Kia ora colleagues,

The Diabetes and Chronic Kidney Disease program aims to slow progression of CKD leading to end-stage renal disease and other diabetes related complications. The aims below are achieved by partnering with the patient/whanau, sharing matauranga/knowledge, improving self-management skills and strategies, and enabling appropriate treatment intensification.

## Aims of intensive management:

Optimise treatment by progressing therapy as appropriate and by improviing patient expertise on self-management on the following parameters:

- Blood glucose levels
- Blood pressure
- Lipid profile
- Other CVD risk factor reduction (i.e. advise on smoking cessation, weight management, ideal exercise according to current best practise guidelines)
- Risk reduction of other diabetes-related complications that contribute to reduced quality of life (i.e. retinopathy, neuropathy, loss of limb)
- Provide knowledge and skills training that promote medication adherence and healthy lifestyle habits

For people living with suboptimal diabetes (Hba1c greater than 53 mmol/mol) and CKD 3B or earlier (eGFR 30 ml/min and above), please see the referral criteria and pathway in appendix 1 below for guidance regarding referrals.

## Appendix 1.

Referrals received from within Diabetes Service, GPs and Waikato Hospital.

## Referral Criteria for Diabetes and CKD Service:

- Diabetes. Patients who already have a CNS within the Diabetes service are
  excluded but can be referred for Renal service medical review if suspecting a nondiabetes related renal disease or has been referred by the Diabetes SMO for renal
  review. Patients with diabetes who are pregnant will not be seen by the Diabetes
  CKD CNS nor dietitian but will be seen by the Diabetes in Pregnancy team instead.
- Age > 18 years
- Willing to attend an intensive Diabetes and CKD management program; at least 2-3 weekly appointments for approximately 3 months
- Urinary albumin: creatinine ratio (uACR) > 70 mg/mmol on at least two occasions
   with eGFR > 30 mL/min

## and/or

CKD – G3A or G3B (eGFR 30 - 59 mL/min)

appointments as per CNS prioritisation assessment.

As per Health care pathways criteria, referrals are received via BPAC or via the referral centre.

Renal Department receives the referral via the Referral Center

Renal Department triages, and assesses if appropriate for diabetes and/or renal review and forwards the referral to corresponding department(s) booking clerk(s).

Diabetes booking clerk provides referrals to the diabetes CNS to vet.

Renal booking clerk uploads and wait lists the referral under the Renal department, and then books the renal appointment.

CNS triages referrals and provides prioritisation to Diabetes booking clerk.

Diabetes booking clerk uploads, wait lists and then books the diabetes CNS and dietitian