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 (< 3 months) by centre 2002

% late referral
Unreferred CKD: Standardised Mortality

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

The National Service Framework for Renal Services

Part One: Dialysis and Transplantation

Part Two: Chronic Kidney Disease,
Acute Renal Failure and End of Life Care

February 2005
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


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
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
INITIAL ASSESSMENT OF CKD 3

- **Hx multi-system disease e.g. SLE, family hx, lower urinary tract symptoms**
- **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**
- **Ca, Phosphate, K, Cholesterol, FBC**
- **Urine dipstick for proteinuria and haematuria PCR**
- **Renal USS if suspicion of stones, lower urinary tract symptoms, malignancy or family history of polycystic kidney disease**

**URGENT ADMISSION**
- Malignant HT
- K+ > 6.5 mmol/l
- BP > 150/90 mmHg on > 3 agents

**REFER TO NEPHROLOGY**
- **PCR > 100 mg/mmol or PCR > 45 mg/mmol + haematuria**
- **PCR > 100 mg/mmol PCR > 45 mg/mmol + haematuria**
- **Micro or macroscopic haematuria**
- **BP > 150/90 mmHg on > 3 agents**

**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

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

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

April 2006
## The CKD Domain of QOF

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

April 2006
GPs to Shoulder the Burden of CKD

Specialists prepare to dump kidney workload on GPs

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

EXCLUSIVE

By Darrell 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 mounting 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 Pole survey of 45 renal departments reveals every single one is predicting a surge in referrals as a result of the QOF. More than 50 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 QOF 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.

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 the QOF 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 Anderson, director of the UK Renal Registry in Bristol, said the new guidelines were "definitely not" an overreaction. "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 Grieve, secretary of North Yorkshire LMC, said: "We are not in the game of having secondary care dumped on us in general practice without additional resources."

Additional reporting by Anna Hodgson.
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.’

May 16, 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.”
<table>
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<tr>
<th></th>
<th>Primary Care</th>
<th>Nephrology</th>
<th>Secondary care</th>
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<tbody>
<tr>
<td>CKD 3</td>
<td>84.6</td>
<td>1.6</td>
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<td>CKD 4</td>
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<tr>
<td>CKD 5</td>
<td>19.8</td>
<td>70.0</td>
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Demystifying and Managing Chronic Kidney Disease

- Education
- Empowerment
- Encouragement

Cultural Change

QOF

- Registration
- Recall
- Review

Integration

Information Technology

Information

eGFR = % Kidney Function