North Island Kidney Clinic

Why & How it Works

&

What we Do

(and you can do it too!)

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The Goal

- To empower clients with renal insufficiency to actively participate in the self-management of their condition with the intent of inhibiting kidney decline and promoting cardiovascular health.

The ‘Why’

- The cost of Chronic Kidney Disease to individual clients and to society, as a whole, can be significantly reduced by early diagnosis and intervention.
- The quality of life for our clients can be maintained or improved with appropriate intervention.

Background

- We are a family practice clinic, Valley Care Medical, based out of Courtenay, B.C.
- 6 full time MDs, 2 part time MDs.
- Another full time MD starting in October.
- 1 Nurse Practitioner, 2 RNs, office staff.

How do renal clients come to our program?

- Based on a referral system from clinic MDs.
- Marlene's 'finds' from locum position.
- Erica's own client population.
- Currently, we are only providing this service to clients of Valley Care Medical clinic.

Criteria for Referral to Us:

- GFR < 60ml/min per 1.73m2
- And/or Proteinuria

Structure of our Program

- Individual visits
- Group visits

Individual Visits

- 1st visit with the NP.
- Involves: Making the client aware

> reviewing GFR/Creat results with the client and observing trends.

> giving tremendous amounts of reassurances.

: Assessment for Etiology of CKD

> Client interviewing

> Completion of H&P

Individual Visits: 1st Visit

- Involves: Sending the Client for Renal bloodwork and ultrasound.
  > explain the need for testing.
  > ensure client's understanding.

: Providing the client with <u>important</u> yet <u>small</u> amounts of written literature.

2nd Visit

- This visit is with Marlene.
- Prior to the visit Marlene completes a full chart and laboratory review. She identifies the need for Nephrology referral if necessary.
- At the client visit: confirmation of Dx
  review of lab results
  plan of care started with
  client input.

3rd Visit

- This visit will be with Marlene again if etiology remains unclear or the client complexity is high.
- The visit may be back with the NP again if the etiology is clear.

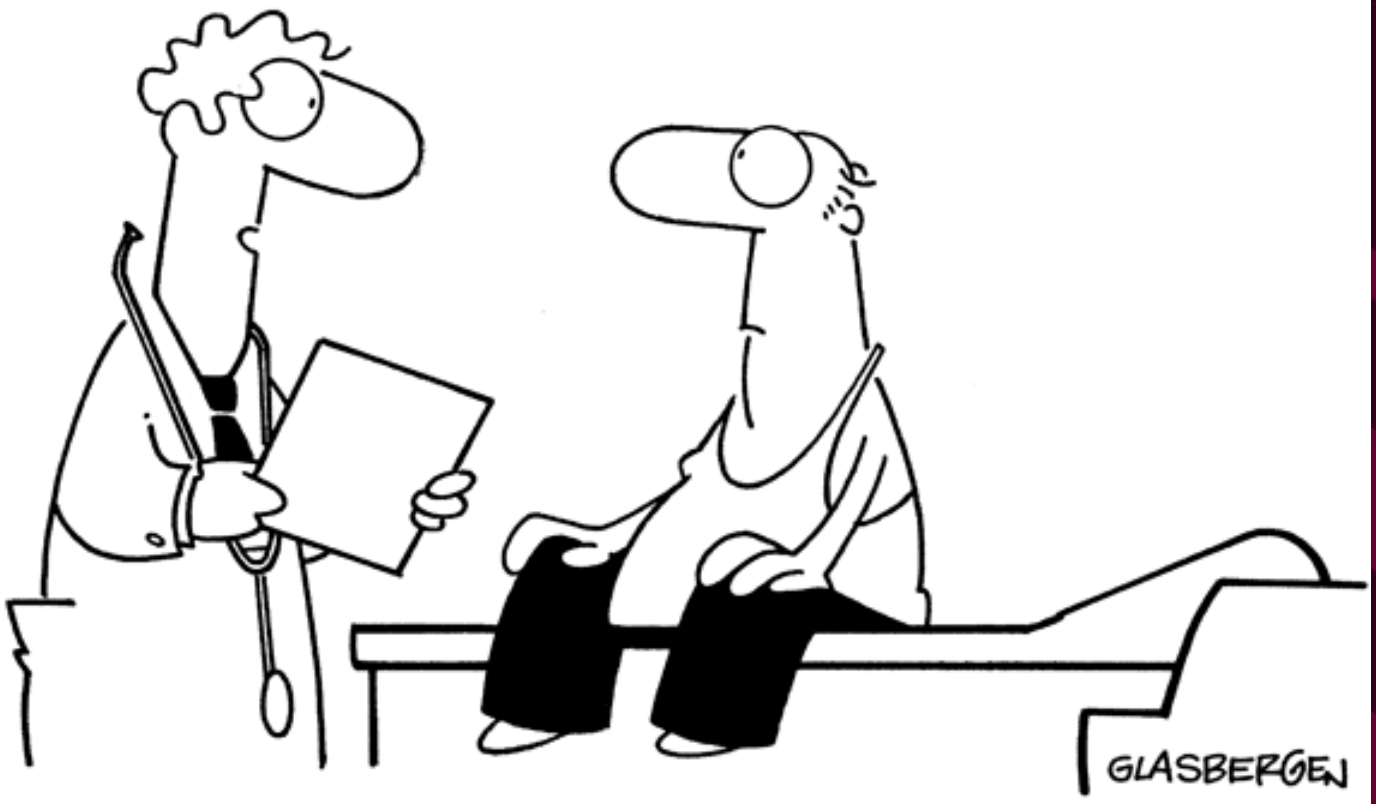
Remainder of Visits

- The number is dependent on individual client needs. Usually 2-3 more.
- These visits will be with the NP.
- Focus is on education and self-management.
- Concentration on: Cardiovascular health
  Importance of exercise
  Dietary Considerations
  Mineral Metabolism
  Psychological Well-being

Why so many Visits?

- These visits increase self management and therefore decreases the need for long visits with their GPs.
- And why is this important??????

  So this doesn't happen…….



**"After age 40, all food is bad for you.
Learn to chew air and eat rocks."**

Group Visits

- We hold group visits every Tuesday AM.
- Currently we have three different ‘groups’.
- Our clients were placed into groups according to their GFRs such that a commonality would be established.
- Usually have 8-10 clients per group.
- We discuss what is important to the group. They decide the agenda.

Follow Up

- Our clients are able to access Marlene or myself during designated scheduled times throughout the week.
- All clients are contacted on a Q3 month basis either by Marlene or myself.
- We do use the CDM Toolkit to aid in client recall
- And of course, follow up is ongoing with their family GP. We have a EMR in our office that allows for easy access to all care provided and recommendations during KCC visits.

Guidelines for Us

- Nephrology Referral:

  GFR < 30 or > 10% decrease annually.

  U-ACR > 20-28 or > 10% increase annually.

  Active urinary sediment.

Guidelines we use and you can too!

- BP <130/80 or 125/75 if diabetic
  - Record at every visit
  - Use ACE/ARB + diuretic + others
  - Quit smoking
- Decrease Proteinuria
  - Use ACE/ARB
  - Check Q6months
- Avoid nephrotoxic drugs

More Guidelines

- A1C < 7%
  Check Q3-6months
- LDL < 2.5mmol/L & Ratio < 4.0
  Consider statins
  Recheck annually
- Hgb > 110g/L
  Treat with oral iron prn
  If not responding, consider Nephrology referral.

More Guidelines

- Renal Osteodystrophy monitoring

  Calcium > 2.2mmol/L

  Phosphorus < 1.4mmol/L

  Parathyroid Hormone < 7.7pmol/L

  (if GFR 30-60)
- Albumin 35-50g/L
- Vaccines up to date such as influenza, Hep B if seronegative and pneumococcal.

Wrap Up

- We continue to provide our service as the demand is great.
- Our colleagues have remarkably high rate of satisfaction with the service.
- The clients are feeling ‘taken care of’ with the degree of individualized care they receive.
- And probably one of the most important points, we are delaying the progression of CKD. Our preliminary data statistics are very encouraging.

You can do this too.

- Thanks for listening.
- We’ll be taking questions at the end of the session.