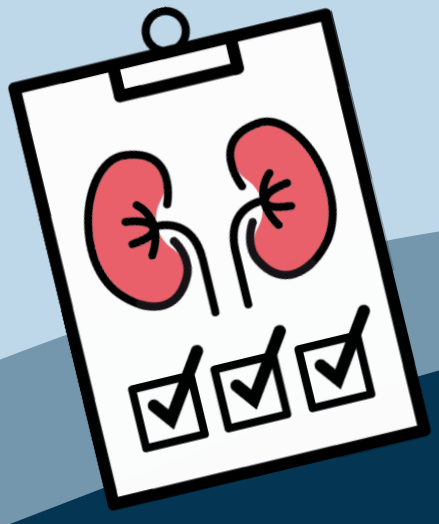

CKD Assessment Made Easy

Use this guide to spot simple opportunities to add Kidney Health Checks into everyday practice workflows

Opportunistic approach

1. Prompt all patients to complete a risk assessment while waiting for their appointment – discuss their results with the GP.
2. During a regular consult, use the risk factor check list or risk assessment cards to identify people with risk factors for CKD.
3. Complete a blood pressure check.

For people with risk factors for CKD:

- Refer the person for a Kidney Health Check - blood test (eGFR), urine test (uACR) and a blood pressure check.
- Book a review appointment for test result discussion.

Planned approach

Utilise existing systems or clinics where people are already visiting the practice for routine health checks. Add a Kidney Health Check – think:

- Diabetes clinics or checks or heart health checks
- GP Chronic Condition Management Plan (GPCCMP) reviews
- 40–49-year-old checks, over 75 health assessments
- Flu vaccinations
- First Nations 715 health check.

Search and recall

Administrative staff or practice teams can find patients in your system by running searches to find people who:

- Are in any chronic disease registers
- Annual health assessments
- No CKD diagnosis + eGFR <60mL/min/1.73 m^2
- No CKD diagnosis + uACR >3mg/mmol
- Smoker
- Obesity defined by BMI >30
- Diabetes (diabetes registers)
- Cardiovascular disease (CVD registers)
- Hypertension (hypertension registers)
- First Nations Australians over 18 years
- Anyone over the age of 60

Invite these patients to make a booking with the PCN for a complementary Kidney Health Check. Implement reminders for:

- Annual Kidney Health Checks
- Pathology reviews
- CKD monitoring requirements
- Follow up of abnormal results
- Chronic disease education

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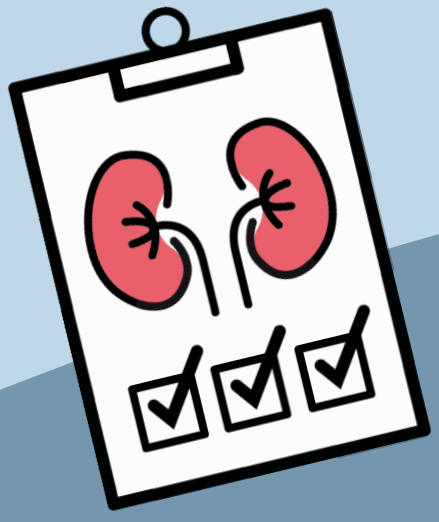

CKD Assessment Made Easy

Know the risks

Suggested workflow

Identify Search records for patients at risk of CKD.

Check Review whether BP, eGFR & urine ACR are current.

Arrange Order outstanding pathology & schedule review.

Assess Review results & identify possible CKD.

Act Implement interventions & GP review. Provide patient education.

Recall Schedule ongoing monitoring & annual Kidney Health Checks.

Documentation

The clinical team (Nurse or GP) should document the following information:

Risk factors

- Diabetes status
- Cardiovascular disease
- Smoking status
- Family history
- Weight and BMI
- Aboriginal and Torres Strait Islander status

Clinical measures

- Blood pressure
- eGFR
- Serum creatinine
- Urine ACR

Current therapy

- ACE inhibitor or ARB use
- SGLT2 inhibitor use (where appropriate)
- Other nephrotoxic medications
- Medication adherence

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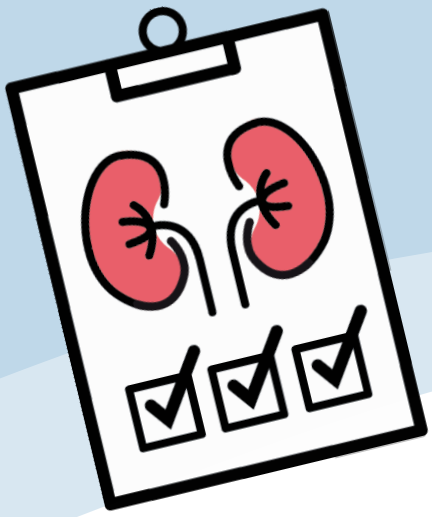

CKD Assessment Checklist

CKD assessment

Further assessment may be required where patients have:

- □ eGFR <60 mL/min/1.73m²
- □ Elevated urine ACR
- □ Persistent abnormalities for ≥3 months
- □ Progressive decline in kidney function

Documentation

If diagnostic criteria are met:

- □ CKD documented in clinical record
- □ CKD added to active health conditions
- □ CKD management plan initiated

Intervention

- □ Support healthy lifestyle changes and optimise evidence-based treatments in collaboration with the GP.
- □ Provide patient education. Refer to Kidney Health Australia resources.

Clinical management

Implement guideline directed medical therapy

- □ Optimise blood pressure
- □ Improve glycaemic management
- □ Review cardiovascular risk
- □ Consider kidney-protective therapies
- □ Avoid nephrotoxic medications where possible
- □ Refer when clinically appropriate

Quality improvement

Complete quality improvement activities as a practice team. Select a SMART goal such as:

- □ Increase the percentage of active adults with a coded diagnosis of CKD to 10% of the active practice population by the end of the year.
- □ Increase the percentage of coded CKD diagnoses amongst active adults aged 65+ by 20%, from a baseline percentage of X%, by the end of the year.
- □ Increase the percentage of people with diabetes or hypertension having a urine ACR in the previous 12 months to 95% by the end of the year.

KIDNEY HEALTH 4 LIFE®

Patient Support

Kidney Health Australia has a range of resources available to help you educate your patients:

- **Refer patients to Kidney Health 4 Life - A health and wellbeing management program for kidney health and kidney disease**
- **Download printable factsheets**
- **Connect with our Kidney Helpline 1800 454 363**

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