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Supporting Shared Decision-Making in Life-Altering Kidney Therapy Decisions for Older Adults
A Review

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IMPORTANCE Older adults represent the fastest-growing population initiating dialysis in the US. For older adults with advanced chronic kidney disease (CKD), initiating dialysis is often the default option presented, as they are often ineligible for kidney transplant. This approach may not align with many older patients' goals, who often prioritize quality of life over life extension. Further, many older patients report not being informed about all available kidney therapy options. This narrative review provides a guide for primary care clinicians to collaborate closely with older adults, their families, and nephrologists to promote shared kidney therapy decision-making in advanced CKD.

OBSERVATIONS Several options exist for older adults with advanced CKD. These include kidney transplant, which aims to prolong life while preserving a good quality of life; dialysis, which focuses on prolonging life; and conservative kidney management, which forgoes dialysis and transplant, prioritizing quality of life over life prolongation. Shared decision-making is a collaborative process in which clinicians and patients jointly develop a care plan based on the best available evidence, the patient's goals and prognosis, and a careful weighing of the pros and cons of each kidney therapy option. This process supports patients to achieve informed and goal-concordant decisions regarding CKD management after careful deliberation. For patients with decisional uncertainty or a desire to maintain the status quo, a time-limited trial of dialysis or a deciding not to decide approach, respectively, can be implemented.

CONCLUSIONS AND RELEVANCE Shared decision-making is essential to help older adults with advanced CKD understand therapy options and make goal-concordant decisions. Primary care clinicians' collaboration with nephrologists to promote shared decision-making and deliver patient-centered, coordinated care is critically important.

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One in 3 older adults has chronic kidney disease (CKD), a progressive condition associated with high morbidity, health care utilization, and mortality.[1,2] CKD is defined by the presence of kidney damage or glomerular filtration rate (GFR) less than 60 mL/min/1.73 m^2 for 3 months or more, irrespective of cause.[3] The leading causes of CKD in the US are diabetes and hypertension, although potentially reversible etiologies, such as drug-induced acute kidney injury, may also contribute.[2,4] Many patients with CKD will progress to advanced CKD (ie, an estimated GFR [eGFR] less than 30 mL/min/1.73 m^2) and eventually be faced with decisions about dialysis initiation. Despite the importance of these decisions, many patients and families report insufficient guidance and emotional support from clinicians during this complex decision-making process.[5-10]

Clinical decision-making in irreversible advanced CKD presents a unique dilemma for older adults; kidney transplant improves survival and quality of life, but many older adults are ineligible due to comorbidities, high surgical risk, or the potential for adverse effects from immunosuppression.[11-15] Dialysis may prolong survival but carries adverse effects (eg, fatigue) and practical demands (eg, frequent in-center sessions) that can worsen quality of life.[16-18] Conservative kidney management—an approach to CKD care that forgoes dialysis and transplant while focusing on improving quality of life—is often not presented as an option, likely because its primary objective is not to prolong survival.[5,8,19] Additionally, individuals with advanced CKD often feel uninformed about the risks and benefits of each treatment option and pressured to initiate dialysis.[5,8,19] These gaps in kidney therapy decision-making are consequential not only to patients but also to the US health care system, given the substantial costs of maintenance dialysis.[2] Nonetheless, clinicians can improve goal-concordant care for older people with advanced CKD by presenting information about a full range of therapeutic options and practicing shared decision-making. As trusted clinicians who commonly manage CKD through its early stages, primary care clinicians (PCCs) are uniquely positioned to participate in shared decision-making in collaboration with a nephrologist for patients and their families.

In this narrative review focused on older adults, we briefly review and compare kidney therapy options for irreversible advanced

CKD along with their supporting evidence. We outline an approach to shared decision-making in advanced CKD, emphasizing the central role of the PCC and the importance of involving caregivers, addressing geriatric syndromes (eg, polypharmacy, dementia, falls, frailty, mood disorders, sensory impairment, incontinence, malnutrition, delirium, and sleep disorders),[20] and fostering interdisciplinary collaboration. We also describe a shared kidney therapy decision-making approach for clinicians to help older adults and their families.[21]

Methods

A librarian (M.K.F.) conducted a literature search in PubMed using Medical Subject Headings, keywords, and Boolean operators to identify relevant literature on CKD in older patients. The search focused on concepts such as shared decision-making, conservative kidney management and outcomes, dialysis and outcomes in older patients with CKD, and kidney transplant and outcomes in older patients with CKD, with filters applied for English language and publication dates between 2015 and 2025. Additional searches included guideline websites and landmark articles to ensure comprehensive coverage (eMethods in the Supplement).

Observations

Understanding the What, Why, and Need for Collaborative Shared Decision-Making in Advanced CKD

Shared decision-making is an approach where clinicians and patients collaboratively approach important medical decisions together based on a discussion of the best available evidence, as well as the patient's goals and preferences.[22] For older patients with advanced CKD, the shared decision-making process begins after a comprehensive medical evaluation that aims to discern and address factors contributing to CKD, such as diabetes and hypertension; optimize medical therapy; and rule out reversible causes of kidney dysfunction (eg, nephrotoxic medications, obstructive nephropathy).[1] For patients whose CKD progresses despite these actions, shared decision-making is crucial to support an informed, goal-concordant kidney therapy choice.[23] Shared decision-making is associated with higher odds of patient activation,[24] preference concordance,[25] decision ownership,[26] decisional satisfaction,[27] and potentially improved survival.[28] Current guidelines[29-32] recommend incorporating shared decision-making when discussing kidney therapy options; however, dialysis as the default persists in the US.[19] More than 80% of patients start in-center hemodialysis instead of home therapies,[2] and patients are rarely informed about conservative kidney management as a viable option.[8] Key barriers to shared decision-making include a short visit time,[33] lack of formal education on shared decision-making and conservative kidney management,[10] and the potential influence of financial incentives for dialysis.[34,35]

PCCs are uniquely positioned to facilitate shared decision-making because of their ongoing therapeutic relationships with patients and their comprehensive understanding of patients' health, goals, and care trajectories. We recommend initiating shared decision-making conversations about kidney therapy options for patients with an eGFR less than 30 mL/min/1.73 m^2, particularly those with a 5-year kidney failure risk exceeding 3% or those with sustained decline in eGFR using the kidney failure risk equation[36] or as part of goals-of-care discussions or advance care planning discussions.[37] PCCs can contribute to the shared decision-making process—in partnership with dialysis educators and nephrologists—by exploring patient preferences, providing information on therapeutic options beyond dialysis, screening for geriatric syndromes,[20] facilitating prognostic discussions, encouraging caregiver involvement, and supporting advance care planning.[38-40]

Kidney Therapy Options for Older Patients With Advanced CKD

Facilitating shared decision-making about kidney therapy requires thorough knowledge of each option's risks and benefits (**Table 1**), enabling patients to weigh trade offs and make goal-concordant decisions.

Conservative Kidney Management

Conservative kidney management is a multidisciplinary care approach that focuses on maximizing quality of life throughout CKD progression and prioritizes 4 basic components: (1) treatment focused on delaying CKD progression and managing its associated complications, such as electrolyte abnormalities, acidosis, anemia, and bone mineral disease; (2) advance care planning, including end-of-life preparation; (3) addressing spiritual, existential, and symptom-focused needs; and (4) crisis planning that includes anticipatory guidance about symptoms of acute uremic decline (eg, anorexia, weight loss, functional decline, sleepiness) and future planning for support and hospice referral.[41] Patients should be assessed for transplant eligibility and counseled on alternative approaches to advanced CKD management prior to initiating conservative management. Further, screening for depression and cognitive impairment is recommended to ensure that decisions are not unduly influenced by treatable medical conditions. Potential conservative kidney management candidates include (1) older adults who prioritize quality of life over longevity; (2) patients who perceive that the drawbacks of dialysis outweigh its benefits; (3) individuals with frailty, functional impairment, or advanced serious chronic illnesses (eg, active cancer, advanced congestive heart failure); (4) patients with advanced dementia where dialysis may be unsafe (eg, by pulling needles); or (5) patients wishing for comfort-focused care.[42] Notably, conservative kidney management requires a multidisciplinary collaborative palliative care approach with hospice initiation guided by 6-month prognosis along with patient preferences and symptom needs.

Dialysis

Dialysis (**Table 2**) is a kidney replacement therapy that can either be performed in a center (in-center hemodialysis) or at home (home hemodialysis or peritoneal dialysis [PD]). The dialysis team typically includes a nephrologist, an advanced nurse practitioner, a social worker, a dietitian, dialysis nurses, and technicians. The general goal of dialysis is to prolong life, either as a maintenance therapy or as a temporary intervention while awaiting kidney transplant. A timely shared decision-making process to select the appropriate access—arteriovenous fistula, graft, PD catheter, or hemodialysis catheter—is essential to avoid emergency dialysis.[37,43]

In-Center Hemodialysis | Currently in the US, most patients receive in-center hemodialysis performed by health care professionals

Table 1. Potential Benefits and Downsides of Each Kidney Therapy Option

Kidney therapy option	Benefits or goals	Expected downsides	Potential downsides
Hemodialysis	• Prolonged life, especially in younger people • Removal of uremic toxins and excess fluid • Potential improvement in some uremic symptoms (eg, low appetite, weight loss) • Social aspect with in-center care may be appealing to some	• Access procedures required • Tiredness after each dialysis session • Time commitment to receive dialysis	• Dialysis complications (eg, hypotension, cramps, infections, bleeding) • Increased risk of hospitalization • Increased risk of decline in functional status or worsening cognition or clinical condition • Caregiving burden
Peritoneal dialysis	• Prolonged life, especially in younger people • Removal of uremic toxins and excess fluid • Potential improvement in some uremic symptoms (eg, low appetite, weight loss) • Early preservation of residual kidney function	• Access procedures required • Tiredness after each dialysis session • Time commitment to receive dialysis • Equipment management • Disruption in home environment	• Dialysis complications (eg, exit site infection, catheter malfunction peritonitis, malnutrition) • Increased risk of hospitalization • Risk for technique failure • Increased risk of decline in functional status • Caregiving burden • Malnutrition and electrolyte disturbances
Conservative kidney management	• Focused on quality of life • Less frequent contact with health care system • Suggestion of better preservation of the functional status • Higher likelihood of receiving hospice services	• Potentially reduced life expectancy compared with dialysis • Progressive decline in function • Increased symptoms related to kidney failure (eg, fatigue)	• Lack of a formal conservative kidney management pathway in many health care systems • Lack of multidisciplinary support for symptom management in some health care systems • Lack of clinician expertise in conservative kidney management • Caregiving burden
Kidney transplant	• Prolonged life • Improved quality of life	• Organ shortage • Comorbidities or frailty exclude many older adults from receiving a kidney transplant	• Prolonged waiting period • Risk of infection • Adverse effects related to immunosuppression • Surgical risks

Table 2. Common Types of Dialysis in the US

Dialysis type	Access preparation	Dialysis schedule	Care setting
In-center hemodialysis	• Arteriovenous fistula: surgical connection between an artery and a vein; takes a few weeks to mature and may need repeated interventional radiology assisted fistulograms for relieving stenosis or fistula malfunction but has the least risk for infection • Arteriovenous graft: surgically placed synthetic tube connects an artery with a vein; matures earlier than a fistula but carries a risk of clotting and infections • Dialysis catheter: inserted in a large central vein and can be used immediately but carries a high risk of infection	Approximately 4-h sessions 3 times per wk	Dialysis clinic
Home hemodialysis	Vascular access surgery: arteriovenous fistula vs arteriovenous graft; catheter is less desirable	2- to 3-h Sessions or more approximately 5-6 times per wk	Home setting
Home peritoneal dialysis	Catheter surgically placed in peritoneal cavity: can be used immediately for urgent start but usually takes approximately 2 wk to mature and carries a risk for infection, leaks, and hernias	7 d per wk	Home setting

3 times per week for about 4 hours per session.[2] However, this choice imposes a substantial burden, including travel time and postdialysis recovery.[44,45] Notably, some centers also provide nocturnal in-center hemodialysis, which can be delivered overnight in center (approximately 3 times per week) or at home. Data suggest that compared with conventional thrice-weekly dialysis, nocturnal dialysis may improve phosphate control, blood pressure, secondary hyperparathyroidism, erythropoietin resistance, and ultrafiltration rates, with potential gains in quality-of-life measures.[46,47] Observational data also show lower mortality with nocturnal hemodialysis, but randomized trials are scarce and inconclusive.[48,49] Downsides include higher vascular access complications, transportation challenges, and sleep disturbances.[50]

Home Hemodialysis | Home hemodialysis is short daily hemodialysis or nocturnal home hemodialysis. Short daily hemodialysis is performed 4 to 5 times per week for approximately 2 hours per session. Unlike in-center dialysis, patients or their family members must perform hemodialysis themselves, including inserting needles in arteriovenous fistula or graft.

Older adults receiving daily home hemodialysis may have improved fluid status, reduced inflammatory markers, and left ventricular size.[51,52] However, home hemodialysis requires training for patients and family members and can place substantial burdens related to treatment duration, frequency, equipment maintenance, disruption of the home environment,[53-55] and risk of vascular-access infection.[56]

PD | PD is performed daily and can be manual (continuous ambulatory PD) or automated overnight (automated PD) with help of machine or a combination of both. PD initiation requires training, strict aseptic technique, and reliable home envi-

ronment. PD advantages for older adults include home-based therapy, enhanced sense of control,[57] flexible scheduling, and the potential preservation of residual kidney function.[58] Disadvantages include infections and associated mortality,[59,60] protein losses, and sleep disturbances.[61]

Kidney Transplant

Kidney transplant, whether from a living or deceased donor, is a therapeutic option for eligible older patients, offering increased survival, improved physical function, fewer dietary and fluid restrictions, and greater overall life satisfaction.[11,12] Older recipients frequently regain independence in their daily activities and report experiencing less fatigue compared with dialysis.[62]

Older patients with advanced CKD may be referred for kidney transplant evaluation once their eGFR falls below 20 mL/min/1.73 m^2,[63] although frailty and comorbidities may preclude many from receiving a transplant despite their wishes.[13-15] Ideal candidates are patients with stable cardiovascular status, no active infections or untreated malignant tumors, good adherence potential and social support, and reasonable expected posttransplant survival.[63] A pretransplant assessment, often done in collaboration with PCCs, involves comprehensive cardiovascular and cognitive testing, cancer screening, functional status and frailty assessment, and targeted evaluation of comorbid conditions to ensure that the benefits of kidney transplant outweigh the risks of surgery and subsequent immunosuppression. Advanced age alone is not a contraindication to kidney transplant. According to the US Renal Data System report, the estimated 2016 median wait time for kidney transplant was 3.2 years.[64] Wait times are highly variable and are influenced by blood type, prior sensitization, regional organ availability, and other recipient factors (eg, an acute illness).

Comparing Different Kidney Therapy Options

Dialysis vs Conservative Kidney Management | In patients older than 75 years with advanced comorbidities, dialysis may extend survival but also increases risks of dialysis-related burdens and adverse effects. Studies comparing survival between dialysis and conservative kidney management are observational in nature and often confounded by lead-time and selection biases with younger patients choosing dialysis and older patients selecting conservative kidney management. Two recent meta-analyses[65,66] suggest that dialysis confers a survival advantage, even among those with a high comorbidity burden, although the results may not be generalizable to octogenarians and older adults with frailty and a high comorbidities burden. A recent trial emulation study demonstrated that older adults who chose dialysis compared with those who continued medical management experienced a modest increase in life expectancy of approximately 78 days but at the cost of spending 15 fewer days at home.[16]

Data from patients and families suggest that more important than survival time is how that time is spent.[67,68] While dialysis can prolong survival, it can also negatively impact quality of life. For example, dialysis involves a substantial time commitment (eg, approximately 115 days per year for in-center hemodialysis), which may not align with a patient's goals. Additionally, symptoms such as fatigue, cramps, and reduced well-being are common with dialysis,[17] and the overall symptom burden is comparable with that of patients with cancer.[18] In contrast, conservative kidney management may offer quality-of-life benefits[65] by avoiding dialysis-related symptoms (eg, cramps, postdialysis fatigue),[69] reducing time spent receiving treatment, focusing on symptom control,[70] and lowering costs.[71] Additionally, dialysis has been associated with higher rates of hospitalization[65,72] and possibly an increased risk of functional decline compared with conservative kidney management.[73,74]

PD vs Hemodialysis | Evidence is still evolving, and it remains unclear whether one modality offers superior survival outcomes.[75,76] Some studies suggest that PD may be associated with higher mortality than hemodialysis in older adults,[77,78] while others have found no difference.[79-81] There are no significant difference in quality of life between PD and hemodialysis among older adults, although there is suggestion that PD may be associated with lower risk of dementia, subdural hematomas, and hemorrhagic strokes.[82-84] Choosing between PD and hemodialysis is preference sensitive, guided by personal goals and lifestyle (eg, remaining at home or continuing full-time work) and tempered by practical feasibility (eg, catheter suitability, home storage and water supply, and transportation).

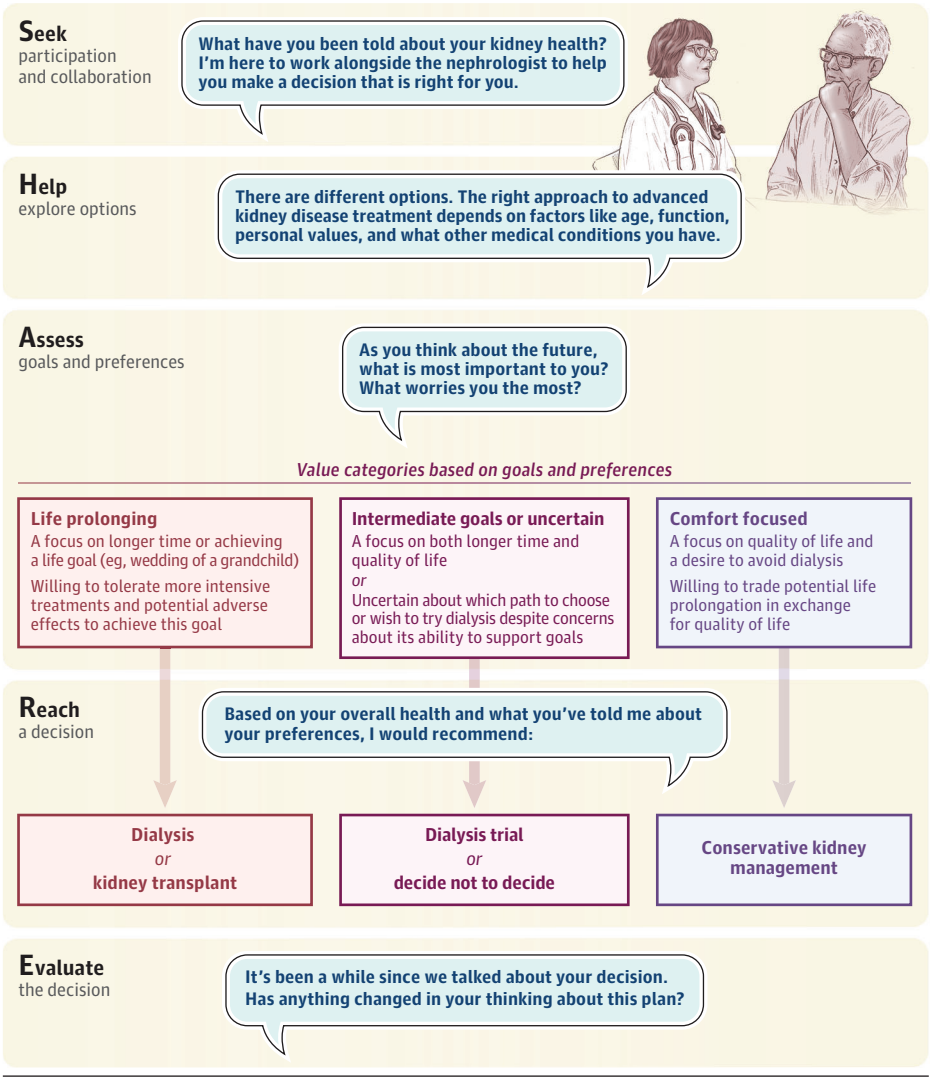
Dialysis vs Kidney Transplant | Kidney transplant in older patients offers a survival and quality-of-life advantage compared with dialysis.[85] Kidney transplant may prolong survival in older patients even after receiving a deceased donor kidney.[86-88] Older kidney transplant recipients, however, tend to experience higher long-term mortality, hospitalizations, infections, cardiovascular issues, malignant tumors, and surgical complications after the transplant than their younger counterparts.[86,89] Nevertheless, graft survival rate for the transplanted kidney is similar between older and younger patients, and most older patients die with a functioning graft.[90,91]

Helping Patients to Weigh the Pros and Cons of Different Treatment Approaches

Global Geriatric Assessment | Older adults with advanced CKD commonly face aging-related problems—frailty, falls, cognitive impairment, reduced mobility, polypharmacy, and depression—that can influence health irrespective of treatment options.[92] For example, frailty in people with CKD is associated with death and hospitalizations.[93,94] Similarly, a patient with limited functional status, cognition, and social support would likely not be able to perform home dialysis tasks. A PCC can conduct an abbreviated geriatric assessment (when geriatrics expertise is not available) to assess functional status,[95,96] frailty,[97] cognition,[98] and social support. A geriatric assessment combined with prognostic estimates (eg, the Kidney Failure Risk Equation for kidney prognosis)[36] and 6-month to 12-month mortality projections[99,100] can provide vital information for shared decision-making. Indeed, dialysis in older patients with frailty may not help with geriatric impairments and can be associated with further cognitive decline[101,102] and functional decline.[73,74]

Role of Decision Aids | PCCs can support the decision-making process by using patient decision aids (PDAs).[103] PDAs "translate evidence into patient-friendly tools to inform patients on their options, help them clarify the value they place on benefits versus harms, and guide them in the process of decision-making."[104] PCCs can use PDAs to provide unbiased knowledge and facilitate informed

Figure. The SHARE Approach to Guide Kidney Therapy Decisions



choices[105] to include conservative kidney management as a valid option.[106-108] An online interactive PDA tested in a large randomized clinical trial of 363 patients significantly improved decision quality as measured by the Decisional Conflict Scale.[108] A recent pilot study using a paper PDA supplemented by palliative care consultation showed significant improvements in shared decision-making within 4 to 6 weeks and in quality of life at 6 months.[109,110] Moreover, evidence-based clinician communication skills trainings, such as Vital Talk, NephroTalk, or the Patient Priorities Care website,[111] are helpful resources to enhance shared decision-making practices.[112,113]

Implementing the SHARE Approach to Promote Shared Decision-Making in Kidney Therapy for Older Patients

The Seek, Help, Access, Reach, Evaluate (SHARE) approach is a valuable model for PCCs to promote shared decision-making in kidney therapy decisions for older patients. The SHARE approach has been used previously to improve patient engagement and shared decision-making.[114,115] In the following sections, we outline the 5 elements from the SHARE approach in context of kidney therapy decision-making (**Figure**).

Step 1: Seeking Patient (and Family) Participation and Reinforce Collaboration

The first step of the SHARE approach[21] is to invite the patient's participation in shared decision-making and to reinforce the PCC's role in collaborating with nephrology. Engaging the patient involves respecting their autonomy by identifying their preferences for decision-making, assessing their health literacy,[116] exploring their disease understanding, addressing their support needs, and discussing the decision-making timeline. Some patients may prefer a passive role in decision-making while others may favor a more directive, clinician-led approach.[117,118] Therefore, the PCCs must tailor the SHARE approach to match each patient's decision-making style.

Step 2: Helping Patients Explore and Compare Kidney Therapy Options

This step involves clearly describing and discussing the available kidney therapy options (Table 1), including their benefits and potential drawbacks. To make an informed decision, patients need a realistic understanding of what the future might look like with each option.[119] Recent data suggest that presenting conservative kidney management as an active choice can enhance patient engagement in the shared

decision-making process.[120] We find using tested decision aids[108,121] or those that discuss conservative kidney management[122] helpful.

Step 3: Assessing Patient Goals and Preferences

Unfortunately, patient goals and preferences are frequently overlooked in kidney therapy decision-making.[6,25] Nearly 20% of patients regret starting dialysis, particularly when the decision was made by physicians or family members.[6] However, the likelihood of perceived goal-concordant care increases significantly with shared decision-making.[25] Older adults with CKD value aspects of quality of life such as independence,[67] avoidance of pain and symptoms, and maintaining the ability to travel.[67,123]

Kidney therapy decisions are preference sensitive and ideally guided by patients' priorities concerning quality of life, existential and emotional concerns, and prognostic considerations. Encouraging patients to envision their future lives and to identify what matters most to them can facilitate a more informed, goal-concordant decision-making process. We emphasize that acknowledging, exploring, and addressing emotions is an essential part of shared decision-making.

Step 4: Reaching a Decision Together

Kidney therapy decision-making in outpatient settings can be an evolving process, often spanning several weeks or months. This time frame allows patients, families, and clinicians to learn about and deliberate on the available choices while reflecting on how their goals and preferences align with expected prognosis and quality-of-life estimates. Exploring the reason for the chosen kidney therapy modality and validating (or questioning) the choice is also part of the decision-making process.

Two special circumstances may arise during kidney therapy decision-making conversations. First, some older patients at low risk for CKD progression may prefer to maintain the status quo and avoid engaging in decision-making. In such cases, patients can decide not to decide[124] and revisit decision-making later at a mutually decided kidney function level (eg, at an eGFR level of 15 mL/min/1.73 m^2). Some patients may never need to make a definitive decision, and by deciding not to decide, they can avoid unnecessary vascular procedures for dialysis preparation.[125]

Second, some patients may remain ambivalent about their choices. A time-limited dialysis trial[29]—lasting weeks or months with goals set collaboratively by clinician and patient—can help decide whether to continue dialysis or shift to conservative kidney management.

Step 5: Evaluating the Decision

Decisional conflict is highly prevalent during kidney therapy decision-making.[7] Therefore, clinicians must address any emotions and lingering questions that may arise during and even following the decision-making. Revisiting the decision is also critical if life circumstances or patient preferences change over time. Additionally, given the often progressive nature of CKD, clinicians should ensure that the chosen kidney therapy option remains aligned with the patient's goals.[111]

Engaging and Supporting Caregivers During Kidney Therapy Decision-Making

Caregivers of individuals with advanced CKD are vital and often overlooked members of the health care team. Caregivers support patient decision-making in multiple ways, serving as advocates, information seekers, and sharers. Allen et al[126] found that caregiver involvement in kidney therapy decision-making added perspectives and questions without altering the total patient questions. Others have shown the positive association of social support with higher patient activation and improved shared decision-making for kidney therapy decisions.[24] However, some evidence also shows that overreliance on caregiver input may be associated with decisional regret.[6]

Caregiver involvement in shared decision-making conversations is essential, as each kidney therapy choice may impact the caregiver's day-to-day life.[127,128] Caregiver involvement is greater for home therapies (for cannulation or dialysis delivery) or when transportation to the dialysis center is required. PCCs can support caregivers by providing information on kidney therapy options, offering anticipatory guidance, and providing psychological support.[129,130]

Engaging in Advance Care Planning and Supporting End-of-Life Care

A crucial aspect of kidney therapy decision-making for PCCs is to engage in discussions about advance care planning and end-of-life care. Inadequate advance care planning may contribute to increased end-of-life health care utilization, unwanted invasive interventions, and cardiopulmonary resuscitation despite poor outcomes for patients with advanced CKD.[131,132] Approximately 20% of patients receiving dialysis eventually decide to stop.[133,134] Dialysis withdrawal is more common in older compared with younger patients, those with chronic illness (eg, cardiovascular disease and dementia), and those receiving hemodialysis compared with PD.[135] Survival after dialysis withdrawal is typically short (approximately 4 to 5 days), with longer survival time when the withdrawal reason is due to psychological reasons rather than medical.[136] Assessing for major depressive disorder, cognitive impairment, and other medical conditions that may influence decision-making is important before proceeding with a request to withdraw dialysis.

Hospice use is less frequent among patients using chronic dialysis than the general Medicare population, likely due in part to Medicare Hospice Benefit limitations, which exclude coverage for services like dialysis or anemia medications related to end-stage kidney disease.[137,138] Concurrent care is an innovative model that may improve hospice access by allowing dialysis with palliative intent to continue alongside hospice services.[139,140]

Facilitating Multidisciplinary Input Into Shared Decision-Making

Effective care for patients with advanced CKD requires synergistic collaboration between nephrologists and PCCs along with other allied specialties, such as palliative care, clinical pharmacy, and nursing. Key features of collaborative care include clearly defining clinical roles and responsibilities, establishing regular communication, and sharing data and clinical impressions throughout the shared decision-making process.[141] Collaboration requires simple yet direct communication methods, such as phone calls or electronic medical record messaging, high-quality letters in the absence of electronic records, or newer integrated models of collaborative advanced CKD care to ensure that patient voices are heard and respected during shared decision-making and care transitions.[142-145]

PCCs play a central role in guiding shared decision-making for advanced CKD by helping older adults clarify goals and presenting all kidney therapy options, including conservative kidney management, screening for geriatric syndromes, discussing prognosis, in-

volving caregivers, coordinating specialty referrals, and facilitating advance care planning.[40,142,146] Further, ongoing care with a PCC provides consistent support during transitions after dialysis initiation or kidney transplant.

Conclusions

Individuals with advanced CKD are often faced with consequential decisions about treatment approaches, including decisions about whether to initiate dialysis, undergo transplant evaluation, or pursue conservative kidney management. Treatment decisions must be individualized, yet evidence suggests that patients may not be adequately informed about the risks and benefits of every treatment approach. PCCs can act as key shared decision-making facilitators and advocate for goal-concordant care in collaboration with nephrologists. It is essential to include patients and caregivers in these critical choices—moving beyond a dialysis-only default to recognize conservative kidney management as a valid and reasonable option that honors the whole person, their goals, and overall well-being.

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