The Chronic Kidney Disease Prevention Strategy in Michigan 2016-2018

An extension of the 2013-2016 plan

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The Michigan Department of Health and Human Services (MDHHS) strives to create a healthier Michigan by promoting access to the broadest possible range of services and taking steps to prevent disease, promote wellness and improve quality of life, all in a fiscally responsible manner. MDHHS is responsible for health policy and management of the state's publicly funded health systems. The CKD Prevention Planning committee wishes to acknowledge the contribution of MDHHS in their support, technical assistance and funding of this prevention strategy.

Our Mission

The mission of the National Kidney Foundation of Michigan (NKFM) is to prevent chronic kidney disease and improve the quality of life for those living with it. The NKFM and its partners achieve their goals through innovative, result-oriented initiatives that focus on education, prevention and disease management as well as through advocacy, research funding, and programs to encourage organ donation. In recognition of its achievements in programming and fiscal responsibility, NKFM has been awarded a Four-Star Charity rating by Charity Navigator for eight years in a row.

A Call to Action

In 2012, the Michigan Department of Health and Human Services and the National Kidney Foundation of Michigan, together with several private and public organizations, collaborated to create the 2013-*2016 Chronic Kidney Disease Prevention Strategy*. This strategy will be extended to 2018 in order to continue this important work. This plan calls upon partners in healthcare, government, and communities to direct their efforts toward a common goal for chronic kidney disease prevention and to achieve the plan's objectives. Ending the public health crisis of chronic kidney disease cannot be accomplished solely by any one organization. Current and potential partners have the opportunity to be engaged in this plan by supporting communities as they work to identify and solve health issues, advocating for a community health worker workforce, and measuring the effectiveness of chronic kidney disease prevention intervention efforts. Toward that end, partners can engage in any or all of the plan's three Catalytic Areas:

1. To continue to deepen engagement in current communities on both the community and health systems base;
2. To develop a recognized sustainable Community Health Worker (CHW) workforce; and
3. To improve collection and measure of intervention efforts with social determinants of health.

Together, we can make a difference through increased awareness, detection, and prevention of chronic kidney disease.

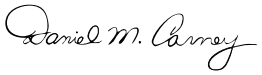
Statement from Daniel Carney, CEO, National Kidney Foundation of Michigan

Prevention has been the National Kidney Foundation of Michigan's highest priority for more than twelve years and is likely to remain so for many more. Our decision to take this on in such a big way was groundbreaking for Affiliates associated with the National Kidney Foundation. It was also groundbreaking for an entire state to focus on prevention programs, which is what Michigan did with the last plan, in 2005. Then, the goal was to develop a strategic plan targeted to health care professionals and communities that could help reverse dangerous health behavior trends and reduce the number of Michigan residents diagnosed each year with chronic kidney disease.

With accomplishments made in part through the adoption of evidence-based programming, expansion of community based approaches, and establishment of *Communities Against Diabetes* coalitions, the NKFM and its partners have succeeded in slowing the increase of number of new cases of kidney failure among Michigan residents. While continuing to rise over the past few decades, the annual increase has decreased from a 7% annual increase a 2.1% increase, even though obesity and diabetes continued to rise significantly. For this reason, the NKFM, in partnership with the Michigan Department of Health and Human Services, physicians and other healthcare providers, health insurance representatives, public health officials, and other stakeholders collaborated to create a three year strategy focused on prevention of chronic kidney disease. This three year strategy will be extended another two years from 2016-2018 in order to complete critical components of the work and insure sustainability.

Historically, stakeholders were brought together during two planning workshops. The group worked together to establish our guiding principle, values, and the three catalytic areas on which we will focus our work over the next three years. The following plan will describe objectives and key indicators we will track to measure our success. This plan also invites other partners to the table to direct their own efforts in each of the three catalytic areas.

Our overall goal is to prevent CKD by reducing the burden of obesity, diabetes, high blood pressure and other contributing factors, and to improve the quality of life for people with CKD through patient empowerment programs and select direct services. We know we will face challenges, as we do this important work. We remain confident that we can overcome these with the support of community, governmental and healthcare partnerships. Working together, we will effectively promote positive health across our state.



Daniel M. Carney
President and CEO
National Kidney Foundation of Michigan

Catalytic Area 1

Continue to deepen engagement in current communities on both the community and health systems base

By 2018, implement the "one community at a time" model in two additional communities to increase awareness, education, and services addressing kidney disease and its leading causes

What's happening in Michigan?

The "one community at a time" model is being executed in three Michigan communities as a part of the *Communities Against Diabetes* project. These communities recognize and understand the need to confront socioeconomic circumstances that negatively impact health, and are identifying and implementing tangible solutions to improve the health and well-being of their communities. Community partners blanket each community with evidence-based prevention, self-management, and other programming, while also focusing on policy and infrastructure changes that can make the healthy choice the easier choice. They recognize that health begins where people live, work, learn, and play. Health starts in strong, loving families and in neighborhoods with sidewalks safe for walking and grocery stores with fresh vegetables. Together, this "one community at a time" model provides support for healthier choices, opportunities and results.

Objectives

- By 2018, seek funding to support implementing the "one community at time" model in two new communities.
- By 2018, identify indicators for CKD and its precursors and track them in communities, measuring their change among specific intervention groups.
- In the two new communities:
    - By 2018, build community support and partnerships by assessing the community need, resources, and capacity before implementing evidence-based programs.
    - By 2018, implement evidence-based programs to meet community needs.

Evaluation Indicators

- Number of communities implementing the "one community at a time" model
- Number of community partners to support these community programs

What Partners Can Do

1. Identify communities at greatest need.
2. Conduct community-led and community-based needs assessment.
3. Create and support a community coalition and related partnerships.
4. Implement evidence-based programming to impact positive health behaviors.
5. Evaluate, make program revisions, and disseminate results.

Catalytic Area 2

Develop a recognized sustainable Community Health Worker (CHW) workforce

By 2018, use Community Health Workers to strengthen the linkage between the health care system and community resources

What's happening in Michigan?

A Community Health Worker (CHW) is a trusted member of and/or has a strong understanding of the community. The CHW serves as a liaison, link, and intermediary between health and social services and the community. They facilitate access to and improve the quality and cultural competency of services. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy. Paid and volunteer CHWs are typically based in community clinics, nonprofit organizations, and public health departments, although they are also found in for-profit and other environments. As the diversity of the population increases, and as the rate of change in health systems accelerates, the opportunity to expand the CHW role grows. Using CHWs to strengthen linkages between the health care system and people with chronic kidney disease or its precursors creates a supportive and learning environment for community members to better manage their health.

Objectives

- Each year, Increase by 5% the number of community health workers trained in evidence based programs.
- Each year, increase by 5% the number of people served by trained community health workers.
- Each year, increase by 5% the overall number of community health workers.

NKFM programs led by CHWs

- National Diabetes Prevention Program
- Personal Action Toward Health (PATH)
- CKD, ESRD, and Organ Donation Peer Mentoring Programs
- Diabetes-PATH

Evaluation Indicators

- Number of CHWs supported by NKFM
- Number of Training Sessions sponsored by NKFM
- Number of CHWs trained by NKFM
- Number reached by NFKM-supported CHWs

In addition to these evaluation indicators, the NKFM will identify a way to measure engagement in self-management and health promoting behaviors for participants served by NKFM-supported CHWs.

What Partners Can Do

1. Advocate for a new credentialing process and CHW reimbursement for services they provide.
2. Promote the integration of CHWs into the health and human services.
3. Support standardized training curriculum for CHW credentialing.

Catalytic Area 3

Improve collection and measure of intervention efforts with social determinants of health

By 2018, develop a comprehensive data tracking system to show intervention success using existing data and new data sources

What's happening in Michigan?

Some surveillance data for tracking patients in CKD currently exists. A few sources of quality data related to kidney failure, stage 5 CKD, are readily accessible. Data sources on the earlier stages of CKD, stages 1-4, however are inaccurate and inconsistent. The CDC recently released a Chronic Kidney Disease Surveillance System (www.cdc.gov/ckd) that provides some national level data. The first chronic kidney disease (CKD) questions on the Behavioral Risk Surveillance Survey (BRFSS) were piloted in Michigan. In 2011, CDC added one CKD question to the national BRFSS, creating the first population estimate of the prevalence of CKD. While these data sources are helpful, a comprehensive data surveillance system is needed. State and community-level CKD will enhance prevention efforts by building awareness of the public health crisis of CKD in Michigan, inform policy and other decision-makers about CKD needs, and close information and tracking gaps in communities.

Objectives

- By 2018, create a dashboard of four CKD-related indicators to track NKFM success.
- By 2018, develop a comprehensive data set to measure NKFM progress over time, with a focus on tracking:
  - The NKFM dashboard indicators;
  - At least one indicator demonstrating impact on the social determinants of health; and
  - At least one patient engagement indicator for participants served by NKFM-supported CHWs.
- By 2018, identify existing or explore new data sources for the comprehensive data set.
- By 2018, report baseline data for the comprehensive data set.

Evaluation Indicators

- Create and Update NKFM Dashboard
- Create comprehensive data system
- Collect and disseminate baseline data

What Partners Can Do

1. Streamline clinical data sets and systems already in existence.
2. Continue to evaluate CKD prevention program effectiveness and disseminate results.
3. Develop a comprehensive data systems exchange to quickly and efficiently share information across the state.

What the Plan Will Accomplish

Chronic Kidney Disease Prevention Strategy in Michigan: 2013-2018 is intended for the NKFM and its partners to **focus** their efforts on preventing chronic kidney disease. More than 900,000 people in Michigan have CKD. While Michigan has demonstrated success in slowing the increase in the new cases of kidney failure, the rates are still climbing. Kidney failure can continue to decline if we reduce the number of people with obesity, prediabetes, diabetes, and hypertension, the most common precursors to CKD, and begin to address some of the social, economic and other factors that negatively impact health.

- **66%** of Michigan adults are overweight or obese, and Michigan's rise in diabetes is in direct correlation to Michigan's rise in obesity.
- More than **2.6 million** Michigan adults have prediabetes, putting them at risk for developing type 2 diabetes.
- In 2011, **10%** of Michigan adults have been diagnosed with diabetes, the most common cause of kidney disease.
- Over **70%** of all kidney failure is caused by uncontrolled diabetes or high blood pressure.
- More than **one-third** of Michigan adults are at risk for developing chronic kidney disease.
- The average per person per year cost of treating kidney failure is approximately **$80,000.**

Completion of the plan's objectives will result in increased infrastructure, implementation of evidence-based interventions, and documentation of progress. Key accomplishments resulting from achieving the plan's objectives are:

- Increased number of community health workers in Michigan.
- Increased number of community health workers trained in Michigan.
- Increased number of people served by trained community health workers in Michigan.
- Expanded community support and partnerships looking at the community need, resources and capacity as they consider and implement evidence-based programs.
- Identifying indicators of chronic kidney disease and its precursors, tracking them in communities, and measuring their change among an intervention group.
- Disseminating research and other information to key stakeholders.
- Seeking funding to support primary prevention programs.

The Process

It is through inquiry and innovation that change occurs. Although the CKD prevention plan is a three year plan, our mission and core values provide a map toward the envisioned future. This plan is a positive outlook for the future and represents a "call to action" of existing and potential partners in creating a healthier Michigan.

Many wise and dedicated individuals were involved in the creation of this plan. The planning committee consisted of 22 individuals from 9 different organizations. The coordinating committee comprised of seven individuals from MDCH and NKFM. Two planning sessions were facilitated by an outside planning professional, and several follow-up meetings were held to further refine the plan.

During the first planning session, chronic kidney disease prevention planning members developed the committee's core values, and envisioned future. The prevention and early detection of CKD is the purpose of the CKD prevention plan, with an envisioned future of a healthier Michigan. The catalytic areas were chosen during the second planning session. These areas address CKD at the primary prevention level, and also address health disparities.

The planning committee believes that this plan lays the ground work for primary prevention interventions that will effectively reduce new cases of kidney failure and reduce the spread of obesity, diabetes and high blood pressure throughout the state of Michigan.

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