

Chronic Kidney Disease Dashboard Project

Overview & Information Session

SESSION #1

THURSDAY SEPTEMBER 28, 2023

Welcome!



Why CKD and Diabetes Matter

Motivation behind project



Minnesota Diabetes and CKD Improvement Initiative Project overview



CKD Dashboard

Overview



Audience Q & A



*This session is being recorded



CKD & Diabetes



Diabetes is the leading cause of kidney disease







Kidney disease progresses slowly, often with few symptoms

Sources.

American Diabetes Association. Diabetes, High Blood Pressure, and Chronic Kidney Disease (CKD). Retrieved from https://diabetes/chronic-kidney-disease/diabetes-high-blood-pressure-chronic-kidney-disease Centers for Disease Control and Prevention (2022). Diabetes and Chronic Kidney Disease. Retrieved from https://www.cdc.gov/diabetes/managing/diabetes-kidney-disease.html National Kidney Foundation. Social Determinants of Kidney Disease. Retrieved from https://www.cdc.gov/diabetes/managing/diabetes-kidney-disease.html Norton, J,M. et al (2016). Social determinants of racial disparities in CKD. J Am Soc Nephrol, 27(9): 2576-2595. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5004663/



CKD Prevention: **Screening**



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American Diabetes Association. Diabetes, High Blood Pressure, and Chronic Kidney Disease (CKD). Retrieved from https://diabetes.org/diabetes/chronic-kidney-disease/diabetes-high-blood-pressure-chronic-kidney-disease National Kidney Foundation (2023). Albuminuria. Retrieved from https://www.kidney.org/atoz/content/albuminuria National Kidney Foundation (2023). Albuminuria. Retrieved from https://www.kidney.org/atoz/content/albuminuria National Kidney Foundation (2023). Estimated glomerular filtration rate (eGFR). Retrieved from https://www.kidney.org/atoz/content/albuminuria National Kidney Foundation (2023). Estimated glomerular filtration rate (eGFR). Retrieved from https://www.kidney.org/atoz/content/gfr#about-estimated-glomerular-rate-egfr

Brock, Matt (2020). Kidney health: A new HEDIS measure. NCQA. Retrieved from: <u>https://www.ncqa.org/blog/kidneyhealth/</u>



CKD Prevention: Managing High Blood Pressure



Sources.

American Diabetes Association (2023). Standards of Care in Diabetes – 2023 Abridged for Primary Care Providers. Clinical Diabetes; 41(1): 4-31. Retrieved from https://diabetesjournals.org/clinical/article/41/1/4/148029/Standards-of-Care-in-Diabetes-2023-Abridged-for Healthy People 2030. Increase the proportion of adults with diabetes and chronic kidney disease who get ACE inhibitors or ARBs – CKD-05. Retrieved from https://health.gov/healthypeople/objectives-and-data/browse-objectives/chronic-kidney-disease/increase-proportion-adults-diabetesand-chronic-kidney-disease-who-get-ace-inhibitors-or-arbs-ckd-05

KDIGO (2021). Blood Pressure in CKD. Retrieved from <u>https://kdigo.org/guidelines/blood-pressure-in-ckd/</u>

National Kidney Foundation. Diabetes and Chronic Kidney Disease. Retrieved from: https://www.kidney.org/news/newsroom/factsheets/Diabetes-And-CKD



CKD Prevention: Managing Blood Glucose

Medication Overview



- SGLT-2 inhibitors (SGLT-2i) lower blood sugar and are effective in slowing progression of kidney disease.
- Although use is increasing, there is currently low use of SGLT-2i, GLP-1RAs in patients with diabetes and CKD (expensive).

Recommendations

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ADA/KDIGO guidelines:

- Initiate SGLT-2i for patients with type 2 diabetes who have diabetic kidney disease and eGFR >20.
- Non-steroidal MRA and GLP-1 receptor agonists are beneficial to reduce CV and CKD progression risk.

Currently...



- Black patients are less likely to receive SGLT-2i or GLP-1a, and Hispanic patients are less likely to get GLP-1a than white patients.
- Black patients are more likely to receive sulfonylureas and develop hypoglycemia.

Sources.

American Diabetes Association (2023). Standards of Care in Diabetes – 2023 Abridged for Primary Care Providers. Clinical Diabetes; 41(1): 4-31. Retrieved from https://diabetesjournals.org/clinical/article/41/1/4/148029/Standards-of-Care-in-Diabetes-2023-Abridged-for KDIGO (2022). Diabetes in CKD. Retrieved from https://diabetesiournals.org/clinical/article/41/1/4/148029/Standards-of-Care-in-Diabetes-2023-Abridged-for KDIGO (2022). Diabetes in CKD. Retrieved from https://diabetesiournals.org/clinical/article/41/1/4/148029/Standards-of-Care-in-Diabetes-2023-Abridged-for KDIGO (2022). Diabetes in CKD. Retrieved from https://diabetes-ckd/ KDIGO (2022). Diabetes in CKD. Retrieved from https://diabetes-ckd/ KDIGO (2022). Diabetes in CKD. Retrieved from https://diabetes-ckd/ KDIGO (2022). Diabetes in CKD. Retrieved from https://diabetes-ckd/ KDIGO (2022). Diabetes in CKD. Retrieved from https://diabetes-ckd/ KDIGO (2022). Diabetes in CKD. Retrieved from https://diabetes-ckd/ KDIGO (2022). Diabetes in CKD. Retrieved from https://diabetes-ckd/ KDIGO (2022). Diabetes in CKD. Retrieved from https://diabetes-ckd/ KDIGO (2022). Diabetes in CKD. Retrieved from https://diabetes-ckd/ KDIGO (2022). Diabetes in CKD. Retrieved from https://diabetes-ckd/ KDIGO (2022). Diabetes in CKD. Retrieved from <a href="https://di

National Kidney Foundation. Diabetes and Chronic Kidney Disease. Retrieved from: https://www.kidney.org/news/newsroom/factsheets/Diabetes-And-CKD

National Kidney Foundation. SGLT2 Inhibitors. Retrieved from: <u>https://www.kidney.org/atoz/content/sglt2-inhibitors</u>

Zhao, J.Z. et al (2021). Glucose-lowering medication use in CKD: Analysis of US Medicare beneficiaries between 2007 and 2016. Kidney Med. 3(2):173-182. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8039422/

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Minnesota Diabetes and CKD Care Improvement Initiative



Purpose

Develop and provide medical groups with analysis, data tools and support for improving screening, diagnosis and treatment of CKD in patients with diabetes



Funding

Funding to support this project has been provided by Bayer Healthcare Pharmaceuticals, Inc.

To ensure program integrity, MNCM is following its Guidelines for Engagement of Commercial Interests.





Dashboard Project Advisory Committee (DPAC) Phase 1



Committee Structure

Comprised of individuals with specific knowledge, experience or involvement in quality improvement activities as it relates to diabetes and CKD

Purpose

Make recommendations about data elements, metrics and data visualizations to be included in a dashboard tool, which will provide actionable data for medical groups to use in care improvement.



Goals

- Determine data elements/metrics to use in tool
- Finalize value sets to be used in calculations of metrics
- Determine data analyses made available in tool
- Provide input on design of evaluation plan

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CKD Dashboard

Brief Overview



What is it?

Data analysis tool created to support medical groups and clinics onboarded into PIPE system for tracking and assessing improvement efforts related to CKD prevention and treatment among patients with diabetes.



What's included?

Features several different analyses for nine metrics developed by the DPAC related to CKD prevention and treatment among patients with diabetes. Medical groups can also access patient-level gap reports, which will be available via MNCM's PIPE system.



Will this information be publicly reported?

No, this information will only be made available to participating medical groups and is intended to be used as a quality improvement tool.



Dashboard Release Schedule

| Dashboard Version | Date of Release | Metrics Included |
|----------------------|--------------------|---|
| vl | 11/21/2023 | Overall CKD Screening among Patients with Diabetes HbA1c Management among Patients with Diabetes Blood Pressure Management among Patients with Diabetes |
| v2 | 2/27/2024 | Overall CKD Screening among Patients with Diabetes HbA1c Management among Patients with Diabetes Blood Pressure Management among Patients with Diabetes Prescription for ACE/ARB among Patients with Diabetes and Hypertension Prescription for SGLT-2 Inhibitor among Patients with Type 2 Diabetes and CKD Prescription for Non-Steroidal MRA among Patients with Type 2 Diabetes and CKD |
| v3 | 5/21/2024 | Overall CKD Screening among Patients with Diabetes HbA1c Management among Patients with Diabetes Blood Pressure Management among Patients with Diabetes Prescription for ACE/ARB among Patients with Diabetes and Hypertension Prescription for SGLT-2 Inhibitor among Patients with Type 2 Diabetes and CKD Prescription for Non-Steroidal MRA among Patients with Type 2 Diabetes and CKD Follow-up UACR among Patients with Diabetes Follow-up eGFR among Patients with Diabetes Missing Diagnosis of CKD among Patients with Diabetes and Abnormal Labs |



Dashboard v1 Metrics

Release Date: 11/21/2023

Overall CKD Screening

Percentage of patients 18-75 years of age who had a diagnosis of type 1 or type 2 diabetes who had the following within the measurement period:

- At least one eGFR and one UACR
- At least one eGFR but no UACR
- At least one UACR but no eGFR
- No UACR and no eGFR

Each eligible patient would be placed in one of the categories above.

HbA1c Management

Percentage of patients 18-75 years of age who had a diagnosis of type 1 or type 2 diabetes whose most recent HbA1c within the last 12 months was:

- HbA1c < 7.0%
- $7.0\% \leq HbA1c \leq 7.9\%$
- $8.0\% \leq HbA1c \leq 8.9\%$
- HbA1c ≥ 9.0%
- HbA1c not present

Each eligible patient would be placed in one of the categories above.

BP Management

The percentage of patients 18-75 years of age who had a diagnosis of type 1 or type 2 diabetes whose most recent blood pressure within the measurement period was:

- BP < 130/80
- BP < 140/90
- BP <u>></u> 140/90
- BP <u>> 160/100</u>
- BP not present

Eligible patients could be placed in more than one category.



Dashboard v2 Metrics

Release Date: 2/27/2024

The following metrics will be added to the dashboard in version 2:

Rx for ACE/ARB

The percentage of patients 18-75 years of age who had a diagnosis of type 1 or type 2 diabetes AND hypertension on their problem list/encounter who are prescribed an angiotensin-converting enzyme inhibitor (ACE) or an angiotensin receptor blocker (ARB), unless contraindication of angioedema.

Rx for SGLT-2 Inhibitor

The percentage of patients 18-75 years of age who had a diagnosis of type 2 diabetes and chronic kidney disease on their problem list/encounter with an eGFR ≥ 20 who are prescribed a sodium-glucose transport protein 2 (SGLT-2) inhibitor medication.

Rx for Non-Steroidal MRA

The percentage of patients 18-75 years of age who had a diagnosis of type 2 diabetes and chronic kidney disease on their problem list/encounter with an eGFR ≥25 who are prescribed a non-steroidal mineralocorticoid (MRA) medication.



Dashboard v3 Metrics

Release Date: 5/21/2024

The following metrics will be added to the dashboard in version 3:

Follow-up UACR Screening

The percentage of patients 18-75 years of age who had a diagnosis of type 1 or type 2 diabetes who had an elevated UACR (≥30 mg/g creatinine) with repeat follow-up UACR within the following time intervals: 3 months; 6 months; 9 months; 12 months.

Percentages will be provided for each time interval.

Follow-up eGFR Screening

The percentage of patients 18-75 years of age who had a diagnosis of type 1 or type 2 diabetes who had an eGFR <60 <u>with</u> repeat follow-up eGFR within the following time intervals: 3 months; 6 months; 9 months; 12 months.

Percentages will be provided for each time interval.

Missing Dx of CKD

The percentage of patients 18-75 years of age who had a diagnosis of type 1 or type 2 diabetes who had two elevated UACRs (≥ 30 mg/g creatinine) and/or two reduced eGFRs (< 60) within 3-6 months of each other <u>without</u> a diagnosis of chronic kidney disease (CKD) on their problem list/encounter.



Featured Analyses

Medical Group/Clinic Performance by Metric



NOTE: This is a mock-up of Dashboard and not the final version; design may be slightly different in final.

- Medical groups will only be able to see their medical group and clinics in the selection menu
- Data will be refreshed quarterly



| Month End Option | 2021 | | | | | | | | | | | 2022 | | | | | | | | | | | |
|---------------------|-----------------------|-----|-----|----------------------|-----|-----|-------|-----------------------|-----|-----|-----|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| | Jan | Feb | Mar | Apr | Мау | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | Мау | Jun | Jul | Aug | Sep | Oct | Nov |
| Dec 2021 | 1/1/2021 - 12/31/2021 | | | | | | | | | | | | | | | | | | | | | | |
| Mar 2022 | | | | 4/1/2021 – 3/31/2022 | | | | | | | | | | | | | | | | | | | |
| June 2022 | | | | | | | 7/1/2 | 7/1/2021 - 6/30/2022 | | | | | | | | | | | | | | | |
| Sept 2022 | | | | | | | | 10/1/2021 - 9/30/2022 | | | | | | | | | | | | | | | |

..etc...

- Data will be refreshed quarterly, but will still use 12-month measure periods
- Oldest data available will be 2021 dates of service and go forward until project end



Featured Analyses

Medical Group/Clinic Performance by Metric and Demographic Variable



NOTE: This is a mock-up of Dashboard and not the final version; design may be slightly different in final.

- Medical groups will only be able to see their medical group and clinics in the selection menu
- Data will be refreshed quarterly
- Stratification variables include:
 Race
 - Ethnicity
 - Language (English vs Non-English)
 - Country of Origin (U.S. vs Not U.S.)
 - Age Group
 - Diabetes Type
 - o Sex
 - Payer Type



Featured Analyses

Peer Comparisons



NOTE: This is a mock-up of Dashboard and not the final version; design may be slightly different in final.

- Medical groups will be able to:
 - View unblinded performance rates by metric for all participating medical groups
 - View up to four medical groups at a time.
 - Choose which medical groups to compare.
- Medical groups will <u>not</u> be able to:
 - View clinic level performance rates of other medical groups
 - View medical group/clinic performance rates by demographics of other medical groups
- Data will be refreshed quarterly



Participating in the Dashboard



Who can participate?

Any medical group onboarded into MNCM's PIPE system will be able to opt-in to the CKD Dashboard. There is no cost for medical group participation.



When can medical groups participate?

There will be three periods (or, cohorts) in which medical groups can opt-in to the dashboard:

- Cohort #1: 11/21/2023 11/18/2025
- Cohort #2: 5/21/2024 11/18/2025
- Cohort #3: 11/19/2024 11/18/2025

Dashboard closes on November 18, 2025



How do medical groups opt-in to the dashboard?

Medical groups will need to enroll in the project and sign an amendment to their existing Data Use Agreement (DUA) with MNCM to authorize MNCM to include their data in the dashboard.



Accessing the Dashboard





Learning Collaborative Sessions



What are the Learning Collaborative sessions?

To provide a space for participating medical groups to share their experiences as it relates to quality improvement in CKD and learn from one another.

Updates related to the dashboard tool will also be provided during these sessions.



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When will the Learning Collaborative sessions take place?

Learning collaborative sessions will take place quarterly once the dashboard has been launched. Below are the tentative dates (may be subject to change):

- LC #1: 1/30/2024 LC #5: 1/28/2025
- LC #2: 4/30/2024 LC #6: 4/29/2025
- LC #3: 7/30/2024 LC #7: 7/29/2025
- LC #4: 10/29/2024 LC #8: 10/28/2025

All sessions will be recorded and sent to participating groups after each session. A library of all past sessions will also be available to medical groups, regardless of cohort.





Q & A

To ask a question, please raise your hand or type question within the chat







Register for second recruitment session <u>here</u>

This will be an open session for medical groups to share what they have learned in preparing for the launch of the dashboard. MNCM staff will also answer any additional questions.

- Enroll in project <u>here</u>
- MNCM staff will send out session slides, session recording and FAQ document

For additional questions, please contact Jess Donovan at donovan@mncm.org

