Care Team Guide:
Transition to Conservative Care (CC)

BCRenal
Provincial Health Services Authority

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.
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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
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3. Assesses and assists patient in the development of a plan to manage symptoms (eGFR<15 or significant KCC-related symptoms) **Refer to Step 3 of the *Transitioning to Conservative Care (CC)* booklet**	Assesses symptoms using the modified ESAS (My Symptom Checklist)* q6 months & more often if significant KCC-related symptoms. Enters results into PROMIS. Assists patient in the development of a plan to manage symptoms. Utilizes symptom management care guides and provides relevant handouts,* as appropriate. Refers patient to PCP, as appropriate. *Refer to BCRenalagency.ca ▶Health Professionals ▶Clinical Resources ▶Symptom Assessment and Managenment
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4. Works with patient to actively plan for the future (illness is serious but stable) **Refer to Step 4 of the *Transitioning to Conservative Care (CC)* booklet** **For clinicians trained in Serious Illness Conversation, refer to: https://bit.ly/33YAmBZ	Identifies possible kidney-related crises (e.g., acute worsening of symptoms, caregivers overwhelmed, etc). Works with patient/family to develop crises management plans. Confirms patient/family has contact numbers and knows who and when to call (e.g., GP, KCC team, nephrologist, home care, palliative care/hospice team, spiritual care). Continues advance care planning (ACP) discussions* including: • Confirming what is important to patient (e.g., beliefs, values, spiritual and cultural needs, treatment preferences) • Identifying a substitute decision maker (SDM). • Developing a representation agreement and/or advance directives, if desired. *Refer to My Voice at www.health.gov.bc.ca/library/publications/year/2013/MyVoice-AdvanceCarePlanningGuide.pdf. Personal planning resource also available at www.nidus.ca. Ensures ACP discussions are documented in PROMIS. Provides education on palliative care services available in local community. When patient/family ready, encourages patient to update will, power of attorney and other relevant forms (e.g., organ donation, bequest forms). If patient open to same and/or as appropriate, reviews desires at end of life (EOL), including place of death (KCC team or via PCP/palliative care team).
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5. Supports patient in later stages of conservative care (increased symptoms, declining kidney function) **Refer to Step 5 of the *Transitioning to Conservative Care (CC)* booklet**	Contacts patient's PCP to discuss desires of patient/family. Confirms role of KCC team and PCP. In most cases, PCP will be the main contact for the patient/family and will arrange home care/support and referral to local palliative care/hospice team, if appropriate. Confirms completion of the following (by KCC team or PCP), as appropriate: • Referral sent to palliative care services • Submission of BC Palliative Care Benefits Program Application form (HLTH 349). www2.gov.bc.ca/assets/gov/health/forms/349fil.pdf • Completion of No CPR form (HLTH 302). www2.gov.bc.ca/assets/gov/health/forms/302fil.pdf • If home death desired, "Notification of Expected Death in the Home" form has been signed by the patient if the patient/family opts for no pronouncement (PCP/palliative care team or KCC team). (form used outside urban areas only). HLTH 3987. www.solacebc.ca/Expected.pdf Ensures patient/family has copies of CPR & "Notification of Expected Death at Home" forms, if relevant. Provides information on compassionate care benefits as appropriate (INS5216B). https://catalogue.servicecanada.gc.ca/content/EForms/en/Detail.html?Form=INS5216B Discuss support required by family.
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6. Approaching end of life (EOL) & providing bereavement support after death **Refer to Step 6 of the *Transitioning to Conservative Care (CC)* booklet**	End-of-life: Provides advice to the PCP, home care/support and palliative care hospice team about pain and symptom management, as requested. Supports patient/family to minimize burden/stress. After death: Acknowledges death with phone call, letter or card to family. As appropriate, offers brief grief and bereavement counselling to the family/ caregiver and provides resources such as funeral packages, community supports and grief counselling resources. e.g., BC Bereavement Helpline (www.bcbh.ca), local counselling/grief support resources, local hospice society and PCP. Discusses and reflects upon the patient's death as a KCC team.