Recognizing the Elephant in the Room
Palliative Care Needs in Acute Kidney Injury

Amar D. Bansal and Jane O. Schell


Patients with advanced kidney disease have substantial palliative care needs, especially toward the end of life, which is characterized by high symptom burden and increased intensity of care despite limited survival (1,2). For many patients with chronic illness, such as kidney disease, palliative care needs emerge well before the last months of life. Data suggest that early palliative care for patients with serious illness can lead to better adjustment and preparation for future setbacks (3,4).

With an often uncertain disease trajectory, the challenge in nephrology is identifying the optimal timing and setting for early palliative care involvement. In this issue of the Clinical Journal of the American Society of Nephrology, Chong et al. (5) sought to understand palliative care provision in patients with AKI requiring dialysis (AKI-D) compared with two groups: those with AKI who did not start dialysis and those with other serious conditions. The premise was that AKI-D likely represents a kidney population who would benefit most from early palliative care involvement. Although this study focuses on hospitalized patients with AKI, the results also underscore opportunities to improve early palliative care for outpatients with CKD.

The strengths of this study include the use of a large database (the National Inpatient Sample), which contains approximately 36 million geographically diverse patient records from the United States. Although not without limitations, ICD-9 codes were used to identify patients with AKI and AKI-D. Records with a dialysis code that did not have a concurrent code for AKI were excluded, because they likely represented patients already receiving dialysis. The primary outcome was defined by the International Classification of Diseases, Ninth Revision, Clinical Modification code for palliative care encounter (“encounter for palliative care”).

There are several findings from the study worth highlighting. The overall provision of palliative care in hospitalized patients was very low (2%). Patients at highest risk of death were more likely to receive a palliative care consult. A small percentage of the 3 million hospitalizations with AKI resulted in dialysis initiation. Only 8% (adjusted for age and sex) of these patients with AKI-D had a palliative care encounter, comparable with other serious conditions. Patients with AKI-D who had a palliative care encounter were more likely to be older and have concomitant life-limiting conditions, including cirrhosis, acute respiratory distress syndrome, and cardiogenic shock. This critically ill population experienced an inpatient mortality reaching near 30%. The highest-risk subgroups included those over 80 years old, those with presence of cancer, or those with advanced chronic illness.

It is also important to examine the larger group of patients with AKI and patients with AKI-D who did not receive palliative care consultation. Although CKD was the most common comorbidity in patients with AKI-D, only 7% had evidence of a palliative care encounter. In fact, the presence of CKD was associated with a lower likelihood of palliative care encounter in patients with AKI and patients with AKI-D. Because CKD is a strong risk factor for future dialysis and hence, future palliative care needs, these data underscore missed opportunities for early palliative care involvement.

Taken together, the findings by Chong et al. (5) suggest that provision of palliative care for AKI-D is largely driven by critical illness rather than the presence of AKI-D. This focus on critical illness may deter opportunities for early palliative care in kidney disease, especially for those with CKD. What do these results tell us, and what questions remain as we envision ideal strategies to deliver timely palliative care for patients with AKI and patients with AKI-D?

First, these results confirm that inpatient nephrology care goes beyond treating AKI and involves caring for patients with accompanying life-limiting illness. As busy nephrology clinicians rounding in the hospital, we encounter these patients daily and experience uneasiness when asked to start dialysis. Our impulse to start dialysis frequently conflicts with our worries that these patients may face limited survival, even with dialysis. The first step toward increasing palliative care for critically ill patients is to acknowledge the elephant in the room—the critical illness.

Recognizing patients who are at or near end of life encourages nephrologists to “step back” from the clinical momentum to start dialysis and instead, consider the big picture prognosis (6). In stepping back, the nephrology provider’s role still includes providing timely dialysis but also encourages frank discussion of overall prognosis and how treatments, like dialysis, fit within a given patient’s overall values and priorities. These important conversations are critical steps toward defining dialysis as a trial and set up the expectation...
that things may not go well, hence encouraging advance care planning conversations. As first-line responders, nephrologists can then tip the balance toward improving palliative care provision for these critically ill patients with AKI.

Inpatient palliative care consultation has been shown to improve palliative care outcomes in patients with kidney disease. In a recent analysis of inpatient palliative care consultation in patients with kidney disease, palliative care consultation led to improved symptom management and clarification of goals of care comparable with other serious illnesses (7). In that study, details of the severity of kidney disease or whether these patients were on dialysis are unknown. The study by Chong et al. (5) examines upstream opportunities to incorporate palliative care and introduce alternative pathways, such as comfort-focused care.

Second, we must improve palliative care provision for those who are not critically ill and stand to benefit the most. In particular, patients with CKD experience symptoms that impact their disease course and may not be aware of treatment options beyond dialysis. Currently, patients with advanced kidney disease, even those who are older and sicker, are more likely to be preparing for or undergoing dialysis rather than receiving conservative care (8). For high-risk patients with CKD, for whom dialysis may not add meaningful survival, AKI during hospitalization may serve as an important trigger to engage in a broader discussion of treatment options and goals of care.

Decisive action within the nephrology community may involve “automatic” or triggered palliative care consults for these patients with AKI and patients with CKD who face limited survival and are not transplant candidates. Within cardiology, the Joint Commission mandates that all patients with heart failure undergoing evaluation for a left ventricular assist device as a destination therapy be seen by a palliative care clinician (9). This early palliative care, described as “preparedness planning,” involves an interdisciplinary palliative care team that addresses symptom and coping needs, goals of care to inform treatment decisions, and anticipatory guidance for how these needs may improve or worsen with a given treatment, including conversations about end of life preferences (10). These triggered palliative care consults may lead to more uniform care, especially in light of racial and socioeconomic disparities that exist in kidney care. Preparedness planning would extend beyond inpatient palliative care consultation to inform outpatient nephrology care, including goals of care and treatment decision making.

Putting these palliative care strategies into action will not be easy given the increasing demand of palliative care relative to the current and projected palliative care workforce. These challenges are especially relevant for rural and nonacademic hospitals, where palliative care may be aspirational rather than routine. Therefore, action must start within nephrology through education and policy. We must empower nephrologists to expand their role beyond assessing dialysis needs to also include addressing basic palliative care needs. As such, nephrology training programs should promote scalable education that teaches these basic skills, including communication around prognosis and goals of care, assessment of symptom burden, and advance care planning.

None of these changes can occur without policy-driven initiatives that incentivize value care. Since 2016, the Centers of Medicare and Medicaid Services, recognizing the importance of advance care planning, provides a payment structure for advance care planning discussions as a separate and billable charge. These policies may promote earlier goals discussions to ensure that patients receive care consistent with their goals.

In summary, Chong et al. (5) help us better understand the landscape of palliative care needs in nephrology. Palliative care consultation is broadly underused across a spectrum of hospitalized patients with AKI and hospitalized patients with AKI-D. We are only now grasping the tip of the iceberg. Important steps for improving kidney care include better identification of palliative care needs, education to address these needs, and policies that incentivize value care.

Disclosures
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References

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See related article, “Infrequent Provision of Palliative Care to Patients with Dialysis-Requiring AKI,” on pages 1744–1752.