Innovative Connections: Revolutionizing Diabetes and Kidney Care through Collaboration

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MN Community MEASUREMENT

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Learning Objectives

1. Describe the health equity implications and public health burden of Chronic Kidney Disease
2. Explain the approaches used through the Ending Disparities in CKD Leadership Summit to develop a collective impact roadmap for improving CKD
3. Identify innovative solutions that can deployed within your own organization to reduce the impacts of chronic kidney disease.

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40% of people with diabetes and 80% of people with hypertension don't get appropriately tested for CKD

1 in 3 adults is at risk for CKD

1 in 7 adults has CKD, 90% don't know they have it

Communities of color, lower income communities and rural populations experience higher rates of CKD

Most people with CKD will die of a cardiovascular incident before advancing to end-stage

100,000 patients on the transplant waitlist, 12 people die per day waiting for a transplant.

808,000 people are living with ESKD with over 565,600 people on dialysis right now.

Upstream

H

Downstream

Source: Public Health Sudbury & Districts www.phsd.ca

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CKD is a costly, disease multiplier

30% higher than non-CKD

CKD

Cardiovascular Disease

Annual medical costs: 1.8x (180%?) higher

Annual medical costs: 1.3x higher (130%)

Diabetes

Heart Failure

Annual medical costs: 2.7x higher (270%)

CKD, DM and HF Annual medical costs: 4.6x

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US Centers for Disease Control and Prevention. CKD Risk Factors and Prevention. https://www.cdc.gov/kidneydisease/publications-resources/annual-report/ckd-risk-prevention.html

(Nichols GA, Ustyugova A, Déruaz-Luyet A, O'Keeffe-Rosetti M, Brodovicz KG. Health Care Costs by Type of Expenditure across eGFR Stages among Patients

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Longstanding Health Disparities Exist in Kidney Disease

Black Americans make up 13% of the U.S. population but represent 33% of the end-stage kidney disease (ESKD) population.
Black Americans are 3.4 times more likely to develop ESKD,
Native Americans are 1.9 times more likely to develop ESKD,
Hispanic Americans are 1.5 times more likely to develop ESKD,
Asian Americans are 1.3 times more likely to develop ESKD
(Compared to White Americans)

Communities of color less likely to:

- Be tested for CKD
- Receive timely referral to nephrology
- Utilize home dialysis
  - peritoneal dialysis
  - home hemodialysis
- Receive a fistula
- Be identified as a candidate for transplant
- Be referred for transplant evaluation
- Be placed on the waiting list
- Secure a living donor
- Receive a kidney transplant

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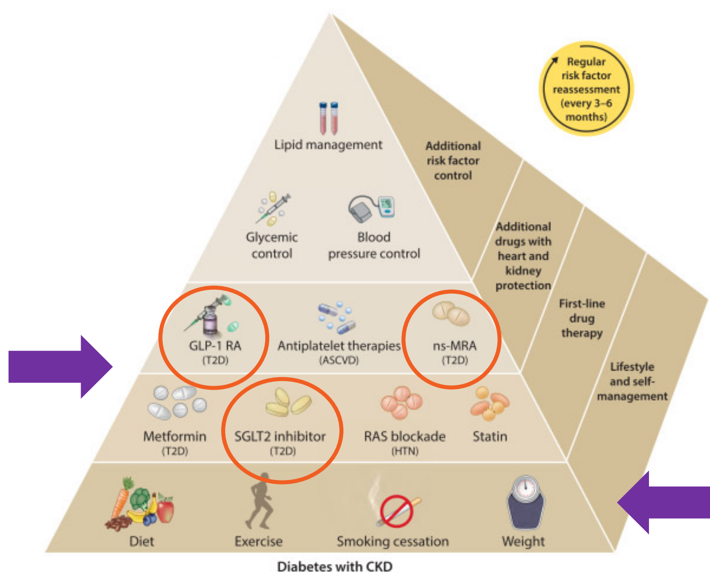
Opportunities to Intervene are Plentiful

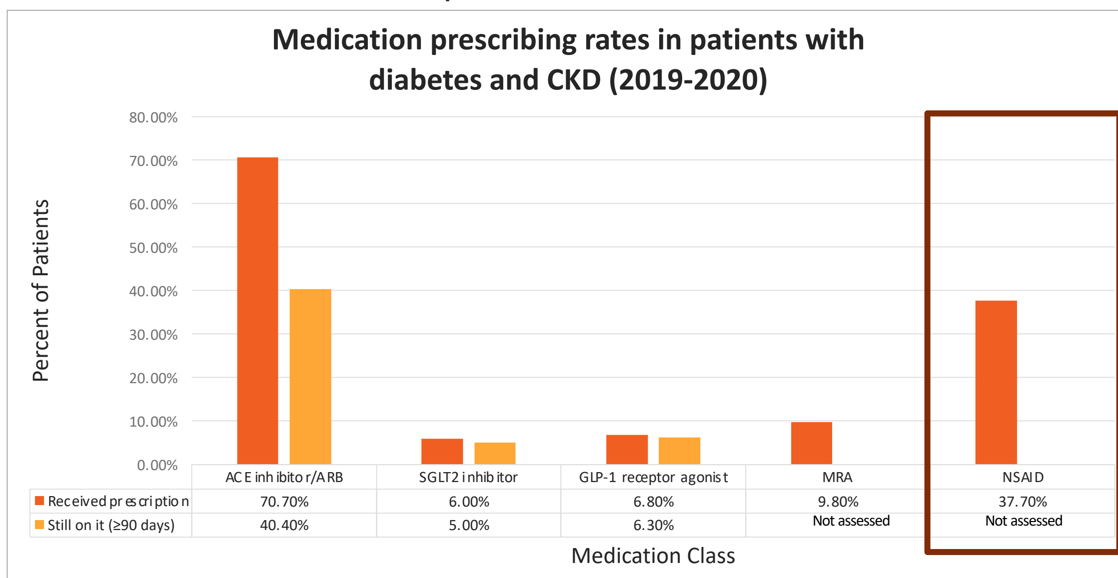
Novel therapies can slow CKD progression and reduce cardiovascular risk but are under-utilized.



Socioeconomic, political, and environmental factors impede access to nutrition, medications and lifestyle changes

References:
Rossing et al, 2022.
CDC Kidney Disease Surveillance program (https://nccd.cdc.gov/ckd/detail.aspx?Qnum=Q719)

But Gaps in Care remain



	ACE inhibitor/ARB	SGLT2 inhibitor	GLP-1 receptor agonist	MRA	NSAID
Received prescription	70.70%	6.00%	6.80%	9.80%	37.70%
Still on it (≥90 days)	40.40%	5.00%	6.30%	Not assessed	Not assessed

Nicholas SB, et al. *Diabetes Obes Metab*. 2023;25(10):2970-2979.

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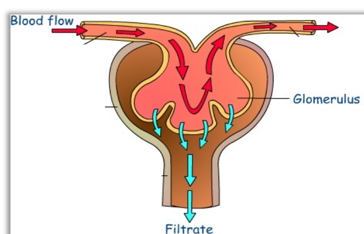
2 Simple Tests for CKD

eGFR = Filter **ability/capacity**



uACR = Filter **integrity/quality**

eGFR *Estimated Glomerular Filtration Rate*

Blood test Shows how well your kidneys filter (clean) your blood

\+

uACR *Urine Albumin to Creatinine Ratio*

Urine test Shows if your kidneys are leaking protein (albumin) into your urine, which may mean kidney damage

Only **20%** of people at risk for CKD are appropriately screened for kidney disease each year.

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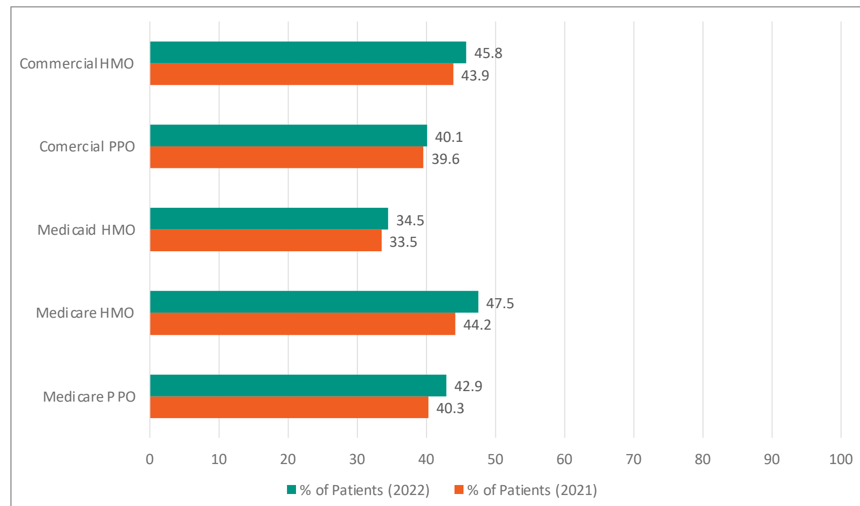
HEDIS Clinical Quality Measure: Kidney Health Evaluation for Patients with Diabetes (KED)

Adults 18-85 years of age with diabetes (type 1 and type 2) receiving an annual eGFR **and** uACR



NCQA. Kidney health evaluation for patients with diabetes (KED).
https://www.ncqa.org/hedis/measures/kidney-health-evaluation-for-patients-with-diabetes/

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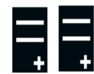
Why is CKD care so poor?

	Consumers & Patients	• CKD doesn't have symptoms, kidneys don't cough • Need lab tests to know you have CKD • Most people don't know what kidneys do
	Clinicians	• CKD management and diabetes/hypertension management in primary care are similar. PCPs may feel they are already managing • Kidney failure feels far away, unaware of heart risk associated with CKD.
	Hospitals and Health Networks	• Not perceived as an important quality target • Unaware of the true costs of CKD • Not aware of heart disease impacts of CKD
	Government	• Significantly greater advocacy and investment in research in other domains • Limited tools to address recently
	**Healthcare Payers**	• Low awareness of costs of CKD in early stages (ROI). • Not aware of heart disease risks • People switch health plans a lot, perception that CKD will be someone else's cost.
	Employers	• Not aware of the volume of patients- prevalence and impact in their work force • Only aware of end stage/dialysis costs, those employees may not still be with the company or will switch to Medicare --"not my problem"

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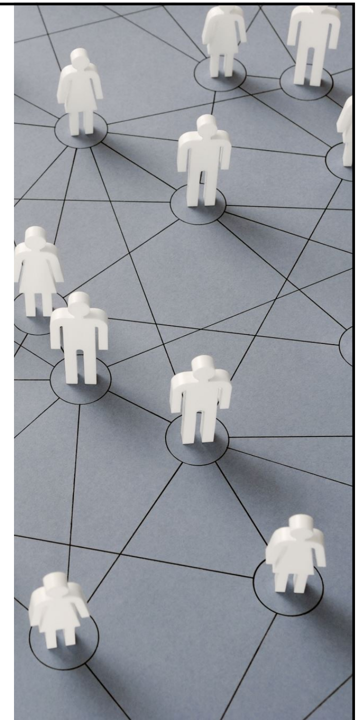
"Collective impact is a network of community members, organizations, and institutions who advance equity by learning together, aligning, and integrating their actions to achieve population and systems-level change."

Reference:
Collective Impact Forum. 2021.



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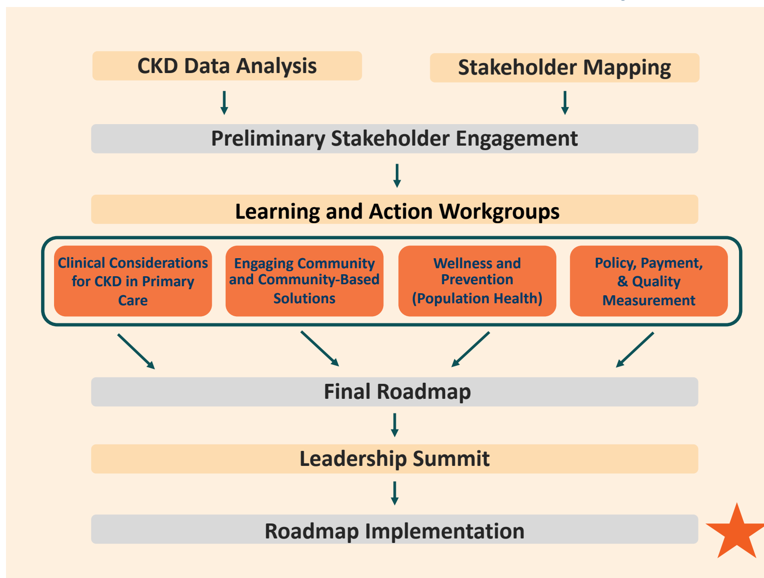
Collective Impact Process



148
participants in summit

67
organizations represented*

12
recommendations developed

65
commitments to advance recommendations

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Stakeholders engaged

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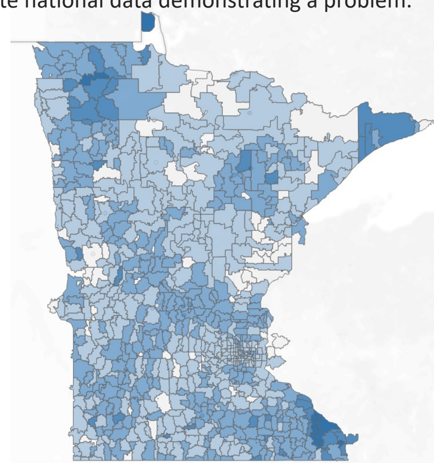
There are significant opportunities to improve guideline concordant screening of CKD in Minnesota

Many people perceive performance is better than it is, despite national data demonstrating a problem.

- **459,058 people at high risk for CKD** (diabetes and/or hypertension diagnosis)
  - *Among Medical Assistance (MA), MN Care, and Medicare FFS population**
- Few are tested appropriately
  - Medicare- **30.4% appropriately tested in 2023**
  - MA- **28.9% appropriately tested**
  - MN Care- **31.4% appropriately tested**
- Bigger gaps in screening for people who are:
  - Not continuously enrolled (80.4%) vs. continuously enrolled (70.9%)
  - Lower income (medical assistance)
  - American Indian (78.0%), Multiracial (74.4%), Non-Hispanic White (75.3%)*



Source: Medicare Fee-For-Service (FFS) CSAT part A and B claims data from January 1, 2023 to December 31, 2023, provided by Centers for Medicare & Medicaid Services (CMS) to Superior Health.

Percent Receiving creatinine w/eGFR AND albumin-creatinine ratio

5.1% — 69.2%

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LAWG Methods

Visual graphic of LAWG methods and discussion

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What are the Barriers to CKD Testing, Diagnosis and Management?

- Knowledge and Perceptions of CKD
- Social Determinants of Health and Lifestyle Factors
- Health Care Systems and Structures
- CKD Testing and Education for Non-Physician Primary Care Team Members, including Reimbursement Challenges
- Competing Priorities in Quality Improvement

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Minnesota Ending Disparities in CKD Roadmap

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THEME

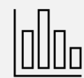
Compile the CKD data for financial justification of ongoing quality measurement.

"Simplistically, organizations organize themselves for how they will be paid. Not just health care. When it's not clear if there is a benefit, either clinically or financially, it's hard to get people rowing in the same direction."

\- **Policy, Payment, and Quality Measurement Workgroup Participant**

RECOMMENDATIONS

Disseminate clinical evidence and build the financial justification to support best practices for guideline concordant CKD screening.



Explore inclusion of the Kidney Health Evaluation Measure in the Minnesota Community Measures D5, or other focused measure sets to build the case for ongoing quality measurement.

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Minnesota Community Measures CKD Dashboard

What is it?
Data analysis tool created to support medical groups and clinics onboarded into PIPE system for tracking and assessing improvement efforts related to CKD prevention and treatment among patients with diabetes. There is no cost for participating in the dashboard project.

Will this information be publicly reported?
No, this information will only be made available to participating medical groups and is intended to be used as a quality improvement tool.

What kinds of analysis are included in the dashboard?
Performance by medical group/clinic, performance by medical group/clinic by demographic variables (e.g., age group, race/ethnicity, sex, country of origin, etc.), and peer comparison (at medical group level).

Metrics Included:

- HbA1c Management
- BP Management
- CKD Screening
- Rx for ACE/ARB
- Rx for SGLT-2 Inhibitors
- Rx for Non-Steroidal MRA
- Follow-up eGFR
- Follow-up UACR
- Missing Diagnosis of CKD after Abnormal Labs

For more information on enrollment, timing, and more, visit: https://mncm.org/mncm-services/#collaboration-and-innovation

or

Contact Jess Donovan: donovan@mncm.org

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CKD spotlight- NKF Data Dashboard

- Screenshots or summary of the tool to be added.

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THEME

Educate and Activate Clinicians

RECOMMENDATIONS

Engage clinicians and healthcare organizations in improving screening and diagnosis of CKD, emphasizing systems change approaches.

Leverage the Project ECHO model, or other novel approaches, to educate and equip clinicians for CKD prevention and management.

"It is very challenging to start a new medication therapy with limited time and competing priorities."
- Clinical Considerations Workgroup Participant

"Focus on quality measure fulfillment/cost-saving opportunities when engaging health systems."

- Clinical Considerations Workgroup Participant

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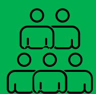

CKD Learning Collaborative

Program Description

Developed as part of the CDC 1817 program and deployed in Virginia and Missouri in integrated health systems, federally qualified health centers and accountable care organizations.

The CKD Learning Collaboratives quality improvement initiatives lead clinical staff to work together to redesign their systems to become more CKD patient-focused and efficient. Participating practice teams:

- Develop data strategies utilizing medical record data to identify individuals with laboratory evidence of CKD
- Develop and implement clinical decision support to ensure routine testing of people at-risk for CKD
- Establish care coordination models are to recruit patients for CKD and risk stratify the severity of CKD.
- Provide primary care focused CKD education

Through individual clinic meetings and peer to peer engagement provide education and implement clinical decision support and workflow changes.

What is possible?

- 60% increase in rate of guideline concordant CKD testing
- 35% decrease in number of undiagnosed CKD patients
- 20+% increase in use of guideline recommended therapies for CKD

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THEME

Expand Team-Based Approaches for CKD Detection and Care

"We need to have a plan in place to keep it going, otherwise we haven't done anything to change the culture."

- **Community-Based Solutions Workgroup Participant**

RECOMMENDATIONS

Expand utilization of team-based approaches, including connection to community-based resources, to systematically improve CKD care.

Deploy Community Health Workers, pharmacists, and other community champions in the dissemination of culturally tailored CKD awareness materials and connection to community-based resources.

Expand access to CKD testing and education through reimbursement for non-physician care team members.

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Community Health Worker Education and Engagement

- Tools and trainings for Community Health Workers, Community Paramedics, and other frontline staff to raise awareness among those they serve.
  - Available at kidney.org/NKF-Community-Health-Workers
- Components:
  - Module video series with a certificate of completion available
  - Training slides and scripts
  - Patient educational resources

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Community Health Workers and Health Educators: Kidney Disease and Risk Factors

Community Health Workers and Health Educators: Kidney Disease and Risk Factors

Community Health Workers and Health Educators: Kidney Disease

CKD Training For Community Health Workers

Faculty

Finess Copeland
(BSN, RN, MHA)

Registered Nurse -- S/NICU
Heath Disparities
Project Director

MORE VIDEOS

0:08 / 19:30 • Introduction

YouTube

Learning Objectives:

- State what the kidneys are & how they work
- State some functions of the kidneys
- Describe how kidney disease progresses
- State ways chronic Kidney disease (CKD) is treated

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How can we increase momentum and impact?

- Which strategies resonate with you?
- Do you have projects that align or compliment this work? Where do you see alignment with your organization
- What opportunities are there for us to disseminate our findings?
- Who are the partners we should collaborate with?
- Other comments?
- Questions?

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Questions or Comments

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