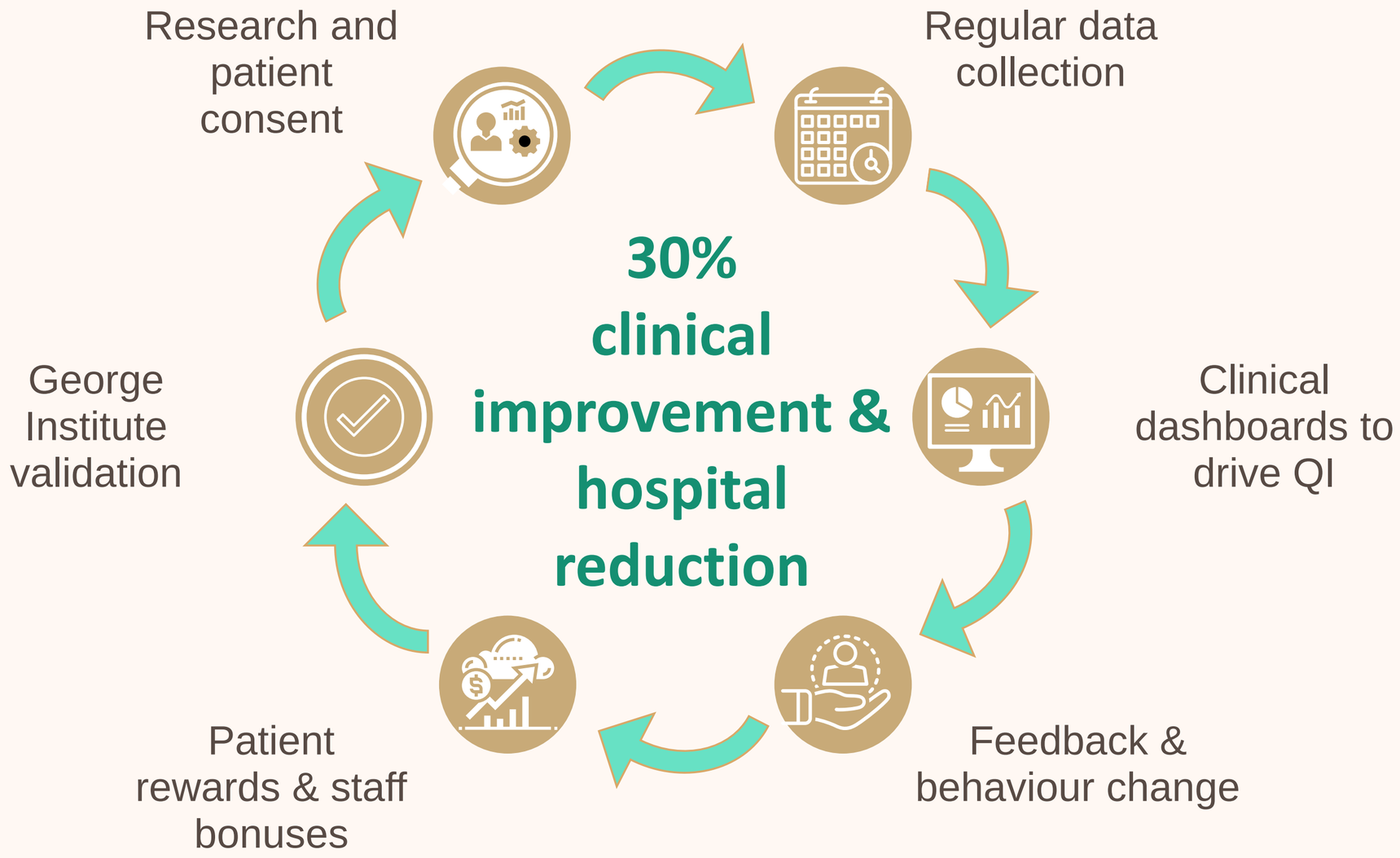
Developing Osana App & improving utilisation

6

2021 2H

Focus on value-based care & vertical integration

DATA SCIENCE

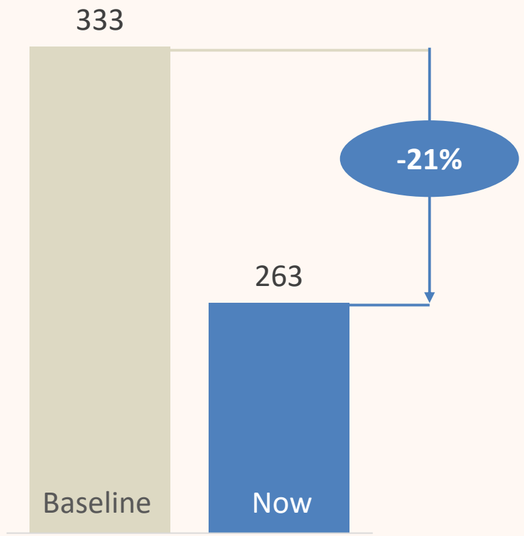


NORMAL GPs vs OSANA TEAM

Activity-driven, works on commission	**Throughput**	**Results**	Outcomes-driven, salary based
Sees patients when they book in & turn up	**Reactive**	**Proactive**	Looks after an enrolled population over time
Works by themself, referring to other clinicians	**Solo**	**Team**	Leads a team, combines expertise & delegates
Focuses on diagnosis & treatment	**Cure**	**Prevention**	Equal focus on behaviour change & lifestyle
Works in a black box – performance is opaque	**Status quo**	**Improvement**	Embraces data to drive quality improvement
Applies standard consults & protocols to all	**One size fits all**	**Individualised**	Tailors service mix & intensity to risk levels
Owns a small part of a person's care	**Silo**	**Holistic**	Works on the whole person & their lives
Rewarded by how busy they are	**Quantity**	**Quality**	Rewarded by what results they achieve

IMPROVED LIFESTYLE BEHAVIOURS

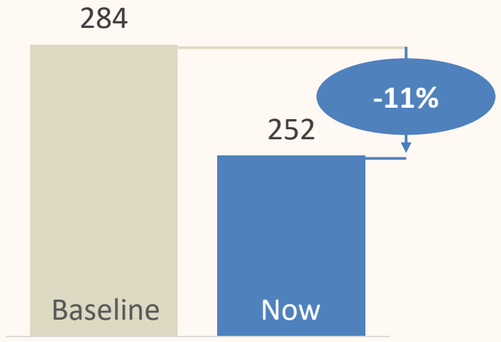
SMOKING & ALCOHOL
Number of patients



Smoking or >10 drinks/week

~$8,638 lifetime saving in medical costs per smoker
Equates to $6.1bn saving if applies to all smokers in Australia

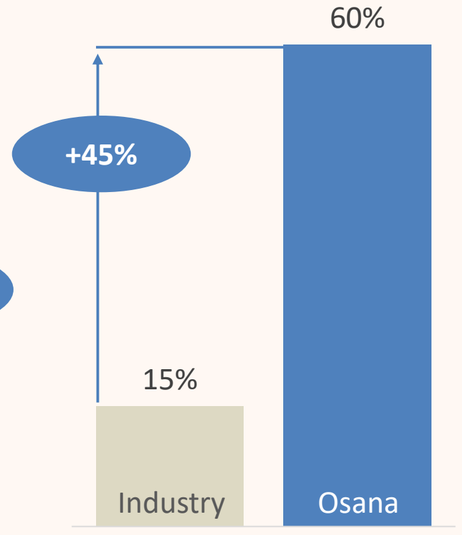
OBESITY
Number of patients



Body mass index >30

~$1,316 saving per obese person, per year
Equates to $1.2bn saving if applies to all obesity in Australia

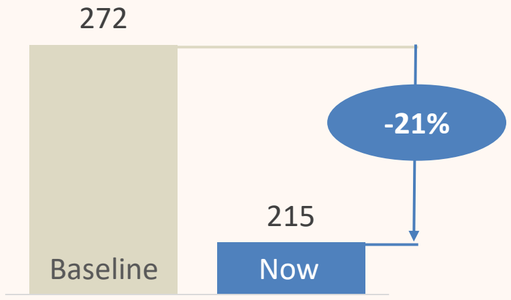
EXERCISE
% of patients



Meeting exercise goals

~$150 annual saving per person (85% don't meet guidelines)
Equates to $1.8bn saving if applies to all Australians

MENTAL HEALTH
Number of patients



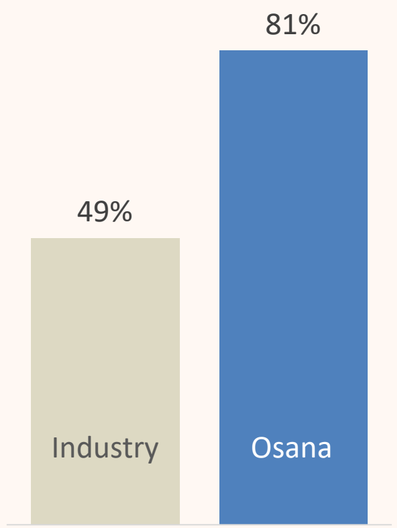
K10 score >20

~$4,000 saving pa in mental health treatment cost per person
~$4.4bn saving if applies to all mental health burden in Australia

SOURCE: OSANA DATASET; https://www1.racgp.org.au/newsgp/professional/smoking-costs-australia-close-to-137-billion; https://www.tobaccoinaustralia.org.au/chapter-17-economics/17-2-the-costs-of-smoking; https://www.mja.com.au/journal/2010/192/5/cost-overweight-and-obesity-Australia; https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1819/Quick_Guides/MentalHealth; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5997342/; https://www.brisbanetimes.com.au/national/queensland/australia-not-meeting-new-who-guidelines-for-physical-activity-20201126-p56ict.html

BETTER CHRONIC DISEASE CARE

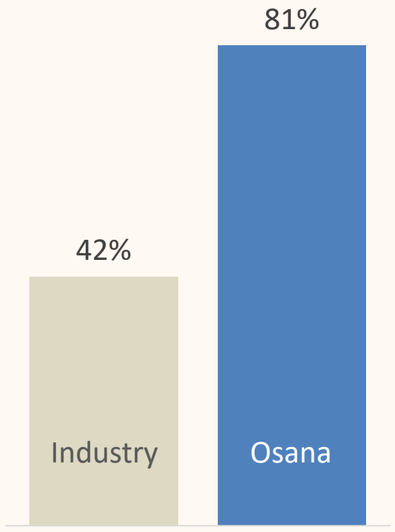
DIABETES
% of patients meeting target



7.5% HbA1c target

~$6,100 annual savings, per diabetes patient if meets target
Equates to $2.3bn savings if applied to all diabetes in Australia

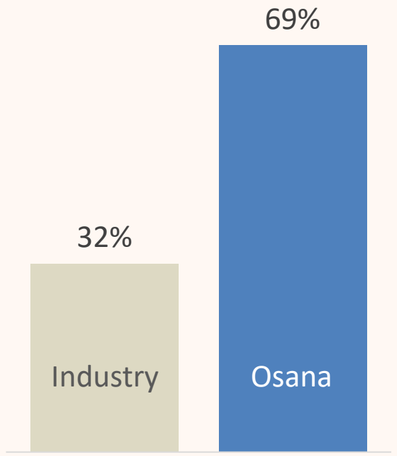
HEART DISEASE
% of patients meeting target



140/90 BP & 4.5 Chol target

~35% reduction in cardiac events if meet target
~$499m saving per year if impacts all heart attacks in Australia

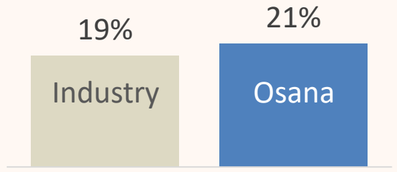
HYPERTENSION
% of patients meeting target



140/90 target

~25% reduction in cardio-vascular events if meet target
Equates to $1.2bn saving if impacts all BP events in Australia

OSTEOARTHRITIS
% change in functional survey



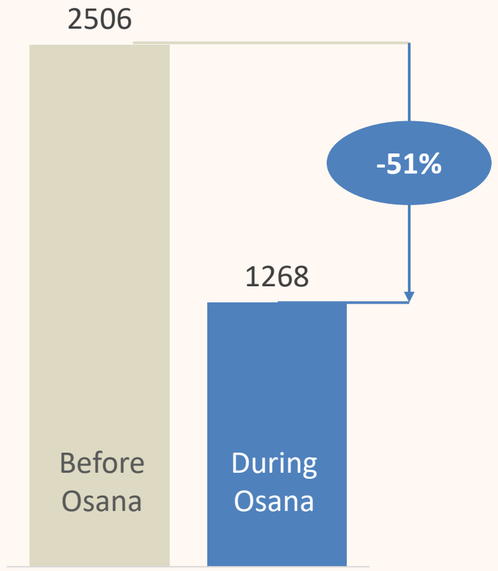
Increase in Oxford Knee

Can save or delay **~$15,000 knee operation cost** per patient
Equates to $1.1bn saving in 2030 if 20% avoid surgery

SOURCE: OSANA DATASET; UK PROSPECTIVE DIABETES STUDY; AUSDIAB STUDY; HTTPS://WWW.AIHW.GOV.AU/REPORTS/DIABETES/DIABETES-INDICATORS-STRATEGY-2016-2020/CONTENTS/BACKGROUND-INDICATOR-DASHBOARD; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4270450; https://www.aihw.gov.au/reports/risk-factors/high-blood-pressure/contents/high-blood-pressure ; https://www.ahajournals.org/doi/10.1161/hypertensionaha.115.06814; https://bmcmusculoskeletdisord.biomedcentral.com/track/pdf/10.1186/s12891-019-2411-9.pdf; https://baker.edu.au/news/media-releases/code-red-cholesterol-report#:~:text=%E2%80%9CIn%20this%20study%2C%20not%20only,men%2C%E2%80%9D%20Professor%20Carrington%20said.; https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/heart-disease-risk-factors

LOWER HOSPITAL ADMISSION RISK

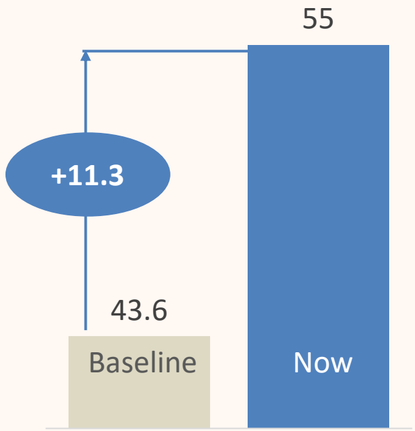
HOSPITAL AVOIDANCE



Hospital bed days

~$2.59m savings per 6000 people, per annum
Equates to $11.2bn saving when applied to Australian population

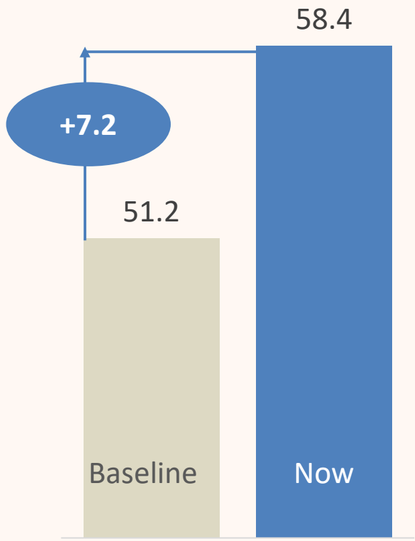
PATIENT ACTIVATION
Level 1 PAM



Patient Activation Measure

~19.2% hospital reduction in the future for this 15% of population
Approximate $2.6bn saving against Australian hospitalisations

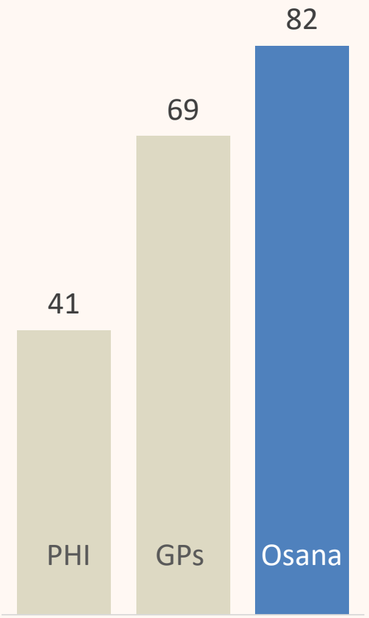
PATIENT ACTIVATION
Level 2 PAM



Patient Activation Measure

~12.2% hospital reduction in the future for this 20% of population
Approximate $1.7bn saving against Australian hospitalisations

MEMBER SATISFACTION



Net Promoter Score

Promoters have **16% higher compliance** and **8% lower readmissions**
Equates to $107m readmissions saving per annum if applied across Australia

SOURCE: OSANA DATASET; INDEPENDENT HOSPITAL PRICING AUTHORITY: NATIONAL HOSPITAL COST DATA COLLECTION; CAROL REMMERS. THE RELATIONSHIP BETWEEN THE PATIENT ACTIVATION MEASURE, FUTURE HEALTH OUTCOMES, AND HEALTH CARE UTILIZATION AMONG PATIENTS WITH DIABETES. KAISER CARE MANAGEMENT INSTITUTE, JUDITH HIBBARD PUBLICATIONS. PETER EVERETT, THE VOICE OF THE PATIENT, https://medicalrepublic.com.au/racgp-private-company-bankrupt/16663. Medibank Private Annual Report; https://nrchealth.com/how-to-use-nps-in-healthcare-a-primer-from-mu-health-cares-cxo/; health.gov.au (Indicator 14: Readmissions per year); AIHW – Hospital admissions in Australia

ACTION

Population health

- Track care gaps, results & hospital visits in real time
- Invest in services that help patients feel healthier & happier

Commissioning

- Procure services that work & achieves the best outcome
- Measure all tax-funded care with a Return-On-Investment lens

Strategy

- Encourage industry reform through a grass-roots approach
- Ensure allocative efficiency by pulling primary care levers

Quality

- Create transparency on performance across GPs
- Navigate patients to services with best bang for buck

Implications for PHNs

OSANA

CONTACT — KEVIN IS HAPPY TO CHAT TO PHNs & SHARE LEARNINGS ANYTIME

KEVIN.CHENG@OSANA.CARE

+61 448 006 666

WWW.OSANA.CARE

Q&A

1 How to make new/Osana's model of care financially sustainable?

- If primary care teams deliver **20-30% better health outcomes**, then patients will be better off & they will need less downstream health services over time, such as medications, hospitals, procedures and specialists. This means less burden on our hospital system, and State Governments, health insurers or public hospitals can harvest potential savings to fund value-based care. It's a win-win.
- To run a model like Osana, you would need approximately **$500 (per person) from State Government or health insurers**, in addition to Medicare and patient co-payments. This would allow a model of care like Osana to breakeven. Alternatively, business partnerships and private funding for "medical wellness" services can ensure sustainability through a corporate health approach.

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2 What prevents system change and how do we overcome barriers?

- There's a long list of reasons why change programs fail (about 70% of them fail according to McKinsey research). In healthcare, it's often clinical inertia, lack of flexible funding to promote innovation, medico-politics and short-term focus of executives that operate health services. But I think the biggest reason is our fee for service orientation, where services are paid based on activity rather than on results
- To change, we need to (i) **tell our communities & industry** about the need & importance of preventative health – most chronic diseases are preventable (ii) build **skills & capabilities in population health management** (iii) **provide incentives for change**, such as rewards & recognition for health improvements, and (iv) showcase **examples and role models** of clinicians who are already implementing change.

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3 What did we do to collect data & display as dashboards?

- We looked at market options such as The Clinician, POLAR, Pen CS, plus talked to the server and cloud based medical record providers – ultimately they were all consultation-focused or were bolt-on Apps that measured data at different points in time. We needed to collect data along the entire 2-3 year journey whilst we provided a longitudinal service under our model of care & tie results to incentives.
- Therefore we built our own App to **digitise the data collection process**, along with our **own health assessment, chronic disease checklist & care planning tools**, our own **BI dashboards**, and more recently a **gamification tool** to reward tokens for healthy behaviour change. Data and health results have become the currency for measuring, evaluating and refining what we do every day at Osana.

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4 What can PHNs do to innovate and learn from the Osana pilot?

- There are 3 ways PHNs can shape their destiny rather than await for primary care policies from Canberra. First, **find a bucket of flexible funding and just get started** with local GPs & primary care teams; it matters less what they do and who they do it to, but more that they do something to initiate change at the frontline. Second, **measure the Return on Investment in every service** you commission; let's all agree the service metrics (how many minutes, consultations, referrals) are less important than the impact on patients (end outcomes & clinical results). Work with local universities or clinical schools. Third, get in touch with us at Osana – we're happy to train local GPs, share what we do in an open book way, and **help you build population health capabilities** to enable healthier & happier communities!