

# Follow The Leader [ National guidelines developed for kidney disease ]

As the chief medical officer for the National Kidney Foundation, Joseph Vassalotti, MD, FASN, is on a mission to “demystify” Chronic Kidney Disease (CKD), and he believes QSource can be a valued partner to aid his cause.



Vassalotti

Vassalotti, an associate clinical professor of medicine at Mount Sinai School of Medicine, helped systematically develop the Kidney Foundation Outcomes Quality Initiative (KDOQI) guidelines to assist practitioner and patient decisions about appropriate healthcare for CKD.

The KDOQI guidelines have improved the lives of thousands of kidney patients since their creation in 1997. However, even more healthcare professionals need to know about the guidelines; and, that is where QSource’s assistance is most needed, he said.

“I believe the QIOs have a great opportunity,” said Vassalotti. “QIOs can help educate primary care physicians (and their staff) about the guidelines and provide technical support for primary care practices’ utilization of the KDOQI guidelines.”

## Guidelines Help Providers Improve Care

The KDOQI guidelines, which were initially developed because of the high mortality of patients on dialysis, were needed because of confusion about the disease and its progression. For example, there were 23 different terms used to describe decreased kidney function in abstracts submitted in 1998 and 1999 to the American Society of Nephrology (ASN).

“Obviously this was very confusing — even to someone who knew the field. These terms would not allow for a concerted public health approach to CKD,” said Vassalotti. “If nephrologists could not agree on what CKD is, what could we do in terms of a public health approach or a patient awareness approach?”

He said, after more than a decade since the guidelines were first published, this “nomenclature mess” has been corrected. There is widespread agreement about the definition of CKD and the association of complications of the disease with stages 1-5 based on GFR levels estimated from serum creatinine. The clinical practice guidelines address evaluation, classification, and stratification.

## Challenges Still Exist

However, there are still significant challenges with the implementation of the guidelines. On a recent teleconference, Vassalotti outlined some of the barriers QSource may be able to help provider and partners overcome. He shared research that

illustrated poor utilization of CKD testing.

“There were higher rates of glucose and lipid testing than serum creatinine. These low creatinine testing rates suggest the importance of more physician education,” he explained.

Vassalotti acknowledged some primary care physicians are still confused about CKD testing. However, evaluation of laboratory measurements for the clinical assessment of kidney disease is occurring now.

“A national standardization program is being undertaken by the National Institutes of Health (NIH) to standardize serum creatinine testing,” he said. “There are so many tests that the physician can pick: the NIH is trying to standardize not only the laboratory measurements but also this byzantine list of different tests for urinary albumin which is confusing for primary care physicians.”

He explained that urinary albumin to creatinine ratio is recommended because it is “more quantitative and more accurate than others.”

The QIO’s specific goal is to increase the adoption of evidence-based standards to identify CKD in Medicare patients through an annual urinary microalbumin measurement for individuals with diabetes.

Vassalotti’s recommendations are clear. He stressed that CKD is poorly inferred from serum creatinine alone. He strongly encourages clinical laboratories to routinely estimate and report GFR when serum creatinine is measured. Routinely reporting estimated GFR (eGFR) with all serum creatinine determinations helps identify reduced kidney function for providers, and thus facilitates the detection of CKD.

“It is very important that these tests are to be used together. These are complementary tests — not alternative tests — you can’t substitute one for the other. GFR is not the only test,” said Vassalotti.



Online resources for more information:

[www.kidney.org/Professionals/kdoqi](http://www.kidney.org/Professionals/kdoqi)

