CHRONIC KIDNEY DISEASE PREVENTION, EARLY RECOGNITION, AND MANAGEMENT

1. REASON FOR ISSUE: This new Veterans Health Administration (VHA) directive establishes policy to improve prevention, early recognition, and management of chronic kidney disease (CKD) in VA medical facilities. The directive describes VHA's strategy for prevention, recognition, management, and evaluation of CKD in the Veteran population, responsibilities of VHA leadership and front-line staff in implementing this strategy, and resources and tools to assist in implementation of CKD programs nationwide.

2. RELATED ISSUES: VHA Directive 1042.01, Criteria and Standards for VA Dialysis Programs, dated May 23, 2016 and VHA Handbook 1101.10(1), Patient Aligned Care Team (PACT) Handbook, dated February 5, 2014.

3. RESPONSIBLE OFFICE: The Office of Specialty Care Services (10P11) is responsible for the content of this VHA Directive. Questions may be directed to the Department of Veterans Affairs (VA) Office of Specialty Care Services (10P11) at (202) 461-7120 or the VHA National Kidney Program Office at VHANationalKidneyProgramOffice@va.gov.

4. RESCISSIONS: None

5. RECERTIFICATION: This VHA Directive is scheduled for recertification on or before the last working day of March 2025. This VHA directive will continue to serve as national policy until it is recertified or rescinded.

BY THE DIRECTION OF THE UNDER SECRETARY FOR HEALTH:

/s/ Lucille B. Beck, PhD.
Deputy Under Secretary for Health for Policy and Services

NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

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CHRONIC KIDNEY DISEASE PREVENTION, EARLY RECOGNITION, AND MANAGEMENT

1. PURPOSE

This Veterans Health Administration (VHA) directive establishes policy to improve prevention, early recognition, and management of chronic kidney disease (CKD) in the Department of Veterans Affairs (VA) medical facilities. The directive describes VHA's strategy for prevention, recognition, management, and evaluation of CKD in the Veteran population, the responsibilities of VHA leadership and staff in implementing this strategy, and resources and tools to assist in implementation of CKD programs nationwide**. AUTHORITY:** Title 38 United States Code (U.S.C.) 7301(b).

2. BACKGROUND

a. Of the 9 million Veterans receiving VA care, 960,000 Veterans, or 11 percent meet the established criteria for CKD. CKD is characterized by the gradual loss of kidney function over several months or years and is one of the most common serious medical conditions affecting adults in the United States (US); in the VA it is the fourth most common diagnosis. If left untreated, CKD can progress to kidney failure and cause premature mortality from cardiovascular disease. The costs of caring for the CKD population rises dramatically with advancing stage of disease, with annual VHA costs estimated up to $19 billion. If the kidneys fail, patients need either a kidney transplant to survive or more commonly, dialysis, which is associated with marked increases in mortality as well as health system and patient out of pocket expense. Despite these consequences, CKD is often unrecognized by providers and patients alike. Currently, only 324,000, or 5 percent of Veterans have been diagnosed with CKD, suggesting limited VA healthcare provider and Veteran awareness of this burdensome illness.

b. Early recognition and management of CKD allows clinicians more opportunities to protect kidney health and prevent kidney failure. Regular assessment, diagnosis, and early intervention has been shown to favorably impact CKD progression and the downstream incidence of end stage renal disease (ESRD). Prevention of CKD progression requires individualized goals that target blood pressure control, use of angiotensin-converting-enzyme inhibitors (ACEi) or angiotensin receptor blockers (ARB) for patients with albuminuria and hypertension, glycemic control, and referral for medical nutrition therapy. Management of CKD includes reducing the patient's risk of CKD progression and risk of associated complications such as cardiovascular disease, acute kidney injury (AKI), CKD anemia, CKD metabolic acidosis, CKD mineral and bone disorder, and CKD associated pain. It also requires pharmacovigilance to reduce the risk of adverse medication outcomes due to impaired drug clearance (e.g. opiate overdose).

3. DEFINITIONS

a. **Chronic Kidney Disease.** Chronic kidney disease (CKD) is a condition where there is an abnormality of kidney structure or function for more than 3 months irrespective of cause, with implications for health, and is characterized as either an estimated glomerular filtration rate (eGFR) < 60 cc/min/1.73m2 and/or albuminuria [an albuminuria excretion rate (AER) ≥ 30 mg/24 hours or spot urine albumin to creatinine ratio (ACR) ≥ 30 mg/g], abnormal urine sediment, electrolyte and other abnormalities due to tubular disorders, abnormalities detected by histology, structural abnormalities detected by imaging, or a history of kidney transplantation.

b. **Telenephrology.** Telenephrology is the use of telemedical services such as VA Video Connect (VVC) or Clinical Video Telehealth (CVT) between a VA provider and patient to enhance Veteran access to nephrology specialty care. ***NOTE:*** *This is also referred to as Virtual Care Nephrology.*

c. **Kidney Health Committee.** The Kidney Health Committee (KHC) is the national multidisciplinary VA committee charged with oversight of VA kidney health services to drive improvements in the health and well-being of Veterans at risk for or with kidney disease. ***NOTE:*** *Refer to Appendix B, for the Kidney Health Committee charter.*

d. **Specialty Care Access Network-Extension for Community Healthcare Outcomes Consultation.** The Specialty Care Access Network (SCAN), Extension for Community Healthcare Outcomes (ECHO) consultation is a program that electronically connects specialists, including nephrology specialty providers, with Primary Care providers in rural and remote locations by leveraging telehealth, specifically clinical videoconferencing equipment, to allow healthcare specialists from a regional healthcare center to provide expert advice to providers in rural healthcare settings.

e. **Patient Aligned Care Team.** The Patient Aligned Care Team (PACT) is a team of health care professionals that provides comprehensive primary care in partnership with the patient (and the patient's personal support person(s)) and manages and coordinates comprehensive health care services consistent with agreed upon goals of care. ***NOTE****: Refer to VHA Handbook 1101.10(1) Patient Aligned Care Team (PACT) Handbook, dated February 5, 2014 for details on VHA PACT policy.*

4. POLICY

It is VHA policy that all eligible Veterans have access to comprehensive care for CKD, and that all VA medical facilities establish and maintain a CKD program within existing PACT operations.

5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b. **Principal Deputy Under Secretary for Health.** The Principal Deputy Under Secretary for Health is responsible for ensuring that the Assistant Deputy Under

Secretary for Informatics and Analytics complies with the responsibilities listed in this directive.

c. **Assistant Deputy Under Secretary for Informatics and Analytics.** The Assistant Deputy Under Secretary for Informatics and Analytics is responsible for developing and maintaining informatics and epidemiologic surveillance tools (such as dashboards) to enable identification of patients at risk for kidney disease.

d. **Deputy Under Secretary for Health for Policy and Services.** The Deputy Under Secretary for Policy and Planning is responsible for appointing members to the KHC, in collaboration with the Deputy Under Secretary for Health for Operations and Management.

e. **Chief Consultant, Specialty Care Services.** The Chief Consultant, Specialty Care Services is responsible for receiving minutes from the KHC or designating the appropriate committee to which KHC minutes should be submitted and ensuring concerns identified by the KHC are addressed with the appropriate leadership official or program office.

f. **VHA National Program Director for Kidney Disease and Dialysis.** The National Program Director for Kidney Disease and Dialysis is responsible for:

(1) Communicating the contents of this directive to the KHC.

(2) Serving as a subject matter expert to support nationwide implementation of this directive and evaluate programmatic performance via tracking of performance metrics and available reports.

(3) Serving as the VHA representative on Federal and non-Federal agency associations related to kidney disease.

g. **Chief Consultant for Preventive Medicine.** The Chief Consultant for Preventive Medicine is responsible for communicating the contents of this directive to Preventive Care councils (i.e. the Preventive Medicine Advisory Committee).

h. **Deputy Under Secretary for Health Operations and Management.** The Deputy Under Secretary for Health for Operations and Management is responsible for:

(1) Appointing members to the KHC, in collaboration with the Deputy Under Secretary for Health for Policy and Services.

(2) Communicating the contents of this directive to each of the Veterans Integrated Services Networks (VISN).

(3) Ensuring that each VISN director has sufficient resources to fulfill the terms of this directive in all the VA medical facilities within that VISN.

(4) Providing oversight of VISNs to assure compliance with this policy.

i. **Executive Director, Primary Care Program Office.** The Executive Director, Primary Care Program Office is responsible for:

(1) Communicating the contents of this directive to appropriate Primary Care councils or committees.

(2) Serving as a subject matter expert to support nationwide implementation of this directive.

j. **Veterans Integrated Service Network Director.** The VISN Director is responsible for:

(1) Communicating this policy to the relevant VISN medicine and specialty care service councils and leads including the VISN Primary Care Council and Lead, the VISN Health Promotion and Disease Prevention (HPDP) Lead, the VISN Dialysis Council, and the VISN Health Education and Information (VHEI) Council to facilitate implementation.

(2) Ensuring compliance with this policy at each VA medical facility in the VISN.

(3) Ensuring a Nephrology lead is available at the VISN level if not at the VA medical facility level who is responsible for collaborating with VA medical facility PACTs via provision of diagnostic, therapeutic, and co-management services to provide CKD care.

(4) Ensuring VISN Clinical Resource Hubs offer telenephrology services.

k. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Ensuring that a CKD program as described in this directive is established within the VA medical facility's PACT structure.

(2) Ensuring that quality improvement processes are implemented to augment guideline concordant care.

(3) Ensuring that telenephrology and virtual care services are established to provide effective support of the facility CKD program.

(4) Ensuring CKD program representation on the VA medical facility-wide Health Promotion and Disease Prevention Committee. ***NOTE:*** *For more information about the Health Promotion and Disease Prevention Committee, refer to VHA Directive 1120.02, Health Promotion and Disease Prevention Core Program Requirements, dated February 5, 2018.*

(5) Ensuring the VA medical facility is implementing the standardized CKD electronic note in VA's electronic health record (EHR).

l. **VA Medical Facility Chief of Staff.** The VA medical facility Chief of Staff is responsible for:

(1) Implementing a CKD program as described in this directive within the existing PACT structure.

(2) Designating a Nephrology lead that is responsible for collaborating with PACT via provision of diagnostic, therapeutic, and co-management services to provide CKD care.

(3) Designating a Primary Care PACT Lead (either locally or via the VISN) that is responsible for collaborating with Nephrology Specialty Care via provision of diagnostic, therapeutic, and co-management services to provide CKD care.

(4) Ensuring adherence by Primary Care staff to the VA/DoD Clinical Practice Guideline for the Management of Chronic Kidney Disease.

(5) Ensuring PACT operations include identification of patients at high risk for CKD and institution of appropriate prevention practices.

(6) Ensuring periodic review of the VA CKD Primary Care Patient Report by the PACT lead and the VA CKD Nephrology Patient Report by Nephrology lead. ***NOTE:*** *Refer to Paragraph 6e and Appendix C for a description of the CKD reports.*

(7) Ensuring electronic laboratory testing panels and order sets as described in this directive are implemented to identify patients at risk for CKD.

(8) Ensuring PACT operations include early CKD management to prevent or delay progression to kidney failure.

(9) Ensuring appropriate and timely referral of patients from Primary Care to nephrology for CKD management.

(10) Ensuring that nephrology services are available through face-to-face care, telenephrology, or virtual care in order to optimally support the CKD program and Veteran's needs.

(11) Ensuring establishment of a care coordination agreement between primary care and PACT and nephrology specialty services, as well as the availability of necessary laboratory testing for the evaluation of Veterans at risk for CKD. ***NOTE:*** *Refer to Appendix A for the Care Coordination Agreement National Template. The template is mandatory, but may be adapted if necessary, to accommodate for different VA medical facility complexity levels.*

m. **VA Medical Facility Primary Care Lead.** The VA medical facility Primary Care Lead is responsible for:

NOTE: *The VA medical facility Primary Care lead typically oversees the leaders of the facility's PACT teams.*

(1) Managing the integration of CKD programs into the existing PACT structure.

(2) Collaborating with Nephrology Specialty Care via provision of diagnostic, therapeutic, and co-management services to provide CKD care.

(3) Reviewing the VA CKD Primary Care Report at least quarterly in collaboration with the local Nephrology lead. ***NOTE:*** *For more information on the VA CKD Primary Care Report, refer to Paragraph 6.e.*

(4) Implementing the VA/DoD Clinical Practice Guidelines for the Management of Chronic Kidney Disease in Primary Care. ***NOTE:*** *For more information on the VA/DoD guidelines, refer to Paragraph 6.g.*

n. **VA Medical Facility Patient Aligned Care Team Providers.** VA medical facility PACT providers are responsible for:

(1) Evaluating patients at risk for kidney disease at least annually for kidney disease, utilizing electronic screening order sets. ***NOTE:*** *For more information on electronic screening order sets, refer to Paragraph 6.d*.

(2) Providing Veterans at risk for kidney disease with information regarding the prevention of CKD, management of comorbidities, and prevention of uremic complications and documenting the education in the Veteran's EHR. ***NOTE:*** *For resources that can be provided to Veterans, refer to Appendix C.*

o. **VA Medical Facility Nephrology Lead.** The VA medical facility Nephrology Lead is responsible for:

(1) Collaborating with Primary Care and PACTs via provision of diagnostic, therapeutic, and co-management services to provide CKD care.

(2) Reviewing the VA Chronic Kidney Disease Nephrology Patient report at least quarterly. ***NOTE:*** *For more information on the VA CKD Nephrology Patient report, refer to Paragraph 6.e.*

p. **VA Medical Facility Nephrology Providers.** VA medical facility Nephrology providers are responsible for:

NOTE: *The provision of nephrology specialty care is generally delivered as part of coordinated effort in conjunction with social workers, dietitians, pharmacists, nurse practitioners, physician assistants, and nursing.*

(1) Providing Veterans with education and information regarding Renal Replacement Therapy (RRT) and kidney transplantation where appropriate and documenting the education in the Veteran's EHR. ***NOTE:*** *For more information on resources for Veterans, refer to Appendix C.*

(2) Managing advanced CKD and related elements of RRT and transplant and care coordination with dialysis units.

6. VA MEDICAL FACILITY CHRONIC KIDNEY DISEASE PROGRAM REQUIREMENTS

VA medical facility CKD programs must:

a. **Implement Chronic Kidney Disease Program into Existing Patient Aligned Care Team Structure.** CKD programs must be integrated into the existing PACT structure managed by primary care and supported by nephrology, nursing, emergency medicine, nutrition, clinical pharmacy, social work, mental and behavioral health, geriatrics and palliative care, podiatry, and surgery.

b. **Establish a Care Coordination Agreement Between Primary Care or PACT and Nephrology.** The agreement will specify the parameters for face-to-face or telenephrology referral, e-consultation, the SCAN ECHO consultation, and co-management of CKD at the facility. ***NOTE:*** *Refer to Appendix A for example care coordination agreement.*

c. **Evaluation of At-Risk Patients at Risk for Chronic Kidney Disease.** VA medical facility providers shall periodically (at least annually) evaluate patients at risk for kidney disease.: ***NOTE:*** *Refer to VA/DoD Guidelines,* https://www.healthquality.va.gov/guidelines/CD/ckd/*, Sidebar 1: At-Risk Populations, for more information.*

d. **Use Electronic Laboratory Testing Panels and Order Sets to Identify Patients at Risk for Chronic Kidney Disease.** To improve screening efficiency, VA medical facility providers shall use electronic screening order sets (serum creatinine, eGFR co-report, and spot urine albumin/creatinine analysis) annually for all patients at risk for CKD.

e. **Use VA-Developed Reports to Identify Patients at Risk for Chronic Kidney Disease and Drive Improvements in Chronic Kidney Disease Care**. This shall be accomplished by periodic review of the VA CKD Primary Care Patient Report by the VA medical facility PACT lead, and the VA CKD Nephrology Patient Report by the VA medical facility Nephrology lead; which provide information targeted at identifying Veterans at high risk for CKD, treating and improving outcomes for patients with CKD, and identifying Veterans at highest risk of adverse outcomes. ***NOTE:*** *The VA CKD Primary Care Patient report can be accessed at https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fPC%2fAlmanac%2fCKDPCPatientReport&rs:Command=Render and the VA CKD Nephrology Patient Report can be accessed at https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fPC%2fAlmanac%2fCKDNephrologyPatientReport&rs:Command=Render. **NOTE:** Access to reports requires real SSN access. Refer to VHA Support Services Center (VSSC) for instructions on obtaining real SSN access. These are internal VA Web sites that are not available to the public.*

f. **Implement Chronic Kidney Disease Patient Education in Primary Care Leveraging VA-Developed Virtual Learning Tools**. PACT providers shall provide Veterans with comprehensive education information regarding the prevention of CKD, management of co-morbidities, and prevention of uremic complications. Nephrology providers shall provide Veterans identified as at risk for CKD with education and information regarding options for Renal Replacement Therapy (RRT and kidney transplantation. Veteran-specific and federally developed approved educational tools (the VA eKidney Clinic, the Veterans Health Library, and the VA Mobile Kidney Application) are available to be utilized. Education shall be documented in the Veteran's EHR using the following Healthcare Common Procedure Coding (HCPS) codes: G0420 (individual) and G0421 (group). ***NOTE****: Refer to Appendix C for more information on the eKidney Clinic, Veterans Health Library, and VA Mobile Kidney Application*.

g. **Implement VA/DoD Clinical Practice Guidelines for the Management of Chronic Kidney Disease in Primary Care**. These guidelines define interventions to improve the patient's health and wellbeing by providing evidence-based information and best practices for CKD care delivery. ***NOTE:*** *More information about the VA/DoD Clinical Practice Guidelines for the Management of Chronic Kidney Disease in Primary Care can be accessed at https://www.healthquality.va.gov/guidelines/CD/ckd/. Clinical Practice Guidelines are intended for use only as a tool to assist a clinician or healthcare professional and should not be used to replace clinical judgment*.

h. **Establish Telenephrology and Virtual Care Nephrology Services Using VA Telenephrology Operations Manual.** Telehealth provides the ability for the VA telehealth provider to pre-screen a patient and determine if a referral is necessary for telenephrology education, without requiring the patient to travel to the VA medical facility. To optimize Veteran access to VA nephrology services and augment Veteran choice of care setting, VA medical facilities shall implement telenephrology services such as CVT between VA community-based outpatient clinics (CBOCs) and VA nephrology services or VA Video Connect (VVC) between Veterans in their home and the VA nephrology service. To reduce wait time for specialty care, e-consultation between Primary Care and nephrology shall be implemented. ***NOTE:*** *Telenephrology services can typically be provided with standard telehealth equipment already in use by VA medical facilities.* ***NOTE:*** *For more information, refer to the VA Telenephrology Operations Manual which can be accessed at https://vaww.infoshare.va.gov/sites/specialtycare/kidney/Kidney%20SP/Telehealth/TeleNephrology%20Supplement%20(tnph-spp)%20Feb%202020%20esigned.pdf. This is an internal VA Web site that is not available to the public.*

i. **Implement a Comprehensive Electronic Chronic Kidney Disease Care Plan.** Veterans with CKD have complex care needs. To efficiently communicate and coordinate those needs between patients and providers, VA medical facilities shall implement an electronic note (when available) for patients with CKD, detailing the patient's care plan goals, treatment, and needs. The e-care plan note shall be completed by the treating provider at each significant transition point (e.g. at the time of diagnosis of CKD, at time of significant change in health status, at time of dialysis

initiation/kidney transplantation/hospice selection). ***NOTE:*** *For more information on the CKD e care plan, refer to the VA KidneySharePoint at*https://vaww.infoshare.va.gov/sites/specialtycare/kidney/Kidney%20SP/Chronic%20Kidney%20Disease%20(CKD)/CKD%20eCare%20Plan.. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

j. **Ensure International Statistical Classification of Diseases and Related Health Problems-10 Coding for Chronic Kidney Disease Grade and Stage is included in the Electronic Health Record Problem List**. Appropriate and accurate coding of CKD for each Veteran meeting criteria for CKD is critical to enable effective disease surveillance. The ICD-10 classifies CKD based on severity. ***NOTE:*** *Refer to Appendix C for CKD coding requirements.*

7. TRAINING REQUIREMENTS

a. There are no required trainings associated with this directive

b. There are no recommended trainings associated with this directive; however, general care coordination training available in the VA Talent Management System (TMS) training portal may be useful. ***NOTE:*** *Refer to TMS Course VA 20679 "T-Coaching-Care Coordination Agreements-Specialty.*

8. RECORDS MANAGEMENT

All records regardless of format (paper, electronic, electronic systems) created by this directive shall be managed per the National Archives and Records Administration (NARA) approved records schedules found in VA Records Control Schedule (RCS) 10-1. Any questions regarding any aspect of records management should be directed to the VA medical facility Records Manager or Records Liaison. See also VHA Directive 6300, Records Management, or subsequent policy issue.

9. REFERENCES

a. 38 CFR 3.309(f).

b. 38 CFR 17.400.

c. VHA Directive 1120.02, Health Promotion and Disease Prevention Core Program Requirements, dated February 5, 2018.

d. VHA Handbook 1042.01, Criteria and Standards for VA Dialysis Programs, dated May 23, 2016.

e. VHA Handbook 1101.10(1), Patient Aligned Care Team (PACT) Handbook, dated February 5, 2014.

f. VA Kidney SharePoint: https://vaww.infoshare.va.gov/sites/specialtycare/kidney/ . ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

g. VA Telenephrology Specialty Operations Manual Supplement dated February 2020: https://vaww.infoshare.va.gov/sites/specialtycare/kidney/Kidney%20SP/Telehealth/TeleNephrology%20Supplement%20(tnph-spp)%20Feb%202020%20esigned.pdf. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

h. VA Chronic Kidney Disease Nephrology Patient Report: https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fPC%2fAlmanac%2fCKDNephrologyPatientReport&rs:Command=Render. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

i. VA Chronic Kidney Disease Primary Care Patient Report: https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fPC%2fAlmanac%2fCKDPCPatientReport&rs:Command=Render. ***NOTE:*** *This is an internal VA Web site that is not available to the public*

j. VA/DoD Clinical Practice Guidelines for the Management of Chronic Kidney Disease in Primary Care., 2019: https://www.healthquality.va.gov/guidelines/CD/ckd/.

k. Kidney Disease: Improving Global Outcomes (KDIGO) CKD Work Group. KDIGO 2012 Clinical Practice Guideline for the Evaluation and Management of Chronic Kidney Disease. Kidney inter., Suppl. 2013; 3: 5: http://www.kdigo.org/clinical_practice_guidelines/pdf/CKD/KDIGO_2012_CKD_GL.pdf

l. American Nephrology Nurses Association Online Library: https://library.annanurse.org/anna/.

VHA MEDICAL FACILITY PRIMARY CARE AND PATIENT ALIGNED CARE TEAM AND NEPHROLOGY CARE COORDINATION AGREEMENT NATIONALTEMPLATE

1. PURPOSE: The goal of this care coordination agreement between Primary Care and Nephrology is to advance efforts to prevent kidney disease and delay progression of kidney disease to kidney failure. This agreement describes the flow of patients between the referring PACT provider to nephrology and establishes criteria for coordination of care such as co-management or discharge back to Primary Care.

2. RESPONSIBILITIES: It is the responsibility of each party to the care coordination agreement to adhere to the details herein, and to participate in frequent communications to assure coordination of care and continuous improvement.

3. CHRONIC KIDNEY DISEASE SCREENING GUIDELINES: PACT providers shall screen all patients for CKD as described in the most recent VA/DoD Clinical Practice Guidelines for the Management of Chronic Kidney Disease in Primary Care.

4. CHRONIC KIDNEY DISEASE PATIENT EDUCATION: PACT providers shall provide CKD education for all patients with one or more CKD risk factors. Education shall be provided using Veteran Centric and federally developed virtual learning tools (i.e., VA eKidney Clinic and VA Mobile Kidney app).

5. REFERRAL GUIDELINES: Primary Care shall refer patients to Nephrology as described in the most recent VA/DoD Clinical Practice Guidelines for the Management of Chronic Kidney Disease in Primary Care.

6. COMMUNICATING RECOMMENDATIONS AND FOLLOW-UP

a. All consults will be completed in the electronic health record, view alerts will be generated when necessary.

b. Follow-up visits with management concerns requiring practitioner notification will have the Primary Care provider added as an additional signer.

c. Renal service will arrange appropriate testing as indicated.

d. Renal service practitioner will make specialty-specific medication adjustments to patients' regimen, unless requested otherwise.

e. Renal service will evaluate and provide recommendations and follow longitudinally those patients with active or complex issues such as CKD stages 4 and 5 (i.e. eGFR below 30 ml/min), glomerulonephritis, renal transplants, and other renal conditions requiring longitudinal nephrology oversight.

f. Stable patients without active management issues and simply requiring continued monitoring of renal function, blood pressure, etc. will be discharged back to Primary Care.

g. Patients with CKD3 and better may not require active co-management with Nephrology and may be discharged back to the Primary Care provider for continuity of care with recommendations.

7. CONTACTS

Title	Name	Phone
Renal Chief		
Hemodialysis Medical Director		
Renal PA or Nurse Practitioner		
Primary Care Chief		
Primary Care PA		

Concurrence:

_____ Date_____

Chief, Primary Care

_____ Date_____

Chief, Nephrology

_____ Date_____

Chief of Staff

VHA VETERAN KIDNEY HEALTH COMMITTEE CHARTER

1. PURPOSE

Due to the complexity involved in caring for Veterans with kidney disease and the significant resource requirements; a proactive and enterprise-wide approach to managing the Veteran kidney population is needed to optimize care delivery and ensure effective stewardship of agency resources. Approximately one million Veterans enrolled in VA have kidney disease and kidney disease is the fourth most common primary diagnosis in VA. Veterans with kidney disease are some of the most resource intensive patients served by VA with an annual care cost to VA up to $19 billion.

2. RESPONSIBILITIES

The Veteran Kidney Health Committee (KHC) (formerly the Dialysis Steering Committee) is a national-level committee responsible for assessing and assisting in the management and treatment of Veterans with kidney disease. Specifically, the KHC is responsible for:

a. Advancing the care of Veterans with kidney disease as a VA health system imperative.

b. Promoting upstream thinking to target CKD prevention in high risk Veteran populations (e.g. homeless Veterans, Veterans with diabetes, hypertension, etc.).

c. Identifying constraints in the VA healthcare system for delivering kidney health services, especially in resource challenged settings (e.g. rural areas) and in fragile Veteran states (e.g. elderly, disabled, mentally ill, etc.).

d. Facilitating nationwide implementation of evidence-based strategies to:

(3) Prevent kidney disease and failure among the Veteran population;

(4) Improve Veteran access to kidney transplantation;

(5) Ensure Veteran access to dialysis through VA or community arrangements;

(6) Increase availability and feasibility of home dialysis for Veterans;

(7) Support the delivery of high quality and safe dialysis care to Veterans;

(8) Propose action plans to mitigate costs and adverse outcomes;

(9) Redesign VA health system to deliver Veteran-centered care across the patient journey;

(10) Adopt digital technology and disseminate tools to optimize Veteran kidney health;

(11) Incorporate advances in science such as genomics to advance the delivery of personalized kidney health services; and

(12) Advance inclusion of Veterans and informal workers in the delivery of kidney care through education, training, and incentives

e. Tracking and evaluating VA epidemiological reports for changes in population kidney health.

f. Contributing to strategic planning for the delivery of kidney care services.

g. Serving as clinical subject matter expert and technical consultants for kidney related initiatives.

h. Advising stakeholders on the impact of policies, procedures, processes, and legislation on Veteran kidney care.

i. Promoting efficient supply chain management by supporting efforts to establish nationwide contracts for dialysis equipment, supplies, and software and providing technical approval or disapproval of national contract waiver requests from the field.

j. Assessing VA internal dialysis capacity, quality of delivered care, capital improvement planning, and clinical restructuring requests related to the delivery of Veteran kidney care.

k. Advocating for research and innovation related to kidney disease prevention and treatment as part of a learning health system.

3. AUTHORITY

The Dialysis Steering Committee (now renamed the Kidney Health Committee) was established by the Under Secretary for Health in 2010 under the Health Services Committee (HSC). As HSC operations have been suspended, the KHC will continue to operate pursuant to the authority of the Deputy Under Secretary for Health for Operations and Management and the Deputy Under Secretary for Health for Policy and Services with the support and approval of the Under Secretary for Health. The KHC is authorized to implement and establish strategies, standards, policies, performance metrics, and plans for addressing the purpose and responsibilities identified above. The Co-Chairs of the KHC have the authority to convene subcommittees to assist in accomplishing its objectives.

4. COMMITTEE LEADERSHIP AND REPORTING RELATIONSHIP

The KHC Co-Chairs are senior officials designated by the Deputy Under Secretary for Health for Operations and Management and the Deputy Under Secretary for Health

for Policy and Services. The KHC will submit meeting minutes to the Chief Consultant, Specialty Care Services for action based on recommendations of the KHC.

5. MEMBERSHIP

Members will be appointed by the Deputy Under Secretary for Health for Operations and Management and the Deputy Under Secretary for Health for Policy and Services. Membership will reflect the broad spectrum of stakeholders involved in the delivery of kidney disease. Ad-hoc members will participate in the KHC as needed. Membership of the KHC is as follows:

a. Director, VHA National Kidney Program (10P11)

b. Program Manager, VHA National Kidney Program (10P11)

c. VISN Chief Medical Officer (10N)

d. VA Facility Nephrology Chief or Dialysis Med Director or Kidney Transplant Med Director (3)

e. Representative, Nursing (10A1)

f. Representative, Community Care (10D)

g. Representative, Office of Reporting, Analysis, Performance Improvement, and Deployment (10A8)

h. Representative, Connected Care (10P8)

i. Ad hoc members:

(1) Representative, Nutrition and Food Services (10P11)

(2) Representative, OCAMES (Capital Asset Management) (10NA5)

(3) Representative, National Surgery Office (Transplant) (10NC2)

(4) Representative, Patient Safety & Risk Awareness (10E2E)

(5) Representative, Procurement and Logistics Office (10NA2)

(6) Representative, Population Health Services (10P4V), which could be:

(a) Representative, National Center for Prevention (10P4N)

(b) Representative, Public Health Services

(c) Representative, Rural Health (10PIR)

(d) Representative, Patient Centered Care & Cultural Transformation (10NE)

(e) Representative, Health Equity (10EB)

(7) Representative, Quality, Safety, and Value (10E2)

(8) Representative, Primary Care (10NC3)

(9) Representative, Policy Analysis & Forecasting (10P1A)

(10) Representative, Health Informatics (10A7A)

(11) Representative, Congressional Legislative Affairs (10B3)

(12) Representative, Regulatory and Administrative Affairs (10B4)

(13) Representative, Finance (10A3)

(14) Representative, Quality Standards and Programs (10E2B)

(15) Representative, Emergency Management (10NA1)

(16) Representative, Clinical Science Research and Development (10P9)

RESOURCES FOR PROVIDERS AND PATIENTS ABOUT CHRONIC KIDNEY DISEASE

1. RESOURCES FOR PROVIDERS

a. **VA/DoD Clinical Practice Guideline for the Management of Chronic Kidney Disease in Primary Care.** These guidelines are designed to provide information and assist decision-making. Topics addressed include: evaluation for CKD, strategies for AKI avoidance, self-management strategies, and clinical management strategies: *https://www.healthquality.va.gov/guidelines/CD/ckd/ .*

b. **VA Chronic Kidney Disease Patient Reports.** The VA Chronic Kidney Disease Nephrology Patient Report and the VA Chronic Kidney Disease Primary Care Patient Report provide information targeted at identifying Veterans at risk for CKD and treating and improving outcomes for patients with CKD, including patient demographics, staging information, laboratory values, vital signs, nutrition, primary care, and nephrology visits, and renal-related medications:
https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fPC%2fAlmanac%2fCKDPCPatientReport&rs:Command=Render;
https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fPC%2fAlmanac%2fCKDNephrologyPatientReport&rs:Command=Render. ***NOTE:*** *Access to reports requires real SSN access. Refer to VHA Support Services Center (VSSC) for instructions on obtaining real SSN access These are internal VA Web sites that are not available to the public.*

c. **VA Renal Nutrition Tool Kit**. This is a collection of resources has been created to support Registered Dietitian Nutritionists (RDNs) and other healthcare professionals in their care of Veterans with CKD and End Stage Renal Disease (ESRD). ***NOTE:*** *The VA Renal Nutrition Tool Kit can be accessed at http://vaww.nutrition.va.gov/clinicalNutrition/RenalTK/Renal_Nutrition_Toolkit.asp. This is an internal VA web site that is not available to the public.*

d. **VA Kidney SharePoint.** This is a central repository of documents intended to assist front-line staff in the care of Veteran kidney patients:
https://vaww.infoshare.va.gov/sites/specialtycare/kidney/ . ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

e. **Centers for Disease Control and Prevention ICD-10-CM Browser Tool.**
https://icd10cmtool.cdc.gov/.

f. **IOM (Institute of Medicine).** 2015. Review of VA clinical guidance for the health condition identified by the Camp Lejeune legislation. Washington, DC: The National Academies Press: https://www.nap.edu/catalog/18991/review-of-va-clinical-guidance-for-the-health-conditions-identified-by-the-camp-lejeune-legislation.

g. **American Nephrology Nurses Association.** https://www.annanurse.org/.

h. National Kidney Disease Education Program (NKDEP): https://www.niddk.nih.gov/health-information/communication-programs/nkdep

2. CHRONIC KIDNEY DISEASE CODING REQUIREMENTS

Appropriate and accurate coding of CKD for each Veteran meeting criteria for CKD is critical to enable effective disease surveillance. The ICD-10 classifies CKD based on severity. The severity of CKD is designated by stages 1-5. Key codes are listed below. ***NOTE:*** *Refer to ICD-10-CM Browser tool (https://icd10cmtool.cdc.gov/) for current and full listing of ICD-10 codes.*

a. CKD Stage 1: N18.1

b. CKD Stage 2 (mild):N18.2

c. CKD Stage 3 (moderate): N18.3

d. CKD Stage 4 (severe CKD): N18.4

e. CKD Stage 5: N18.5

f. ESRD: N18.6

g. CKD unspecified: N18.9

h. Acute kidney failure codes may also be used and are as follows:

(1) Acute kidney failure with tubular necrosis: N17.0

(2) Acute kidney failure with acute cortical necrosis: N17.1

(3) Acute kidney failure with medullary necrosis: N17.2

(4) Other acute kidney failure: N17.8

(5) Acute kidney failure, unspecified: N17.9

i. Diabetic CKD: E08.22, E09.22, E10.22, E11.22, E13.22

j. Hypertensive CKD: I12, II13

3. RESOURCES FOR VETERANS

NOTE: *These web-based resources may be printed.*

a. **VA eKidney Clinic**. The eKidney Clinic is an online education tool where Veterans can watch videos and view animated illustrations to learn about kidney disease: http://ckd.vacloud.us/.

b. **VA MobileKidney Application (app).** The MobileKidney app allows Veterans to enter, view, and track personal information related to kidney health so Veterans can monitor their own health between visits and share data with their VA care team for review at regularly scheduled appointments: https://mobile.va.gov/app/beta/mobilekidney ***NOTE:*** *App is currently in beta testing.*

c. **VA Healthy Teaching Kitchen.** The VA Healthy Teaching Kitchen is a public website that includes handouts on cooking and video recipes that are designed to teach Veterans and their families how to make healthy food choices and prepare food. ***NOTE:*** https://www.nutrition.va.gov/Healthy_Teaching_Kitchen.asp.

d. **VA Veterans Health Library: Kidney Problems.** The Veterans Health Library is a public website that provides Veterans with health information. A section of the website is devoted to kidney disease topics such as monitoring kidney health, living with high blood pressure and kidney disease, managing glucose level for diabetes and kidney disease, coping with kidney disease, etc.: https://www.veteranshealthlibrary.va.gov/DiseasesConditions/Kidney/

e. **VA/DoD Clinical Practice Guideline for the Management of Chronic Kidney Disease in Primary Care: Patient Guide.** The patient guide defines CKD, describes the causes, diagnosis, and treatment of CKD, and includes links to additional resources: https://www.healthquality.va.gov/guidelines/CD/ckd/.

f. **VHA National Kidney Program Webpage.** http://www.va.gov/health/services/renal/.

g. **VA Virtual Medical Center CKD Clinic.** https://vavmc.com/.

h. **VA Nutrition and Food Service Kidney Disease Webpage.** https://www.nutrition.va.gov/Kidney.asp.

i. 38 C.F.R. 3.309(f).. Diseases Associated with Exposure to Containments in the Water Supply at Camp Lejeune: A Rule by the Veterans Affairs Department on 1/13/2017: https://www.federalregister.gov/documents/2017/01/13/2017-00499/diseases-associated-with-exposure-to-contaminants-in-the-water-supply-at-camp-lejeune.

j. VA National Transplant Program: https://www.va.gov/health/services/transplant/

k. Veterans Transplant Association Webpage: http://www.govta.org/

l. VHA YouTube Kidney Health: https://www.youtube.com/watch?v=8FhjHM57EH8&list=PL3AQ_JVoBEyyjpIFEjvB2Y7S0tbPlkMH2

4. GENERAL CHRONIC KIDNEY DISEASE PATIENT RESOURCES.

NOTE: *Below list is not exhaustive.*

a. National Kidney Foundation (NKF): https://www.kidney.org/patients.

b. Centers for Disease Control and Prevention (CDC) Chronic Kidney Disease Initiative: https://www.cdc.gov/kidneydisease/index.html.

c. National Kidney Disease Education Program (NDKEP): https://www.niddk.nih.gov/health-information/communication-programs/nkdep.

d. American Kidney Fund: http://www.kidneyfund.org/.