Figures and Tables

Figure 1: 71 Completed multidisciplinary CKD Clinic surveys by province

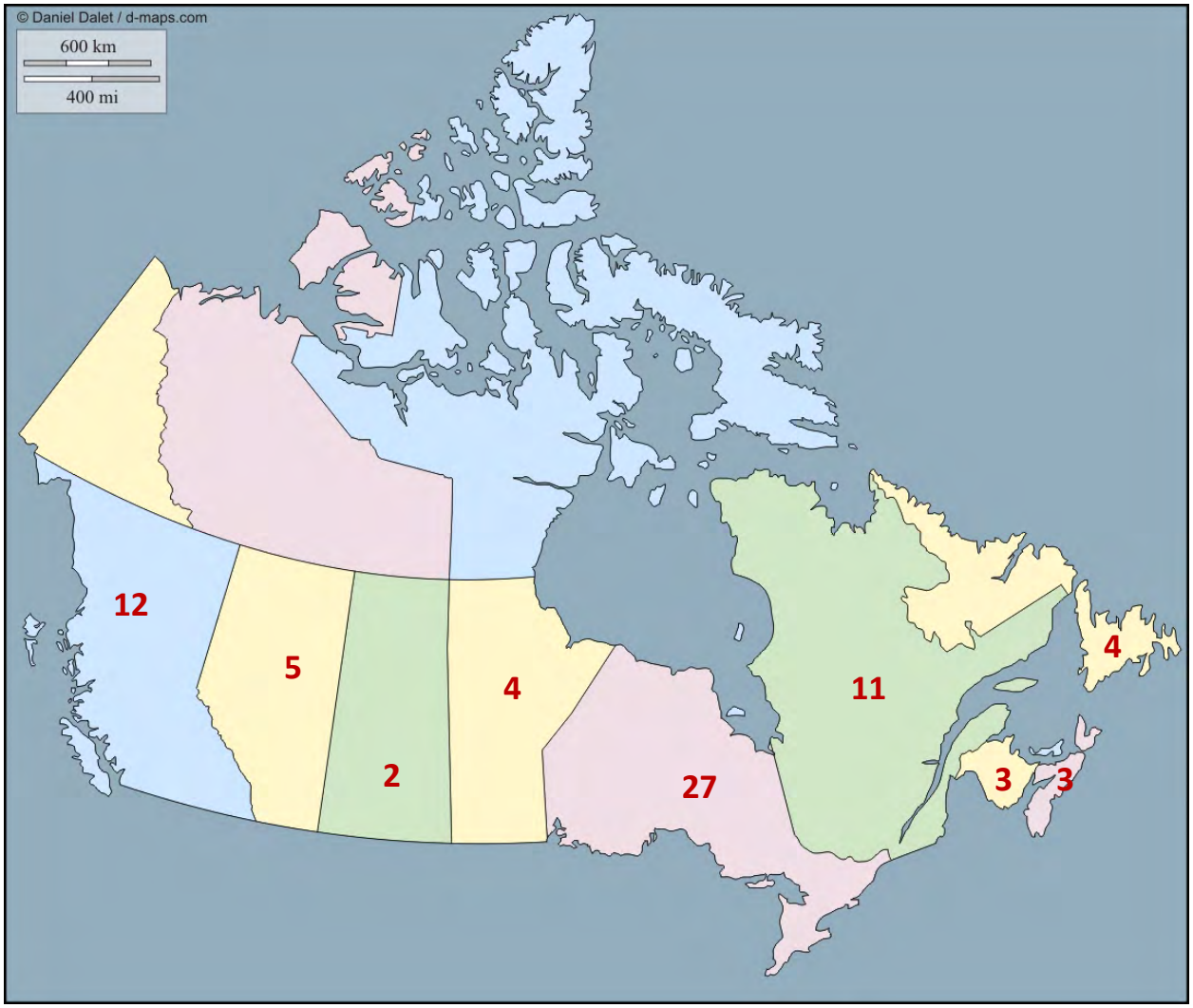
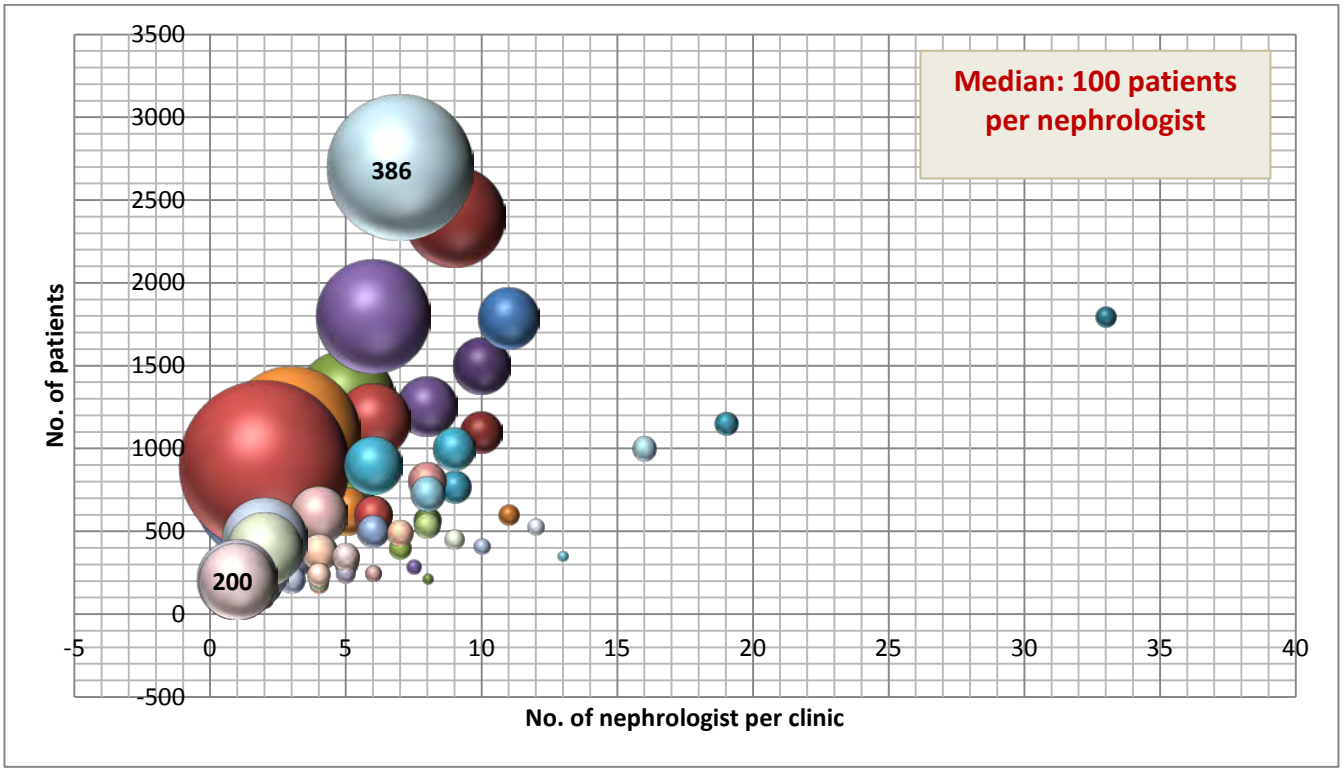
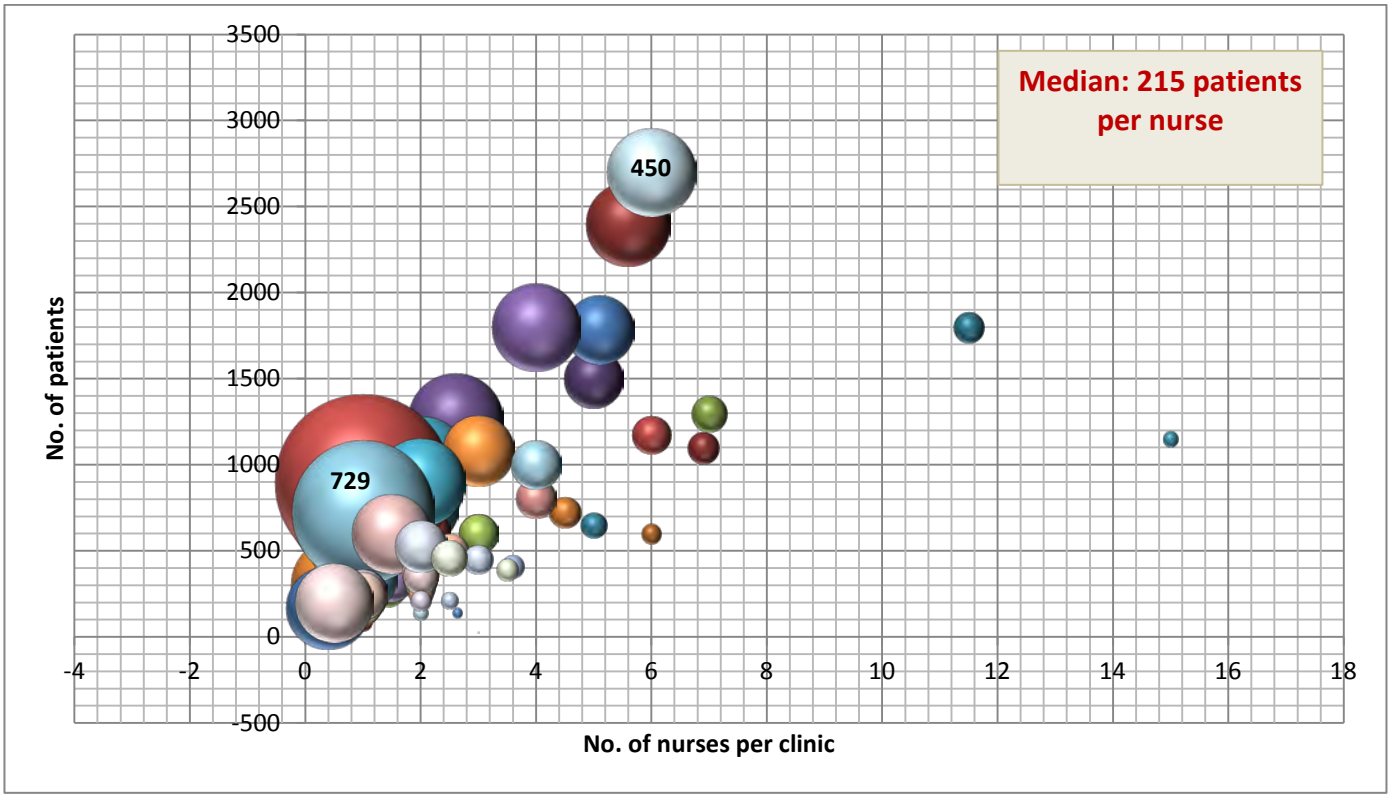


Figure 2: The number of patients and nephrologists in each multidisciplinary CKD clinic



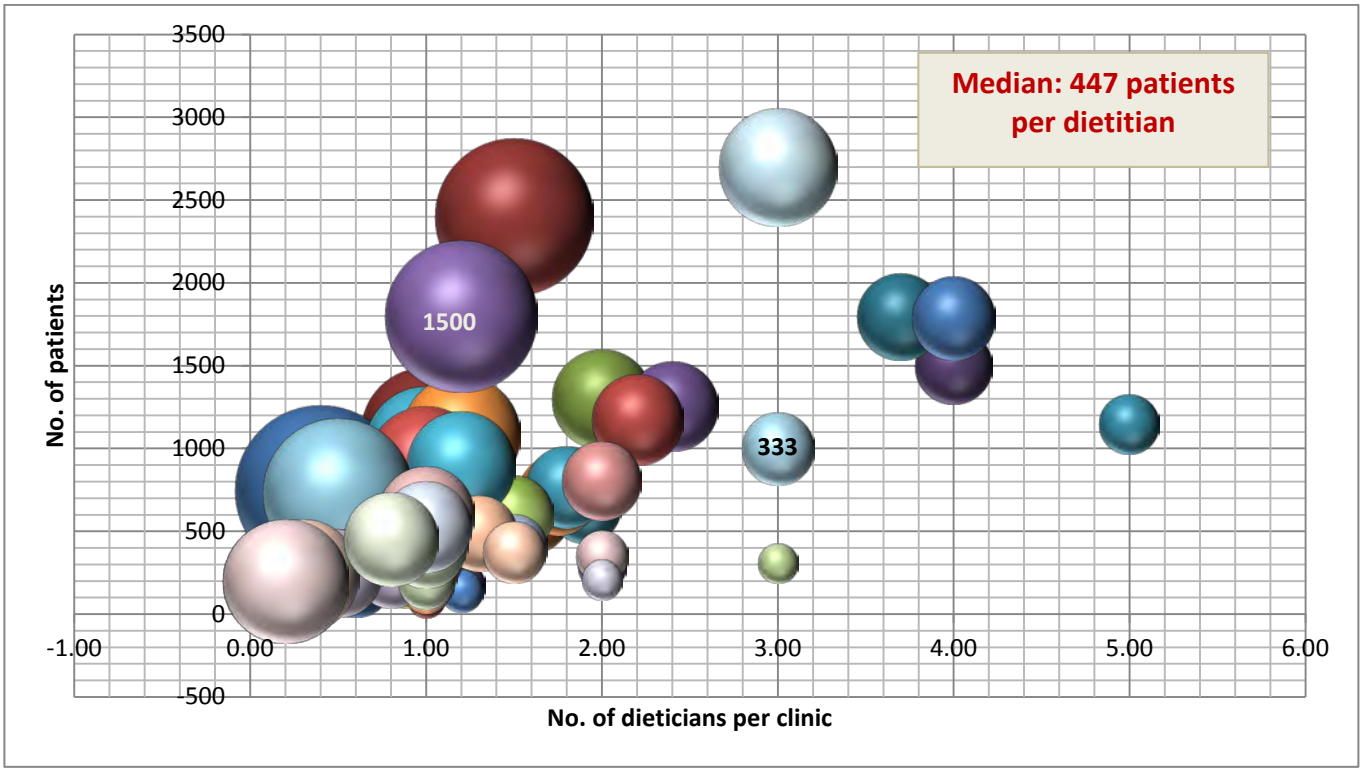
* Each bubble represents the ratio of the number of patients/ number of nephrologists (larger bubbles represent a larger ratio)

Figure 3: The number of patients and nurses in each multidisciplinary CKD clinic



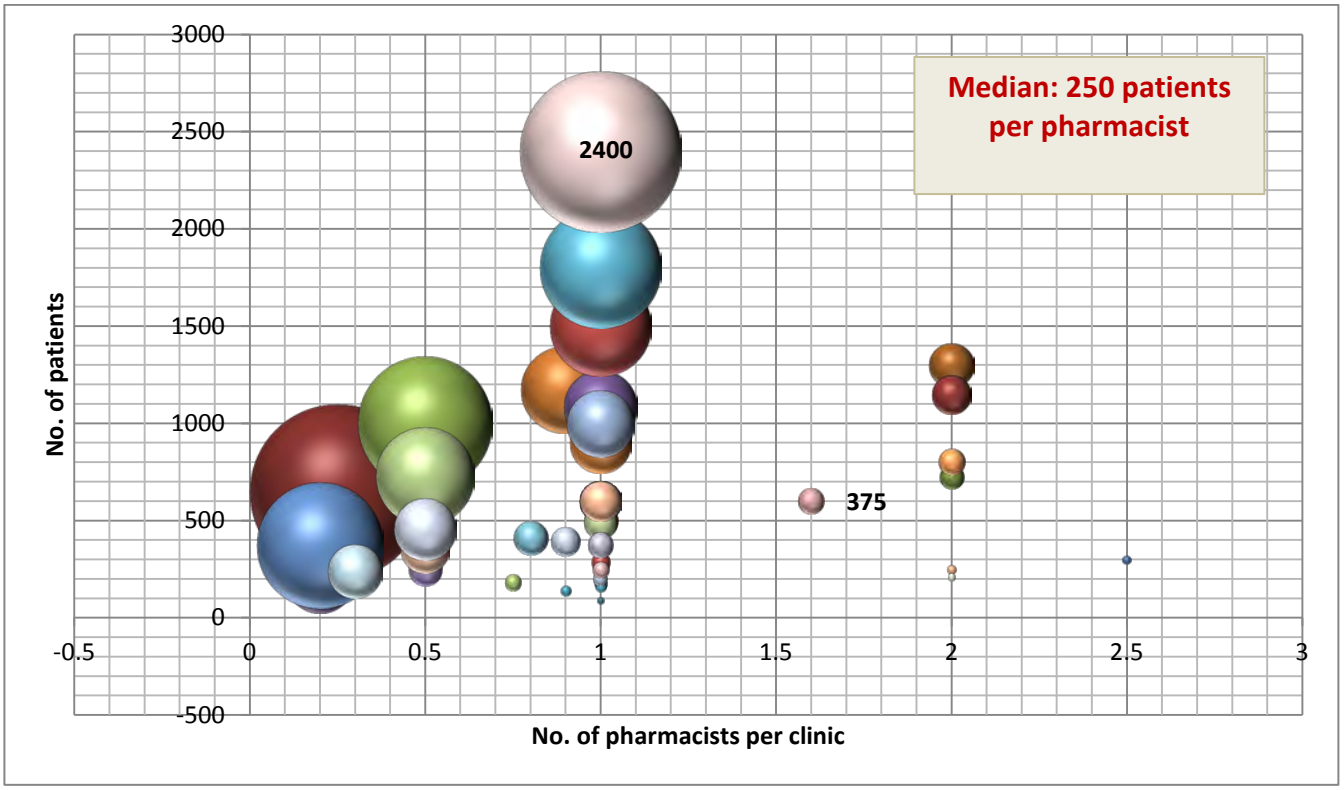
* Each bubble represents the ratio of the number of patients/ number of nurses (larger bubbles represent a larger ratio)

Figure 4: The number of patients and dietitians in each multidisciplinary CKD clinic



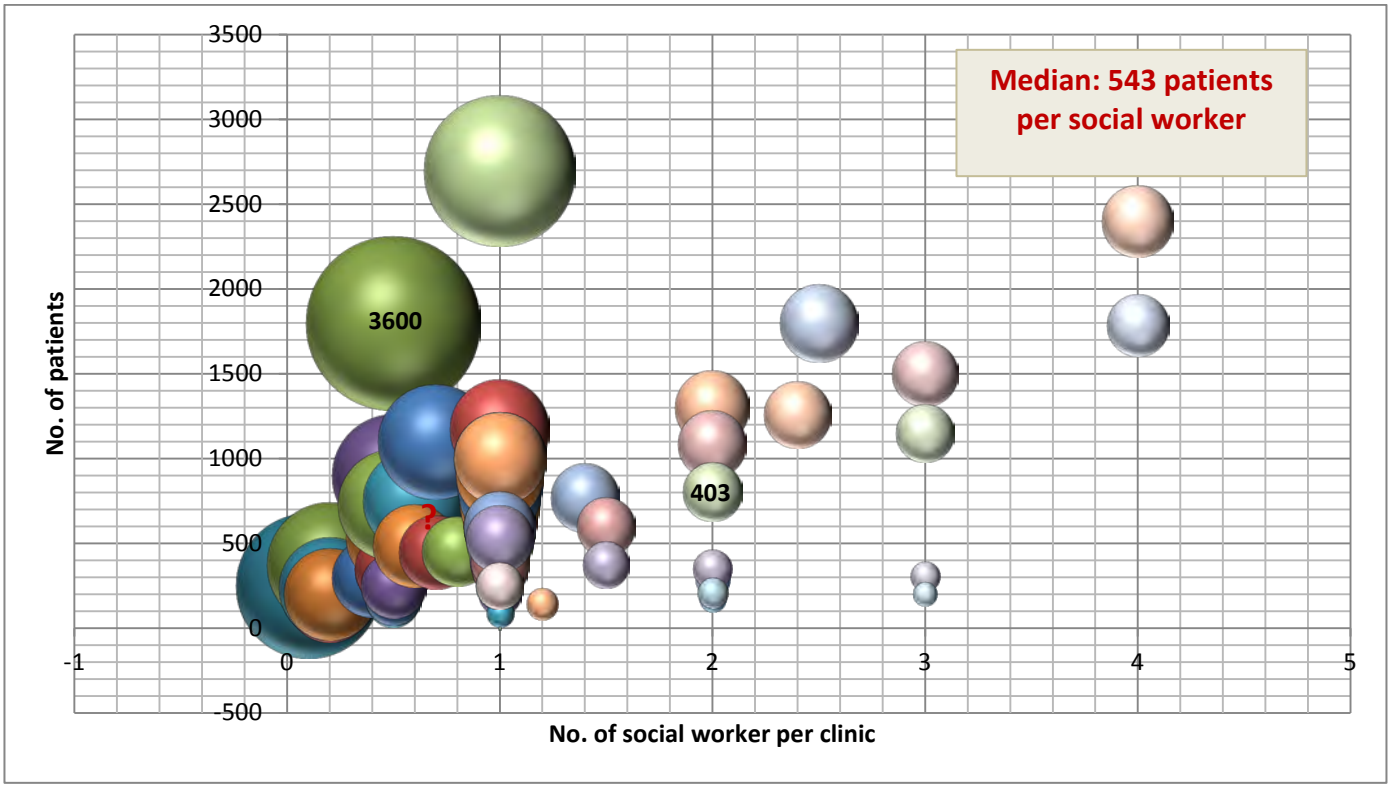
* Each bubble represents the ratio of the number of patients/ number of dietitians (larger bubbles represent a larger ratio)

Figure 5: The number of patients and pharmacists in each multidisciplinary CKD clinic



* Each bubble represents the ratio of the number of patients/ number of pharmacists (larger bubbles represent a larger ratio)

Figure 6: The number of patients and social workers in each multidisciplinary CKD clinic



* Each bubble represents the ratio of the number of patients/ number of social workers (larger bubbles represent a larger ratio)

Figure 7: The percentage of clinics that work within renal programs offering different types of dialysis

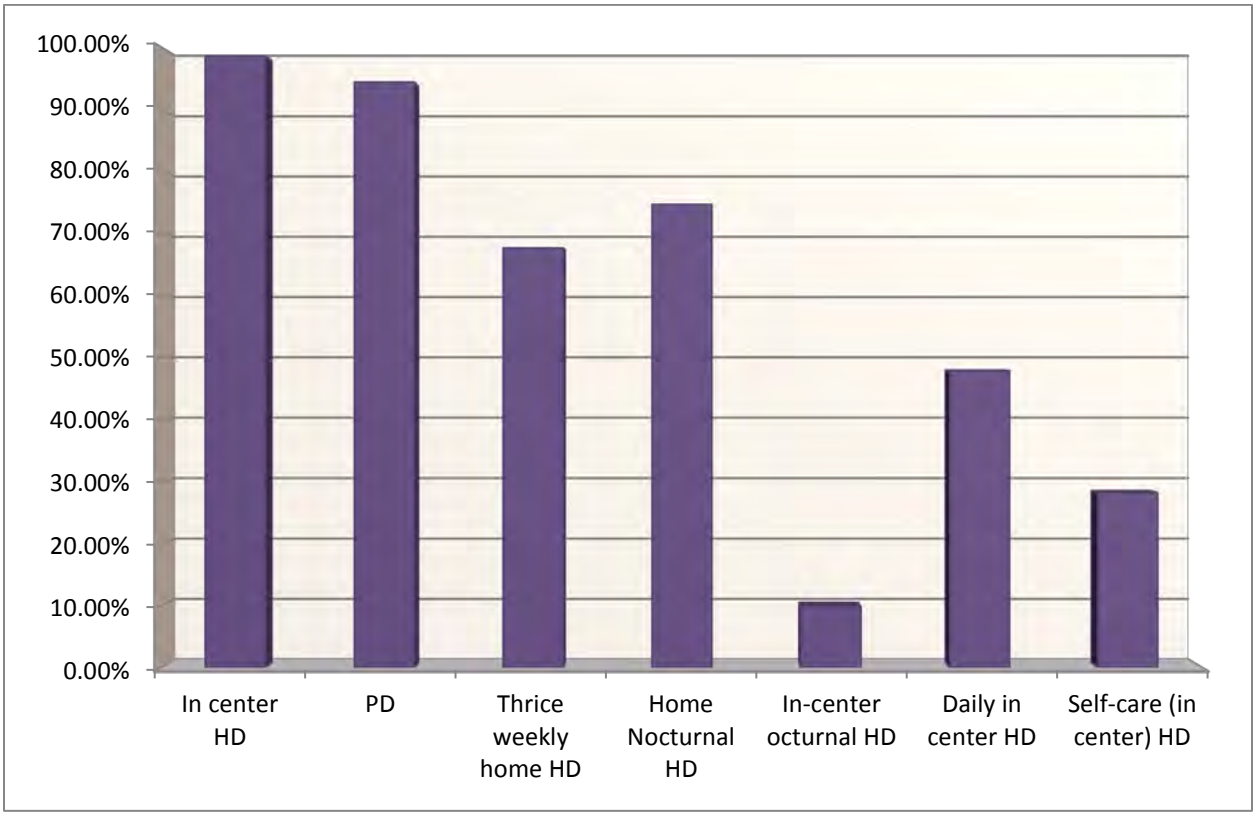


Table 1: The characteristics of multidisciplinary CKD clinics

Referral criteria to CKD clinic		
Referral criteria?	57/71	**80.28%**
eGFR cut off as part of the criteria?	35/57	**61.40%**
Management of patients nearing dialysis initiation		
Policy whereby all patients assessed for home dialysis	52/71	**73.24%**
All patients offered dialysis modality education?	71/71	**100.00%**
Dialysis modality education		
During clinics visits or through educational materials	29/71	**40.85%**
Group dialysis modality education (or combination)	42/71	**59.15%**
Decision to initiate dialysis made in conjunction with regular multidisciplinary team meetings	27/71	**38.03%**
Dedicated dialysis modality coordinator? *	23/71	**32.39%**
Do they see all patients who are approaching the need for dialysis?	18/23	**78.26%**

*though individual nurses may fulfill this role in some centers

Table 2: Targets are in use for home dialysis therapies

Centers are aware of home dialysis target	**53/71**	**74.65%**
Target is based on prevalent patients	22/53	**41.51%**
Target is based on incident patients	4/53	**7.55%**
Both	26/53	**49.06%**

Figure 8: Decision to start on patient on dialysis - reviewed/ decision made by whom?

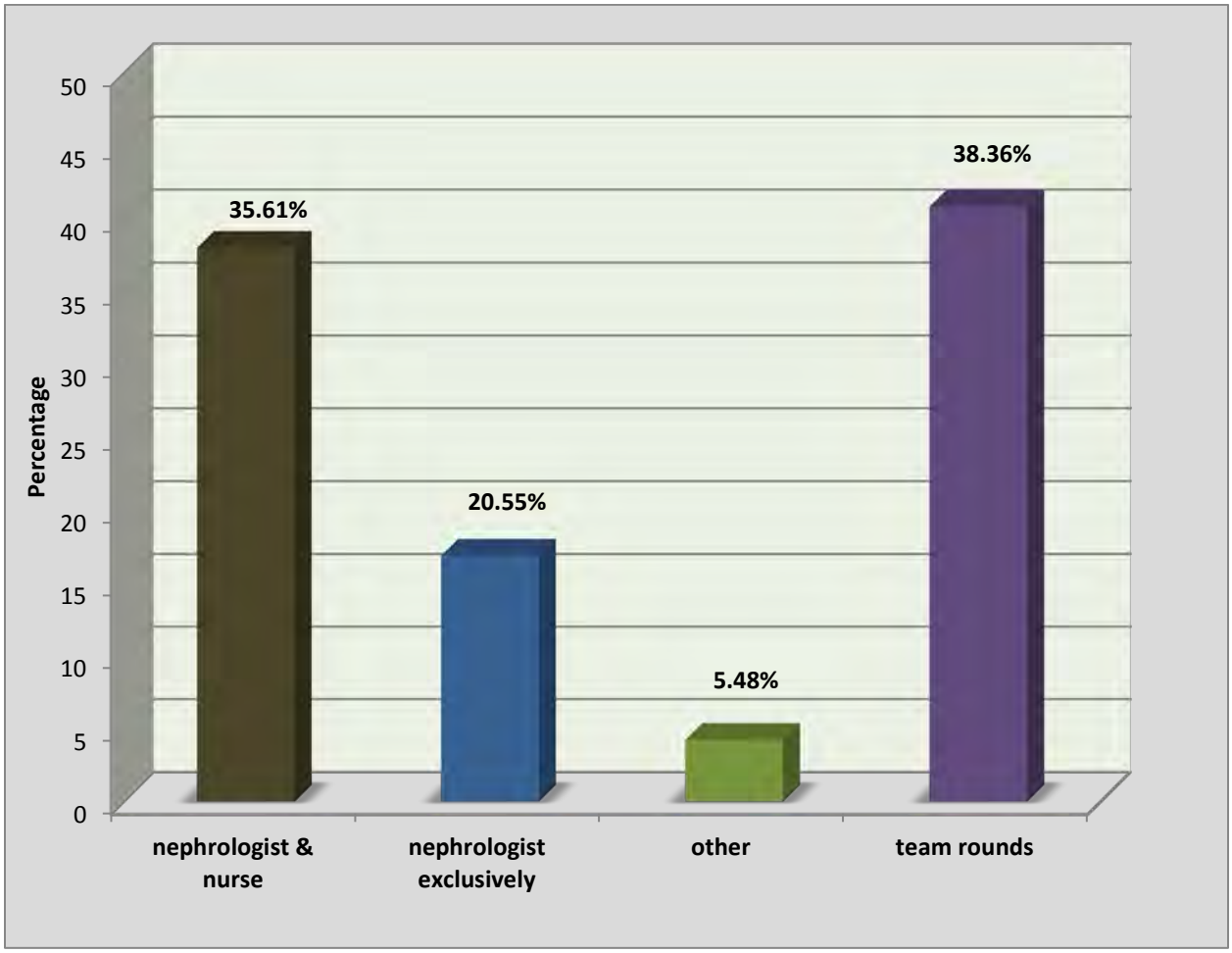


Figure 9: Model of nephrologist and nurse care within the CKD clinic

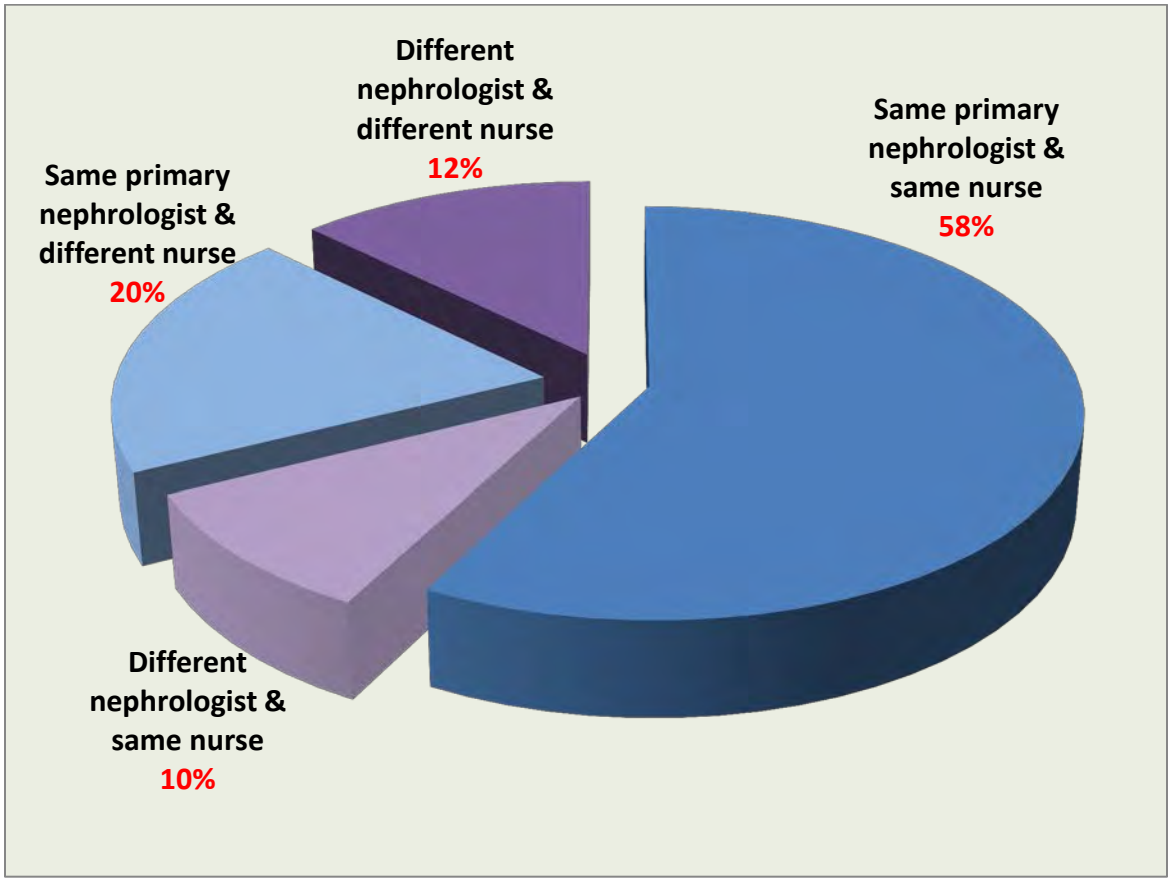


Table 3: Multidisciplinary CKD clinic staff opinions for program improvement

	Suggestions for improvement (overall themes)
1	Request for more staff (or more time from existing staff) (nurses, nephrologists, experts, clerical staff, data leads, etc)
2	Need for more space
3	Need for more/improved/standardized teaching or educational aids/tools
4	Need for better CKD clinic processes (better flow of patient referral, standardized guidelines, decrease wait times, offer telehealth, offer clinical pathway, timely insertion of catheters, better communication, team model, etc)
5	Encourage home therapies, more dialysis options, support for dialysis for patients in rural communities , early identification of patients for home therapies, patient council, etc.
6	Early outreach/referral of patients, preventative programs

Table 4: Multidisciplinary CKD clinic staff opinions about things that worked well in their renal programs

	What worked well in the care of patients with kidney disease (overall themes)
1.	Starting new initiatives around conservative care as more people are choosing this option.
2.	Developing in-house teaching and educational tools that are specific to their population/clinic
3.	Traveling band of health care providers who provide outreach in the community for early CKD detection
4.	The “buddy system” (dedicated nurse assigned to a patient who worked with the nephrologists) allows for greater interaction with the patient and builds trust.
5.	A nurse-led telehealth clinic in a remote area allows CKD patients to stay in their communities while being followed by the multidisciplinary team in a large center.
6.	Patient support groups (where patients support new patients)
7.	Having a strong/well-resourced team of unit clerks and administrative staff at the CKD clinics play a large and important role in clinic activities.
8.	Inclusion of CKD patients in QI project teams
9.	Having a strong multidisciplinary team, dedicated and supportive staff, and good teamwork despite limited resources
10.	Timely and appropriate vascular access