A GP's / NEPHROLOGIST'S PERSPECTIVE – Whose Job is It Anyway?

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The GP’s Jobs

- Screen high risk populations for CKD per guidelines
- Manage CVS Risk Factors
  - Hypertension
  - Hyperlipidemia
- Manage comorbid diseases per guidelines
  - Diabetes, CHF, CVS disease
- Monitor and manage proteinuria
- Review labwork – contact nephrologist if unsure of management

The GP's Jobs

- Refer to Kidney Care clinic
  - Patient education and diet counselling
- Refer to Nephrology when appropriate
  - Referral letter with pertinent labs, investigations, question to be answered
  - Use consultant's letter as template for ongoing care
  - Communicate changes in patient status to nephrologist
    - Hospital admission, other consults, etc.
- Involve office staff in follow-up and patient education
- Communicate, communicate, communicate
  - Fax, letter, phone, email (if secure)

Nephrologist's Jobs

- High quality & timely
  - Response to consult request
    - When / investigations requested / suggest pre-consult care
    - Telephone availability
  - Consult report
    - Suggested investigations / management plan
      - Allocation of specific follow-up tasks, including multidisciplinary renal care team
  - Continuing care

EXAMPLES OF SHARED CARE

- BP control
  - Patient to see GP 2 wks after consultation for BP recheck, assess validity of home monitor, titrate BP meds as per care plan
- Anemia management
  - GP to administer erythropoietin injections, monitor hemoglobin, and adjust Epo dose
- Monitoring renal function
  - During intercurrent illness / change in clinical status

DISCHARGE FROM NEPHROLOGY CARE

- *I have not scheduled a follow-up visit, but would be pleased to see this patient again at your request. Specific triggers for re-referral should include:*
  - *Decline in GFR faster than 10 mL/min/yr*
  - *Progressive decline in GFR to < 30 mL/min*
  - *Proteinuria > 1 gram*

CONTINUING CARE - EXAMPLES

- Whose Responsibility?
  - K = 5.7
  - Creatinine 247 (prior baseline 160-180)
  - Hemoglobin 97 (was 114 1 month ago)

KEY POINTS - Nephrologist

- Careful communication is key
  - Can be successfully achieved non-verbally
  - PICK UP THE PHONE if important issue(s)
  - Can be ‘systematized’ with service agreement
- Involve, inform, educate the patient
- Request / expect information back from PCP
- Kidney Care Clinic / multidisciplinary team key component of shared care

Key Points - GP

- Communicate, Communicate, Communicate
  - Developing professional relationship enhances patient care (i.e. know who is at the end of the phone)
- Take time to carefully read and follow consults
  - Opportunity to learn new skill sets
  - Send extra information as required
- Involve the patient in self-care
  - Can be a useful go-between between specialists and GP's
  - Refer to Kidney Care Clinic
- Involve office staff in follow-up
  - Important communication link