



The Essential Role of Kidney Supportive Care in Value-Based Care

Coalition for Kidney Supportive Care

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Patients diagnosed with kidney disease face high disease burden, including symptoms, unwanted hospitalizations and procedures. While Value-Based Kidney Care (VBKC) aims to shift from volume to quality care, there is a significant gap of fully integrated Kidney Supportive Care (KSC). This leads to aggressive, costly interventions that are often misaligned with patient needs and preferences, leaving clinical and financial value "on the table."

What is Kidney Supportive Care?

Kidney Supportive Care, as defined by Kidney Disease Improving Global Outcomes (KDIGO) and the International Society of Nephrology (ISN), is a core component of integrated kidney care. KSC supports patients at all stages of CKD, and complements life-prolonging therapies, by combining symptom management, shared decision-making (SDM), and advance care planning (ACP) with psychosocial and spiritual support.

Why Kidney Supportive Care Matters

- **Patient Benefit:** KSC transforms the nephrology paradigm from a "dialysis-default" model to a "patient-choice" model, reducing treatment regret and ensuring healthcare resources are patient preferred.
- **Provider Benefit:** KSC increases professional satisfaction and reduces burnout by mitigating the moral distress associated with delivering non-goal-concordant care. It also equips providers with essential primary palliative care skills to manage complex patients.
- **Financial Alignment:** International evidence suggests KSC aligns clinical excellence with financial sustainability, supporting a positive return on investment.
- **Policy Alignment:** KSC principles coincide with national and international standards (KDIGO, ISN, NCOA), directly leading to higher patient satisfaction scores and better alignment with mandated quality measures.

The Path Forward

Embedding KSC into VBKC models is essential to realizing the full potential of this care. Successful integration is achieved through five strategic pathways:

- **Education:** Incorporating KSC, SDM, and ACP training into provider education as core competencies.
- **Access:** Ensuring patients have access to all treatment options, including Conservative Management (Active Medical Care without Dialysis).
- **Policy Reform:** Aligning payment models to remove barriers—such as those preventing concurrent hospice and dialysis and palliative dialysis—and utilizing existing frameworks like Medicare's Chronic Care Management (CCM).
- **Clinical Integration:** Developing structured workflows for incorporating goals-of-care conversations, symptom assessment and management, and interdisciplinary coordination.
- **Partnership:** Partnering with providers, payers, and patients to normalize KSC as a standard of care rather than an alternative.

Conclusion

KSC is an ethical imperative, financially viable and evidence-based strategy that enhances the success of VBKC models. By integrating KSC, patient outcomes will improve, costs will be avoided, and care will be truly patient centric and goal concordant.

1. The Opportunity: Kidney Supportive Care in a Value-Based World

What is Kidney Supportive Care?

Kidney Supportive Care (KSC) is a patient-centered model designed to improve the health-related quality of life (HRQoL) for individuals with chronic kidney disease (CKD) at any stage or age. It is defined by international clinical leaders, including the Kidney Disease: Improving Global Outcomes (KDIGO) and the International Society of Nephrology (ISN), as a comprehensive approach that identifies and treats physical, psychosocial, and spiritual suffering through early assessment and shared decision-making.

At its core, the ISN defines KSC as:

[A]n approach that aims to improve the quality of life for people for whom kidney disease, either directly or indirectly, substantially impacts their well-being, treatment options, or access to care, and their families, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual (Davison et al., 2024).

This model emphasizes that KSC is not restricted by disease severity; rather, it is intended to run concurrently with life-prolonging therapies like dialysis to ensure that clinical care remains aligned with a patient's personal values and day-to-day well-being (Stevens et al., 2024). By integrating these perspectives, KSC shifts the focus from managing the disease process alone to actively supporting the patient's holistic experience throughout their treatment journey.

What is Value-Based Care?

Value-Based Care (VBC) is a healthcare delivery model that shifts the focus from the volume of services provided to the quality of outcomes achieved, replacing traditional Fee-for-Service (FFS) models where reimbursement was tied to service frequency. At its core, the model utilizes a "Value Equation", defined as Quality / Cost, to incentivize providers to enhance patient experience and clinical excellence while reducing total expenditures. While early iterations of this approach appeared as managed care in the 1970s and 80s and through value-based purchasing in the early 2000s, the model's trajectory was fundamentally reshaped by the passage of the Affordable Care Act (ACA) in 2010.

Following the ACA, the Centers for Medicare & Medicaid Services (CMS) and its Innovation Center aggressively prioritized VBC to address rising national healthcare costs. By linking payment to performance rather than volume, this legislative environment provides the necessary flexibility for integrated frameworks, such as Kidney Supportive Care, to thrive, as they prioritize holistic outcomes over fragmented service delivery. Throughout the rest of this paper we refer to VBC when discussing care models that address patients with and without kidney disease. When discussing value-based kidney care specifically, we refer to it as VBKC.

How do KSC and VBC Align?

At their core, KSC and VBC are philosophically and operationally symbiotic. VBC seeks to improve patient outcomes while managing the total cost of care, while KSC provides the specific clinical framework needed to address these issues for the complex CKD population. By prioritizing "right-sized" care, medical interventions that are explicitly aligned with a patient's values and life goals, KSC transforms the nephrology paradigm from a "dialysis-default" model to a "patient-choice" model. This alignment ensures that healthcare resources are directed toward interventions that patients actually want, thus reducing the utilization of high-intensity, high-cost treatments that do not improve quality of life.

The Problem

Despite the natural alignment between KSC and VBC, current VBKC models have not yet fully integrated KSC into their standard operating procedures. This oversight leaves significant clinical and financial value "on the table." This white paper from the Coalition for Kidney Supportive Care outlines the clinical rationale for integrating KSC into VBKC models and identifies specific, actionable opportunities to bridge this gap.

2. Landscape and Impact of VBC Models

History of VBC and Kidney Care Models in the United States

While the promise of VBC is to empower provider flexibility to focus on quality of care over volume of care, the actual implementation through CMS has been a gradual evolution. Over the last 15 years, the Centers for Medicare & Medicaid Services (CMS) has tested several VBC models, with some specifically focusing on nephrology. These models aimed to transition the healthcare industry away from fee for service mechanisms in hopes of improving overall quality of care. Over time, many of these models have shown mixed results regarding quality metrics and cost savings, and few have successfully integrated evidence-based KSC as a core component.

Early models—including Accountable Care Organizations (ACOs), Hospital Value-Based Purchasing (HVBP), and the Hospital Readmissions Reductions Program (HRRP)—did not specifically target kidney care or address the unique requirements of KSC. Instead, they focused on broad cost reduction, general quality improvements, and care coordination for all patient populations (Tummapali et al., 2022). Furthermore, these early frameworks did not include explicit quality metrics or requirements related to KSC services.

Newer VBC models have taken modest steps toward incorporating KSC, but progress remains limited. The ESRD Treatment Choices (ETC) and Kidney Care Choices (KCC) models were implemented to improve patient access to home dialysis and transplants while elevating the quality of care. However, evaluations found that the ETC model did not significantly change transplant or home dialysis initiation rates, leading to early termination due to high Medicare costs (Tummapali et al., 2022; CMS, 2025a). Conversely, the KCC model has shown improvements in quality metrics, including increased "optimal starts" (starting dialysis with a permanent access or at home), better blood pressure control, and increased member savings, alongside a decrease in hospitalizations (Duke-Margolis Institute for Health Policy, 2025; Monogram Health, 2025; Tommey & Skluzacek, 2025; Interwell, 2025). Detailed information on these models and their included KSC services can be found in Table 2.

Over the last 15 years, few of the VBC models introduced by CMS have successfully integrated kidney supportive care as a core component

In addition to improved quality metrics, the KCC model offers voluntary enhancements that could foster KSC by waiving specific Medicare requirements. These include broadening the allowable timing for kidney disease education (which facilitates SDM) and allowing concurrent dialysis and hospice care (which supports preference-aligned, end-of-life care). Unfortunately, because these enhancements are voluntary, few participating organizations have actually implemented these crucial KSC services.

Overall, current value-based models leave significant opportunities on the table by failing to mandate a comprehensive KSC framework. While the KCC model makes strides in care coordination, it lacks formal requirements for essential supportive services such as systematic physical and psychological symptom management, spiritual care, and the explicit sharing of prognosis. Furthermore, critical transitions, including dialysis withdrawal, crisis planning, and bereavement support, remain largely unaddressed or siloed from standard nephrology workflows. Integration with community services and robust ACP are also treated as optional rather than foundational. Ultimately, these individual elements are less effective when separated; only by integrating them into a unified, mandatory requirement can VBC models truly meet the complex needs of the kidney care population and significantly reduce unwanted hospitalizations and procedures.

2. Landscape and Impact of VBC Models

Patient Impact: Healthcare Challenges within VBKC Models

HOSPITALIZATIONS

VBC models often prioritize tracking hospitalization rates and related health outcomes, such as readmission, infection, and length of stay. These measures are crucial for benchmarking quality, as high rates of readmission or prolonged stays often indicate suboptimal care. Furthermore, they incentivize cost-efficiency by shifting reliance away from hospital-based treatment toward more effective, community-based services like case management and home care. Hospitalizations are a significant concern for patients with kidney disease, who frequently experience multiple hospital stays. Without SDM and patient preferences incorporated, their wishes regarding care and quality of life during hospitalizations are often overlooked (USRDS 2025).

The success of current VBKC models in reducing hospitalizations and associated costs has been mixed. The Comprehensive ESRD Care (CEC) model aims to decrease hospitalizations by focusing on interventions that improve quality of life through better case management, care coordination, and symptom management. This model demonstrated an overall decrease in hospitalizations for patients with ESKD, while the KCC model showed only marginal improvements in hospitalizations, with expenses remaining roughly the same (CMS, 2022).

Notably, the CEC model reduced earlier hospitalizations but did not significantly impact those occurring at the end of life. This persistent gap in end-of-life care represents a critical, unrealized opportunity to enhance value. KSC provides the skills and services to address this specific gap.

REDUCING UNNECESSARY PROCEDURES AND SURGERIES

The current emphasis on Fistula First or Optimal Starts in nephrology care pushes people who are not sure they want to proceed with dialysis long term to have an access placed “just in case” they change their minds. For people who are leaning toward conservative management (CM), this is an unwanted procedure. KSC identifies those people who prefer CM so they can avoid the need for initial fistula surgery and reduce the risks of infection or reintervention associated with fistula maturation failure. Recent guidelines from the American Society of Nephrology emphasize that CM, chosen by patients in the context of shared decision-making, reduces unwanted procedures and should be more readily available (Wong et al 2026). Forthcoming results from the Prepare for Kidney Care clinical trial will likely provide more precise estimates of the magnitude of procedures, which can be avoided by providing comprehensive CM (Murphy et al., 2021; Worthington et al., 2024).

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ADVANCE CARE PLANNING, SHARED DECISION-MAKING, AND GOALS-OF-CARE DISCUSSIONS

Addressing ACP and goals-of-care discussions is crucial to improving the end-of-life experience for patients with kidney disease. During the CEC model, some End-Stage Renal Disease Seamless Care Organizations (ESCOs) demonstrated increased comfort in discussing ACP and end-of-life treatment. However, many other providers within the ESCOs felt unprepared to engage in such conversations (CMS, 2022b). Provider comfort with ACP and end-of-life discussions is likely a prerequisite for reducing the high hospital utilization at end of life frequently experienced by ESCO patients.

Despite growing recognition of its importance, ACP implementation remains a challenge within the VBKC models. While it is best practice to engage patients and their families in repeated ACP conversations over time, it is not well integrated into VBKC model evaluation. Notably, while the CEC model incorporated ACP into performance measures, it only required completion of a single ACP to achieve the highest performance rating. This is concerning, as numerous studies have demonstrated that effective, repeated ACP can decrease overall hospital expenditures and improve patient satisfaction through honored values and wishes (Reich et al., 2017; Kurella Tamura et al., 2017; Sellars et al., 2019; Ladin et al., 2018).

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PATIENT EDUCATION AND ACCESS TO CARE OPTIONS

Patient education about care options is essential for SDM and for reducing decision regret (Saeed, 2025). Recent VBKC models have encouraged patient education, but only the KCC model explicitly included an option to increase participation in Kidney Disease Education (KDE). This model has a voluntary benefit enhancement that provides KDE sooner in a patient's disease trajectory. Preliminary findings indicate that participating organizations have prioritized education on diverse treatment modalities. This investment correlates with a 10% increase in home dialysis utilization, driven specifically by a 14% growth in peritoneal dialysis enrollment (CMS, 2025f).

Furthermore, while recent VBKC models aim to increase patient activation, the KDE provided has primarily emphasized transplantation and home dialysis, outcomes directly incentivized by these models. Consequently, conservative management (CM) has received scant attention, creating a gap between patient engagement and the full spectrum of care options (CMS, 2025f). Recent guidance from the American Society of Nephrology provides a conceptual structure for better integration of CM. (Wong et al., 2026.) This issue is compounded by a limited infrastructure for alternative treatments and a lack of provider capacity. Current evidence suggests that VBKC frameworks have yet to bridge the need for specialized training in non-dialytic care, cultural humility, and the advanced communication skills required for truly neutral SDM (Tentori et al., 2019; Wong et al., 2019; Li et al., 2025; Sowden et al., 2025; Hole et al., 2025).

3. Why Kidney Supportive Care Matters in Value-Based Care

Patient Benefits

KSC has evolved over the past two decades to address numerous issues identified by nephrologists and patients that impact patient care. These gaps, famously enumerated at the KDIGO 2013 Controversies Conference, represent the primary drivers of suboptimal outcomes and high costs in the traditional "dialysis-default model" (Davison et al., 2015). Key patient-centered needs addressed by KSC include:

- **Symptom & Psychosocial Burden:** Relieving the high burden of unmanaged physical symptoms and the distress caused by fragmented care.
- **Informed Autonomy:** Addressing inadequate Shared Decision-Making (SDM), which currently leaves many patients feeling uninformed or funneled toward specific treatments, resulting in treatment regret for approximately 20% of those starting dialysis (Saeed, 2020).
- **Access to Choice:** Overcoming insufficient access to non-dialytic options like Conservative Management (CM) and providing support through dialysis withdrawal.
- **Goal Alignment:** Reducing low utilization of Advance Care Planning (ACP) and addressing barriers to hospice, particularly for those preferring concurrent care.

The International Society of Nephrology (ISN, 2024) has identified several core components essential to bridge these gaps. These interventions do more than improve patient well-being; they fundamentally align clinical practice with VBC objectives:

- **Proactive Assessment & Prognosis:** Tools like the IPOS-Renal (Davison et al., 2015) and the "Surprise Question" (Moss et al., 2008) identify high-risk patients early, allowing for timely, cost-effective supportive interventions before a crisis occurs.
- **Collaborative Planning:** By standardizing SDM and ACP, KSC ensures treatment pathways align with a patient's lived experience. This facilitates access to appropriate services like hospice while avoiding the expensive, aggressive, and often unwanted ICU interventions that characterize reactive end-of-life care.
- **Systemic Enhancements:** Broad solutions, including provider education and standardized withdrawal guidance, shift the focus toward holistic care models that stabilize spending by eliminating non-beneficial treatments.

Additional tools and resources are detailed in Table 1.

Ultimately, these mechanisms facilitate a fundamental paradigm shift: moving from a volume-based 'dialysis-default' approach to a coordinated, value-based model that prioritizes the patient's choice, addressing major issues patients with kidney disease face, and stabilizing healthcare spending by eliminating non-beneficial, unwanted care.

3. Why Kidney Supportive Care Matters in Value-Based Care

Provider Benefits

Integrating KSC into practice provides significant benefits for providers, moving beyond patient benefits. Here are three key benefits for nurses and providers implementing KSC into VBKC:

- **Increased Professional Satisfaction and Reduced Burnout:** KSC emphasizes SDM and aligning care with patient values. This leads to fewer instances where providers feel compelled to deliver aggressive, life-prolonging care that conflicts with the patient's known wishes. Engaging in meaningful, holistic care fosters greater professional fulfillment and can significantly reduce related moral distress and burnout.
- **Enhanced Skill Set and Team Efficiency:** KSC necessitates structured training in primary palliative care skills including advanced communication, symptom management, and psychosocial assessment. Equipping providers with validated training elevates their clinical skill set beyond dialysis management. Furthermore, KSC introduces an integrated team approach (often involving social workers and advanced practice providers), allowing nephrologists to delegate routine supportive care tasks and focus their time on complex medical decision-making and technical procedures.
- **Risk Mitigation:** Clear ACP and thorough documentation of patient goals-of-care discussions provide a strong basis for care delivery. Providers using these best practices are better protected from claims of providing non-goal-concordant care (i.e., care that violates the patient's documented preferences near the end of life). This clear, standardized process reduces ambiguity at critical junctures in care.

Delivering a high standard of KSC helps reduce health care fragmentation and improve health outcomes. The CMS Value-based Care Innovation Center also provides tools for clinicians who choose to participate in new innovative care models (CMS, 2025c). This is key to the successful delivery of KSC within VBKC programs.

VBKC Organization Benefit

VBKC Organizations are increasingly aware of the need to integrate KSC into VBKC, as evidenced by the inclusion of supportive care elements in national quality frameworks and the evolution of accreditation standards. Embedding KSC into VBKC is becoming a requirement for organizations seeking to demonstrate high-value, person-centered care in a competitive, risk-bearing environment.

To better understand how the current landscape is responding to this need, Table 3 summarizes leading VBKC organizations and their respective care model highlights. These entities represent a range of payer-provider partnerships, health management platforms, and integrated kidney care delivery systems that have emerged in response to value-based payment models and the growing demand for person-centered CKD management. Each organization is evaluated based on the scope of its services and whether KSC or ACP is explicitly mentioned as part of the care approach on its website.

Notably, Table 3 indicates whether each organization holds NCQA accreditation. This alignment with the National Committee for Quality Assurance (NCQA)—specifically in Population Health and Case Management—serves as a critical quality improvement strategy. While ACP and KSC are not always explicit requirements for accreditation, they are deeply consistent with NCQA's emphasis on person-centered care and whole-person assessment. For organizations seeking to maintain these national standards, KSC serves as a practical clinical pathway to demonstrate adherence to best practices in managing complex, high-risk populations.

3. Why Kidney Supportive Care Matters in Value-Based Care

Financial Alignment

Evidence increasingly suggests that KSC aligns clinical excellence with financial sustainability by reducing unwanted interventions and avoidable hospitalizations. By prioritizing patient-centered outcomes, KSC programs, particularly those incorporating Conservative Management (CM), generate measurable cost savings and a positive return on investment (ROI) compared to traditional dialytic care.

International data underscore this financial potential. A 2025 analysis projected that implementing KSC in Australia could produce a \$109 million ROI over a 15-year period through significant reductions in healthcare service utilization (Brady et al., 2025). These projections are supported by clinical outcomes in Australia, where patients choosing non-dialytic treatment options through KSC programs experienced fewer hospitalizations and reduced symptom burden. Notably, the financial benefits were longitudinal; as patients participated in these programs longer, their healthcare utilization and associated costs continued to decrease (Sowa et al., 2019; Chou et al., 2023). Similar results were observed in the United Kingdom, where a palliative-integrated CKM program maintained stable HRQoL for patients while keeping expenditures significantly lower than the average cost of dialysis (Phair et al., 2018).

Despite these promising findings, a critical gap remains in the United States. While the international evidence further underscores the need to refine both healthcare outcomes and financial metrics (Morton et al., 2016), additional research is required to quantify the specific savings KSC can achieve within the structure of the U.S. healthcare system. To bridge this gap, it is necessary to continue honing implementation strategies that fully integrate KSC into current care models, ensuring that financial incentives are aligned with the delivery of high-value, supportive care.

Policy Alignment

KSC principles align with national standards (KDIGO, ISN, NCQA, ASN) and VBKC priorities such as reducing hospital use, improving outcomes, and delivering person-centered care. Professional consensus emphasizes an increased focus on patient-centered health planning, the development of palliative service education, and the fostering of partnerships with palliative care and peer support organizations (RPA, 2021). Recently, the ISN called for all nephrologists to offer KSC as a key tenet of care. Achieving this integration requires a multi-pronged approach including ensuring nephrology training bodies mandate KSC competency (Brown et al., 2025). Further, the ASN recently affirmed that CM should be part of the standard of care to implement goal-concordant kidney care (Weiss et al, 2026). The policy foundation for KSC is already supported by three primary pillars:

- **Quality and Patient Experience Metrics:** KSC directly addresses and improves patient-centered quality metrics mandated by programs like the KCC Model (CMS's VBKC program). These models emphasize outcomes like SDM, care coordination, and reducing hospital utilization. KSC protocols, specifically those focused on ACP and comprehensive symptom management, directly lead to higher patient satisfaction scores and better alignment with mandated quality measures (Chen et al., 2018; Sturgill, D. & Bear, A., 2019).
- **Cost Management and Avoidable Utilization:** Federal VBKC policies are fundamentally designed to shift risk to providers and incentivize lower costs through reduced unnecessary utilization. KSC interventions are proven to reduce high-cost events, particularly by decreasing aggressive, non-beneficial care near the end of life, emergency department visits, and avoidable hospitalizations. This directly supports the financial goals of VBKC payment structures like two-sided risk arrangements and capitation models.
- **The Chronic Care Management (CCM) Framework:** KSC services fit squarely within the established frameworks for continuous, non-face-to-face services reimbursable under Medicare's CCM codes. These codes are designed to support complex care planning, medication management, and ongoing communication—all core tenets of KSC.

Policy alignment ensures a sustainable revenue stream for KSC coordination activities, making its integration financially feasible for VBC organizations through existing billing mechanisms.

4. The Path Forward: KSC Integration is an Ethical Imperative

Strategies for Successful Integration and Implementation

While the healthcare industry is aware of the need for kidney supportive care services, the transition from awareness to standardized implementation remains a challenge. Fulfilling the promise of VBKC requires moving beyond "voluntary" supportive care enhancements toward a structured implementation framework. Based on the landscape of current clinical gaps and organizational requirements, successful integration can be achieved through five strategic levers:

- **Incorporating KSC, SDM, and ACP training into provider education:** Moving beyond technical dialysis management to include advanced communication and symptom management as core competencies.
- **Ensuring access to comprehensive non-dialytic options:** Providing patients with standardized access to Conservative Management (also called Active Medical Care without Dialysis) when it aligns with patient preference.
- **Aligning payment models to remove barriers:** Supporting KSC services and removing obstacles such as the barriers to concurrent hospice and dialysis or palliative dialysis.
- **Developing structured workflows:** Standardizing goals-of-care conversations, symptom assessment and management, end-of-life support, and interdisciplinary coordination into the daily clinical routine.
- **Normalizing KSC through partnership:** Partnering with providers, payers, and patients to establish KSC as a standard of care rather than an alternative, building it into the contract and culture of the VBKC organization.

Evidence of Feasibility and Remaining Barriers

Over the past decade, several studies have demonstrated that this integration is possible and highly effective.

- The MYWAY project and the Shared Decision-Making Renal Supportive Care (SDM-RSC) intervention successfully used targeted training to increase ACP completion and improve patient and family satisfaction (Cohen et al., 2020; Lupu et al., 2022).
- Building on this, the HIGHWay study showed how to incorporate ACP into the workflows of resource-limited dialysis centers, resulting in a fifteen-fold increase in prognostic discussions (Rodriguez de Sosa et al., 2025).
- Use of a structured decision aid about CM increased discussions of CM from 3% in usual care to 26% with the decision aid (Wong et al., 2023).
- Similarly, the Pathways project used a collaborative model to disseminate 14 evidence-based practice recommendations for KSC, resulting in a measurable increase in advance directives (Moss et al., 2023).
- Scherer demonstrated integration of a KSC program at a safety net hospital with resulting improvement in symptoms (Scherer 2025).

However, these implementation efforts identified persistent structural barriers that must be addressed to reach full scale, including a lack of provider buy-in, misalignment with current dialysis performance measures, and Medicare policy constraints (Kurella Tamura et al., 2022). Among CKDopps sites, none reported a clinic or protocol for managing patients choosing CM (Scherer et. al 2023) Overcoming these hurdles is the final step in moving from pilot success to system-wide standard of care.

5. Conclusion

Despite the critical need, current nephrology and VBKC models remain deficient in the integration of kidney supportive care services.

KSC should be implemented into pre-existing care models, and is essential for delivering high-quality, dignified care and ensuring that all patients receive comprehensive support. This also allows for more effective symptom and pain management, treatment decisions, and better access to necessary services. Integrating KSC is crucial, both clinically as well as ethically.

Clinically, the KSC model empowers providers to deliver quality care while honoring patient goals and needs.

Ethically, KSC supports patient autonomy, fosters transparency and trust across the care team and family, and provides holistic care that respects the patient's physical, mental, emotional, and spiritual well-being.

Ultimately, this supportive care is critical for providing quality care that harmonizes seamlessly with value-based goals: it **improves clinical outcomes, significantly reduces avoidable healthcare utilization and associated expenditures, and ensures that care is always a reflection of what is most important to the patient.**



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7. Appendix

Appendix Table 1.

Kidney Supportive Care Components that Address Opportunities for Improvement in Usual Kidney Care

Opportunities for Improvement	Solutions provided by Kidney Supportive Care Components	Tools & References
<p>Symptom Assessment and Management</p> <p>- Lack of standardized symptom screening and patient-provider communication leads to untreated symptom burden.</p>	<p>- Standardize screening (e.g., IPOS/ESAS-Renal) and implement a stepwise, non-pharmacological-first management approach.</p>	<p>IPOS Renal (https://pos-pal.org/maix/ipos-renal-in-english.php)</p> <p>ESAS Renal (https://www.albertahealthservices.ca/frm-20351.pdf)</p> <p>ExPAND Guide for Symptom Assessment and Management in Patients with Advanced Chronic Kidney Disease (https://www.kidneysupportivecare.org/symptom-assessment-and-management-patients-advanced-chronic-kidney-disease)</p> <p>Renal and Hypertension Service. St George Hospital and Community Health Services. Symptom Management. Available at: https://stgrenal.org.au/for-health-professionals/learning-resources/symptom-management/</p> <p>Kidney Supportive Care Research Group, University of Alberta. Conservative Kidney Management. Symptom Management Guidelines. https://ckmcare.com/Resources/PraIndex</p>
<p>Prognostication</p> <p>- Prognostic communication is inconsistent; providers often conflate prognosis exclusively with survival time, failing to address patient priorities like</p>	<p>- Adopt a patient-centered approach:</p> <ol style="list-style-type: none"> 1) Assess patient information preferences; 2) Use empathic, clear communication; 3) Frame prognosis broadly (function, quality of life, living situation); 	<p>Touchcalc surprise question calculator for 6, 12, & 18 month mortality for dialysis patients https://www.zkidney.com/sq-sp</p> <p>Serious Illness Conversation Guide https://www.ariadnelabs.org/resources/downloads/serious-illness-conversation-guide/</p>

<p>functional status and quality of life.</p>	<p>4) Use screening tools like the "Surprise Question" (Would I be surprised if this patient died in the next 6/12 months?) to trigger early advance care planning.</p>	
<p>Shared Decision-Making (SDM)</p> <p>- Providers are not adequately engaging in SDM with patients</p>	<p>- SDM is required for the patient and provider to provide patient-centered care to honor patient goals and wishes.</p>	<p>Saeed F, Jawed A, Gazaway S, et al. Supporting Shared Decision-Making in Life-Altering Kidney Therapy Decisions for Older Adults: A Review. <i>JAMA Intern Med.</i> 2025;185(12):1479-1488. doi:10.1001/jamainternmed.2025.5554</p>
<p>Advance Care Planning (ACP)</p> <p>- Providers are not adequately engaging in ACP with patients</p>	<p>- ACP should be implemented early so that patients' wishes and goals are addressed at all points during the disease. Consider revisiting after hospitalization or change in diagnosis.</p>	<p>Coach Guide: Advance Care Planning Conversations (MY WAY Project) https://www.kidneysupportivecare.org/coach-guide-advance-care-planning-conversations-my-way-project National POLST collaborative https://polst.org/ Prepare for Your Care https://prepareforyourcare.org/en/prepare/welcome</p>
<p>Active Medical Care without Dialysis (Conservative Management)</p> <p>-Infrastructure to support patients who choose this pathway is lacking.</p>	<p>- Structured programs to support patients who choose Active Medical Care without Dialysis should be widely available and integrated into choices offered to patients.</p>	<p>ASN Kidney Health Guidance on Conservative Management in People with Kidney Failure https://journals.lww.com/jasn/fulltext/9900/asn_kidney_health_guidance_on_conservative.963.aspx</p>
<p>Spiritual Care</p> <p>-Spiritual needs are important to patients but are not addressed in clinical settings</p>	<p>- Spirituality (a search for meaning and purpose) is integral to whole-person care; spiritual history and existential needs</p>	<p>FICA Spiritual History Assessment Tool https://gwish.smhs.gwu.edu/programs/transforming-practice-health-settings/clinical-fica-tool</p>

	assessments are essential for identifying sources of support and distress.	
Dialysis Withdrawal -There are limited directions and processes for dialysis withdrawal	- Dialysis clinics should develop guidance on how to support patients and their families during this decision, and when to discuss dialysis withdrawal, including patient support after they withdraw	Renal Physician Association Guidelines, "Appropriate Initiation of and Withdrawal from Dialysis" (Renal Physicians Association, 2010)
Crisis Planning	-Determine resources and after-hours symptom management.	
Integration with Community Services at End of Life	-Consider referral to community palliative care and/or hospice care when needed	
End-of-life care considerations and bereavement -Support and resources for end-of-life care for the patient and their care partner is limited. -Bereavement support for care partners is also non-existent	Bereavement services are available in most communities through a local hospice, even for patients who were not hospice patients.	SAMHSA information on grief https://www.samhsa.gov/communities/coping-bereavement-grief CaringInfo, a program of the National Alliance for Care at Home, grief information https://www.caringinfo.org/planning/grief-and-loss/

Appendix Table 2.

Comparison of Federal Value-Based Care programs and Inclusion of Kidney Supportive Care Practices

Program/ Year Established	Population Supported	Care Model Highlights	Use of Supportive Care	Comments
Accountable Care Organizations (ACO) -2012	- Originally for high-need Medicare, now adopted by broader practices.	<ul style="list-style-type: none"> - Shared savings from Center for Medicare and Medicaid Services (CMS) if the ACO exceeds minimum quality metrics. - Lower expenditures from beneficiaries - Care coordination - Multidisciplinary care activities 	- No explicit KSC services were noted (Tummapalli et al., 2022)	- Improved quality relative to standard Medicare but failed to reduce costs in most cases.
Hospital Value-Based Purchasing -2012	- For Medicare beneficiaries in acute inpatient care.	<ul style="list-style-type: none"> - Reimbursements tied to clinical, safety, cost, and patient engagement metrics. - Performance-based shared risk (incentives/penalties). - Evidence found improved patient satisfaction and metrics were being met. 	- Limited to acute inpatient metrics (symptom management); omits broader KSC components. (Tummapali et al., 2022)	- There was no control group for comparison. Unclear if the model was more or less successful.

<p>Hospital Readmissions Reductions Program - 2012</p>	<ul style="list-style-type: none"> - Focuses on Medicare and younger cohorts with specific cardiac, pulmonary, and orthopedic conditions. 	<ul style="list-style-type: none"> - A 3% payment reduction in diagnosis-related group payments for in-patient hospitalizations based on 30-day risk standardized readmission ratios. - Significantly reduced readmissions across both targeted and non-targeted conditions. 	<ul style="list-style-type: none"> - Omits core KSC components; limited to only addressing readmission/symptom management. (Tummapali et al., 2022). 	<ul style="list-style-type: none"> - Findings are inconclusive regarding whether lower readmissions increase mortality. - Readmission rates dropped modestly (23.5% to 22.7%) between 2008-2014 (Dharmarajan et al., 2017). - Some reductions may stem from "upcoding" (e.g., classifying ED visits as outpatient) rather than systemic improvements (Ibrahim et al., 2018). - Metrics ignore patient-centered goals (e.g., life-prolonging care vs. comfort care) (Cassel et al., 2010). - Hospitals may have avoided palliative care, which is linked to high-acuity, to artificially lower readmission rates (Kroch et al., 2010).
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<p>End Stage Renal Disease Quality Incentive Program - 2012</p>	<p>Targets Medicare ESRD patients receiving in-center dialysis.</p>	<ul style="list-style-type: none"> - Pay-for-performance program for dialysis facilities. - Evaluates dialysis facilities on 14 measures. - Facilities can lose up to 2% of their Medicare payments if they perform poorly. 	<ul style="list-style-type: none"> - Quality measures (e.g., depression screening, patient surveys, health equity) only tangentially address KSC core domains (CMS, 2025b). - Notable that no measures of end-of-life are included. 	<ul style="list-style-type: none"> - No evidence of causal link between QIP incentives and patient outcomes (Tummapali et al., 2022). - Quality metrics (e.g., Kt/V) discourage flexible treatment options like palliative dialysis or incremental dialysis (CMS, 2025b).
<p>Bundled Payments of Care Improvement (BPCI) - 2013</p>	<ul style="list-style-type: none"> - Targets Medicare beneficiaries requiring specific clinical treatments (e.g., joint replacement, Congestive Heart Failure, COPD). 	<ul style="list-style-type: none"> - Pays reconciliation payments if provider care costs were lower than the target price. - Renal failure is included as part of BPCI episodes. - Lowered mortality rates. 	<ul style="list-style-type: none"> - Omits core KSC components; limited to addressing potential future costs of hospitalization and symptom management (Tummapali et al., 2022). 	<ul style="list-style-type: none"> - Patients eligible for Medicare due to ESRD are excluded from BPCI. - Did not result in net savings after reconciliation payments (Tummapali et al., 2022).

<p>Merit-Based Incentive Program</p> <p>- 2015</p>	<p>- Medicare-enrolled clinicians who receive reimbursements for caring for Medicare beneficiaries</p>	<p>- Performance-based payment adjustments (metrics: quality, interoperability, improvement activities, and cost).</p> <p>- Mandatory for Medicare clinicians (exempt if clinician is in two-sided risk Alternative Payment Model).</p>	<p>- Outcome measures (e.g., care coordination, population management) only partially cover KSC domains (symptom management, ACP, end-of-life).</p> <p>- Key KSC measures, such as ACP and depression remission, remain optional for providers to report (CMS, 2025g).</p>	<p>- Metrics are self-reported by participating groups.</p> <p>- In 2018 nephrologists had a median score of 100 (max score) with 99.5% receiving an increased payment (Tummapali et al., 2022).</p> <p>- "Perfect" scoring indicates a ceiling effect, limiting the program's ability to identify opportunities for care improvement.</p>
<p>Comprehensive ESRD Care Model (CEC)</p> <p>- 2015</p>	<p>- Targets Medicare ESRD patients receiving dialysis within specific ACOs.</p>	<p>- Uses specialty-specific ACOs: ESRD Seamless Care Organizations (ESCOs).</p> <p>- Facilities hold financial responsibility for quality, cost, and patient experience.</p> <p>- Assessed on 26 quality measures including patient safety, patient and caregiver experience, communication and care coordination.</p> <p>- Documented reduction in hospitalizations (CMS, 2023).</p>	<p>- Outcome measures (e.g., care coordination) partially integrate KSC domains (symptom management, prognostication, ACP, and end-of-life care).</p> <p>- Measures specifically include:</p> <ul style="list-style-type: none"> - Standardized Mortality Ratio - Advance Care Planning - Influenza Immunization for the ESRD Population - ICH CAHPS (includes Nephrologists') 	<p>- 1.3% reduction in Medicare spending driven by lower utilization (CMS, 2022a).</p> <p>- Savings driven primarily by decreased hospital/ED utilization.</p> <p>- Savings metrics fail to distinguish between life-prolonging vs. end-of-life care.</p> <p>- Providers reported reluctance to discuss palliative/hospice care (CMS, 2021)</p>

			<p>Communication and Caring, Quality of Dialysis Center Care and Operations, Providing Information to Patients, Rating of Kidney Doctors, Rating of Dialysis Center Staff, Rating of Dialysis Center)</p> <p>- Screening for Clinical Depression and Follow-Up Plan</p>	<p>- Select sites successfully integrated palliative care, improving outcomes and reducing costs (CMS, 2021).</p> <p>- Net savings were offset by shared savings payments (Tummapali et al., 2022).</p>
<p>ESRD Treatment Choices - 2021</p>	<p>- Targets randomized dialysis facilities serving Medicare ESRD beneficiaries.</p>	<p>- Pay-for-performance: Metrics include facility performance, home dialysis, transplant waitlisting, and living donation rates.</p> <p>- 30% of facilities randomized for participation.</p> <p>- Financial bonuses/penalties were implemented to encourage increased home dialysis and living donation rates.</p>	<p>- Lacks mandatory KSC metrics, though improved education/options potentially enhanced SDM and autonomy (CMS, 2025a).</p>	<p>- No significant impact on transplant or home dialysis rates (Tummapali et al., 2022).</p> <p>- Disproportionate financial penalties for smaller dialysis organizations (Tummapali et al., 2022; Koukounas et al., 2024).</p> <p>- Early termination due to increased Medicare costs and implementation challenges (CMS, 2025a).</p>

<p>Medicare Advantage Plans - 2021</p>	<ul style="list-style-type: none"> - Eligible Medicare (Part A/B) beneficiaries; MA access extended to ESRD patients in 2021. 	<ul style="list-style-type: none"> - Medicare Advantage (MA) offers flexible, supplemental coverage (e.g., Rx, vision, dental) beyond standard Part A/B benefits. - Specialized plans (e.g., for ESKD) demonstrate lower mortality and utilization rates. 	<ul style="list-style-type: none"> - KSC domain integration varies significantly by individual plan design. ESRD plans mandate interdisciplinary care, structured risk/care planning, and specialist access. 	<ul style="list-style-type: none"> - Data on clinical efficacy and longitudinal outcomes for ESKD in MA plans remains limited. - Qualitative research (Brazier et al., 2025) highlights pervasive/misleading marketing, restricted networks, and inadequate coverage for complex ESKD needs.
<p>Kidney Care Choices - 2022</p>	<ul style="list-style-type: none"> - Targeted at organizations managing care for late-stage CKD and ESRD populations. 	<ul style="list-style-type: none"> - Model tracks: Kidney Care First (KCF) and Comprehensive Kidney Care Contracting (CKCC) (CMS, 2025d). - KCF: Quarterly capitated payments for CKD professional services + transplant bonuses. - Payments are also adjusted on quality metrics: Gains in patient activation scores at 12 months; Depression remission at 12 months; High blood pressure control; Optimal ESRD starts; Hospitalization costs; - Total per capita costs - CKCC: Shared savings/losses model for total cost and care quality. - Voluntary benefit enhancements related to KSC include: 	<ul style="list-style-type: none"> - The KCF quality metrics lack explicit KSC integration. - Waivers facilitate SDM/end-of-life care but exclude broader KSC domains. - KSC-aligned enhancements are optional, not mandatory, for CKCC participation. 	<ul style="list-style-type: none"> - There have been positive clinical outcomes: Improved BP control, increased optimal ESRD starts, and reduced hospitalizations (Duke-Margolis, 2025; Monogram, 2025). - Financial volatility: \$304M Medicare loss in 2023 led to stricter discounts, lower bonuses, and reduced capitation (CMS, 2025e). - Very few providers implemented the hospice concurrent care benefit enhancement. Even among those who made the benefit, there was scant uptake by providers or patients.

		<ul style="list-style-type: none">- waiver of kidney disease education requirements to broaden availability-waiver allowing patients to have concurrent care of dialysis (or other current care) and Hospice		
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Appendix Table 3.

Comparison of Value-Based Kidney Care Organizations and Inclusion of Kidney Supportive Care Practices

Organization (Website)	Care Model Highlights	Mentions of Supportive Care or ACP on website	NCQA certified?
DaVita Integrated Kidney Care (IKC) https://www.davita.com/about/businesses/ikc	<ul style="list-style-type: none"> · Predictive analytics for early patient identification, timely intervention and proactive care management to help delay CKD progression · Patient education helps patients manage their health and determine the modality that best fits their lifestyle, including home dialysis and transplant · Care coordination to help patients schedule appointments, access resources and find support 	<p>“We are committed to looking at everything that may impact your health, so that we can get you the best care possible.”</p>	<p>Yes</p>
DCI REACH https://www.reachkidneycare.org/	<ul style="list-style-type: none"> · Personalized care management for people with the highest clinical needs to slow disease progression · Patient-centered dietary services offered in collaboration with CKD care management · Evaluation of patients’ medications to ensure optimal medication therapy through REACH Clinical Pharmacy 	<p>Collaboration with patients and providers to ensure a supportive, smooth transition to the patient’s choice of care, including transplant, dialysis or medical management without dialysis.</p>	<p>Yes</p>

<p>Duo Health https://duohealth.com/</p>	<ul style="list-style-type: none"> · Field-based, physician-led, multi-disciplinary care team delivers holistic care in the setting of the patient's choice · Predictive analytics and Health Mobilization™ platform support proactive, coordinated care to slow CKD progression and manage total cost of care · Full-service medical group model that integrates with nephrologists and assumes total cost of care risk for CKD Stage 3b+ through transplant 	<p>"Your Duo team is purpose-built around you and your needs..." "We don't dictate. We listen. We help you connect the dots. And we honor your unique experience. No one knows you better than you."</p>	<p>No</p>
<p>Evergreen Nephrology https://evergreennephrology.com/</p>	<ul style="list-style-type: none"> · Nephrologist-led interdisciplinary care model focused on slowing CKD progression, improving outcomes, and increasing quality of life through early, individualized intervention. · Technology-enabled partnerships provide nephrologists with real-time tools, resources, and analytics to support whole-person care across the CKD to ESRD continuum. · Personalized care planning that includes mental, emotional, and physical health needs, with patient-centered goals and support from a full care team: APPs, social workers, nurses, dietitians, and pharmacists. 	<p>"Your care plan is just for you." "We take your total well-being into account - including mental and emotional health - to help you achieve your personal health care goals."</p>	<p>Yes</p>
<p>Healthmap Solutions https://healthmapsolutions.com/</p>	<ul style="list-style-type: none"> · Kidney Health Management (KHM) Program uses predictive analytics for early identification and proactive support for CKD, ESRD, and related chronic conditions · Care Navigation, a multidisciplinary complex care management service, addresses medical, social, and logistical barriers between doctor visits · Compass Platform, a HITRUST-certified technology, delivers real-time data and engagement tools to support timely transitions to transplant, in-home dialysis, or conservative care 	<p>"Holistic, patient-centered care to support treatment and medication adherence, overcome social determinants of health barriers, and empower patients with information they need to be engaged and active in their own care."</p>	<p>Yes</p>

		<p>“Optimizing renal replacement therapy by emphasizing in-home dialysis, transplant, and conservative care, as appropriate.”</p>	
<p>Interwell Health (Fresenius) https://www.interwellhealth.com/</p>	<ul style="list-style-type: none"> · Interwell 360 delivers personalized kidney care through nurse, dietitian, and care coordinator support to manage CKD, diabetes, hypertension, and lifestyle needs · Acumen EHR platform provides nephrology-specific decision support, real-time alerts, and improved care coordination across practices and dialysis centers · Remote monitoring, education tools, and patient engagement services enable proactive care, personalized treatment planning, and improved patient self-management 	<p>“Conservative care focuses on managing kidney disease symptoms without dialysis or transplant... If your kidney disease progresses and becomes severe, palliative care and/or hospice will be needed to help you stay comfortable at home and maintain your quality of life... You should complete advance directives, including a living will and a durable healthcare power of attorney...”</p>	<p>Yes</p>

<p>KidneyLink (USRC + Satellite) https://kidneylink.com/</p>	<ul style="list-style-type: none"> · Predictive analytics used to guide timely, personalized interventions that slow disease progression and improve quality of life · Nephrologist-centered model focused on comorbidity management, home dialysis support, transplant coordination, and advance care planning · Proactive patient engagement to reduce hospitalizations and ensure informed, goal-aligned care decisions 	<p>“Ensure that advance care planning supports the transitions of care and provides a better understanding of the path forward.” “We listen to our patients’ goals and preferences, and work closely with their nephrologist and other providers to ensure care aligns with what matters most to them.”</p>	<p>No</p>
<p>Monogram Health https://www.monogramhealth.com/</p>	<ul style="list-style-type: none"> · Multispecialty in-home care teams (nephrology, cardiology, endocrinology, pulmonology, behavioral health) deliver personalized, evidence-based treatment for patients with CKD and multiple chronic conditions · Proprietary medication therapy management and social support services (e.g., food access, transportation, financial assistance) address medical and social needs at home · 24/7 availability with locally embedded clinical “pod” teams and a holistic, longitudinal care approach that reduces hospitalizations and improves patient outcomes 	<p>Integrated palliative and supportive care services, including advance care planning, symptom management, and end-of-life counseling, delivered in-home to align treatment with patient values and improve quality of life</p>	<p>Yes</p>

<p>Panoramic Health https://panoramichealth.com/</p>	<ul style="list-style-type: none"> · Comprehensive care management delivered by a leading nephrology provider group across the CKD-ESRD spectrum · Predictive analytics platform powered by one of the world’s largest real-time CKD databases for early risk stratification and intervention · Integrated, longitudinal care model combining patient engagement, provider alignment, and decision support to reduce hospitalizations and improve quality of life 	<p>Not explicitly stated; “We leverage data and analytics to customize treatments based on each patient’s stage and risk profile.”</p>	<p>No</p>
<p>Renal Care 360 https://renalcare360.com/</p>	<ul style="list-style-type: none"> · Polychronic Health Management to support patients with multiple chronic conditions through coordinated, patient-centered care · Kidney Health Education (SPARK) using proprietary tools covering transplant, dialysis, nutrition, and medication literacy · Care Advocacy and Social Services Coordination to address Social Determinants of Health and provide holistic support between provider visits 	<p>Not explicitly stated</p>	<p>No</p>
<p>Somatus https://somatus.com/</p>	<ul style="list-style-type: none"> · Delivers individualized, community-based care through local support teams (nurses, dietitians, health advocates) and services like in-home dialysis, nutrition counseling, and coaching to help patients manage kidney and heart conditions. · Leverages RenalIQ®, a proprietary AI-driven technology platform that ingests billions of data lines to identify at-risk patients, drive evidence-based interventions, and provide real-time insights for care teams. · Provides patients with access to mySomatus, an online portal offering care plans, health education, appointment information, and connection to their care team, as well as a peer-support community. 	<p>Not explicitly mentioned; Somatus provides individualized clinical, emotional, and social support, including 24/7 nurse availability, personal health coaching, and community resources to improve patient quality of life and help them manage kidney and cardiovascular conditions at home.</p>	<p>Yes</p>

<p>Strive Health https://strivehealth.com/</p>	<ul style="list-style-type: none"> · Delivers high-touch, holistic kidney care through Kidney Heroes™, a multispecialty, NP-led care team that includes social workers, dietitians, and care coordinators who manage comorbidities, address social determinants of health, and engage in shared decision-making including transplant education and care planning. · Uses the CareMultiplier™ platform, a machine learning-based technology that integrates diverse data sources to identify at-risk patients and inform individualized care plans to slow disease progression and reduce hospitalizations. · Partners with nephrologists and provider groups to embed care teams that act as clinical extensions, support transitions to home modalities, and reduce avoidable hospital readmissions 	<p>Strive Health’s Kidney Heroes™ care team provides high-touch, compassionate support that helps patients understand their disease, explore treatment options like transplant or in-home dialysis, and receive individualized care that aligns with their goals and improves quality of life.</p>	<p>Yes</p>
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