
The Nephrology Interdisciplinary Team: An Education Synergism

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Patients with kidney disease often have a poor understanding of their condition. The interdisciplinary team can effectively educate these patients to slow disease progression and enhance self-management. The kidney community needs large, well-designed studies to determine the best way to educate patients and hopefully stem the tide of a rapidly increasing population of kidney patients. Congress authorized payment to eligible providers for kidney disease education for Medicare beneficiaries. However, this benefit is not being optimally used. In addition, reimbursement denials were 14-17% in 2011 and 20-23% in 2012. This is more than 4 times the usual Medicare denial rate for current procedural terminology (CPT) codes.

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When professionals gather, there is often the exchange of stories of times when patients' questions took us off guard. Often, we thought we had prepared our patients and their families by educating them on the disease process and their own progress. Then, a question comes out of the blue and makes us question what we have been missing.

The following are just 3 of the many quotes that the authors have personally heard from patients. Each directed us to re-examine our approach. As we have shared them with others, we have found we were not unique: Other practitioners have had similar experiences and were likewise taken aback.

"I know I have a touch of kidney disease." This was spoken by a 68-year-old African-American female who smokes and is an overweight type II diabetic, is sedentary, and has an estimated glomerular filtration rate (eGFR) of 24 mL/minute/1.73 m².

"I want to donate my kidneys. Who do I call?" This question was asked to an advanced practitioner (AP) by a dialysis patient.

"Oh, I have kidney disease?" This question was asked by a Stage 4 CKD 75-year-old patient who has been followed by nephrology for 11 years.

These are real questions posed by real patients. Unfortunately, these are not isolated incidents.

The Scope of the Problem

The nephrology community recognizes that CKD is approaching epidemic proportions. Data from 2010 show that 116,946 patients initiated renal replacement therapy (RRT) in the United States.¹ Annual costs for hemodialysis (HD) and peritoneal dialysis (PD) in this country exceed

\$47.5 billion annually. In 2010, the National Kidney Foundation (NKF) estimated there were 26 million people with CKD and 8 million in Stage 3 or 4.² The value of early referral to nephrology has long been known. Patients who are referred when their disease is well advanced reach end stage more rapidly, have increased incidence of associated conditions such as anemia and cardiovascular complications, are more prone to initiate dialysis with a catheter, have an increased hospitalization rate, and have poorer survival rates.³ The specter of an oncoming tide of kidney patients is not confined to the United States. The same prospects of an increasing number of patients with kidney disease are found in the United Kingdom.⁴ In Australia, between 7.5% and 11.4% of the population is estimated to have reduced kidney function.⁵ Awareness comes through education, and it takes a team to educate the patients and empower them to be active participants in their own care. The result can be a synergism of the parts. Patients who are informed and have the knowledge to participate are often more likely to adhere to the care plan, have better outcomes, and are wiser users of health-care resources.⁶ The composition of the health-care team (interdisciplinary team [IDT]) depends on the resources available. Ideally, it includes a nephrologist, AP, registered nurse (RN), renal dietitian (RD), social worker, pharmacist, and patient volunteers. Team members and their contributions to patient education vary widely based on resources and availability. The IDT is not a new concept. It has been promoted since the early 1990s. In fact, using the IDT for patient care is required in the Conditions of Coverage in the dialysis units.⁷ However, there have been few large-scale studies to support its use in the CKD clinic.

One model kidney disease education (KDE) program, the Missouri Kidney Program initiated patient education in 1984. The 6 sessions were led by a renal social worker and the individual sessions were led by a social worker, RD, or RN. Topics included modality education, nutrition, and financial issues that patients face.⁸

Mendelssohn suggests 2 main reasons that the team is not more widely used.³ The first barrier he suggests is nephrologists' attitudes. The second is a lack of resources. Until IDTs can demonstrate a financial advantage in the clinical setting, their use will be limited. On the basis of

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limited evidence, Mendelsohn predicts that the team will prove its worth as a cost-effective measure by delaying initiation of renal replacement therapy (RRT) and increasing the number of patients initiating RRT with a permanent access, choosing more home modalities and requiring fewer hospitalizations. He contends that the study of the economics of CKD is fairly new and it will take time and study to determine the dollar value of team intervention.³

Education is the right thing to do for patients to provide good care, and it has economic benefits. Patient education has been associated with all of the benefits suggested by Mendelsohn.³ The demographics speak for themselves. Although the U.S. population with Stage 4 CKD is less than 1%, the numbers have greatly increased over the last 20 years and the largest increase is in the patients over 65 years old.⁹ Education can often delay the onset of dialysis, increase the use of home therapies, and improve overall outcomes; however, patients often report dissatisfaction with the information they receive or a lack of knowledge of their disease and options.⁹ Twenty-six million people in the United States have CKD, and nearly 1/3, or 8 million, are in the late stages.¹⁰

What patients need to know and what is important to them varies with their stage. In the early stages (1-3A), the focus needs to be on disease management to prevent or delay progression. In the later stages (3B-4), education is more intense and should focus on medication, nutrition, lifestyle, and financial management as well as RRT modalities. It is in these stages that involving all available members of the team is most beneficial.

Patients rank knowledge of kidney disease, treatment options, access care, and medication compliance as their most pressing issues. Maintaining social relationships and activities is a prime concern for patients for when they initiate RRT. Kidney practitioners are well versed in symptom management. However, they may not always recognize what the patient wants and needs to know.² A report investigating the CKD awareness of U.S. adults showed that despite the increased numbers of patients with CKD, awareness remained low. The report also noted the same prevalence of CKD among Caucasians and African Americans, although there are 4 times as many African Americans with ESRD. A 3rd finding was that the increased numbers of ESRD patients might be a result of improved survival and earlier recognition of CKD.¹¹ The American Association of Kidney Patients surveyed ESRD patients from their database and found that although nearly 70% reported receiving education about in-center HD, only 58% reported being told of PD and 31% of home HD.¹² This is particularly concerning in that PD patients have reported increased satisfaction with modality

choice and that dialysis has less of an effect on their lives than their HD counterparts.¹³ A 2003 study of ESRD patients' decision-making showed that although 41.5% of the patients wanted shared decision-making, 48.4% believed that decisions were being made for them without their input.⁶

Addressing these needs is a task for the entire team. The roles of the nephrologist, AP, and RN are self-explanatory. The other team members contribute by adding their expertise to individualize care for the patients and their families. In this case, the budget and resources are the limits, not the sky.

Although the practitioner is the best resource for managing and explaining the disease process, the RD can provide 1-on-1 nutritional education and help the patient incorporate the dietary restrictions imposed by kidney disease into their lives. The social worker is invaluable for identifying financial needs and accessing resources. If available, a pharmacist is valuable in educating patients regarding the multiple medications that most are prescribed. The pharmacist also serves as a staff resource regarding drug dosing, drug interactions, and new products.

The role of the patient volunteer is relatively unexplored.

It has been 1 of the author's experience that patients often relate well to other patients, and talking to someone who has "been there, done that" is beneficial and reassuring. One finding showed that patients discuss more personal issues, including how a condition affects one's daily life and coping strategies.¹⁴

The team approach is consistent with the emphasis on patient-centered care with the focus on shared decision-making and patient

choice. The providers share with patients the information for them to make their own decisions.¹⁵ This establishes a partnership between the health-care providers and the patient as opposed to the former model in which the provider dictates the plan of care. The focus shifts from talking at the patient to talking with the patient.¹

Education

In addition to a lack of familiarity with using the IDT approach and the financial considerations, research in using teams for predialysis education is sorely lacking. The studies are often small, and practices vary in different countries that have different medical models. Strand and Parker conducted an extensive literature review of studies comparing the IDT and the traditional model and the effect on patient outcomes. Initially, 927 articles published between 1990 and 2009 were considered; after evaluation, 4 met the criteria. Outcome measurements included laboratory values, blood pressure, time to dialysis, and quality of life. Two of these were randomized control trials (RCTs) and 2 were observational studies. Although the end points

CLINICAL SUMMARY

- Kidney disease is approaching epidemic proportions worldwide.
- Early referral to nephrology and education have demonstrated improved patient outcomes.
- The team approach to patient care is likely effective, but large scale studies are lacking.
- MIPPA provides reimbursement for Medicare Stage 4 CKD patients, but is an under-utilized benefit.

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