

National Renal Healthcare Program in Uruguay Prevention and Early Detection of Renal Disease.

Application for ISN call for

Non-communicable Chronic Disease Prevention
Programs in Developing Countries



FACULTAD DE MEDICINA
CENTRO DE NEFROLOGIA



SOCIEDAD URUGUAYA
DE NEFROLOGIA

SECTION A: GENERAL PROJECT INFORMATION

1. The Project will take place in Uruguay, Latin America. It will be developed for the entire population of the country.
2. National Renal Healthcare Program in Uruguay. Prevention and Early Detection of Renal Disease.
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5. Duration of the project: five years

SECTION B: PROJECT DESCRIPTION

I. The Uruguayan Context for the National Renal Health Program

Uruguay has an area of 176.215 km² divided in 19 Departments and 3.241.003 inhabitants, 13.7% of them are older than 65 years (1). The ethnic distribution was 93.2% of white race and 5.9% of black race (2). In 2001 the gross domestic product (GDP) per capita was US\$ 8.400 and the human development index 0.834. Relative expenditure in health was 10.9% of the GDP.

The life expectancy at birth was 75 years and the infant mortality rate was 14 per 1000 live birth. The percentage of the population with access to potable water and adequate sanitation was 98% and 94% respectively. The adult literacy rate was 97.6% (3).

So far, the Health Service is dual (public and private system) and give coverage for the total population of the country (around 50% each).

1. End Stage Renal Disease (ESRD) and Renal Replacement Therapy (RRT) in Uruguay.

Renal Replacement Therapy in Uruguay expanded rapidly after the creation of the National Found of Resources (NFR) in 1980. The NFR supports the treatment by dialysis and renal transplantation for all patients with ESRD. Since 1981, the Dialysis and the Renal Transplant Registry has accumulated data from the entire population in RRT program in the country (4, 5). The prevalence of ESRD patients reached 916 patients per million populations (pmp) by December 2004. The incidence of dialysis patients had a progressive growth from 32 pmp in 1981 to 152 pmp in 2004. This incidence is similar to the reported in most developed countries (6) and had not changed significantly in the last ten years, differing from other countries (7, 8) (14, 15, 16). The renal transplants per year reached 32 pmp in 2004, being 89% from deceased donors. In 1999-2004 the gross mortality rate in dialysis patients varied from 12.3 to 15.9 deaths per 100 patient-years of which were cardiovascular disease (CVD) 34.4%, infectious diseases 18.8%, cancer 9.7% and withdrawal from treatment 11.6%. In the same period, the nine year survival in patients with a deceased donor transplant was 88% for patients and 53% for grafts. The cost of renal replacement therapy in Uruguay represents almost 3% of total health budget (one third of the NFR budget).

2. The Uruguayan Society of Nephrology (SUN) is a non-profit scientific society, founded in 1982. It has developed the Uruguayan Dialysis and Renal Transplant Registry, and the Uruguayan Registry of Glomerulonephritis.

3. Human Resources in Nephrology.

There are 41 Hemodialysis Units and 10 Peritoneal Dialysis Units distributed in 17 of the 19 Departments. In each Dialysis Unit there are 4 to 6 nephrologists working and the most of them live in the same area of the Unit. There are 169 nephrologists in the country: about one every 20.000 of general population. The Dialysis Units also have Dieticians, Social Worker, Psychological support and Renal Nurse.

4. Surveys for Populations at risk.

The two most important populations at risk for CKD are those with arterial hypertension and diabetes mellitus. The incidence of ESRD secondary to vascular nephropathy increased up to 37.3 pmp and the incidence of diabetic nephropathy

increased up to 37.6 pmp in 2005. The incidence of obstructive nephropathy (13.1 pmp in 2001-2002) is a matter of concern in Uruguay, because it is the third most frequent etiology on patients over 65 years old. It was three times higher than the reported in the USRDS in 1997-2001 (6, 16). The prevalence of hypertension (systolic blood pressure ≥ 140 mm Hg, diastolic blood pressure ≥ 90 mm Hg) in Uruguay ranges between 33% and 39% (9,10,11,12). The prevalence of diabetes in the general population of Montevideo City was 8% in a recent survey of people between 20 and 79 years, to whom a fasting serum glucose test was made. The percentage of them that wasn't aware of the diabetic status was 1.6%. (13). Up today, there is no study on the prevalence of CKD in Uruguay. With the aim of knowing the prevalence of risk factors for CVD and renal disease in Uruguay, a national survey will be performed.

5. Prevention of Non Communicable Disease in Uruguay

The Public Health Ministry (PHM) has developed in recent years different kind of programs to fight against the risk factors of non communicable diseases:

- a) Reduction of tobacco smoking in the general population. On May 31, 2005 the government began to develop a normative that restricted tobacco habit (initially by the limitation of the tobacco publicity, and the creation of non-smoking areas in any public place) and finally by the smoking prohibition in every closed public area. This Health Policy of Uruguay was rewarded with the WHO Director Prize in March 2006.
- b) Since 2005 it is being developed a national campaign for Healthy Diet.
- c) It was implemented a National and Obligatory Diabetes Program which includes a National Registry for diabetics patients that is held in the Health Ministry, the free administration of diabetic medication (insulin or oral medication) and the blood glycemia test. This program includes the whole private and public assistance population of the country.
- d) Secondary Prevention in Cardiovascular Disease. In February 2004, the NFR began a National Program for patients younger than 70 years old, who have had a coronary bypass or a Percutaneous Angioplasty. It included the administration of statins, platelets anti-aggregates and anti hypertensive drugs. It was initially applied for the public population and now is progressively covering the private assistance population.
- e) In 2005, the PHM constituted a committee with representative members of the Societies of Cardiology, Nephrology, Diabetes, Arterial Hypertension, Arteriosclerosis and Obesity to develop a global prevention program. This multidisciplinary committee of Non-Communicable Diseases (NCD) has developed coordinated guidelines of prevention for the physicians of primary attention (17, 18, 19, 20, 21) and so far is organizing a National Survey of Risk Factors for Non-communicable Diseases according to the WHO stepwise approach (22) to be performed from October to December 2006.

6. Prevention of CKD in Uruguay

The prevention of CKD started in Uruguay with the Program for Prevention and Treatment of the Glomerulonephritis (PPTG). This program was implemented in 1989 by the School of Medicine of the National University and the Uruguayan Society of Nephrology (SUN) and was made official by the PHM in 2000. The data obtained from the Uruguayan Registry of Glomerulonephritis have shown that the patient referral to nephrologists is performed in the last years with less impairment of renal function and with a better control of the blood pressure. The outcome analysis showed that the frequency of patients in "clinical remission" increased from 13.7% (1980-1989) to 22.1%

(2000-2004). The ESRD frequency in the first three months diminished from 18.1% (1990-1994) to 7.6% (2000-2004). The lower risk of ESRD was statistically significant even after the adjustment to age, sex, initial serum creatinine and etiological diagnosis. The ESRD rate per 100 patient-years after the third month didn't show significant changes in the different periods. (23)

II. National Renal Healthcare Program

In 2004 a National Program of Renal Healthcare (NPRH) was planned after the Declaration of the Montevideo Workshop (with authorities of PHM, SUN, School of Medicine of the National University, Subcommittee of Renal Health of the Latin American Society of Nephrology and Hypertension (SLANH), NFR, and nephrologists). The NPRH was planned by the SUN, according the new renal health concept proposed by the SLANH and under the logical framework matrix, in agreement with the PHM and the NFR authorities (24, 25, 26).

The authorities of the PHM, the NFR and the SUN decided to develop the NPRH by steps, beginning with a Pilot Program in the Public Health Assistance population of Montevideo, of almost 274.800 affiliated individuals aged 20 years and over. The Pilot Program began on October 2004. Two nephrologists were assigned to act in the Primary Healthcare. The program included the administration of the renoprotective drugs and the registry of patients with CKD. The patients stage IV-V were referred to a recently initiated pre-dialysis clinic with an interdisciplinary team at a third level hospital (27). Actually, the NRHP includes the public assistance population from Montevideo and public and private population of two Departments close to Montevideo (28, 29, 30, 31).

The CKD Registry included until august 31 2006, 925 patients (40 new patients each month) from 8 Primary Health Clinics of the Public Healthcare System of Montevideo, 4 Primary Health Clinics of San José Department, and 2 Primary Health Clinics of Florida Department.

This registry includes patients with renal abnormalities imaging test, or two positive tests in a three month period of at least one of the following conditions: 1) serum creatinine greater than 1.5 mg/dl; 2) GFR lower 60 ml/min/1.73m²; 3) proteinuria >300 mg/day; 4) diabetic patients with microalbuminuria >30 mg/day. The median age was 65.3±14.6 years, 458 (49.5%) were women and 467 (50.5%) were men, with a predominance of white population? (88.2 %). The most frequent risk factors for CKD were: diabetes 37.4% hypertension 88.1%, hypercholesterolemia 57.2%, hyperuricemia 25.7%, tobacco habit 14.3%, body mass index ≥ 25 kg/m² 74% (obesity 39%), obstruction of urinary tract 9.0%, recurrent urinary tract infection 13.5%. Cardiovascular co morbidities: coronary artery disease 22.8%, stroke 10.6% and peripheral vascular disease 7.2%. The most frequent CKD nephropathies were Primary glomerulopathy 3.1%, Tubulointerstitial disease 0.9%, obstructive nephropathy 6.4%, diabetic nephropathy 16.8%, vascular disease 41.4%, others 14.9%, and unknown diagnosis 16.8%. At the first visit the Stage of CKD frequency was stage I- 4.1%, stage II- 11.2%, stage III- 59.5%, stage IV- 17.23%, and 2.8% in stage V.

At August 31, 47 patients died, 8 were in ESRD in RRT, 382 had more than one visit. The comparison of the last control with the first visit in 311 patients at a median of 251 days, showed a reduction of median systolic blood pressure from 151.3 to 145.2 mmHg (p<0.05), a reduction of median diastolic blood pressure from 85.3 to 82.2 mmHg (< 0.05), a reduction of median cholesterolemia from 226. to 197 mg/dl (< 0.05), and of LDL from 140 to 107 mg/dl (p<0.05). The utilization of ACEIs or ARBs rose from 67.6 to

80%. The creatininemia decreased from 1.81 to 1.66 mg/dl and GFR rose from 41.7 to 48.4 ml/min.

III. Objectives of the National Renal Health Program

The goal of the NRHP is to improve the Renal Healthcare of the total population and to make sustainable and tenable the prevention of kidney diseases and the integral assistance of patients with kidney disease by the generalization of the Pilot Program to the whole country.

The specific objectives are:

- 1) To promote the education for renal care and healthy lifestyles in the general population to reduce exposure to factors which cause CKD such as diabetes, high blood pressure and obesity;
- 2) To integrate the renal healthcare into the Primary Healthcare (renal care decentralization);
- 3) To promote early diagnosis of CKD in high risk population;
- 4) To optimize patients care in all stages of CKD.
- 5) To prevent the high cardiovascular mortality in this population.

IV. Plan of the Project and Methodology

The treatment of ESRD patients with RRT is already provided in the whole country with the financial support of the NFR, as was previously stated.

The PHM and the related Scientific Societies have developed a primary prevention program for NCD. It is crucial for the NRHP to implement an Educational Program for primary physicians in the whole country for the best understanding of NCD risk factors to diminish the prevalence of these factors and the incidence of CKD. The General Practitioners will promote to make screening for CKD in high risk populations, specially in elderly people, diabetic and hypertensive patients and in people with a family history of ESRD. It's a real priority since secondary prevention of renal disease begins with the early diagnosis and referral to nephrologists after screening in high risk population.

The NRHP is planned to be a long-term program without an ending date. It isn't expected that the impact of the program will be obtained in less than five years. And we assume that the complete generalization of the program to the whole country will demand about a year.

POPULATION

The core of NRHP is mainly directed to the secondary prevention of renal disease and cardiovascular morbidity and mortality in the entire population of Uruguay. It aims to include all the patients with CKD stage I to V (previous to RRT) in a progressive way. The number of patients who might have CKD is about 6.7% of the population. This number was estimated by the extrapolation from USA data from NHANES III and adjusted to Uruguayan prevalence of dialysis patients. The population with stages I to III is estimated in 6.4 % and in stages IV and V 0,124 % each.

STRATEGY

a) Educational Program

It is crucial to integrate in each Department of the country the Educational Program for the diffusion of the management guidelines of NCD risk factor, including early diagnosis of CKD based in the estimation of the glomerular filtration rate (MDRD formula) for early referral to nephrologists.

b) Clinical Coordinator for CKD Registry

Each Private institution of Montevideo City (with 30 to 200.000 population aged 20 years and over) and each Department (with 30 to 100.000 aged 20 years and over) must design a Clinic Coordinator that will be responsible of:

1. The inclusion of patients in the electronic CKD Registry (centralized in the NFR). Each patient will have an initial data registration and at least one control data by semester.
2. The implementation of a system directed to improve the follow-up of patients by calling up the ones who fail to keep an appointment.

c) Standardization of serum creatinine assay

For achieving comparable results the Standardization of serum creatinine assay will be implemented in the whole country with the Committee for Standardization and Quality Control (CSQC) by calibration to an isotope dilution mass spectrometry (IDMS) reference method. (32)

d) Long-term adherence to medication and follow-up control:

1. Easy access to antihypertensive, antiproteinuric and statins medication.
2. Insulin and oral hypoglycemic drugs are assured by the diabetes program.
3. Easy access to nephrologists and dieticians visits.
4. Easy access to urine and serum creatinine tests.

e) Renal Healthcare

The structure of the clinic differs for stage I-III and for stage IV patients:

- ◆ For Patients with CKD stage I to III is proposed a decentralization of Renal Healthcare:

A nephrologists and a trained nutritionist will be incorporated to the standard health assistance team in each Primary Health Clinics for two controls per year in stable patients. The need of two hours of nephrologists per 10.000 aged 20 years and over population in each region was calculated assuming that half of the expected CKD patients could be detected.

The **Nephrologists** will have the responsibility for implementing the national guidelines of renal care to delay the progression of CKD. The nephrologists must ensure that appropriate test have been undertaken to make a diagnosis, must identify and treat the co-morbidities associated with CKD, must rule out any potentially treatable or reversible etiologies, must review the current medications to ensure the absence of nephrotoxic medications or potentially harmful interventions and must make the referral to the predialysis clinic when appropriate. The referral of the patients from the General Practitioner will be stimulated by visits, talks, and with the distribution of printed material about the benefits of the early referral. The patients will be referred by the primary care doctor in a reference-counter reference manner; or could be derived directly from the laboratory when the urine or the serum creatinine tests detect an abnormality.

- ◆ For patients in stage IV is proposed attention in a Pre-dialysis clinic

A Pre-dialysis clinic (PDC) will be created (at least one by department or Private Health institution in Montevideo city) to attend one hour every 10.000 population aged 20 years and over, for patients with advanced CKD. The Pre-dialysis clinic will be coordinated by the nephrologists and integrated by a formal interdisciplinary team: renal nurse, dietician, social worker, psychiatrist/psychologist, and vascular surgeon. Each integrants of the team will have specific or individual functions:

A) The **Nephrologists** will be the general coordinator of the multidisciplinary team and will have the responsibility for implementing the national guidelines of renal care to delay the progression of CKD and must coordinate the preparation of patients for kidney replacement therapy (modality selection, access placement and timely initiation). The attended population will be patients with glomerular filtration rate less than 30 ml/min, estimated in 0,12 % of the Uruguayan population.

B) The **renal nurse** will facilitate the care of patients in liaison with the rest of the team, will train patients in renal disease and treatment options, will monitorize the performance of lab test results (of blood and urine tests), and implement protocols such as hepatitis screening and vaccination, and follow-up care. The administration of pneumococcus and influenza vaccines will be also recommended.

C) The **Dietician** will evaluate the nutritional status, habits, and the adequate dietary prescription depending on the nutritional status, the CKD stage and other morbidities.

D) The **social worker** may provide assistance about the available resources for renal patients (financial assistance, employment, retiring, insurance issues), may assess emotional needs such as acceptance of kidney disease and end-of-life issues and other concerns of patients and their families, and may investigate the social and familiar support for the selection of the dialysis modality.

E) The psychological support will be offered for ensuring the process of adaptation to the illness, the evaluation for a home therapy, and the help needed for an optimal treatment adhesion.

F) A vascular surgeon will be integrated to the team to see patients delivered by the nephrologists for vascular or peritoneal access performing, at least 6 months in advance of anticipated start.

Activities	Assigned population	Productivity	Instrument	Resources
Primary Health Clinic. Public or private (depending of the Institution and Department)	Nephrology clinic for two hour attendance every 10.000 population aged 20 years and over.	4 patients per hour	Nephrologists Nutritionists Clinic coordinator	Depending on the global population
Second or third level nephrology clinic. Pre-dialysis Clinic Public or private	Nephrology clinic for one hour attendance every 10.000 population aged 20 years and over.	2 patients per hour	Nephrologists Clinic Coordinator Nutritionists Renal Nurse Social worker Psychiatrist/Psychologist	Depending on the global population

f) Strategy for the generalization and sustainability of the NHRP

A National and Integrated Healthcare System (NIHS) is planned to be implemented by the Health Ministry in the next years in substitution of the current dual Private and Public healthcare System, and will include the NRHP as an obligatory health service. So far the sustainability and generalization of the program is assured by the PHM and NFR. The NFR that give financial support to RRT is especially interested in achieving amelioration on the incidence of ESRD, by slowing the progression of the CKD.

In order to incorporate these Institutions in Montevideo Department, the NFR and the Renal Healthcare Program Committee (RHPC) planned different meetings to show the preliminary results of the Pilot Program and invited them to sign a contract as part of the formal agreement.

The inclusion of the rest 18 Departments requires a previous consensus of the authorities from the public and private assistance in order to pool all the human and economical resources in each region and also sign a contract of agreement. As the public health assistance is divided in three regions (North, East and West regions), the RHPC is working with the Director of the Public Assistance Service Administration for the Inner Regions and the responsible managers of each region, to incorporate the private assistance. Different meetings have been planned in each region to show the preliminary results of the Pilot Program.

The NFR will compromise to:

- a. Give electronic support to the CKD patients registry.
- b. Provide the teaching materials required for the Educational Programs.
- c. Collaborate with the free administration of Renoprotective drugs if necessary.
- d. Provide the vaccine for B Hepatitis for patients with CKD stage IV
- e. Initiate the financial support for RRT since the first day (in opposition of the almost 3 weeks period currently disposed for the administrative authorization).

The RHPC will compromise to implement:

- i. The Clinical Guides for Identification, Evaluation and Management of patients with CKD in the Primary Health Care directed to primary care physicians (edited by the NFR, in press).
- ii. The Clinical Guides for Management of CKD patients with stages IV – V (PDC).
- iii. The Educational Program for the Clinical Coordinators of the CKD Registry, and the rest of the multidisciplinary team and other caregivers, the patient and the family.

V. Program evaluation and expected outcomes

There will be a semester and an annual evaluation of the performance based on structure indicators, process indicators and outcome indicators.

1. The structure indicators are:
 - i. weekly nephrology attendance hours
2. The process indicators are:
 - Number of visits by patient
 - Number of patients treated with ACEI's or ARB's
 - Number of patients treated with statin drugs
 - Number of new patients by month

3. The outcome indicators are:

- Number of patients in control
- Number of patients lost of follow-up
- Stage of CKD at the first visit
- Quality of control indicators
 - a. Patients with less than 130 mm Hg of systolic blood pressure and 80 mm Hg of diastolic blood pressure
 - b. Patients with a normal body mass index (18,5-25 Kg/m²).
 - c. Patients that stop smoking
 - d. Patients with less than 200 mg/dl of total cholesterolemia
 - e. Patients with target GFR decline (≤ 2 ml/min/year).
 - f. Patients with target proteinuria (<0.5 g/day)
 - g. For Stage IV CKD patients:
 - i. Number of patients with Hepatitis B, Pneumococcus and Influenza Vaccine
 - ii. Number of patients with AVFistula
 - iii. Patients wellbeing and quality of life
- morbidity rates
 - a. number of hospitalized patients
 - b. number of cardiovascular events
- mortality rates

Impact:

- o Decrease in the glomerular filtration rate deterioration
- o Decrease in the occurrence of cardiovascular events
- o Decrease in the total incidence of ESRD by diabetic nephropathy, nephroangiosclerosis, and obstructive nephropathy

VI. Chronogram

- b. Program planning: August to December 2006.
- c. Making contacts with the other Program coordinators as Diabetes Program, and with Chief Representatives of the Private Healthcare Institutions: August and September 2006.
- d. Making contact with Director of the Committee for the Standardization and Quality Control of Laboratories. August and September 2006.
- e. Making contacts with the Directors of the regional areas through 2006 and 2007 for the incorporation of new Regions.
- f. Evaluation of the Outcomes of the Program: monthly evaluation of the development of the program, every three months for the patients outcome and annual for the whole program.

SECTION C: RELEVANT REFERENCES TO THE PROJECT

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SECTION D: BUDGET

- Educational Program

The Resources for the Educational Program will be provided mainly by the NFR, the Uruguayan Society of Nephrology and local pharmaceutical industry with talks, Continual Medical Educational Courses, printed material, brochures, edition and distribution of the Clinical Guidelines.

- Human Resources

The human resources for the implementation of the program will be provided: a) for the clinics in the public health attendance sector by the Administration of the State Services, and b) for the private attendance population by each private health service.

- Special Found will be required for:

1. The electronic registry will be centralized in the NFR.

The initial implementation of a remote electronic communication System and a Clinical Coordinator will be required for the CKD Registry which has an estimated expenditure of U\$ 700 annually for each Department out of Montevideo. Montevideo Department will require 5 Clinical Coordinators (2 for the public system and 3 for the private system). After the complete development of the NRHP is obtained, the integrate department health system will be in charged of assuring the continuity of a Clinical Coordinator.

The Registry budget also covers the specific courses that will be delivered to the Clinical Coordinators to assure the quality of the Registry.

The total expenditure for the Registry will be U\$16.100

2. The CSQC will participate with the optimization of creatinine analysis and will require funds for:

- The preparation and sending to the 100 participant clinical laboratories of a sample of lyophilized serum with assigned value for creatinine by the reference method (IDMS isotope dilution mass spectrometry), for determine the total error (imprecision and bias), has a total expenditure of U\$900.
- According to the standardization program, in the 12 months, the participants will receive three different samples, separated by six months, that will be performed at the beginning, in the 6th month and 12th month. Each complete sample represents U\$900 so it demands U\$2700 annually. Since then, they will receive samples once a year.
- For obtaining a traceable sample of creatinine to an IDMS in three opportunities requires to deliver the sample to an external laboratory with a total expenditure of U\$1200.

SECTION E: SHORT SUMMARY OF THE PROJECT

The National Renal Healthcare Program will be developed in Uruguay, which is a developing country with a dual Health System but with remarkable health indicators in the Latin American context, especially with a privileged established program for RRT for all patients with ESRD since 1980. This Program is aligned with a change in the Health Care System directed by the PHM towards a Preventive Model. The NRHP was planned by the SUN and the School of Medicine, and developed with the support of the NFR and PHM. The Program is supervised by Drs Nelson Mazzuchi and Emma Schwedt, and coordinated by Drs Laura Solá and Pablo Ríos.

The core of NRHP is mainly directed to promote adequate management of modifiable and preventable risk factors of renal disease, and to the secondary prevention of renal disease and cardiovascular morbidity and mortality in the CKD population.

The Pilot Program developed in the last two years, has been useful for testing the designed methodology and the CKD Registry, and its outcome indicators have already shown promising results.

A strategy for the generalization of the NRHP for the entire population of the country was planned with an organization of the available resources of the public and private health institutions. Especial funds are requested for the implementation of the national CKD Registry and the standardization of the creatinine assay all over the country.

The sustainability of the NRHP is assured by the good results of the Pilot Program and by the support of the principal governmental health institutions the PHM and NFR.

SECTION F: ETHICAL COMMITTEE APPROVAL AND INFORMED CONSENT DOCUMENT

The Project: “National Renal Healthcare Program in Uruguay. Prevention and Early Detection of Renal Disease” was reviewed and approved by the Institutional Review Board (IRB) “Comité de Ética para Proyectos de Investigación de la Facultad de Medicina” (Universidad de la República).

This IRB is registered in the U.S. Department of Health and Human Services (DHHS)

IRB Registration Number: IRB00003601

Parent Organization: IORG0002991



UNIVERSIDAD DE LA REPÚBLICA — FACULTAD DE MEDICINA

Montevideo, 25 de setiembre de 2006.-

El Comité de Ética para proyectos de investigación de la Facultad de Medicina deja constancia de la aprobación en el día de la fecha del proyecto titulado "Renal Health Care Program in Uruguay. Prevention and Early Detection of Renal Disease" cuya investigadora responsable es la Dra. Laura Solá.-

Prof. Agda. Dr. Carlos Ketzoian

(Ex. Prof. Agda.) Dra. María Teresa Retondo

**PROGRAMA DE SALUD RENAL: REGISTRO DE ENFERMEDAD RENAL
CRONICA**
Ministerio de Salud Pública - Fondo Nacional de Recursos- Sociedad Uruguaya de
Nefrología-
Facultad de Medicina (Universidad de la República)

CONSENTIMIENTO INFORMADO

El Programa de Salud Renal tiene como finalidad prevenir la Enfermedad Renal y mejorar la calidad de la atención médica de las personas con Enfermedad Renal. El Programa ha implementado el Registro de Enfermedad Renal Crónica

¿Cuál es el propósito del Registro?

El Registro tiene el propósito de conocer la realidad de la Enfermedad Renal Crónica, estimar el número de personas afectadas, las manifestaciones clínicas más frecuentes, el control médico, el tratamiento y la evolución.

De esta manera se podrá evaluar la eficacia del Programa de Salud Renal y planificar estrategias para mejorar la calidad de la atención médica. Para ello es necesario que los datos de su historia clínica y los de todas las personas con Enfermedad Renal sean almacenados en la Base de Datos del Registro ubicada en el Fondo Nacional de Recursos, bajo la responsabilidad de la Comisión Honoraria de Salud Renal.

Este registro podría beneficiar en el futuro a los pacientes que sufran Enfermedad Renal, incluso a Usted.

Confidencialidad

Si acepta que los datos de su historia clínica se incluyan en la Base de Datos del Registro, la información será guardada confidencialmente de acuerdo con la legislación vigente. Su identidad así como cualquier información obtenida en relación con el registro será confidencial. La estructura de la base de datos del registro separa la información que lo identifica del resto de sus datos y ambas informaciones se asociarán únicamente a los efectos de su atención médica

Estoy de acuerdo en que datos de mi historia clínica sean almacenados en la base de datos del Fondo Nacional de Recursos – Ministerio de Salud Pública y utilizados estrictamente para los fines antes descritos. Entiendo que la decisión de participar o no en el Registro no afectará el cuidado médico que recibo, ni recibiré ninguna remuneración especial por participar

FIRMA DEL PARTICIPANTE

FIRMA DEL MÉDICO

ACLARACIÓN y C.I.

ACLARACIÓN y C.I.

Fecha: / /

Dra. Laura Solá. Comisión Honoraria de Salud Renal. Fondo Nacional de Recursos. Fono: 901 40 91 (Int 141). E-mail: chsr@fnr.gub.uy