"Feel like the help should have been sooner before reaching the level I am so I can improve it."
~MKC Patient

"MKC services have been very helpful; especially having a dietitian helps a lot."
~MKC Patient's Family

Mālama
KIDNEY CENTER

"Sometimes we need a refresher because we forget and don't care about ourselves"
~MKC Patient

Empowering You on Your Health Journey

"MKC has been very helpful. I've been able to follow the recommendations and even my Dr. has seen improvement in my health." ~MKC Patient

"Lots of help with the transition into dialysis and helped alleviate some fears about starting dialysis."
~MKC Patient's Family

"The program helps keep me on track with my health goals. Speaking with someone and talking about it helps make sure I'm keeping on track to do the right things like check my blood pressure and keep track of my diet."
~MKC Patient

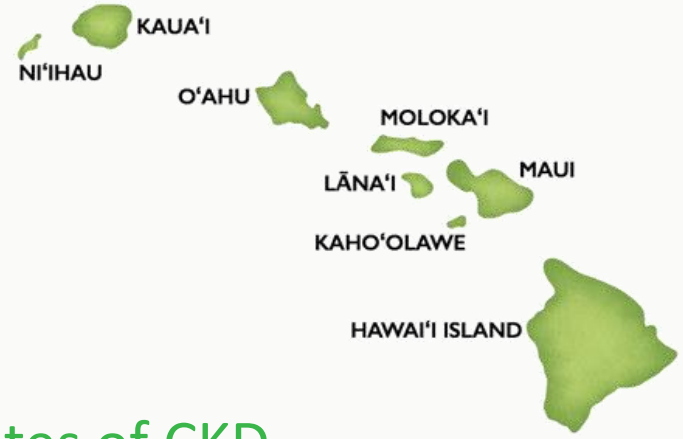
VISION

To delay the progression of kidney disease and improve the quality of life for patients with Chronic Kidney Disease in Hawaii.

MISSION

To support Nephrologists and empower patients to be active participants in their own health journey.

Prevalence in Hawai‘i



High Rates of CKD

Named as one of three states with the highest rates of CKD among Medicare beneficiaries at 17% (USRDS 2020)

Kidney failure rate is 30% higher than the national average with more than 4000 patients currently on dialysis

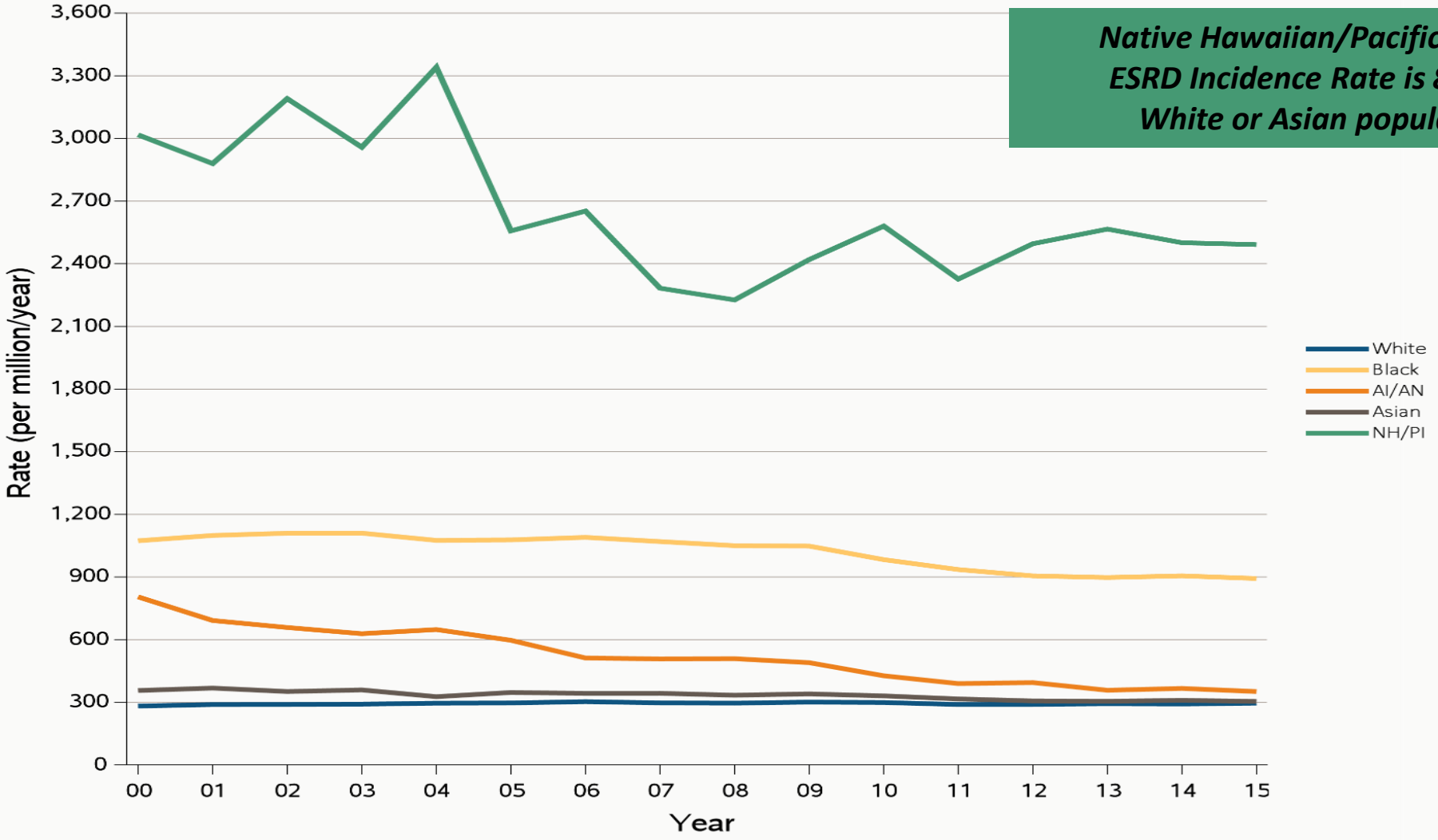
ESRD is 9.5 times greater among the Native Hawaiian Population

ESRD 1.3 times greater among the Asian American population than non-Hispanic white population.

(NCBI, 2012; USRDS, 2019 and 2020; ESRD Network 17, 2017s; PCD, Volume 17, E84, 8/2020)

Trends in adjusted ESRD rate, by race, in the U.S. population, 2000-2015

Native Hawaiian/Pacific Islander ESRD Incidence Rate is 8+ times White or Asian populations



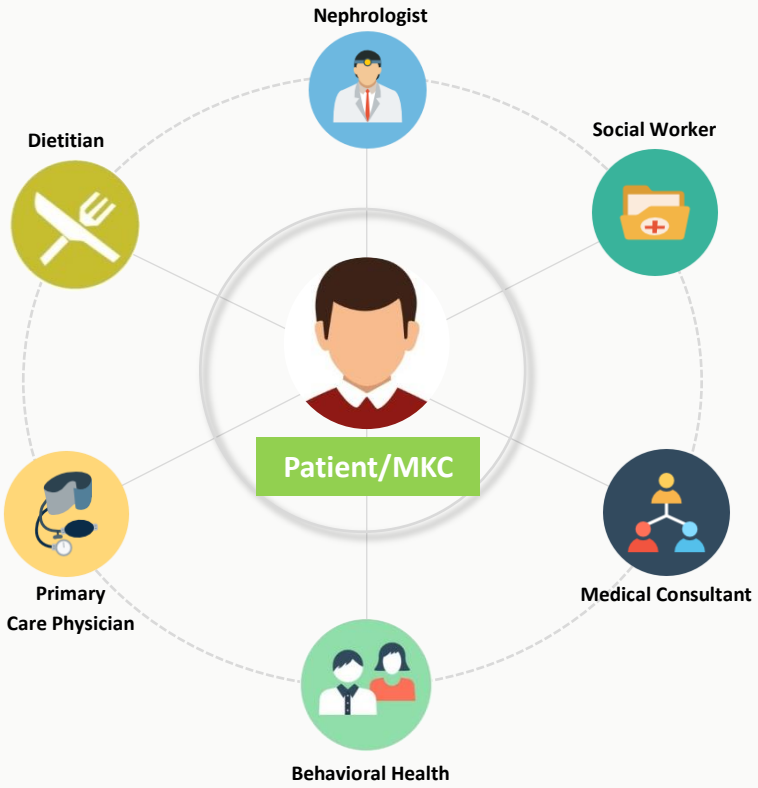
How do we help patients?

Targets

High Risk CKD stage 3b, 4, and 5

- High-Risk comorbidities: Hypertension, Diabetes, Congestive Heart Failure, & Depression

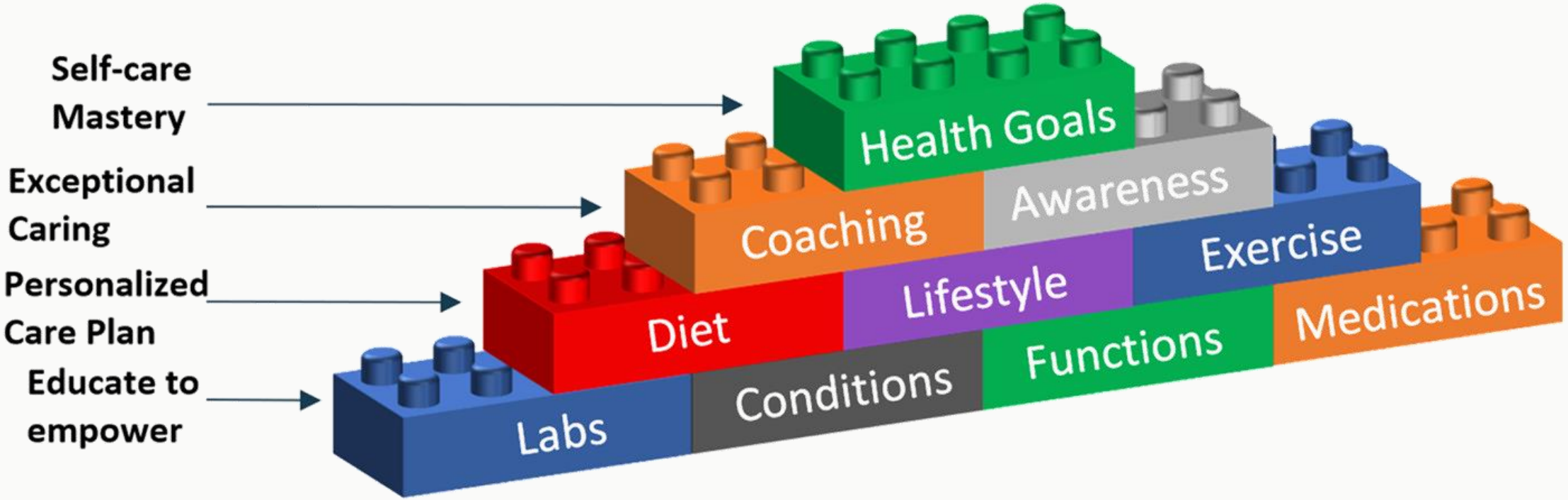
MKC: Integrated Practice Unit



Goals

- *PREVENT* or delay progression to ESRD
- Address the *psychosocial* aspects of CKD
- Reduce symptoms and improve quality of life
- Decrease complications (avoid hospitalization, ED, & emergent procedures)
- Improve engagement & decision making
- Improve RRT *transition experience*
- Increase home dialysis
- Increase transplant referrals
- Increase conservative care management awareness (including palliative care)

Activating Patient Self Care & Engaging Patients in Shared Decision-making



MKC's Supportive Role

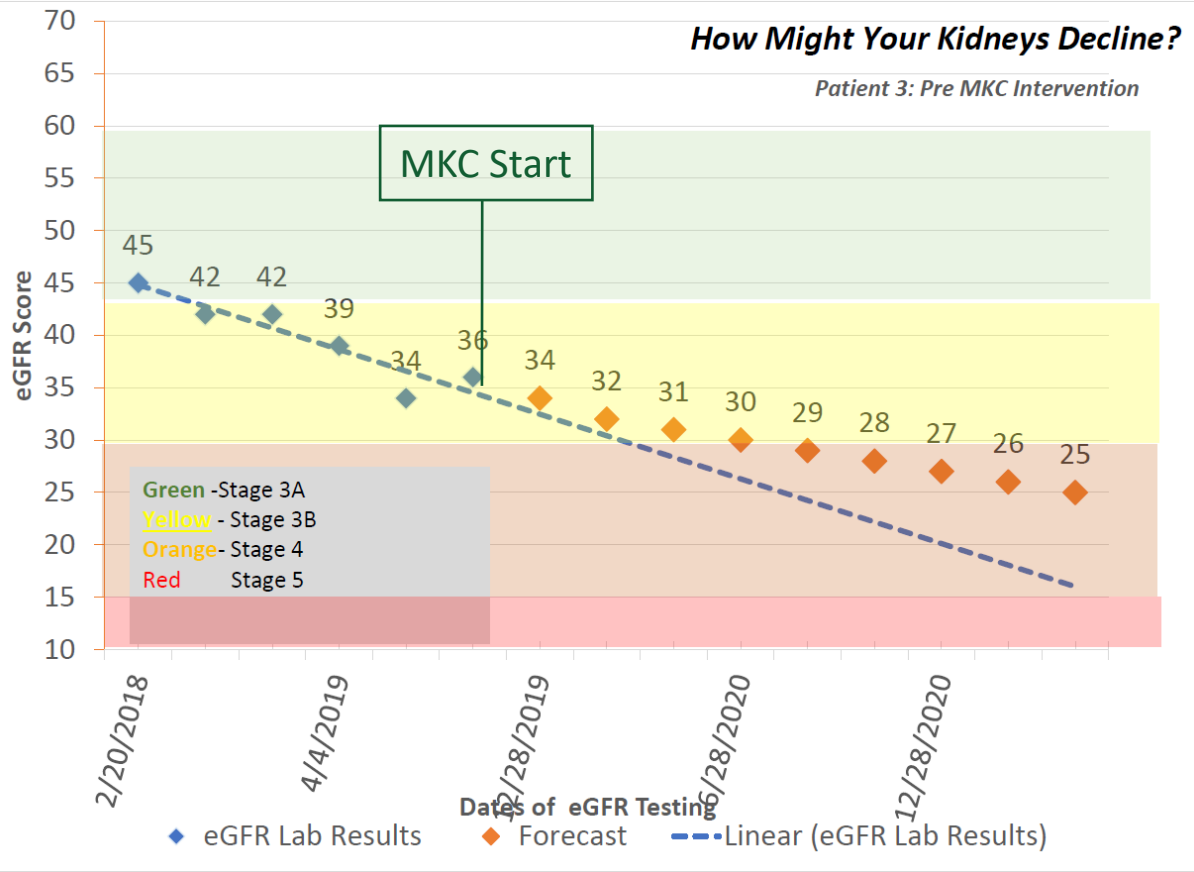
What Physicians Do for Patients:	What MKC Does For Patients:
Provide diagnosis or treatment recommendations.	Provide education about their health conditions and how it may affect their kidneys.
Order or change medications/supplements.	Help patients understand and manage their medications.
Order and interpret labs.	Educate patients on what to watch for, such as labs and symptoms.
Counsel about care.	Identify patient concerns and provide support and referral to community resources as appropriate.
Give nutritional goals such as avoiding potassium.	Empower patients to achieve their health and nutritional goals through monthly education, monitoring and support.
Make recommendations on what health decisions are best for your patients. These decisions are only made with you, your patients, and their families.	Help patients to attain their health goals by developing a plan of care that is attainable.

The MKC Impact on Dylan

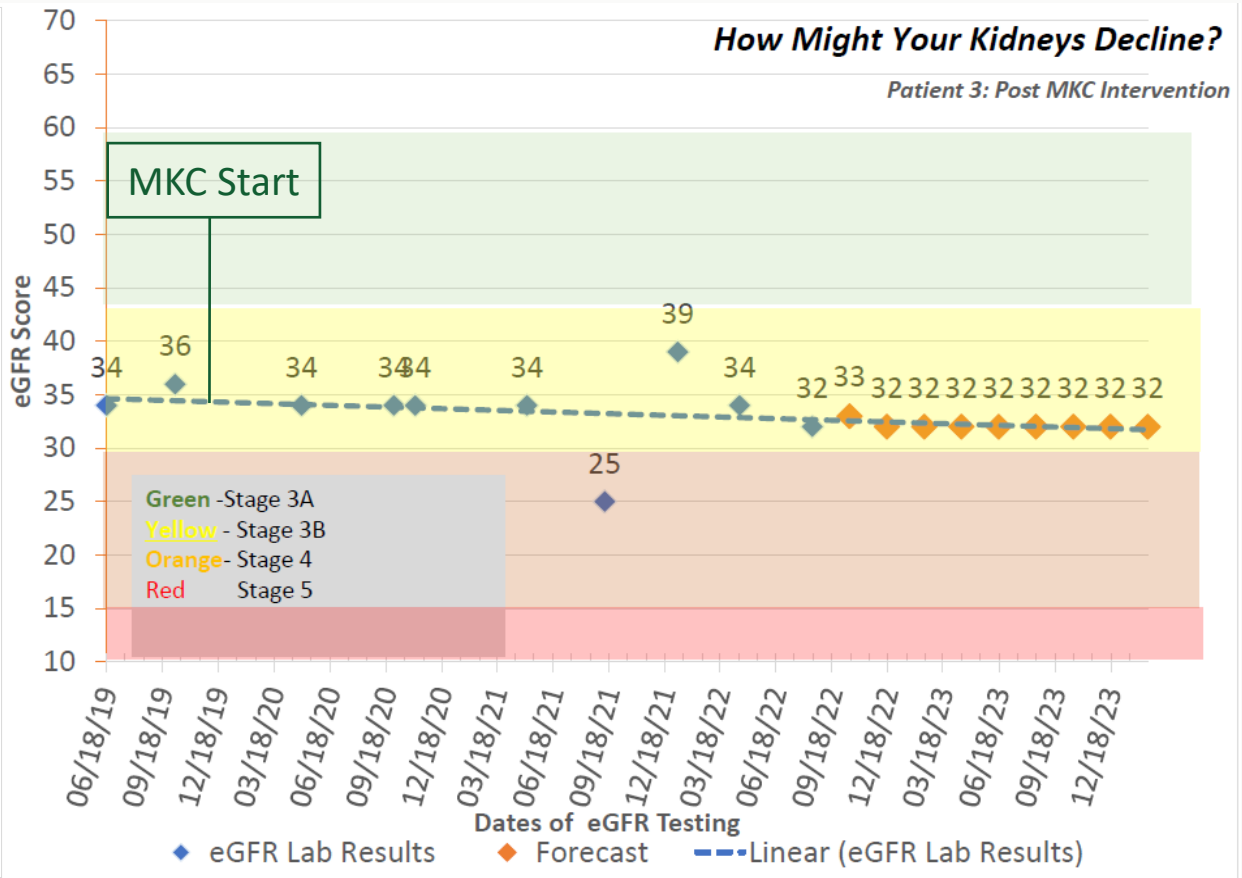
Status at time of referral (11/2019):

82 y/o male. CKD 3b (eGFR 42 & creatinine 1.6). History of hyperlipidemia, hypertension, hyperparathyroidism, and malignant neoplasm of prostate.

Before MKC Intervention



After MKC Intervention



Easing Transition to Renal Replacement Therapy

- Increase patient understanding of condition
- Improve patient decision making through:
  - ✓ Goal Identification and Advance Care Planning (including AHCD & POLST)
  - ✓ Shared Decision-Making
- Encourage timely access creation: insertion of fistula, graft, or PD catheter
- Encourage understanding of all options including transplant and no RRT for future reference
- Enhance patient education
  - ✓ Access care, infection control, and volume management
  - ✓ Lifestyle changes
  - ✓ Expectations upon RRT start
- Complete medication reconciliation
- Promote completion of required vaccinations (Flu, Hep B, Pneumococcal)

Transition during the first 90 Days of Dialysis

GOAL: Decreased adverse incidents within the first 90 days of starting dialysis

- Follow closely every 2-4 weeks from start of RRT
  - ✓ Monitor for signs and symptoms of fluid overload, anemia, and infection
- Monitor and educate patients about BP and weight changes with new tx
- Discuss access management
- Review medication regimen
- Provide psychosocial support
  - ✓ Adjustment to new reality
  - ✓ Involvement of support system (family, caregivers, and friends)
- Assist with care coordination (transportation, communication with facility/nephrology clinic, and in-home needs)

Mālama Mau Transition

CKD Stage	Time to meet patient goals with MKC	Check-in intervals
Stage 3b	8 - 12 months	6 month and 1 year check-in to determine patient stability.
Stage 4	12-18 months	Check-in every 3-6 months to determine patient stability
Stage 5	90 days post RRT start	N/A – Dialysis Oversight Only after 90 days

After MKC program completion, patients are transitioned to the Mālama Mau Program (unless transitioned to dialysis):

- Intermittent telephone check-ins with an MKC team member to determine patients' status
- Check-in cadence dependent upon patients' CKD stage and stability at time of transition
- Ensure patients' ability to provide self care and/or strong connection to dialysis center
- No cost to payers or patients

HEDIS & MIPS Kidney Care Measures

HEDIS, MIPS, and MKC recommend patients with diabetes, hypertension, or other indicators be regularly evaluated for kidney disease.

HEDIS and MIPS Recommendations:

1. Monitor:
    1. Annual Comprehensive Metabolic Profile - eGFR
    2. Annual urine albumin-creatinine ratio (uACR)

2. Nephrology referrals are often made for patients with CKD stage 3b but it is recommended to refer to a nephrologist if:
    1. eGFR is less than 30 mL/min
    2. eGFR is less than 45 mL/min & eGFR decline is more than 4-5 mL/min per year
    3. uACR higher than 300 mg/g
    4. Difficult to manage complications such as drug complications, anemia, vit. D deficiency, or requiring phosphorus binders
    5. Serum potassium is higher than 5.5 mEq/L
    6. Confirmed or presumed hereditary kidney disease
    7. Provider feels nephrology follow-up is necessary

Getting Patients Enrolled with MKC

To ensure patients with CKD are followed by a nephrologist and their kidney health education follows their specific kidney care plan, we ask that patients be referred by the nephrologist.

If a patient has CKD 3a-5, and you believe they may benefit from MKC education and coaching, you may consult with the patient's nephrologist.

Aloha Kidney Classes

Aloha Kidney Classes are a great resource and MKC is designed to complement the group classes.

Who can benefit?

- Anyone interested in kidney and body health
- Those with CKD at any stage or excess urine protein
- Those at risk for CKD, with diabetes, high blood pressure, heart disease, stroke, PAD or has a family member with CKD.

For more information, go to www.alohakidney.com
or
call (808) 585-8404.

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Mahalo for your time!

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