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UCLA Kidney Medical Home: A Model for Specialty Value-Based Care

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Learning Objectives

- Develop population health governance and leadership engagement to manage high-cost clinical conditions such as chronic kidney disease.
- Apply a specialty medical home value-based care model to manage cost, quality and patient experience.
- Describe innovative technology, complex care management and team-based care to enhance clinical outcomes.

UCLA Kidney Medical Home: A Model for Specialty Value-Based Care

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Agenda

- Imperative for the Future
- CMS Kidney Care First Overview
- Operationalizing the UCLA Kidney Care Medical Home


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Culver CIty
Mobile Homeless Clinic
Samoshel Shelter
Orthopaedic Inst for Children
Venice Simms/Mann
Martin Luther King, Jr. Community Hospital
Venice Family Clinic
Manhattan Beach
Charles Drew UCLA Joint Program
Student Run Homeless Clinic (SRHC)
Redondo Beach
Torrance
Harbor UCLA Torrance
Palos Verdes
Harbor UCLA Wilmington
Orange
Fountain Valley
Harbor UCLA Harbor City
Laguna Hills
Irvine
23
118
210
5
170
101
134
2
405
10
60
605
710
110
90
105
91
FY2022 Highlights
1,931 Clinical FTE Physicians
262 Practice Sites
6.0 Million Encounters
2.6 Million Visits
14% Year-over-year Growth
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Imperative for the Future

Future of Healthcare is Here

Requires Capability to Manage Populations

- Aging population
  - Chronic conditions
- Convenience/access
- Health equity

Patients

- Rising healthcare costs
- Alternative Payment Models (Governmental & Commercial)
  - Pressure to take on financial risk
- Competition: Niche Players
- Narrow insurance networks
- CMMI Strategic Refresh

Landscape

- Infrastructure to manage populations
  - Medical home models
  - Care management
  - Integrated health system

Capability

Adopting a Medical Home Model Approach to Succeed in Alternative Payment Models

Traditional Care Models

- Facility-Centric
  Condition-Centric
- Unclear Access
- Individual Work
- Uncoordinated

Why a Medical Home Model?

Adding Value
Patients/Competitors

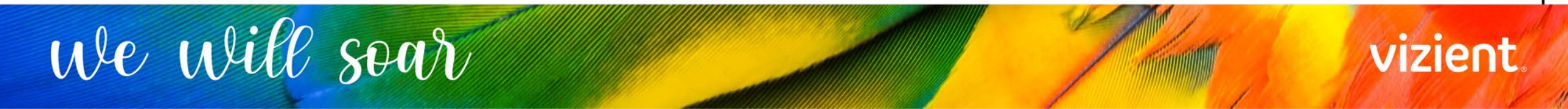
Change in Healthcare Culture
A better way to practice

Payer-Provider Networks/Partnerships
Focus on outcomes

Alternative Payment Models
Focus on Quality and Cost

Patients, Payers, and Marketplace Drive Changes and Demand Outcomes

CMS Kidney Care First Overview

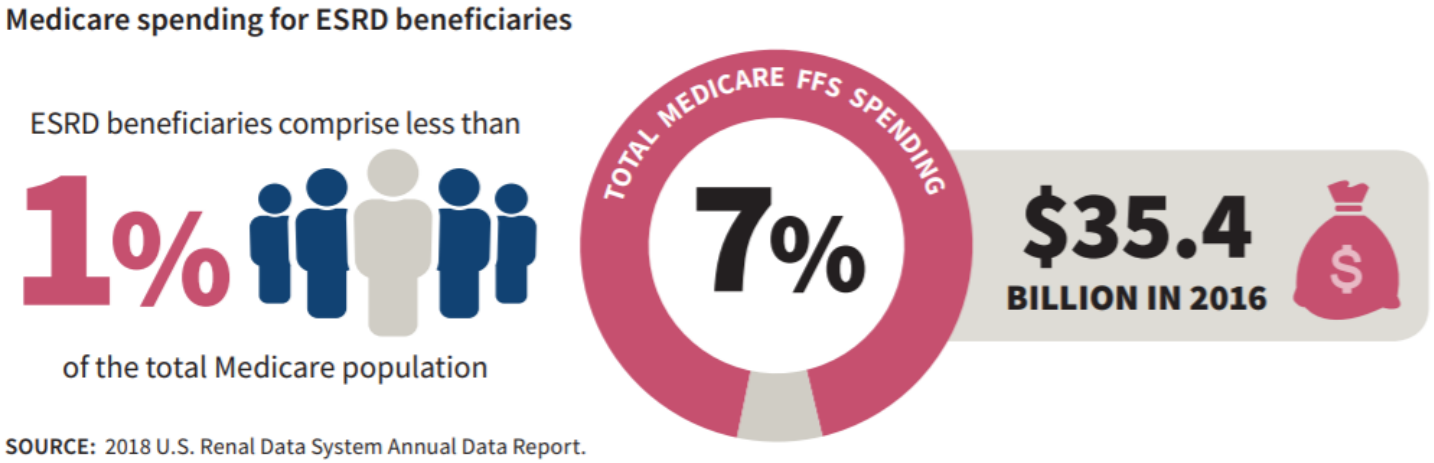


Impact of Kidney Disease Today

- More than 1 in 7, that is, 15% of US adults, are estimated to have Chronic Kidney Disease – many do not know it.
- Nearly 786,000 people in the United States are currently living with ESKD: 71% are on dialysis and 29% are living with a kidney transplant.
- About 1/3 of ESKD cases have never seen a kidney specialist prior to starting dialysis.
- High mortality in first 3 months of dialysis
- 5-year survival in dialysis patients is less than many common cancers
- 12% home dialysis penetration rate

Note: ESRD is End Stage Renal Disease or End Stage Kidney Disease (ESKD)

President Launched Advancing American Kidney Health Initiative in 2019



Advancing American Kidney Health Initiative Goals

- Prevention of Kidney Failure
- Increase Home Dialysis
- Improve Kidney Availability for Kidney Transplants

Centers for Medicare & Medicaid Services

Note: ESRD is End Stage Renal Disease or End Stage Kidney Disease (ESKD)

CMS Developed a Kidney Care Medical Home Model

Alternative Payment Model Incentivizes Prevention, Transplants, and Home Dialysis

Voluntary Payment Program <u>Kidney Care First</u>

- Launched January 2022
- Focus on CKD Stage 4, 5, and ESKD
- Incentivize Home Dialysis and Transplant
- Capitated Payments Adjusted based on Performance and Outcomes (e.g., Depression Response, Patient Activation, Optimal ESKD Starts, and Total Cost of Care)
- Bonus payment for every successful Kidney Transplant

Source: CMS

Kidney Care First Model Payments Overview

Total Kidney Care First Model Payments

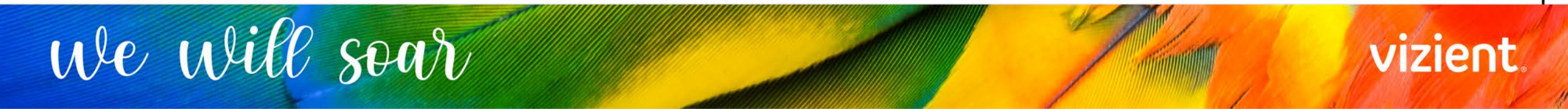
Total Kidney Care Payments + **Performance-Based Adjustment PBA**

- CKD Quarterly Capitated Payment (CKD QCP) — **CKD Stage 4 & 5**
- \+ Adjusted Monthly Capitation Payment (AMCP) — **ESKD**
- \+ Kidney Transplant Bonus — **ESKD**

Starting Q3 of CY2023, 2-Step Performance-Based Adjustment Applied on CKD QCP+ AMCP [Adjustment Ranges from -20% to +20%]

1. ***Relative Performance (RP)***: Outcomes compared to other KCF Practices & Medicare Nephrology Practices nationwide
2. ***Continuous Improvement (CI)***: UCLA compared against own performance over time (effective starting PY2)

Operationalizing the UCLA Health Kidney Care Medical Home



UCLA Health Medical Home Concept: Primary Care and Specialty Care

Alignment with Kidney Care Medical Home Goals with UCLA Health Population Health Goals

UCLA Health Medical Home Model

Kidney Care Medical Home

- Patient Engagement & Advocacy
- Availability and Access to Care
- Comprehensive Team-Based Care
- Quality Improvement
- Safety

1. pcpcc.org. Accessed June 24, 2021
2. https://pcmh.ahrq.gov/page/creating-patient-centered-team-based-primary-care accessed June 24, 2021
3. ASCO.org accessed June 24th, 2021

Reimagining Kidney Care using a Medical Home Model Approach

Collaboration between Division of Nephrology, Primary Care, IT, Operations, Care Coordination, and Population Health

Early Identification and Prediction of Worsening

- Identify CKD Patients
- Predict worsening of renal function
- Chronic Kidney Disease Registry

CY 2019

Referral and Collaboration

- Appropriate referral to specialty care
- Co-Management between Primary Care and Nephrology
- Slow disease progression

CY 2019

Shared Decision Making and Complex Care Management

- Transplant as primary treatment option
- In-Center versus Home Dialysis Shared Decision Making
- Patient engagement & advocacy
- Conservative management
- Kidney Care First Application Process

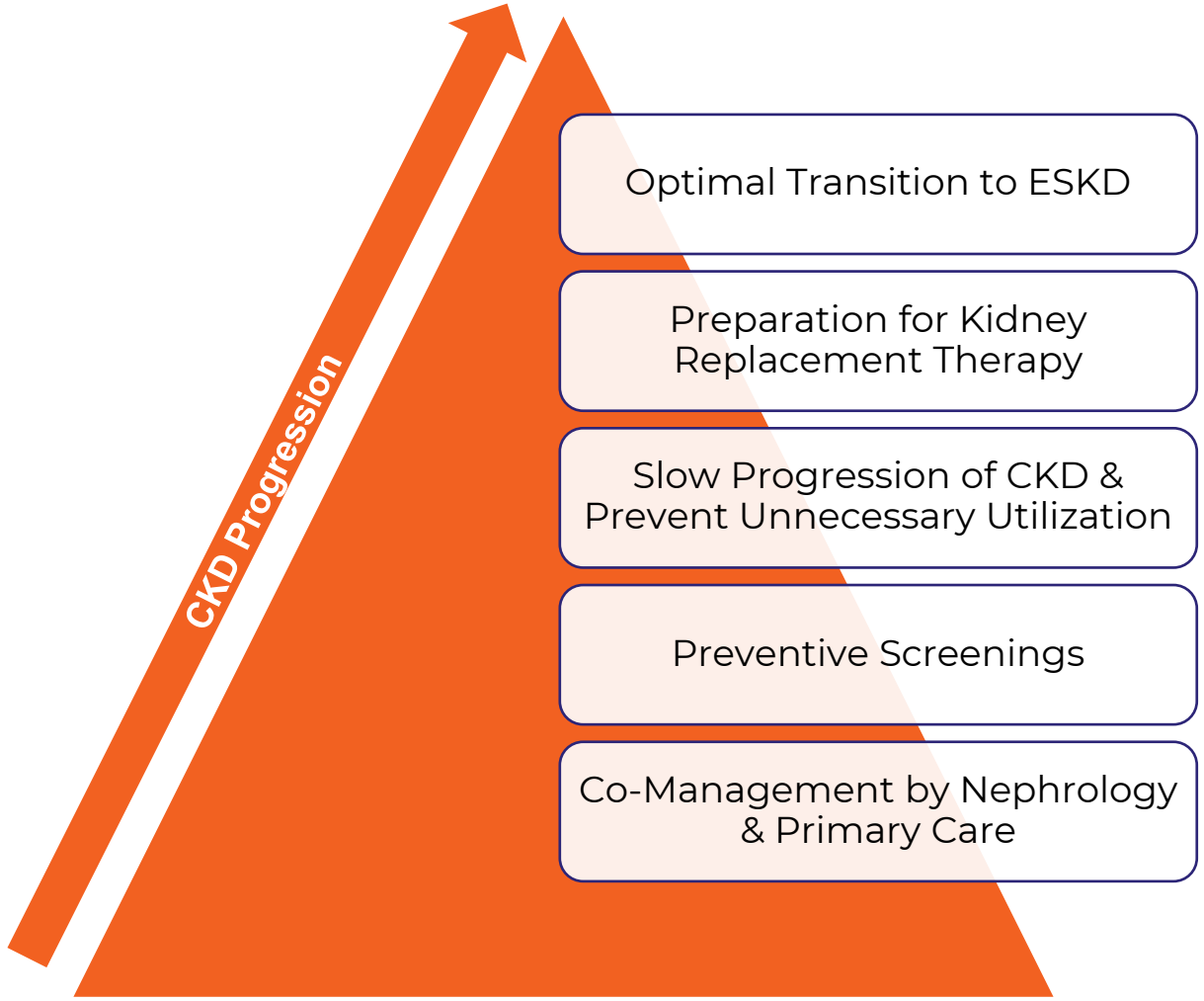
CY 2019 – CY 2021

Participation in CMMI Alternative Payment Model (APM)

- CMS Kidney Care First started January 2022
- Capitated payments rather than fee for service
- Total cost of care and quality outcomes determine reimbursement
- Aligned with UCLA Health Kidney Care Population Health Goals

January 2022

UCLA Kidney Care Medical Home Enhances Capabilities & Preparation for a Value-Based Future



Interventions

- Coordinate permanent access and dialysis facility placement to ensure optimal dialysis start
- Coordinate outpatient IR procedures to prevent unnecessary admission
- Kidney Education Program (KEP) & Shared Decision Making
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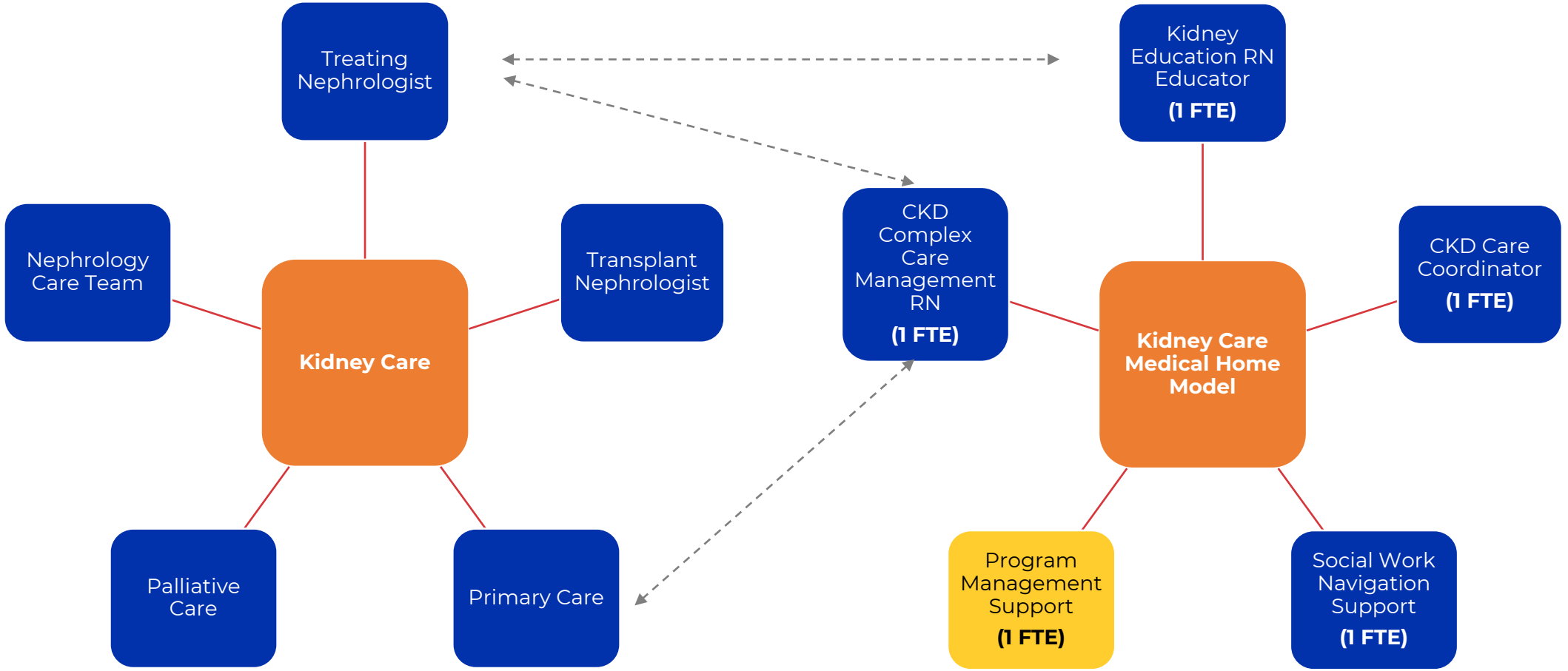
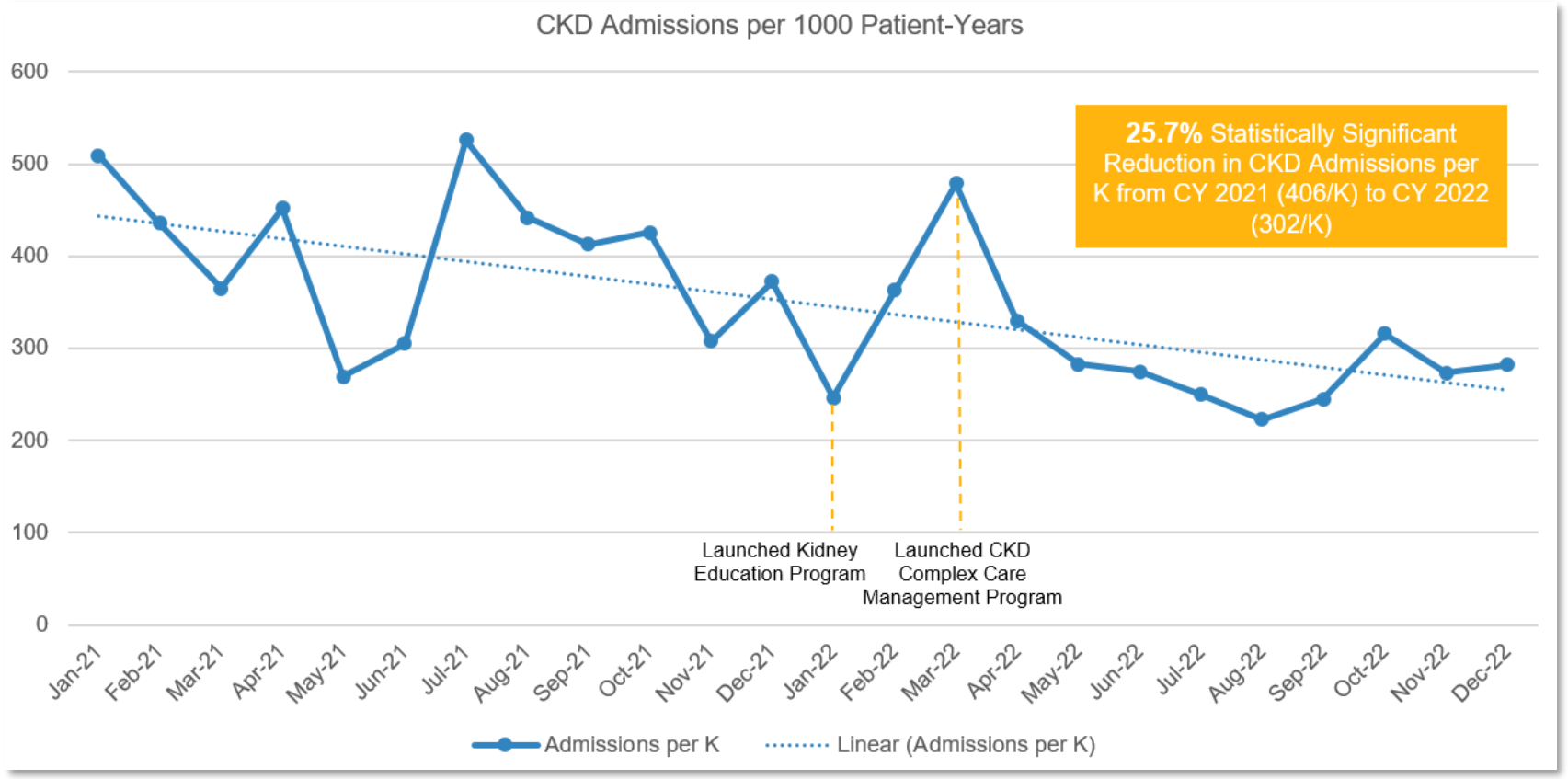
- Identify CKD Patients & Refer to Nephrology

A Successful Medical Home Model Takes a Village



Notable Reductions in CKD Admissions and ED Visits Following Launch of UCLA Health Kidney Care Medical Home



Source: UCLA CKD Management Dashboard; January 2021 to December 2022
Filters: Accountable Care & Medical Group Populations

Lessons Learned

- The UCLA Kidney Care Medical Home has the potential to decrease cost, enhance quality, and provide patient-centered care.
- Integration of primary care and specialty care in value-based care models is an important approach to providing seamless care.
- Patient engagement is central to the success of the UCLA Kidney Care Medical Home, empowering patients to discuss their specifics goals, values, and preferences.
- The UCLA Kidney Care Medical Home can be set up by most organizations and requires few additional resources.

Key Takeaways

- Integrate primary care and specialty care in value-based care models
- Collaboration across disciplines provides a successful model in value based care
- Align with national initiatives when preparing value-based care models
- Understand desired outcomes to measure success

Questions?*

UCLA Health

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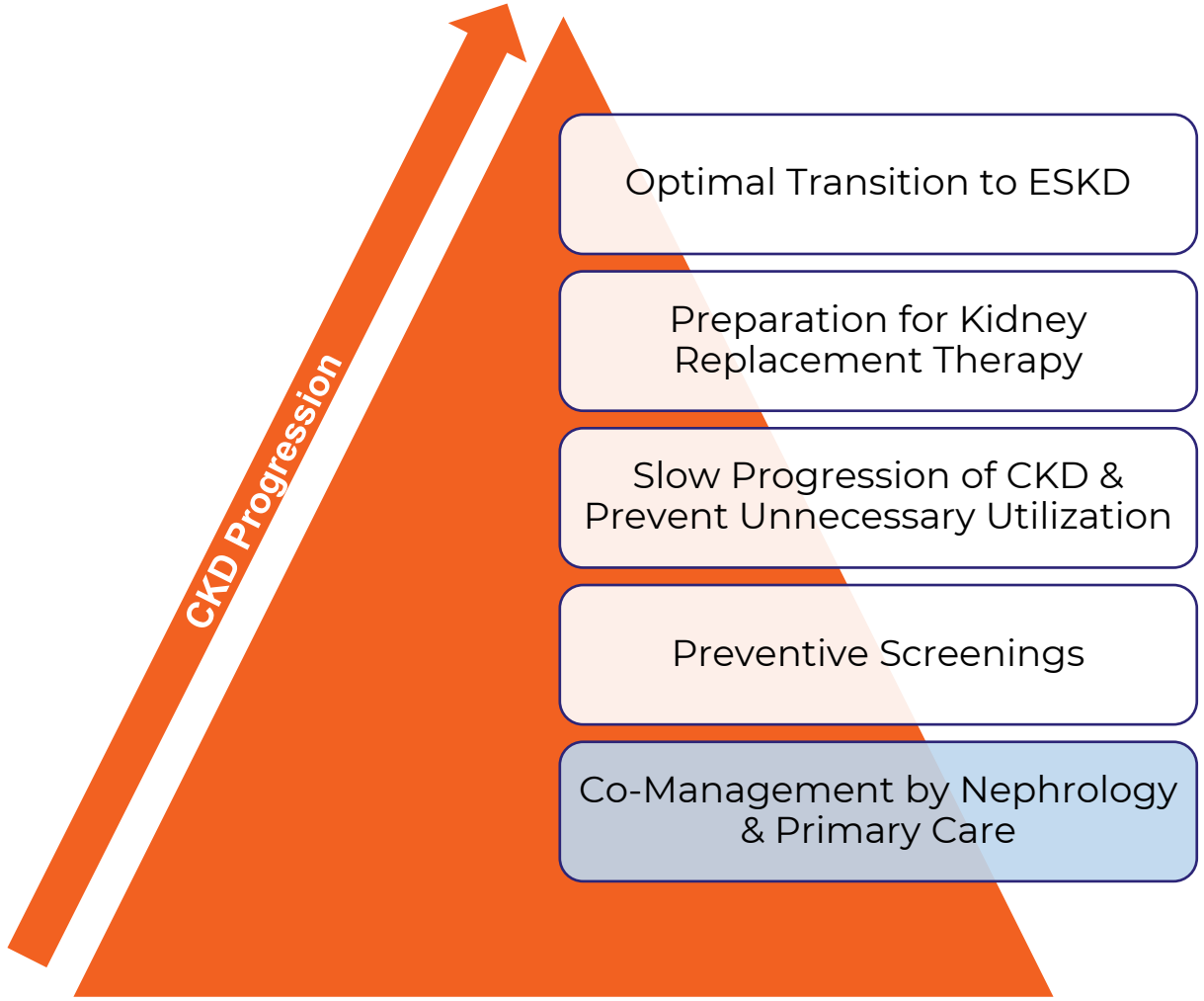
This educational session is enabled through the generous support of the Vizient Member Networks program.

*See Appendix

Appendix

UCLA Kidney Care Medical Home Enhances Capabilities & Preparation for a Value-Based Future



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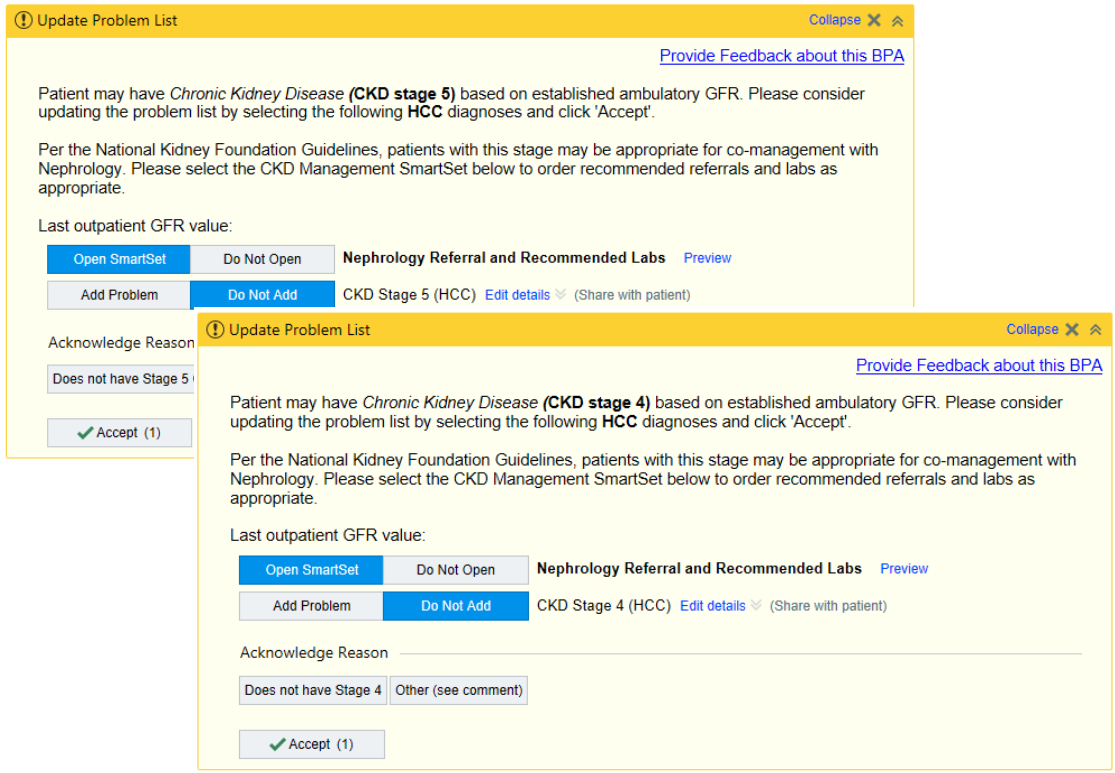
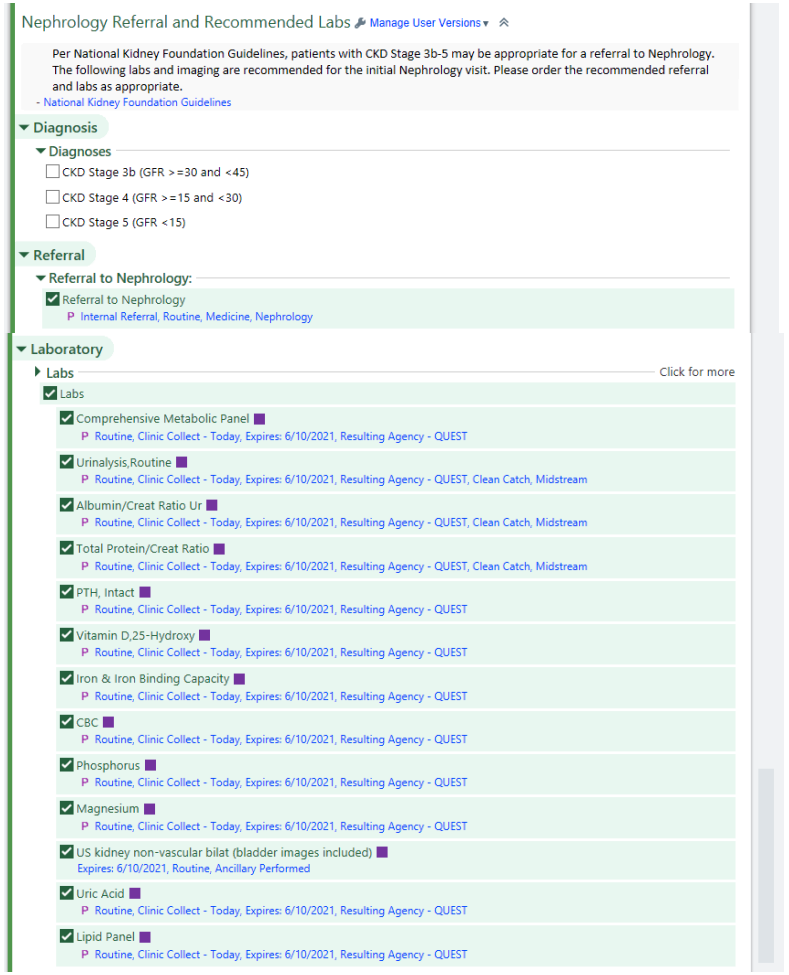
EMR Workflows to Support Early Diagnosis and Co-Management between Nephrology & Primary Care

Leveraging Best Practice Advisories & SmartSets





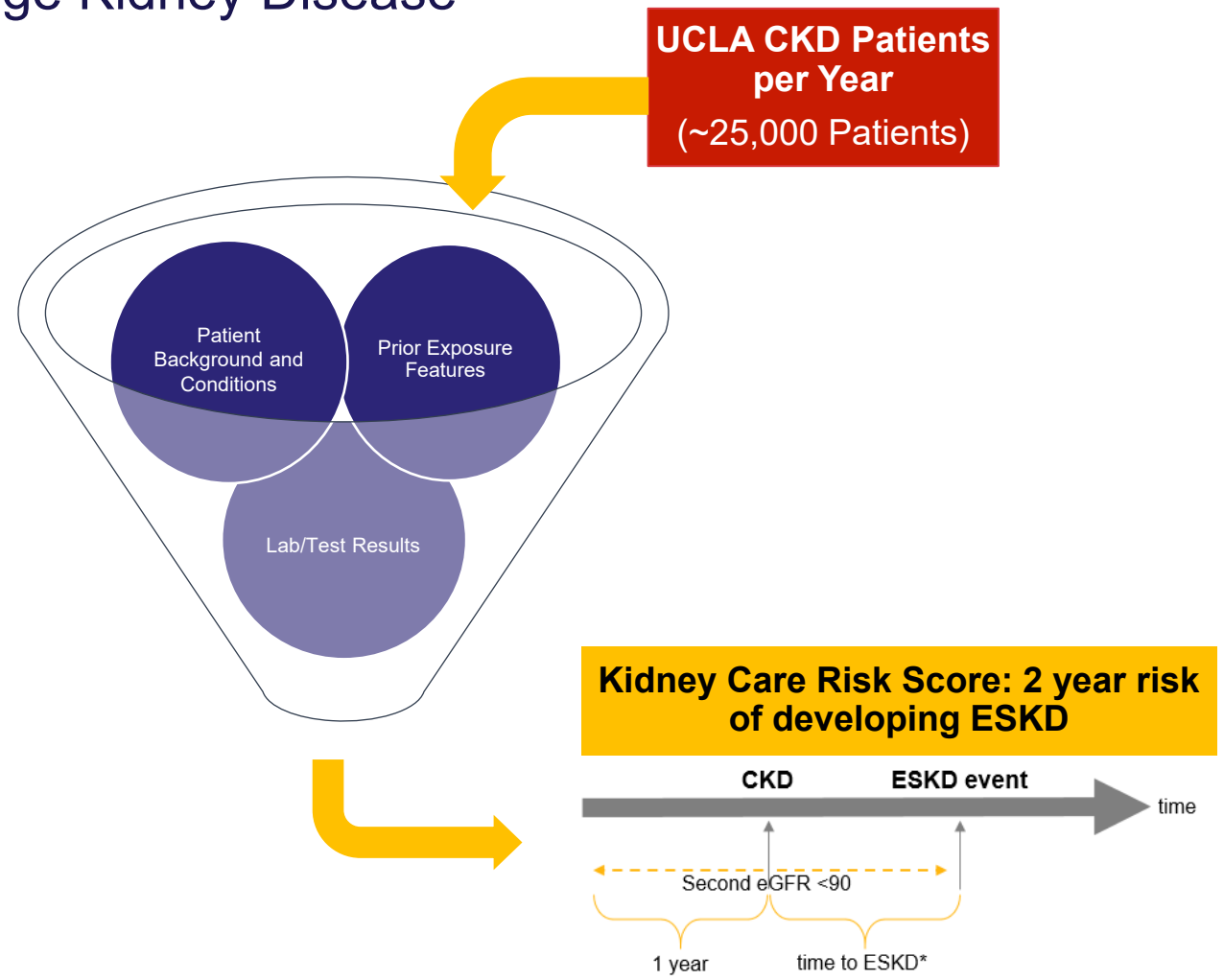
Leverage Artificial Intelligence to Identify At-Risk Patients

Predict Risk of Rapid Progression to End-Stage Kidney Disease

UCLA Kidney Health Predictive Model:

- Identify patients at risk of rapid progression from CKD to ESKD within two years
- Increase physician and care team awareness of risk of rapid progression of CKD to ESKD
- Offer interventions to slow CKD progression and preserve renal function

To Launch in 2023



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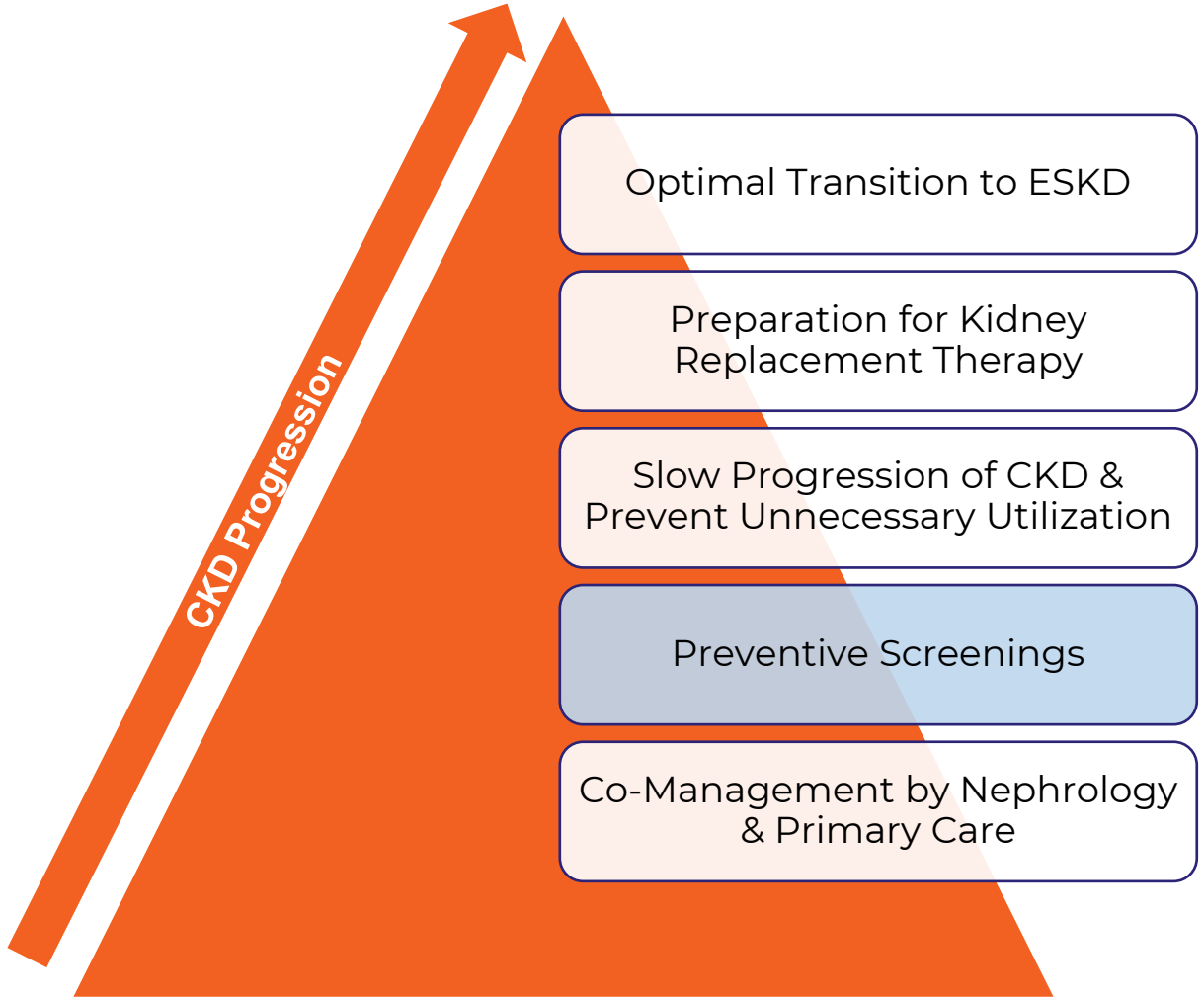

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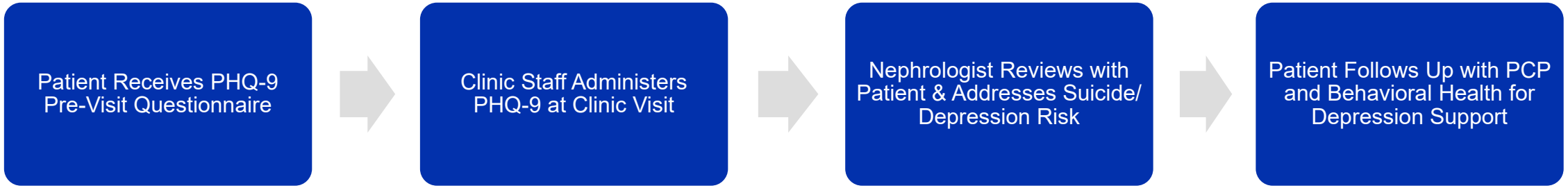
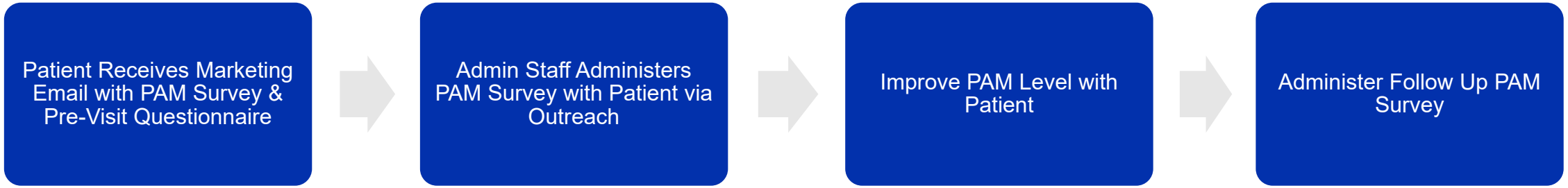
Key Elements of Whole-Person Care Embedded in Depression and Patient Activation Workflows

Kidney Care First Depression Workflow in Launched in January 2022



Kidney Care First Patient Activation Measure Workflow Launched in January 2022



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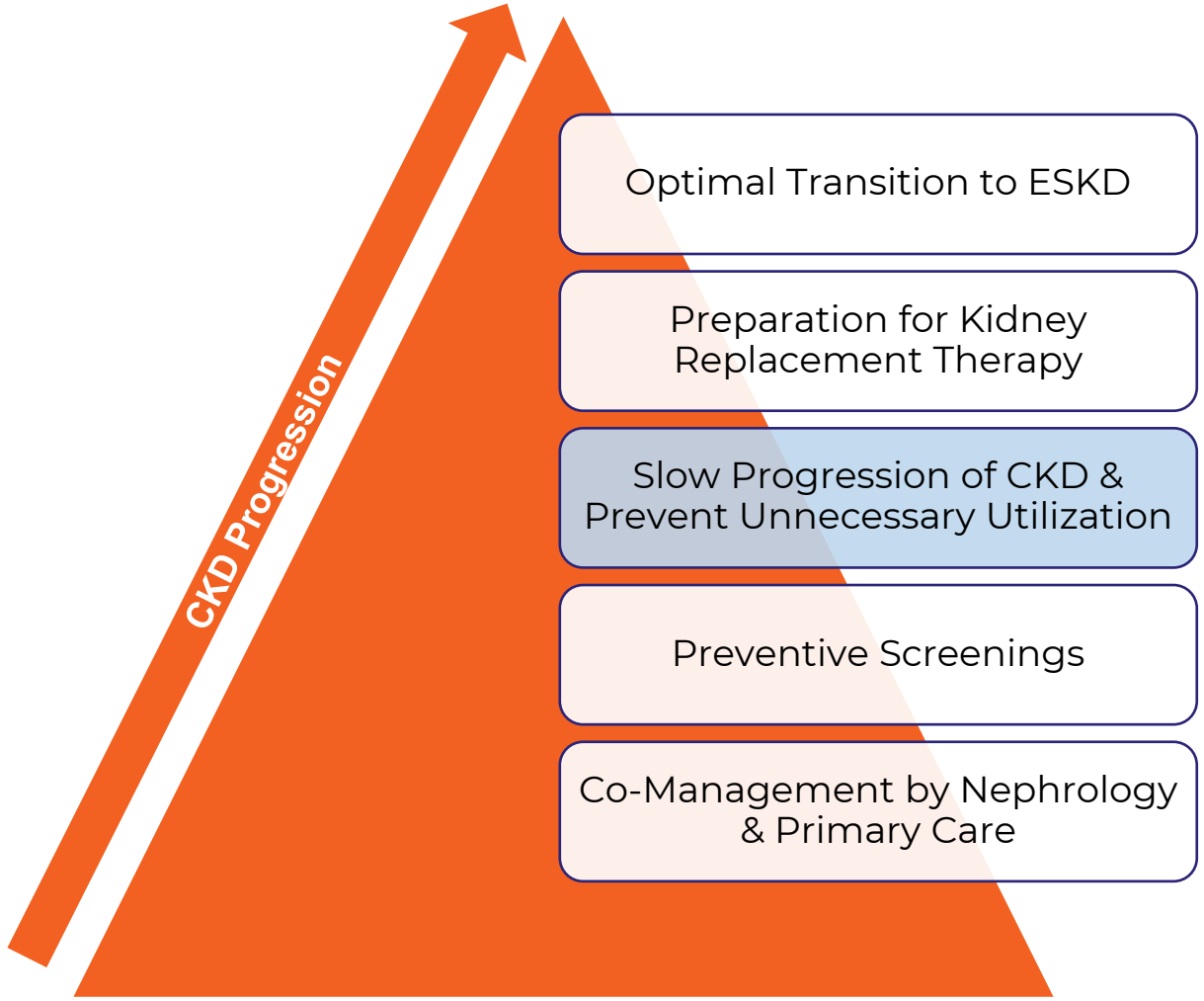

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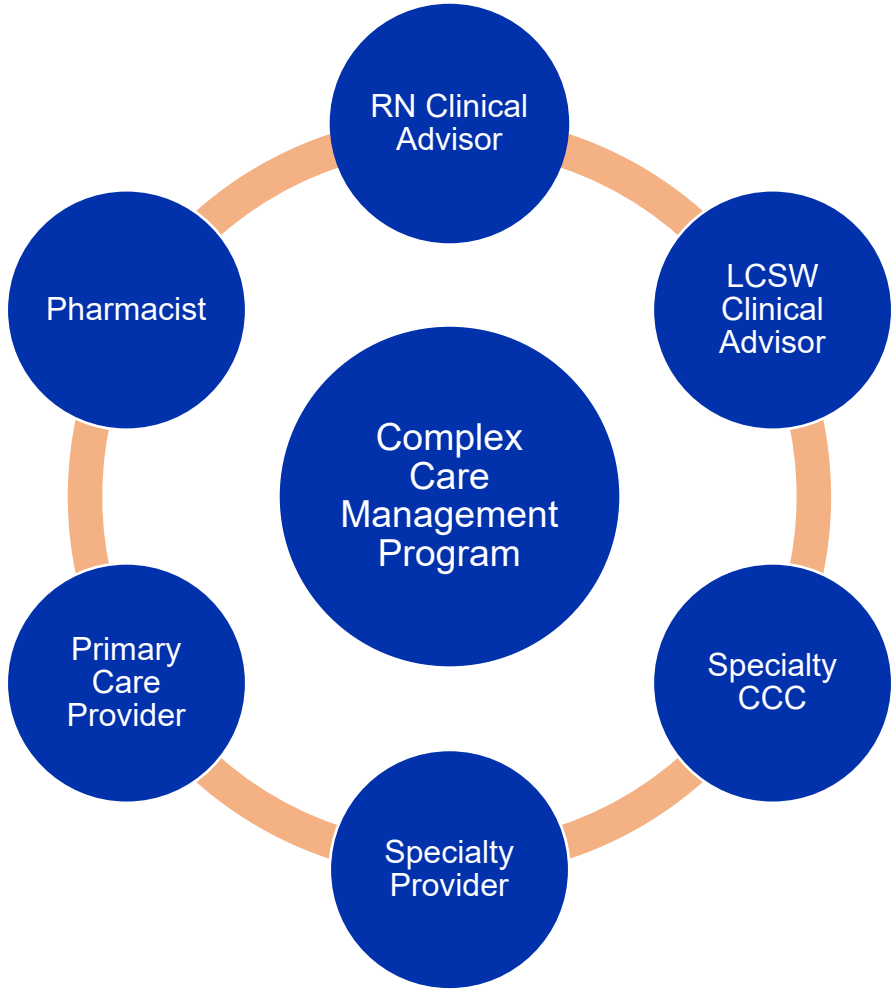
CKD Complex Care Management (CxCM) Program Launched March 2022

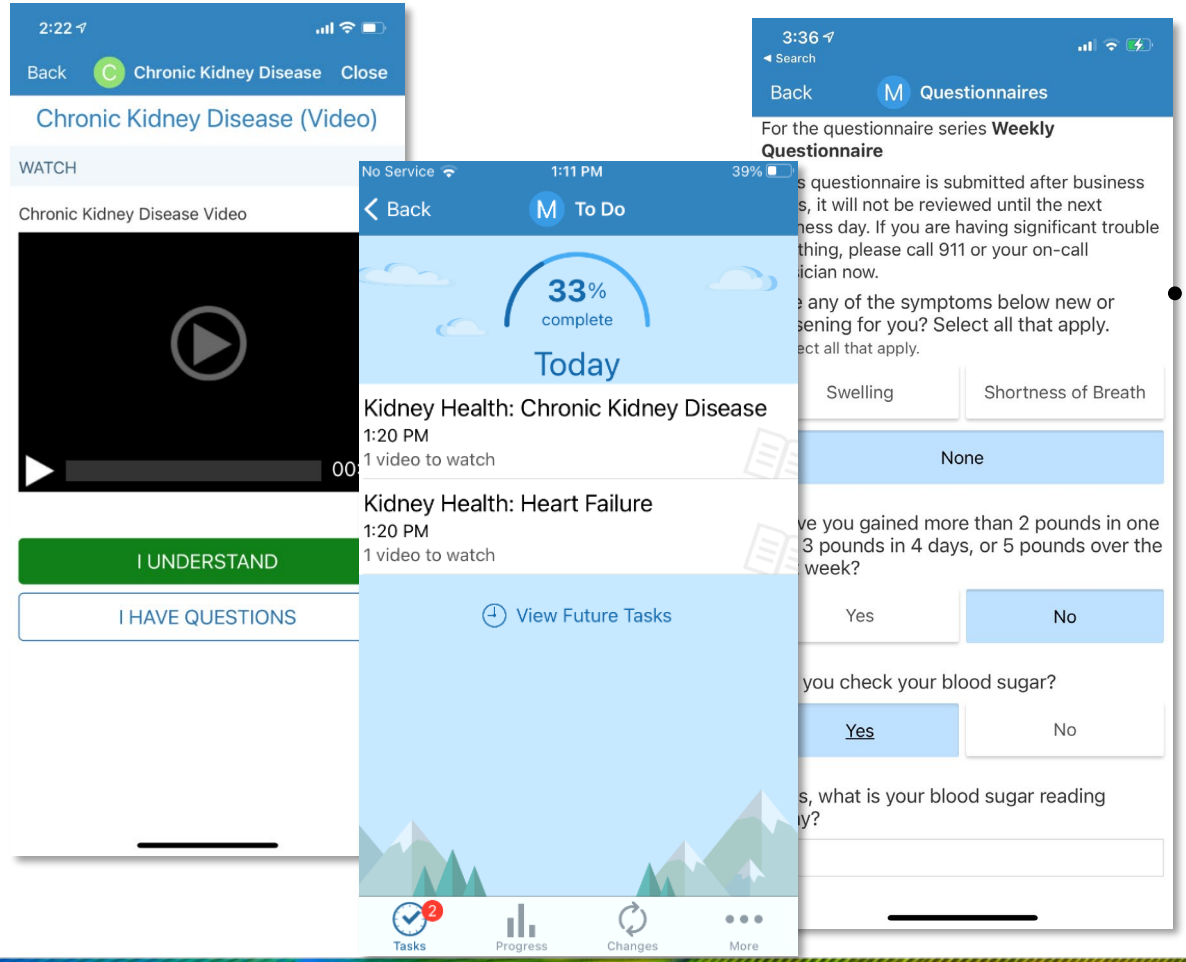
To accommodate the growing needs and complexity of our CKD patients, complex care management is required to:

- Manage patients with multiple chronic conditions and psychosocial needs
- Enhance care coordination
- Slow progression of CKD
- Prevent unnecessary utilization

Estimated Patient Panel:
~50 Patients

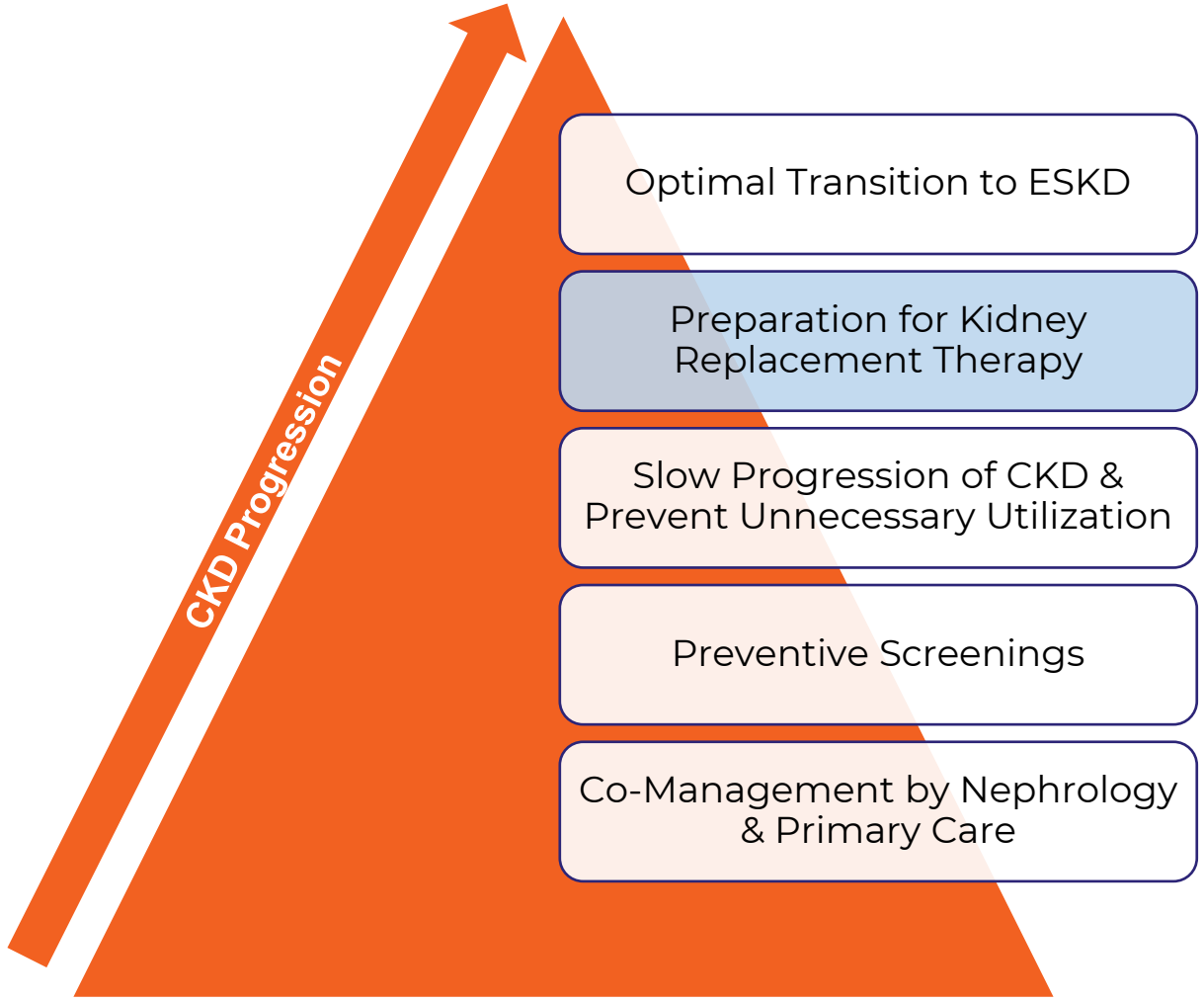


Engaging Patients through Remote Patient Monitoring to Improve Health Outcomes



- CKD Complex Care Management using Care Companion:
  - ✓Weekly & Quarterly Check-In Tasks
  - ✓Educational Videos

UCLA Kidney Care Medical Home Enhances Capabilities & Preparation for a Value-Based Future



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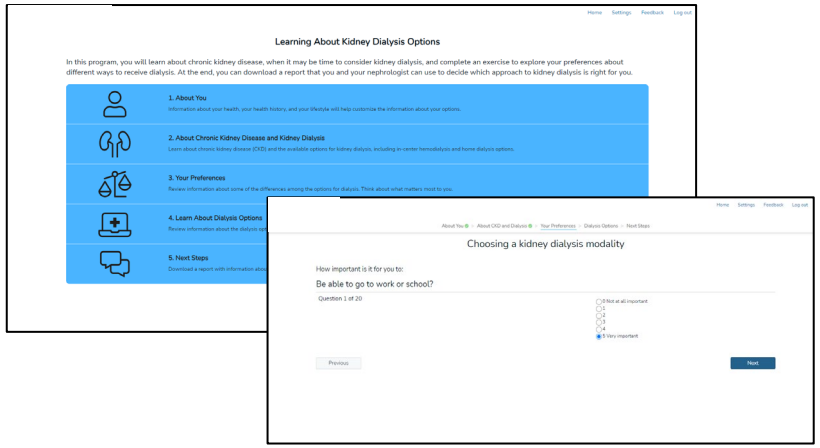
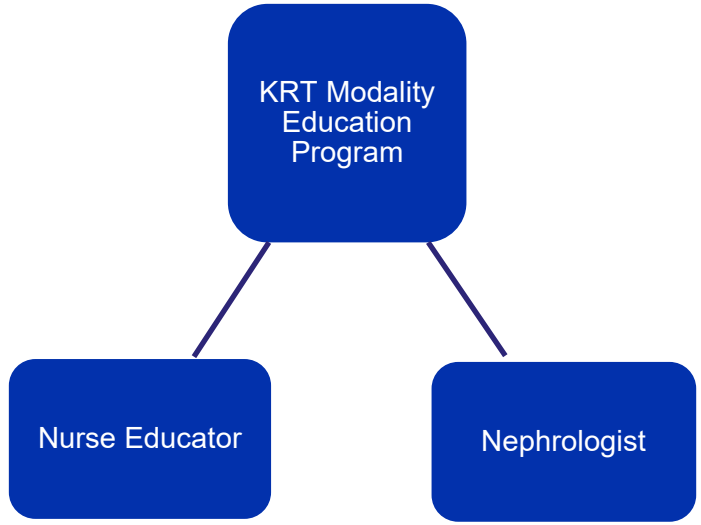
Kidney Education and Shared Decision Making Program Launched January 2022

Shared Decision Module & Patient Stories Video



Use Shared Decision Module and Patient Stories to Educate, Capture Patient's Values and Preferences, and Engage Patients in the Shared Decision Making Process for KRT Modality Decision

Kidney Replacement Therapy Education



UCLA Nurse Educates Patients on KRT Modalities and Diet and Support Shared Decision Making Process with Patient and Provider

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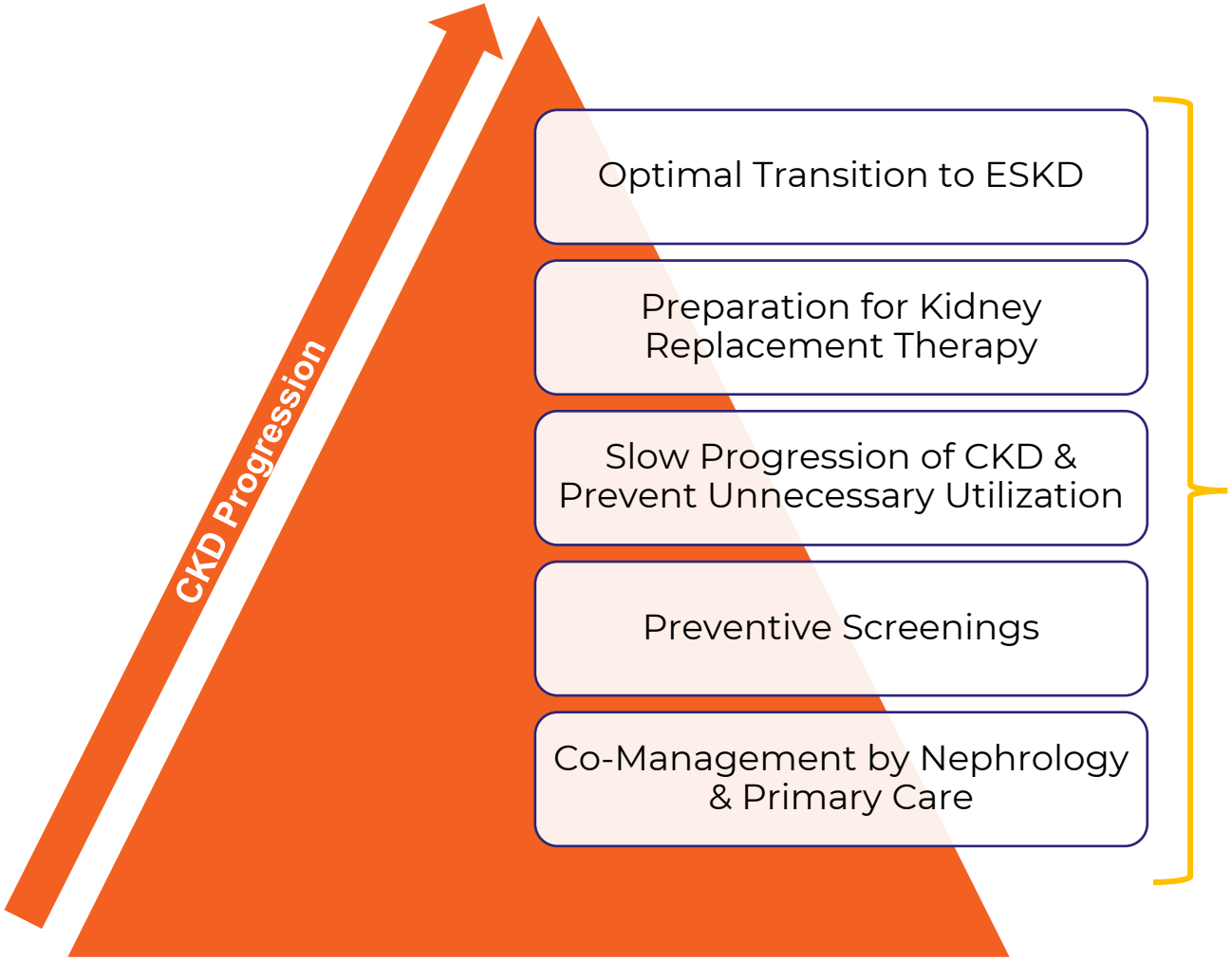

UCLA Kidney Care Medical Home