Expert Teams – Home Dialysis

Case-Based Learning & Mentorship

Thursday, June 23, 2022

Facilitator: Julie Moss, ESRD National Coordinating Center

Meeting Logistics

- Call is being recorded
- Attendees are welcome to unmute their own line
  - Please stay on mute unless you are speaking
  - Do not place the call on “hold”
- Everyone is encouraged to use the video and chat features
- Meeting materials will be posted to the ESRD NCC website.

Meeting Guidelines

INTRODUCE YOURSELF BEFORE SPEAKING

KEEP PATIENT-SPECIFIC INFORMATION CONFIDENTIAL

BE WILLING TO SHARE SUCCESSES AND DIFFICULTIES

BE OPEN TO FEEDBACK

ASK THE DIFFICULT QUESTIONS

RESPECT OTHERS

USE "…AND" STATEMENTS

KEEP TO TIME LIMITS

Introductions

- Meeting Focus – Improving Access to Home Dialysis
- Guest Expert – Sijie Zheng, MD, PhD, FASN, FNKF
- Case Study Presenter – Theresa Gwinnett MS, RD
- High Performing Organizations
- ESRD Networks
- Centers for Medicare & Medicaid Services (CMS)

What are Expert Teams?

- A group made up of individuals from different high performing organizations, each with their own deep experience and knowledge
- Help others learn faster by sharing what worked (and what didn't work) in their organization
- Bring the best possible solutions to the table
- Continually learn and improve

Questions to Run On

How Might We …

- Collaborate with other healthcare providers and stakeholders to increase the number of patients that start dialysis at home?
- Educate differently to increase patient transition to a home modality?
- Utilize telemedicine more effectively to provide patients with access to a home modality?

Presentation by Guest Expert

Sijie Zheng, MD, PhD, FASN, FNKF

The Permanente Medical Group/Kaiser Permanente Northern California

Non-Compliance/Adherence Patient?

- 40 Y male with HTN, DM, ETOH use, obesity
- Presented with cellulitis in Dec, 2021,
- Found to have creatinine of 10 g/dl, was 6-7 g/dl few months ago
- was followed by a nephrologist (Multiple calls to arrange appointment with patient has been ignored).
- Also has anemia, hyperphosphatemia, hypocalcemia and acidosis (16-17).
- Still making urine.
- No uremic symptoms, no EKG changes

Non-Compliance/Adherence Patient?

- He lives with his partner in a house,
- Owns his house
- Work full time at a radio station, enjoys his work

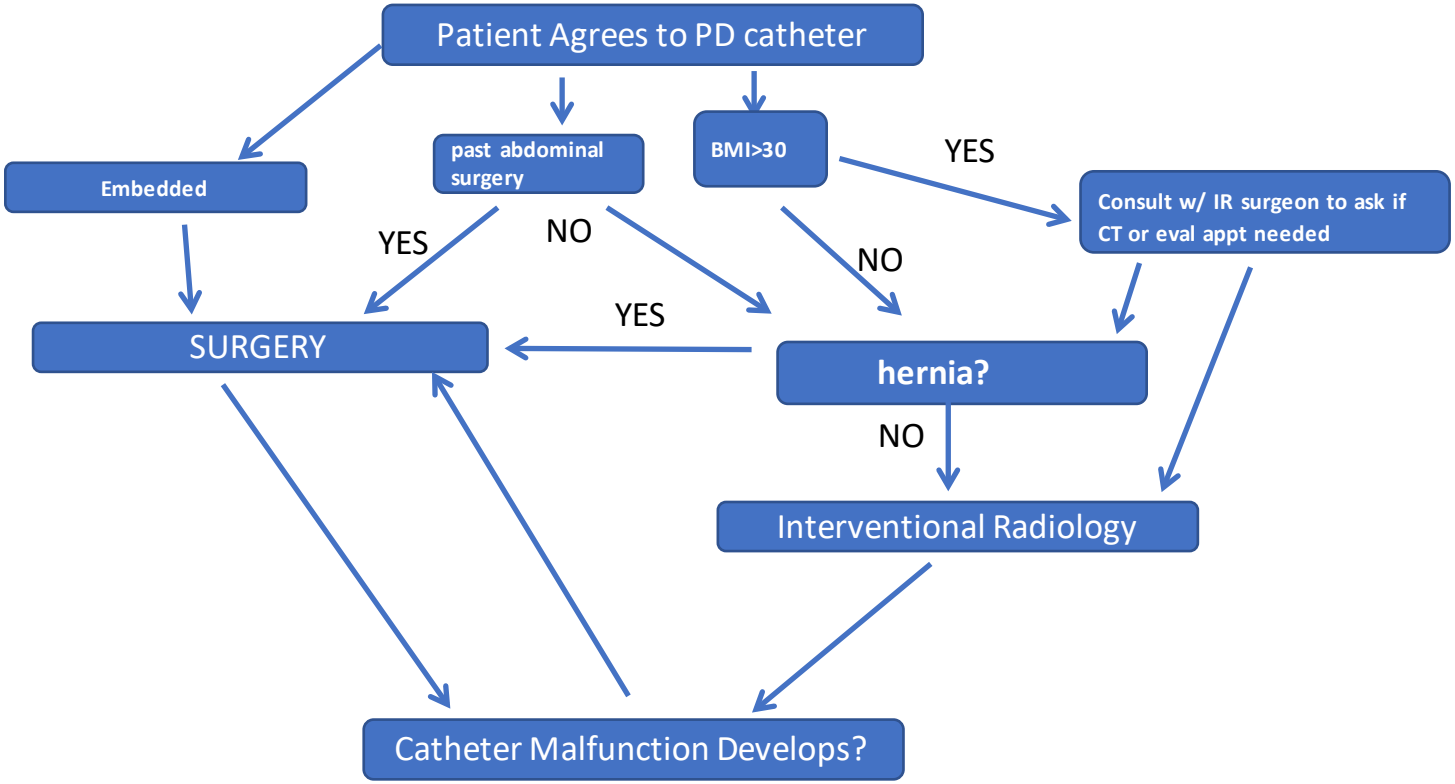
- I had a prolong discussion at bedside with him and his partner:
  - PD vs. ICHD vs. HHD.
- Given his young age, working, owns his home and has family support, I recommend PD or HHD first, can switch to ICHD if he decides/not able to do later.

Non-Compliance/Adherence Patient?

- Pt chose PD
- Surgeon on vacation that 2 weeks.
- BMI of 36. (IR usually place under BMI of 30).

- Patient was discharged home and plan for outpatient PD catheter placement in 2 weeks.

KP East Bay Peritoneal dialysis catheter IR/Surgery decision tree



Note: Pls indicate placement timeframe:

- within 1 wk: check with surgeons, hosp admit?
- within 2-4 wks: consider IR if pt is appropriate or check with surgeons
- within 4-6 wks or more: Surgery's routine schedule unless otherwise specified

Updated 2/14.2022 bvy RNS/RN

Case

- Presented with cough, phlegm, and weakness. with subjective fevers. able to walk around, feed himself, but poor appetite.
- Also has a productive cough with clear phlegm

Case

- Positive COVID test
- Creatinine of 10, HCO: 11, K: 5.5
- Surgery postponed for 7 weeks due to COVID per anesthesiology guideline.

- Start HD via a temporary CVC in the hospital
- HD x 5

- PD catheter placement by IR
- Temporary CVC removed.

Case

- Urgent PD start 2 days later at outpatient PD clinic
- Doing well on PD.

AJKD
Perspective

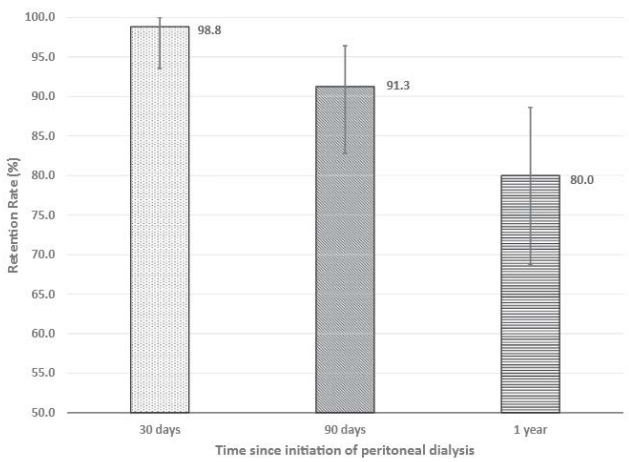
Urgent-Start Peritoneal Dialysis: A Chance for a New Beginning

Rohini Arramreddy, MD,[1,2] Sijie Zheng, MD,[3] Anjali B. Saxena, MD,[1,4] Scott E. Liebman, MD,[5] and Leslie Wong, MD[1,2]

Peritoneal dialysis (PD) remains greatly underutilized in the United States despite the widespread preference of home modalities among nephrologists and patients. A hemodialysis-centric model of end-stage renal disease care has perpetuated for decades due to a complex set of factors, including late end-stage renal disease referrals and patients who present to the hospital requiring urgent renal replacement therapy. In such situations, PD rarely is a consideration and patients are dialyzed through a central venous catheter, a practice associated with high infection and mortality rates. Recently, the term urgent-start PD has gained momentum across the nephrology community and has begun to change this status quo. It allows for expedited placement of a PD catheter and initiation of PD therapy within days. Several published case reports, abstracts, and poster presentations at national meetings have documented the initial success of urgent-start PD programs. From a wide experiential base, we discuss the multifaceted issues related to urgent-start PD implementation, methods to overcome barriers to therapy, and the potential impact of this technique to change the existing dialysis paradigm.
Am J Kidney Dis. ■(■):■-■.

INDEX WORDS: Peritoneal dialysis; urgent peritoneal dialysis; urgent-start peritoneal dialysis; late end-stage renal disease (ESRD) referral; acute-start peritoneal dialysis; acute peritoneal dialysis.

Urgent Start Peritoneal Dialysis: A Population-Based Cohort Study



Original Research

Kidney Medicine

Urgent Start Peritoneal Dialysis: A Population-Based Cohort Study

Neelam M. Bhalla, Neiha Arora, Jeanne A. Darbinian, and Sijie Zheng

Implementation of a Staff-Assisted PD Program in the United States

Implementation of a Staff-Assisted Peritoneal Dialysis Program in the United States
A Feasibility Study

Wael F. Hussein,[1,2] *Paul N. Bennett*,[1,3] *Ayesha Anwaar*,[1,2] *Jugjeet Atwal*,[1] *Veronica Legg*,[1] *Graham Abra*,[1,2] *Sijie Zheng*,[4] *Leo Pravoverov*,[4] *and Brigitte Schiller*[1,2]

CJASN 17: 703–705, 2022. doi: https://doi.org/10.2215/CJN.00940122

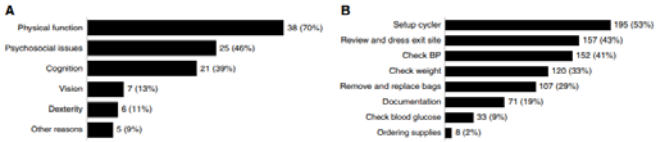


Figure 1. | **Referral indications and provided services.** (A) Indications for referral to staff-assisted peritoneal dialysis (number and percentage of patients) and (B) services provided (number and percentage of visits). Percentages do not add up to 100% as categories are not mutually exclusive. Commonly documented services under the "other" category (not shown) included observing patients perform the aseptic technique correctly and moving and organizing supplies.

Conclusion

- 1. Dialysis Initiation should not be based on eGFR value, instead should be based on patient clinical situation and readiness (opinion):
  - IDEAL Study
  - Predialysis eGFR varies among countries, average:
    - 5 ml/min per 1.73 m^2 in Taiwan;
    - 8.5 in the UK,
    - 7.3 in Australia,
    - 6.4 in New Zealand,
    - 9–10 in Canada and France,
    - 11 in the US

Conclusion

- 2. Knowing patient's social, living, employment and family situation are as important as clinical information.
- 3. Every patient is unique; therapy need to fit his/her lifestyle to minimize disturbance of their routines.
- 4. try to understand why "non-compliance/non-adherence".
- 5. family support is crucial
- 6. Need to make "recommendation"; not "let patient decide" or "decide for the patient".
- 7. It takes a village to take of ESRD patients, building a good team/relationship/network with your surgeons, IR, nurses, hospital administrators, dialysis providers are good "investment" that will yield great "Dividend'.

Reference

- Sood MM, Manns B, Dart A, et al. Variation in the level of eGFR at dialysisinitiation across dialysis facilities and geographic regions. Clin J Am SocNephrol. 2014;9:1747–1756.
- Gilg J, Pruthi R, Fogarty D. UK Renal Registry 17th Annual Report: Chapter1 UK Renal Replacement Therapy Incidence in 2013: National andCentre-specific Analyses. Nephron. 2015;129(Suppl 1):1–29.
- United States Renal Data System. Annual Data Report 2017: ChronicKidney Disease (CKD) in the United States: Chapter 8: Transition of Carein Chronic Kidney Disease. Available at: https://www.usrds.org/2017/view/v1_08.aspx. Accessed February 8, 2018.
- ANZDATA Registry. 39th Report, Chapter 1: Incidence of End Stage KidneyDisease. Adelaide, Australia: Australia and New Zealand Dialysis andTransplant Registry; 2017. http://www.anzdata.org.au.

Q&As

Case Study Presentation & Discussion

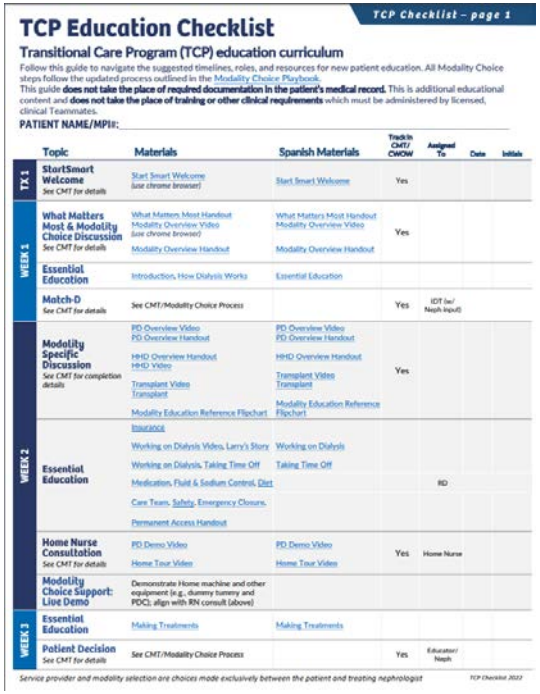
Theresa Gwinnett MS, RD
Renal Dietician
DaVita Hidden Valley Dialysis

Insights from a Transitional Care Unit

Theresa Gwinnett MS, RD

Value of the TCU

- Many ESRD patients crash into dialysis
- Limited time in hospital
- Thorough modality education
- Individualized for the patient



TCP Checklist – page 1

TCP Education Checklist

Transitional Care Program (TCP) education curriculum

Follow this guide to navigate the suggested timelines, roles, and resources for new patient education. All Modality Choice steps follow the updated process outlined in the Modality Choice Playbook.
This guide **does not take the place of required documentation in the patient's medical record.** This is additional educational content and **does not take the place of training or other clinical requirements** which must be administered by licensed, clinical Teammates.

PATIENT NAME/MPI#:

	Topic	Materials	Spanish Materials	Track in CMT/ CWOW	Assigned To	Date	Initials
TX 1	**StartSmart Welcome** *See CMT for details*	Start Smart Welcome *(use chrome browser)*	Start Smart Welcome	Yes			
WEEK 1	**What Matters Most & Modality Choice Discussion** *See CMT for details*	What Matters Most Handout Modality Overview Video *(use chrome browser)* Modality Overview Handout	What Matters Most Handout Modality Overview Video Modality Overview Handout	Yes			
	Essential Education	Introduction, How Dialysis Works	Essential Education				
	Match-D *See CMT for details*	See CMT/Modality Choice Process		Yes	IDT (w/ Neph input)		
WEEK 2	**Modality Specific Discussion** *See CMT for completion details*	PD Overview Video PD Overview Handout HHD Overview Handout HHD Video Transplant Video Transplant Modality Education Reference Flipchart	PD Overview Video PD Overview Handout HHD Overview Handout Transplant Video Transplant Modality Education Reference Flipchart	Yes			
	Essential Education	Insurance Working on Dialysis Video, Larry's Story Working on Dialysis, Taking Time Off Medication, Fluid & Sodium Control, Diet Care Team, Safety, Emergency Closure, Permanent Access Handout	Working on Dialysis Taking Time Off		RD		
	Home Nurse Consultation *See CMT for details*	PD Demo Video Home Tour Video	PD Demo Video Home Tour Video	Yes	Home Nurse		
	Modality Choice Support: Live Demo	Demonstrate Home machine and other equipment (e.g., dummy tummy and PDC), align with RN consult (above)					
WEEK 3	**Essential Education**	Making Treatments	Making Treatments				
	Patient Decision *See CMT for details*	See CMT/Modality Choice Process		Yes	Educator/ Neph		

Service provider and modality selection are choices made exclusively between the patient and treating nephrologist

TCP Checklist 2022

Timing is key!

- Every patient is on a different timeline
- Perspective is warped in crisis state
- Patients need a reason that outweighs cons
- Motivational interviewing

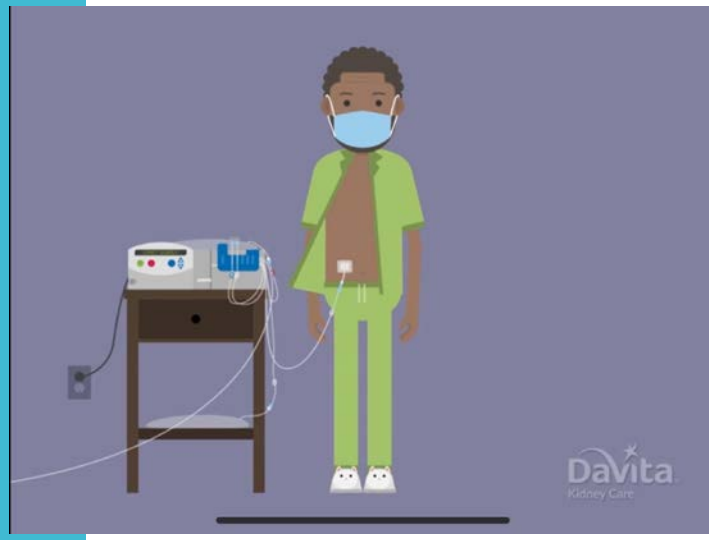
Understand Your Patient's Motivations

Healthcare Practitioner	Patient	Patient
Asks why patient would want to change ►	Explores own reasons for change ►	Reinforces own reasons

Case study 1

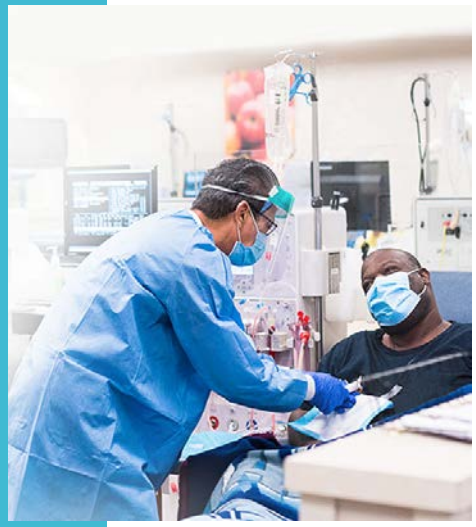
- 70 year old female with Diabetes
- Declined home dialysis in hospital and upon admit to clinic
- After **7 months,** had difficulty limiting fluid intake; icHD caused severe cramping
- **Reason**: less cramping

Case study 2



- 28 year old male with blurry vision
- Believed he was AKI
- Began to feel dizzy and nauseous after treatments
- Felt worse after **6 months**
- **Reason**: less fatigue and malaise

Case study 3



- 60 year old male with Diabetes
- Declined home dialysis; wanted aggressive fluid removal from legs
- After **2 months,** began to see progress and self efficacy improved
- Realized he could feel good enough to go back to work one day
- **Reason**: go back to work

Case Study Discussion and Q&As

Knowledge Into Action

Top Take-Aways

What is one thing you learned today that you could start doing immediately?

How will this action improve your current way of doing the practice/process?

Who is involved and how can they support the action to make it sustainable?

What If . . .

You took one thing you learned today and changed a current process in your organization

You shared information you learned today with colleagues from other facilities who were not on this call

You committed to …

Recap & Next Steps

- Additional pathways for learning
  - Sharing Best Practices to a greater community
  - Using Case Study examples to identify new ways of doing something and missed opportunities

- Next meeting – Thursday, September 22, 2022, at 2:00 p.m. ET

Social Media

ESRD National Coordinating Center

@esrd_ncc

@esrdncc

ESRD NCC | End Stage Renal Disease
National Coordinating Center (NCC)

Thank You

Julie Moss
jmoss@hsag.com
813-300-6145

This material was prepared the End Stage Renal Disease National Coordinating Center (ESRD NCC) contractor, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy nor imply endorsement by the U.S. Government. Publication Number FL-ESRD NCC-NC2TDV-06212022-01