KIDNEY CARE PARTNERS

Principles for Care Coordination

KCP believes that care coordination for CKD non-dialysis, dialysis, and transplant patients should:

- Maintain a patient-centered focus that is assessment-driven, intended to meet the needs and preferences of patients, while enhancing the care-giving capabilities of clinicians, providers, and suppliers.

- Address an individual's interrelated medical, behavioral, and health care educational needs with the goal of optimizing health and wellness, as well as non-clinical needs that impact patient care/outcomes, such as transportation, nutrition;

- Promote optimal modality choice, such as transplant and home dialysis among patients with kidney failure, and other treatment options, including palliative care and conservative care; and

- Seek to improve health disparities of disadvantaged patients by focusing on gaps in care and treatment related to social determinants of health.

- Assist patients navigate health-related assistance programs.

Scope and Capabilities

- Care coordination for CKD non-dialysis, dialysis, and transplant patients should:

  - Be patient-centered and support the patient's active participation in health care decision-making.

  - Be designed with the explicit purposes of:
    - Promoting the prevention of CKD, particularly for high-risk patients, through earlier intervention and treatment.

    - Slowing the progression of kidney disease and working to address issues.

    - Preparing patients nearing kidney failure for transplant, emphasizing modality choice, as well conservative care.

    - Improving patient outcomes through enhanced care coordination among the patient's provider/supplier care teams.

- Support patient choice, including, but not limited to, transplant evaluation, palliative care, evaluation for hospice eligibility, telehealth services, vascular access care, and conservative care.

- Engage health equity experts to implement programs and protocols to address gender, racial, ethnic, economic, and language inequities.

- Allow physician practices, dialysis facilities, groups of affiliated physicians, insurers, prescription drug plans, and others to enter into agreements to partner in care delivery.

- Include interdisciplinary care teams who establish individualized care plans that include modality choices (including conservative care), transplant evaluation, vascular access care coordination, the delivery of relevant non-clinical services (such as transportation and nutrition), delivery of care in alternative settings, and education programs.

- Emphasize medical assessment and care planning in which providers/suppliers work with the individual (and, to the degree appropriate, with the family) to assess medical needs, preferences, and goals and develop comprehensive care plans to optimize care outcomes.

- Leverage health assessments to evaluate physical, psychological, nutrition, language, cultural and other needs of patients.

- Identify and manage all referrals, services, and supports; facilitate connections with the above, and manage continuous communication across the referrals.

- Support and facilitate care transitions among providers/suppliers, as well as patient care options, including providing necessary education to facilitate patient decision-making and ease the transition process; coordinate with pediatric nephrologists to facilitate transition from pediatric to adult dialysis as well.

- Remove obstacles for clinicians, providers, and facilities to share knowledge and information to enhance patient understanding of medical conditions and encourage effective self-care.

- Promote adherence to treatment, including medication management, dietary restrictions, etc, including working to create a common understanding of what adherence means among patients and their clinicians, providers, and facilities.

- Eliminate silos that fragment care by coordinating:
    - Part A, B, and D benefits, including transplant;
    - All Medicaid medical benefits for dual eligible beneficiaries, allowing for coverage of long-term services and supports; and
    - Additional benefits and services, as identified by providers/suppliers.

Accountability

- Care coordination for CKD non-dialysis, dialysis, and transplant patients should:

    - Include protocols for collecting and submitting information on clinical measures, quality of life measures, and patient experience with care measures across various health care settings.

    - Allow savings from care coordination activities, including but not limited to including reduced emergency department visits, reduced hospitalizations/ rehospitalizations, reduced redundancy and duplication of tests and/or services, and reduced costs related to transplant, to be used to improve care for CKD non-dialysis, dialysis, and transplant patients.

Incentivize Coordinate Care

- Care coordination for CKD non-dialysis, dialysis, and transplant patients should:

    - Ensure that Medicare and Medicaid reimbursement supports adopting coordinated care interventions.

    - Eliminate federal laws and regulations that unnecessarily create barriers to coordinating care.

    - Establish payment options that will appropriately incentivize care coordination, especially for providers/suppliers who have historically been reluctant engage in such activities.