

Chronic Kidney Disease Program

An Innovative and Cost-effective Chronic Kidney Disease Awareness and Prevention Program (CKD-APP)

According to the 2017 National Chronic Kidney Disease Fact Sheet from the Centers for Disease Control and Prevention (CDC), an estimated 30 million people or 15% of U.S. adults have CKD; of those, 48% have severely reduced kidney function, are not on dialysis, and are unaware of having CKD.

The Challenge

Chronic Kidney Disease (CKD) is an underdiagnosed, insidious disease with dramatic long-term public health costs and consequences. Unfortunately, CKD is often asymptomatic, with 96% of individuals unaware of their condition and primary care clinicians rarely catching it before it progresses to a chronic condition.¹

Yet opportunities to prevent CKD and decrease the progression of the disease exist through implementation of evidence-based interventions that engage providers, patients, and families/ caregivers.

Program Description

IPRO's Chronic Kidney Disease Awareness and Prevention Program (CKD-APP) is a two-year Special Innovation Project (SIP) that engages patients, caregivers, and grassroots stakeholders with the goals of increasing CKD screenings, delaying disease progression, and improving patient outcomes. IPRO's multi-faceted approach aims to elevate CKD diagnosis and manage-

ment to the front lines of preventative health for New Yorkers. The CDK-APP amplifies local awareness of kidney disease and creates a culture where early detection and slowing disease progression become imperative. Moreover, the project presents strategic recommendations for conducting activities that will generate the broadest impact and have replication potential for future OIN-OIO initiatives.

Program Goals and Metrics

IPRO is working with providers and commuity-

Create
Supportive
Environment

Self Management/
Develop Personal
Skills

Strengthen
Community
Action

Delivery System
Design/Re-orient
Health Services

Decision
Support
Productive Interactions
& Relationships

Population Health Outcomes/
Functional & Clinical Outcomes

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Figure 1. Chronic Care Model

based organizations to achieve four bold aims within the two-year project period:

- Educate 1,000 Medicare beneficiaries at risk for CKD (hypertension & diabetes) and those who have Stage 3 CKD using the IPRO-developed Chronic Kidney Disease Self-Management Programs (CKDSM).
- Enroll a minimum of 40 providers with a high volume of at-risk CKD Medicare beneficiaries (including dual eligible) and those who have Stage 3 CKD.
- Reduce the patient rate of disease progression from CKD Stage 3 to Stage 4 by 10% (relative improvement) among CKD participating providers.



Chronic Kidney Disease Program

continued

Program Goals and metrics (continued)

- 40% of CKDSM program participants at-risk for CKD will be screened for CKD.
 - At-risk CKDSM program participants screened for CKD sustain behavior changes and don't progress to CKD
- 80% percent of CKDSM program participants improve knowledge and behavior post-survey scores and complete the Passport to Kidney Health.

Figure 2. CKD-APP Activities and Alignment to CMS Goals.

24 Months

Improved
Patient Outcomes
and Cost Savings

Year 2 CKD-APP Activities

Implementation of Improvement Activities Based on the Interim Assessment

12-Month Interim Assessment

Technical Assistance:

Provider Progress Reports, Care Management Plan & CKD Screening Guidelines

Measurement:

Juality Improvement

Part-B Claims Analysis, CKD-APP Pre & Post Surveys, Passport to Kidney Health

Identification of CDK Stage 3 Patients

CKDSM/plus Community Dissemination

Passport to Kidney Health Completion

Pre & Post Knowledge & Behavior Test Collection

IMPLEMENTATION CKDSM & CKDSMplus Workshops

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Implementation of Referral System & Passport to Health

Identification of Participating Practices for Program Enrollment (Part-B Claims Data)

Provider Outreach Establish Baseline -3 Months

Development of Passport to Kidney Health & Patient surveys

Patient & Family Focus Groups

Activation: CKD-APP Advisors, Grassroots Organizations and Stakeholders

Diabetes Self management Program Graduates Activation

Expected Outcomes

- Increased ESRD Awareness & Prevention
- Increased CKD Screenings & Awareness
- Increased Referral to CKD Prevention Education
- Improved Communication Community / Provider
- Improved Blood Sugar & Blood Pressure Levels

Patient Engagement

- Improved Communication Patient/Provider
- Empowered Patients / Self-Managers

IPRO brings policy ideas to life

IPRO helps clients realize better health through its organizational competencies. We

- Support state and federal government agency problem solving
- Foster consensus among varied stakeholders for quality improvement action
- Evaluate and select most appropriate methodologies to investigate clinical quality problems
- Facilitate collaborative provider education and action
- Harness information technology to drive quality improvement
- Build and apply quality measures
- Collect and analyze data on large scale
- Create tools to assess performance

^{1. 2017} National Chronic Kidney Disease Fact Sheet from Centers for Disease Control and Prevention (CDC). https://www.cdc.gov/diabetes/programs/initiatives/ckd-fact-sheet.html