

Health Equity and Kidney Disease Management



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HEALTH EQUITY IS THE FIRST PILLAR OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) STRATEGIC PLAN.¹ CMS

defines health equity as *“the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes.”*

Among its specific health equity goals, CMS aims to:

- **Close the gaps in health care access, quality, and outcomes** for underserved populations
- **Promote culturally and linguistically appropriate services** to ensure understandable and respectful care and services
- **Expand and standardize the collection and use of data** across CMS programs
- **Build on outreach efforts to enroll eligible people** across Medicare, Medicaid/CHIP, and the Marketplace
- **Evaluate policies to determine how CMS can support safety net providers,** partner with those providing care in underserved communities, and ensure care is accessible to those who need it

The overarching goal is *“... to eliminate avoidable differences in health outcomes experienced by people who are disadvantaged or underserved and provide the care and support that people need to thrive.”*

In this article, we will look at health equity in the context of chronic kidney disease (CKD) and examine the challenges of addressing health disparities in CKD population management. Topics will include:

- **The incidence of kidney disease** in minority populations
- **Social determinants of health** and access to care
- **The federal initiative** to close the gap in healthcare access
- **How value-based kidney care can help providers** achieve equity goals

The incidence of kidney disease in minority populations

One in three Americans is at risk for kidney disease. However, as the National Institute of Diabetes and Digestive and Kidney Diseases notes:

African Americans are almost four times as likely as Caucasians to develop kidney failure. While African Americans make up about 13 percent of the population, they account for 35 percent of the people with kidney failure in the United States. Diabetes and high blood pressure are the leading causes of kidney failure among African Americans.

A growing number of Hispanics are diagnosed with kidney disease each year. **Since 2000, the number of Hispanics with kidney failure has increased by more than 70 percent.** Compared to non-Hispanics, Hispanics are almost 1.3 times more likely to be diagnosed with kidney failure.

Native Americans also are disproportionately affected by kidney failure. **Compared to Caucasians, Native Americans are about 1.2 times more likely to be diagnosed with kidney failure.**²

Evidence demonstrates that minority populations are more likely to develop CKD and progress to end-stage renal disease (ESRD). Yet, according to the American Institute of Research:

- Black or African American patients are less likely than patients of other racial groups to receive any kidney-related care before they reach ESRD.
- **Black, Indigenous, and People of Color (BIPOC) patients are less likely than white patients to be referred for transplant evaluation,** complete evaluation for transplantation, be placed on the waiting list, and receive a kidney transplant.³

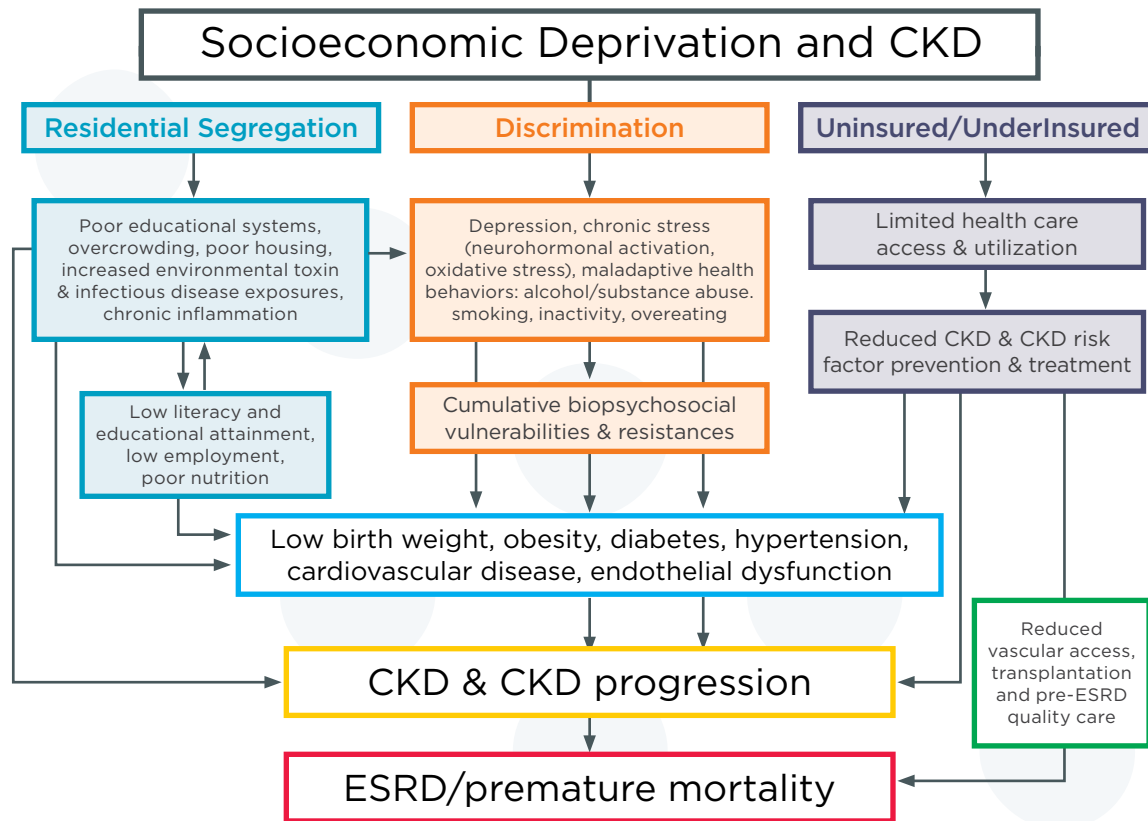
Why is the incidence of CKD and ESRD higher in BIPOC populations? And what is preventing them from receiving an equitable level of renal care?

Social Determinants of Health and Access to Care

As the National Kidney Foundation points out, *“Minority populations have much higher rates of high blood pressure, diabetes, obesity, and heart disease, all of which increase the risk for kidney disease.”*⁴

Their susceptibility to these chronic comorbidities appears in part due to suboptimal diet (a reliance on packaged foods, for example) and high levels of stress due to unfavorable or unstable socioeconomic circumstances (employment, neighborhood environment, family), and differences in healthcare access.

An article⁵ published on the National Kidney Foundation website **Advances in Chronic Kidney Disease** included the graphic below:



According to the article:

The figure shows that many of the determinants of CKD such as obesity, diabetes, and hypertension, as well as chronic inflammation, neurohormonal activation and oxidative stress, may have their foundation in socioeconomic deprivation and its outcroppings or extensions. These include, but are not limited to discrimination and segregation, substandard living conditions, reduced quality health care to the uninsured or underinsured, limited health literacy, poor educational systems and chronic stress that result in measurable and quantifiable pathologic factors that contribute to and enhance the development of CKD and eventually to ESRD and premature mortality.

Until very recently, there had also been a race-based disparity in algorithms used to measure kidney function. Because Black people tend to have higher creatinine levels in their blood than White populations, a modifier was put into historical algorithms for estimated glomerular filtration rate (eGFR). It was thought that this adjustment would produce a more accurate eGFR, but it actually resulted in lower detection of CKD among Black populations, which led to reduced interventions to slow disease progression and delayed nephrology referrals.

This was borne out by a study⁶ of the “*Clinical Implications of Removing Race from Estimates of Kidney Function*,” published in the **Journal of the American Medical Association**. The study found that:

Removing race may increase the prevalence of CKD among Black adults from 14.9% to 18.4%. Concurrently, 29.1% of Black adults with existing CKD may be reclassified to more severe stages of disease, with significant clinical and pharmacologic implications. ... Similarly, the prevalence of CKD stage 4 or higher may change from 1.0% to 1.3%, affecting 0.29% of Black adults in which the race adjustment was removed from evaluations. When they were finally diagnosed, they had already progressed to late-stage CKD.

This race modifier also contributed to another disparity, noted by the National Kidney Foundation:

Although a kidney transplant is the optimal treatment for kidney failure, **Black patients face barriers to access at every step of the process and on average wait a year longer than White patients to receive a kidney transplant.** Black patients are less likely to receive a transplant evaluation, have less access to the waitlist, spend longer on the transplant waitlist, are less likely to survive on the waitlist, and have lower rates of graft survival post-transplant.⁷

A factor in the longer waitlist time is the dearth of Black kidney donors. Unfortunately, the same social barriers to health that put Black people on the kidney waitlist also make it difficult to find donors.

The Federal Initiative to Close the Gap

Efforts have been and are being made to root out the causes of health inequity and find solutions.

In 2000, the U.S. Department of Health and Human Services launched an initiative called *Healthy People 2010*, one of its broad goals being to eliminate racial and ethnic healthcare disparities. (The *Healthy People initiative* was subsequently updated for 2020 and 2030.)

The movement began in earnest with the passage of the **Patient Protection and Affordable Care Act** in 2010. According to a 2016 publication in the Journal of the American Society of Nephrology:

The Patient Protection and Affordable Care Act (ACA) has been heralded as providing significant opportunity to reduce racial and ethnic disparities in access to health insurance and health care. Early assessment of changes to healthcare access following implementation of the ACA suggest it has already begun to equalize access to care by reducing disparities in insurance status. The prevalence of uninsured individuals decreased to a greater degree among both Black and Latino Americans compared with white Americans.

Another decisive push came in 2021 when CMS announced action to close health equity gaps in ESRD treatment. As the press release⁹ stated:

Through the ESRD Prospective Payment System (PPS) annual rulemaking, CMS is making changes to the ESRD Quality Incentive Program (QIP) and the ESRD Treatment Choices (ETC) Model and updating ESRD PPS payment rates. The changes to the ETC Model policies aim to encourage dialysis facilities and health care providers to decrease disparities in rates of home dialysis and kidney transplants among ESRD patients with lower socioeconomic status, making the model one of the agency's first CMS Innovation Center models to directly address health equity.

And:

Consistent with President Biden's *Executive Order 13985 on 'Advancing Racial Equity and Support for Underserved Communities through the Federal Government,'* CMS is addressing health inequities and improving patient outcomes in the U.S. through improved data collection for better measurement and analysis of disparities across programs and policies.

This was in addition to the alternative payment/accountable-care models that have also been implemented to reduce healthcare costs and improve quality and outcomes.

Numerous institutions, professional associations, and nonprofit organizations have also spoken out on the issue of health equity and the need for change, especially in relation to the dramatic rise in CKD.

How Value-based Kidney Care Can Help

In his recent interview, Healthmap Solutions CEO Eric Reimer cited health equity as a major factor in the company's rapid growth. As Mr. Reimer pointed out, Healthmap's unique approach to value-based kidney care was quickly perceived as a pathway to equity in healthcare. The reasons?

Advanced data collection and analysis. Healthmap's proprietary analytical tools search out and identify health plan members and patients who have CKD (but may not be aware of their diagnosis yet) and those who are most at risk for disease progression. Identification leads to appropriate standard-of-care interventions, as when indicated per nephrology guidelines.

Education and information. Patient education is one of the most important factors in health equity. Lower-income minority populations have less access to medical information and may not be able to fully understand what information is available. To address this knowledge gap, Healthmap's team of Care Navigators (CNs), made up almost exclusively of RNs with kidney care experience, contact members and speak directly with them about important aspects of CKD care in order to help them better understand their condition.

Ongoing patient and provider support. Healthmap's CNs also work with members to improve their adherence to their provider's recommended treatment plans, provide education about important diet and lifestyle changes, and otherwise optimize their kidney care. CNs also help members identify barriers to treatment, such as childcare and transportation, and connect them with community resources.

Meanwhile, multidisciplinary teams of Quality Practice Advisors (QPAs) (largely consisting of nurses) collaborate with and support providers across the full continuum of kidney care. In essence, they become an extension of the primary care provider's practice, supplying up-to-date actionable information and clinically proven care recommendations. Healthmap QPAs also coordinate the activities of nephrologists, cardiologists, endocrinologists, and other specialties, to help ensure that CKD is not overlooked when treating comorbidities.

As patients progress in their disease state, Healthmap CNs and QPAs work with providers to map out a planned, seamless transition to renal replacement therapy, with a strong emphasis on in-home dialysis or transplant, as clinically appropriate.

An equitable, value-based kidney care solution must put the patient first and provide care for the whole individual, regardless of their socioeconomic situation. Compare Healthmap's capabilities with the CMS goals listed earlier and it is clear why payers and providers are finding value in Healthmap's NCQA-accredited kidney population health management program.

¹ www.cms.gov/files/document/health-equity-fact-sheet.pdf

² www.niddk.nih.gov/health-information/kidney-disease/race-ethnicity

³ www.air.org/resource/field/addressing-health-inequities-kidney-care

⁴ www.kidney.org/atoz/content/minorities-KD

⁵ www.kidney.org/atoz/content/minorities-KD

⁶ jamanetwork.com/journals/jama/fullarticle/2773808

⁷ www.kidney.org/advocacy/legislative-priorities/health-disparities

⁸ jasn.asnjournals.org/content/27/9/2576

⁹ www.cms.gov/newsroom/press-releases/cms-takes-decisive-steps-reduce-health-care-disparities-among-patients-chronic-kidney-disease-and

ABOUT HEALTHMAP SOLUTIONS

Healthmap Solutions is an NCQA-accredited kidney population health management company serving health plans, health systems, accountable care organizations (ACOs), and provider groups seeking a value-based solution to improve the lives of millions of Americans living with kidney disease. Using its advanced technology, predictive analytics, and clinical expertise Healthmap detects kidney disease early and recommends clinically proven interventions to delay or slow disease progression. Healthmap's Care Navigation team works with patients and a full spectrum of providers (primary care, nephrologists, cardiologists, endocrinologists, and dialysis providers), to deliver personalized whole-person care. Our approach is to proactively plan care transitions, and optimize renal replacement therapy, with a focus on in-home dialysis treatment and transplant. This approach results in improved care, outcomes, and experience for the person living with kidney disease, while lowering total medical costs for health plans and provider groups.

To arrange a personal briefing on Healthmap's comprehensive Kidney Health Management Program and how it supports early CKD diagnosis and treatment, please contact Claudia Knowles at claudia.knowles@healthmapsolutions.com



The road to better kidney health starts
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