DaVita VillageHealth
bringing quality to life℠

Case Study

Managing Full Risk for ESRD Patients

What We Learned in Managing a Medicare Advantage C-SNP

Riverside & San Bernardino ESRD C-SNP[1]

- Started in **2006** as a CMS demonstration project
- Launched in **2011** as an ESRD C-SNP
- Serves **~800** enrolled ESRD patients
- Includes more than **30** participating nephrologists
- Includes more than **25** dialysis clinics
- Is **one** of only 5 ESRD C-SNPs across the country. DaVita VillageHealth takes fully delegated risk on 3 of them.

[1] 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.

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 VillageHealth 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 eight years of investment and program evolution, we have achieved success with a **nearly $8,000 per-member per-year savings, an average hospitalization rate 26 percent lower than the national average and patient satisfaction outperforming all other California C-SNP plans in 2013.** Our success is a result of targeted clinical pathways, protocols and processes, focused care coordination, new proprietary technology and operational enhancements to 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.

Building the San Bernardino and Riverside C-SNP took tremendous effort and investment. We experienced many hiccups along the way, but never lost sight of our ultimate goal: to give the gift of integrated care to our patients. We've reached a point of improved clinical outcomes and patient quality of life, but the work is not done. There will always be an ongoing effort to enhance services and care delivery.

— Stephen McMurray, MD
Medical Director of VillageHealth

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ESRD Patient Profile >

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

Take more than **21 pills** a day

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

Have a **44% diabetes** comorbidity rate

Have a **75% hypertension** comorbidity rate

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, we refined our 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 must ensure optimal 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.

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 optimizes program results.

ESRD Care Team

LESSONS LEARNED (CONTINUED)

Operations

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

Collaboration with Dialysis Center Staff

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. This can be achieved by creating an advisory board with staff inclusion and participation in care team meetings.

Physician Engagement & Reporting

Consistent physician engagement leads to better outcomes, but 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

Open networks optimize patient enrollment but inhibit the ability to manage clinical outcomes. Narrow networks can better control clinical outcomes but result in lower enrollment. Networks should be designed to achieve the right balance between enrollment and clinical outcomes.

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, this investment 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 care management technology platform is a necessity, yet not a single IT vendor offers a platform customized for ESRD patient management. Developing an effective platform involves significant financial investment and requires three core components: (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 apps for patients and their care teams.

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ESRD Population Profile >

1% of Medicare population but **6%** of costs

Average **$8,000** more per admit versus general Medicare population

Hospitalized nearly **2x** per year

36% readmission rate

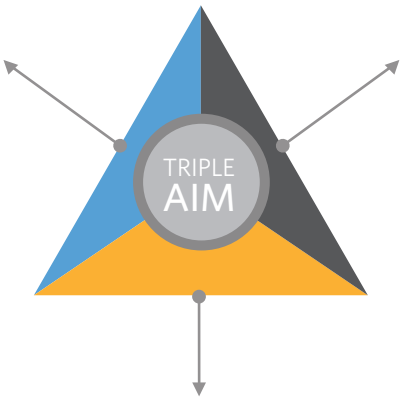
Results

The many challenges we experienced—e.g., building a successful care model, high-risk patient management, predictive analytics and technology platform development, and physician engagement—ultimately made us stronger. After eight years of hard work and financial investment, we achieved the Triple Aim. Given our year-over-year improvements leading up to success in 2014, we have since launched two additional C-SNPs.

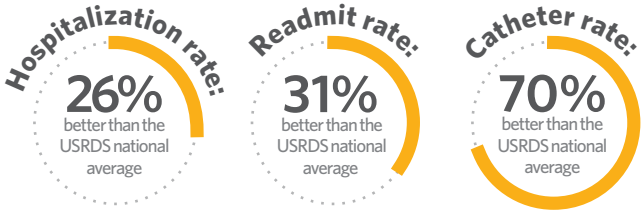
Enhanced patient experience

Patient satisfaction rating:

92% satisfaction rating in Medicare's Consumer Assessment of Healthcare Providers and Systems (CAHPS) 2013 survey



Improved population health[1]



Reduced cost[2]

Non-dialysis cost savings:

15% better than the Medicare fee-for-service sample

Per-member per-year savings:

Nearly **$8,000** per year

Enhanced Patient Experience[3]

"My VillageHealth 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 VillageHealth 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 VillageHealth team. —Margaret

"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 VillageHealth program had a nurse practitioner come out to my home and treat me for my infection. I appreciate not having to go to the emergency room for treatment. —William

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About VillageHealth

VillageHealth, the integrated kidney care and population health division of DaVita HealthCare Partners, has delivered integrated care programs under all types of value-based reimbursement—including full risk—since 1998. VillageHealth 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.
For more information about VillageHealth email VillageHealth-Inquiries@villagehealth.com.

[1] Source: 2013 Annual Data Report from the United States Renal Data System and the Fistula First website.
[2] VillageHealth vs. Medicare FFS analysis performed by an independent actuarial firm; p-value for 2009 = 0.04, 2011 = <0.01.
[3] These are statements of real patients. The likenesses have been changed to protect their identities.