

Chronic Kidney Disease Detection and Education Program Case Story



Key Learnings for CDC Cooperative Agreement DP23-0020 (2320) Recipients



BACKGROUND ON

Chronic Kidney Disease

Over 35 million adults in the United States live with chronic kidney disease (CKD), and millions more are at risk of developing it due to high risk factors such as diabetes and high blood pressure ([the first and second leading causes of CKD](#)). Furthermore, 90 percent of U.S. adults living with CKD do not even know that they have it. Costing Medicare \$130 billion in 2018 and creating a quality-of-life burden for individuals, CKD increases healthcare utilization significantly even in its earliest stages due to its significant impact on risk for cardiovascular events. Early diagnosis can greatly reduce the health impacts and save lives. A cross disciplinary approach is needed to coordinate across specialists (nephrology, endocrinology) and primary care to effectively identify, screen, and care for patients with CKD.

The National Kidney Foundation (NKF) developed a [CKD Change Package](#), a collection of evidence-based interventions demonstrated to improve CKD care in primary care settings. To facilitate implementation of these changes, NKF also developed a CKD Learning Collaborative framework. Beginning in February 2023, NKF practice facilitators implemented the NKF CKD Learning Collaborative in a safety net healthcare system in Missouri: University Health. Sixty-five clinicians and administrators participated in CKD education, workflow discussion, identification of care coordination strategies, and other practice changes to improve population health.

RESULTS FROM

CKD Learning Collaborative

University Health demonstrated an over 60 percent improvement in the number of people at risk for CKD, meaning people with diabetes or high blood pressure, receiving both tests recommended to identify CKD. Furthermore, there was a statistically significant improvement of over 25 percent in patients with laboratory evidence of CKD who had an appropriate CKD diagnosis documented in their medical records. There were also statistically significant improvements in the use of medications which can keep CKD from getting worse among those individuals in the program with a CKD diagnosis. The model also improved clinician knowledge of CKD's impact on the healthcare system and confidence in identification of CKD with appropriate CKD testing, risk stratification, and care coordination.



NATIONAL ASSOCIATION OF
CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

101 W. Ponce De Leon Ave., Suite 400
Decatur, GA 30030
chronicdisease.org

The "Diabetes Technical Assistance and Support for State Health Departments" project is supported by the Centers for Disease Control and Prevention (CDC) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$4,000,000 with 100 percent funded by CDC/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CDC/HHS, or the U.S. Government.



Key Learnings

The results of the NKF CKD Learning Collaborative with University Health offer promising learnings for state health departments (SHDs) and other 2320 recipients working on CKD early detection strategies and activities. Below, we highlight potential steps for a SHD to take in engaging partners in an NKF CKD Learning Collaborative program or other quality improvement activities.

Understand the impact of CKD and articulate the need to address CKD.

Addressing CKD begins with understanding the impact of the disease in the population and the strategies different stakeholders can implement to address barriers to early detection and treatment. In discussions with potential partners, 2320 recipients should articulate the clinical, financial, and social needs to address CKD. This can be done by pulling data that shows where there is a high prevalence of CKD in the state or region. One factor that contributed to University Health's decision to prioritize CKD was an awareness of the need for increased CKD prevention efforts due to high incidence rates in the Kansas City area. For health systems, highlighting institutional gaps in testing and diagnosis are often sufficient to stimulate a larger conversation regarding overarching CKD care. Understanding risk factors, such as diabetes and high blood pressure, can also help identify where screening efforts may have the biggest impact. Often, CKD results from a combination of physical, environmental, and social factors. Understanding social determinants of health (SDOH) and health disparities can further aid in identifying geographic areas and populations of focus to direct CKD efforts. University Health was identified as an important partner because of their geographic location serving 58 zip codes across the Kansas City metro area encompassing both suburban and rural communities, and the diverse population they serve (e.g., as many as 16 percent at or below the federal poverty level (FPL)).

Identify partnership opportunities.

When identifying partnership opportunities, 2320 recipients are well positioned to serve as bridges to connect organizations. The Missouri Department of Health and Senior Services (MO DHSS) helped identify high priority geographies and potential local organizations for NKF to partner with, one of which was University Health. NKF leveraged both existing relationships within the nephrology space, and the partnership of MO DHSS to facilitate early discussion with University Health. In addition to making introductions and connections with other organizations, 2320 recipients can offer important feedback, provide critical advocacy and messaging around the importance of CKD, and lend credibility to the work. Recipients may also identify potential funding for start-up costs, including opportunities for braiding and blending funding. For example, state partners already working on screening for other chronic disease, or that already have mobile clinics in certain communities, may layer CKD screening onto existing work.

Recipients can also lead CKD screening and education initiatives or serve as conveners to get other partners involved. In this role, having a project coordinator who is flexible and responsive to clinicians is extremely beneficial for health systems participating in a collaborative, multi-specialty CKD quality



Chronic Kidney Disease Detection and Education Program Case Story

Key Learnings for Health Systems and Clinics

improvement initiative. This allows the work to steadily move forward and keeps clinicians accountable. Alternatively, if recipients don't have the capacity to serve as lead organizations, other groups with subject matter expertise who have robust knowledge of CKD, change management, and the related landscape may be a good fit. The NKF Population Health Partnership team is available to support this work through the NKF offices throughout the U.S.

When considering if a health system would be a good fit for a CKD screening and education initiative, 2320 recipients may look for those that have a culture of learning and collaboration and are advocates for CKD and other chronic disease prevention and management efforts. Building upon an existing commitment to this work can make CKD screening and education a natural extension of other prevention and management initiatives. Without a commitment to primary and secondary prevention of diabetes and other chronic diseases, a health system's motivation to address high rates of CKD may be limited. University Health had a preexisting focus on diabetes prevention and management that developed a spirit of collaboration, as well as a commitment to addressing health disparities.

Create a statewide coalition.

In partnership with the Missouri Kidney Program (MoKP) and MO DHSS, NKF advanced the Ending Disparities in CKD Leadership Summit in June 2022 which brought together over 130 senior leaders to discuss disparities in CKD, what needs to change at the state level, and how to accomplish this. Solutions developed out of this summit aligned with the priorities of the CKD Learning Collaborative, and further built support among health care systems to prioritize CKD quality improvement. 2320 recipients may consider similar opportunities in their states/regions to bring together and introduce partners, leverage joint goals, and discuss opportunities to collaborate. When partnerships are identified, ensure that clear roles and responsibilities are established upfront and identify how success will be measured. In your collaboration plans, be consistent, but also leave some room for flexibility and adjustment. NKF and University Health agreed on a structured approach but allowed for adaptation and evolution in their relationship over time. Even though the formal NACDD program has ended, they will continue to collaborate to expand the NKF CKD Learning Collaborative to other primary care teams within University Health.

Conclusion

The lessons learned from this initiative provide valuable insights for 2320 recipients looking to implement a CKD Learning Collaborative or other CKD early detection initiatives. When pursuing these initiatives, recipients may consider focusing on regions with high CKD prevalence, existing collaborative relationships, and partners committed to diabetes prevention and management and health equity. The strategies outlined in this case story provide a framework recipients can use to meaningfully contribute to better health outcomes and reduce the public health burden of CKD.

