

The Emperor...has found his underwear

BOB CUMMINGS



It might come as no surprise that chronic kidney disease management is a rapidly growing problem, from a fiscal and a patient care standpoint. Chronic kidney failure more than doubled in the United States between 1990 and 2001, largely due to climbing rates of diabetes and high blood pressure. CKD is the ninth leading cause of death in the United States and is estimated to affect about 20 million American adults. In the next five years, current trends indicate there will be almost double the current number of dialysis patients. More than \$20 billion was spent on chronic kidney failure in 2001.



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In addition, Medicare payments for chronic kidney failure tripled from 1991–2001, rising from \$5.8 billion to \$15.4 billion.¹ While this particular fact may seem like good news for the dialysis industry, it in fact is not. This is due to two factors:

1. Dialysis units have historically, at best, broken even with regards to reimbursement for Medicare patients
2. The larger this number grows, the more of a target for cutbacks it becomes.

The dialysis industry has already been confronted with very few and far between composite rate increases, as well as with limited drug reimbursements. With the ESRD population still growing, projections estimate that more than 2 million people will have ESRD in 2010, at a cost that will exceed \$1 trillion.² Certainly, a breaking point is not far off in the future.

The facts confronting the dialysis industry as a whole are not pretty. Dialysis providers are expected to deal with fewer nephrologists, nursing shortages, ever-shrinking reimbursement, and a rapidly

increasing patient population. All four of these issues have been discussed *extensively*, but the central problem remains: patients are not being diagnosed early enough to prolong kidney function and avoid stage 5 CKD—renal failure.

"The Emperor has no clothes (but has a catheter)" by Lazarus et al. was published in the November 2005 issue of NN&I. This illustration, provided by the authors, missed our press deadline, but suggests that, as we improve our efforts at CKD care, the Emperor may find some clothes after all—starting, as Mr. Cummings notes in his article, with some underwear.

New legislation

Originally introduced by New Jersey Democratic state senator Fred Madden and signed into law by Acting Governor Richard J. Codey, the bill that may change the lives of millions reads as follows:

C.45:9-42.34a *Calculation of glomerular filtration rate when testing to diagnose kidney disease.*

1. *The director of a clinical laboratory licensed in this State pursuant to P.L. 1975, c.166 (C.45:9-42.26 et seq.) shall provide that when the laboratory tests a specimen to determine a patient's serum creatinine level, as ordered or prescribed by a health care professional authorized to make such an order or prescription, the laboratory shall calculate the patient's glomerular filtration rate using such information as is provided by the health care professional or patient, as applicable. The laboratory shall include the patient's glomerular filtration rate with its report to the health care professional.*

It is rare that a simple piece of legislation has the potential to profoundly affect so many people. Catching renal disease in the early stages is crucial to keeping patients from ever needing to go on dialysis, or at least prolonging ESRD. Currently, this law has been enacted only in New Jersey, but the potential for the bill to be picked up on a national level is strong.

Why GFR matters

The GFR is a measure of how well your kidneys are cleaning your blood. The National Kidney Foundation Kidney Disease Outcomes Quality Initiative Clinical Practice Guidelines on Chronic Kidney Disease offer the following classifications in Figure 1.

three crucial items need to be addressed:

1. A study on the effectiveness of this bill, and the actions to be taken.
2. A stronger commercial payor structure for CKD care.
3. Other states to pilot this bill, or for the bill to be picked up nationally.

Enacting this bill is a win-win-win-win

state and federal legislators to raise their attention to these life saving steps to help control CKD.

For more information and a free GFR calculator visit www.kidney.org/professionals/kdoqi/gfr_calculator.cfm. ♦

References

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4. Howard RL. The Wellpoint/Anthem approach to chronic kidney disease. *Nephrol News Issues* 11:49-51, 2005
5. Lazarus JM, Hakim RM, Maddux FW, Amedia CA. The Emperor has no clothes (but has a catheter). *Nephrol News Issues* 11:45-48, 2005

Figure 1: K/DOQI stages for renal disease

STAGE	DESCRIPTION	GFR Level
Normal kidney function	Healthy kidneys	90mL/min or more
Stage 1	Kidney damage with normal or high GFR	90mL/min or more
Stage 2	Kidney damage with mild decreased GFR	60–89 mL/min
Stage 3	Moderately decreased GFR	30–59 mL/min
Stage 4	Severely decreased GFR	15–29 mL/min
Stage 5	Kidney failure	Less than 15 mL/min or on dialysis


Patients diagnosed with renal disease in Stages 1–2 can significantly prolong and, in some cases, reverse the damage done to the kidneys. In addition to delaying or eliminating the need for dialysis or a kidney transplant, patients should have a better quality of life with CKD. Early intervention and education provides patients with the tools they need to live with the disease, decreasing the need for more frequent hospitalizations and doctor visits typically associated with patients in Stage 5 of kidney disease. Early detection of renal failure allows for more time for fistula maturation, and attention can be given to bone and mineral metabolism, nutrition, preventive vaccination, and hematocrit levels.

situation for the four P's involved: patients, providers, politicians, and payers. The onus of educating those with the ability to enact the bill on a broader scale is on the renal community as a whole. Start by writing your


The future

In the November 2005 issue of *NN&I*, Dr. Randy Howard wrote that “obtaining the serum creatinine value and calculating the estimated GFR remains a major challenge for CKD disease management programs.”⁴ It was also written by Drs. Lazarus, Hakim, Maddux and Amedia that there is “lack of accepted criteria for referral to a nephrologist for specific CKD care.”⁵ Almost as if on cue, this bill took effect in New Jersey on Nov. 26, 2005.




For this bill to be proven effective,



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