



**PLANTING SEEDS  
OF CHANGE**

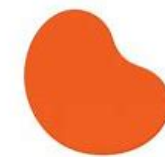
*Ending Disparities in  
Chronic Kidney Disease in Illinois*

# Ending Disparities in Chronic Kidney Disease in Illinois

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*A Collective Impact Approach to  
Improve Testing and Diagnosis  
of CKD in Primary Care*

Tuesday, June 27<sup>th</sup>  
9:00-11:00 AM CT



**NATIONAL KIDNEY  
FOUNDATION®**

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of Illinois

# Introductions

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**Phyllis P. Hayes, EdD**  
University of Illinois Chicago  
Assistant Vice Chancellor for External Engagement



**Emily Cooper, MPP**  
Chicagoland Chamber of Commerce  
Vice President of Programs

# AGENDA

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## ➤ WELCOME AND BACKGROUND

- Welcome Video
- Summit Purposes and Goals
- Patient Journey
- The State of CKD in Illinois

## ➤ ROADMAP FOR ILLINOIS (Recommendations and Call to Action)

- Illinois CKD Roadmap Process
- National Strategy Alignment
- Roadmap strategies, existing activities, and partnership opportunities

## ➤ CLOSING AND COMMITMENTS

- We can't wait for you to join us!



# GOALS OF TODAY'S SUMMIT

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01

## REVIEW THE SCOPE OF THE PROBLEM

- PREVALENCE, TESTING, AND DIAGNOSIS OF KIDNEY DISEASE
- WHAT IS THE IMPACT OF UNDIAGNOSED KIDNEY DISEASE?
- HOW ARE WE DOING IN ILLINOIS TODAY?

02

## WHAT CAN WE DO TO IMPROVE?

- WHAT ARE THE IMPACTS FOR ILLINOIS IN THE SHORT AND LONG TERM?
- WHAT BARRIERS DO WE NEED TO ADDRESS?
- WHAT ARE THE STRATEGIES AND SOLUTIONS WE CAN TRY?

03

## HOW WILL WE GET THERE?

- DISCUSS OPPORTUNITIES FOR PARTNERSHIP & COLLABORATION
- LAUNCH A COLLECTIVE APPROACH TO CHANGE

# CKD Patient Story by

Monica Fox

*Kidney Transplant Recipient  
Director, Outreach and Government  
Relations*

*National Kidney Foundation of  
Illinois (NKFI)*



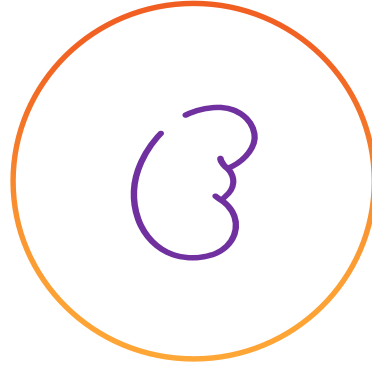
# SLIDO POLL TIME

1. Do you know what your cholesterol level is?
2. Do you know what your blood pressure is?
3. Do you know what your eGFR is? (Test of kidney function)



# CHRONIC KIDNEY DISEASE: AN ENORMOUS PUBLIC HEALTH BURDEN

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**37 MILLION (37,000,000)**

THE # OF ADULTS IN THE UNITED STATES CURRENTLY DIAGNOSED WITH KIDNEY DISEASE

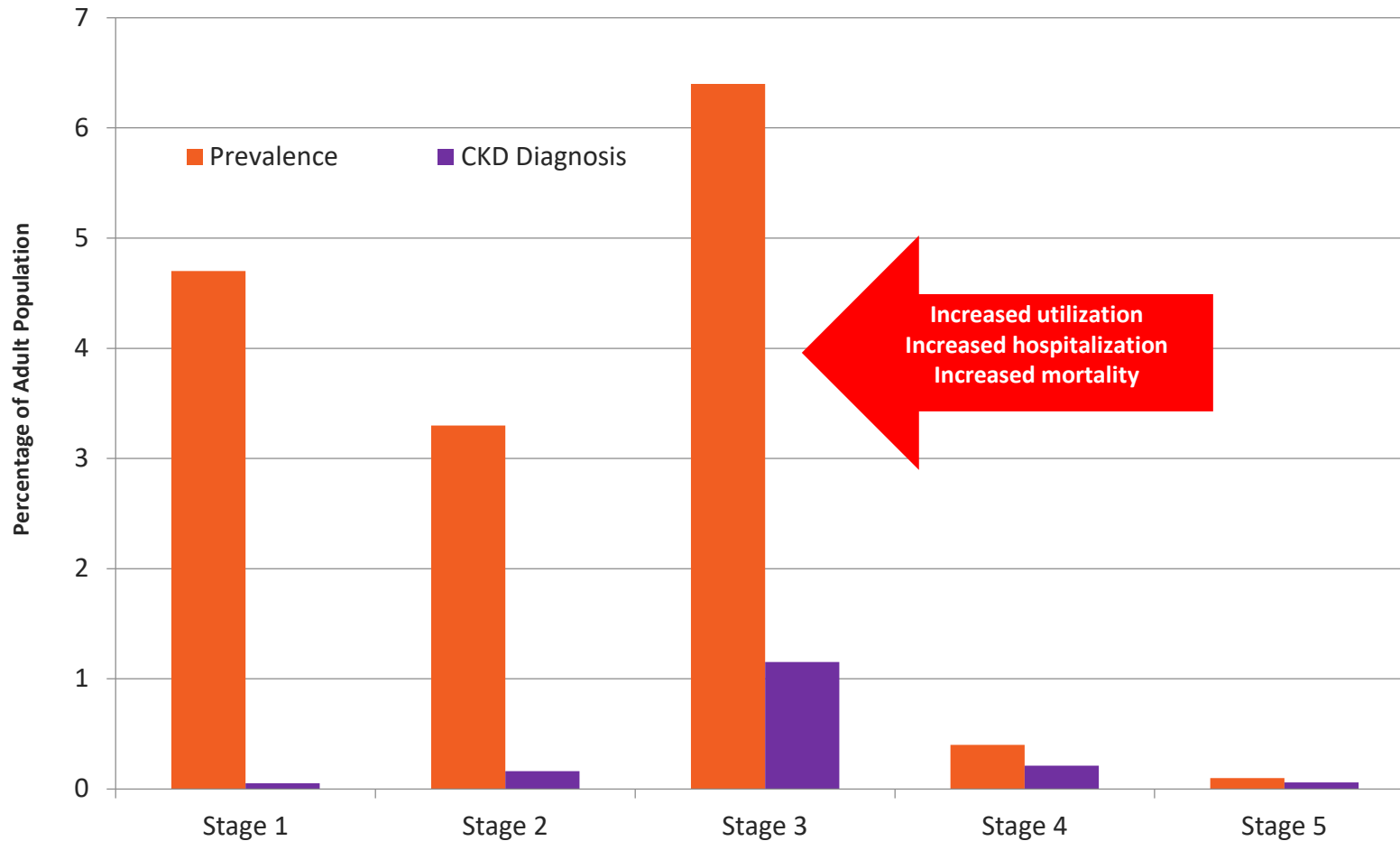


## CONSEQUENCES OF UNDIAGNOSED CKD

- END STAGE KIDNEY DISEASE (KIDNEY FAILURE)
- CARDIOVASCULAR INCIDENTS & MORTALITY

1. Centers for Disease Control (CDC). Chronic Kidney Disease in the United States, 2019. [www.cdc.gov](http://www.cdc.gov)
2. Tonelli M, et al. *J Am Soc Nephrol*. 2006;17:2034-2047.

# CKD Often Goes Undiagnosed



People with **undiagnosed CKD** are **less likely** to:

- ① **Know** they have CKD
- ① Get **needed tests** to track kidney health
- ① Get **recommended care** to help slow progression



# Kidney disease is costly. Costs rise as CKD progresses.

## A. Commercial group.

Commercial (aged <65 years)



## B. Medicare group.

Medicare (aged ≥65 years)



CKD indicates chronic kidney disease; ED, emergency department; ESRD, end-stage renal disease; IP, inpatient; OP, outpatient; Rx, prescription.  
All Comparisons  $P < .0001$ . Total Costs and costs by service category have been rounded to the nearest dollar.

# Most people at risk for CKD do not get recommended screening tests

## TWO TESTS ARE NEEDED

For diagnosis and risk stratification

### 1. Glomerular Filtration Rate (GFR)

A blood test to estimate kidney function using serum creatinine and/or cystatin C

### 2. Urine Albumin-to-Creatinine Ratio (UACR)

A urine test to assess kidney damage

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

### Prognosis of CKD by GFR and Albuminuria Categories

				Albuminuria categories		
				A1	A2	A3
				Normal to mildly increased	Moderately increased	Severely increased
				<30 mg/g <3 mg/mmol	30-299 mg/g 3-29 mg/mmol	≥300 mg/g ≥30 mg/mmol
GFR categories (mL/min/1.73 m <sup>2</sup> )	G1	Normal or high	≥90	Green	Yellow	Orange
	G2	Mildly decreased	60-89	Green	Yellow	Orange
	G3a	Mildly - moderately decreased	45-59	Yellow	Orange	Red
	G3b	Moderately to severely decreased	30-44	Yellow	Red	Red
	G4	Severely decreased	15-29	Red	Red	Red
	G5	Kidney failure	<15	Red	Red	Red

Green: low risk (if no other markers of kidney disease, no CKD); Yellow: moderately increased risk; Orange: high risk; Red, very high risk.

KNIGO 2012

# Disparities in kidney disease

## Stage 1

- No differences in CKD prevalence across population subgroups
- Limited genetic contribution

## Stage 2

## Stage 3

## Stage 4

## Stage 5

Communities of Color disproportionately affected

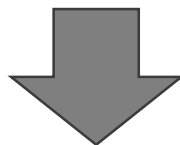
Communities of Color disproportionately affected

Less likely to:

- receive timely referral to nephrology

Less likely to:

- Be on home dialysis modalities
- receive fistula
- be identified as a candidate for transplant
- be referred for evaluation
- complete the transplant evaluation
- be placed on the waiting list
- secure a living donor
- receive a kidney transplant

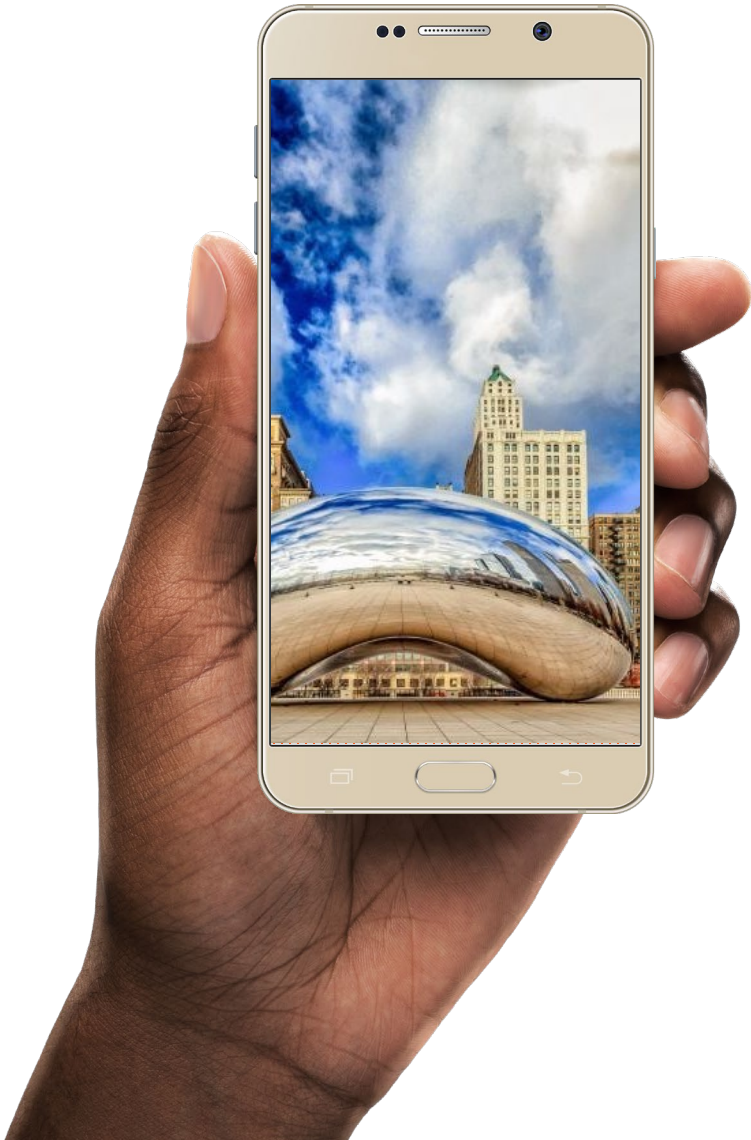


We must better understand the multiple factors that conspire to influence progression to ESRD.

Implementing quality improvement activities to close gaps is only one solution

# Understanding the CKD Burden in Illinois

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## CKD Prevalence and Diagnosis

Approximately  
**1,480,660 adults** in IL affected by CKD.  
only **177,680 adults** are aware of it.

## Population At High Risk

- People with Diabetes: **1,368,519 adults** (10.8% of the population)
- People with Hypertension: **3,801,440 adults** (30% of the population)
- People who are obese
- People over age 60
- People with a family history of kidney failure

### Sources:

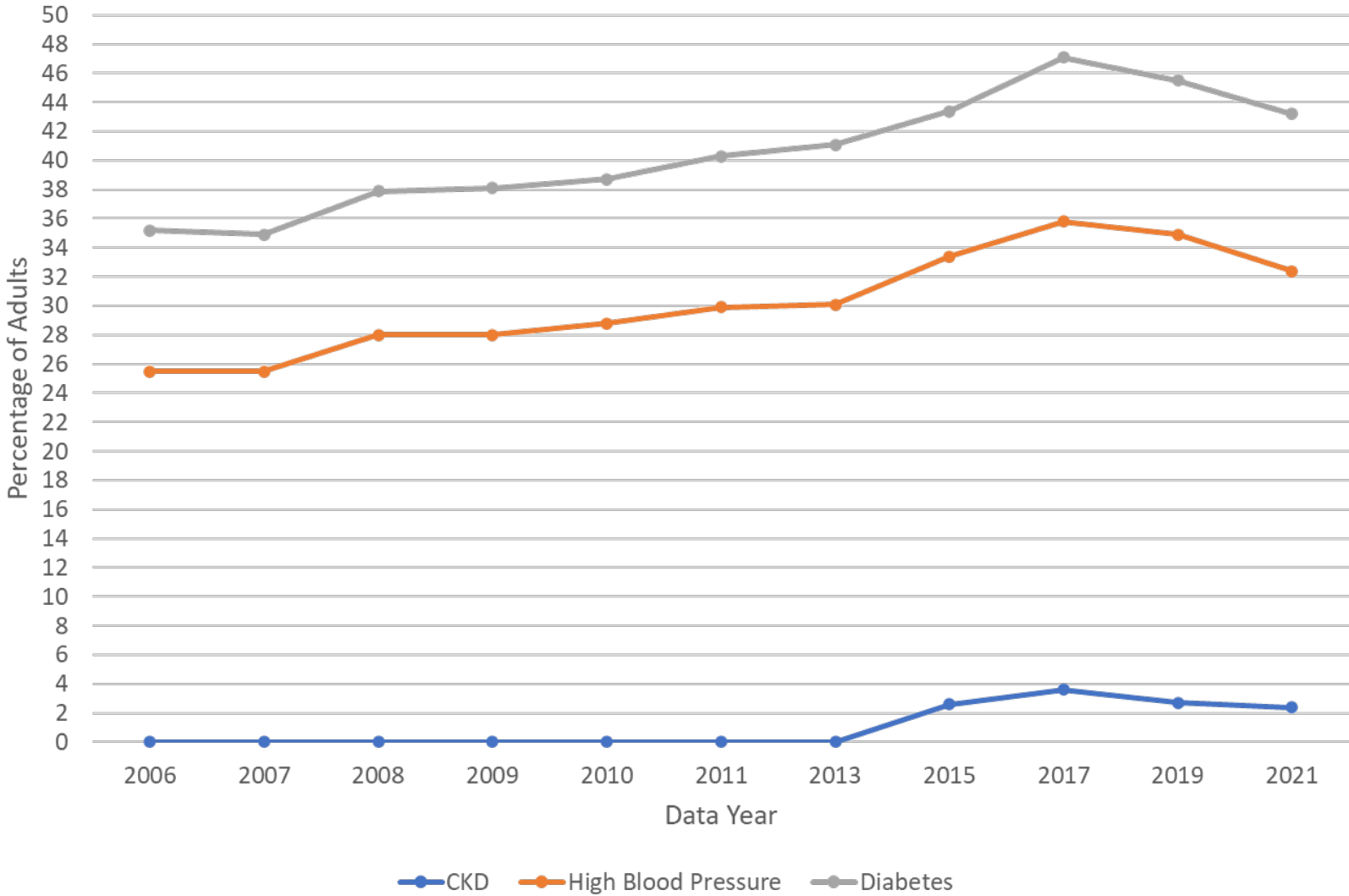
*CKD Diagnosis:* Szczech, L.A., et al., *Primary care detection of chronic kidney disease in adults with type-2 diabetes: the ADD-CKD Study (awareness, detection and drug therapy in type 2 diabetes and chronic kidney disease)*. PloS one, 2014. 9(11): p. e110535.

*Prevalence/Cost Data:* *United States Renal Data System. 2016 USRDS annual data report: Epidemiology of kidney disease in the United States.* Bethesda, MD: National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases; 2016.

*U.S. Census Bureau QuickFacts:* <https://www.census.gov/quickfacts/IL>

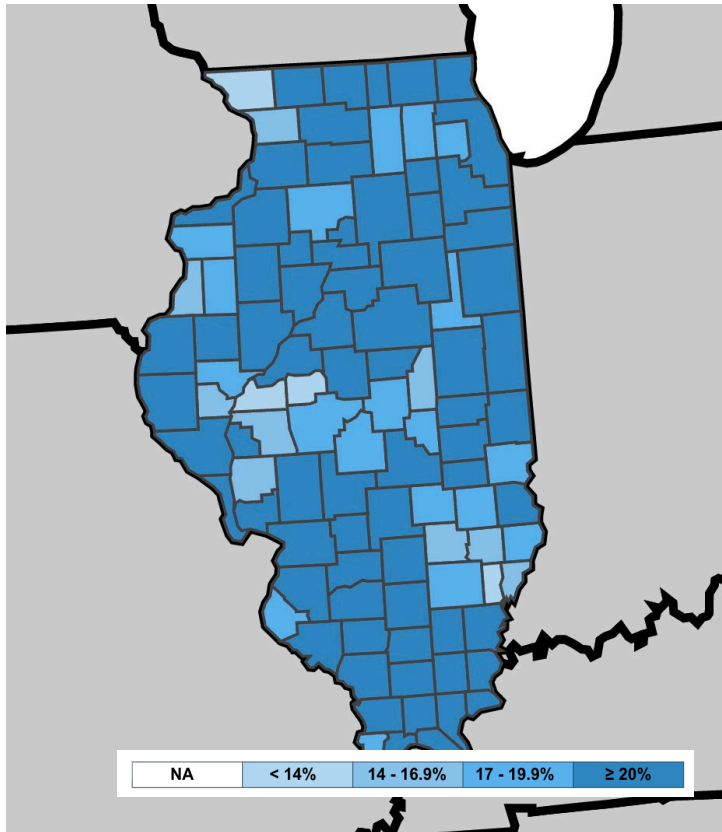
# Rising Diabetes and Hypertension Prevalence in Illinois

Percentage of adults who reported being told by a health professional that they had the following condition(s):



# Illinois CKD Facts

Prevalence of Diagnosed CKD Among Medicare Beneficiaries Aged ≥ 65 Years



Prevalence of CKD by State and County - Centers for Medicare & Medicaid Services - Medicare-Illinois  
Centers for Disease Control and Prevention. Chronic Kidney Disease Surveillance System—United States.

- ③ **34,458** Illinois residents are living with end-stage renal disease
- ③ **5,466 New Cases** of kidney failure were diagnosed in Illinois in 2018
- ③ **5,312** patients went on dialysis
- ③ **154 patients** were able to get a transplant
- ③ Only about **1 in 4 Illinois patients** on the waiting list received a kidney transplant in 2020

# Burden of CKD and State of Care in Illinois

*Out of 155,673 patients with a CKD diagnosis in IL:*

27.14% = Low-Income

27.11% = Medicare and Medicaid Population

13.36% = Black

56.37% = ACEi or ARB in CKD

8.80% = SGLT2i in CKD

*Source: AstraZeneca Atlas Database Analysis, 2023*



# Only 18.6% of at-risk patients in Illinois received the appropriate testing

- Data from a national clinical laboratory
- Sample of 28,295,982 at-risk patients, of these
  - 16.2% with diabetes
  - 63.8 % with hypertension
  - 20.1% with both diabetes and hypertension

State	2013	2014	2015	2016	2017	2018	Mean	Trend	p
Illinois	14.4	14.8	17.6	19.8	21.5	23.8	18.6	Increasing	0.027

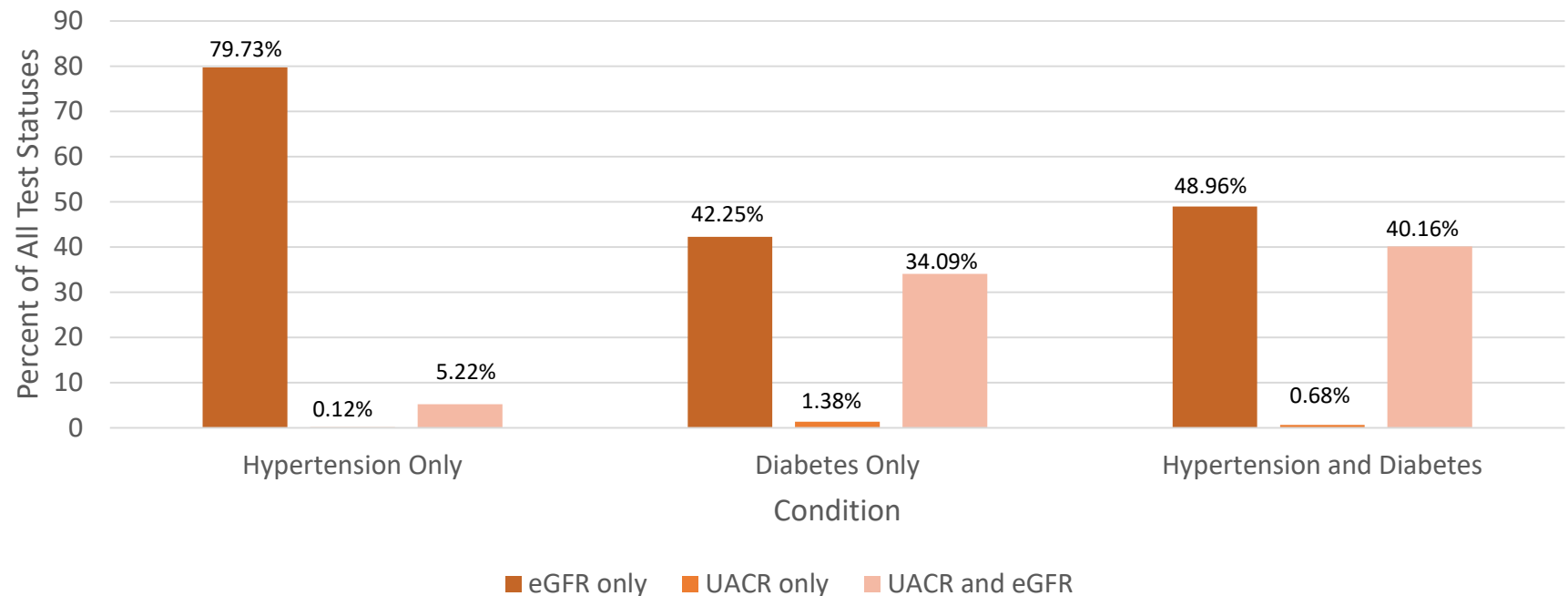
Table 2—Testing rates of patients at risk for CKD across the U.S. from 2013 to 2018

State	2013	2014	2015	2016	2017	2018	Mean	Trend	P
Wisconsin	42.7	49.8	21.8	16.5	26.9	23.3	30.2	No trend	0.462
Washington	15.6	17.6	22.7	29.0	28.5	27.1	23.4	No trend	0.462
Florida	20.0	20.0	21.3	23.2	24.6	26.9	22.6	Increasing	0.027
California	19.5	19.0	21.4	23.2	23.9	24.8	22.0	No trend	0.086
Texas	16.0	18.2	20.7	23.1	24.9	26.2	21.5	Increasing	0.027
Illinois	14.4	14.8	17.6	19.8	21.5	23.8	18.6	Increasing	0.027
Pennsylvania	14.2	13.2	18.1	20.2	20.4	20.8	17.8	No trend	0.086
Idaho	9.8	12.4	15.6	20.3	20.1	19.1	16.2	No trend	0.462
Maryland	13.6	13.7	15.9	17.2	17.5	18.1	16.0	Increasing	0.027
Missouri	14.8	14.8	15.1	16.0	16.3	16.1	15.5	No trend	0.086
Oregon	10.2	10.6	13.5	18.1	18.6	21.4	15.4	Increasing	0.027
Virginia	12.8	13.5	14.5	16.4	17.5	17.7	15.4	Increasing	0.027
Delaware	14.2	13.7	15.5	16.4	16.6	15.7	15.3	No trend	0.462
New Mexico	11.4	13.0	18.9	16.7	14.8	16.5	15.2	No trend	0.221
Alaska	17.3	15.2	16.0	12.9	11.6	11.8	14.1	No trend	0.086
Kansas	13.4	12.3	13.2	13.1	14.7	16.4	13.8	No trend	0.221
Colorado	11.7	11.6	13.0	14.8	15.3	16.2	13.8	No trend	0.086
South Dakota	11.1	15.2	14.3	18.2	10.1	13.7	13.8	No trend	1.000
New Hampshire	12.0	11.4	12.6	14.7	15.9	15.3	13.7	No trend	0.221
New Jersey	12.0	12.2	13.3	14.2	14.7	15.4	13.6	Increasing	0.027
Maine	7.6	9.1	8.2	16.8	20.0	19.6	13.6	No trend	0.086
Georgia	10.9	11.5	13.2	14.0	14.8	15.1	13.2	Increasing	0.027
Rhode Island	8.7	9.7	15.0	16.3	14.6	14.9	13.2	No trend	0.221
New York	11.3	11.2	13.0	13.7	13.8	14.7	13.0	No trend	0.086
Arizona	7.4	8.6	10.8	13.6	17.7	19.5	12.9	Increasing	0.027
Massachusetts	11.9	12.0	13.2	12.4	12.1	15.9	12.9	No trend	0.086
Montana	13.5	14.8	14.5	12.9	14.8	14.5	12.9	No trend	0.086
North Dakota	13.7	13.9	15.6	12.6	13.9	15.6	12.6	Increasing	0.027
North Carolina	13.7	13.7	14.9	12.2	13.7	14.9	12.2	Increasing	0.027
Ohio	13.5	14.1	14.4	11.9	13.5	14.4	11.9	Increasing	0.027
Oklahoma	12.2	13.4	14.2	11.1	12.2	14.2	11.1	Increasing	0.027
Tennessee	11.0	11.7	11.9	10.6	11.0	11.7	10.6	No trend	0.086
Utah	11.4	12.1	12.8	10.4	11.4	12.8	10.4	Increasing	0.027
West Virginia	11.0	12.1	8.3	10.4	11.0	12.1	10.4	No trend	0.806
Wyoming	11.1	11.2	11.7	10.0	11.1	11.2	10.0	Increasing	0.027
Louisiana	8.4	8.0	9.3	10.3	11.1	11.3	9.7	No trend	0.086
Indiana	5.6	6.8	8.4	10.5	11.1	11.3	8.9	Increasing	0.027
Alabama	7.0	6.8	7.4	8.3	9.4	10.6	8.3	No trend	0.086
Kentucky	6.8	6.9	7.7	8.7	9.2	9.9	8.2	Increasing	0.027
Iowa	3.0	6.2	7.6	9.2	11.5	10.4	8.0	No trend	0.086
Nebraska	3.8	3.4	5.1	5.8	11.2	14.0	7.2	No trend	0.086
Minnesota	3.3	4.4	7.5	9.2	10.4	5.5	6.7	No trend	0.221
Arkansas	4.7	5.3	6.1	6.7	7.9	8.0	6.5	Increasing	0.027
Michigan	3.5	4.0	4.2	5.6	9.6	10.8	6.3	Increasing	0.027
Oklahoma	2.8	3.7	5.1	7.2	8.6	8.2	5.9	No trend	0.086
Mississippi	4.6	4.3	5.1	5.4	5.3	6.3	5.2	No trend	0.221
Wyoming	7.2	3.3	4.7	3.4	4.6	4.9	4.7	No trend	0.806
Mean	10.7	11.4	12.5	13.9	14.8	15.2	13.1	Increasing	0.027

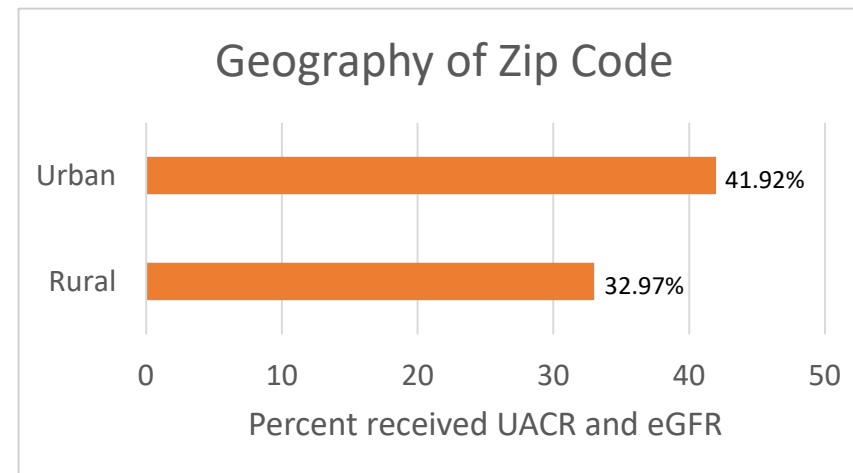
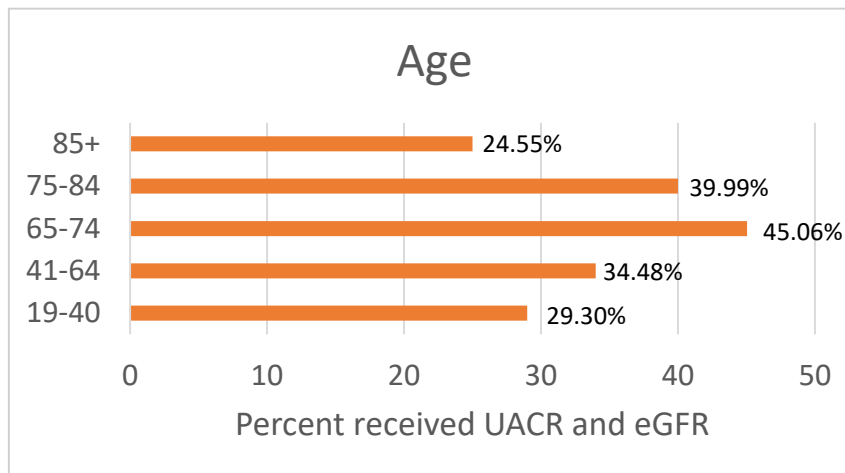
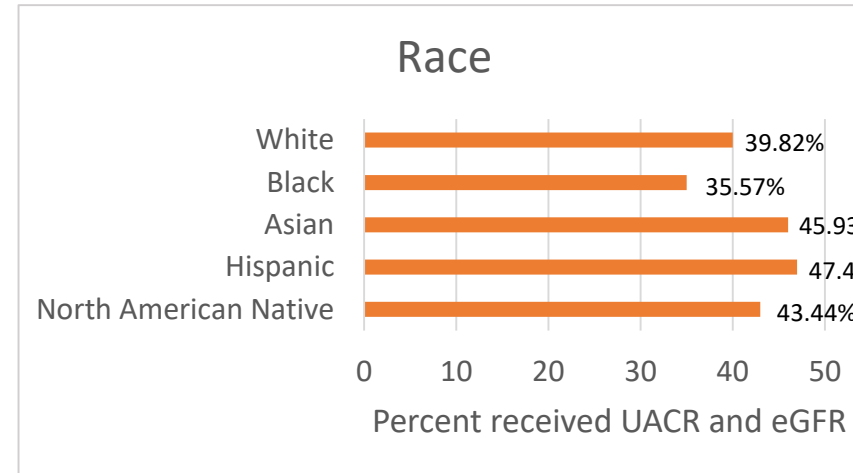
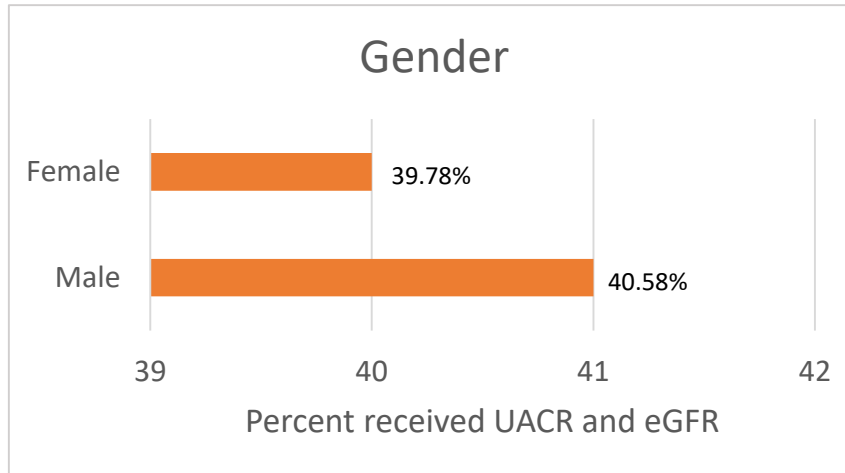
# Guideline Concordant CKD Testing among Individuals without Chronic Kidney Disease

*In IL, there were a total of **719,515** people at risk for CKD (having diabetes only, hypertension only, or both). Of these, **124,503** people received both UACR and eGFR testing. Meaning, a total of **17.3%** of those at risk have been properly tested.*

UACR *and/or* eGFR Testing for Individuals with Hypertension and Diabetes and without Chronic Kidney Disease

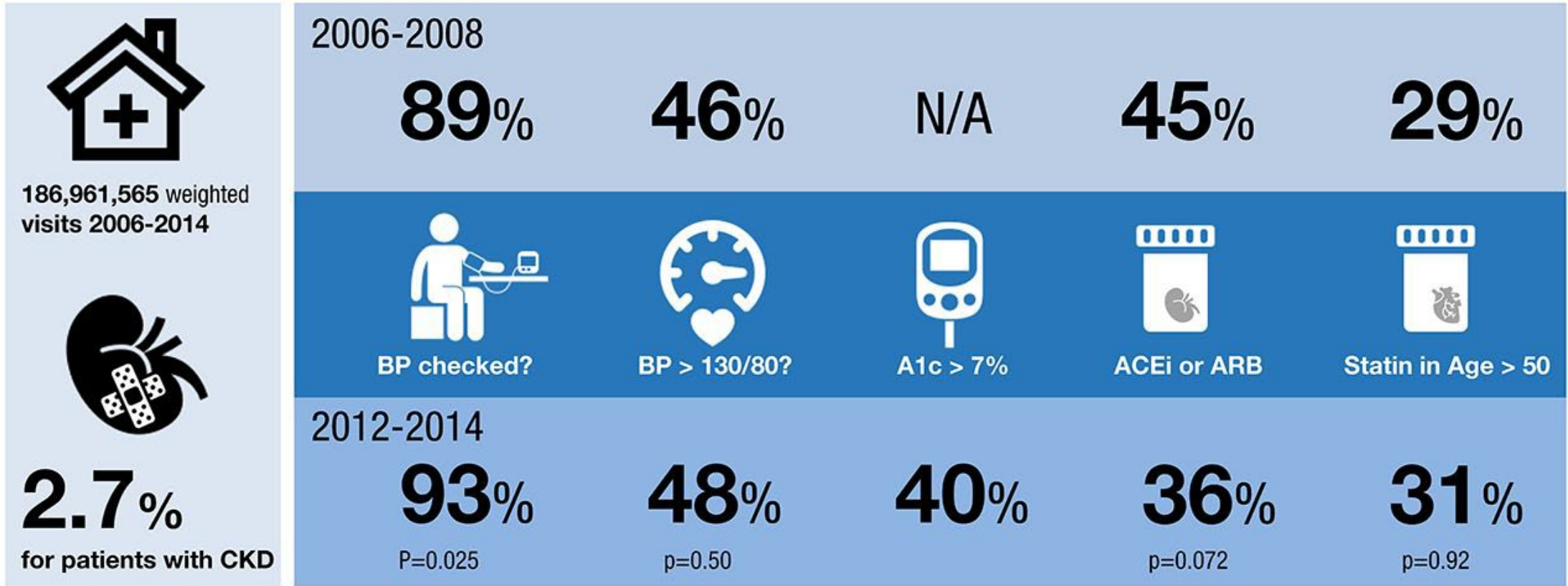


# Guideline Concordant CKD Testing among Individuals with Hypertension and Diabetes and without Chronic Kidney Disease



# Why does it matter?

# So how's CKD care in America?



**Conclusions** Patients with diagnosed CKD had a high prevalence of uncontrolled hypertension and diabetes. ACE and ARB use decreased and statin use was low and did not improve over time.

Sri Lekha Tummalapalli, Neil Powe, and Salomeh Keyhani. **Trends in Quality of Care for Patients with CKD in the United States.** CJASN doi: 10.2215/CJN.00060119. **Visual Abstract by Joel Topf, MD, FACP**

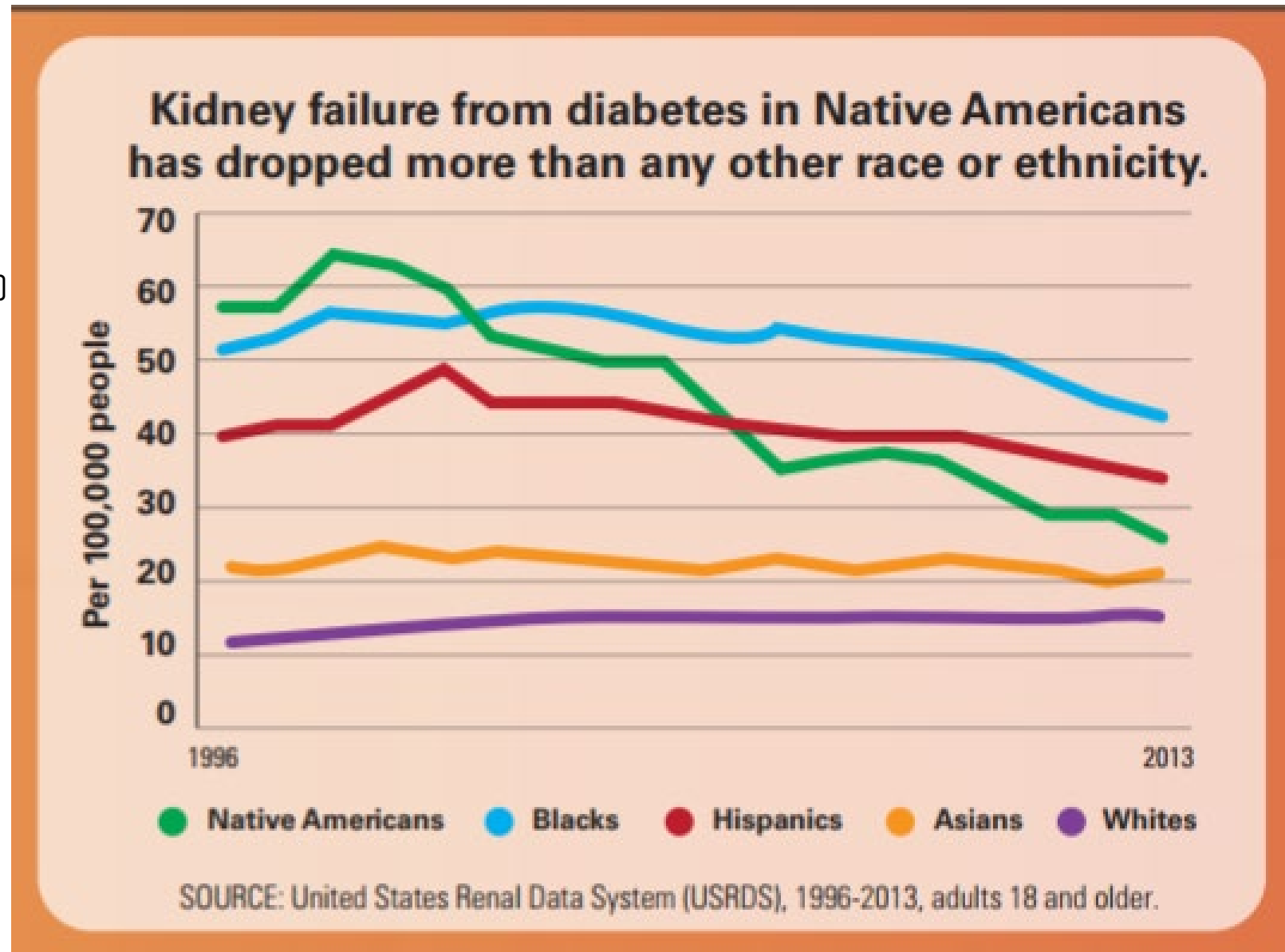
<https://cjasn.asnjournals.org/content/14/8/1142>

# Impact of CKD Population Health Model in Indian Health Service

## Interventions:

- ⊙ Screening for CKD in primary care
- ⊙ Expanded diabetes standards of care to include CKD
- ⊙ Nutritional counseling
- ⊙ Culturally tailored education
- ⊙ Continuing education for clinicians
- ⊙ CKD case management
- ⊙ ↑ ACE/ARBs

**54% decrease in diabetic kidney failure** among Native American populations



# Q u e s t i o n   &   A n s w e r

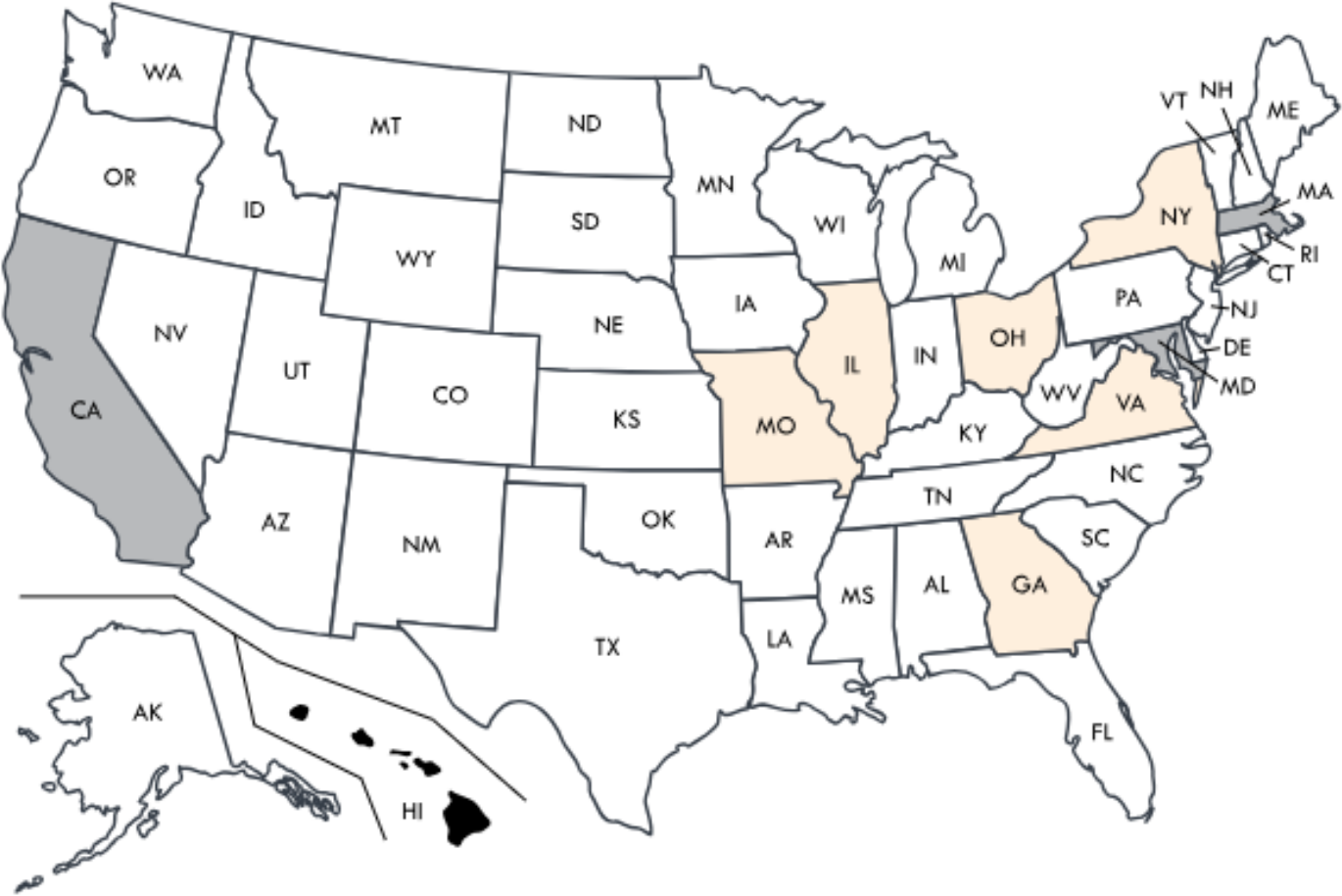
*For virtual participants, please enter your questions in the Zoom Q & A function.*

*For in-person participants, please line up at the nearest microphone.*

# Ending Disparities in CKD Initiative



# Ending Disparities in CKD throughout the USA:



States that have launched      Coming soon

# LEVERAGING THE COLLECTIVE IMPACT MODEL

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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.”**

# Illinois Roadmap: Where are the opportunities in Illinois?



# Stakeholders

## Health Care Providers

Quality Improvement Facilitators, Integrated Health Systems, and Medical Societies

## Community Organizations

Community Health Organizations, Patient Advocacy Organizations, Health Care Organizations, and Health Care Associations



## Payers

Insurers and Employers

## Government/Public Institutions

State and Local Departments of Health and Academia

# Illinois Workgroup Facilitators

Engaging Community and Community-Based Solutions	Wellness and Prevention	Clinical Considerations	Policy, Payment, & Quality Measurement
<p><i>Dan Lietz</i> Illinois Secretary of State</p>	<p><i>Darren Dunahee</i> SSM</p>	<p><i>Lara Tushla, LCSW</i> Rush Medical College</p>	<p><i>Knitasha Washington, DHA, MHA, FACHE</i> ATW Health Solutions</p>
<p><i>Marion Shuck</i> Gift of Hope</p>	<p><i>Lynden Schuyler</i> Illinois Public Health Association (IPHA)</p>		<p><i>Milda Saunders, MD, MPH</i> University of Chicago Medicine</p>

"Primary care physicians have not been as deeply schooled in CKD and would see it as the role of the nephrologist to pursue testing and treatment."

*-Policy workgroup participant*

"The nephrology community has not embraced early detection of CKD and I think that influences primary care."

*-Community workgroup participant*

"There are beginning to be more conversations tying in other conditions such as diabetes, high blood pressure, etc. Beginning to break down the belief that CKD is a standalone condition."

*-Wellness workgroup participant*

"Another key barrier is, the number of individuals who just don't have a primary care physician. So they're not in the healthcare system, they're not aware at all."

*-Community workgroup participant*

"Having a one stop shop for trusted information and resources; and marketing that, so that patients automatically go there when they need information."

*-Wellness workgroup participant*

- The precursors of CKD are unknown
- Resources, treatment, and care options are not discussed with patients
- Understanding of how to navigate the health system
- Low health literacy
- Cultural disconnect between patients and providers
- Different communities have different barriers
- Lack of chronic disease management skills
  - Medication, managing referrals, etc.



Consumers/  
Patients



Medical Societies  
& Clinicians

- Lack of awareness of KDIGO guidelines
- No CKD related guidelines from ACP or AAFP
- Disconnect between quality metrics and patient care goals
- Need for language of kidney health versus complications of eGFR and uACR
- Limited options for referring patients to nephrology
- Low utilization of proper testing

- Messaging and marketing pertaining to CKD needs to be adjusted
- Lack of interconnected resources for patients
- Staff limitations for patient education
- Low utilization of new eGFR equation



Hospitals &  
Health  
Networks

- Lack of general CKD knowledge and awareness
- Fragmentation in the care team
- Lack of resources for CKD patients



Payers

- Reimbursement rates are low for nephrology
- Challenges implementing value-based care or other payment models
- Lack of incentives for quality measure performance
- Lack of data or benchmarking on testing rates

- Economic stability of the patient is a barrier to access providers and insurance
- Access to food, transportation, living situation and other SDOH are prioritized over health



Public Health

- Number of individuals who do not have a PCP
  - Lack of priority as a public health issue
- Current patient perceptions of CKD diagnosis



# We need all of you...

Increasing Public Awareness and Understanding of CKD

Clinician and Health Care System Opportunities

Building the Case and Changing the Conversation

Leveraging Policy, Payment, & Quality Measures

## Increasing Public Awareness and Understanding of CKD

- **Expand engagement with diverse stakeholders in the community to develop awareness messages and CKD educational content.**
- Assess the community knowledge of kidney health and the effectiveness of existing content and delivery of CKD education.

"There is a lack of awareness of the precursors of CKD. Most people are unaware that uncontrolled high blood pressure and diabetes can lead to CKD and don't realize that they should be getting their kidney function tested regularly if they are living with those conditions. So awareness is really key."

- *Community workgroup participant*

"There's this thought, if you have kidney disease there's not much you can do, which really is a false belief. But that's what you're hearing."

- *Community workgroup participant*

# Increasing Public Awareness and Understanding of CKD

➤ Utilize the Collective Impact model to engage a wide group of partners in the implementation of a CKD awareness campaign strategy.

"We need to understand the narrative in different communities. If there's this belief that there's not much you can do, and this belief that it's inevitable and you're going to end up on dialysis, it's important to understand that."  
 - Community workgroup participant

## Potential Partners and Programs

ADA	AHA	Illinois ICAN	American Cancer Society
Illinois AFP	Rural health Associations	County health departments	Illinois State Medical Societies
Managed Care Organizations	ACO's	Employers/ Business Community	Medicaid plans
FQHC's	Pharm and biotech	Chronic Disease Programs	Community-based organizations

## Increasing Public Awareness and Understanding of CKD

- **Partner with community organizations to develop a cadre of trusted CKD ambassadors to disseminate CKD information and resources.**
- Develop a train-the-trainer approach to support these organizations and CKD messengers

"I know people are frequently afraid to do cancer screenings because they're afraid of the findings. As time has gone on, we've seen that kidney disease is surpassing (cancer) as a killer, so how do we look at that? If people are finally understanding the need for cancer screenings, how do we move them from where they are now of being afraid to being afraid not to?"

*-Clinical workgroup participant*

"Making sure we are including family, friends, church community, etc. Not just focusing on health care providers. These are lifestyle changes that individuals are having to look at and the more people on their side the better."

*-Clinical workgroup participant*

# Clinician and Health Care System Opportunities

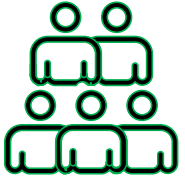
"And it really is a disease specific, value-based care model that is coming out of a CMS center for innovation. And we're leaning heavily into those...I think it's the right thing to do for the patient."

*-Policy workgroup participant*

- ① **Increase primary care team knowledge and capacity to support CKD testing, diagnosis and management.**
  - ① Create (or promote) educational opportunities to increase clinician knowledge about CKD and CKD management in primary care.
  - ① Utilize systems change approaches to optimize workflows and technology in primary care settings to facilitate testing.
- ② **Build Capacity and Opportunities to Integrate Community Health Workers into primary care settings to support care coordination, patient education, and self-management.**

"We need to identify the problem but more importantly, effectively manage it, so we reduce the risk and trajectory which is going to require what I call the iron triangle. It's going to require team-based care, very adequate and trusting assessment of social drivers of health, and shared decision making"

*-Clinical workgroup participant*



# CKD Learning Collaborative

## Program Description

- ① **Learning Collaboratives are quality improvement initiatives in which clinical staff work together to redesign their systems to become more patient-focused and efficient.**
  - ① Develop data strategies utilizing medical record data to identify individuals with laboratory evidence of CKD
  - ① Develop and implement clinical decision support is developed to ensure routine testing of people at-risk for CKD
  - ① Establish care coordination models are established to recruit patients for CKD and risk stratify the severity of CKD.
  - ① Provide primary care focused CKD education
- ① Through individual clinic meetings and peer to peer engagement provide education and implement clinical decision support and workflow changes.
- ① The NKF CKD Learning Collaborative model is currently employed in Virginia and Missouri. **In Virginia, participating practices have realized as much as a 28- 55% increase in CKD testing and diagnosis within the first year of the program implementation.**

# Clinician and Health Care System Opportunities



"We do need a way to not get overwhelmed with the registry of CKD patients without any new tools to help them."

- *Clinical workgroup participant*

- **Develop and deploy tools to optimize the EMR for CKD testing, diagnosis, and management.**
- Create a coalition amongst health care systems & health information technology and electronic health record (EHR) software to create standard tools.
- Encourage adoption within large medical institutions in the region.

"As we build these tools, its critical to have input from a number of PCPs who are routinely seeing patients. The last thing we want to add is another decision support that becomes something to ignore or that frustrates clinicians."

- *Clinical workgroup participant*

# TAKING CKD AWARENESS AND PREVENTION "TO THE STREETS"

## Clinician and Health Care System Opportunities

- **Expand engagement with "non-traditional," community-based care providers including faith-based organizations, pharmacies, community centers, and food banks to support CKD testing and management.**
  - Determine the clinical and health education services provided by these organizations.
  - Identify opportunities for testing at these sites or referral to labs/other health care facilities for CKD testing.
  - Increase linkages from CKD resources and educational tools to primary care to ensure management of CKD.

"There are a lot of misconceptions about CKD among the general population. This is the biggest deficiency as an insider."

*-Wellness workgroup participant*



# WHAT GETS MEASURED, GETS DONE!

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"The major barrier to that is the fact that the quality of the data historically has been poor. Unless there are efforts to do the education and funding to do the adoption, that's the only way to build up the quality of that data."

*-Policy workgroup participant*



## Building the Case and Changing the Conversation

- ① **Develop a workgroup to create a CKD data story/dashboard for Illinois.**
  - ① Leverage state or local Illinois data and research on diagnosis, disease progression, disability/work force implications, progression, and death to tell the story of CKD and need for intervention.
- ② **Demonstrate Return-on-Investment for earlier detection and management of CKD.**
  - ① Provide tools for organizations (health care, employers, payers, or otherwise) to build the business case for earlier intervention in CKD.

"It is important to the do stratification because you will see pockets of risk and pockets of illness that you might not expect to see"

*-Policy workgroup participant*

# Leveraging Policy, Payment and Quality Measures

"Funding becomes a barrier. The funding to implement, to build out the tools, to educate, and the training required once the tool is in place. You know being able to adopt that technology."

*-Policy workgroup participant*

"Its funding to support development of future tools. Its funding to support the adoption and the roll out of tools. But then it's also funding even past that initial adoption for that continued education so that tools are being used in a much richer more enhanced way over time."

*-Policy workgroup participant*

- ① **Increase awareness and prioritization of quality measures that encourage CKD testing and early diagnosis.**
  - ② Increase awareness of Kidney Health Evaluation HEDIS and MIPS measures and impact of score on overall ratings, reimbursement, etc.
  - ③ Develop composite quality measures/measure sets that will capture quality CKD care in early stages.
- ④ **Advance funding and reimbursement models to support primary care capacity, especially to support deployment of CHWs or others for care coordination and patient support.**

# WE NEED ALL OF YOU

## Improve public awareness and understanding of CKD

Expand engagement with diverse stakeholders in the community to develop awareness messages and CKD educational content.

Utilize the Collective Impact model to engage a wide group of partners in the implementation of a CKD awareness campaign strategy.

Partner with community organizations to develop a cadre of trusted CKD ambassadors to disseminate CKD information and resources.

## Clinician and Health Care System Opportunities

•Develop and deploy tools to optimize the EMR for CKD testing, diagnosis, and management.

Increase primary care team knowledge and capacity to support CKD testing, diagnosis and management.

Expand engagement with “non-traditional,” community-based care providers to support CKD testing and management.

Build Capacity and Opportunities to Integrate Community Health Workers into primary care settings.

## Building the Case and Changing the Conversation

Develop a workgroup to create a CKD data story/dashboard for Illinois

Demonstrate Return-on-Investment for earlier detection and management of CKD.

## Leveraging Policy, Payment, and Quality Measures

Increase awareness and prioritization of quality measures that encourage CKD testing and early diagnosis.

Advance funding and reimbursement models to support primary care capacity.

# Q u e s t i o n & A n s w e r

*For virtual participants, please enter your questions in the Zoom Q & A function.*

*For in-person participants, please line up at the nearest microphone.*



# SLIDO POLL TIME

HOW WILL YOU HELP?

*After reviewing all the recommendations put forward by the workgroups, which recommendation(s) will you and your organization commit to working with the support /guidance of our team? (Choose all that apply)*

# National Kidney Foundation Staff

# THANK YOU!

## NKF of Illinois

- Jackie Burgess-Bishop, Chief Executive Officer
- Monica Fox, Director of Outreach and Government Relations
- Rachel DePauw, Senior Director of Programs
- Amanda Grandinetti, Population Health Partnership Manager

## NKF HQ

- Elizabeth Talbot-Montgomery, VP Learning Strategies & Primary Care Programs
- Katelyn Laue, National Program Development Director
- Megan Schultz, Senior Manager, Population Health Partnerships
- Mallory Caron, Program Implementation Manager