



CKD Quality Initiative

CKD UPDATE

JULY 2011



FACT: Chronic Kidney Disease (CKD) and/or anemia have been shown to be associated with a high co-morbidity burden in the nursing home population.

You can assist your residents who have or are at risk for CKD by:

- Providing an annual urine microalbumin screening
- Knowing the estimated glomerular filtration rate, or eGFR
- Prescribing an ACE inhibitor and/or ARB agent for all diabetic, hypertensive patients with CKD to slow the progression of the disease down, unless contraindicated
- Avoiding NSAIDs
- Managing anemia
- Protecting the veins for future vascular access
- Referring residents to the nephrologist no later than CKD Stage 3
- Referring residents to the surgeon for vascular access placement, preferably an AV fistula

For help on how to implement these actions and available resources: 678-527-3678 or www.gmcf.org/CKD

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Gotta go?



If you have diabetes...
Check with the nurse first to see if you need to give a sample.



DO YOU KNOW YOUR NUMBERS?



May is National High Blood Pressure Education Month

Get Your **FREE** Blood Pressure Check

WHEN: _____
WHERE: _____

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Over the past three years, GMCF has worked with you to improve the incidence and decrease the progression of CKD, improve care among Medicare beneficiaries through provider adoption of timely and effective quality of care interventions, and develop and foster key relationships for system change as a part of community collaboration. The theme team worked with over 200 primary care physicians, nephrologists, general and vascular surgeons, hospitals, and community pharmacists across the state to improve the following clinical measures:

- Timely testing to detect the rate of kidney failure due to diabetes
- Slowing the progression of kidney disease in hypertensive individuals with diabetes through the use of an ACE inhibitor and/or ARB agent
- Arteriovenous (AV) fistula placement and maturation (as a first choice for arteriovenous access where medically appropriate) for individuals who elect, as a part of timely renal replacement therapy counseling, hemodialysis as their treatment option for kidney failure

System level changes that were implemented included use of electronic health records (EHR) to improve timely testing and ACE/ARB use, implementing CKD referral plan at time of referral to the nephrologist, utilizing diabetes flowsheet to guide decision making in diabetes outcomes such as blood pressure and urine microalbumin screening, implementing CKD Clinical Pathway, monitoring estimated glomerular filtration rate (eGFR) to determine renal function/stage of CKD, flagging high-risk patients to remind of need for annual urine microalbumin screening, in-service for use of full range of appropriate surgical approaches to AVF evaluation and placement, implementing alert for vascular access to protect the veins, and utilizing referral fax form to community between primary care and nephrology offices.

At the end of the measurement period, there was an improvement of over 20% for timely testing to detect the rate of kidney failure due to diabetes. Even though ACE inhibitor and/or ARB agent use and AV fistula placement and maturation did not see such an improvement, your hard work and effort did not go unnoticed.

On August 1, we will begin the 10th Statement of Work that will include work in Improving Individual Patient Care, Integrating Care for Populations and Communities, and Improving Health for Populations and Communities. Even though the new work is not specific to CKD, there are opportunities to make an impact on CKD and ESRD by reducing avoidable readmissions. If you would like more information on this new work, please do not hesitate to contact JoVonn Givens at jovonn.givens@gmcf.org or 678-527-3678.

It has been a pleasure working with you all and it is our hope that you continue to implement the system changes you have put into place to improve CKD care of all of your patients.

Warm regards,
Your GMCF CKD Quality Initiative Team