

Safety in Transitions from CKD to Dialysis

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Transitions from CKD to Dialysis

Challenges in Patient Safety

- Health care system (hospitalization risks)
- Communication between providers
- Access placement
- Dialysis treatment complications
- “Crashing” into hospital for first dialysis
- Catheter vs. Fistula (risk of infection)
- Lack of patient knowledge and information
- More frequent hospitalization

Mortality Rates in the ESRD Medicare Population

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Unadjusted & adjusted mortality rates in the ESRD & general Medicare populations, age 65 & older (per 1,000 patient years at risk)

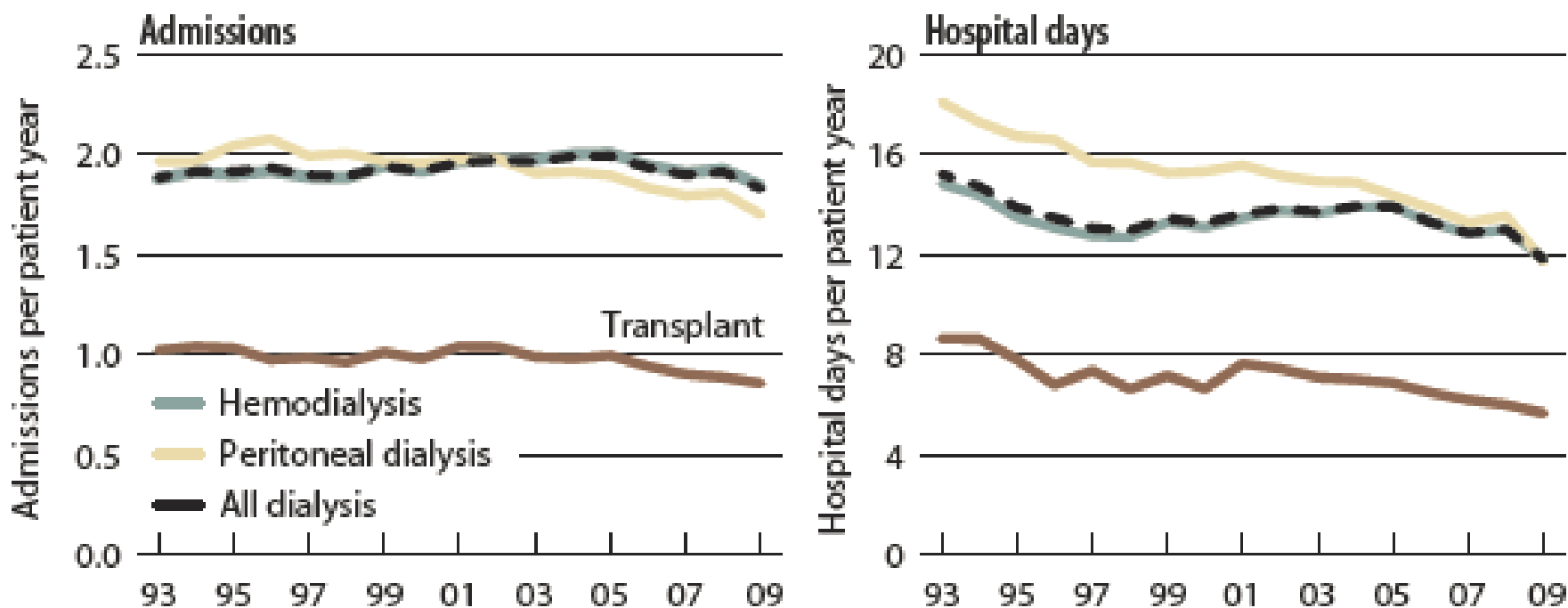
	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Unadjusted															
ESRD	321	322	318	322	325	318	315	310	303	297	293	282	272	262	254
Dialysis	336	339	337	342	347	340	340	336	330	327	325	316	307	299	292
Transplant	99	94	87	99	93	98	94	90	92	88	86	82	82	75	78
Adjusted															
ESRD	377	371	361	362	363	356	354	344	330	323	291	301	290	281	281
Dialysis	386	381	373	373	377	370	368	359	346	337	311	321	312	304	304
Transplant	186	188	198	204	174	208	184	174	175	177	139	151	138	127	151

Adjusted hospital admission rates & days, by modality

Figure 3.2 (Volume 2)

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Adjusted hospital admission rates & days, by modality



Period prevalent ESRD patients. Adj: age/gender/race/primary diagnosis; ref: ESRD patients, 2005.

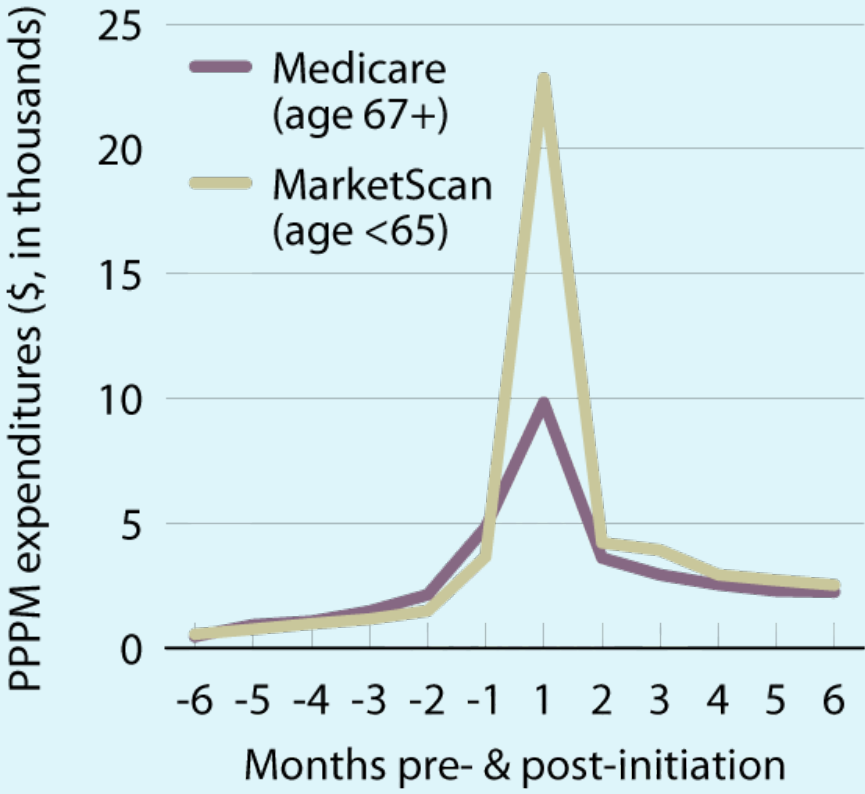
Savings By Delaying Start of Dialysis

Cost for a patient with CKD compared to CKD Stage 5 on dialysis

- CKD, 6 months before dialysis: **\$878/month**
- Next 5 months: **\$3,114/month**
- First month of dialysis: **\$14,781/month**
- Next 5 months: **\$6,747/month**

Per person per month inpatient costs during the transition to ESRD, 2007

Figure 11.9 (Volume 2)



Medicare: patients 67 years & older, initiating in 2006, with Medicare as primary payor.
MarketScan: ESRD patients age <65, initiating in 2007.

Transitions from CKD to Dialysis

Potential Solutions for Better Safety

- Prevention of progression to dialysis
- CKD Program
 - Relationship building
 - Patient education
 - Diet
 - Medication adherence
 - Transplant readiness
 - Choice of modality or medical management
 - Access types and care of access (“Ticket”)
 - CKD program documentation
 - TCC - provider to provider communication and documentation

Benefits of Early Intervention

- Fewer progress to CKD Stage V and dialysis
- Fewer start in hospital—more in clinic
- More patients choose to dialyze at home
- More patients dialyze with permanent access
- Increased patient involvement and decision-making regarding:
 - Transplantation
 - Seeing nephrologists and vascular surgeons
 - “Management” but no dialysis

CKD Screening

Screening recommendations

- Blood pressure
- Blood glucose
- GFR
- Albumin in urine

For more information

National Kidney and Urologic Disease Information
Clearinghouse

Toll free at 1-866-4 KIDNEY
(1-866-454-3639)

www.nkdep.nih.gov

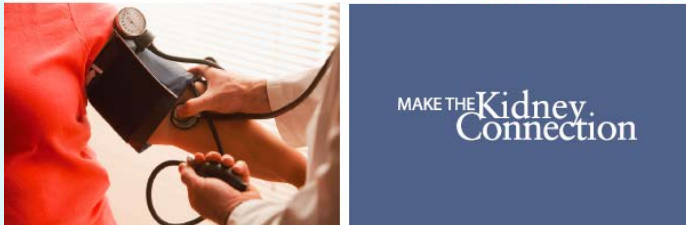


Focused Demographic CKD Screening

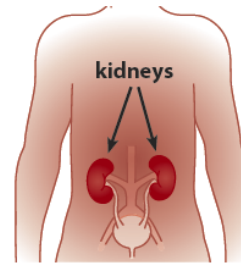
<http://www.nkdep.nih.gov/resources/get-checked-kidney-disease.shtml>

What African Americans with Diabetes or High Blood Pressure Need to Know

Get Checked for Kidney Disease



 **NKDEP**
National Kidney Disease
Education Program



You have two kidneys located near the middle of your back, just under your rib cage. Their main job is to filter wastes and extra water from the blood to make urine. Wastes can build up in the body when the kidneys are damaged.

How will I be checked for kidney disease?

Two tests are used to check for kidney disease:

- A blood test checks your GFR, which tells how well your kidneys are filtering. GFR stands for glomerular filtration rate.
- A urine test checks for albumin. Albumin is a protein that can pass into the urine when the kidneys are damaged.

FACTS:

- Diabetes is the #1 cause of kidney failure among African Americans. High blood pressure is the #2 cause.
- African Americans have a higher rate of kidney failure than any other group of people.

Recommendations for CKD Education

1. GFR < 60 -- Early education to delay progression -- goal of *preventing* the transition to dialysis
2. GFR < 30 -- Education re: options and navigation services.
 - transplant
 - medical management without dialysis
 - home dialysis
 - importance of permanent access if choose in center dialysis
3. Navigation services to help patient be empowered to implement best therapy for him/her
 - partner with champion access surgeon, and make appointment for placement of access
 - help in navigating system to get on transplant list at GFR 20, instead of waiting for dialysis

Recommendations for CKD Education

4. Partner with local nephrologists to follow patient more closely as approach need for dialysis, treat symptoms, delay time that need to start
5. Arrange for first treatment in clinic, not in hospital
6. Utilize EMR in CKD clinic to build demographics, medication list, H&P, episodes of care, lab work, payer information, etc. to promote easier transition from CKD to dialysis
7. Early intervention through CKD education promotes a *safer* transition from CKD to dialysis or transplantation.

Job Description for CKD / Integrated Care Coordinator

Essential Duties and Responsibilities:

- Education of patients and families in the community, identifying those at risk and following referral protocols.
- Educate patients and families about treatment options, including transplantation, home therapies, and in-center therapies (individual and group education).
- Encourage prevention of need for dialysis
- Encourage transplantation as the treatment of choice
- Encourage early placement of fistula, regardless of treatment option chosen.
- Integrated care coordination follows and coordinates care of the patient as s/he approaches the need for renal replacement through the first 90 days of renal replacement.

Job Description for CKD / Integrated Care Coordinator

Qualifications:

1. Registered Nurse with current licensure in applicable state(s).
2. Applicant must have strong leadership skills, excellent communication skills and a demonstrated high level of clinical excellence.
3. Minimum of 3 years hemodialysis experience.
CNN or equivalent certification in nephrology nursing is strongly preferred.
4. Must possess and maintain valid CPR certification.
5. Other skills required include the ability to teach to various education level audiences, the ability to use Microsoft applications to track progress and develop reporting tools.

Citations

National Kidney and Urologic Disease Information Clearinghouse.

<http://www.nkdep.nih.gov/resources/get-checked-kidney-disease.shtml>

U.S. Renal Data System, USRDS 2011 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2011.

<http://www.usrds.org/adr.aspx>