Table 1

Barrier	Solution	Resources
Providers uncertain about how to discuss ACP	Use a conversation guide; enhance provider communication skills.	CSCKP ACP curriculum (kidneysupportivecare.org); VitalTalk training online (www.vitaltalk.org); Serious Illness Conversation Guide (https://www.ariadnelabs.org/areas-of-work/serious-illness-care/resources/#Downloads& Tools)
Uncertainty over who should initiate ACP—nephrologist? Primary care provider? Patient?	Commit to taking the lead.	See CSCKP resources for professionals (http://www.kidneysupportivecare.org/For-Professionals/Advance-Care-Planning.aspx)
Uncertainty over which patients are appropriate and when	Use an opt-out standard—assume that all patients should be offered ACP unless there is a specific contraindication.	
Need educational materials and forms for patients	Multiple resources now available; review and select the one that best suits your practice and patients.	Prepare for your care (https://www.prepareforyourcare.org/page); recognized forms in all states (www.caringinfo.org/i4a/pages/index.cfm?pageid=328); additional resources (www.kidneysupportivecare.org/For-Patients-Families/Advance-Care-Planning.aspx)
Time crunch for nephrologist	Involve other team members, such as nurse practitioners, social workers, or other trained coaches.	American Nephrology Nurses Association's "Techniques to Facilitate Discussions for Advance Care Planning (ACP)" module is the first in a series of educational modules on EOL decision-making, and the Nephrology Nurse is an in-depth national program to promote education for nurses and improve end-of-life care
Not part of regular workflow of clinic	Develop a standard process; make it a standing agenda item at QAPI meetings.	The CSCKP has a model Advance Care Planning Policy template to assist dialysis facility staff in developing ACP policies and procedures (http://www.kidneysupportivecare.org/For-Professionals/Advance-Care-Planning.aspx)
Not integrated within EMR	Use a template within the EMR that captures key data, including proxy contact information and content of discussions about patient values and preferences; train all staff so that ACP discussions are consistently documented in the same location.	Most EMRs have a place where advance directives can be stored; use the EMR capacity and improve on it with custom fields; however, make sure everyone knows how to use it, what information needs to be documented, and where to find the information when needed
ACP documents information not shared across settings	Participate in the POLST registry if your state has one; participate in other registries as available; if no local registry, make sure that ACP information is conveyed routinely to other providers along with information, such as laboratory values; help patients recognize the importance of keeping documents accessible.	POLST programs by state (http://polst.org/programs-in-your-state/)
This all takes time, which is costly	Appropriately code ACP sessions to receive Medicare reimbursement for ACP.	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf
Do not know whether ACP is making improvements	Adopt quality measures and conduct performance improvement projects for ACP.	Measuring What Matters—measures 7 to 9 (http://aahpm.org/quality/measuring-what-matters); additional suggestions in the work by Mandel et al. (13)

Abbreviations: ACP = advance care planning; CSCKP = Coalition for Supportive Care of Kidney Patients; EMR = electronic medical record; EOL = end of life; POLST = Physician's Orders for Life-Sustaining Treatment; QAPI = Quality Assurance & Performance Improvement.

Integrating Geriatrics into Nephrology: A Report on the 2017 American Geriatric Society Annual Scientific Meeting

By Rasheeda Hall, MD

The US dialysis population is growing faster than the number of new nephrologists. At the same time, our population is aging, and there is a shortage of geriatricians. Beyond efforts to expand the nephrology and geriatrics workforces, it is also extremely important to pursue interdisciplinary collaboration. How can we ensure that older adults receiving dialysis receive quality care for their geriatric conditions? How can geriatricians be great partners in managing older adults with chronic kidney disease? Communication between nephrologists and geriatricians will add value for patient care and generate ideas for research.

As the liaison between the American Society of Nephrology (ASN) and the American Geriatric Society (AGS), I attended the AGS annual meeting in May 2017. The meeting focused on current issues in aging and was geared toward all health care professionals who care for older adults, including nephrologists. The value of individualized care for older adults on the basis of life expectancy prediction was the focus of a compelling talk by Sei Lee of the University of California, San Francisco Department of Medicine, Division of Geriatrics. Patients predicted to have limited life expectancy are not likely to benefit from preventive interventions, such as colon cancer screening, Lee noted. This theme overlapped with my own presentation showing that the cost-effectiveness of arteriovenous fistula is reduced in older adults with limited life expectancy.

Beyond life expectancy, another key theme at the meeting was co-management. A poster from Laura Fernandez and Julie Paik at the Boston Veterans Affairs Medical Center highlighted a Geriatric-Nephrology Collaborative Clinic, in which a geriatrician performed comprehensive geriatric assessments in older veterans with chronic kidney disease. The geriatrician then identified geriatric syndromes and provided treatment recommendations to the nephrology team. Although functional impairment was the most common geriatric syndrome, the most common treatment recommendations were medication changes followed by referrals to nonphysician services, such as rehabilitation or audiology.

Laura Plantinga and her colleagues at Emory University presented a study about the association of serious fall injuries in dialysis patients who received a kidney transplant. They found that patients who experienced a serious fall injury were nearly 80% less likely to be waitlisted. Among the waitlisted patients, those who had a serious fall injury were 53% less likely to subsequently receive a transplant. Prior studies show that falls increase mortality risk in dialysis patients, so these findings bring attention to yet another complication of injurious falls in this population.

Another highlight from the AGS annual meeting is its annual morning meeting for medical subspecialists. As ASN liaison, I highlighted the ASN's Supportive Care online community and the Coalition for the Supportive Care of Kidney Patients Luncheon held at Kidney Week 2016. I also described current National Institute on Aging–funded research involving frailty, disability, and shared decision-making in older adults with ESRD. From other subspecialists' presentations, I learned about integrated working groups, such as the Cancer and Aging Research Group that pursues research collaborations across multiple institutions. This model of collaboration among various specialists at multiple institutions is an intriguing example for growing the field of geriatric nephrology.

Want to learn more and/or get involved in geriatric nephrology? Through the ASN's website, you can access the Online Curriculum on Geriatric Nephrology and the Supportive Care online community. At ASN Kidney Week 2017, you may network with members of the Supportive Care online community who will be present for a Supportive Care Meetup at the ASN Communities Lounge. Last, consider attending the next AGS annual meeting May 3 to 5, 2018, in Orlando, FL.

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