Predialysis Nephrology Care Improves Dialysis Outcomes: Now What? Or Chapter Two

Thomas A. Golper

Medical Specialties Patient Care Center, Vanderbilt University Medical Center, Nashville, Tennessee


“Knowing is not enough; we must apply. Willing is not enough; we must do.”
—Goethe

Bradbury and associates utilized the Dialysis Outcomes and Practice Patterns Study (DOPPS) database to identify predictors of early mortality among recent US incident hemodialysis patients (1). This editorial addresses the implications of those findings within the context of numerous other observations supporting that notion. This is not a new or contentious position (2). Perhaps a randomized controlled trial might settle the question of the efficacy of predialysis care, but surely we understand that rationale and have wiser ways to use limited resources.

Maybe we are asking the wrong question. Why has progress toward implementing predialysis care been so slow, ineffective, inefficient, and inadequate? The first of the two subtitles of this editorial suggests a cynical “Now what?” We’ve had a pretty clear picture for more than two decades as to what we need to do, but we have failed to implement what we know to be the best practices and to provide the direction as to how to do it. This lack of success is not restricted to the US. Perhaps our systems are so broken and incentives so misaligned that, for all practical purposes, well-demonstrated benefits of predialysis nephrology care are lost.

Or, ever the optimist, are there some potential solutions? We have been attempting to fix this problem for more than 20 years with minimal success. We could continue to take small, ineffective steps, and see no real progress until those of us reading this editorial are long retired. Alternatively, we can attempt bold initiatives that use the available evidence and our experiences to do what needs to be done. The alternative subtitle to this editorial is “Chapter Two,” implying a new start; let’s move on. Let’s figure out a way to make guidelines palatable to nephrologists and others and let’s address the workforce and economic issues that prevent us from providing quality care to our patients.

In 1995, the National Kidney Foundation’s Kidney Disease Outcomes Quality Initiative carried on from the Renal Physiologists Association’s (RPA) effort at clinical practice guideline development. Regardless of their abuse by regulators, such guidelines were intended not to be recipes but rather roadmaps. As roadmaps they provide direction to health care providers, including general primary care physicians, nephrologists, advanced-practice nurses, physician’s assistants, and the other members of nephrology teams (nurses, dieticians, social workers, and technicians).

The problem with existing guidelines is that they are complex, difficult to digest, contained in hundreds of pages, and are sometimes contradictory. Disease management organizations have attempted to align guidelines and delivery systems in an efficient and cost-effective manner, but have made only a little headway. Nonetheless, it is prudent for nephrology associations to pool their resources and to simplify and unify the guidelines so that busy practitioners can effectively apply them to the care of chronic kidney disease (CKD) stage 3 to 5 patients. Nonnephrology physicians are encumbered with guidelines in everything from low back pain to renal osteodystrophy. They see more patients with vascular disease than CKD. How is the busy generalist to digest thousands of pages of guidelines for renal disease management? We must simplify things and make information accessible to family practice and internal medicine trainees. Generalists must receive both training and guidance in the care of CKD patients (3).

Where are the future health care providers for late-stage CKD going to come from? There is no excess capacity in the existing nephrology workforce. In 1990 the RPA hired Phillip R. Kletke to analyze the nephrology workforce situation; this analysis culminated in a 1995 RPA Position Paper (4). Very few of those recommendations have been implemented. Kletke’s report became public in 1997 (5) and still had little impact. The Pew Commission’s report on subspecialty training in the health care workforce advocated more generalists at the expense of subspeciality training (6), a theme considered paramount to the “Clinton health plan.” In anticipation, the Council of American Kidney Societies (CAKS) jointly formed an ad hoc committee to report on the future workforce and training requirements for nephrology (7). Numerous models were created with various assumptions. The committee recommended an expansion of training programs cognizant of the concern about oversupply (and cost) of specialists. By extrapolation, the Bradbury et al. report supports such an enhancement for nephrology care in

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Address correspondence to: Dr. Thomas A. Golper, S-3303 Medical Center North, Vanderbilt University Medical Center, 21st Avenue South, Nashville, TN 37232. Phone: 615-343-2220; Fax: 615-322-8653; E-mail: thomas.golper@vanderbilt.edu

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late-stage kidney disease. Perhaps it is time to revisit the wisdom of the Pew Commission report.

The empirical landscape has changed. The premier nephrology training programs see their mission as training the scholars, teachers, leaders, and role models. Not every training program can or should have such a mission. Training programs ought to train to their strengths and the apparent need. We need more practicing clinicians. The question is how many more and at what expense to basic research training positions?

If we all agree that we exist to take optimal care of patients with CKD, then there needs to be a cohesive plan to address the workforce situation.

One direction for the expansion of the workforce is for postgraduate education of non-physicians (advanced-practice nurses and physician’s assistants.) For these practitioners to succeed in the complex endeavor of providing late-stage CKD care, adequate training must occur. At the moment in the US there is only one advanced-practice nurse training program specifically aimed at nephrology training (Vanderbilt University School of Nursing). The RPA was prescient to organize training conferences in conjunction with the American College of Nurse Practitioners and the American Academy of Physicians Assistants. In my view this is a good starting point. Our major meetings need to have multiday sessions directed toward these practitioners and the National Kidney Foundation Spring Clinical Meetings and the Annual Meeting of the American Society of Nephrology (ASN) must plan accordingly. Some of this is occurring but much more needs to be done and the pace accelerated. It is in everyone’s interest that we pursue this training strategy. Why are these organizations, which should be cooperating, not putting the common goals ahead of their individual agendas? The RPA took the lead in nonphysician training in 1994 with a joint ASN Position Paper on nonphysician personnel delivering nephrology care (8), in the subsequent 2000 Position Paper on effective collaborative practice models (9), and its update in 2007 (workgroup chaired by W. Kline Bolton). Furthermore, again in anticipation of a workforce shortage and need for care by nonphysician practitioners, the RPA developed a Position Paper on the use of clinical care algorithms in the delivery of such care (10). The recommendations of these position papers are paramount to improve the situation.

Beyond the workforce issue is another major barrier: the payment structure of the current US health care system. We have incentives toward overutilization while we ignore preventive health care, despite the Bradbury et al. observations and all of the preceding observations. The Institute of Medicine recently completed its report “Rewarding Provider Performance: Aligning Incentives in Medicare” (11). The Goethe quote at the top of this editorial and its sentiments are borrowed from that report. Several excerpts from that report are quoted below:

“...the overall quality of health care delivered to Americans is worse than it should be. While many quality improvement efforts have been undertaken, their success has been limited by current payment systems. The existing systems do not reflect the relative value of health care services in important aspects of quality, such as clinical quality, patient-centeredness, and efficiency. Nor do current payment systems recognize or reward care coordination, an omission reflected in such shortcomings as the limited focus on prevention and the treatment of chronic conditions as patients move across various care settings. Fundamental changes in approaches to health care payment are necessary to remove impediments to and create incentives for significant quality improvement.” (11)

“Pay for performance is not simply a mechanism to reward those who perform well or to reduce costs. Its purpose is to align payment incentives to encourage ongoing improvement in a way that will ensure high-quality care for all. Pay for performance will not necessarily reduce the cost of care but it will help ensure that what is paid for will be more beneficial.” (12)

“The lack of incentives for comprehensive, coordinated care discourages services targeting early intervention and prevention services that can ultimately reduce the costs of expensive services, such as avoidable hospitalizations. Providers often miss opportunities for collaboration since the (present) payment system rewards neither team management nor the integration of services across care settings.” (13)

This model needs to be closely monitored because it can increase disparities and unintended consequences such as decreased access to care (“cherry picking”) and impediments to innovation (14). I firmly believe a pay for performance model can be a disaster if left to politicians and administrators. We physicians must be the agents and major drivers of change. CKD care coordination is just one of many reasons to pursue alternative payment models toward incentives for prevention. Nephrology practice and the delivery of end-stage renal disease services have certainly been examined and the directions toward and need for innovations are supported and clear. Do we have the capacity to take it to the next step; are we ready for Chapter Two? Do we have the cohesion to advocate and lead change in a very broken health care system for a better future for our patients? It remains to be seen. We can interpret the message in the Bradbury paper many ways (1). Are we arguing for the science, the need for randomized controlled trials, and risk adjustments? Or do we have the courage at last to go after reshaping a health care system to actually address the needs of patients we serve? Are we cynical or optimistic?

Disclosures

None.

References

8. RPA/ASN Position Paper on the Role of Non-physician Medical personnel in Delivering Nephrologic Care, Rockville, April 30, 1994; revised April 21, 1996
9. RPA Position on Development of Effective Collaborative Practice Models for Chronic Renal Care, Rockville, October 29, 2000
10. RPA Position on the Use of Clinical Care Algorithms in the Delivery of Such Care, Rockville, July 18, 2003

See the related article, “Predictors of Early Mortality among Incident US Hemodialysis Patients in the Dialysis Outcomes and Practice Patterns Study,” on pages 89–99.