



National Institute of  
Diabetes and Digestive  
and Kidney Diseases

## Kidney Interagency Coordinating Committee Meeting

Virtual Meeting  
September 11, 2020

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## **Welcome and Introductions**

*Susan Mendley, M.D.*

*National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), National Institutes of Health (NIH)*

Dr. Susan Mendley welcomed members and attendees to the NIDDK Kidney Interagency Coordinating Committee (KICC) meeting. She noted that the virtual KICC meeting platform is working and will be used for the next several meetings. Dr. Mendley reminded participants that the KICC was mandated by Congress in 1987 to meet yearly; however, because of the enthusiasm, the structure changed from a *pro forma* meeting to one that meets twice yearly with the goal of coordinating a federal response to chronic kidney disease (CKD). The aim is to encourage cooperation, communication, and collaboration among all federal agencies engaged in kidney research and related activities. The NIDDK hosts the [Federal CKD Matrix](#), an online resource that summarizes CKD-related activities. Dr. Mendley explained that the meeting summary will be posted to the NIDDK website and noted that a separate closed Zoom session for federal employees only will follow the open session.

Dr. Robert Star, Director, Division of Kidney, Urologic, and Hematologic Diseases, NIDDK, welcomed everyone and expressed appreciation to Dr. Mendley and Ms. Jenna Norton for continuing the tradition and enthusiasm of the KICC meetings. He called attention to the NIH's increased awareness, continued interest, and activities regarding health, health disparities, and health delivery, including establishing new working groups to review the issues and then act. Dr. Star remarked on the underrepresentation of scientists in the biomedical community and the science (e.g., research) and stated that he anticipates real change at the NIH. Ms. Norton invited meeting attendees to introduce themselves.

## **NIDDK Kidney Disease Systems Change Efforts and Education Resources**

*Jenna Norton, M.P.H.*

*Dana Sheets, M.A.*

*NIDDK, NIH*

Ms. Norton informed the KICC members that the National Kidney Disease Education Program (NKDEP) has transitioned the content and outreach and promotional activities under the banner of the NIDDK main website to meet ongoing needs. Ms. Norton explained that systems change efforts, including the NKDEP Laboratory Working Group (LWG) and the Health Information Technology Working Group (HITWG), will be managed by the Division of Kidney, Urologic, and Hematologic Diseases. The communication and outreach efforts, including the patient and clinician educational materials, will be managed by the NIDDK Office of Communication and Public Liaison (OCPL). She noted that the Pharmacy Working Group has met their key deliverables and has been sunset, but the products (e.g., clinical tools/education materials) they developed will continue to be available under the NIDDK education and outreach efforts.

Ms. Norton provided an overview and update on the NKDEP working groups. The LWG was formed in 2003 with the aim of standardizing the serum creatinine measurement used to determine estimated glomerular filtration rates (eGFRs). Standardized creatinine measurement is now widely implemented, and variability in the laboratory results has significantly improved. In addition, the LWG promoted eGFR reporting with each creatinine result, and the number of clinical laboratories reporting increased from 3 in 2013 to 92 in 2019. In collaboration with the International Federation of Clinical Chemistry Working Group for Standardization of Albumin in Urine, the LWG is currently focusing on standardization of

urine albumin measurement. A reference measurement system is being developed to achieve standardized results, which will help reduce misclassification of near clinical decision boundaries. The National Institute of Standards and Technology is supporting this effort. The next LWG meeting is scheduled for January 25, 2021.

The HITWG has several subgroups—CKD Electronic (e) Care Plan Working Group, CKD Computable Phenotype Working Group, and CKD Business Case—to support its activities. The e-CKD phenotype was published in 2019, and the alpha version of the CKD Population Health Cost Model has been made available for testing and validation. The CKD e-Care Plan reported on at the March 2020 KICC meeting has been expanded into a partnership with the Agency for Healthcare Research and Quality (AHRQ) to focus on people with multiple chronic conditions. The AHRQ–NIDDK e-Care Plan Project will (1) expand data elements and standards for interoperable exchange of key clinical and social data, (2) develop and test patient- and clinician-facing applications to integrate with electronic health records (EHRs), and (3) support care coordination and research. The Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services (HHS) Patient-Centered Outcomes Research Trust Fund has funded this project.

Ms. Dana Sheets provided an update on NIDDK health information and resources for health professionals, noting revised areas of the NIDDK website. The current landscape of health information is multichannel, and NIDDK seeks to make information available to patients and health care providers via their existing channels. The patient education content has been consolidated into the Health Topics webpage. The clinical tools and patient management resources have been consolidated into the Health Professionals section and are organized by disease area. The continuing medical education (CME) and continuing education (CE) modules are featured in the For Health Professionals section. Four CME courses are live on the NIDDK website: (1) Counseling Patients on NSAID Use; (2) Helping Diabetes Educators Care for Patients with Kidney Disease; (3) Chronic Kidney Disease Nutrition Management Training Program; and (4) Chronic Kidney Disease Management for Pharmacists. Health professionals can view the courses at no cost or enroll for CE credit through an accrediting partner. A Google search of NIDDK CME provides easy access. Ms. Sheets expressed appreciation to former NKDEP Director and current IHS consultant, Dr. Andrew Narva, as well as all who have assisted in developing CMEs.

In addition, Ms. Sheets elaborated on how health information is imported to EHRs and OCPL's current pilot projects. In 2019, the NIDDK partnered with MedlinePlus Connect to syndicate all the Health Topics and the patient education content. MedlinePlus Connect is a service of the NIH National Library of Medicine that responds to Health Level 7 (HL7) code and information button requests from EHRs. MedlinePlus Connect received 252 million requests for content in 2019. Ms. Sheets explained that MedlinePlus Connect contains only patient education content and responds to Systematized Nomenclature of Medicine (commonly called SNOMED) and International Classification of Diseases (ICD) 9 and 10 codes. After the linkages to the NIDDK content, visits to the health information website increased—including 77 percent of first-time users connecting from a desktop computer, indicating reach to a new audience (as the majority of users access the NIDDK website via mobile devices). Ms. Sheets explained that the next steps will be to conduct a pilot study to explore points in the patient-to-provider journey within an EHR workflow, from registration to the end of a visit, where the content can best be presented. Potential examples under consideration include an EHR alert and presentation of a kidney GFR function clinical consultation aid from NIDDK content. The NIDDK is seeking private- and public-sector collaboration partners for this EHR pilot. KICC members who are interested in participating in the pilot or who know of potential health systems collaborators can contact Ms. Sheets at [dana.sheets@nih.gov](mailto:dana.sheets@nih.gov).

## ***Discussion***

- Ms. Nilka Ríos Burrows called attention to the Centers for Disease Control and Prevention (CDC) Division of Diabetes Translation's 5-year cooperative agreement, Diabetes Program (DP) 18-1817, which supports 11 grantees who are using clinical decision tools in the EHRs to identify CKD and people with type 2 diabetes. These grantees could be potential collaborators, and Ms. Burrows will consult with the DP18-1817 project officer about that possibility.

## **From Directive to Delivery: U.S. Department of Veterans Affairs (VA) and Veterans Health Administration (VHA) Directive 1053 for the Prevention, Early Detection, and Management of CKD**

*Susan Crowley, M.D., M.B.A., FASN*  
*VHA*

Dr. Susan Crowley discussed the new VA policy issued in response to the VHA 1053 Directive, noting that this policy aligns with the recent pivot in the VHA National Kidney Program from primarily focusing on dialysis and optimization to focusing on CKD. She acknowledged nephrologist Dr. T. J. O'Neal (formerly of the VA) for his efforts in increasing awareness in the American Society of Nephrology community about the new VHA CKD Directive. Dr. Crowley explained that a prior study the VA conducted evaluating National Health and Nutrition Examination Survey (NHANES) data over a 10-year period (2008 to 2019) revealed that the VA population with diabetes increased to 20 percent from 2008 to 2014 and likely was driven by high rates of risk factors for CKD (e.g., obesity). In a subsequent analysis, these same NHANES data indicate that CKD prevalence is higher in the VA population than the general population and revealed that in 2019, 470,000 to 1.24 million veterans met the criteria for CKD. Dr. Crowley noted an issue with the range of reported CKD prevalence in the VA population, which reflects how CKD is defined. For the past decade, the VHA health system has used ICD coding for CKD to prompt clinical reminders for a data analysis. When using the clinical laboratory e-phenotype for CKD, which is based on the Kidney Disease: Improving Global Outcomes (commonly called KDIGO) guidelines and incorporates eGFRs and creatinine values, the estimates in CKD prevalence are substantially higher. VHA's estimates (400,000) are likely underestimating the CKD prevalence. Adjusting for the number of enrolled veterans, the CKD prevalence estimates range from 7.4 to 19.5 percent of the total VA population, and incorporating proteinuria can further raise estimates to 30 percent.

To address the high prevalence of CKD risk factors, the VA has been reviewing its opportunities to optimize kidney health in the veteran population by focusing on increasing awareness of CKD, screening for CKD, optimizing treatment, and preventing end-stage renal disease (ESRD) and its adverse outcomes. In terms of awareness, the CDC reports reveal that 40 percent of the VA population is recognized as having CKD based on the ICD coding, and most have advanced disease. The VA aims to focus attention to upstream kidney disorders, which reflects the highest numbers of veterans and substantially lower per person treatment costs. For screening, even in the high-risk population (veterans with diabetes), less than 50 percent had a urine albumin-to-creatinine ratio (UACR) analysis performed annually. Regarding treatment, a recent report (Navaneethan *et al.*, 2018) evaluating kidney disease care in a cohort of 281,000 veterans with CKD across 130 VA facilities, showed that 37 percent of patients had a urine albumin measurement, 66 percent had received angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs), and 44 percent had controlled blood pressure (BP) (i.e., less than 140/90 millimeters of mercury [mmHg]). Dr. Crowley emphasized that the VA's effort on CKD awareness, screening, and treatment all need improvement, which the new VA policy actively is addressing. She

noted the high rate of statins being prescribed to CKD patients in the Navaneethan *et al.*, 2018 study and suggested leveraging or modeling the cardiology care practices.

Dr. Crowley informed the KICC members that the VHA Directive 1053 was issued on March 17, 2020, to establish policy to improve prevention, early recognition, and management of CKD in VA medical facilities. The primary goals are threefold: (1) describe VHA's strategy for prevention, recognition, management, and evaluation of CKD in the veteran population; (2) detail the responsibilities of VHA leadership and frontline staff for implementation; and (3) identify resources and tools to assist in implementation of CKD programs nationwide. The secondary goal is to codify the VHA Kidney Health Committee (KHC) by an official charter. The KHC membership has been extended to include the VA's offices of primary care, connected care, and population health. The KHC is charged with facilitating national evidenced-based strategies targeting CKD prevention, ensuring access and identifying constraints in the VA health care system for delivering kidney health services, proposing action plans to mitigate costs and adverse clinical outcomes, and advocating for research and innovation related to kidney disease prevention and treatment as part of a learning health care system.

Dr. Crowley pointed out that the policy directs that all eligible veterans have access to comprehensive care for CKD and all VA medical facilities establish and maintain a CKD program within the existing Patient Aligned Care Team structure. She noted the assignment of responsibilities for the Veteran Integrated Service Network (VISN) and VA medical centers leadership and highlighted the VHA Directive 1053 resources regarding implementation, including fact sheets, training videos, guidelines, and toolkits.

### ***Discussion***

- Dr. Star asked whether the VA MobileKidney application (app) included patient-specific information imported from the EHR. Dr. Crowley explained that the MobileKidney app and the EHRs are not linked, and data are not automatically extracted. Patients can access their medical records via the My HealtheVet portal. With the MobileKidney app, patients can monitor and generate graphs of their vital signs, which can be shared securely with their providers.

### **CKD: Lessons from the Indian Health Service (IHS)**

*Ann Bullock, M.D.*

*IHS*

Dr. Ann Bullock provided an update on the diabetes and CKD care in the American Indian/Alaska Native (AI/AN) population served by the IHS. Per the CDC National Diabetes Statistics Report 2020, from 2017 to 2018, the AI/AN population had the highest incidence of diabetes mellitus (DM) among racial and ethnic groups across the United States. Dr. Bullock reminded KICC members that the IHS Special Diabetes Program for Indians (SDPI) was established by Congress in 1997 and provides \$150 million per year for 301 IHS/Tribal/Urban (I/T/U) grant programs for diabetes prevention and treatment. Since the initial investments in the SDPI, significant progress has been made in the number of programs reporting different types of diabetes services. The IHS Diabetes Care and Outcomes Audit (Audit) of SDPI programs from 1997 to 2019 across the I/T/U showed that the mean hemoglobin (Hb) A1C decreased by 1 percent and is now averaging 8.1 percent and that BP was tightly controlled with little to no variability. The audits also revealed significant decreases in low-density lipoprotein cholesterol, attributable to use of

statins, improvements in testing and diagnosis for CKD, and increases in the use of ACE inhibitors and ARBs.

Dr. Bullock reported on the progress in DM prevention and kidney failure outcomes. A recent IHS study, in collaboration with the CDC, revealed that the prevalence of DM in the AI/AN population decreased from 15.4 percent in 2013 to 14.6 percent in 2017 and extends across all age groups. This first-known decrease in DM for the AI/AN population occurred simultaneous to a decrease in diabetes-related mortality, suggesting a decrease in DM incidence. Data analysis of 54,000 AI/AN individuals with DM who participated in the IHS Joslin Vision Network Tele-retinal Program from 2011 to 2016 showed that diabetic eye disease had decreased by about half relative to reports from the 1980s and 1990s. AHRQ data on hospital admissions for uncontrolled diabetes showed an 84 percent decrease in hospitalizations in the AI/AN population from 2000 to 2015. The January 10, 2017, edition of *Morbidity and Mortality Weekly Report* (Burrows *et al.*, 2017) reported a 54 percent reduction in kidney failure in AI/AN adults from 1996 to 2013 than the other racial and ethnic groups based on U.S. Renal Data System (USRDS), U.S. Census Bureau, and IHS audit data.

The HHS ASPE took notice of the significant improvements in DM and kidney failure outcomes in the IHS and conducted a health care cost savings estimate, which it published in May 2019. ASPE estimated that the decrease in new cases of kidney failure due to diabetes in the AI/AN population resulted in 2,200 to 2,600 fewer cases and \$436 to \$520 million of Medicare savings over a 10-year period, with some part attributable to the SDPI. In addition, a new study by CDC and IHS authors (Burrows *et al.*, 2020) reported sustained kidney failure reductions in AI/AN as well as African Americans and Hispanics. Dr. Bullock highlighted some lessons on CKD from the IHS, emphasizing that the IHS is a primary care system, is involved with the community in its care of the patient, addresses social determinants of health, provides care to all eligible patients regardless of insurance status, and takes a long-term perspective as to what it takes to prevent diabetes and its complications over the lifespans of AI/AN people.

Dr. Bullock invited Dr. Narva, formerly an IHS nephrologist for 20 years, to comment. Dr. Narva remarked that the IHS has only 40 percent of the funds per capita that other U.S. health systems have to care for their patients. Many of the barriers to care can be reduced by moving kidney care into the primary care setting. Discussions on this topic are ongoing in kidney organizations, but implementation of what that would look like remains a question. The IHS efforts in DM and kidney care did not involve a nephrology-centric, top-down approach. The novel aspect of the IHS efforts is incorporating kidney disease care into an existing diabetes care delivery system, both of which are common to all health care systems. Also, IHS efforts focus less attention on when a nephrology referral occurred using only kidney-centric cutoff points.

Regarding interdisciplinary care, Dr. Narva highlighted that from 2006 to 2016, NKDEP leveraged the lessons learned by the IHS and disseminated them to the kidney community, improving their tools over time. Efforts also focused on outreach and development of tools for non-physician health care professionals, which resulted in pharmacy education programs, as well as trainings for dietitians. Similar efforts with comprehensive team-based diabetes care in Scandinavia have had analogous outcomes, showing improvements in kidney disease, diabetic eye disease, and other complications. Pointedly, the progress in the IHS occurred because the system worked together in the interest of the community and was not based on technology or changing the incentive structure for providers.



Dr. Bullock noted that the population the IHS serves is overwhelmingly rural and some groups are remote rural (e.g., reservations in Alaska). Having a primary health care system that includes other key health professionals to meet the needs of the rural population remains a necessity. Significant efforts are ongoing in tribes to educate patients and the broader community about diabetes and its complications. Dr. Bullock emphasized that it can take decades for improvements in care to result in improvements in chronic diseases (e.g., DM or hypertension), noting that the IHS is proud of the remarkable changes brought about with community-based interventions.

### ***Discussion***

- Dr. Crowley thanked Dr. Bullock for the presentation and Ms. Burrows for publishing these data, which will be an encouragement for primary health care in the VA, acting as a model of success from a sister agency—IHS. She remarked that the lessons from the IHS demonstrate primary care-based and not technology-based success in care, which could be implemented in the VA without waiting for the Cerner Corporation's EHR system. Dr. Bullock commented that the materials, including treatment algorithms developed over the years in Indian Country, can be accessed from the IHS website (<https://www.ihs.gov/diabetes/>).
- Because it can take 20 years or longer to realize the impact of population health-based efforts (e.g., SDPI), Ms. Norton noted the challenge to observe these effects in the current NIH research paradigm of 5-year funding cycles. Dr. Star explained that the NIH has the ability to extend projects for longer periods, in 5-year intervals, and emphasized that the current structure is capable of supporting long-term projects.
- Dr. Mendley asked Dr. Crowley how the VA would recognize when the first few steps have been taken, given the comprehensive policy regarding CKD. Dr. Crowley pointed out that discussions are ongoing in the VA with primary care physicians on how improvements in care would be assessed and noted that the VA will initially focus on CKD screening in high-risk populations and standardizing screening for kidney disease in this group. Efforts next will focus on coding for the CKD based on the clinical laboratory phenotype, incorporating these data into the existing VISN dashboards for generating reports for the regional medical leadership, which are reviewed by primary care leadership and health care providers.
- Dr. Narva commented on the track record of the VA for delivering superior care in DM and ESRD outcomes. As the largest provider of CKD care and example of coherent care with a functional approach, the VA can make a strong case for focusing the health care system in this area. Dr. Crowley called attention to hurdles to overcome in the VA: the absence of acceptance in National Quality Forum standardized measures and metrics for evaluating new tools.
- In response to a question from Ms. Norton on implementing the VHA Directive 1053 activities in places where veterans may be seeking care outside of the VA health system and how this might inform non-integrated health care systems, Dr. Crowley explained that the VA is a primary care health system in which the Directive's drivers of improvement are embedded. With the exception of specialty services, enrolled veterans generally receive primary care within the VA system, which could be further enhanced by the use of telemedicine.

- Dr. Kevin Abbott remarked to Drs. Narva and Bullock on their updates on the changes to the care that were independent of any modifications to provider reimbursements and inquired about the key components of that process and whether they would be portable to Medicare and/or private insurance. Dr. Narva suggested addressing the phobia of or hesitation to begin kidney care and implementing a strategy that would be easy to use and not increase the workload among physicians/providers, whose goals are to be above average and sufficient in terms of patient care and ratings. Dr. Bullock added that the effectiveness of the primary care and integrated interdisciplinary team approach—without any changes in provider reimbursements—in the IHS has been reflected in the data at the national and local levels in the care for CKD and DM. Outreach to the community through public health nurses and the IHS Community Health Representative Program has been critical. Dr. Narva emphasized that the non-physician health care professionals usually lead the implementation of changes around care; accountability through a whole team, the enhanced role that each plays, and an equal distribution of power all make a difference.
- Dr. Ivonne Schulman asked whether a comparison had been made between the VHA system and/or the IHS with private integrated health care systems, such as Kaiser Permanente. Dr. Narva explained that Kaiser Permanente Southern California has been meticulous about collecting data and implementing a population health–based approach. Ms. Norton added that those comparisons have not been made, but similar population health interventions have been successful in private systems, including Kaiser Permanente.
- In response to a question from Dr. Schulman about ways to educate primary care physicians located in private health care systems on screening for CKD, Dr. Afshin Parsa remarked that, with the clinician’s busy schedules, time is more of a factor than the motivation to screen patients for CKD. He noted that providing paid time (e.g., 2 hours) for education would be one option to consider in health care systems like the VHA. Dr. Narva noted that the IHS has seen progress with simple interventions in BP control, use of ACE inhibitors and ARBs, glucose control prior to kidney disease development, and use of statins; the most radical thing to do with a kidney disease patient is to have a conversation about the disease.
- Dr. Star asked how new treatments, such as sodium-glucose cotransporter-2 (SGLT-2) inhibitors, and recent initiatives, including the Kidney Precision Medicine Project (KPMP), would be incorporated into existing practices at the VA and IHS. Dr. Bullock responded that the SGLT-2 inhibitors have been added to the IHS national formulary, which means that all federal sites must provide at least one as a treatment choice. Dr. Crowley noted that SGLT-2 inhibitors also have been added to the VA national formulary, and the Pharmacy Benefits Management services are reviewing data on dapagliflozin to potentially include this class of drugs in the future.
- In response to a query from Dr. Star about additional research questions that can be addressed and the types of NIH research that would be beneficial, Dr. Narva replied that a biopsy at the time of diagnosis, as the KPMP data are suggesting, would be easier to implement. Dr. Crowley added that business models and cost-economic analysis would be far-reaching to positive incentives for implementing preventive measures. Dr. Star also commented that the KPMP is revealing that many of the working assumptions used in the nephrology field for the past 40 years are incorrect, even with only 35 biopsies being completed. Data are being reviewed further.

## **Race and eGFR: Group Discussion**

*Nilka Rios Burrows, M.P.H., MT, ASCP*

*CDC*

*Jenna Norton, M.P.H.*

*Susan Mendley, M.D.*

*NIDDK, NIH*

Ms. Burrows called attention to ongoing conversations in the field on the use of race adjustment and race coefficient in the kidney function (e.g., eGFR) equations, which will impact the Federal CKD Matrix agencies. In August 2020, the National Kidney Foundation (NKF) and the ASN formed a joint task force to reassess the use of race in kidney function equations and its use to diagnose kidney disease. Some groups have proposed using muscle mass as an indicator. Recent reports from South Africa evaluated both the Modification of Diet in Renal Disease (MDRD) Study and the Chronic Kidney Disease Epidemiology Collaboration (CKD–EPI) equations with and without the race adjustment. The results showed no improvement in performance by including the race adjustment in the equations and that performance improved without the race adjustment for eGFR greater than 60 mL/min/1.73 m<sup>2</sup>.

Ms. Burrows emphasized that this issue is coming to the KICC for discussion.

Ms. Norton explained that the objectives of the present discussion are to identify the right questions, determine the level of interest in the KICC, and consider whether (and how) the topic should be included in a future KICC meeting. Dr. Mendley requested input on whether the initial list of questions is appropriate, redundant, or missing key points. An initial list of questions was presented and discussed.

### ***Discussion***

- Dr. Abbott commented that originally the rationale for including race adjustment in the kidney function equations was to improve the accuracy of findings, but he has observed that the use of this adjustment raises the GFR trend for African Americans compared with non-African Americans. He posed one question: Is use of race-adjusted eGFR desirable in a system that already has health disparities? Dr. Abbott noted a prior study by the Division of Kidney, Urologic, and Hematologic Diseases showing that, with the use of the unadjusted eGFR, the metrics of care for African Americans was comparable with and indistinguishable from whites in the USRDS data. Dr. Mendley commented on this example of a negative consequence of the race-adjusted eGFR and thought it would fit with the research questions on the initial list.
- Dr. Star asked whether there are better ways to improve the accuracy of the MDRD Study and the CKD–EPI equations across subgroups in the United States?
- Dr. Aliza Thompson explained that the FDA is seeking to understand better what the tool, race-adjusted eGFR, is best used to indicate and also thinking broadly about different tools for different purposes. From a drug standpoint, in terms of dosing, the FDA is examining the most accurate measure (e.g., eGFR or clearance of the drug). The concept of targeting a population at high risk of disease progression and focusing on directing this group to education and/or therapies poses a different question, and the equations may be different. She asked a fundamental question: What is the kidney community trying to accomplish with race-adjusted eGFR? Historically, estimating equations have been used for disease staging and drug dosing.

- Dr. Parsa commented that the case in point goes beyond just differences between African American and white populations or European or African ancestry because differences have been observed in Asian Americans and Hispanics. Creatinine also introduces limitations into the equations related to the size of the individual. He posed the question: How do we move beyond creatinine to better performers (e.g., statins)?
- Dr. Narva has been clarifying to providers that eGFR is an imprecise tool with a wide degree of uncertainty for a performance measure, and he remarked on how making clinical decisions based on this one measurement in the absence of other correlative data would be an error. Dr. Parsa agreed that eGFR is imprecise, can vary from 20 to 28 percent between morning- and night-measured GFR, and has a high coefficient of variance. Dr. Parsa noted that measured GFR itself has a high degree of inaccuracy. In fact, the ongoing Chronic Renal Insufficiency Cohort (commonly called CRIC) Study evaluated predictions of eGFR versus measured GFR and reported that eGFR has a better prediction. Dr. Parsa reminded participants that the eGFR is calculated based on creatinine—the gold standard—which is an average of measures taken over 1 to 2 days.
- Dr. Jesse Roach agreed with the comments regarding the accuracy of the eGFR, which brings about another disparity because this measurement is inflated in African American patients. He proposed a question: What is the scientific reason for including race in the eGFR equations? Dr. Roach also emphasized that any particular government viewpoint will set future precedence in similar matters. Using race to decrease a disparity would be beneficial.
- Dr. Abbott presented other questions: How are we using the eGFR in clinical practice? Does the eGFR determine options for treatment and/or referral to ESRD?

Ms. Norton requested the KICC members to email additional comments or questions about this topic, which the NIDDK will plan to incorporate for future discussions.

## **Around the Table: Agency Updates**

### ***Agency for Healthcare Research and Quality***

Dr. Christine Chang provided an update on two systematic reviews (SRs) started in the AHRQ in the past 2 months, both of which were described at prior KICC meetings. The transitions of care for children with special health care needs SR has launched, and the scope is being finalized. The SR will be evaluating the transition from pediatric to adult care and will include children with renal disease as a subgroup. The ESRD in the Medicare population SR has been completed and is being funded by CMS for the AHRQ Technology Assessment Program. This SR focuses on the administration of computerized dialysis in the Medicare population and examines timing and frequency. The report will be made available in the coming months.

### ***Centers for Medicare & Medicaid Services***

Ms. Burrows announced that CMS is collaborating with the NKF to encourage people with kidney disease and other chronic conditions to get their flu shots and has developed materials and hosted social

media events. CMS is planning several events, including a webinar for dialysis care teams on September 30, 2020, and a Facebook Live event on October 6, 2020. Further details will be forwarded when they are made available. The CKD fact sheet will be updated in fall 2020, and input from the KICC members is requested.

### ***U.S. Food and Drug Administration***

Dr. Thompson reported that on September 3, 2020, the FDA issued revised draft guidance titled “Pharmacokinetics in Patients with Impaired Renal Function—Study Design, Data Analysis, and Impact on Dosing.” She encouraged KICC members to review the recommendations and provide feedback as appropriate. The FDA cohosted workshops with the NKF and NephCure on drug development for kidney disease, including the August 28, 2020, “Externally Led Patient-Focused Drug Development Meeting on Focal Segmental Glomerulosclerosis” and the recent “Complement-Mediated Glomerular Diseases”, which is anticipated to inform clinical trials.

### ***U.S. Department of Veterans Affairs***

Dr. Anne Utech reported that the VHA Directive 1438 “Clinical Nutrition Management and Therapy,” issued on September 19, 2019, requires Healthy Teaching Kitchens (HTK) at every VA medical facility. She announced that a HTK that focuses on kidney health was a winner at a VA Shark Tank Innovation, was funded, and received program management support; the program is to be expanded to additional sites.

### **Adjournment**

Dr. Mendley thanked the presenters and attendees for their participation and adjourned the open session of the meeting.