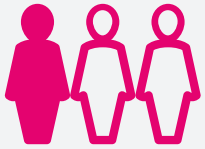
Caring for Our Nation's Most Vulnerable Patients

The United States health care system is currently not meeting the needs of our nation's **Most Vulnerable Patients** (MVPs), who typically suffer from multiple chronic conditions and are significant utilizers of health care services. The scale, resources and capabilities required to care for these patients holistically can be challenging within traditional care models.

A new model—one that meets patients when and where they need care most—is needed to better address this unique patient population. **Patients who receive high-touch, personalized care are less likely to delay essential care and less likely to go to the emergency department for non-urgent care, thus less likely to accrue avoidable costs.**[1]

Most Vulnerable Patient Insights[2]



1 in 3
visit ER at least 1X per year

1 in 4
have at least 1 hospital stay per year

1 in 5
are readmitted within 30 days[3]

Most Vulnerable Patients with 5+ Chronic Conditions[4]

of the United States population

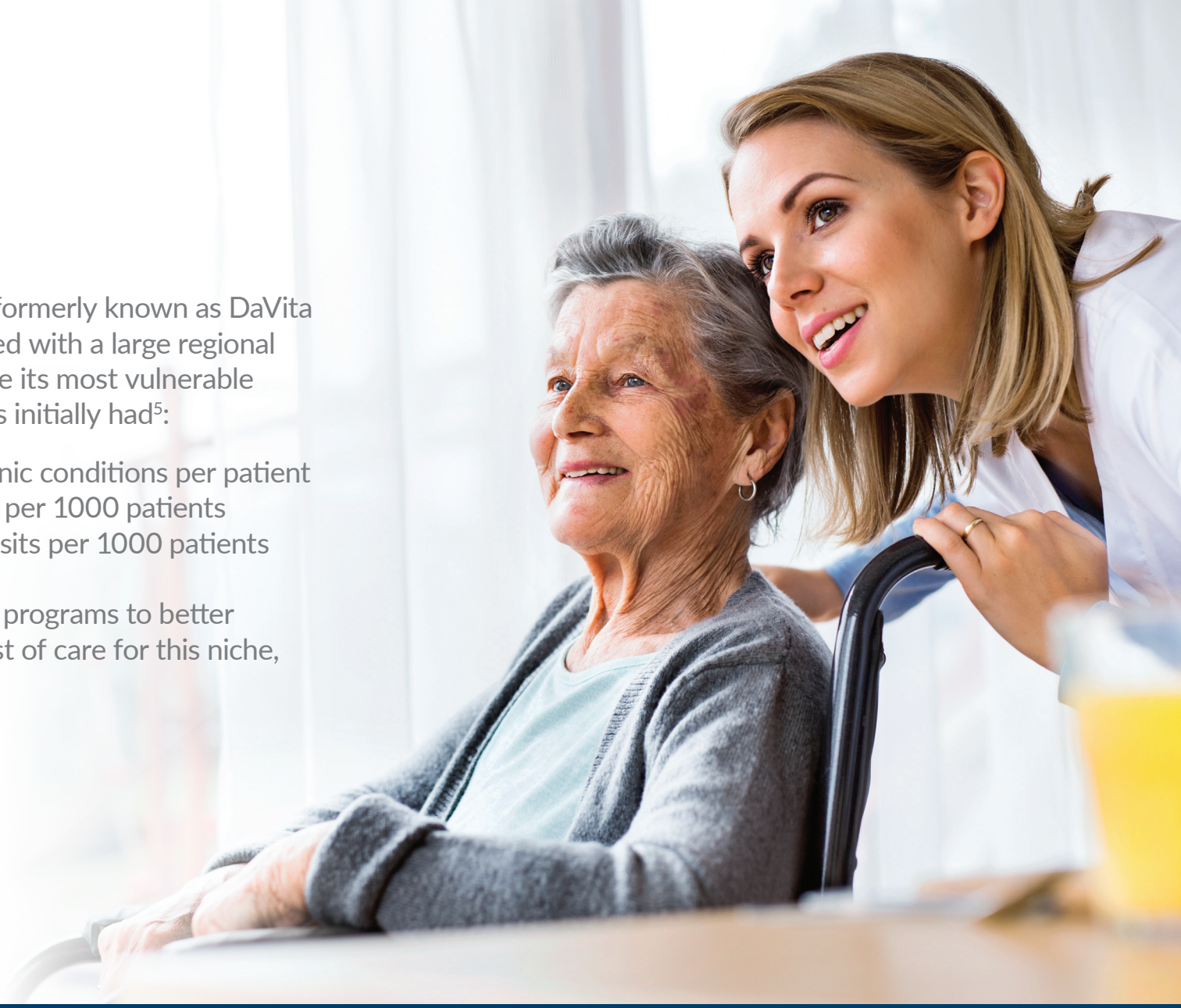
of total health care spend

The Challenge

In 2016, Vively Health™, formerly known as DaVita Health Solutions, partnered with a large regional health plan to help manage its most vulnerable members. These members initially had[5]:

- 4 or more high risk chronic conditions per patient
- 650 hospital admissions per 1000 patients
- 800 emergency room visits per 1000 patients

Vively identified essential programs to better impact the quality and cost of care for this niche, vulnerable population.



20 doctor visits on average each year

51 medications on average filled each year

The Solution

Vively took full clinical and financial risk for the health plan's Most Vulnerable Patient population. Vively established a community-based medical group of experienced providers to deliver medical, psychosocial and behavioral care within member homes and transitional care settings, while also offering 24/7 care coordination and support.

Program Overview

House Calls

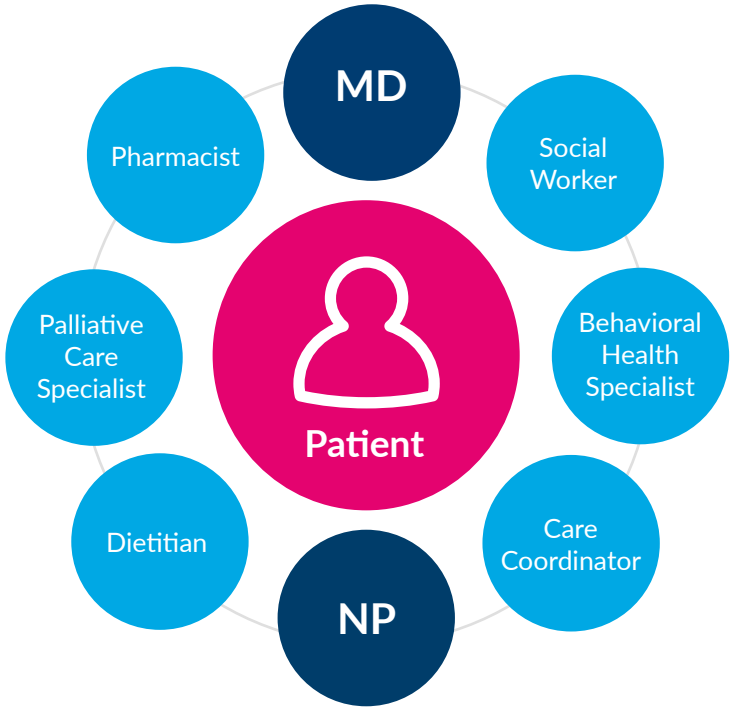
- Routine home-based medical, behavioral and psychosocial care
- Annual comprehensive health assessments and planning
- Individualized care plans based on health goals
- Coordination with PCPs, specialists and community resources
- Medication reconciliation and management
- 24/7 support and direct access to clinicians
- Telephonic chronic disease education and symptom management
- Advanced care planning and end-of-life supportive care

Post-Acute Care

- SNF-based care management by employed clinicians and registered nurses to help coordinate care and reduce complications
- Day 1 discharge planning to ensure smooth transitions home
- Discharge follow-up and coordination with house calls care team

"[In the home] I have a lot more time to spend with patients than I would in the office setting, so I get to know the patients better. I get to literally see how they're living, what their day to day activities look like, if there is food in the fridge, how they take their medications."

— ***Dr. Stephanie***, *House Calls Physician**



Physician-led, interdisciplinary care team

Operations Overview

Patient Management

- Weekly case reviews with comprehensive care team
- Consistent communication with patients and families
- Direct hand-off conversations at transition of care
- Proactive outbound calls to patients and families
- Regular engagement with patient PCP and specialists

Program Management

- Robust outreach campaigns to perform preventative in-home screenings and immunizations, helping improve coordination across community providers
- Predictive modeling to help identify patients' future medical needs and support accurate documentation and chronic condition management
- Quarterly program outcomes reporting

"One of the amazing things that I have found since taking care of people at home is understanding their medications and diet. In the office [people will say], 'oh, of course I take all of my medicines,' but then you're in in the home and you see that there are 3 full bottles that haven't been filled for the past 7 months."

— ***Dr. Joe***, *House Calls Medical Director**

The Impact

In the first 18 months, the program served approximately 7,000 patients in partnership with over 600 local primary care physicians, specialists and extended care teams including family members, caregivers, hospitals, skilled nursing facilities and home care agencies.

In the first year alone, Vively demonstrated measurable results[6]:

- 10-15% fewer emergency room visits
- 35-40% fewer hospitalizations
- 15-20% lower cost of care
- 46% lower SNF length of stay (9 days)
- 64% lower SNF-to-acute 30 day readmission rate (14.6 point reduction)
- 91% patient satisfaction rating
- >3,800 HEDIS gaps addressed for engaged patients within four months

"I thought physicians who made house calls had gone out with the horse and carriage. I can't thank you enough for this program. With a growing elderly population who has chronic conditions that can be maintained at home, House Calls reduces the strain on inpatient services and helps to maintain patients' dignity and independence in their home."

— ***Karen***, *Daughter of a House Calls Patient**

What's Next?

Vively Health is introducing its care model into new markets and making strides towards helping MVPs get better access to high-quality care at a lower cost.

"Before the House Calls program, I was probably hospitalized six times with congestive heart failure, fluid in my lungs, pneumonia and different pains in my chest. Since my House Calls nurse practitioner got me on a regimen…I've only been hospitalized one time. That's an awesome feeling."

— ***Harold***, *House Calls Patient**

Vively Health™

VivelyHealth.com

Vively Health delivers home-based primary care to our nation's Most Vulnerable Patients, individuals with an interrelated set of chronic conditions such as diabetes, cardiovascular disease, chronic kidney disease, COPD, depression and anxiety. Under full risk arrangements, Vively's community-based, physician-led care teams deliver medical, behavioral, social and palliative care to chronically ill patients within the home. Our house calls programs have enhanced the lives of thousands of patients with a 91% satisfaction rating; 35-40% reduction in hospitalizations; 10-15% reduction in emergency room visits; and 15-20% reduction in cost of care. Vively leverages nearly 20 years of experience in managing high-risk patients under at-risk arrangements with payors and risk-bearing entities. Vively Health is a standalone subsidiary of DaVita Inc. For more information, visit www.VivelyHealth.com.

*These are statements from real patients and providers. 1. J. Ryan, M. K. Abrams, M. M. Doty, T. Shah, and E. C. Schneider, How High Need Patients Experience Health Care in the United States: Findings from the 2016 Commonwealth Fund Survey of High Need Patients, The Commonwealth Fund, December 2016. 2. (Data includes all payor types, 5 or more chronic conditions) Buttorff, Christine, Teague Ruder and Melissa Bauman. Multiple Chronic Conditions in the United States. Santa Monica, CA: RAND Corporation, 2017 (https://www.rand.org/pubs/tools/TL221.html). 3. (Medicare data only) Jencks, S.F., Williams, M.V., Coleman, E.A. Rehospitalizations among patients in the Medicare fee-for-service program. N Engl J Med. 2009;360:1418–1428 (https://www.ncbi.nlm.nih.gov/pubmed/19339721). 4. Buttorff, Christine, Teague Ruder and Melissa Bauman. Multiple Chronic Conditions in the United States. Santa Monica, CA: RAND Corporation, 2017 (https://www.rand.org/pubs/tools/TL221.html). 5. Vively analysis of partnership results, June 2018 6. Vively analysis of partnership results, June 2018