In June 2016, the National Kidney Foundation established a multidisciplinary workgroup that included patients, family physicians, internal medicine physicians, nephrologists, advanced practitioners, a dietitian, and a social worker to develop a payment model to improve earlier detection and treatment of chronic kidney disease (CKD). The model, intended to allow primary care physicians (PCPs) and nephrologists to participate regardless of practice size or experience with APMs, the model can be tailored to allow for cross-participation. The National Kidney Foundation encourages the participation of community health centers and their practitioners because CKD has a disproportionate impact on individuals with social risk factors. Accessible healthcare that puts patients first is the most important goal that any new model for payment and care delivery should have at its center. The shift from a fee-for-service system toward reimbursement for delivering value has great potential to improve patient outcomes through better engagement. This shift in payment also creates opportunities for a more rewarding career environment for healthcare practitioners by providing the resources necessary to support earlier intervention and strengthen patient engagement. Early on, the National Kidney Foundation identified the potential of value-based payment models as an opportunity to address a question that we hear from our patients who are living with ESRD.

A comprehensive-CKD-Care-Model_CMMI-RFI.pdf.

Why did I not know I had kidney disease?

In June 2016, the National Kidney Foundation established a multidisciplinary workgroup that included patients, family physicians, internal medicine physicians, nephrologists, advanced practitioners, a dietitian, and a social worker to develop a payment model to improve earlier detection and treatment of chronic kidney disease (CKD). The model, intended to allow primary care physicians (PCPs) and nephrologists to participate regardless of practice size or experience with APMs, the model can be tailored to allow for cross-participation. The National Kidney Foundation encourages the participation of community health centers and their practitioners because CKD has a disproportionate impact on individuals with social risk factors.

Value over volume

The CKDIntercept model enhances care delivery by establishing a set of criteria to allow participants flexibility in designing the plan specifically to address each criterion during the application process (Table 1). The model defines which services would not be separately billable in fee for service. The criteria outline what is necessary to improve quality, lower costs, and enhance patient engagement while allowing participating practitioners flexibility in how they would address the criteria. Because the model proposes payment to practitioners up front monthly as opposed to a shared savings arrangement, the initial investments by practices to meet the criteria should be recovered in a relatively short time. This approach is similar to what is used in the Oncology Care Model.

We can, and we must, do better for patients now. We must develop and test new models of care that promote earlier detection of those at highest risk for the disease, and improved treatment of those with it. As a kidney community we must stop looking at individuals with CKD as being in a "predialysis" state and focus on delivering the right care to the right patient at the right point in time. Delivering on this promise of earlier and better care will take the engagement of the primary care community and kidney community and a commitment to work together. The CKDIntercept model is a work in progress. The organizations that represent these communities must come to the table to help shape the details for this model, support its testing, and solve the perceived challenges that a new model of care poses. Only through this coordinated effort can we truly improve the lives of kidney patients.

Full details of the National Kidney Foundation’s proposed model, including the proposed quality measures and evidence base, can be found at https://www.kidney.org/sites/default/files/20171120-CKD-Intercepts-Comprehensive-CKD-Care-Model_CMMI-RFI.pdf.

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Table 1. Overview of the CKD Interceptor model

<table>
<thead>
<tr>
<th>Examples of services included in the model (not separately payable)</th>
<th>CKD eGFR &lt;60–30 ACRI 30–299</th>
<th>CKD eGFR &lt;30 ACR &gt;300</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical nutrition therapy by a dietician</td>
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<tr>
<td>Office visits for evaluation (including evaluation of common comorbidities)</td>
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<tr>
<td>Care coordination with patients’ other healthcare practitioners</td>
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<tr>
<td>24/7 patient access to healthcare team</td>
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<tr>
<td>Longitudinal care management</td>
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<tr>
<td>Patient-centered care planning, addressing patient life goals, culture, and values</td>
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<td></td>
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<tr>
<td>Evaluation of community/social services needs</td>
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<tr>
<td>Depression/anxiety assessment</td>
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<tr>
<td>Access to pharmacists for medication questions</td>
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<tr>
<td>Live or virtual kidney disease education sessions</td>
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<tr>
<td>Insurance navigation and coordination</td>
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<tr>
<td>Coordination with vascular access surgeon, transplantation center as appropriate</td>
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</tbody>
</table>

Abbreviations: eGFR = estimated glomerular filtration rate; ACR = albumin to creatinine ratio

The DCI REACH Program

By Doug Johnson

Dialysis Clinic, Inc., has been providing care coordination to patients with chronic kidney disease (CKD) since 2010. This program was started in Spartanburg, South Carolina, and has since grown to care for more than 4000 patients in more than 15 locations in 12 states. In one location we have enrolled more than 400 patients under a program in a partnership with a local health plan. For all other programs, we provide this service free of charge to patients as a community benefit.

Four years ago we officially named our program REACH Kidney Care. REACH stands for Real Engagement Allowing Complete Health. As a nonprofit provider, we believe that when possible we should fully inform people with kidney diseases about their choices in care, and work with them to determine the course that best meets their culture, values, and life goals. More information about the REACH program is provided at http://www.reachkidneycare.org. Below is a summary of our program.

**Patient population**

We serve patients with GFR below 30 mL/min per 1.73 m² and patients with GFR 30 to 59 mL/min per 1.73 m², with albuminuria detectable on dipstick, exceeding 300 mg/g creatinine.

**Primary goal**

Our primary goal is to treat a patient with late-stage CKD, focusing care on meeting that patient’s current clinical needs instead of treating the patient as someone who may need dialysis.

**Secondary goals**

For patients whose kidney disease has progressed to the point where GFR is below 20 mL/min per 1.73 m², we provide education on choices of care for renal replacement therapy (RRT), including transplantation, home dialysis, in-center dialysis with a permanent access, and medical management without dialysis. For a patient choosing a modality for RRT, we help the patient navigate the healthcare system to implement this choice.

We recognize that not all patients desiring transplantation will receive a transplant before they start dialysis. If a patient chooses transplantation, we also work with the patient to choose a dialysis modality to prepare the patient in case the patient does not receive a preemptive transplant. For a patient choosing medical management without dialysis, we follow and support the patient closely through this journey, let the patient and his or her family know that we will not abandon them, and add additional services as needed and requested, including palliative and hospice care.

**Tertiary goal**

For a patient who has chosen a modality for RRT, we follow the patient closely, in partnership with the patient’s nephrologist, to allow a safe start of dialysis later in the progression of the patient’s CKD. Nationwide, 11.7% of patients start with a GFR at or above 15 mL/min per 1.73 m². In Spartanburg, only 3% of patients since January 1, 2014, have started with a GFR above 15 mL/min per 1.73 m², and 71% start with a GFR 5 to 10 mL/min per 1.73 m².

**Frequency of visits**

The frequency of visits depends on the clinical needs of the patient. At a minimum, the nurse care coordinator sees the patient at the same frequency as the patient’s nephrologist, with these visits alternated so that the patient is seen twice as often. In some instances, the patient is seen by the nurse care coordinator on a weekly basis. The nurse care coordinator sends a progress note for each visit to the patient’s nephrologist and other physicians.

**Staff**

- Nurse care coordinator: role described above.
- Dietitian: helps the patient learn what she/he can eat, instead of providing a list of foods to be avoided. Specific attention is paid to include foods important to the patient’s culture of origin.
- Social worker: educates the patient on available resources; provides supportive counseling.

**Very advanced CKD**

For patients with very advanced CKD who plan eventual dialysis, and who otherwise would have been referred to start dialysis but do not have a clinical need to start, we provide a framework of support and services for the patient to allow a safe transition to dialysis later in the progression of CKD, delaying the burden of thrice-weekly dialysis. A patient could visit the care coordinator once a week to allow for close evaluation. We provide consistent support, close follow-up, and clear communication with the nephrology team. The level of care of a patient with late-stage CKD should be comparable with the care given to patients receiving dialysis, without the requirement for dialysis or thrice-weekly clinic visits.

Doug Johnson is Vice Chairman of the Board, Dialysis Clinic, Inc.