

Improving the Transition to Dialysis After Kidney Transplant

Renal Network 11
April 29, 2015



Welcome

- Thank you all for being part of this call today!
- All lines are muted.
- Please submit questions via the “Chat” or “Questions” panel.
- This webinar is being recorded.

Why Is This Important?

- Although transplanted kidney survival time has increased dramatically over the last several years, there are still times when the transplant no longer works and patients need to go onto dialysis
- In 2013, 300 patients in Network 11 needed dialysis after their transplant failed.

Why Is This Important?

- During the transition from transplant to dialysis, patients have shared a variety of different feelings and responses.
- Literature search shows little data regarding this transition process

Listening to the Patient's Voice...



Mitzy Riley

Insight Into Transition from Transplant to Dialysis

Sheila Jowsey-Gregoire, MD
Mayo Clinic



Psychological Implications of the Transition from Transplant to Dialysis

Sheila Jowsey-Gregoire MD

Mayo Clinic

April 29 2015

Dialysis after Transplant

- **Worse quality of life than other dialysis patients**
- **Possibly due to infection risk in immunocompromised patient (PD more than hemodialysis)**
- **Hemodialysis patients after transplant were more depressed, at times as severe as in suicidal populations**

Typical Responses

- **Grief – associated with guilt, depression possibly with suicidality, anger , irritability, sadness.**
- **Associated with deception about the loss, feelings of loss of control**
- **Denial- no reported emotional response**
- **Occasionally relief to return to highly valued dialysis experience**

Grief

- **May predict low long-term quality of life after transplant**
- **Associated anxiety, depression, hostility may have negative impact on compliance**

Denial

- **May be associated with increased medical noncompliance**

Other Factors

- **Pain**
- **Lethargy**
- **Altered body image**
- **Family issues**

Influences in Dialysis

- **Older women – shared decision making, collaboration, communication, education, relationships**
- **Mid-age men – shared decision making, collaboration, relationships**

Influencers cont.

- **Older males – relationships**
- **Late middle age men - shared decision making, relationships**

Recommendations

- **Monitor for depression**
- **Engage support network**
- **Nonjudgmental approach**
- **Consider motivational interviewing**
- **Support a sense of mastery – small steps to improve QOL, return to work**
- **Encourage resilience**

Resilience

- Optimism
- Problem solving
- Flexibility
- Resilient role models
- Humor
- Help others
- Moral compass/faith

Teaching to be Understood

Anna Heining

What is Health Literacy?

Health literacy is the degree to which individuals have the capacity to **obtain, process, and understand** basic health information and services needed to make appropriate health decisions.

Teach Back....What is it?

- Asking patients to repeat **in their own words** what they need to know or do, in a non-shaming way.
- **NOT** a test of the patient, but of how well **you** explained a concept.
- A chance to check for understanding and, if necessary, re-teach the information.

Teach-Back . . . When?

The teach-back technique should replace the more common practice of simply asking a patient, *“Do you understand?”*

Experience shows that patients often answer “yes” to such questions, even when they understand nothing.

Teach-Back . . . How?

Ask patients to demonstrate understanding

- “If someone asked you how to explain this, how would you do so?”
- “I want to be sure I explained everything clearly, so can you please explain it back to me so I can be sure I did.”
- “Show me what you would do.”

Chunk and check

Summarize and check for understanding throughout, don't wait until the end.

Do NOT ask . . .

- “Do you understand?”

The Transitioning from Transplant to Dialysis Project

Asking the “Five Questions”

1. Before your transplant, what was your experience with dialysis? What questions do you have now about dialysis?
2. What are your feelings about having to go on dialysis?
3. How can we make this transition better for you?
4. What did your doctor tell you about home dialysis or getting another kidney transplant?
5. Would you like to speak with a patient who has been through this process?



The Five: A Checklist for Patients Transitioning from Transplant to Dialysis

1. Before your transplant, what was your experience with dialysis? What questions do you have now about dialysis?
 - Refer to the RN to explain dialysis process, need for permanent access, medications
 - Refer to dietitian for changes in diet restrictions
 - Refer to social worker for transportation needs
2. What feelings are you having about going on dialysis?
 - Refer to social worker for psychosocial assessment
 - Include information in the patient assessment and care plan regarding patient's feelings
3. How can we make this transition better for you?
 - Concerns about scheduling, working, childcare
 - Are there family concerns also?
 - Include this information in the patient assessment and care plan
4. What did your doctor tell you about home dialysis or getting another kidney transplant?
 - If necessary make arrangements for patient to meet with their nephrologist or the transplant coordinator
 - If indicated, make arrangements for patient to meet with home dialysis staff or refer the patient to a home dialysis program
5. Would you like to speak with a patient who has been through this process before?
 - If so, work with social worker to identify a patient who would be a good peer resource for this patient
 - If not, this question may be asked later on after the patient has adjusted more to treatment



Project Steps

- May 2015
 - Review PowerPoint with facility staff
 - Review “Five Questions” with facility staff
 - Submit to Network 11 how many patients started dialysis after a transplant during April
- June – September 2015
 - Go over the “Five Questions” with each patient that starts dialysis after transplant
 - Submit completed information form to Network 11 by the 10th of each month for the previous month

Data Collection Tool



Renal Network 11 Transition from Transplant to Dialysis Project

Facility Name:	
CMS Certification Number:	
Name of Project Lead:	
Project Lead Back-up:	
Telephone #:	

	Number of patients starting dialysis after a failed transplant	Number of patients who received education from the checklist
April 2015		
May 2015		
June 2015		
July 2015		
August 2015		
September 2015		
October 2015		



Please complete this form and FAX to the Network office on the last working day of each month. You may also email the completed form to Kristen Ward at kward@nw11.esrd.net as long as the form does not include any patient-specific information.

Questions? Please contact Jan (jideane@nw11.esrd.net) or Kristen at 651-644-9877

Renal Network 11
FAX: 651-644-9853
Attn: Jan or Kristen



Data Collection Tool

	Number of patients starting dialysis after a failed transplant	Number of patients who received education from the checklist
April 2015	2	1
May 2015	0	0
June 2015		
July 2015	 <p>Don't enter census</p> <p>Enter the # of eligible patients</p> <p>Can be 0</p>	 <p>Enter the # of eligible patients with whom you reviewed the "5 Questions"</p>
August 2015		
September 2015		
October 2015		

Submitting Data

FAX to 651-644-9853

or

Email to kward@nw11.esrd.net
by the last day of the month

**If sending via email, make sure the form does not
include any patient-specific information**

thank you!

Questions

Kristen Ward kward@nw11.esrd.net

Jan Deane jdeane@nw11.esrd.net

Phone: 651-644-9877