

patients at risk for CKD. These partnerships are critical, in light of the shortage of practicing nephrologists (there are currently 3,700 nephrologists in the United States; of this number, 1,500 are no longer practicing). The panel recommends the NMA advocate that primary care physicians refer their patients at stage 3 of CKD progression to a nephrologist for evaluation. Further, the panel suggests that such partnerships utilize service agreements, similar to those used by the Veterans Administration, to ensure that the primary care physicians receive support from the nephrologists, and to alleviate fears of patient “co-option.”

The panel supports the idea of cultural competence in the workforce, but recognizes that physicians must be knowledgeable of CKD issues specific to the African American community. In light of this recommendation, the panel proposed several vehicles for CKD physician education:

- A Continuing Medical Education (CME) training, sponsored by the NMA, on management of African American patients with CKD and ESRD.
- A joint session at the NMA Annual Convention combining CKD with key related sections, such as Internal Medicine or Cardiology. Section chairs would be advised to promote the combined sessions to NMA members and affiliates.
- A portable training session—“CKD in a Box”—utilizing training materials and Power Point/slide deck presentations, to be presented to local affiliates in partnership with a pharmaceutical representative. The panel also recommended using this low-cost, easily disseminated “boxed session” approach to provide training in all seven of the NMA’s priority disease focus areas.

The panel also recommends that, in light of the epidemic of CKD, and the intersection of CKD and the chronic diseases and risk factors prevalent in the African American community, that the NMA make CKD a focus at future annual conventions, in its publications, and activities.

Legislation and Policy

The panel recognizes and applauds legislation and policy that promotes and raises awareness of best practices and policies that benefit African Americans living with CKD and ESRD; promotes CKD prevention and education for the African American community and other minority communities; widens health care access to disadvantaged communities, and supports the physicians that serve them. The 110th Congress has introduced several bills regarding kidney disease and health care access for minority and disadvantaged communities. Summaries of legislation that was discussed at the Consensus Panel Meeting and other CKD-related legislation follow.

The **Kidney Care Quality and Education Act of 2007**, H.R. 1193, introduced by Senator Kent Conrad (D-ND) and Representatives Dave Camp (R-MI) and John Lewis (D-GA), would direct the Secretary of Health and Human Services to establish demonstration

projects to increase public awareness about CKD risk factors, prevention, treatment, and the prevention of ESRD. The bill will also allow for the enhancement of surveillance systems and expansion of research to better assess the prevalence and incidence of kidney disease; and enable individuals with ESRD to develop self-management skills.

H.R. 1193 would also amend title XVIII (Medicare) of the Social Security Act to provide for Medicare coverage of kidney disease patient education services. It also would direct the Secretary to: (1) establish blood flow monitoring demonstration projects; and (2) arrange with the Institute of Medicine of the National Academy of Sciences to evaluate the barriers to increasing the number of individuals with ESRD who elect to receive home dialysis services or other treatment modalities under Medicare, and set forth required training for patient care dialysis technicians.

The bill also directs the Secretary to establish an independent, multi-disciplinary, nonpartisan End-Stage Renal Disease Advisory Committee; establishes the annual update framework for the Medicare ESRD composite rate; and directs DHHS to establish a three-year continuous quality improvement initiative under which quality payments are provided to renal dialysis facilities, service providers, and physicians that (1) provide products and services to individuals with ESRD enrolled under Medicare part B (Supplementary Medical Insurance); and (2) meet quality benchmarks and demonstrate quality improvements.

H.R. 1193 would also require the Secretary to make quality incentive payments to facilities and providers whose services to individuals with ESRD have substantially improved or exceeded a certain threshold and extends Medicare as secondary payer with respect to individuals with ESRD.⁵⁰

The **Kidney Disease Educational Benefits Act of 2007** (S. 432), introduced by Senator Blanche Lincoln (D-AR), would amend title XVIII (Medicare) of the Social Security Act to provide for Medicare coverage of kidney disease education services.⁵¹

The **Charlie W. Norwood Living Organ Donation Act** (H.R. 710), which has been passed in the House and Senate, would make paired kidney donation legal and allow organizations like the United Network for Organ Sharing to track eligibility for paired donation. Paired donation is a process in which living incompatible donor-recipient pairs are matched with other living incompatible donor-recipient pairs in order to find successful matches.⁵²

Currently, the practice of matching a kidney transplant candidate and an incompatible living donor with another such incompatible pair is not allowed under the National Organ Transplant Act. An article in the *Journal of Transplantation* estimated that, if paired donation becomes legal, the number of living kidney donor transplants performed each year will increase by 14 percent.^{53,54}

The **Minority Diabetes Initiative Act** (H.R. 1031), introduced in February 2007 by Rep. Maxine Waters (D-CA), is based on the suc-