NC IOM TASK FORCE ON CHRONIC KIDNEY DISEASE

May 30, 2007
NC Hospital Association
10:00-3:00

Legislative Charge:

(1) Reduce the occurrence of chronic kidney disease by controlling the most common risk factors, diabetes and hypertension, through preventive efforts at the community level and disease management efforts in the primary care setting.

(2) Educate the public and health care professionals about the advantages and methods of early screening, diagnosis, and treatment of chronic kidney disease and its complications based on Kidney Disease Outcomes Quality Initiative Clinical Practice Guidelines for chronic kidney disease or other medically recognized clinical practice guidelines.

(4) Make recommendations on the implementation of a cost-effective plan for prevention, early screening, diagnosis, and treatment of chronic kidney disease and its complications for the state's population.

(5) Identify current barriers to adoption of best practices and potential policy options to address these barriers.

ATTENDEES

Task Force/Steering Committee: Tammie Bell, Paul Bolin, Jr., Celeste Castillo Lee, Annette DuBard, Thomas DuBose, Jr., Ronald Falk, Deidra Hall, Donna Harward, Jeffrey Hoggard, Bill Hyland, Cynda Johnson, Ann Lefebvre, Monica McVicker, Denise Michaud, John Middleton, Marcus Plescia, Barbara Pullen-Smith, Leanne Skipper, John Smith, Laura Edwards, Chip Killian, Janet Reaves

Interested Persons/Staff: Abby Boston, Jacqui Brett, Missi Britt, CJ Chapelle, Maria Ferris, Bill Haskins, Lynne Johnson, Maura McCann, Uptal Patel, Meenal Patwardhan, Denise Rouse, Paula Szypko, Skip Ward, Kimberly Alexander-Bratcher, Thalia Fuller, Mark Holmes, Kiernan McGorty, Daniel Shive

WELCOME AND INTRODUCTIONS

Marcus Plescia, MD, MPH
Co-Chair
Chief, Chronic Disease and Injury Section
NC Division of Public Health
Department of Health and Human Services

Leanne Skipper
Co-Chair
Chief Executive Officer
National Kidney Foundation of North Carolina

Dr. Plescia welcomed the participants and asked them to introduce themselves. Then Dr. Plescia summarized discussions from previous meetings about the proposed estimated Glomerular Filtration Rate (eGFR) legislation. He then introduced Dr. Szypko, who would speak on behalf of the pathology society.

NORTH CAROLINA SOCIETY OF PATHOLOGISTS: RESPONSE TO eGFR LEGISLATION

Paula E. Szypko, MD, FCAP
North State Pathology Associates
Former President, North Carolina Society of Pathologists
Chair, Federal and State Affairs Committee,
College of American Pathologists

Dr. Paula Szypko is a general pathologist in High Point. Her background is in Internal Medicine, and she specializes in Pathology. She works mainly with live patients and in the laboratory. She is involved in the College of America Pathologists (CAP). They provide laboratory support to labs and physician offices. She has been involved both statewide and nationally due to her love of pathology and appreciation of what the field has done for her. She is currently Chair of the CAP Federal and State Affairs Committee and former president of the North Carolina Society of Pathologists (NCSP).

She explained that eGFR legislation came into prominence in 2004-2005. In the state of New Jersey, a law passed mandating when a lab reported serum creatinine, eGFR must be calculated. CAP received feedback from laboratories with problems. Several small laboratories needed updated equipment in order to comply with the law. Then bills in several states began mandating eGFR calculation with serum creatinine measurement. The National Kidney Foundation (NKF) was contacted to understand their position, but the group found many pharmaceutical companies behind the legislation. They were still receiving complaints from people in New Jersey who were having computer system problems with the Modification of Diet in Renal Disease (MDRD) equation and substituted an easier equation. There were calls about the possibility of liability for providers because of the eGFR calculation.

Dr. Fleming’s previous presentation to the Task Force provided a good background on the problems of calculating eGFR. The MDRD equation is very complicated but has been found to be the most current, accurate, and available equation to measure chronic kidney disease. Research has been conducted with people who already have CKD. It does not

appear to work or has not been validated for the following conditions younger than 18 or ages 70-75, variations in muscle mass (ie, very muscular, malnourished), various diets (ie, vegetarian, high protein), medication, hospitalized patients, or normal kidney function. In the patients with normal kidney function, the eGFR calculation was off by 30% or more. It is the best current measure, but CAP believes it is not something that should be set into law. From a lab perspective, the eGFR calculation is not always easy to implement into the laboratory system. The hospital where Dr. Szypko works collaborated with the laboratory information staff to implement the procedure. One of the main limitations is the MDRD equation requirement for the patient's sex, age, race, and other factors. They are currently calculating two equations, one for African-Americans and one for all other races.

The standardization of creatinine measurement is another major problem with using eGFR. There are several ways that creatinine is measured. Small deviations in the measurement can drastically change the eGFR value. The physician office's lab also may be mandated to perform the calculation whenever the serum creatinine is ordered. Having a laboratory technician calculate the eGFR can lower the proficiency of the other lab tests. There are new tests including cystatin C, microalbuminuria, and others that should be explored rather than mandating eGFR. The Cockcroft-Gault equation is used by pharmacists to calculate eGFR. There may be confusion between the professional communities about which is best and which equation should be used at what time.

CAP, NKF, and some pharmaceutical companies met to discuss the issue of mandated eGFR. The NKF explained that mandating the standard of practice seemed like the best thing, but in light of further information may not be the best use of resources. CAP and the NCSP are in favor of prevention and early treatment of chronic diseases (ie, pap smears, etc). They are also in favor of the work of the Task Force, just not the mandated legislation. The NKF and CAP have a joint statement on eGFR that is included in the packet. Last year the American Medical Association House of Delegates passed a position statement against mandated eGFR calculation. Many of the states in which legislation has been proposed were defeated. Several other states watered down the wording of their legislation. Dr. Szypko applauds the efforts increasing the awareness of CKD in the population at large and the medical community. She requested that section 2 be withdrawn from HB 1878. She explained that mandating the equation legislates the practice of medicine and puts the pressure on the laboratories instead of the provider giving the required information. She believes the emphasis should be on research rather than a legislative mandate.

Comments/Questions: The discussion that followed addressed many issues Dr. Szykpo discussed. One participant explained that he was not interested in legislating the practice of medicine either but had concerns about the education of providers by the laboratory. He gave several examples of descriptions of tests that have explanations and have changed the practice of medicine. He discussed the problems of the serum creatinine test and suggested an interpretation of the bad test rather than getting rid of the test. He suggested an automated paragraph that gets printed with the serum creatinine and eGFR explaining the limitations of the test. Dr. Szypko explained that her hospital has that type

of paragraph, but patients have eGFR drawn much more frequently than the serological tests for which the paragraph is currently printed. The participant then asked for the CAP suggestion of how to deal with the test. CAP is focusing on patient and physician education and has started a website (mybiopsy.com) that explains the test in lay terms.

Another participant asked about the ability to reach all the general practitioners in order to deal with the problem. Physicians should discuss the limitations of the eGFR value. One example is the problem with the value in acutely ill hospital patients. eGFR has value when viewed in the total clinical context like BMI. Both measures depend on many of the same characteristics. The participant agreed that providing advice is the role of the physician.

The American Society of Nephrologists supports eGFR, but the practicing of using eGFR has not been adopted or applied. One participant was concerned that attacking the equation removes the focus from the legislation issue which is the problem. The calculation is easily available and is educational. For many patients with serum creatinine levels that are low, eGFR reporting has allowed detection of changes in the patient. Interpreting the data is the role of the clinician and may provide a great service to those that might not otherwise have been detected. The presenter agreed that many radiologists in her hospital have asked how to handle patients with low eGFRs, which has led to many discussions with nephrologists. CAP and NCSP do not oppose the calculation of eGFR but rather the law mandating the reporting of eGFR. They believe education and research are the answer rather than legislation.

There is the possibility that not all laboratories may be able to upgrade their equipment without legislation. By mandating the calculation, it levels the playing field of the various sized laboratories. The presenter explained that larger laboratories may have the capability but smaller ones may not.

Another participant explained that he printed off the bills proposed for the legislative committees on health. The list included more than 40 bills. He asked about the standard that should be applied to all of those bills and which should be legislated as opposed to the education and research approach. The CAP has the Federal and State Affairs Committee and others to deal with legislation. Another participant suggested that this Task Force impact the issue for the state. Another explained that NKDEP has already done that on a national level. NKF, CAP, and ASN were all a part of that group.

REPORT OF PRIMARY CARE WORKGROUP

Marcus Plescia, MD, MPH
Chief, Chronic Disease and Injury Section
NC Division of Public Health
Department of Health and Human Services

Dr. Plescia explained that the last meeting of the Task Force was a small group focused on primary care. He explained that the areas of focus were CKD management in Community Care of North Carolina (CCNC), the State Employees Health Plan (SHP), and primary care generally.

He gave a brief overview of CCNC, a statewide network of integrated care teams providing a medical home. CCNC is coordinated around the idea of case management, a collaborative process with little top-down management. The program is focused on the Medicaid population which has two main age groups and a third of the aged, blind, and disabled population. There is also the potential for expansion of CCNC to Medicare. Their statewide initiatives are focused on asthma, diabetes, decreasing emergency room use, congestive heart failure, and hypertension. The CCNC case managers share data from chart audits, utilization, and claims data. They work directly with patients and practices. The services they provide are limited to high risk patients.

CCNC uses national guidelines for their standards. The American Diabetes Association (ADA) guidelines for diabetes recommend microalbumin and creatinine to estimate eGFR. CCNC does not currently collect and report data on eGFR. For hypertension, they use the Seventh Report of the Joint National Commission on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC-7), but they may soon convert to the NKF guidelines. Hypertension affects more than 80% of people over 50, more than 50,000 Medicaid patients, and requires a more intensive chart review process.

The State Health Plan uses the Health Dialogue SMART registry to provide information to primary care providers on their patients with chronic diseases. The registry reports whether microalbumin levels have been checked and tries to identify gaps in service for providers. Identified patients can be referred to health coaches for education about kidney disease. Renaissance is the contractor working with both SHP and UNC to test the most effective way to review claims data. These data can then be referenced with laboratory data to obtain eGFR values.

The small group focused on enhancing current disease initiatives or creating new ones, screening based on CKD risk factors or incorporating CKD screening in the diabetes and hypertension management, forming the best treatment guidelines, and maximizing treatment benefits. It was noted that these are complicated systems in which to implement recommendations. The NKF KDOQI guidelines, especially their anemia management recommendations, are controversial because of conflict of interest of involved companies. In terms of screening and treatment, certain antihypertensive medications will manage CKD better in particular patients.

The group made several preliminary recommendations for both the short and long term. CCNC should incorporate a CKD management focus into both diabetes and hypertension chronic disease management programs and develop a proposal for its implementation throughout the networks. Other recommendations include co-training case managers in CKD and increasing reporting and use of eGFR and add eGFR to the clinical standards. CCNC should screen people with hypertension but not diabetes for CKD to determine its

prevalence. SHP should use claims data and lab results to identify people, improve the Renaissance program, and use SMART registry to give feedback to providers. For the long term, CCNC should create a CKD focused disease management initiative in conjunction with the 646 waiver program for dually eligible Medicaid and Medicare recipients. A study of CKD screening in the general population would provide evidence-based guidelines for screening.

Long term recommendations also focused on eGFR and screening. Microalbumin and eGFR should be obtained from all diabetic and hypertensive patients. The use of beneficial medications should be increased along with patient education opportunities. Indicators for nephrology referral and effective treatment should be added to electronic medical records. Medicaid should require eGFR for all lab results, while quality initiatives, professional societies, SHP, and other insurers should request eGFR calculation. Screening should focus on patients with diabetes, hypertension, and other risk factors and should eventually be extended to the general population. Several issues were left for further discussion including defined guidelines, treatment and screening of patients with pre-diabetes and pre-hypertension, and screening for the general population.

Comments/Questions: The discussion that followed focused on the recommendations and steps to clarifying them. The CDC has contracted with RTI and universities to study some of these issues and should present at the next Task Force meeting. A SHP representative explained that Health Dialogues is specifically for those with diabetes. Their next registry is going out in August and will discuss microalbumin and the work of the Task Force. In February there will be more information for providers. A representative from CCNC was concerned that if a legislative mandate was not pursued, Medicaid and other organizations should be contacted to describe the position of the Task Force. Another participant volunteered to lead a small group meeting on eGFR for pathologists and the various organizations in the state with positions on the issue. Renewed focus on patients, difficulty with ICD-9 codes, inclusion of cardiovascular disease, and details of the 646 waiver system were also discussed.

PRIMARY CARE ISSUES FOR PEDIATRIC PATIENTS

Maria Ferris, MD, MPH, PhD
Associate Professor of Clinical Medicine
University of North Carolina Kidney Center

Dr. Ferris is a pediatric nephrologist at the UNC Kidney Center. She explained that there are no accurate estimates of pediatric CKD in North Carolina. Great diversity exists between pediatric onset CKD patients, and end stage renal disease/end stage kidney disease (ERSD/ESKD) account for only a small portion of these patients. There is a need to track pediatric CKD patients in the state.

For both adults and children, the UNC Kidney Center uses KDOQI guidelines for screening and treatment. Pediatric GFR depends on body size and age and is not

automatically reported on laboratory reports as it is for adult patients at UNC. When infants reach two years of age, they may reach adult GFR levels.

In the US, pediatric cases account for only 2% of all ESKD. Since 1990, the prevalence of pediatric ESKD has increased 32% as opposed to 126% overall. Internal medicine nephrologists treat one-third of all pediatric dialysis patients. This data comes from the North American Pediatric Renal Cooperative Study (NAPRTCS), a volunteer organization that tracks data until 18, and United States Renal Data System (USRDS).

Renal replacement therapy for pediatric ESKD patients in the US is comprised of hemodialysis, peritoneal dialysis, and renal transplant. Of those using dialysis treatments in 2003, almost 60% used hemodialysis while only 40% used peritoneal dialysis. There were more than twelve transplant recipients per one million people. New patients were more likely to choose hemodialysis, but a majority of pediatric patients and the fastest growing group were transplant recipients. Most pediatric CKD patients did not receive recommended preventative health measures. In 2004, the point prevalence for ESKD in North Carolina was much greater than the national average for patients ages newborn to four years and 25 to 74 years. The ten year survival rate for adolescent onset ESRD increased from just over 70% in from 1973 through 1977 to more than 88% if patients were diagnosed in 1993 or later. There were some disparities among survival; 83% for White patients versus 72% for African-American patients and 82% for transplant recipients versus 79% for dialysis recipients. White patients were more likely to receive a transplant than African American patients.

Adherence, or following the treatment plan, is a major obstacle for pediatric and adolescent CKD patients. It is the number one cause of transplant loss. Transplant is the preferred and most common treatment modality and children get extra points on the transplant list.

Not all pediatric CKD patients are equal. Some have inherited conditions and the family may be prepared for the complications. Younger patients may be diagnosed prenatally. Patients with kidney and urinary tract anomalies have longer enuresis (bedwetting) and less hypertension and growth issues. Teenagers mainly have acquired diseases and more hypertension.

Personal and medical issues are substantial for CKD pediatric patients. They may include distorted physical appearance, social consideration, self perception, cognitive abilities, healthy siblings, and parents who attend medical visits. Additional challenges for pediatric CKD patients include complexity of care, technology and medication dependence, distance from treatment site, and insurance difficulties with transition to adult care. The leading cause of death among young adults with pediatric onset CKD is cardiovascular disease. The kidney and heart relationship is complex and depends upon blood pressure control, bone health or calcifications, anemia, inflammation, and nutrition.

Neurocognitive function is significantly lower in pediatric CKD patients than their counterparts at the same age. Patient IQs improve by 15 points after receiving a renal

transplant. The average literacy scores are below national averages for all pediatric CKD patients, with worse scores for minorities. Children had greater literacy scores than their parents. Low parental literacy was associated with a higher incidence of perotinitits (even when patients were treated by the same providers), more emergency room visits, and lower adherence.

Transition is the term used to describe patients progressing from pediatric to adult CKD care. The Pediatric Nephrology survey (PEDNEPH) included international participants. Additional data from the Glomerular Disease Collaborative Networks was combined to draw conclusions about transitioned patients. In general, US patients began transition at a later age and most patients were not in a transition program. Only 2% of US patients seen by adult nephrologists are transition patients. Difficulties associated with late transition include parents asking questions for patients and less knowledge of medication and disease. A study comparing transition patients in Wisconsin versus North Carolina showed unfavorable results for North Carolina. The long term outcome showed North Carolina patients were older age at transition, had less participation in transition programs, and less knowledge about diagnosis and medications.

At Victory Junction Gang chronic disease camps, focus groups were conducted among parents. The parents of CKD patients thought education from a health provider was the most important transition issue while parents of children with heart or lung diseases thought insurance was the most important issue. Both groups of parents chose prescription adherence as the least important issue.

The UNC Successful Transition to Adulthood with Treatment (STARx) Program attempts to help overcome the barriers associated with transition. They developed the UNC TRANSITION Score, which correlates with age. Each of the ten measures are given a score from zero to one and the score is used to track patient progress. Traditionally only 7% of patients have information about insurance after leaving their pediatric provider and only 2% know their adult provider. The program has created the transition ID card. It lists pertinent medical information for the patient and provider. It is another tool to ease the transition from pediatric to adult CKD patient.

Monique Winslow, PhD
Children with Special Health Needs
Women's and Children's Health Section
NC Division of Public Health

Dr. Monique Winslow is the new Specialized Services Center Manager and is also new to the state. Dr. Gerri Mattson prepared the presentation, but Dr. Winslow made the presentation in her absence. She explained that a team approach is used to care for families including physicians and case managers. The definition of Children and Youth with Special Health Care Needs (CYSHCN) was pulled together by a task force and published in *Pediatrics* in 1998. It includes children with and at risk for special needs and considers the complexity of their environment. The Children with Special Health Needs

unit is responsible for health promotion, developing and planning community based systems of service for optimal function of children with special health care needs, and ensuring and extending other state initiatives.

The unit uses several tools to assess the needs of CYSHCN. The Child Health Assessment Monitoring Survey (CHAMP) identifies and addresses risk factors. The birth defects monitoring program is a national program used to track codes and counts of children with birth defects. In 2002, the program collected data showing 506 defects classified as the four ICD-9 codes related to kidney disease. Data from the Southeastern Kidney Council reiterated the higher prevalence in North Carolina than the national averages of CKD in patients aged newborn to 4 and 15 to 24. In 2005, the dialysis rates for North Carolinians aged 5 to 24 were 30.9 per million persons for incidence, and the prevalence was 72.7 per million persons.

Another function of the unit is to assure or provide care for CYSHCN. About 40 health departments provide pediatric primary care. Health Check outreach and Medicaid for children provide a medical home from birth to 21 years and include the promotion of Early Periodic Screening, Diagnosis, and Treatment (EPSDT). Special funds are available for children with chronic conditions receiving Medicaid benefits through the Children's Special Health Services (CSHS) program. The State Children's Health Insurance Plan (SCHIP) and Commission on Special Health Care Needs ensure the maximum benefit possible to CYSHCN. Genetic counseling is available to families and may provide information about CKD. A telephone help line provides information about insurance programs and community resources for families and providers. The Child Service Coordination Program is designed for children from birth to age five. A provider determines family needs, connects families to needed services, and creates a family care plan. Early Intervention, designed for children from birth to age three, is a federally mandated program under the Individuals with Disabilities Education Act (IDEA) that can serve children with developmental delays or future implications. Finally, medical nutrition therapy is available through Medicaid or Children's Development Service Agencies and provides access to assessment and ongoing care by a registered dietician.

Transition of youth with special health care needs from pediatric to adult care is a critical time in the life of these patients. Carolina Health and Transition (CHAT) program is developing a curriculum to facilitate the transition period for patients, parents, and providers. Patients are living longer and having quality of life issues associated with adulthood. The program creates collaboration between youth and family curricula and a written care plan for transition by the age of 14. Medical home demonstration projects provide ongoing assessment and improve the quality of care delivery.

Improving Pediatric Access through Collaborative Care (IMPACC) is a statewide initiative involving Community Care of North Carolina, the Division of Medical Assistance, Duke Endowment, and six pediatric tertiary care centers. The goal of the program is to improve communication and management of care between medical homes and specialty clinics. Two of the tertiary care centers will have coordinators for the nephrology clinics.

There were several suggested program needs for CYSHCN: a medical home for every child, more care coordination, more resources, better enrollment in available programs, quality improvement, more education, mentoring, reimbursement, and funding, common strategic plans, and use of universal communication principles to address low health literacy. Strengths of the CYSHCN programs are the numerous stakeholders, strong champions, and interest in both quality improvement and the transition process.

Comments/Questions: The discussion that followed addressed both pediatric presentations. Further details were requested about the CHAT project. In the absence of CKD prevalence information, other factors including obesity, metabolic syndrome, and first degree relative on dialysis should receive emphasis. Barriers to nephrology care of pediatric patients including the cost, training, and insurance needed to provide care were also discussed.

INVOLVING THE COMMUNITY IN HEALTH EDUCATION AND OUTREACH: CHURCHES, LAY HEALTH ADVISORS

Barbara Pullen Smith, MPH
Director
Office of Minority Health and Health Disparities
North Carolina Department of Health and Human Services

Ms. Pullen-Smith expressed her enthusiasm for the work of the Task Force. She provided an overview of the Office of Minority Health and Health Disparities (OMHHD). The OMHHD represents racial and ethnic minorities and underserved communities and advocates for systems change. The OMHHD has multiple focus areas. Capacity building at the state and local level is achieved through research and data. The health disparities report card with 37 indicators is created in the office. Cultural and language focus is met through training initiatives, reflecting and respecting understanding about different communities. Policy and legislation occurs through the 15 member Minority Health Advisory Council that advises the governor and cabinet secretary. Other areas of focus include communications and partnership development.

One fairly new strategy to engage communities is the Community Health Ambassador Program (CHAP). The goals of the program are to build the capacity of communities to prevent illness and complication, recognize early warning signs, and increase access to health, human services, and resources. Program participants are trusted leaders, volunteers in the community, advocates rather than experts, bridge builders, and are not required to have a clinical background. The curriculum focuses 20 classroom hours and 2 continuing education units (CEU) on diabetes and cancer. Requirements for completion include continuing education, resource directory, 100 encounters per year, healthy lifestyle memorandum of understanding, and exam scores of 80. Upon completion of the program, participants receive a small stipend to cover expenses and a vest to wear identifying them as CHAP members. The program staff is comprised of three instructors

and a statewide coordinator, who is also a minister, nutritionist, and doctor of naturopathic medicine. Active partners include community and faith based organizations (CBO & FBO), NC Community College System, NC Department of Health and Human Services, and Old North State Medical Society.

The CHAP program was initially piloted in the spring of 2006 with the support of 34 community and faith based organizations. Ten training sessions were completed, totaling more than 300 Community Health Ambassadors. The pilot was focused on communities in Buncombe, Mecklenburg, Guilford, Durham, Wake, Lee, Cumberland, Pitt, Martin, Bertie, and Hertford counties, and there are intentions to expand statewide. The faith community has been the primary access point. Components of the program have been translated into Spanish and participants represent a variety of ethnic communities.

The OMHHD Call to Action Model is an integrated approach to eliminating health disparities. The stages are to develop partnerships, equip staff and volunteers, engage communities, and influence policy. Solutions to eliminating disparities are local. A mistake many groups make is failing to engage community or change steps around. While the staff of OMHHD is multiethnic and representative of communities, they are still viewed as government workers. Applying the model to the CHAP program demonstrates its success. CHAP developed partners with 34 FBO & CBO collaborators. These partners were involved in recruitment, retention, leadership, and evaluation. The program continues building on long term relationships in a win-win situation for all partners at the table. CHAP engages communities by becoming partners with them, including weekend events and supporting partner activities. The staff and volunteers were equipped with training, resources, and support. CHAP influenced policy through partner approval of curriculum, communication with other stakeholders in the communities, and support of pending legislation that attempts to eliminate health disparities.

Ms. Pullen Smith concluded her presentation by playing interviews with CKD patients describing some of the challenges they faced. She noted that, "Knowing what to do is not enough, people need support to be healthy'.

Comments/Questions: The short discussion that followed focused on the relationship between CKD and the CHAP program including curriculum, funding, and resources for statewide expansion.

GROUP DISCUSSION

Dr. Holmes discussed the process of NC IOM Task Forces in two phases; 1) information presentation and 2) discussion and possible recommendations. He explained that it would be useful to determine the information needed to address the remaining sections of the Task Force charge. Participants suggested presentations from the local chapter of the American Nephrology Nurses Association, Council of Nephrology Social Workers, dialysis providers, and patients. Other suggested topics to discuss included the certificate of need (CON) program with an emphasis on

pediatric patients and review for relocation or expansion, obesity, delays in insurance coverage for certain CKD procedures and treatment, transplant organ donation and reimbursement, primary care implementation of task force recommendations, CKD programs separate from or included in diabetes and hypertension program, and barriers to optimal health and wellbeing for CKD patients.