



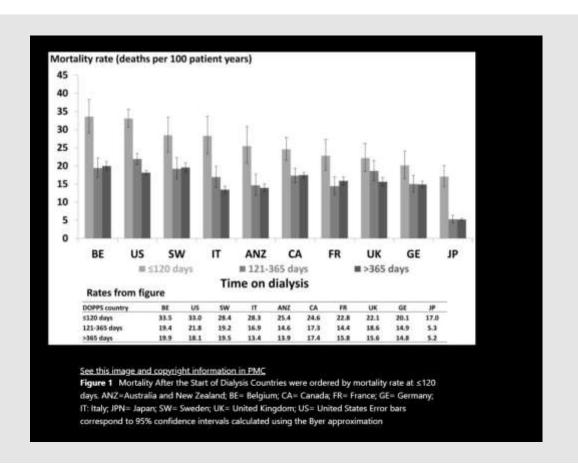
Transitional care unit
A physician's perspective

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Transitional care unit

- Dedicated space created to cater to the most vulnerable time in the life of an ESRD patient.
- 52% of patients crash into dialysis...suboptimal start.
 - 24% of patients crash without ever being diagnosed with CKD
 - Sizeable portion of patients, irrespective of predialysis nephrology care, may not have access to adequate preparation due to sudden rapid GFR decline.
 - Crashes increase costs per patient by approximately \$53,000 during the first year on dialysis
 - 74% of patients start dialysis without the preferred vascular access in place

Transitional Care Unit Why:

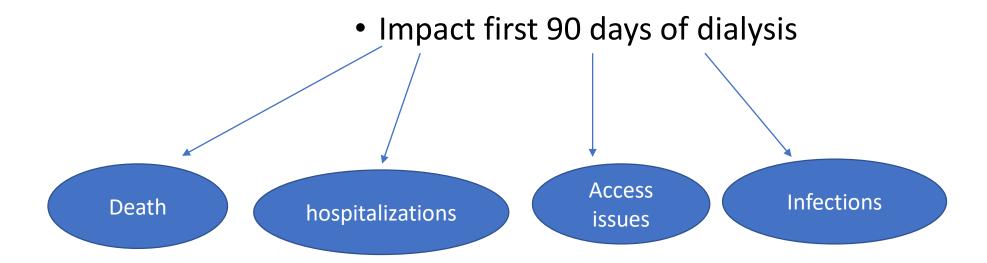


• <u>Kidney Int. 2014 Jan; 85(1):</u> 158–165.

Transitional Care Unit: Who:

- Most patients start dialysis sub optimally
- Dialysis education may have occurred months before
- Rapid or accelerated loss in egfr.
- All patients can benefit

Transitional care unit



- High cost
- High hospitalization rates,
- Mortality

2017 USRDS Annual Data Report: Epidemiology of Kidney Disease in the United States, Bethesda, MD, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, 2017

Historical perspective

Dialysis orientation unit. Established at northwestern Kidney Centers in 1981: Dr Joel Eshbach

2-month stabilization program emphasizing modality, diet education, patient "rehabilitation," and transitioning safely to home dialysis.

- Physically separate unit,
- high staff-to-patient ratio, and
- close collaboration with the home training group. Unit staff members were selected not only on the basis of clinical skill but also on the ability to empathize and educate.

93 patients in the first year

- 62% chose a home modality
- 24% chose self incenter program
- 10% chose incenter dialysis

Eschbach JW, Seymour M, Potts A, Clark M, Blagg CR: A hemodialysis orientation unit. Nephron 33: 106–110, 1983

TCU structure

3-4 week program.

3-4 treatments per week.

Provide extensive education and curriculum with goals identified each week.

Dedicated space.

Dedicated and knowledgeable staff model interested in teaching

Flexibility

Ability to deal with high volume

Buy in from Physicians

Support from you dialysis vendor

Transitional Care



Clinical stabilization of the patient

Dedicated team focused on this population

Tailor dialysis to the individual



Educate the patient.

Modality

Nutrition

Financial aspects



Emotional and psychologic support



Welcoming environment



Streamline access appointments and transplant referrals

Local data

120 patients to date 36 have chosen PD 7 HHD 35% home penetrance

Transitional care unit

- Empowers patient.
- Patient and physician can choose the modality that fits the patient best
- Become better patients overall:
 - 27% lower missed treatment rate
 - 12% lower CVC rate
 - Decreased access placement latency
 - Decreased hospitalization rates and mortality
 - Improved transplant referral
 - Improved adoption of home therapies
 - Reduce disparities in home therapies

Clin J Am Soc Nephrol. 2019 May 7; 14(5): 765–767.



TCU Challenges

- Throughput and consistent census
- Bottlenecks related to modality choice