

Using Data to Drive Chronic Kidney Disease Management

azara2026

USER CONFERENCE APRIL 13-15 | BOSTON, MA



Today's Speakers

15



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Association



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Michigan Primary Care
Association



Agenda

1. MPCA Overview
2. Why Address CKD?
3. Project Evolution
4. Learning Collaborative
5. CKD Playbook
6. Clinical Performance Consulting
7. Wrap-up & Questions





Michigan's Primary
Care Association



Michigan's Clinically
Integrated Network



Michigan's Health
Center Controlled Network



Your ALLY in Healthcare
IT Solutions

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



Value-Based Care
Delivery



Health Information
Technology & Data



Health Center Resilience
& Excellence



People, Workforce &
Training



Government Affairs &
Advocacy

MPCA Membership

Member Organizations		
42 FQHCs - 40 health centers - 3 look-alikes	2 Tribal Health Centers	1 Urban Indian Health Program

HCCN
41 health centers

CIN
40 health centers

ACO
18 health centers

A woman with curly hair, wearing a white lab coat, is smiling and looking towards a man in a white lab coat. She is holding a tablet. The man is looking at her. In the background, another person is visible, but they are out of focus. The entire image has a purple tint.

Problem Statement

CKD Prevalence, Diagnosis, and Annual Cost

Prevalence:

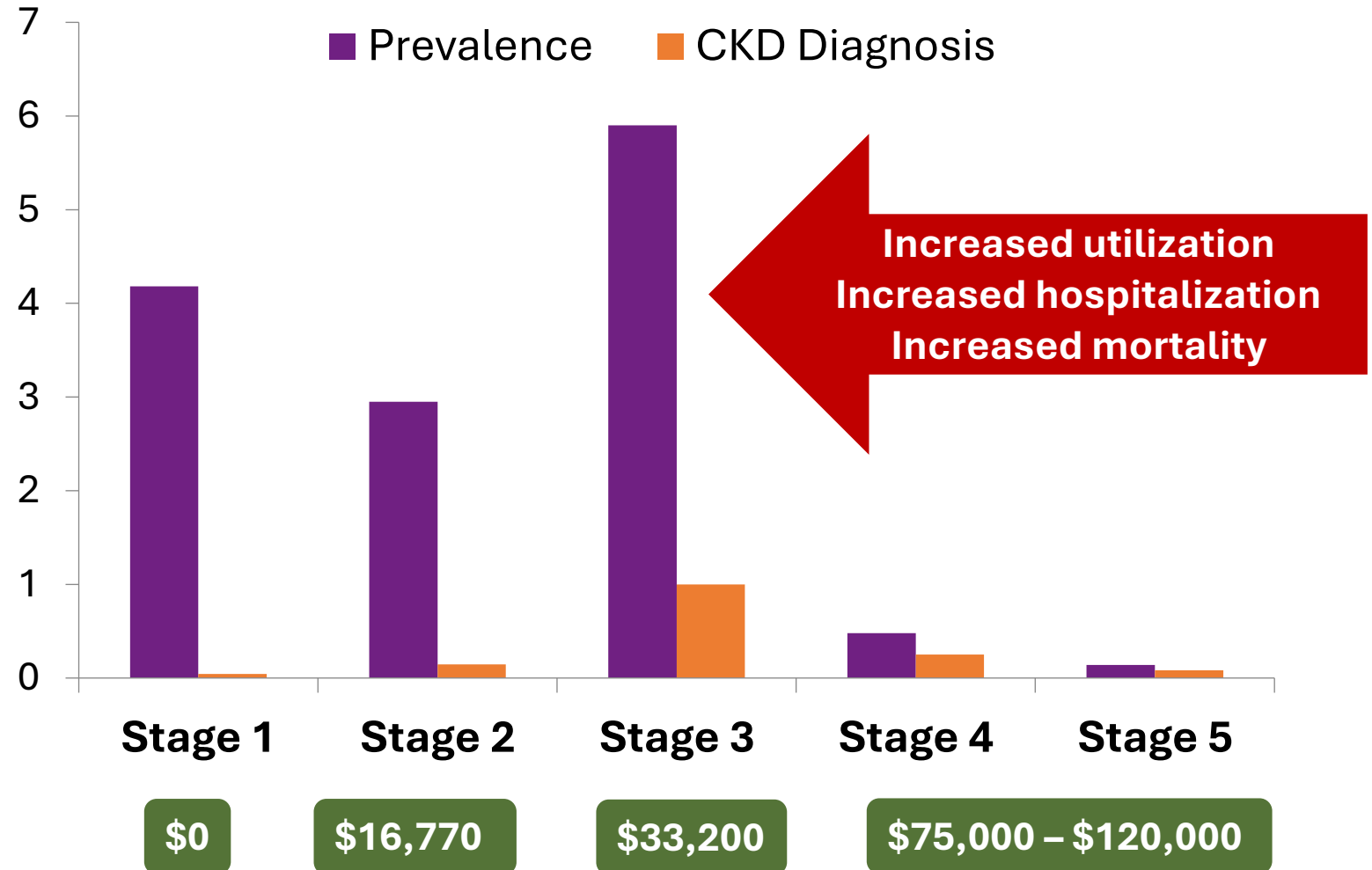
United States Renal Data System. 2015 USRDS annual data report: Epidemiology of Kidney Disease in the United States. National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2015.

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:

Szcech, 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.



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



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.

Sources:

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

Project Evolution Overview





Initial Approach: Learning Collaborative

Approach and Framework



Optimal Team-Based Care Framework

1. Foster mutual trust and physical and psychological safety.
2. Clarify roles and expectations.
3. Practice effective communication.
4. Track a set of shared measurable goals.



Phases of Care

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

Learning Collaborative

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

Learning Collaborative

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

Second Iteration of Learning Collaborative

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

Second Iteration of Learning Collaborative

Meetings

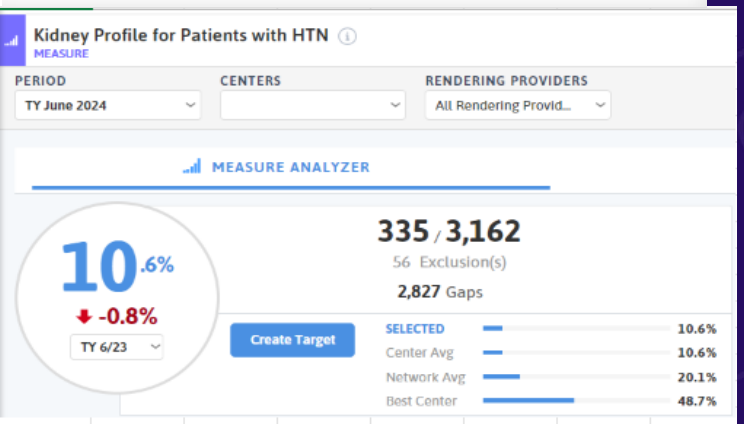
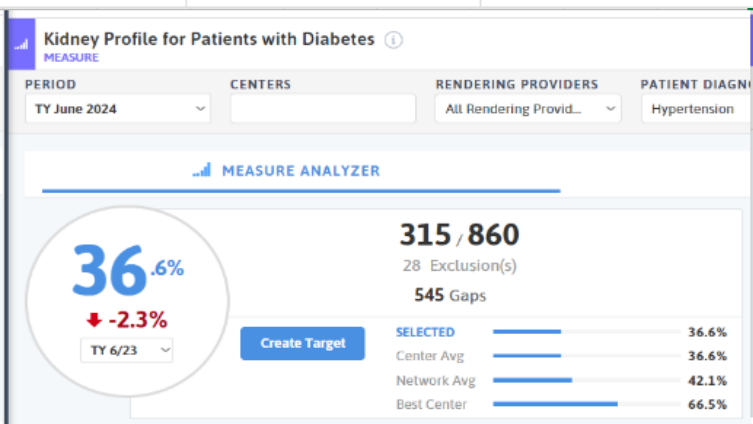
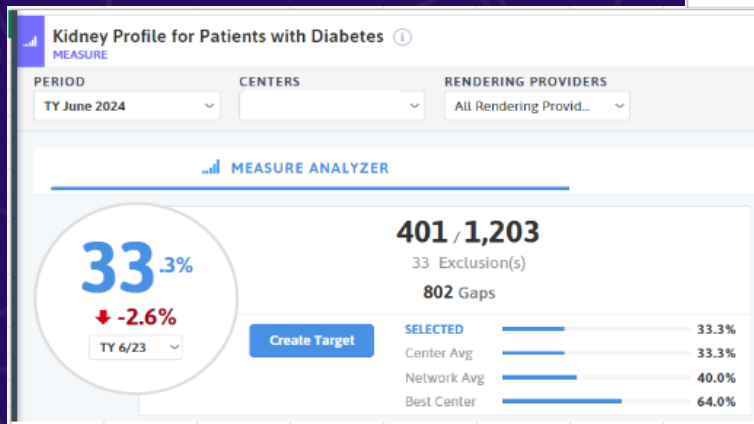
- Monthly cadence
- MPCA support from Clinical Performance Consultant and Data Team
- Co-created action plan for two interventions
- Reviewed action plan and tracking dashboard

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

mpca THE VOICE OF COMMUNITY HEALTH CENTERS		NATIONAL KIDNEY FOUNDATION of Michigan	
CKD Learning Collaborative Action Plan			
Health Center Name:			
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	
Focus Intervention #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	





Lessons Learned → Playbook Development

Lessons Learned from NKFM Projects

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
- Regular provider education at staff meetings, creating one-pager for ordering labs
- 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.)

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

- a. 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

CKD Playbook



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

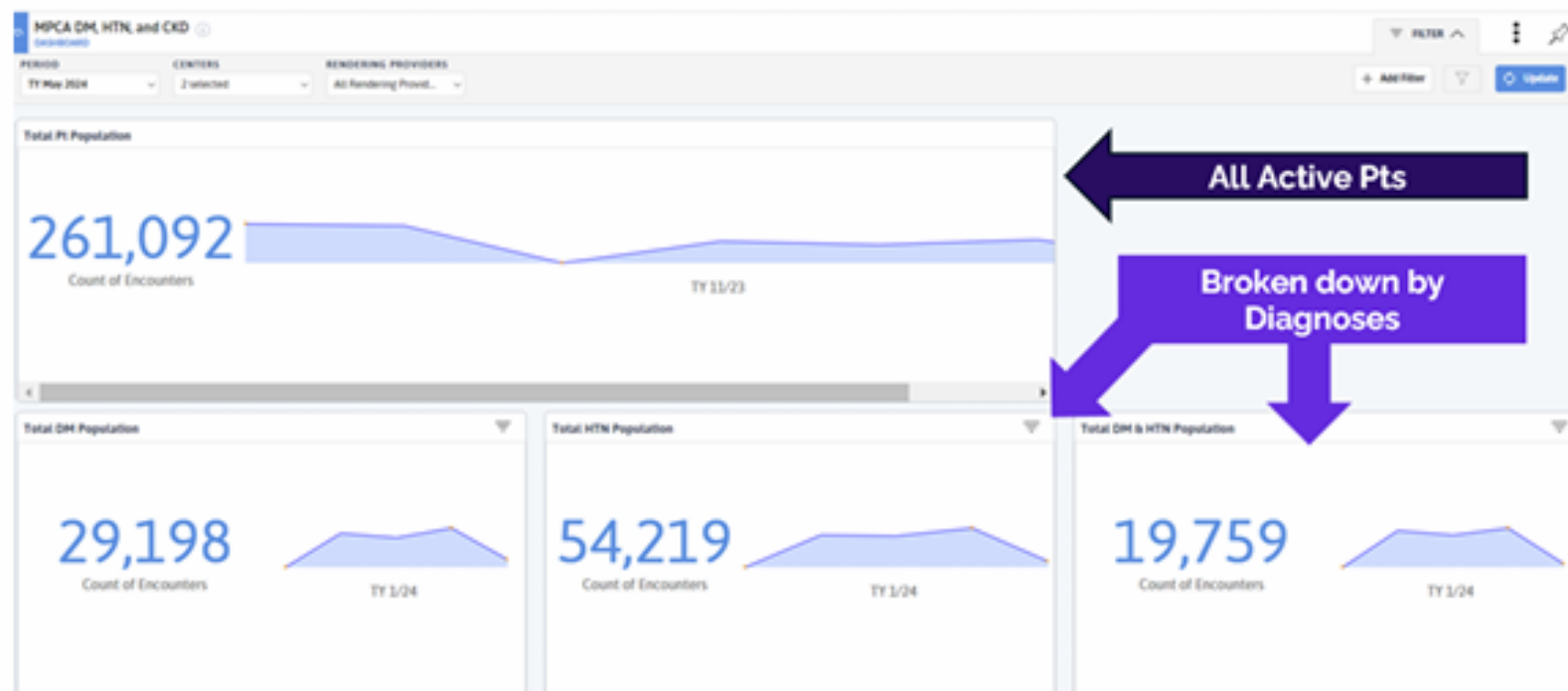
CKD Playbook



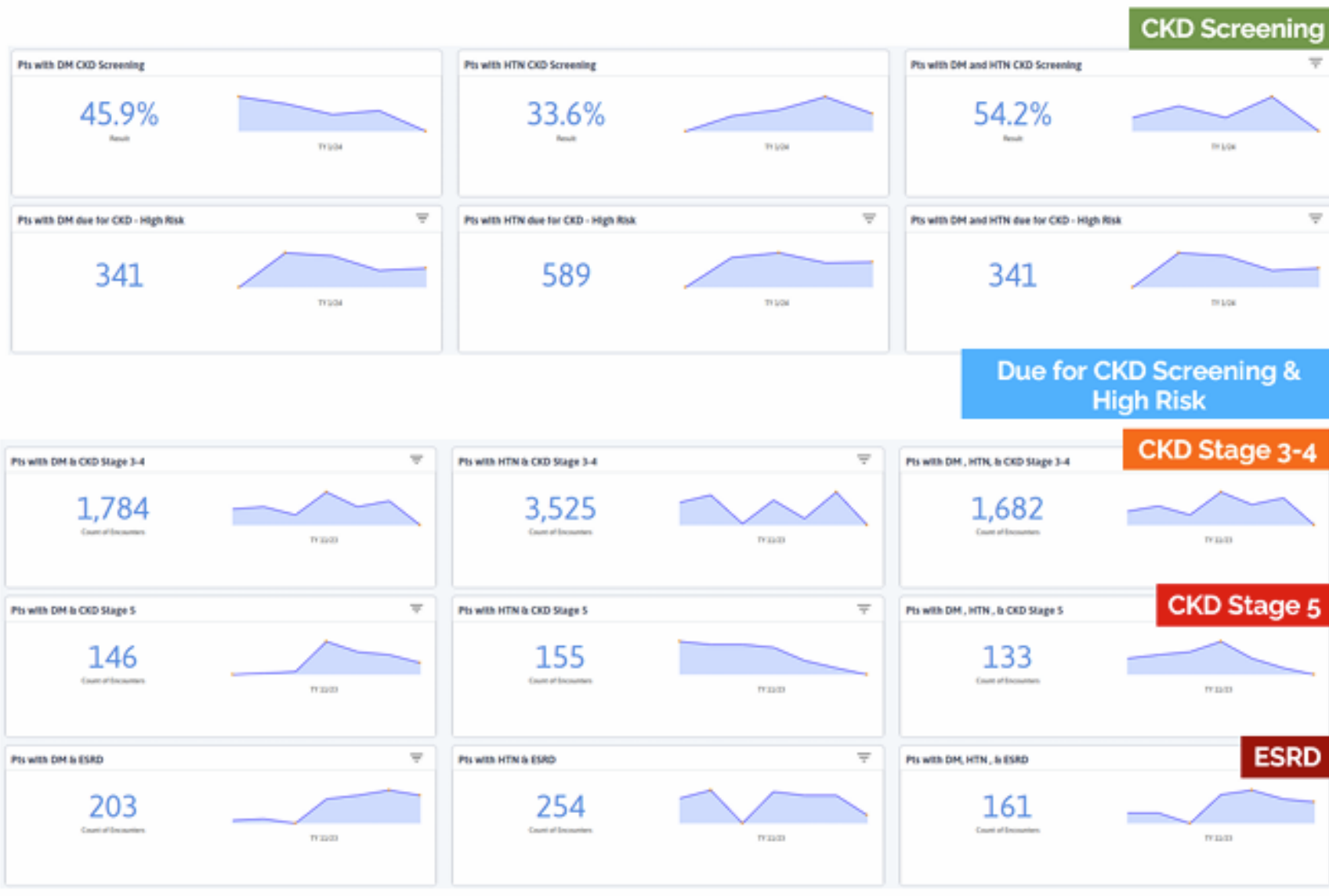
	Pre-Engagement	Pre-Visit	Rooming	Visit	Post-Visit
Team Member	<ul style="list-style-type: none"> Clinical support staff Quality improvement 	<ul style="list-style-type: none"> Clinical support staff Providers 	<ul style="list-style-type: none"> Clinical support staff Providers 	<ul style="list-style-type: none"> Clinical support staff Providers 	<ul style="list-style-type: none"> All team members
Identification	<ul style="list-style-type: none"> Registry: MPCA Chronic Kidney Disease Dashboard: MPCA DM, HTN & CKD 	<ul style="list-style-type: none"> Automated patient outreach 			
Screening	<ul style="list-style-type: none"> Dashboard: MPCA CKD Screening Gaps 	<ul style="list-style-type: none"> Alerts: CKD Screening for Patients with DM or HTN 	<ul style="list-style-type: none"> Standing Orders Quest Kidney Profile 	<ul style="list-style-type: none"> Quest Kidney Profile Clinical Decision Tool for CKD 	<ul style="list-style-type: none"> Measures: Kidney Profile for DM or HTN Measure: Lab Volume Measure: Alert Closure (POC) Dashboard: MPCA CKD Screening
Diagnosis	<ul style="list-style-type: none"> Registry: MPCA Undiagnosed CKD 			<ul style="list-style-type: none"> Clinical Decision Tool for CKD CKD Heat Map 	<ul style="list-style-type: none"> Cohort: High-Risk Kidney Profile Registry: MPCA Undiagnosed CKD
Management & Monitoring					<ul style="list-style-type: none"> Dashboard: MPCA DM, HTN & CKD Care Effectiveness Report (CER): customized

MPCA DM, HTN, and CKD Dashboard

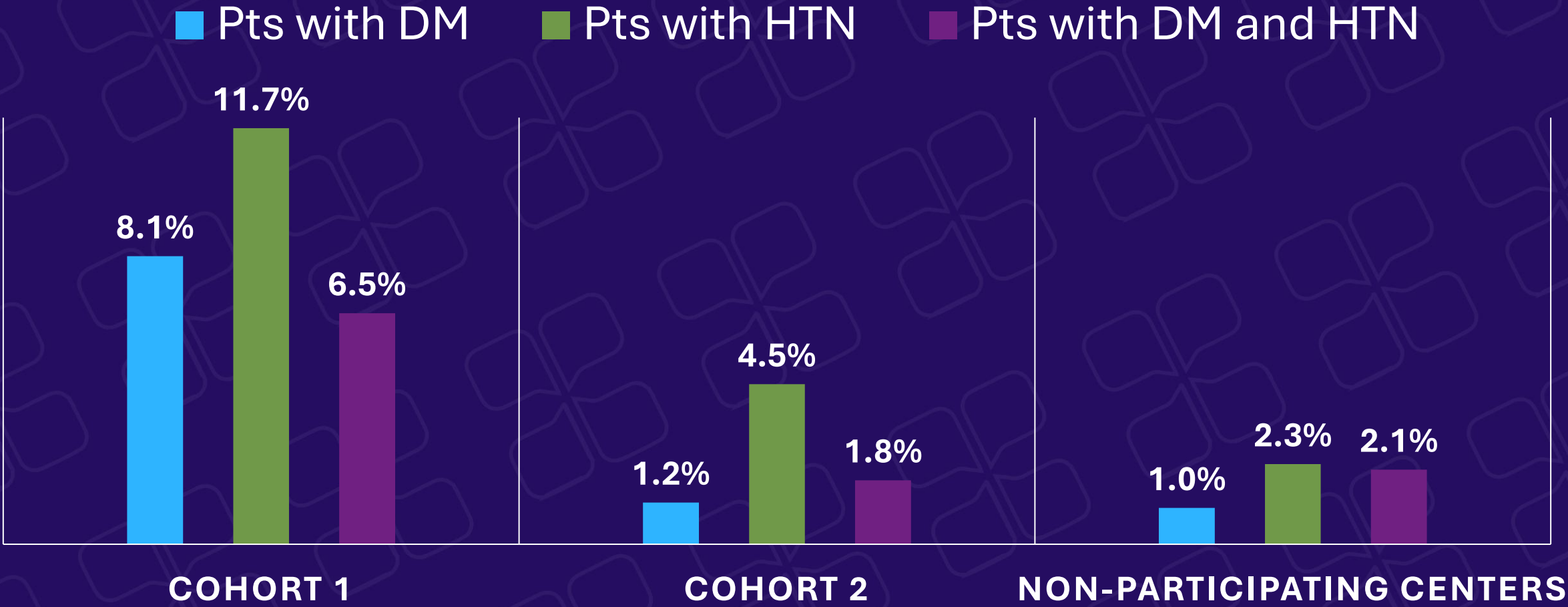
What is the tool?	Azara dashboard to track and manage the CKD screening and staging diagnosis trends for patients with diabetes and/or hypertension.
Who would use the tool?	<ul style="list-style-type: none"> Care managers/care coordinators Quality improvement
When would they use the tool?	Post-Visit: <ul style="list-style-type: none"> Improve care management of patients with diabetes and/or hypertension
How would they use the tool?	<ul style="list-style-type: none"> Review Customize the data elements to include appointments, behavioral health, or medications to better understand the care needs of this population Close screening gaps to ensure patients have A1c, blood pressure, and CKD results



MPCA DM, HTN, and CKD Dashboard Continued

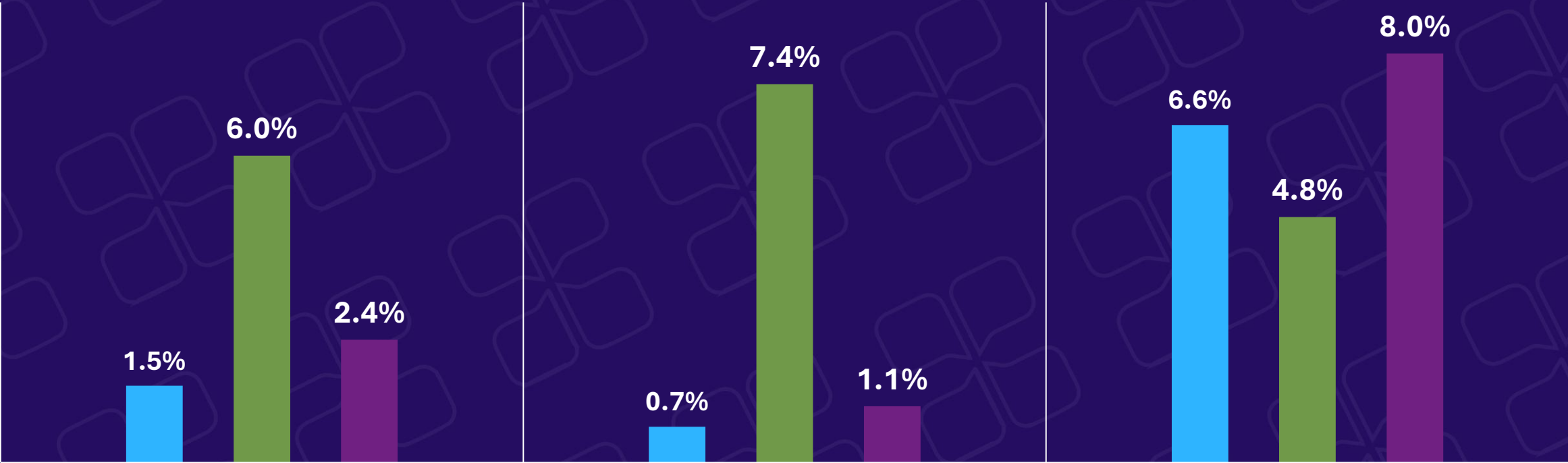


CKD Screening Rate Changes from TY Aug 23-24



CKD Screening Rate Changes from TY Aug 24-25

■ Pts with DM ■ Pts with HTN ■ Pts with DM and HTN



COHORT 1

COHORT 2

NON-PARTICIPATING CENTERS



Clinical Performance Consulting

What is Michigan Community Health Network (MCHN)?

Clinically Integrated Network (CIN) owned by MPCA and 40 of its member health centers.

Formed in 2015 by Michigan community health centers for the purpose of group contracting with Michigan Medicaid Health Plans – **creating new, sustainable funding opportunities through value-based contracting** with primary focus on the triple aim.

Alignment and integration with MPCA, HCCN and VirtuAlly to deliver **comprehensive support and services** to our member Health Centers.

Negotiates **value-based agreements** on behalf of its members for the purpose of **improving overall outcomes of the patients served** and **sharing in the resulting cost savings**.

Seek to support **improved health of our communities** through increasing **access to care, improving HEDIS measures** and **decreasing utilization and total cost of care**.

Currently focused on **Medicaid populations** with recent diversification into a **Medicare ACO and Medicare Advantage Plans**– evaluating all products.



Clinical Performance Structure and Approach



Member health centers are assigned a clinical performance consultant (CPC) **and** a data analytics specialist.



Facilitate and guide health center staff in the planning, implementing and testing of evidence-based interventions to improve performance in clinical quality measures.

2025 Clinical Performance Strategies

Health Center-Centered
Approach



Team-Based Care



Collaborative Resources



Harnessing HIT

MCHN (CIN) Focus Measures

**Adult Access to
Care 20+ years**

**Well-Child Visit
0-15 months**

**Well-Child Visit
15-30 months**

HTN BP Control

**Breast Cancer
Screening**

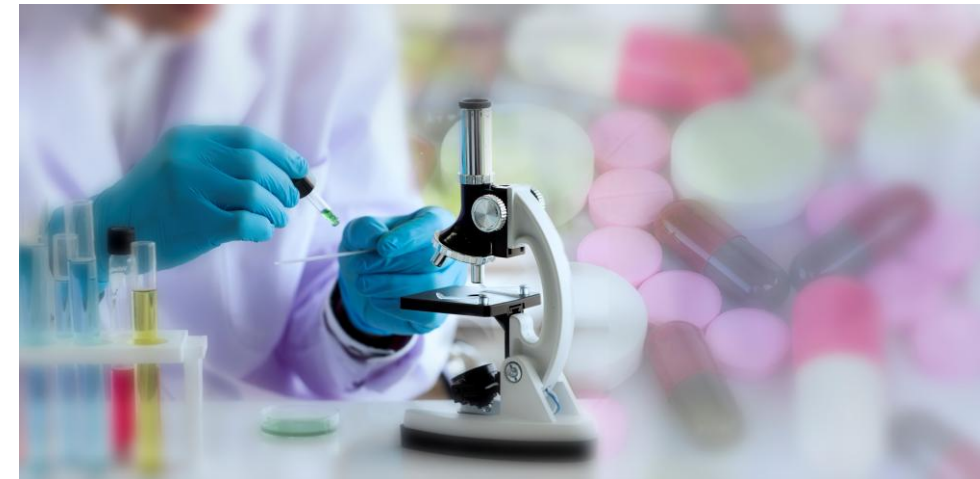
**Cervical Cancer
Screening**

**Kidney Health
Diabetes**

Kidney Health Evaluation for Patients with Diabetes

Patients aged 18-85 years of age with diabetes (type 1 and 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR) during the measurement year

- Patients must receive **both** of the following lab tests:
 - At least one lab test completed for eGFR
 - At least one completed lab test for uACR identified by either of the following
 - Both a quantitative urine albumin test *and* one urine creatinine test with service dates *four or less days apart*
 - At least one completed test for uACR



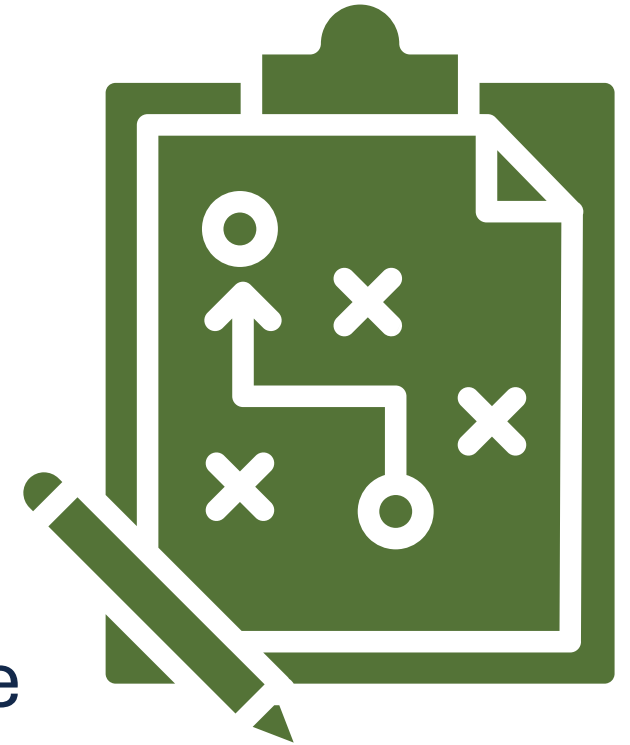
Action Plan

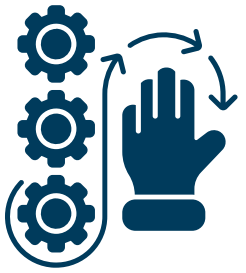


Conduct current state assessments and use Azara data to identify gaps in clinical processes.









Guide the health center in the development of an action plan that includes evidence-based interventions to improve performance and overall care delivery.





Interventions

-  Point of Care Alerts to collect UACR
-  Standing Orders
-  Order sets in EHR (Quest Lab uses a Kidney Profile lab order)
-  Collecting urine on all patients
-  Collecting urine on all patients with chronic conditions
-  Educating staff and patients about leaving urine samples

Clinical Performance Consultant Support



Provide resources relevant to the health center's selected interventions & priority focus areas.



Promote independent data tracking in Azara.

Data Team Support

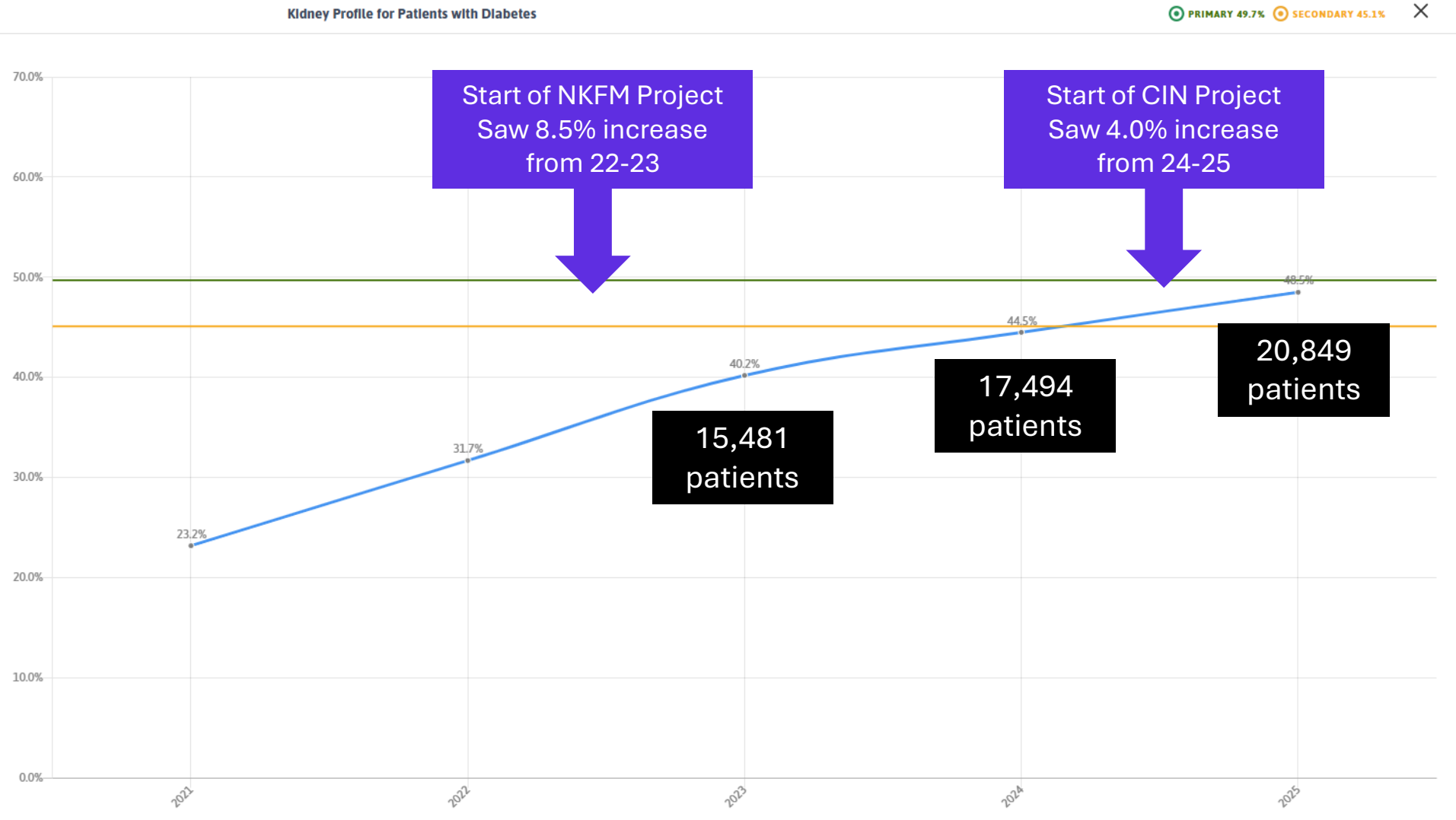


Support health center staff in the utilization of Azara to track progress of intervention implementation.

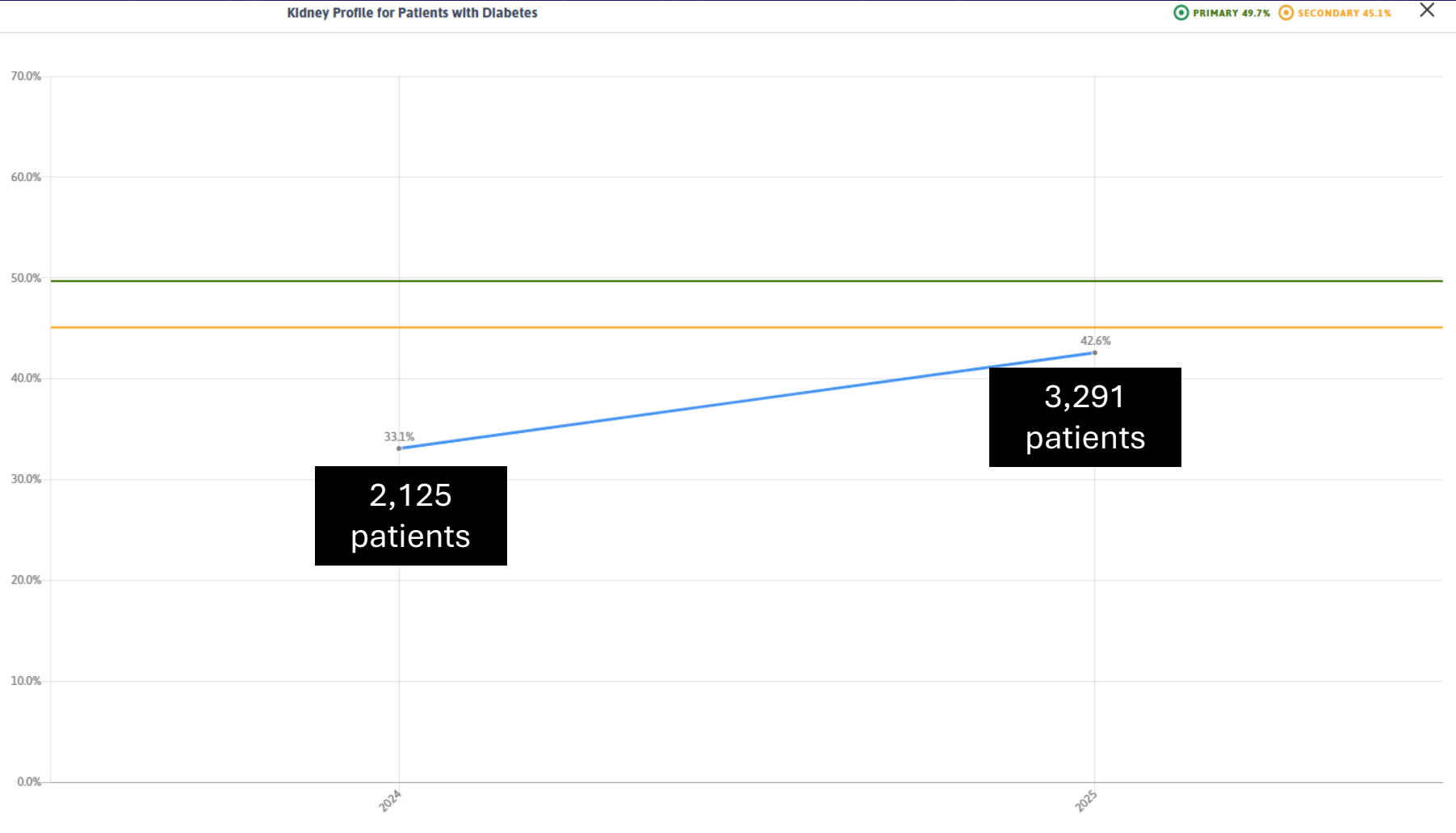


Use Azara data to monitor performance improvement.

Kidney Profile Screening Trends Over Time – Medicaid Patients

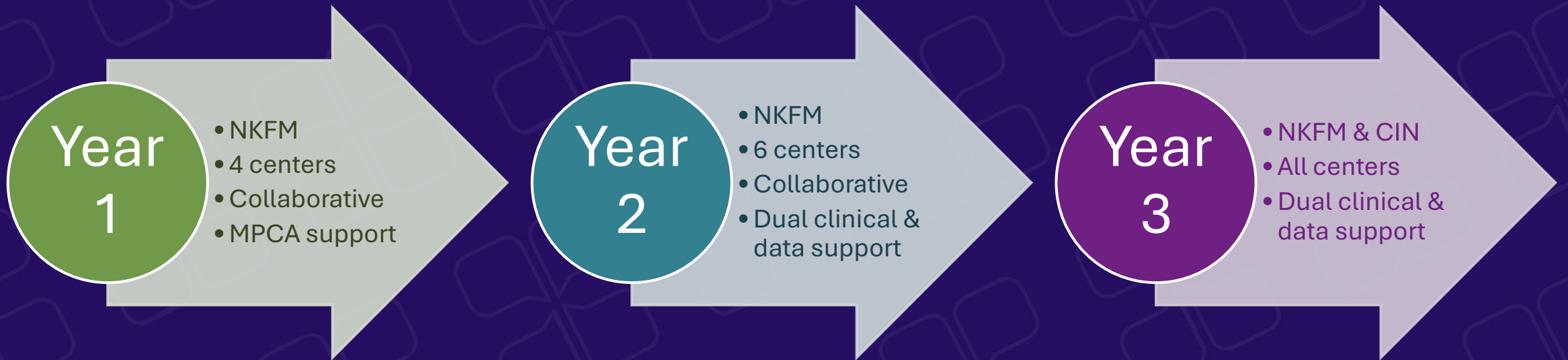


Kidney Profile Screening Trends Over Time – Medicaid Patients, Priority Centers



Wrap-up

Project Evolution Overview





**SUPPORTING MICHIGAN
HEALTH CENTERS**

Thank you

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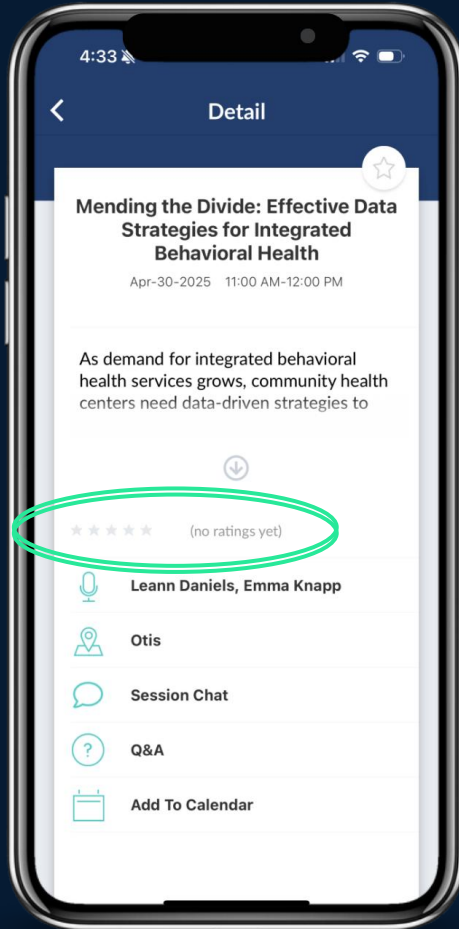


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Click the stars in the center of your screen to rate and provide feedback.



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