PROGRAM PROFILE

Nephrology–Palliative Care Collaboration to Promote Outpatient Hemodialysis Goals of Care Conversations

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Background: Goals of care conversations and corresponding life-sustaining treatment (LST) progress notes were completed for only one-fourth of patients on outpatient dialysis despite hospital-wide training with nephrologists at the Edward Hines, Jr. Veterans Affairs Hospital. The purpose of this quality improvement project was to increase completion of LST progress notes and corresponding orders among patients on dialysis through an interdisciplinary nephrology–palliative care collaboration.
Observations: The nephrology and palliative care departments began an interdisciplinary collaboration for nephrology to consult palliative care to initiate goals of care conversations and complete LST progress notes with patients on dialysis. A coordinated workflow process was created that included multidisciplinary efforts for patient selection, patient education, and introduction and completion of goals of care conversations for patients on dialysis. Completion rates for LST notes increased from 27% to 81% following the 13-month intervention, with 69 of 85 patients having a documented LST progress note.
Conclusions: A collaboration between nephrology and palliative care increased high-quality LST progress note completion. The next steps include expanding these collaborations at other dialysis units and evaluating the impact on patient outcomes.

Estimates of chronic kidney disease (CKD) among veterans range between 34% and 47% higher than in the general population.[1] As patients progress to end-stage kidney disease and begin chronic dialysis, they often experience further functional and cognitive decline and a high symptom burden, leading to poor quality of life.[2] Clinicians should initiate goals of care conversations (GOCCs) to support high-risk patients on dialysis to ensure that the interventions they receive align with their goals and preferences, since many patients on dialysis prefer measures focused on pain relief and discomfort.[3,4] While proactive GOCCs are supported among nephrology associations, few such conversations take place.[5,6] In one study, more than half of patients on dialysis stated they had not discussed end-of-life preferences in the past 12 months.[4] As a result, patients may not consider the larger implications of receiving dialysis indefinitely as a life-sustaining treatment (LST).

In May 2018, the US Department of Veterans Affairs (VA) National Center for Ethics in Health Care rolled out the Life-Sustaining Treatment Decisions Initiative to proactively engage patients with serious illnesses, such as those with end-stage kidney disease, in GOCCs to clarify their preferences for LSTs.[7] After comprehensive training, a preliminary audit at the Edward Hines, Jr. VA Hospital (EHJVAH) in Hines, Illinois, revealed that only 27% of patients on dialysis had LST preferences documented in a standardized LST note.

Nephrologists cite multiple barriers to proactively addressing goals of care with patients with advanced CKD, including clinician discomfort, perceived lack of time, infrastructure, and training.[8,9] Similarly, the absence of a multidisciplinary advance care planning approach—specifically bringing together palliative care (PC) clinicians with nephrologists—has been highlighted but not as well studied.[10,11]

In this quality improvement (QI) project, we aimed to establish a workflow to enhance collaboration between nephrology and PC and to increase the percentage of VA patients on outpatient hemodialysis who engaged in GOCCs, as documented by completion of an LST progress note in the VA's electronic health record (EHR). We developed a collaboration among PC, nephrology, and social work to improve the rates of documented GOCCs and LST patients on dialysis.

IMPLEMENTATION

EHJVAH is a 1A facility with > 80 patients who receive outpatient hemodialysis on campus. At the time of this collaboration in the fall of 2019, the collaborative dialysis team comprised 2 social workers and a nephrologist. The PC team included a

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TABLE 1 Workflow to Identify and Engage Patients on Hemodialysis in GOCCs

Component	Description
Establishing collaboration	PC director presented to nephrologists and dialysis nurses to introduce the collaboration and secure staff buy-in; presentation highlighted the high health care utilization rates for patients on dialysis and need for PC.
Education and training	PC coordinator created nephrologist and SW script from NCEHC guidance introducing GOCCs to patients (eAppendix, available online at doi:10.12788/fp.0422); dialysis nurse script focused on answering patient questions; both scripts noted phrases to use/avoid and focused on communication skills and sought to reduce staff discomfort and normalize GOCCs among patients; dialysis SW visited PC clinic to develop skills and mirror PC language.
Risk stratification	Nephrologist champion reviewed active patients on outpatient dialysis; HD Mortality Predictor used to stratify 6-, 12-, and 18-month survival; those with the highest risk of death were approached first to engage in GOCCs.[17]
PC introduction to patients	Nephrologist or SW introduced PC-nephrology collaboration to patients; a letter explained the collaboration as a new standard of care; SW provided patient with NCEHC Setting Healthcare Goals guide, which reviews LSTs, their risks/benefits, and what to expect; patients were encouraged to review guide with their health care surrogates.[18]
GOCCs	SW scheduled patients for PC visit (and follow-ups), including health care surrogates; initial PC visit was 60 min, and follow-ups were 30-60 min; most patients had 1-3 PC visits and focused on LST preferences.
LST documentation	After visit, LST progress note was input in the electronic health record that detailed patient LST preferences.
New patients	SWs invited to discuss new patients during weekly PC meeting to encourage clear and frequent communication.

Abbreviations: GOCCs, goals of care conversations; HD, hemodialysis; LST, life-sustaining treatment; NCEHC, National Center for Ethics in Health Care; PC, palliative care; SW, social worker.

coordinator, 2 nurse practitioners, and 3 physicians. A QI nurse was involved in the initial data gathering for this project.

The PC and nephrology medical directors developed a workflow process that reflected organizational and clinical steps in planning, initiating, and completing GOCCs with patients on outpatient dialysis (Table 1). The proposed process engaged an interdisciplinary PC and nephrology group and was revised to incorporate staff suggestions.

A prospective review of 85 EHJVAH hemodialysis unit patient records was conducted between September 1, 2019, and September 30, 2020 (Table 2). We reviewed LST completion rates for all patients receiving dialysis within this timeframe. During the intervention period, the PC team approached 40 patients without LST notes to engage in GOCCs. PC completed LST notes for 29 of 40 patients (72%). Of the 11 patients without LST notes, 7 declined a visit and 4 were lost to follow-up. At the end of the study period, 69 patients (81%) on outpatient dialysis had LST progress notes in the EHR.

DISCUSSION

Over the 13-month collaboration, LST note completion rates increased from 27% to 81%, with 69 of 85 patients having a documented LST progress note in the EHR. PC approached nearly half of all patients on dialysis. Most patients agreed to be seen by the PC team, with 72% of those approached agreeing to a PC consultation. Previous research has suggested that having a trusted dialysis staff member included in GOCCs contributes to high acceptance rates.[12] As such, the QI project relied heavily on the existing rapport between the dialysis staff—in particular the dialysis social workers—and their patients to normalize the PC consultation for all patients on dialysis. This introduction by a trusted staff person may have contributed to higher acceptance rates, and at the time patients on dialysis arrived for the PC appointment, they had a good understanding of the project. By including PC specialists with expertise in advance care planning and communication skills, the partnership successfully created a collaborative process that relied on the skill set of multiple staff and disciplines.

PC is a relatively uncommon partnership for nephrologists, and PC and hospice services are underutilized in patients on dialysis both nationally and within the VA.[13-15] Our outcomes could be replicated, as PC is required at all VA sites. One implementation consideration is the additional time this collaboration requires. Although no formal time study was completed, the PC team spent several hours educating nephrology staff, and

TABLE 2 Patient Characteristics (N = 85)

Criteria	No. (%)
Race	
Asian	1 (1)
Black or African American	45 (45)
White	37 (44)
Declined to answer	2 (2)
Sex	
Male	84 (99)
Female	1 (1)
Ethnicity	
Hispanic or Latino	6 (7)
Not Hispanic or Latino	78 (92)
Declined to answer	1 (1)

the social workers spent considerable time reaching, educating, and scheduling veterans into the PC clinic.

CONCLUSIONS

The innovation of an interdisciplinary nephrology–PC collaboration was an important step in increasing high-quality GOCCs and eliciting patient preferences for LSTs among patients on dialysis. PC integration for patients on dialysis is associated with improved symptom management, fewer aggressive health care measures, and a higher likelihood of dying in one's preferred setting.[16] While this partnership focused on patients already receiving dialysis, successful PC interventions are felt most keenly upstream, before dialysis initiation.

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Disclaimer

The opinions expressed herein are those of the authors and do not necessarily reflect those of *Federal Practitioner*, Frontline Medical Communications Inc., the US Government, or any of its agencies.

Ethics and consent

The Edward Hines, Jr. Veterans Affairs Hospital Institutional Review Board approved this study with a waiver of exemption.

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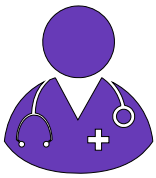
Nephrology Script for Palliative Care Collaboration

Sample introduction to the renal/palliative care collaboration

"Hi Mr./Ms. _____. I wanted to introduce you to a new initiative that promotes more patient-centered care for our patients on dialysis. In the coming months, all of our patients will be meeting with the renal team and palliative care team to better understand your health care preferences. Your goals for treatment are important to us, and we want to make sure the health care we're providing is in line with those goals. I'm going to ask our social worker, Sarah, to set up a meeting to talk further."

Provider Script for responding to difficult questions:

"What is this whole thing about, anyway?"



"*This initiative is about providing the type of health care that you <u>want</u>. But the only way we'll know is by asking you, so we're sitting down with all of our patients to do just that*."

"Why are you doing this now? Are you giving me this letter because you think I'm going to die?"

"You sound worried about your health. I want to assure you that you're not being singled out. This letter is being given to <u>ALL patients</u> who receive dialysis. Meeting with the palliative care team is now a standard part of care for all of our patients on outpatient dialysis."

"What do you mean when you say 'goals for health care?' I don't understand."

"Knowing what your personal goals are for the future is important to us. Based on those goals, we can make recommendations about your healthcare. We want to know what's important to you so that we can make sure the medical care we're providing matches your life goals."

Points to emphasize:

- A palliative care meeting is now a **<u>standard part of care</u>** for outpatient dialysis patients
- **<u>All patients on dialysis</u>** are now receiving palliative care visits; no one is being singled out
- In order to provide the type of medical care a patient wants, <u>we need to ask them</u>
- Having goals of care conversations is one way to understand what types of medical interventions a patient <u>would want</u> and <u>would want to avoid.</u>

Phrases to avoid:

- "*You don't have to attend this appointment; we can put it off until a time when you feel more up to it*."
- "*This is an appointment to talk about your code status*."