

# Nephrology Times

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*Practical News, Trends, and Analysis*



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**Emerging Therapies for PKD**  
Please see pages 7 and 9 for information on how research into the pathophysiology of polycystic kidney disease is giving way to therapeutic trials.

## Group Medical Visits Seek to Relieve Physician Burden, Improve Care

By Brande Victorian

At Harvard Vanguard Medical Associates (HVMA), a new approach to physician-patient visits aims to combine quantity with quality.

The approach is shared medical appointments (SMAs), whereby multiple members of the health care team meet with a group of patients, all at once.

These shared medical appointments involve eight to ten patients being seen for a general or follow-up visit, while physical shared medical appointments (PSMAs) include a group of eight patients being seen for a physical exam. Both visit types last 90 minutes.

“We know that there just aren’t enough doctors in this country to provide the sort of care that’s required, and the situation’s only getting worse,” said Zeev Neuwirth, MD, an internist and Vice President for Clinical Effectiveness and Innovation at HVMA, in a phone interview.

“Quite honestly, I don’t know of any other innovation—there is no policy



Physicians at Harvard Vanguard Medical Associates meet with eight to ten patients at the same time, conducting 90-minute group visits for physical exams, or for general or follow-up care.

fix, there is no insurance fix—that is going to be able to fix this problem. The best I’ve seen is shared medical appointments.”

### Expanding the Approach

A year ago, Ed Noffsinger, PhD, who pioneered shared medical appointments

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### • ASN RENAL WEEK 2008 •

## CBT Effectively Treats Depression in ESRD, Randomized Trial Finds

By Michelle Hogan

PHILADELPHIA—In patients on chronic hemodialysis (HD) who have major depression, cognitive-behavioral therapy (CBT) led to a significantly larger reduction in depressive symptoms compared with usual care, concluded a prospective, randomized, controlled trial reported here at the American Society of Nephrology Renal Week 2008.

“Our study suggests that CBT is effective in decreasing depressive symptoms

and improving the quality of life of HD patients,” wrote Ricardo Sesso, MD, who conducted the study with colleagues at the Federal University of São Paulo in São Paulo, Brazil, in an e-mail message.

“Therefore, we believe that it should be considered as an alternative (without adverse effects) to treat depression in these patients.”

### Three Scales Used

Randomized in the study were 90 pa-

tients from two dialysis units at Federal University who were diagnosed with major depression, Dr. Sesso said in his presentation of the study’s results.

The intervention group consisted of 12 weekly, 90-minute-long cognitive-behavioral therapy sessions led by a trained psychologist over three months, followed by a six-month maintenance period of monthly group sessions for reinforcement.

Patients in the control group had the

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## Shared

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in the mid-1990s, joined Atrius Health, the alliance of community-based medical groups of which Harvard Vanguard is a member, to implement these types of visits.



*“Quite honestly, I don’t know of any other innovation—there is no policy fix, there is no insurance fix—that is going to be able to fix this problem. The best I’ve seen is shared medical appointments.”—Zeev Neuwirth, MD*

Since then, HVMA has launched 22 SMAs or PSMAs in internal medicine, geriatrics, obstetrics and gynecology, cardiology, and pediatrics, Dr. Neuwirth said. This year’s goal is to implement an additional 30 programs in other specialties, including nephrology, as well as dermatology, neurology, otolaryngology, and psychiatry.

“From our perspective, we believe that the vast majority of patient visits can take place in a group format, but at this point in time it is really new so we are just going where the interest is—the doctors who are interested, the

patients who are interested,” Dr. Neuwirth said. “Once a patient goes in, the vast majority want to come back for a second one.”

In an in-house survey of 720 patients who participated in a shared medical appointment at Harvard Vanguard between February 25, 2008, and October 31, 2008, 77% of patients said they would schedule another group appointment, and 73% of patients said they felt their provider knew them better and their relationship

had improved as a result of the shared appointment, Dr. Neuwirth said.

### ‘Team Medicine’

A crucial underpinning of the shared medical appointment model is the involvement of multiple members of the health care team in each step of the appointment. “It’s not just that it’s a shared medical appointment; it’s team medicine,” Dr. Neuwirth said.

Before a visit begins, patients sign confidentiality agreements stating that they will not share what is discussed during the visit.

The facilitator writes the names of all the patients in the room on a board, along with their medical problems and lab test results. A nurse or licensed practical nurse (LPN) checks vital signs and gives immunizations.

The physician moves from patient to patient, reviewing each of their data and

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*“By decompressing your census by having these shared medical appointments, then in theory that will open up other places in my schedule where I can hopefully see new patients.”—Bradley M. Denker, MD*

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performing physical exams that do not require disrobing. Physical exams that do require disrobing are delayed until later in the visit and are done privately.

In the physical SMA, patients are taken into an exam room three at a time. The first 45 minutes of the visit are spent doing physical exams.

*These shared medical appointments involve eight to ten patients being seen for a general or follow-up visit, while physical shared medical appointments include a group of eight patients who need physical exams. Both visit types last 90 minutes.*

In both types of group visits, a documenter trained in the electronic medical record system takes notes for the physician, eliminating the time physi-

cians spend on charting, Dr. Neuwirth said.

As the physician and documenter check the notes, the facilitator talks with the group, discussing any issues brought up by the patients.

## Renal Care Pilot

This spring, HVMA plans to launch a pilot shared medical appointment

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program in renal care that will be open to all patients with chronic kidney disease (CKD) who are not on dialysis.

Bradley M. Denker, MD, Chief of Nephrology at Harvard Vanguard and Associate Professor of Medicine at Harvard Medical School, as well as a member of

*“It’s not just that it’s a shared medical appointment; it’s team medicine.”*

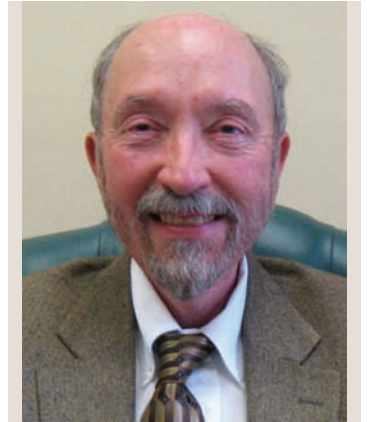
the *Nephrology Times* Editorial Board, has a 500-patient practice and plans to parti-

cipate in the pilot, conducting shared visits with 12 to 14 patients once every week or every other week.

Renal care is suited to shared medical appointments because each CKD patient receives very similar information, Dr. Denker said.

“It may vary a little based on the stage of the patient, but there are so many common issues in terms of anemia management and blood pressure and calcium

and phosphorus, and we talk about this with every patient every time.”



*“For those of us who enjoy relationships with our patients over the years it’s a little unsettling... I think that’s one of the things that would be lost.”—W. Kline Bolton, MD*

Waiting time for a new patient visit or routine follow-up at Dr. Denker’s clinic currently is four months, and this model could shorten that, Dr. Denker said.

“By decompressing your census by having these shared medical appointments, then in theory that will open up other places in my schedule where I can hopefully see new patients.”

## Personal Relationships

Nephrology professionals not involved with shared medical appointments weighed the positives and the negatives of the model in interviews for this article.



*“Most of my patients in nephrology are complex and probably would not be suitable for this kind of interaction because they have so many problems, and it would surprise me if a nephrology patient, unless it was an early CKD patient that’s relatively straightforward, were in this group.”—Jay B. Wish, MD*

“It’s an entirely new concept,” said W. Kline Bolton, MD, Professor of Medicine  
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## Depression

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usual care offered in the dialysis units—a brief individualized psychotherapy session—given at the same frequency as treatment in the intervention group.

The Mini International Neuropsychiatric Interview (MINI), Beck Depression Inventory (BDI), and Kidney Disease Quality of Life–Short Form (KDQOL–SF) were used to assess patients at baseline, three months, and nine months. Included in the three-month assessment were 41 patients in the intervention group and 44 patients in the control group, and 36 patients from the intervention group and 38 from the control group were assessed at nine months.

## Significant Improvement

In the MINI questionnaire, where the higher the score the more severe the depression, scores were significantly lower in the cognitive-behavioral therapy group than in the control group at three months and at nine months: In the CBT group,

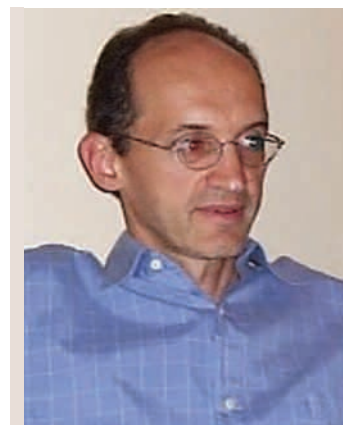
average scores went down from 6.4 at baseline to 1.9 at three months and 2.0 at nine months, while scores in the control group went from 6.4 at baseline to 4.3 at three months and 3.5 at nine months, Dr. Sesso said.

The same pattern was true of the overall Beck Depression Inventory scores, where higher scores also demonstrate more severe depression: Average scores in the intervention group were 24.2 at baseline, 14.1 at three months, and 10.8 at nine months, compared with 27.3 at baseline, 21.2 at three months, and 17.6 at nine months in the control group.

In addition, the cognitive and somatic subscales of the BDI also showed statistically significant differences between the two groups at three months and nine months, as noted in the abstract.

At three months, for example, the average cognitive subscale score in the intervention group was 7.1, and the average somatic subscale score was 7.0, compared with 12.1 and 9.1, respectively, in the control group.

And three-month average scores from the KDQOL–SF, where higher scores indicate better health or quality of life, also



*Further randomized clinical trials of cognitive-behavioral therapy in patients on hemodialysis should be done with larger sample sizes and more participating centers. The treatment also should be compared with antidepressants—and associations between the two studied—and CBT should be evaluated in patients with more severe degrees of depression.—Ricardo Sesso, MD*

showed significant differences between the intervention and control groups: bur-

den of renal disease, 44 versus 27, respectively; overall health, 64 versus 55; quality of social interaction, 81 versus 67; sleep, 68 versus 58; and mental component summary, 47 versus 39. These differences persisted through nine months.

## ‘Stunned by the Results’

Depression is underrecognized, understudied, and undertreated in patients with end-stage renal disease, said Suzanne Watnick, MD, co-moderator of the session during which the study was presented, in a phone interview.

“I along with my co-moderator chose this out of 100-plus different abstracts that were submitted to this category because really it’s so rare that you find a prospective, randomized, controlled trial regarding interventions for depression and applications for end-stage renal disease,” added Dr. Watnick, who is Associate Professor of Medicine at Oregon Health and Science University and Medical Director of Dialysis at the Portland Veterans Affairs Medical Center.

The study was well designed, agreed  
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## Shared

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in the Division of Nephrology at the University of Virginia and a member of the Board of Directors of the Renal Physicians Association.

“I have mixed feelings about it. There are clearly a lot of patients who have very similar problems in terms of dietary issues and blood pressure issues and medication issues, and so we do indeed give the same sort of spiel to each patient.”

In addition, the benefit of greater access to care with shared medical appointments certainly is desirable, but what may be lacking is the ability for physicians and patients to form a bond, Dr. Bolton said.

“For those of us who enjoy relationships with our patients over the years, it’s a little unsettling. I have patients I’ve followed for 20 or 30 years, and I know about their kids going to college and they know about mine, and I think that’s one of the things that would be lost. Maybe that’s less of an issue than being able to have more access.”

## Complex Patients

“Most of my patients in nephrology are complex and probably would not be suitable for this kind of interaction because they have so many problems, and it would surprise me if a nephrology patient, unless it was an early CKD patient



*“Being a nurse and an educator, when I have my classes, we have a social worker, we have a dietician, and it’s so neat how patients maybe don’t pick up what I say, but they pick up what another patient says.”—Roberta Wager, RN, MSN*

that’s relatively straightforward, were in this group,” said Jay B. Wish, MD, Professor of Medicine in the Division of Nephrology at Case Western Reserve University, when asked to comment in a phone interview.

“For advanced CKD patients who need multiple medications and a lot of interventions and lab tests, and one-on-one interpretation regarding those lab tests and interaction regarding their symptoms—and certainly for ESRD [end-stage renal disease] patients—I would be very surprised that this would be workable.

“But it’s a new thing. I’m open-minded, and I would certainly be interested in seeing how this thing plays out. What works for primary care doesn’t necessarily work in a complicated subspecialty-based practice.”

Group visits could be useful for dialysis education, Dr. Wish added.

“For a patient who has late Stage 3 or 4 CKD where part of the agenda is to try to demystify dialysis and get the patient ready and let them know they are not the only person who has experienced this issue and to try to make it less intimidating and have other people in there venting so that it’s sort of a shared anxiety and you can have some of these issues addressed in a group, that would be very efficient.”

## Shared Experience

The different needs of patients in various stages of CKD is a concern, said Roberta Wager, RN, MSN, President of the American Association of Kidney Patients. Overall, though, she said she sees shared visits as a positive thing for patients.

“I have learned more about my problems—side effects and that—from other patients and from my peers,” said Ms. Wager, who is a dialysis patient. “Being a nurse and an educator, when I have my classes we have a social worker, we have a dietician, and it’s so neat how patients maybe don’t pick up what I say, but they pick up what another patient says.” •

## Shared Medical Visits ‘Incredibly Customized and Standardized’

While the concept of a group patient visit may seem simple, conducting a successful shared medical appointment program is actually quite complex, said Zeev Neuwirth, MD, an internist and Vice President for Clinical Effectiveness and Innovation at Harvard Vanguard Medical Associates (HVMA), in a phone interview.

Dr. Neuwirth knows from experience: He attempted to set up group patient visits at academic medical centers twice in the past and failed,

he said, because he didn’t have the operational understanding needed to make it work.

One of Harvard Vanguard’s goals is to create a training program for physicians, academic medical centers, and community health centers on conducting shared medical appointments, providing support to them in the process.

“It is incredibly customized and standardized, and there are lots of training and work flow issues. There are lots of metrics that we’re watching.”