

# **National Kidney Disease Education Program**

## **Primary Care Providers Meeting**

**Summary of Meeting, July 1, 2002**

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A list of attendees is attached as Appendix A.

### **A. Welcome, Introductions, and Purpose of Meeting**

**Dr. Hostetter**

Dr. Hostetter welcomed the group and asked the participants to introduce themselves. He then reviewed the objectives of the meeting. These included updating the meeting participants on the current guidelines for treating chronic kidney disease; providing summary findings on NKDEP's formative research on health care providers and at-risk individuals; reviewing the plan for the NKDEP pilot site activities; and obtaining advice from meeting participants on NKDEP's campaign to reach primary care providers.

### **B. Current Goals and Existing Guidelines Pertaining to Chronic Kidney Disease**

**Dr. Hostetter**

Dr. Hostetter raised the concern that in the near future there will be an insufficient number of nephrologists in the United States to care for the rising number of people with chronic kidney disease and those with glomerular filtration rates (GFR) of 30 to 60 ml/min/1.73 m<sup>2</sup> and that the bulk of care for people with kidney disease will fall to primary care providers.

The rising incidence of chronic kidney disease is one reason that NKDEP was initiated. The goal of the program is to raise awareness of the seriousness of kidney disease, specifically for at-risk African Americans (those with diabetes, hypertension, and/or a family history of kidney failure) and primary care providers. Additional program messages include the importance of early screening and the availability of treatment to slow or prevent kidney failure. Dr. Hostetter outlined the successes of previous national education programs in improving the awareness, treatment, and control of hypertension, hypercholesterolemia, and diabetes.

Dr. Hostetter reviewed current guidelines for testing and diagnosing kidney disease. These included guidelines from the National Kidney Foundation; the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure VI (JNC VI); the Veteran's Health Administration; and the American

Diabetes Association. Components of the guidelines include the frequency of testing, criteria used for diagnosis, blood pressure levels, and types of medications prescribed.

Dr. Hostetter pointed out that the relative risk for cardiovascular disease (CVD) increases with creatinine levels greater than 1.4 mg/dl. Microalbuminuria also increases CVD risk by 1.5 to 2.5 times. Annual mortality from CVD is 10 to 100 times greater with end-stage renal disease (ESRD.) Dr. Daniel Stryer stated that it may be more effective to “bundle” the information about cardiovascular disease risk together with the chronic kidney disease message.

Dr. Hostetter concluded his presentation by discussing the goals for the meeting, including developin, and establishing recommendations and creating informational, awareness, and motivational messages.

### **C. K/DOQI Guidelines and Hypertension K/DOQI Guidelines**

**Dr. Levey**

In 1997, the National Kidney Foundation (NKF) published the Dialysis Outcomes Quality Initiative (DOQI). In 2000, NKF expanded its focus to the Kidney Disease Outcomes Quality Initiative (K/DOQI) and released its Chronic Kidney Disease Guidelines in 2002. In 2003, NKF will release the Blood Pressure Management Guidelines.

Dr. Andrew Levey reviewed the *K/DOQI Clinical Practice Guidelines for Chronic Kidney Disease: Evaluation, Classification and Stratification*. Diabetes causes 33% of ESRD, vascular diseases account for 21%, and glomerular diseases for 19%. Tubulointerstitial and cystic diseases account for the remainder. The report defined chronic kidney disease as structural or functional abnormalities of the kidneys for more than 3 months, as manifested by either:

1. Kidney damage, with or without decreased GFR, as defined by
  - Pathologic abnormalities
  - Markers of kidney damage, including abnormalities in the composition of the blood or urine or abnormalities in imaging tests.
2.  $GFR < 60 \text{ ml/min/1.73m}^2$ , with or without kidney damage.

Dr. Levey outlined the stages in the progression of CKD and therapeutic strategies. Sixty-four percent of Americans have normal ( $GFR > 90$ ), 31% are at increased risk of CKD ( $GFR 60-89$ ), 4.3% have kidney damage ( $GFR 30-59$ ), and 0.4% are in kidney failure or dialysis. A Clinical Action Plan outlined the type of screening and CKD risk reduction steps to be followed with decreasing GFR.

Risk factors for the progression of kidney disease and the development of CVD were compared. Proteinuria, diabetes, hypertension, dyslipidemia, and male sex are common to both. Younger persons and African Americans are at greater risk for CKD, whereas older Caucasians are at greater risk for CVD.

Dr. Levey previewed the K/DOQI guidelines for blood pressure management in CKD. The report states that hypertension should be the primary concern in the management of people with CKD. Those with CKD should receive ACE inhibitors or ARB medication. Blood pressure targets need to be <125/75 for both patients with diabetic kidney disease and in those with non-diabetic kidney disease with proteinuria. For patients with non-diabetic kidney disease without proteinuria, the target should be <130/85.

Dr. Timothy Myers raised the issue that <125/75 may be an impossible goal to achieve. It was suggested that it may be better to say that every guideline adheres to a specific goal but that in some people, lower is better. In addition, it needs to be emphasized that the systolic blood pressure level is the most important.

#### **D. What Works for PCPs and What Doesn't**

**Dr. Johnson**

Dr. Cynda Johnson discussed several barriers that interfere with providing patients with effective care. Given the limited amount of time they have to manage acute, chronic, and preventative care, primary care physicians (PCPs) are often overwhelmed. There also is a focus on many other chronic diseases including diabetes, hypertension, asthma, and hyperlipidemia. In addition, inconsistent management guidelines from different groups makes caring for patients confusing and complicated since there is no one authoritative source.

There is also a lack of awareness among PCPs about CKD. In December 2000, the K/DOQI Advisory Board consensus statement reported that "Chronic Kidney Disease is not perceived by clinicians to be an important problem, nor are they aware of the clinical manifestations of CKD. There is a definite need for awareness, and this should be considered in guideline development." Other barriers to awareness about CKD include new issues, guidelines, staging, and formula.

Dr. Johnson emphasized that saying "we've got to get the word out" is not enough. Other strategies that do not work include specialty journals and meetings, inconsistent consults, and having PCPs find the answer. Time-consuming instructions and complicated messages also do not promote action. What is needed are clear and concise guidelines for kidney disease and for kidney associations to embrace these guidelines.

What works in building awareness and an action plan is a "targeted message to a targeted audience." The target audiences are family practice physicians, general practitioners and internists, nurse practitioners, physician assistants, obstetricians and gynecologists, patients, and the public. The targeted clinical messages include stressing the importance of a urinalysis, especially protein levels, the importance of GFR, prediction equations, the need to measure height on patients, and the lack of importance of a 24-hour urine sample. Effective channels to deliver messages to medical professionals are medical meetings and academies.

Dr. Johnson noted that strategies for change for PCPs include imparting the knowledge to medical schools, board review courses, and PCP journals and then developing ways to measure that knowledge.

Strategies for the public include interesting the public and increasing their awareness of the issue through, for example, the “know your number” campaign or the use of the Internet. Dr. Johnson added that it is important to advocate for reimbursement changes, offer simple coding ideas, and heavily promote the issues in the press, the medical literature, and through pharmaceutical representatives.

Dr. Johnson referred to an article she authored, *Issues in Anemia Management: Primary Care Perspective*. The article reviewed the roles and responsibilities of PCPs and other non-nephrology specialists and nephrologists in the treatment of patients with CKD. The article also reviewed the importance of focusing on CKD. The main points included the epidemiology of CKD, the role of the family physician, CKD risk factors, staging and assessment based on estimated GFR, and main messages.

As an action item, Dr. Johnson recommended developing a universal consultation form that can be accessed on the Internet and be updated regularly to be consistent with guidelines. She also stated that old messages need to be debunked, including that 140/90 is acceptable for all patients. Consensus is needed on one other target that is lower. A CVD message is important because it ties together other chronic disease messages.

In her summary, Dr. Johnson stressed that family physicians can play an important role in preventing and treating CKD but they need simple messages, consistent consultations, repetition of the information through many sources including PCP journals and meetings, and a financial impetus.

Dr. Levey stated that the target audience should be those with a family member with CKD, not ESRD. PCPs tend to identify more with people over 70 with CKD, but NKDEP needs to focus on a younger age group.

#### **E. Formative Research on PCPs and At-Risk Patient Populations      Dr. Melcher**

Dr. Melcher shared results from NKDEP’s literature review and in-depth interviews with health care providers to assess the knowledge and practices of PCPs in kidney disease, diabetes, and hypertension. A summary of the findings includes that screening practices for CKD could be improved and that treatment practices and knowledge are often related to specialty. Physicians expressed that treatment guidelines are understood but not always followed. Treatment can prevent or slow CKD but physician buy-in is needed. Race was not seen as a primary risk factor for CKD. PCP’s expressed a strong interest in CKD educational materials for themselves, their staff, and patients.

Dr. Melcher reviewed focus group findings on at-risk adults, specifically African Americans with hypertension, diabetes, and/or a family history of end-stage renal disease. Dietary practices, such as a high fat diet, contributed to illness incidence and management. These practices also contributed to obesity, which appears to be more tolerated in the African American community.

Respondent knowledge about kidney disease tended to be low. The causes of kidney disease did not seem to be well understood. Many of the participants had not been tested for kidney disease, and many did not think of themselves at risk for CKD. Most felt it was important for people to know the warning signs for kidney disease and how it could be prevented. Doctors are were considered an important source of health information.

Dr. Melcher also reviewed findings from focus groups with ESRD patients. Few persons knew they had CKD before going on dialysis, and most patients had not thought they were at risk for kidney disease. Some patients indicated that kidney disease was inevitable. Most patients did not know that close family members were at increased risk.

#### **F. Status of Campaign at the Pilot Sites**

**Ms. Lising**

The goal of the pilot site intervention is to raise awareness of kidney disease and encourage audiences to take appropriate action. Through the pilot site campaign, NKDEP will identify effective materials and strategies for the national campaign.

The target audience is at-risk African Americans (those with diabetes, hypertension, and/or a family history of kidney failure). A second target audience is primary care physicians, family physicians, physician assistants, and nurse practitioners. The pilot site locations are Jackson, MS; Atlanta, GA; Baltimore, MD; and Cleveland, OH.

The messages for the public are to know the risk factors for kidney disease, to get tested if you are at risk, and that there are effective treatments to delay or prevent kidney failure.

NKDEP intends to build a community-based coalition in each city by summer 2002. Groups that are part of the coalition include kidney voluntaries (AAKP, NKF, and AKF), research and care centers (ESRD Networks, AASK, Jackson Heart Study), interested voluntaries (AHA, ADA, ADietA), professional associations (RPA, AAPA, ANNA) and other State and local health departments and churches.

Support and technical assistance will be provided to the coalitions throughout the development and implementation of the campaign. Materials, including a community-action toolkit, media kit, and patient fact sheet and brochure will be provided to each coalition. Professional materials will also be developed and provided.

From spring through winter 2003, there will be a media outreach campaign, a kick-off meeting in Washington, DC, a pilot site launch, and a baseline evaluation. At the end of the pilot site campaign, a follow-up and an in depth evaluation will be completed. In winter or spring of 2004, NKDEP will launch a national campaign.

#### **G. Personal Data Assistant (PDA) and Other Venues To Reach PCPs**

**Dr. Rosenberg**

Via conference call, Dr. Rosenberg stated that medical information from all sources is out of date as soon as it is printed. A benefit of the Internet is that information can be kept current. PDAs can play an important role in assisting physicians in managing CKD. PDAs are a helpful tool, easy to use, portable, and relatively inexpensive and can contain references, guidelines, equations, and patient information.

Dr. Rosenberg mentioned one program, “Nephro To Go,” which is a comprehensive handbook of nephrology for the palm-pilot. It provides CKD guidelines, calculations, and equations. In the discussion, it was suggested that this type of program would benefit PCPs if it was integrated into general medicine applications for the PDA.

#### **H. Discussion**

**All**

##### **Effective Channels/Venues**

The discussion prompted the following suggestions from the group:

- Have professional societies hold local PCP meetings.
- Direct mailings to PCPs would be a good way to kick-off the program but direct mailings are ineffective without other approaches.
- Hosting talks at medical society meetings, local hospital grand rounds, and practice groups are good methods for reaching PCPs.
- For family practice physicians, State academies are important venues, followed by national academies and journals.

##### **Influencers**

- Nephrologists need to become involved in providing simple messages to PCPs. It is important to obtain “buy-in” from them.
- Academic medical centers are opinion leaders. Explore CRIC centers and other NIH-sponsored clinical study centers.

##### **Useful Products**

- Slides are very useful and effective. These need to be simple for PCPs and more comprehensive for nephrologists. A slide set on “Why you don’t need a 24 hour urine” was recommended.
- Universal Consult

- Pocket Card
- PDA

### **Strategies**

The group reviewed and commented on the draft messages to health care providers.

- Use multiple mediums with both simple and complex messages.
- Coordinate and partner with other organizations that develop guidelines such as JNC, NHLBI, ADA, and the U.S. Preventative Task Force.

### **I. Next Steps**

**Dr. Hostetter**

- Refine messages to health care providers and send back to work group for their review.
- Encourage involvement of other health care provider groups such as the AANP and ACOG.
- Launch the NKDEP campaign in March 2003.

**Appendix A  
Participants List**

**National Kidney Disease Education Program  
Primary Care Providers Meeting  
July 1, 2002**

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