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ASN Kidney Health Guidance on Conservative Management in People with Kidney Failure

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Abstract

Conservative management is holistic and whole-person care for people with kidney failure. This care pathway is often a good choice for patients who prioritize independence, quality of life, and avoidance of burdens associated with life-prolonging therapies such as dialysis. This Kidney Health Guidance aims to provide evidence-based clinical guidance to promote best practices in conservative management care delivery. Conservative management comprises three components, including customized CKD care, symptom management, and smooth navigation of care transitions. This Kidney Health Guidance describes the application of these three components across the illness trajectory, including the role of shared decision-making, care partner engagement, and interdisciplinary collaboration. Practical strategies are outlined for health care professionals to integrate conservative management care delivery into practice.

Introduction

Research and clinical advances have broadened the range of available treatment options for people with kidney failure. Conservative management can be considered the “fourth pathway”—alongside hemodialysis, peritoneal dialysis, and kidney transplantation—and is a legitimate and proactive therapeutic option for patients. As dialysis treatment for kidney failure has become widely available and our understanding of patients’ experience of this therapy has deepened, so too has recognition of its limitations and the burdens the therapy can impose. The clinical, physical, social, and cognitive effects of starting and maintaining a dialysis regimen are well documented and inform treatment decisions for patients, care partners, and health professionals.^{1–4} Trade-offs in kidney failure treatment options can be especially complex for older adults with multiple chronic conditions, who comprise a growing segment of the population of patients with kidney failure. Concurrently, modern medicine has shifted from a disease-centered model focused on survival to a holistic, person-centered approach guided by patients’ values, goals, and preferences.⁵ For all these reasons, dialysis should no longer be regarded as an automatic or default treatment for kidney failure, and conservative management can be considered as a viable treatment option depending on patients’ clinical context, goals, and preferences.⁶

Conservative management is an active choice made through a shared decision-making (SDM) process, rather than a passive approach in the absence of KRT. Conservative

management focuses on personalization and whole-person attention across the CKD continuum of illness that is flexible to the needs and priorities of the patient. Thus, conservative management is dynamic and highly individualized and can be delivered in a variety of practice settings. However, there is a need to clearly define overarching best practices for its widespread dissemination and implementation. Because language describing this option has varied and continues to evolve,^{7,8} there is also a need for pragmatic, relatable terms and definitions that support meaningful discussion about conservative management between patients, their care partners, and health professionals.

In this article, we provide evidence-informed and actionable guidance on best practices for conservative management. We clarify the principles of conservative management, delineate its core components, and outline steps for its implementation in everyday practice in the United States. The work is a product of a comprehensive literature review of available evidence for conservative management (which is largely observational in nature), synthesis of guidelines and recommendations from professional societies, and expert opinion.^{6,9,10} The current guidance applies to all patients who choose conservative management, with special attention to older, frail, and highly comorbid individuals who comprise most patients selecting this approach. It is also written for nephrology and non-nephrology professional audiences and can support their therapeutic alliance with patients and care partners. This Kidney Health Guidance (KHG) was developed under the direction of the American Society of Nephrology's KHG Oversight Committee and authored by the KHG Workgroup on Conservative Kidney Management comprising experts representing nephrology, geriatrics, palliative care, bioethics, social work, and advanced practice professionals.

Core Components of Conservative Management

Conservative management comprises three core components: (1) customized CKD care, (2) symptom management, and (3) navigating care transitions.

1. Customized CKD care: CKD care directed at preserving kidney function and managing its medical complications (hypertension, hypervolemia, electrolyte derangements, anemia, and bone mineral disease) is customized to support a patient's values, goals, and care preferences. As such, medical recommendations for CKD care may be continued, adapted, or relaxed from guideline-based biometric targets to better align with what matters most to a patient and to minimize treatment burden and side effects. Active CKD management may cease altogether when patients are at the end of their lives.
2. Symptom management: Physical and psychologic symptoms, including psychosocial and spiritual/existential distress, are common in patients with kidney failure.^{3,11} These symptoms are carefully and routinely assessed and addressed through diet and lifestyle modification, pharmacotherapy, and coordination with additional interdisciplinary services, such as mental health and social work, as needed. Hospice services can also assist with symptoms and family bereavement support at the end of life.

3. Transition navigation: Open conversations about prognosis and what to expect with kidney failure are necessary across the illness course to help patients and care partners anticipate and plan for future decline in health. Ongoing discussion about who or what is important to patients when making medical decisions, what their priorities are when they become sick, and wishes for future care ensure that patients receive care that is right for them. It also involves creating proactive action plans to avoid or minimize the effect of future health crises, including planning for end-of-life and hospice services.

Although conservative management, dialysis, and kidney transplantation are distinct treatment pathways, they share considerable overlap with respect to these three care components. What distinguishes conservative management, however, is its flexibility; placement of patient values front and center in driving care decisions; and responsiveness to patient needs, clinical circumstances, and preference across the care continuum.

The approach to care also evolves with changes in the patient's health status, which may be: (1) stable or slowly declining, (2) deteriorating, and (3) rapidly declining (Figure 1). The plan of care begins with anticipating the patients' illness trajectory and corresponding needs and laying the foundation for a patient-centered and holistic approach to care. Care is initiated as needs arise and then intensifies and expands to engage other health professionals to meet growing illness demands. Care culminates with expertly supporting patients and care partners at the end of life.

Successful conservative management depends not only on the patient, who—often with their care partners—is central to all treatment decisions but also in a culture that actively supports SDM and interdisciplinary collaboration (Figure 2).

Care Partners

Conservative management is often enhanced by a patient's care partners, who may be family members, friends, or other close people who assist patients with medical decision-making and participate in care. Care partners may manage instrumental tasks (*e.g.*, managing medications, medical appointments, activities of daily living) and occupy supportive roles (*e.g.*, moral support, reinforcing health behaviors) to augment effective conservative management. For patients without care partners, additional support may be necessary from allied health professionals.

SDM

SDM is foundational to conservative management and guides how each component of conservative management is tailored and delivered. SDM is the process by which the health care team applies their clinical expertise toward formulating a therapeutic plan that incorporates the patient's values, goals, and preferences.¹²

Interdisciplinary Care

Diverse clinical expertise supports coordinated, whole-person conservative management. Interdisciplinary collaboration is led by a nephrology professional, who may be a nephrologist or advanced practice practitioner, who recruits other members of the kidney

care team, and allied health professionals as needed, to support the delivery of conservative management. In practices with limited access to other kidney team members and allied health professionals, strong partnership with primary care, who can bridge patients to these services, becomes vital. Proactive communication and coordination with primary care and other specialty health professionals provides valuable collateral medical information to support SDM and help to align all aspects of the patient's care with their choice for conservative management.

Patient Experience with Conservative Management

Although conservative management is an option for all patients approaching kidney failure, available evidence on conservative management primarily represents the experiences of patients who have made a proactive choice to forgo dialysis. These patients are generally aged 75 years or older with significant comorbid burden and frailty and are expected to have limited life expectancy and significant complications with dialysis. The experiences of patients reported in the literature are summarized below.

Quality of Life

Patients who choose conservative management often feel just as good, or better, physically and mentally as those on dialysis,^{13–17} with many reporting not only feeling more satisfied with their lives but also their decision to choose conservative management.^{13,18} Their symptoms usually stay stable for most of their illness and tend to worsen only in the last few months of life, at which time hospice can help keep them comfortable.^{15,19–22}

Health Care Utilization

Patients who choose conservative management spend less of their lives in medical settings than patients on dialysis, particularly near the end of life. As compared with patients on dialysis, patients who choose conservative management spend less time in the hospital,^{14,17,23,24} have fewer emergency department visits,^{17,25–27} and undergo fewer invasive procedures.^{24,28} They are also more likely to plan ahead, receive palliative and hospice care, and spend their final days at home and not in a hospital.^{24,28,29}

Survival

Patients who choose conservative management might not live as long as those who start dialysis; however, this difference may only be a matter of several months²⁷ or even less than that.^{28,30–35} It is also important for patients to consider that a significant portion of the extra time gained with dialysis is often spent in medical settings instead of at home.^{25,27}

Making the Choice for Conservative Management

Conservative management should be presented as an active rather than a passive therapy option to all patients. Although all patients should be aware of conservative management to support informed decision-making about kidney failure, deeper discussion can be especially valuable for patients for whom this option may offer comparable or superior outcomes to dialysis.

Decision-making around treatment options for kidney failure should take into consideration the potential benefits as well as the anticipated prognosis and burdens that accompany each therapeutic option. Many patients experience functional and cognitive decline after dialysis initiation.^{36,37} Dialysis can impose significant financial and caregiving burdens on patients and families. Even while dialysis can offer life extension, some patients may not view this time as quality time due to the sacrifices that accompany life on dialysis.^{27,38} Many older adults prioritize maintaining independence, reducing symptoms, and avoiding hospitalizations over longevity^{39,40} and would be willing to trade potential added survival to ensure a path that supported these other goals.^{41,42} As such, patients who might derive some benefit from dialysis may still choose conservative management if the treatment aligns with their priorities and the trade-offs that they are willing to tolerate. Decision aids have been developed to help patients explore their wishes around dialysis as well as to help health care professionals make recommendations about conservative management (Supplemental Table 1). Other tools help health professionals estimate life expectancy with and without dialysis to inform decisions (Supplemental Table 2).

The ideal timing to initiate discussions about conservative management and other kidney failure therapies is not well defined and currently falls to clinician judgment.^{6,43–45} Importantly, the timing of discussions should occur as early as the nephrology team anticipates progression to kidney failure or during CKD stage 4 or 5 at the latest. The decision-making process typically evolves over multiple, iterative conversations with the patient and their care partners.

The discussion and decision to pursue conservative management should be documented and communicated to relevant members of the patient's care team to ensure this decision is honored and carried out. The agreed-upon treatment decision should not be considered immutable, as patients' priorities and preferences may shift over time. At the same time, the decision should not be repeatedly revisited unless prompted at the request of the patient or care partner or to ensure consensus when there has been a change in the care partner or health care team. Repeated or excessive questioning can undermine the patient's autonomy and confidence in their choice.⁴⁶

A patient's ambivalence about conservative management should not be viewed as indicating a definitive preference for dialysis treatment. Decisional conflict about conservative management and dialysis is common and reflects the high-stakes nature of this decision, the trade-offs involved, and potential for regret regardless of the option chosen.⁴⁷ Patients may prefer a "wait and see" approach, may change their minds, or may decide not to decide.^{48–50} When a patient vacillates in this decision, health professionals can support them by expressing patience and compassion, revisiting previously expressed values, exploring hopes and fears, and reaffirming their support for the patient and their care partner no matter which option is chosen.

Conservative Management in Practice

Forging Relationships with Care Partners

Involving care partners in treatment plans requires intentional and deliberate arrangements to regularly communicate with care partners during patient encounters and/or separately from these encounters. Not hearing from health professionals can be, at best, misinterpreted as good news of no active medical concerns, or at worst, misconstrued as lack of respect for the care partners' engagement and contribution to the patient's care. Establishing the best means (*e.g.*, phone call, message) and cadence (*e.g.*, with clinic visits, hospital admissions) of communication up front facilitates transparency, builds mutual trust, and opens the door to better outcomes with challenging conversations that might arise. Involving care partners in decisions helps to amplify patients' care wishes and enact care plans, especially when patients have cognitive impairment or are too ill to advocate for themselves. When care partners disagree with a patient's preferences, it is possible to acknowledge these differences while remaining grounded in common goals, including wanting the best for the patient and wishing to respect their expressed values and preferences. Palliative care specialists and ethics consultants can assist with conflicts in complex medical decision-making. In situations in which no care partner is identified, discussion with the patient should include exploration of support options and anticipatory guidance for when clinical condition may change or more caregiving is necessary.

Making SDM a Part of Practice

SDM involves key steps in guiding decisions about conservative management and along the conservative management pathway (Table 1), which include preparing (oneself, the patient, and care partners) for the conversation, sharing medical information in a meaningful way (*e.g.*, Ask-Tell-Ask framework, I Worry statements), attending to emotional distress caused by illness (*e.g.*, NURSE statements), mapping patient's values to navigate decisions, formulating recommendations that align with their values, and defining next steps once or until a decision is made.^{51,52} Training programs and communication guides are available to help health professionals deepen their skills with conversations (Supplemental Table 1).

Cultural Considerations

Practicing within a multicultural community requires sensitivity and humility to the diverse values and beliefs that may shape decision-making. Especially for marginalized and underserved communities, extra attention may be needed to build trusting therapeutic relationships. Effective SDM involves showing genuine interest through open-ended, nonjudgmental questions about beliefs and practices and making an effort to strengthen decision-making agency in patients and care partners (Box 1).⁵³

Leveraging Interdisciplinary Collaboration

A first step to collaboration across the patient's different health care teams is ensuring shared understanding about the patient's prognosis, values, goals and preferences. This is best achieved through conversation with the different teams, which expedites care planning and avoids confusion. When decisions for conservative management and those along the

conservative management pathway have implications on other aspects of the patient's care (*e.g.*, candidacy for or outcomes with other treatments), this should be discussed in advance with relevant health professionals to ensure coherence in the care that patients receive across all health care settings.

Once treatment decisions have been made, helpful documentation to all health care teams makes clear the decision and the values and priorities that supported this decision. For example, "As the nephrology clinician caring for Ms. Smith, we have made a plan together to manage her kidney failure with conservative management to honor her preferences for maximizing symptom management and avoiding dialysis."

How interdisciplinary collaboration is approached and which health professionals are enlisted will depend on a given practice setting, resources available, and the patient's needs and preferences. Interdisciplinary collaboration also requires deliberate effort to create a flow of communication between health professionals. Asynchronous (*e.g.*, copy progress notes, email, and messaging) and synchronous (*e.g.*, conference discussion, multispecialty clinic visits) communication approaches can help to overcome professional and structural silos. This ensures that different health professionals are not only aligned on a patient's care plan but also working synergistically toward optimizing a patient's care experience and outcomes.

Customizing CKD Care

A conservative management care plan will vary according to each patient's individual values, goals, and preferences and evolves as the illness progresses. We demonstrate one possible customized care plan but, by definition, customized plans will be unique to each patient on conservative management (Supplemental Table 3). Easing or departing from guideline-recommended targets, such as for hypertension or mineral metabolism, to achieve a patient's goals is neither medical negligence nor "doing nothing" when it is thoughtfully reasoned. Similarly, actions to safely maximize quality of life, even at the expense of potentially longer life, are justified when they are aligned with a patient's priorities. Clearly communicating to patients, care partners, and other health professionals the rationale underlying care plans can alleviate possible distress and avoid misunderstanding.

Special Considerations in Older Adults: Given the advanced age, frailty, and other geriatric syndromes present in many patients choosing conservative management, the care plan should follow an age-friendly 4Ms approach that incorporates a patient's cognition, function, medication regimen, and priorities into customized CKD care (Table 2).⁵⁴ Specific geriatric syndromes can also be formally assessed during a routine visit using tools that provide practical information to guide care plans (Supplemental Table 4).

Customizing Nutrition: Nutrition plays a key role in a patient's quality of life and their self-care, giving patients meaningful control over and agency in their health. A thoughtful nutrition plan carefully considers a patient's preferences; usual dietary patterns; and relationship and access to food, level of kidney function, symptom burden, and presence of malnutrition, weight loss, sarcopenia, and frailty to support quality of life and safety^{55,56}

(Supplemental Table 5). A kidney dietitian can assist with nutritional assessment and tailored recommendations.

Proactive Symptom Management

Regular assessment of symptoms allows identification of not only where patients are along their illness trajectory and proximity to the end of life but also their response to treatment. Symptom assessment can be facilitated using validated tools (Supplemental Table 6). Health professionals should consider the patient's prognosis, values, and goals when evaluating symptoms; the extent of workup pursued; and the treatments used (Table 3). All pharmacologic treatments should be initiated with a plan for close monitoring for side effects and titration or deescalation as needed.

Psychosocial and Spiritual Considerations: Kidney failure has a profound effect on a patient's function and quality of life, which, in turn, can have strong psychosocial implications. Patients also commonly grapple with existential questions about the meaning of life and their illness as well as their value or purpose in the world as they navigate health decline and their mortality.^{57,58} Symptom management in conservative management includes addressing psychosocial and existential distress brought on by kidney failure, exploring how patients and care partners are coping with these effects and connecting them with allied health professionals to ensure comfort, dignity, and well-being in the face of illness (Table 4).

Transition Navigation

Regardless of the chosen kidney failure treatment modality, all patients should be provided anticipatory guidance and prepare for future health decline including death. Proactively discussing and planning for this expected trajectory with conservative management can be difficult, even distressing, for many patients and care partners. Staying patient and thoughtfully revisiting these topics over time and exercising the steps of SDM can aid in building resilience in patients to face these transitions.

When patients are in a relatively stable or slowly declining state, a patient's care preferences for future care can be affirmed by documenting their wishes in the medical record and by completing an advance directive, durable power of attorney, and/or portable medical order.

When the patient's condition is declining, it is important to have a plan in place to ensure patients receive care that avoids unnecessary hospitalizations and institutionalization. Educating patients and care partners about early signs of a symptom crisis or adverse events, providing as-needed medications at home that they can try to de-escalate symptoms, and giving direction and means to contact their health professionals for support may help to avoid and mitigate episodes of illness crisis (Table 5). It is also beneficial to signpost for patients and care partners the signs and symptoms that are potentially reversible, those that indicate disease progression and for which additional supports (*e.g.*, home aid) are needed, and those that signify that patients are nearing the end of life when services, such as hospice, are appropriate.

Establishing a Conservative Management Pathway

Implementation of a conservative management pathway requires logistical, staffing, and financial considerations (Table 6). The comprehensiveness of the conservative management model that is implemented, such as the composition of the kidney team and whether other allied health professionals (*e.g.*, palliative care specialists) are embedded, is frequently subject to availability of local resources and practice capacity. Consequently, implementation is often fluid and opportunistic, while still grounded in the core components of conservative management to achieve best practices. We outline core action items that are essential to all nephrology practices as well as enhanced items that are within reach of well-resourced practices in Table 7.

Advancing conservative management in the United States requires targeted reforms in policy, research, and professional education.

- Expand education/training requirements for nephrology to include experience with caring for patients on conservative management and explicit instruction in serious illness communication skills, symptom management, and advanced care planning for patients with kidney failure.
- Facilitate cross-training and continuing education on conservative management across interdisciplinary health professionals.
- Increase research funding for conservative management to optimize care practices and outcomes.
- Promote research to assess outcomes with conservative management and disseminate findings to support implementation and continuous quality improvement.
- Create reimbursement parity with dialysis for conservative management and expand insurance benefits for allied health professional services.
- Introduce value-based models that reward improvement in quality-of-life measures.

Conclusion

Conservative management is a care pathway for people with kidney failure that is focused on preserving independence, managing distressing symptoms, and avoiding burdens that accompany dialysis. Care plans are individualized and tailored to a patient's care needs, values, and goals. SDM, alliance with care partners, and interdisciplinary collaboration are integral to delivery of conservative management across the illness trajectory. In capacity-limited settings, successful implementation requires creative assembly of available resources to create the clinical infrastructure to support its delivery. Advancement and expansion of conservative management will require comprehensive policy, education, and research reform.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgments

The following acknowledgment statement is specific to ASN KHG. The content of this article reflects the personal experience and views of the authors and should not be considered medical advice or recommendation. This ASN KHG is intended to reflect current practice and is intended as a resource and concise point of reference geared toward clinicians caring for people with kidney diseases. The guidance should not preclude clinical judgment and must be applied in the context of the specific patient, with adjustments for patient preferences, comorbidities, and other factors.

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Key Points

- Conservative management is customized CKD care, symptom management, and support to navigate care across the CKD trajectory through end of life.
- Conservative management is defined by shared decision-making and interdisciplinary teamwork in alliance with patients and care partners.
- Implementation of conservative management hinges on each practice's logistical considerations and resource availability.

Box 1.**Pearls for addressing multicultural considerations in shared decision-making****Explore**

- “How do you and your family usually go about decision-making when someone has a serious illness?”
- “Is there someone in your community whom you trust and would like to consult as you make these medical decisions?”
- “What have your prior experiences been like with our health system? Have they affected the way you approach your kidney disease?”
- “We want to take the best care of you. What does doing our best look like to you?”
- “What traditions do you practice when caring for someone who is sick or near the end of life?”

Support

- Provide professional interpreters and/or cultural liaisons during discussions
- Invite trusted community leader to accompany patient to medical appointments
- Provide patient-facing materials in multiple languages and with pictures representing persons with diverse backgrounds
- Educate patient about safely incorporating their traditional medicine into local practices

Illness trajectory (approximate time from death)	Patient needs	Conservative Management Pathway Components		
		Customized CKD Care	Symptom Management	Navigating Transitions
Stable or slowly declining (months-years) 	Able to care for most needs independently	Continue usual CKD care focused on mitigating disease progression and complications	- Implement routine symptom screening - Educate about possible future symptoms	- Clarify values, goals, and wishes - Forge relationship with care partners - Complete durable power of attorney indicating health care proxies - Complete an advanced directive indicating wishes for care - Acquaint with primary care and specialty teams
Deteriorating (weeks-months) 	Able to self-care for some needs, requires considerable assistance	- Adapt, relax, or diverge from biomedical treatment targets to optimize quality of life and minimize treatment burden and side effects - Deprescribe longevity-focused medications	- Increase symptom assessment - Intensify medications with the goal of symptom control - Partner with primary care to engage interdisciplinary health professionals for additional support	- Create action plans to manage possible future symptom crisis - Complete a portable medical order indicating comfort-focused care and no dialysis - Discuss the option of specialty palliative care and hospice - Consider referral to hospice if expected prognosis is less than 6 months
Rapidly declining (days-weeks) 	Unable to self-care, requires 24-hr assistance	- Stop lab monitoring - Decrease visits and clinic evaluations	Collaborate with hospice services to provide end-of-life and bereavement care	- Educate about terminal stage of kidney failure and the dying process - Refer to hospice services

Figure 1.
Conservative management pathway.

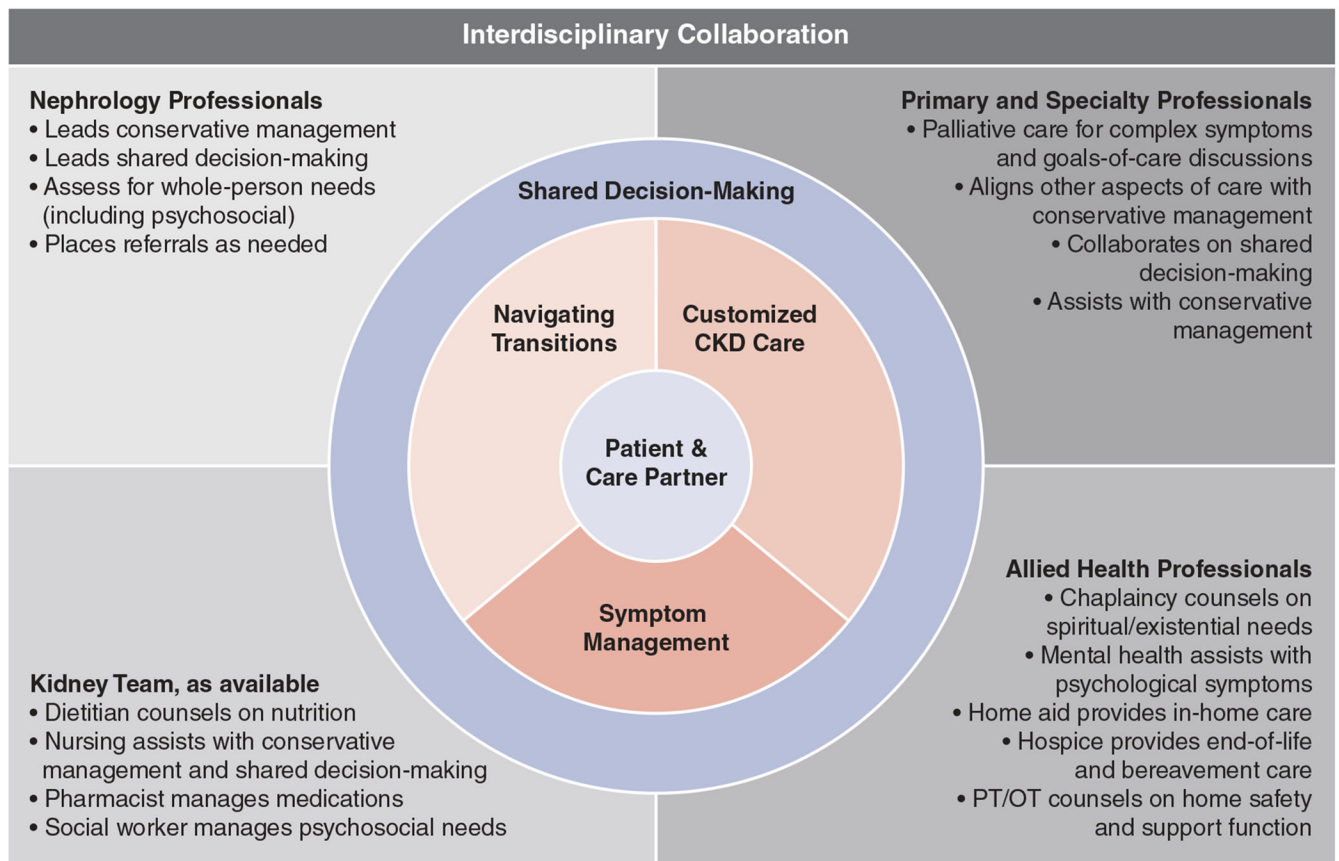


Figure 2. Conservative management and the culture of care.
PT/OT, physical therapy/occupational therapy.

Table 1.

Key steps for shared decision-making practice

Steps	Points	Tools/Examples
Prepare for discussion	• Review patient’s medical history • Estimate prognosis with each treatment option • Seek input from other health professionals with relevant expertise • Prespecify time and location • Invite care partners to discussion	• Surprise question: “Would I be surprised if this patient died within 1 year?” • “What would life look like for this patient with each treatment option?” • “Who helps you make difficult medical decisions?”
Share medical information and its meaning	• Use simple, nontechnical language • Check the patient’s understanding of their illness to know what information is necessary to share • Provide frank discussion of prognosis • Confirm patient’s understanding of new information • Acknowledge importance of emotions in synthesizing information	• I Worry statements: “Given your other medical problems, I worry that dialysis might not add meaningful time and lead to more setbacks.” • Ask-Tell-Ask framework: Ask: “What have you been told about your condition?” Tell: “Your condition has worsened to the point that we need to discuss what kind of care makes most sense to you. Your input is needed to determine which option makes the most sense to you.” Ask: “I have shared a lot of information today. What are the important points of our conversations that you might tell your family?” • NURSE^a statements: Name: “I can see how difficult it is to hear this.” Understand: “This news would be upsetting to anyone.” Respect: “I cannot imagine how hard this is for you.” Support: “I will support you every step of the way.” Explore: “Tell me more.”
Elicit values and preferences	• Use open-ended questions • Use multiple questions to understand the patient’s perspective • Elicit realistic goals	• “Given your current condition, what is most important to you?” • “As you think about the future, what are you most worried about?” • “Some people value time and are willing to put up with more medical interventions. Other people value the quality of their life and wish to avoid more medical interventions even if that means they might not live as long. What type of person are you?”
Offer a goal-concordant recommendation	• Respect patient autonomy by asking permission to share • Articulate how recommendations are guided by the patient’s values and preferences	• “Would it be helpful to you in your decision-making if I made a recommendation?” • “Given your goals are to focus on quality of life, I recommend we pursue conservative management and focus on managing your symptoms. I also recommend we do not do dialysis because it would not help you toward your goal of staying out of the hospital.”
Arrive at consensus	• Allow for multiple conversations to reach consensus • Involve other health professionals important to patient’s care	• “When would be a good time to come back to this topic?” (if no decision is reached) • “Can I share next steps in how we will care for you?” (if decision reached)

^aNURSE is an acronym that stands for: Name the emotion; acknowledge the patient’s feelings. Understand the emotion; show that you comprehend the patient’s experience. Respect the emotion; validate the patient’s feelings and experiences. Support the patient; offer reassurance and support. Empower the patient; encourage the patient to express their feelings and concerns.

Table 2.

A geriatrics-informed 4Ms approach to assessing care needs

Domains		Example Probes ^a	How Information Can Inform Customized Care Plan
Mentation	• Cognitive impairment • Memory problems • Mood disorders	• "Have you had any new problems with memory, confusion, or thinking lately?" • "How are you managing daily tasks that require focus?" • "How is your mood?"	• Recommend care partner attend medical visits • Refer to mental health professional or start medications for mood disorders
Mobility	• Physical activity • Fall risk • Ability to self-care	• "How often do you leave your home and spend time outside?" • "Have you had any falls or near-falls in the past 6 months?" • "Do you need help with taking care of yourself, like dressing or bathing?"	• Refer to PT/OT for fall prevention • Reduce or stop medications that increase fall risk and sedation • Refer to social work or for home aid
Medications	• Complex medication regimen • Altered pharmacokinetics and pharmacodynamics of medications	• "Do you ever miss taking your medication? Why?" • "Are any of your medications difficult to take?" • "What side effects do you have with your medicines?"	• Reduce or stop medications that alter cognition • Consult pharmacy about drug interactions, age-appropriate dose adjustments, and medication reminder tools
what Matters	• Values and goals of care • Health care proxy	• "Have you completed a living will?" • "Who should I go to for medical decisions if you were to become so sick that you could not make decisions for yourself?" • "What matters most to you?"	• Complete an advanced directive, durable power of attorney, and portable medical order

PT/OT, physical therapy/occupational therapy.

^aNote on example probes: If a patient's response does not endorse a problem but clinician remains concerned, then they should evaluate further or refer to appropriate clinician.

Table 3.

Approach to common symptoms

Symptom	Evaluation	Management
Pain	- Consider underlying pathology, such as ischemia, injury, arthritis, etc., and treat accordingly - Evaluate for existential/emotional suffering that can affect physical pain	- Multimodal approach including mindfulness, physical therapy, analgesics, massage, yoga, and cognitive behavioral therapy - Combine pharmacologic and nonpharmacologic interventions - Have patient keep a pain diary to monitor triggers that exacerbate and alleviate as well as response to treatment - Noiceptive: start with acetaminophen, topical NSAID/lidocaine if joint related - Neuropathic pain: gabapentin 100/pregabalin 25 mg every other night, titrate as tolerated, cautious use with close monitoring for side effects - If pain is not controlled, may consider opioids, starting with hydromorphone 0.5–1 mg every 6 h as needed or oxycodone 2.5 mg PO every 6 h pm - Monitor closely for side effects. Suggest consult with specialty palliative care or pain management if pain uncontrolled and fentanyl, buprenorphine, or methadone is considered
Pruritus	Evaluate and treat systemic causes, such as malignancy and dermatitis	- Skin hydration with emollient and anti-itch cream (e.g., pramoxine, gamma linolenic acid) - Use breathable (e.g., linen) clothing and bedding - Consider gabapentin 50 mg/pregabalin 12.5 mg daily if there are other indications - Mirtazapine 7.5 mg qhs
Poor sleep	- Evaluate and treat nonrenal causes, such as thyroid disorder and obstructive sleep apnea - Evaluate and treat other symptoms that can cause poor sleep, such as pain, anxiety, depression, pruritus, restless leg syndrome, and nocturia	- Review sleep hygiene - Cognitive behavioral therapy - Mirtazapine 7.5 mg PO qhs - Melatonin 2–5 mg PO qhs - Daily exercise
Fatigue	- Evaluate and treat systemic causes, such as anemia, protein energy wasting, iron deficiency, anxiety/depression, and volume depletion - Consider medication side effects	- Assess sleep hygiene - Aromatherapy - Use assistive devices (e.g., walker, wheelchair) to conserve energy
Nausea and vomiting	Evaluate for gastrointestinal causes, such as obstruction and constipation	- Smaller, more frequent meals - Avoid greasy or spicy foods - Ondansetron 4 mg PO every 8 h, as needed, can titrate up to 8 mg PO every 8 h as needed - Metoclopramide 2.5 mg PO every 4 h - Haloperidol 0.5 mg every 8 h - Olanzapine 2.5 mg every 8 h
Restless legs syndrome	Evaluate for iron deficiency or medication-induced causes (e.g., SSRIs, mirtazapine, SNRIs, metoprololamide)	- Avoid stimulants such as alcohol/caffeine/nicotine - If patient has other indications, can trial gabapentin/pregabalin - Pramipexole 0.125 mg PO 2 h before bedtime, titrate by 0.125 mg every 7 d - Rotigotine transdermal patch 1 mg/24 h can increase weekly - Ropinirole 0.25 mg PO 2 h before bedtime can increase by 0.25 mg every 7 d
Shortness of breath	Evaluate for anemia, other disease-related etiologies (heart failure, lung disease, anxiety)	- Titrate diuretic dose to address volume overload - Fan blowing gentle air across face - Mindfulness, meditation, music/relaxation therapy - Consider opioids if none of the above work (start low dose as needed basis)
Anorexia	- Check BUN, medication-induced constipation - Monitor body mass index, BUN, albumin, and micronutrients	- Ask patient to keep a food diary to track intake - Consult with dietitian - Consider nutritional supplementation
Anxiety/depression	Assess using validated tools (e.g., PHQ-2, PHQ-9, GAD-7)	- Meditation, yoga - Journaling - Regular exercise, as tolerated

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Symptom	Evaluation	Management
		• Refer to mental health • Start sertraline 25 mg daily

GAD-7, Generalized Anxiety Disorder seven-item scale; mg, milligram; NSAID, nonsteroidal anti-inflammatory drug; PHQ, Patient Health Questionnaire; PO, by mouth; PRN, as needed; QHS, every night at bedtime; SNRI, serotonin and norepinephrine reuptake inhibitors; SSRI, selective serotonin reuptake inhibitor.

Table 4.

Psychosocial and spiritual assessment

Aspect	Considerations	Implications
Psychosocial	• Loss of function can result in loss of independence and employment, financial strain, emotional distress, and social isolation • Increased caregiving needs can lead to change in roles between patient and care partner; emotional distress, and effect on care partner's life	• Regularly assess psychosocial effect: • "Kidney failure brings about many life changes. How are you coping?" • "How has illness affected the way you live your life?" • Refer to social work and mental health as needed
Spiritual	• Illness can disrupt life plans and injure sense of self, leading to loss of hope, goals, and purpose • Beliefs may influence coping strategies, care preferences, perception of illness, and engagement with health care • Spiritual leaders or teachings can weigh heavily on treatment planning, especially near the end of life	• Routinely assess spiritual needs: • "Does religion or spirituality play a role in how you cope with illness?" • "What brings meaning to your life and helps you in difficult situations?" • Respect and incorporate patient's spiritual practice • Refer to chaplaincy or spiritual care, as needed

Table 5.

Crisis planning

Steps	Example: Dyspnea and Air Hunger	
Education about early signs and symptoms	Weight gain, worsening orthopnea, worsening peripheral edema, new wheezing, and wet cough	
Provide tools to de-escalate	Fan or gentle breeze on face, tripod breathing, increase home diuretic dose, and opioids	
Give instructions on how to seek help	Contact name and phone number of relevant health professionals	
Signposting	If on maximal doses of diuretics, it signals disease progression and near end of life, appropriate for hospice referral	

Table 6.
Considerations for implementation of conservative management

Domain	Considerations
Logistical	• Clinic space • Scheduling support • Integrated primary and specialty care electronic medical records • Telemedicine capabilities • Information technology (IT) support • Established referral networks • Convenient transportation
Staffing/personnel	• Relevant expertise and education/training • Time and effort • On-call and after-hours support • Efficient hiring and onboarding practices • Professional and administrative buy-in • Practice champions • Attitudes and beliefs toward conservative management versus dialysis • Continuing educational and enrichment opportunities
Financial	• Personnel costs • Space and facility costs • Server and data storage costs • Incentive structures • Insurance coverage and reimbursement

Table 7.

Summary of core and enhanced action items for nephrology practice

Conservative Management Domains	Core Items (Recommended for All Practices)	Enhanced Items (As Resources Allow)
Patient identification	- Older adults with kidney failure, high comorbidity burden and frailty - Patients with limited life expectancy - Patients who express a preference to avoid dialysis and value quality over longevity	Use risk prediction and prognostic tools (Supplemental Table 2)
Making the choice about conservative management	- Present conservative management to all patients to support informed decision-making about kidney failure - Engage in deeper discussion of conservative management with patients for whom this option may offer comparable or superior outcomes to dialysis - Explain conservative management as an active treatment pathway - Explore illness understanding and share prognosis - Document decision for conservative management in medical record and communicate decision to other care teams	- Offer patient decision aids (Supplemental Table 1) - Create medical record alerts and flags to indicate decision for conservative management
Engaging care partners	- Include them in decision-making and treatment planning - Invite them to medical appointments - Establish a means and cadence of regular communication to exchange information on patient's condition	Consult palliative care or ethics with complex decision-making
SDM (Table 3)	- Elicit and document patient's values, goals, and treatment preferences - Engage care partners in decisions - Revisit values, goals, and preferences over time - Engage patient's other care teams to support decision-making	- Use communication tools and skills training to enhance discussions (Supplemental Table 1) - Engage specialty palliative care and ethics consultation for complex decision-making - Create designated areas in medical record to facilitate documentation and identification of patient's values, goals, and preferences
Interdisciplinary collaboration (Figure 2)	- Copy progress notes to other care teams - Update other care teams using email and messaging services - Partner with primary care to bridge patient to allied health professionals	- Assemble kidney care team to assist conservative management delivery - Embed allied health professionals into practice - Synchronous, collaborative review of patient case with other care teams - Multispecialty clinical visits
Customized CKD care (Figure 1; Supplemental Table 3)	- Monitor vitals and laboratory values with focus on slowing CKD progression and mitigating complications - Adapt or liberalize biometric targets (e.g., BP <150/90 mm Hg) to align treatment with patient's personal goals and to minimize treatment burden and side effects - Allow for flexibility based on illness trajectory and patient's needs - Offer nutritional counseling (Supplemental Table 5) - Consider geriatric syndromes in treatment approach (Table 2)	- Use geriatric assessment tools (Supplemental Table 4) - Offer home and telehealth visits to improve access to care
Symptom management (Table 3)	- Routine assessment of common symptoms (pain, dyspnea, pruritus, fatigue, and nausea) - Screening for psychosocial and spiritual concerns - Symptom-directed medication adjustments - Address multicultural considerations (Box 1) - Referral to allied health professionals	Use of validated symptom scales (Supplemental Table 6)
Transition navigation	- Crisis planning for hospitalization, clinical decline, and end-of-life care (Table 5) - Complete advance directive, durable power of attorney, and portable medical orders - Discuss and offer referral to hospice	Provide after-hours services to manage potential illness crisis

SDM, shared decision-making.