



Audrey Paulman, MD, MMM

Audrey Paulman is a part time Clinical Associate Professor in the Department of Family Medicine at the University of Nebraska. She also works at CIMRO of Nebraska, the Nebraska Medicare Quality Improvement Organization. Through her work at CIMRO of Nebraska, Dr. Paulman serves as the Task Lead for CareTrek, the Nebraska Care Transitions project. CareTrek is funded by the Centers for Medicare & Medicaid Services.

The mission of the Nebraska Kidney Association is to improve the lives of all Nebraskans through advocacy, education, early disease detection and patient services.

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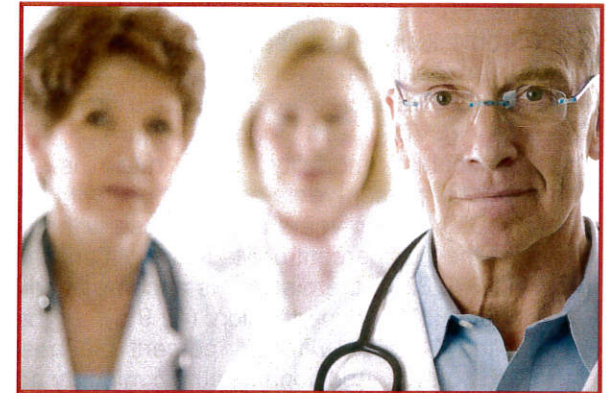
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Keeping and Caring for Patients with End Stage Renal Disease in the Primary Care Setting

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Omaha NE 68144
402.932.7200
NE Toll Free: 800.642.1255
e-mail: develop@kidneyne.org

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Careful Care Transitions: Keeping and Caring for Patients with End Stage Renal Disease in the Primary Care Setting

Audrey Paulman, MD, MMM
University of Nebraska Medical Center

Kidney disease, specifically end stage renal disease, does not usually exist in isolation in a single patient. Nor is treatment for kidney disease done exclusively by nephrologists. As the family physician provides care for an individual, he or she also cares for the other illnesses and injuries that occur in a patient with chronic kidney disease (CKD).

Chronic kidney disease affects 11 percent of the U.S. population over the age of 65; those affected are at increased risk of cardiovascular disease (CVD) and kidney failure. The cardiovascular mortality risk rate is 32 deaths/1000 person-years among those with CKD vs. 16/1000 person-years among those without it. In more than 90 percent of Medicare patients with CKD (1,336,320), the disease is accompanied by diabetes (4.1%), hypertension (42.9%), or both diagnoses (43.9%), with 9.1 percent diagnosed with CKD only.¹ Additionally, ethnic minority populations are more likely to develop kidney failure, particularly African-Americans (four times more likely than Whites), Hispanics (two times more likely than Whites) and American Indians (three times more likely than Whites).

Care transitions, the process of moving from one care setting to another, is difficult in the best of situations. Statistics show that as many as one in five Medicare patients who are sent home from the hospital are readmitted within one month.

Those with CKD have an increased incidence of readmission to the hospital. The Centers for Medicare & Medicaid Services has noted beneficiaries with end stage renal disease or dialysis are more likely to be readmitted to the hospital within 30 days of an admission for acute myocardial infarction, heart failure or pneumonia. The readmission rate for Omaha Medicare beneficiaries with ESRD services is 28 percent; compared to 16 percent for those without.

When a primary caregiver is involved, the transition can be much easier and safer for the patient. Here are some ways you can help your patient who is being discharged from the hospital.

1. Upon discharge, invite them to schedule a follow-up appointment within one-week post-discharge to answer questions.
2. Assist patients in reconciling their medications when you encounter them in an outpatient setting. You should be aware of other diseases present and what medications the patient should be taking. Address medications that may have been discontinued or changed during the hospitalization.
3. If there are medication discrepancies or dosages that need adjusted due to kidney disease, help your patient access that information. The pharmacist, nephrologist or cardiologist may also be able to help the patient if you provide encouragement.
4. Clarify the key roles in the ongoing management of the patient's care. Identify who is responsible for appropriate referrals to ophthalmology, management of hyperlipidemia and glycemic control. Determine how you will communicate lab results and information with the nephrologist. Access a regional health information organization for assistance.
5. There is a need for routine healthcare maintenance. If appropriate, routine vaccinations and health screenings need to be performed.

6. When discharging a patient on dialysis from the hospital, schedule an appointment to restart dialysis, along with an appointment to see you, their family physician.

Given the high prevalence of chronic kidney disease, we need to do our part to increase awareness, diagnosis and treatment if we are going to reduce the rate of progression and complications. The first step is ensuring patients are given appropriate information, resources and the opportunity to get their questions answered. The transition of care as a patient leaves the hospital is a good place to start.

Source: USRDS 2006 Annual Data Report

Note - Please send us your email address so that in the future you may receive these electronically. Send your email address with your name to: Sherri Petersen - develop@kidneyne.org

FOR MORE INFORMATION
Contact Dr. Paulman at 402.559.7200
or via e-mail at
apaulman@neqio.sdps.org