Transitions between Modalities/ Delivery Methods (Overview)

BCRenal
Provincial Health Services Authority

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*, ideally by the time the patient's GFR is 25 mL/min and/or at risk of rapid progression. Where applicable, a transplant referral is initiatied in PROMIS.
3. The KCC team provides education to patients about *dialysis options* (peritoneal dialysis, home hemodialysis and hemodialysis) and/or *conservative care* when the patient's GFR is 20-25 mL/min and/or at risk of rapid progression. Goal is to have a preferred modality identified at a GFR of 20 mL/min. (Note: Patients interested in pursuing transplant are also asked to identify a dialysis option as back-up).

All Patients (KCC patients and patients currently on dialysis):

4. If the patient meets the inclusion criteria, options are presented in the following order:
    a. Transplant (transplant prior to dialysis start is preferred)
    b. Independent dialysis: Peritoneal dialysis (PD), then home hemodialysis (HHD).
    c. Dependent hemodialysis (HD): Community dialysis unit (CDU), then in-centre.
        - Patients are expected to go to a CDU once stable after an initial run(s) in an in-centre unit. Another option is nocturnal dialysis (if available).
        - Patients unsuitable to move to a CDU will dialyze in an in-centre hemodialysis unit.
5. If the preferred modality is transplant, patients are supported in developing a Living Donor Outreach Plan.
6. 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).

Provision of ongoing care up to the point of transfer to modality:

7. KCC/modality team (e.g., PD, HHD, HD), actively monitors, treats and provides physical care and psychosocial support up to the point of hand-off to the receiving transplant/modality team.
8. KCC/modality team (e.g., PD, HHD, HD) advises the receiving transplant/modality team of significant changes in the patient status. Receiving transplant/modality team reassesses suitability of the patient for the planned transplant/modality.

Decision to start modality (not applicable if conservative care chosen):

9. The patient, nephrologist, KCC/modality team (e.g., PD, HHD, HD) and receiving modality team jointly determine the appropriate modality start date.

Preparation for transition once the modality date is known:

10. KCC/modality team (e.g., PD, HHD, HD) prepares patient for tests/consults/procedures (incl access creation) prior to transition to receiving modality, if required.
11. KCC/modality team (e.g., PD, HHD, HD) prepares and forwards a current patient summary to the receiving modality team. The patients primary care

provider (PCP) is notified of the upcoming change.

12. KCC/modality team (e.g., PD, HHD, HD) makes arrangements to cancel services no longer required post transition to the new modality (e.g., standing lab orders, mobile lab to home, etc).
13. Responsibility for care is transitioned as follows:
    a. Transitioning to PD: Care transfers to the PD team on the day the PD catheter is inserted.
    b. Transitioning to HHD: Care transfers to the HHD team on the first day of home HD training.
    c. Transitioning to facility-based HD: Care transfers to the HD team on the first day of dialysis.
    d. Transplantation:
        - Care transfers to the Transplant Team (Vancouver) on the day of the transplant.
        - Care transfers from the Transplant Team (Vancouver) to the Regional Transplant Centre upon discharge of the patient from the Transplant Team (usually at ~ three months post-transplant).
14. For patients choosing conservative care, care continues to be provided by the KCC team, in collaboration with the PCP. Roles of the KCC team vis a vis the PCP are regularly reviewed and adjusted to best meet patient needs and wishes.

Transition Guides

Care Team Guides:

1. Transition to Peritoneal Dialysis (PD)
2. Transition to Home Hemodialysis (HHD)/ Independent HD
3. Transition to In-Centre/Community Dialysis (CDU)/ Nocturnal Hemodialysis (NHD)
4. Transition to Conservative Care (Kidney Care Clinics)
5. Transition from Dialysis Treatment to Palliative Care

Patient Guides & Posters:

1. Transitioning to Peritoneal Dialysis (PD) (guide & poster)
2. Transitioning to Home Hemodialysis (HHD) (guide & poster)
3. Transitioning to Conservative Care (Kidney Care Clinics) (guide)
4. Welcome to the Hemodialysis Unit
5. Stopping Dialysis Treatment: What you need to know before deciding
6. Frequently Asked Questions about Stopping Dialysis Treatment