Transplant

Increasing Access to Transplant & Home Dialysis: Concepts for the ESRD Networks December 2020

Transplant Trailblazer: Provides short-term peer support to a dialysis patient from a transplanted patient with the goal of the dialysis peer achieving active transplant waitlist status. Transplant Trailblazers are local (e.g., same or sister facility or program, same transplant center, same healthcare system), goal-focused, who are paired with local dialysis patients that may include family or caregiver interaction. The partnership between individuals is designed to support dialysis peers on kidney transplant, although peers may remain in contact after being placed on the waitlist, if they choose.

Considerations for Implementation

- Introduce the program to and partner with Transplant Centers to identify potential Transplant Trailblazers
- Promote Transplant Trailblazers at dialysis facilities within Network Service area and coordinate with the facility patient representatives
- To document impact, participating facilities may wish to track engagement, including:
    - Number of Transplant Trailblazers introduced to facilities in the Network service area
    - Number of dialysis participants and transplant patients (partners) paired
        - Date of first documented meeting with dialysis peers
        - Date active on the transplant waitlist
    - Facility- and patient-level feedback to foster rapid cycle testing and future iterations of this program
- Recognize and celebrate facilities and partner pairs who meet goal of the dialysis patient becoming active on transplant waitlist

High-KDPI Patient Education Video: Delivers easy-to-understand education directed to patients and is intentional in promotion of the possibilities of receiving a high KDPI or increased risk kidney transplant. It may be shown at the dialysis facility with the introduction to transplant and shared with transplant centers to be incorporated in their educational materials for patients and families. It is also relevant for dialysis facility staff to reinforce current education.

Considerations for Implementation

- Promote video link to transplant centers within Network service area and collaborate to drive adoption. Recommend that transplant centers track the number of patients who consent to a high KDPI or increased risk kidney after watching the video.
- Operationalize sharing of video at dialysis facilities, nephrology practices, and home programs.
- Track and trend the transplant centers, dialysis facilities, home programs, and nephrology groups who agree to share the video in waiting room areas or during consultation for a transplant center referral.

Kidney Transplant Hub: Acts a centralized hub for patients for trusted information on each step of the kidney transplant process. There will be periodic updates to the site based on feedback from the community and in alignment with change package drivers.

Considerations for Implementation

- Promote to professionals and patients across the Network service area via social media, a link from your Network website, and inclusion in your provider and patient newsletters.
- Spread the website link through your Patient Advisory Committee members (past and present) and encourage patients to use credible information to take action as outlined in the “What Will You Do Now?” section of site.
- Share the website in your Network transplant activities.
- Request patients share ideas for future materials to include on the website using the built-in feedback collection tool.

ESRD = End Stage Renal Disease; KDPI = Kidney Disease Profile Index

Home

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Regional Nephrologist Roundtables: Focuses on knowledge-sharing via virtually-hosted, moderator-led sessions between more experienced nephrologists and those less experienced in the specialized areas of home dialysis and telemedicine or transitional dialysis care units. The aim is to increase use of telemedicine and overall home dialysis use and transitional care units across the country through experiential success.

Considerations for Implementation

- Identify home dialysis nephrologists with data-demonstrated success in Network service area with knowledge and effective practices related to home dialysis census or growth rates and use of telemedicine.
- Recruit knowledgeable nephrologists in specialty of home dialysis and telemedicine.
    - Identify Network home dialysis faculty to act as expert advisers to the Network's Regional Roundtable.
- Define the organization and structure of virtual meetings. Use polling features within virtual applications to keep discussion topics on target.
- Provide mechanisms for professionals to connect and close geographic gaps in practice by spreading effective practices, successes, and information sharing virtually (e.g., listservs, forums, or polling tools).

Home Dialysis Heroes: Provides short-term peer support to an in-center hemodialysis (ICHD) patient from a successful home dialysis patient. Unlike peer mentoring, Home Dialysis Heroes are local, goal-focused, may include family and caregiver interaction, and are paired with local dialysis patients. The formal support program is designed to promote patient peer experiences with the goal of dialysis peers making a referral to a home program, although peers may remain in contact indefinitely, if they choose.

Considerations for Implementation

- Promote Home Dialysis Heroes at all ICHD facilities and Home programs within Network service area.
- Promote Home Dialysis Heroes at dialysis facilities within the Network service area and coordinate with facility patient representatives.
- Document facility- and patient-level feedback to foster rapid cycle testing and future iterations of this program and recognize facilities and patient pairs who meet goal of dialyzing at home.

Universal Home Education for Professionals: Raises awareness of home dialysis to ICHD staff to increase their comfort level in talking about home dialysis options with patients. The modules introduce the basics of peritoneal dialysis and home hemodialysis with a focus on benefits, myths, overcoming barriers, and the role of the ICHD unit in driving patient transition to home dialysis. Facilities should encourage home dialysis referral and follow-up by empowering all facility staff to share education during teachable moments between staff and patients (e.g., when a patient shares a life-changing event occurred any staff should feel comfortable encouraging exploration of home dialysis, including progression to the next step in home program referral in line with the facility's process).

Considerations for Implementation

- Networks to distribute the link to the education modules with ICHD facility administrators who pass the information to all ICHD staff and request completion within a determined time period.
    - NCC to assist Networks to track and monitor progress of 1) registration; 2) completion of courses.
- Encourage facilities to host staff meetings, team huddles, and QAPI meetings related to the content of the modules. Celebrate module completion and recognize patient referrals to a home program.

NCC = National Coordinating Center

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