Patients with progressive chronic kidney disease (CKD) should receive education about all available options as kidney disease worsens, including the various forms of dialysis and renal transplantation. When dialysis is presented, both the modality and the location of care, including home treatment, should be included.

Although most patients who choose home dialysis, home hemodialysis (HD) or peritoneal dialysis (PD), will thrive and have an improved quality of life, this is not true for all. The current significant drop-out rates for these modalities (1) suggest that there is an opportunity for improvement in ongoing care as well as in the initial selection of patients. It is, therefore, in the best interests of the patient, the partner, the payer, and the dialysis staff for there to be a carefully structured patient selection process as the plan of care is developed and a modality decision is made.

Although there are a few contraindications to home HD or PD, the determinants of modality selection are largely nonmedical (2). Individual patient medical and psychosocial needs should be matched with the chosen dialysis modality. As the wide diversity in the ESRD population would suggest, there is no one-size-fits-all approach to modality selection. There are some patients and partners who are better suited for in-center dialysis and others for home therapy. Home HD requires managing a water system, drawing and sending blood and water specimens; maintaining aseptic technique during setup, tear-down, and treatment; and access care. Think of how long it takes nurses and technicians to learn these skills, and now imagine the responsibility of learning these skills as a nonmedical patient and/or partner. Some basic considerations need to be applied: patient and partner education levels, language barriers, physical demands, psychosocial needs, and the physical setup of the home, i.e., whether or not the patient has enough room for supplies, and even if the patient has a home. In considering if a patient is the right candidate for PD, the team considers body image concerns with the catheter, caregiver support, scarring in the peritoneum, co-morbid conditions, cognitive ability, and willingness to commit to daily dialysis.

A good selection process for home therapy should be started during the pre-dialysis visits to the nephrologist and the interdisciplinary dialysis team with education about renal replacement options. The modality decision should be based on the patient’s medical condition, physical abilities, support system, overall psychosocial needs, and learning capacity. If a patient is interested in a home modality or if he or she is determined to be a candidate for a home therapy, interviews with the interdisciplinary team are scheduled and assessments completed. During this interview, the Match-D tool (3) is used to identify a good modality fit. The patient’s rights and responsibilities are reviewed with the patient/partner team to make sure they understand the scope of the undertaking. For home HD, part of the interview is completed with both the patient and partner together, and then with a member of the interdisciplinary team meeting with the patient and partner separately.

We have discovered that sometimes a spouse will profess to support the patient’s decision to dialyze at home when the patient is present, but will confess privately to a nurse or social worker that he or she doesn’t want the responsibility or fears the situation. A home visit follows the interview. We recommend the home visit be performed by a nurse and a social worker. We have often found that a skilled social worker can identify potential barriers to home HD that can be removed or decreased, making home dialysis possible.

We use a similar interdisciplinary approach to patient selection, interviewing, and care planning for PD, but the criteria are not so stringent given that the PD patient does not require a partner. The training is not as complex since there is no water system, patients do not need to draw their own labs, and the dialysis is less complex. The team works with the patients to determine ways to incorporate PD into the patient’s life with the existence of one or more of these issues. Studies have shown that 76 percent to 95 percent of incident patients do not have any medical contraindications for PD, yet only a third of those patients are offered the choice of PD (4–7).

We have coordinated practices among different modalities to allow for a continuum of care among in-center self-care, home therapies, and in-center staff-assisted care. Because our experience taught us that the number one reason for patient dropout was partner burnout, we encourage respite care. Respite care can be provided either in-center or in the home training area where the patient can care for himself under the purview of a nurse. We encourage the patient to take as much responsibility and involvement in his or her own care as possible. As needed, we also encourage staff-assisted home dialysis (where available), and training the patient in the home.

We agree that the key to success is patient education regarding the disease process and treatment options during the pre-dialysis period and throughout dialysis care. With good training, most patients can function quite well at home, but failing on home dialysis can lead to frustration and fear for the patient. This fear can carry over to other dialysis modalities, and because the relationship among patient, partner, and nurse is more of a case management role, if the patient fails, the nurse may also feel a sense of failure.

We believe the best scenario is for the patient to be able to move through several modalities as their situation and health status permit. By using a patient selection process, the interdisciplinary team can help guide the patient toward the right care at the right time, to set up for success the patient, partner, and staff. Home HD, PD, in-center self-care, and in-center staff-assisted dialysis each have their strengths and challenges. It is the interdisciplinary team’s responsibility to guide the patient in making the best modality choice.

References

Allen Nissenson, MD, is chief medical officer of DaVita and Mary Showers, RN, is director, outcomes and quality management at DaVita at Home.