Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/clinicians-roundtable/bridging-gaps-in-kidney-care-how-to-improve-referrals-transitions-and-coordination/37224/

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Bridging Gaps in Kidney Care: How to Improve Referrals, Transitions, and Coordination

Announcer:
You're listening to *Clinician's Roundtable* on ReachMD. On this episode, we'll hear from Dr. Mallika Mendu, who's an Associate Professor of Medicine at Harvard Medical School, Chair of the American Society of Nephrology's Quality Committee, and Chief Population Health Officer for Mass General Brigham. She'll be discussing common challenges systems face when it comes to improving outcomes in dialysis and chronic kidney disease care, which was a focus of her presentation at the American Society of Nephrology's 2025 Kidney Week conference. Here's Dr. Mendu now.

Dr. Mendu:
So first off, we are reliant on, oftentimes, patients being referred to us from primary care. It's rare that a patient comes directly to us. Most of the time, the primary care providers identify the chronic kidney disease or the dialysis need and then the patient gets referred. And so barrier number one is that we need to ensure that our primary care colleagues are true partners in screening, and identification, and timely referral to nephrology. Ideally—and there's literature to support this—patients who are referred earlier, meaning at least three to six months before a patient needs to transition to a dialysis, do much better. And that makes sense, right? Because as nephrologists, we can think about how we can actually stem the progression of chronic kidney disease to dialysis. So that's issue number one: we need to make sure that primary care is engaged on this issue related to kidney disease, that they are adhering to quality guidelines, that they're measuring proteinuria and creatinine on a regular basis for those patients who have risk factors, and then finally, that they're referring to us in a timely way.

The second is that care is often fragmented across the healthcare spectrum. So if we take a patient who's on dialysis as an example, particularly in-center dialysis, oftentimes the patient will be getting care in a dialysis unit, and then maybe their primary care provider will be in a different system, or they often get admitted to a hospital that is not connected to the dialysis unit. And so the electronic health records are disparate, they're not communicating with one another, and we're relying on old technology like faxes. And so that's a real gap and struggle for patients. And actually, we've done some initial work here at Mass General Brigham where we've actually surveyed and asked patients who get admitted, "Do you know where you get dialysis? Do you know who your nephrologist is? Do you know what your weight should be?" And these are really basic questions that we take for granted. And not shockingly, the rates of correct answers are very low, and so that is a major gap that we need to remedy.

And then the third I'd say is that as we're trying to improve outcomes, we need to recognize that there needs to be real investment in that. Our structures have not been set up to optimize clinical outcomes and quality. Optimal starts is a great example. The path of least resistance for the system is that if a patient needs dialysis, they present to the emergency department, they get admitted, and all of that gets coordinated in the hospital. But that does not help patients, quality, or outcomes because what we're then doing is we're taking up a tremendous amount of inpatient hospital resources to coordinate care that could have been done as an outpatient; oftentimes, the patient sits in an inpatient bed in the hospital for two or three weeks waiting to find an outpatient dialysis unit; and then third, we actually often miss opportunities to transition patients to home dialysis because the hospitals aren't oriented towards home dialysis. And so as a result, if you're going to change that paradigm, then you need to ensure that the path of least resistance becomes something else. In the case at Mass General Brigham, what we're looking at is an advanced care coordinator program where we have a coordinator who's somebody that our nephrologist and our primary care providers can reach out to to help do this coordination so that patients don't need to get admitted.

Announcer:

That was Dr. Mallika Mendu sharing highlights from her presentation at the 2025 Kidney Week conference. To access this and other episodes in our series, visit *Clinician's Roundtable* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!