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Ending Disparities in CKD Leadership Summit – Missouri

Overview:

The goal of the National Kidney Foundation's (NKF) Ending Disparities in CKD Leadership Summits is to drive a cultural shift in primary care toward increasing the early diagnosis and management of chronic kidney disease (CKD). Using the Collective Impact model as a framework, NKF and the Missouri Kidney Program convened stakeholders from across health care delivery, payers, public health, and the community to develop and advance equitable strategies to improve CKD testing and diagnosis in primary care across the region.

Through a series of Learning and Action Working group discussions, stakeholders identified barriers and solutions to improve CKD awareness, detection, and management in Missouri. **58 stakeholders representing 40 organizations across the region participated in the working group discussions.**

On June 9, 2022, NKF, in partnership with the Missouri Kidney Program and Missouri Department of Health and Senior Services, hosted a virtual summit to present the recommendations and engage partners in joining the Collective Impact Approach. **Over 220 key healthcare and public health stakeholders registered, and 134 attendees participated in this convening.** Of the 12 recommendations presented at this event, **71 individuals** made commitments to advance one or more recommendations of the roadmap at varying levels of support.

CKD in Missouri

- Approximately **700,000** adults in Missouri have CKD, but only **84,000** adults are aware that their kidneys are impaired.
- Fewer than **17% of people with risk factors for CKD** (diabetes or hypertension) are **tested appropriately** each year in Missouri.
- Undiagnosed CKD **increases risk for of cardiovascular mortality**, and is associated with **higher health care costs and utilization**
- Black or African Americans, Hispanic or Latinos, American Indians or Alaska Natives and other communities of color are disproportionately affected by CKD.

- Improve public awareness of CKD
- Clinician, Health System and Payer Opportunities
- Payer Roundtable & Chronic Disease Conference planning committee
- Participate in CKD data dashboard work group
- Pilots to explore novel testing approaches
- Funding to support strategies

Methods:

The National Kidney Foundation and the Missouri Kidney Program convened health care, public health, and community stakeholders across Missouri to participate work groups that focused on 1) Clinical Considerations for CKD in Primary Care, 2) Engaging Community and Community-Based Solutions, 3) Policy, Payment, and Quality Measurement, and 4) CKD in a Population Health Model. During these meetings, participants:

- Analyzed the prevalence of undiagnosed chronic kidney disease (CKD) in Missouri, and its impact on patient outcomes, healthcare costs and health inequities.
- Discussed strategies and approaches that can be employed to improve CKD recognition and care in primary care settings.
- Evaluated the impact the new Kidney Health Evaluation HEDIS measure can have on improving breakdowns in care and develop a strategy to streamline CKD testing in primary care from a policy and payment perspective.
- Developed a strategy to incorporate CKD testing and diagnosis into community wellness and prevention practices.
- Developed strategies to advance CKD awareness through community engagement and to ensure that health care providers are aware of the community resources available to delay CKD progression.

Results of the Discussions:

In total, 16 hours of facilitated discussions were held with stakeholders across the state. Numerous barriers to diagnosis and management were identified, and consensus was reached around a series of solutions denoted below.

Barriers to Kidney Disease Recognition and Early Diagnosis

Awareness: Across all workgroups, the commonly identified barrier was low level of kidney disease awareness. There are specific gaps in knowledge of risk factors, guideline concordant screening, and the impact of CKD on health outcomes and health care costs before kidney failure. Particularly problematic is a lack of understanding the link between kidney disease and cardiovascular disease. Despite efforts to improve patient outcomes and reduce the cost of care associated with late-stage kidney disease, very few providers and payers are focused on upstream interventions. With new medications that can slow progression and reduce cardiovascular impact, early recognition is more important now than ever.

Among clinicians, specifically those in primary care, there are awareness gaps around the guidelines for testing. While new quality measures, such as the new NCQA Kidney Health Evaluation for People with Diabetes (KED) HEDIS measure, have potential to increase guideline concordant testing rates among people with diabetes, many clinicians remain unaware of the specific details of these quality measures. Further, no such quality measures exist for patients with hypertension, which may continue to add confusion around the recommendations for testing.

At the individual level, despite knowing one’s risk for kidney disease, there are social and emotional challenges that can preclude people from acting on their awareness. Community organizations are needed to support patient awareness and activation but often lack the appropriate educational tools.

Specifically, they need skilled educators to provide culturally relevant materials written at an appropriate health literacy level for the communities most at risk for CKD.

Systems Challenges: Competing priorities and limited time of clinicians in primary care are significant barriers. Various quality measures and chronic condition care guidelines can be burdensome. Additionally, EMR tools and technology are not optimized for CKD, making it easy for clinicians to lose sight of CKD testing and management. Alongside that, there are opportunities to improve the utilization of specific care team members, including pharmacists and community health workers, that are not always leveraged in the primary care setting to their full potential. Community-based resources are also underutilized and the linkages between the health care setting and the community could be improved. However, it was noted that attention needs to be paid to solutions that address potential fragmentation of care, and communication channels and documentation solutions need to be developed.

Few clinicians have Electronic Health Record (EHR) systems that include clinical decision support tools for kidney disease. Some EHRs make it challenging to find the laboratory results indicating a person may have CKD. Many systems have implemented solutions for diabetes and hypertension population health, such as smart sets and checklists, but these tools have not incorporated CKD testing recommendations.

Access to Testing: The tests to diagnose kidney disease, especially the urine Albumin-to-Creatinine ratio (uACR) is not as ubiquitous or easy to get as it could be. There are logistical challenges with getting urine tests for some patients, especially if their insurer requires that they utilize a specific laboratory located outside of the clinic setting. Clinicians also voiced concerns about the potential costs of these tests; however, this is more of a perception than a reality. CKD testing is not a USPSTF preventive service covered without copay, but the data from laboratories and payers show costs to be relatively low ($30-$60). While this relatively low cost could still be a burden for some patients who are uninsured or underinsured, the costs of the tests should not a deterrent for clinicians to order them.

The Role of Health Equity in Kidney Disease: Poverty, food insecurity, and other social disadvantages are associated with higher rates of diabetes, hypertension, and kidney disease. Limited appreciation of the role of social determinants of health and structural racism in CKD hampers appropriate intervention. Throughout our discussions, health disparities were acknowledged as a significant contribution to low testing, awareness, activation, and proper disease management. Clinicians and payers need resources to address these underlying factors, so all individuals can manage their health. There are community organizations and individuals providing these resources, but funding and capacity can be a challenge, and again linkages between health care and the community should be improved to increase access. Limited appreciation of the role of social determinants of health and structural racism in CKD also hampers appropriate intervention. Disparities in CKD will not be addressed without recognition and action to address these root causes.

Lack of Data and Measurement: We also face a lack of measurement for CKD. Not having the full data picture of the impact of kidney disease on the state is a significant barrier to success and contributes to challenges related to awareness and prioritization of the problem. There is a need for state, county, and zip code level data to show current testing and diagnosis rates, and to highlight areas of opportunity in the state. More data is essential to fully understand the impact of social determinants of health on one's risk for chronic diseases and the health disparities in the state.

Solutions: A Roadmap for Missouri

National Strategies:

Some of the recommendations have a broader scope than Missouri alone. There is opportunity for NKF and other national organizations to leverage their national spheres of influence to change the landscape.

1. **Update the United States Preventative Services Task Force (USPSTF) recommendations regarding CKD testing**
2. **Expand CKD Quality Measures to include Hypertension**
3. **Work with EHR vendors to create and share clinical tools for CKD globally**
4. **Utilize Medicare Wellness visits for CKD Testing**
5. **Emphasize the Role of Social Determinants of Health in CKD and its progression**

Missouri Strategies:

At the state/ local level, there was consensus across stakeholders that the following strategies, driven by motivated partners in a collective impact approach, could be implemented to advance change.

1. **Improve public awareness of CKD**.
    - Partner with Missouri advocates to engage with those disproportionately burdened by kidney disease to tailor and expand the reach of NKF Kidney Risk Campaign resources.
    - Develop tools and training for Community Health Workers, Community Paramedics, and other frontline staff to raise awareness among those they serve.
2. **Deploy tools and systems change approaches to improve CKD diagnosis in primary care**.
    - Implement the Kidney Profile in all institutions in Missouri.
    - Increase clinician participation in the Show-ME Kidney Disease ECHO.
    - Expand NKF's CKD Learning Collaborative to engage more health systems and primary care clinicians in an active process of change.
    - Convene payers in Missouri in a roundtable discussion to explore strategies to prioritize CKD including the KED HEDIS measure and forthcoming MIPS measure.
3. **Increase available data on CKD testing in Missouri.**
    - Establish a work group to explore creation of a comprehensive data system to measure CKD testing and management to reflect the landscape of CKD underdiagnosis and monitor progress in the state of Missouri.
4. **Establish a cohesive Chronic Disease improvement strategy** for clinicians and community partners.
    - Develop comprehensive messaging and an approach to chronic disease awareness and improvement, to reduce the burden in both primary care and the community.
5. **Execute pilot programs to explore novel approaches to improve CKD testing rates**.
    - Leveraging community pharmacists for CKD testing and education.
    - Evaluating the use of Community Health Workers to support CKD screening and diagnosis.

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