

Expert Teams – Home Dialysis

Case-Based Learning & Mentorship

Thursday, March 28, 2024

Facilitator: Julie Moss, MS

ESRD National Coordinating Center



Meeting Logistics

- Call is being recorded
- Participants can unmute themselves
 - 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.



Who Is On The Call?

Clinician and
Practitioner
Subject Matter
Experts

Dialysis Facility
and Transplant
Professionals

ESRD Network
Staff

Kidney Care
Trade Association
Members

Centers for
Medicare &
Medicaid Services
(CMS) Leadership

What are Expert Teams?



Participants from varying levels of organizational performance, each with lived experience and knowledge, come together to support continual learning and improvement



Help others learn faster by sharing what worked and what didn't work around a particular case, situation, or circumstance



Bring the best possible solutions to the table

Home Dialysis Goals

- Increase the number of incident ESRD patients starting dialysis using a home modality
- Increase the number of prevalent ESRD patients moving to a home modality
- Increase the number of rural ESRD patients using telemedicine to access a home modality




Questions to Run On ...

- 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?

Guest Expert Presentation

Matthew Robinson, RN, CDN
Home Therapies Clinical Manager II
Fresenius Kidney Care Gardiner
Gardiner, Maine





Home Therapies Program Growth

MATT ROBINSON RN, HOME THERAPIES CLINICAL MANAGER

Key Components



Physician Referral
and referral process



Patient education



Retention



Referrals

- ▶ Physician:
- ▶ Pro home therapies
- ▶ Barriers to Peritoneal referrals
- ▶ Barriers to HHD referrals: Solo
- ▶ What can be done?



Referrals Continued:

- ▶ Referral Process:
- ▶ Kidney Care Advocate
- ▶ Communication with physician group
- ▶ Communication with the program manager and home team
- ▶ Pipeline Calls



Patient Education

- ▶ Kidney Care Advocate
- ▶ Transitional Care Unit and the home therapies team
- ▶ Home Champion

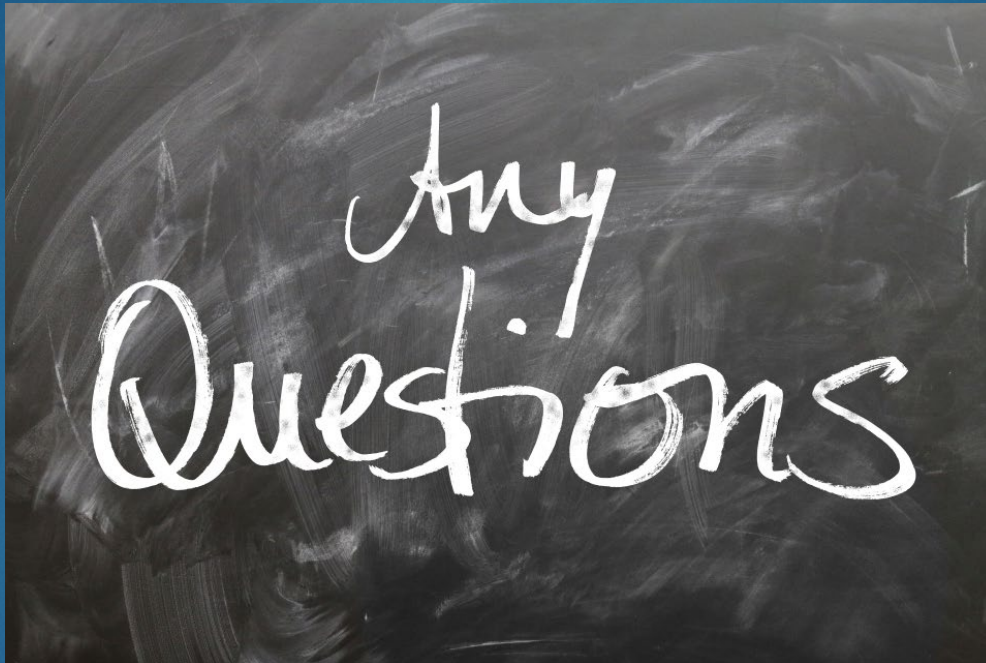


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Retention

- ▶ Staffing Calls: Assessing high risk patients
- ▶ Retention calls: Regionally based. Members of leadership, RN's, Social Work, Dietician, Area Technical Manager, involved home team.
- ▶ IDT meeting
- ▶ Respite
- ▶ TCU
- ▶ PD to HHD

Thank you



Case Study Presentations

Andre Guedez, MS, RD, LD
Minerva Douglas, RN
Medical Mall Dialysis
Jackson, MS

Jacqui Faidherbe, Facility Administrator
DaVita Hernando





Home Modality Expert Teams Presentation
March 28, 2024

Medical Mall Dialysis –
Jackson, MS
Independent Dialysis Facility

Andre Guedez,
MS, RD, LD

Minerva
Douglas, RN

Patient Case Study

- Started pediatric home dialysis at the age of 15; currently 24 years old.
- Originally from Mexico and self-pay.
- Has been able to apply for patient assistance programs for help with coverage.
- Transitioned to adult program in 2018 and switched to an adult dialysis machine in 2022.

Patient Case Study, cont.

- Very successful on home dialysis with no peritonitis infections. Extremely compliant with treatment.
- Successful trainings and reinforcement of proper techniques to avoid infections from a supportive RN staff.
- Proactive nephrologist that advocates for his patients.

Patient Case Study, continued .

- Nephrologist was persistent when working with local hospital and surgeon to provide this patient with a much-needed parathyroidectomy.
- Physician sent many messages to other physicians to review her case.
- Process of advocacy took over a year, but in January 2024, this patient was able to receive a successful parathyroidectomy.
- Success is attributed to the overall team approach to go above and beyond for their patients.

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Ridgeland, MS 39157
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1-877-936-9260

Email: nw8info@allianthealth.org

Website: <https://quality.allianthealth.org/nqiic/esrd/esrd-network-8/>



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ESRD NETWORK 8



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ESRD Network of Texas



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ESRD Networks 8 and 14



DaVita Hernando Kidney Center – Home Conversion

Network 7



DaVita Hernando Kidney Center – Home Conversion

- ▶ Patient A.B.
- ▶ 29 year old male
- ▶ History of Alport Syndrome
- ▶ Depression and multiple psychosocial issues
- ▶ Dialysis start date 05/16/2023
- ▶ Extremely noncompliant



DaVita Hernando Kidney Center – Home Conversion

- ▶ What stage of grieving is the patient in
- ▶ Determine the “why” behind noncompliance
- ▶ Find out what motivates the patient
- ▶ Be the cheerleader
- ▶ Multiple teammates involved in transition



DaVita Hernando Kidney Center – Home Conversion Continued 1 of 2

- ▶ Patient successfully transferred to PD
- ▶ Doing much better
- ▶ Encouraged and motivated to continue to get better
- ▶ More stable psychosocially



DaVita Hernando Kidney Center – Home Conversion Continued of 2

- ▶ Frequent check-ins
- ▶ Hand-off when getting discouraged
- ▶ Always have an alternate plan
- ▶ Involve the patient in making decisions
- ▶ It takes a village

Questions and Answer Discussion

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?

Recap & Next Steps

- Additional pathways for learning
 - Sharing Best Practices to a greater community through coalition meetings
 - Using Case Study examples to identify new ways of doing something and missed opportunities
- Next meeting – TBD

Visit the ESRD NCC website to find materials and share

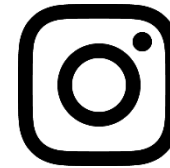
<https://esrdncc.org/en/professionals/expert-teams/>



Social Media



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National Coordinating Center (NCC)



Expert Teams – Case-Based Learning & Mentorship

Thank You

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