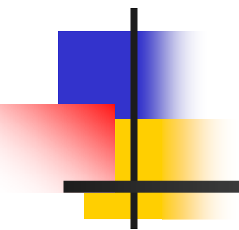
STEP-DOWN CLINIC AND OTHER NEW MODELS FOR CKD CARE



Dr. Nancy Craven

Vancouver Island Health Authority
Collaboratives Program

THE TRADITIONAL MODEL

- Family doctor discovers (often late) that patient has decreased renal function
- Additional tests are done to diagnose cause of CKD
- Patient is referred to nephrologist
- Nephrologist takes over care

PROBLEMS WITH THIS MODEL

- The number of new cases of CKD is growing and exceeds capacity of nephrologists to see all of them, and continue to see all of them
- Waiting time for appointments is getting longer
- Patients may have further decline in renal function while they wait

- Improved tools for GPs to monitor their patients
- Practical education for GPs to manage their CKD patients better
- Improved communication between GPs and specialists
- Return stable patients back to GP with a care plan

EDUCATION ENHANCING COMMUNICATION

- 1-hour small group case discussion to be held in renal conference room
- GPs each select a CKD case and fax info in advance to nephrologist
- Nephrologist prepares relevant slides, handouts
- Group discusses cases and has time to see renal unit afterwards

EXAMPLES OF EXISTING TOOLS FOR FAMILY DOCTORS

- BC MOH on-line toolkit
- Electronic Medical Records (recall reports, trend plots, decision support)
- Uniform lab reporting of eGFR
- Care plan templates for complex patients (+new BCMA fee structure)

The Expanded Chronic Care Model: Integrating Population Health Promotion

BRITISH COLUMBIA | Ministry of Health

BC Renal Agency

BRITISH COLUMBIA MEDICAL ASSOCIATION

CHRONIC KIDNEY DISEASE
COLLABORATIVE FLOW SHEET/ ENCOUNTER FORM

♦ = MANDATORY FIELDS

♦ PATIENT NAME	♦ HEALTH # (E.G. BC PHN)	♦ DATE OF VISIT (DD-MMM-YYYY)

♦ BIRTHDATE (DD-MMM-YYYY)	♦ GENDER ☐ MALE ☐ FEMALE	♦ PHONE (INCLUDE AREA CODE)	CHART NUMBER

PRACTICE TEAM ID	♦ PROVIDER ID (MSP PRACTITIONER NUMBER / NAME)

CO-MORBID CONDITIONS

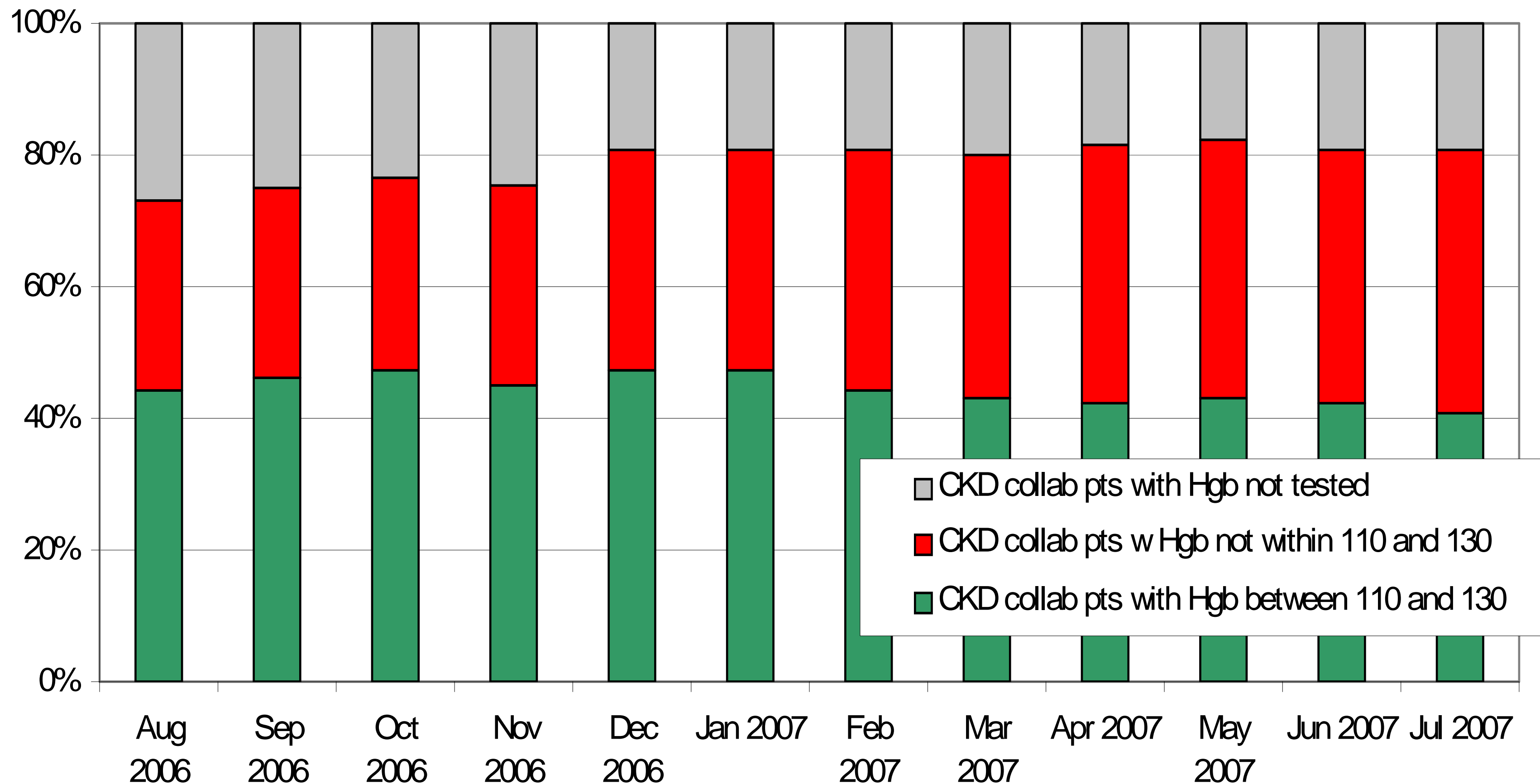
☐ ALCOHOL OVERUSE	☐ CARDIOMYOPATHY	☐ DIABETES	☐ LIVER DISEASE	☐ SUBSTANCE ABUSE
☐ ARTHRITIS	☐ CHF	☐ HEPATITIS C	☐ OBESITY	☐ VALVULAR HD
☐ ASTHMA	☐ COPD	☐ HYPERTENSION (HTN)	☐ OTHER RHYTHM PROBLEM	☐ OTHER
☐ ATRIAL FIBRILLATION	☐ CAD	☐ KIDNEY DISEASE	☐ PERIPH. VASC. DISEASE	
	☐ DEPRESSION	☐ LIPID ABNORMALITY	☐ SMOKING	

♦ DIAGNOSIS: TYPE OF KIDNEY DISEASE	DATE OF DIAGNOSIS (DD-MMM-YYYY)
☐ DIABETES ☐ HYPERTENSION ☐ POLYCYSTIC KD ☐ OTHER	

PATIENT ENCOUNTERS, DIAGNOSTIC/CLINICAL DATA, BY DATE

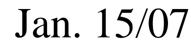
✔ = RECALL

REVIEW			MOST RECENT DATA			NEW DATA
EVERY VISIT	PHYSIOLOGY	Blood Pressure < 130/80				ENTER VALUE /
EVERY VISIT	PHYSIOLOGY	Weight BMI Target: Stable (18.5 - 24.9)				☐ LBS ☐ KG ☐ FT IN ☐ CM - or - BMI:
6 MONTHS	KIDNEY FUNCTION	eGFR Target: Stable (< 10% reduction per year)				ENTER VALUE
6 MONTHS	KIDNEY FUNCTION	ACR ≥ 50% reduction from Baseline Microalbumin Screen (Albumin: creatinine ratio) For CKD, normal range = 2-20 M, 2.8-28 F				ENTER VALUE OR ☐ POS ☐ NEG
3 MOS	SUGAR	A1C Target: < 7% (< 0.070)				ENTER VALUE
ANNUALLY OR AS INDICATED	LIPID PROFILE	LDL-C *< 2.5 mmol/L High Risk; < 3.5 mmol/L Moderate*				ENTER VALUE
ANNUALLY OR AS INDICATED	LIPID PROFILE	Ratio (TC/HDL) *< 4.0 High Risk; < 5.0 Moderate*				ENTER VALUE
ANNUALLY OR AS INDICATED	ANEMIA	Hgb Target: >110 g/L				ENTER VALUE
ANNUALLY OR AS INDICATED	ANEMIA	TSAT Target: >20%				ENTER VALUE
ANNUALLY OR AS INDICATED	MINERAL METABOLISM	Calcium Target: > 2.1 mmol/L				ENTER VALUE
ANNUALLY OR AS INDICATED	MINERAL METABOLISM	Phosphorus Target: 0.8 - 1.4 mmol/L				ENTER VALUE
ANNUALLY OR AS INDICATED	MINERAL METABOLISM	iPTH in Normal Range *Target 3.85-7.70 picomols/L if eGFR between 30 & 60*				ENTER VALUE


Patients of CKD Collab Physicians with last eGFR <50 and
Hgb tested (and between 110 and 130) in previous 12 months
100%
80%
60%
40%
20%
0%
Aug 2006
Sep 2006
Oct 2006
Nov 2006
Dec 2006
Jan 2007
Feb 2007
Mar 2007
Apr 2007
May 2007
Jun 2007
Jul 2007
CKD collab pts with Hgb not tested
CKD collab pts w Hgb not within 110 and 130
CKD collab pts with Hgb between 110 and 130
VIHA CDM Collaborative Meeting 12 September 2007

QUALITY IMPROVEMENT FEEDBACK IN **VIHA** COLLABORATIVE

- GPs may sign an authorization for medical lead to view their patient data
- GPs then grant access on-line to their patients in CKD sub-group
- Medical lead views data extremes, completeness, adherence to guidelines and provides confidential feedback



Jan. 15/07

Dear ,

Thank you for returning the authorization and granting me access to your CKD patients on the toolkit.

After reviewing the 2 patients with eGFRs <50, the data seems complete and up to date.
I can't tell if these patients have had an ultrasound to r/o any obstruction or other surgically treatable causes of renal impairment. This may be something you would consider if not done already.

I see that N___ B___ has come to the clinic for an education session, and you may want to offer this to E______ E_____ as well. Just call our receptionist at 370-8224.

Please feel free to contact me if you have any questions about these or other kidney patients.

Sincerely,
Nancy Craven, MD

Complex Care Plan Template

Initial Planning Date: ______________________________

Patient Name: ____

Condition #1: ______________________________ **Condition #2:** ______________________________

Diagnostic Code: ______________________________

Patient Values/Goals: ____

____

____

____

Plan for Management of Co-Morbid Conditions:

____

____

____

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____

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____

Linkage with other Heath Care Professionals:

____

____

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Discussed with AHP: ______________________________

Expected Outcomes:

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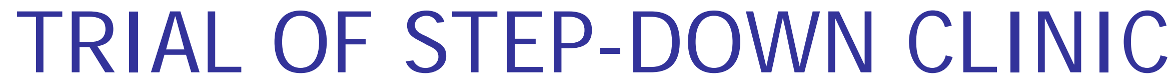
Time frame for Re-Evaluation: ____

Discussed with: Patient ______________________________ **Representative:** ______________________________

TRIAL OF STEP-DOWN CLINIC



- One nephrologist, 6 GPs
- Patients had been referred and followed for > 1 year by nephrologist
- Patients had stable GFR and other parameters; suitable for return to GP
- Consent by GP and patient

STEP-DOWN CLINIC PROCEDURES

- One patient appt. with liaison GP in Kidney Care Clinic
- Review of patient's concerns, key medical issues, lab results, meds
- Brief exam, BP measurement
- Completion of Care Plan form, with copies to patient, GP and file

KIDNEY CARE STEP-DOWN CLINIC

CARE PLAN

Patient: **DOB:** **Copies to:**
Family Doctor:

Date Seen:

eGFR:

PATIENT'S CONCERNS/ISSUES

-
1.
2.
3.
4.

MAJOR CURRENT MEDICAL ISSUES

-
1.
2.
3.
4.

CARE PLAN

-
Goals:

Lab test monitoring:

Cautions/risks:

- Shared care service agreements between GPs and specialists
- Group visits (1 physician/allied health provider seeing several patients at once)
- Satellite CKD clinic in rural community
- Telehealth consultations