

Optimal Preparation of Patients for RRT

Transitioning from Chronic Kidney Disease to Renal Replacement Therapy

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Step by Step: Considerations in Optimal Preparation of Patients for Dialysis Therapies.

Saggi A et al. Nature Reviews Neph 8(7), 381-9,2012

What are the problems?

- ❖ No pre-dialysis nephrology or dietary care
 - ❖ 1 in 5 patients first see nephrologist within 1 month of starting HD (DOPPS)
- ❖ No permanent access

45% mortality in 1st 3 months of RRT (DOPPS)



“Well, what seems to be the trouble, Mr. Sims?”

Predictors of need for RRT

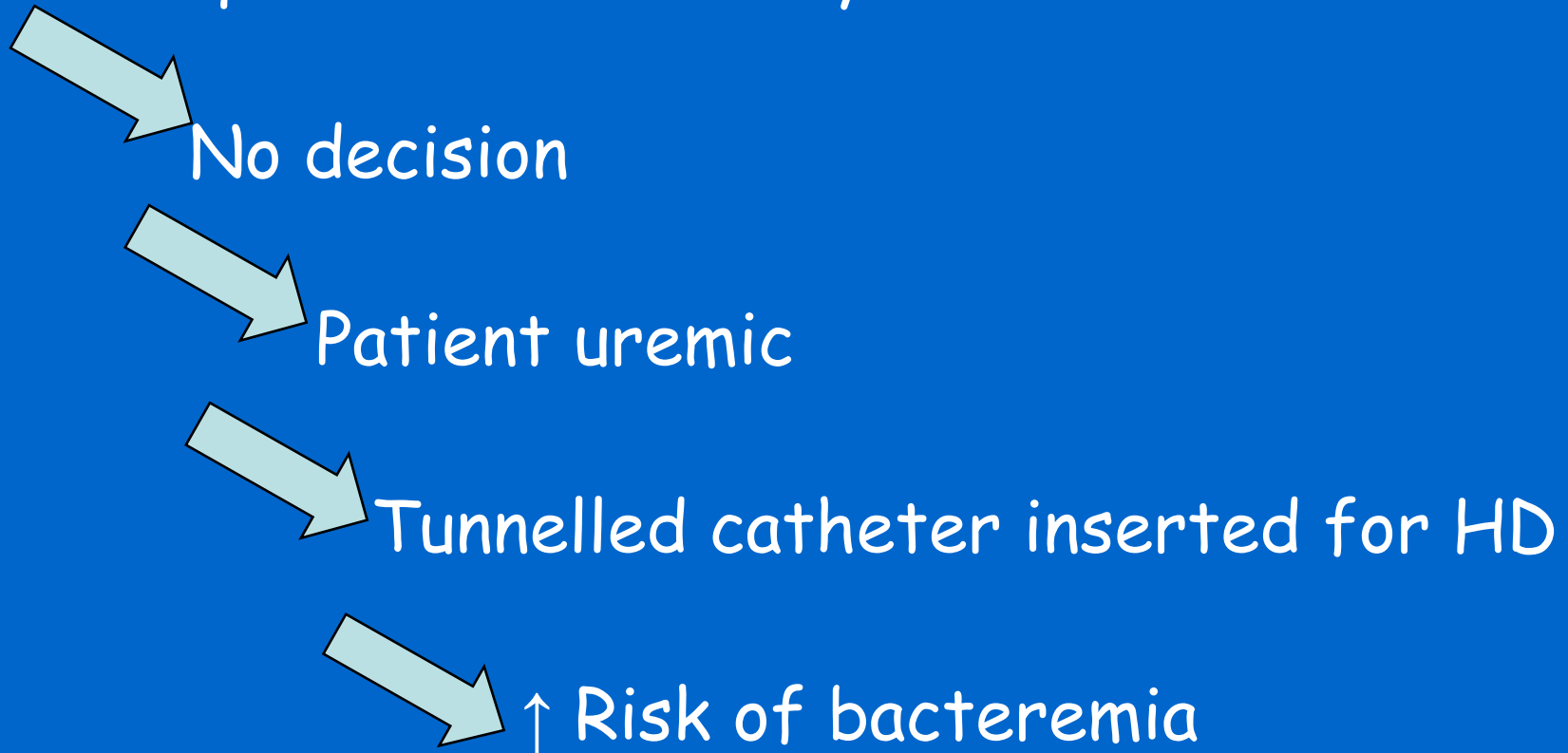
Levin A. et al. *AJKD* 52,661-71, 2008

Study of 4213 Canadian patients with CKD 4:

- ❖ advanced age
 - only 17% >85 years old needed RRT
- ❖ increased /uncontrollable blood pressure
- ❖ increased phosphatemia
- ❖ increased albuminuria
- ❖ decreased hemoglobin

All too common pathway for dialysis initiation

Inadequate or no modality education



No patient education: WHY?

- ❖ Lack of education services
- ❖ Lack of coordination of services
- ❖ Absence of commitment by care givers
- ❖ Control issues of MD and RN
 - ❖ We should not try to decide which modality is best for a patient
- ❖ Some patients assume MD only one skilled enough to make the "right" decision.

Barriers to CKD Education:

- ❖ time restrictions with patients
- ❖ old habits
- ❖ “MUM” effect
- ❖ inadequate interaction skills
- ❖ lack of feedback on current performance
- ❖ low confidence in new approaches

The Messenger

- ❖ Natural aversion to telling bad news
 - ❖ fear of “kill the messenger”
 - ❖ wish to shield the patient
- ❖ Few physicians or nurses are prepared
 - ❖ <10% of oncologists have any formal training to deliver message
 - ❖ only 32% observed interviews during training where “bad news” was given

What is bad news?

Any information which adversely affects an individual's view of their future.

What happens when a patient is told the "bad news" ?

(aka dialysis is impending)

Reactions pre-dialysis

- ❖ Term "end stage renal disease" is frightening
- ❖ Fear of death develops
- ❖ Stress of decisions about therapy
- ❖ Stress of learning and adhering to dietary and medical regimens
- ❖ Deny dialysis is needed
- ❖ Fear loss of job, income, lifestyle

Emotional responses

- ❖ Assess reactions—
let the patient know
you recognize their
reaction, acknowledge
your own sadness or
other emotions



crying



silence, disbelief



denial



anger

Furthermore:

With repeated exposure to the bad news process, physicians and nurses may become less aware of their discomfort or not experience discomfort at all.

but the patient is hearing it for the first time...

Approach to chronic disease:

- ❖ 5 encounters with the patient before the patient actually "gets it".

Ptacek and Eberhardt, JAMA 1996

- ❖ IF MD introduces bad news at one clinic, RN, NP, PA, RD, SW can make subsequent contacts to allow the patient time to hear the same message repeatedly.

Case Study 1: Ms X is a 58 year old woman with CKD secondary to DM.

- ❖ Full time social worker with active social life.
- ❖ Told there is bad news, that she soon will need dialysis, GFR <15mL/min
 - ❖ Consult, so first meeting with nephrologist.
 - ❖ Previous physician told her it would be years before she needed dialysis

Case study 1, continued...

- ❖ Begins to cry.
- ❖ Develops anxiety, severe insomnia and depression.
- ❖ Difficulty making decisions and concentrating

We'll return to this case later...

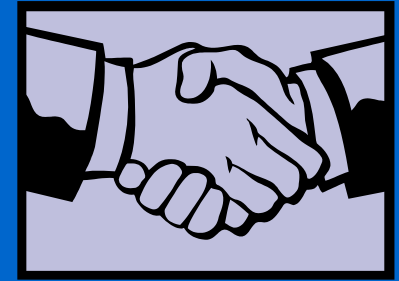
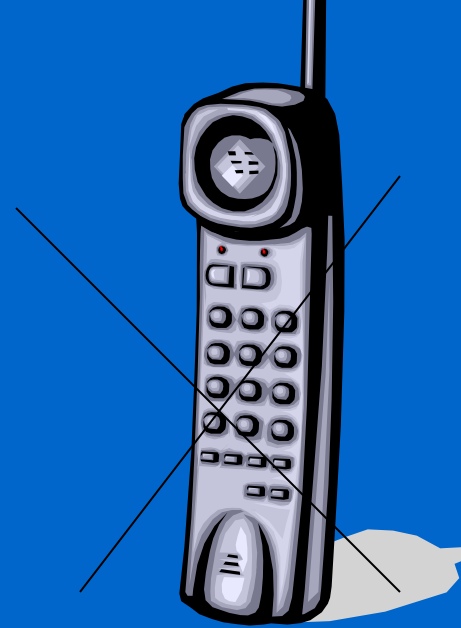
Pre-dialysis Education: the process

Primary Goal:

- ❖ To provide information about choices of therapy

Secondary Goals:

- ❖ Help patient accept RRT
 - ❖ Realize that they are choosing the therapy to *begin with*, but that many will eventually have all therapies at different times in order to prolong their lives and maintain their quality of life
 - ❖ May choose conservative therapy (no dialysis or transplant)—we need to support them and continue to provide non-judgemental care
- ❖ Help integrate RRT with patient's life
- ❖ Avoid admission for emergent start of dialysis
- ❖ Avoid temporary HD access



physical setting quiet and private

news given in person by someone who knows the patient

physical contact with the patient

allow patient to dress before discussion

Perception of the patient "before you tell, ask"



Determine the Patient's Goals and Priorities

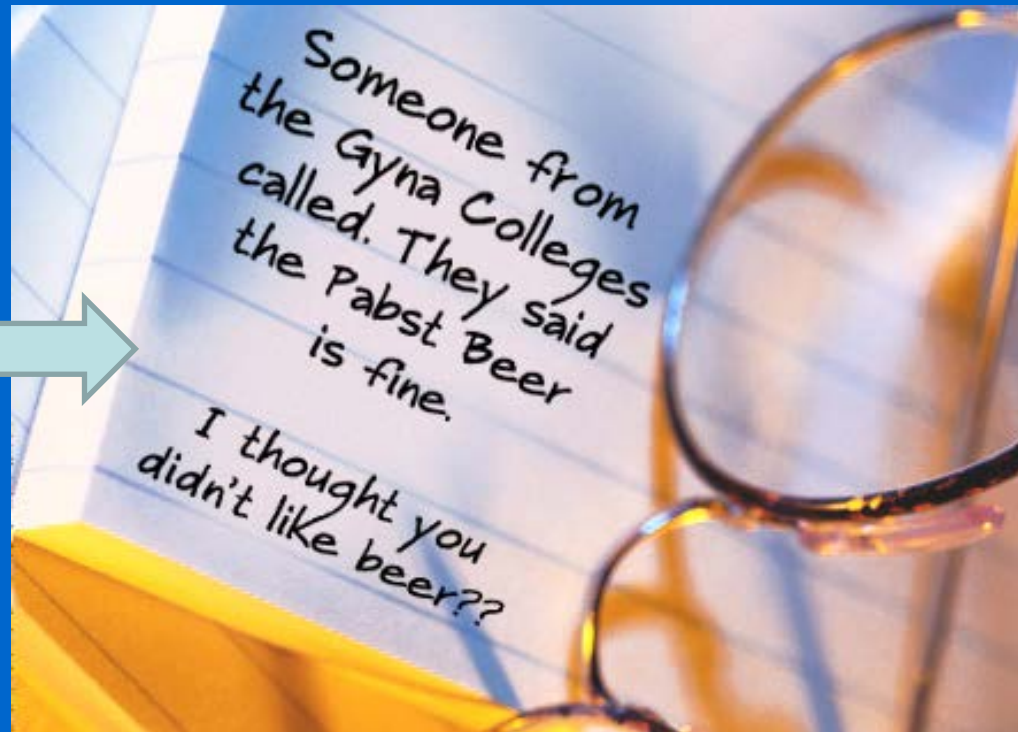
- ❖ What's most important in the patient's life?
- ❖ What does he or she want to be able to continue to do?
- ❖ How important is independence to the patient?

Strategy

Share decision-making,

Check for misunderstandings,

acknowledge unrealistic expectations



The Message Receiver

- ❖ Needs us to acknowledge their losses and face the sadness with them
- ❖ Needs to understand what is to happen to them, even if it is unpleasant
- ❖ Needs help in "reframing" expectations
- ❖ **remember:** 5 encounters with the patient before the patient actually "gets it".

97% of Dialysis Patients Want Survival Data

	Do NOT want to know	Would like to know	Absolute need to know
Life expectancy on dialysis	3%	46%	51%
Limitations on quality of life	1%	45%	54%
What it does to the body	3%	44%	53%
What it will accomplish	4%	43%	53%
Possible side effects	4%	48%	48%

And for the physician to provide it without having to be prompted

The Process...

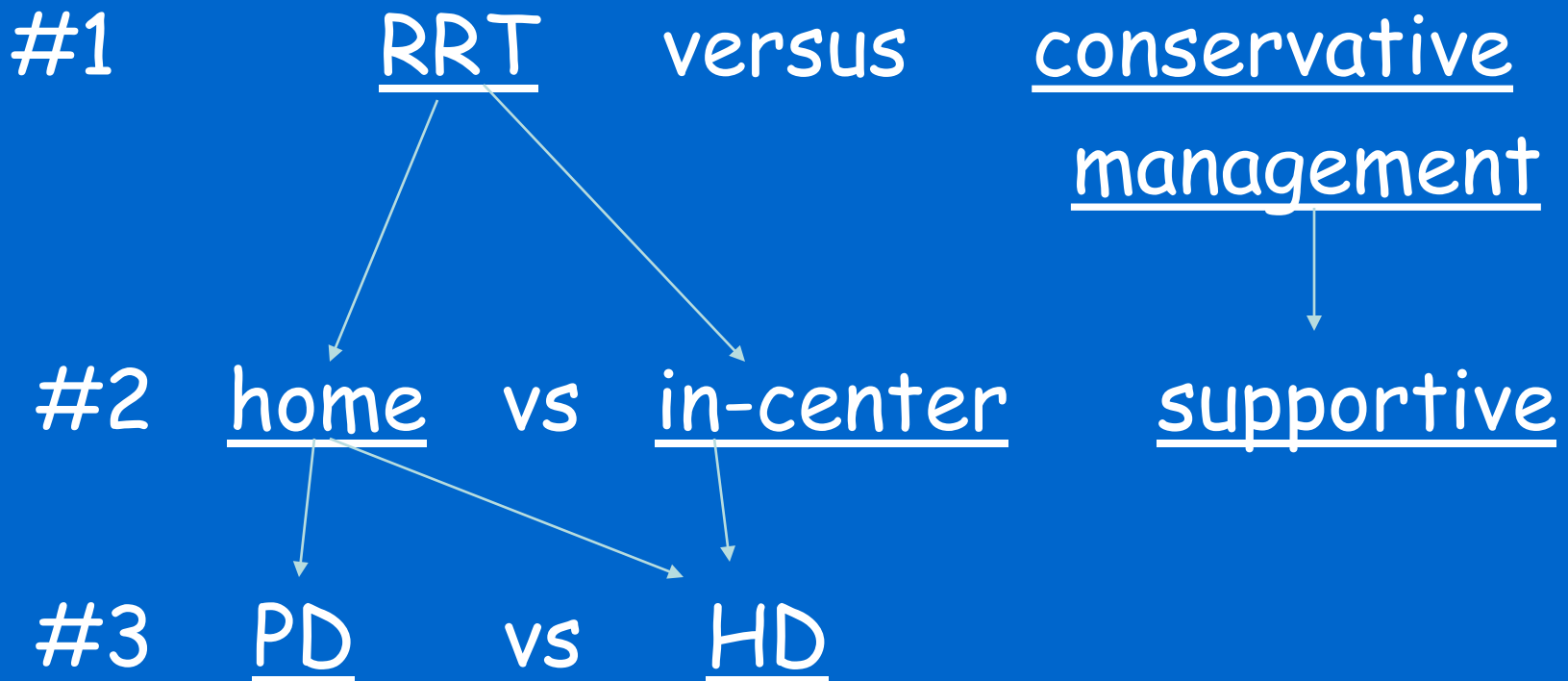
- ❖ Patients do not want insensitive truth telling
- ❖ But they do want truthful facts with your support for decision making

The Process of Patient Education

- ❖ Begin session with open ended questions
 - ❖ Tell me about what you know about your kidney disease...
 - ❖ Have you ever known anyone with kidney failure... tell me about them...
 - ❖ Tell me what you have been told you about your kidney disease (or RRT or transplant or not wanting RRT)

The Process...

❖ Discuss choices



The Process...

❖ patient fills out a grid of pros & cons



Choice:

Continue with other grids for in-center vs home, then PD vs HD

Patient Preferences: A review of published surveys

Benbassat et al, Behavioral Medicine 1998

- ❖ The vast majority want to be informed about their disease
- ❖ Patient satisfaction higher when healthcare givers *shared* in care decisions
- ❖ With acute distress, lower interest in participating in decisions

Choices: PD versus HD

- ❖ Because there is no consistent evidence one modality is superior to the other, this choice should be primarily the patient's, based upon their lifestyle.
- ❖ There are few absolute contraindications for HD or PD:
 - ❖ The principal reason for the modality choice should be simply that the patient chooses it after receiving unbiased education about the modalities.

Informed Patients Often Choose PD

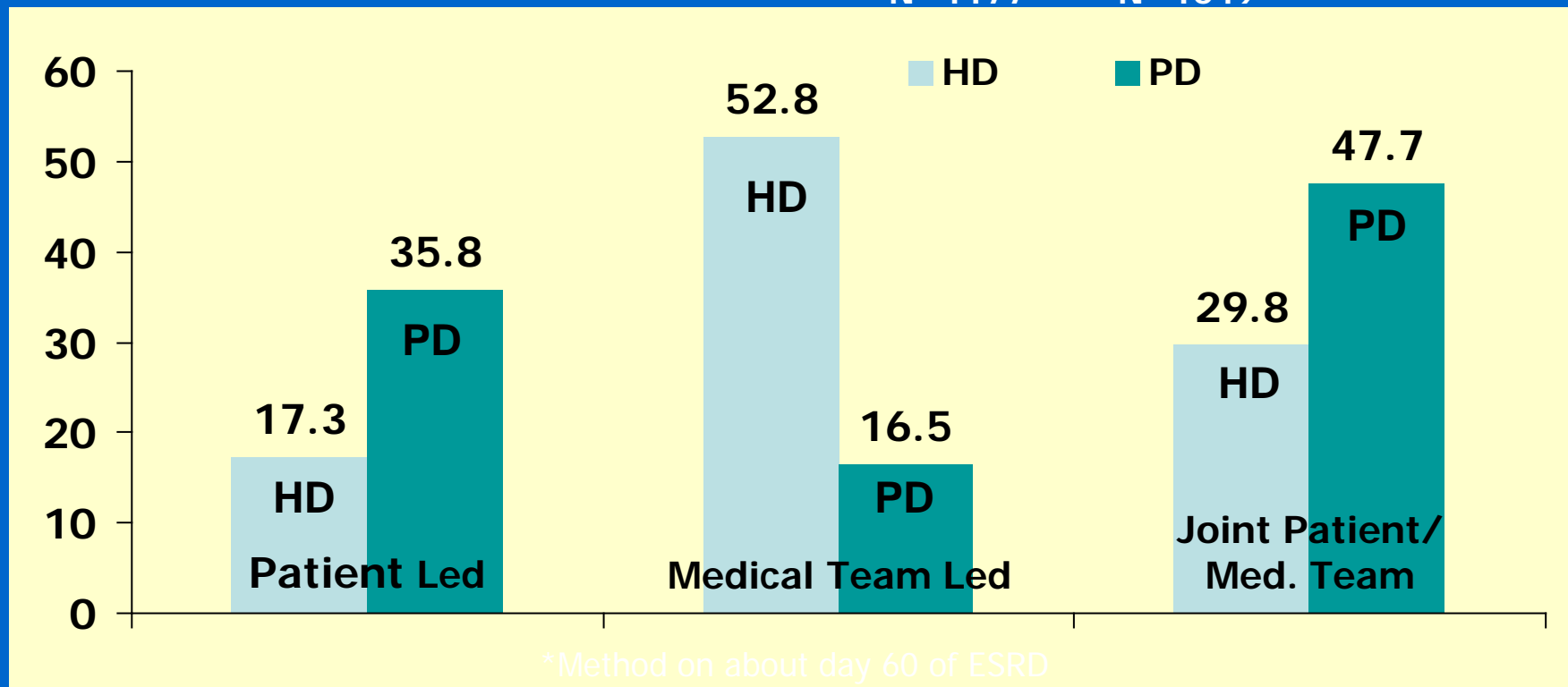
When Providers Choose, Most Patients Receive HD

Percent of Patients

Adds to 100% each

N=1177

N=1049



The USRDS Dialysis Morbidity and Mortality Study: Wave 2. *Am J Kidney Dis.* 1997;30(suppl):S67-S85.
Schreiber M et al. *Nephrol News Issues.* 2000;14:44-46.

Effects of predialysis education

Klang et al, J Adv Nursing, 1998

- ❖ 28 patients with GFR <20mL/min
 - ❖ 4 group sessions with nurse educator
- ❖ 28 patients with "usual care" predialysis
 - ❖ Information from physician on

3 mo after started dialysis, CKD educ pts had:

- ❖ better mood, less mobility problems,
less functional disabilities, less anxiety

Effects of Patient Education on Initiation of RRT

Binik et al, J Nervous and Mental Dis, 1993

- ❖ 204 ESRD patients pre-dialysis or transplant
- ❖ randomly assigned to enhanced or standard education
 - ❖ Enhanced education initiated dialysis 4.6 months after standard education group
 - ❖ Speculated diet education alone may have delayed onset of dialysis

Pre CKD education and coping styles.

Devins et al, AJKD 2003

- ❖ random assignment of 297 patients to 90 minute, 1:1 educational intervention compared to "usual care"
- ❖ Intervention included phone calls every 3 weeks until dialysis began
- ❖ Compared coping mechanisms:
Intervention significantly delayed time to start of dialysis (17 vs 14 months, $p < 0.001$)

Do Educated, Empowered Patients Have Better Outcomes?

Latham, JASN, 1998

- ❖ improved quality of life
- ❖ more likely to be employed
- ❖ more satisfied with care
- ❖ less utilization of health services
- ❖ cost effective:

for every \$ invested in patient education,
\$3-4 saved on ER, admission or MD visits

Can Patient Education Maximize Success of Therapy?

Golper, Nephrol Dial Transp, 2001

USRDS Wave 2 Study and CHOICE Study
1700 patients

- ❖ Education early in course of CRI
 - ❖ reduced anxiety
 - ❖ improved respect for healthcare givers
 - ❖ more likely to remain employed
 - ❖ more timely initiation of dialysis
 - ❖ improved compliance with therapy

Does Patient Education Influence Modality Choice?

Golper, JASN 2000

National Pre-ESRD Education Initiative

- ❖ 2850 patients enrolled
- ❖ 55% chose HD, 45% chose PD



98% went on HD



75% went on PD

-change in health status

-physician-driven change

-patient changed mind

How to evaluate your CKD education program

- ❖ What % of your CKD patients receive CKD education?
 - ❖ The goal is for 100% to receive CKD education
 - ❖ You may want to consider a protocol with an automatic referral to CKD education at a specific GFR (such as 30)

- ❖ What % of your CKD patients choose home therapies?
 - ❖ Research shows 30-50% will choose home therapy with good CKD education

 - ❖ If your center's take-on rate for home therapy is less than this, you should re-evaluate your CKD program

Return to Case Studies...

Case I, a 58yo woman with DM:

- ❖ Begins to cry.
- ❖ Develops anxiety, severe insomnia and depression.
- ❖ Difficulty making decisions and concentrating.

- ❖ She returned in 2 weeks with a friend to tour the dialysis unit.
- ❖ Numerous phone calls and clinic visits
- ❖ Chose APD
 - ❖ difficulty with training due to cognitive problems (depression)
- ❖ Placed on antidepressant; encouragement from staff
- ❖ After 1 month, returned to work and active social life

Educational Options

- ❖ 1 on 1
- ❖ group session(s)
- ❖ nurse, physician or other educator
- ❖ meet or talk with a dialysis patient
- ❖ support group

When to begin CKD education

❖ Options:

❖ as soon as CKD diagnosis is made

- ❖ This may not be altogether practical

- ❖ Advantage: allows for early education about diet and medications to delay onset of RRT

❖ when GFR is ≤ 30 mL/min

- ❖ At this point, all patients should receive CKD education about RRT and conservative management

- ❖ This allows for timely placement of a permanent dialysis access or to address issues of donors for transplant or other issues of conservative treatment when requested

My approach :

- ❖ Referral from clinic or MD for each patient with $GFR \leq 30\text{mL/min}$
- ❖ Out patient
 - ❖ Call patient, set up individual tour of dialysis unit
 - ❖ Family and/or significant others invited to tour
- ❖ In patient
 - ❖ Visit patient, provide information
 - ❖ Clinic tour after discharge if possible
- ❖ After tour, send email or call MD about patient's choices, family dynamics, limitations, etc.
- ❖ Phone and clinic contact until begins dialysis
 - ❖ This keeps the patient from "falling through the cracks" during this critical period

What about the "parachute" patient?

(presents with ESRD and urgently needs dialysis)

How can modality education be provided?

Is PD an option for urgent start?

- ❖ Yes! Nephrologist or nurse educator briefly presents choices of RRT vs conservative management, home vs in-center, and HD vs PD.
- ❖ PD can be used for urgent start if have infrastructure in which surgeon available for urgent placement of PD catheter (just as have for urgent HD catheter).
 - ❖ PD catheter can be used immediately post-operatively if patient remains recumbent with low volumes.
 - ❖ Use cycler with continuous 1 liter exchanges over 24-48 hours.
 - ❖ Advantage of urgent PD is avoidance of HD catheter and subsequent risk of bacteremia. If patient chooses HD after urgent PD start, permanent HD access can be placed and change to HD done in orderly fashion when access mature.

Summary

- ❖ Pre-dialysis education is an important patient right.
- ❖ Formats vary--it is not clear what's best
- ❖ Several studies identify benefits of pre-dialysis education, including increasing the likelihood of a patient choosing a home therapy.

Questions?