PDSA Cycle for Chronic Kidney Disease Management Plan

Background

CKD is one of the most under-diagnosed and under-managed chronic diseases. Two laboratory tests, eGFR and ACR, provide the earliest detection and assessment of CKD-related kidney damage. United States Renal Data System (USRDS) data suggest that: • Less than 50% of people with diabetes are routinely tested for albuminuria yearly. • Only 10% of people with hypertension are tested annually for albuminuria. Many at-risk patients already have evidence of CKD in their medical records but no CKD diagnosis.

Goals Statement

Enhance early detection and management of CKD among patients, particularly those with risk factors such as diabetes and hypertension.

Target Population: Adults aged 18-85, especially those with diabetes, hypertension, obesity, a family history of CKD, or over the age of 60.

Primary Goal is to improve the early detection and management of CKD in primary care, enhancing health equity and care quality.

Specific Objectives:

- Increase the percentage of at-risk patients (diabetes, hypertension) screened for CKD from current levels to at least the _____percentile of national benchmarks within one year.
- Enhance patient education on CKD management and the importance of regular screening.
- Increase the adoption of the Kidney Profile (eGFR and uACR) for CKD screening.

Measures for Improvement

- Increase the percentage of at-risk patients (diabetes, hypertension) screened for CKD from current levels to at least the _____ percentile of national benchmarks within one year.

Strategies to Achieve the Goal

- **Clinical Decision Supports**: Integrate best practice alerts in the EHR for CKD screening and management.
- **Phases of Care**: Develop and implement Pre-visit Planning, Rooming, and Visit Protocols.
- **Provider and Patient Education**: Increase awareness of CKD risk factors, standards of care, and management through ongoing educational programs and materials.

Metrics to Measure Success

- **Screening Coverage:** Proportion of at-risk individuals who undergo CKD screening.
- **Diagnosis:** Number/percent of patients diagnosed with CKD in the practice.
- **Satisfaction Levels:** Satisfaction ratings from patients and providers regarding newly implemented protocols and educational initiatives.

Do

Implementation Actions

Technology Integration: Deploy EHR functionalities to support CKD screening alerts and the Kidney Profile order sets.

Adopt: Kidney Profile (eGFR and uACR) for CKD screening

Educational Programs: Roll out training sessions for healthcare providers on using new CKD therapies and screening protocols.

Patient Engagement: Engaging patients in managing Chronic Kidney Disease (CKD) with a multi-faceted approach that emphasizes education, communication, and support.

Community Engagement: Utilize platforms like "Are You the 33%?" to educate patients on CKD risks and encourage screenings. Use awareness campaigns in waiting rooms and exam rooms, local media, social media, and public service announcements to educate the community about CKD risk factors and prevention.

Study

Review and Analysis

Collect data on the number/percentage of patients diagnosed with CKD.

Act

Adjustments Based on Outcomes

If screening rates are below targets, investigate barriers such as EHR integration issues or provider compliance and adjust strategies accordingly.

Enhance provider education and patient engagement strategies based on feedback.

Scale and Spread

Expand successful strategies to additional practices within the health system.

Disseminate findings and best practices through professional networks and at healthcare conferences.