Action Points
Sessions

Training Issues
Transplantation
Dialysis in the Elderly / Palliative Care
CARI
AKTN
KHA Consumer Surveys
Dialysis outcomes
KPIs and League Tables
HT & Proteinuria – RAAS and SNS blockade
Training Issues

- Curriculum – seemed to be accepted
  - Concern that acute transplant experience is mandated
- SAC/TSANZ - Trainees & workforce
  - Increasing numbers of trainees, <50% expect to be FT
    - Need to have state health authority work out numbers of nephrologists required in future. Difficulty in restricting trainee numbers
  - Inability to guarantee training a major concern
    - Need to co-ordinate training system either state or national so that ad hoc training system is eliminated. Current system is not acceptable. Must be able to guarantee that a trainee that is accepted onto the program can complete training

- Actions
  - Need to reconsider mandated specific target exposures in training program
  - Need for state/national trainee program
  - ? Need for workforce survey/planning
Training Issues

• Curriculum – seemed to be accepted

• SAC /TSANZ - Trainees & workforce
  • Increasing numbers of trainees, <50% expect to be FT
  • Inability to guarantee training
    – Training v service tensions
  • Eventual long-term employment implications
    – ? Regarding SAC requirements – Acute Tx, procedures

• Actions
  – ?? Need for specific target exposures in training
  – ? Need for state/national trainee allocation
  – ? Need for workforce survey/planning
Transplantation

• Quo Vadis
  – “Non-Immunological” Matching
    • Kidney Donor Profile Index / Candidate Estimated Post Tx Survival
      – “left shifts” allocation age distribution
      – Avoids older to young grafts
  – Luminex for sensitized recipient, acceptable mismatches

• PKE
  – Low match rate – but early days
    • Stringent HLA Ab allocation, sensitization, no ABOi
    • ? Change DSA threshold, include ABOi/unsensitized pairs/altruistic

• ABOi
  – Good outcomes, increases donor pool by 10% (30/300)
  – Move to lesser immunosuppression
    no Rituximab, no PE in low risk)
  – ? Should there be standardized protocols reporting
Transplantation

• Living Donor Registry
  – Multiple concerns
    • Donor work-up – GFR measures, DM assessment, 1/5 obese
    • High morbidity and mortality
      – 10% complication rate, 2/2051 deaths
    • Poor long-term data
      – 72% lost to follow-up - ? patient/unit/system failure
      – Anecdotal reports of donors on dialysis

• Action Points
  – Need for Mortality Review reporting to ?RTAC/other
  – Need some mechanism to improve current loss to follow-up of patients
Dialysis in the Elderly / Palliative Care

• General population
  • ESKD incidence 20:100,000/year
  • 1:1 Rx to non-Rx, 70% of those untreated >80yo

• Dialysis in the elderly
  • Big problem getting bigger, variable outcomes,
  • Who to start – comorbidities/surprise question
  • What to do – “SplitEnz” Marshall – give it a whirl

• Palliative Care
  • Integration into clinical practice, symptom control
  • End-of-life issues, advance directives
  • Non-dialysis palliative care pathways
Dialysis in the Elderly / Palliative Care

• Action Points
  – Do we need more information?
    • RCT / NZ observational cohort
  – Development of treatment protocols
  – Increasing awareness knowledge
    • St George Seminar, Pall Care Meeting, other
CARI

• Process
  – Lean, efficient, productive, well reviewed

• Guidelines
  – CKD – BP targets, referral
  – CVD –

• Action Points
  – Updating / timeliness of guidelines
AKTN

• Summary
  • has grown, large number of trials
  • Need to “bring them in” and also for a “whao factor” trial to maintain viability
  • Building ties to improve recruitment
  • Inability of smaller units / private to recruit
    – Trials staffing

• Action Points
  • Explore ability to support smaller / private
KHA Consumer Surveys

• Physicians
  • All think HHD / EH-EF Dialysis better
  • Why the low rates of HHD?

• Nurses
  • Generally believe they have physician/physical resources
  • Need more support for patients / reimbursement of costs

• Patients
  • 40-60% recall having choice in modality selection
  • 1/3 do not want to self care
  • Few (5-15%) want to change modality

• Action Points:
Dialysis

• IDEAL – safe to start late
• PINOT – late education, 15% palliative
• SHARP – lowering LDL works - ? Changes practice
• Access Implemention – late surgical referral
• Surgical – ‘goldilocks” phenomenon
• Interventional - >95% AVF
• Question on increased catheter use with AVF first approach

• Action Point
  – Lift our game
  – Audit process – local or KPI or other
Dialysis

• PD
  – Bad outcomes, poor treatment compliance
  – Large variation
  – Implementation study
    • Insertion/Exit site antibiotic guidelines
    • Further data

• Action Point
  – ? Watch the space
KPIs

• Action Point
  – Identified unit reporting
    • Increase data reporting