NATIONAL PERITONEAL DIALYSIS COLLABORATIVE:

PERITONEAL DIALYSIS HOME SUPPORT PROGRAMME COUNSELLING CHANGE PACKAGE

MOHT | MOH OFFICE FOR HEALTHCARE TRANSFORMATION

NiU
National Improvement Unit
Singapore

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MESSAGE BY NIU DIRECTOR

The National Peritoneal Dialysis (PD) Collaborative was built on a simple but powerful idea: when teams apply improvement science with discipline and consistency, share their learnings with each other, meaningful change becomes achievable and sustainable. Early experience with the Peritoneal Dialysis Home Support Programme (PDHSP) showed that while the programme addressed a critical need, enrolment outcomes were limited by how counselling was delivered along the patient journey. The challenge was not intent, but design.

Since its founding in 2021, the National Improvement Unit (NIU) has acted as the convenor and catalyst for collaborative learning, building networks among Singapore's healthcare professionals and using improvement science to enhance patient care. Through this dynamic learning network, teams across Public Healthcare Institutions (PHIs) used improvement science—problem definition, data-driven learning, and rapid-cycle testing through Plan–Do–Study–Act (PDSA) cycles—to understand the counselling process more deeply. These small, structured tests enabled teams to try new approaches safely, learn quickly, and refine their counselling workflows based on evidence rather than assumptions.

The result of this collective effort is two practical counselling models that have emerged from real-world testing. PHIs implementing the PHI-integrated counselling model demonstrated that when counselling is progressive, coordinated, and reinforced across renal coordinators and multidisciplinary teams, patient readiness and confidence grow. Institutions that incorporated cross-boundary hospital–community counselling also saw promising early gains, showing the value of visible and aligned support during the transition to home-based PD.

As you engage with this change package, I encourage you to view it not as a prescriptive manual but as a foundation for your own improvement journey—one that will undoubtedly be shaped by your unique context, patient populations, and organisational strengths.

I extend my deepest gratitude to the Ministry of Health Singapore, our healthcare partners, community collaborators, and especially the patients and clinical teams who contributed their expertise, time, and unwavering commitment to ensure that every patient considering PD receives counselling that is timely, coordinated, and truly supportive of their journey towards home-based care.

Together, we continue building toward a healthier Singapore, one patient, one team, and one collaborative effort at a time.

Dr. Eunice Wong
Director, NIU

EXECUTIVE SUMMARY

Despite strong national intent to increase peritoneal dialysis (PD) adoption, enrolment into the National Peritoneal Dialysis Home Support Programme (PDHSP) remained consistently lower than expected. This gap was not driven by programme availability or clinical eligibility, but by how PDHSP counselling was structured and experienced across the patient journey.

Across Public Healthcare Institutions (PHIs), PDHSP counselling had evolved organically within existing workflows. Renal coordinators, multidisciplinary PD teams and community home service providers contributed meaningfully, but counselling often remained fragmented, inconsistently timed, and variable depth. Patients and caregivers frequently faced unresolved concerns around home readiness, caregiver demands, costs, and continuity of support that were not consistently addressed during counselling. These uncertainties contributed to late decision-making and, in many cases, missed or delayed enrolment.

This Change Package addresses these operational gaps by consolidating learning from the National PD Collaborative into a practical guide describing what effective PDHSP counselling should look like in routine care and how PHIs can deliver it reliably. Through cross-institutional testing, two operational counselling models emerged:

- **Model A** — PHI-Integrated Counselling Model: A redesigned, end-to-end counselling process that can serve as the national baseline standard for consistent delivery within PHIs.
- **Model B** — Cross-Boundary Hospital–Community Counselling Model: A more advanced model for PHIs with capacity to integrate coordinated counselling between hospital and community partners.

This Change Package provides PHIs with clear implementation guidance, success factors, and a focused measurement set to support adoption, learning and sustainment of improvement in routine practice.

PERITONEAL DIALYSIS HOME SUPPORT PROGRAMME

Intent, Reality and the Need for Redesign

Peritoneal dialysis uptake has remained low despite its clinical and quality-of-life advantages. A key barrier has been patient and caregiver concerns about managing PD at home, particularly without sustained community-based support. The Peritoneal Dialysis Home Support Programme was introduced to address this by strengthening support and continuity of care in the community.

However, since its launch in 2022, PDHSP enrolment has remained lower than expected. The challenge was not programme availability or clinical eligibility, but how counselling was structured and experienced across the patient journey.

From the patient's perspective, decisions about PDHSP are rarely driven by clinical suitability alone. Patients and caregivers weigh confidence in self-management, home readiness, caregiver burden, financial implications, and what ongoing support will look like after discharge. These concerns emerge progressively and require time, reinforcement, and trust to address.

Across PHIs, PDHSP counselling evolved organically rather than as a deliberate standardised national care process. Counselling was often:

- Delivered as isolated conversations rather than a connected series of touchpoints,
- Dependent on local workflows and timing,
- Variable in content, depth, and sequencing.

This resulted in fragmented information and delayed resolution of key concerns, limiting opportunities to build confidence before decisions were made.

Systemwide, renal coordinators, multidisciplinary teams, and community providers all played important roles, but their contributions were not consistently aligned within a shared counselling structure. Differences in workflow, sequencing, and handovers led to gaps, inconsistent messaging, and absence of a baseline counselling approach.

Improving enrolment required not only a community support programme, but a redesign of how PDHSP counselling was organised and delivered across the entire patient journey. This recognition led to the National PD Collaborative, which provided a structured platform for teams to examine, test, and align counselling practices. Through this work, counselling was redesigned as a deliberate, progressive care process that forms the foundation for the operational models in the next section.

THE BUILDING BLOCKS FOR PDHSP COUNSELLING

Overview

At the start of the National PD Collaborative, PDHSP counselling existed across PHIs but was not consistently organised as an end-to-end process. Renal coordinators led most discussions, with variable involvement from MDT teams and limited structured engagement with community providers.

The collaborative focused on organising existing counselling activities into a clearer, more intentional sequence of patient support. Three essential counselling elements emerged:

- **Element 1 (E1): Renal Coordinator (RC)-led Counselling**
  PDHSP counselling is delivered primarily by the Renal Coordinator, typically as a single or limited interaction, and represents the prevailing pre-collaborative model of PDHSP engagement.

- **Element 2 (E2): PHI Multidisciplinary Counselling Across Care Encounters**
  PDHSP counselling is delivered by PD physicians, PD nurses, and medical social workers within the PHI, across one or more clinical encounters, addressing clinical suitability, psychosocial readiness, and financial considerations.

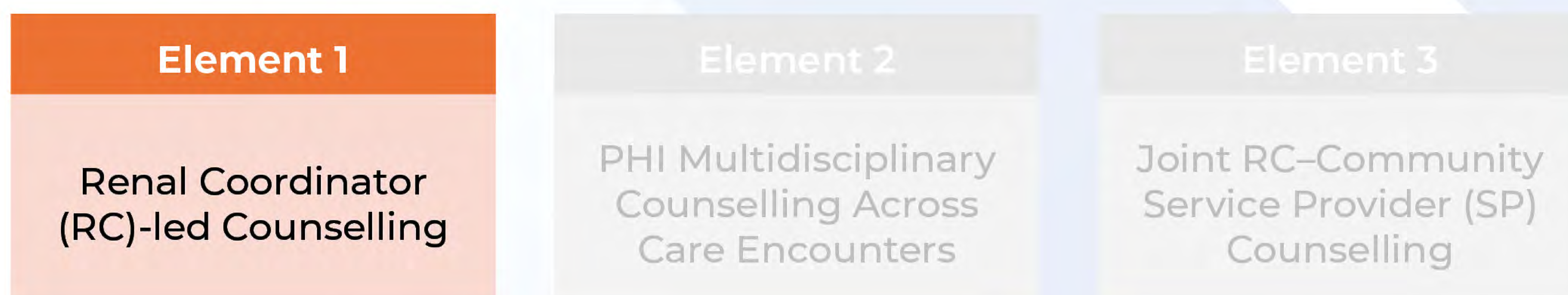
- **Element 3 (E3): Joint RC-Community Service Provider Counselling**
  PDHSP counselling is delivered jointly by the PHI renal coordinator and community service provider teams, aligning understanding of post-discharge, home-based support beyond the hospital setting.

Taken together, these elements illustrate that effective PDHSP counselling is not dependent on a single role or encounter but on a small number of essential components that, when appropriately combined and sequenced, support patients to understand, prepare for, and commit to PDHSP. These elements do not constitute new roles introduced by the collaborative; rather, they reflect core components already embedded in routine care that were strengthened, aligned, and intentionally applied through testing.

E1 alone was not tested, as it represented the pre-existing baseline. Instead, teams tested different combinations of E1–E3, informed by local capacity, patient needs, and the availability of community home services.

THE ELEMENTS OF CHANGE

Change Element 1



What is this element?

Renal coordinator-led counselling represents the traditional counselling approach that existed across PHIs prior to the PD Collaborative and forms the historical baseline for PDHSP engagement. In this model, the RC serves as the foundational point of contact for PDHSP discussions, providing patients and caregivers with early orientation to PDHSP and establishing a trusted relationship through which information can be introduced, revisited, and clarified over time.

What does this element contribute to the counselling journey?

E1 anchors the counselling journey by providing continuity and a consistent point of contact across the PD pathway. It supports early engagement and ensures that PDHSP is introduced in a timely and accessible manner.

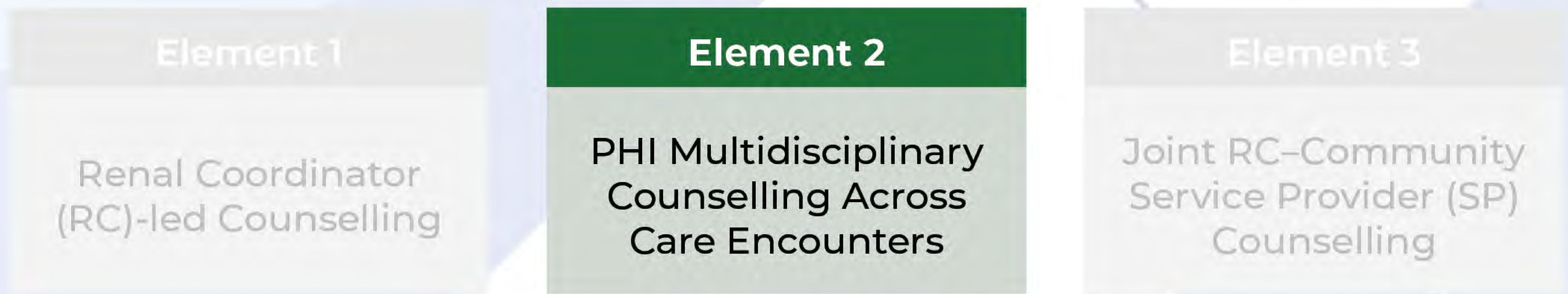
Why does this element matter?

As the earliest and most consistent counselling touchpoint, E1 plays a critical role in programme awareness and trust-building. However, on its own, it is not designed to address the full range of clinical, psychosocial, and practical considerations that influence enrolment decisions.

What should PHIs consider when implementing this element?

- E1 should occur early and be revisited across multiple encounters.
- Counselling should be documented to support continuity across providers.
- Renal coordinators should be supported by clear escalation pathways to MDT-based counselling and community partners.

Change Element 2



What is this element?

E2 refers to PDHSP counselling delivered across encounters with PHI multidisciplinary PD team members, typically involving PD physicians, PD nurses, and medical social workers (MSWs). Rather than occurring as a single joint counselling session, E2 reflects how different professionals engage patients at distinct time points along the PD journey.

E2 builds on Renal Coordinator–led counselling (E1) by incorporating clinical, psychosocial, and financial perspectives through coordinated, role-specific counselling interactions.

What does this element contribute to the counselling journey?

E2 enables counselling to occur progressively across the PD pathway, with different MDT members reinforcing and expanding earlier discussions according to their clinical and professional roles.

Within routine care, PHI MDT members already engage patients during modality counselling, pre-operative assessment, PD training, and follow-up. E2 makes these encounters intentional PDHSP counselling touchpoints rather than incidental or ad hoc discussions.

Through E2, counselling addresses:

- Clinical suitability, safety, and ongoing support for PD at home.
- Practical readiness for PD training and technique, including available support under PDHSP.
- Psychosocial considerations such as caregiver capacity and home environment.
- Financial concerns, subsidies, and affordability of PDHSP services.

Why does this element matter?

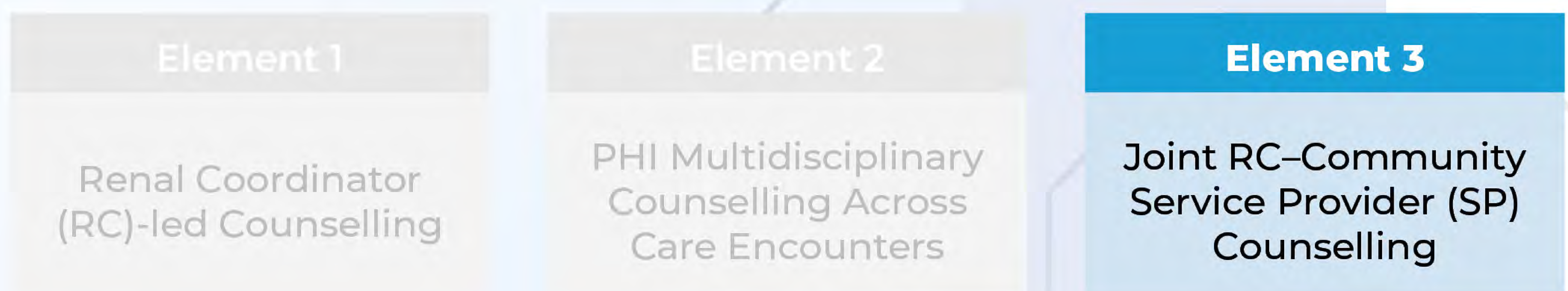
Findings from the PD Collaborative showed that enrolment decisions were rarely driven by a single concern. While patients may accept PD clinically, uncertainty often remains around home management, caregiver readiness, financial implications, and how support will function after discharge from hospital-based care.

E2 allows these concerns to be addressed by the appropriate professional at the appropriate stage of the PD journey, improving patient understanding and confidence through aligned, multidisciplinary counselling.

What should PHIs consider when implementing this element?

- Intentionally integrating PDHSP counselling into existing MDT encounters.
- Aligning MDT counselling messages with earlier renal coordinator discussions.
- Using sequential MDT encounters to reinforce and build on prior counselling rather than duplicate information.
- Ensuring documentation supports continuity and shared understanding across MDT members.

Change Element 3



What is this element?

E3 refers to PDHSP counselling delivered jointly across PHI renal coordinators and community service provider teams. This element extends counselling beyond the hospital setting by allowing patients and caregivers to receive coordinated counselling from both hospital-based and community-based providers.

Unlike E2, which distributes counselling across professionals within the PHI, E3 integrates counselling across care settings to support patient understanding of how PDHSP operates after discharge and during home-based care.

What does this element contribute to the counselling journey?

E3 helps patients and caregivers visualise and understand the transition from hospital-based care to home-based PD support. It provides opportunities for patients to clarify expectations regarding community support services, roles of home-based care teams, and practical aspects of receiving PDHSP outside the hospital environment.

Through joint counselling interactions, E3:

- Aligns messaging between PHI and community providers.
- Builds patient confidence in continuity of care.
- Addresses uncertainties related to home-based service delivery.
- Facilitates smoother transition planning between hospital and community care.

Why does this element matter?

Findings from the PD Collaborative showed that patients frequently expressed uncertainty about how PDHSP would function after discharge, even when they were clinically suitable and supported within the PHI. Questions often related to the reliability of home support, coordination between providers, and practical caregiving arrangements.

E3 addresses these uncertainties by allowing patients and caregivers to engage directly with community service providers alongside PHI teams, strengthening trust in post-discharge support and improving readiness for PDHSP enrolment.

What should PHIs consider when implementing this element?

- Establishing structured opportunities for joint counselling between PHI and community providers.
- Aligning counselling messages across hospital and community teams.
- Ensuring clear communication pathways between PHI and community providers before and after counselling encounters.
- Identifying patients who would benefit most from cross-setting counselling, particularly those with higher caregiver or home support needs.

How the elements led to the counselling models?

PHIs tested different combinations of E1–E3 based on their workflows, capacities, and community partnerships. These tests resulted in two distinct operational counselling models, described in the next section.

THE TWO DEPLOYABLE COUNSELLING MODELS

Overview

Analysis from the National PD Collaborative showed that the three counselling elements (E1–E3) could be combined into two coherent and deployable counselling models. These models reflect distinct, practical ways PHIs can organise PDHSP counselling while maintaining the core elements identified through testing.

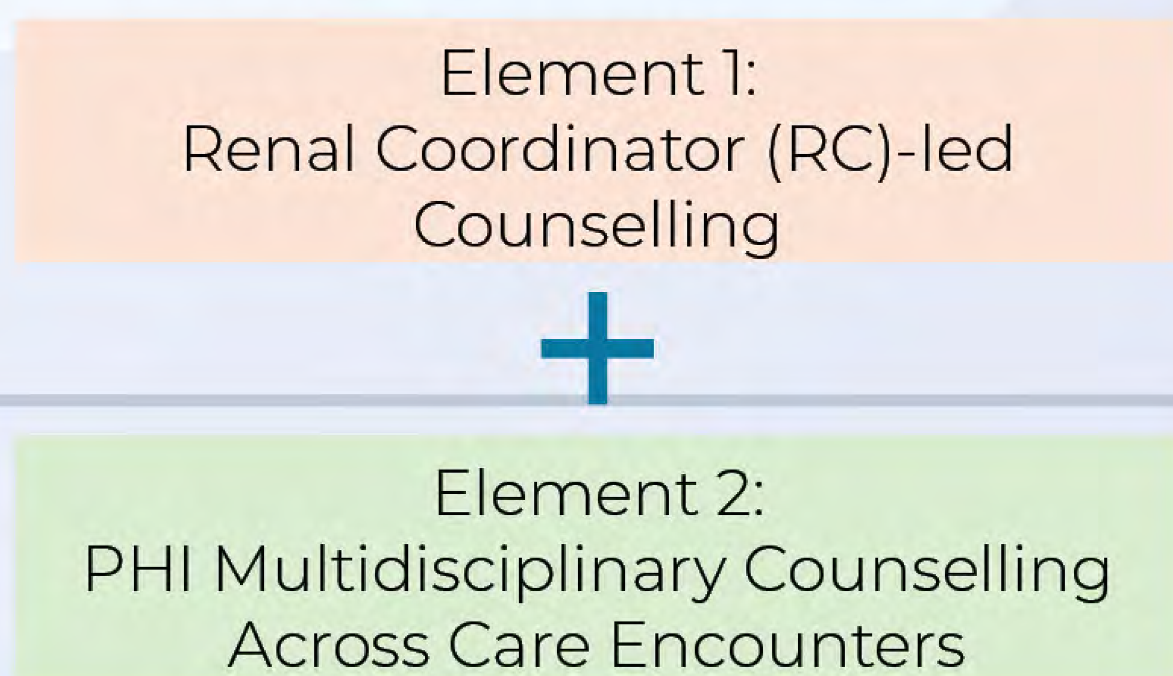
The models are not prescriptive pathways. Instead, they describe real-world configurations that PHIs developed and refined through iterative testing. Each model demonstrates how counselling elements can be combined to support patient understanding, decision-making, and readiness for PDHSP enrolment within different organisational settings.

The two models (Figure 1) are:

Model A: PHI-Integrated Counselling Model
(E1 + E2) — Counselling delivered within the PHI by renal coordinators and multidisciplinary teams.

Model B: Cross-Boundary Counselling Model
(E1 + E2 + E3) — Counselling extended across PHI and community settings through joint hospital–community engagement.

Model A:
PHI-Integrated Counselling Model



Model B:
Cross-Boundary Counselling Model

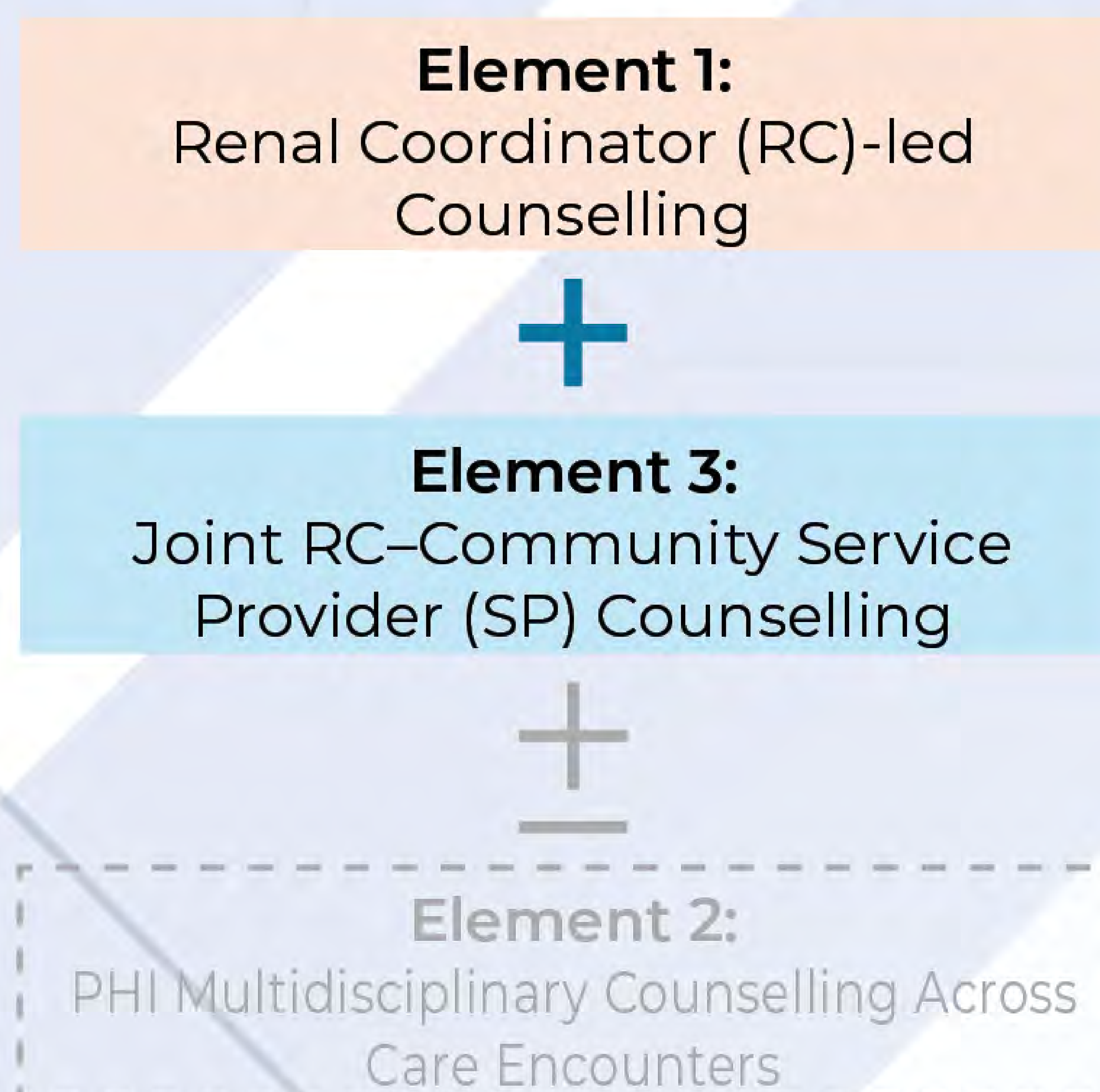


Figure 1: *Deployable PDHSP counselling models illustrating combinations of counselling elements tested across participating institutions.*

Model A: PHI-Integrated Counselling Model (E1 + E2)

Model A integrates renal coordinator–led counselling (E1) with PHI multidisciplinary team counselling (E2) into a structured and progressive counselling process embedded within routine PHI workflows. Counselling is introduced early, reinforced across multiple encounters, and addresses clinical, psychosocial, and financial concerns over time to support patient readiness for PDHSP enrolment.

Model A at a Glance

Aspect	Model A: PHI-Integrated Counselling Model
Core elements	E1: Renal Coordinator–led counselling E2: PHI team counselling across multidisciplinary PD team members
Counselling flow	Counselling is introduced early by the RC and progressively reinforced across multiple PHI team encounters throughout the PD journey, ensuring repeated and consistent patient engagement.
Where counselling happens	PHI-based encounters including clinics, PD training sessions, MSW reviews, inpatient reviews where applicable, and follow-up visits across the care journey.
How concerns are managed	Patient concerns are systematically surfaced and escalated within the PHI team, allowing clinical, psychosocial and financial readiness issues to be addressed through coordinated team-based management rather than isolated counselling interactions.
Role of RC	Anchors counselling continuity, coordinates engagement across PHI team members, and ensures counselling progresses in alignment with patient readiness and clinical milestones.
Role of PHI team	Reinforces counselling messages across touchpoints, ensures consistent patient education, and supports comprehensive readiness assessment across clinical, psychosocial and financial domains.
Role of Community Service Provider	Not routinely involved in PDHSP counselling; home support discussions typically occur after enrolment or through referral pathways.
What changes from pre-collaborative practice	PDHSP counselling becomes a deliberately coordinated, team-based and longitudinal care process, moving from episodic counselling encounters to a structured and progressive patient journey.
Key implementation requirements	• Clear counselling ownership within PHI teams • Documented and reliable counselling touchpoints across the care journey • Consistent counselling messaging across PHI team members • Established escalation pathways within PHI teams to address patient readiness barriers

Outcomes from PHIs Implementing Model A

Across four participating PHIs (SGH, TTSH, SKH and NTFGH) that only operationalised Model A, PDHSP enrolment improved from a baseline median of 39% to 80%. These aggregated outcomes suggest that a structured, PHI-led counselling approach can substantially strengthen patient confidence and support enrolment decisions. The enrolment trend across these sites is illustrated in Chart 1 below.

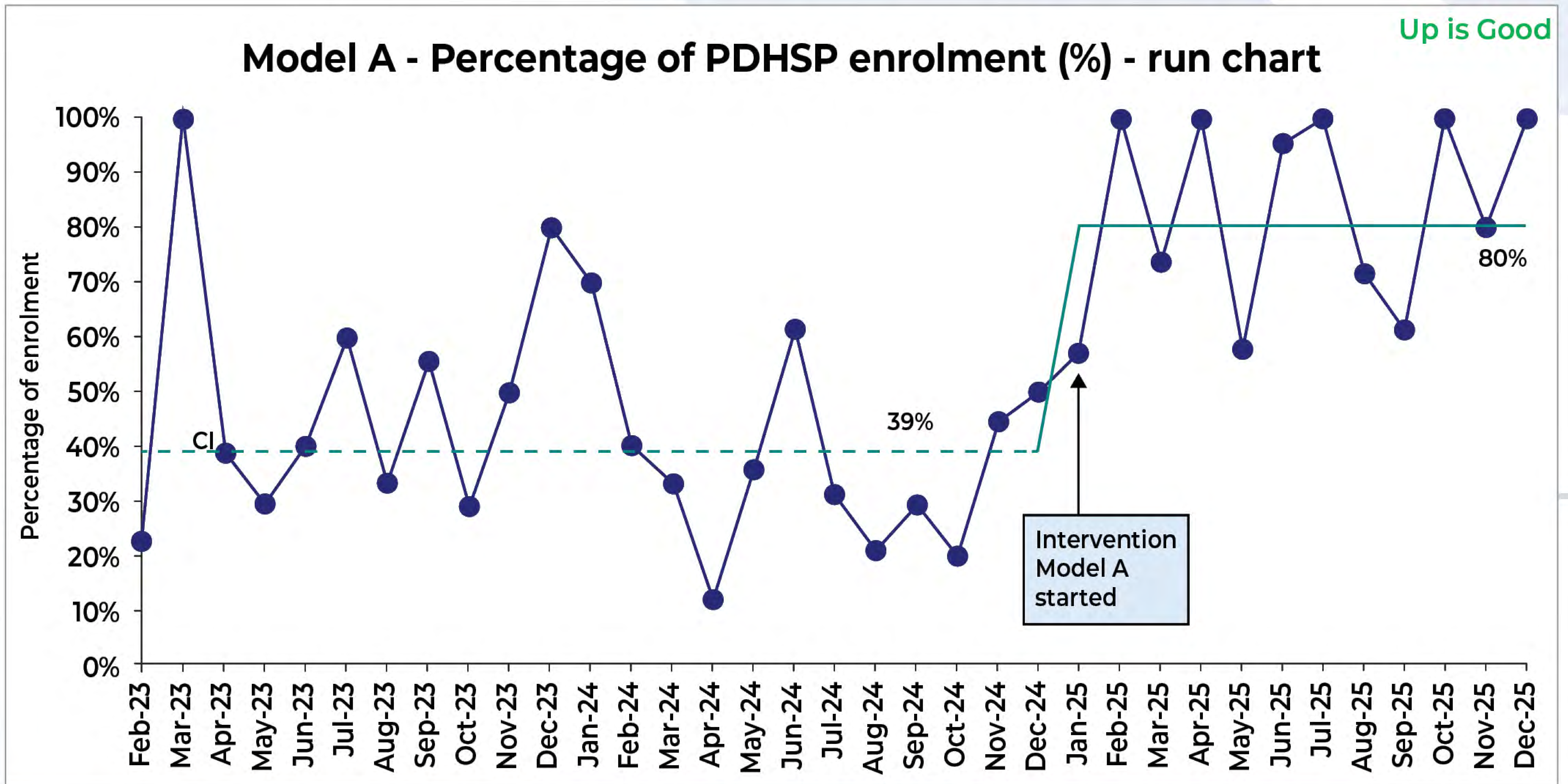


Chart 1: *Run Chart on Model A enrolment percentage (Testing period of Model A: started from Jan 2025)*

Model B: Cross Boundary Counselling Model (E1 + E3 ± E2)

Model B extends PDHSP counselling across both PHI and community care settings, integrating renal coordinator–led counselling (E1) with joint renal coordinator–community service provider counselling (E3). This model represents a deliberate shift from institution-bounded counselling to cross-boundary counselling that bridges hospital and community care settings.

Within the collaborative, Model B was tested in two PHIs, each implementing a distinct configuration. One PHI implemented cross-boundary counselling by integrating joint RC–Community Service Provider counselling directly with Renal Coordinator–led counselling (E1 + E3). The second PHI implemented cross-boundary counselling alongside PHI multidisciplinary team counselling (E1 + E2 + E3). While the configurations differed, both tested the incorporation of structured community partner engagement as part of PDHSP counselling. The defining feature of Model B is therefore the inclusion of joint hospital–community counselling (E3).

By introducing early and visible engagement with community partners, Model B positions PDHSP counselling as a shared hospital–community responsibility, strengthening care continuity and aligning patient expectations as individuals prepare to initiate and sustain PD at home.

Model B is designed to support:

- Reinforcement of patient confidence during the transition from modality decision to enrolment readiness.
- Increased visibility of coordination between hospital and community teams for patients and caregivers.
- Joint clarification of practical concerns related to home support arrangements, escalation pathways, and continuity of care across settings.

Model B at a Glance

Aspect	Model B: Cross-Boundary Counselling Model
Core elements	E1: Renal Coordinator–led counselling E3: Joint Renal Coordinator–Community Service Provider Counselling E2: PHI multidisciplinary PD team counselling (optional, site-dependent)
Counselling flow	RC-led counselling is extended through joint RC–Community Service Provider engagement as patients initiates PD and transition to home PD.
Where counselling happens	PHI-based counselling encounters supplemented by joint hospital–community counselling sessions or coordinated cross-setting engagement.
How concerns are managed	Patient concerns related to home implementation, care continuity and escalation pathways are addressed through coordinated engagement between PHI teams and community service providers.
Role of RC	Anchors counselling continuity and coordinates engagement between PHI teams and community service providers.
Role of PHI team	When E2 is included, PHI teams reinforce counselling messages, align hospital-based care planning with community support arrangements, and support readiness across clinical, psychosocial and financial domains.
Role of Community Service Provider	Provides practical guidance on home support arrangements, reinforces patient confidence for home PD, and clarifies escalation and support pathways within the community setting.
What changes from pre-collaborative practice	PDHSP counselling extends beyond the PHI boundary, making hospital–community coordination and home support structures visible to patients and caregivers.
Key implementation requirements	• Established coordination workflows between PHI teams and community service providers • Structured joint counselling touchpoints or defined shared engagement processes • Clear escalation and communication pathways across care settings

Outcomes from PHIs Implementing Model B

As Model B was tested in only two PHIs (KTPH & NUH), and outcome observations associated with this model should be interpreted with proportionate consideration of the limited testing footprint. While results from these sites provide important signals regarding the potential contribution of cross-boundary counselling, the smaller quantity of implementation experience reduces the overall strength of inference regarding effectiveness.

PDHSP enrolment increased from a baseline median of 17% to 88% in KTPH (Model B: (E1+E2). For NUH, where Model B (E1+E2+E3) testing commenced in July 2025, based on the available data as of December 2025, process stability has not yet been established. There is insufficient statistical evidence to conclude that a sustained system change has occurred. No run chart signals have been triggered to indicate non-random variation. At this stage, conclusions regarding improvement or deterioration would be premature. Continued monitoring over time is required to determine whether a stable shift in performance emerges.

These early observations provide important signals on the potential contribution of integrated hospital–community counselling. Continued monitoring and accumulation of data will be important to better understand the impact and sustainability of Model B across different institutional contexts. See charts below for the Model B enrolment trend.

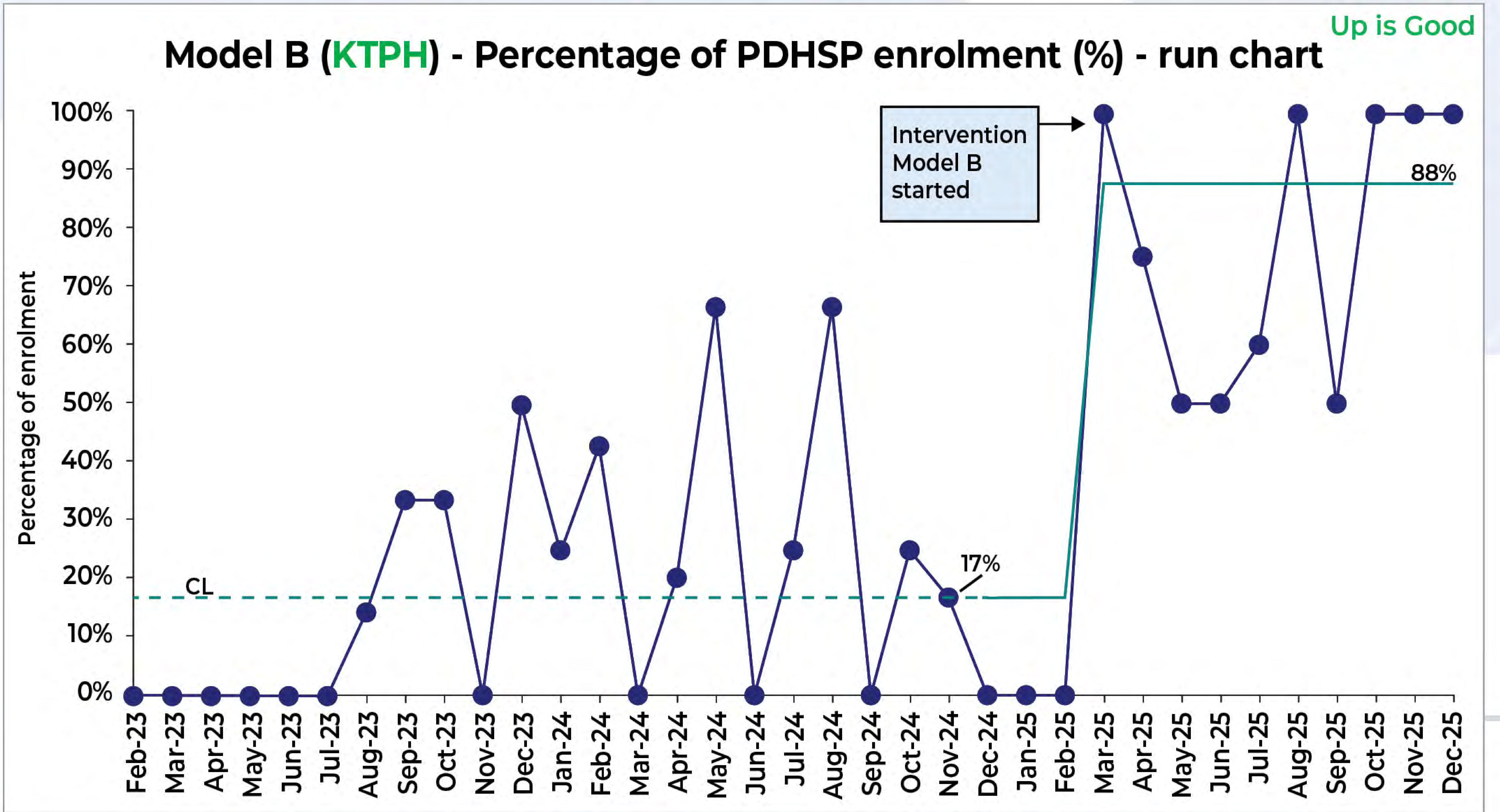


Chart 2: *Run Chart on Model B (KTPH) enrolment percentage (Testing period of Model B: started from March 2025)*

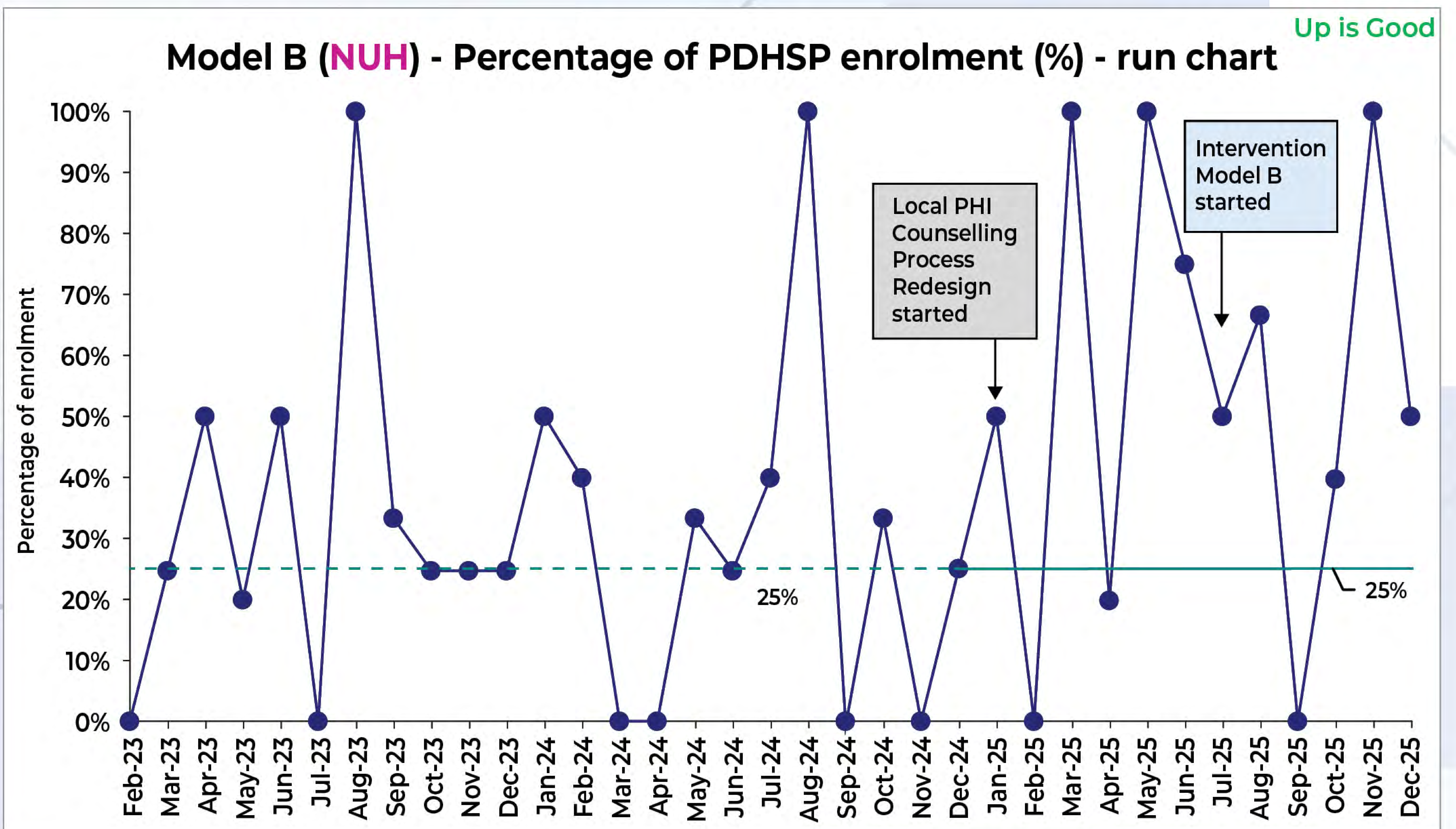


Chart 3: *Run Chart on Model B (NUH) enrolment percentage (Testing period of Model B: started from July 2025)*

OPERATIONALISING THE COUNSELLING MODELS IN YOUR PHI

Overview

The PDHSP counselling models are designed to be embedded within existing PD care pathways rather than delivered as standalone interventions. Successful implementation depends less on creating new roles or appointments and more on intentionally activating existing touchpoints, clarifying ownership, and aligning counselling messages across teams.

This section outlines how PHIs can operationalise PDHSP counselling by establishing Model A as the foundational counselling approach and progressively incorporating Model B where service partnerships and operational capacity allow.

Establishing the foundational counselling infrastructure (Model A)

Model A represents the minimum standard for PDHSP counselling across PHIs. It focuses on strengthening and establishing the core components, such as coordination and consistency within PHI teams to ensure patients receive structured and progressive counselling throughout the PD journey.

PHIs should prioritise building reliable internal counselling processes before introducing cross-boundary integration. The table below summarises the core implementation components that support reliable internal counselling and what this means in practice.

Implementation Component	What this means in practice
Clear counselling ownership	A named role (typically the Renal Coordinator) anchors the counselling journey and ensures follow-up across patient touchpoints.
Shared understanding of the counselling model	PHI team members understand how counselling elements (E1 and E2) work together and how counselling responsibilities are distributed.
Intentional use of existing touchpoints	Clinic visits, PD training sessions and MSW reviews are deliberately used for counselling reinforcement rather than relying on single counselling encounters.
Documentation and visibility of counselling discussions	Counselling conversations are recorded to support continuity and coordination across PHI team members.
Defined internal escalation pathways	Clear routes exist for renal coordinators to escalate clinical, psychosocial or financial concerns to appropriate PHI team members.

Extending counselling across care boundaries (Model B – Optional)

Where PHIs have established reliable PHI-led counselling processes and community service provider partnerships, Model B may be introduced to strengthen patient transition to home-based PD care.

Model B builds upon Model A by incorporating structured hospital–community counselling engagement, particularly as patients approach enrolment readiness and PD initiation.

Additional operational requirements

PHIs implementing Model B will need to establish:

- *Formalised PHI–community coordination workflows*
  Clear referral processes, communication channels and shared-care responsibilities between PHI teams and community service providers.
- *Joint counselling or coordinated engagement processes*
  Opportunities for PHI teams and community partners to engage patients jointly or through coordinated counselling encounters.
- *Cross-setting escalation pathways*
  Defined processes for escalation and support across hospital and community care settings.

Common implementation pathway

Implementation of Model B (optional) can be adapted based on local partnership structures and service capacity and to follow a staged approach:

Stage 1 – Stabilise Model A (E1 + E2)

- Align counselling messages across PHI team members.
- Ensure counselling occurs consistently across multiple PD touchpoints.
- Build confidence in a coordinated PHI-led counselling approach.

Stage 2 – Introduce Model B (E1 + E3 ± E2)

- Introduce joint counselling at points of enrolment readiness.
- Strengthen continuity between hospital counselling and home-based PD support.
- Adapt counselling frequency and format based on service capacity.

This staged approach allows PHIs to establish reliable internal counselling processes before extending counselling across care boundaries.

Embedding counselling into routine clinical workflow

Sustained implementation of PDHSP counselling depends on integrating counselling into routine PD care processes rather than introducing parallel or standalone counselling activities. Participating PHIs achieved this by intentionally incorporating counselling elements into existing clinical workflows across the PD patient journey.

Embedding counselling within routine care allows counselling to be delivered progressively, reinforces patient understanding through repeated encounters, and reduces reliance on single counselling sessions.

The PDHSP Counselling Touchpoints Process Map (Figure 2) illustrates common patient touchpoints across the PD care journey and highlights where counselling elements (E1, E2 and E3) may be incorporated.

The process map is intended to support PHIs in:

- Identifying existing patient touchpoints where counselling can be strengthened.
- Reviewing current workflows to identify missed counselling opportunities.
- Supporting coordination of counselling responsibilities across PHI teams.
- Guiding iterative counselling integration across the patient journey.

PHIs may adapt the process map based on local service configurations and patient pathways and operationalise counselling integration by:

- Mapping existing PD workflows against counselling elements to identify alignment and gaps.
- Assigning counselling responsibilities across PHI team members at key patient touchpoints.
- Testing counselling integration through small-scale workflow adaptations.
- Monitoring counselling reliability through documentation and team communication processes.

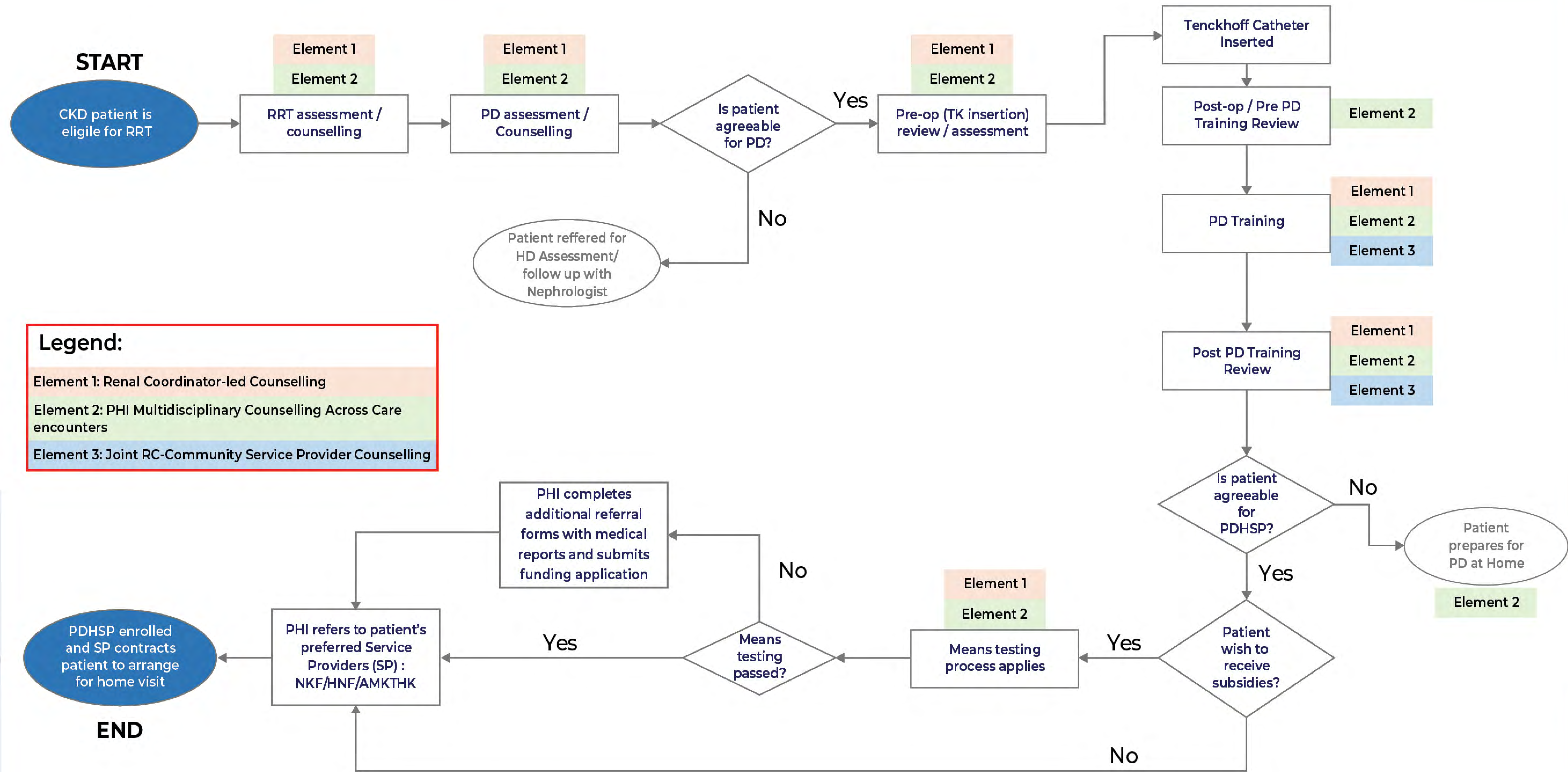


Figure 2: *PDHSP Counselling Touchpoints Process Map Across the PD Patient Journey.*

MEASUREMENT TO SUPPORT IMPLEMENTATION AND LEARNING

PDHSP counselling implementation should be monitored using existing programme indicators submitted to MOH. These indicators remain the primary measures used to assess PDHSP enrolment, counselling reach and patient outcomes.

The intent of this change package is not to introduce additional mandatory indicators but to support PHIs in using existing data more effectively to guide implementation, learning and workflow refinement.

Displaying Counselling Measures Over Time

While existing indicators provide important system-level visibility, PHIs are encouraged to display and interpret counselling measures longitudinally to support implementation learning. Displaying measures over time allows teams to:

- Identify trends in counselling reach and enrolment outcomes.
- Detect variation in counselling delivery across patient pathways.
- Understand the impact of workflow changes on patient readiness and enrolment.
- Distinguish sustained improvement from short-term fluctuations.

Where feasible, PHIs are encouraged to use time-series displays such as run charts or control charts to support interpretation of counselling implementation performance.

Establishing Regular Data Review Cadence

Regular team-based review of counselling measures supports shared learning and coordinated workflow improvement. PHIs may consider incorporating PDHSP counselling measures into routine PD programme meetings, multidisciplinary case discussions or quality review forums.

Regular review allows teams to:

- Identify gaps in counselling delivery across touchpoints.
- Explore reasons for missed counselling opportunities.
- Adjust counselling timing, content or coordination approaches.
- Monitor whether workflow changes are translating into improved enrolment and patient experience.

Review cadence should be sufficiently frequent to support learning while remaining practical within routine clinical operations.

KEY RECOMMENDATIONS

The PD Collaborative demonstrated that improving PDHSP enrolment depends not on the volume of counselling but on how counselling is structured, coordinated and reinforced across the patient journey. Participating PHIs showed that consistent renal coordinator anchoring, intentional multidisciplinary engagement and, where feasible, integration with community service providers all contribute to greater patient readiness for home-based PD.

This Change Package translates those lessons into practical recommendations to support sustainable adoption across PHIs. The priorities below outline the system, organisational, and workflow requirements needed to strengthen PDHSP counselling and support smooth transition to home-based care.

1. **Implement PHI-integrated counselling as the foundational standard**
   PHIs should implement Model A (PHI-integrated counselling) as the minimum standard for PDHSP counselling. Strengthening coordination, consistency and progressive reinforcement of counselling across PHI teams ensures counselling is delivered as a structured, longitudinal care process.
2. **Establish organisational infrastructure to support counselling delivery**
   PHIs should establish clear counselling ownership, structured counselling touchpoints across the PD care journey, aligned counselling messaging across PHI teams and defined escalation pathways to support consistent and coordinated counselling delivery.
3. **Extend counselling across care boundaries where capacity allows**
   PHIs with established internal counselling processes and community service provider partnerships can implement Model B to strengthen patient transition to home-based PD care and improve continuity of support across hospital and community settings.
4. **Integrate longitudinal data monitoring for improvement and sustainability**
   PHIs should incorporate PDHSP counselling indicators into routine programme monitoring processes and review data trends over time to support sustained implementation, identify workflow gaps and guide ongoing service improvement.

ACKNOWLEDGEMENT

This change package was co-developed through the collective effort of the Peritoneal Dialysis Collaborative teams across participating institutions. We extend our sincere appreciation to the clinicians, nurses, coordinators, improvement facilitators and community partners whose testing, feedback and shared learning shaped the models presented in this document. We gratefully recognise the teams and members whose commitment and collaboration made this work possible. The full list of participating teams and members is provided in Annex A.

ANNEX A

A. National PD Collaborative Teams and Team Members

1	A/Prof Marjorie Foo Wai Yin (Overall Lead for PD Collaborative 2025)
NHG HEALTH	
	TTSH
1	Dr Penelope Maxine Wong
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5	Ong Ee Ling
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