Transitions

“Lunch & Learn” Webinar
October 31, 2019 & November 4, 2019
Why focus on transitions?

Kidney patients & their families have many unique transitions:

- Treatment for kidney failure
- Changing the type of treatment received
- Choosing to end treatment

Transitions are a source of stress & fear.

- Impacts lifestyle, diet, medications, schedules, ability to work/finances, control over bodies and future

Changes that seem routine for provider staff may be highly stressful for patients

Clear, coordinated and consistent communication is key to success
From a patient perspective, what makes transitions difficult?

<table>
<thead>
<tr>
<th>Lack of understanding of the treatment plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not being included in making the plan or goals in the first place</td>
</tr>
<tr>
<td>Being overwhelmed and dazed</td>
</tr>
<tr>
<td>Anger and/or depression</td>
</tr>
<tr>
<td>Lack of resources (e.g., transportation)</td>
</tr>
<tr>
<td>Discomfort and pain</td>
</tr>
<tr>
<td>Getting conflicting advice from others</td>
</tr>
<tr>
<td>Distrust of providers</td>
</tr>
<tr>
<td>Other issues, such as work schedule or family needs</td>
</tr>
<tr>
<td>Denial that the illness is even present</td>
</tr>
<tr>
<td>Fear of the unknown—or even of the known—effects of following the treatment plan</td>
</tr>
</tbody>
</table>

Source: Transitions of Care Toolkit: forum of ESRD Networks’ Medical Advisory Council, 2017
Guides to support transitions: Care team & patient guides

<table>
<thead>
<tr>
<th>Care Team Guides:</th>
<th>Patient Guides:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Initially developed by the KCC Committee (Best Practices Paper, 2014)</td>
<td>• Requested by care teams &amp; patients (telephone needs assessment)</td>
</tr>
<tr>
<td>• More recently, guides expanded to include all modalities (with broad input from kidney care providers)</td>
<td>• Patient partners involved in development</td>
</tr>
<tr>
<td>• <strong>Purpose:</strong> To guide staff through the steps &amp; activities of transition with allocation of responsibility &amp; communication/information flows</td>
<td>• <strong>Purpose:</strong> To provide a step-by-step roadmap for patients/families to guide them through the transition process &amp; encourage active participation in the process</td>
</tr>
</tbody>
</table>
Steps of the patient & care team guides are aligned
Care team guides

• Transition between Modalities/Delivery Methods (Principles)
• Transition to PD
• Transition to HHD
• Transition to In-Centre/Community/Nocturnal HD
• Transition to Conservative Care (Kidney Care Clinics)
• Transition from Dialysis Treatment to Palliative Care
Patient guides & posters

- Transitioning to PD (guide & poster)
- Transitioning to HHD (guide & poster)
- Transitioning to Conservative Care (Kidney Care Clinic)
- Welcome to the HD Unit
- Stopping Dialysis Treatment: What you need to know before deciding
- FAQs about Stopping Dialysis Treatment
Guides to support transitions (sorted by modality)

<table>
<thead>
<tr>
<th>Modality</th>
<th>Care Team Guide</th>
<th>Patient Guide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peritoneal dialysis:</td>
<td>Care Team Guide: Transition between Modalities/Delivery Methods (Principles)</td>
<td></td>
</tr>
<tr>
<td>• Care Team Guide: Transition to PD</td>
<td>Patient Guide: Transitioning to PD</td>
<td></td>
</tr>
<tr>
<td>Home HD:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Care Team Guide: Transition to HHD</td>
<td>Patient Guide: Transitioning to HHD</td>
<td></td>
</tr>
<tr>
<td>In-Centre/Community/Nocturnal HD:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Care Team Guide: Transition to HHD</td>
<td>Patient Guide: Welcome to the HD Unit</td>
<td></td>
</tr>
<tr>
<td>Transition to Conservative Care (Kidney Care Clinics)</td>
<td>Care Team Guide: Transition to Conservative Care</td>
<td>Patient Guide: Transitioning to Conservative Care</td>
</tr>
<tr>
<td>Stopping dialysis:</td>
<td>Care Team Guide: Transition from Dialysis Treatment to Palliative Care</td>
<td>Patient Guides: Stopping Dialysis Treatment: What you need to know before deciding FAQs about Stopping Dialysis Treatment</td>
</tr>
</tbody>
</table>
Pilot test: PD & HHD Patient Guides

Target audience

• Patients with CKD/ESRD who are interested in transitioning to either PD or HHD
• Care team that looks after these patients (KCC, HHD, PD staff)

Pilot sites:

• RCH (PD) and VGH (HHD)

Control sites:

• SMH and ARH (PD) and PGH (HHD)

Evaluation tools:

• Pre & post quantitative surveys of patients, pilot & control sites
• Post-implementation qualitative interviews of patients at pilot site
• Pre & post-implementation quantitative survey of Care Team at pilot & control sites
• Post-implementation qualitative interviews with Care Team at pilot & control sites
• Documentation of dates of each step of guide for each enrolled patient
Pilot test outcomes: 
*Patient surveys*

- Decreased anxiety re PD/HHD training
- Improvement in patient knowledge about what will happen at training
Pilot test outcomes: *Patient surveys*

Improvement in patients’:

• Level of preparedness for training
• Understanding of health management
Pilot test outcomes: Patient interviews

• Given good information at the time of choosing PD
• Usually read once
  • ”I read the book once” and was able to retain knowledge
• Most patients were anxious about the catheter insertion, information provided was sufficient
• The training information was the most helpful part of the transition
• Some wanted more information about timelines
Pilot test outcomes: *Patient interviews*

- “I’ve always been a planner. When things are planned well in advance, I feel much less anxious about the future.” ~Jan

- “This document expresses caring and assistance and it has a reassuring tone which is helpful to me as I think about my options” ~Dennis

- “This document has helped me think about my future. Even though I am not there yet, I am glad I have this information.” ~Dolly
Pilot test outcomes: *Care team surveys (post)*

- Most were able to identify the 6 steps within the transition
- Patients found it helpful (PD pilot site)
- Minimal workload
- “100% valuable, one more piece of information to make the transition better for patients”
- Provides a framework for other information that patients receive
Pilot test outcomes: Learnings

• Constructive feedback:
  • Guide was given out & reviewed at Step 1 but was not referred to after that by the Care Team
  • Patients did not noticeably refer to the guide during the transition process

• Learnings from the pilot test for the broader roll-out:
  • Timing of handing out the guide
  • Weaving the guide language into daily conversation
  • Create visual reminders (e.g., posters of the 6 steps in waiting rooms)
Guide roll-out: Provincial action

**BCR website:**

- Transition-specific “stream” created & all guides & posters uploaded (health info & health professional sections)

**Familiarization of kidney care teams to the guides:**

- Lunch & learn webinar (today!)
- Start-up packages sent to every HD unit (in-centre & CDU) & Kidney Care, PD & HHD clinics (samples of all guides & posters).
- Will be added to the agenda of all relevant BCR provincial committees
Guide roll-out: Local action

Care Team Guides

Please review as a care team and ask yourselves:

• Are the roles for the “sending” & “receiving” teams clear at every step & for each transition?

• What are our areas of strength? What can we do to better support patients during transition?
Guide roll-out: Local action

Patient Guides

Please review as a care team and ask yourselves:

• What is the best time(s) & who is the most appropriate person(s) to provide the guide to patients?
  Possible scenarios:
  • KCC staff (RN, SW) after patient has decided to proceed with a modality or has chosen conservative care
  • PD or HHD staff (RN, SW) at the PD/HHD assessment meeting
  • Nurse navigator/transition nurse if the patient is interested in proceeding with PD/HHD

• How can we encourage patients to use the guides beyond the initial distribution?
  Possible options:
  • Asking patients to bring the guide to every clinic visit during the transition period
  • Encouraging one person on the care team to review which step a patient is in at each visit & review any concerns or questions
Acknowledgements

**Modality Committees:**
- Kidney Care Committee (Best Practices Paper)
- PD Committee
- HHD Committee
- HD Committee

**Patient Partners**

**Pilot project/control sites:**
- PD (Patient Guide):
  - Pilot - Royal Centre/RCH
  - Control - Abbotsford/SMH
- HHD (Patient Guide):
  - Pilot: VCH HHD Team
  - Control: Prince George
Questions & answers