



Strategic Plan

2014 to 2017

Developed at September 2013 Coalition Meeting

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Coalition for Supportive Care of Kidney Patients: STRATEGIC PLAN

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Strategic Plan 2014

Executive Summary

OVERARCHING GOAL

Create culture change that transforms the treatment of persons with kidney disease, putting every patient at the center and integrating palliative principles and practices throughout the care continuum.

VISION

Offer palliative care to everyone with chronic and end-stage kidney disease, from the time of diagnosis through end of life and bereavement. Informed, supported patients and families receive the care they want.

MISSION

Promote effective interchange among patients, families, health care professionals, and payers to ensure the provision of patient-centered supportive care for patients with kidney disease.

STRATEGY

Change requires a multi-pronged strategy of innovative and transformative actions in the strategic domains of **policy, quality, clinical paradigms, research** and **education**. CSCKP goals in each of these areas are:

Education: *Public Education:* Patients and families feel fully informed and understand palliative care in the kidney disease treatment setting, including their right to participate in advance care planning.

Professional Education: All providers of kidney disease care have knowledge of, skills in, and appreciation of palliative care.

Clinical Care: Primary supportive care is integrated throughout kidney care; specialty palliative care is readily accessible and use of hospice care for ESRD is increased.

Research: A robust evidence base informs and grows kidney/palliative care and systems.

Quality: Palliative quality domains and patient-reported outcomes are included in all renal quality initiatives and pay-for-performance initiatives.

Policy: All kidney patients have access to palliative care and hospice throughout the care continuum.

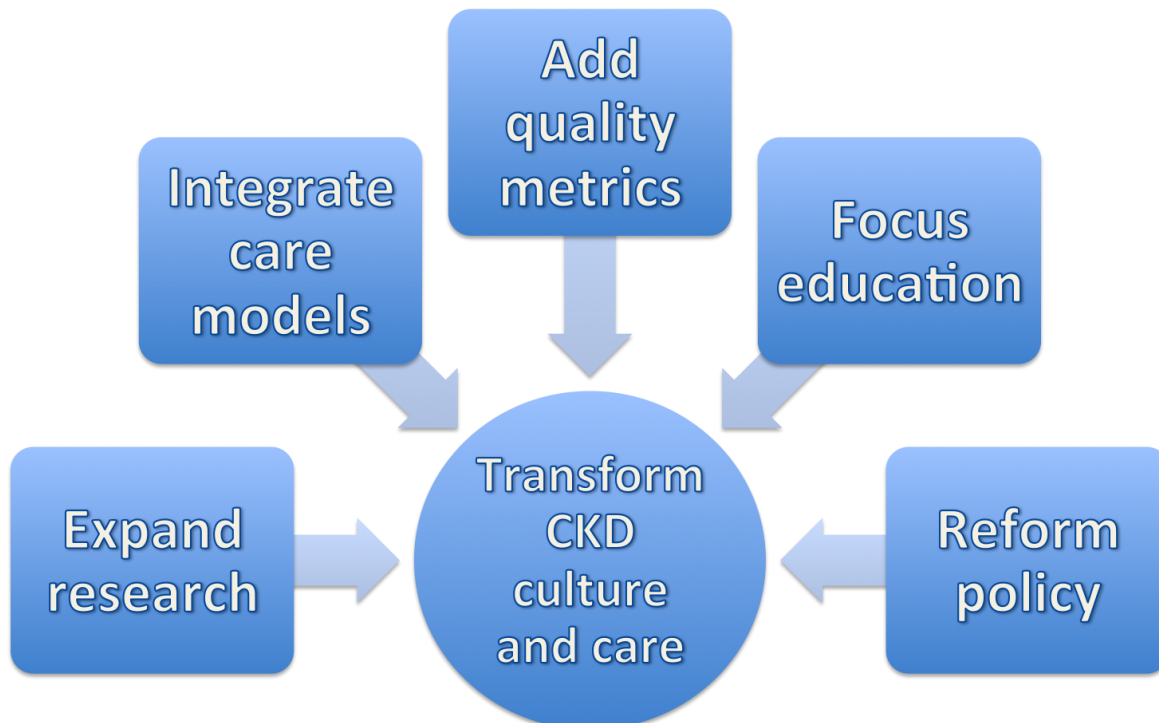
CSCKP Strategic Plan 2014

Plan & Background

INTRODUCTION

In March 2013 the Steering Committee of the Coalition for Supportive Care of Kidney Patients met and agreed to revitalize its effort to improve supportive care for kidney patients. A number of short-term goals were identified, along with a need to develop a longer range strategic plan. The Steering Committee met again on September 16, 2013 to agree on a strategic plan to achieve its overarching goal: *create culture change that transforms the treatment of persons with kidney disease, putting every patient at the center and integrating palliative principles and practices throughout the care continuum*. The CSCKP agreed that change will require a multi-pronged strategy of innovative and transformative actions in the strategic domains of **policy, quality, clinical paradigms, research and education**.

The Coalition’s strategic plan is expressed as a goal in each domain, along with a prioritized set of key activities to achieve that goal. A final section addresses infrastructure and identity aspects needed to implement the strategic plan. Additional analysis of the environment, barriers, drivers, objectives and tasks in each domain are included in Appendix 1. Each domain incorporates issues articulated when the committee met in March 2013; those raised by “Five Policies to Promote Palliative Care for Patients with ESRD,” by Manjula Kurella Tamura and Diane E. Meier, *Clinical Journal of the*



American Society of Nephrology (CJASN) June 6, 2013; and some that have been discerned by the consultants.

VISION

Offer palliative care to everyone with chronic and end-stage kidney disease, from the time of diagnosis through end of life and bereavement. Informed, supported patients and families receive the care they want.

MISSION

Promote effective interchange among patients, families, healthcare professionals, and payers to ensure the provision of patient-centered supportive care for patients with kidney disease.

GOALS AND PRIORITIES BY DOMAIN

The top six priorities as voted on by the entire steering committee are marked with asterisks. Time frames suggested by each committee are given in parentheses. Short range refers to starting the task in the next 6 months. Mid range means starting the task in the next 12-18 months. Long range means starting the task in the next two to three years.

Education

Public Education Goal: Patients and families feel fully informed and understand palliative care in the kidney disease treatment setting, including their choice to participate in advance care planning.

Professional Education Goal: All providers of kidney disease care have knowledge of, skills in, and appreciation of palliative care.

- 1) Seek partners for collaboration on defining palliative care in relevant terms that addresses barriers such as cultural differences, health literacy, dynamics, spirituality, etc. (short range) ***
- 2) Concurrently develop multidisciplinary renal palliative curriculum and renal exam questions. (mid-range)
- 3) Incorporate curriculum in multidisciplinary trainings that optimize palliative care delivery in the kidney care environment. (long range)

Clinical Care

Goal: Primary supportive care is integrated throughout kidney care; specialty palliative care is readily accessible and use of hospice care for ESRD is increased.

- 1) Develop tools for point-of-care decision making. (mid-range) ***
- 2) Incorporate palliative/supportive care into care plans; to be patient-centered, patient context-specific. (short range) ***
- 3) Disseminate evidence-based practices, shared decision-making guideline. (long range)

Research

Goal: A robust evidence base informs and grows kidney/palliative care and systems.

- 1) Develop plan to get federal workshop in order to set research priorities. Goal: to generate PA/RFA. (short range) ***

- 2) Grow junior researchers to develop diversified workforce (e.g. more K awards.) (long range)
- 3) Public awareness campaign aimed at building Congressional support, similar to “Red Dress” campaign. (mid-range)

Quality

Goals:

- 1) Palliative quality domains are included in all renal quality initiatives and pay-for-performance initiatives.
- 2) Patient-reported outcomes are included in all kidney care quality reporting.
 - 1) Urge the inclusion of well-informed palliative/renal care quality metrics recommended by NQF to be adopted by CMS (mid-range) ***
 - 2) Advocate the resolution of countervailing metrics that inhibit full integration of palliative care and renal care. (long range)
 - 3) Advocate for research to utilize KDQOL/PedsQL as a measure of unaddressed needs for palliative care. (mid-range)
 - 4) Advocate revising 2746 to include date of hospice referral, provision of hospice care, department of the hospital where death occurred. (short range)

Policy

Goal: All kidney patients have access to palliative care and hospice throughout the care continuum.

- 1) Advocate for POC-CDS tools performance measures under meaningful use (MU) (short range) ***
- 2) Explore identification of national champion to “study” ESRD program (i.e. IOM, RWJ, IHI) (short range) ***
- 3) Enhance availability and content of chronic kidney disease (CKD) education benefit to include EOL/non-dialysis options, education and coverage for services recommended (mid-range)

Identity and Infrastructure

The Coalition’s **identity and infrastructure** are not addressed as strategic domains for strategic planning purposes, but development of a cohesive action plan will require consideration of both areas. To move ahead in the planning domains discussed here, the Coalition needs to pay serious attention to branding and identity issues going forward, as well as develop a comprehensive communication plan to advance the strategic priorities. In addition, a plan for developing staffing and infrastructure resources will be needed.

PRIORITIES ESTABLISHED AT SEPTEMBER STEERING COMMITTEE MEETING

- #1 – **Clinical Care:** Incorporate palliative / supportive care discussions into regular plan of care from its outset and through the course of treatment.
- #2 – **Education:** Develop educational materials for patients and families that address barriers (cultural, literacy, family dynamics, spirituality) to understanding and embracing palliative and supportive kidney care.
- #3– **Quality:** Urge the inclusion of well-informed palliative renal care quality metrics recommended by NQF to be adopted by CMS.
- #4 – **Clinical Care:** Develop tools for point of care – clinical decision support (POC-CDS).
- #5 - **Research:** Develop plan with ASN work group to ensure an NIH-sponsored workshop to set research priorities.. Goal: PA/RFA to be issued by NIH.
- #6 - **Policy:** Advocate for POC-CDS tools performance measures under the federal Meaningful Use (MU) electronic medical record policies.
- #7 – **Clinical Care:** Disseminate shared decision making guideline.
- #8 – **Policy:** Enhance availability and content of CKD education benefit to include end of life (EOL)/non-dialysis options, education and coverage for services recommended.
- #9 – **Education:** Concurrently update and develop renal palliative curriculum and renal exam questions for interdisciplinary healthcare trainees.
- #10- **Research:** Grow junior palliative researchers (with an eye toward diversity of workforce, and using mechanisms such as K awards).
- #11- **Research:** Public awareness campaign to influence Congressional support (such as the “Red dress” campaign).
- #12- **Policy:** Explore identification of national champion to “study” ESRD program (i.e. IOM, RWJ, IHI).
- #13 - **Education:** Incorporate curriculum in Interdisciplinary trainings that optimize palliative care delivery in the renal care environment.
- #14 - **Quality:** Advocate for research to utilize KDQOL/PedsQL as a measure of unaddressed needs for palliative care.
- #15 - **Quality:** Advocate the resolution of countervailing quality metrics in federal renal program that inhibit the full integration of palliative care & renal care.

Appendix 1:

DETAILED ENVIRONMENTAL ASSESSMENTS OF DOMAINS

Appendix 1: **DETAILED ENVIRONMENTAL ASSESSMENTS OF DOMAINS**

The current status of each of the five strategic domains is summarized here.

Education

Professional education in palliative medicine for ESRD care providers is severely lacking. At the root of the problem: clinicians don't know what they don't know. There is little, if any, formal training in palliative and end-of-life care for nephrologists, and there is a paucity of palliative care faculty and role models. Currently, palliative care training is neither included in renal fellowship programs nor overtly covered on renal fellowship board examinations. A core curriculum in nephrology for palliative care has been advanced but is not widely used, requiring further development and implementation of curricula. Little continuing education is available, and most symposia of major nephrology professional associations do not include significant content on palliative and end-of-life care. Although nephrologists in other countries, such as the UK, are versed at discussing conservative management of ESRD patients who have a poor prognosis on dialysis, this practice is rare among nephrologists in the US.

The Coalition developed a collection of resources for supportive and end-of-life care, posting them on its website, but these resources are not widely used by the nephrology community. NephroTalk's communication skills framework has likewise made little headway.

At the same time, little information is **publically available for patients and their families** as they consider starting, continuing, or possibly withdrawing from dialysis. Societal reluctance to acknowledge mortality plays a role here. There is evidence that patients and families do not understand limitations of dialysis; that it is not life-saving but possibly only life-prolonging. High rates of low health-literacy (up to 1/3) are a factor. Surveys among ESRD care providers indicate the need for more education for these patients and families as well as for the providers themselves.

Public Education:

Barriers:

- Societal reluctance to deal with death and dying
- Concerns about rationing or denial of care
- "Health care language" may alienate and is hard to understand

Drivers:

- Patients' desires to have their individual goals and values supported
- Availability and visibility of patient-friendly engagement resources, allowing patients to consider a variety of options and to express and implement their choices.

Objective:

- Raise awareness of available supportive care resources for kidney patients and their families.

Professional Education

Barriers:

- Societal reluctance to deal with death and dying—including clinicians. Contributing factors: cultural differences, health literacy, dynamics, hope, spirituality, and communication
- People don't know what they don't know.

- Understanding meaning of palliative care, conservative care, supportive care, and other terminology
- Educators unsure what to teach about kidney palliative care, or how
- Lack of role models and renal palliative care faculty
- Minimal training or continuing education
- Lack of educational tools
- Inability to discuss the disease trajectory with the patient

Drivers:

- Transformed education and certification models
- Successful collaboration with influence leaders

Objective:

- Initiate a culture change... through the education of nephrologists, renal fellows, nurses, social workers, beneficiaries, and the medical community at large.

Clinical Paradigms in ESRD

Surveys of kidney care providers indicate that end-of-life care among ESRD patients is suboptimal, fragmented, and suffering from communication deficits. Dialysis patients have a higher percentage of hospitalizations, longer lengths of stay, greater intensive care admissions, and a higher percentage of hospital deaths in the final months of life than either cancer or heart failure patients. The continuation of non-beneficial treatment is endemic. Patients from cultural minorities or of low-income face even higher barriers to accessing effective EOL care. The number of frail elderly dialysis patients—nursing home residents, those with dementia, weight loss, multiple comorbid illnesses, multiple dependencies, and limited decision-making capacity—is increasing, despite evidence of poor outcomes in this group.

Likewise, the number of patients who die while on dialysis is also increasing, and hospice use among ESRD patients is half the national average, even though at least one study indicates that many ESRD patients prefer good quality of life to mere longevity. There is noteworthy variation in hospice use within the 18 networks of renal dialysis care.

The field of palliative care is growing, but not in nephrology. A workforce deficit currently exists in the field of renal palliative care. Consolidation of dialysis providers resulted in two of the Large Dialysis Organizations (LDOs) now covering over 70 percent of the market.

There is a lack of formal clinical assessment and few prognostication instruments, including online versions, for managing ESRD patients. The few available tools are not widely used. The Renal Physician Association (RPA) produced a guideline, “Shared Decision-Making in the Appropriate Initiation of and Withdrawal from Dialysis,” but it has not been widely disseminated or embraced by the nephrology community.

Barriers:

- Providers remain committed to non-beneficial disease-directed therapies
- Fragmented care
- Insufficient communication
- Patients and families have unrealistic outcomes of care
- Lack of skill set on part of providers in supportive care

- Discomfort with issues of death and dying
- Fear of taking away hope
- Lack of awareness of available resources

Drivers:

- Collaboration between all providers caring for the patient
- Communication as a priority
- CMS move toward bundled payment
- Hospice interest in serving these patients

Objectives

- Nephrologists regularly identify high symptom burdens, family distress, and poor prognosis, including the “surprise” question, at sentinel events in the patient’s care.
- A process is in place for regular discussions of prognosis as well as the burdens and benefits of dialysis.
- Facility staff has the skills and the time to address patient and family issues. (This is an identified priority on the facility survey.)
- Multidisciplinary palliative care teams are appropriately called for consultation.

Research

There has been growing research in ESRD that documents symptom burdens comparable to or greater than with cancer and AIDS; ESRD patients have significantly higher rates of hospitalizations, ICU admissions, intensive procedures, death in the hospital, and lower use of hospice, which is indicative of sub-standard EOL care. Existing research on prognosis in ESRD patients shows that the frail elderly with multiple comorbidities, cognitive impairment, and weight loss have poor prognoses on dialysis. Tools to estimate prognosis are available online but as previously stated, get little use.

The cadre of researchers is inadequate. In spite of this recent wave of research, US studies on the use of conservative management options for ESRD are lacking, although data exists in other countries. Indeed, it is easier to enumerate research deficits than successes: there is little data on the role primary care physicians play in having EOL discussions with patients initiating dialysis, as well as on coordination of care between the primary physician and the nephrologist. There is suboptimal understanding of regional variations in hospice use and rate of withdrawal from dialysis; a paucity of understanding of the ESRD patients’ desires at the end of life, including their goals of care; and little information about the role of depression in requests to withdraw from dialysis.

Moreover, data on the assumption that acquainting patients with their prognoses and having ongoing conversations about goals and preferences can improve EOL care is scarce. Kidney patients’ perceptions/ misperceptions of palliative care/supportive care are poorly understood. Published research regarding cultural differences with regard to EOL preferences are hard to find, as are studies on health literacy with regard to these preferences.

Most important: there is a deficit of research demonstrating the value of concurrent palliative/ hospice care and kidney dialysis, and such research would be a significant driver for culture change. Scarce funding for research bears much of the blame. Across-the-board research funding at the NIH is felt by all disciplines. Currently, NIH’s National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) funding for renal palliative care is miniscule—less than 5 percent of all NIH funding for palliative care, which comprised only 0.1 percent of total NIH research funding.

Barriers:

- Nearly nonexistent funding for palliative care research
- Insufficient cadre of researchers
- Palliative care is not a priority or on the agendas of research funders

Drivers:

- Relationships with research leaders

Objectives:

- Fund research relating to palliative/renal integration.
- Cultivate researchers sufficient for diverse studies in the field.

Quality

The scarcity of integrated dialysis and palliative care models is reflected in the near-absence of quality metrics. Palliative care measures are absent from Medicare's ESRD Quality Incentives Program (QIP). Indeed, there are no standards even requiring palliative care to be included in the treatment of advanced kidney disease, so outcome measurements have been minimal. Initiatives are often contradictory: documenting a reduction in mortality during the first three months of dialysis may push against palliative goals of patient-determined plans of care. Quality measurement programs speak the language of patient-centered care but do not explicitly focus on palliative care or end-of-life care or goals.

Moreover, there has been little interest in advancing outcome measures as perceived by patients and families. Some post-care satisfaction surveys may exist, but we are not aware of seeking and reporting such measures concurrent with the progression of care. For instance, the In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems Survey (ICH CAHPS) does not include specific questions about palliative care.

The roll-out of CMS's CROWNWeb (Consolidated Renal Operations in a Web-enabled Network), which was intended to facilitate network data collection that in turn would expedite analysis, has been problematic, hampering ESRD networks' capacities to monitor and report data.

The Affordable Care Act requires public reporting of performance measures, and CMS will usually adhere to the National Quality Forum's (NQF's) endorsement of these measures. NQF has endorsed several measures and is studying others. CMS's quality measures linked to payment can provide new avenues for palliative care metrics.

Barriers:

- No standards requiring inclusion of palliative care in kidney care
- No quality measures in the ESRD QIP
- Few (or no) kidney care metrics in palliative care domains
- Countervailing metrics of service providers and Medicare
- Little importance given and no reportable measures to address concerns about satisfaction, comfort, and end-of-life issues of the patient and family
- Absence of specific questions about palliative care in the ICH CAHPS
- Absence of quantitative information on form 2746 (death notification)
- Quality of life is not seen as important metric; survival time is usually the predominant metric
- Exclusion criteria includes dialysis (hospice).

- No standards for intervention for acute kidney injury
- CMS to buy/support/include palliative care
- Failure to include palliative care in ESRD Seamless Care Organizations (ESCOs) model
- Cost of palliative care in a capitated environment

Drivers:

- ACA requirements for public reporting of quality measures
- CMS move toward value-based purchasing
- Collaborative relationships with influence leaders, NQF, AHRQ

Objectives:

- Incorporate quality measures into the ESRD QIP.
- Require palliative care quality measures in all kidney care metrics.
- Elevate the importance of patient- and family-reported outcomes in all reported quality metrics.

Policy

The success of changing the culture of kidney disease care rests heavily on public policy. Discussions of end-of-life care, both privately and on the policy-making level, have become highly politicized, inflamed earlier by references to “death panels.” Most important is that there is no payment mechanism for palliative care concurrent with dialysis, and hospice access is also limited by payment structures and regulations.

Medicare, facing funding losses, is implementing strategies to cut spending that often are not ultimately strategic, and they are often not in the interest of patient-centered care.

Barriers:

- Politicization of end-of-life care discussions
- Hospice access limited by both payment and regulation
- No payment mechanism for palliative care concurrent with kidney dialysis
- Anxiety over imminent change in health care regulations and systems
- Condition that requires discussion of advance directives
- CKD Education coverage option and delivery module are unclear
- No recognized POC tool and measurement system to support (electronic health record) work on documenting education
- No easily identifiable funding source
- Lack of primary physician involvement in and knowledge of treatment alternatives
- No national champion
- No attention, leadership from IOM – lack of funding to sponsor IOM study

Drivers:

- Public opinion
- Collaboration among, nephrology, LDOs, hospice and palliative care programs
- Coalition capacity for advocacy

Objectives:

- Payment systems are reformed to cover concurrent dialysis and palliative care or hospice.

- Shared savings models (bundling) receives further study about how to integrate palliative care and hospice
- Hospice regulations, conditions of participation and payment rates allow patients receiving dialysis to also receive hospice care.
- Palliative care consultations readily available to kidney patients (resolve regulatory, workforce and payment barriers).
- Advance care planning and coordination of care used by kidney patients.
- There is adequate capacity for rational dialogue on end-of-life care.

Identity and Infrastructure: Internal Assessment of the Coalition

Strengths	Weaknesses
Effective convener - brings representatives from all types of stakeholders to the table.	No infrastructure (no staff, no governance structure, no membership criteria,)
Clear mission agreed on by participants (culture change to infuse supportive care throughout kidney care)	No financial resources of own (no budget, no income, no development or grant-writing capacity)
Can call on resources of MARC and of members to a certain extent	“Brand” is unknown, only modest organizational visibility.
Enthusiastic volunteer leadership	Current “to do” list of projects not supported by realistic operational plan (including priorities and resources).
Member expertise and knowledge of kidney supportive care	
Current website contains a strong collection of resources	
Potential to piggy-back on member activities and resources	
Understands the kidney environment and players as well as palliative care environment and players	
Since March meeting, have been nimble and flexible enough to act on emergent opportunities: IOM testimony; CMMI grant, Fast Facts resources for web, response to CSJ article	

Appendix 2:

GOALS AND TASKS REVIEWED BY STEERING COMMITTEE

Appendix 2: GOALS AND TASKS REVIEWED BY STEERING COMMITTEE

Education

Public Education Goal: Patients and families feel fully informed and understand palliative care in the kidney disease treatment setting, including their choice to participate in advance care planning.

Tasks:

- Seek partners for collaboration on defining palliative care in relevant terms that address barriers, such as health literacy. (High resource/high impact)
- Increase the quality of and access to palliative/kidney patient education resources. (This is identified a priority in the provider survey and is high resource/low impact.)

Professional Education Goal: All providers of kidney disease care have knowledge of, skills in, and appreciation of palliative care.

Tasks:

- Disseminate newly developed kidney palliative curriculum outline and further develop instructional materials. (High resource/high impact)
- Promote the inclusion of kidney palliative care in milestones and entrustable professional activities (EPAs) of ACGME-accredited renal fellowship programs.
- Promote an increase in percentage of renal board exam questions related to palliative care
- Emphasize palliative care training for dialysis nurses, social workers, pharmacists.
- Provide technical assistance through the website, publications, webinars and speaking engagements. (This was a CSCKP priority, March meeting.)
- Continue to upgrade and maintain Coalition website.
- Work with professional associations to develop more CME and CE opportunities in kidney palliative care, including Maintenance of Certification (MOC) module.
- Incorporate curriculum in multidisciplinary trainings in a way that optimizes palliative care values and skills in kidney care environment.

Clinical Care

Goal: Primary supportive care is integrated throughout kidney care; specialty palliative care is readily accessible and use of hospice care for ESRD is increased.

Tasks

- Define basic palliative care skills for the kidney care IDT. (This is a priority from the CSCKP March meeting; low resource/low impact)
- Develop consensus on CKD and ESRD cases requiring formal specialist palliative care consultation. (A priority, CSCKP March meeting; high resource/high impact.)
- Standardize symptom assessment and treatment (Low resource/high impact)
- Disseminate evidence-based recommended practices based on 2010 *Shared Decision-Making Clinical Practice Guideline* and recently published articles. (A priority, CSCKP March meeting; high resource/high impact)
- Develop tools for point-of-care decision support for nephrologists. (A priority, CSCKP March meeting; low resource/high impact)

- Promote making time: to do advance care planning, complete POLST, listen and learn. (High resource/high impact)
- Include discussion of prognosis, burdens and benefits of dialysis in the multidisciplinary care meeting and plan on a regular basis. (Low resource/high impact)

Research

Goal: A robust evidence base informs and grows kidney/palliative care and systems.

Tasks:

- Identify research influence leaders at NIH to advocate for research priorities.
- Seed NIH study panels with kidney palliative care experts.
- Identify foundations and NGOs that fund research and whose priorities are aligned with the Coalition.
- Develop research agenda for renal palliative care.
- Cultivate and fund junior and mid-career kidney palliative care researchers.
- In collaboration with ASN geriatric workgroup leadership, seek support for IOM study panel
- Building on outcomes from Mexico conference, advocate for NIH federal workshop to set research priorities

Quality

Goals:

- 1) Palliative quality domains are included in all renal quality initiatives and pay-for-performance initiatives.
- 2) Patient-reported outcomes are included in all kidney care quality reporting.

Tasks:

- Urge the inclusion of well-informed palliative/kidney care quality metrics in the measures recommended by NQF, to be adopted by CMS.
- Advocate for the resolution of countervailing metrics that inhibit the full integration of palliative care and kidney care.
- Advocate for research to utilize KDEOL/PedsQL as measures of palliative care needs (unaddressed needs for palliative care).
- Advocate revising the 2746 form to include date of hospice referral, location in hospice, were hospice services used.

Policy

Goal: All kidney patients have access to palliative care and hospice throughout the care continuum.

Tasks:

- Update Conditions of Participation for dialysis units to include requirements for advance care planning and the provision of palliative care.
- Seize opportunities for public testimony, such as the recent public comments and follow-up written testimony to IOM's Committee on Approaching Death.

- Revisit the previously rejected provision to provide access to palliative care services concurrent with dialysis as a condition for being designated as an Accountable Care - Organization (ACO).
- Foster policies to address current manpower shortage in palliative care in general, and kidney palliative care in particular.
- Demonstrate viability of concurrent dialysis/supportive care model. (Participate in CMMI grant if funded, find other funding if not.)
- Convert existing guidelines to POC tool for electronic medical records for meaningful use utilizing performance measures.
- Primary care physician education
- Dialysis center requirements
- Expand coverage for CKD education to non-Medicare population
- Quality measures for EOL
- National champion for supportive kidney care
- Secure support for IOM study
- Disseminate consensus guidelines
- Standardize symptom assessment and treatment
- Develop tools for point of care decision making
- Define palliative care primary/specialty level skills