



Care Coordination and Care Transitions in **VALUE-BASED KIDNEY DISEASE MANAGEMENT**

Effective care coordination and transition planning are essential for delivering high-quality care and improving patient outcomes while containing unnecessary healthcare expenditures. This is especially true when managing patients with complex, long-term conditions like chronic kidney disease (CKD) and end-stage kidney disease (ESKD), which require consistent communication and collaboration between various providers to be managed effectively.

Not only does better coordination among providers lead to improved outcomes, but the absence of effective communication can actually expose patients to unnecessary risks. According to the Centers for Medicare and Medicaid Services¹ (CMS),

“When doctors and other healthcare providers don’t communicate effectively with each other ... [the] patient is more likely to get unnecessary repeat tests. Worse yet, lack of coordination can lead to negative health outcomes for patients, more use of emergency care, medication errors, poor transitions of care from hospital to home, and medical errors.”

CMS identifies several critical points when coordinated care is needed, including:

- **Follow-up care** after an emergency hospital visit.
- **Care between a patient’s primary care provider (PCP) and multiple specialists** for a chronic health condition.
- **A temporary stay** in a skilled nursing facility.
- **Healthcare providers coordinating with social services** to help a patient with social determinants of health that negatively affect access to care, such as housing, transportation, or food insecurity.

This article offers an overview of best practices in care coordination and care transitions as they apply to kidney disease management, how these practices can be implemented, and how they are incorporated into Healthmap Solutions’ Kidney Population Health Management program. By following these guidelines, providers can expect to improve the quality of care they deliver, while reducing costs and achieving financial goals.

The Role of Care Coordination in Kidney Health

The role of care coordination is to ensure patients receive comprehensive and seamless care across various healthcare settings. Important for all patients, care coordination is critical for CKD/ESKD patients, who often suffer from multiple comorbidities such as diabetes, hypertension, and cardiovascular disease and generally see a variety of specialists along with their PCP.

Effective care coordination offers numerous benefits for patients with kidney disease, including:

- Enhanced patient engagement and empowerment, making them more comfortable and in control of their health journey.
- Reduced total healthcare expenditures by preventing unnecessary hospitalizations and emergency department visits.
- Improved healthcare outcomes and overall quality of life for patients.

The key components of effective care coordination are:

- **Interdisciplinary teams:** Bringing together professionals from various specialties to collaborate on patient care, ensuring a whole-patient approach.
- **Patient-centered care plans:** Developing personalized plans that address the unique needs of each patient and put everyone involved on “the same page.”
- **Enhanced communication:** Utilizing an omnichannel approach (telephonic, digital, and mail), electronic health records (EHRs), and secure messaging to ensure seamless communication.
- **Patient and care partner engagement:** Educating and empowering patients and their care partners to actively participate in the care process.

Challenges in Care Coordination

Several factors can impede effective care coordination. They include:

- **Lack of patient knowledge:** Many patients and their care partners do not fully understand the nature of their condition and the basis for their treatment.
- **Social determinants of health (SDoH):** Socioeconomic conditions such as lack of transportation and financial constraints can limit access to care (We discuss this topic in depth in the Executive Briefing “Health Equity and Kidney Disease Management”²).
- **Siloed care:** Multiple providers often operate independently, leading to fragmented care and such problems as duplicative or unnecessary procedures and contraindicated medications (See the Healthmap Issue Brief “Tearing Down Treatment Silos”³ for more on this issue).

CKD and ESKD patients face additional challenges, such as:

- **Complex treatment plans:** Kidney care often involves intricate, multi-step procedures requiring extensive coordination. For instance, creating a fistula for hemodialysis is a complicated procedure, involving multiple steps with various providers. Any breakdown in coordination can delay treatment and negatively impact patient outcomes and experience. Further, treatment plans for CKD/ESKD patients typically involve multiple medications to manage symptoms, slow disease progression, and prevent complications, requiring careful monitoring and adjustments by the various prescribing doctors.
- **High hospitalization rates:** CKD/ESKD patients have notoriously high hospitalization rates. A study⁴ published in PLOS Medicine found that “adults with CKD had a higher hospitalization rate than the general population that is hospitalized, and even moderate reductions in kidney function were associated with elevated rates of hospitalization.” Interestingly, the causes of hospitalization for patients with kidney disease are often not directly related to their kidneys but rather are frequently related to the comorbidities that commonly accompany kidney disease, such as cardiovascular disease and endocrine conditions. When working with a population that already has a high risk of being hospitalized, care coordination and effective transition planning are necessary to avoid preventable admissions and readmissions.

Strategies for Improving Care Coordination

What steps can provider groups take to improve care coordination? Healthmap recommends the following tactics:

- **Implement interdisciplinary care teams** that bring together professionals from different fields to collaborate on patient care, ensuring all aspects of a patient's health are addressed.
- **Utilize data analytics and management technology.** Electronic health records (EHRs) and secure messaging facilitate communication among providers. Remote monitoring systems allow for continuous patient health tracking. Predictive analytics help identify patients at risk of adverse events, allowing for timely interventions.
- **Enhance patient and care partner education** to improve their understanding of the patient's condition and take a positive, active role in treatment.
- **Employ comprehensive care management programs** to centralize communication, help coordinate care planning efforts, and enhance provider capabilities. Working with a third-party company like Healthmap Solutions that specializes in kidney population health management can help providers achieve these goals without interrupting their workflow or adding administrative burden.

Care Transitions: Critical Points in Kidney Care

Smooth care transitions are critical in preventing hospital readmissions and ensuring continuity of care. Common transition points for kidney patients include:

- **Hospital-to-home:** Ensuring patients have appropriate follow-up care and support from both the inpatient setting and emergency department.
- **Dialysis initiation:** Coordinating the start of dialysis to avoid delays and complications.

Risks and Mitigation Strategies

Poor transitions can lead to adverse outcomes, such as medication errors or missed follow-up appointments. Strategies to mitigate these risks include:

- **Detailed discharge plans:** Ensuring patients understand their post-discharge care instructions.
- **Follow-up appointments:** Scheduling office-based follow-up appointments before discharge to ensure continuity of care.
- **Provider coordination:** Communicating with other providers on the patient's care team after a discharge to share any changes in the patient's diagnosis or treatment plan.

Healthmap Solutions' Approach

Healthmap's Kidney Population Health Management program facilitates coordinated, value-based care management through:

- **REAL-TIME DATA SHARING:** Healthmap is an acknowledged leader in the use of artificial intelligence and advanced predictive analytics. Our proprietary systems ensure early identification of CKD risks and enable providers to deliver timely interventions and proactive care. By monitoring patient data in real time, Healthmap can also inform providers of any relevant updates in a patient's care, including admission, discharge, and transfer (ADT) alerts, newly prescribed medications, and test results.
- **PROVIDER COMMUNICATION:** Our provider-facing clinicians work directly with practices to facilitate complete and consistent communication among all providers involved in a patient's care.
- **PATIENT EDUCATION:** Our multidisciplinary Care Navigation team (consisting of registered nurses, social workers, registered dietitians, behavioral health clinicians, and pharmacists) empowers patients with the information and resources they need to understand their condition, help manage their treatment, and overcome barriers to care.

Conclusion

Effective care coordination and care transitions are vital components of value-based kidney disease management and are essential for improving patient outcomes and reducing healthcare costs. By implementing interdisciplinary teams, leveraging technology, and embracing value-based care models, healthcare providers can significantly enhance the quality of care for patients with kidney disease while containing total cost of care.

Through the effective implementation of these strategies and innovations in our Kidney Population Health Management program, Healthmap Solutions is ideally positioned to assist provider organizations in delivering the comprehensive, coordinated care their patients deserve.



Visit www.healthmapsolutions.com or contact Healthmap at KidneySolutions@healthmapsolutions.com for more information.

REFERENCES

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