GFR Reporting: Experience-UK

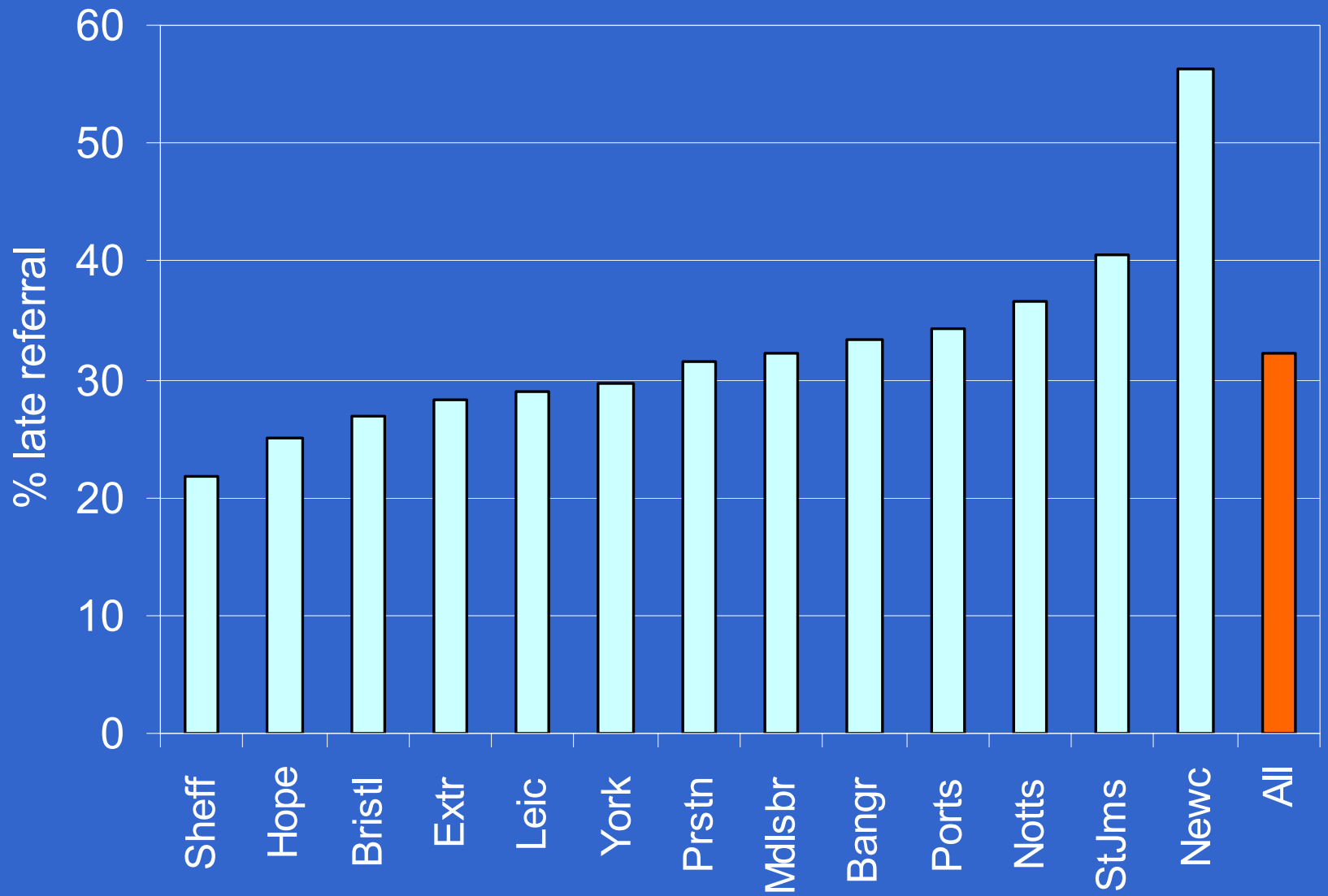
Dr Donal O'Donoghue
Co-Chair Renal Advisory Group

KDIGO – Controversies Conference
The Renaissance, Amsterdam
October 2006

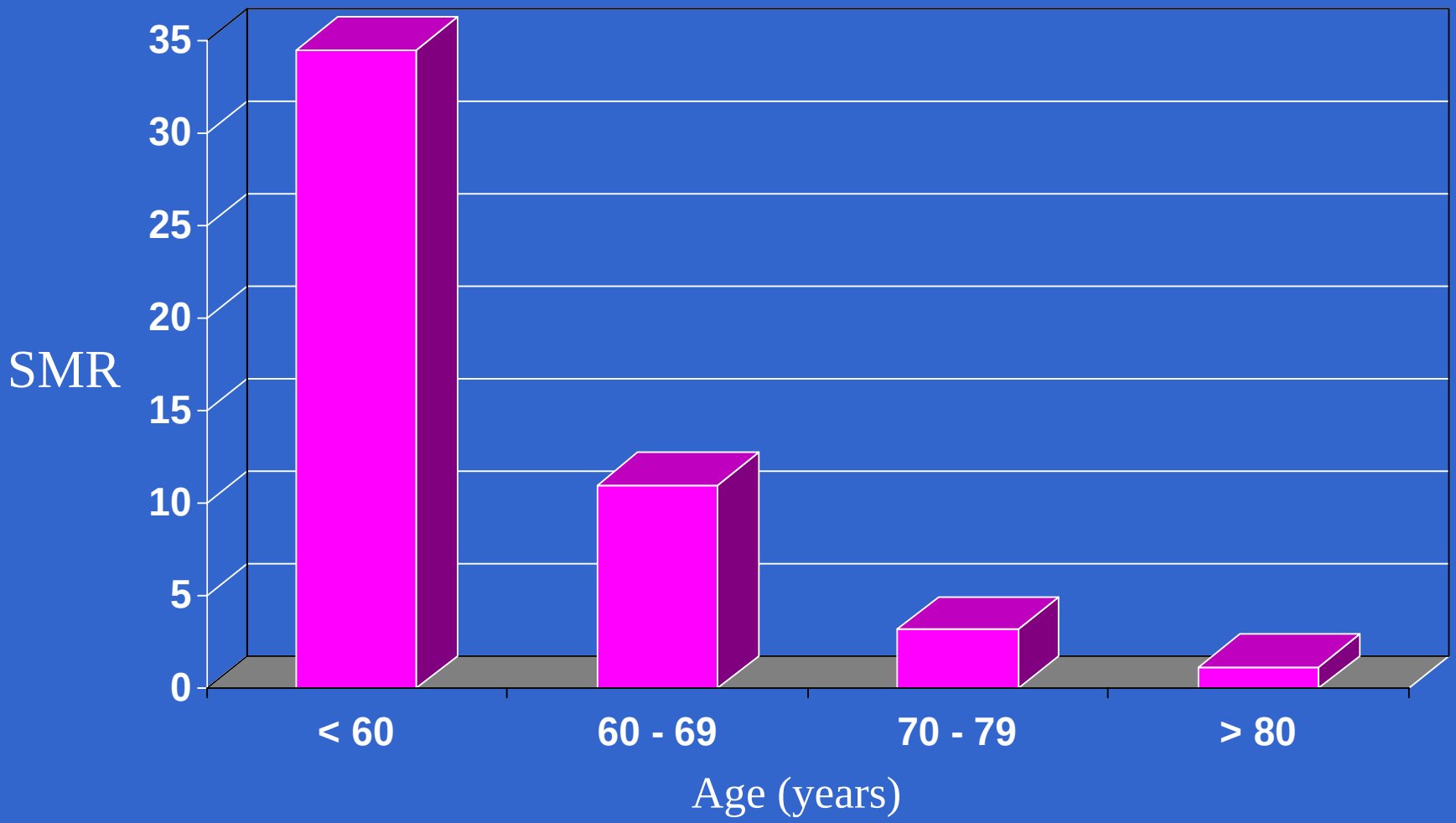
GFR Reporting: Experience-UK

- Background
- Policy Drivers
- eGFR Reporting
- IntegratedCare

Percentage late referrals (< 3months) by centre 2002

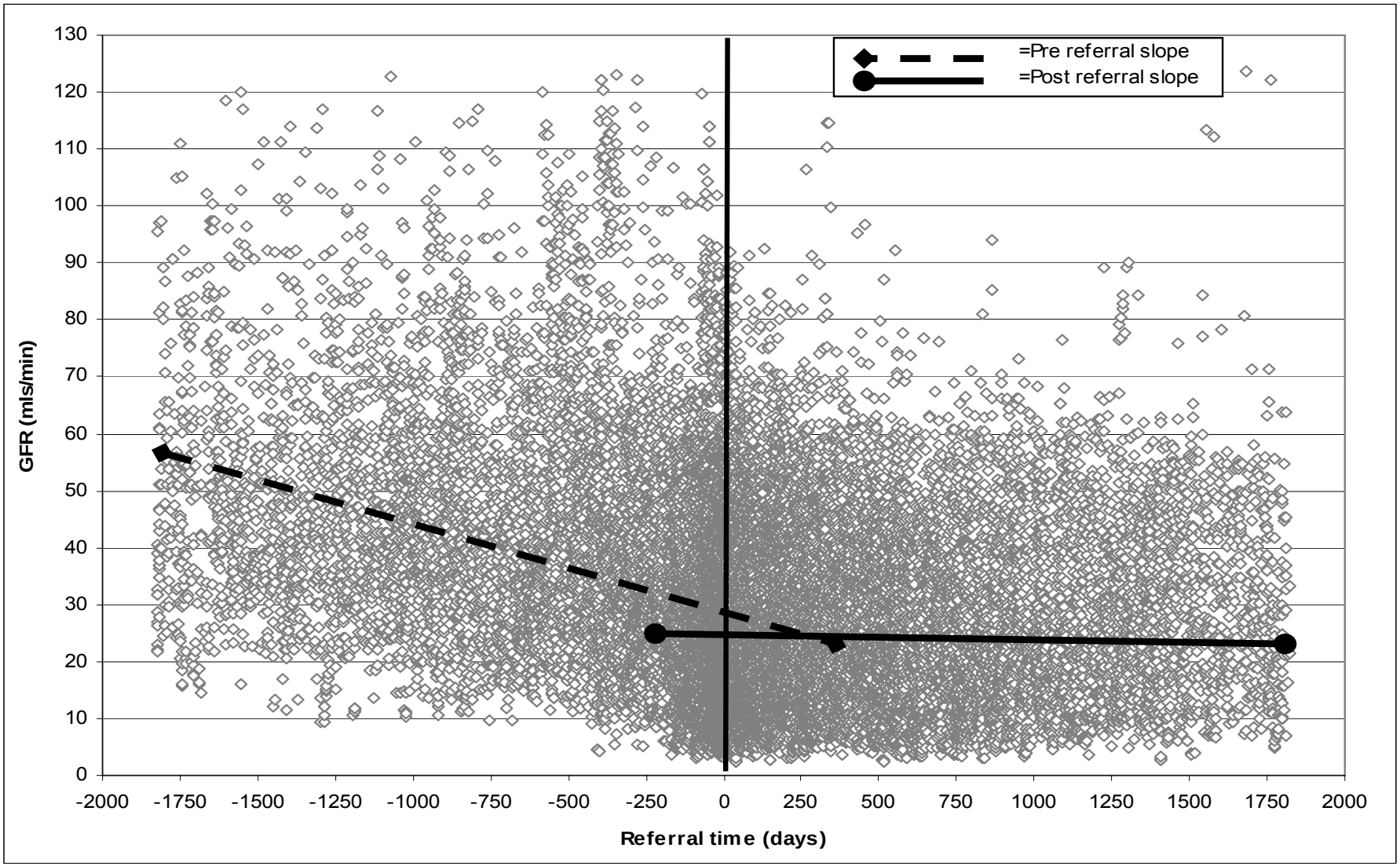


Unreferred CKD: Standardised Mortality

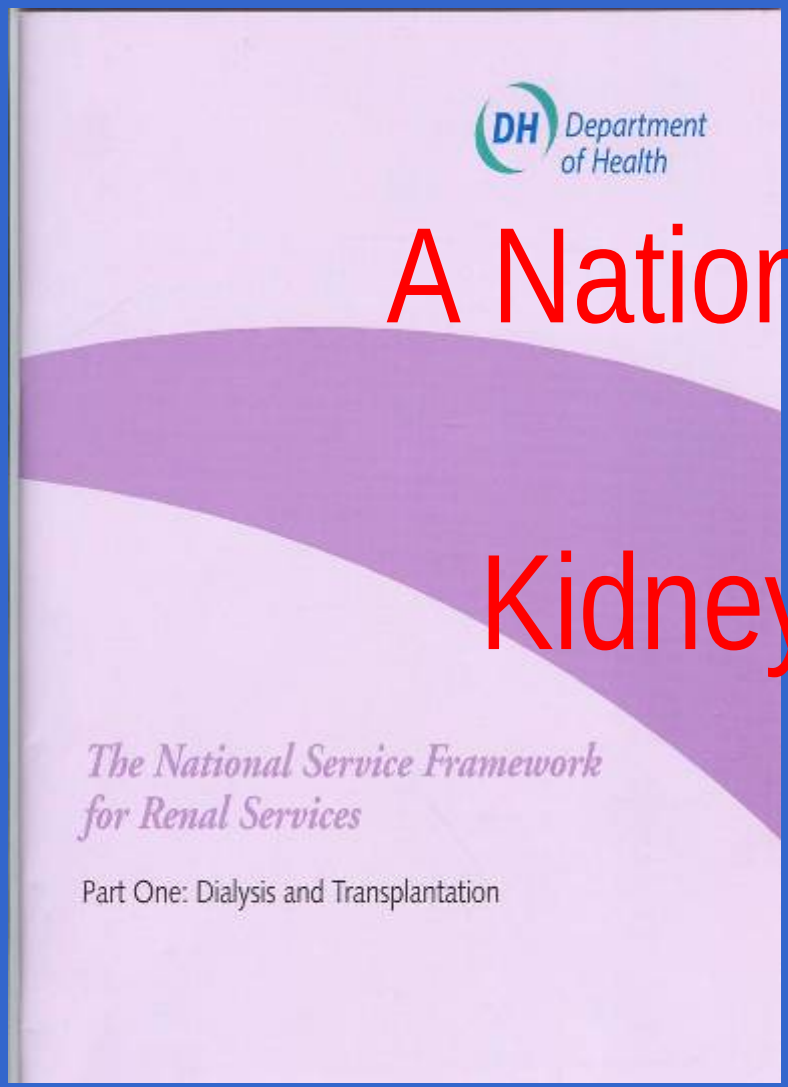


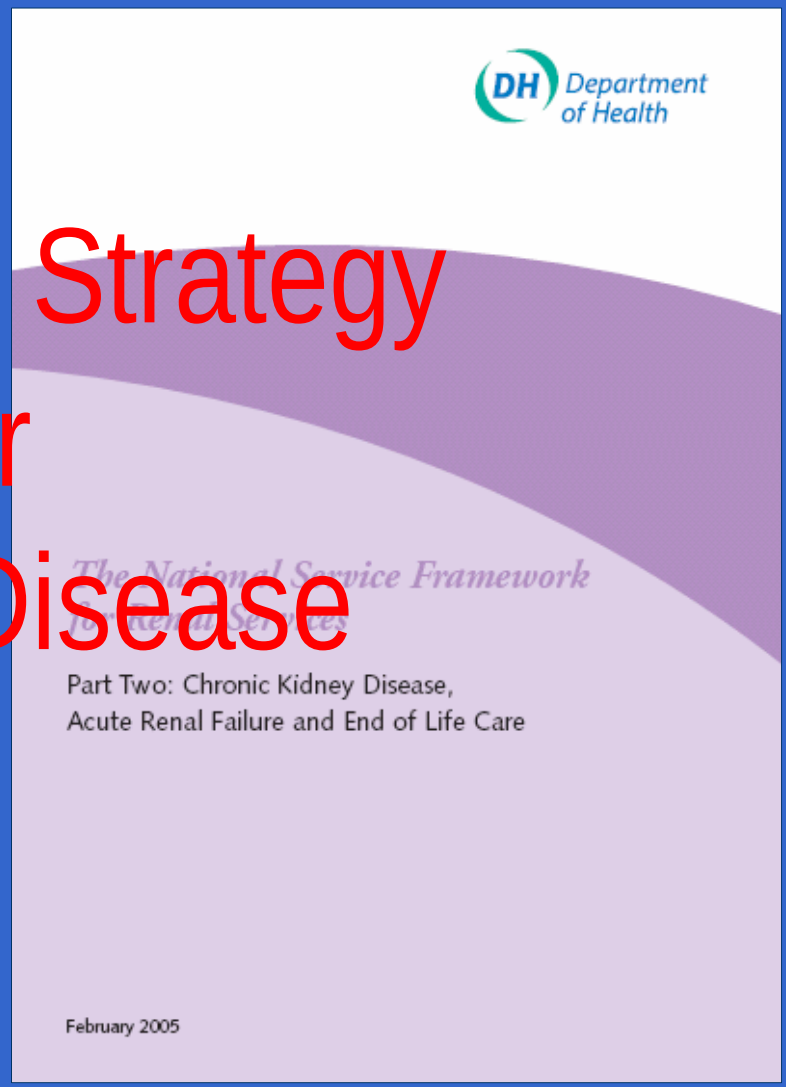
John et al. AJKD 2004;43(5):825–35

Survival following Nephrology referral in a thousand patients with Stage 3-5 CKD



Jones C et al Renal Association 2004





A National Strategy for Kidney Disease

Minimising the Progression and Consequences of CKD

- Integrated care pathways
- Early identification
- Testing kidney function

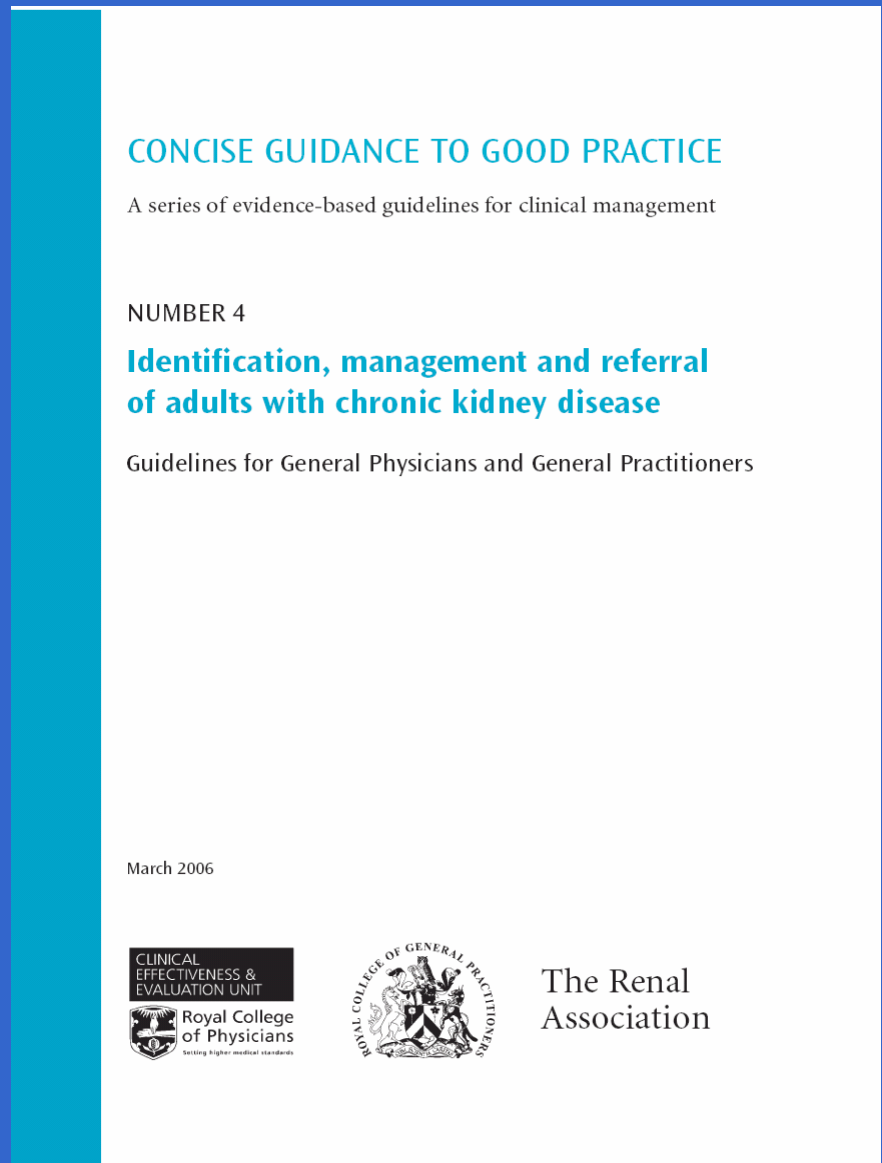
“eGFR calculated and reported automatically by all laboratories”

Renal NSF Part 2 Feb 2005

UK CKD guidelines

- Developed by the RCPL/RA Joint Specialty Committee with
  - RCGP
  - Diabetes UK
  - British Geriatrics Soc
  - Association of Clinical Biochemists
  - Society for DGH Nephrologists

Burden R, Tomson C. Clin Med 2005; 5: 635


CONCISE GUIDANCE TO GOOD PRACTICE

A series of evidence-based guidelines for clinical management

NUMBER 4

Identification, management and referral of adults with chronic kidney disease

Guidelines for General Physicians and General Practitioners

March 2006

CLINICAL EFFECTIVENESS & EVALUATION UNIT

Royal College of Physicians

ROYAL COLLEGE OF GENERAL PRACTITIONERS

The Renal Association

UK CKD Guidelines

- Report 4v MDRD eGFR
- CKD 3 Management
  - Check GFR/Hb/Potass/Cal/Phos/Bicarb 6/12ly
  - If Dipstick urinalysis positive – ACR or PCR
  - Target BP <130/80mmHg or <125/75mmHg if proteinuria (PCR>100mg/mmol)
  - CVD risk factor management
  - Immunization
  - Regular review to avoid nephrotoxic drugs

Renal Management and Referral Guidelines for Adults with Chronic Kidney Disease

Greater Manchester Renal Managed Clinical Network
West Sector
NHS

Staging classification of Chronic Kidney Disease		
1	GFR ≥ 90ml/min	Other marker of kidney damage such as albuminuria/haematuria/ structural abnormality also required
2	GFR 60-89ml/min	
3	GFR 30-59ml/min	No other marker of kidney damage required
4	GFR 15-29ml/min	
5	GFR ≤ 15ml/min	

CKD STAGE 3

? NEW DIAGNOSIS
- Review previous eGFR
- Review previous creatinine - calculate eGFR: http://cgi.www.renal.org/cgi-bin / www.renal.org/eGFR/GFR.pl
- If no previous result and clinically well repeat test within 2/52
- If no previous results and clinically unwell repeat in 5/7

CKD STAGE 4&5
Refer (urgently in stage 5) if clinically indicated

For further advice see http://www.renal.org/CKDguide/ckd.html

INITIAL ASSESSMENT OF CKD 3

Hx multi-system disease e.g.SLE, family hx, lower urinary tract symptoms

Multisystem disease, family hx of renal disease

Ex heart failure, hypovolaemia, sepsis, bladder enlargement

Medication management review potentially nephrotoxic drugs (NSAID's,mesalazine,lithium,ciclosporine) For safe use of ACEI see Tip 2 overleaf

BP and cardiovascular assessment

Malignant HT

URGENT ADMISSION

$K^+ \geq 6.5$mmol/l

Ca, Phosphate, K, Cholesterol, FBC

Urine dipstick for proteinuria and haematuria
PCR

PCR >100mg/mmol
PCR>45mg/mmol +haematuria
Micro or macroscopic haematuria

Renal USS if suspicion of stones, lower urinary tract symptoms, malignancy or family history of polycystic kidney disease

Long term management of CKD

Unwell with deterioration in eGFR >25%

URGENT ADMISSION

Fall in GFR > 5ml/min in 12/12
Fall in GFR >15% after ACEI/A2RB
Hb <11g/dl
K^+>6mmol/l
Phosphate >1.6mmol/l on ≥ 2 occasions
Ca <2.1mmol/l on ≥ 2 occasions

PCR >100mg/mmol or PCR>45mg/mmol +haematuria

BP >150/90mmHg on > 3 agents

REFER TO NEPHROLOGY

Information required for referral

Dates and results of previous renal function measurements
PMHx and drug hx
BP
Urine dipstick and PCR
FBS, Bicarbonate, Calcium, Phosphate, Albumin
Renal USS

eGFR Read Code:415E

CKD STAGE 3 MANAGEMENT PATHWAY

6 monthly eGFR, Ca, Phosphate, K, FBC

12 monthly urine PCR if proteinuria, haematuria, glomerulonephritis, diabetes, or reflux nephropathy

Target BP <130/80mmHg or <120/75mmHg if PCR >100mg/mmol
Lifestyle measures
ACEI/ARB 1st line if CCF, proteinuria or diabetes

CVD risk factor management
Lifestyle measures
Statins and Aspirin if 10yr risk of CV disease > 20%

Influenza/pneumococcal vaccine

Regular medication review to minimise nephrotoxic drugs eg NSAID's

Classification | Referral criteria | Management pathway | Patient evaluation | Investigation | Treatment

1001-06/Amsterdam121006

Date of preparation March 2006. For Review September 2007

Implementation and Harmonisation of eGFR - UK

Report field creatinine and eGFR

4 – variable ID-MS traceable version of MDRD equation

UK NEQAS – derived slope adjusters for correction

When eGFR exceeds 89 report as >90

All adult samples requesting creatinine

UK NEQAS

April 2006

The CKD Domain of QOF

	Points	Payment Stages
CKD 1 A register of patients aged 18 years and over with CKD (Stage 3-5 CKD)	6	
CKD 2 Percentage of patients with a record of blood pressure in the previous 15 months	6	40-90%
CKD 3 Percentage of patients with a BP of 140/85 or less	11	40-70%
CKD 4: Percentage of patients who are treated with an ACEi and ARB (unless a contraindication)	4	40-80%

April 2006

GPs to Shoulder the Burden of CKD

Renal units impose tough new referral guidelines and plan to shunt patients back to GPs

Specialists prepare to dump kidney workload on GPs

EXCLUSIVE

By Daniel Cressey

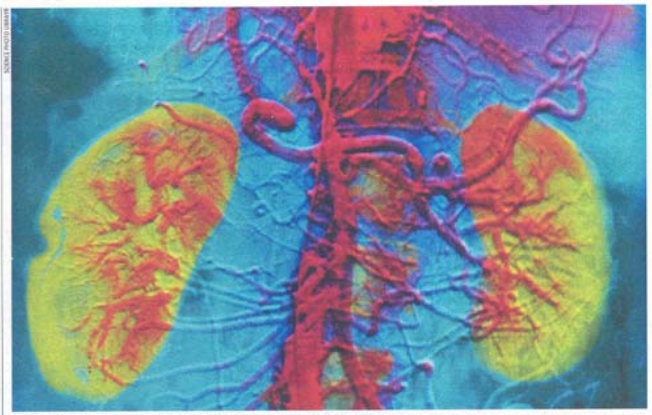
GPs will be forced to take back up to half of their renal patients currently treated by specialists – and must brace themselves for many new referrals to be bounced back.

Renal units across the UK are drawing up tough new referral guidelines aimed at forcing GPs to shoulder the soaring workload from chronic kidney disease.

GPs face having to treat a high proportion of the 10 per cent of patients set to be diagnosed with CKD under the QOF – including potentially complex cases.

A Pulse survey of 43 renal departments reveals every single one is predicting a surge in referrals as a result of the QOF. More than 90 per cent are introducing new guidelines aimed at blocking GP referrals judged to be inappropriate.

Guidelines will insist patients are only referred if a low eGFR is in decline for several months or accompanied by factors such as haematuria – with GPs first expected to attempt to hit stringent 130/80mmHg BP targets.



GPs face having to manage a high proportion of the 10 per cent of patients set to be diagnosed with CKD under QOF

How renal units are mobilising

100% expecting increase in GP referrals

100% introducing new guidelines

95% seeking to 'more clearly define' GP referrals

85% planning to send current patients back to GPs

Source: Pulse survey of 43 renal departments

Some 85 per cent of renal units plan to shunt back to GPs patients they are currently managing to clear the decks for more complex cases.

Professor Neil Turner, consultant in nephrology at Edinburgh Royal Infirmary, said his department had already seen a 'significant increase' in referrals since the introduction of eGFR in January. 'Many have been dealt with by a letter suggesting management in primary care. In anticipation of the increased number of new referrals we have discharged many stable patients who were under occasional review.'

North Staffordshire Hospital said it would be sending 'up to half' its general nephrology patients back to GPs.

Dr David Ansell, director of the UK Renal Registry in Bristol, said the new guidelines were 'definitely not' an over-reaction. 'Even if you double or triple the number of nephrologists you are not going to be able to cope with the influx from GPs unless most are managed in primary care.'

But GPs said it was 'unacceptable' to block referrals because of lack of capacity and questioned whether they had the expertise to manage large numbers of CKD patients.

Dr John Givans, secretary of North Yorkshire LMC, said: 'We are not in the game of having secondary care dumped on to general practice without additional resources.'

Additional reporting by Anna Hodgekiss

dcressey@cmpi.biz

▶ Comment, back page

May 11th, 2006

Quality Outcomes Framework: BP Recording 2005-06

- BP 4 (BP recorded in last 9 months) – 94%
- CHD 5 (BP recorded in last 15 months) – 97%
- DM 11(BP recorded in last 15 months) – 98%
- Stroke 5 (BP recorded in last 15 months) – 100%

Kidney workload fears 'unfounded'

Adam Legge

MORE THAN 90% of patients with chronic kidney disease (CKD) will already be on another cardiovascular disease register, say primary care renal specialists.

Concerns that the quality and outcomes framework's CKD requirements would swamp GPs were unfounded, they said, adding that almost all the points could be achieved simply by merging patient details from other registers.

GP Dr Ian Wilkinson, Oldham PCT's renal clinical champion, analysed his list and found 97% of patients with CKD grade 3 or higher were already on registers for hypertension, diabetes, CHD or stroke.

He said: 'I've just looked over my first year's QOF data, and found the work we were already doing would have got us 26 out of the 27 CKD points.'

Dr Donal O'Donoghue, clinical director of renal medicine at Hope Hospital in Salford, and chairman of the DoH renal advisory group, said: 'We've done some work with local practices and found they can get 25 out of the 27 points by merging other registers.'

The data, presented at the British Renal Society conference in Harrogate, were supported by other information from Newcastle upon Tyne GP Dr Steve Blades, the RCGP representative on last year's UK chronic kidney disease guidelines committee.

He told *Doctor*: 'In our practice, we've found that 85% of patients with an estimated glomerular filtration rate [eGFR] under 60 are already under treatment for hypertension, diabetes, stroke or ischaemic heart disease.'

There have been concerns that 10% of practices' populations could be diagnosed with CKD based on eGFR – twice the figure expected by the GPC.

But Dr Wilkinson said: 'There has been a misunderstanding of the data – the QOF includes only patients from CKD stage 3 to 5, which is about 5% of the population.'

GPs have also been debating whether referral rates to renal specialists would soar, with nephrologists bouncing large numbers of patients straight back to GPs. Dr Wilkinson said: 'I've talked to dozens of nephrologists over the past couple of weeks and, although there's a feeling referral rates will rise, no one's expecting a wholesale dumping of patients back to primary care.'

He said any GP using the UK CKD referral guidance would have a strong argument against a referral being bounced back.

Dr Blades added: 'There's bound to be some rebalancing in the system. Although I can see where some of the current worry has come from, I think there has been a little bit of unnecessary hype.'

UK CKD referral guidance

eGFR of 60-89: Referral not required unless other problems are present

eGFR of 30-59: Routine referral if:

- Progressive GFR falls or creatinine increases
- Microscopic haematuria
- Urinary PCR less than 45mg/mmol
- Unexplained anaemia, or abnormal potassium, calcium or phosphate
- Suspected systemic illness, such as SLE
- Uncontrolled BP (>150/90 on three agents)

eGFR of 15-29: Urgent referral

eGFR of <15: Immediate referral

Dr doctor@rbi.co.uk

THE TIMES

24 July 2006

A success in the fight against renal failure

"An eGFR will now become as much part of the GP's medical check as a patient's haemoglobin, blood count, blood sugar, cholesterol levels and, of course, their blood pressure."

Who Looks After The Patients (%)

	Primary Care	Nephrology	Secondary care
CKD 3	84.6	1.6	13.9
CKD 4	57.2	28.8	14.0
CKD 5	19.8	70.0	10.1

Demystifying and Managing Chronic ~~Kidney~~ Vascular Disease