NORTHWEST Kidney Centers

January 25, 2016

The Honorable Johnny Isakson
United States Senate
131 Russell Building
Washington, DC 20510

The Honorable Mark Warner
United States Senate
475 Russell Building
Washington, DC 20510

Dear Senators Isakson and Warner:

Northwest Kidney Centers appreciates the opportunity to provide the Senate Finance Committee's Chronic Care Working Group with comments on the December 2015 document outlining policy options for improving care of Medicare beneficiaries.

Northwest Kidney Centers is a not-for-profit provider of kidney care services, including dialysis, in Seattle- King County Washington. Northwest Kidney Centers was founded in 1962 as the world's first out-of-hospital dialysis program, and we started home dialysis services shortly thereafter in 1964. Today we provide care to 1600 dialysis patients in 15 centers and in their home - in fact 18% of our patients do self-treatment at home. We have a deep commitment and extensive experience with home dialysis, both peritoneal and home hemodialysis.

We wish to comment on one element in your paper- Expanding Access to Home Dialysis (page 7 of policy options document).

We are pleased you included the proposal to expand home access. As you may know, the vast majority of home dialysis patients receive peritoneal dialysis. Therefore we **recommend that this policy recommendation be sure to clearly include home peritoneal dialysis patients as well as home hemodialysis patients.**

We endorse the working group's recommendation to expand Medicare's qualified originating site to include free-standing renal dialysis facilities located in any geographic area. There are two important changes embedded in this recommendation:

1) Definition of the originating site to include outpatient ESRD facilities. If the monthly encounter between the dialysis patient and their nephrologist could occur via telehealth-- with the patient at the dialysis unit and the nephrologist in the office-- this would enhance patient care in two ways: First, the dialysis unit staff could be present to support interdisciplinary conversation about care; and second the patient could avoid a trip to the doctor's office that month. Note: It is not clear if "free-standing" includes hospital-owned outpatient dialysis facilities. We recommend that hospital-owned outpatient dialysis facilities be specifically included in this recommendation as a qualified originating site as they function as outpatient dialysis facilities.
2) Located in any geographic area. We strongly support elimination of the rural restriction to qualify as a telehealth originating site. Home patients in urban areas may also face transportation challenges getting to their nephrologist's office for their monthly visit. Telehealth could facilitate a monthly encounter without transportation and scheduling challenges.

We endorse safeguards for safety and quality oversight:
We believe that home dialysis patients benefit from a monthly encounter with a renal professional for safety and quality oversight. In our home program, home patients visit their dialysis unit's home department monthly in person. During this clinic visit they see their dialysis nurse for a physical assessment, consultation and education; have blood drawn for lab tests; and receive IV medications as necessary. They also may encounter their social worker or dietitian. We would not envision telehealth as replacing the monthly visit with the dialysis unit. However we note there is no ESRD Condition for Coverage that requires a home dialysis patient be seen for a face-to-face encounter in their dialysis unit on any frequency.

Therefore for safeguards we recommend the following:

a. **A telehealth encounter should only be made with the concurrence of the patient and the physician.** If either believes a face-to-face visit is desired, then a direct encounter should occur.
b. **If the dialysis unit is the originating site, the interval for a required in-person interaction between the patient and physician should be once every three months**, i.e. a home dialysis patient should have a face to face encounter with their physician once every three consecutive calendar months. (It is important to define consecutive so it is not, for instance, a visit in January and again in June which could be perceived as "once a quarter.")
c. You asked for comment on the home as an originating site for telehealth between the patient and the physician. ***If* the Committee agrees to recommend the patient's home as an originating site for a telehealth encounter between the patient and their physician, then we would revise our recommendation that the face to face visit with the physician occur every other month rather than every three consecutive months.** We offer this modification because the ESRD Conditions for Coverage do not require that a home patient visit their unit monthly for nursing oversight at any set interval, although that is highly preferable. Given the lack of Conditions for Coverage requirement for the home patient to encounter their dialysis unit, it would be important from a safety perspective to ensure that at least every 60 days the physician is encountering the home patient in a face to face visit.

In summary, the Policy Option recommendation from the Chronic Care Working Group would reduce the number of required in-person interactions between doctors and dialysis patients and substitute telehealth visits. We believe this reduction in in-person visits will maintain a high level of quality, safety and service to home dialysis patients, while reducing impacts associated with travel and additional scheduling.

Thank you for this opportunity to provide input. Please contact me with any questions at 206/720-8500 or joyce.jackson@nwkidney.org.

Sincerely,
Joyce F. Jackson
President and CEO