

## NC IOM TASK FORCE ON CHRONIC KIDNEY DISEASE

July 23, 2007  
NC Medical Society  
10:00-3:00

- (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:* Celeste Castillo Lee, Sam Cykert, Annette DuBard, Thomas DuBose, Jr., Linda Gross, Deidra Hall, Donna Harward, Bill Hyland, Cynda Johnson, Jim Keene, Jenna Krisher, Ann Lefebvre, Monica McVicker, Denise Michaud, John Middleton, Marilyn Pearson, Marcus Plescia, Barbara Pullen-Smith, William Purcell, Leanne Skipper, Laura Edwards, Janet Reaves

*INTERESTED PERSONS/STAFF:* Missi Britt, Patrick Buffkin, Amy Cook, Kristina Ernst, Jim Martin, Victoria McClanahan, Anne Rogers, Denise Rouse, Leighann Sauls, Virginia Wang, Kimberly Alexander-Bratcher, Sarah Haseltine, Mark Holmes, Kiernan McGorty, Daniel Shive, Pam Silberman

### 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 called the meeting to order and asked the participants to introduce themselves. Dr. Silberman thanked the NC Medical Society for hosting the meeting and provided some logistics of the meeting space. Dr. Plescia introduced Laura Edwards, RN, the NC Kidney/Epilepsy Program Coordinator. She had copies of the newly available book, *The Burden of Kidney Disease in North Carolina, 2007*, from the University of North Carolina Kidney Center funded by the North Carolina Department of Health and Human Services, Division of Public Health.

**THE STATE MEDICAL FACILITIES PLAN AND CERTIFICATE OF NEED**

**Jim Keene**

Planner

Medical Facilities Planning Section

Division of Health Service Regulation

North Carolina Department of Health and Human Services

Mr. Keene introduced himself and reminded the group of the new name of the Division of Facilities Services, the Division of Health Service Regulation. He explained that the division is a regulatory agency in the NC Department of Health and Human Services. He worked in the Medical Facilities Planning Section and was responsible for the Semiannual Dialysis Reports from 1993 until his recent retirement. At the end of the Task Force meeting in May, some questions were raised regarding the Certificate of Need (CON) process and Mr. Keene explained his hope that his presentation would help resolve those questions.

The State Medical Facilities Plan is an integral part of the CON process. It is important to note, however, that a variation of the plan existed well before the CON program, dating back to the Hill-Burton Hospital Construction Act of 1946. That legislation was followed by a series of amendments, the Regional Medical Programs in 1965 and the Comprehensive Health Planning and Public Health Service Amendments in 1966. A number of states established CON programs between 1964 and 1973; however, federal legislation (PL 93-641) effectively mandated CON programs nationwide in 1974. While the scope of the programs developed varied widely, renal dialysis has been a regulated category of service from the beginning. By 1980, the District of Columbia and all states except Louisiana were operating CON programs.

In 1978, the Certificate of Need program began in North Carolina. Statutes G.S. 131 E-175 through G.S. 131 E-190 provide the framework for the CON program and the State Medical Facilities Plan. In the mid-1980s, there was discussion about taking dialysis facilities out of the statutes, but no action was taken. There have been no recent efforts to

change CON regulation of dialysis facilities in the state. The federal mandate for CON programs was lifted in 1986, lasting just over ten years. Since that time, fourteen states have eliminated their CON programs while the others maintain varying degrees of coverage. The density of shading of the map “States with CON Programs” represents the relative degree of CON regulation, the darker the shading the stronger the controls. As of last year, materials from the American Health Planning Association indicate that thirteen programs continue to regulate renal dialysis.

The rationale for CON was based on health care planning, particularly for expensive health care facilities and equipment. The goal was to assure an adequate supply of health care facilities and services, without creating a surplus of either one. Underutilized facilities and services have fixed costs, which increases the expenses per patient. Because taxes, as represented in the Medicare and Medicaid payments, pay a significant portion of health care expenses, the public has an appropriate financial and fiduciary interest in controlling unnecessary growth of health care facilities and services.

The annual State Medical Facilities Plan (SMFP) governs the number and type of new medical facilities and services which can be developed in North Carolina. A copy of the inside cover and table of contents was included as a handout. The NC State Health Coordinating Council (SHCC), a twenty-seven member council appointed by the Governor, oversees development of the annual SMFP. The SHCC relies on public hearings across the state to inform its decisions. All council members serve on a voluntary basis. The NC CON statutes state that need determinations in the SMFP are the determinative limit on the number of new beds or services that can be developed. The SMFP also allows SHCC members to recommend adjusted need determinations, which can focus on special populations that might be underserved, and policies which can lend priority to certain issues.

In response to the discussion in May about influencing local dialysis providers by placing conditions on future Certificates of Need, Mr. Keene spoke with the Division Director, Bob Fitzgerald, and the Chief of the Certificate of Need Section, Lee Houffman. They believed a more appropriate approach would be to identify specific issues which need to be addressed then petition the SHCC for an adjusted need determination or a new policy in the SMFP to address a specific issue. He explained that some desires may be beyond the scope of the SMFP or CON processes, but that several special population adjustments have been successful in the past. The examples include nursing homes, home health agencies, dialysis stations, an open-heart surgery program, operating rooms, and hospitals. Policies are the other type of governing factor. They define special circumstances which allow exceptions to need determinations by the standard methodologies without the necessity of individual petitions. He provided an example of a policy that applied to heart-lung bypass machines for emergency coverage.

In the event that the Task Force might make recommendations to the SHCC, Mr. Keene thought it would be helpful to provide a quick synopsis of the annual planning cycle. The SMFP is reviewed each year. At the beginning of the year, petitions with statewide implications are considered. After new information is included, a proposed SMFP is

published. Then public hearings are held to allow petitions for adjusted need determinations. The council committees review the petitions and make recommendations to the full SHCC, which makes recommendations to the Governor. He or she reviews the proposed plan and signs it to take effect on January 1<sup>st</sup>. The dialysis chapter is distinct in that only the methodology and timeline for publishing of the semiannual reports is included in the SMFP. The current SMFP and most recent Semiannual Dialysis Reports can be found on the division website at [www.ncdhhs.gov/dhsr](http://www.ncdhhs.gov/dhsr).

**Discussion/Questions:** The discussion that followed focused on the SMFP, semiannual dialysis reports, and their relevance to chronic kidney disease. Mr. Keene clarified that most policies make allowances rather than restrictions. In the SMFP, there are no separate requirements for peritoneal dialysis sites apart from those for hemodialysis or pediatric dialysis apart from adult dialysis. Many pediatric patients use peritoneal dialysis. Peritoneal dialysis units must be certified. Peritoneal dialysis does not require travel to a dialysis unit three times per week, rather once per month if there are no complications. One option for recommendation by the Task Force is requesting an adjusted need determination and the council may be responsive. Access to pediatric nephrologists is a major problem, there are only 400 pediatric nephrologists in country. One regional community should be filing application to resolve that issue for themselves. There is the possibility of statewide review of need for pediatric facilities, but there are only a small number of pediatric CKD patients.

Other questions included information for the Task Force about dialysis education by providers of dialysis care, financial incentives of one modality of dialysis over another, the possibility of electronic real-time data monitoring for pediatric nephrology, delineation between the roles of pediatrician, pediatric nephrologist, and adult nephrologist, the scope of the CON program and SMFP, and the lack of data on patient preferences for dialysis modalities.

During the break, Dr. Keene was able to locate data on pediatric dialysis patients in North Carolina. According to the Southeastern Kidney Council, between ages 0-4 there were 9 prevalent and 8 incident cases, between ages 5-9 there were 2 prevalent and 4 incident cases, ages 10-14 had 16 prevalent and 11 incident cases, and ages 15-19 had 35 prevalent and 17 incident cases. This demonstrated the relatively small numbers of cases of pediatric dialysis patients compared to the adult population.

**CENTERS FOR DISEASE CONTROL AND PREVENTION:  
NATIONAL CKD INITIATIVE**

**Kristina Ernst RN, CDE, BSN**

Public Health Advisor and Program Consultant

The Kidney Disease Initiative

Division of Diabetes Translation

National Center for Chronic Disease Prevention and Health Promotion

Centers for Disease Control and Prevention

Member- Steering Committee  
National Kidney Disease Education Program  
National Institute of Diabetes and Digestive and Kidney Diseases  
National Institutes of Health

Dr. Plescia introduced Ms. Ernst. She explained that her position and the new CKD program are both located in the Division of Diabetes Translation. She provided a brief overview of the burden of CKD including information that was discussed in detail by previous presentations. Kidney disease is one of the most devastating and expensive complications of diabetes. It is the 9<sup>th</sup> leading cause of death in the United States. The number of cases of end stage renal disease (ESRD) has doubled since 1990 and is expected to increase with the increasing prevalence of kidney disease risk factors such as diabetes.

The Centers for Disease Control and Prevention (CDC) has developed a rationale for a public health approach to CKD in the US. Kidney failure is a public health problem. Economical, effective testing and therapy exist, but are being inadequately applied. There is a spectrum of CKD beginning with normal kidney function, through the five stages, and ending in death. There are appropriate prevention and treatment measures for each level through stage five. Most of what we know focuses on end-stage CKD or normal kidney function with hypertension and diabetes. The traditional public health approach is stepwise from surveillance to application. A new coordinated approach includes each of the traditional steps in conjunction with each other. It is called the Triple A approach and involves synergistic, comprehensive public health strategies for preventing chronic kidney disease.

Recently legislation was passed allocating funds to the CDC for the study, surveillance, and health outcome programs for CKD. They were asked to convene a panel of experts to begin a public health action plan for kidney disease. The mission includes prevention, awareness, early diagnosis, and improved outcomes and quality of life for those with CKD. The CDC partners with many other organizations. Currently, the Centers for Medicare and Medicaid (CMS) pays for most therapy, the US Renal Data System (USRDS) provides data, and the National Kidney Disease Education Program (NKDEP) uses a three pronged educational approach. The many divisions of the CDC including the National Center for Health Genomics, National Center for Health Statistics, National Health and Nutrition Examination Survey (NHANCES), State Diabetes Prevention and Control Programs (SDPCP), and National Center for Environmental Health are partners with the program.

There are many current initiatives underway including the expert panel to begin Public Health Strategies for Chronic Kidney Disease Prevention, national CKD surveillance protocol, demonstration project for identifying high risk individuals, economic studies and various data sets. The CDC is also working to develop partnerships both internally and externally with groups like NKDEP, NKF, and others. Additionally, a study of the

natural history of CKD is being undertaken in the Veterans Administration in the Puget Sounds area. They are also raising awareness with World Kidney Day. This year it was commemorated in the Morbidity and Mortality Weekly Report (MMWR).

Ms. Ernst shared some preliminary recommendations from the CDC expert panel which met in Atlanta in March. The group included experts and representatives from the National Center for Health Statistics, USRDS, Veterans Administration, managed care, Agency for Healthcare Research and Quality, Centers for Medicare and Medicaid Services, and nonprofit organizations. They used meta-analyses to make recommendations on preventing progression of CKD to kidney failure. They also make recommendations about who to test and how to test for CKD, who should be treated and how to treat them for CKD, engaging primary care providers and nephrologists, and developing partnerships. The SDPCP is a partnership at the state level which is uniquely wise in being able to leverage resources. Louisiana and Texas are receiving funding in addition to North Carolina through the program. Ms. Ernst provide other resources including the NKDEP African American Family Reunion Program ([www.nih.nkdep.gov](http://www.nih.nkdep.gov)) and the Kidney Disease Initiative website ([www.cdc.gov/diabetes/projects/kidney.htm](http://www.cdc.gov/diabetes/projects/kidney.htm)).

Discussion/Questions – The discussion that followed focused on the CDC initiative and its logistics including intervention and outcome measures be implemented by 2009, integration of CKD into other funding announcements, feedback about the initiative’s website, the expert panel, and NKDEP program implementation difficulties. Ms. Ernst noted that the expert panel recommendations will build on K-DOQI guidelines. A program participant mention the dietary issue, that American Nutrition Therapy is one of the least utilized resources. Other target policies of the initiative include learning from each other. North Carolina is the first to have a CKD Task Force. Texas and Michigan were just allocated \$1 million for similar initiative in their states.

#### **EDUCATION OF HEALTH PROFESSIONALS AROUND CHRONIC KIDNEY DISEASE: CONTINUING EDUCATION OPTIONS**

##### **Sam Cykert, MD**

Associate Director  
Medical Education and Quality Improvement  
NC Area Health Education Center

Dr. Cykert explained that education is a big part of quality initiatives. AHEC has generally had four roles: 1) teaching sites, 2) sponsorship of primary care residencies, 3) disperse specialists where needed in rural areas, and 4) continuing medical education (CME) providing up to 150,000 person hours. North Carolina licensure requires 50 category 1 credits per year.

An example of CME credit might proceed as follows; baseline chart review on chronic disease topic - 5 credits, design intervention - 5 credits, implement project - 5 credits, full project – 5 bonus points. Potential outcomes measuring care processes or outcomes rarely happen. Other formats are variable in success. Printed materials only work with

funding and requirements. Workshops like case presentation of eGFR that are physician driven work. Audit and feedback works best on low performing practices as a sort of shock approach. Outreach activities, like Quality Improvement Consultants (QICs) work well for practice redesign and system change to seamless activities. Research shows that many current forms of CME are not effective, but the outreach format is one of the most effective methods.

It is necessary to reform CME coupling socialization with performance improvement. There is the possibility of requiring performance improvement CME. Offer them during regional conferences, encourage participation of providers, and infiltrate professional organizations. Future strategies include the statewide quality initiative, board certification, medical licensure, and pay for performance (P4P).

In terms of CKD, we need to identify short list of what we want practices to do, achievable measures, provide tools, and explain the high burden of disease and cost. These efforts should be integrated into the statewide quality initiative, incorporate into other initiatives, and provide education and practice support.

Comments/Questions: The discussion that followed focused on improving CME through AHEC. Dr. Cykert noted a change in CME to practice-based methods, but no requirement for improvement. The targets require a lot of work. Board certification will soon be tied to performance. The American Board of Medical Specialties, which is comprised of 24 U.S. specialties, Maintenance of Certification is working to be tied to licensure and requirement for various payers. A participant notes that it is important to focus on the patient activation aspect as well. Another participant asked about objective studies to compare dollars spent on public (patient) versus professional (provider) education. Dr. Cykert answered that the UK spent much more money on quality improvement than they believed necessary to achieve excellent progress.

## **PRELIMINARY DISCUSSION OF RECOMMENDATIONS**

### **Pam Silberman, JD, DrPH**

President & CEO

North Carolina Institute of Medicine

Dr. Silberman explained the process of making recommendations by reviewing the minutes to organize ideas by the charge set by the North Carolina General Assembly (NCGA). She explained that she would review all the recommendations for a general overview and then review each separately with concepts rather than specific words.

For the first part of the legislative charge, outreach to public can be achieved by increasing NCGA funding to support the work of the Division of Public Health, the National Kidney Foundation of North Carolina and other organizations including barber shop and beauty shop outreach.

Outreach to health professionals can be achieved by standardizing the relationship between primary care providers (PCP) and nephrologists to determine who does what and when. The Task Force should consider a state effort of pay for performance both for specialists and PCPs. Also eGFR eliminates the need for reminder pop-ups about CKD.

For the second part of the charge, prevention can be achieved through screenings, statewide cooperation between medical school programs, direct linkage to appropriate follow-up care, and funding for existing programs rather than across the board. Screening tools could include SCORED or other tools. In order to activate the population, send something to patients to ask provider about CKD. The State Employees Health Plan should develop more effective referral systems to cue PCPs about identification for patients with eGFR<60.

Comments: All payer organizations should be targeted with recommendations. Eliminate the statement that patients identified with CKD should be offered case management services. Multiple opportunities should be used to provide the message of CKD. Plans should develop criteria to identify patients with CKD who should be provided with case management services. Remove 646 case management from this section.

Case management could be cross-training or single disease, a two-tiered approach. CKD educators and coordinators are focused on prevention rather than stage 4 like most case management.

Comments: Include community capacity like health departments as primary care, not just health plans. Support CKD curriculum and training through NC Community College system. It could also be implemented into NC Health Ambassador Program. Further research should include more specific target groups. In recommendations for testing, cite a rationale for the need. The comparison of NHANES III & HUNT II (Norwegian data) shows US problems with screening, identification, and treatment. Include allusion to investment of prevention of underlying problems.

Other potential recommendations related to systems of care include eGFR whether mandate or voluntary reporting, best practices and performance measures, uninsured funding to support the safety net, support for pediatric patients by asking for adjusted need determination, ask SHCC or Southeastern Kidney Council to build assessment for pediatric dialysis centers.

The next meeting of the Task Force will be held in September.