



National Institute of  
Diabetes and Digestive  
and Kidney Diseases

### **Kidney Interagency Coordinating Committee Meeting**

John Edward Porter Neuroscience Research Center  
Building 35A, Room 640  
National Institutes of Health  
Bethesda, MD  
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### **Meeting Participants and Summary**

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## **Welcome and Introductions**

*Andrew Narva, M.D., FACP*

*National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), National Institutes of Health (NIH)*

Dr. Andrew Narva welcomed members and attendees to the NIDDK Kidney Interagency Coordinating Committee (KICC) meeting. The KICC was mandated by Congress in 1987 to meet yearly to encourage cooperation, communication, and collaboration among all federal agencies engaged in kidney research and other related activities. The KICC meets twice yearly and provides an active forum for communication among federal agencies working in kidney disease. Recognizing that the federal response to chronic kidney disease (CKD) is multifaceted and interconnected, the NIDDK hosts the Federal CKD Matrix, an online resource that summarizes CKD-related activities.

Today's meeting will include: (1) an overview of the proposed CKD changes for the Healthy People (HP) 2030 project implemented by the Office of Disease Prevention and Health Promotion (ODPHP), U.S. Department of Health and Human Services (HHS), (2) inclusion of CKD in the next Centers for Medicare and Medicaid Services (CMS) Quality Improvement Program, and (3) a report on opioid prescription use in end-stage renal disease (ESRD) patients, as well as agency updates. Dr. Narva noted that the KICC served as a source of vetting for the CKD objectives for the original HP 2020.

## **Overview of HP 2030 and Proposed Changes to CKD Measures**

*Nilka Ríos Burrows, M.P.H., M.T. (ASCP)*

*Centers for Disease Control and Prevention (CDC)*

Ms. Nilka Ríos Burrows updated participants on the process to set the CKD objectives for HP 2030, which are a component of the broader 10-year initiative to monitor and improve the health of all Americans. The HP 2020 included more than 1,200 objectives covering 42 topics or public health areas. The objectives are divided into three categories: measurable objectives with a data source and a national baseline; developmental objectives with a potential data source but no baseline; and informational objectives of public health importance with a data source and baseline but without target values. At the December 1, 2016, meeting on developing the HP 2030 framework, the HHS Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030 (Secretary's Advisory Committee) was charged to streamline and significantly reduce the overall number of objectives from HP 2020's 1,200 to 450 for HP 2030. To begin this process, the CKD Workgroup—composed of representatives from the NIH, CDC, and ODPHP—was charged with reviewing the current HP 2020 CKD objectives. The Workgroup solicited feedback from the United States Renal Data System (USRDS) External Expert Panel and coordinated with the CDC's Division of Diabetes and Translation to avoid overlap with the diabetes objectives. In the first iteration, after removing the informational and sub-objectives and adding no new objectives, the 24 CKD objectives were reduced to 14. After a second iteration requested by HHS, 10 objectives remained.

Ms. Burrows emphasized that the withdrawn HP 2020 CKD objectives are not less relevant and that different agencies or organizations may continue to prioritize them for programmatic or tracking purposes. Withdrawn objectives for people with CKD include—

- CKD 7, Deaths
- CKD 4.2, Creatinine/lipids/albumin testing/A1C/eye exams (among people with diabetes and CKD)
- CKD 6.2, Statin use
- CDK 10, Pre-ESRD care

Withdrawn objectives for people with ESRD include—

- CKD 9.1 and 9.2, ESRD-diabetes mellitus (DM) incidence
- CKD 11.1 and 11.3, Fistula use
- CKD 12, Waitlisted/transplanted in 1 year
- CKD 13.2, Transplant at start of therapy
- CKD 14.2–14.5, Cardiovascular deaths, deaths among people in the first 3 months of dialysis, and deaths among people receiving a transplant

In its HP 2030 CKD Proposal to the ODPHP Federal Interagency Workgroup (FIW) in August 2018, the CKD Workgroup proposed the following changes: (1) Extend CKD awareness and use of angiotensin-converting enzyme (ACE) inhibitors and angiotensin-receptor blockers (ARBs) to younger age groups. (2) Use the National Health and Nutrition Examination Survey (NHANES) as a data source for capturing ACE/ARB use. (3) Use a shorter time interval for evaluation of kidney function after acute kidney injury (AKI). (4) Include the diabetes and hypertension (HTN) subgroups for data assessment. For the 10 objectives, two data sources—four from NHANES and six from USRDS—were proposed.

Ms. Burrows remarked on the role and efforts of the CKD Workgroup to justify and present the 10 HP 2030 CKD objectives to the FIW. Two objectives—CKD prevalence and ESRD incidence—were voted as priorities to be included in HP 2030, and eight objectives were voted as having met the minimum criteria to be considered for HP 2030. Ms. Burrows discussed current progress on the proposed 2030 objectives. Four objectives—evaluation post-AKI, creatinine/lipids/albumin testing, catheter use, and deaths on dialysis—have met their HP 2020 target values. There was improvement in ESRD incidence and little or no change in CKD prevalence, but rates of transplantation worsened.

The next steps in the HP 2030 development process will be a second round of reviews by the FIW to discuss reducing the 420 core objectives to 375. The addition of 75 developmental objectives will bring the total of HP 2030 objectives to 450. It is unclear whether this further reduction will impact the 10 CKD HP 2030 objectives. Baselines and targets will need to be developed for the proposed objectives. These draft objectives will then be posted in the *Federal Register* for a public comment period.

### **Group Discussion and Feedback to Proposed HP 2030 CKD Measures**

- Dr. Paul Kimmel lauded the Workgroup’s efforts to change the AKI surveillance for 3 months and called attention to the Assessment, Serial Evaluation, and Subsequent Sequelae in Acute Kidney Injury (ASSESS-AKI) study, a major initiative of the Division of Kidney, Urologic, and Hematologic Diseases (KUH) with outcomes that will strengthen the CKD HP 2030 proposed objectives. Dr. Kimmel also wondered whether the little or no change in the proportion of CKD patients who had updated their blood pressure (BP) goals or use of ACE inhibitors was due to inaccurate goals. Data from the Systolic Blood Pressure Intervention Trial (SPRINT) revealed lower BPs in people with CKD ages 60 years and older who were sedentary. Ms. Burrows did not know the exact reasons for the limited change in BP goals, but speculated that contrasting guidelines and ongoing debate on ACE/ARB use among people with diabetes and with or without hypertension might explain in part the lack of progress.
- Dr. Kevin Abbott explained that CKD is the only disease with 100 percent ascertainment of the mortality outcomes-based measures in the ESRD population and that mortality rates should continue to be a priority for the HP 2030. Given that changes to AKI surveillance will improve recognition of disease progression from CKD to ESRD, reviewers and clinical practitioners are constrained by the current terminology. Efforts in the CKD research community should focus on

a consensus on introducing new terminology that more aptly describes the abrupt decline and rapid and slow pathways to ESRD. HP 2030 CKD Workgroup coordinators Ms. Burrows and Dr. Abbott noted differences in the FIW review and rating of process and outcome objectives across HP topic areas that strongly highlighted the need to keep CKD at the forefront of any decisions of the FIW and Secretary's Advisory Committee.

- Dr. Robert Star wondered what an additional CKD objective for the HP 2030 would be, had the CKD Working Group been given that choice. Ms. Burrows responded that hospitalization due to infection in the hemodialysis population would be an eleventh objective if given the choice. This had initially been suggested as a new objective for HP 2030, to align with initiatives to prevent bloodstream infections such as the Making Dialysis Safer Coalition, among other initiatives.
- Dr. Robert Nee sought clarity on the definition of HTN in the CKD objectives and the impact of the SPRINT. Ms. Burrows clarified that the BP cutoff of 140/90 mmHg will be used for the HP 2030 CKD objective on hypertension.
- Dr. Narva observed that the CKD objectives have improved since the HP initiatives began in 2010. He encouraged the KICC to prompt change by vetting new CKD objectives and informing others of them. Dr. Narva also noted that the integration of CKD, dialysis, and transplant as a clinical continuum is important for improving quality of care.
- Dr. Susan Crowley asked about investigating the transition from CKD to ESRD in the next USRDS update. Dr. Abbott pointed out that this work has been identified as a core task for the USRDS to be addressed in the coming months. Dr. Crowley also asked whether the AKI follow-up required a nephrologist or whether a primary care physician (i.e., a non-specialist) would suffice. Ms. Burrows clarified that the CKD objective specifies an AKI follow-up laboratory measure, which is not restricted to nephrologists.
- Dr. Anne Utech asked about the HP 2020 CKD 10 objective regarding pre-ESRD care and details on the public comments for the HP 2030. Ms. Burrows explained that although pre-ESRD care would not be included in HP 2030, this objective could continue to be a priority at the discretion of particular agencies or organizations. She said that information about the public comment period would be forthcoming on the HP website.

## **Inclusion of CKD in the Next CMS Quality Improvement Organization (QIO) Program**

### **Scope of Work**

*Renee Dupee, J.D.*

*CMS*

Ms. Renee Dupee discussed the inclusion of CKD in the scope of work—12th in the QIO Program—and efforts to establish a Network of Quality Improvement and Innovation Contractors (NQIICs). She noted that Dr. Janet Wright, who is the CMS subject-matter expert on the QIO program, sends her regrets for not attending this meeting. Ms. Dupee also explained that information on the Quality Improvement Networks will be limited during the sensitive procurement phase, which currently is in progress. Participants can expect a full report on the activities of the Networks at the next regular meeting of the KICC.

The CMS has established five large-scale, action-focused networks to disseminate quality improvement and generate results on a national level: the Partnerships for Patients; Transforming Clinical Practices Initiative (TCIP); ESRD Networks; Quality Innovation Network (QIN)-QIO; and Medicare Access and Children's Health Insurance Program Reauthorization Act and Quality Payment Program—Small

Underserved, Rural Support. Each network functions independently and has its own statutory mandate. The TCIP and QIN-QIO engage in similar activities and interactions, but the more than 7,000 dialysis facilities comprising the ESRD Networks remain siloed, and access is limited to ESRD patients and not accessible to CKD patients (i.e., pre-ESRD patients). To address this issue, the CMS has developed the NQIICs to serve as quality improvement experts, facilitators or change agents for health care transformation, and innovators of quality improvement. It is anticipated that the NQIICs, which will function as an umbrella organization to the five existing networks, will provide an integrated approach that addresses the CMS mission needs regarding quality improvement.

The crosscutting aims for the NQIICs will focus on rural health, vulnerable populations, and patient and family engagement. Potential action areas based on CMS goals and priorities are—

- Reducing workforce burden
- Improving behavioral health, including opioid overuse
- Improving public health through improved chronic disease management
- Increasing patient safety
- Increasing the quality of care transitions
- Improving long-term care

Regarding CKD focus areas, the CMS plans to work with the CKD stage 4 and 5 populations to address issues on vascular access and access to a transplant. Direct engagement with nephrology practices in the TCIP, as well as implementation of new interventions, will be possible. The existing chronic disease self-management practices will be maintained.

Ms. Dupee detailed the 13 intended approaches for the CKD 12th scope of work activities. Four of the 13 directly pertained to methods and outcome, work at the national scale, close partnerships between patients and providers, and aligning with administration priorities and other federal programs and agencies.

Ms. Dupee invited the participants to provide input to the CMS on the following questions:

- What is currently working in CKD management and what is causing it to work?
- What excites you about the proposed CKD 12th scope of work activities?

## **Discussion**

- Dr. Narva inquired about the NQIIC contracting mechanism and communications within the ESRD networks. Ms. Dupee clarified that the NQIICs will work from task orders within the Indefinite Delivery, Indefinite Quantity (IDIQ) award contract, focusing on different core equities. This approach will allow collaborations across networks and engagement at a level not witnessed before at the CMS. Ms. Dupee also noted that the ESRD Networks already are sharing data and are expected to continue with improved transparency in all activities.
- Dr. Star lauded the efforts of CMS to prioritize CKD management and called attention to previous discussions on establishing a kidney care strategy, a concept developed from prior renal disease conferences and meetings. Ms. Dupee commented on the value of the CMS Quality Improvement Group in setting goals and aims, which will affirm expectations and progress for the NQIICs.
- Dr. Abbott identified knowledge gaps in ESRD hospitalizations as one key area to consider as a focus for further investigations. Ms. Dupee remarked on the ongoing efforts at CMS to reduce hospitalizations by improving communications between dialysis facilities, hospitals, and patients.

- Dr. Star called attention to initiatives that have worked for CKD management, including bundling services for care improvement and outcomes of the NIDDK-sponsored Hemodialysis Fistula Maturation Project.
- Dr. Paul Eggers observed that many studies have confirmed negative outcomes following an early start on dialysis, especially in elderly Medicare CKD patients. Beginning dialysis based on an estimated glomerular filtration (eGFR) rate of 15 mL/min/1.73 m<sup>2</sup> may not be in the best interest of the patient and is worth discussing in the CMS Networks.
- In response to a query by Dr. Abbott on operationalizing a NQIIC and the IDIQ contract, Ms. Dupee explained that in a competitive process the NQIICs will be expected to engage all potential target networks (e.g., interested stakeholders) and target populations (e.g., patients with CKD) using innovative approaches to quality management. Progress, milestones reached, and successful outcomes will determine a NQIIC's ability to maintain the project. Overarchingly, mitigating CKD and disease progression will be key.
- Dr. Narva asked whether the NQIICs will address the health disparities in access to transplants across health care providers. Ms. Dupee conveyed that CMS has, within its ESRD Networks, reached out to providers for their input on implementing new practices and recently engaged large dialysis organizations (LDOs) regarding approaches to reducing infections in ESRD transplant patients. The LDOs are charged to increase the number of patients on the transplant waitlist, which will require fostering relationships with transplant centers.
- Dr. Kenneth Wilkins remarked on the potential data sharing initiatives expected to result from the proposed CKD 12th scope of work activities and wondered whether data would be available to the broader renal research community. Ms. Dupee will confirm the future data sharing agreements for the ESRD Networks.

### **Opioid Prescription, Morbidity, and Mortality in U.S. ESRD Patients**

*Paul Kimmel, M.D., MACP*

*Paul Eggers, Ph.D.*

*NIDDK*

Dr. Kimmel reviewed the report titled “Opioid Prescription, Morbidity, and Mortality in United States Dialysis Patients” published in the September 2017 issue of the *Journal of the American Society of Nephrology*. He acknowledged the collaborative efforts of the KUH, Social and Scientific Systems, and other colleagues to generate this report. Determinants of surviving hemodialysis include age, socioeconomic status, and—by some accounts—pain. The socioeconomic factors impacting health as reported by NIDDK scientists in a recent review, “Social Determinants of Racial Disparities in CKD,” are physiologic, social, residential/ecologic, and income. Although thought to be common in dialysis patients, pain in ESRD patients is not well understood. Binik *et al.* reported in 1982 that pain was a factor common to the majority of dialysis and transplant patients in Canada. Subsequent studies have shown that the prevalence of pain in U.S. populations varies significantly across dialysis facilities. Ethnic disparities on the perception of pain exist, and associations between pain, quality of life, and depression vary. Nevertheless, pain is thought to be common in hemodialysis patients.

Dr. Kimmel explained that the KUH/NIDDK's interest in this topic is based on decisions to use Medicare Part D data for assessing prescription drug use in CKD and ESRD patients, and the desire to investigate opioid use in the dialysis population given the opioid epidemic in the general U.S. population. He noted two activities incident to the U.S. opioid epidemic. First, the Joint Commission (formerly the Joint

Commission on the Accreditation of Healthcare Organizations) issued standards on the identification and treatment of pain, which resulted in recommendations that changed prescription patterns beginning in 1997. Second, data from the pharmaceutical industry asserted the nonaddictive quality of an opioid sustainable-release formulation for pain. The Joint Commission later acknowledged the unintended consequences of broadly issuing new standards. Nationally, it has been recognized in the medical literature and the press that overprescribing opioids resulted in adverse outcomes in the general population. In fact, reports have shown that prescription opioid use in the general U.S. population nearly doubled from 4.6 percent in 2007 to 7.3 percent in 2012 and was associated with a 60 percent increase in hospitalizations. The use of opioids in the U.S. dialysis population increased by 40 percent from July 2006 to December 2008.

To address this issue, the CDC established guidelines for prescribing opioids for chronic pain in the United States in 2016. In parallel, the NIDDK conducted a study to evaluate the U.S. opioid epidemic in the ESRD population. The aim was to assess (1) the prevalence of chronic opioid prescription in ESRD patients; (2) factors associated with prescription opioid use in dialysis and kidney transplant patients; and (3) morbidity and mortality related to chronic prescription and dose. Methods included use of the standard USRDS analysis files, Medicare Part D prescription claims data, chronic opioid prescription data, and a morphine equivalent daily dose metric. Annual cohorts of patients older than 20 years of age were assessed for all-cause death, discontinuation of dialysis or graft loss, and hospitalization. The dialysis study population (i.e., cohort) included patients from 2006 to 2010; a 2010 prevalent subset of dialysis patients alive from January 1, 2011, to December 31, 2012; and transplant patients from 2006 to 2010. The selection of a 2010 prevalent dialysis or transplant populations included patients who were continuously (at least 365 days) treated with dialysis or had a functional graft and also were enrolled in Medicare Parts A, B, and D.

The prevalent dialysis population was overrepresented by black males and Medicare dual-eligible beneficiaries; 94 percent were on dialysis, and 60 percent had received one opioid prescription. High rates of opioid use were observed in women ages 45–64 years, nursing home residents, dual-eligible patients, and those who had prior pain-related hospitalization. The most commonly prescribed opioids were hydrocodone, oxycodone, and propoxyphene. The percentages of dialysis patients with an any opioid prescription and chronic opioid prescription use by state were consistent with the general national data.

The transplant cohort studied had a higher proportion of patients who were women, older, or black. The prevalent transplant cohort was overrepresented by white males and primarily dual-eligible patients; 48 percent had received one opioid prescription, and 14 percent had chronic opioid prescriptions. Associations with highest rates of opioid use were observed in women ages 45–60 years, those who were living in low-income neighborhoods or rural areas, and nursing home residents. The most commonly prescribed opioids were the same as in dialysis patients. Opioid drug prescription was associated with (1) increased dialysis patient risk of death, dialysis discontinuation, and hospitalization and (2) increased transplant patient risk of death, transplant failure, and hospitalization.

Dr. Kimmel noted key recommendations:

- Do not allow hospitalization to become a source of non-nephrologist opioid prescription.
- Limit the dose and duration of opioid prescription in ESRD patients.
- Assess patients for coexisting conditions, including anxiety and depression and for social function and status.
- Consider alternative therapies in ESRD patients with chronic pain.
- Consider alternative therapies in ESRD patients with chronic opioid prescriptions and pain.

## Discussion

- Dr. Eggers explained that 100 percent of dual-eligible beneficiaries are enrolled in Medicare Part D at any given time.
- Dr. Crowley commented on the U.S. Department of Veterans Affairs (VA) system that uses a quality dashboard with built-in risk prediction equations to flag opioid and benzodiazepine co-prescriptions in renal disease patients, which could be a model for other health care systems or providers.
- Dr. Eggers observed that an estimated 30 percent of patients exceeded the CDC-recommended average daily dose for opioids.
- Ms. Loida Tamayo asked about the effect of chronic opioid use in rural areas and the impact to Medicare dual-eligible beneficiaries. Dr. Kimmel replied that in the study cohort, prescriptions often were observed in patients living in rural areas and were strongly associated with low-income households.
- Dr. Gregory Germino wondered whether the data reflected a health care center or provider-based cluster. Dr. Kimmel agreed that investigating these types of relationships is important and could be considered for the future. He called attention to a broad NIH initiative to support interventional studies on opioid use.
- Dr. Crowley asked about universal reporting practice across the United States regarding opioid prescriptions. The VA has a formal structure in which the primary care physician fills out a checklist, monitors patient urine, and check the mandatory state prescription registry. Dr. Kimmel noted that regulatory campaigns and standards on opioid use and precautions are effective, but he was not aware of requirements for universal reporting practices.
- Related to the study findings on higher rates of opioid use in rural settings, Dr. Nee wondered whether opioid use in urban settings among younger dialysis patients had been assessed. Dr. Kimmel explained that within the study geographical strata, the proportion of usage by age was similar. No direct assessments of data on younger urban dialysis patients were evaluated, but this could be revisited.
- Dr. Narva remarked on the opportunity to promote pain self-management in dialysis patients and to educate the CKD and ESRD populations on the adverse effects of long-term prescription opioid use. The NIDDK National Kidney Disease Education Program could play a role in developing educational tools if the necessary resources were available. Ms. Tonya Shaffer added that the National Kidney Foundation (NKF) has been interested in educating the kidney disease populations on opioid use and that the findings from the NIDDK study provide strong evidence that warrants developing such an educational initiative.

## Agency Updates

### ***NIDDK: CKD of Uncertain Etiology (CKDu) in Agricultural Communities Workshop***

*Susan Mendley, M.D.*

*NIDDK*

Dr. Susan Mendley called attention to the reported epidemic of early-onset CKDu in the coastal lowlands of Central America, as well as parts of Sri Lanka and India. The population most affected is agricultural workers, especially those harvesting sugarcane crops, in low-resource communities. A Pan American Health Organization (PAHO) study investigating CKD mortality from 1995 to 2013 in Central America revealed that the death rate was unequally distributed across the region; was more pronounced in El Salvador and Nicaragua; and occurred in both males and females, but was higher in males. CKDu is a public health crisis in Central America, and its care and treatment accounts for 4 percent of the Sri Lankan health budget. Furthermore, the progression to ESRD from CKDu is the leading cause of hospital deaths in El Salvador. CKDu is predominately a tubulointerstitial disease absent some common risk factors, such as DM, HTN, glomerular nephritis, or advanced age.

It appears that CKDu occurs in the United States among farmworkers migrating from Central America to the United States, especially Texas. Because of the various etiological aspects to development of ESRD in the U.S. population, it is also not well understood whether CKDu is an underlying contributor. To address the impact of CKDu worldwide, the NIDDK, in collaboration with the National Institute of Environmental Health Sciences (NIEHS), sponsored a workshop on Chronic Kidney Diseases in Agricultural Communities on June 25–26, 2018, in Bethesda, Maryland. The workshop brought together experts in epidemiology, environmental health, toxicology, and nephrology to discuss a case definition of CKDu, outcome measures, and potential etiologies. The NIDDK is considering a longitudinal cohort study to assess the burden of kidney disease in heavily affected communities, examining environmental exposures, work practices, and genetics. Study partners will include the Fogarty International Center, CDC, Consortium for the Epidemic of Nephropathy in Central America and Mexico, NIEHS, PAHO, and the U.S. Geological Survey.

### ***Agency for Healthcare Research and Quality (AHRQ): Systematic Review of ESRD in the Medicare Population***

*Elise Berliner, Ph.D. and Aysegul Gozu, M.D., M.P.H., FACP*

*AHRQ*

Dr. Elise Berliner described a new project for the AHRQ: a systematic review (SR) of ESRD in the Medicare population, including technology assessment for dialysis. She explained that CMS requested a review of the frequency and duration of dialysis and the related Medicare coverage. In 2015, the NKF Kidney Disease Outcomes Quality Initiative (KDOQI™) conducted an SR on the frequency and duration of dialysis in which randomized and non-randomized controlled clinical trials were assessed. Subsequent guidelines established by KDOQI leveraged observational studies not included in their SR. In this SR project, the Johns Hopkins Evidence-based Practice Center, under contract to the AHRQ Technology Assessment Program, will perform an SR and synthesis of all available evidence. To begin the SR process, four questions have been developed, including questions on the validity and reliability of patient-reported outcomes for ESRD. The AHRQ is now seeking input from key informants and stakeholders, including patients, and assembling a technical expert panel.

Dr. Berliner highlighted the Kidney Innovation Accelerator (KidneyX), which is focusing on new technologies to replace dialysis in the long term. KidneyX is one futuristic approach to address ongoing questions regarding the frequency and duration of dialysis. The questions about (1) the reliability of

patient-reported outcomes and (2) study design and validity and will be helpful to inform future evaluation of the treatments developed through KidneyX.

The AHRQ would appreciate input from KICC members as key informants or technical experts. Members can contact either Dr. Berliner or Dr. Gozu for further details.

### **Discussion**

- Dr. Jesse Roach asked whether the characteristics of CKDu and Balkan endemic nephropathy were similar. Dr. Mendley explained that urothelial tumors are a signature of Balkan endemic nephropathy but are not observed in CKDu.
- In response to a query by Dr. Paul Fanti, Dr. Mendley clarified that infectious diseases (e.g., leptospirosis) will be assessed as risk factors in the etiology of CKDu and that CDC experts will assist with those efforts.
- Dr. Berliner clarified that the AHRQ is not conducting a clinical trial, but will be reviewing the existing research and addressing the SR questions. Dr. Christine Chang added that technical experts will respond to the key questions in the TA and a draft report will be made available to the public. Also, a portal will collect “scientific” information during the SR process.
- Dr. Narva announced that the NIDDK is funding a large-scale pragmatic clinical trial to evaluate the management of phosphorus in dialysis patients.

### **Adjournment**

Dr. Narva thanked the presenters and attendees for their participation. He noted that the next meeting of the KICC is scheduled for March 29, 2019.