OAK STREET HEALTH

Population Health Colloquium
20 March 2018

Griffin Myers, M.D., M.B.A.
Co-founder & Chief Medical Officer

OAK STREET HEALTH

REBUILDING HEALTH CARE AS IT SHOULD BE

Personal
Equitable
Accountable

OAK STREET HEALTH

- Primary care centers for adults on Medicare.
- In medically-underserved communities (i.e.,>50% dually eligible).
- Located in high-density, low-income areas to create access.
- Integrate primary care, care management, transportation among other services.
- Fully “at-risk” for all cost of care.

CONCIERGE WITHOUT A FEE

OAK STREET HEALTH

25
CENTERS
(37 by December)

6
MARKETS
(8 by December)

11
HEALTH
PLAN PARTNERS

1,200
OAKIES

140
PROVIDERS

5
YEARS

42,000
PATIENTS

OAK STREET HEALTH

WHAT DO WE MEAN “FULL-RISK?”

Serve >50% dually eligible patients in communities with poor access to care.

Oak Street is 100% accountable to what patients need, all cost of care.

Enables Oak Street to invest in interventions that don’t add up under shared savings.

OAK STREET HEALTH

WHAT IS POPULATION HEALTH?

Are we talking about the same thing?

OAK STREET HEALTH

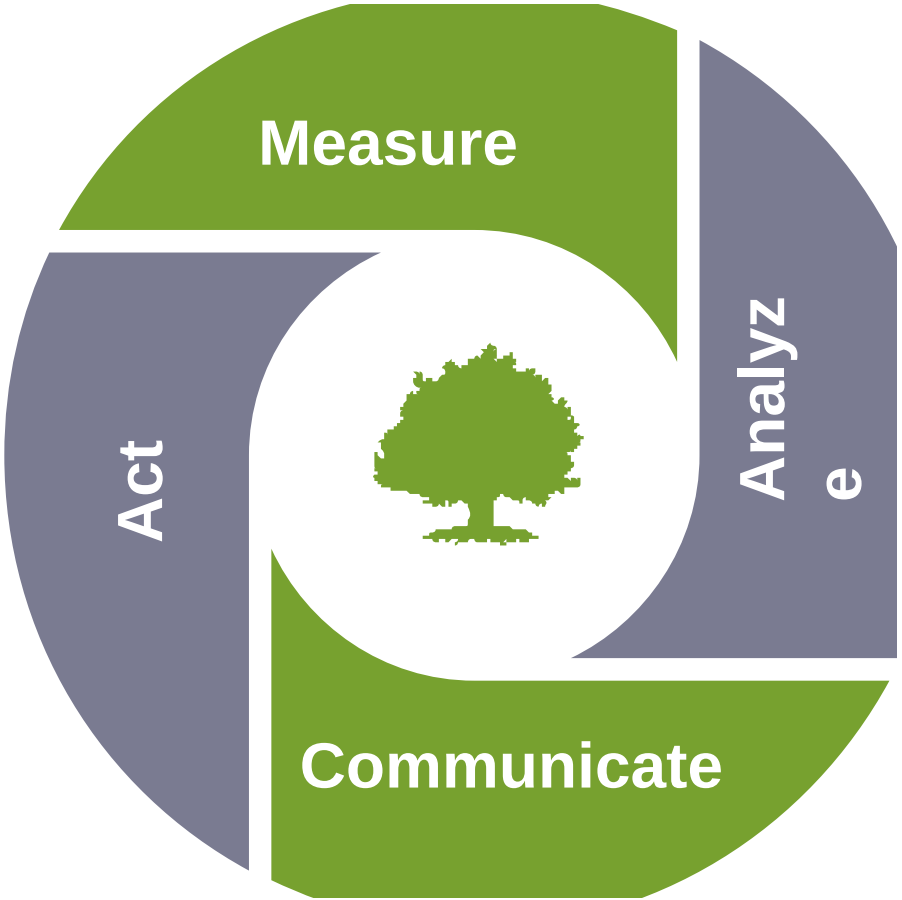
Delivery of evidence-based care to a population

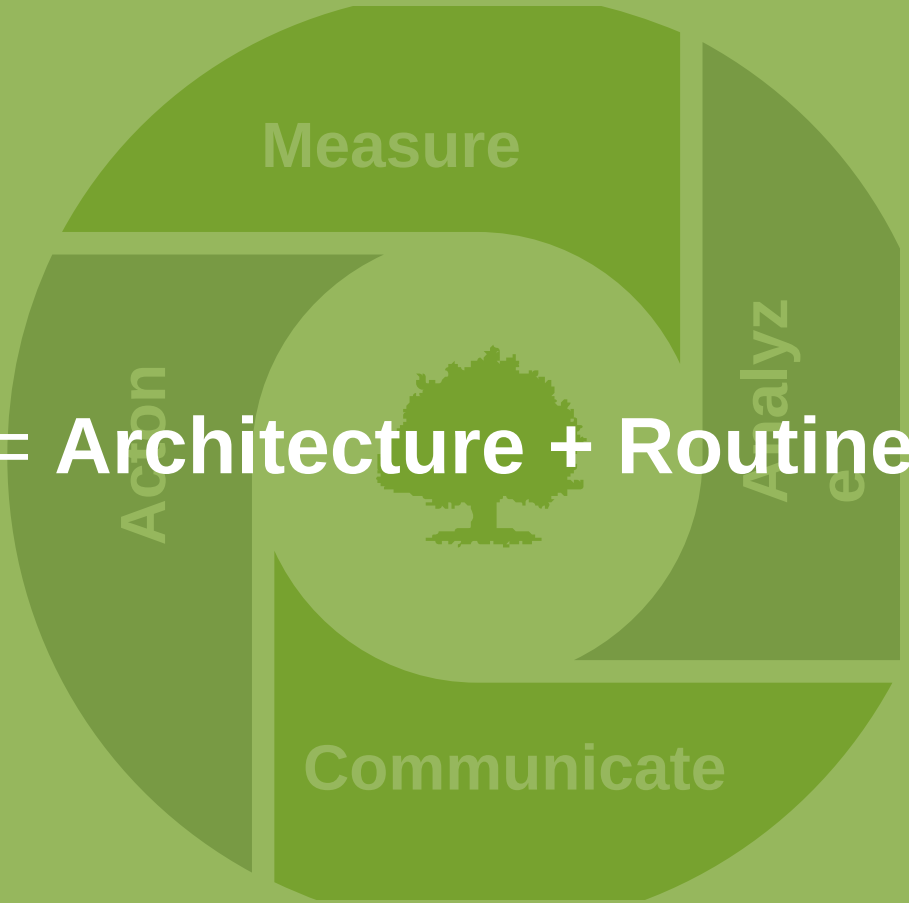
Must create measurably better health outcomes

OAK STREET HEALTH

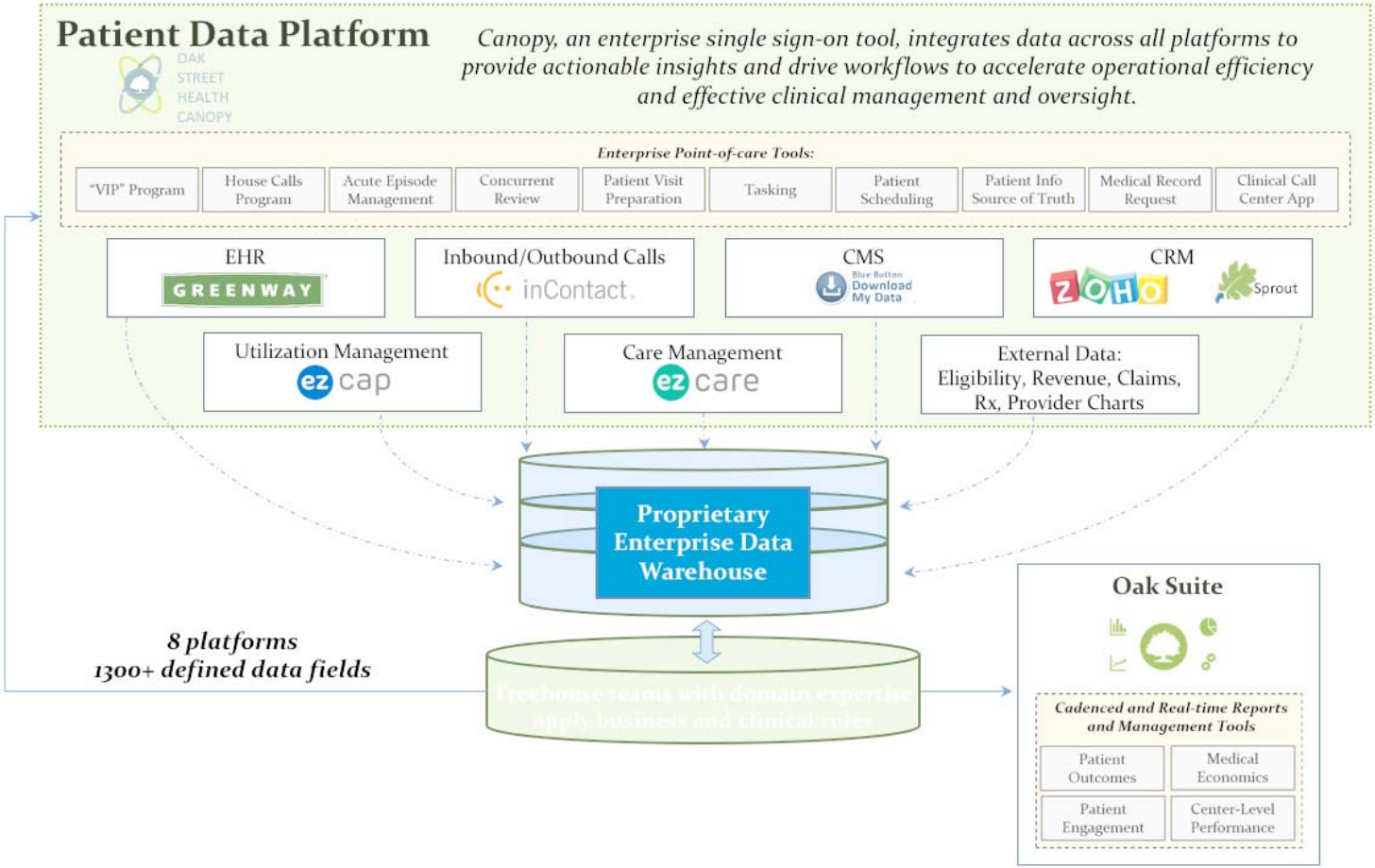
WE THINK ABOUT DELIVERING POPULATION HEALTH AS CLOSED-LOOP CYCLES


1
Measure what is going on, i.e., create/capture data
2
Analyze the data to generate actionable insight
3
Communicate the insight with caregiver(s)
4
Act on the insight, i.e., facilitate behavior change in caregiver(s) and/or patient(s)


Measure
Analyze
Communicate
Act



Platform = Architecture + Routines + Culture


Patient Data Platform
OAK STREET HEALTH CANOPY
Canopy, an enterprise single sign-on tool, integrates data across all platforms to provide actionable insights and drive workflows to accelerate operational efficiency and effective clinical management and oversight.
Enterprise Point-of-care Tools:
"VIP" Program
House Calls Program
Acute Episode Management
Concurrent Review
Patient Visit Preparation
Tasking
Patient Scheduling
Patient Info Source of Truth
Medical Record Request
Clinical Call Center App
EHR
GREENWAY
Inbound/Outbound Calls
inContact
CMS
Blue Button Download My Data
CRM
ZOHO
Sprout
Utilization Management
ezcap
Care Management
ezcare
External Data: Eligibility, Revenue, Claims, Rx, Provider Charts
Proprietary Enterprise Data Warehouse
8 platforms
1300+ defined data fields
Treehouse teams with domain expertise apply business and clinical rules
Oak Suite
Cadenced and Real-time Reports and Management Tools
Patient Outcomes
Medical Economics
Patient Engagement
Center-Level Performance

OAK STREET HEALTH

LET’S TALK ABOUT TWO REAL EXAMPLES

1 Supporting Our Inpatients
2 Supporting Targeted Benefits

OAK STREET HEALTH

SUPPORTING OUR INPATIENTS

Interventions to Reduce 30-Day Rehospitalization: A Systematic Review

Luke O. Hansen, MD, MHS; Robert S. Young, MD, MS; Keiki Hinami, MD, MS; Alicia Leung, M

Background: About 1 in 5 Medicare fee-for-service patients discharged from the hospital is rehospitalized within 30 days. Beginning in 2013, hospitals with high risk-standardized readmission rates will be subject to a Medicare reimbursement penalty.

Purpose: To describe interventions evaluated in studies aimed at reducing rehospitalization within 30 days of discharge.

Data Sources: MEDLINE, EMBASE, Web of Science, and the Cochrane Library were searched for reports published between January 1975 and January 2011.

Study Selection: English-language randomized, controlled trials; cohort studies; or noncontrolled before–after studies of interventions to reduce rehospitalization that reported rehospitalization rates within 30 days.

Data Extraction: 2 reviewers independently identified candidate articles from the results of the initial search on the basis of title and abstract. Two 2-physician reviewer teams reviewed the full text of candidate articles to identify interventions and assess study quality.

Data Synthesis: 43 articles were identified, and a taxonomy was developed to categorize interventions into 3 domains that encompassed 12 distinct ac
tient education, mec
scheduling of a follo
charge interventions
activated hotlines, timely communication with ambulatory providers, timely ambulatory provider follow-up, and postdischarge home visits. Bridging interventions included transition coaches, physician continuity across the inpatient and outpatient setting, and patient-centered discharge instruction.

Limitations: Inadequate description of individual studies' interventions precluded meta-analysis of effects. Many studies identified in the review were single-institution assessments of quality improvement activities rather than those with experimental designs. Several common interventions have not been studied outside of multicomponent "discharge bundles."

Conclusion: No single intervention implemented alone was regularly associated with reduced risk for 30-day rehospitalization.

Primary Funding Source: None.

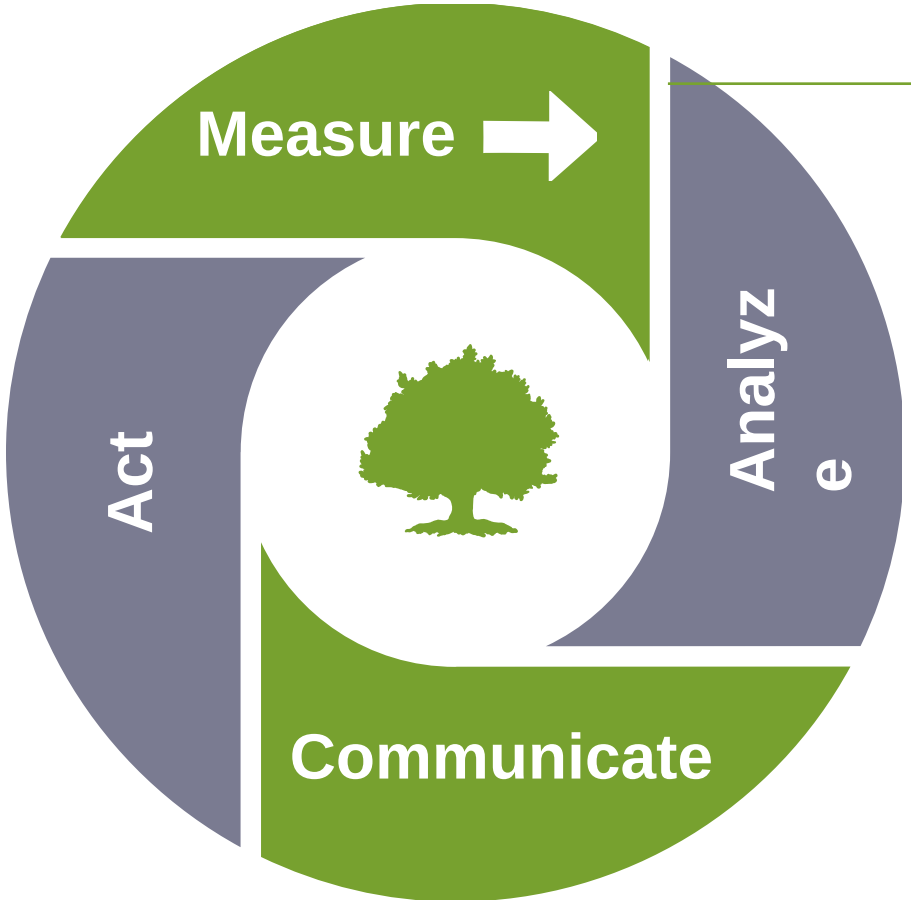
Ann Intern Med. 2011;155:520-528. www.annals.org

For author affiliations, see end of text.

No single intervention implemented alone was regularly associated with reduced risk for 30-day rehospitalization.

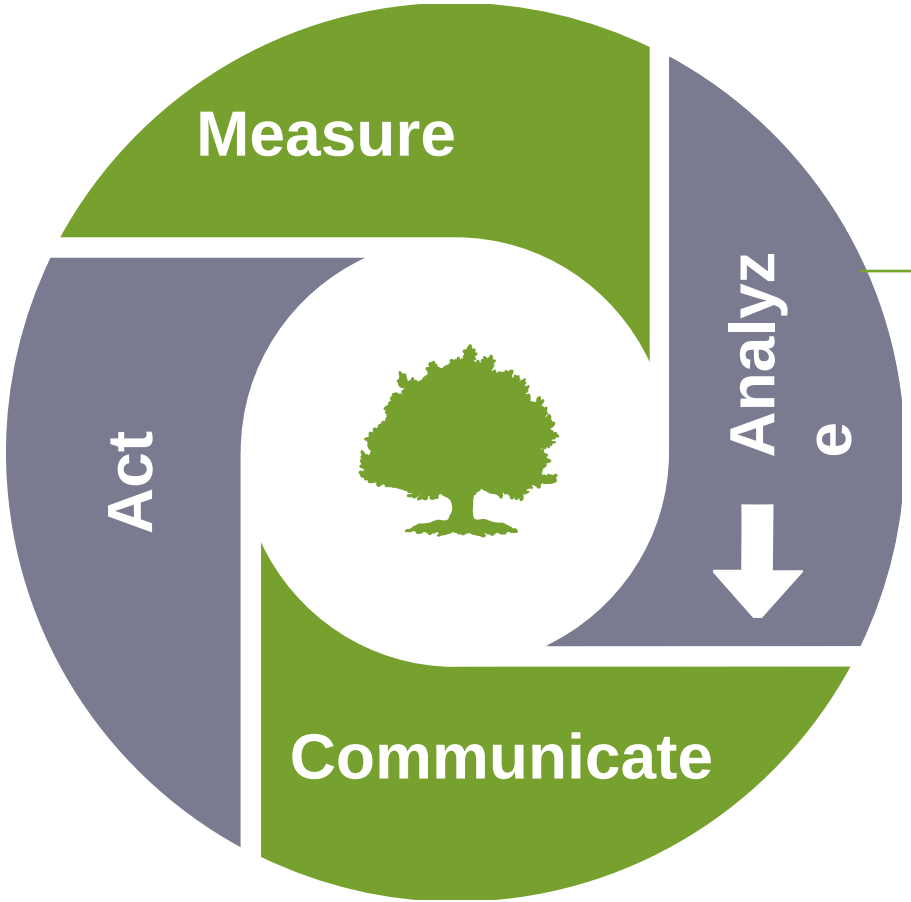
Table 2. **Interventions Tested Among Studies Selected**

Study, Year (Reference)	Predischarge Interventions				Postdischarge Interventions		
	Patient Education	Discharge Planning	Medication Reconciliation	Appointment Scheduled Before Discharge	Timely PCP Communication	Timely Clinic Follow-up	Follow-up Telephone Call
Randomized, controlled trials							
Balaban et al, 2008 (12)					✓		✓
Braun et al, 2009 (13)							✓
Coleman et al, 2006 (14)							✓
Dudas et al, 2001 (15)							✓
Dunn et al, 1994 (16)							
Evans and Hendricks, 1993 (17)		✓					
Forster et al, 2005 (18)		✓					
Jaarsma et al, 1999 (19)	✓						✓
Jack et al, 2009 (20)	✓	✓	✓		✓		✓
Koehler et al, 2009 (21)	✓	✓	✓		✓		✓
Kwok et al, 2004 (22)							
McDonald et al, 2001 (23)	✓						✓
Naylor et al, 1994 (24)	✓	✓					✓
Parry et al, 2009 (25)	✓		✓			✓	✓
Rainville, 1999 (26)	✓						
Wong et al, 2008 (27)							



Census pulls from a variety of sources (e.g., plan lists, authorization feeds)

Local teams add admissions as they occur.



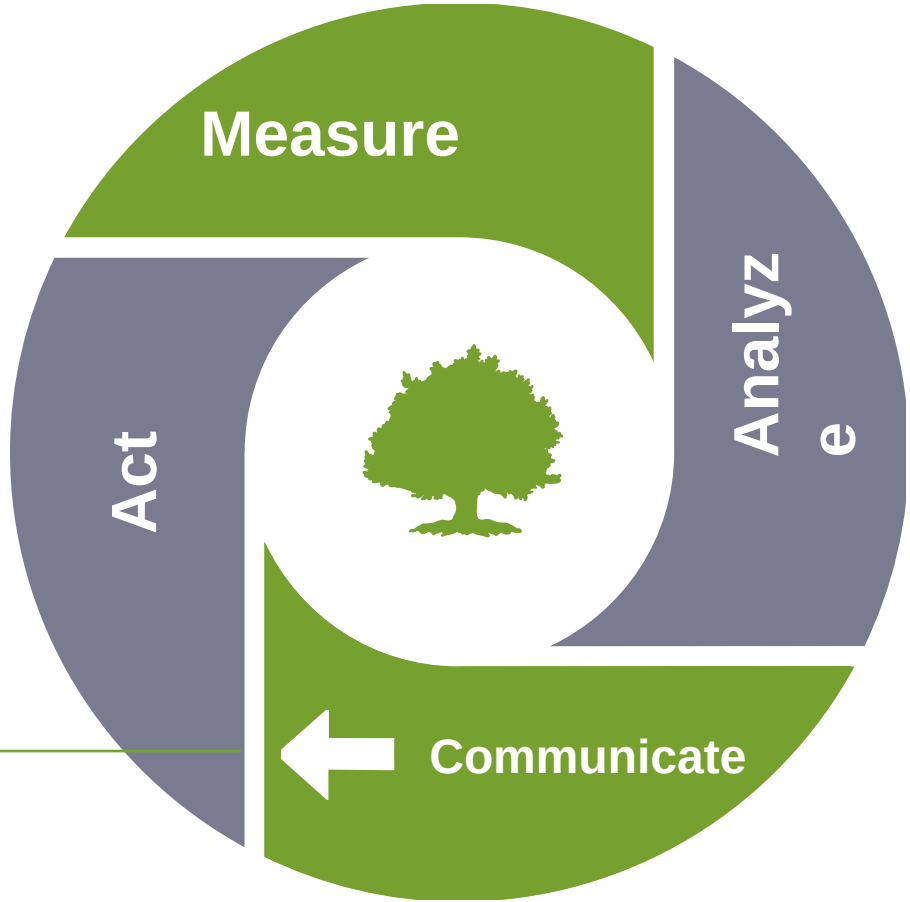
Data is aggregated in the warehouse *and* integrates care team experience with the patient

Scrubbed and sorted to maintain consistent fields for diagnosis, site, LOS.

Alerts programmed for extended LOS, high-risk cases, out-of-network.

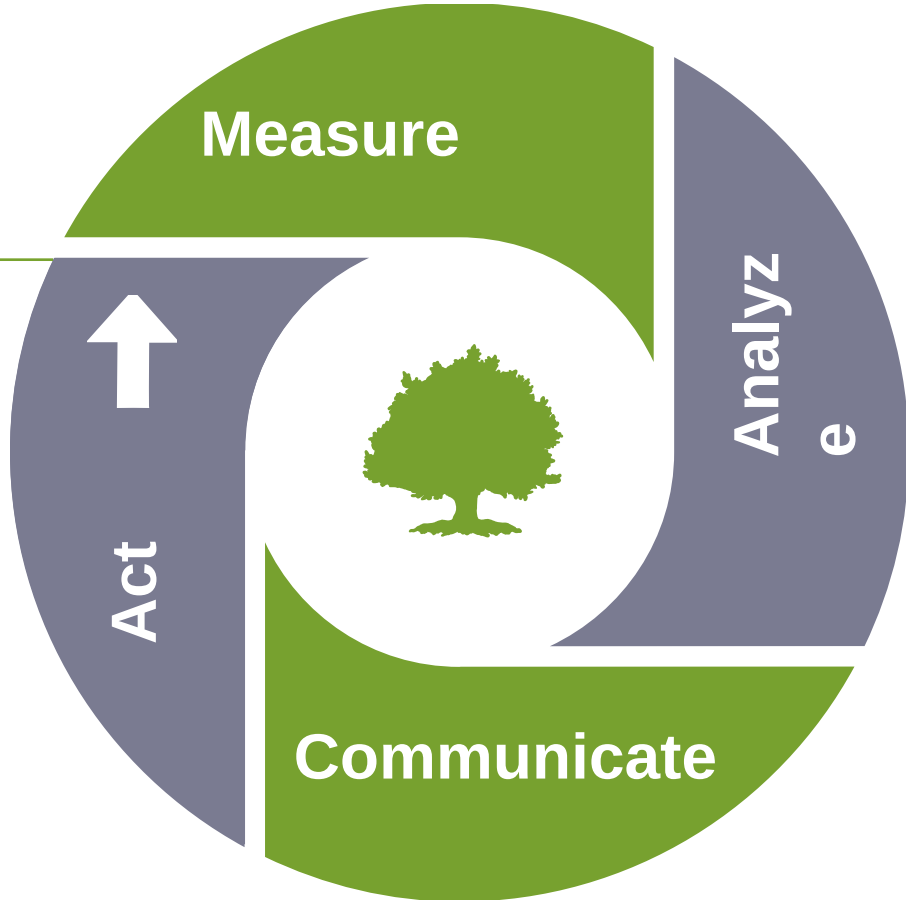
Canopy app automatically notifies the team every day of census and status.

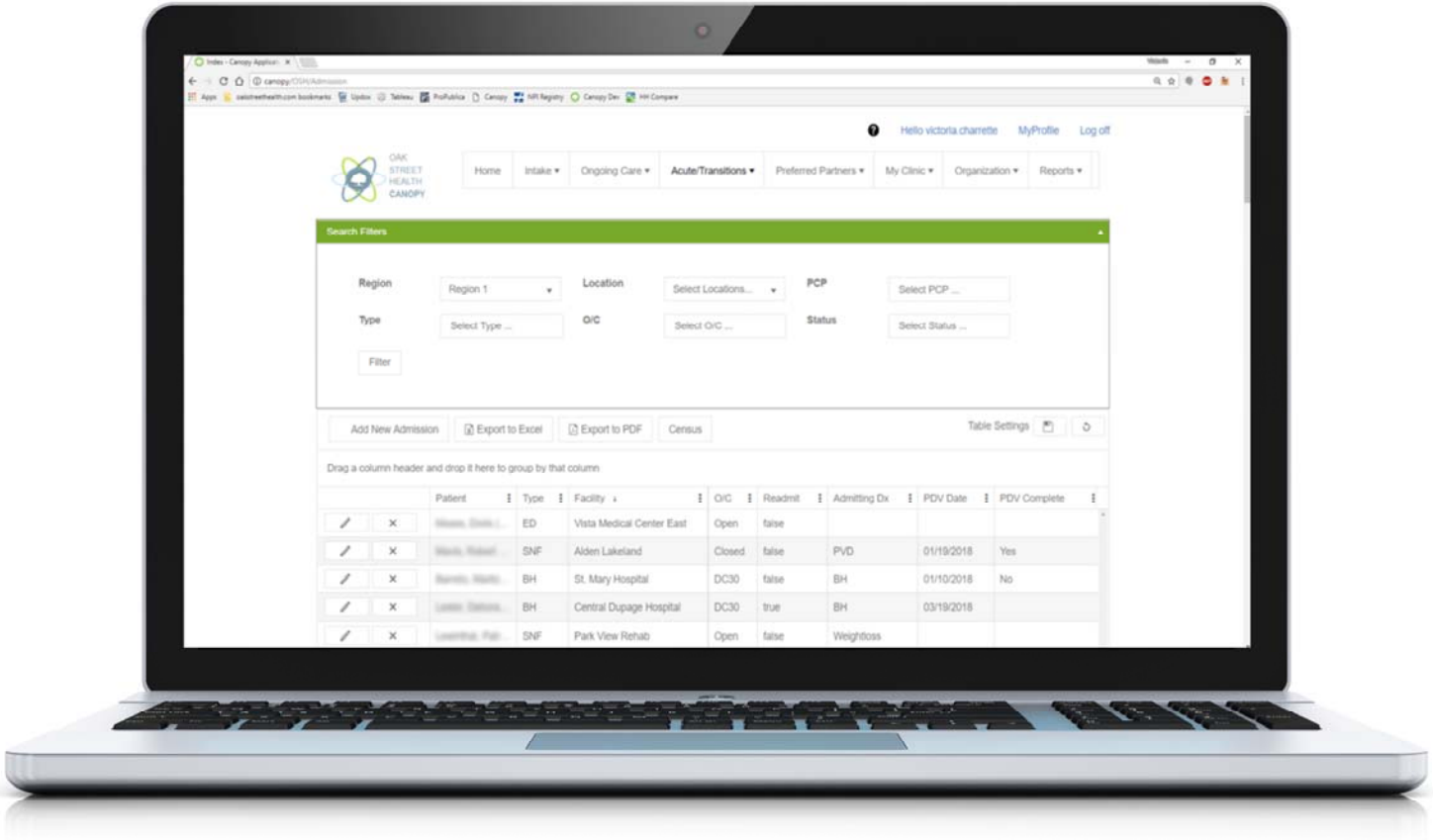
Team members add information as available.

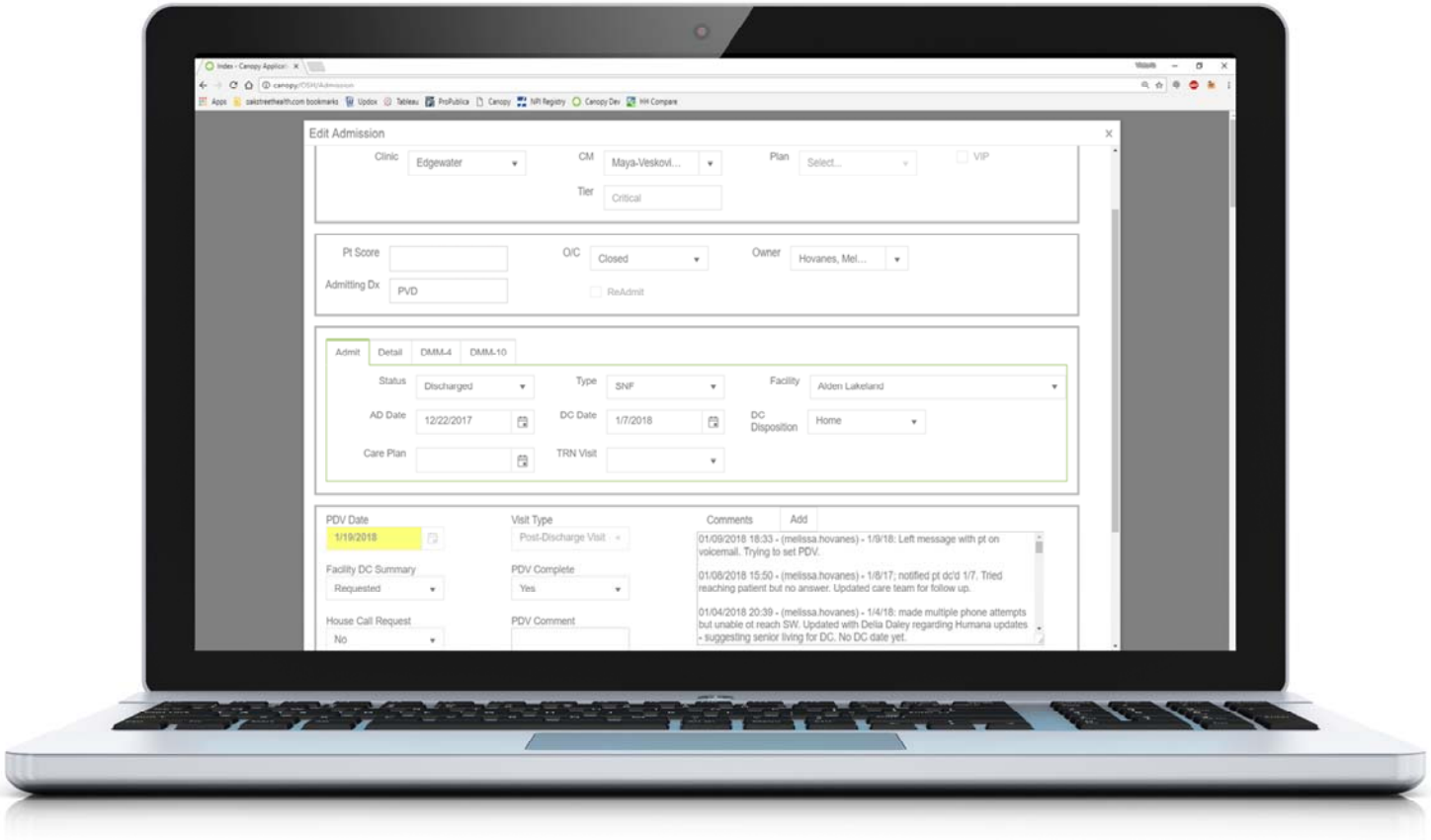


Medical director leads team huddle to review census and make recommendations.

Canopy app guides team through evidence-based interventions, such as:
•Post-discharge visit (with transportation)
•Medication reconciliation by our pharmacists
•In-home assessment by Complex Care Team




Hello victoria.charrette
MyProfile
Log off
OAK STREET HEALTH CANOPY
Home
Intake
Ongoing Care
Acute/Transitions
Preferred Partners
My Clinic
Organization
Reports
Search Filters
Region
Region 1
Location
Select Locations...
PCP
Select PCP ...
Type
Select Type ...
O/C
Select O/C ...
Status
Select Status ...
Filter
Add New Admission
Export to Excel
Export to PDF
Census
Table Settings
Drag a column header and drop it here to group by that column
Patient
Type
Facility
O/C
Readmit
Admitting Dx
PDV Date
PDV Complete
ED
Vista Medical Center East
Open
false
SNF
Alden Lakeland
Closed
false
PVD
01/19/2018
Yes
BH
St. Mary Hospital
DC30
false
BH
01/10/2018
No
BH
Central Dupage Hospital
DC30
true
BH
03/19/2018
SNF
Park View Rehab
Open
false
Weightloss


Edit Admission
Clinic
Edgewater
CM
Maya-Veskovi...
Plan
Select...
VIP
Tier
Critical
Pt Score
O/C
Closed
Owner
Hovanes, Mel...
Admitting Dx
PVD
ReAdmit
Admit
Detail
DMM-4
DMM-10
Status
Discharged
Type
SNF
Facility
Alden Lakeland
AD Date
12/22/2017
DC Date
1/7/2018
DC Disposition
Home
Care Plan
TRN Visit
PDV Date
1/19/2018
Visit Type
Post-Discharge Visit
Comments
Add
01/09/2018 18:33 - (melissa.hovanes) - 1/9/18: Left message with pt on voicemail. Trying to set PDV.
01/08/2018 15:50 - (melissa.hovanes) - 1/8/17; notified pt dc'd 1/7. Tried reaching patient but no answer. Updated care team for follow up.
01/04/2018 20:39 - (melissa.hovanes) - 1/4/18: made multiple phone attempts but unable ot reach SW. Updated with Delia Daley regarding Humana updates - suggesting senior living for DC. No DC date yet.
Facility DC Summary
Requested
PDV Complete
Yes
House Call Request
No
PDV Comment

OAK STREET HEALTH

SUPPORTING OUR INPATIENTS

Results

15% Year-Over-Year Reduction in 30-Day Readmissions

OAK STREET HEALTH

SUPPORTING TARGETED BENEFITS

SUPPORTING TARGETED BENEFITS

What is access?

Transportation?
24/7 phone line?
Evening/weekend hours?
Cultural competence?

I CAN’T DO THAT INSULIN

OAK STREET HEALTH

SPECIAL NEEDS PLANS (SNPS)

Medicare SNPs are a type of Medicare Advantage Plan (like an HMO or PPO). Medicare SNPs limit membership to people with specific diseases or characteristics. Medicare SNPs tailor their benefits, provider choices, and drug formularies to best meet the specific needs of the groups they serve.

Warehouse aggregates data from outreach events, enrollment, EMR, claims, health plan plan contracts

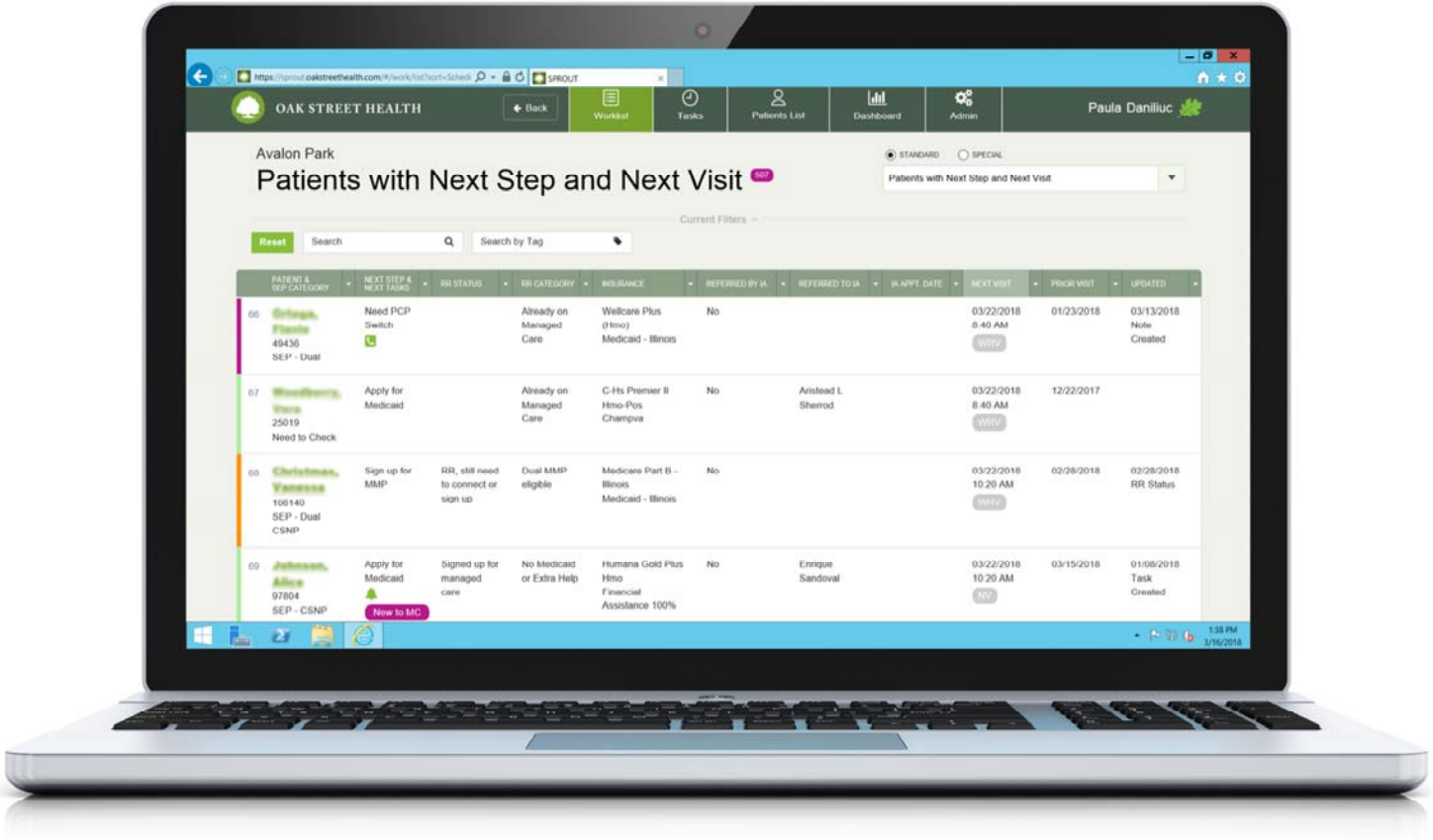
Proprietary algorithms identify opportunities where patients may benefit from exploring plan options

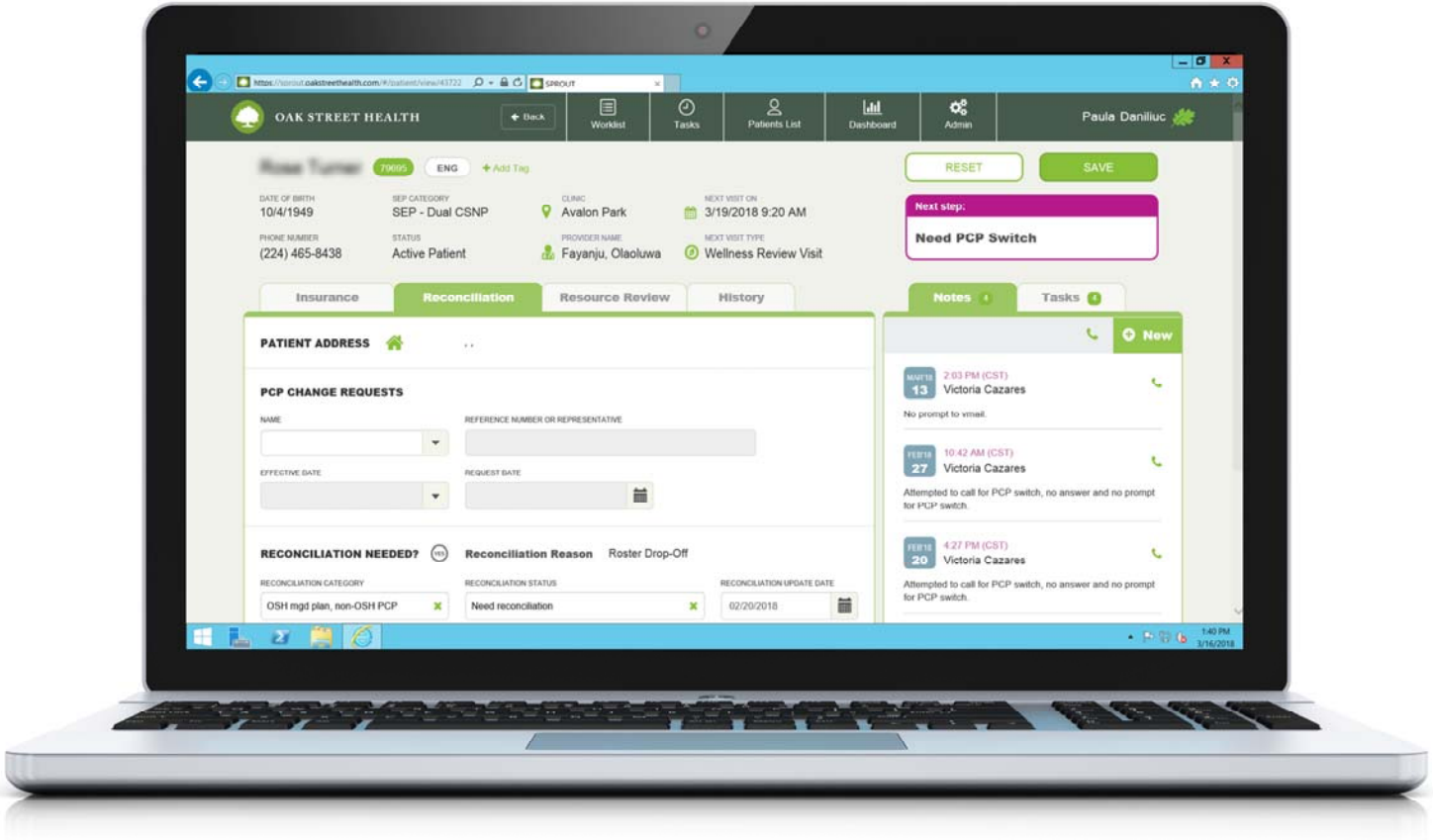
Canopy app notifies team when a theoretical benefit-optimization opportunity exists

Team notifies patients of options available

In-center experts available to connect patients as desired by patient

Plus: when a problem arises (“I can’t afford my insulin”) providers have a resource in the clinic to support these patients


OAK STREET HEALTH
Back
Worklist
Tasks
Patients List
Dashboard
Admin
Paula Daniliuc
Avalon Park
Patients with Next Step and Next Visit
607
STANDARD
SPECIAL
Patients with Next Step and Next Visit
Current Filters
Reset
Search
Search by Tag
PATIENT & SEP CATEGORY
NEXT STEP & NEXT TASKS
RR STATUS
RR CATEGORY
INSURANCE
REFERRED BY IA
REFERRED TO IA
IA APPT. DATE
NEXT VISIT
PRIOR VISIT
UPDATED
66 Ortega, Flavia 49436 SEP - Dual
Need PCP Switch
Already on Managed Care
Wellcare Plus (Hmo) Medicaid - Illinois
No
03/22/2018 8:40 AM WRV
01/23/2018
03/13/2018 Note Created
67 Woodberry, Vera 25019 Need to Check
Apply for Medicaid
Already on Managed Care
C-Hs Premier 8 Hmo-Pos Champva
No
Arstead L Sherrod
03/22/2018 8:40 AM WRV
12/22/2017
68 Christmas, Vanessa 106140 SEP - Dual CSNP
Sign up for MMP
RR, still need to connect or sign up
Dual MMP eligible
Medicare Part B - Illinois Medicaid - Illinois
No
03/22/2018 10:20 AM WRV
02/28/2018
02/28/2018 RR Status
69 Johnson, Alice 97804 SEP - CSNP
Apply for Medicaid New to MC
Signed up for managed care
No Medicaid or Extra Help
Humana Gold Plus Hmo Financial Assistance 100%
No
Enrique Sandoval
03/22/2018 10:20 AM NV
03/15/2018
01/08/2018 Task Created


OAK STREET HEALTH
Back
Worklist
Tasks
Patients List
Dashboard
Admin
Paula Daniliuc
ENG
+ Add Tag
RESET
SAVE
DATE OF BIRTH
10/4/1949
SEP CATEGORY
SEP - Dual CSNP
CLINIC
Avalon Park
NEXT VISIT ON
3/19/2018 9:20 AM
PHONE NUMBER
(224) 465-8438
STATUS
Active Patient
PROVIDER NAME
Fayanju, Olaoluwa
NEXT VISIT TYPE
Wellness Review Visit
Next step:
Need PCP Switch
Insurance
Reconciliation
Resource Review
History
Notes
Tasks
New
PATIENT ADDRESS
PCP CHANGE REQUESTS
NAME
REFERENCE NUMBER OR REPRESENTATIVE
EFFECTIVE DATE
REQUEST DATE
RECONCILIATION NEEDED?
Reconciliation Reason
Roster Drop-Off
RECONCILIATION CATEGORY
OSH mgd plan, non-OSH PCP
RECONCILIATION STATUS
Need reconciliation
RECONCILIATION UPDATE DATE
02/20/2018
2:03 PM (CST)
Victoria Cazares
No prompt to vmail.
10:42 AM (CST)
Victoria Cazares
Attempted to call for PCP switch, no answer and no prompt for PCP switch.
4:27 PM (CST)
Victoria Cazares
Attempted to call for PCP switch, no answer and no prompt for PCP switch.

OAK STREET HEALTH

SUPPORTING TARGETED BENEFITS

Results

94% of patients with qualifying criteria for comprehensive coverage met with an licensed, third-party expert

"NOW I CAN AFFORD MY INSULIN

OAK STREET HEALTH

OTHER CORE INITIATIVES:

Behavioral Health & Telepsychiatry

Home Visits

eConsults

Medication Management & Pharmacy

Post-acute Management

End-of-Life & Advanced Care Planning

Pain Management

OAK STREET HEALTH

POPULATION HEALTH IS NOT

A business function.
Reaches across traditional silos and must be cross-functional.

A health coach or care manager.
Must be a choreographed effort by a team.

An EMR or software product.
Necessary but not sufficient: tools are required to coordinate and structure care.

A fee-for-service exercise.
Only works in a full-risk model where accountability exists to fill patient needs.

OAK STREET HEALTH

MUST DELIVER BETTER OUTCOMES.

For our patients at Oak Street:
•40+% reduction in hospitalizations.
•92% Net Promoter Score.

SUMMARY: THE OAK STREET APPROACH

Ours is a de novo model focused on a specific patient population.

We're highly structured to ensure consistency and scalability.

We see minimal variation in results across centers, regions, plans.

Our model is financially sustainable, improving over time and vintage.

Rebuilding healthcare as it should be.

OAK STREET HEALTH

WHAT'S UP NEXT FOR OAK STREET?

Delegation for more integration between plan-provider functions.

More custom apps to structure process, eliminate variation.

Obsessive focus on social determinants to support our patients.

THANK YOU

OAK
STREET
HEALTH