Frequency of Physician Visits to Patients on In-Center Maintenance Hemodialysis: Does One Strategy Fit All?

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The best way to win an argument is to begin by being right! — Jill Ruckelshaus

In 1996, the Renal Physician Association (RPA) and American Society of Nephrology (ASN) released a position paper on minimal frequency for direct nephrologist-dialysis patient contact. The discussion leading up to the final position was thorough, scholarly (only limited relevant data), opinionated, and occasionally emotional. As the deliberations progressed, a consensus evolved toward recommending more frequent visits. At that point, one physician from a medium-sized town described his lengthy travels to rural dialysis units. It became clear that what was “right” for an urban setting was illogical in other settings. The argument was not going to be settled by one recommendation being right for all situations. Reason prevailed, and hardship circumstances (e.g., patient unwillingness, unfavorable geography, and manpower limitations) were considered (1).

Held et al. (2) first suggested that dialysis unit staffing patterns might influence mortality. McClellan et al. (3) using unit-specific data (rather than patient-specific data) proposed that one or more physician visit per week improved mortality but to a degree less than that observed for increasing Kt/V. This internal reference frame is even more meaningful after the HEMO study. In a preliminary report at the 2002 ASN meeting, the Dialysis Outcomes and Practice Patterns Study (DOPPS) noted that mortality risk was slightly lessened by more frequent physician visits (4). Apparently this DOPPS abstract stimulated Thomas A. Scully, the Administrator of the Centers for Medicine and Medical Services (CMS), to propose a Medicare payment policy revision whereby the monthly capititated payment would be replaced by a fee for service payment based on visit frequency. This proposal bypassed all current methodology for such change as agreed upon by organized medicine and CMS. Consequently, the Medicare Payment Advisory Commission, the American Medical Association, the American Association of Family Physicians, the American College of Physicians, ASN, and RPA sent responses to CMS articulating their concerns related to both process and medical issues. In the midst of this regulatory firestorm, Plantinga et al. (5) actually provide crucial data.

Plantinga et al. utilized the EQUAL/CHOICE database with a questionnaire to medical directors or head nurses used to define each clinic’s customary practice with regard to the frequency of a physician’s visit with a patient during hemodialysis treatments. The type or degree of contact in any other setting was not analyzed, nor were the roles of the non-physician practitioners such as nurse practitioners or physician assistants. Patient survival, hospitalization rate, quality of life, and overall rating of care were not influenced by the frequency of physician visits on dialysis. When physician visits were less frequent, patients were more likely to skip dialysis, have lower Kt/V and hematocrit values, but were more likely to be on the transplant wait-list and censored from the study due to transplantation. The validity and potential extrapolation of these observations are crucial to the definition of what is the appropriate visit frequency.

Extensive individual-level data were analyzed, including the validated Index of Coexistent Disease (ICED), which was time-varied adjusted in the models. Yet more patients in the low frequency visit units were transplant wait-listed and censored for transplantation. Wait-listing for transplant generally is viewed as a surrogate for co-morbidities. Thus, I think that the ICED co-morbidity adjuster is missing something important. It is possible that healthier patients were intentionally sent to units where they would be seen less frequently. That has happened where nephrologists arrange more intense staffing at units where they intentionally send sicker patients. So it is possible that patients are selected to attend certain units. However, it is far more likely that patients were dialyzed in units near their homes and were coincidentally seen less frequently, but did well. These are modern-era data (last follow-up June 2002), and presumably modern practice approaches were being utilized. Yet it is not known whether non-physician practitioners visited the study patients either in addition to or in lieu of the physician visits. The authors and Kline Bolton (6,7) discuss the positive role this could have played. It certainly could skew the interpretation of the results in that the non-physician practitioners have provided a positive influence on the outcome in the low-visit frequency group, but the visit by the non-physician practitioner was not detected or counted in the questionnaire design. In the same manner, it is not clear whether treatment algorithms or standing order protocols were in place, and this is particularly relevant when the patients in the low--
visit frequency units had lower Kt/V and hematocrits, both easily addressed by algorithms.

Both sides of the debate over the “right” frequency of visits have something to claim from Plantinga et al. It certainly appears that the major health outcome measures (mortality, hospitalization, quality of life) are not adversely affected by low frequency of physician visits. I am not yet convinced that this should be extrapolated to all patients in all settings. Despite the ICED adjustment, patients at the lower-visit frequency units were healthier, as defined by transplant waitlisting or transplantation. Perhaps their physicians recognized this and visited them on a need-only basis. Some would label this as efficient. However, the patients at low-visit frequency units had lower Kt/V and hematocrit values, which while not influencing outcome, suggest that not all is right in the delivery of care.

It seems at this point that there is a need for local oversight regarding visit frequency. That local group should be the medical director and governing body of the dialysis facility, the physicians in attendance at the unit, and either the patient or the patient’s representative. For example, the social worker or head nurse at the facility could reflect the patient’s views if the patient is not comfortable doing so. To demand a visit frequency (advocated by CMS using the payment lever) does not guarantee quality of care and carries a tangible risk of reducing access to care. If a patient is dissatisfied with one physician, there are alternatives. Patients transfer from physicians and units frequently. Physicians also have alternatives that include directing sicker patients to units that the physician visits more frequently or using non-physician practitioners (8). While the argument over the proper visit frequency is far from over, there is no winner, because neither side has proven that they are right.

References


See related article, “Frequency of Patient-Physician Contact and Patient Outcomes in Hemodialysis Care,” on pages 210–218.