THE PROVISION AND OUTCOMES OF DIABETIC CARE OF HEMODIALYSIS PATIENTS

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Questions for discussion:
1. Better title?
2. Is it clear which results came from patient interview and which came from physician interview?
3. Are tables/figure clear?
4. Suggestions for other analyses?
5. Points to emphasize in introduction/discussion sections (as yet unwritten)?
6. Limitations?
7. Suggestions for future work? How can we use these findings to improve quality of care?

ABSTRACT

Context: About half of all hemodialysis patients have diabetes mellitus, yet little is known about their diabetic care.

Objective: To examine the provision and outcomes of diabetic care

Design: Cross-sectional survey

Setting: Nine chronic hemodialysis facilities in northeast Ohio

Participants: One hundred eighty-eight randomly selected diabetic hemodialysis patients. Thirty-three nephrologists, 91 primary care physicians, and 10 endocrinologists providing diabetic care to these patients.

Measures: Patient and physician reports of care provided for six domains (diet, diabetes medications, hypertension, cholesterol, feet, eyes). Chart abstraction of five patient outcomes (glucose control, blood pressure, interdialytic weight gain, albumin, cholesterol).

Results: Most patients had a nephrologist, a primary care physician, an eye specialist, and a podiatrist. Few patients had an endocrinologist. A majority of patients and physicians stated that each domain of care was addressed on a regular basis. Nephrologists and primary care physicians differed greatly on who should provide care for specific domains. For example, only 12% of nephrologists felt that primary care physicians should manage hypertension while 74% of primary care physicians felt that they should manage hypertension ($p<0.001$). Patient outcomes were often suboptimal: 34% of patients had a hemoglobin A1c >7.0%, 51% had a pre-dialysis blood pressure >160/95 mm Hg, and 23% had a cholesterol >200 mg/dL. One-fifth of patients with high hemoglobin A1c were not receiving insulin, three-fourths of patients with elevated blood pressure were receiving fewer than three antihypertensive medications, and two-thirds of patients with high cholesterol were not receiving a lipid lowering medication. There was little difference in outcomes between patients with a primary care provider and those without a primary care provider. Primary care physicians felt frustrated by a lack of communication from nephrologists about lab results, medication changes, or procedures.

Conclusion: Although diabetic hemodialysis patients appear to receive timely care from a variety of physicians, patient outcomes are often poor. Medication use is suboptimal, nephrologists and primary care physicians disagree on their roles, and communication among physicians is limited. Interventions to improve outcomes of diabetic hemodialysis patients should address these impediments.