

Managing Full Risk for ESRD Patients

WHAT WE LEARNED IN MANAGING A MEDICARE ADVANTAGE C-SNP

OUR JOURNEY

The shift from volume- to value-based reimbursement is accelerating. Under this evolving paradigm, leading health systems are investing in population health management. An important component of this approach involves next-level risk management for medically complex groups that, despite their low volume, are highly volatile and account for a disproportionately large percentage of overall costs.

Our DaVita Integrated Kidney Care (IKC) team adopted fully capitated risk for one such population—end stage renal disease (ESRD) patients receiving dialysis—by partnering with a health plan to develop a Medicare Advantage ESRD Chronic Condition Special Needs Plan (C-SNP) in San Bernardino and Riverside, California. Given the unique complexities of renal disease, we knew it wouldn't be easy and would take a significant investment. Building a successful Medicare Advantage plan and achieving the Triple Aim with ESRD patients is far more challenging than with other chronic populations.

Following ten years of investment and program evolution, we have achieved success with an **over \$8,000 per-member per-year savings, an average hospitalization rate 22 percent lower than the national average and a top five patient satisfaction rating among all California C-SNP plans since 2013.**^{1,2} Our success is a result of targeted clinical pathways, protocols and processes, focused care coordination, new proprietary technology and operational enhancements to help improve quality of life for ESRD patients. Here we offer insights about what it takes to successfully manage ESRD patients under a fully delegated risk agreement.



After laying the foundation for improved patient health-related quality of life and clinical outcomes, our integrated care team continues to refine how we support and deliver care in the Riverside/San Bernardino C-SNP. By using data to identify high-risk patient events, piloting new programs in the C-SNP and working to further engage nephrologists in quality improvement, the Riverside/San Bernardino C-SNP remains a novel, successful and innovative site for integrated kidney care.

— Bryan Becker, MD
Chief Medical Officer, IKC

Riverside & San Bernardino ESRD C-SNP

- Started in **2006** as a CMS demonstration project
- Launched in **2011** as an ESRD C-SNP
- Serves **~850** enrolled ESRD patients
- Includes more than **30** participating nephrologists
- Includes more than **40** dialysis clinics
- Is **one** of the only 15 ESRD C-SNPs across the country. DaVita IKC takes delegated risk on 8 of them.

Note: A C-SNP is a type of Medicare Advantage plan that restricts enrollment to patients who have specific severe or disabling chronic conditions. The benefits, provider choices and pharmacy options are tailored to meet the needs of the specific group that is served.



LESSONS LEARNED

Patient Care

Providing care and support is the mainstay of a managed care program. Through a disciplined approach, grounded in patient- and provider-centric partnership across the entire care team, DaVita IKC refined its ESRD model of care for this vulnerable population.

Clinical Protocols & Pathways

It is important to use pathways designed for renal patients that support frequent clinical needs such as fluid overload, infections, vaccinations and comorbidity management. These are most successful when integrated into the care management IT platform and managed in partnership with the dialysis clinic.

Care Management

Clinical programs alone do not adequately address the lifestyle and psycho-social obstacles ESRD patients face. A successful ESRD program should promote communication and coordination across the continuum of care. Components include patient education, care coordination, medication management, mental health coordination, transition support, advanced care, directive planning, transportation services, dental and vision support, and pharmacy services.

Integrated Specialized & Dedicated Care Team

Nurses, social workers, dietitians and other care team members require specialized training in renal care. Frequent in-center care team rounding that includes the nephrologist is essential. While telephonic care management is invaluable, physically integrating the team into each dialysis center, when scale permits, further promotes program results.

Integrated ESRD Care Team



Typical ESRD Patient Profile

Spend approximately **11 days** per year in the hospital

Take more than **19 pills** a day

Dialyze **12-15 hours** weekly if receiving in-center hemodialysis

Have a **38.2% diabetes** comorbidity rate

Have a **98% hypertension** comorbidity rate

Note: United States Renal Data System. 2017 USRDS annual data report: Epidemiology of kidney disease in the United States. National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2017.



LESSONS LEARNED (CONTINUED)

Operations

Through trial and error, DaVita IKC developed a highly efficient operational framework designed specifically for the unique needs of complex renal patients.

Collaboration with Dialysis Center Staff

Typically, dialysis center staff spend 12–15 hours a week with each patient. It is essential to increase the staff's sense of program ownership and participation. Creating an advisory board with staff inclusion and participation in care team meetings can help achieve this.

Physician Engagement & Reporting

Consistent physician engagement can lead to better outcomes, but it is a challenge to achieve. Coupling physician report cards with shared goals helps increase engagement. Continued alignment can be achieved through transparency of patient and clinical outcomes reporting under the leadership of a program medical director.

Network Optimization

Networks should be designed to achieve the right balance between clinical outcomes and enrollment.

Technology

Commercially available technology platforms and analytics fall short of the customizations necessary for managing the complex and unique health needs of ESRD patients. While it required significant investment and was challenging to build, an ESRD-specific technology and analytics platform proved a key pillar of the program's success.

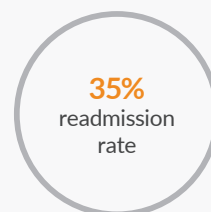
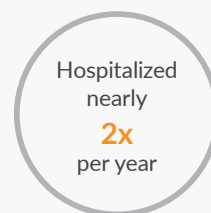
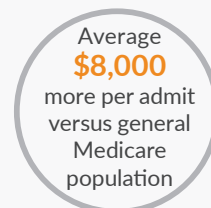
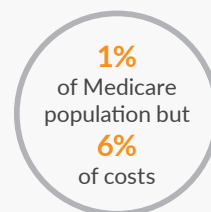
Predictive Models & Analytics

Custom-developed, ESRD-specific predictive models help stratify ESRD patient risks to forecast patients most likely to be hospitalized. Individualized care plans are subsequently developed to help prevent admissions. Industry-available risk models are not adequate given the complex and unique needs of dialysis patients.

Integrated Renal Technology Platform

A robust technology platform that can specifically address the totality of ESRD patients is necessary for success care management. Three core components are essential for such a platform: (1) care management software customized for ESRD patients, (2) an integrated care team rounding tool with real-time decision support and (3) mobile connectivity and application for patients and their care teams.

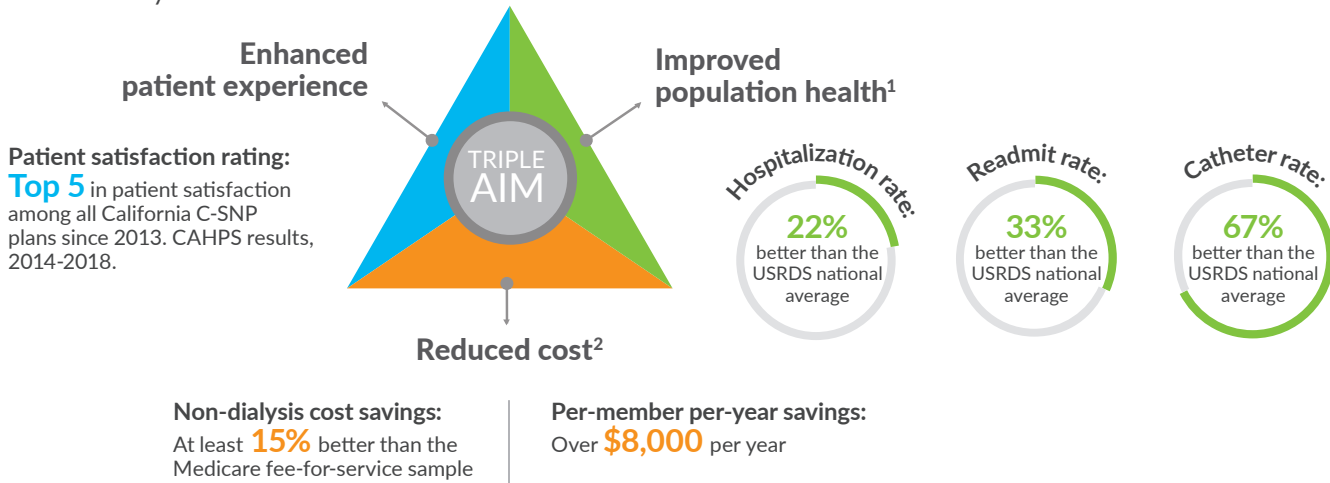
Typical ESRD Patient Profile



Note: United States Renal Data System. 2017USRDS annual data report: Epidemiology of kidney disease in the United States. National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2017.

Results

The many challenges we experienced—which included building a successful care model, managing high-risk patients, developing predictive analytics and a technology platform, and engaging physicians—ultimately made us stronger. After ten years of hard work and financial investment, we achieved the Triple Aim. Given our year over year improvements in patient outcomes, effectiveness and efficiency of care, we have continued to expand our program with seven additional C-SNPs in the last four years.



Enhanced Patient Experience³



“My DaVita IKC program helps me control my blood sugars by working with my healthcare team to adjust my oral medications.”

I am a 60-year-old woman who lives in San Bernardino, California, and I have been a dialysis patient since January. I am a diabetic and also have high blood pressure. My DaVita IKC program helps me control my blood sugars by working with my healthcare team to adjust my oral medications. I also feel much more open to express my feelings thanks to the personal interest in my health from the DaVita IKC team.



“I appreciate not having to go to the emergency room for treatment.”

I am a 56-year-old man who lives in San Bernardino, California, and I am new to dialysis since December. Going to dialysis is difficult. I go to the dialysis center three times a week, four hours a day. I had a kidney infection several weeks ago and I could not get in to see a doctor for treatment. The DaVita IKC program had a nurse practitioner come out to my home and treat me for my infection.

About DaVita IKC

DaVita Integrated Kidney Care is the integrated care affiliate of DaVita Inc. DaVita IKC has delivered integrated care programs under many types of value-based reimbursement—including eight C-SNPs, three ESCOs and numerous value-based commercial programs—since 1996. DaVita IKC partners with health systems, health plans and government entities to measurably improve clinical outcomes, patient experience and cost of care for ESRD and CKD patients. DaVita IKC currently impacts the lives of more than 25,000 kidney patients each month.

For more information about DaVita IKC's solutions for managing ESRD risk, email IKCInquiries@davita.com.

¹ Source: 2017 Annual Data Report from the United States Renal Data System and the Fistula First website.

² DaVita IKC vs. Medicare FFS analysis performed by an independent actuarial firm; p-value for 2009 = 0.04, 2011 = <0.01.

³ These are statements from real patients. The likenesses have been changed to protect their identities.