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

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

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<th>Year</th>
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<th>Adjusted</th>
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USRDS 2011 Annual Data Report (ADR)
Adjusted hospital admission rates & days, by modality

Figure 3.2 (Volume 2)


USRDS 2011 ADR
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

What African Americans with Diabetes or High Blood Pressure Need to Know
Get Checked for Kidney Disease

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
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.
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.
National Kidney and Urologic Disease Information Clearinghouse.  

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