The Chronic Kidney Disease Prevention Strategy in Michigan

2021-2026

This plan is created in partnership with the National Kidney Foundation of Michigan and the Michigan Department of Health and Human Services

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The National Kidney Foundation of Michigan (NKFM) was founded with the mission of preventing kidney disease and improving the quality of life for those living with it. NKFM, in collaboration with the National Kidney Foundation, is an independent 501(c)3 with statewide reach, with offices in Ann Arbor, Detroit, and Grand Rapids. Prevention is our first priority and guides our work. For the 13th consecutive year, the NKFM has been recognized for its sound fiscal management and performance by receiving the coveted 4-star rating from Charity Navigator, the leading charity evaluator in America, and holds platinum level recognition from GuideStar.

The NKFM works in high need communities to address the social determinants of health associated with chronic disease and healthcare needs throughout Michigan. We provide evidence-based health prevention programs and innovative approaches to healthcare access and services throughout the lifespan to strengthen the healthy lifestyles of residents. Our outreach efforts reach people at every facet of life, and work to increase health-based knowledge as well as improve self-efficacy among Michigan residents.

The Michigan Department of Health and Human Services (MDHHS) is located in all 83 Michigan counties and provides a variety of services to the residents of Michigan via thirteen offices and departments. MDHHS provides opportunities, services, and programs that promote a healthy, safe, and stable environment for residents to be self-sufficient. Our vision is to develop and encourage measurable health, safety, and self-sufficiency outcomes that reduce and prevent risks, promote equity, foster healthy habits, and transform the health and human services system to improve the lives of Michigan families.

Introduction

In Michigan…

- One in seven adults have chronic kidney disease and most don't know it.[1]
- Diabetes and high blood pressure causes 64% prevalent cases of kidney failure.[2]
- One in three adults age 20+ have high blood pressure.[3]
- 1.09 million people have type 2 diabetes.[4]
- People of any age with underlying medical conditions, including chronic kidney disease, obesity, serious heart conditions and type 2 diabetes, are at great risk of experiencing serious illness and/or death if they contract COVID-19.[5]

Health disparities are prominent within individuals with chronic kidney disease and its two leading causes, diabetes and hypertension. Compared to Whites, minority groups have a higher risk of developing end stage kidney disease: African Americans have 4 times the risk; Native Americans have 2 times the risk; Latinos have 2 times the risk and Asians have 1.6 times the risk.[6] In Michigan, African Americans make up only 14% of the general population yet make up 43% of the dialysis population.[7] Per Organ Procurement and Transplantation Network data as of 07/30/2020, African Americans comprise 37% of the kidney transplant waiting list. Research from the United States Department of Agriculture demonstrates a link between social determinants of health and chronic disease diagnosis, such as hypertension, diabetes, and kidney disease. Among US households, 11% experience food insecurity but among adults with advanced chronic kidney disease that rises to 25%.[8]

Ending the public health crisis of chronic kidney disease cannot be accomplished solely by any one organization. Therefore, for more than a decade, the Michigan Department of Health and Human Services and the National Kidney Foundation of Michigan, together with several private and public organizations, have collaborated to create a statewide *Chronic Kidney Disease Prevention Strategy*. This plan calls upon partners in healthcare, government, communities, and residents to direct their efforts toward a common goal of chronic kidney disease prevention. The 2021-2026 Chronic Kidney Disease Prevention Strategy focuses on kidney disease prevention, early detection, and management and control efforts across Michigan.

Public Sector Consultants (PSC), a Lansing- and Detroit-based nonpartisan research and consulting firm, was engaged to facilitate the development of this strategic plan. As part of this process, PSC performed a document review, conducted 18 key informant interviews, and facilitated two in-person planning sessions with NKFM staff, leadership, and key stakeholders including providers/physicians, payers/insurers, state legislators, state agencies, funders, and state and national nonprofit organizations. These efforts sought to identify elements of the existing kidney disease prevention strategy that have been achieved, are working well, need improvement, or are missing. Emphasis focused on identifying synergies between

stakeholders that could leverage improved outcomes for kidney disease prevention, early detection, management and control in Michigan.

The result of this process is a joint, action-oriented, five-year strategic plan consisting of four high-level goals, each with objectives and activities for stakeholders to pursue. Goals include:

- Transforming kidney care by aligning partner activities to leverage kidney disease data and shared metrics;
- Increasing awareness, knowledge, and understanding of preventable kidney disease;
- Increasing adoption and reach of evidence-based programs and policy, systems, and environmental change strategies; and
- Maximizing financial sustainability of kidney disease prevention, detection, management and control efforts

The overall goal of the plan is to have a comprehensive and collaborative kidney disease strategy that reduces preventable kidney disease and its progression with communities at greatest risk and/or least access in Michigan. We know we will face challenges as we do this important work. We remain confident we can overcome these with the support of community, governmental, and healthcare partnerships. Working together, we will effectively promote positive health across our state. It is with hope and excitement that we present the Chronic Kidney Disease Prevention Strategy in Michigan 2021-2026.

Linda Smith-Wheelock, President and CEO of the National Kidney Foundation of Michigan

Elizabeth Hertel, Director of the Michigan Department of Health and Human Services

Goals, Objectives, and Activities

Goal 1: Transform Kidney Care by Aligning Partner Activities to Leverage Kidney Disease Data, Shared Metrics and Evidence-Based Strategies

- **Objective 1.1:** Increase the Number of People with Diabetes and/or Hypertension Screened and Managed for Kidney Disease.
    - **Activity 1.1.1:** Engage Michigan laboratories to offer the Kidney Profile and Laboratory Engagement Plan, a combination of estimated glomerular filtration rate (eGFR) and albuminuria (ACR) testing, for early identification of kidney disease.
    - **Activity 1.1.2:** Integrate kidney disease testing for at-risk populations as routine standard of care in primary care by integrating this into the electronic health record for primary care appointments.
- **Objective 2.1:** Articulate the Cost-benefit/Return on Investment of Kidney Disease Prevention.
    - **Activity 1.2.1:** Pilot a kidney disease cost-benefit demonstration project using existing healthcare provider and payer data to identify and manage undiagnosed kidney disease, in partnership with the National Kidney Foundation, at least one healthcare provider, and one health plan.[7]
    - **Activity 1.2.2:** Conduct a pilot with a healthcare provider to screen for kidney disease among individuals with hypertension and achieve increased controlled hypertension among an agreed upon percentage for the healthcare provider of participants.

Goal 2: Increase Awareness, Knowledge, and Understanding of Preventable Kidney Disease

- **Objective 2.1:** Create and Implement a Marketing and Communications Plan to Raise Awareness of Kidney Disease among Key Audiences.

- **Activity 2.1.1:** Leverage existing data to identify high-risk and high-burden audiences assuring health equity and eliminating health disparities among Michigan's populations of color.

- **Activity 2.1.2:** Create and adopt standard messages across partner organizations.

- **Activity 2.1.3:** Integrate education on the risk factors, management, treatment and control of diabetes, hypertension, and cardiovascular disease into risk-reduction activities

- **Activity 2.1.4:** Equip and encourage people to share their kidney disease diagnosis with peers in their social networks, and encourage these peers to complete a risk assessment, and to get screened for risk factors of kidney disease.

- **Activity 2.1.5:** Understand the impact of COVID-19 history on kidney function and health disparities by integrating educational messages within communities.

Goal 3: Increase Adoption and Reach of Evidence-based Programs and Policy, Systems, and Environmental Change (PSE) Strategies

- **Objective 3.1**: By 2026, Increase Annual Referrals of People with Prediabetes into the Diabetes Prevention Program and other Evidence-based Self-management Programs by 10%.

    - **Activity 3.1.1:** Work closely with the Michigan Department of Health and Human Services (MDHHS) Diabetes Prevention Network.

    - **Activity 3.1.2:** Educate primary care providers and resident physicians on the benefits of the Diabetes Prevention Program and other evidence-based programs (e.g. connection to value-based payment).

    - **Activity 3.1.3:** Increase the number of referrals through electronic health records and/or health information exchange platforms.

    - **Activity 3.1.4:** Address social determinants of health that contribute to health inequities for racial and ethnic minority populations in Michigan by partnering with organizations who serve persons of color to conduct onsite screenings

within key community settings combined with referral to self-management programs.

- **Activity 3.1.5:** Increase awareness of the Diabetes Prevention Program and other evidence-based programs among Michigan residents.

- **Objective 3.2:** By 2026, Increase the Reach of Nutrition and Physical Activity Education Programming by 10%.
  - **Activity 3.2.1:** Conduct an environmental scan to determine what programs, policy, systems and environmental change, and social marketing strategies are in use and most effective.
  - **Activity 3.2.2:** Deliver culturally and linguistically appropriate nutrition and physical activity education programming.
  - **Activity 3.2.3:** Implement social marketing approaches to increase physical activity and healthy food consumption.
- **Objective 3.3:** Support and Create Community Environments that are Conducive to Healthy Eating and Physical Activity that Also Addresses Social Determinants of Health.
  - **Activity 3.3.1:** Educate policymakers on the social determinants of health, health disparities and return on investment for incentivizing healthy lifestyles for all residents.
  - **Activity 3.3.2:** Work with the Michigan Local Food Council Network to improve local and regional food environments for at-risk residents.
  - **Activity 3.3.3:** Ensure that the Michigan Good Food Charter is informed by chronic disease prevention and improved health outcomes for racial and ethnic minority populations in Michigan.
  - **Activity 3.3.4:** Increase access to safe and free or low-cost physical activity for children and adults, including greenspace and water trails.
- **Objective 3.4**: Increase Community-based Prevention Workforce Development.
  - **Activity 3.4.1:** Increase the number of health behavior change coaches/leaders, skilled in kidney disease prevention.

- **Activity 3.4.2:** Obtain funding to improve access to kidney disease prevention through virtual programming technologies in collaboration with MDHHS.
- **Activity 3.4.3:** Educate people about existing kidney disease smartphone apps and seek funding for new apps, as necessary.
- **Activity 3.4.4:** Provide racial equity and cultural sensitivity training to existing community-based prevention workers.

Goal 4: Maximize Financial Sustainability of Kidney Disease Prevention, Detection, Management, and Control Efforts

- **Objective 4.1:** Secure Foundation and Other Funding to Demonstrate Collective Impact.
  - **Activity 4.1.1:** Assess areas of foundation alignment with strategic plan goals, objectives, and activities and related funding streams.
  - **Activity 4.1.2:** Conduct multi-stakeholder outreach to foundations with areas of alignment.
  - **Activity 4.1.3:** Increase reimbursement for kidney disease prevention services.
- **Objective 4.2:** Secure State and Federal Resources for Prevention Services and Programming.
  - **Activity 4.2.1:** Educate policymakers on the importance of evidence-based kidney disease prevention programming and the impacts of COVID-19 for Medicaid and Medicare participants.
  - **Activity 4.2.2:** Encourage further advancement of reimbursement for kidney disease prevention services.
  - **Activity 4.2.3:** Promote a payment policy that reduces preventable illness and its progression.
  - **Activity 4.2.4:** Secure Medicaid reimbursement for the Diabetes Prevention Program.

- **Activity 4.2.5:** Work with the National Kidney Foundation national office to advance adoption of a new Kidney Health Healthcare Effectiveness Data and Information Set (HEDIS) measure for kidney disease screening.

- **Activity 4.2.6:** In coordination with MDHHS, Heart Disease and Stroke Prevention Unit, secure funding for hypertension control based on ability to control co-occurring hypertension and kidney disease.

Chronic Kidney Disease Development and Review Team

Key stakeholders collectively defined their commitment to kidney disease prevention and the strategic action plan's purpose as follows:

We are committed to a comprehensive and collaborative kidney disease strategy that reduces preventable kidney disease and its progression with communities at greatest risk and/or least access in Michigan.

Gary Roth, DO, Chief Medical Officer, Michigan Health and Hospital Association

David Shepherd, President and CEO of Community Care Services, Henry Ford Health Systems, Chair of the National Kidney Foundation of Michigan Board of Directors

Richard Wimberley, Section Manager, Diabetes and Other Chronic Diseases, Michigan Department of Health and Human Services

Lauren Neely, Manager, Diabetes and Kidney Unit, Michigan Department of Health and Human Services

Lisa Hardy, Vice President, Business Performance and Execution, Blue Care Network and National Kidney Foundation of Michigan Board of Director

Richard Murdock, Founder of R.B. Murdock Consulting, National Kidney Foundation of Michigan Board of Director

Silas Norman, MD, Associate Professor, Michigan Medicine, National Kidney Foundation of Michigan Board of Director

Phyllis Meadows, PhD, Senior Fellow of Health Programs, Kresge Foundation

Sarah Panken, Senior Director of Community Impact, Michigan Fitness Foundation

Ken Resnicow, PhD, Professor of Health Behavior and Health Education, University of Michigan School of Public Health

Sheila Jackson, Person with kidney disease and Advocate

Cynthia Nichols-Jackson, Person with kidney disease and Advocate

Jeffrey Miles, Senior Director, Center for Early Childhood Excellence at United Way for Southeastern Michigan

Holly Riley, Manager, Greenfield Health Systems, Henry Ford Health System, National Kidney Foundation of Michigan Detroit Leadership Committee

Tanya Smith, Community Program Specialist, Gift of Life MOTTEP, National Kidney Foundation of Michigan Board of Director

Jan Delatorre, Program Officer, Michigan Health Endowment Fund

Megan Murphy, Senior Program Officer, Michigan Health Endowment Fund

Tiffany Stone, Medicaid Policy Director, Michigan Association of Health Plans

Rich Pirog, Director of MSU Center for Regional Food Systems

Lindsey Scalera, Community Food Systems Collaboration Specialist at MSU Center for Region Food Systems

Laura Appel, Senior Vice President and Chief Innovation Officer, Michigan Health and Hospital Association

Linda Chang, Honor Community Health

Elizabeth Montgomery, Vice President, Learning Strategies and Primary Care Programs, National Kidney Foundation

Linda Smith-Wheelock, President and CEO, National Kidney Foundation of Michigan

Crystal D'Agostino, Senior Program Manager, National Kidney Foundation of Michigan

Ann Andrews, Senior Program Manager, National Kidney Foundation of Michigan

Charlene Cole, Vice President, National Kidney Foundation of Michigan

Facilitated by: Scott Dzurka and Justin Fast at Public Sector Consultants

Source:

1. Calculation based on Michigan census population (2010 US Census Bureau) and Centers for Disease Control data that one in seven American adults have chronic kidney disease (CDC in the US 2019).
2. U.S. Renal Data System. USRDS Table 1.6 Percent of prevalence of ESRD. 2018. Accessed 10/01/20.
3. Centers for Disease Control (CDC) High Blood Pressure Fact Sheet.
4. American Diabetes Association.
5. U.S. Centers for Disease Control and Prevention. People with Certain Medical Conditions. 2020; CDC website about COVID-19 and people with medical conditions. Accessed 08/02/2020.
6. Nicholas SB, Kalantar-Zadeh K, Norris KC. Racial disparities in kidney disease outcomes. Semin Nephrol. 2013;33(5):409-415.
7. U.S. Renal Data System. USRDS Renal Data Extraction and Referencing (RenDER) System. 2018.
8. U.S. Centers for Disease Control and Prevention. One in Four Adults With Advanced Chronic Kidney Disease Is Food Insecure. 2020; CDC website about adults with chronic kidney disease and food insecurity. Accessed 07/31/2020.