Exploring CKD Detection, Management and Disparities Reduction

Webinar Transcript

Krista Davis: Good afternoon everyone. And welcome to today's QIN-QIO regional support and sharing call Exploring CKD Detection, Management and Disparities Reduction. My name is Krista Davis and I'm a communications specialist at Quality Insights and your host for today's presentation. We'll get started with today's presentation in just a few moments but first I want to take care of a few housekeeping items. All participants entered today's webinar in a listen only mode. Should you have a question or a comment during today's call we ask that you please type it into either the chat or the Q and A box on the right side of your screen. To activate your chat box, click on the word chat with the speech bubble in the bottom right corner of your screen.

The slides you see today have been posted on our website on the webinars page. The link to download them will be posted in the chat box momentarily. I would now like to introduce today's guest speaker, Andrea Moore Project Manager at Quality Insights is the director of the Kidney Care Project and e-learn series. She is a medical and administrative social worker with experience in quality and performance improvement, kidney disease, public and population health and project management. Andrea's framework for quality improvement in the delivery of kidney care is rooted in addressing health inequities and social determinants of health. It is my pleasure to now turn the program over to Andrea Moore.

Andrea Moore: Good afternoon. Thank you Krista and thank you all for taking time out to join us on today's webinar. So, let's jump right into the background of the significance and the far reaching impact of Chronic Kidney Disease or CKD. More than 37 million, that's roughly 15% of adults in the United States have chronic kidney disease. One in three American adults is at risk for CKD and those with hypertension and/or diabetes possess the highest risk of developing CKD in addition to people of black or African American, Hispanic, Native American, Asian, or Pacific Islander descent are at an increased risk for CKD.

Despite kidney disease being the ninth leading cause of death in America, the vast majority of individuals who have kidney disease are completely unaware of their compromised kidney function until their condition has progressed to the point of imminent intervention. This lack of awareness greatly contributes to not only the health burdens CKD poses to patients but it's also a massive economic burden to the United States healthcare system. Approximately 20% of Medicare dollars are spent on beneficiaries with kidney disease. And to really

drive home the economic burden, the 20% of dollars spent equates to $114 billion, with a B, dollars spent annually on individuals with kidney disease.

So, it is with all of that information in mind that Quality Insights and other organizations throughout the country have really started to take an upstream approach to slowing the progression of kidney disease. In 2018 Quality Insights funded the Kidney Care Project. And we started our journey off by performing a pretty comprehensive literature review and we followed that by developing a Technical Expert Panel or TEP. Our kidney care TEP consisted of a billing and coding specialist, patient subject matter experts, nephrologists, pharmacists, dieticians, primary care providers and social workers.

So together with our TEP we began to identify best practices for slowing the progression of CKD. We also identified and in some cases we developed evidence-based tools and resources whose aim was also to impact or slow the progression of kidney disease. And since we launched the Kidney Care Project I feel like the stars must have truly been aligned because shortly thereafter in the summer of 2019 the Department of Health and Human Services launched the Advancing American Kidney Health Initiative.

And this initiative if you're not familiar, sets forth three pretty aggressive goals. The first goal being to reduce the number of Americans developing kidney failure by 25% by 2030. So, that is a pretty aggressive goal but the work of the Kidney Care Project in collaboration with primary care providers can directly impact that goal. The other goal set forth by this initiative is having at least 80% of new kidney failure patients in 2025 either receiving dialysis at home or receiving a transplant. So if we go back to those statistics that I just reviewed about chronic kidney disease then we know that quite a few patients who have kidney disease don't know about their compromised kidney function and that results very often in them crashing in the ER and by crashing in the ER I mean that these are individuals who have never been seen by a nephrologist, they go into the hospital and they require emergent dialysis. This typically means that they end up having a catheter placed which is not always the best access for these individuals and can lead to other issues quite frankly.

And we have these patients who show up in the ER, they never have an opportunity to align their dialysis modality with their own goals, with their healthcare goals and their lifestyle goals. And so, there is definitely an opportunity to speak to these patients earlier, to screen them earlier and to follow their progression and try to stop that progression so that we can impact that second goal. The third goal of the initiative is doubling the number of kidneys available for transplant by 2030.

Also, taking the upstream approach is CMS. I think many of you may already be familiar with the CMS CKD Disparities Educational Guide for primary care providers. This guide was prepared by the National Committee of Quality Assurance, or NCQA. This educational guide was introduced in February of this

year and I'm pretty sure that Kia may have shared this guide with you all. If so, I would love to hear from you all.

So, in the chat if you are familiar with the educational guide and you have looked at it and you have thoughts about it or if your practice has actively tested out the key change ideas laid out in the guide I'd be really, really interested in hearing how easy or difficult was it to uptake some of those key changes in the guide. So, feel free to chat about that. Krista if we happen to get anyone responding to this call for feedback on the guide then maybe we can circle back around to it later in the presentation. So, I'm very open and interested in hearing what your thoughts are and whether or not you've tried to implement some of the key change ideas into your practice.

Also in 2020, the Kidney Care Project started development on interactive e-learn, six in total. So we started the development on an interactive e-learn series to complete the educational guide. And the reason I say that the e-learns complete the educational guide is because the e-learn series provide an interactive way to teach the key change ideas in the guide. And so it's just another way and I think a more enhanced way to take what is put in the guide and to learn from it.

So, I've already shared a little bit about the origin of the Kidney Care Project. But I really want to review the overarching goal of the Kidney Care Project and that is to promote in the primary care setting risk stratification of CKD, early detection of CKD, improved monitoring and management of CKD, and to support timely and appropriate referral to nephrology. As primary care providers who regularly see individuals most at risk for kidney disease I think that primary care providers are in a really great position to stop or slow the progression of CKD. Primary care providers really are at the intersections of so many systems so you all have an opportunity to get in and have these conversations very early with patients to either help stage CKD or to inform them of their risks and then try to slow or prevent progression. Primary care providers can help reduce disparities in care for CKD by focusing on early identification and treatment, monitoring progression, collaborating with nephrologists and other specialists and also by building care teams to better engage patients.

So let's take a closer look at the foundation of the guide. Per the CKD Disparities Guide there are three primary approaches to reducing disparities and these three pathways are approaches to identifying CKD, approaches to treatment and monitoring of CKD and then approaches to centering care on the patient. If you've seen the guide then you know that each of these approaches are supported by key actionable processes. So what the Kidney Care Project has done is done a crosswalk between the guide and what the literature says as far as what we need to do to stop or slow the progression of CKD.

So, what you're seeing here on this slide is really just a snapshot of the six individual e-learns that make up the Kidney Care Series. I'm going to take some time to dive into each of these e-learns individually. So if you remember, one of the pathways that the guide outlines for reducing key CKD disparities are approaches to identifying CKD. So to support the approaches to identifying CKD, the Kidney Care Project has produced an e-learn all about promoting CKD detection at every opportunity. In this particular e-learn we explore the methods for CKD detection and evaluation during preventative and routine well-care visits including two specific tests, EGFR and ACR, to detect CKD over a three month period.

I want to make note that in this e-learn we highlight the implications of including race in the most widely used equations for diagnosing kidney disease. The MDRD method of calculating GFR what it does is it often boosts or elevates GFR score for black patients because it does include race. And so, when you are using the EGFR or the NDRD method for calculating GFR you're including the patient's race. And if you note that this patient is black or African-American the GFR for that patient is going to be elevated. And that really increases the likelihood of delay to a referral to a nephrologist and it delays a patient being referred for transplant. And this really contributes to the historical disparity in kidney care.

So in this e-learn you'll note that we do highlight the implications of including race and you'll be interested to know that there has recently been a task force developed where this task force between ASN and in NKF... So ASN is the American Society of Nephrologists, NKF the National Kidney Foundation, they formed a joint task force of individuals, different clinicians who are assessing the consequences of including race in EGFR. So by the end of this year, I am expecting for the task force to roll out evidence-based recommendations for what do we do knowing these consequences.

And so, the e-learn series is living and breathing. What I mean by that is there are going to be opportunities where we can revise and strengthen the e-learn to make sure that we're always including the most accurate information. So as this task force rolls out evidence-based recommendations we will update our e-learns to reflect the most recent evidence. Also in promoting CKB detection at every opportunity we will explore risk factors for developing CKD in kidney failure as well as the risk factors for CKD progression. We include in this e-learn CKD calculators and we provide an interactive experience for you to use these CKD calculators based on a fictional patient profile. We also examine the ways to integrate CKD detection into your practices, routine processes, care management programs, and within the community to prevent or slow CKD progression.

And lastly, we include in this e-learn educational resources, activities, and community-based programs to assist with patient engagement for diabetes prevention and self-management as well as controlling hypertension. Also to

support the guide's approaches to identify CKD is the Kidney Care e-Learn on leveraging EHRs and improving detection rates. So in this particular e-learn we explore the implications for early identification of CKD. And I'll pause myself here just to let you know that the information in this e-learn about EHRs it is for general purposes but in most cases what we have here, the content in this e-learn, can be applied to a variety of EHR and health systems.

So in this EHR, we examine the ways to leverage electronic health records to identify a managed care of individuals at risk for developing CKD using very specific quality indicators. And so, some of the quality indicators that we review in this e-learn are cardiovascular disease, control of cholesterol levels, glycemia control for diabetes, screening for CKD through labs, family history and age, and also diagnosis of CKD using those two tests I mentioned earlier, EGFR and ACR. Those are the most widely acceptable tests at this point. We also examine ways to improve detection rates of CKD using medication focused quality indicators. And so, we dive in by identifying very specific drugs that put patients at an increased risk for developing CKD.

The second approach laid out in the guide are approaches to treatment and monitoring of CKD. So for this particular approach, what we did at the Kidney Care Project is we wanted to make sure that we developed e-learns that focus on team based kidney care. We really explore the benefits of a multidisciplinary team in managing patient care. We examine team-based care planning, who should be a part of the care team and at what point should they be involved. We go on further to really dissect the pharmacist role.

And the reason why we focus so heavily on the pharmacist role in kidney care, for several different reasons. One being that medication management is really important to identifying patients who are at risk and using pharmacy interventions to slow the progression of CKD. But also with the new payment model, there are ways to better incorporate pharmacists into primary care.

We do the same for the dietician's role. We make sure that we talk about all of the different roles as far as team members who are part of the primary care team which includes of course the primary care physician, nurse practitioner, nurse navigator in some cases, social workers in some cases. But we do hone in on the pharmacy role and the dietician role. With the dietician role we make sure that we explore the dietary differences for CKD stages three and four. We also examine the ways and the reasons for prioritizing dietary treatment based on labs, diet, medications, nutrition intake and history. And equally if not more important the patient's biggest concern that is of utmost importance when prioritizing dietary treatment. We also examine in this particular e-learn the relationship between phosphorus and kidney decline.

So I went to make note that while we take a look at the dietician and pharmacy role it is not to say that we expect or that we are encouraging primary care physicians to take on these roles and incorporate this into their regular

workflow. We know that that is impossible for a primary care physician to do the role of the dietician and the pharmacist. What we are sharing in these e-learns is the advantages of including these two disciplines and how you establish a relationship with both a dietician and a pharmacist. And of course we talk about establishing a relationship with the nephrologist so that there can be timely and appropriate referral to nephrology.

So in this particular e-learn we do review the indications for a nephrology referral. We explore effective co-management of patients. When is co-management even useful? It is not a one size fits all so we do review different scenarios for when co-management is useful. We explore best practices and protocols for communicating with and referring to nephrologists and we also examine the interventions and tools to address multi-faceted and complex health needs.

So, the last approach that is outlined in the CKD guides are approaches to centering care on the individual. Now, while this is a pathway of its own in the guide and the Kidney Care Project we develop an e-learn specifically for this approach. I do want to emphasize that patient centeredness is at the core of each of our e-learns. Yes, we have one e-learn that is specifically dedicated to talking about centering care on the individual but patient centered care is truly the thread of the e-learns.

So, we do have an e-learn on social determinants of chronic kidney disease and in this e-learn we talk about how determinants of health impact clinical health outcomes. I want to go back and remind you of what I mentioned as far as how so many individuals who have kidney disease are unaware. One of the reasons why so many individuals are unaware of their compromised kidney function is because they don't have access for several different reasons. And we know their social determinants play a huge role in having access to care. Health literacy levels play a huge role in understanding your risk for CKD. And so, we spend a great deal of time reviewing social determinants and how they impact clinical health outcomes and how they impact quality of life for patients.

We explore in this e-learn ways in which primary care teams can take action to understand and address social determinants of health. We also examine the ways in which primary care teams can address social determinant barriers through education, programs and reinforcement. In terms of revealing the actions that primary care teams can undertake is we make sure that we review different assessment tools so evidence-based reliable assessment tools that can be used to assess your patient's social determinants. What are the patients' needs based on their conditions? What are the patient's risks based on their conditions? We also touch on Z Codes and how Z Codes can be useful in documenting a patient's social determinants. Also in the social determinants e-learn we examine ways in which primary care teams can leverage their understanding of social determinants and health literacy levels to inform patients of their risks and again of their CKD stage.

So, that was pretty much a high level overview of all six of the e-learns that make up the kidney care e-learn series so I hope that with me going over some details of each individual e-learn that you are interested in learning more and wanting to enroll in the e-learn series. And so if that's you, if you are interested, I will not keep you in suspense any longer and I will tell you that the Kidney Care e-Learn series will be made available in November. And so, what I'll do is I'll share with Kia and Dawn a flyer and on that flyer there will be all of the registration information and you will then be able to take that, register for the e-learns. And I encourage you to share the flyer widely. Share it with your colleagues. The more people we can get to learn more about CKD the better our chances are for making an impact.

To register is very simple, all you would need to do is create an account on the EDISCO platform where we house the e-learns. It is a secure account portal so you will create an account and from there you'll have access not only to Kidney Care e-Learns but all of Quality Insights e-learns. There are no prerequisites so although I consider the Kidney Care e-Learn to be a series, a complete package, if you feel you don't need a refresher on leveraging EHR for example then you are not required to take that in order to move on and take a another e-learn course.

There is no sequential order to this. You take the e-learns in the order of your choice. The e-learns are completely self-paced so you can have the ability to start and stop the e-learns, to come back whenever you want. I certainly hope that you will take all six of the e-learns but you are not required. And I think one of the most important pieces is to share that Quality Insights is sponsoring free CMEs and CEs for each of the e-learns. Once the e-learns become available next month the CEs for nurses will be made available immediately. However, CMEs will not be made available until the end of December, early January.

This is just a snapshot of what the EDISCO platform looks like. So, when you are registering for the Kidney Care, e-Learns this is what you'll see. You'll see this web page and you'll see this sign up here. From there you will have access to the Kidney Care e-Learns and other e-learns that have been produced by Quality Insights. Webinars and other resources will all be made available for you here.

I won't read this slide bullet by bullet but I will just share with you the advantages of this e-learn platform or this learning system. It is extremely engaging and interactive. Each of the e-learns that I review for you today they all have case studies. They all have case studies. Well, some of them have branching scenarios where you will read a patient's profile and make a decision and based on the decision that you make for that patient it will take you in one of two directions and you will be able to really apply the knowledge that you learn. So you have an opportunity to do that with this interactive e-learn.

I see that there's some questions rolling in and we are reaching the question and answers portion of this presentation. And so, I would love to kick off the Q

and A portion by asking you all a question. So if you look to the right of your screen, you'll see that there is a poll question and I would love if you took some time just to share with me what certification organization your office staff uses for office practice managers. So, do you all use Certified Physician Practice Managers, Certified Medical Office Managers, Certified Physician Practice Manager, Certified Medical Manager, Certified Medical Practice executive or is there some other organization that you use? And if you use a different certification organization please let me know in the chat. This will all be helpful information for the CEs. So, as you all provide your responses I am going to move on and open up for questions from you all. Krista, if there are questions for me I am happy to do my best to answer.

Krista Davis: Thank you Andrea and once more if you do have questions we invite you to now type them into either the chat box or the Q and A box which you'll find both of those on the right side of your screen. So, the first question that we have Andrea is regarding the educational guide you referred to earlier. And the question is, "Where can we find the guide?"

Andrea Moore: So you can find the guide, it's actually on CMS's website. They released the guide in February of this year, the end of February, I believe February 27th or 28th. So, you can find the guide on CMS's website. There's actually several links to the educational guide in the e-learns so as you go through the e-learns you'll find that there will be several links to the educational guide as well.

Krista Davis: Thank you. And I will add that we have the educational guide here at Quality Insights so we will also be posting that on our website. So, we will let you all know when that is available. Our next question is, "Can you explain in more detail the process for receiving CEs?"

Andrea Moore: The process is actually very simple and I'm sure many of you have received CEs at some other point. Once you finish the e-learns you will have an opportunity to complete an evaluation. There will also be pre and post test questions, knowledge check questions throughout the e-learns. All you would need to do is complete the pre and post questions, complete the evaluation, and you'll receive a certificate granting you those credits.

Krista Davis: Thank you. And our next question is, "Are the e-learns beneficial for a non-physician office setting such as nursing homes?"

Andrea Moore: Wow that is a great question. I'm sure there are. Quality Insights has a lot of experience providing quality improvement to dialysis patients throughout the mid-Atlantic region and I would say probably somewhere between 40 to 60% of our patients are nursing home patients. So we know that in nursing homes, a lot of individuals there are individuals who have kidney disease or kidney failure. So a lot of this can be applied to nursing home personnel. So, absolutely.

Absolutely. And I would consider nursing home personnel a part of the care team depending on the patient being cared for.

Krista Davis: Thank you. And our next question is, "Does the e-learn series provide nursing CEs?"

Andrea Moore: Absolutely. And it's the nursing CEs that will be made available as soon as the e-learns are released in November. So as I said, the CEs for the nurses available immediately. So starting in November, you can register, enroll, begin taking your e-learns and receive your nursing credits. It's the CMEs for the physicians and the pharmacists those will come at a later date so into December early January. But as far as the nursing CEs absolutely you will receive those credits starting November as long as you enroll and complete your pre, post test questions as well as the evaluation.

Krista Davis: Thank you. And our next question is actually one that I will answer. That question is, "This was a great presentation. Will we be able to receive a recording or possibly share it with colleagues?" And if you all would look in your chat box a little higher up we posted a link to download the slides. On that same page is where you will be able to find the link to the recording and the transcript from today's program. We invite you to share that page with any of your colleagues that you think this program would be of benefit to and they can also listen to the recording and download the slides for themselves. And I don't currently see any further questions in the chat or the Q and A. So Andrea, do you have any final words for our group?

Andrea Moore: No, I don't have any final... Well, I thought I had a question but we'll see. I'll move on to my contact here. And so, for those of you who were too shy to ask a question or if you find that you have some questions after this presentation is over please reach out to me. I can best be reached by email. And my parting words to you all would be that chronic kidney disease as you can tell from the statistics is a pretty significant public health issue in this country.

And so, all of the work that we are doing, the Giving Kidney Project, it's really positioned primary care providers to be able to speak with the patients who they're already seeing, be able to speak with them early, be able to risk stratify and identify those patients who are at risk for it and who already have CKD. And to be able to stage them and really start to provide them with the care needed to stop or at the very least delay progression. We are all working towards the same goals and so with the shared goals in mind, and I think those shared goals are probably further highlighted by the Advancing American Kidney Health Initiative that I read off earlier. With those shared goals in mind I'm really looking forward to collaborating with you all and providing whatever assistance that I can and learning from you all so that we can all achieve this shared goal.

Krista Davis: Thank you once again Andrea for sharing your knowledge and expertise with all of us, and thank you to all of you who were able to join us this afternoon. Again, we encourage you to check out the slides and the educational guide when that is posted and to contact Andrea with any further questions. We hope you have a great afternoon.

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