

# Value-based Kidney Care: Tearing Down Treatment Silos

by Stephanie Toth-Manikowski, MD, MHS, Corporate Medical Director, Healthmap Solutions, Inc.

## ***Dialogue between primary care providers and nephrologists is essential to slow the progression of chronic kidney disease (CKD)***

Treatment silos have long been part of the healthcare landscape. Fragmented, uncoordinated care has led to higher costs and utilization, as well as unintended patient outcomes. This problem is especially evident in the context of chronic kidney disease (CKD) management.

As a leading Kidney Population Health Management company, Healthmap Solutions understands the importance of bridging the gap between primary care providers (PCPs), nephrologists, cardiologists, and endocrinologists to improve health outcomes in patients with CKD. Healthmap's Kidney Health Management (KHM) Program is designed to foster a meaningful partnership between patients, providers, and Healthmap's clinical team, with the goal of tearing down treatment silos and improving care coordination. When done effectively, the results are both clinically and financially impactful, delivering a "complete" solution to include clinical, operational, and service excellence for all stakeholders.

What is it about CKD that makes care coordination so complex? An article<sup>1</sup> published in the *Journal of General Internal Medicine* by Greer *et al.* points out:

*"Patients with CKD often have multiple co-morbid conditions that are managed by multiple providers across various settings, often without clear communication between providers. **This decentralized system can lead to fragmented care that adversely affects patients' health and the provision of efficient and high-quality care** to mitigate patients' risks of CKD progression (e.g., delayed care, unnecessary and/or inappropriate tests, or medical errors)."*

There are many reasons why treatment silos have become commonplace, such as structural, economic, technological, and practical, as well as the high level of specialization prevalent in modern medicine.

In managing complex conditions like CKD, a PCP will traditionally refer patients with advanced disease to a nephrologist and other appropriate specialists. Theoretically, PCPs are ideally situated to provide this necessary care coordination. However, an ever-present and often overwhelming workload leaves PCPs with little time to integrate information from specialists, especially if specialty consultants do not function within the PCP's electronic medical record or health system. (See *"Do Primary Care Providers Have the Time for Kidney Disease Management?"*<sup>2</sup> for more on the time issue.)

Unfortunately, CKD management is itself siloed by an institutional focus on end-stage renal disease. In a review article<sup>3</sup> published in *Kidney360*, Drs. Jain and Weiner write:

---

*“The care of patients with advanced kidney disease in the United States remains siloed, with multiple incentives resulting in a greater focus on care delivery to the patient population who are highly vulnerable and on dialysis, than to other CKD populations. **In contrast to the highly structured processes in place for dialysis care, there are few organized, well-funded programs that target preventing or slowing the progression of kidney disease ...**”*

---

## How Do We Tear Down the Silos?

Undoubtedly, treatment silos are a major obstacle to providing value-based care, especially for patients with chronic kidney disease. Important questions to address when attempting to eradicate treatment silos include:

- **How do we** tear down the silos?
- **Who should lead** the coordination effort (if not the PCP)?

**The answer to the first question involves improving communication between providers and ensuring that patients receive adequate education and support regarding their condition throughout the diagnosis and management of their kidney disease.** Better educated and empowered patients will more readily be able to advocate for themselves in a fragmented medical system. Through Healthmap's KHM program, patients connect with one of Healthmap's Care Navigators (a highly qualified registered nurse with a background in kidney disease and care coordination) who provides comprehensive education tailored to each patient's medical conditions and treatment plans. Care Navigators also help patients traverse the multiple providers they encounter, few of whom have the opportunity to communicate with peers in an optimal way. By providing continuous support, education, and care coordination to each patient in our KHM program, Care Navigators help patients feel more empowered and engaged in their disease journey.

Equally important, Care Navigators can help facilitate collaboration between a patient's PCP, nephrologist, and other specialty providers by directly communicating any updates in the patient's care management plan. Read more about our Care Navigators in our recent blog, *“Value-based Kidney Care: The Care Navigator's Perspective.”*<sup>4</sup>

Our answer to the second question posed, specifically when it involves a patient with CKD, is the nephrologist. **In many cases, patients with advanced CKD see their nephrologists more often than their PCPs. In this situation, a nephrologist is ideally situated to play quarterback.**

However, for the nephrologist to be able lead a patient's care, appropriate and early timing for a nephrologist referral is paramount. Delayed nephrology referrals are a major issue in CKD care. Because the early and middle stages of CKD are asymptomatic, treatment often focuses exclusively on the management of comorbidities such as diabetes and hypertension. The patient's PCP often manages these and other common comorbidities. While appropriate, this is a missed opportunity for nephrology involvement when specialist care is warranted. Identifying patients early with CKD is important to ensure that there is a smooth transition from the PCP to the nephrologist to coordinate later-stage disease management. Time and again we see that patients with CKD progress to advanced stages—CKD Stages 4, 5, and even to end-stage renal disease (ESRD)—before they are referred to a nephrologist. Given the advent of new pharmacologic agents that slow CKD progression, advances

---

in non-surgical arteriovenous fistula creation, and the opportunity to provide patients with an individualized approach to renal replacement therapy, this time lag in referral must be reduced. For this reason, nephrologists must be brought in sooner to help guide the management of these clinically complex patients.

This idea is supported in the Kidney Care Choices (KCC) model developed by the Centers for Medicare and Medicaid Services Innovation Center (CMMI) and is summarized in the aforementioned *Kidney360* article:

*“The KCC model is a voluntary program intended to reinforce the leadership role of nephrology clinicians and incentivize patient-centered care to promote transplant, optimal dialysis starts, and efforts to slow the progression of CKD.”*

An important strategy to increase early and timely nephrologist involvement includes first addressing any barriers or delays associated with nephrology referrals. Once a PCP decides to issue a referral, there are still several factors that can delay nephrologist consultations and inhibit an effective partnership between the nephrologist and PCP. The ***Journal of General Internal Medicine*** article cited earlier surveyed PCPs practicing in four major U.S. cities and identified the following:

**Limited access to nephrologists:** “Some PCPs described challenges obtaining nephrology consultations in a timely fashion due to a shortage of nephrologists in their area and/or insurance restrictions.”

**Inadequate or delayed communication:** “Some PCPs reported not receiving consultative notes from nephrologists at all or in a timely fashion. Some PCPs felt nephrologists may fail to recognize that PCPs may not be familiar with all aspects of the management of advanced CKD and CKD-related complications, such as metabolic acidosis.”

**Unclear delineation of roles and responsibilities:** “Most PCPs also reported a lack of clarity regarding roles and responsibilities. They felt that the responsible party for managing each aspect of CKD was not explicitly documented in the nephrologists’ notes. They also felt that patients were often unclear of the role of the nephrologist and the resulting difficulty in having patients keep nephrology appointments.”

---

## A Third-party Solution

How can PCPs and nephrologists be brought together in a productive working relationship? Considering the nephrologist shortage, how can PCPs gain ready access to one? How can multi-specialty providers be brought together in a coordinated team effort to improve patient outcomes while at the same time reducing medical costs?

In the general business article “Cross-Silo Leadership,”<sup>5</sup> the authors offer several suggestions based on real-world experience, one of which may be the most immediately practical: deploy “cultural brokers.”

***“Cultural brokers promote cross-boundary work in one of two ways: by acting as a bridge or as an adhesive.”***

*“A bridge offers himself as a go-between, allowing people in different functions or geographies to collaborate with minimal disruption to their day-to-day routine. Bridges are most effective when they have considerable knowledge of both sides and can figure out what each one needs. This kind of cultural brokerage*

---

*is efficient because it lets disparate parties work around differences without investing in learning the other side's perspective or changing how they work.*

*"Adhesives, in contrast, bring people together and help build mutual understanding and lasting relationships. Adhesives facilitate collaboration by vouching for people and helping them decipher one another's language."*

The Healthmap Solutions KHM Program is set up to precisely provide this kind of interface, serving as both a "bridge" and an "adhesive" to optimize care in a CKD population. Our clinical teams eliminate gaps in care, provide actionable clinical insights, and facilitate collaboration through direct, continuous communication with all providers on a kidney patient's care team. This collaboration is designed to support providers and enhance their care management abilities without disrupting their existing routine and workflow. In addition to improving coordination between a patient's providers, Healthmap's approach includes the patient in the conversation. Experience has demonstrated that our program not only enhances the partnership between providers but also supports improved patient satisfaction and health outcomes.

In 2013, Healthmap Solutions was founded with a mission to improve care and lower costs for kidney patients. In our experience, improving communication and collaboration between providers has a tremendous impact on patient outcomes, and we have the data to support it. Today, we apply a unique combination of advanced technology and clinical expertise to deliver operational service excellence through our NCQA-accredited Kidney Population Health Management Program. We fully support early identification of CKD patients, early referrals to nephrologists when appropriate, and the central role of nephrologists in providing coordinated, patient-centric CKD/ESRD care. Healthmap and our clinicians have years of experience with coordinating care and finding solutions that work for providers and their patients. By promoting coordination between patients, their providers, and the Healthmap team, we become one step closer to tearing down CKD treatment silos and improving outcomes for kidney patients.

---

<sup>1</sup><https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6614220/>

<sup>2</sup><https://news.healthmapsolutions.com/blog/do-primary-care-providers-have-the-time-for-kidney-disease-management>

<sup>3</sup><https://kidney360.asnjournals.org/content/2/10/1677> [kidney care choices]

<sup>4</sup><https://news.healthmapsolutions.com/blog/value-based-kidney-care-the-care-navigators-perspective>

<sup>5</sup><https://hbr.org/2019/05/cross-silo-leadership>

---

To learn more about our program, visit **[www.healthmapsolutions.com](http://www.healthmapsolutions.com)**  
or email Tom Gaffney, *Chief Growth Officer*, at  
**[tom.gaffney@healthmapsolutions.com](mailto:tom.gaffney@healthmapsolutions.com)** for more information.

---



We Are Leaders in innovative kidney care management. We Are Healthmap!  
**[healthmapsolutions.com](http://healthmapsolutions.com) • 877-546-7004**