In-Center Hemodialysis to Peritoneal Dialysis Conversions

A Story of Wofford Dialysis’ Success
Where is Wofford Dialysis?

Wofford Dialysis is in Spartanburg, SC, which is about 30 miles northeast of Greenville, SC.
Spartanburg, SC

• Population: 37,498
  – Greenville, SC population: 68,219
  – Charlotte, NC population: 859,035

• Major hospitals: 1

• Dialysis providers: 3

• Total dialysis population: 2,146
  – Based on 2017 ESRD Data in Greenville, SC
Wofford Dialysis

• Wofford Dialysis provides all modalities:
  – In-center hemodialysis (ICHD),
  – Peritoneal dialysis (PD),
  – Home hemodialysis (HHD)

• Wofford modality data as of December 2017:
  – ICHD census: 33
  – PD census: 5
  – HHD census: 5
  – Home penetration: 23%
  – ICHD missed treatment rate: 7.8%
The Process

• December 2017
  – All DaVita ICHD programs in SC and Coastal Georgia were required to choose a Home Ambassador

• January 2018
  – All Home Ambassadors were required to attend regional trainings with the Divisional Vice President (DVP), Regional Operations Directors (ROD), and Facility Administrators (FAs)
Home Ambassadors

Who are they?

• Interested ICHD teammates
  – Including:
    ▪ Patient care technicians
    ▪ Administrative assistants
    ▪ Dietitians
    ▪ Nurses
    ▪ Social workers
  – Selected by the program sponsor to be educated on the benefits of PD and act as their centers’ modality education expert

Criteria:

• Home Ambassadors must:
  – Have strong communication skills
  – Be interested in professional development
  – Be willing to share PD education with peers

Note: These efforts are not to be confused with CMS-required modality education and must be provided by a clinical teammate.

Non-clinical teammates are encouraged to shadow a home nurse for a clinic or training day, attend PD prep (if approved by FA), and attend a modality options Kidney Smart class, to support their own learning.
Home Ambassadors (cont.)

Primary responsibilities include:

• Routinely engaging and communicating with ICHD patients to identify and educate clinically appropriate potential candidates who express interest in PD
• Acting as the "eyes and ears" on the treatment floor, communicating with the interdisciplinary team (IDT) for follow-up

Communication responsibilities include:

• Attending local home team meetings
• Participating in monthly ambassador home room calls
• Attending facility IDT meetings to discuss candidates
• Supporting PD education by participating in facility home room meetings using approved materials
• Communicating with the program sponsor at least monthly to report on PD conversion candidates
ICHD Education Process
Prevalent/Incident Patients

Address with medical director at monthly quality meeting →
Monthly home room meeting with home room lesson →
ICHD educator completes Match D and initial assessment of patients →
ICHD educator refers high (green) and medium (yellow) patients to home team →

ICHD educator completes tracker weekly ←
Weekly call with home liaison and ICHD educator ←
FA reviews modality choice with patient (green) ←
Home team assesses high (green)/medium (yellow) patients

Tracker submitted to Andrea/ROD/DVP weekly ←
Celebrate conversions with email from FA to DVP copying ROD/Andrea ←
Consolidate tracker monthly

Legend
- Physician
- ICHD
- Home Team
- Process
Helping Interested Patients Transition Home

When a patient expresses interest in a home modality—

• **The ICHD teammate:**
  – Immediately requests support of the home nurse to help deliver additional education and assessment
  – Contacts the patient’s physician within 48 hours of patient interest
  – Updates progress notes regarding modality education

• **The home nurse:**
  – Facilitates shared decision between patient and physician regarding modality choice
  – Helps coordinate placement of PD catheter or fistula access, as appropriate
  – Communicates any updates back to ICHD team
Wofford’s Success Story

December 2018
• ICHD census: 32
• PD census: 19
• HHD census: 6
• PD conversions in 2018: 10
• Home penetration: 44%
• ICHD missed treatment rate: 5.2% (down from 7.8%)

SUCCESS!!!!
Why Did it Work Here?
Steps to Success

1. Establish a fully engaged team that starts with the facility administrator and medical director

2. Ensure the entire team is discussing HOME at least 3–4 times per week
   a. During physician rounds, IDT meetings, daily huddles

3. Encourage ICHD teams to specifically identify patients who have high missed treatments and non-adherence
   a. These can be great home patients
4. Remind patients that diet is improved with PD  
   a. Constant education during lab reviews by entire team, including dietician, nurse, and physician

5. Ensure the vascular surgeon is **fully engaged** and:  
   a. Considers himself part of the team  
   b. Frequently uses a laparoscopic study of a patient’s abdomen before deciding if a patient is a candidate  
   c. Communicates often.

6. Celebrate when an ICHD patient completes PD training  
   a. Every teammate in the building celebrates
What Else Worked?

• Respite treatments
  – Allowing PD patients who may need a break to run ICHD for a few treatments

• Strong communication between ICHD and home teams
  – Ensuring they consider themselves ONE team

• Early patient education about treatment options by patient care technician, nurse, and facility administrator
  – Discussing home options on first or second treatment with EVERY patient

• Urgent Start PD
  – Ensure medical director and surgeon are fully on board

• Senior leadership communication with teams
  – Should occur often regarding patient education on modality options as a top-three priority
Questions
Debra Bowser, RN

Group Administrator
Wofford Dialysis

Thank You