Providing Supportive Care: Tools & Resources for the Journey

December 11, 2018

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Center for Aging, Health & Humanities
George Washington University
Learning Objectives

After completing this course, the learner will be able to:

- Identify at least one tool for implementing each of these aspects of supportive kidney care:
  - Identifying seriously ill patients
  - Communicating about prognosis and serious illness
  - Advance care planning
  - Symptom assessment and management
  - Decision aids for medical management without dialysis
- Locate at least one comprehensive framework for integrating supportive kidney care, including medical management without dialysis, into practice
- Choose a new tool or practice to pilot in his/her setting
The rationale and evidence for primary supportive care in nephrology:

- ~20% of patients with kidney disease are seriously ill
- Many patients do not realize they had a choice; regret decision to start dialysis
- No medical management without dialysis pathway in U.S. kidney care
- Palliative care rarely utilized to identify goals and optimize patients’ QOL
- Many patients’ symptoms underdiagnosed and undertreated
- More patients with poor prognosis started on dialysis than in other countries
- High hospital death rate with intensive treatments
- Hospice utilization is low
This Session – Tools and Resources

- An elephant orchestra!
  - What are the tools and instruments?
Table 9 | Recommendations for supportive care in CKD populations

1. Primary supportive care should be available to all patients with advanced CKD and their families throughout the entire course of their illness. Provision of supportive care should be based on need rather than solely an estimation of survival. To optimally deliver primary supportive care, multiprofessional renal teams should do the following:
   (a) Identify those patients who are most likely to benefit from supportive care interventions.
   (b) Assess and manage symptoms effectively.
   (c) Estimate and communicate prognosis (survival and future illness trajectory) to the best of their ability.
   (d) Develop appropriate goals of care that address individual patients’ preferences, goals, and values.
   (e) Possess knowledge of, and experience with, available local supportive care services, and be aware of when and how to refer.
   (f) Assist with care coordination including referral to specialist supportive care and hospice service as available and appropriate.
Implementing Supportive Care in Your Practice

1. Identify patients who are seriously ill and likely to have supportive care needs
2. Elicit patients goals and values
   - For current care: shared decision making
   - For future care: advance care planning
3. Manage symptoms, including psychosocial and spiritual needs
4. Provide option of medical management without dialysis
5. Plan for and manage care transitions and end-of-life care
Identifying “Seriously Ill” Patients
Definition of “Serious Illness”

- High risk of death over the course of a year
  AND
- Strong negative impact on one’s QOL and functioning
  OR
- Is highly burdensome to a person and his or her family

Audience Response Question

- How do you identify “seriously ill” patients in your dialysis center or practice?
  
  A. Do not explicitly identify seriously ill patients.
  
  B. Do not explicitly identify them AND do not think it would be helpful to single them out. Might even be harmful to patient if they knew we thought they were at risk.
  
  C. Case by case - each practitioner informally knows who needs extra support or is at increased risk.
  
  D. Use a systematic approach – keep a list, everyone on team knows who needs extra support.
  
  E. Use “surprise question” as part of systematic approach.
Identifying Seriously Patients

- Why identify these patients?
  - Likely to have supportive care needs
  - Extra layer of support to “catch” patients when end-of-life cascade begins
“Surprise Question”

- The “surprise question” — “Would I be surprised if this patient died in the next six months? In the next year?”
  - Nephrologists, NPs, experienced nurses
  - “No, I would not be surprised” - that patient 3.5x more likely to die in next year

- “Has been found to be the single best predictor of early mortality in patients with chronic kidney disease and end-stage renal disease.”
“Surprise Question” PLUS – Integrated Prognostic Models

- **CKD**: 6- and 12-month prognosis
  
  [Link](https://qxmd.com/calculate/calculator_446/Predicting-12-Month-Mortality-in-CKD-patients)


- **Dialysis patients**: 6-, 12-, and 18-month prognosis
  
  [Link](http://touchcalc.com/calculators/sq)

Predicting 6 and 12 Month Mortality in CKD patients

Estimate mortality in patients with stage IV or V chronic kidney disease.

Would I be surprised if this patient died in the next 6 months?
- Yes
- No

Would I be surprised if this patient died in the next 12 months?
- Yes
- No

Age at office visit?
- 90 Years

Karnofsky Performance Scale Index (KPSI)
- KPS 0 = Normal activity with some symptoms OK better
- KPS 1 = Can’t work; needs help and frequent medical care
- KPS 2 = Disabled; requires special care and assistance, or worse

Results

| Estimated 6-Month Mortality | 28.7% |
| Estimated 12-Month Mortality | 41.4% |

Discrimination:
Area Under the Curve - ROC statistics:
0.78 for 12-month model
0.80 for 6-month model.
## Dialysis Patient Prognosis:

**HD MORTALITY PREDICTOR**

Programmed by Stephen Z. Fadem, M.D., FASN and Joseph Fadem

**DOWNLOAD IPHONE APP**

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SERUM ALBUMIN</strong></td>
<td>3.5 g/dL</td>
</tr>
</tbody>
</table>

**SURPRISE QUESTION**

- I would NOT be surprised if my patient died in the next 6 months.
- I would be surprised if my patient died in the next 6 months.

**AGE** 65 years

**DEMENTIA**

- My patient HAS dementia.
- My patient does NOT have dementia.

**PERIPHERAL VASCULAR DISEASE**

- My patient HAS peripheral vascular disease.
- My patient does NOT have peripheral vascular disease.

XBETA: -154.59

Predicted Six Month Survival: 89%

Predicted Twelve Month Survival: 74%

Predicted Eighteen Month Survival: 60%
Eliciting Patient Goals and Values
Audience Response Question

In your practice, what is the main obstacle to discussing prognosis with patients?

A. No real obstacles. We do this all the time and most of our patients have all of the prognostic information they want.

B. Time. We are too busy. Simply don’t have time for long conversations.

C. Communication skill. Not quite sure how to bring this up, how to phrase it, how to deal with patient responses.

How to Share Prognostic Information

Ask-tell-ask approach

Ask: What does patient know? Want to know?
Tell: Frame as “hope...worry” statement
Ask: Pause, allow silence, time for emotion, integration

https://eprognosis.ucsf.edu/communication/video-ask-tell-ask.php
Serious Illness Conversations in ESRD

Mandel EI, Bernacki RE, Block SD. Special Feature Serious Illness Conversations in ESRD. 2016:1-10. doi:10.2215/CJN.05760516
# Serious Illness Conversation Guide

## Conversation Flow

<table>
<thead>
<tr>
<th>Step</th>
<th>Patient-Tested Language</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Set up the conversation</td>
<td>“I’d like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want — is this okay?”</td>
</tr>
<tr>
<td>2. Assess understanding and preferences</td>
<td>“What is your understanding now of where you are with your illness?”  “How much information about what is likely to be ahead with your illness would you like from me?”</td>
</tr>
<tr>
<td>3. Share prognosis</td>
<td>“I want to share with you my understanding of where things are with your illness...”  <em>Uncertain:</em> “It can be difficult to predict what will happen with your illness. I hope you will continue to live well for a long time but I’m worried that you could get sick quickly, and I think it is important to prepare for that possibility.”  OR  <em>Time:</em> “I wish we were not in this situation, but I am worried that time may be as short as ___ (express as a range, e.g. days to weeks, weeks to months, months to a year).”  OR  <em>Function:</em> “I hope that this is not the case, but I’m worried that this may be as strong as you will feel, and things are likely to get more difficult.”</td>
</tr>
</tbody>
</table>
### Serious Illness Conversation Guide

#### CONVERSATION FLOW

4. **Explore key topics**
   - Goals
   - Fears and worries
   - Sources of strength
   - Critical abilities
   - Tradeoffs
   - Family

   **Patient-Tested Language**
   - “What are your most important goals if your health situation worsens?”
   - “What are your biggest fears and worries about the future with your health?”
   - “What gives you strength as you think about the future with your illness?”
   - “What abilities are so critical to your life that you can’t imagine living without them?”
   - “If you become sicker, how much are you willing to go through for the possibility of gaining more time?”
   - “How much does your family know about your priorities and wishes?”

5. **Close the conversation**
   - Summarize
   - Make a recommendation
   - Check in with patient
   - Affirm commitment

   **Patient-Tested Language**
   - “I’ve heard you say that ____ is really important to you. Keeping that in mind, and what we know about your illness, I **recommend** that we _____. This will help us make sure that your treatment plans reflect what’s important to you.”
   - “How does this plan seem to you?”
   - “I will do everything I can to help you through this.”

6. **Document your conversation**

7. **Communicate with key clinicians**

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[https://www.talkaboutwhatmatters.org/documents/Providers/PSJH-Serious-Illness-Conversation-Guide.pdf](https://www.talkaboutwhatmatters.org/documents/Providers/PSJH-Serious-Illness-Conversation-Guide.pdf)
Another Approach:

Best Case/Worst Case Decision Aid for Dialysis vs Medical Management

Best Case
- Tired but some good days in between
- Over time more complications
- Live 1-3 years

Most Likely
- Sleep on HD days
- Health declines
- More hospitalizations
- Live ~1 year

Worst Case
- Rough going
- Complications, hospital time
- Health declines quickly
- Time is short

Dialysis & palliative care

No dialysis & palliative care

Best Case
- Medicines/diet
- Regular office visits
- Health declines slowly
- Symptoms worsen
- Live 1-2 years

Most Likely
- Short of breath, some good days
- Few hospital stays
- Live 3-9 months

Worst Case
- More tired uncomfortable
- Go to hospital
- Time is short

Palliative care to control symptoms and quality of life concerns

Time to Recast Our Approach for Older Patients With ESRD: The Best, the Worst, and the Most Likely
Vanessa Grubbs. AJKD 2018;71(5):605-607
Advance Care Planning for CKD patients

Staff guide

Patient Guide

A Guide for People with Chronic KIDNEY DISEASE
– Normalize ACP – everyone should have a plan!
– 5-step approach
– Motivational interviewing technique, readiness to change
– Elicit patient values & preferences, not a list of do/don’t of specific interventions
– NOT the same as decision-making about dialysis or no, or preferred form of dialysis

MY WAY Material Available on CSCKP Website

Patient brochure
https://www.kidneysupportivecare.org/Files/ACPforCKDbrochure4302018Web.aspx

Staff guide
Assessing And Managing Symptoms
Audience Response Question

- How do you assess symptoms?
  
  A. Each practitioner does own assessment during exam as needed.
  
  B. All practitioners use a validated symptom assessment but administer it themselves.
  
  C. Standard symptom assessment form (paper) presented to patient at check-in every visit.
  
  D. Electronic tablet used for standard symptom assessment every visit.
Under treatment of Symptoms

Renal Provider Recognition of Symptoms in Patients on Maintenance Hemodialysis

“We renal providers are largely unaware of the presence and severity of symptoms in patients who are on maintenance hemodialysis. Implementation of a standardized symptom assessment process may improve provider recognition of symptoms and promote use of symptom-alleviating treatments.”

Weisbord SD. CJASN 2007
# Quick Resource Links

## Symptom Assessment

<table>
<thead>
<tr>
<th>Resource</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESAS-renal validated symptom assessment tool in ESRD</td>
<td><a href="http://www.palliative.org/assets/ESAS-r_Renal_RLS%2020171010.pdf">http://www.palliative.org/assets/ESAS-r_Renal_RLS%2020171010.pdf</a></td>
</tr>
</tbody>
</table>

## Symptom Management

<table>
<thead>
<tr>
<th>Resource</th>
<th>Link</th>
</tr>
</thead>
</table>
Future webinars devoted entirely to pain and symptom assessment and management!!
Decision Tools for Medical Management without Dialysis
Audience Response Question

- How do you discuss the option of medical management without dialysis?
  
  A. N/A – I work at a dialysis center. All our patients already on dialysis.
  
  B. Rarely discussed. If discussed, described as “no care” or “not doing dialysis.”
  
  C. Discussed with selected patients who may be high risk with dialysis (many co-morbidities, frail patients).
  
  D. Routinely presented as an available option. When discussed, described as active care.
## Nephrologist Attitudes toward Medical Management without Dialysis

**N**=35

CM=conservative management

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### Box 1. Factors Associated With Nephrologists’ Decisions to Discuss Conservative Management

#### CM Discussions Routinely Included in Care Conversations
- Perceive role to discuss CM with all patients and present CM neutrally
- Proactive engagement in end-of-life conversations
- Patients engaged in decision making
- Communication with family members
- Strong institutional support
- Some patient engagement
- Limited institutional support
- Concern over variation in approaches to CM within nephrology team
- Focus discussion on active options like dialysis modalities (perceiving CM as no care)

#### CM Discussions Included Only When Triggered
- Perceive role to present dialysis first, not to present CM neutrally
- CM presented as last resort
- Circumventing CM discussions by tailoring and restricting information to few patients (based on age, comorbid conditions, quality of life)
- Patient engagement in decision making
- Limited institutional support
- Concern over variation in approaches to CM within nephrology team
- Focus discussion on active options like dialysis modalities (perceiving CM as no care)

#### CM Discussions Not Integrated in Usual Care
- Rarely discuss CM
- CM not presented neutrally
- Focus on active treatment
- Limited patient engagement in decision making
- Lack of uniform approach to CM conversations among nephrology team
- Confronting institutional barriers

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Patient-Centered
Why Patients May Value CCC* over Dialysis

- Freedom to travel, not being tied down to a schedule
- Willing to tradeoff longer survival for independence
- Quality of life
- Lower symptom burden
- Hospital-free days
- Less impact on caregivers-do not want to be a burden

*comprehensive conservative care=medical management without dialysis

Is Dialysis Right for Me?

Introduction

Patient Decision Aid

As your kidney function declines, one of your biggest choices is whether to get dialysis or conservative kidney management (CKM).

Dialysis is not for everyone. Dialysis can't cure kidney failure, but it may help you live longer and feel better. The older and sicker you are, the less likely it is that dialysis will help you. Some people will live as long and feel better with CKM, which does not include dialysis.

It's your choice whether to have CKM or dialysis.

This tool is to help you decide if CKM or dialysis is right for you. You can use it to talk with your healthcare team and loved ones about your decision.

It should take 15 to 25 minutes to complete. You can come back to it, or share it with someone you trust by using the email button or printing your responses. How you respond is anonymous and confidential.

“The Patient Decision Aid helped make sure that he knew the decision he was making, why he was making it, and using the right sort of values for what he was choosing.”

- Family Member

http://ckmcare.com/Resources/Details/pda#Introduction
Patient Decision Aid - Survey

2. Do you suffer from dementia or cognitive impairment?
   - Yes
   - No

3. How old are you?
   - Under 60 years old
   - 60-69 years old
   - 70-79 years old
   - 80 Years or older

4. Are you suffering from other chronic diseases or conditions?
   - Few other health problems
   - Heart disease
   - Many other health problems (with or without heart disease)

5. How would you describe your health this week?
   - I am able to care for most of my own needs but I might need occasional assistance
   - I need quite a bit of assistance and I might need frequent medical care.
   - I spend much of my time in bed or lying down.

The more health problems you have, the less likely it is that dialysis will lengthen your life. When you consider how time-consuming dialysis is — each treatment can take the better part of a day, three days a week — dialysis could take up much of the time you have remaining.

Note: most of this information comes from patients 70 years or older

Older than 70 years
Low kidney function (GFR less than 15) but not at the point of needing dialysis

LIFE EXPECTANCY

Conservative Kidney Management
With heart disease
About 55% will live 1 year

Dialysis
About 70% will live 1 year

Conservative Kidney Management
With few other health problems
About 75% will live 1 year

Dialysis
About 95% will live 1 year

http://ckmcare.com/Resources/Details/pda#Survey
### My Treatment Options

Here is a summary of your treatment options. Your doctor and other health care providers suggest treatment. However, you are free to discuss the possible benefits and risks of each, and make a decision about the type of treatment you would like to pursue. Each option is briefly described below:

#### How does this treatment work?

**Conservative Kidney Management (CKM)**

- No dialysis or transplant

CKM is a treatment option that helps in managing kidney failure.

- Treating symptoms
- Preventing or reducing problems.
- Protecting remaining kidney function.
- Psychosocial care
- Helping plan for your future needs.

CKM does **NOT** include a dialysis prescription, which does include all of the above options as well as in-center dialysis care. The goal of CKM is to provide the best possible care for you and your family. If you are planning to receive dialysis, you should make sure you understand the potential benefits and risks. For information about CKM click [here](#).

#### Can I change from one treatment to another?

You can change your mind about your treatment options at any time.

### My Prognosis

How long you live and how you will feel is based on your age and overall health as indicated on the survey:

<table>
<thead>
<tr>
<th></th>
<th><strong>Conservative Kidney Management (CKM)</strong></th>
<th>No dialysis or transplant</th>
<th><strong>Dialysis</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality of Life</strong></td>
<td>Quality of life is anticipated to remain stable until the last 1-2 months of life. At that time you are likely to feel more weak and may lose interest in the details of daily life.</td>
<td></td>
<td>Dialysis is <strong>NOT</strong> likely to make you feel better. The side effects and burden of dialysis may even lower your quality of life.</td>
</tr>
<tr>
<td><strong>Symptoms</strong></td>
<td>Symptoms are common with kidney failure. The severity of symptoms tend to remain stable with CKM until the last month of life when they may increase. These symptoms can be treated and aggressive symptom management will be a part of your CKM care.</td>
<td></td>
<td>Symptoms are common with kidney failure. The severity of symptoms will likely <strong>NOT</strong> improve with dialysis. The dialysis procedure may cause or worsen some symptoms such as muscle cramping and fatigue.</td>
</tr>
<tr>
<td><strong>Function</strong></td>
<td>Level of physical and mental function will either remain stable or continue on its natural progressive course until the last weeks or days of life when you will likely feel more weak and may feel confused.</td>
<td></td>
<td>Patients with poor physical and mental function are unlikely to do well on dialysis. Most people will progressively lose physical and mental function after starting dialysis. It is felt that dialysis may speed up this process.</td>
</tr>
<tr>
<td><strong>Survival</strong></td>
<td>Your life span will likely be the same with CKM as with dialysis. About 55% will live 1 year*</td>
<td></td>
<td>Dialysis is unlikely to keep you alive much longer than if you had CKM, especially if you have dementia. Estimated probability of dying after starting dialysis: Within 6 months: 47%**</td>
</tr>
</tbody>
</table>

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* Data from people older than 70 years, with low kidney function (GFR less than 15) but not at the point of needing dialysis.

** Note: calculated from nearly 70,000 kidney failure patients age 67 *
Frameworks for Supportive Kidney Care, Including End-of-Life Care
### Table. Intensity of Care During the Final Month of Life

<table>
<thead>
<tr>
<th>Intensity of Care</th>
<th>Medicare Beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dialysis (Present Study)</td>
</tr>
<tr>
<td>Hospitalization, %</td>
<td>76.0</td>
</tr>
<tr>
<td>Days hospitalized, mean</td>
<td>9.8</td>
</tr>
<tr>
<td>Intensive care unit admission, %</td>
<td>48.9</td>
</tr>
<tr>
<td>Days in an intensive care unit, mean</td>
<td>3.5</td>
</tr>
<tr>
<td>Any intensive procedure, %</td>
<td>29.0</td>
</tr>
<tr>
<td>Hospice use, %</td>
<td>20.0</td>
</tr>
<tr>
<td>Death in a hospital, %</td>
<td>44.8</td>
</tr>
</tbody>
</table>

Abbreviation: NA, not available.
Executive summary of the KDIGO Controversies Conference on Supportive Care in Chronic Kidney Disease: developing a roadmap to improving quality care

### Table 8 | Conservative care recommendations

- Comprehensive conservative care should be provided as a viable, quality treatment option for patients who are unlikely to benefit from dialysis.

- A multiprofessional team should ideally deliver comprehensive conservative care. Composition will likely vary between and within countries, potentially including the following: (1) nephrologist/nurse/psychosocial worker/counselor or psychologist/dietician/allied health professionals/chaplain; (2) family doctors/community staff/health-care volunteers; and (3) integration and/or liaison with specialist supportive care, according to country and region.

- Additional training or expertise in comprehensive conservative care is recommended, and this care should be accessible across settings (e.g., home, hospital, hospice, and nursing homes).

- Further research into conservative care is a priority for the international nephrology community. Research priorities include the following:
  1. Develop international consensus on the terminology and definitions of comprehensive conservative care to promote shared understanding and consistent clinical practice, research, and policy.
  2. Determine the illness trajectory for those managed conservatively and how this compares and contrasts with those managed with dialysis.
  3. Study the HRQL, symptoms, functional status, illness, and care experiences including family experiences, hospitalizations, survival, and quality of dying of patients treated with comprehensive conservative care.
  4. Determine effective and cost-effective models for the provision of comprehensive conservative care across diverse health systems.

*Abbreviation: HRQL, health-related quality of life.*
Plan

Step 1
Choosing CKM
If your patient requires support, consider using the Patient Decision Aid

Step 2
Initiate Care Planning
• Care Plan
• Engage Primary Care

Manage

Step 3
CKM Care
Clinical Assessments
• Symptom Management
• CKD Management
Advance Care Plan
Establish Community Support & Referrals
Crisis Management Plan
End of Life Plan
Update CKM Care Plan

Support

Step 4
Grief & Loss

http://ckmcare.com/PractitionerPathway/AtAGlance
British Columbia Pathway

Appendix 3: Alignment of the Phases of KCC Care with the Phases in BC’s Palliative Care Guideline & End-of-Life Module for Primary Care Physicians

CONSERVATIVE MANAGEMENT PATHWAY FOR ADVANCED CHRONIC KIDNEY DISEASE IN BC

<table>
<thead>
<tr>
<th>All CKD patients</th>
<th>CKD patients on a conservative pathway</th>
</tr>
</thead>
<tbody>
<tr>
<td>eGFR &gt; 25</td>
<td>eGFR 25-15</td>
</tr>
<tr>
<td>eGFR &lt; 15</td>
<td>eGFR &lt; 15 and declining</td>
</tr>
</tbody>
</table>

**CKD Care**
- KCC Phase 1a: active KCC care
- KCC Phase 1b: modality selection
- KCC Phase 1c: supportive ongoing care
- KCC Phase 2: decompression prognosis < 8 mos
- KCC Phase 3: ↑ symptoms prognosis < 1 mo
- KCC Phase 4: decline/last days
- KCC Phase 5: death & bereavement

**Primary Care**
- PCP EOL Module: Transition 1: disease advancement
- PCP EOL Module: Transition 2: decompression Palliative Performance Scale 50% prognosis < 8 mos
- PCP EOL Module: Transition 3: EOL care planning
- PCP EOL Module: Transition 4: decline/last days
- PCP EOL Module: Transition 5: death & bereavement

**GPAC Guideline Part 1**: Approach to Care
- GPAC Guideline Part 2**: Pain + Symptom Management
- GPAC Guideline Part 3**: Grief & Bereavement

*GPAC Guideline on Palliative Care for the Patient with Incurable Cancer or Advanced Disease

CKD = Chronic Kidney Disease
KCC = Kidney Care Clinic
GPSC = General Practice Services Committee
PCP = Practice Support Program
EOL = End-of-life
# Appendix 1: Staff Reference Tool - CKD Patients on a Conservative Care Pathway

This Staff Reference Tool is intended to provide KCC staff with an overview of the phases of KCC care and the major activities at each phase. See Appendix 2 for additional detail and relevant resources.

<table>
<thead>
<tr>
<th>CKD Patients on a Conservative Care Pathway (CKD Stage 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>eGFR</strong></td>
</tr>
<tr>
<td><strong>KCC Phase</strong></td>
</tr>
<tr>
<td><strong>Description</strong></td>
</tr>
<tr>
<td>PCP Communication</td>
</tr>
<tr>
<td>Advance Care Planning</td>
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<tr>
<td>Goals of Care</td>
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Take-Home Messages

- Supportive kidney care is growing around the world. Many new tools are being developed for
  - Prognostication, communication, shared-decision making, advance care planning, symptom assessment and management, end-of-life coordination

- Pick ONE tool or practice that seems to fit your setting. Invite one colleague to try it with you as a pilot for a week. See what you learn. Adjust and repeat.

- It takes time to form an elephant orchestra. But you have to start by giving the elephant an instrument to play.
Up Next in Our Webinar Series…

“Navigating the Landscape: Decision Making & Palliative Care for the Older CKD Patient” with Vanessa Grubbs, MD

January 24, 2019, 12:00 noon ET
Tell us what you think! Please **complete our evaluation** before you go!
Join the Coalition!

804.320.0004

csckp@nw5.esrd.net

www.kidneysupportivecare.org

@kidneycoalition