House Calls Are Changing the Way DaVita Cares for its High-Risk Patients

IT BEGAN IN 2007 WITH 200 PATIENTS IN LOS ANGELES, WHERE IT NOW TREATS MORE THAN 4,000 PATIENTS EACH YEAR

With the shift from volume- to value-based care, the health care industry is increasingly recognizing the importance of investing in innovative care models for high-risk, medically complex patients—those who account for a disproportionately large percentage of overall costs. These patients include high-utilizing patients who are often older, experience multiple chronic conditions and account for 86 percent of health care costs in the United States.[1]

Our Journey

Ten years ago, DaVita Medical Group recognized the opportunity to improve outcomes and reduce costs for high-risk patients by increasing their access to comprehensive, coordinated care.

Within two of its largest markets in the greater Los Angeles area, recently discharged high-risk patients with multiple chronic conditions and limited access to consistent care accounted for the following:[5]

- 68% hospital admission rate
- 20% 30-day hospital readmission rate
- 1,400 hospital admissions per 1,000 patients
- 9,500 inpatient days per 1,000 patients
- Over 700 Emergency Department visits per 1,000 patients

To improve these patients' access to quality care, reduce addressable hospitalizations and lower costs, DaVita Medical Group developed one of the first physician-led, home-centered care models in the country.

Chronic Population Overview

- **86%** of the nation's $2.7 trillion annual health care costs are for people with chronic conditions.[1]
- More than **one-third** of Medicare beneficiaries suffer from 4+ chronic conditions.[2]
- The average elderly patient with five or more chronic conditions sees **13 doctors** and fills **50 prescriptions** in a year.[3]
- Among Medicare fee-for-service beneficiaries, people with multiple chronic conditions account for **~98%** of all Medicare hospital readmissions and **~93%** of total Medicare spending.[4]

DaVita® Health Solutions

Our Care Model

DaVita Medical Group implemented a highly personalized model of care, comprised of "house calls" and post-acute care to reach this most-vulnerable patient population in their home or transitional care setting. Every patient is treated by a physician-led, interdisciplinary care team that consists of a nurse practitioner, social worker, care manager and other healthcare professionals, including behavioral health specialists, dietitians, clinical pharmacists and on-call clinicians available 24/7.

Program Overview

House Calls

- Consistent home-based medical, behavioral, psychosocial and palliative care
- Comprehensive medical assessments
- Individualized care plans
- Coordination with PCPs, specialists and community resources
- Medication reconciliation and management
- 24/7 care team support
- Advanced care planning and end of life supportive care

Post-Acute and Outpatient Care

- Employed clinicians and care managers manage patients within the hospital or skilled nursing facility (SNF) and coordinate care during patient discharge home
- Palliative care, behavioral health and social support services provided to patients through comprehensive outpatient care centers
- Chronic disease education and symptom management

Our Results

Since launching its House Calls and Post-Acute Care programs in Los Angeles ten years ago, DaVita Medical Group has seen a significant decrease in emergency room and hospital utilization and an increase in overall quality of care. In 2016, the more than 4,000 patients enrolled in these programs experienced on average the following care improvements:[5]

- **20%** reduction in ER visits
- **36%** reduction in hospital admits
- **15%** lower hospital readmission rate compared to industry average
- **57%** reduction in SNF average length of stay (28 days to 12 days)
- **50%** reduction in 30-day SNF-to-hospital readmission rate (18% to 9%)

DaVita currently operates House Calls and Post-Acute Care programs that serve more than 12,000 patients in five markets, in partnership with 4,000 independent and employed primary care physicians. DaVita is now partnering with health plans through its high-risk patient care division, DaVita Health Solutions, to care for their chronically ill and clinically complex members.

About DaVita Health Solutions

DaVita Health Solutions is a subsidiary of DaVita Inc., a Fortune 500 company and leading provider of integrated health and kidney care services. DaVita Health Solutions offers payors and risk-bearing organizations a suite of home- and outpatient-based care programs to address the needs of their high-risk, medically complex patient populations. Its programs include physician-led house calls that extend primary care into the home with a heavy focus on palliative care and behavioral health, advanced post-acute care with employed SNFists and dialysis center-based comprehensive care.

For more information, contact healthsolutions@davita.com.

1. Gerteis J, Izrael D, Deitz D, LeRoy L, Ricciardi R, Miller T, Basu J. Multiple Chronic Conditions Chartbook. AHRQ Publications No, Q14-0038. Rockville, MD: Agency for Healthcare Research and Quality; 2014. 2. Centers for Medicare and Medicaid Services. Chronic Conditions among Medicare Beneficiaries, Chartbook, 2012 Edition. Baltimore, MD. 2012. 3. The Centers for Medicare and Medicaid Services (2011). More people with Medicare receiving free preventive care [Press release]. 4. "Multiple Chronic Conditions." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 20 Jan. 2016. 5. DaVita Internal Data, 2017.

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