Dallas Nephrology Associates: Value-Driven Healthcare: Quality Outcomes, Cost Efficiency, and Wellness for All

2025 AMGA Acclaim Award Honoree

Dallas Nephrology Associates is an honoree of the 2025 AMGA Acclaim Award. As part of the Acclaim Award application process, healthcare organizations are asked to submit narratives describing major systemwide initiatives that exemplify the goals of the award. One of the narratives from Dallas Nephrology Associates' application is summarized below.

Dallas Nephrology Associates
Kidney Care Excellence Since 1971

Dallas Nephrology Associates (DNA) is a national leader in creating person-centered value-based care in nephrology, with a focus on innovation and patient choice. North Texas's first private nephrology practice, DNA has grown to 106 physicians and 25 advanced practitioners serving the Dallas-Fort Worth metroplex. For over 50 years, DNA has been a trusted source of information and education resulting in quality kidney care.

As an Acclaim Award honoree, DNA was recognized for the following initiatives:

- Adding personnel to serve as "Navigators" for patients with chronic kidney disease (CKD) to help create optimal health outcomes
- Creating person-centered, value-based care in nephrology by implementing provider and staff education programs on population health management
- Developing a value-based, "outcome-focused" alternative payment approach to pay for kidney health, not kidney failure, to better manage patients and improve outcomes
- Sponsoring a variety of initiatives to support employees' physical and emotional health, workforce satisfaction, and career progression, such as Manager Retreats, a Helping Hands program, and volunteer opportunities

Narrative: Nurse Navigator Program

CKD disproportionally affects minority populations and those with lower-than-average income and education, and >90% of DNA's patients also have multiple comorbidities. Thus, their healthcare is delivered by numerous specialists, primary care, and multidisciplinary support services. This often leads to disjointed, uncoordinated, and duplicative management and can leave patients feeling confused and overwhelmed.

DNA cares for patients across the Dallas-Fort Worth metroplex, incorporating >32 primary care practices, 115 dialysis clinics, 83 hospitals, two vascular centers, and four transplant programs. They realized that to achieve a value-based care system, they would need to apply a coordinated, proactive, and consistent approach to identifying and managing patients with Stage 4–5 CKD. By employing a holistic, patient-centered "Navigator" program across all clinics and providers, DNA believed they could improve patient outcomes, reduce the total cost of care, and develop stronger provider commitment. This forward-thinking idea required a substantial financial and resource investment along with a complete culture shift across the entire organization.

The Nurse Navigator would coordinate care across the healthcare continuum and explain the rationale for the planned treatment pathway.

The objective was to design a system whereby each step of the patient pathway was clearly mapped and staff responsibilities allocated. A Nurse Navigator would be assigned to each of 12 offices, supporting primary care practitioners to identify patients approaching Stage 4 CKD so they could be referred to specialist services in a timely manner. They would also ensure that any comorbidities that could affect the progression of their kidney disease were well managed to slow the development of disease and hopefully delay the need to start renal replacement therapy. As patients' disease inevitably progresses, the Navigators would engage patients and their families in an education program to help them understand their condition, available treatment options, and the social and psychological implications of living with kidney failure. DNA envisioned that Navigators would also support patients with the transplant application process, assist with dialysis choices, and refer them to surgeons for timely dialysis access placement. These services would ensure a planned start to treatment and avoid the use of risky, temporary vascular access.

However, this was uncharted territory. As a new concept in nephrology, there were no benchmarks or policies to research and then incorporate into the design of the service. This would be a complete culture change for the organization and all of their providers and support agencies. DNA had some big challenges.

Profile of the Nurse Navigator

Above all, DNA needed to ensure that they recruited the most appropriate people into the role of Nurse Navigator. Fundamentally, Nurse Navigators would need to be the patients' advocates and educators. Their role would require them to be resourceful and collaborative, ensuring that the multidisciplinary team and appropriate third-party services were involved in the patients' care in a timely manner. This would require

good listening skills, flexibility, empathy, and the ability to work proactively using their own initiative. To achieve positive outcomes, DNA believed the clinical competency of Nurse Navigators would be vital for success and would strengthen their credibility. They would need to be able to clinically assess patients and understand both the anatomy and physiology of renal disease (including its pharmacology), and the social and psychological aspects of care.

Overall, the Navigator role would be to coordinate care across the healthcare continuum and explain the rationale for the planned treatment pathway. For all of these reasons, DNA decided to recruit and employ licensed nurses to the role of Navigator. Although they are more expensive than unqualified staff, the organization was confident they would be the most clinically and cost-effective option. Once recruited, all Navigators would receive comprehensive training and education on their role, value-based-care, the clinical outcomes they aim to achieve, and how these would be measured.

Patient Activation Measurement enables the Nurse Navigator to assess the patient's knowledge, skills, willingness, and confidence to manage their condition.

Data Collection and Analytics

If DNA were to be successful in delivering outcomes-driven, high-quality, value-based care, they would need to measure the impact of their interventions. Thus, they needed to develop multiple IT platforms for use by the Nurse Navigators, physicians, Nurse Managers, and other individual staff roles. Building these platforms was a challenge for the Clinical Informatics and Analytics Departments. For example, they needed to create a new field for a "Navigator Note" within the electronic health record and devise a method for Nurse Navigators to keep track of patient surveys required and completed, clinic referrals, biochemical and clinical test results. Navigators were trained on the importance of accurate and consistent data collection, as they would be the lynchpin to keeping track of value-based metrics and monitoring success.

Staff Training and Culture Change

Staff training and education on the role of the Nurse Navigator was multifaceted and needed to be delivered to everyone involved in patient care and support. This included administration and reception staff, primary care and specialist clinicians, and DNA's management team, physicians, and nurses. Appropriate training was developed for each role. The shift from a fee-for-service to a value-based care model required a substantial amount of education to all staff and providers. DNA had to develop their understanding of the philosophy of reimbursement for the quality of care versus volume of clinical activity, and how the role of the Nurse Navigator was an essential component of the model. Fully utilizing the Nurse Navigators required a clear process, enhanced patient flow, and ultimately, changes to practice and culture.

Standardization

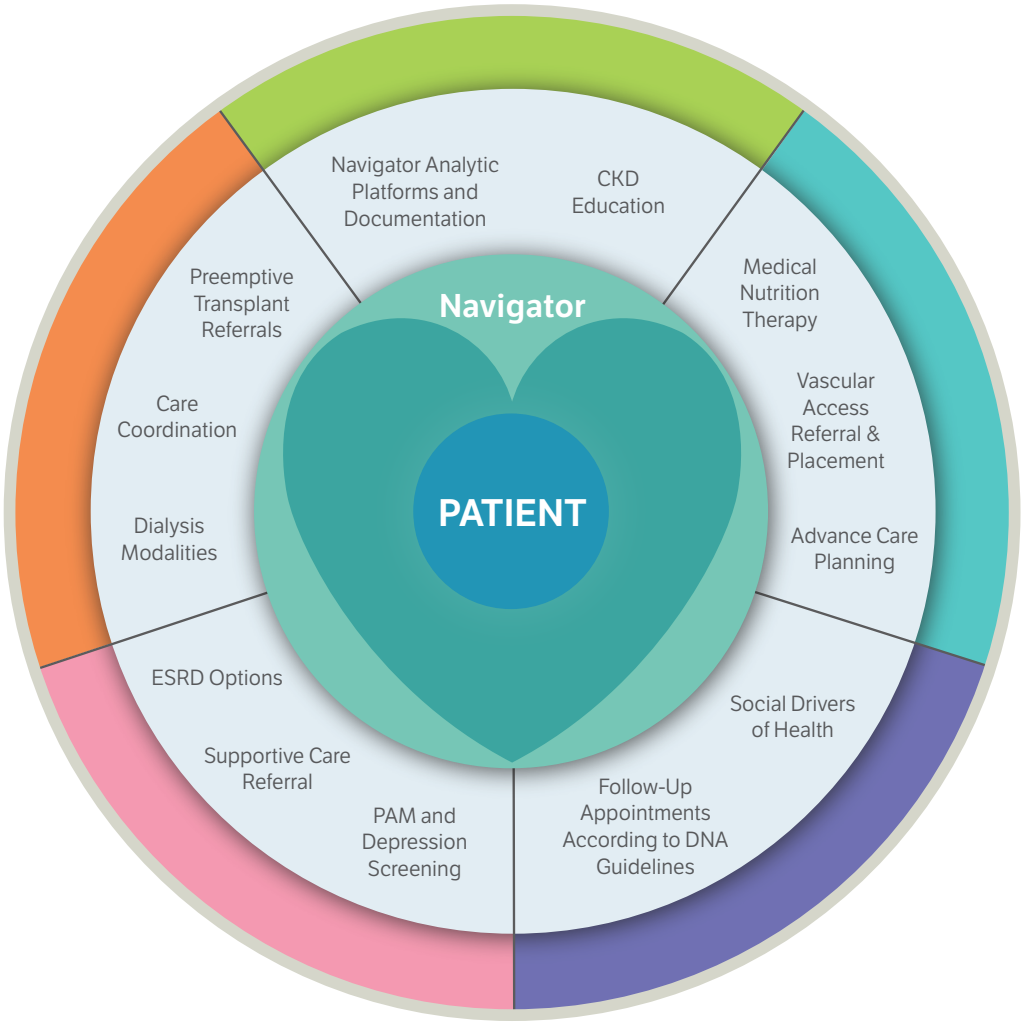
DNA believed that a standard approach to the delivery of care across all clinics, offices, and providers would be the simplest way to ensure consistent high-quality care. While many aspects of standardization were easily achievable (e.g., development of job descriptions, policies, protocols, Nurse Navigator annual

performance review requirements), the implementation into some areas was challenging. Each provider had their own preferences with regard to the Nurse Navigator relationship, and these preferences needed to be accommodated. This included different communication styles, patient care preferences, and social skills. Other challenges included physician adherence to Nurse Navigator guidelines that outline patient visit intervals; ordering of CKD education and nutritional therapy; and preparation for discussions around transplant, dialysis, and advanced care planning.

The Nurse Navigators are now embedded into the organization and are supported by a Team Leader. Navigators are focused on ensuring patients have access to all the resources they require to ensure compliance with their recommended treatment. Ultimately, they provide patient-centered care to help them overcome barriers to positive health outcomes. This involves face-to-face interactions with patients and their families, along with correspondence and coordination with outside agencies and resources. Nurse Navigators assess patients' risks from different perspectives, not only physical. They administer surveys to assess a patient's mental health and their ability to be engaged in their own care.

The Patient Activation Measurement (PAM) is a crucial part of patient's ongoing management. It enables the Nurse Navigator to assess the patient's knowledge, skills, willingness, and confidence to manage their condition. The PAM tool is made up of 13 questions, the answers to which determine the patient's

Figure 1: Patient-Centric Nurse Navigator Role



"activation" score, ranging from 1 to 4. Level 1 represents patients who are disengaged and overwhelmed; level 2 represents patients who may recognize they could do more but lack the confidence or knowledge to change behaviors. Those at levels 3 and 4 are taking action and maintaining behaviors, even under pressure. Being able to identify patients who are not well activated gives the team the opportunity to develop an action plan and provide the help and resources required for improvement. The measurement is repeated after six months to assess the impact of interventions and review the plan. To date, the main issues identified are multiple comorbidities that have overwhelmed the patient, understanding their role in their care and what adjustments need to be made, understanding their medications, and expressing to the Nurse Navigator and provider what they do not understand.

The Team Lead Navigator collects all the data and analytics relating to the Nurse Navigator duties. This information is used at weekly meetings, when challenging cases and successful changes to processes and patient care are discussed. In addition, she runs a monthly meeting to discuss all nonoptimal starts with the Nurse Navigators and the Value-Based-Care Medical Director. Each case is considered openly, areas for improvement are identified, and success stories are shared. The Team Lead also provides educational support to the Nurse Navigators and acts as a resource in clinics.

Results

A multidisciplinary approach and patient-centered care is at the heart of the Nurse Navigator role (see Figure 1), and the success of the program has been overwhelming. Since the role was introduced, DNA has increased the percentage of patients with a planned start to dialysis from 44% in 2020 to 73% by the end of 2023. Transplantation referrals have increased from 26% to 61%. Referral of patients with Stage 4 CKD to educational workshops increased from 39% to 71%, and referral to medical nutrition therapy increased from 32% to 56%.

DNA now has 92% of PAM surveys completed by patients with CKD, and follow-up interventions have led to improved patient adherence with education and nutritional therapy, better understanding and support from families, and an overall improvement in compliance with care.

AMGA Acclaim Award

The AMGA Acclaim Award honors healthcare delivery organizations that are bringing the American healthcare system closer to the ideal delivery model – one that is safe, effective, patient-centered, timely, efficient, and equitable.

AMGA's prestigious Acclaim Award highlights the continued research and investigation toward finding the finest models of medical management, coordination of care delivery, and a systemic approach to improving the patient and provider experience.

Henry Ford Health has been named AMGA's 2025 Acclaim Award recipient. For their accomplishments, Dallas Nephrology Associates and WellSpan Health were named Acclaim Award honorees.

The 2025 Acclaim Award finalists were:

- BJC ACO
- Mayo Clinic
- Mercy Medical Group
- Northwell Health
- Ochsner Health
- Southwest medical Associates
- SSM Health
- SSM Health Oklahoma

For more information about applying for the 2026 Acclaim Award, visit **amga.org/acclaim**.