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KIDNEY HEALTH MANAGEMENT



ADVANCING KIDNEY CARE AND BEYOND

A Conversation with Healthmap Solutions' Medical Leaders

Kidney disease rarely occurs in isolation. Patients often face interconnected clinical, behavioral, and social challenges that require coordinated, specialized support. At Healthmap Solutions, our medical leadership team provides the clinical expertise and direction to improve health outcomes while delivering meaningful savings to health plans. In the following interview, Healthmap Chief Medical Officer **Jonathan Gavras, MD, FCCP** and Chief Nephrology Officer **Stephanie Toth-Manikowski, MD, MHS, FASN** share their perspectives on the following topics:

- Barriers health plans and providers face when managing a complex population;
- Healthmap's care management model and how it supports members and providers; and
- The roles of technology and specialty expertise in improving kidney care.

What are the biggest challenges health plans and providers are facing today in managing kidney disease and other complex chronic conditions?

Dr. Gavras: The biggest challenges we're seeing with chronic condition management are the early identification of members and how to get them engaged. Member engagement and provider engagement remain significant hurdles in getting people the right care, in the right place, at the right time.

Access to specialists, particularly nephrologists, cardiologists, and other specialists who care for people with kidney disease, is also a serious barrier. Due to the shortage of specialists, increasing provider consolidation, and a significant wait time to get an appointment, it can be difficult to get members to the physicians they need to see.

To address these challenges, Healthmap is highly focused on promoting evidence-based medicine and the guidelines around it. We use claims and other available data, along with condition-specific algorithms, to identify members earlier and determine where we can make the greatest difference. From there, our care team reaches out to members, works alongside their providers, reinforces their care plans, and helps address barriers that may keep them from following through. Ultimately, it's about helping each member get the right care—not just more care—at the right time, in the right place, and from the right people.

What complex needs do you see most often among high-risk patients with kidney disease, and how does Healthmap's Kidney Health Management model help address them?

Dr. Toth-Manikowski: There's a high prevalence of social barriers to care within the chronic kidney disease (CKD) and end-stage renal disease (ESRD) population. When a doctor is speaking one-on-one with a patient in a clinical setting, they often lack access to various resources that can help their patients overcome those barriers. Healthmap provides a

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multidisciplinary care team approach that exists outside the four walls of the clinic. As an example, when somebody has transportation or financial barriers that are preventing them from getting care, our nurses and social workers jump in and help coordinate and advocate for these patients. That makes a big difference.

We also see a lot of behavioral health issues, especially in members transitioning from advanced CKD to ESRD. There's a lot of anxiety and depression that happen at that time, understandably. It's a tremendous change in a person's life, and having access to a nurse who can walk you through what's happening and connect you with resources in your community is a tremendous value-add. As part of Healthmap's program, we screen members for these behavioral health concerns and make sure they're getting the care they need without having to navigate this difficult time alone.

Comorbidity management is another complex need that our program addresses. To prevent CKD progression, a person must have the comorbidities that cause CKD in the first place (primarily hypertension and diabetes) under good control. Our nurses can break down what it means to have controlled blood pressure, discuss dietary changes, review blood pressure values, and work with members over time to achieve their target blood pressure. Realistically, providers may not always have sufficient time to do this comprehensively in the clinic or office, but our nurses do. When you can help control those comorbidities, it can make a significant impact on slowing the progression of kidney disease.

Disease awareness is yet another benefit. One in seven people has CKD, and 90% of adults with CKD are unaware they have it.[1] We start upstream, identify members early, and begin outreach and management when members have CKD Stage 3. Early intervention and carrying that message to the patient goes a long way. That's when lifestyle intervention is most important and when early initiation of appropriate therapy to slow CKD progression matters, because hopefully the provider and patient can prevent progression and dialysis altogether.

Finally, a lot can happen after a hospital discharge. Our program engages members in the post-hospital setting and gets them working with our nurses. By doing that, we're not only reducing the likelihood of readmission and connecting them with their doctors but also slowing CKD progression. Preventing accelerated progression of kidney disease in the post-discharge setting is tremendous, and another benefit of our program that we don't talk enough about.

How does Healthmap work with providers in a way that supports care without adding unnecessary administrative burden?

Dr. Toth-Manikowski: Most people don't have a lot of face time with their healthcare providers. When a doctor knows that we are complementing and reinforcing their care plans outside the office setting, they're happy to have our support. Somebody else is holding their patient's hand, walking them through the care plan, advocating for them, and educating them about what they need to know.

In addition, when we engage with providers, we do our best not only to bring care gaps to them but also to highlight those that are most meaningful, clinically impactful, and actionable. We call these high-impact interventions "next best actions," or NBAs. The feedback from provider groups has been that NBAs are very valuable and allow providers to act on them almost immediately, because we're often identifying individuals who have fallen through the cracks. While we're focused on improving kidney health, that doesn't preclude us from targeting cardiac health, hypertension, diabetes, and other care gap opportunities.

To further promote some of the most critical interventions, we've tied some of our NBAs to an incentive program for providers that we will be rolling out next year, and we have also tailored the opportunities to the specialty groups most likely to close them, including primary care providers, nephrologists, and cardiologists.

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How is Healthmap's clinical model different from traditional approaches to care management?

Dr. Gavras: We believe in promoting care and working in conjunction with providers. We are not a utilization management company; we are a population health management company. We believe the most important thing is to get patients the care they need; not more or less care—but the appropriate care.

We include the patient along with all other stakeholders involved in that person's care, including all providers and caregivers. As part of our holistic model, we have a biopsychosocial approach to care management. On the biological side, we focus on condition management using proven, evidence-based pathways, supported by the most recent literature and by our Scientific Advisory Board, which is made up of various specialists, including nephrologists and cardiologists.

On the psychological side, we know that many members experience a crisis because of their chronic illness. We work directly with members who are struggling while also coordinating with our payers' behavioral health programs and community resources. On the social side, we assess barriers to care. Those may include pharmacy barriers, housing, meals, shelter after discharge, or caregiver support. As these members' illnesses progress, they often require significant help with activities of daily living.

In short, we believe in promoting the right care rather than taking a utilization management approach that dictates what care a member can receive. Better outcomes are tied to coordinated care, and in the end, access to appropriate healthcare is also the most efficient healthcare.

Why is it a challenge for health plans to manage members with chronic kidney disease on their own?

Dr. Gavras: Patients with chronic illnesses are very complicated and require significant resources specialized in chronic condition management. You need specially trained nurses, specialty-developed algorithms, and specialty-developed care management protocols.

Science is also exploding. This is a very exciting time in healthcare, with tremendous amounts of new modalities of testing, treatment, and care being released daily. It takes a significant effort to stay current with the technology, medical policy, and therapies available to members.

Pulling together everyone involved in a CKD member's care requires a very focused effort that requires not just nurses or care managers, but also the clinical and operational input of a specialty-focused organization. You need to bring together member-specific data, quality measures, and care gap metrics, and then focus on that population to make sure members get what they need. Traditional payers have had success with this in the past, but they are stretched further and further by increasing populations of complicated chronic disease members and the rapid development of new treatment protocols, drugs, and approaches to care.

What role does technology play in the success of Healthmap's program?

Dr. Gavras: Technology plays a large role in our success. Over time, we've developed algorithms and expertise to take in tremendously large amounts of data from multiple and disparate sources, not just claims data. This gives us a very good understanding of both the population we're managing and the individual members within it.

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It allows us to look for gaps in care, disease characteristics, how individual members seek care, and how we can help guide them through the system. AI also has an increasing role. For example, we have developed a tool to examine the quality of interactions between our nurses and members, as well as the results of specific interactions. We've found that certain ways of interacting with members lead to significantly better outcomes along the care journey, including fewer hospitalizations and better medication adherence.

We also use technology for digital outreach so that we can engage members in multiple ways, in addition to telephone and written mail. Carium (Healthmap's digital platform and mobile app), for example, helps us engage members in the methods they prefer. If members choose to communicate with Healthmap through the digital app, they can download it, communicate with us, and exchange information. Its capabilities include messaging, reminders, care gap notifications, and prompts related to preventive care, helping members manage their health in a more automated, high-tech way.

How does Healthmap ensure technology supports clinical judgment rather than replacing it?

Dr. Toth-Manikowski: I believe strongly that people go into healthcare to help others. Healthcare providers are highly competent individuals who are balancing multiple variables that are changing constantly, such as a person's age, comorbidities, allergies, response to therapy, imaging and laboratory results, personal circumstances, socioeconomic factors, and limited resources within the healthcare setting. Clinical judgment sounds easy, but it's often much more difficult because of the individual-level variables that may change from visit to visit.

Physicians are also human, and we err from time to time. Patients are living longer with more complex medical conditions. There is an explosion of data, care is often fragmented, primary care shortages are expected to grow, and burnout remains rampant among physicians, nurse practitioners, and physician assistants. When you take all of that into account, it's easy to see how things may slip through the cracks. Technology gives us an opportunity to help prevent that.

We use AI-enabled resources and predictive models, along with other data inputs, to identify individuals with a high risk of a future hospitalization or adverse event so we can get ahead of the event and try to prevent it. Technology also helps us identify next best action opportunities so we can personalize conversations with members by focusing on the most impactful care gaps.

But technology never replaces clinical judgment. If anything, it helps us support providers who are working in a very busy environment that may not be allowing them to practice in the way they intended when they entered healthcare.

Why is a specialty-focused approach important for complex chronic conditions?

Dr. Gavras: Within each organ-related illness, there is a tremendous amount of complexity, and the knowledge requirements continue to grow. There is an explosion of science around specialty medical care. For a complex kidney, heart, oncology, or pulmonary patient, the science, treatments, and testing continue to expand rapidly. There is an incredible amount of knowledge needed to manage these patients, and they often have multiple specialists whose care must be coordinated.

Population health management tends to be so broad that it's difficult to have the expertise and technological capabilities to focus on the patients who drive a tremendous amount of cost. About 5% of patients drive nearly half of all healthcare spending.[2] Those patients often have chronic diseases and multiple admissions, with kidney disease and heart disease among the costliest conditions.[3]

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If those patients are placed into general population management, they can be lumped in with people across many disease states, without enough focus on these very complex comorbid, sick patients who ultimately consume the most healthcare resources. Managing them also requires attention beyond care management, including community resources and other support systems. These patients often face financial, social, and psychological challenges related to chronic illness. Their needs require a focused approach that a less intensive, broad population program cannot provide.

How is Healthmap expanding into cardiac care while continuing to strengthen its current Kidney Health Management services?

Dr. Toth-Manikowski: Our expansion into the cardiac space reflects what primary care providers, nephrologists, cardiologists, and endocrinologists have always known: There is significant overlap among kidney disease, cardiac disease, and metabolic syndrome. We now have a term for this compilation of disorders—cardiovascular-kidney-metabolic, or CKM, syndrome.

Our movement into this space reflects what is naturally and clinically appropriate, managing the entire individual across these disease spectrums. Managing kidney disease isn't just about focusing on the kidney. It means stepping back and looking at the member holistically. What cardiac and metabolic conditions do they have? Are they overweight or obese? Do they have diabetes or hypertension, and are those conditions controlled? We then target therapy optimization across those conditions so we can improve the health of the kidneys, heart, and the whole person at once.

We have enhanced our focus to include the management of heart failure, coronary artery disease, post-myocardial infarction, and other cardiac conditions. We're thinking about this population comprehensively and asking what we can do to improve a member's heart conditions, because we know that will help not only their heart health, but also their kidney health and overall health.

Dr. Gavras: As we expand our programs, we're also always looking for ways to strengthen the services we already provide. That includes continuing to improve how we engage members and guide them through the healthcare system. We're using AI to enhance our clinical databases and identify which interventions produce the best outcomes, so we can build on what's working and develop approaches that may be even more effective.

Moving Care Forward

Managing kidney disease and other complex chronic conditions takes more than addressing a single diagnosis. It requires early identification, meaningful member engagement, close provider collaboration, and support for the clinical, behavioral, and social factors that shape a person's health. Healthmap brings these pieces together through specialized expertise, data-driven insights, and a multidisciplinary care team. As we expand our program offerings, we remain equally focused on strengthening our current services, learning from what works, and helping members receive the right care at the right time.

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Jonathan Gavras, MD, FCCP
Chief Medical Officer

Dr. Jonathan Gavras is a healthcare executive focused on promoting innovative changes to healthcare delivery. Jon's past positions have included roles as Market President, Specialty Pharmacy Leadership and President of a comprehensive laboratory benefit management company. Dr. Gavras was Florida Blue's Senior Vice President, Delivery System and Chief Medical Officer and served as the founding President of GuideWell Health. He also served as Chief Medical Officer and head of Specialty Pharmacy for Prime Therapeutics. Before joining Florida Blue in 2006, Jon held several senior executive leadership positions at UnitedHealth Group and Prudential Healthcare. Dr. Gavras transitioned to being a full-time healthcare executive after a successful clinical career in Pulmonary and Critical Care Medicine. Dr. Gavras holds a BA in Chemistry and Psychology from Case Western Reserve University and a Medical Doctor Degree from New York Medical College, and he is a member of Alpha Omega Alpha.



Stephanie Toth-Manikowski, MD, MHS, FASN
Chief Nephrology Officer

Dr. Stephanie Toth-Manikowski is a double board-certified physician in internal medicine and nephrology and practices nephrology in Chicago. She earned her bachelor's degree in Biology with honors from Harvard College, her Doctor of Medicine from the University of Illinois Chicago College of Medicine, her Master of Health Science from the Johns Hopkins Bloomberg School of Public Health, and completed her nephrology fellowship at Johns Hopkins. She is a member of the American Society of Nephrology and the National Kidney Foundation.

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