azara 2025
USER CONFERENCE APR 29–MAY 1 | BOSTON, MA

Tackling Chronic Kidney Disease Screening Rates

Azara Tools and Practical Strategies

Today’s Presenter

Halli Rennaker
Data and Analytics Specialist
Michigan Primary Care Association

Agenda

1. MPCA Overview
2. Project Overview
3. Tools for CKD Screening and Management
4. Collaborative Data
5. Lessons Learned and CKD Playbook

Who We Are

SUPPORTING MICHIGAN HEALTH CENTERS

Mission
To ensure the delivery of excellent care that advances equitable health outcomes.

Vision
Everyone has a fair and just opportunity to attain their highest level of health.

Driving Principles

Advocacy-We champion health and social policies that support health centers and the patients and communities they serve.

Collaboration-We bring together member organizations to encourage peer sharing and learning and support relationships between health centers and a diverse set of partners to further integration and common objectives.

Improvement-We support health centers in the continuous pursuit of high-quality, patient-centered services, the advancement of value-based care, and organizational excellence.

Equity-We endeavor to overcome economic, social, and other barriers to healthcare, reduce preventable health disparities, and contribute to solutions addressing systemic health inequities.

MPCA Membership

44 Member Organizations		
41 FQHCs - 39 health centers - 2 look-alikes	2 Tribal Health Centers	1 Urban Indian Health Program

HCCN	CIN	ACO
39 health centers	39 health centers	13 health centers

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Project Overview

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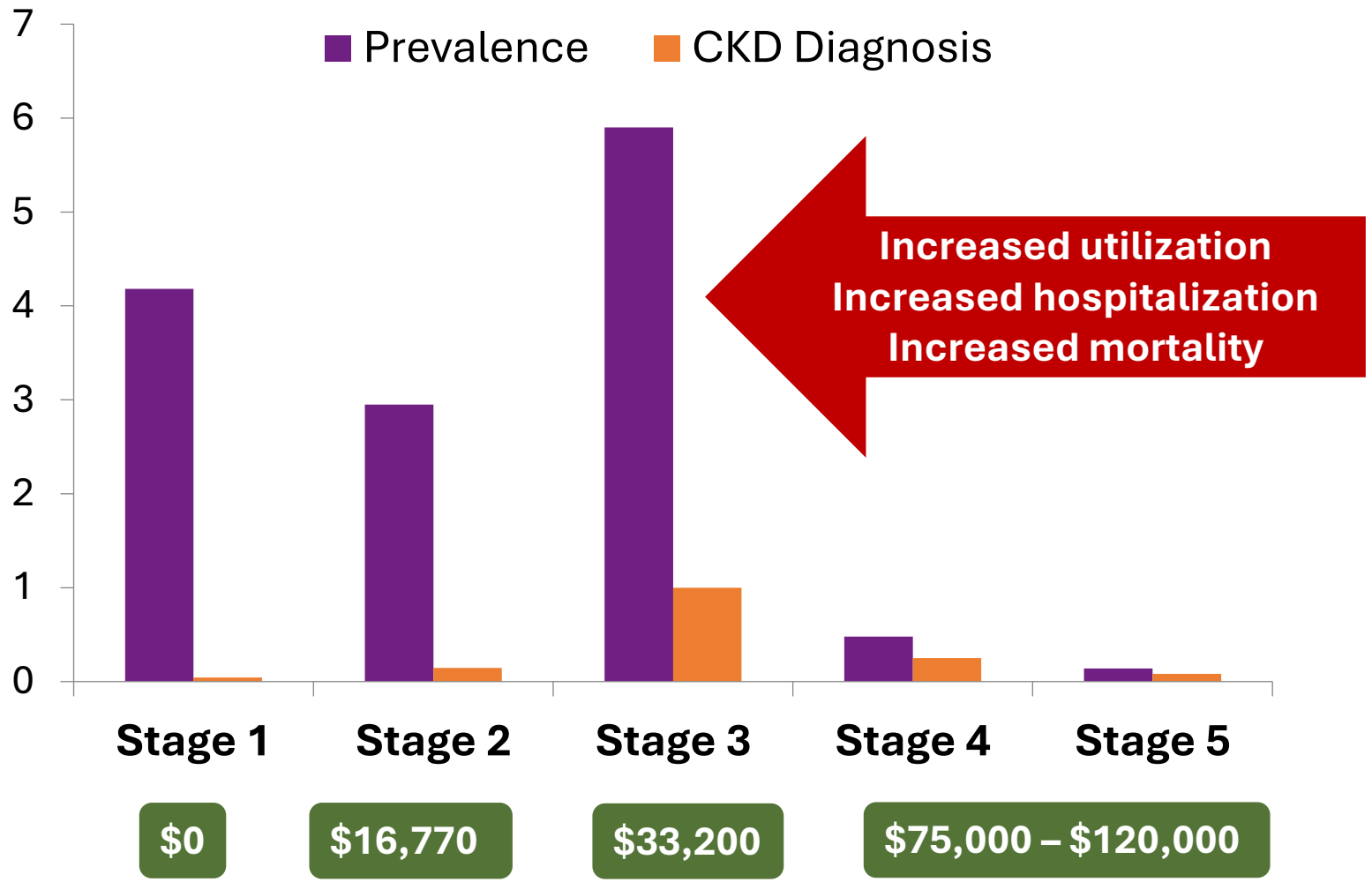
CKD Prevalence, Diagnosis, and Annual Cost

Prevalence:
United States Renal Data System. 2015 USRDS annual data report: Epidemiology of Kidney Disease in the United States. National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2015.

Cost per stage:
Ladan Golestaneh,et al, *All-cause costs increase exponentially with increased chronic kidney disease stage*. American Journal of Managed Care, 2017. 23(10): p. S161.

CKD Diagnosis:
Szczech, L.A., et al., *Primary care detection of chronic kidney disease in adults with type-2 diabetes: the ADD-CKD Study (awareness, detection and drug therapy in type 2 diabetes and chronic kidney disease)*. PloS one, 2014. **9**(11): p. e110535.



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THE STATE OF CHRONIC KIDNEY DISEASE IN MICHIGAN

1 in 7 adults
in Michigan have chronic kidney disease **(CKD)** and **most don't know it.**[1]

Many adults in Michigan have **risk factors** for chronic kidney disease...

Over 2.7 MILLION have prediabetes.[2]

Nearly 1.2 MILLION have type 2 diabetes.[2]

35% have high blood pressure.[3]

70% are obese or overweight.[3]

One in three children in Michigan are **obese or overweight.**[4]

Sources:
1. CDC, 2019 and US Census Bureau, 2010 2. American Diabetes Association, 2021 3. CDC BRFSS and MiBRFSS, 2021 4. Child and Adolescent Health Measurement Initiative, 2019-2020

Key Statistics

37 million American adults (age 20+) have chronic kidney disease. More than a million Michigan adults (age 20+) have chronic kidney disease.

1 in 3 American adults, or 33%, is at risk for kidney disease.

Black or African Americans are **more than 3 times as likely** and Hispanics or Latinos are **1.3 times more likely** to have kidney failure compared to White Americans.

More than **16,000 people** are on dialysis in Michigan.

As the incidence of obesity in children increases, so does the rate of type 2 diabetes, which is a leading cause of kidney failure. **One in three** kids born in 2000 will develop diabetes.

2,050 people were waiting for a lifesaving kidney transplant in Michigan on August 1, 2024.

The Collaborative – Year 1

NATIONAL KIDNEY FOUNDATION® of Michigan

Goals

1. Increase CKD screening rates
2. Increasing knowledge of kidney disease treatment
3. Increasing knowledge of kidney disease management in primary care
4. Implementing processes to diagnose and stage kidney disease
5. Referrals to a kidney specialist

Populations

1. Patients with Diabetes
2. Patients with Hypertension
3. Patients with both Diabetes and Hypertension

Time Period

January – July 2023

The Collaborative – Year 1

Participation

- 4 health centers
- Learning sessions
- 1:1 technical assistance meetings with MPCA team

Learning Sessions

1. Screening and Early Detection
2. Technology and Workflows to Facilitate CKD Screening and Management in Your Clinic
3. Lifestyle Approaches to Preventing CKD Progression
4. Preventing CKD Progression from a Pharmaceutical Perspective
5. Recap/Sharing of Strategies Between Health Centers

The Collaborative – Year 2 [January – July 2024]

Cohort 1

2 *continuing* health centers

- Learning sessions
- 1:1 technical assistance meetings with MPCA team

Learning Sessions

1. Diagnosis and Staging using the CKD Heat Map
2. Deep Dive into Technologies to Facilitate CKD Management in Your Clinic
3. Team Based Care and Referrals to Support CKD Management in Your Clinic
4. Recap/Sharing of Strategies Between Health Centers

Cohort 2

4 *new* health centers

- Learning sessions
- 1:1 technical assistance meetings with MPCA team

Learning Sessions

1. Screening and Early Detection
2. Technology and Workflows to Facilitate CKD Screening and Management in Your Clinic
3. PATH Program and Referral Mechanism
4. Lifestyle Approaches to Preventing CKD Progression
5. Preventing CKD Progression from a Pharmaceutical Perspective
6. Recap/Sharing of Strategies Between Health Centers

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1:1 Meeting Structure

Meetings

- Monthly cadence
- MPCA support from Clinical Performance Consultant and Data Team
- Co-created action plan for two interventions
- Reviewed action plan and tracking dashboard

Interventions

1. Standing orders for screening
2. Workflow best practices
3. Supporting team-based care practices
4. Provider education support
5. Troubleshooting lab ordering/results in Azara
6. Azara tool education and training
7. Reviewing data and trends

Action Plan

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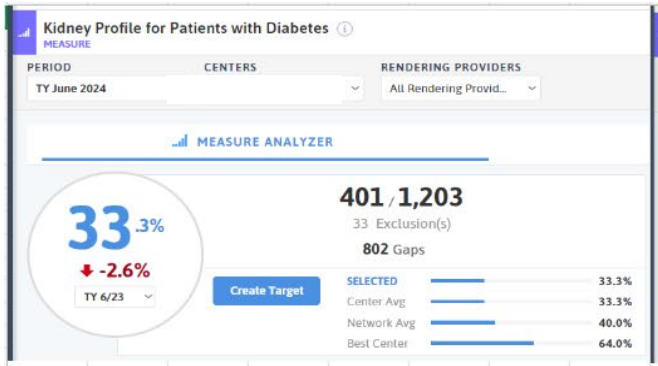
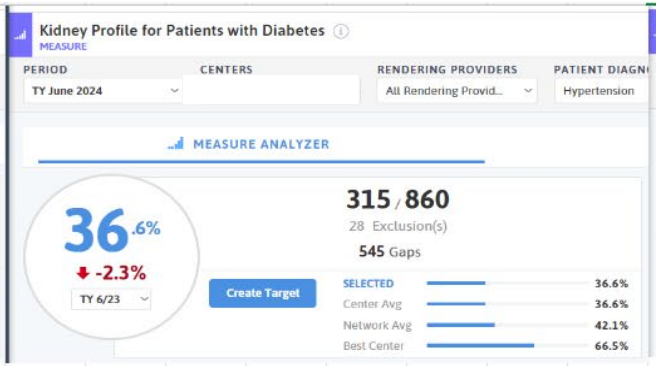
NATIONAL KIDNEY FOUNDATION of Michigan

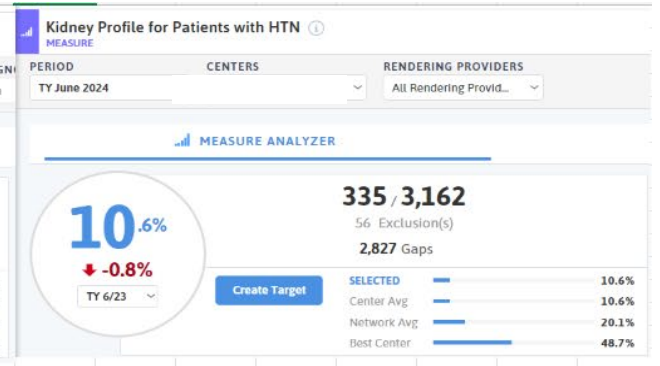
CKD Learning Collaborative Action Plan

Health Center Name: [redacted]

Focus Intervention #1	Activities/Staff Responsible	Tools and Best Practices/Resources	Notes
Enable alerts in Azara for CKD screening for Diabetic and Hypertensive Patients	1. Turning on alerts and educating staff-Sandy 2. Educating providers-Rachel	Discussed alert best practices, dashboards, best practices for mapping	[redacted]
Focus Intevention #2	**Activities/Staff Responsible**	**Tools and Best Practices/Resources**	**Notes**
Create CKD screening standing orders	1. Educate staff-Sandy 2. Educate providers-Rachel	Sent sample copy of standing order for health center reference and use	[redacted]







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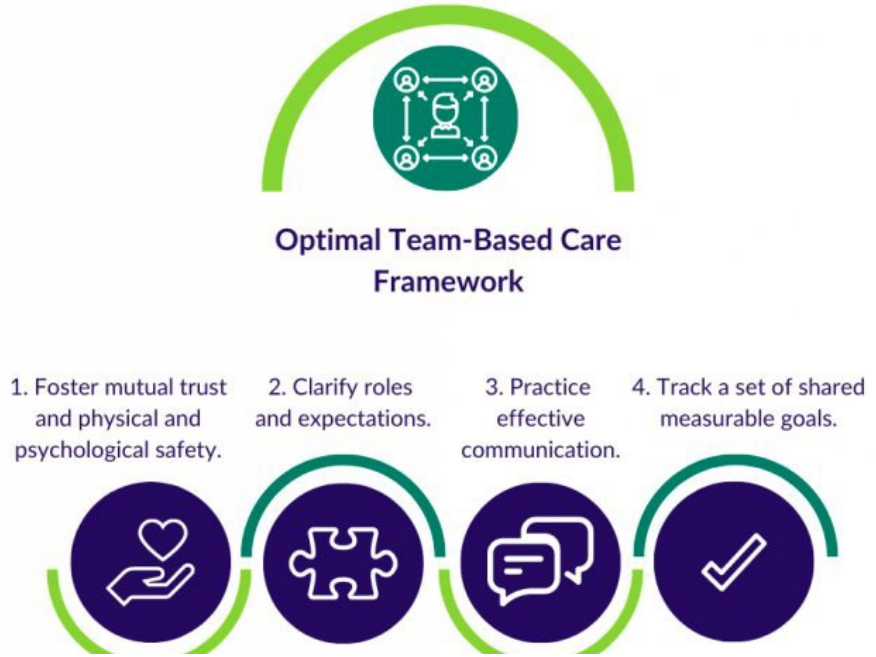
Approach and Framework



Phases of Care

Pre-Engagement	Pre-Visit	Rooming	Visit	Post-Visit
A patient may or may not have an appointment. Patients have open gaps in care. Outreach occurs during this phase.	The Patient has an appointment and is going to be seen today/tomorrow/etc. Chart prep occurs here. Azara PVP utilized during this phase.	The patient has been taken back to the room and MA/nurse is completing health history/vitals/etc. Standing orders utilized during this phase.	The provider is seeing the patient. Clinical support tools are used during this phase; education occurs during this phase	Lab results may be in, and staff review results and follow up with patients as needed. Staff may use this phase to monitor trends/quality metrics/referrals/etc.

Azara Tools for CKD Management

1. **Dashboards**
    a. MPCA CKD Screening
    b. MPCA CKD Screening Gaps
    c. MPCA DM, HTN, & CKD
2. **Registries**
    a. MPCA Chronic Kidney Disease
    b. MPCA Undiagnosed CKD
3. **Cohort** – Dynamic High Risk Kidney Profile
4. **Care Effectiveness Reports (CERs)**
5. **Measures**
    a. Kidney Profile for DM
    b. Kidney Profile for HTN
    c. Completed Lab Volume
    d. Alert Closure – Point of Care
6. **Alerts**
    a. CKD screening for DM
    b. CKD screening for HTN

Measure Validation

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Kidney Profile Measure Review

Kidney Profile for Patients with HTN

Endorser: None
Steward: Azara

Patients aged 18-85 with an active diagnosis of Hypertension within the measurement period who have received an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR) result within the last 12 months.

Numerator:

Patients who have received an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR) test within the last 12 months.

- Urine albumin-creatinine ratio (uACR) test in the last 12 months
  - Or Urine albumin and Urine Creatinine results that are collected within 4 days of each other in the last 12 months
- AND
- Estimated glomerular filtration rate (eGFR) result in the last 12 months

Denominator:

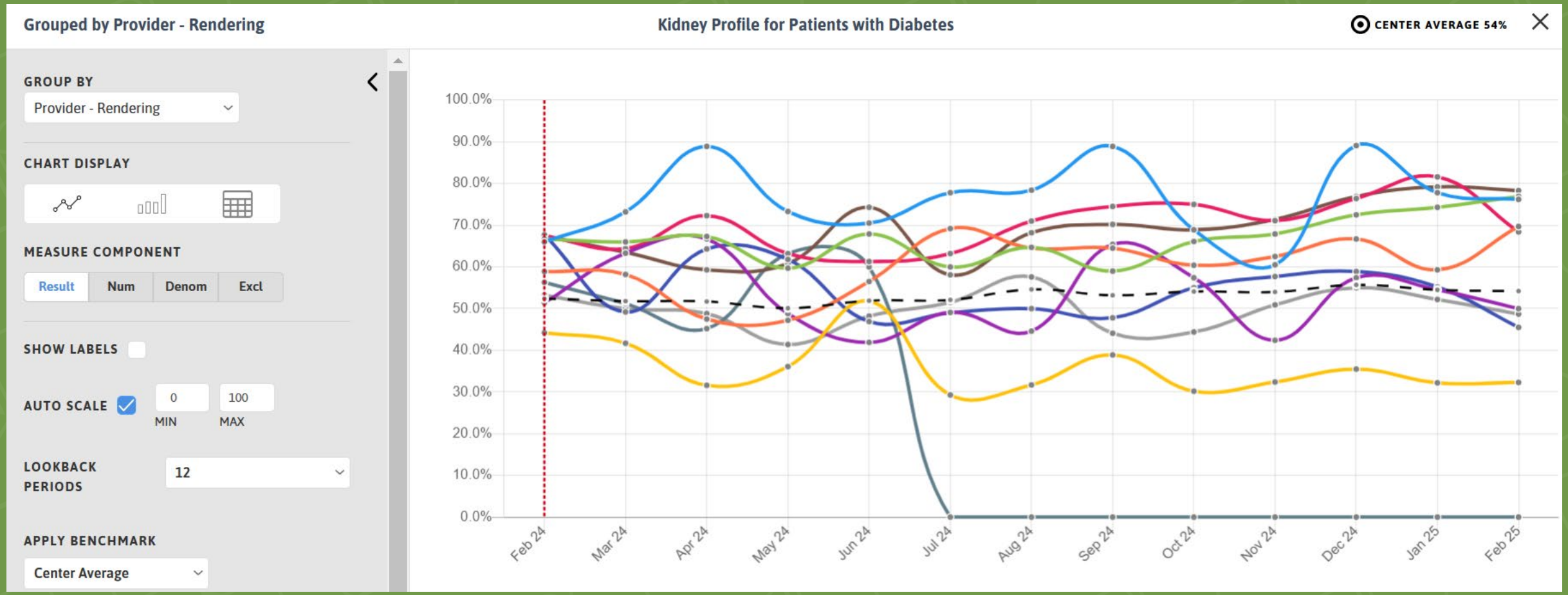
Patients aged 18-85 with an active diagnosis of Essential Hypertension at the beginning of the measurement period with a qualifying encounter in the last 12 months.

- Ages 18-85
- Active diagnosis of Essential Hypertension
- Qualifying encounter in the last 12 months

Previously *only* **eGFR**

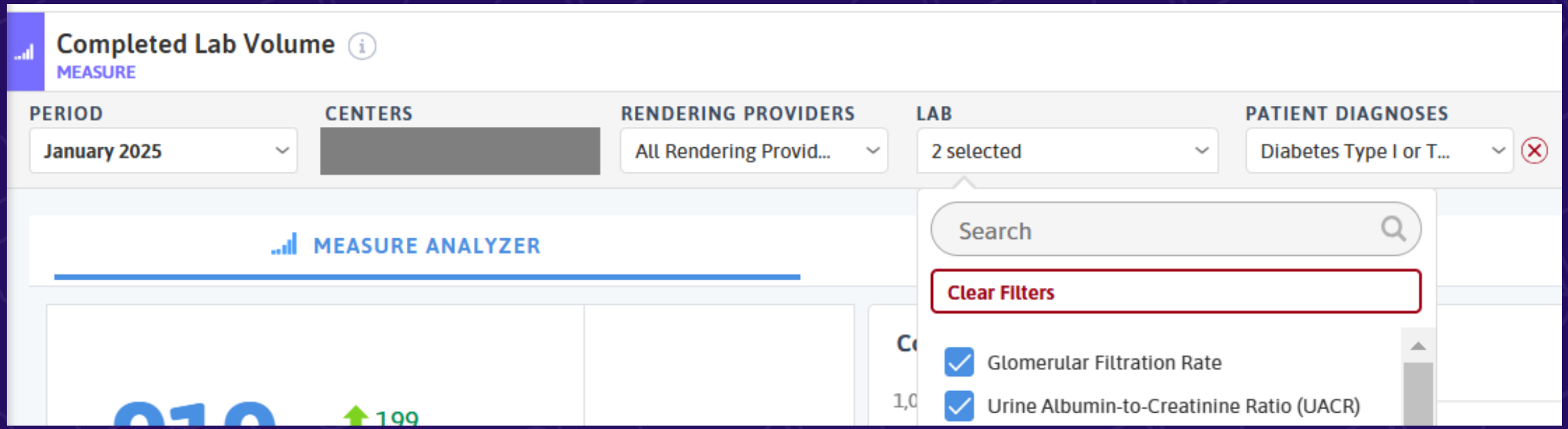
Now includes *both* **eGFR and uACR**

Kidney Profile Measure Trendline Window

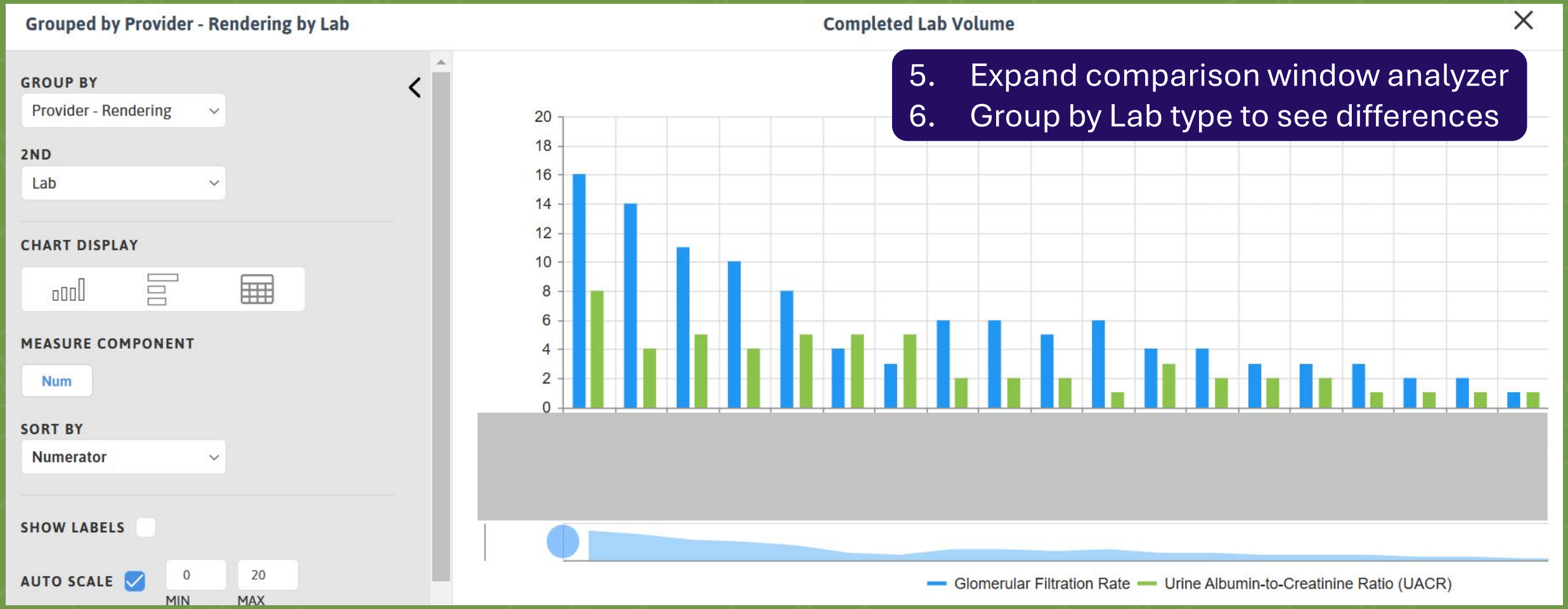


Lab Volume Review

1. Go to Completed Lab Volume Measure
2. Select eGFR and uACR lab types
3. Apply Patient Diagnosis filter for DM and/or HTN



Lab Volume Review Continued



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Lab Results – Mapping Admin

1. Go to Lab Results in Mapping Admin
2. Type in key words in EHR Lab Type
3. Review all lab order types

Mapping Administration

MAPPING CATEGORY: Lab Results | CENTER | TIME PERIOD: Last Year | MAPPED LAB RESULTS: All

EHR LAB TYPE	EHR CPT CODE	EHR LOINC CODE	MAPPED LOINC CODE	MAPPED LOINC DESCRIPTION	COUNT
ALBUMIN, RANDOM URINE W/CREATI...	Unknown	14957-5	1754-1	Albumin [Mass/volume] in Urine	4,223
ALBUMIN, RANDOM URINE W/CREATI...	Unknown	2161-8	2161-8	Creatinine [Mass/volume] in Urine	4,223
ALBUMIN, RANDOM URINE W/CREATI...	Unknown	9318-7	9318-7	Albumin/Creatinine [Mass Ratio] in Uri...	4,223
KIDNEY PROFILE | ALBUMIN, URINE	Unknown	14957-5	14957-5	Microalbumin [Mass/volume] in Urine	1,102
KIDNEY PROFILE | CREATININE, RAND...	Unknown	2161-8	2161-8	Creatinine [Mass/volume] in Urine	1,102
KIDNEY PROFILE | ALBUMIN/CREATINI...	Unknown	9318-7	9318-7	Albumin/Creatinine [Mass Ratio] in Uri...	1,102
KIDNEY PROFILE | CREATININE	Unknown	2160-0	2160-0	Creatinine [Mass/volume] in Serum or ...	879
ALBUMIN/CREAT URINE RATIO | ALBU...	Unknown	14957-5	14957-5	Microalbumin [Mass/volume] in Urine	207
ALBUMIN/CREAT URINE RATIO | URIN...	Unknown	14959-1	14959-1	Microalbumin/Creatinine [Mass Ratio] i...	207
ALBUMIN/CREAT URINE RATIO | URIN...	Unknown	2161-8	2161-8	Creatinine [Mass/volume] in Urine	207
ALBUMIN/CREAT URINE RATIO | Note	Unknown	Unknown	Unmapped	Unmapped	207
MICROALBUMIN/CREAT URINE RATIO ...	Unknown	14957-5	14957-5	Microalbumin [Mass/volume] in Urine	27
MICROALBUMIN/CREAT URINE RATIO ...	Unknown	2161-8	2161-8	Creatinine [Mass/volume] in Urine	27
MICROALBUMIN/CREAT URINE RATIO ...	Unknown	14959-1	9318-7	Albumin/Creatinine [Mass Ratio] in Uri...	27
MICROALBUMIN/CREAT URINE RATIO ...	Unknown	Unknown	Unmapped	Unmapped	27

Columns

1 to 15 of 29 | Page 1 of 2

Dashboards

Visualize Risk & CKD Management

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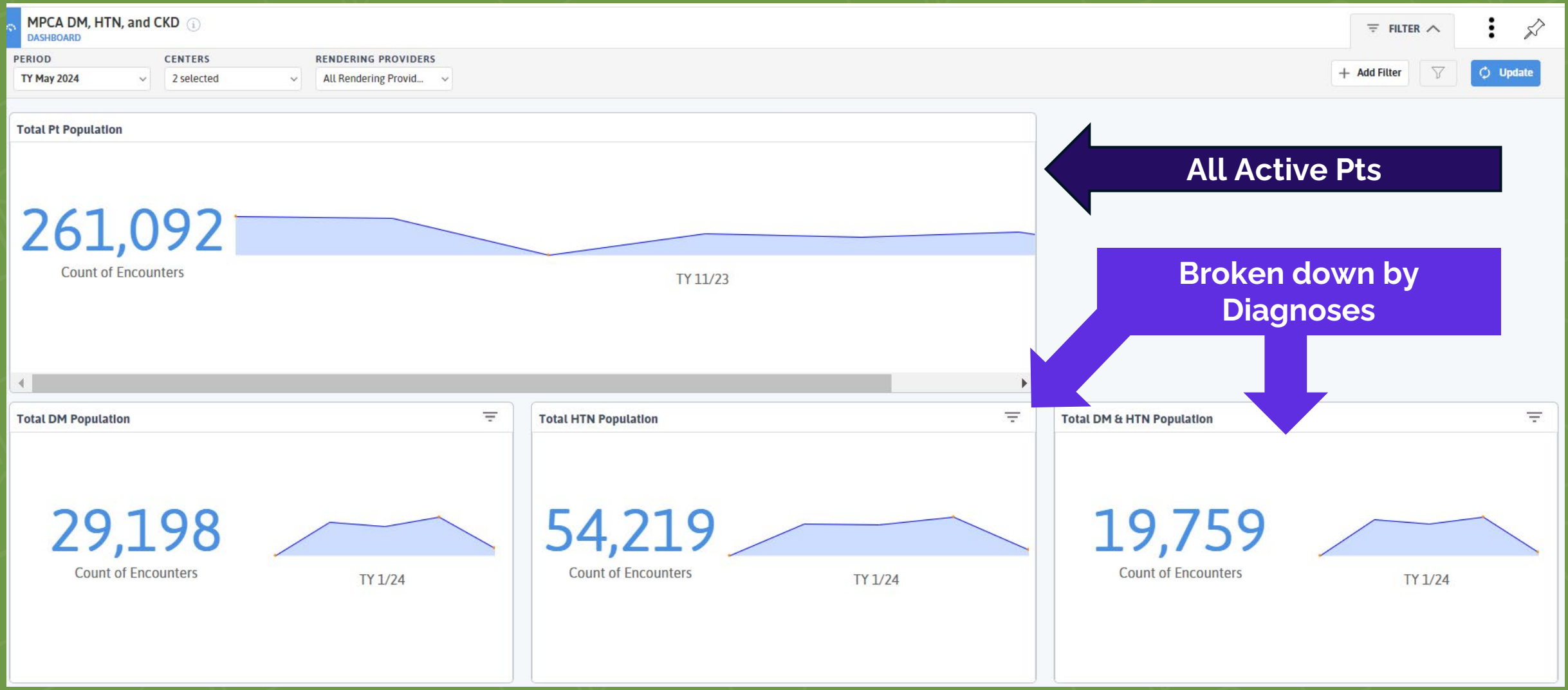
DM, HTN, and CKD Dashboard – 1

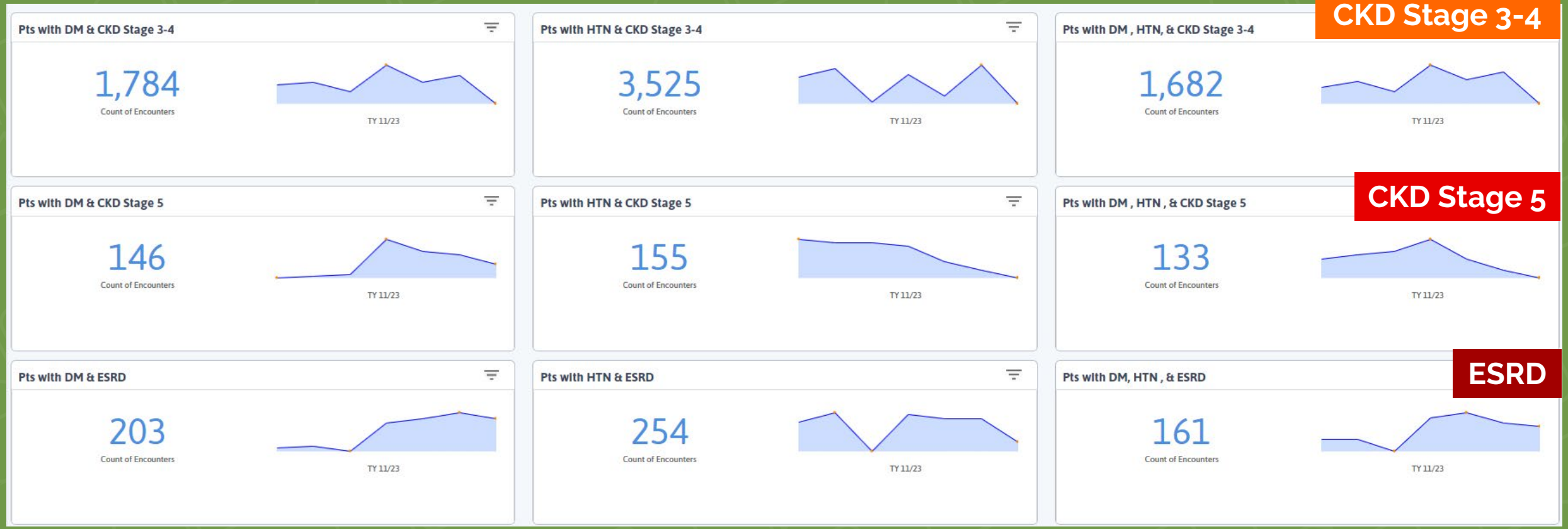


DM, HTN, and CKD Dashboard – 2

CKD Screening

Due for CKD Screening & High Risk

DM, HTN, and CKD Dashboard – 3



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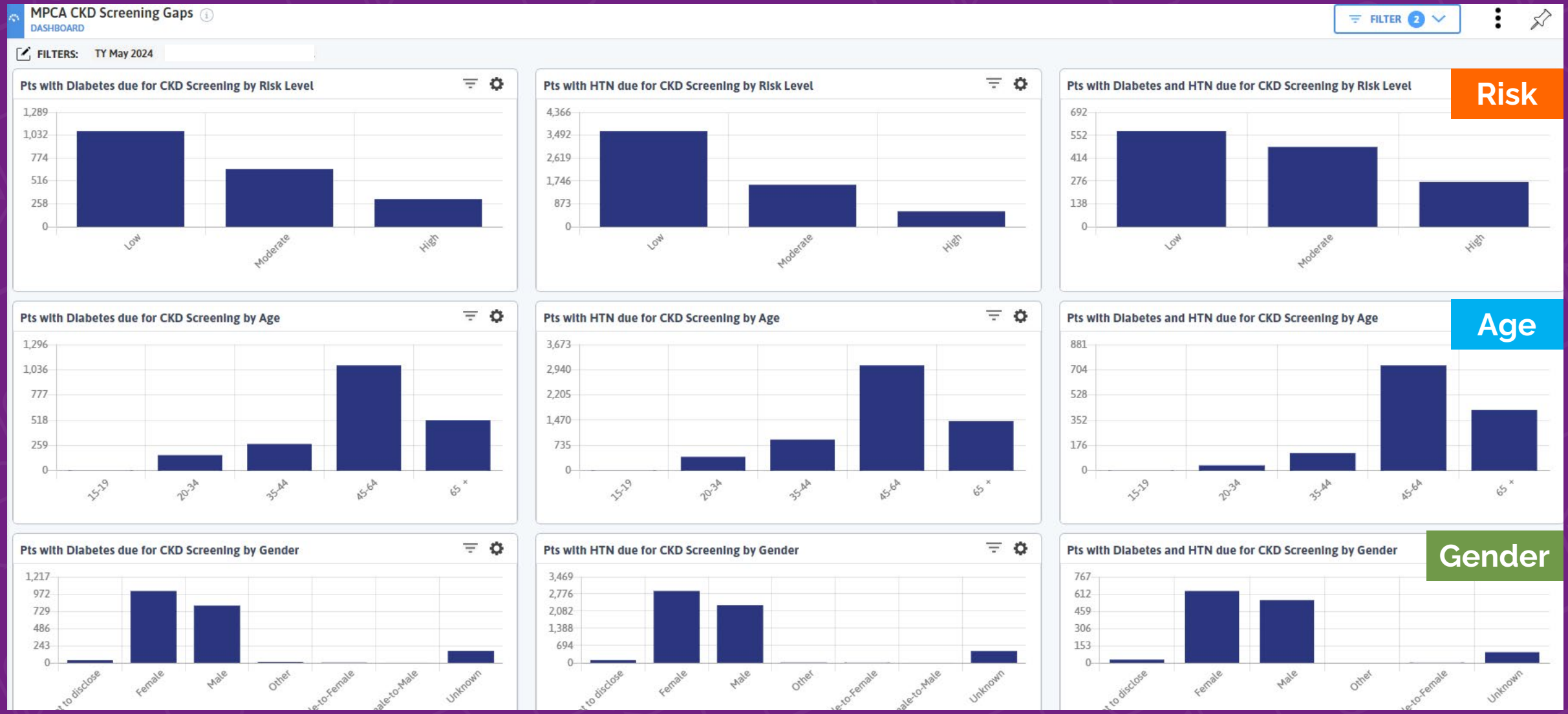
CKD Screening Gaps Dashboard – 1



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CKD Screening Gaps Dashboard – 2

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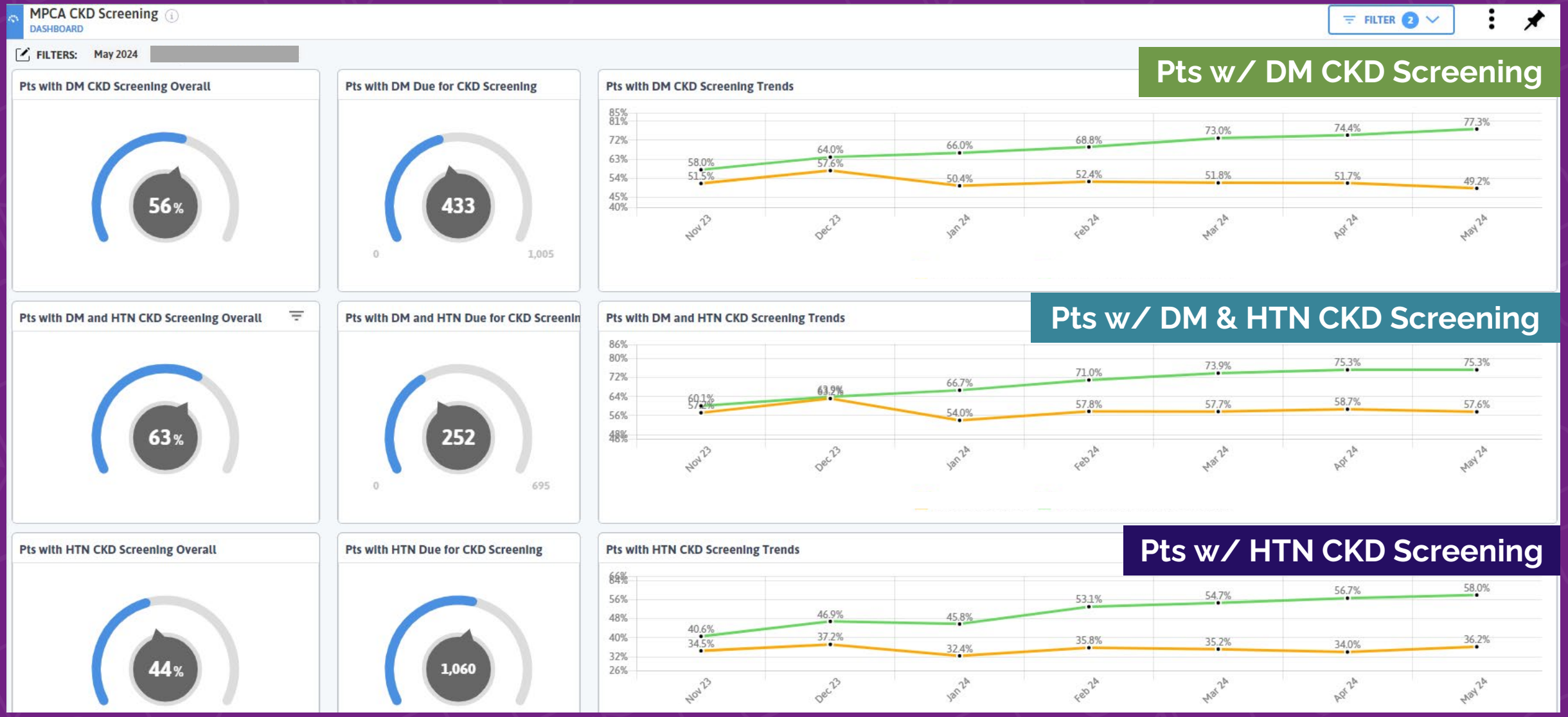
CKD Screening Dashboard – 1



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CKD Screening Dashboard – 2

Pts w DM CKD Screening

Pts with Diabetes CKD Screening

CENTERS	RESULT	NUMERATOR	DENOMINATOR	GAP
[redacted]	57.3%	277	483	206
[redacted]	78.0%	181	232	51

Closed CKD Screening Alerts for Pts with Diabetes

CENTERS	RESULT
[redacted]	33.3%

Missed Opportunities - Open Alerts for Pts with Diabetes

CENTERS	GAP
[redacted]	30

Pts w HTN CKD Screening

Pts with HTN CKD Screening

CENTERS	RESULT	NUMERATOR	DENOMINATOR	GAP
[redacted]	39.7%	355	895	540
[redacted]	58.7%	361	615	254

Closed CKD Screening Alerts for Pts with HTN

CENTERS	RESULT
[redacted]	11.6%

Missed Opportunities - Open Alerts for Pts with HTN

CENTERS	GAP
[redacted]	283

Pts w DM & HTN CKD Screening

Pts with Diabetes and HTN CKD Screening

CENTERS	RESULT	NUMERATOR	DENOMINATOR	GAP
[redacted]	61.0%	217	356	139
[redacted]	76.0%	146	192	46

Closed CKD Alerts = pts were screened when they came in for visit

Open CKD Alerts = pts were not screened when they came in for visit aka missed opportunity

Registries, Cohorts, & Care Effectiveness Reports

Identify & Track High Risk Patients

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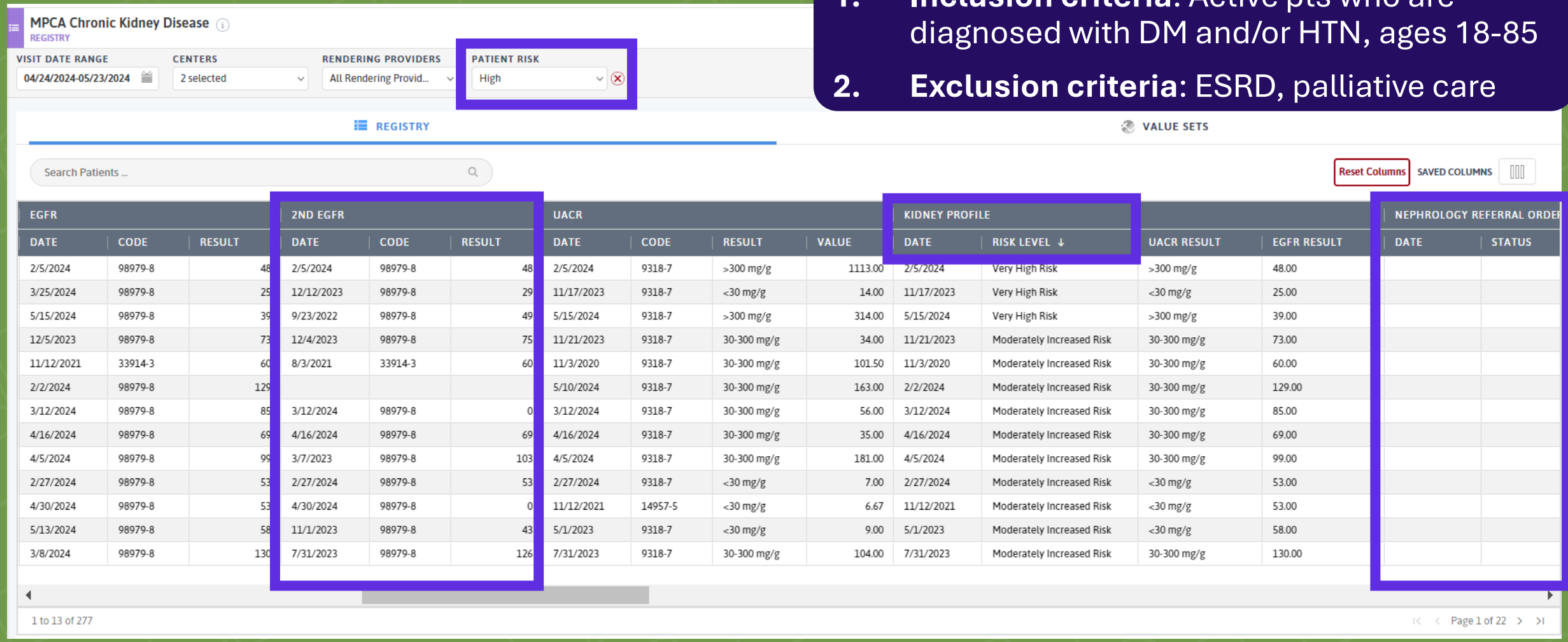
MPCA CKD Registry – Applying Risk Filter

1. **Inclusion criteria**: Active pts who are diagnosed with DM and/or HTN, ages 18-85
2. **Exclusion criteria**: ESRD, palliative care



EGFR			2ND EGFR			UACR				KIDNEY PROFILE				NEPHROLOGY REFERRAL ORDER	
DATE	CODE	RESULT	DATE	CODE	RESULT	DATE	CODE	RESULT	VALUE	DATE	RISK LEVEL ↓	UACR RESULT	EGFR RESULT	DATE	STATUS
2/5/2024	98979-8	48	2/5/2024	98979-8	48	2/5/2024	9318-7	>300 mg/g	1113.00	2/5/2024	Very High Risk	>300 mg/g	48.00		
3/25/2024	98979-8	25	12/12/2023	98979-8	29	11/17/2023	9318-7	<30 mg/g	14.00	11/17/2023	Very High Risk	<30 mg/g	25.00		
5/15/2024	98979-8	39	9/23/2022	98979-8	49	5/15/2024	9318-7	>300 mg/g	314.00	5/15/2024	Very High Risk	>300 mg/g	39.00		
12/5/2023	98979-8	73	12/4/2023	98979-8	75	11/21/2023	9318-7	30-300 mg/g	34.00	11/21/2023	Moderately Increased Risk	30-300 mg/g	73.00		
11/12/2021	33914-3	60	8/3/2021	33914-3	60	11/3/2020	9318-7	30-300 mg/g	101.50	11/3/2020	Moderately Increased Risk	30-300 mg/g	60.00		
2/2/2024	98979-8	129				5/10/2024	9318-7	30-300 mg/g	163.00	2/2/2024	Moderately Increased Risk	30-300 mg/g	129.00		
3/12/2024	98979-8	85	3/12/2024	98979-8	0	3/12/2024	9318-7	30-300 mg/g	56.00	3/12/2024	Moderately Increased Risk	30-300 mg/g	85.00		
4/16/2024	98979-8	69	4/16/2024	98979-8	69	4/16/2024	9318-7	30-300 mg/g	35.00	4/16/2024	Moderately Increased Risk	30-300 mg/g	69.00		
4/5/2024	98979-8	99	3/7/2023	98979-8	103	4/5/2024	9318-7	30-300 mg/g	181.00	4/5/2024	Moderately Increased Risk	30-300 mg/g	99.00		
2/27/2024	98979-8	53	2/27/2024	98979-8	53	2/27/2024	9318-7	<30 mg/g	7.00	2/27/2024	Moderately Increased Risk	<30 mg/g	53.00		
4/30/2024	98979-8	53	4/30/2024	98979-8	0	11/12/2021	14957-5	<30 mg/g	6.67	11/12/2021	Moderately Increased Risk	<30 mg/g	53.00		
5/13/2024	98979-8	58	11/1/2023	98979-8	43	5/1/2023	9318-7	<30 mg/g	9.00	5/1/2023	Moderately Increased Risk	<30 mg/g	58.00		
3/8/2024	98979-8	130	7/31/2023	98979-8	126	7/31/2023	9318-7	30-300 mg/g	104.00	7/31/2023	Moderately Increased Risk	30-300 mg/g	130.00		

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MPCA Undiagnosed CKD Registry

1. **Inclusion criteria**: Active pts who are diagnosed with DM and/or HTN
2. **Exclusion criteria**: CKD diagnosis (Stage 1-5, ESRD)

MPCA Undiagnosed CKD
REGISTRY

VISIT DATE RANGE: 05/16/2024-05/23/2024 | CENTERS: 2 selected | RENDERING PROVIDERS: All Rendering Provid...

REGISTRY

Search Patients ...

Reset Columns | SAVED COLUMNS

	2ND EGFR			UACR				KIDNEY PROFILE				NEPHROLOGY REFERRAL ORDER	
	DATE	CODE	RESULT	DATE	CODE	RESULT	VALUE	DATE	RISK LEVEL	UACR RESULT	EGFR RESULT	DATE	STATUS
22	2/12/2024	98979-8	25	2/13/2024	9318-7	30-300 mg/g	107.00	2/13/2024	Very High Risk	30-300 mg/g	22.00		
48	1/30/2024	98979-8	58	1/30/2024	9318-7	>300 mg/g	1187.00	1/30/2024	Very High Risk	>300 mg/g	48.00		
58	2/23/2023	98979-8	57	2/23/2023	9318-7	>300 mg/g	3639.00	2/23/2023	Very High Risk	>300 mg/g	58.00		
.05				2/5/2024	9318-7	30-300 mg/g	107.00	2/5/2024	Moderately Increa...	30-300 mg/g	105.00		
.25				12/4/2023	9318-7	30-300 mg/g	54.00	11/14/2023	Moderately Increa...	30-300 mg/g	125.00		
.20				5/2/2024	9318-7	30-300 mg/g	63.00	5/2/2024	Moderately Increa...	30-300 mg/g	120.00		
95				5/16/2024	9318-7	30-300 mg/g	60.00	5/16/2024	Moderately Increa...	30-300 mg/g	95.00		
.14	5/12/2022	33914-3	60	10/11/2023	9318-7	30-300 mg/g	85.00	10/11/2023	Moderately Increa...	30-300 mg/g	114.00		

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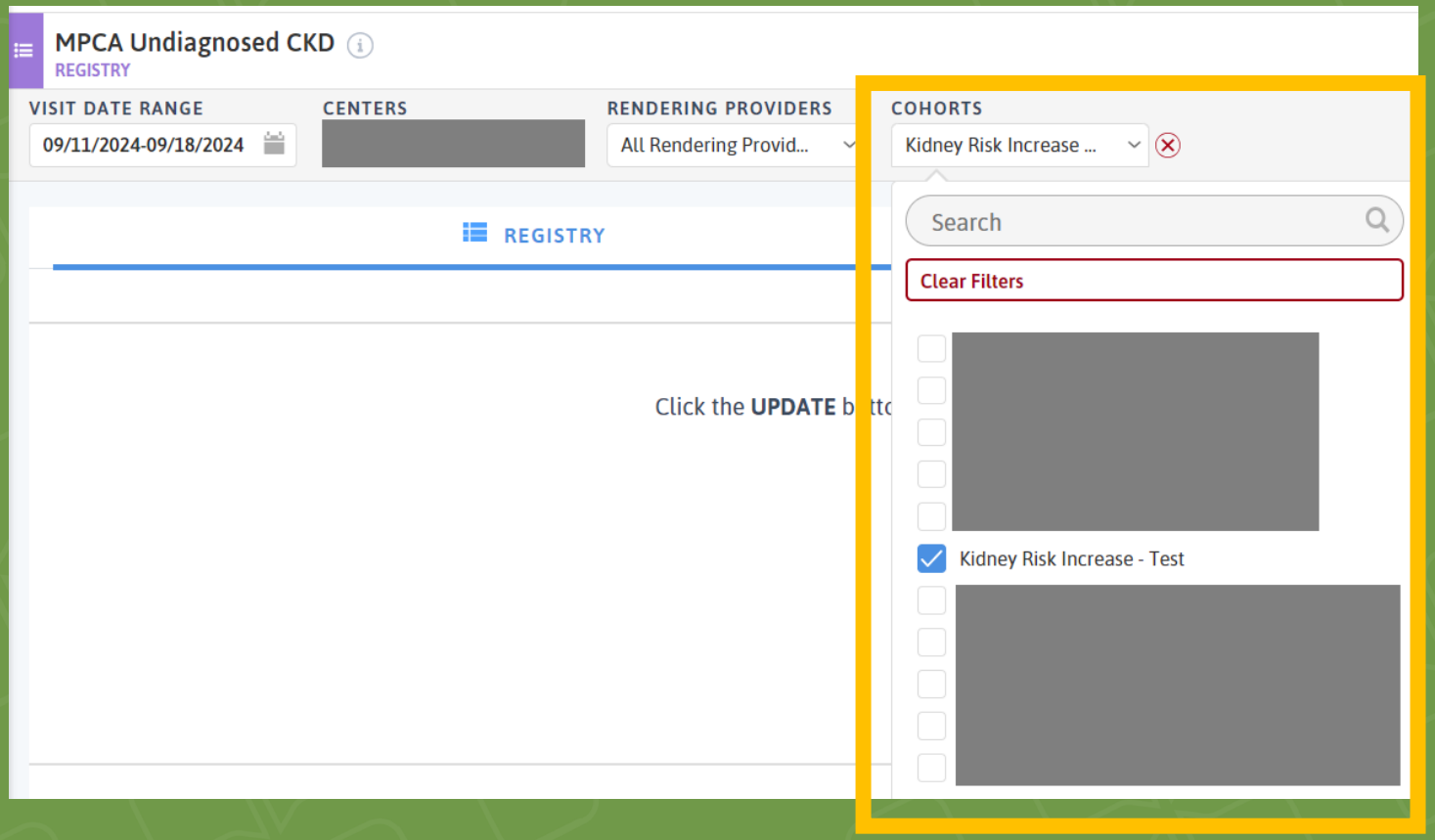
Using Dynamic Cohort – Undiagnosed CKD Registry



1. Apply High Risk Kidney Disease dynamic cohort filter (once enabled) to Undiagnosed CKD registry
2. Now have list of pts with:
   a. DM and/or HTN diagnosis
   b. No CKD diagnosis
   c. Kidney health declining

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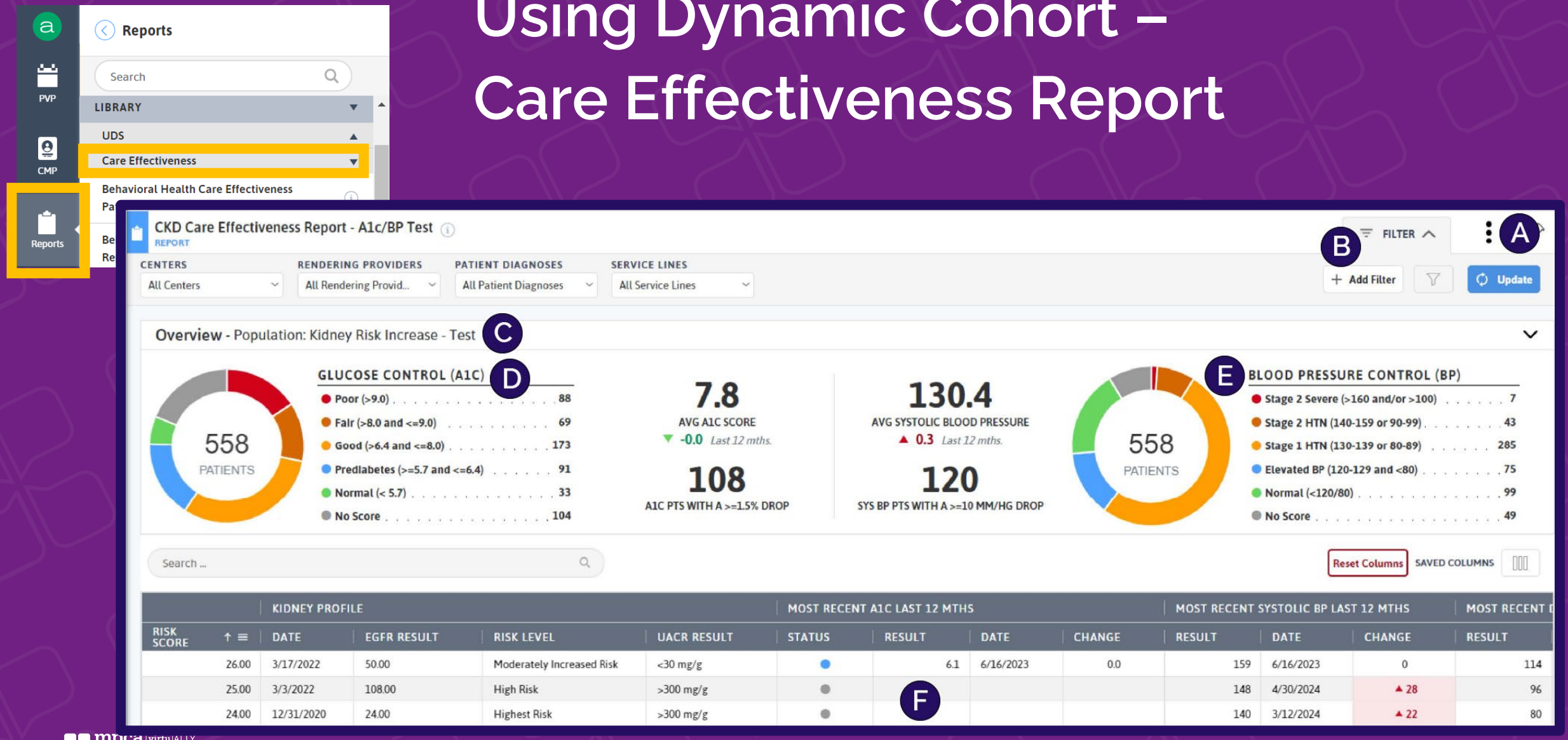
Using Dynamic Cohort – Care Effectiveness Report



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CKD Learning Collaborative Data

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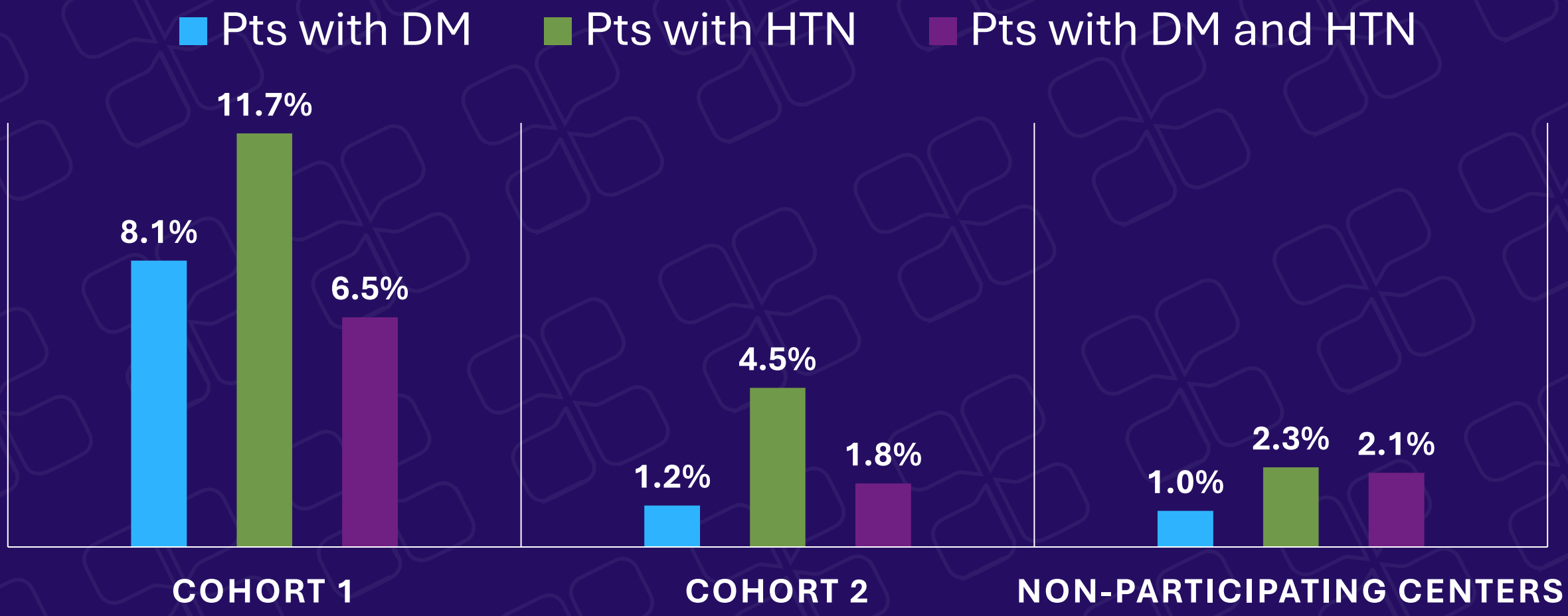
CKD Screening Rate Changes from TY Aug 23-24



MPCA Lessons Learned

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MPCA Lessons Learned

Azara-Related Lessons

- Include lab order name in alert display name on PVP
- Sort CKD screening rates by provider
- Review lab mappings (especially uACR)
- Limit Azara tools to avoid overwhelming staff

Workflow-Related Lessons

- Review provider practices related to high and low screening rates
- Provide regular provider education at staff meetings, creating one-pager for ordering labs
- Secure provider champion
- Use order sets that are already commonly used among staff

Organizational Lessons

- Align CKD screening and management with other priority populations and initiatives
- Example: MCHN focus measure for DM eye exams and controlling blood pressure measure
- Include complete care team (clinical, outreach, quality improvement, Azara Super User, etc.)

CKD Playbook

NATIONAL KIDNEY FOUNDATION® of Michigan

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CHRONIC KIDNEY DISEASE PLAYBOOK

OVERVIEW

The Michigan Primary Care Association, in collaboration with the National Kidney Foundation of Michigan, has developed a comprehensive playbook to enhance the screening, diagnosis, and management of chronic kidney disease. This playbook incorporates Azara and other clinical support tools, along with a wealth of resources and educational materials, to assist health centers in effectively addressing chronic kidney disease.

APPLICABLE HEALTH CENTER STAFF

- Clinical support staff (registration, CHWs, MAs, nurses, etc.)
- Providers (MDs, NPs, PAs, residents)
- Care managers/care coordinators
- Quality improvement
- Pharmacy

CKD Playbook

	Pre-Engagement	Pre-Visit	Rooming	Visit	Post-Visit
Team Member	• Clinical support staff • Quality improvement	• Clinical support staff • Providers	• Clinical support staff • Providers	• Clinical support staff • Providers	• All team members
Identification	• Registry: MPCA Chronic Kidney Disease • Dashboard: MPCA DM, HTN & CKD	• Automated patient outreach			
Screening	• Dashboard: MPCA CKD Screening Gaps	• Alerts: CKD Screening for Patients with DM or HTN	• Standing Orders • Quest Kidney Profile	• Quest Kidney Profile • Clinical Decision Tool for CKD	• Measures: Kidney Profile for DM or HTN • Measure: Lab Volume • Measure: Alert Closure (POC) • Dashboard: MPCA CKD Screening
Diagnosis	• Registry: MPCA Undiagnosed CKD			• Clinical Decision Tool for CKD • CKD Heat Map	• Cohort: High-Risk Kidney Profile • Registry: MPCA Undiagnosed CKD
Management & Monitoring					• Dashboard: MPCA DM, HTN & CKD • Care Effectiveness Report (CER): customized

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Thank you

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Questions?

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Click on the session from your agenda in the conference app.
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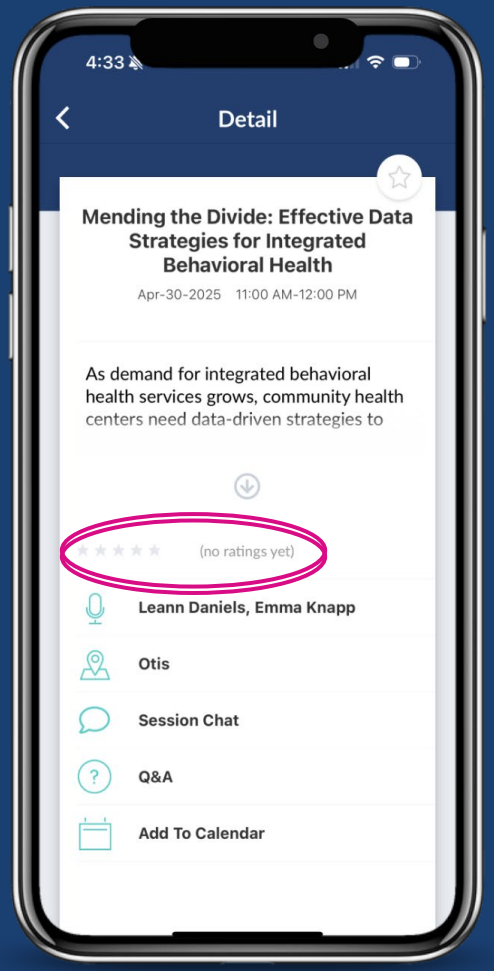

Quick and Easy

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Achieve, Celebrate, Engage!

ACE'd it? Share your DRVS success story and become an Azara ACE!

azara healthcare

ACE Program

Show your organization has used DRVS to **A**chieve measurable results, **C**elebrate improvement in patient health outcomes, and effectively **E**ngage care teams and/or patients. Stories should showcase how DRVS helped your organization overcome a challenge, the tools and solutions used to drive improvement and details of the successes that resulted from your initiatives. ACEs should be able to provide examples that quantify quality improvement, cost savings, operational efficiency or patient health improvement.

Benefits:

- Azara will help tell your story and provide a client-branded version for your use
- Potential to create a 2-4 minute video or hour-long Azara-hosted webinar
- Potential to be featured at next year's Azara User Conference
- Win Azara swag!

Submit your success story by completing the form at this link.

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Thanks for attending!