WHITE PAPER

A Nephrologist's Guide to CCM & RPM

Enabling Proactive, Supportive Kidney Care







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Executive Summary

Chronic kidney disease (CKD) is one of the costliest and most complex chronic conditions in the U.S.—but also one of the most underserved when it comes to coordinated, preventive care. Nephrologists are often left managing high-risk patients with little support between visits, escalating the risk of hospitalizations, non-adherence, and progression to dialysis.

This white paper explores how **Chronic Care Management (CCM)** and **Remote Patient Monitoring (RPM)** empower nephrology practices to:

- Improve patient outcomes through early intervention
- Support sustainable care delivery through CMS-recognized reimbursement models
- Prepare for value-based care success with scalable, evidence-based programs

The State of Kidney Care Today

- Fragmented communication between specialists, primary care, and care teams
- Rising prevalence of CKD and ESRD among aging and comorbid populations
- High hospitalization and readmission rates, often preventable with better monitoring
- **Time and staffing constraints** that limit nephrologists' ability to deliver ongoing care between visits

These challenges demand a shift—from **reactive care** to **proactive care**. That's where CCM and RPM come in.



What Are CCM and RPM?

Chronic Care Management (CCM) provides non-face-to-face care coordination for patients with two or more chronic conditions, including CKD, hypertension, and diabetes. Services are typically delivered by clinical staff under general supervision and include:



Monthly outreach



Medication reconciliation



Care plan updates



Social determinant of health support

Remote Patient Monitoring (RPM) involves the use of connected devices (e.g., blood pressure cuffs, weight scales) to collect and transmit patient data daily. It enables providers to:



Detect deterioration early



Adjust treatment in real time



Reduce hospitalizations

Together, CCM and RPM extend your reach beyond the clinic—while supporting patient care continuity.

Why Nephrologists Should Care

CKD is uniquely suited for remote care:

- BP control, weight trends, and medication adherence are leading indicators of worsening kidney function
- Co-management with PCPs often lacks follow-through—CCM bridges that gap
- Patients are at **high risk for readmission**, yet frequently miss signs of trouble

Implementing CCM and RPM allows nephrologists to:

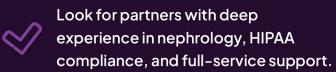
- Track at-risk patients daily and intervene before they crash
- Improve quality metrics aligned with MIPS and other programs
- Enhance care coordination while building value-based infrastructure



How to Get Started

Implementing CCM and RPM doesn't require overhauling your practice. Many nephrology groups partner with third-party vendors to:

- Enroll eligible patients
- Provide clinical staff support
- Supply and manage connected devices
- Handle documentation and billing



Real Results: What the Data Shows

Across nephrology and internal medicine, CCM and RPM have shown:

- 45% reduction in hospitalizations
- Improved medication adherence rates
- **Higher** patient satisfaction scores
- Increased visibility into social and behavioral risks

Proactive, ongoing care like this still isn't happening at scale for most patients. CCM and RPM help bridge that gap by adding practical, cost-effective touchpoints between visits, extending your reach and improving outcomes without adding heavy overhead.

Conclusion: Don't Wait to Modernize Kidney Care

Value-based care is no longer optional—it's here. CCM and RPM offer a practical way to close gaps in care and set your nephrology practice up for long-term success.

By delivering continuous, connected care, you can help patients avoid costly complications, strengthen care delivery, and lead the charge in transforming kidney care.

Want to Learn More? Explore our supporting resources:



Blog: Kidney Care Is Fragmented. Value-Based Models Can't Wait



Ready to see how this works for your practice? Book a 1:1 Demo

