

# Stop the Revolving Door

## 3 Steps to Reduce Costs and Improve Care Transitions for Renal Patients

**Patients with chronic conditions typically require the bulk of a hospital's time and resources, yet account for just a small percentage of the overall patient population. Patients with end stage renal disease (ESRD) are one such high-risk group.**

ESRD, or renal failure, is the fastest-growing cause of hospitalizations, and the fifth leading reason for readmissions.<sup>1,2</sup> With extensive care needs both in and out of the hospital, ESRD patients can negatively impact a hospital's bottom line. In an era of healthcare reform, hospitals are responsible for a greater percentage of the costs associated with high-risk patients, such as those suffering from end stage renal disease.

**Follow these three steps to better manage the ESRD population in your hospital.**

### 1 Recognize the Cost and Care Challenges

Patients with ESRD are among the most costly patient populations—accounting for just 1% of the Medicare population but nearly 10% of the costs.<sup>3</sup>

#### Renal Patients:

- Account for approximately **20% of all Medicare readmissions**<sup>4</sup>
- Stay **0.7 days longer** than non-renal patients<sup>5</sup>
- Cost **\$7,975 more per admission** when compared with all Medicare patients<sup>5</sup>

### 2 Prevent Avoidable Renal Readmissions

Renal failure is the fifth leading cause of readmissions.<sup>2</sup> ESRD patients face numerous clinical, emotional and financial challenges that can lead to unnecessary readmissions.

#### Tips for Reducing Avoidable Renal Readmissions:

- **Invest** in specialized care coordination
- **Efficiently place patients** in a chronic center that meets their needs
- **Support patients with clinical post-discharge follow-up** by a specialized renal nurse

### 3 Tackle Gaps in Renal Population Management

Acute care management solutions that address the specific needs of ESRD patients can deliver cost savings while improving the quality of inpatient renal care.

#### Reduce the Cost Impact of ESRD Patients:

- **Understand** your inpatient renal population
- **Analyze** this complex patient population
- **Identify** targeted areas for improved care management
- **Partner** with an expert in renal care

**Improve your bottom line with the following average results:**<sup>6</sup>

**18%** reduction in overall readmission | **½-day** reduction in length of stay per patient | **82%** increase in patient engagement  
**9.5 out of 10** patient experience scores

# 1

## Recognize the Cost and Care Challenges

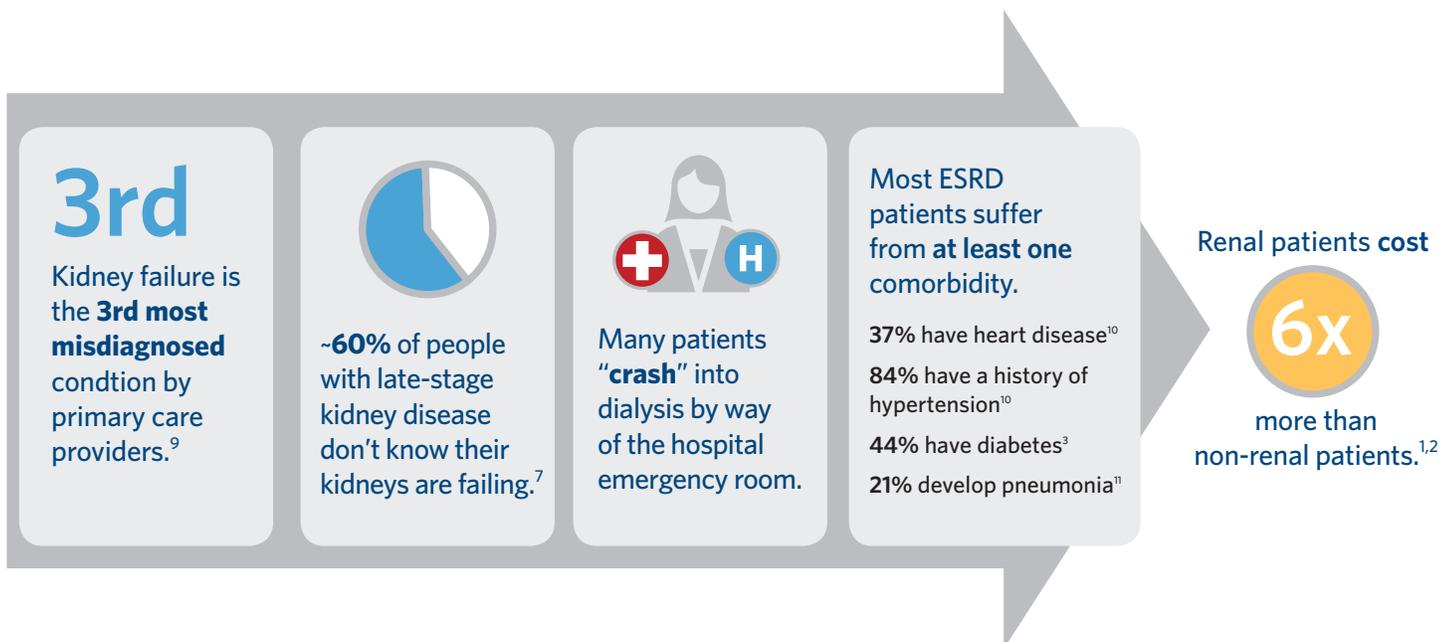
**Addressing the full spectrum of clinical, emotional and financial needs of ESRD patients becomes crucial in keeping them healthy and out of the hospital.**

Fewer than half of Americans with chronic kidney disease, the precursor to ESRD, are aware their kidneys are damaged. Many don't learn of their condition until they are hospitalized for renal failure.<sup>7</sup>

This abrupt ESRD diagnosis is met with the immediate and ongoing need for life-saving dialysis treatments in the outpatient setting. Coupled with a high incidence of comorbid conditions—such as congestive heart failure, diabetes and pneumonia—costs quickly climb. (See Fig. 1)

Following an ESRD diagnosis, patients face numerous challenges, such as finding a dialysis center, adding three or more treatments per week to their schedule, adjusting their diet, understanding the impact on employment and insurance coverage, undergoing a vascular access procedure and adopting an intensive prescription drug regimen.

**More than 20 million Americans have kidney disease.**<sup>8</sup> (Figure 1)



## 2 Prevent Avoidable Renal Readmissions

**One in four renal patients will be readmitted within 30 days.**<sup>2</sup> The high costs and complex care needs of ESRD patients underscore the importance of implementing effective care transitions that help diminish the risk of readmissions and improve long-term clinical outcomes. (See Fig. 2)

As ESRD patients transition to outpatient dialysis, they leave the hospital having to juggle complicated insurance issues, a new prescription drug regimen and the need for multiple weekly treatments. Many of these patients return to the hospital simply because of a lack of understanding of how to manage their health.

By investing in a comprehensive care model that addresses the unique needs of renal patients in the hospital and continues post-discharge, you can improve outpatient treatment adherence and ultimately reduce readmissions.

Fig. 2

### Tips for Reducing Avoidable Renal Readmissions

**Help renal patient take control of their health and improve their quality of life.**



**Invest in specialized care coordination:** Kidney disease education, vascular access coordination, diet and medication management, insurance coordination and other renal-specific services provided by a care manager help ensure ESRD patients have the resources to take control of their own health in the outpatient setting.



**Efficiently place patients in a chronic center that meets their needs:** Efficiently discharging patients to a dialysis center that suits their treatment preferences and location needs allows patients to leave the hospital sooner and helps improve post-discharge care coordination.



**Clinical post-discharge follow-up by a specialized renal nurse:** Supporting patients in the days following discharge increases care plan and medication adherence and ultimately reduces the likelihood of readmissions.

# 3 Tackle Gaps in Renal Population Management

It is essential to grasp the full impact of the ESRD patient population and the effectiveness of renal care transitions in your hospital to determine if there is opportunity to better manage the high cost of kidney care.

To reduce the cost impact of ESRD patients, keep the following actions items in mind:

- ✓ **Understand your inpatient renal population.** Look at the number of admissions, rate of 30-day readmissions, average length of stay, bed cost per day and number of acute dialysis treatments per admission.
- ✓ **Analyze this complex patient population.** Assess the skill gaps in the level of support your hospital staff can dedicate to the unique needs of ESRD patients. Determining the effectiveness of your current care management programs can help highlight opportunities to better serve your vulnerable kidney patients.
- ✓ **Identify targeted areas for improved care management.** Pinpoint the need for more efficient discharge or enhanced care coordination of ESRD patients. Focusing on your hospital's exact requirements for comprehensive renal care can ultimately help control costs.
- ✓ **Partner with an expert in renal care.** Complement your existing staff with provider-neutral kidney care experts. Work together to create a roadmap for caring for ESRD patients to reduce readmissions and length of stay while improving the quality of patient care.

**Contact Patient Pathways for a complete analysis and to find out how renal patients are impacting your readmission rates and overall costs.**

**Patient Pathways' customized solutions can help your hospital control costs and improve patient satisfaction, as seen in the following average results:<sup>6</sup>**

**18%** reduction in overall readmission

**1/2-day** reduction in length of stay per patient

**82%** increase in patient engagement

**9.5 out of 10** patient experience scores

Patient Pathways, a provider-neutral acute care management and discharge planning subsidiary of DaVita HealthCare Partners Inc., offers hospitals specialized support in the care coordination of end stage renal disease patients.



For an analysis of your hospital's renal care program and a strategy for reducing readmissions and improving the quality of renal care, contact us at:

**patientpathways@davita.com**  
or **(855) 382-4677**.

## Sources

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- <sup>2</sup> Elixhauser A (AHRQ), Steiner C (AHRQ). Readmissions to U.S. Hospitals by Diagnosis, 2010. HCUP Statistical Brief #153. April 2013. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb153.pdf>.
- <sup>3</sup> U.S. Renal Data System, USRDS 2013 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2013. ESRD patients represent 1.4% of Medicare patients and account for 7.2% of Medicare spending (429,000 ESRD patients, 2011 Medicare data).
- <sup>4</sup> June 2007 MedPAC Report, Advisory Board data.
- <sup>5</sup> U.S. Renal Data System, USRDS 2013 Annual Data Report (2011 data); as compared to 100% MedPAR Inpatient Hospital National Data for FY2011.
- <sup>6</sup> Patient Pathways average data as of January 2012.
- <sup>7</sup> Adv Chronic Kidney Dis. 2010 May ; 17(3): 225–236. doi:10.1053/j.ackd.2010.03.002.
- <sup>8</sup> Centers for Disease Control and Prevention (CDC). National Chronic Kidney Disease Fact Sheet: General Information and National Estimates on Chronic Kidney Disease in the United States, 2014. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention; 2014
- <sup>9</sup> JAMA Intern Med. 2013;173(6):418-425. doi:10.1001/jamainternmed.2013.2777.
- <sup>10</sup> MarketScan data, USRDS 2010 Annual Data Report, 1:137. MarketScan is a commercial claims dataset composed of 10.5 million covered lives that USRDS uses as a benchmark for CKD utilization.
- <sup>11</sup> Nephrol. Dial. Transplant. (2008)23 (2): 680-686. doi: 10.1093/ndt/gfm474 First published online: November 19, 2007.