National Kidney Foundation of Illinois
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Ending Disparities in CKD Leadership Summit – Illinois

Overview:

The goal of the National Kidney Foundation of Illinois's (NKFI) Ending Disparities in CKD Leadership Summit 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, NKFI 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 state.

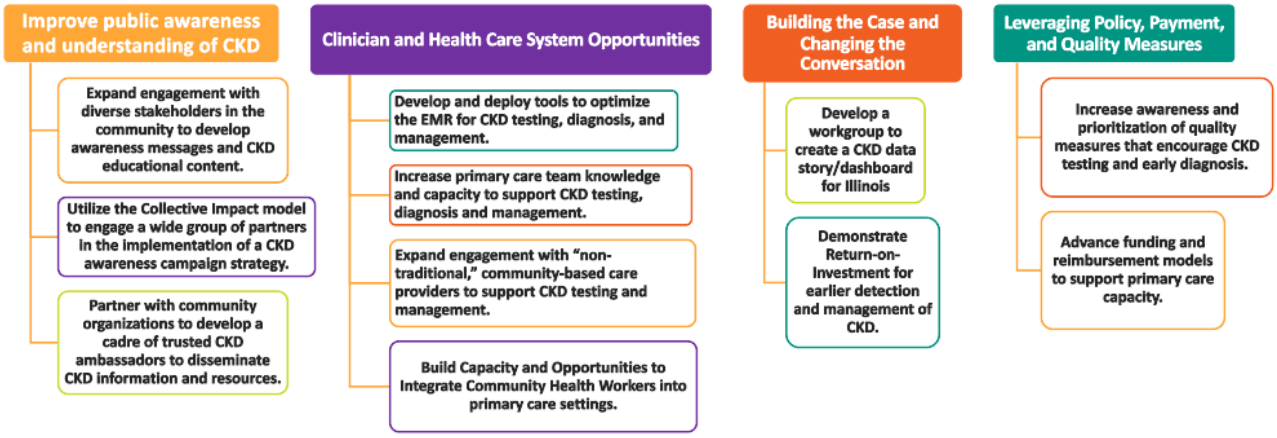
Through a series of Learning and Action Workgroup discussions stakeholders identified barriers and solutions to improve CKD awareness, detection, and management in Illinois. **38 stakeholders representing 29 organizations across the region participated in the workgroup discussions.**

On June 27, 2023, NKFI hosted a hybrid summit to present the recommendations and engage partners in joining the Collective Impact Approach. Over 203 registered and the NKFI team is currently gathering stakeholder commitments in implementing the recommendations.

CKD in Illinois

- Nearly **1.5 million adults** in IL are affected by CKD. However, only 177,680 are aware they have it.
- Only **17.3% of people with risk factors for CKD** (diabetes and/or hypertension) are **tested appropriately**.
- 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.

Recommendations:



Methods:

NKFI convened health care, public health, and community stakeholders from across the state of Illinois 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 Illinois, 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 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 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:

Barriers to CKD testing, diagnosis, and management

Knowledge and Awareness: There is a general lack of CKD knowledge and awareness across multiple stakeholders. Among the general public and patients, the precursors of CKD are unknown. Therefore, patients are not knowledgeable when to get tested, and even if patients are tested, they are not equipped with the chronic disease self-management tools needed to handle their diagnosis. Patients are in need of better access to information or tools to help manage medications, navigate referrals to specialists, and make diet or lifestyle changes to manage CKD. Challenges with health literacy and navigating a complex health system compound this issue.

The lack of knowledge and awareness does not only apply to patients but also clinicians. Within a community context, there is often a cultural disconnect between patients and providers. This spans across different communities as well, as they have different barriers to access to care. In a clinical context, primary care clinicians identified lack of awareness for CKD care guidelines as a barrier as well as a disconnect between quality metrics and patient care goals pertaining to CKD.

Health Care Systems and Structures: Participating group members agreed that providing the best care to patients is done most effectively with an interdisciplinary team. Stakeholders identified fragmentation in the care team as a barrier. Staffing limitations in different parts of the care team affect this issue, as well as the baseline knowledge of CKD amongst each of these roles.

Clinicians identified specific barriers in their role being low utilization of the eGFR (estimated Glomerular Filtration Rate) equation – a tool used to estimate kidney function, as well as lack of data or benchmarking on CKD testing rates among at risk individuals. This affects the utilization of proper testing needed to diagnosis CKD. The challenges of implementing a value-based care or other payment model were also discussed within the workgroups.

Lack of Resources for CKD Patients: During the workgroups, a lack of resources for CKD patients was identified as a major barrier to care. Social determinants of health, such as economic stability, transportation, and others, prevent patients from seeking adequate care or managing their health conditions, but clinicians don't always have the resources or bandwidth to provide referrals. Additionally, it was identified that resources, treatment, and care options are not discussed in depth with patients. Therefore, there is a general lack of awareness of available resources or information for patients with a CKD diagnosis.

Solutions: A Roadmap for Illinois

- **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.
  - 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.
    - Develop a train-the-trainer approach to support these organizations and CKD messengers.

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

        - Create a coalition amongst health care systems and health information technology and electronic health record (EHR) software to create standard tools.
        - Encourage adoption within large medical institutions in the region.
- **Building the Case and Changing the Conversation**
    - Develop a workgroup to create a CKD data story/dashboard for Illinois.
        - 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.
    - Demonstrate Return-on-Investment for earlier detection and management of CKD.
        - Provide tools for organizations (health care, employers, payers, or otherwise) to build the business case for earlier interventions in CKD.

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