Author's response to reviews

Title: Specialist and Primary Care Physicians' Views on Barriers to Adequate Preparation of Patients for Renal Replacement Therapy: A Qualitative Study

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Author's response to reviews: see over
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Dear Editors,

We are submitting the revised manuscript, entitled “Specialist and Primary Care Physicians' Views on Barriers to Adequate Preparation of Patients for Renal Replacement Therapy: A Qualitative Study” (MS: 1824957840147603) for consideration as an article in *BMC Nephrology*. We greatly appreciate the excellent comments and questions from the reviewers, and believe the requested changes have improved the content and clarity of our manuscript. We have provided a detailed point-by-point response to each of the reviewers’ comments in this letter (below).

Thank you for considering our manuscript for publication in your journal and we look forward to your review of the revised manuscript.

Sincerely,
Raquel C. Greer, MD, MHS
Corresponding author
RESPONSE TO REVIEWERS COMMENTS:

REVIEWER: David Mendelssohn

REVIEWER'S REPORT:

Greer et al submit a qualitative, interview based study of nephrology care providers and primary care physicians. The study sought to determine barriers to adequate preparation for RRT. The results do offer some novel insights into the process, and identify some new research opportunities that could lead to better care pathways.

I am not an expert in qualitative methods or in statistics. I am a clinician who has done lots of academic work in preparation for and transition into ESRD.

1. The Mendelssohn paper (ref 32) should be cited on page 6 line 22, since it clearly shows suboptimal care despite early referral

Author’s response: We have now included the citation for the Mendelssohn paper on page 7 line 6.

2. The study is a very small convenience sample in only 2 centers. I wonder if it should be called a pilot study?

Author’s response: Given the small sample size, we understand the reviewers concern and have included this as a limitation of our study on page 22, paragraph 3, line 17. We conducted the study to identify modifiable patient, provider and system-level barriers providers face to adequately preparing patients for renal replacement therapy that could be targeted for future interventions and believe our findings are reflective of providers’ perspectives of common challenges to RRT preparation across the United States. Since our intention was not assess the feasibility of conducting a larger qualitative study and have no immediate plan to redo the study in a larger sample, we did not feel it was appropriate to refer to it as a pilot study.

3. The authors have missed a critical study that totally supports what they find about the frequency of and importance of patient related delays and how to identify and overcome them. It is S.A. Hughes, J.G. Mendelssohn, S. Tobe, P.A. McFarlane and DC Mendelssohn. Factors Associated with Suboptimal Initiation of Dialysis Despite Early Nephrologist Referral. NDT 28: 392-7; 2013. (doi: 10.1093/ndt/gfs431). This study must be referenced and discussed.

Author’s response: We have now included this important citation to further support the findings of our study on page 19, paragraph 2, line 14.

“These findings are supported by those from a single Canadian study which identified patient-level delays such as patients’ hesitation to receive education or to consider vascular access, and their lack of adherence to nephrologist recommendations to pre-dialysis care as barriers to suboptimal RRT preparation.”
4. I am not sure about BMC nephrology standard formats for manuscripts, and also not sure about how to present qualitative research results. Having said this, there is no discussion section (or the discussion section that begins on page 17 is wrongly labeled conclusion – and another conclusion section begins on page 22)?

Author’s response: We have now correctly labeled the discussion section on page 18, line 6.

5. The Canadian Society of Nephrology has guidelines that inform primary care providers about when to refer patients with CKD. I could cite several documents, but likely only one is required and this one would be the best. Guidelines for the Management of Chronic Kidney Disease. CMAJ 179; 1154-1162: 2008. I am not certain if American organizations have similar guidelines. The CSN guideline might be referenced and any USA based ones too. Note that similar referral guidelines exist in the UK and Australia. Ensuring that primary care providers are made aware of these recommendations is an implementation challenge, but the recommendation itself is a starting point.

Author’s response: We have now referenced clinical practice guidelines regarding the timing of nephrology referral on page 21, paragraph 2, line 11.

“Clinical practice guidelines recommend referral to subspecialty care among patients with advanced (estimated glomerular filtration rate <30 ml/min/1.73 m²) and/or progressive CKD to afford sufficient time to plan and prepare for RRT.39-41 PCPs late referrals, as well as limited patient-physician discussions about CKD prior to the nephrology visit likely stem from numerous factors including their uncertainties about when to refer patients,42,43 visit time constraints, fears of overwhelming patients with news of kidney disease, and their lack of self-efficacy with educating patients about CKD.23”

REVIEWER: Jyoti Baharani

REVIEWER’S REPORT:

In my opinion this is a thoughtful qualitative paper, that is well written. It explores perspectives and viewpoints on health care providers perceptions of what comprises of barriers to the adequate preparation of patients for RRT.

6. As it is based in North America, it remains to stand, that readers not working in that environment may not be well versed with the health-care structure and the premises under which Nephrology is practiced. It would therefore be important for the authors to include information to provide more insight to readers. This should include, referral numbers per annum and size of dialysis population. Numbers of patients commencing
home therapy versus those that start treatment in the hospital. Numbers of unplanned starts, numbers starting on non-permanent access etc. These would be valuable in setting the scene and providing insight to readers.

Author’s response: We have revised the introduction to provide readers with information regarding the size of the dialysis population in the US, as well as the trends in treatment modality and patients’ preparation at initiation (page 6, paragraph 1, line 2):

“Among the approximately 100,000 patients who developed end-stage renal disease (ESRD) in the United States in 2012, the overwhelming majority (89%) initiated renal replacement therapy (RRT) on hemodialysis. Few patients initiated RRT with self-care dialysis (8.3%) or received a preemptive kidney transplant (2.5%). Over half (61%) of patients initiating hemodialysis started treatment with a catheter for vascular access. Low rates of self-care dialysis and suboptimal vascular access at initiation may both be related to patients’ lack of timely preparation for renal replacement therapy (RRT).”

7. Although the authors correctly state that there is little information on this subject in the literature, they should what is known on this topic in other areas of medicine- in particular parallels from other chronic illness such as Diabetes where this sort of work has been done.

Author’s response: We have revised the discussion to include examples from other chronic illnesses when evidence related to RRT was limited:

Page 20, Paragraph 1, Line 2
“Patient navigators have also been employed to help patients make complex medical decisions including pursuit of kidney transplantation, and have been shown to be beneficial in improving patients’ self-management of chronic conditions, including diabetes.”

Page 20, Paragraph 2, Line 21
“Early interventions to improve patient-provider communication to enhance shared and informed decision-making on RRT are being developed, but they have not yet been integrated into routine clinical practice. In other chronic conditions, efforts to increase the implementation of shared decision making and/or motivational interviewing in clinical practice have been shown to improve patients’ self-confidence in approaching changes in treatment management, and to improve patients’ engagement in care, risk factor management, achievement of informed, values-based treatment choices. Programs incorporating shared decision making and motivational interviewing principles to help nephrology providers gain these skills (e.g. during nephrology fellowship training) could substantially improve the degree to which providers feel enabled to help patients better prepare for RRT.”

8. They have perhaps mistakenly headed the discussion as conclusions- this needs to be re-headed.
Author’s response: We have now correctly labeled the discussion section on page 18, line 6.