MINISTRY OF HEALTH
MANATŪ HAUORA

Chronic Kidney Disease Consensus Statement

Helen Rodenburg

MINISTRY OF HEALTH

6/11/2014

MINISTRY OF HEALTH
MANATŪ HAUORA

Vision:

New Zealanders living with Long Term Conditions can expect:

- High quality, patient focussed care
- That is **integrated** across the health system
- And to be regarded as leading partners in their care

Patient Centred Care

"Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions."

IOM (Institute of Medicine)

MINISTRY OF HEALTH
MANATŪ HAUORA

Integrated Care

"The Management and delivery of health services so that clients receive a continuum of preventive and curative services according to their health needs over time and across different levels of the health system"

WHO 2008

Chronic Kidney Disease Consensus Statement

The reasons for development include:

•The rising incidence and prevalence of ESKD.

•The need to improve identification and management of CKD in Primary Care

•The need for effective national screening of at risk patient groups

•The need for broad implementation of patient-centred strategies in Primary Health Care to manage most patients with CKD

Chronic Kidney Disease Consensus Statement

Guidelines for the management of CKD are well established
Implementation of best practice for CKD in primary care settings is challenging for several reasons:

•Variable implementation of decision-support tools based on current guidelines
•The complexity of incorporating detection and management of CKD into primary practice patterns
•The skills and work load required for effective collaboration with patients to make significant lifestyle changes
•The need for a focused case-management approach in high risk patients with progressive CKD

Chronic Kidney Disease: Identification

Detection and management of chronic kidney disease (CKD) requires a systematic approach in primary care,
This includes adding *serum creatinine* and *urinary albumin:creatinine ratio* to current laboratory tests when they have not been otherwise documented.
High risk groups require earlier assessment.

CKD should be classified *by stage 1 to 5* and as *stable or progressive*

Chronic Kidney Disease: Management

- People with *stable CKD stages 3-4* are at >20% 5 year CVD risk (with diabetes) or >15% 5 year CVD risk (without diabetes).
They need appropriate CVD risk management.
- People with *progressive CKD stages 3-4* (rate of loss GFR > 5 ml/min/yr) have even higher CVD risk and a much higher risk of developing renal failure with need for dialysis or transplant.
Intensive management is required to reduce risk with weekly or fortnightly risk factor management and review until stable.
- The great majority of patients, particularly those with *stable Stage 3 CKD* or *who are older (>75years) with early stable Stage 4 CKD*,
can be fully managed in primary care, noting that prescribing of medication should be carefully considered.

Chronic Kidney Disease: Enablers/monitoring

Software based decision support, audit and recall systems for best practice. Bpac tool to be available

Example: Nurse-led clinics to manage high risk CKD patients
A primary care nurse managing a group of high risk CKD patients through regular clinics:

- that are identified in the primary care practice
- using an individualized programme with each patient
- supported by specialist secondary care nursing,
- as well as both primary and specialist medical expertise
- aiming to improve identified risk factors for these patients.