

# Comprehensive care for high-risk patients



Today's healthcare delivery system is not designed for high-risk, medically complex patients—a population that represents only 5 percent of patients, yet drives 50 percent of our nation's healthcare costs. These patients tend to have greater difficulty accessing medical care, are more likely to rely on emergency department visits for ongoing care and are a population that is projected to grow dramatically in number over the next 20 years.<sup>1</sup>

## Personalized Care for Your Most Vulnerable Patients: When and Where They Need It

DaVita® Health Solutions was designed to improve the health of complex patients so that they can live life to the fullest. Our model is unique in that we provide high-quality, comprehensive medical care for high-risk patients when and where they need it most—at home, in a post-acute care facility or within the dialysis center.



Both domestically and abroad, home-based primary care programs have proven to help lower costs by more than 20%, reduce hospital admissions and emergency department visits by up to 40% and improve quality of life for patients and caregivers.<sup>2</sup>

DaVita Health Solutions offers a broad suite of home- and outpatient-based care programs to fill the gaps in today's healthcare delivery system for your most complex patients. Our physician-led House Calls program delivers 24/7 primary care, behavioral health, palliative care, comprehensive health assessments and other clinical services within the patient's home. Our Post-Acute Care program provides patients at skilled nursing facilities (SNFs) with smoother and faster care transitions. Our Integrated Kidney Care program delivers comprehensive care services to end stage renal disease (ESRD) patients within the dialysis center where they already spend 12-15 hours per week.

With nearly 40 years of combined experience managing House Calls, Post-Acute Care and Integrated Kidney Care programs, DaVita has consistently delivered measurable results over time.<sup>3,4,5,6</sup>



### House Calls

Clinicians deliver in-home primary care and complementary healthcare services to patients and their caregivers as quickly and frequently as needed.

- 36%** fewer hospitalizations
- 20%** fewer ER visits
- 32%** lower cost per patient
- 18%** higher patient satisfaction



### Post-Acute Care

Employed SNFists within skilled nursing facilities plan for discharge on day one and work with the house calls care team to ensure patients experience smooth transitions home.

- 50%** lower SNF length of stay
- 57%** lower SNF-to-acute readmission rates



### Integrated Kidney Care

Clinicians utilize the dialysis center as a medical home to care for ESRD patients, in partnership with nephrologists, dialysis center and house calls care teams.

- 20%** fewer hospitalizations
- 27%** lower readmission rate
- 29%** fewer hospital days
- Up to \$12k** PMPY savings

## High-Risk, Poly-Chronic Patients

**5%**

of patients account for ~50% of healthcare costs

**2/3**

of seniors over age 65 experience multiple chronic conditions

**13**

doctors on average are seen each year by elderly patients with 5+ chronic conditions

**50**

prescriptions on average are filled each year by elderly patients with 5+ chronic conditions

**20%**

of Medicare patients released from the hospital are readmitted within 30 days of discharge

# Delivering a proven model of care tailored for high-risk patients



## Model of Care: Patient-centered, MD/NP driven

Our programs are driven by a physician- and nurse practitioner-led interdisciplinary care team that extends primary care outside the traditional office setting, increases communication across care providers and helps to ensure seamless transitions from post-acute settings.

Our innovative model of care is designed to deliver patient-centered, high-quality medical care inside the patient's home, in a post-acute care facility or while the patient receives treatment within the dialysis center.



COMPREHENSIVE  
HEALTH ASSESSMENTS  
& PLANNING



ACCURATE CODING  
& DOCUMENTATION



MEDICATION  
MANAGEMENT



PALLIATIVE CARE



ADVANCED CARE  
PLANNING



BEHAVIORAL HEALTH



HEALTH EDUCATION &  
RESOURCES



COORDINATION OF CARE  
& POST-DISCHARGE  
FOLLOW-UP



24/7 ON CALL  
CLINICIAN SUPPORT



## RECENTLY ENROLLED PATIENTS

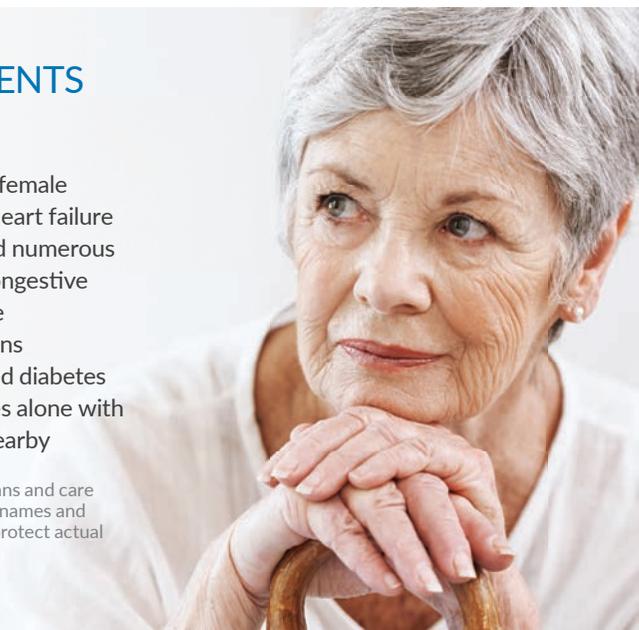
### James

- 83 year old male
- Blind, diabetic
- Amputee, wheelchair bound
- Wife is very ill and recently admitted to hospital
- Lives with grandson suffering from PTSD

### Susan

- 74 year old female
- End-stage heart failure
- Hospitalized numerous times for congestive heart failure exacerbations
- Uncontrolled diabetes
- Widow; lives alone with no family nearby

Patient stories provided by program clinicians and care team are offered as examples only. Patient names and imagery are used in a fictitious manner to protect actual patient privacy.



## Additional Information

<b>Target Population</b>	<ul style="list-style-type: none"><li>• Highest-risk, most costly and chronically ill patients (typically 1–5%)</li><li>• Patients with 5 or more chronic conditions who are most likely to drive future utilization, as identified by our proprietary algorithm</li></ul>
<b>Economics</b>	<ul style="list-style-type: none"><li>• DaVita is fully at risk for model of care expenses—there is no cost to a health plan or system, only upside savings potential</li><li>• Shared savings after model of care costs are recouped</li></ul>
<b>How We Work with Physicians</b>	<ul style="list-style-type: none"><li>• Support primary care providers (PCPs) by increasing communication across care settings and working collaboratively to help execute patient care plans</li><li>• Extend PCP care by providing 24/7 support for patients outside the office setting</li></ul>

## DaVita—a differentiated partner, a differentiated solution

- **Proven results over time:** 15 years of experience managing high-risk patients under at-risk and shared savings arrangements with proven results
- **Comprehensive, customizable approach:** Unlike many solutions that solve for only one aspect of the patient’s care, we can help address all elements of care for high-risk patients across settings
- **Provider-led solution and care model:** Goes far beyond typical disease/care management or advanced analytics-based solutions to meet patients where they are and deliver all the services they may need
- **Structurally advantaged in ESRD management:** Leading integrated kidney care provider with routine access to patients as they dialyze 12–15 hours per week, national scale and strong nephrologist relationships
- **We take all the risk:** You don’t pay a dime and we don’t make a dime unless we save more than we spend; we share in the savings only after our model of care costs are recouped

## 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 integrated kidney care.

DaVita Health Solutions leverages more than 15 years of experience in managing high-risk patients under at-risk and shared savings arrangements. Through its medical group, DaVita currently operates house calls programs that serve more than 12,000 patients in five markets, in partnership with 4,000 independent and employed primary care physicians. Through its integrated kidney care division, DaVita manages the total care for more than 20,000 renal patients, of which nearly 7,000 are under at-risk arrangements, in 16 markets and several national programs.

**For more information and to discuss options to help you better understand and manage your chronic population, contact DaVita Health Solutions at [healthsolutions@davita.com](mailto:healthsolutions@davita.com).**

1. Melnick GA, Green L, Rich J. House calls: California program for homebound patients reduces monthly spending, delivers meaningful care. *Health Aff (Millwood)*. 2016;35:28–35.v 2. Stall N, Nowaczynski M, Sinha SK. Systematic review of outcomes from home-based primary care programs for homebound older adults. *J Am Geriatr Soc* 62:2243–2251, 2014. 3. DaVita internal data on file, 2016 4. Source: American Medical News, "House Calls Increase Satisfaction and Cut Hospital Admissions Among Elderly", 2012 5. DaVita Medical Group patient results. Internal data on file, 2017 6. VillageHealth CKD managed members with GFR<25 2014-2015.