Ending Disparities in Chronic Kidney Disease—Leadership Summit

EXECUTIVE SUMMARY

NATIONAL KIDNEY FOUNDATION®

Overview

The goal of the National Kidney Foundation's Ending Disparities in Chronic Kidney Disease (CKD) Leadership Summit is to drive a cultural shift in primary care toward increasing the early diagnosis and appropriate management of CKD in Minnesota. Profound disparities exist across the continuum of kidney disease care, delaying proper detection and diagnosis. Using the Collective Impact model as a framework, the National Kidney Foundation (NKF) 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 Workgroup discussions stakeholders identified barriers and solutions to improve CKD awareness, detection, and care. In Minnesota, **63 stakeholders representing 38 organizations across the region participated in the workgroup discussions.**

On July 24th, 2024, NKF hosted a virtual summit to present the final recommendations and engage partners in joining the Collective Impact approach. Over **230 registered** and **148 attended the Summit** with **65 commitments** to support implementation of the 12 recommendations.

CKD in Minnesota

- An estimated **642,000 adults** in Minnesota are **affected by CKD**. However, **only 77,000 know** they have it.
- **Approximately 6.7% of people with risk factors for CKD** (diabetes and/or hypertension) are **tested appropriately**.
- Undiagnosed CKD **increases risk of cardiovascular mortality** and is associated with **higher health care costs and utilization.**
- Black/ African Americans, Hispanic Americans, Native Americans, and other racial and ethnic minority groups are disproportionately affected by CKD.

Methods

NKF convened health care, public health, and community stakeholders from across the state of Minnesota to participate in workgroups that focused on Clinical Considerations for CKD in Primary Care, Engaging Community and Community-Based Solutions, Policy, Payment, and Quality Measurement, and Wellness and Prevention in CKD. During these meetings, participants:

- Analyzed the prevalence of undiagnosed chronic kidney disease (CKD) in Minnesota, 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 Kidney Health Evaluation HEDIS and MIPS measures and Minnesota Community Measurement can have on improving breakdowns in care and developed 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 population health, 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 CKD Testing, Diagnosis, and Management

Knowledge and Perceptions of CKD

- Lack of CKD awareness among the public and clinicians, including knowledge of risk factors, testing recommendations, effective medications for slowing disease progression, and management tools
- Misconceptions and stigmas surrounding CKD hinder patient engagement and preventive practices.
- Lack of publicly available CKD data to inform educational outreach and prioritize intervention

Social Determinants of Health and Lifestyle Factors

- Lack of reliable transportation, health literacy challenges, limited access to healthy food, financial barriers to healthcare, and other factors that collectively increase the risk of diabetes and hypertension, which in turn heighten the risk of CKD
- Cultural intricacies and communication challenges between patients and providers can create fear of the medical system, particularly concerning CKD interventions.
- Competing patient priorities and time constraints impede CKD prevention and management.

Health Care Systems and Structures

- Clinical workflows, operations, and electronic health record (EHR) tools are not always optimized, creating inefficiencies and barriers to care.
- Lack of funding to support EHR optimization or the implementation of appropriate technology to help care teams efficiently diagnose, test, and manage CKD
- Importance of effective communication and referral pathways between healthcare and community-based resources or programs to prevent delays and streamline care delivery

CKD Testing and Education for Non-Physician Primary Care Team Members, including Reimbursement Challenges

- Patient difficulties navigating the healthcare system
- Pharmacists are not reimbursed as a provider type
- Lack of reimbursement for point-of-care testing, or the time nursing and care teams spend educating patients on CKD
- Different payment models across insurers
- Call for data-driven evidence, cost-benefit analyses, and return on investment assessments to support advocacy and policy changes.

Competing Priorities in Quality Improvement

- Various quality measures for both providers and payers, compounded by a lack of clarity and consensus on outcome measures for CKD.
- Value-based incentives for CKD screening are often not prioritized, leading to insufficient emphasis across employer wellness programs.
- Need to establish clear, actionable quality measures and incentivize CKD testing and management within the broader framework of chronic disease care.

Solutions: A Roadmap for Minnesota

Theme: Expand CKD public awareness and education

1. *Expand education on the connection between CKD and other chronic diseases.*
   - Develop checklists and tools for patients and their loved ones to ask their doctor about the co-morbidities associated with CKD.
   - Integrate CKD education into existing chronic disease programs and resources.
2. *Develop and integrate CKD awareness messaging across public health campaigns.*
   - Identify and segment audiences for awareness messaging based on literacy levels, preferred messaging channels, and cultural backgrounds.
   - Partner with community-based organizations to co-create culturally specific awareness messaging and materials.
   - Support, financially and otherwise, trusted community messengers to disseminate awareness messaging verbally and through digital platforms.
3. *Integrate CKD prevention within risk factor focused initiatives, aligning with Healthy People 2030 objectives, Minnesota Department of Health's 2035 plan, and health organizations' goals.*
   - Integrate CKD prevention strategies within broader health equity initiatives.
   - Collaborate with organizations focused on chronic disease management to integrate CKD awareness messaging into existing programs, including expansion of NKF's Kidney Risk Awareness Campaign.
   - Engage payers in securing funding to embed CKD prevention into their value-based care arrangements and wellness initiatives.

Theme: Enhance CKD screening and care through cultural collaboration

4. *Partner with community organizations and culturally tailored programs that conduct social determinants of health screenings to support individuals at risk for or living with CKD.*
   - Engage communities and public health professionals in asset mapping to evaluate the existing wellness programming and assess alignment for support of at-risk communities.
   - Embed social determinants of health (SDOH) screening tools into existing wellness programming to identify and connect individuals to the necessary CKD resources.
   - Engage culturally relevant healthcare providers and leadership across minority offices, clinics, and centers.
   - Explore grant funding to support effective community-clinical linkages.
5. *Build a compendium of organizations working across Black, indigenous, and people of color (BIPOC) communities in Minnesota to improve early identification of CKD and access to patient-centered care.*
   - Create a catalog of community-based resources designed to address SDOH barriers encountered by individuals impacted by kidney disease and disseminate it in key directories used by health care professionals.
   - Develop clear referral protocols for communication and collaboration between community-based organizations and healthcare providers.

Theme: Educate and activate clinicians

6. *Engage clinicians and healthcare organizations in improving screening and diagnosis of CKD emphasizing systems change approaches.*
   - Highlight the relationship of CKD, cardiovascular disease, and diabetes and build models to integrate CKD testing and management into overarching chronic disease care.
   - Leverage clinical decision support tools and implement CKD population health dashboards.

7. *Leverage the Project ECHO model, or other novel approaches, to educate and equip clinicians for CKD prevention and management.*
    - Seek funding to build a statewide Extension for Community Healthcare Outcomes (ECHO) model to virtually engage primary care providers in learning, mentoring, peer support, anonymous case discussion, and recommendations to improve the quality of CKD care.
    - Consider Continuing Medical Education (CME) or Grand Rounds presentations to encourage provider prioritization of CKD preventive practice.

Theme: Expand team-based approaches for CKD detection and care

8. *Enhance expansion of team-based approaches, including connection to community-based resources, to systematically improve CKD care.*
    - Educate and engage community pharmacists, community paramedics, and community health workers in increasing knowledge of CKD prevention and management.
    - Engage diversity, equity, inclusion and accessibility (DEIA) departments as well as nurses and care managers in supporting patients across the continuum of CKD care.
    - Collaborate with payers and health systems in identifying and securing funding.
9. *Employ Community Health Workers, pharmacists, and other community champions in the dissemination of culturally tailored CKD awareness materials and connection to community-based resources.*
    - Partner with trusted community messengers to develop and disseminate CKD-specific training.
10. *Expand access to CKD testing and education through reimbursement for non-physician care team members.*
    - Build the case for expanded provider types, demonstrating the success of similar models.
    - Advocate for the expanded authority and reimbursement of community pharmacists to connect at-risk individuals to appropriate CKD testing and care.

Theme: Enhance clinical practice and financial justification for CKD screening

11. *Disseminate clinical evidence and build the financial justification to support best practices for guideline concordant CKD screening.*
    - Disseminate CKD screening guidelines to trusted messengers and leaders in primary care.
    - Review the literature and disseminate evidence on CKD game-changing therapies and cost-effective interventions that reduce adverse outcomes.
    - Analyze data from the Minnesota Community Measures dashboard and Minnesota electronic health record consortium to identify and support patients.
12. *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.*
    - Collaborate with payers to develop a comprehensive financial case that highlights the return on investment of prioritizing the Kidney Health Evaluation (KED) measure.
    - Enhance awareness and education of the KED measure through CME programs and educational presentations for primary care providers.
    - Integrate the KED measure into clinical measure sets, performance programs, and payer contracts to reinforce the guidelines and incentivize provider performance

Call to Action:

If you and your organization align with any of the above proposed strategies, please contact the NKF Serving Minnesota at claire.johnson@kidney.org

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