



National Institute of Diabetes and Digestive and Kidney Diseases

Kidney Interagency Coordinating Committee Meeting

Virtual Meeting
March 11, 2022

Meeting Summary

Welcome and Introductions

Susan Mendley, M.D., Program Director, National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), National Institutes of Health (NIH)
Jenna Norton, Ph.D., M.P.H., Program Director, NIDDK, NIH

Dr. Susan Mendley welcomed members and attendees to the NIDDK Kidney Interagency Coordinating Committee (KICC) meeting. She reminded participants that the KICC was mandated by Congress in 1987 to meet yearly; however, because of the enthusiasm, the structure changed from a *pro forma* meeting to one that meets twice yearly with the goal of coordinating a federal response to chronic kidney disease (CKD). The aim is to encourage cooperation, communication, and collaboration among all federal agencies engaged in kidney research and related activities. The NIDDK hosts the [Federal CKD Matrix](#), an online resource that summarizes CKD-related activities across federal agencies. She noted that the meeting summary will be posted to the NIDDK website. Dr. Jenna Norton invited meeting attendees to introduce themselves.

The United States Renal Data System (USRDS) COVID-19 Surveillance Efforts

Kirsten Johansen, M.D., Director, USRDS Coordinating Center, Chief of Nephrology, Hennepin Healthcare, Professor of Medicine, University of Minnesota

Dr. Kirsten Johansen presented on USRDS efforts to monitor COVID-19 and its effect on patients with CKD and end-stage renal disease (ESRD). She explained that the COVID-19 pandemic necessitated the collection of current data on these populations. The aims of this surveillance initiative were to document the vulnerability of the ESRD population, to examine differences in impact based on treatment modalities and on race and ethnicity, and to generate data that could be used to guide infection control and policy decisions. Dr. Johansen summarized key findings of these efforts. She explained that data from 2020 revealed an unprecedented decline in the prevalence of ESRD. The onset of COVID-19 was associated with a significant incidence of COVID-19 hospitalization and an increase in mortality among ESRD patients. Compared with the general population, patients with ESRD had significantly higher rates of infection, hospitalization, and mortality related to COVID-19. Dr. Johansen commented that the effect of the pandemic on this vulnerable patient population was so striking that it was covered by such media outlets as *ProPublica*.

Data Sources and Analysis

Dr. Johansen explained that USRDS collects ESRD and CKD population data from the Centers for Medicare & Medicaid Services (CMS) and private payers with a typical 18-month lag associated with claims processing. She noted that the End Stage Renal Disease Quality Reporting System (EQRS), formerly known as CROWNWeb, provides quarterly updates based on CMS forms and clinical data from ESRD providers. EQRS real-time updates include hospitalization information. With the help of CMS and

NIDDK colleagues, USRDS also obtained updated quarterly information (i.e., Medicare 5 percent samples and 100 percent ESRD claims) from Medicare beginning in late 2020. Although the data were incomplete, analysis of consecutive quarterly extracts demonstrated that the incompleteness was predictable and could be corrected with inflation factors.

Race, Ethnicity, and Age Effects

Dr. Johansen presented COVID-19 hospitalization data from Medicare beneficiaries during the second quarter of 2020 (i.e., weeks 13 to 27), which varied by race, ethnicity, and modality. During week 15, hospitalizations of Black beneficiaries were twice that of white beneficiaries or beneficiaries of other races; this trend equalized over the following weeks. Hispanic and non-Hispanic hospitalization rates were initially identical but diverged over the course of the quarter, ending with Hispanic beneficiaries being hospitalized at a rate three times that of non-Hispanic beneficiaries. When adjusted for age and other factors, non-Hispanic Black and Hispanic patients were hospitalized at a higher rate than white patients across the period of the quarter. During the early weeks of the pandemic, older patients (ages 65 and older) were more likely to be hospitalized than patients between the ages of 45 and 64. This effect decreased over time and was not observed during weeks 23 through 27 of 2020. Younger patients (ages 18 to 44) were less likely to be hospitalized than patients between the ages of 45 and 64, and this trend persisted throughout the period examined.

Modality Effects

Initially, COVID-19 hospitalization rates among hemodialysis (HD) patients were four times higher than those of peritoneal dialysis (PD) patients; this gap continued throughout the quarter but narrowed to a twofold difference by week 23. Dr. Johansen highlighted a considerable drop in non-COVID-19 hospitalizations among ESRD patients when compared with data from previous years. This decline began during week 12 and continued throughout the first half of 2020, a period when hospital closures were prevalent. Adjusted, interval-specific 2020 incidence rate ratios of HD, PD, and pre-emptive kidney transplant confirmed the drop in patient treatment incidences during the early weeks of the pandemic. This trend also was observed in adjusted, interval-specific differences in the mean estimated glomerular filtration rate (eGFR), which remained unprecedentedly low into the summer of 2020. All-cause mortality among patients undergoing dialysis or with a functioning transplant peaked above rates observed during previous years and did not return to baseline levels during 2020. Weekly initiations of dialysis or pre-emptive transplantations decreased with the onset of the pandemic but did return to previous years' baseline levels by the summer of 2020. When dialysis modality data was stratified by nursing home exposure, in-facility HD patients with no history of skilled nursing facility (SNF) care were less likely to be diagnosed with COVID-19 than patients receiving HD in an SNF or in-facility HD patients with a recent history of SNF care. In-facility HD patients experienced higher incidences of COVID-19 diagnoses than either HD or PD patients receiving treatment at home. Dr. Johansen pointed out that these trends were more exaggerated in the early weeks of the pandemic. Similar patterns were observed in COVID-19 hospitalization and mortality data.

ESRD Patient Vulnerability

Dr. Johansen presented Coronavirus Disease 2019 (COVID-19)-Associated Hospitalization Surveillance Network (COVID-NET) data on COVID-19 hospitalization rates in the general population and compared these with the rates observed in the dialysis population. She noted the high correlation between these rates ($r = 0.90$ across all 14 surveilled states) but added that rates among dialysis patients were approximately 40 times higher than in the general population. This trend persisted in data from the second half of 2020. By the end of 2020, almost 16 percent of dialysis patients, almost 10 percent of transplant patients, and almost 8 percent of CKD patients had been diagnosed with COVID-19. A similar gradient of vulnerability for such patients was evident in hospitalization data. Dr. Johansen noted high incidences of

acute kidney injury in both CKD (50 percent to 60 percent) and non-CKD (20 percent to 40 percent) patients hospitalized with COVID-19. Similar rates of intensive care utilization, however, were observed among non-CKD, CKD, dialysis, and transplant populations. Following the onset of the pandemic, cumulative all-cause deaths were 18 percent higher among ESRD patients in 2020 than in previous years; this trend continued in 2021 data. Dr. Johansen highlighted a joint statement from the National Kidney Foundation (NKF) and the American Society of Nephrology (ASN) released on January 18, 2022, which emphasized the vulnerability of ESRD patients to COVID-19. The hope is to make use of these data in advocating for patients and effecting beneficial policy changes. She thanked Chronic Disease Research Group and NIDDK collaborators for their assistance with these surveillance efforts.

Discussion

- Drs. Robert Star and Susan Crowley asked why the decrease in treatment incidences was not followed by a corresponding increase in treatment. Dr. Johansen answered that this issue is being discussed but is still not well understood.
- Ms. Nilka Ríos Burrows commented that the statistics team at the Centers for Disease Control and Prevention (CDC), Division of Diabetes Translation, is submitting for publication data showing the average number of weekly dialysis session remained unchanged during 2019–2020. She added that it was a remarkable accomplishment for dialysis centers to continue providing treatment for their patients at typical rates despite challenges during the pandemic. Dr. Crowley noted the importance of monitoring the long-term effects of changes to treatment regimens.
- In response to a question from Dr. Abigail Ryan about capturing data from private payers who migrated to Medicare, Dr. Johansen affirmed that these patients were captured in EQRS mortality and hospitalization data from the entire U.S. population. Dr. Ryan noted that exceptions were made during the pandemic to allow SNFs that were not Medicare certified to bill treatments as being “in facility” and asked whether this shift was captured in the data. Dr. Johansen confirmed that the data used for this study were determined by billing codes. She remarked that the mixing of these populations might explain why COVID-19 incidence trends from in-facility HD patients converged with those from SNF HD patients over time. In response to a question from Dr. Ryan about tracking COVID-19 vaccine and treatment data in these patients, Dr. Johansen replied that the 2022 annual data report will include this information. Drs. Ryan and Johansen agreed that early vaccine efforts were disorganized and difficult to capture. Dr. Shalon Quinn commented that these vaccination data have been documented through the CDC National Healthcare Safety Network.
- Dr. Crowley asked about possible efforts to prioritize ESRD and transplant patients for preventive COVID-19 therapies. Dr. Johansen answered that societies are using these data to advocate on behalf of patients.
- Dr. Andrew Narva commented that data from American Indian (AI) populations should be investigated because this population is vulnerable to COVID-19 for several reasons (e.g., high rates of ESRD, close living quarters). In response to a question from Dr. Mendley about whether vaccination data from the Indian Health Service would be more complete, Dr. Narva replied that vaccination rates were higher and surveillance was more accurate in this population.
- Ms. Burrows commented that the Dialysis Safety Team in the Division of Healthcare Quality Promotion at the CDC would be a good partner to involve in efforts to prioritize dialysis patients for COVID-19 therapeutics. She mentioned Dr. Shannon Novosad as a potential point of contact with this team. Dr. Mendley asked about the need for additional pharmacological and efficacy testing of antiviral therapies in dialysis patients. Dr. Aliza Thompson invited U.S. Food and Drug

Administration (FDA) colleagues to comment on this issue. Dr. Kirk Chan-Tack remarked that FDA guidance on COVID-19 treatments encourages sponsors to enroll patients with renal impairments and includes a post-marketing requirement for evaluation of a dedicated renal impairment study. He added that sponsors are often reluctant to include such patients in initial trials because of high morbidity and mortality rates in these populations. Participants discussed potential avenues for additional FDA studies in dialysis patients.

- Dr. Murray Sheldon asked whether data regarding the efficacy of vaccinations in dialysis or transplant patient populations are available. Dr. Johansen pointed out that these patients were not vaccinated until 2021 and these data were captured but are not yet available for analysis.
- Dr. Kevin Abbott asked whether easier access to COVID-19 testing and treatments could be provided at ESRD facilities. Dr. Ryan answered that testing already is provided but that treatments at the site of care—even for conditions other than COVID-19—have been difficult to provide under Section 1881 of the Social Security Act. Any treatments provided by ESRD facilities would require congressional approval.
- Dr. Paul Palevsky commented that CDC guidance on moderately and severely immunocompromised patients—which is relevant to fourth vaccine doses and access to such medications as Evusheld—currently does not include ESRD patients. He added that vaccines were not made available to patients in dialysis units until the middle of spring 2021. Dr. Crowley affirmed that updated CDC guidance on therapeutics is necessary. Dr. Stephanie Troy commented that state requests have ordered only 20 percent of the U.S. supply of Evusheld. Ms. Miriam Godwin agreed that increasing state orders might improve access to this therapeutic.

Chronic Kidney Disease Surveillance: National Center for Health Statistics USRDS Data Linkage

Nilka Rios Burrows, M.P.H., Epidemiologist, CDC

Ms. Burrows reviewed the activities of the CDC Chronic Kidney Disease Initiative. The CKD Surveillance System, which she has been leading since 2015, is the largest project in this portfolio. The initiative supports the National Health and Nutrition Examination Survey (NHANES) kidney component with laboratory measures that form the foundation of the CKD surveillance system. Recently, Ms. Burrows has been in conversations with the National Center for Health Statistics (NCHS) to incorporate the recommendations of the NKF-ASN Task Force on kidney function estimating equations by adding cystatin C to the current laboratory measures. Other projects include studies using electronic health records in collaboration with the U.S. Department of Defense and the joint Providence Saint John's Health Center and the University of California, Los Angeles, the Center for Kidney Disease Research, Education and Hope (commonly called CURE-CKD) registry. The initiative's activities include other national (e.g., NKF) as well as international (e.g., German Diabetes Center) collaborations.

The CDC CKD Surveillance System covers several major CKD topics, such as burden, awareness, risk factors, health consequences, quality of care, and health care system capacity. The surveillance system incorporates data from national surveys, including NHANES; registries; health care administrative information from CMS and the U.S. Department of Veterans Affairs (VA); and large cohort studies. This surveillance system also incorporates data on emerging CKD topics. Ms. Burrows anticipates adding data from Labcorp and data on COVID-19 in the future.

KICC members were updated on the USRDS data linkages with NCHS surveys, including NHANES. The aim of this effort is to study changes in health status and health care utilization among patients diagnosed with ESRD. The linked ESRD data are available for NCHS survey participants who consented to the linkage, agreed to provide personally identifiable data to NCHS, and were able to be matched by NCHS with USRDS administrative records. The available ESRD patient linked data cover service from 1974

through 2018, which is a 10-year extension beyond the previously available linked data to 2008. For the NCHS-USRDS ESRD data files, these data are restricted-use files and accessible only through the NCHS Research Data Center (RDC); no public-use study files are available. To access data, investigators must submit a research proposal to the RDC; the instructions for doing so can be accessed from the NCHS RDC website. Data are divided into six file categories: Match Status, Patient Profile, Medical Evidence Report, Detailed Treatment History, Condensed Treatment History, and Payer History. The methodology, analytic considerations, variable list, and dictionaries are accessible at NCHS RDC website. Ms. Burrows expressed appreciation to NIDDK Program Official Dr. Abbott, who provided USRDS oversight, for his efforts in helping to extend this data linkage.

Regarding the data sources, several NCHS surveys have been linked to USRDS ESRD data:

- 1994–2018 National Health Interview Survey (NHIS)
- 1999–2018 NHANES
- NHANES I Epidemiologic Follow-up Study
- Third National Health and Nutrition Examination Survey (NHANES III)
- Second Longitudinal Study of Aging (commonly called LSOA II)
- 2004 National Nursing Home Survey

Across continuous NHANES surveys linked to USRDS, 70 percent to 85 percent of the adult NHANES participants were eligible for the linkage and had laboratory results available.

Ms. Burrows described research ideas that can be proposed using NHANES data linked to the CMS ESRD Disease Medical Evidence Report, Form 2728. These data can be used to examine the characteristics of people with CKD across disease stages; evaluate risk factors (e.g., hypertension, albuminuria, food insecurity); and investigate care practices, including the use of angiotensin-converting enzyme inhibitors, angiotensin-receptor blockers, or sodium-glucose cotransporter 2 (SGLT2) inhibitors. These data also allow assessment of the duration, awareness, and comorbidities of CKD and examination of pre-ESRD care, including nephrology visits and dietician visits and the potential use of erythropoiesis-stimulating agents. Research in these areas, Ms. Burrows emphasized, could provide insight into why the declines in incidence rates in kidney failure from diabetes mellitus in AI and Alaska Native (AI/AN), Hispanic, and African American populations have reached a plateau. Ms. Burrows collaborated with Dr. Ann Bullock, then director of the Division of Diabetes Treatment and Prevention at the Indian Health Service, to examine these trends. These findings were published in the September 2020 issue of *Diabetes Care*.

KICC members were informed of NHANES' new content and proposal guidelines. The call for proposals soon will open for continuing and new content submission for the 2024 NHANES cycle; no 2023 NHANES data will be collected. A March 17, 2022, webinar will be held to discuss details of the survey and the proposal submission process. The data collection contract has not been awarded, and the survey design details have not been finalized. NHANES staff will continue to conduct household interviews, administer health examinations, and collect biospecimens. NHANES interviews and examines 5,000 participants annually, and each year will be nationally representative in the new survey design. The sample design will again oversample by race and ethnicity. Upgrades will incorporate new mobile units (i.e., smaller mobile examination center space) to travel within a county or primary sampling unit. Ms. Burrows noted the opportunity to provide input on any improvements to NHANES and the survey questions on kidney disease.

Discussion

- Dr. Abbott noted to the NHANES investigator group that some changes with the assays, particularly for urine albumin, are likely because of the change in the contractor providing these services.
- Ms. Burrows confirmed that updates to NHANES regarding cystatin C could be performed using stored serum samples from the NHANES Biospecimen Program, and data on SGLT2 inhibitors are already being collected.

Delivering Patient-centered Care for CKD in the Context of Multiple Chronic Conditions (MCC)

Arlene Bierman, M.D., Director, Center for Evidence and Practice Improvement, Agency for Healthcare Research and Quality (AHRQ)

Dr. Arlene Bierman noted that the mission of AHRQ is twofold: (1) to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable and (2) to work with the U.S. Department of Health and Human Services (HHS) and other partners to make sure that the evidence is understood and used. Within its role, AHRQ's vision is to improve the lives of patients, with the aim of helping health care systems and professionals deliver high-quality, safe, and high-value care. AHRQ's competencies include health systems research, practice improvement, and data and analytics. The Center for Evidence and Practice Improvement (CEPI) has several Divisions and Centers whose work aligns with the goals of NIDDK kidney health initiatives, including the National Center of Excellence in Primary Care Research; the Evidence-based Practice Centers, which conduct systematic reviews; and the U.S. Preventive Services Task Force (USPSTF), which makes recommendations on clinical preventive services.

Dr. Bierman highlighted several challenges AHRQ is addressing. The health care system in the United States fails its patients in many different ways, and failures were further exacerbated by the COVID-19 pandemic. Patient outcomes are often suboptimal (e.g., when they receive only 50 percent of recommended care), and preventable harm results in deaths. Waste exists in the health care system that results from a poor flow of information and evidence. It is well documented that annually, \$210 billion is wasted on unnecessary services and \$130 billion on inefficient services. Clinician burnout has been a problem for some time and has worsened during the COVID-19 pandemic. To address these challenges, AHRQ developed Learn and Care Model to inform the Agency's research agenda setting. This model brings together two critical health system functions, (1) caring for people in a community and social context and (2) the data-driven synthesis, implementation, and generation cycle of learning health systems.

In terms of health challenges related to MCC, Dr. Bierman pointed out that nearly 1 in 3 American adults and 4 in 5 Medicare beneficiaries are living with MCC. The mismatch between the current disease-specific method of care delivery and patients' needs results in fragmented, suboptimal care; poor outcomes; and increased costs. People with MCC account for 64 percent of all clinician visits, 70 percent of all in-patient stays, 83 percent of all prescriptions, 71 percent of all health care spending, and 93 percent of Medicare spending. The 2018 CMS comorbidity data for Medicare fee-for-services beneficiaries showed that approximately 50 percent of patients with CKD have at least five other chronic conditions, whereas less than 5 percent of patients with CKD have no other chronic conditions. These data suggest that to improve care for CKD, care needs to be in the context of the other health conditions present. The 2017 CMS data showed that 17 percent of Medicare beneficiaries with six or more chronic conditions account for 83 percent of all hospital readmissions, which highlights the need for comprehensive patient-centered care. Conversely, 32 percent of Medicare beneficiaries who do not have a chronic condition or have one chronic condition account for only 6 percent of Medicare spending. In addition, MCC is a health equity issue. Individuals from low-income households and racial and ethnic

minorities develop MCC at earlier ages, have a higher burden of illness, and have more functional impairments. Disadvantaged populations are more likely to encounter barriers to access, experience care of lower quality, have multiple social risks, and have fewer resources to navigate the health system. Across all age groups, women are more likely than men to have MCC. The increasing prevalence of MCC has risen to the status of a new syndemic. Dr. Bierman pointed out that multimorbidity, a term often used synonymously with MCC, includes individuals with more than one chronic physical condition, more than one mental health diagnosis, or both. Others in the field use this term to include additional factors that contribute to the burden of illness, such as disease severity, functional impairments and disabilities, syndromes, and social factors (e.g., homelessness).

Dr. Bierman conveyed that from AHRQ's standpoint, transforming care for MCC is central to improving health care and requires a patient-centered approach. She noted that current conditions—including the ongoing COVID-19 pandemic, misaligned payment incentives, and increased awareness of health inequities—have drawn attention to the problem of MCC. This has created a window of opportunity to implement innovative solutions and new models of care, which together with novel research methods increase the likelihood of success. AHRQ's vision for people living with MCC is a sustainable health care system that delivers high-value, coordinated, and integrated patient-centered care based in primary care that optimizes individual and population health by preventing and effectively managing MCC. AHRQ aims to address MCC across the risk continuum by supporting prevention interventions that reduce the likelihood of MCC for those at risk, targeted interventions to improve health of those who are at rising risk, and targeted interventions for those who are at high risk.

Dr. Bierman shared the details of AHRQ's agenda on research needs to transform MCC care, which was published in November 2021. Interventions are needed at the patient, practice, community, and health system levels, along with multilevel interventions. Progress requires culture change in practice and training, including the integration of behavioral health and primary care. Partnerships and policies are needed to address social determinants of health (SDoH) and to address pervasive health inequities. Patients and their families and caregivers, clinicians, and communities can accelerate progress as coproducers of evidence. Current payment models present a barrier to innovation, and evidence is needed on different payment models and incentives. The needs exist both to deliver care differently and to do research differently.

KICC members were updated on the AHRQ-NIDDK e-Care Plan for MCC Project. The aim is to build capacity for pragmatic patient-centered outcomes research by developing an interoperable e-care plan to facilitate aggregation and sharing of critical patient-centered data across home-, community-, clinic-, and research-based settings for people with MCC. The project will focus on developing data elements, value sets, clinical information models, and Fast Health Interoperability Resource (FHIR[®]) mappings; a pilot-tested patient-, clinician- and caregiver-facing e-care plan; and a Health Level Seven (HL7) FHIR Implementation Guide. The Project will disseminate all deliverables through open-source channels.

Participants were reminded that AHRQ is the lead agency under the Affordable Care Act responsible for dissemination and implementation of evidence into practice. The approach has been to integrate quality improvement and implementation science. The AHRQ initiative [EvidenceNow](#) is a model for delivering external support to primary care practices to improve health care quality and implement new evidence into care delivery. Dr. Bierman highlighted EvidenceNOW projects relevant to kidney disease, including Advancing Heart Health, Advancing Equity in Heart Health by Building State Capacity, and Managing Unhealthy Alcohol Use in Primary Care. She further elaborated on the Managing Urinary Incontinence in Primary Care initiative, noting that urinary incontinence is a public health burden, is relevant to people with MCC, and aligns with a comprehensive e-care plan model. Interventions are sponsored in several states.

Regarding research and the science of care, AHRQ's aims are to understand what works and how to make care work; learn while implementing; conduct multilevel interventions; promote agile implementation; use mixed methods; and address the complexity of science. Grantees are encouraged to propose innovative research ideas that fit the scope of these aims. Dr. Bierman noted EvidenceNOW tools and resources and highlighted the Academy for Integrating Behavioral Health and Primary Care, patient-reported outcome measures, and the Patient-Generated Health Data (PGHD) guide.

Discussion

- Dr. Star commented that AHRQ appears to make changes either within the health care or the payment system to elicit change in the direction needed. A broader question, in the context of the health equity framework, is how to prompt change externally and how the U.S. Government and society can test interventions to see if they are working as intended. Dr. Bierman pointed out that AHRQ is interested to know what the role of the health system is in addressing SDoH in the context of health care and how health systems can establish multisectoral partnerships to more effectively address them. She called attention to a recent series of grants in which awardees were asked to link data on SDoH, chronic disease, with information about community services to develop dashboards for primary care practices to better manage individual and population health. One grantee is examining ways to stratify risk for people with MCC using algorithms to allow case managers who then connect them to community services. Dr. Bierman explained that having access to shared information that can be used by both health and social care organizations along communities would foster implementing interventions and partnerships to address SDoH. There is a large research age and to determine both what works and how to make it work in this regard. In addition, Dr. Bierman noted that the HHS has released its SDoH action plan to implement a coordinated approach across the department to address SDoH, including determining ways to integrate social care and health care to leverage existing efforts. She expects this to be an area relevant to kidney disease in terms of the associated risk factors.
- In response to a question from Dr. Star on how to address the health problem for all rather than on an individual-by-individual basis, Dr. Bierman noted that, in terms of health equity and disparities, social conditions increase an individual's risk for chronic conditions among those who also experience access-to-care issues and disparities in quality of care, compounding their impact on health and well-being. She underscored that improving health care delivery entails being cognizant of upstream factors and determining ways to partner with other sectors (e.g., housing, education) to address an overall health problems.
- Dr. Ryan explained how the CMS Division of Chronic Care Management is focused on health equity in all aspects of the payment system and pointed out two common themes of the CMS Prospective Payment System: comorbidities and co-payment. Both ESRD providers and ESRD facilities support extra payments for comorbidities. Co-payments are not waived within the payment structure and remain a problem for Medicare beneficiaries who are unable to afford them. She emphasized that balancing innovation and research with these aspects of the payment system should be considered. Dr. Bierman conveyed that AHRQ does not address payments directly, although it does study the impact of different payment models, and she acknowledged that these and other issues need to be addressed. She also noted that AHRQ's budget is relatively small compared with the resources needed to build the evidence base for health care transformation.
- Dr. Abbott commented that the literature indicates that the more chronic conditions an individual has, the more likely they are to experience consequent conflicts in treatments, such as diuretics versus incontinence and heart medications versus kidney medications. He asked for input on how

to help patients and providers address these issues. Dr. Bierman noted the work of the Evidence-based Practice Centers to conduct systematic reviews on various topics for professional societies, some of which are developing guidelines that address multimorbidity and making these types of decisions. She added that the National Institute for Health and Care Excellence (United Kingdom) has published guidance on managing multimorbidity, as well as relevant clinical guidelines, and noted this as an area of research the NIH could consider.

- When asked about the need for a USPSTF screening recommendation as a foundational issue to address, which also is a priority for the NKF, Dr. Bierman clarified that recommendations from the USPSTF are prioritized by topic and noted that this process—which includes conducting a systematic review and drafting a research protocol informed by input from the respective community—can take up to 2 to 3 years to complete. The USPSTF is an independent body and is currently considering a proposed recommendation on CKD screening. AHRQ works closely with the HHS Office of Disease Prevention and Health Promotion on the evidence reviews to address evidence gaps.
- Dr. Bierman reminded participants that AHRQ was requested by Congress to produce a report of evidence of the potential for algorithms to introduce racial and ethnic bias into clinical practice. The development included soliciting public comments and reviewing the robust responses to inform the draft report, which is now in the review process. As an outcome of this report, AHRQ anticipates convening an expert panel to develop consensus about strategies to mitigate bias in algorithms, including the development, testing, and validation of such algorithms. Dr. Abbott said that reconciling conflicts between published practice guidelines for different diseases and different societies was beyond the scope of the current project. The project will need to “skate to where the puck will be” to align as best as possible.
- Dr. Crowley asked whether AHRQ is developing tools to capture the patient experience of those with MCC, which can be then used for examining the CKD population. Dr. Bierman highlighted ongoing research on patient-reported outcomes that is relevant to MCC, investigations on improving care transitions that also are challenging for people with MCC, and the recently released PGHD guide that provides information on how to incorporate patient-generated data into EHRs. She also noted Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys that capture patient experience and that she will follow up with the AHRQ CAHPS team after the meeting.

Around the Table: Agency Updates

Agency for Healthcare Research and Quality

Dr. Christine Chang informed the KICC that the draft report on the use of clinical algorithms and racial/ethnic bias will be available for public comment in summer 2022; the final report is anticipated by the end of the year.

Centers for Disease Control and Prevention

Ms. Burrows reported that the USPSTF just approved adding CKD Screening to the list of preventive service topics under active consideration. The next step is prioritizing CKD Screening for review in 2022. She announced her retirement from the CDC after 30 years of service and expressed appreciation to the NIDDK for the opportunity of being a member of the KICC. The announcement for Lead of the CDC Chronic Kidney Disease Initiative will be posted soon, with the intent of her tenure overlapping with that of the incoming staff.

U.S. Department of Veterans Affairs

Dr. Palevsky noted that the VA has mandated that its laboratories start reporting the 2021 CKD-Epidemiology Collaboration creatinine eGFR by April 1, 2022. At least one laboratory within the VA Integrated Service Networks will be required to provide cystatin C as an in-house assay by September 1, 2022.

Centers for Medicare & Medicaid Services

Mr. Siddhartha Mazumdar reported that the CMS Innovation Center launched the Kidney Care Choice Model in January 2022 after 2 years of development. This model is designed specifically for patients with late-stage CKD.

Adjournment

Drs. Mendley and Norton thanked the presenters and attendees for their participation. Dr. Mendley noted that the next meeting is scheduled for September 16, 2022, and could be a hybrid of in-person and virtual attendance. She adjourned the meeting.

Meeting Participants

Susan Mendley, M.D.

Executive Secretary, Kidney Interagency
Coordinating Committee
National Institute of Diabetes and Digestive and
Kidney Diseases
National Institutes of Health
Email: susan.mendley@nih.gov

Kevin Abbott, M.D., M.P.H.

National Institute of Diabetes and Digestive and
Kidney Diseases
National Institutes of Health
Email: kevin.abbott@nih.gov

Barbara Barton, M.D., M.P.H.

Agency for Healthcare Research and Quality
Email: barbara.barton@ahrq.hhs.gov

Arlene Bierman, M.D.

Agency for Healthcare Research and Quality
Email: arlene.bierman@ahrq.hhs.gov

Nilka Ríos Burrows, M.P.H.

Centers for Disease Control and Prevention
Email: nrrios@cdc.gov

Kirk Chan-Tack, M.D.

U.S. Food and Drug Administration
Email: kirk.chan-tack@fda.hhs.gov

Christine Chang, M.D., M.P.H.

Agency for Healthcare Research and Quality
Email: christine.chang@ahrq.hhs.gov

Katherine Clarridge, M.D.

U.S. Food and Drug Administration
Email: katherine.clarridge@fda.hhs.gov

Susan Crowley, M.D., M.B.A., FASN

Veterans Health Administration
Email: susan.crowley@va.gov

Sandeep Dayal, Ph.D.

National Institute of Diabetes and Digestive and
Kidney Diseases
National Institutes of Health
Email: sandeep.dayal@nih.gov

Melissa Dorsey

Centers for Medicare & Medicaid Services
Email: melissa.dorsey@cms.hhs.gov

Tom Duvall

Centers for Medicare & Medicaid Services
Email: tom.duvall@cms.hhs.gov

Paul Eggers, Ph.D.

National Institute of Diabetes and Digestive and
Kidney Diseases
National Institutes of Health
Email: paul.eggers@nih.gov

Evan Fisher, M.D., M.H.S.

U.S. Food and Drug Administration
Email: evan.fisher@fda.hhs.gov

Shannon Givens, M.P.H.

National Institute of Diabetes and Digestive and
Kidney Diseases
National Institutes of Health
Email: shannon.givens@nih.gov

Christina Goatee, R.N., M.S.N.

Centers for Medicare & Medicaid Services
Email: christina.goatee@cms.hhs.gov

Miriam Godwin, M.P.H.

National Kidney Foundation
Email: miriam.godwin@kidney.org

CAPT Gregory Gorman, M.D.

Walter Reed National Military Medical Center
Email: gregory.h.gorman.mil@mail.mil

Daniel Gossett, Ph.D.

National Institute of Diabetes and Digestive and
Kidney Diseases
National Institutes of Health
Email: daniel.gossett@nih.gov

Raquel Greer, M.D., M.H.S.

National Institute of Diabetes and Digestive and
Kidney Diseases
National Institutes of Health
Email: raquel.greer@nih.gov

Delia Houseal, Ph.D., M.P.H.
Centers for Medicare & Medicaid Services
Email: delia.houseal@cms.hhs.gov

Austin Hu, M.D.
U.S. Food and Drug Administration
Email: austin.hu@fda.hhs.gov

Frank Hurst, M.D., FASN
U.S. Food and Drug Administration
Email: frank.hurst@fda.hhs.gov

Kirsten Johansen, M.D.
United States Renal Data System
Coordinating Center
University of Minnesota
Email: kjohansen@cdrg.org

Paul Kimmel, M.D., MACP
National Institute of Diabetes and Digestive and
Kidney Diseases
National Institutes of Health
Email: kimmelp@extra.niddk.nih.gov

Jeffrey Kopp, M.D.
National Institute of Diabetes and Digestive and
Kidney Diseases
National Institutes of Health
Email: jeffrey.kopp@nih.gov

Siddhartha Mazumdar
Centers for Medicare & Medicaid Services
Email: siddhartha.mazumdar@cms.hhs.gov

Laura Missett, M.P.A.
Centers for Medicare & Medicaid Services
Email: laura.missett@cms.hhs.gov

Kirtida Mistry, M.D.
U.S. Food and Drug Administration
Email: kirtida.mistry@fda.hhs.gov

Neda Najmitabrizi, M.S.
Centers for Medicare & Medicaid Services
Email: neda.najmitabrizi@cms.hhs.gov

Andrew Narva, M.D., FACP, FASN
Indian Health Service
Email: andrew.narva@ihs.gov

Robert Nee, M.D., FACP
Walter Reed National Military Medical Center
Email: robert.nee.civ@mail.mil

Deepak Nihalani, Ph.D.
National Institute of Diabetes and Digestive and
Kidney Diseases
National Institutes of Health
Email: deepak.nihalani@nih.gov

Jenna Norton, Ph.D., M.P.H.
National Institute of Diabetes and Digestive and
Kidney Diseases
National Institutes of Health
Email: jenna.norton@nih.gov

Matthew Oldham
National Institute of Diabetes and Digestive and
Kidney Diseases
National Institutes of Health
Email: matthew.oldham@nih.gov

James Oliver, III, M.D., Ph.D.
Walter Reed National Military Medical Center
Email: james.d.oliver@us.army.mil

Paul Palevsky, M.D.
Veterans Affairs Pittsburgh Healthcare System
Email: paul.palevsky@pitt.edu

Shalon Quinn, Ph.D., M.P.H.
Centers for Medicare & Medicaid Services
Email: shalon.quinn@cms.hhs.gov

Tracy Rankin, M.D., Ph.D.
National Institute of Diabetes and Digestive and
Kidney Diseases
National Institutes of Health
Email: tracy.rankin@nih.gov

Abigail Ryan, Ph.D.
Centers for Medicare & Medicaid Services
Email: abigail.ryan@cms.hhs.gov

Jennifer Rymaruk
National Institute of Diabetes and Digestive and
Kidney Diseases
National Institutes of Health
Email: jennifer.rymaruk@nih.gov

Ivonne Schulman, M.D.
National Institute of Diabetes and Digestive and
Kidney Diseases
National Institutes of Health
Email: ivonne.schulman@nih.gov

Murray Sheldon, M.D.
U.S. Food and Drug Administration
Email: murray.sheldon@fda.hhs.gov

Robert Star, M.D.
National Institute of Diabetes and Digestive and
Kidney Diseases
National Institutes of Health
Email: robert.star@nih.gov

Robert Tamburro, M.D., M.Sc.
Eunice Kennedy Shriver National Institute of
Child Health and Human Development
National Institutes of Health
Email: robert.tamburro@nih.gov

Aliza Thompson, M.D., M.S.
U.S. Food and Drug Administration
Email: aliza.thompson@fda.hhs.gov

Stephanie Troy, M.D.
U.S. Food and Drug Administration
Email: stephanie.troy@fda.hhs.gov

Shamir Tuchman, M.D., M.P.H.
U.S. Food and Drug Administration
Email: shamir.tuchman@fda.hhs.gov

Anne Utech, Ph.D., R.D.N., L.D.
U.S. Department of Veterans Affairs
Email: anne.utech@va.gov

Kenneth Wilkins, Ph.D.
National Institute of Diabetes and Digestive and
Kidney Diseases
National Institutes of Health
Email: kenneth.wilkins@nih.gov