AbsoluteCare

BEYOND MEDICINE

Providing concierge care for our most vulnerable and chronically ill neighbors. We address medical, behavioral, and life challenges through a PCP-led care team in our clinics and communities.

Identify
Using proprietary algorithms to identify the population best suited for our model

Engage
Team-based approach engages each member in the way that will be most effective for them

Transform
Change the member's health trajectory & life to improve outcomes & reduce risk

Primary Care:
We accept same-day and walk-in appointments. In-house x-ray, pharmacy with deliver and more.

Chronic Disease Management:
Our PCP-led, integrated teams work to create a treatment plan that focuses on a member's whole health.

Behavioral Health:
We create trust and work with members to achieve their personal health and life goals.

SDoH:
Access to housing, Food is Medicine program, transportation, social & community support, etc.

National Results

400% Increase in Primary Care Visits

50% Reduction in Inpatient Admissions

49% Reduction in Inpatient Days

24% Reduction in Specialist Visits

92%	94%	98%	100%	86%
Hypertension control	Breast cancer screening	Diabetic HbA1c testing	Annual SSI adult visit	Cervical cancer screening

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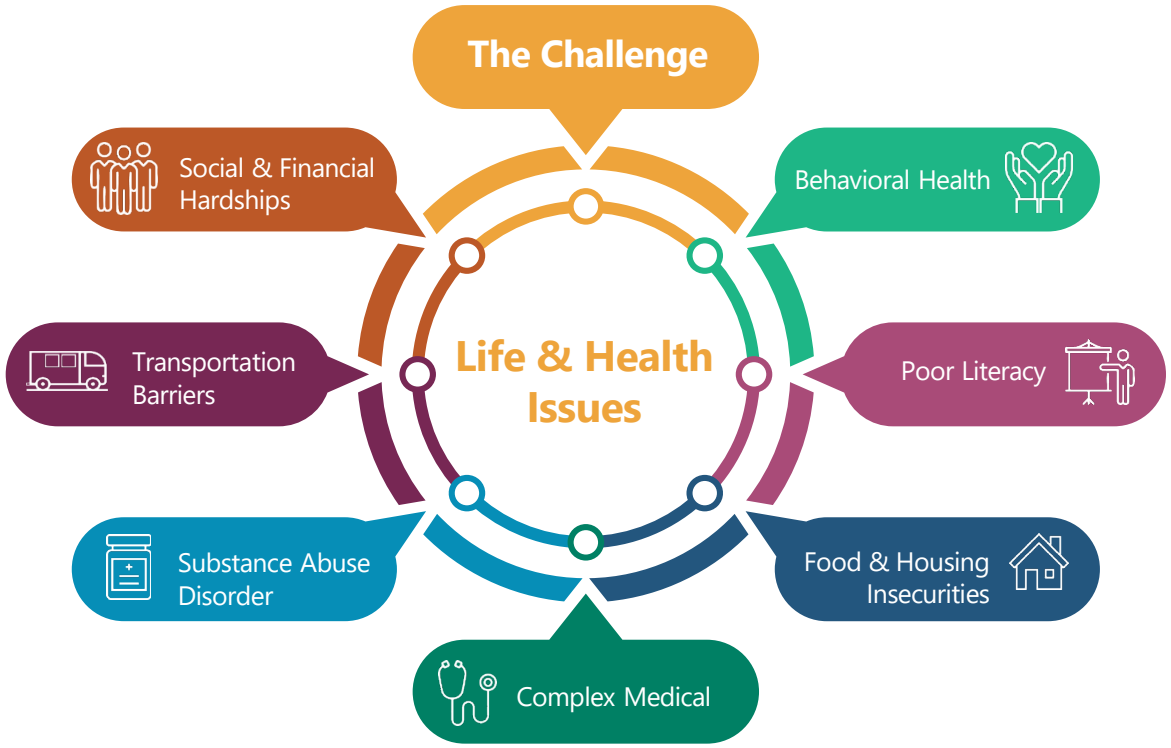

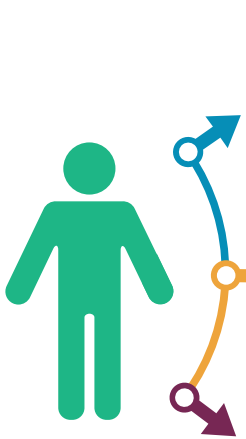

Behavioral Health and Substance Use Disorders
50% of our members suffer from behavioral health issues and/or substance use disorders

Medical and Pharmacy Needs
On average, our members have 13 diagnoses, and are on 10 medications

Social Determinants of Health (SDoH)
On average 77% of our members purport having food insecurity, 18% have unstable housing, and 13% experience illiteracy

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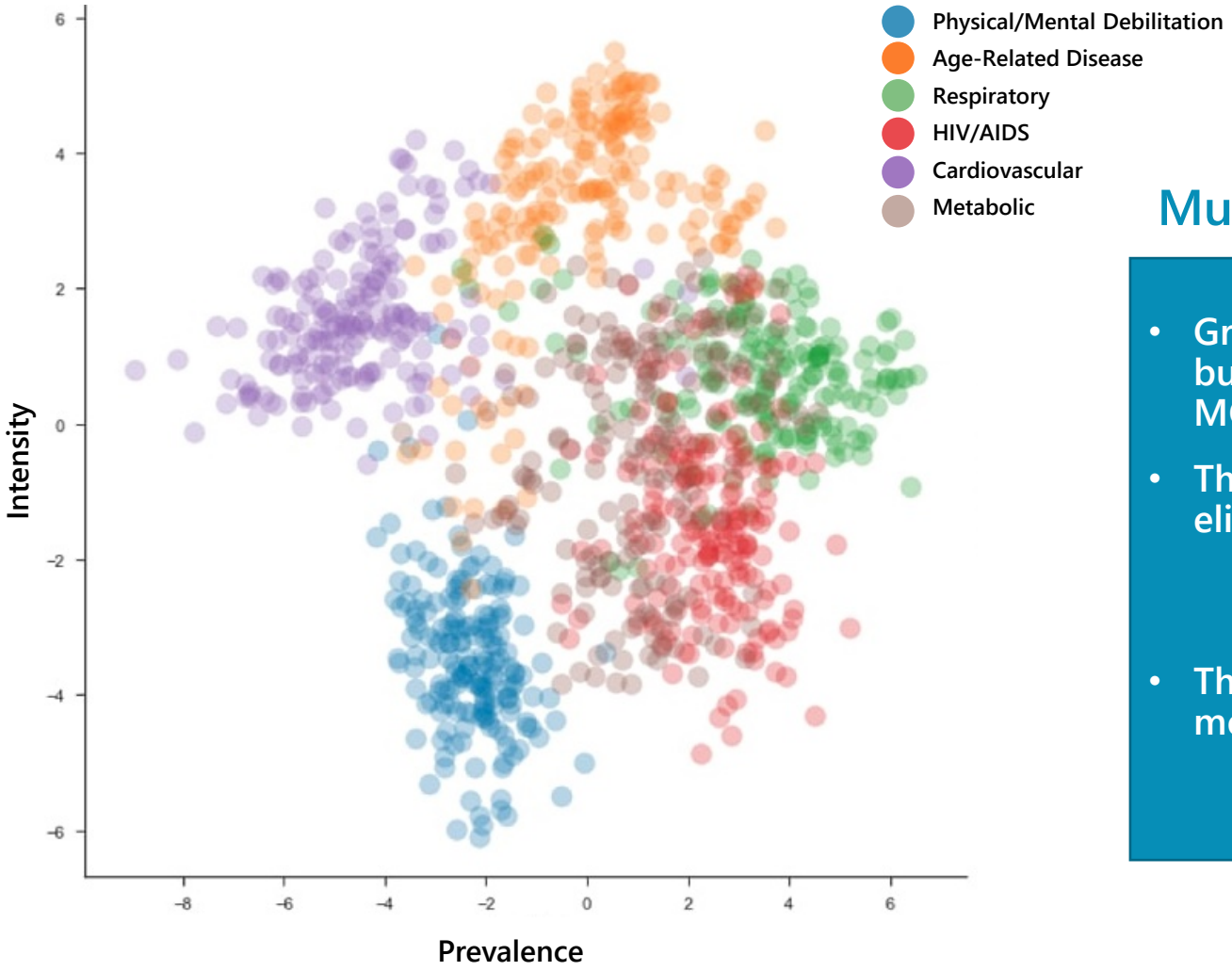

Multiple Chronic Condition ("MCC") Clustering

- Graph is a sample representation the intersection of illness burden, utilization, and persistence over time of a subset of MCC clusters
- The attribution approach provides the flexibility to tailor the eligible population based upon a health plan's priorities
  - Individuals with 2 or more clusters
  - Individuals with 3 or more clusters
- The attribution method yields persistent, high-cost members with costs 3-5+ times average

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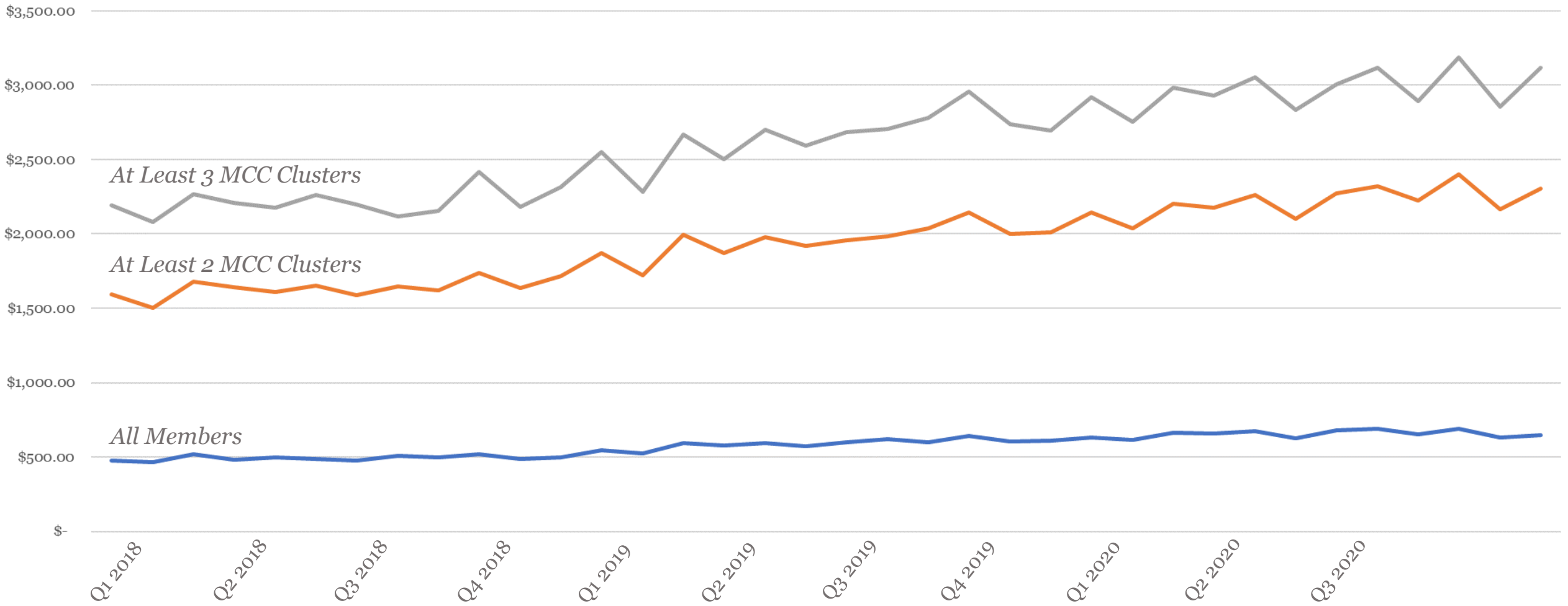

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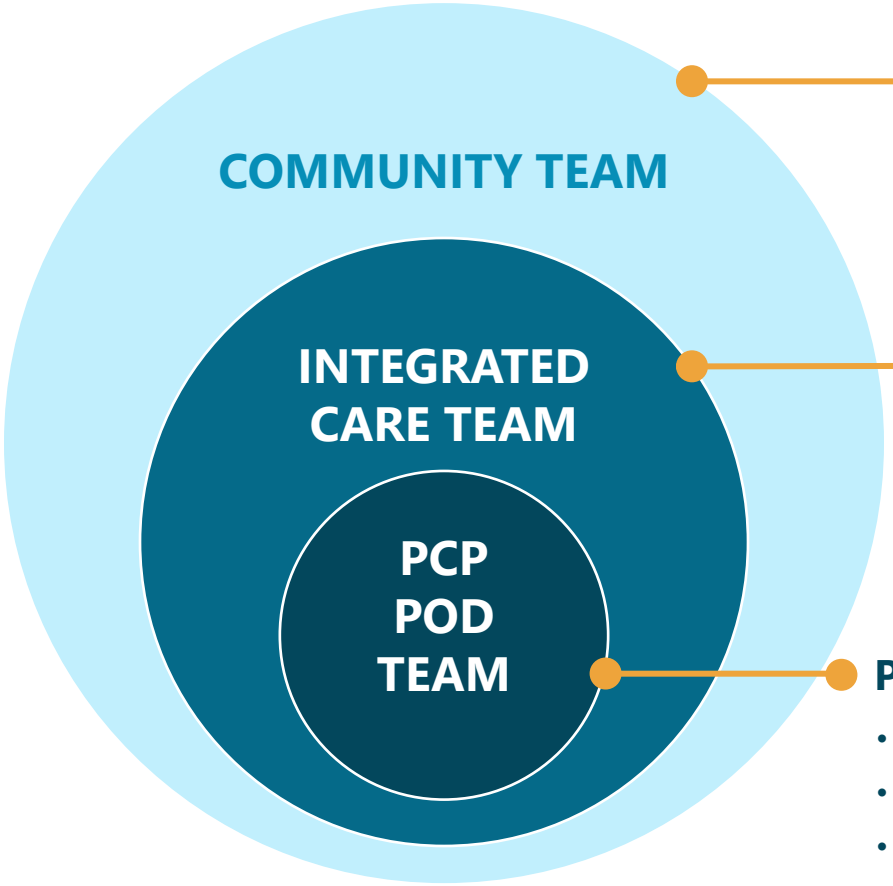

PCP Pod Team

- PCP
- 2 RN Care Managers
- LCSW
- 2 Medical Assistants
- X-ray & Labs

Integrated Care Team

- Transitional Care Managers
- Behavioral Health (PhD, MSW)
- Substance Use Treatment
- Pharmacy
- Medication Therapy Management
- Acute Treatment, Urgent Care & Infusions
- Infectious Disease
- Nutrition

Community Team

- Community Health Worker & Outreach
- New Member Enrollment
- Transitional Care Management
- Home-based Care
- Home-based RN Care Manager
- Social work
- Transportation
- Network Team

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IDENTIFY

55-year-old male with a history of GI bleeds, osteoarthritis, an unsteady gait, & substance use disorder. Presenting to the ED each night as a result of his SUD & his homelessness.

ENGAGE

Established trust to stabilize life issues: placed him in housing, enrollment in Food is Medicine Program, & completed SSI application.

TRANSFORM

Immediate impact on utilization:

- **Street homeless – annual utilization $255,542**
- **Stable housing – annual utilization $719**

99.7% COST REDUCTION

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Our care goes beyond medicine.