Copyright 2026 American Nephrology Nurses Association (ANNA) All rights reserved. No part of this document may be reproduced or transmitted in any form without the written permission of the American Nephrology Nurses Association. January/February 2026 Volume 53, Number 1

NNJ NEPHROLOGY NURSING JOURNAL

Empowering Kidney Care: An ANNA-ASN Conference with Nurse-Physician Partners – Home Dialysis

Graham Abra, MD, Frank Liu, MD, Lucy Todd, MSN, ACNP, CNNe, FANNA, Louisa Freiberger, RN, CDN, and Leah Foster-Smith, MSN, APRN, FNP-BC, CNN-NP, FNKF, FAANP

Copyright 2025 American Nephrology Nurses Association

Abra, G., Liu, F., Todd, L., Freiberger, L., & Foster-Smith, L. (2026). Empowering kidney care: An ANNA-ASN conference with nurse-physician partners – Home dialysis. *Nephrology Nursing Journal, 53*(1), 25-32, 48. https://doi.org/10.37526/1526-744X.2026.53.1.25

Editor-in-Chief's Note

On September 27, 2025, ANNA and ASN collaborated on a one-day meeting at ANNA's Nephrology Nursing Summit to bring nurses and physicians together to discuss important issues in nephrology. This article is based on the panel discussion on home dialysis that focused on how innovative solutions as well as best practices can enhance patient care, improve outcomes, and reduce health care burden, while also fostering a collaborative approach between nurses and physicians. The recorded version of the panel discussion is available in ANNA's Online Library (https://library.annanurse.org/p/s/home-dialysis-26207).

Keywords:
Quality, safety, dialysis, home dialysis, nephrology, nurse-physician collaboration.

Leah Foster-Smith: Welcome everyone. We're so glad to see your faces here today on this exciting collaboration day. My name is Leah Foster-Smith. I'm a proud member of the ANNA Conferences Committee. This panel discussion is going to be on home dialysis therapy.

It's my pleasure to introduce Dr. Graham Abra, a clinical associate professor at Stanford and also the former Chief Medical Officer Home Therapies at Satellite Healthcare. He completed medical school and internal medicine training at the University of California – San Diego, where he spent an additional year as a chief medical resident. He completed a nephrology fellowship at Stanford University and spent two years at the Stanford Clinical Excellence Research Center. His current clinical practice focuses on the care of patients with advanced chronic kidney disease and management of patients on home dialysis. Next, we have Dr. Frank Liu, who is a nephrologist at the Rogosin Institute. He's been the medical director at Rogosin Hemodialysis Program since 2009 and a co-director of the PEAK Multidisciplinary CKD Clinic. Next, we have Lucy Todd. She's been an active member of ANNA since 1993, serving in many positions along the way, including serving on the ANNA Board of Directors. She is a current member of the ANNA Conferences Committee and the *Nephrology Nursing Journal* Editorial Board. She's President of ANNA's Blue Ridge Chapter. She presented many times for ANNA over the years. She received her BSN from Old Dominion and MSN from Vanderbilt University. Our next speaker is Louisa Freiberger. She has been a dialysis nurse for over 17 years and worked in education for eight years. Originally from Indiana, she has lived in Alaska since 2012. She's an educator in her practice there. She's been a member of ANNA since 2016, and she also currently serves on the ANNA Conferences Committee.

Graham Abra: Thank you for that kind and very generous introduction. We're really looking to make this session today, myself and the panelists, to be really an interactive session with you as the audience. So I'm going to give you guys the power. I'm going to hand a microphone

Graham Abra, MD, is Director of Inpatient Nephrology, Stanford Hospital, Palo Alto, CA.

Frank Liu, MD, is Director, Home Hemodialysis, The Rogosin Institute, New York NY.

Lucy Todd, MSN, ACNP, CNNe, FANNA, is a member of the *Nephrology Nursing Journal* Editorial Board, and President of ANNA's Blue Ridge Chapter.

Louisa Freiberger, RN, CDN, is Area Manager of Education, Liberty Administrative Services, Anchorage, AK; a member of the ANNA Conferences Committee; and a member of ANNA's Pacific Northwest Chapter.

Leah Foster-Smith, MSN, APRN, FNP-BC, CNN-NP, FNKF, FAANP, is Director of Advanced Practice Providers, Metrolina Nephrology Associates, Charlotte, NC; a member of the ANNA Conferences Committee; a member of the ANNA Health Policy Workgroup; and President of ANNA's Greater Charlotte Chapter.

Statements of Disclosure:
Graham Abra, MD, disclosed that he is on the Home Dialysis US Medical Advisory Board for Fresenius Medical Care

Frank Liu, MD, disclosed that he is a consultant on the Medical Advisory Board for CVS/Accordant; a consultant on the Home Dialysis Advisory Board for Fresenius; and on the Speakers' Bureau for AstraZeneca.

Lucy Todd disclosed that she is a consultant for Anasept, Total Quality Medical; and a presenter with Pentec.

Copyright 2026 American Nephrology Nurses Association (ANNA) All rights reserved. No part of this document may be reproduced or transmitted in any form without the written permission of the American Nephrology Nurses Association. January/February 2026 Volume 53, Number 1

out to the audience here so that you can jump in and help us as we talk through some of the issues that we encounter in home dialysis. And related to the talks we heard earlier today, how we can collaborate as nurses and physicians. I thought all of the talks this morning were really inspiring. And something I took from them was the importance of how we work together as health professionals, as nurses and physicians, to take care of our patients. And home dialysis, as many of you – if not all of you – know, is a fantastic example of that teamwork.

I'll kick us off with our first question for the panel. And you know, one of the critical things in home dialysis really is education – Education for our patients and ensuring they have all the information they need to make informed choices about their kidney care when they become symptomatic from their kidney disease and when they have very advanced disease and low GFRs. And we know that education works. When we educate our patients, larger fractions, to choose home therapies, they're more satisfied with their care; outcomes can be better. And it's important for us to understand how to do this well. Dr. Lui, I was wondering if we could start with you. Maybe you could talk a little bit about how you've seen education be delivered to patients and what works well, what's maybe less effective. Talk a little bit about that for us.

Frank Liu: In a perfect world, patients have been seeing a nephrologist, they've been going through the channels. If we suspect that it's getting ready to be the time that they're going to need to start looking at dialysis, at all the different options, then we provide an options class. In reality, that's generally not what happens. They go to see a nephrologist. They get told, "Hey, you're starting to have some renal failure. These are the things you should do." The patient kind of freaks out for a minute and they think, "I can handle this. I can go take care of this on my own." And a year and a half later, they wind up in the ER in full-blown renal failure. And now it's, "We have to make a decision quickly." Generally, they're talking to a nurse or maybe an attending physician who doesn't have a lot of knowledge about all of the options that are available for home therapies. So they do a quick 10-minute conversation – "These are your options. What do you want to do? We're going to go ahead and put a CVC in your chest because we need to start dialysis." So by the time they come to us, they are already either doing in-center dialysis or they're starting, and they really haven't had a whole lot of information on opportunities. I think what I have seen a lot of times is patients who come in feeling like they were kind of gipped. They're like, "Well, I didn't know I could do this. I didn't know I could change my mind." Or they come in thinking, if they choose to go to in-center, they can't change their mind and decide to go to home therapies. Or if they go to PD and they decide they really don't like that, they don't realize they can change and have a choice to go to home hemodialysis. We really need to start in the hospitals, making sure that we educate the nurses and physicians because as soon as they find out it's nephrology-related, a lot of times they'll just hand it off. "Oh, it's nephrology. Let's have the nephrology go in there." For me, that has always been the thing that stood out the most as the root cause of how a lot of these patients come to us and make sure that we can do it the right way so they can come to us with a well-informed decision of what they want to do.

Graham Abra: Those are really, really excellent points. Dr. Liu, I'm kind of wondering, from the physician's perspective, how can we as physicians work with the nurses to educate our patients? What are some of the ways in which we complement the nurses and vice versa?

Frank Liu: Well, I think from a physician perspective, we need to be honest with ourselves in terms of what we're good at, what we're not good at. Some physicians are great at educating others. It's a little bit more of a checkbox and people are feeling very rushed to get to the next patient, to

Copyright 2026 American Nephrology Nurses Association (ANNA) All rights reserved. No part of this document may be reproduced or transmitted in any form without the written permission of the American Nephrology Nurses Association. January/February 2026 Volume 53, Number 1

the next patient, to the next patient. I actually spent the time to read one of the postmortems on the ETC model, and one of the things that stood out to me was that the physicians and the facilities thought they did a great job educating patients on home dialysis. And then the patients in a patient advisory group (or something like that) said that education was totally inadequate. So there's a big disconnect between what the care team thinks they're doing and what the patients think they're getting. If you make it your business as the physician to do it, that's great, but a lot of physicians don't have the time or the skill, really, to talk to patients in the same way that a nurse or a nurse practitioner who has a wealth of experience at the bedside with the patients does. So I think working with a team, people can sort of figure it out. We have this PEAK program that was mentioned in which I think we know who is good at what and who is not so good at what, and I think that has really helped.

Graham Abra: I think matching the skills to the task is a critical thing, and we're so lucky in home dialysis in that many of our home therapy nurses are born educators, and they really excel in that role. It's always a joy as a physician to work with the home nurses because our nurses are teaching patients about PD. They're training patients for home hemodialysis. And in the same way, many of them are incredibly engaged with teaching patients before they need dialysis about what those various options are. We touched on this a little bit, but not everybody, either as nurses or as physicians, in their training gets to learn a lot about kidney care generally, and certainly not more specifically, about peritoneal dialysis and home hemodialysis. Lucy, could you talk a little bit about what your perception is of the readiness of nurses and physicians to step into these roles?

Lucy Todd: That's a huge issue. Nurses don't get any of it in nursing school, whether in a two-year program or a four-year program. There's just almost no nephrology at all. And the fellowship programs are quite varied. When I worked for Baxter, I was teaching fellows for 16 years and they're all over the map as to what they get and what they don't get. You learn PD in the clinic. That's where you learn it. And so for the fellows, it takes time in the clinic. They can't just have a month over at another program where they're sort of exposed to it and they're not going to learn it. And for the nurses, it's pretty much all on-the-job training. I personally think there needs to be a real focus on structuring this kind of education between ANNA, ASN, RPA, putting things together. I could talk a long time on that.

Graham Abra: Today is an excellent first step.

Lucy Todd: Putting together solid training programs of what it takes is hard. Too often, in the nursing part of it, the clinic will say, "Well, Mary, you've been working in hemodialysis here for however many years, and we want you to go over to home therapy. Susie's over there, and she's been there two years and she's going to teach you." But who knows what she knows? Has she been vetted? Is she up to date? Who knows? And then you get physicians whose fellowship program didn't have much on home therapies, and they're just sort of doing this because the clinic wants more people on home. And they're not all that up to date. And it becomes a real struggle.

Graham Abra: Well, here's a little bit of a secret from the physician side – we learn from the nurses.

Lucy Todd: That's true. The smart ones know to lean on the nurses. If you're not sure, ask the nurse.

Graham Abra: It does bring up an important point. How can we as physicians and nurses collaborate to address these knowledge gaps that we know are out there? There's a lot of variability.

Lucy Todd: I think for those physicians who are knowledgeable and find that the nurses have gaps, we need to structure some education for them. It's also helpful if the physician is not as knowledgeable and if they're open to it, perhaps the nurse can educate them.

Graham Abra: Absolutely. I think we have a question in the audience here.

Audience Question/Comment: If we're talking about an underserved community, we're going to need someone who can basically translate it for those patients in terms that they'll understand. The other thing about the modality education that I have seen happen is if you have a patient who shows any kind of interest in home therapy, you need to encourage them instead of being totally neutral. You know, you don't want to have someone who says, "Well, you can do hemodialysis, you can do home therapy, or you can consider what else do you want to do." You want somebody that's going to say, "From what you've said, I think this would be good for you."

Lucy Todd: I think it's really important to say that. It's like if you go to a financial planner, you don't want somebody to say, "Well, we could be aggressive or we could be kind of middle of the road." You would be concerned. The patient wants to know what the person who's doing the education thinks and who says, "I think you can do this. I think this would work well for you."

Graham Abra: Those are really wonderful points. I think mentoring is a critical aspect, both for nurses and for physicians, to take advantage of the wealth of knowledge that's out there in the community. One of the things that we did while I was an administrative physician was that every month we brought together all 40 of our whole home programs and had the programs present their difficult cases. And we talked about it collectively as an interdisciplinary team. We talked with the dietitians, the nurses, the social workers, and the physician leadership. We talked about different aspects of the cases. And it was amazing, the experience and the learnings that would come out of that because as you looked across a large number of clinics, you would almost always find someone who had seen a similar situation, if not the exact case that you were describing. It was just hugely helpful. Thank you for raising both of those points. I think the panel wants to wrestle back control of patients on home dialysis in the hospital and the educational gaps over time.

Copyright 2026 American Nephrology Nurses Association (ANNA) All rights reserved. No part of this document may be reproduced or transmitted in any form without the written permission of the American Nephrology Nurses Association. January/February 2026 Volume 53, Number 1

Louisa Freiberger: I do. I totally have a piggyback off of that. So talking about staffing, I had a huge crash course. I was a chronic in-center nurse in Indiana, and I moved to Alaska. I started in home therapies. I really didn't know much about it. You know what you know, but you don't know what you don't know. I started in May 2012, and by November 2012, I was the most experienced nurse in my facility in my home department. We covered all of Alaska, so there weren't many home therapies. We were the only one. So I had to learn the do's and don'ts very, very quickly. Luckily, I had amazing nephrologists who really helped mentor me and guide me. But I also learned how to do things right by doing things wrong, which was unfortunate. When the next group of nurses came in, it was much easier for me to help transition. To the point of education, when you have patients dialyzing in-center, they might show some interest in home therapies, but the in-center staff may not really know about home therapies. When we recognized this, we started doing Lunch and Learns. We buy them lunch because that is our love language. You've got to feed us. So we would get them lunch and a couple of us home nurses would just talk about it. We would have discussions about home therapy, so if they had a patient who asked about it, they could answer some basic questions, but we also let them know if they have a patient interested in home therapy to call us. We'd be more than happy to come over and talk to them. Then we started seeing our nephrologist seeing patients with in the facility and then on the other side. So we started scheduling lobby days. We would have a PD setup and a home hemodialysis machine. We'd all sit out in the lobby. So not only would we catch our CKD patients coming out from seeing the nephrologist, we'd also catch regular patients coming in, going in and out of their shifts, going on treatment. And they'd see us sitting there with all of this equipment and they'd ask, "What are you doing?" And of course, we'd have some sugar-free snacks and food. Then we would start a discussion and invite them to do a full-blown options class. "We'd love for you to come and ask us questions." One other thing – some dialysis centers have non-licensed persons who have never worked in any modality as a clinical staff, leading them to simply read a PowerPoint. How do we feel this may impact the quality of education? Clearly, it's going to impact their education because if people have questions, they're just reading a PowerPoint. It's not going work. It's not sustainable. Yes, it could probably work in a pinch if you needed to do that, but it's not going be a sustainable therapy in my opinion.

Frank Liu: I can say something about the in-hospital PD issue. It's hard. Nurses know – There's tons of turnover on the inpatient side. My wife happens to be an ICU NP who's responsible for making sure that the ICUs stay up to date and able to operate CRKT effectively. So I hear a lot about how there's a 20% nursing turnover. And the issue is, especially as it comes to PD, unless you have a critical mass of patients coming through, the nurses are never going to see it enough that they feel comfortable. We have a relatively large PD program, and what we ended up doing is to have one specialized nursing unit. Only that unit really gets repeated PD training, and as much as possible, all the patients needing PD are admitted to that floor. There are cyclers there, and they can also do regular exchanges. And then you do your best, really, as much as you can, with the other units, and you just keep the patients needing PD away from the units where they don't have experience with it. That's been pretty successful. The other side of it is that when they leave the hospital, they need to be able to go somewhere if they can't go home. You need to build a rehab component on the back end, which is even harder because they maybe only have one or two patients at any given time. It takes a lot of legwork to support a patient on PD all the way through the process.

Graham Abra: Absolutely! On the topic of peritoneal dialysis, let me shift gears a little bit here. The International Society for Peritoneal Dialysis has recently issued a position statement on staff-assisted PD. And this is a modality that's used in many parts of the world, but as you all know, it's not something that's widely available here in the United States. Let me ask the panel here if anybody has experience with some form of staff-assisted, either PD or home hemodialysis, and what do you think staff-assisted home dialysis, of whatever modality, how would that bring benefit to our patients, and how can physicians and nurses collaborate to make this something that's a reality for our patients?

Lucy Todd: I don't have any experience with staff-assisted. It's not funded. Medicare doesn't pay for it. But you know, we would teach family members how to assist with the cycler, and it can become a big burden on the family for that sort of thing. So staff-assisted would really be a benefit and for a patient who's not able to do it themselves, this can be literally a lifeline for them to have staff-assisted. Is it ever going to come in this country? I don't know.

Graham Abra: What are some of the clinical scenarios you would think about, Dr. Liu, for a staff-assisted patient, either PD or home hemodialysis, incident prevalent clinical conditions that might benefit from such a modality.

Frank Liu: We have a small population of staff-assisted patients at any given time. Most of these patients are people who can pay privately for someone to come in and just do their hemodialysis. It's nice for them, but obviously not scalable, and probably costs six figures per year. In terms of all the rest of the patients who cannot afford it, I think the main benefit would be in transitions home after training. They might get a week maybe with a nurse or a tech or someone who can come in and just make sure everything is okay – one last set of training wheels before you take the training wheels off. We just had a patient, actually still ongoing, who's been on home hemodialysis for a very, very long time. She's been in our program for about 20 years and had a relatively significant access problem that needed a revision. And then her husband, who's 82 years old and has been her care partner this whole time, was really just having a hard time cannulating. So they ended up paying for somebody to come in privately just to help with

Copyright 2026 American Nephrology Nurses Association (ANNA) All rights reserved. No part of this document may be reproduced or transmitted in any form without the written permission of the American Nephrology Nurses Association. January/February 2026 Volume 53, Number 1

the cannulation, which was only for about 30 minutes of time. That ended up being a lot less expensive than hiring somebody to come in for the whole treatment. You could theoretically structure a staff assist sort of anywhere along the process. If it's just for cannulation, that is, it opens the door to a lot more people and maybe not so expensive for payers because I know that's a big issue in terms of people wanting to do home dialysis and avoiding catheters and being able to go home quickly. The next thing where steps would be extremely beneficial, same patient, is for care partner respite. What I've said to people is being a care partner for someone on home dialysis is like at least a part-time job, if not a full-time job. And nobody would take a job that didn't have any vacation, including the people who are making policies about it. I think providing even two weeks respite, when someone could come in the home and not force the patient to go in-center, where getting there and getting back may be even more difficult than just doing the thing yourself. That would be really useful.

Graham Abra: Hearing the potential clinical benefits, Lucy, you obviously raised the barriers that are there in terms of resources to make such programs available. Maybe this is another area where ANNA and ASN can collaborate to make such things happen for our patients.

Lucy Todd: I think so. The shared voice would have great impact.

Graham Abra: Wonderful! Let's continue on with the issue of staffing. Staffing is a very persistent challenge that we have in our home programs. Many times not having the nursing staff and the teams that are able to provide the therapy can be a barrier to getting patients started on PD and particularly home hemodialysis. Louisa, could you talk a little bit about staffing challenges in your practice, and perhaps how physicians and nurses can collaborate to address such issues?

Louisa Freiberger: I think being in Alaska is a little unique. I specialize in remote. People live in the middle of Nowhere, Alaska, for a reason. So trying to keep them there has always been the biggest priority. There is literally a waiting list of patients who are trying to go on PD. Typically in the PD world, patients are trained for about four weeks. We train them on PD in a week. And then we follow them to wherever they're going, whatever island they live on, whatever's going on. Then we make sure that everything is good, they've got what they need, and then we take the training wheels off and they fly back to start training another one. You also have to account for the emergent starts – the ones that fall out of the sky. Our nephrologists are amazing. They're extremely patient. They are all about patient advocacy. So if they can prevent patients from getting a CVC catheter and having to do hemodialysis, they'll put a PD catheter in them and say, hey, we have an urgent start, the patient needs to start tomorrow. And there's three dialysis nurses and they're all in trainings. It's one of those situations in which we really have to try to come together, talk to the nephrologist, and do a lot of moving things around. There are even times when you're training two people at the same time. You're training someone in the morning, and then you have another patient training in the afternoon. So that's been my perspective. It's a little unique in that we span the entire state of Alaska, but there are only about five PD nurses. We've grown a little bit in the last 10 years or so because they're recognizing that, and then we had the home initiative that started, which really kind of got the ball rolling with getting PD and home hemodialysis going.

Audience Question/Comment: Hi, everyone. This is a wonderful session. I'm Shweta Bansal from UT San Antonio. I would like to touch on a few topics related to the previous topics we were talking about. About the modality education – 40% of the patients start dialysis not knowing that they even had CKD. As you're saying, falling from the sky, parachuting, that's the word we use. And as you mentioned, it's still at that time, they're uremic, need education and logistics. Many times, we don't even know if they are citizens or if they are eligible for Medicare or not, or if they're uninsured. Louisa, you are, I would say, like the luckiest that you have a really invested nephrologist. But let me tell you the real-life practices. In clinics, they have a 20-minute appointment. CKD stage 4 patients have issues with blood pressure control, volume control, their bicarb is low, their potassium is high, their phosphorus is high. That's what these physicians end up just doing and KRT education goes onto the back burner most times. I feel that each program needs that nurse champion. Don't even wait to have that call coming from the physician – have a nurse champion there in that clinic who can do modality education. They are the best people to do that. In my program, when we had that, we could increase our rate of home dialysis very quickly. If you lose that nurse champion, and then the physicians are not doing modality education or they just talk one sentence. So that's why I need help from the nurses. And for my second point, I'm totally thinking out of box. We are talking about the shortage of nurses and home dialysis nurses. And I'm really, really thinking about this idea that – is it possible that we can do a dialysis track during the nursing school or little higher up education? You know, like we have different kind of tracks in our residency program, in our medical school program. So why not do a dialysis track in the nursing school or later on? And I'm really seriously thinking about to start something like that in our nursing school, and I need help from ANNA to create that track and what can be done in there. And then we especially emphasize home dialysis in that track.

Louisa Freiberger: We absolutely have teamed up with the student nurses and have a strong interest in programs like what you're talking about in the nursing schools. We have a couple of ANNA members who have really focused some work on that. And there's an article in a recent issue of the *Nephrology Nursing Journal* about the work that they're doing with the nursing schools (Larson, 2025).

Audience Question/Comment: I'm Abel Otabias, the Home Dialysis Program nurse at the Birmingham VA Healthcare System. We have some learning deficits across the board for home dialysis therapy. I would like to let you

Copyright 2026 American Nephrology Nurses Association (ANNA) All rights reserved. No part of this document may be reproduced or transmitted in any form without the written permission of the American Nephrology Nurses Association. January/February 2026 Volume 53, Number 1

know that for the physicians, for the fellows, we have a home dialysis academy at UAB. You can reach out to our doctors and some other UAB attendings in our nephrology division about this. So that might address the issue as far as nephrology resident training is concerned. Second is, at the Birmingham VA, we know that Alabama has one of the highest rates of comorbidities, and we understand that we also have to do our fair share. As you can hear from Dr. Montgomery's discussion at this meeting, Alabama was a part of the xenotransplantation. There are a lot of exciting things going on there. In our health care system, we provide a full suite of kidney care services ranging from CKD education, transplantation, preventive care through our primary care. We also have a full suite of kidney care treatments, such as home hemodialysis or home dialysis. We refer our patients to community care for home dialysis. We also provide a lot of options for veterans. We also have what you call this in-center dialysis. We provide acutes with all that good stuff. I created the first national VA peritoneal dialysis community of practice. So if you have VA nurses who are willing to understand more about home dialysis, you can send them over to us, and we will meet their need. Lastly, we are also very proactive in trying to teach our future professionals when it comes to home dialysis and all kidney modalities through post-baccalaureate nurse residency program, nurse buddy program, and I'm the point of contact for medical residents who come to us for training.

Leah Foster-Smith: We need to bridge the gap for nurses and nurse practitioners. I'm here in Charlotte. In 2011, we launched a CKD clinic that was partnered with physicians as well as with nurse practitioners. That clinic now serves over 30,000 patients in this area. In that clinic, we have scheduled focused education that starts early in CKD stage 4. We start referring patients for transplant at a GFR of 25. If one of our providers (APP or physician) doesn't get the education done, our nurses take over. Everybody knows what that goal is. Education starts early and continues. It sets us up really well for optimal starts and value-based care. Patients can do a 60-minute APP-led CKD or educational visit. We also have six education modules that patients can watch. They come in, watch a 20-minute video, and then have a 30-minute provider visit. We also have our nursing staff doing education and we are billing through the chronic care management codes. And we are using our nursing and clinical staff to then call and contact the patients. We've seen great engagement with those patients. The other thing that we did was our internal onboarding. We have 46 APPs in our practice, and we educate nationally on home therapies and in-center. We are home top heavy; in-center care is the last option. We talk about home and transplant, and then if the patient isn't interested or they're really not a candidate, we focus on in-center. We flipped the script about five or six years ago, and that's what I would suggest if you're in CKD clinics. We have also involved our APPs in home therapies. For patients who miss their physician visit, we have an APP clinic visit at all of our home therapy clinics at the end of the month. We have engaged all of our APPs, especially if they're in a clinic where it's in-center and home together. We want the patients to know and be in communication with their home therapy nurses so that we can get them seen during training. It's vital education. You just have to have an advocate inside of your practice.

Audience Question/Comment: I also work at UAB along with our fantastic nurse. I think part of why ASN is here is to try and find ways to collaborate with ANNA and see how can we develop a workforce over the next decade or two decades where people are not doing home dialysis because they're tired of in-center and they want better hours, but they truly believe in it. I think the idea of having a track is interesting, but I want to get a sense from ANNA and our leadership in terms of is there like a track in nursing school where you talk to people about why home dialysis and why being a home dialysis nurse is such a phenomenal thing? You get to work banking hours, you have much more personal contact with patients, you have a lot more ownership than in-center dialysis where you just connect, move on, connect, move on. And then, for ASN, we need to talk to the dialysis organizations because truly home dialysis is a stepchild. We only have 10% to 12% of the population. Leadership opportunities for home dialysis nurses are few and far between compared to in-center nurses. How do we talk to the dialysis organizations and say, you've got to make it lucrative for this set of nurses so that they want to do this? It seems like some work is already in progress, but I would strongly recommend we do this in nephrology and with our trainees – that we train them early on home dialysis. It should be one of the first choices, not a fallback.

Lucy Todd: I ran a PD program here in Charlotte a number of years ago. I had come out of ICU, and I was tired of all of that for a lot of reasons. And it occurred to me, you know, you'd end up working every other holiday and all that kind of stuff. And then the distress of ICU. I loved PD. I loved the chronicity and all of that. And I think we're working with student nurses, but I think there's a real need to have more of it in nursing school. Some nursing programs have observation days in an in-center hemodialysis program, but that's it. Most of them don't. And most of your hospital nurses get no real exposure to the dialysis nurses, to get the nursing schools on board; I think getting the nursing schools on board is something that we can really focus on. We can focus on the advantages of working with patients on home therapy. If you really like to get to know your patients and their families, and you know about the dog and the neighbor next door and the grandkids and all the things that come along with being a home nurse, this is a place for you. And that's where we ought to begin.

Audience Question/Comment: I'm Shamel Spivey. I'm a clinical coordinator in my company, and I also work the unit. I got a crash course in home and PD. I didn't really know much about it, but we have a PD and home educator. When our new patients come in, I educate them on every access and their modality on day one. So once they

Copyright 2026 American Nephrology Nurses Association (ANNA) All rights reserved. No part of this document may be reproduced or transmitted in any form without the written permission of the American Nephrology Nurses Association. January/February 2026 Volume 53, Number 1

say yes or maybe, I tell them to just get the education first. And she comes in and sits chairside with them and she discusses the different modalities and the different accesses. And a lot of times they go ahead and decide they want to do PD. I've been asking – why not home hemodialysis? And most of them say, "I can't stick myself." Understandable. Recently I took a class in cannulation, and it was for us to learn about cannulating in-center. So that's something we're going to start doing. We're going to do training for four to six weeks, and we're going to walk those patients through cannulating themselves so they can get ready to go to home hemodialysis.

Graham Abra: Those are wonderful examples of how the in-center environment can work with the home environment to bring great care to patients.

Audience Question/Comment: I'm very lucky to come from an organization where the nephrologists are great, referring over their patients before they are the crash and burn patients from out of the offices. And we bring them in and we do training on all aspects. One of the barriers is that they're nervous about causing too much anxiety by approaching this subject or sending them to me too early. And I agree, the earlier, the better. I think that it empowers them. What I say to them is, "I'm sorry, you have to meet me, but let me give you back control that your disease took from you by controlling the path that you want to go." The second barrier that I'm seeing, and maybe you all could give me some feedback, is that the patients with comorbidities – the larger obese patients, the patients who've had previous abdominal surgeries – they're not even considered. And for some of these patients, I think we could try this. I'm like Inspector Gadget. You need to show me the barrier and I'm going to figure out a way to get us over it. And I think in PD especially, that we come up with some really unique ways of getting over barriers that are very individualized. But are there criteria, or is there a need to discuss criteria that totally take patients off that maybe should be re-considered?

Graham Abra: I think it's a really important point to think about some of the common barriers and then bring to those barriers the data that we do have available to show how patients in many of those categories can be successful. So the example of abdominal surgery, right? We actually have great data from the North American PD Catheter Registry showing that a large fraction of those patients actually aren't going to have adhesions and are going to do just fine when the surgeon goes in to take a look.

Audience Question/Comment: I was just telling somebody that all my 40 patients have diabetes. My 100% PD unit is patients with diabetes and 70% of my patients have BMIs above 30. And I just published case series with 10 patients with BMI above 40. For those who transferred to hemodialysis, obesity was not the reason for the transfer. There were totally usual reasons that you see in non-obese people. Each month I see them and I just feel so proud for them, for my nurses and my unit that we are keeping them in home. and confidence of the surgeons and my IR team who place the catheter. Otherwise, most of the time, those surgeons and IR people just say no, you're not a candidate for PD.

Lucy Todd: I would echo that. I was the section editor for the last two editions of ANNA's *Core Curriculum*. One of the big changes I made in the last one was the opening of the whole section where it started out with "who can't do PD." I looked at that and I thought, that's terrible. That's just terrible – because most people can do it. So quit thinking about it like just a special handful of patients that can do this because most people can do it, but they need your support, they need encouragement, and they need a good environment at home. Most people can do PD, so quit thinking about it as being some sort of special subset of people.

Graham Abra: Let me switch gears for us a little bit again. Remote monitoring of patients is something that has come about in the last several years for both PD and home hemodialysis. We now have the ability to see our patients' treatments and monitor various pieces of data for our patients who are on home therapy. Louisa, maybe I could pull you in and Dr. Liu as well. Talk a little bit about what your experience has been with remote monitoring of patients and what the benefits are and some of the things it can bring to practice.

Louisa Freiberger: Well, I can honestly say Alaska is extremely behind the curve. We just recently tried to start doing remote monitoring. Like I said, given that we've got patients living on islands, we've got patients living very remotely. So trying to do Wi-Fi, trying to do anything like that is extremely difficult. Now with our patients who are a little bit local, kind of in the Anchorage or Wasilla area, we can do a little bit more. So unfortunately, I don't have a whole lot of input. The input I can give is that we've had some success with the ones who are doing some remote monitoring, but we're still kind of old school. We still pick up the phone and call and say, "Hey, tell me what's on your sheet that day." And then when we do a clinic in Kodiak, and the patients who live kind of close will fly into Kodiak and they'll bring their sheets and we'll make copies and go through their data.

Graham Abra: Dr. Liu, how about in Manhattan?

Frank Liu: I was lucky enough to take over the program from two of the other doctors on our group who started the home hemodialysis program back in 2000. And this was after the Canadians, Dr. Pieratos and company, published their data on nocturnal dialysis. So we started as a purely nocturnal program over 25 years ago. And whether they meant to or not, New York State said, nocturnal feels a little weird; someone has to be able to watch them or something. But a lot of patients don't have care partners. And so, again, this is before my time. My colleagues were just visionary with this. They created a remote monitoring system that plugged into the hemodialysis machines. And since then, we've actually gotten real-time remote monitoring. I think we're still maybe one of two programs in the country that provided that for our home hemodialysis patients. I'm a big advocate of not just remote monitoring in that you get a store and forward of a flow sheet after, but

Copyright 2026 American Nephrology Nurses Association (ANNA) All rights reserved. No part of this document may be reproduced or transmitted in any form without the written permission of the American Nephrology Nurses Association. January/February 2026 Volume 53, Number 1

monitoring in real time. It costs money because you have to pay staff to do it. But I think the patients really feel like somebody is there with them, even if nobody is physically there with them. Our monitoring program is available for patients who dialyze overnight six nights a week. I think that has made a huge difference in terms of people not being afraid to dialyze at home because they feel like somebody is always there with them. Our monitors will reach out if they see a blood pressure drop. They'll call and make sure that everything is okay or if there's an alarm that's not being attended to appropriately. The problem is it's expensive. It would be wonderful if the powers that be would provide some sort of remote monitoring add-on, as they do in pretty much every other field. That's my feeling about remote monitoring. I think there are some studies suggesting that people are much more likely to consider home dialysis and especially nocturnal if there is monitoring in place.

Louisa Freiberger: What is the ratio of the nurse monitoring to overnight patients?

Frank Liu: On any given night, the most patients we'll have on is about 15 or so and one tech monitoring.

Graham Abra: Collaboration between nurses and physicians is the point of this ASN ANNA forum we are at.

Audience Question/Comment: I'm learning a lot here. This has come up a few times – Louisa and Lucy talked about hospitals and how to engage them and have nurses from outpatient dialysis units do education in the hospitals. How do you get hospitals to buy into this? And maybe we had a chance with value-based care, but I'm not sure that's necessarily the future for every place in this country. What's your secret of those programs that have been able to engage the hospitals? Because I'd love to take that back to where I practice.

Lucy Todd: Well, I think in the hospital world, there are legal issues in them not letting the nurse from XYZ dialysis clinic in to educate the hospital's patients. In places where you've still got hospitals that own outpatient clinics, they're able to do it. When I was running my clinic, I was able to go to the hospitals here and educate patients, and it was very helpful because then when they started, they already knew me. Also, the family is often there in the hospital and patients want their family to hear this too. That's really beneficial for the patient. It's the right thing to do.

Graham Abra: I think that's an important thing to start with. What is the right thing to do? That's a commonality to begin with.

Frank Liu: We actually conscript our fellows into doing it, which doesn't work in all care settings, of course. That's been useful on a number of levels. Talking to someone is a skill that you have to practice and learn and optimize. I think it's like fellow education on top of patient education, and we can provide some mentoring on that aspect. We don't bring outside dialysis organizations in, we just do it ourselves. Just one thing about the remote monitoring thing that I wanted to clarify.

Audience Question/Comment: Yes, thank you. My name is Marion Sade. I'm from Puerto Rico. I have a lot of experience with home therapies years ago. Now I'm a diabetes educator because that's where the CKD patients are. For patients, CKD stage 4 is the ideal setting to start KRT education. It's usually the professional nurses who do the education. We have the knowledge and we have the skills to teach and start teaching patients about home therapies. That takes more than one encounter. Videos are good, but you need to do an assessment of the family situation and guide them through this. When times come and they need dialysis, education cannot happen when the patient gets to the emergency room and gets a central venous catheter because they need dialysis. Unfortunately, that happens. The best thing is we can have CKD clinics. We have some CKD clinics on the island, but they are at the endocrinologist's office and the cardiologist's office, but they should be at a CKD clinic with nephrologists. In our experience on the island, we've got a lot of patients who went to home hemodialysis, but then after several months, maybe one year, they get exhausted and the family gets overwhelmed. We need to give a lot of follow up and support to see what's going on, what's going on in the family setting that they get overwhelmed, and help them with our support.

Graham Abra: That was a perfect comment to circle back to where we began with education. Maybe each of our panelists can leave us with a parting thought from our discussion today. Lucy, do you want to kick us off?

Lucy Todd: I think the crux of this whole session is ways in which nephrologists and nephrology nurses can work together. We've illustrated a number of situations in which just being aware of each other's roles, each other's difficulties, where things fall short, where things work well, we can work together, gain better insight, and move forward. And I personally believe that getting clinicians educated is critical and that it's going to be essential for both physicians and nurses to work together to get that done, not only to have them better educated, but also to really understand what they're doing.

Louisa Freiberger: I absolutely agree. Home therapies is such a unique part of dialysis. Those of us who have worked in home therapies know the unique relationship you have with patients when you're a home nurse. You go into their house; you become a part of their family. So when you lose these patients, it's like losing a family member. It is so much more than just learning the complexities of the machine, but learning how to get creative because that's the whole point. We want patients to be able to stay at home and not have to go in-center. So if we have to get creative and figure out things that we need to do, then that's what we do. And if that means we put in a 12-hour day, that's what we do. I remember showing up at one of my clinics at 11:30 at night to switch out a PD catheter for a patient because that was the right thing to do. You put your patient first, and it's something that you choose to do as far as home therapies. Watching your patients benefit from that is just immeasurable.

continued on page 48

Copyright 2026 American Nephrology Nurses Association (ANNA) All rights reserved. No part of this document may be reproduced or transmitted in any form without the written permission of the American Nephrology Nurses Association. January/February 2026 Volume 53, Number 1

Empowering Kidney Care

continued from page 32

Frank Liu: I always tell our fellows that nothing about home dialysis is easy. It's like the opposite of going to McDonald's; it's home cooking, which means everything is a little bit harder along the way, but the final result tastes better and it's better for you. I think it's great that we're all getting together. There are so many little tiny inefficiencies and problems along the way. The only way to make it easier is to knock them off a little bit at the time from each direction. So I think it's great that we had this kind of conference.

Graham Abra: Absolutely! This was a really rich and wonderful discussion between the panel and all of you, who brought some amazing insights, programs, resources, and things you're actively doing. I hope that everyone leaves energized from the session today, thinking about how the American Society of Nephrology, ANNA, and all of us in our individual practices can help bring the benefits of home therapies to patients and inspire the next generation of nurses and physicians to care for these patients and carry the therapies forward. On behalf of ANNA and ASN, I'd like to thank you all for coming, and thank you to the panelists for a wonderful session.

Reference

Larson, K. (2025). Implementing a student nurse rotation in a freestanding dialysis unit. *Nephrology Nursing Journal, 52*(2), 158-160. https://doi.org/10.37526/1526-744X.2025.52.2.158