Meet Them Where They Are: Bringing Palliative Care to Dialysis Patients

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NORTHWEST Kidney Centers
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Introduction

Northwest Kidney Centers (NKC) is a non-profit dialysis organization serving over 1,700 patients in Washington State.

- Participating in the Center of Medicare and Medicaid Innovation (CMMI) End-Stage Renal Disease Seamless Care Organization (ESCO) Program

Background:

- Older ESRD patients are more likely to receive intensive interventions at end-of-life (EOL) compared to their counterparts with advanced cancer or heart failure, and are less likely to receive hospice or palliative care.
- Access to palliative care was deemed poor by dialysis professionals—only 4.5% of dialysis professionals believed that high-quality supportive care was provided by their organization.
- Improving advance care planning (ACP) and symptom management for all dialysis patients is patient-centered and may be cost effective as well.

Program Description

Mobile Renal Supportive Care (RSC) Team employed by NKC:

- Nephrologist/Palliative Care Physician (0.5 FTE), Clinical Social Worker (0.8 FTE), Registered Nurse (1.0 FTE)

Identification of Patients:

- Via electronic medical record (EMR) trigger, dialysis unit staff, primary nephrologist, monthly "Huddle" meetings with interdisciplinary team from each dialysis center
- Program Coordinator (LICSW) intake all referrals
- Referral cleared with the patient's primary Nephrologist
- Triage first meeting and follow-up care plan based on palliative care need, RSC Team census, patient/family readiness to engage in ACP

Meeting Locations Based on Patient Preference:

- Dialysis Unit, Private Residence, Skilled Nursing Facility (SNF), Assisted Living Facility (ALF), Adult Family Home (AFH), Hospital, Community Location

Communication to Primary Providers and Caregivers:

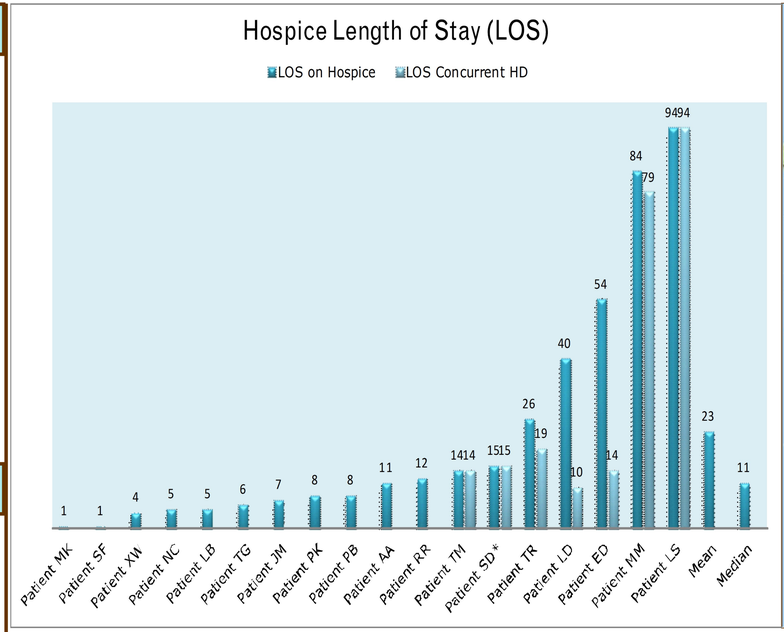
- Via secure texting and e-mail, phone calls/voicemails, routine meetings, EMR chart notes

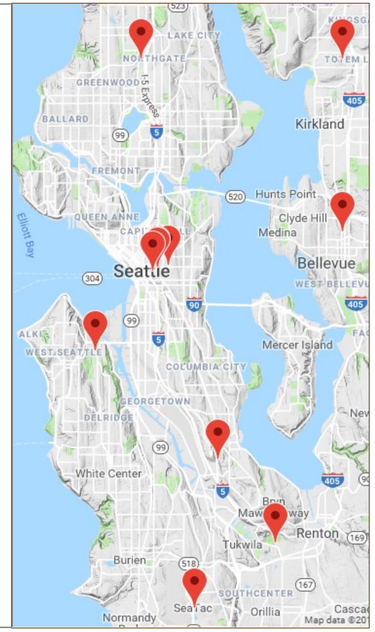
Primary Palliative Care Education:

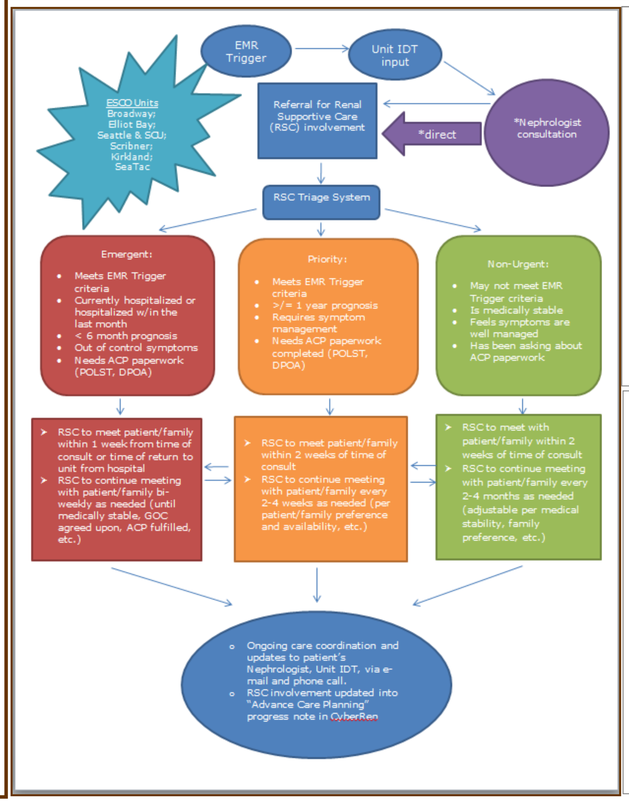
- New Employee Orientation, Dialysis Unit in-service presentations

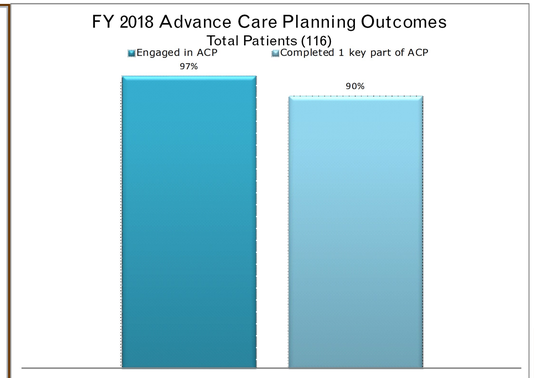
Outcomes Measurement:

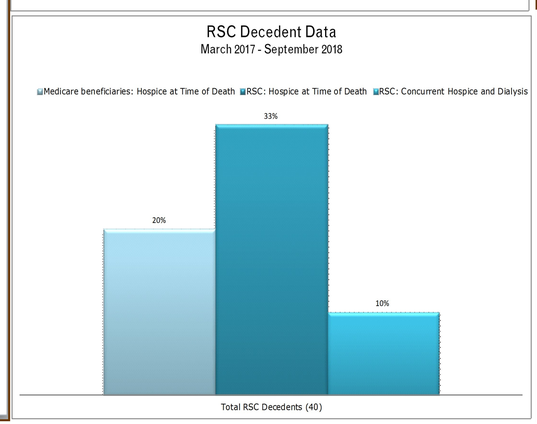
- Percent of decedents on hospice care at EOL
- Hospice length of stay (LOS)
- LOS with hospice care and concurrent dialysis
- Advance Care Planning (ACP) metrics including: documented Goals of Care (GOC); preferred surrogate decision-maker, Durable Power of Attorney for healthcare (DPOA) or Legal Next of Kin (LNOK)











Discussion

- 96.6% of RSC patients engaged in advance care planning (ACP)
- 89.7% of RSC patients completed a key task of ACP, defined as:
  - Establishing preferred health care agent
  - POLST form completed for patients whose care preferences dictate limiting aggressive measures
  - Documented goals of care
  - Completed a living will or advance directive
- "Late" referrals:
  - Patients dying before RSC Team able to meet the patient
  - Patients declining too quickly to be engaged in outpatient setting
- Capacity issues
  - Serving 6 dialysis centers with ~700 eligible patients
  - Geographic radius of provider catchment of 25 miles
  - Communication "bottleneck" with primary nephrologist office
  - Coordination tasks to engage family and/or healthcare surrogate decision-makers
- Organizational loss of spiritual care provider
- EMR interoperability between NKC and health systems
- Disparity of access to hospice services for Medicare beneficiaries receiving dialysis treatment versus general Medicare population
  - 100% of beneficiaries requesting concurrent hospice and dialysis requiring escalation to Medical Director for approval of services.

Conclusions & Future Directions

- Mobile visit model is effective in providing specialty level palliative care to dialysis patients
- Specialty level palliative care resulted in increased hospice use as compared to national rates of ESRD Medicare beneficiaries
- Address disparities in access to hospice by targeting hospice-specific barriers in addition to policy barriers
- Formalize advance care planning pathways for dialysis patients with progressive dementia
- Further primary palliative care dialysis staff education
- Address capacity issues via regional teams, telemedicine

References

Bowling CB, Plantinga L, Hall RK, et al. Association of Nondisease-Specific Problems with Mortali ty, Long-Term Care, and Functional Impairment among older Adults Who Require Skilled Nursing Care after Dialysis Initiation. Clin J Am Soc Nephrol 2016; 1-7

O'Hare AM, Hailpern SM, Wachterman M, et al. Hospice Use And End-of-Life Spending Trajectories In Medicare Beneficiaries On Hemodialysis. Health Affairs 2018;980-987.

Tamura MK, Meier DE. Five Policies to Promote Palliative Care for Patients with ESRD. Clin J Am Soc Nephrol 2013; 1-7

Wachterman MW, Pilver C, Smith D, et al. Quality of end-of-life care provided to patients with different serious illnesses. JAMA In tern Med 2016;176:1095e1102.

Wong SP, Kreuter W, O'Hare AM. Treatment intensity at the end of l ife in older adults receiving long-term dialysis. Arch Intern Med 2012;172:661e663; dis cussion 3e4.