

Nephrologists and Integrated Kidney Disease Care: Roles and Skills Essential for Nephrologists for Future Success

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As the costs of caring for patients with end-stage renal disease have grown, so has the pressure to provide high-quality care at a lower cost. Prompted in large part by regulatory and legislative changes, reimbursement is shifting from a fee-for-service environment to one of value-based payment models. Nephrologists in this new environment are increasingly responsible not only for direct patient care, but also for population management and the associated clinical outcomes for this vulnerable population. This Perspective article aims to recognize the key role and skills needed in order to successfully practice within these new value-based care models. The new paradigm of delivering and financing care also presents opportunities for nephrologists to shape how care is delivered, define meaningful quality metrics, and share in the financial outcomes of these approaches. Though it will take time, the training and mind-set of nephrologists must evolve to accommodate these expanded practice expectations required by a system that demands measurement, reporting, accountability, and improvement, not only for individuals but also for populations of patients.

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Introduction

Nephrology has come a long way since the first dialyzer was invented more than 70 years ago. Ground-breaking technical advances have extended physicians' abilities to treat diseases beyond acute kidney injury, including end-stage renal disease (ESRD), polycystic kidney disease, kidney stones, and other conditions. In addition, there have been profound advances in how care is delivered and reimbursed, prompting nephrologists to acquire new leadership skills to navigate and thrive in the rapidly evolving world of coordinated, integrated, performance-based care.

A significant shift in public policy occurred in 1972 for those with the most advanced stages of chronic kidney disease (CKD) when Medicare was amended to provide dialysis to people regardless of age, many of whom may have otherwise not received treatment due to the high cost and lack of availability. What was initially envisioned to be a small socially redeeming program has grown to serve more than 700,000 patients as of June 2016, with increasingly complex chronic comorbid conditions.^{1,2} According to the US Renal Data System, Medicare fee-for-service spending on patients with ESRD totaled nearly \$31 billion in 2013, accounting for 7.1% of the overall Medicare paid claims costs.³

Introduction of the Medicare entitlement facilitated the growth of outpatient dialysis facilities. These facilities had clinical oversight provided by nephrologists, who helped manage the facility, most of which were independent and provided individual patient care. By the 1990s, as the patient population expanded and technical and medication advances were adopted,

the system for delivering care changed, with the nephrologist in a medical director role providing both population health oversight for all patients in a facility and individual care for their personal patients. This was a time of consolidation in the dialysis industry, and nephrologists increasingly contracted with dialysis providers to provide these medical director services. Interdisciplinary care teams were formed to not only perform technical duties associated with providing dialysis, but to ensure that patient care was provided as efficiently as possible.

These changes set the stage for the current day, which has a large number of people with CKD and a steadily increasing number of patients with more advanced kidney failure. As the costs of caring for patients with ESRD have grown, so has the pressure to provide high-quality care more efficiently. Nephrologists in this new environment are increasingly responsible not only for direct patient care, but also for population management beyond processes in the dialysis unit and associated clinical outcomes for this vulnerable population. This article highlights the

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opportunities and challenges that nephrologists will face in preparing to deliver care and lead care teams in the world of value-based care.

Evolving Models of Care

The roots of change in the models of care for kidney disease are embedded in the roadmap that the Centers for Medicare & Medicaid Services (CMS) envisions for all publically funded health care, shifting from a fee-for-service approach to a variety of value-based payment models for physicians (Fig 1). Similar models have been adopted by private payers. That road map has changed the relationship between the provider and the health care system while also setting the course for evolving the payment systems so that providers are reimbursed for care of the population rather than for episodes of care.

Inherent in this system of change are a number of guiding principles articulated by CMS (Box 1). These principles, embodied in both legislation and regulation, directed changes to a system that is driving health care providers toward responsibility for both clinical outcomes and sustainable resource use.⁴ The evolution began with numerous pieces of legislation that enabled CMS to create pay-for-performance models, bundled payments for specific clinical conditions, quality incentives for clinical outcomes and processes of care deemed desirable, and models of payment that enabled providers to take financial responsibility for health costs through gain sharing, shared savings programs, and capitated payment models. The necessary components for the migration to these value-based payment models (Fig 1) include quality/efficiency measures, payment redesign, and data infrastructure that support the development of managed and organized care delivery systems that

recognize both quality and cost, as described in Michael Porter's vision of value in health care.⁵

For dialysis, these efforts began many years ago through the development of the ESRD Networks and their tracking of clinical performance measures, as well as the reporting of clinical data to the US Renal Data System. This early effort at measuring and gauging the performance of the evolving kidney care delivery system provided an opportunity for nephrology to be one of the first specialties to experience bundling of payment, first implemented in 1983 and including all elements of the dialysis treatment while excluding payment for injectable medications. The ESRD Quality Incentive Program, a performance-based dialysis facility-level payment mechanism, was the first pay-for-performance system mandated legislatively and was joined to the ESRD prospective payment system, the provider monthly capitation payment model, and incentives under the Health Information Technology for Economic and Clinical Health (HITECH) Act⁶ to adopt electronic health records.

The federal government has prioritized several sectors for value-based payments, including physicians, home health, skilled nursing, and ESRD facilities, with efforts evolving from pay-for-reporting activities to pay for performance.⁷ Today we are in the middle of this evolution and are seeing many more sophisticated attempts to influence the behavior of physicians and provider organizations. Viewed across health care, these programs aim to drive physicians and other providers to assume greater responsibility for patients with earlier-stage kidney disease, emphasizing approaches to either slow the progression of kidney disease or direct patients toward preemptive transplantation, supportive care options, or controlled initiation of kidney replacement therapy.

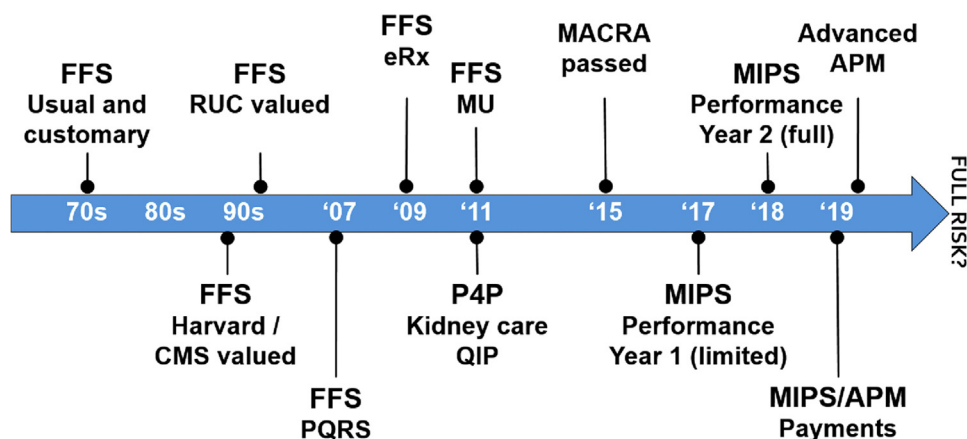


Figure 1. Timeline of shift from volume to value. Abbreviations: APM, advanced alternative payment models; CHIP, Children's Health Insurance Plan; CMS, Centers for Medicare & Medicaid Services; eRx, electronic prescriptions; FFS, fee-for-service; MACRA, Medicare Access & CHIP Reauthorization Act; MIPS, merit-based incentive payment system; MU, meaningful use; P4P, pay-for-performance; PQRs, Physician Quality Reporting System; QIP, quality incentive program; RUC, Relative Value Scale Update Committee.

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