Transitions

“Lunch & Learn” Webinar
October 31, 2019 & November 4, 2019

BCRenal
Provincial Health Services Authority

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?

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

Source: Transitions of Care Toolkit: forum of ESRD Networks' Medical Advisory Council, 2017

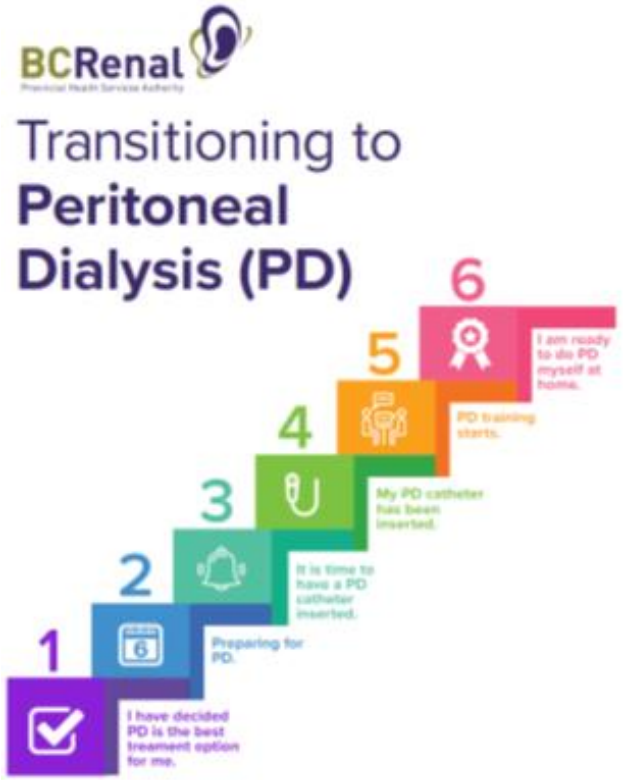
Guides to support transitions: Care team & patient guides

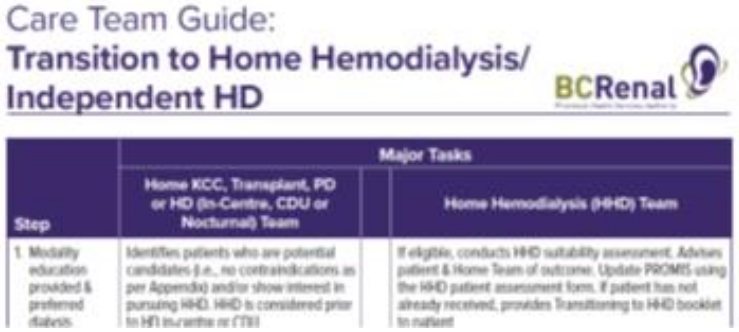
Care Team Guides:

- Initially developed by the KCC Committee (Best Practices Paper, 2014)
- More recently, guides expanded to include all modalities (with broad input from kidney care providers)
- **Purpose:** To guide staff through the steps & activities of transition with allocation of responsibility & communication/information flows

Patient Guides:

- Requested by care teams & patients (telephone needs assessment)
- Patient partners involved in development
- **Purpose:** To provide a step-by-step roadmap for patients/families to guide them through the transition process & encourage active participation in the process





Care Team Guide:
Transition to Home Hemodialysis/ Independent HD

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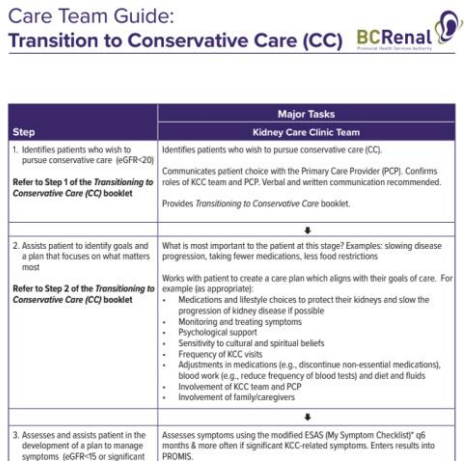
Step	Major Tasks	
	Home KCC, Transplant, PD or HD (In-Centre, CDU or Nocturnal) Team	Home Hemodialysis (HHD) Team
1. Modality education provided & preferred dialysis	Identifies patients who are potential candidates (i.e., no contraindications as per Appendix) and/or show interest in pursuing HHD. HHD is considered prior to HFI insertion or CTBI	If eligible, conducts HHD suitability assessment. Advises patient & Home Team of outcome. Update PROMIS using the HHD patient assessment form. If patient has not already received, provides Transitioning to HHD booklet to patient

Steps of the patient & care team guides are aligned

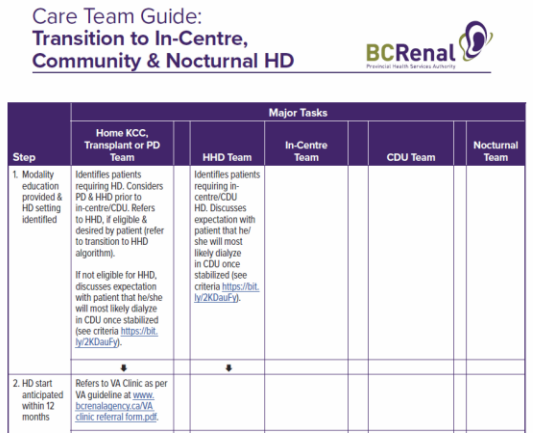
Care team guides

- 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



Care Team Guide:
Transition to Conservative Care (CC) BCRenal

Step	Major Tasks Kidney Care Clinic Team
1. Identifies patients who wish to pursue conservative care (eGFR<20) **Refer to Step 1 of the *Transitioning to Conservative Care (CC)* booklet**	Identifies patients who wish to pursue conservative care (CC). Communicates patient choice with the Primary Care Provider (PCP). Confirms roles of KCC team and PCP. Verbal and written communication recommended. Provides *Transitioning to Conservative Care* booklet.
2. Assists patient to identify goals and a plan that focuses on what matters most **Refer to Step 2 of the *Transitioning to Conservative Care (CC)* booklet**	What is most important to the patient at this stage? Examples: slowing disease progression, taking fewer medications, less food restrictions Works with patient to create a care plan which aligns with their goals of care. For example (as appropriate): • Medications and lifestyle choices to protect their kidneys and slow the progression of kidney disease if possible • Monitoring and treating symptoms • Psychological support • Sensitivity to cultural and spiritual beliefs • Frequency of KCC visits • Adjustments in medications (e.g., discontinue non-essential medications), blood work (e.g., reduce frequency of blood tests) and diet and fluids • Involvement of KCC team and PCP • Involvement of family/caregivers
3. Assesses and assists patient in the development of a plan to manage symptoms (eGFR<15 or significant	Assesses symptoms using the modified ESAS (My Symptom Checklist)* q6 months & more often if significant KCC-related symptoms. Enters results into PROMIS.



Care Team Guide:
Transition to In-Centre, Community & Nocturnal HD
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Step	Major Tasks Home KCC, Transplant or PD Team	HHD Team	In-Centre Team	CDU Team	Nocturnal Team
1. Modality education provided & HD setting identified	Identifies patients requiring HD. Considers PD & HHD prior to in-centre/CDU. Refers to HHD, if eligible & desired by patient (refer to transition to HHD algorithm). If not eligible for HHD, discusses expectation with patient that he/she will most likely dialyze in CDU once stabilized (see criteria https://bit.ly/2KDauFy).	Identifies patients requiring in-centre/CDU HD. Discusses expectation with patient that he/she will most likely dialyze in CDU once stabilized (see criteria https://bit.ly/2KDauFy).			
2. HD start anticipated within 12 months	Refers to VA Clinic as per VA guideline at www.bcrenalagency.ca/VA_clinic_referral_form.pdf.				

Transitions between Modalities/ Delivery Methods (Overview)

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Modality education and identification of preferred modality:

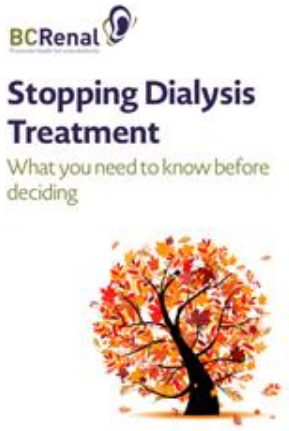
Kidney Care Clinic (KCC) Patients:

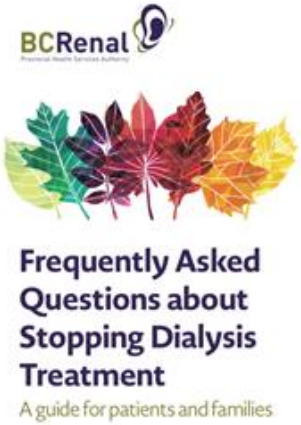
1. The KCC team has a systematic process in place to identify patients who are potential candidates for transplant education.
2. The KCC team provides education to potential candidates re transplant and living donation. For patients who are interested in transplant and do not have any contraindications, a transplant referral is initiated in PROMIS, ideally by the time the patient's GFR is 25 mL/min and/or at risk of

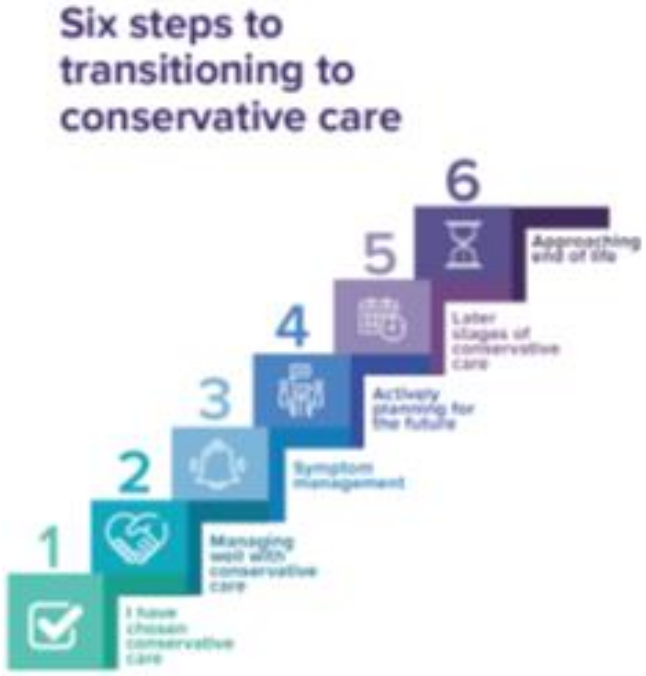
   Donor Outreach Plan.
   b. If a KCC patient, patient is asked to select a dialysis option as back-up.
6. Regardless of the setting of the patient, there are processes in place within each HA to regularly review the eligibility of patients for transplant and independent modalities/settings. Where appropriate, transplantation and/or transition to independent modalities is encouraged (e.g., if patient is on HD and is appropriate for PD, transition to PD is encouraged; if a patient is dialyzing in an in-centre unit and is appropriate for HHD, transition to HHD is encouraged).

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)

Care Team Guide: Transition between Modalities/Delivery Methods (Principles)

Peritoneal dialysis:

- Care Team Guide: Transition to PD
- Patient Guide: Transitioning to PD

Home HD:

- Care Team Guide: Transition to HHD
- Patient Guide: Transitioning to HHD

In-Centre/Community/Nocturnal HD:

- Care Team Guide: Transition to HHD
- Patient Guide: Welcome to the HD Unit

Transition to Conservative Care (Kidney Care Clinics)

- Care Team Guide: Transition to Conservative Care
- Patient Guide: Transitioning to Conservative Care

Stopping dialysis:

- Care Team Guide: Transition from Dialysis Treatment to Palliative Care
- Patient Guides: Stopping Dialysis Treatment: What you need to know before deciding
- FAQs about Stopping Dialysis Treatment

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:

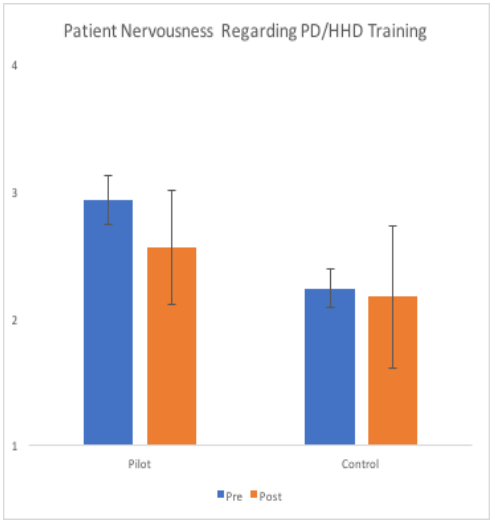
- SMH and ARH (PD) and PGH (HHD)

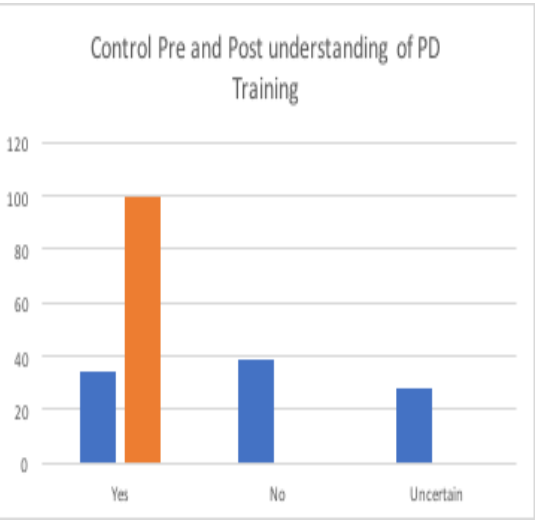
Evaluation tools:

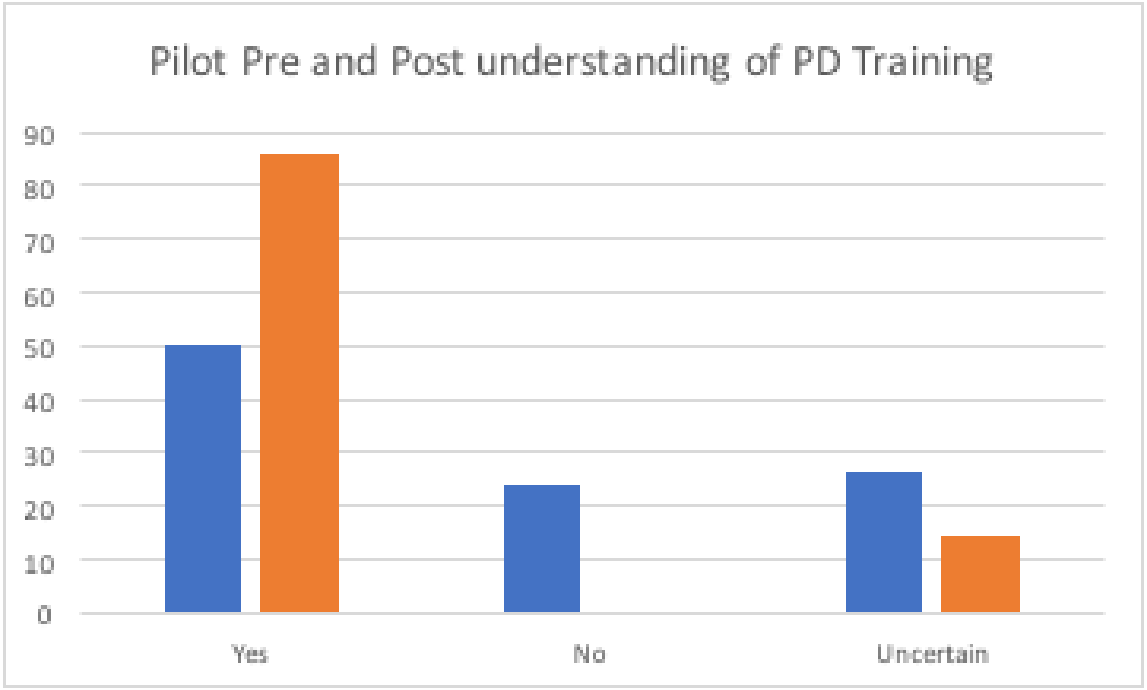
- Pre & post quantitative surveys of patients, pilot & control sites
- Post-implementation qualitative interviews of patients at pilot site
- Pre & post-implementation quantitative survey of Care Team at pilot & control sites
- Post-implementation qualitative interviews with Care Team at pilot & control 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



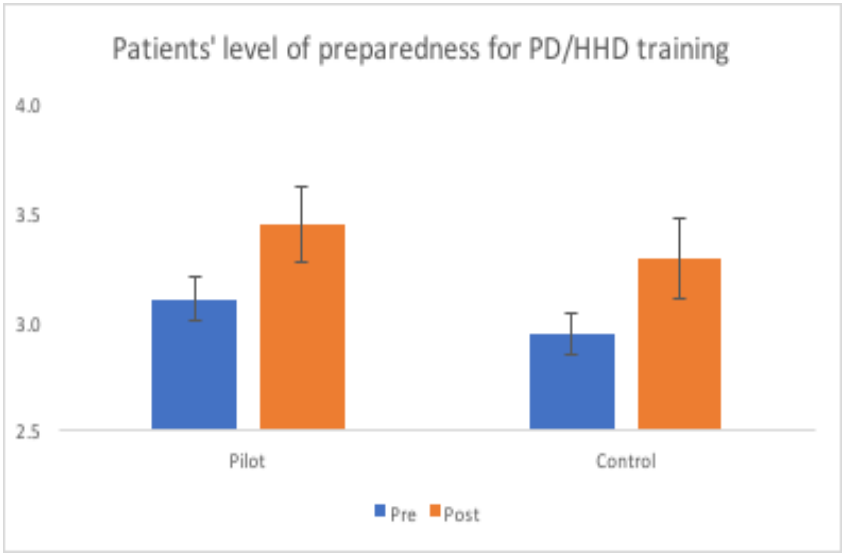


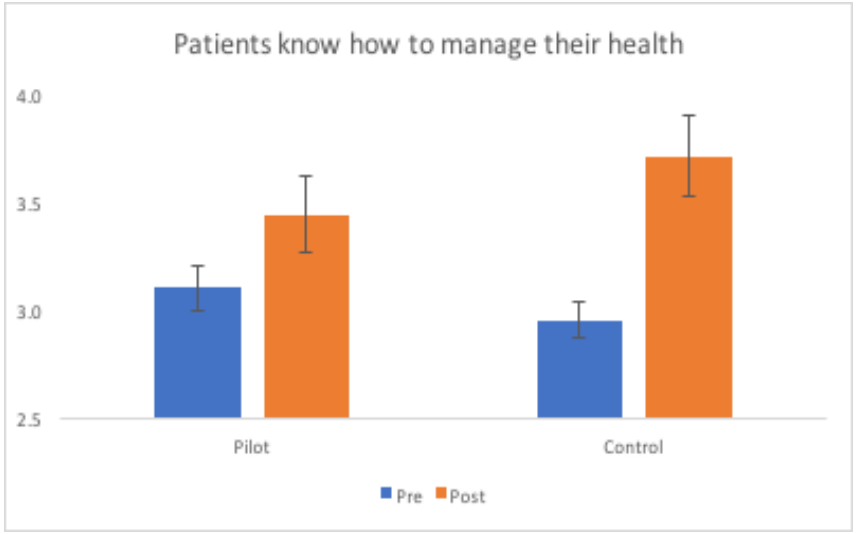


Pilot test outcomes: *Patient surveys*

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 thing 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