

Shared Decision-Making in Advanced CKD

**Recommendations and Practical Tips
for the Primary Care Provider from
2025 VA-DOD CKD CPG**





Objective:

To support clinicians in conducting shared decision-making (SDM) conversations with patients who have advanced Chronic Kidney Disease (CKD), focusing on the selection between Kidney Replacement Therapy (KRT) and Conservative Kidney Management. This tool is intended to help clinicians ensure that treatment pathways align with each patient's individual goals, preferences, and life context.



Clinical Context:

Patients with CKD stage 4 or 5 with low-functional status or high co-occurring conditions face challenging decisions regarding how to manage kidney failure. Life expectancy, symptom burden and patient values must be considered.



Two primary treatment pathways exist:

- **Kidney Replacement Therapy (KRT):** Approach aims to replace lost kidney function and includes options, such as hemodialysis, peritoneal dialysis, and kidney transplantation. KRT may come with substantial physical, emotional, logistical, and financial burdens.
- **Conservative Kidney Management:** A proactive, non-dialytic care model that emphasizes quality of life and symptom relief. Conservative management is not synonymous with the absence of treatment — it is an active management strategy that avoids the burdens of dialysis when KRT is unlikely to offer meaningful benefit.

Given the complexity and personal nature of these decisions, early and structured SDM conversations are crucial. These discussions should begin well before the need for dialysis arises and include input from family or care partners when appropriate.



Effective SDM ensures that:

- Patients understand the risks, benefits, and realities of each treatment option
- Clinical recommendations are tailored to the patient's medical condition and goals
- Documentation supports continuity and coordination of care

This tool distills relevant guidance from the 2025 VA/DOD CKD Clinical Practice Guideline to help clinicians lead these conversations with clarity and compassion.

CPG-Based Recommendations

Use Shared Decision Making

Recommendation 8: We suggest utilizing shared decision-making regarding kidney replacement therapy versus conservative management.

- Begin SDM discussions well in advance to allow time for patient reflection, information gathering, and family input.
- Normalize these conversations as a routine part of CKD care, not solely end-of-life planning.
- Consider using risk prediction models, decision aids and communication tools to support discussions.
- Use simple terminology and lay language.
- Plan for repeated discussions and inclusion of family or caregivers to ensure informed decision-making especially for patients with limited health literacy or cognitive impairment.

Early Referral for Preparation for Either Conservative Management or Dialysis

Recommendation 9: We suggest that patients with high co-occurring conditions or low functional status be referred to nephrology with sufficient time for comprehensive preparation for conservative management or dialysis, depending on patient values and preferences.

Recommendation 10: In patients with high co-occurring conditions/low functional status approaching the need for dialysis, there is insufficient evidence to recommend for or against dialysis to improve quality of life.

KRT prolongs life but is associated with complications, hospitalizations and interventions. The increased life expectancy diminishes with advancing age, increasing medical complexity, and decreasing functional status. Thus, the survival associated with dialysis may not outweigh the burden of therapy in older patients and may impact lifestyle and quality of life.

Conservative Kidney Management is a structured, patient-centered approach that includes:

- Active symptom control (e.g., edema, fatigue, pruritus, nausea)
- Medication optimization for comfort and safety
- Psychological and spiritual support
- Advance care planning (e.g., code status, place of death)
- Palliative care integration when appropriate

Document the Shared Decision-Making Process

We recommend clear and thorough documentation of the SDM discussion, including:

- Treatment options reviewed and patient comprehension
- Identified goals of care and preferences (e.g., longevity vs. quality of life)
- The chosen treatment pathway and rationale
- Involvement of surrogate decision-makers or family, if applicable

Suggested Documentation:

- EHR SDM templates
- Social work, palliative care, or ethics consultation notes
- Advance directives or Physician Orders for Life-Sustaining Treatment (POLST) forms

Shared Decision-Making Workflow

1. Initiate Early Conversations

- Begin SDM discussions when eGFR falls below 30 mL/min/1.73m² or risk of ESKD calculated by a validated risk prediction model exceeds 40% over 2 years.
- Provide anticipatory guidance about progression, treatment options, and expected course.
- Emphasize that these discussions are not only about end-of-life planning but also living well.



2. Present Treatment Options Clearly

- Use plain language to explain KRT (dialysis or transplant) and Conservative Kidney Management.
- Highlight potential benefits, burdens, and limitations of each option.
- Position Conservative Kidney Management as legitimate, patient-centered option.
- Collaborate with Nephrology for patient education and management.
- Leverage interdisciplinary care team (nutrition, palliative care, etc) if deemed appropriate



3. Explore What Matters Most

- Understand the patient's goals, values, and quality-of-life preferences.
- Ask about functional priorities, lifestyle, and personal definitions of acceptable outcomes.
- Incorporate family or care partner perspectives when appropriate.



4. Deliberate and Decide

- Facilitate two-way dialogue, allowing time for reflection and follow-up.
- Respect decisional autonomy - acknowledge when patients prioritize comfort over life prolongation.
- Assist patients with articulating their goals of care
- Ensure alignment of the care plan with patient goals.



5. Document the Decision-Making Process

- Record goals, preferences, and selected treatment plan in the EHR
- Include details about discussions and tools used.
- Update care plans as patient circumstances or goals evolve.

Comparative Considerations: Kidney Replacement Therapy vs. Conservative Kidney Management

| Category | Kidney Replacement Therapy | Conservative Kidney Management |
|--------------------|---|---|
| Purpose | Replace kidney function with dialysis or transplant | Manage symptoms and maintain quality of life without dialysis |
| Goal of Care | Life prolongation with kidney function replacement | Comfort, symptom relief, and psychosocial support |
| Treatment Modality | Hemodialysis, peritoneal dialysis, or kidney transplant | Non-dialytic management plan, emphasizing comfort and support |
| Burden on Patient | High: frequent interventions, invasive access, hospitalizations | Lower-care coordinated with fewer clinical visits |
| Quality of Life | May prolong life but can limit independence or flexibility | Focuses on preserving function, comfort, and patient-defined goals |
| Patient Autonomy | Shared but bounded by treatment protocols and dialysis requirements | Emphasizes autonomy and choices aligned with personal priorities |
| Symptom Management | Secondary to treatment objectives (e.g. fluid/electrolyte balance) | Primary goal; includes pain, fatigue, nausea, and other symptoms |
| Support Services | May involve dialysis educators, nephrologists, and transplant teams | May involve palliative care, social work, home-based care |
| End-of-Life Focus | Often not integrated early | Integrated into care approach from the start More likely to be referred to palliative care/hospice |

Research Comparing Kidney Replacement Therapy with Conservative Kidney Management

- Meta-analysis that examined survival among elderly patients with ESKD showed that one-year survival was higher in patients choosing dialysis (6 studies, 84.2% dialysis vs. 72.7% supportive care); however, individual studies in the meta-analysis were limited by presence of unadjusted confounders, small sample sizes, and lack of clarity on missing data (**A**).
- Retrospective study evaluated the association between dialysis versus medical (nondialytic, conservative) management on survival at different ages and levels of kidney function in a large, contemporary, national cohort of >70,000 Veterans with advanced CKD (eGFR <30 mL/min per 1.73 m²) (**B**). During the follow-up period, 15% of patients started dialysis and 52% died, and the cumulative incidence of dialysis initiation was lower at older ages. Dialysis initiation at eGFR<6 mL/min per 1.73 m² was associated with a higher median life expectancy of 54, 26, 25, and 17 months for patients 60, 65, 75, and 85 years, respectively. However, the potential gain in life expectancy associated with dialysis was diminished for older patients and at higher eGFRs.
- Retrospective cohort study of 838 ESKD patients aged 65 years or older found a survival benefit of up to three years in the dialysis group (**C**). However, these patients also experienced a 40% increased risk of hospitalization.
- A retrospective cohort study of 14,701 VA patients aged 65 to 84 years with an eGFR below 15 mL/min/1.73 m² found that patients who elected not to pursue dialysis had significantly lower rates of hospital admission, intensive procedures, and death occurring in the hospital (**D**). Patients in the non-dialysis group were more likely to use palliative care and hospice services (38.7% non-dialysis vs. 18.2% dialysis) and had significantly fewer hospital days.
- Target trial emulation in a cohort of 20,440 Veterans aged 65 and older with an eGFR <12 mL/min/1.73m² found that survival was 78 days longer but time at home was shorter by 15 days among those starting dialysis compared to the group continuing medical management (**E**).

(A) Foote C, Kotwal S, Gallagher M, Cass A, Brown M, Jardine M. Survival outcomes of supportive care versus dialysis therapies for elderly patients with end-stage kidney disease: A systematic review and meta-analysis. *Nephrology (Carlton)*. 2016 Mar;21(3):241-53.

(B) Kurella Tamura M, Desai M, Kappahn KI, Thomas IC, Asch SM, Chertow GM. Dialysis versus Medical Management at Different Ages and Levels of Kidney Function in Veterans with Advanced CKD. *J Am Soc Nephrol*. 2018 Aug;29(8):2169-2177.

(C) Tam-Tham H, Quinn RR, Weaver RG, et al. Survival among older adults with kidney failure is better in the first three years with chronic dialysis treatment than not. *Kidney Int*. Sep 2018;94(3):582-588.

(D) Wong SPY, Yu MK, Green PK, Liu CF, Hebert PL, O'Hare AM. End-of-Life Care for Patients With Advanced Kidney Disease in the US Veterans Affairs Health Care System, 2000-2011. *Am J Kidney Dis*. Jul 2018;72(1):42-49

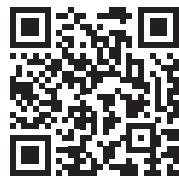
(E) Montez-Rath ME, Thomas IC, Charu V, et al. Effect of Starting Dialysis Versus Continuing Medical Management on Survival and Home Time in Older Adults With Kidney Failure : A Target Trial Emulation Study. *Ann Intern Med*. Sep 2024;177(9):1233-1243.

Resources

See the “A Guide to Conservative Kidney Management - Treating Kidney Disease Without Dialysis”



See the Conservative Kidney Management Website



See the 2025 VA/DOD Clinical Practice Guideline for the Primary Care Management of Chronic Kidney Disease



See the VA eKidney Clinic site

