Dialysis Patients' Preferences on Resuscitation: A Cross-Sectional Study

Geriatric Nephrology: New Insights

PO1376

Nurse-Driven Advance Care Planning in a Hemodialysis Unit in a Veteran Population

Sam Tonthai,1,2 Rebecca Yamarik,2 Jocell Fernandez,2 Jennifer Ballard-Hernandez,2 Marysol Cacciapuoti,2 Pankaj Gupta,2 Joline L. Chen.2,3 University of California Irvine, Orange, CA; 2Long Beach Veteran Affairs Healthcare System, Long Beach, CA.

Background: Patients with end-stage kidney disease (ESKD) face difficulty choices near their end of life. Advance care planning (ACP) allows patients and their providers to plan for treatments that align with patients' goals. In the US, only 6-35% of all ESKD patients have advance directives (AD). PREPARE is an interactive ACP website that helps patients complete AD and express their wishes regarding medical decisions. The goal of the study was to assess the feasibility and acceptability of using a nurse to facilitate ESKD patients to completing the PREPARE ACP during dialysis.

Methods: Inclusion criteria included patients without a documented AD within the past 3 years. Exclusion criteria are dementia/cognitive impairment, psychosis, deafness, or blindness. Pre and post engagement surveys were completed. Barriers related to navigating the PREPARE website were documented.

Results: Of 55 patients at the dialysis unit, 25 were eligible and 14 were enrolled. All participants are male with mean age of 69. All participants completed their AD within 1 dialysis treatment. In the pre-PREPARE questionnaire, the Likert scale of 1 to 5 (1 for "not at all" to 5 for "extremely likely"), patients reported a mean score of 4.07 for readiness to talk about end-of-life care to a close family/friend, 4.23 for readiness to talk to a care provider, 4.46 for readiness to express wishes in writing, and 4.61 for readiness to sign official documentation. In the post-PREPARE questionnaire, on a scale of 1 (very hard) to 10 (extremely easy), patients scored 7.61 for ease, 7.23 for comfortability, and 8.07 for helpfulness. Analysis of PREPARE AD showed that on a scale of 1 (AD goal mainly to extend life) to 5 (to focus on the quality of life), the mean score is 3.06 suggesting that patients value both "extend life" and "maintain quality of life". Five patients expressed wishes for full care, 6 wanted a trial of resuscitation, and 3 requested DNR. Barriers to using PREPARE included patient difficulty navigating the website without help and using a laptop during dialysis when both hands are not always free.

Conclusions: Our study shows that PREPARE is a feasible method in facilitating ACP during dialysis, however, many patients needed assistance to complete the process. Future studies are needed to apply PREPARE and ACP wishes in the ESKD population.

Funding: Private Foundation Support

PO1377

Dialysis Patients’ Preferences on Resuscitation: A Cross-Sectional Study Design

Husam Alzayed,1,2 Annette M. Geraghty,1 Kuruvilla K. Sebastian,2,3 Hardashar Panesar,2 Donal N. Reddan.2,4 Galway University Hospitals, Galway, Ireland; 2Mayo University Hospital, Castlebar, Ireland; 3National University of Ireland Galway, Galway, Ireland; 4Western University, London, ON, Canada; 1Royal College of Physicians of Ireland, Dublin, Ireland.

Background: End-stage kidney disease is associated with a 10-100-fold increase in cardiovascular mortality compared to age-, sex-, and race-matched population. Cardiopulmonary resuscitation (CPR) in this cohort has poor outcomes and is often followed by increased functional morbidity. Advance care planning (ACP) is an important aspect of patients’ care that is often missed in chronic kidney disease (CKD) and there is growing support for creating plans in end-of-life care decisions for their patients and frequent end-of-life care discussions can provide insight and valuable assistance to patients in the process of decision making.

Methods: 2-center cross-sectional study design. Adults >18 years undergoing regular dialysis for at least 3 months were included. Patients with severe cognitive impairment or unable to understand discussion secondary to language barrier were excluded. After consent, a questionnaire was delivered during a structured interview during a routine dialysis session or clinic visit. Demographic data were collected and baseline Montreal Cognitive Assessment, Patient Health Questionnaire-9, Duke Activity Status Index, Charlson Comorbidity Index, and Willingness to Accept Life-Sustaining Treatment tool were used.

Results: 70 participants were included in this analysis representing a 62.5% response rate. There was a clear effect of treatment burden, nature of clinical outcome, and likelihood of the outcome on patients’ preferences. Low-burden treatment resulting in return to baseline (vs death) was associated with 98.5% willingness to accept treatment and 94.2% if it was high-burden. When the outcome was severe functional or cognitive impairment then 54.3% and 71.9% would decline low-burden, respectively. The response changed based on the likelihood of the outcome. In terms of resuscitation, 82.8% and 77.4% of the participants would be in favour of receiving CPR and mechanical ventilation, respectively, at their current health state. Over 94% of patients stated they had new discussed ACP while 59.4% expressed their wish to discuss this with their primary nephrologist.

Conclusions: ACP should be incorporated in managing CKD with an aim to improve communication and encourage patient and family involvement.

PO1378

Evaluation of a Concurrent Hospice-Dialysis Program for Patients with ESRD

Mayumi Robinson,1 Natalie C. Ernecoff,1 Erica M. Motter,1 Keith Lagnese,2,3 Robert Taylor,1 Jane O. Schell.1 1University of Pittsburgh School of Medicine, Pittsburgh, PA; 2UPMC Family Hospice, Pittsburgh, PA; 3University of Pittsburgh Medical Center, Pittsburgh, PA; 4Dialysis Clinic Inc, Nashville, TN.

Background: Most dialysis patients are hospitalized in the last month of life, nearly half of whom receive intensive care. Hospice financing poses a major barrier to hospice delivery to dialysis patients, increasing inequities for high-quality end-of-life care. The Concurrent Hospice-Dialysis Program aims to promote timely hospice services for dialysis patients with limited prognosis by offering concurrent hospice and dialysis.

Methods: We conducted a mixed methods study comprised of chart reviews and semi-structured interviews with 10 bereaved caregivers of deceased patients who were enrolled in the Concurrent Hospice-Dialysis Program and 13 clinicians who provided care as part of the program.

Results: Four major themes were identified: 1) Decisional distress regarding stopping dialysis; 2) The option to continue dialysis served as a psychological bridge to hospice; 3) Clear referral process, formal patient education, and care coordination between hospice and dialysis teams facilitated successful implementation; 4) Providing hospice and dialysis promoted goal-concordant care at end-of-life.

Conclusions: Bereaved caregivers and clinicians involved with the Concurrent Hospice-Dialysis Program found the program broadly acceptable and recommended it for patients on dialysis interested in hospice services. They offered suggestions for systematizing and disseminating the program.

Table 1. Key Themes

PO1379

Concurrent Hospice Dialysis: Perspectives on Dissemination

Erica M. Motter,1 Mayumi Robinson,1 Natalie C. Ernecoff,1 Keith Lagnese,2,3 Robert Taylor,1 Jane O. Schell.1 1University of Pittsburgh School of Medicine, Pittsburgh, PA; 2UPMC Family Hospice, Pittsburgh, PA; 3University of Pittsburgh Medical Center, Pittsburgh, PA; 4Dialysis Clinic Inc, Nashville, TN.

Background: In the United States, people receiving dialysis have traditionally been unable to enroll in hospice without ceasing dialysis treatments due to policy constraints. Therefore, these patients are often denied the full benefits of quality end-of-life care, either dying in hospitals or spending only a few days on hospice after dialysis is stopped. An alternative model would allow people living with end-stage renal disease (ESRD) to receive hospice services concurrently with dialysis treatments.

Methods: We implemented a concurrent hospice-dialysis program in one health system, based on a model of concepts. In this project, we have built evidence for feasibility and program requirements for extending such programs to other settings across the country. We conducted semi-structured interviews with people living with ESRD, family caregivers, hospice and dialysis clinicians, and health system administrators from the Pittsburgh area and other regions in the U.S. Interviews elicited perceptions of strengths and weaknesses of a scalable concurrent hospice and dialysis program, including barriers and facilitators of implementation across various settings.

Results: We conducted 25 interviews with 2 patients (8%), 3 caregivers (12%), 15 clinicians (60%), and 5 administrators (20%). Preliminary themes include important considerations: 1) Mechanisms and operational definitions for identification of eligible patients; 2) Procedures for decision-making conversations with patients and families; and 3) Protocols for communication between hospice and dialysis teams to coordinate care. Medicare policy and funding restrictions were also frequently discussed as barriers to the program.

Conclusions: Perspectives from patients, caregivers, clinicians and administrators describe critical implementation processes and resources for a successful concurrent hospice and dialysis program. These include the following: clear criteria for patient eligibility, consistent language to use when talking with patients and families, education for both hospice and dialysis teams, and a well-defined plan for care coordination between teams. Future evaluation of such programs may lead to policy change to make concurrent care broadly financially feasible.

Funding: Other NHLBI Support - Palliative Care Research Cooperative Group (PCRC)