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Caring for Older Adults in a Value-Based Model

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Based in Chicago, Oak Street Health provides value-based primary care exclusively to older adults in underserved urban neighborhoods, driving industry-leading patient satisfaction scores, quality metrics, and a reduction in hospitalizations.

KEY TAKEAWAYS

1. Focusing exclusively on one population — for us, older adults, who are typically low-income and living in underserved, urban neighborhoods — allows care teams to truly "specialize" in the unique needs of that population.
2. Devoting more resources to primary care — measured in time spent with a physician, number of primary care visits, or simply dollars of primary care expense — can reduce unnecessary and expensive acute episodes.
3. The population health model is most effective when practically implemented, relying as much on culture and routine as on technology.

The Challenge: The average older adult is 73 years old and has significant health concerns: 24% have diabetes, 17% have congestive heart failure, and 12% have major depression. Yet she (55% are female) is also ill-equipped to manage her health: 56% have a high school education or less, 45% live under 200% of the federal poverty line, and 29% live alone. The average older adult makes just three visits to a primary care physician/provider per year, each lasting a mere 17 minutes. The mismatch is even worse for older low-income adults and for those in underserved urban neighborhoods where access to health care services is often poor.

> *The everyday mantra for Oakies, as we call ourselves, is simple: keep our patients happy, healthy, and out of the hospital."*

The Goal: The goal at Oak Street Health is to deliver excellent primary care to older adults in a value-based economic model. We operate a globally capitated, at-risk model in which better outcomes and lower costs are rewarded. The everyday mantra for Oakies, as we call ourselves, is simple: keep our patients happy, healthy, and out of the hospital. Why? Happy patients engage in their care. Engaged patients are more likely to be healthy. And healthy patients don't require expensive hospital admissions. We invest in prevention to reduce downstream costs. That is the virtuous cycle of value-based primary care that we are trying to achieve.

The Execution: We founded Oak Street Health in 2012 to be an at-risk network of primary care clinics exclusively for older adults. We started with a single clinic and, with backing from venture capital, have grown to 15 locations across the Midwest. Our typical clinic is located in a low-income neighborhood, can serve 2,000-4,000 patients in a footprint of 8,000 square feet, and employs over 50 health care professionals, most of whom live in or near the neighborhoods they serve. Roughly 50% of our patients are "dual-eligibles" (e.g., Medicare and Medicaid), though the rate in some clinics reaches 80%. Successful execution of our model rests on three principles: (1) a value-based economic model, (2) integrated population health, and (3) team-based care.

Our Value-based Practice

The Oak Street business model is an integral part of supporting the way we deliver care. Rather than a traditional fee-for-service model, we are a globally capitated/at-risk practice. We partner with not-for-profit and for-profit health plans to create risk-sharing contracts with Medicare Advantage and dual demonstration programs. Although we serve everyone with Medicare who seeks care with us (including fee-for-service Medicare), some 80% to 85% of our patients are in Medicare Advantage or dual-eligible programs.

> *While medical scribes are a growing part of the health care workforce, Oak Street ninjas [clinical informatics specialists] are tasked with far more than mere data entry."*

Because we have financial responsibility for the entirety of care for these patients — all primary, specialty, acute, and post-acute care — we can make substantial investments in primary care services that have a positive health (and therefore economic) return for our practice. These services allow us to build relationships with our patients, and include transportation between home and primary care visits, substantially longer primary care visits (averaging over 30 minutes), and in-house care management that helps patients coordinate their care across multiple providers. The economic model thus fuels the care model.

Our Technology-enabled Approach to Population Health

Oak Street also has a highly structured and data-driven approach to population health. With the help of processes that we developed, patients are "triaged" into one of four tiers based upon inputs such as age, comorbidities, recent utilization patterns, and degree of social support. A patient's tier helps to determine a variety of parameters to his/her care, including primary care visit cadence and allocation of care management resources. For example: the sickest 5% of our patients are identified as "Critical," and Oak Street works to see them in our clinic once every three weeks. Conversely, the healthiest 30% — classified as "Good" — are scheduled far less frequently.

A patient's tier is constantly reevaluated. As a part of this iterative triage exercise, patients undergo regular, structured geriatric assessments that include evidence-based screenings for depression, fall risk, and adverse drug interactions. These assessments feed into a population health function that captures the need for indicated preventive testing, such as colorectal cancer screening.

More than just a simple software solution, Oak Street's model of population health combines automation with manual routines that are run by a team working across all of our clinics to identify, refine, and share population-level insights. This creates specific tasks and tools (for example, monitoring medication compliance) that guide patient care. This population health team helps to answer critical questions, such as which patients are at highest risk for admission, or haven't been to clinic in a while, and thus are unengaged with their care. The information equips our primary care teams to build relationships, educate patients, and improve outcomes.

Our Team-Based Model

Oak Street care teams consist of a physician, nurse practitioner, registered nurse, medical assistant, care manager, and clinical informatics specialist. Team members have explicit roles during and between visits, and teams have structured daily "huddles" to ensure that resources are focused on patients with greatest need.

One unique part of our team-based approach is the role of the clinical informatics specialist, whom Oakies lovingly call the "ninja." As one may expect, practicing medicine in an at-risk model with a highly comorbid population requires the collection, analysis, and use of an enormous amount of data at the bedside. While medical scribes are a growing part of the health care workforce, Oak Street ninjas are tasked with far more than mere data entry. They capture and structure clinical data at the point of care and deliver population health insights as the clinician executes the care plan, during and between visits. Typically "ninjas" are pre-medical or medical students who defer their studies for a year or two to join Oak Street. They undergo intensive training on ICD-10, data documentation processes, CPT coding, population health dashboards, and other technology platforms.

40%+

reduction in hospitalizations of managed care patients

The Metrics: We regularly measure three high-level objectives that address our "happy, healthy, and out of the hospital" mantra:

1. **The patient experience as customer experience:** Oak Street uses the Net Promoter Score as a summary metric for patient satisfaction and has achieved a net promoter score of 91 (versus a score of 3 for primary care overall on a scale of -100 to +100 as described by The Advisory Board).
2. **Evidence-based preventive/chronic care:** For managed care patients who have been in the practice for at least 12 months, Oak Street has achieved a 5-star rating in HEDIS metrics.
3. **Hospital admissions:** Relative to a geographically-matched Medicare cohort, Oak Street has achieved a 40%+ reduction in hospitalizations of managed care patients from 364 to just over 200 admissions per 1,000 beneficiaries per year, in a population that is notably sicker than average as measured by correlates for morbidity such as socioeconomic status, Medicaid (i.e., "dual-eligible") status, and prevalence of disease conditions relative to benchmarks.

Where to Start: An organization interested in a value-based model of care should consider:

- Is your organization structured to allow team-based care? Is your reporting infrastructure sufficient to support the practice of population health?
- Are primary care providers able to lead and manage a team? Do they share the vision and mission to practice in a team-based model with full transparency of clinical outcomes/performance and in recognition of scarce resource allocation?
- Is your organization committed to transitioning to a value-based economic model, or are traditional fee-for-service economics too ingrained to change?

Disclosure: Griffin Myers, Geoff Price, and Mike Pykosz are founders and part owners of Oak Street Health.

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