Chapter 25: Interactions of Dialysis Teams With Geriatricians

Nicole Stankus* and Kellie Campbell†

*Section of Nephrology, University of Chicago, Chicago, Illinois; and †Section of Geriatrics, University of Chicago, Chicago, Illinois

In 2006, >500,000 patients received dialysis for end-stage kidney disease (ESKD), a 3.4% growth since 2005. Of 110,854 incident patients, almost 50% were elderly (38,185 were over 65 and 15,657 were over 80 yr of age). Geriatric patients accounted for 64% of all deaths (of 87,654 patients who died, 35,950 were over 65 and 20,362 were over 80).[1]

Medicare's spending on ESKD has reached $22.7 billion, or 6.4% of total spending. To improve dialysis patient outcomes, the new Centers for Medicare and Medicaid Services (CMS) Conditions of Coverage for chronic ESKD were issued in 2008, replacing the original ones from 1976. CMS focuses on the uniqueness of each patient and requires individualized multidisciplinary care based on patient participation.[2]

There is considerable overlap in the populations served by nephrologists and geriatricians. Close involvement of the geriatrician as a member of a multidisciplinary care team would be the next obvious step in the integration of care for dialysis patients. However, there are no published models that describe how interactions between dialysis teams and geriatricians might be facilitated.

COMPREHENSIVE DIALYSIS PATIENT ASSESSMENT AND PLAN

Each dialysis facility has an interdisciplinary team (IDT) that includes the following: (1) the patient (or designee); (2) primary dialysis nurse; (3) nephrologist; (4) social worker; and (5) registered dietitian.

This team is responsible for providing each patient with an individualized and comprehensive assessment of his/her needs and using it to develop a treatment plan and expectations for care.[3] Geriatricians can be a valuable resource for the dialysis team (Table 1).

RECOMMENDED INTERACTIONS BETWEEN IDT AND GERIATRICIANS

The management of conditions associated with ESKD may be at odds with competing medical conditions or patient preference. The heterogeneity of elderly patients' comorbid conditions and cognitive and functional abilities makes individualization of care essential. Referral of all elderly patients before the initiation of dialysis therapies would be preferable but is not always possible. IDT needs to prioritize geriatric consultations in certain situations.

LONG-TERM RENAL REPLACEMENT THERAPY GOALS

Selection of Dialysis Setting (In-Center *Versus* at Home or Self-Care)

All dialysis patients should be offered home care options.

Self-care abilities of the elderly may be significantly limited and the geriatrician should be involved in assessing not only the patient (vision, dexterity, memory) but also the extent and involvement of the home support systems. One should be cautious when choosing a home care modality in frail patients with limited support.

Some elderly patients may initially do very well with home dialysis, but the loss of a spouse/friend/child could be an indication to discuss with the geriatrician whether a transition to an in-center dialysis would be a safer option.

Assistance with dialysis treatments at home by the trained dialysis staff, especially in peritoneal di-

Correspondence: Nicole Stankus, Section of Nephrology, University of Chicago, 5841 South Maryland Avenue, MC 5100, Chicago, IL 60637. E-mail: nstankus@medicine.bsd.uchicago.edu

Table 1. Interdisciplinary care of older dialysis patient

Comprehensive Assessment	Team Leader	Comprehensive Care Plan
Physical health	Nephrologist	Yearly history and physical
Comorbidities, medications, immunizations	Geriatrician	With updated comorbidities and their medical management
Mental and psycho-social health	Social worker	Interventions are individualized to:
Cognitive status, mental health	Geriatrician	Meet patient's needs and achieve psychosocial and rehabilitation goals
Ability to meet basic needs and follow dialysis prescription		Inform about advance directives
Coping with and adjusting to dialysis		Perform annual survey of physical and mental functioning (KDQOL-36)
Rehabilitation goals		SW refers to:
Home environment		Community mental health services
Legal issues (advance directives)		Transportation providers
Financial capabilities and resources		In-home support services
Access and eligibility to available federal, state, or local resources		
Activities of daily living (ADLs)	Registered Nurse	Encouragement and referrals for PT/OT/rehabilitation to maintain or return to optimal functioning at home and in the community
	Social worker	
Instrumental abilities of daily living (IADLs)	Geriatrician	
Nutrition	Registered dietitian	Achieve an effective nutrition:
Nutritional parameters to be addressed:	Geriatrician	Chewing and swallowing
Nutritional and hydration status		Route of nutrition
Anthropometric data such as height, weight changes, volume status		Use of supplements
Information from the person that cooks and provides meals for the patient		Communication with the long-term care facilities to provide continuity of nutritional care for patients

Table 1 reflects current CMS Conditions of Coverage outlining the comprehensive assessment and plan of care for dialysis patients. Each team member has to be intimately familiar with overall assessment and plan of care, but specific parts of assessment are under direct responsibility of the team leader (underlined). Geriatricians integrate naturally into this framework (highlighted) in every specific component, because many of these tasks are routinely performed by geriatricians as part of a comprehensive geriatric assessment. Goals of care for older patients change over time. Geriatricians are skilled in modifying treatment plans not only to address the acuity, severity, or emergence of new medical problems, but also to align both long-term and short-term goals with patient preferences and remaining life expectancy.

alysis, may become more available in the United States in the future, as it is practiced in other countries. It would be a very viable option for patients with self-care limitations who wish to continue with home dialysis.

Transplantation Referral

Age is no longer a single limiting factor for kidney transplantation, and reasons for a nonreferral must be documented by the IDT for every dialysis patient. In most elderly patients with significant comorbidities, nonreferral is quite obviously a correct choice.

Even a highly functioning older dialysis patient would benefit from a comprehensive geriatric assessment as a part of the transplant evaluation. Functional abilities can dramatically decrease after initiation of dialysis and timely interventions by geriatricians could help maintain physical and mental capabilities of waitlisted older patients.

Combined Medical Records

Sharing of the comprehensive assessment and care plans yearly with patient's geriatrician can improve care by improving communication.

Integration of the comprehensive geriatric assessment in a dialysis patient's records is important for coordination of care.

Decision About Withdrawal of Dialysis

Discontinuing dialysis and entering hospice care is usually a joint decision between nephrologist and geriatrician. Initial conversation with the family and patient is best held outside of the dialysis facility, with the focus on the overall prognosis and palliative care options.

The nephrologist should reach out to geriatricians early on, if an elderly patient is developing increasing difficulties and discomfort during dialysis treatments, because it takes collaborative effort to make a difficult decision to stop a life-sustaining therapy. Institution of time-limited trials may be appropriate for some patients.

ONGOING COORDINATION OF CARE

BP Management

Monthly reassessment of medication needs, fluid gains, and

adjustments in target weight require not only knowledge of the patient's pre/intra/post-BP but also INTERdialytic BP.

Utilization of office BP and home-health through the geriatrician's offices may be essential to ensure interdialytic BP stability and avoid causing dizziness and falls in the elderly patients.

Monthly Laboratory Testing

Printed results of dialysis laboratories should be provided to each patient monthly. Patients should be advised to bring those results to their regular appointments with the geriatrician. This will help to ensure that the dialysis patient gets goal-driven individualized care.

Encourage geriatricians to limit in-office blood draws and rather submit requests for additional testing to the dialysis centers. This improves patient satisfaction, helps minimize unnecessary blood draws, and preserves veins for access.

Dialysis Access Type and Maintenance

Every patient, regardless of age, should be encouraged to obtain permanent dialysis access. The efficacy of the hemodialysis (HD) patient's vascular access and the peritoneal dialysis (PD) patient's peritoneal catheter correlates with the quality (adequacy) of their dialysis treatments and is vital to their overall health status.

Nephrologists must communicate with and ensure support of the geriatrician to assure the most expeditious permanent dialysis access placement; this helps to overcome apprehension in older patients, who often are resistant to surgical procedures.

Patients With Functional or Cognitive Decline

Changes in activities of daily living (ADLs)/instrumental activities of daily living (IADLs), KDQOL/SF-36 scores, patient falls, and cognitive decline should trigger an evaluation by the geriatrician. Functional decline has impact on mortality but can also decrease patient independence and quality of life (QOL).

Geriatricians are able to offer interventions to help improve those conditions that might be amenable to intervention, such as improving IADLs. They are also able to recommend services for patients and families that can improve the QOL for both patients and families.

The presence of cognitive impairment can impact decision making for the patient but can also interfere with the dialysis procedure itself. Geriatricians are trained to help with behavioral problems associated with impaired cognition that can negatively affect the ability to comply with the dialysis prescription.

Geriatricians can help to identify depression in elderly patients on dialysis, distinguish this from dementia, and institute appropriate treatment plans. Depression is common in these patients. Medical management of depression allows patients to achieve their best quality of life, improves their compliance with medication and dialysis prescription, and helps them maintain their independence.

INDIVIDUALIZED COMPREHENSIVE PLAN OF CARE

The plan is developed and implemented by the IDT and includes measurable and expected outcomes and estimated timetables to achieve them. For all patients, and especially older ones, their needs, wishes, and goals have to be considered.

The written patient plan of care is based on the comprehensive assessment and includes (1) problem(s) identified at assessment/reassessment; (2) measurable goals/outcomes; (3) planned interventions for achieving goals; and (4) time tables and reassessment date(s).

When a specified target is not met, the IDT could involve a geriatrician to help define further actions and decide whether the goal for the patient should differ from the standards and is adjusted appropriately for an older and/or frail patient.

A copy of the Plan of Care should be sent to the geriatrician and, if specific changes in goals/timelines are suggested by the geriatrician, the IDT should reassess whether targets selected for an older patient are reasonable and appropriate for the severity and acuity of the problems and also ensure that planned interventions are coordinated to avoid duplication of services.

The IDT needs to enlist geriatricians' help in educating patients to understand their role in managing the prescribed diet and medications. Without patient involvement in their own care, it is impossible to attain goals of care and achieve the best outcomes.

CONCLUSIONS

In summary, geriatricians are perfectly suited to help in the care of older dialysis patients. They are well trained in comprehensive assessments and are familiar with working in interdisciplinary teams. Dialysis IDTs need to take a leadership role to establish and maintain communications with the geriatricians and use their expertise in providing planned and goal-driven care. Caring for an older dialysis patient provides a unique opportunity to develop models of specialty–specialty interactions.

TAKE HOME POINTS

- Geriatricians should be viewed as an integral part of the multidisciplinary care team for older dialysis patients and be included in development of comprehensive care plan and institution of appropriate interventions, thereby meeting CMS guidelines and avoiding duplication of care
- Consultations with geriatricians are especially important when concerns arise about functional, cognitive, or psychosocial status of older patients that might interfere with dialysis treatments
- Geriatricians should be involved in major decisions, such as permanent dialysis access placement, referral for transplantation, and discontinuation of dialysis, because these are pivotal changes in the life of an elderly patient and impact their overall quality of life

DISCLOSURES

None.

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REVIEW QUESTIONS: INTERACTIONS OF DIALYSIS TEAMS WITH GERIATRICIANS

1. Geriatricians would be least helpful in performing which of the following comprehensive assessments:
   a. Ability to follow dialysis prescription
   b. Assessment of cognitive status
   c. Discussion of advance directives
   d. Physical exam including review of medical comorbidities and immunizations

2. Current dialysis interdisciplinary teams do NOT include which of the following:
   a. Registered dietician
   b. Nephrologist
   c. Primary care physician
   d. Social worker

3. A geriatric consultation should be initiated for an older dialysis person when:
   a. Functional decline occurs
   b. The patient is considered for renal transplantation
   c. Patient expectations or goals of care change
   d. All of the above

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