

HIN 2023 CVD Fellowship – Chronic Kidney Disease QI Project Guidance

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CKD Detection, Monitoring And Optimisation Projects

CKD projects may look at case finding, re-coding, treatment optimisation or process redesign of CKD. CKD SNOMED codes should now be changed to include both the blood (eGFR) and urine (ACR) values relevant to CKD detection use group 1 coding rather than group 2. This presents an opportunity to send patients for renal function testing and then re-code them.

CKD management slows the progression toward renal failure and prevents cardiovascular related sequelae of CKD, by optimising blood pressure, cholesterol and diabetes control. Sample project aims might be:

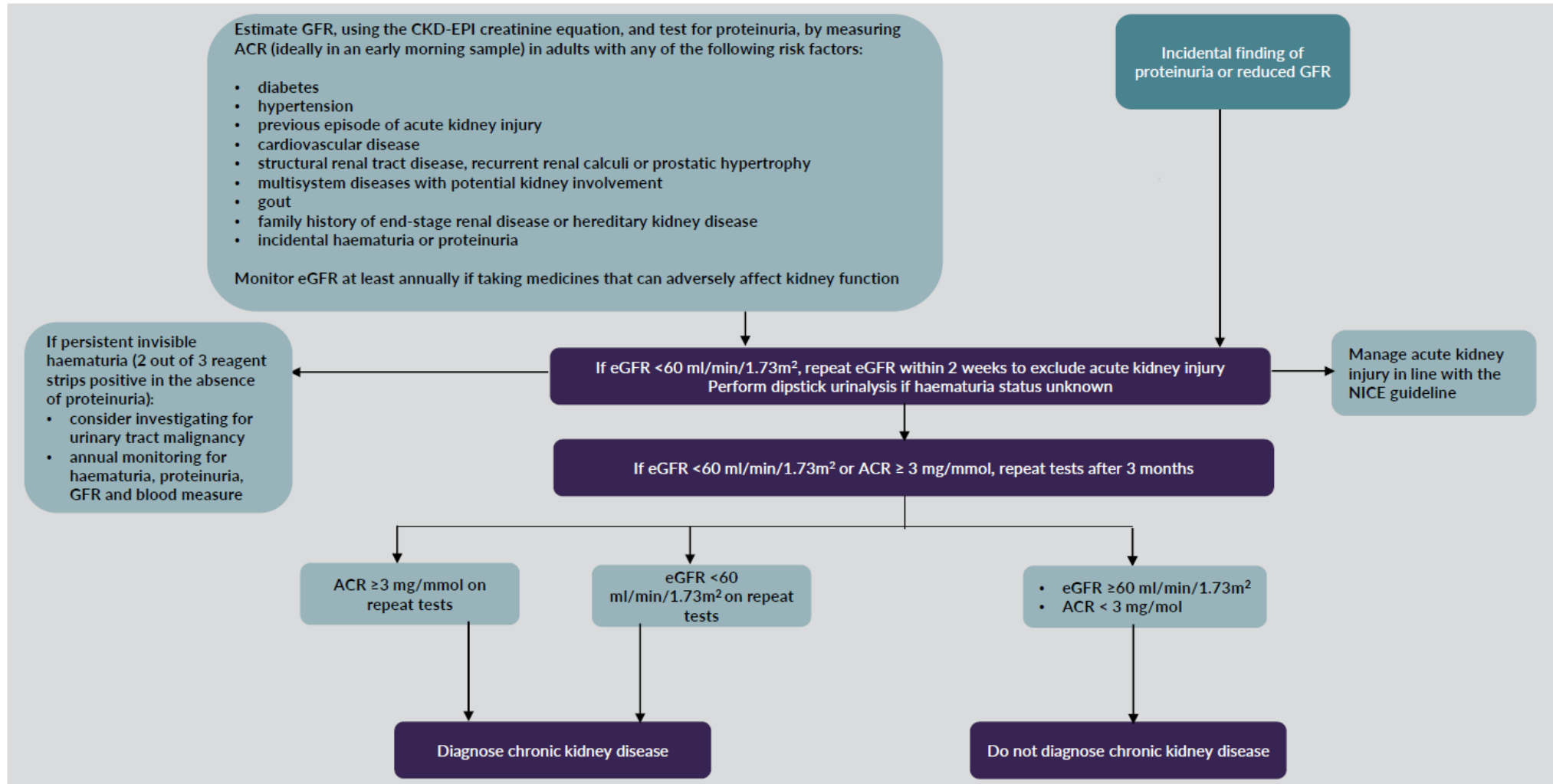
- Search for OLD SNOMED CKD coded patients, check patients urinary ACR and GFR – re-code as appropriate.
 - SMART aim: To re-code 20% of CKD patients by January 2024 based on up-to-date eGFR and urinary ACR.
- Up titrate ACE inhibitors / ARBs to maximum tolerated dose
 - SMART aim: To review 20 CKD patients and optimise treatment (ie to up titrate their ACEi or ARB to the maximum tolerated dose) by December 2023
- Find patients at risk of CKD and send for testing
 - SMART aim: Review 100 patients with a history of hypertension and diabetes who are not coded for CKD and send them for urinary ACR and eGFR by January 2024.
- Offer SGLT2 inhibitors to eligible patients
 - SMART aim: Offer 50 appropriate CKD patients SGLT2i and monitor with follow up by January 2024.

A SMART Aim is Specific, Measurable, Achievable, Relevant, & Timebound

NICE Guide To Identifying CKD In Adults – [Link Here](#)

Identifying chronic kidney disease in adults

NICE National Institute for Health and Care Excellence



CKD Projects – Ideas for Delivery

Following are ideas for delivery to get you started in planning your project. Your project will need to reflect ways of working in your practice, staff and patient need, and any other factors – but this can help you get started.

CKD Coding Sample Project

To implement a project relating to CKD coding you may:

1. Construct a process map of how you would proceed with searching for the patients, contacting them, sending them for testing and then discussing the results with them. Refer to local and national guidelines.
2. Identify stakeholders and invite them to co-design the process with you, this may include administration staff and other clinicians. Engage patient representatives to help you co-design the patient facing aspects, such as communications and the patient journey.
3. Use a search to identify how many patients are coded as CKD to create your baseline group.
4. Chose a manageable amount of this group to focus on for the first PDSA cycle. Review their healthcare records, remove any patients who appear to have been coded incorrectly.
5. Re-code patients as required.
6. Invite the remainder for testing. Record the number of invites you send.
7. Review the results and notify patients of normal results, invite the others to have their condition reviewed with their clinician.
8. Re-code these patients as appropriate and record the outcome.
9. Review the process - what worked well, what didn't?
10. Implements another PDSA cycle with the next group using learning from the first group, perhaps different approaches to contacting them or timelines for the discussion.

CKD Medication Optimisation Sample Project

To implement a medication optimisation project you might:

1. Engage with relevant staff (administrative and clinical) as well as patient representatives to co-design a process map.
2. Discuss with prescribers the required appointment length and factors which may make a patient more complex.
3. Search for patients coded for CKD in a target group ie:
 1. Not prescribed a statin and have not previously declined.
 2. Not currently prescribed an ARB or ACE inhibitor and have not previously declined.
 3. Prescribed a low dose of ARB or ACEi and have not previously declined.
 4. Are on an ARB or ACEi but and may be suitable for a SGLT2 inhibitor and have not previously declined.
4. Invite a set number of these patients for review based upon what is achievable in the time frame
5. Discuss their medications and make changes where appropriate. Prepare FAQs and patient information leaflets to provide to the patient.
6. Review what worked well, what didn't? Make changes to the process map.
7. Repeat PDSA cycles working through your decided cohort.

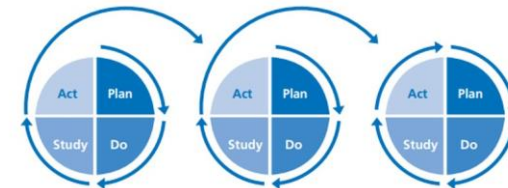
CKD Case Finding Sample Project

A project plan to identify new cases of CKD could involve:

1. Draft a process map, engaging others who may be involved in the process, such as administration staff and other clinicians. Refer to local and national guidelines.
2. Engage patient representatives to create communication materials and develop a patient journey, including required support and education information.
3. Undertake a search for patients who have hypertension AND diabetes WITHOUT history of CKD. Consider patients who have uncontrolled hypertension and diabetes.
4. Select a set number of these patients based upon what is achievable in the time frame and review their notes and refer appropriately for review or testing. These reviews could coincide with their regular reviews.
5. Communicate with patients regarding their results and manage appropriately, refer to [shared decision-making tools](#), and local guidelines.
6. Review this cycle, what worked well, what didn't?
7. Start another cycle, with any changes that were required, with the next group of patients.

CKD Process Improvement Sample Project

1. Refer to local and national guidelines and identify any areas which may be different to your practice processes.
2. Engage with relevant staff, administrative and clinical, to identify the ideal process for identifying and managing CKD in your practice
3. This may focus on:
 1. when is best to collect urine samples
 2. how long and how frequent appointments are
 3. best timing to start statins, antihypertensives or SGLT-2i (as appropriate).
4. Engage with patient representatives to co-design a process map which looks at the journey of a patient from diagnosis through management to living with CKD
5. Implement your new process
6. Review the process and identify what works well? What doesn't?
7. Survey staff and/or patients about their experience and gather their feedback, where there any issues? Components they found difficult?
8. Co-design any changes with patients and staff
9. Implement the new process and continue with PDSA cycles as required.



CKD resources to support your project

- Fellowship [Data Dashboard](#)
- HIN [Protected Characteristics Dashboard](#)
- NICE Guidance: [Identifying CKD in Adults](#) and [CKD Assessment and Management](#)
- NICE Resources: [KFRE Calculator and other tools](#)
- London Kidney Network: [CKD in Primary Care](#) and [Guide to coding CKD in Primary Care](#)
- SWL ICB: [Investigation and Management of CKD in Adults in Primary Care](#)
- CESEL: [CKD Guide for SEL Primary Care \(Adult\)](#)

CKD resources for patients

- Kidney Care UK: [Chronic Kidney Disease Information](#) and [Kidney Failure Information](#)
- Kidney Failure Risk: [5 Year risk of requiring renal replacement therapy \(stages 3-5\)](#)
- Think Kidneys: [Patient Information Leaflets](#)
- Patient Info: [Chronic Kidney Disease](#)

 Please get in touch – hin.cvd@nhs.net



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