The New Health Care Legislation: A Look Ahead

By Rachel Shaffer

Congress and the Obama administration took a historic step toward expanding access and improving health care for all Americans in passing health reform legislation last month. The most comprehensive health reform in decades, “The Patient Protection and Affordable Care Act (HR 3590),” was built upon through subsequent legislation “The Reconciliation Act of 2010 (HR 4872),” also passed by Congress and signed into law by President Obama last month.

The health reform legislation focuses primarily on expanding insurance coverage and increasing its affordability, reducing health care costs, and transforming care delivery. Eventually, the legislation aims to ensure coverage for 32 million people—meaning more than 94 percent of all legal U.S. residents will be covered. However, reforms laid out in the bills will not be implemented immediately, and some of the most important provisions will not go into effect for years. Significant responsibility for carrying out health reform goes to the Department of Health and Human Services (HHS); H.R. 4872 appropriates $1 billion to HHS for enactment. Table 1 shows when provisions of the health care legislation become effective and highlights components pertinent to the kidney care community, and can also be downloaded as a pdf from ASN’s Kidney News website at http://asn-online.org/publications/kidneynews/.

Many aspects of these broad reforms—greater access to coverage, emphasis on prevention, closure of the donut hole, expansion of comparative effectiveness research—will almost certainly influence patients at every level in the coming years, including those with kidney disease. Health reform does not address kidney disease at length, but there are a number of key sections of interest for the nephrology community in the 2400-plus pages of legislation.

Models of care delivery

Transforming the delivery system is a primary focus in the health care bill. The legislation paves the way for a host of pilot programs and enables physicians to begin sharing in savings derived from improved care delivery as early as 2010.

President Obama Outlines Budget Priorities

Although the First Step in a Long Process, Budget Proposes Increases for NIH, NIDDK, VA, AHRQ, FDA, and NSF

By Rachel Shaffer

With the U.S. economy struggling, the budget deficit expanding, and his health reform effort facing an uphill battle, President Obama released his proposed $3.8 trillion budget for fiscal year 2011 (FY 2011), which will start October 1, 2010. Despite a spending freeze on all discretionary funds, except those dedicated to defense or national security, medical care and research remain clear priorities for the Obama administration. Nearly every health-related research agency—except the Centers for Disease Control and Prevention (CDC)—received an increase in the president’s budget.

Each February, the president submits a budget to Congress proposing funding for federal departments and agencies, including justifications for spending reductions or increases. The House and Senate Budget Committees then draft budget resolutions, nonbinding legislation that sets overall discretionary spending and divides spending totals into categories. The budget is organized into “functions” of related spending categories. For instance, function 550 includes all health programs, such as the National Institutes of Health (NIH) and the Agency for Healthcare Research and Quality (AHRQ).

The budget regulates two types of spending: mandatory spending for “entitlement” programs that the law requires the federal government fund annually, such as
Before you start, stop.

Because the benefits should accumulate. Not the risks.

Renvela® (sevelamer carbonate) tablets or for oral suspension is an effective first-line monotherapy for controlling serum phosphorus in dialysis patients — without calcium or metal accumulation. Renvela is the only phosphate binder available in both tablet and powder dosing options.

Important Treatment Considerations
Renvela® (sevelamer carbonate) is indicated for the control of serum phosphorus in patients with chronic kidney disease (CKD) on dialysis. • Renvela is contraindicated in patients with bowel obstruction • Caution should be exercised in patients with dysphagia, swallowing disorders, severe gastrointestinal (GI) motility disorders including severe constipation, or major GI tract surgery • Uncommon cases of bowel obstruction and perforation have been reported • Serum bicarbonate and chloride levels should be monitored • Vitamins D, E, K (coagulation parameters), and folate acid levels should be monitored • The most frequently occurring adverse reactions in a short-term study with sevelamer carbonate tablets were nausea and vomiting • In a short-term study of sevelamer carbonate powder dosed three times daily, adverse events were similar to those reported for sevelamer carbonate tablets • In long-term studies with sevelamer hydrochloride, which contains the same active moiety as sevelamer carbonate, the most common adverse events included vomiting, nausea, diarrhea, dyspepsia, abdominal pain, flatulence, and constipation • Cases of fecal impaction and, less commonly, ileus, bowel obstruction, and bowel perforation have been reported • Drug-drug interactions may occur with some medications and should be taken into consideration when instructing patients how to take Renvela • Patients should be informed to take Renvela with meals and to adhere to their prescribed diets

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Health care reform

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able Care Act establishes a "shared savings program" through which groups of providers coordinate care for Medicare beneficiaries in accountable care organizations (ACOs). ACOs—which are groups of providers and suppliers with shared governance that meet quality performance standards determined by the HHS secretary—will be eligible to receive payments for shared savings beginning January 1, 2012. Intended to promote efficient service and accountability for a patient population, the ACO program encourages investment in infrastructure and redesigned care processes.

Among other things, qualified ACOs must promote evidence-based medicine and patient engagement, and have patient-centeredness criteria specified by the secretary, such as through the use of individualized care plans.

Although the Act grants the HHS secretary discretion in further defining ACOs, it suggests that ACOs may be formed of an array of providers and organizations, including professionals in group practice arrangements, networks of individual practices, and hospitals employing ACO providers. This inclusive model would afford nephrologists numerous avenues to participate in an ACO—and potentially to improve the delivery and quality of care for patients with kidney disease at any stage of progression from stage I through dialysis.

In addition to the ACO program, the Act creates a Center for Medicare and Medicaid Innovation (CMI) within CMS, tasked with testing innovative payment and service delivery models beginning no later than January 2011. The HHS Secretary will select for testing models that address a specific population for which a care deficit exists, or a population with potentially avoidable expenditures. The patient-centered medical home (PCMH) model and Healthcare Innovation Zones (HIZ) are among possible opportunities for funding and investigation in the legislation.

GAO study on access under bundled payments

Although CMS has yet to release a Final Rule on the bundled rate payment system for end stage renal disease (ESRD) care, health reform legislation includes a provision requiring the Government Accountability Office (GAO) to conduct a study on the impact on Medicare beneficiary access to dialysis drugs, including drugs or biologicals for which there is no injectable equivalent or other non-oral form of administration. The report will examine providers' abilities to furnish oral medications, and assess their ability to comply with state pharmacy licensure requirements. Furthermore, GAO will assess whether appropriate quality measures exist to safeguard care for patients being furnished oral drugs by providers and renal dialysis facilities. This independent analysis of patient access under the bundled payment system will be vital to ensure quality and accessibility of care. Yet the provision is also of interest because of its relationship to the forthcoming Final Rule on the bundled payment system. One possible interpretation of this language is that Congress intended the study to be prospective—and that CMS should therefore delay implementation of bundling until it is completed. Conversely, it could be interpreted that Congress intends for all drugs without injectable equivalents—including calcimimetics and phosphate binders—in the bundle as of January 1, 2011.

Payment

As the nephrology community prepares for implementation of the bundled rate payment system for ESRD care, the health reform bill lays groundwork for further shifts toward payment bundling. Specifically, the Act requires the HHS secretary to develop a pilot program for integrated care during an episodic hospitalization. Most important, the pilot bundle would include physicians’ serv-
Health care reform

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Table 1. Implementation timeline

<table>
<thead>
<tr>
<th>Implementation Year</th>
<th>Legislation</th>
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| 2010                | • Bars insurance companies from rescinding coverage when enrollees get sick  
                     • Requires insurance companies to cover preventive services (applies to plans that are new in 2010)  
                     • Eliminates lifetime limits on benefits in group health plans and bars plans from imposing pre-existing conditions on children’s coverage  
                     • Provides sliding scale tax credits to help small businesses afford insurance  
                     • Reduces the Medicare prescription drug donut hole in 2010 and eliminates it by 2020  
                     • Establishes an independent, nonprofit institute for comparative effectiveness research |
| 2011                | • Allows unused Graduate Medical Education training slots to be redistributed to increase primary care training at other sites  
                     • Increases reimbursement for primary care services under Medicare and Medicaid (2013-2015)  
                     • Establishes a “shared savings program” under which groups of providers may manage and coordinate care in “accountable care organizations” (ACOs) and receive payments for shared savings |
| 2012                | • Establishes a national pilot program on payment bundling to encourage provider collaboration and care coordination  
                     • Requires drug, device, and other medical manufacturers to routinely submit records of payments or other transfers of value to physicians to the HHS secretary |
| 2013                | • Bars insurance companies from discriminating based on pre-existing conditions, health status, age, or gender and from imposing annual limits on coverage  
                     • Increases Medicare eligibility to 133 percent of the Federal Poverty Level for all non-elderly individuals  
                     • Provides federal matching payments to states for the cost of services to newly eligible Medicaid enrollees  
                     • Creates health insurance exchanges—competitive marketplaces where individuals and small businesses can buy affordable health care coverage  
                     • Provides sliding scale tax credits to help individuals afford insurance  
                     • Requires most individuals to obtain health insurance, or pay a fee if they do not  
                     • Prohibits health plans from dropping or denying coverage because an individual participates in a clinical trial |
| 2014                | • Establishes an Independent Payment Advisory Board to submit proposals to Congress and the private sector aimed at extending Medicare solvency, lowering costs, and improving health outcomes  
                     • Creates a value-based (rather than volume-based) physician payment program for Medicare |
| 2015                | • Establishes a national pilot program on payment bundling to encourage provider collaboration and care coordination  
                     • Requires drug, device, and other medical manufacturers to routinely submit records of payments or other transfers of value to physicians to the HHS secretary |

The Act contains a limited number of exceptions, including delayed publication of payments made related to research on a potential new medical technology or application, and of those
made in connection with a clinical investigation regarding a new drug or device. Notably, nephrologists, like other physicians, will not share any reporting burden; the Act places this responsibility solely on industry.

**Workforce**

The number of U.S. medical students pursuing careers in nephrology has been declining for years, and many consider the lack of student interest in internal medicine residencies to be part of the problem. Seeking to address this short-fall of general interest and other primary care physicians, Congress included numerous approaches to encourage more students to go into primary care.

In addition to multiple incentive payment programs and loan repayment options for students entering primary care, the bill also distributes 65 percent of currently unused residency training slots and directs those slots to hospitals in certain states in July 2011. “The nation’s medical schools and teaching hospitals have expressed their full support for this bill to President Obama,” said Association of American Medical Colleges (AAMC) President and Chief Executive Officer Darrell G. Kirch, MD (2).

**Comparative effectiveness research**

“The most significant thing [in the health care bill] is comparative effectiveness research,” said the National Institute of Health (NIH) Director Francis Collins, MD (3). Indeed, the legislation establishes a “Patient-Centered Outcomes Research Institute,” an independent, nonprofit corporation to increase the quality and relevance of medical services and treatment through comparative effectiveness research. The institute is tasked with identifying national priorities for comparative effectiveness research, including areas of disease incidence, prevalence, and burden—and emphasizing chronic conditions and gaps in evidence in terms of clinical outcomes, among other factors.

In carrying out its research agenda, the institute will enter into contracts to manage funds and conduct research with federal government agencies as well as the academic and private sectors.

ASN will be actively engaged in collaborating with members of Congress, HHS (particularly the Centers for Medicare and Medicaid Services), and the rest of the nephrology community to implement these reforms and address other important aspects of the U.S. health care system not included in this historic legislation.

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**BUDGET PRIORITIES**

Medicare and Medicaid, and “discretionary” spending, such as CDC and AHRQ. Each year, Congress must decide whether to appropriate funds for discretionary programs. Following development of the congressional budget, House and Senate Appropriations Committees allocate discretionary funding to agencies within funding areas. With the exception of the Medicare End-Stage Renal Disease (ESRD) Program, the majority of agencies and programs of interest to the nephrology community rely on discretionary funding.

**Proposed budget includes robust funding for medical research**

Requesting a $1 billion increase in discretionary NIH funding for FY 2011—a 3.2 percent increase from FY 2010 levels—President Obama’s nearly 3 percent priority for comparative effectiveness research in this year’s budget (Table 1). Of the total $32.2 billion requested for NIH for FY 2011, approximately $1.96 billion is targeted toward the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), a 2.6 percent jump from FY 2010. Similarly, the budget includes a 2.9 percent increase over last year for both the National Heart, Blood, and Lung Institute (NHLBI) and the National Institute on Aging (NIA), nearly $3.1 billion and just over $1.1 billion, respectively.

NIH Director Francis Collins, MD, recently outlined five “exceptional opportunities” for the agency to pursue that could reap substantial downstream benefits. In developing the budget, NIH mapped the portfolio of each institute or center against these five broad areas or institutes and adjusted for other area- or institute-specific contingencies:

- Applying high-throughput technologies to understand fundamental biology and to uncover the causes of specific diseases.
- Translating clinical science discoveries into new and better treatments.
- Pivoting science to work for the benefit of health reform.
- Encouraging a greater focus on global health.
- Reinvigorating and empowering the biomedical research community.

Collins also emphasized medical research as a sound investment in the economy. NIH data show that each dollar of NIH funding creates more than two dollars in state economic output per year, and each grant generates approximately seven jobs.

Although pleased with the proposed increase, the Ad Hoc Group for Medical Research, whose executive committee ASN served, had recommended that NIH receive a $35 billion budget in FY 2011. This figure reflects the FY 2010 budget adjusted for medical inflation, plus half the value of funds that were awarded as part of the American Recovery and Reinvestment Act (ARRA, better known as the economic stimulus package), to ensure continuation of ongoing research.

Last year, Congress appropriated the Department of Veterans Affairs (VA) approximately $47 billion in discretionary funding for medical care and an additional $13 billion for health research. For FY 2011, the Obama administration proposes a nearly 8.5 percent boost in medical care spending totaling over $515 billion.

VA health research also stands to gain—although somewhat modestly—at 1.5 percent over FY 2010 levels, or just shy of $600 million. ASN serves on the executive committee of the Friends of the Veterans Affairs Medical Care and Health Research (FOVA), which has recommended a $700 million research budget to support returning veterans from Iraq and Afghanistan and to bring VA research facilities into the 21st century.

**Comparative effectiveness research gets likely boost**

With a proposed budget increase of 5.4 percent above FY 2010 funding, AHRQ receives the largest budget boost of any healthcare-related agency in the president’s budget. The $611 million outlined in the request is nearly $214 million more than AHRQ saw last year. Given the administration’s focus on health reform, AHRQ’s ability to fund research within the health care, quality and relevance of medical services and treatment through comparative effectiveness research. The institute is tasked with identifying national priorities for comparative effectiveness research, including areas of disease incidence, prevalence, and burden—and emphasizing chronic conditions and gaps in evidence in terms of clinical outcomes, among other factors.

In carrying out its research agenda, the institute will enter into contracts to manage funds and conduct research with federal government agencies as well as the academic and private sectors.

ASN will be actively engaged in collaborating with members of Congress, HHS (particularly the Centers for Medicare and Medicaid Services), and the rest of the nephrology community to implement these reforms and address other important aspects of the U.S. health care system not included in this historic legislation.

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**Table 1. Federal budget comparison, FY 2010 versus FY 2011**

<table>
<thead>
<tr>
<th>Federal agency</th>
<th>FY 2010 actual</th>
<th>FY 2011 proposed</th>
<th>Percent increase/decrease</th>
</tr>
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<tbody>
<tr>
<td>NIH</td>
<td>$32,247,200,000</td>
<td>$32,247,200,000</td>
<td>0.0%</td>
</tr>
<tr>
<td>NIDDK</td>
<td>$1,957,364,000</td>
<td>$2,007,589,000</td>
<td>2.5%</td>
</tr>
<tr>
<td>NHLBI</td>
<td>$3,085,812,000</td>
<td>$3,187,516,000</td>
<td>2.9%</td>
</tr>
<tr>
<td>NIA</td>
<td>$1,109,800,000</td>
<td>$1,142,337,000</td>
<td>2.9%</td>
</tr>
<tr>
<td>VA Medical Care</td>
<td>$47,055,000,000</td>
<td>$51,533,000,000</td>
<td>9.5%</td>
</tr>
<tr>
<td>VA Health Research</td>
<td>$561,000,000</td>
<td>$590,000,000</td>
<td>5.5%</td>
</tr>
<tr>
<td>ARRA</td>
<td>$397,900,000</td>
<td>$410,900,000</td>
<td>3.3%</td>
</tr>
<tr>
<td>FDA</td>
<td>$3,296,000,000</td>
<td>$4,035,658,000</td>
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<tr>
<td>NSF</td>
<td>$6,872,110,000</td>
<td>$7,424,000,000</td>
<td>8.0%</td>
</tr>
<tr>
<td>CDC</td>
<td>$6,742,760,000</td>
<td>$6,611,478,000</td>
<td>-1.9%</td>
</tr>
</tbody>
</table>

PhosLo® is indicated for control of hyperphosphatemia in end-stage renal failure. Patients with higher-than-normal serum calcium levels should be closely monitored and their dose adjusted or terminated to bring levels to normal. PhosLo® is contraindicated in patients with hypercalcemia. No other calcium supplements should be given concurrently with PhosLo®. Nausea, hypercalcemia and pruritus have been reported which may represent allergic reactions. OVERDOSAGE: Administration of PhosLo in excess of appropriate daily dosage can cause severe hypercalcemia (see ADVERSE REACTIONS). In the event of overdose, the patient should be observed closely and dialyzed if necessary. 

**CONTRAINDICATIONS:** PhosLo is contraindicated in patients with hypercalcemia.

**WARNINGS:**

- **PhosLo** is contraindicated in patients with hypercalcemia. No other calcium supplements should be given concurrently with PhosLo. Nausea, hypercalcemia and pruritus have been reported which may represent allergic reactions. 

**ADVERSE REACTIONS:**

- **PhosLo** is well tolerated with limited GI side effects.
- **PhosLo** has not been associated with metabolic acidosis.
- **PhosLo** offers potential cost-savings for patients.

**PhosLo** is indicated for control of hyperphosphatemia in end-stage renal failure. Patients with higher-than-normal serum calcium levels should be closely monitored and their dose adjusted or terminated to bring levels to normal. PhosLo is contraindicated in patients with hypercalcemia. No other calcium supplements should be given concurrently with PhosLo. Nausea, hypercalcemia and pruritus have been reported which may represent allergic reactions. OVERDOSAGE: Administration of PhosLo in excess of appropriate daily dosage can cause severe hypercalcemia (see ADVERSE REACTIONS).
Interdisciplinary Care of the CKD Patient

PARTNERING IN CARE—A PATIENT’S PERSPECTIVE

By Lori Hartwell

One of my earliest memories of having a health care professional empower me to become a partner in my own care occurred when I was eight years old. My pediatric nephrologist, Dr. Richard Fine, was determined that I learn how to take my own blood pressure and that I fully understand the medications I was taking. I had been under his care since the age of two, and he finally challenged me to take a more active role in managing my disease. His confidence in my ability to monitor my own status inspired me to learn more about kidney disease and to strive to be the best patient that I possibly could be.

When I was a teenager there were exciting developments in the treatment of kidney disease. Many of the therapies that people now take for granted were in their infancy, and I was often one of the first persons to try a new treatment. Although I trusted my doctor’s knowledge, I still felt like I needed to understand the new therapies or procedures so that I did not feel like a guinea pig. I believe that my interest in being involved with my own care led to a better relationship with my nephrologist.

Throughout the process he treated me as an equal partner. His expectation that I would be interested and involved in my own care helped me understand how my actions could help maximize the benefits of therapies, ultimately leading to a more successful outcome.

Based on my own lifelong experience with kidney disease, I believe that patients of all ages can become active partners with their health care providers. When you hear the phrase “partner in care,” it may seem like a very abstract expression, and many patients (and health care professionals) may ask, “Does becoming a partner in care really matter?” The answer is a definite yes!

A partnering relationship between the patient and physician is essential for patient empowerment, which has been repeatedly demonstrated to yield better outcomes—especially for patients with a chronic disease.

So let’s assume that physicians want to build partnering interpersonal relationships with their patients. How can they pursue that goal? Encouraging patient empowerment often has more to do with the physician’s nonverbal communication skills than with the information conveyed. Based on my 40-year (and counting) lifelong experience living with chronic kidney disease, I would like to offer the following tips to physicians who want to partner with and empower their patients.

Invest the time to partner with your patients

I feel very fortunate because I’ve had a good relationship with my present nephrologist for the past 20 years. He knows me and I know him. We have gotten to know each other’s quirks and personalities and are comfortable communicating with each other. He realizes that to be an empowered patient I need to understand and make my own decisions regarding my care. He routinely provides me with information about my current status, and I reciprocate by providing ongoing and proactive updates of my status from my perspective.

I believe that my understanding of my disease and the ability to recognize the different “danger signs” that occasionally arise have helped in his assessments and led to an improvement in my own care and outcomes. We work as partners in determining treatment plans. He lets me know the options (including the positives and negatives), helps me understand the decisions that I have to make, and provides his medical perspective of the route to the best care. Ultimately, however, I am the decision maker.

In contrast, I also receive care from a number of physicians from other disciplines with whom I don’t have either that rapport or that partnership—yet they are responsible for some very important aspects of my health.

Patients and physicians both need to understand the other’s communication style. Physicians should realize that patients communicate differently—some

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Partnersing

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verbally and some nonverbally. I recom-
mend that at the initial visit between a
doctor and patient, the physician take
the lead by having a frank discussion on
how the two parties will communicate.
For example, the physician could pro-
vide a short bio or a personal philos-
ophy video that would help the patient
get to know him.

If physicians devote the time to let-
ting patients know that they want them
to become partners in their own care, it
will go a long way toward encouraging
patient involvement. Physicians might
also provide a list of what kind of com-
munication they encourage from pa-
tients. This list should include not just
what to do in an emergency, but also how
patients can become educated and active
participants, and the kind of information
that they should track and share with the
physician at each office visit.

It is never too late to open up or change
the lines of communication. I encourage
physicians to surprise your current pa-
tients by adapting a similar approach and
investing the time to show them you care
about their input and opinions. I believe
the short- and long-term outcomes that
will result will more than make up for the
time investment.

Be mindful of the tone of your
communications

One thing that can make or break a
partnership is the doctor’s tone of voice
and body language. If a doctor seems
to be distant and “not there,” or is
cdescending, the patient frequently
just shuts down, leaving the physician
wondering why a message is not getting
through. Conversely, a partnership
relationship is fostered when the physi-
cian’s voice and body language make it
clear that he or she sincerely wants the
patient to be involved and do better.

Patients have a tendency to dissect
and remember whatever communica-
tions they have with the doctor in detail.
Remember that although the physician
has dozens of interactions with patients
a day, for the patient these interactions
with a crucial individual in their lives
happen infrequently. It is not uncom-
mon for me to remember almost word
for word a conversation I had with my
physician weeks earlier.

Even a minor tone shift by the doc-
tor that is misinterpreted or accompa-
nied by conflicting body language can
result in the doctor’s intended mes-
sage being totally missed or misunder-
stood. Although a physician tells me
one thing, I may focus more on his fa-
cial expressions or body language and
“hear” something totally different. It is
therefore very important that the physi-
cian ask the patient for input, ask him
or her to repeat back the information that
was provided, and clarify any questions. It
is also vital that the physician review
the decisions that were jointly made to
ensure that the intended messages were
actually heard.

Encourage the use of peer
resources

Because doctors must deliver good news
and bad news on a daily basis, these
messages are most effectively received
by the patient when delivered with
compassion, care, and a good dose of
hope.

It is difficult and challenging to care
for patients in such a way that you are
honest in delivering the hard facts while
simultaneously providing the patient
with a sense of shared purpose, partner-
ship, and hope for a worthwhile future.
What makes this even harder is limited
resources that do not allow physicians
to spend unlimited time with each pa-
tient.

One factor that can significantly help
a doctor achieve these challenging goals
is leveraging outside resources. Such
resources can complement the physi-
cian’s message and prepare patients to
be more knowledgeable and educated
partners with their caregivers.

In 1993, I founded the patient-run
Renal Support Network (RSN), which
offers several programs that reach out
to patients and provides substantial
resources to develop hope, knowledge,
and partnership skills. These include a
dynamic website (RSNHope.org) that
offers online support including a pa-
tient-run bulletin board (Kidney Space),
educational patient meetings, a patient-
run radio program (KidneyTalk), essay
tests, and written articles.

RSN offers a one-of-a-kind nation-
wide toll free support program called
HOPELine, (1-800-579-1970), where
patients can call in and interact at
length with experienced and trained pa-
tient peers. The peers’ primary mission
is to share their experience, strength,
and hope, as well as to direct callers to
other helpful resources.

Learning about such peer resources
and directing patients to them helps
physicians demonstrate that they care
about more than just clinical issues and
are truly concerned for the patient’s
emotional well-being. This attention to
treating the patient as a complete per-
son helps build trust that, in turn, leads
to a stronger physician-patient part-
nership and mutual respect. Fostering
such a relationship may help improve
patient quality of life and better overall
outcomes.

Anthony Messana is executive director
of St. Joseph Hospital in Orange, CA.

Contribution of the Dialysis Technician

By Anthony Messana

O

ver the years, the evolution of
dialysis technology has en-
abled us to measure delivered
adequacy of dialysis, precisely predict
and remove fluid volume, and perfect
the patient monitoring process dur-
ing treatment. Another area of evolu-
tion is the expanded collaborative role
of the multidisciplinary team provid-
ing care to kidney patients and their
families. In years past, patient care
was provided primarily by licensed medical
professionals. Over time the multi-
disciplinary team has expanded to include
unlicensed professionals in a collabora-
tive effort to provide holistic care to a
patient population that is growing in
number, age, and co-morbidities.

Who are these multidisciplinary
team members and what attributes
are required of each member? The
team consists of the nephrologist,
registered nurse, patient care tech-
nician (PCT), dietitian, and social
worker. Each team member must be
a professional who, based on their
education, skill sets, and scope of
practice, is committed to providing
safe and competent care to patients.
Because the attributes of the team
members differ, the definition of care
provided by each member will differ.
A true multidisciplinary team results
when these varying definitions of
care are brought together.

The new Medicare Conditions for
Coverage (CfC) have broadened the
care provider focus to include all
the members of the patient care
team. The conditions set forth qualifica-
tions and roles for the medical direc-
tor, nurse manager, nursing staff in
both home and in-center modalities,
dietitian, social worker, PCT, water
treatment and reprocessing techni-
cian, and CEO/administrator. Defin-
ing the team in a broader scope has
allowed Medicare to better define the
education and training requirements
for each team member and to iden-
tify expected competencies for each
team member.

In the new CfC, each patient is
required to have an individualized
patient assessment by nursing and
social and dietary services in addi-
tion to the nephrologist’s medical
documentation. The conditions help
those caring for kidney patients move
from an isolated and sequential as-
sessment process into the required
interdisciplinary “plan of care.” In their
surveying process, Medicare is examin-
ing the collaborative nature of these plans and will
be citing facilities if they fall short in
meeting this requirement.

An integral member of the multi-
disciplinary team is the PCT. With
growth of the dialysis patient popu-
lation, the role of the PCT has ex-
panded to one of caregiver. As a re-
sult of this expanded role, Medicare
and the dialysis community have
recognized the importance of meas-
uring the clinical competence of the
PCT. The new CfC require all PCTs
to have a minimum of a high school
diploma or to have worked as a PCT
for at least four years prior to Oc-
tober 2008. Also included is a new
condition requiring all PCTs to pass
a nationally recognized certification
exam and to maintain the certifica-
tion through continuing education
or retesting.

In the day-to-day activities of the
dialysis facility, the PCT interacts
with the patient more frequently than
other care providers. The PCT initi-
ates the dialysis treatment, monitors
the patient response to treatment,
and discontinues the treatment. As
a result of these frequent and close
interactions, the patient develops
a bond of trust with the PCT. This
opens up communication and allows
the patient to discuss problems and
concerns. The PCT, in turn, shares
this information with the multidis-
ciplinary team and provides valuable
input to the care planning process.

Clearly, the PCT is an important and
valuable member of the team.

Anthony Messana is executive director
of St. Joseph Hospital in Orange, CA.
The role of the registered dietitian in renal care is to help those with chronic kidney disease (CKD) maintain adequate nutritional status. Maintaining nutritional status needs to be considered a lifestyle change rather than a diet with limitations and overwhelming restrictions. Optimal renal nutrition provides the opportunity to live a longer life with renal replacement therapy (RRT) as it is indicated.

Prior to RRT, the primary goal is to limit excess uremic toxins and prevent protein-energy malnutrition. The Kidney Disease Quality of Life Index (KDOQI) recommends that individuals with chronic renal failure (glomerular filtration rate [GFR] < 25 mL/min) who are not undergoing maintenance dialysis follow a low-protein diet providing 0.60 g protein/kg/day. For individuals who will not accept such a diet or who are unable to maintain adequate daily energy intake with such a diet, an intake of up to 0.75 g protein/kg/day may be prescribed (1).

The registered dietitian needs to work with the patient at regular intervals to ensure adequate protein intake. Greene et al. documented reduced intake of protein as GFR declined. Adequate calorie intake is recommended to protect protein and to reduce the risk of catabolism. The calorie goal is 35 kcal/kg for those younger than 60 and 30–35 kcal/kg for those 60 and older. The registered dietitian can assess the patient’s typical intake and develop a plan for the patient to coordinate the reduced protein levels, while achieving the additional caloric requirements. Tools such as Protein Nitrogen Appearance (PNA) and subjective global assessment (SGA) can assist in quantifying the patient’s risk of malnutrition.

The team must be alert to signs of inadequate intake or uremic symptoms, which may indicate the need for initiation of dialysis or a renal transplant. Earlier intervention with RRT may correct a decline in nutritional status. The registered dietitian can assess weight trends, appetite, and ability to acquire and prepare appropriate foods, as Leon determined (2). The recommended protein for clinically stable peritoneal dialysis patients is 1.2 to 1.3 g/kg body weight/day; and for maintenance hemodialysis patients, 1.2 g/kg/day. The calorie goals continue to be generous to protect the protein and prevent catabolism; however, peritoneal dialysate calories should also be considered.

Kaysen suggested that inflammation contributes to anorexia. It reduces the effective utilization of dietary protein and caloric intake, and contributes to catabolism of the key somatic protein, albumin (3). Nephrologists can potentially improve the nutritional status of patients by arranging permanent dialysis access placement.

A large study of over 4000 patients showed that central venous catheters can contribute to the inflammatory state and decreased albumin levels (4). Caregivers providing and overseeing dialysis can also reduce the risk of inflammation and infection with attention to access care and dialyze preparation. Implementation of quality process flow to assure timely intervention with erythropoiesis stimulating agents and bone mineral metabolism can improve appetite and reduce risk of inflammation, respectively.

Adequate food intake may be impeded by an individual’s inability to function independently. The nephrology social workers can assist in assessing the support systems available and appropriate coping skills.

Nutritional intervention to improve oral intake may include calorie dense foods, small, frequent meals, and possibly oral supplements. The use of oral supplements during hemodialysis has been studied in 85 patients with significantly improved albumin, prealbumin, and SGA during six months of supplementation compared to the three months of baseline nutrition intervention alone (5). Appetite stimulants have been shown to be beneficial (6), and in extreme cases, intervention with tube feeding or total parenteral nutrition can be instituted for the nonworking gastrointestinal tract.

The American Dietetic Association has taken the position that access to adequate amounts of safe, nutritious, and culturally appropriate food at all times is a fundamental human right. Food is a basic human need. Many patients, however, reside in “food deserts” with little or no access to fresh foods or lower cost grocery options. The registered dietitian can assist with recommending organizations and programs that address food insecurity. Assistance in teaching patients methods for preparing less costly cuts of meat is necessary to achieve the goal of 50 percent high biological value protein. Recommending use of lower potassium seasonal fruits and vegetables as less costly nutritional sources or reducing the sodium content of canned vegetables are methods to help accommodate a limited food budget.

Transplantation offers an alternative to the regimen of dialysis and has the benefit of less strenuous protein needs. The primary nutritional goals emphasize maintenance of desirable body weight and use of poly- and monounsaturated fats. Patients are encouraged to exercise and maintain healthy weight ranges.

A team approach is the most effective method to achieve the lifestyle change needed.

Rita Solomon-Dimmitt, RD, is with the Vanderbilt Dialysis Clinic in Nashville, Tenn.

References
Psychosocial Barriers to Chronic Kidney Disease Patient Outcomes

By Teri Browne

The current paradigm for the provision of chronic kidney disease (CKD) care mandated by the 2008 Conditions for Coverage requires an interdisciplinary approach to outcomes-driven patient care. In CKD, dialysis, and kidney transplant centers, master’s level social workers can work with these interdisciplinary teams to help patients ameliorate psychosocial barriers to optimal outcomes. Social workers can be of particular help in the areas of patient self-management of diet, fluid restriction, medications, treatment recommendations, and modality selection. Social workers are often the team expert on palliative care, and can help patients explore starting and stopping treatment, pain, advance care planning, and coping with the losses associated with kidney disease and its treatments.

Social workers can assist patients with all of these psychosocial barriers to optimal patient laboratory outcomes by exploring and addressing health beliefs, pill burden, literacy, community resources, social network influence, and socioeconomic factors. The nephrology social worker is often the expert in palliative care on CKD teams and can help patients explore starting and stopping treatment, pain, advance care planning, and coping with the losses associated with kidney disease and its treatments. All dialysis patients now must be assessed for their physical and mental functioning. The Clinical Performance Measurements require that patients’ Kidney Disease Quality of Life (KDQOL) be measured routinely by social workers. Patient quality of life has been empirically linked to patient mortality and morbidity. It is a critical area for patient assessment and intervention that should be an important part of any dialysis unit’s Quality Assessment and Performance Improvement program.

Eighty-nine percent of kidney disease patients report experiencing significant lifestyle changes from the disease (1). Researchers including Auslander, Dobrof, and Epstein (1), Burrows-Hudson (2), and Kimmel et al. (3) have found that psychosocial issues negatively impact health outcomes of patients and diminish quality of life. Because of the importance of these factors, every dialysis and kidney transplant center must have a master’s level social worker on its interdisciplinary team to help patients with psychosocial barriers to CKD outcomes.

References
Fistula First aims to increase arteriovenous fistula (AVF) use in prevalent hemodialysis patients from 32.4 percent (2003) to 66 percent, while reducing central venous catheter (CVC) use.

Stakeholder efforts ranging from vascular surgeon collaborations to restructuring reimbursement have driven the AVF rate up to 52.6 percent in 2009. But gaps remain in new AVF creation and in cannulation afterward. In-center continuous quality improvement protocols focusing on AVF processes are necessary, but not sufficient. Considering the patient side of the AVF equation may help us to reach—or exceed—that 66 percent goal.

Walk a mile in a patient’s shoes

Many patients who start dialysis are poorly informed of their treatment choices and unaware of what “treatment” entails. Among 109,321 incident ESRD patients, only 50 percent had nephrology care in the 24 months before dialysis (1). Dialysis is a tremendous mental, physical, and psychological blow even when patients are prepared. They are asked to change schedules, diets, fluid intake, and medications. They may lose jobs, homes, or relationships. Some third may have intradialytic hypotension, with painful muscle cramps, headaches, nausea and vomiting.

With CVCs in place, patients can observe their chair neighbors who have fistulas. From the patient’s perspective, the sight of a fistula may create concerns or even fears. The following quotes are from patients who participated in a public dialysis-support email listserv that highlight needle-related concerns reported by some dialysis patients.

Have you seen those needles?

Needle fear is an underrecognized cause of refusal to have an AVF or permit one to be cannulated. Among the general population, an estimated 10 percent have needle phobia that triggers an involuntary vasovagal response—dizziness, nausea, fainting, even cardiac arrhythmias (1).

In 2007, 341,264 Americans used hemodialysis. If 52.6 percent of patients have AVFs, this represents more than 56 million cannulations per year, with 17 to 14 gauge dialysis needles. A PubMed search of “hemodialysis needle fear” found just two studies, both only peripherally addressing the topic (2,4). Yet for patients, needles can be a deal-breaker. Below are two quotes taken from a public dialysis-support email listserv that highlight needle-related concerns reported by some dialysis patients.

Moving forward with fistulas

It is important that the entire dialysis care team recognize that new dialysis patients may have no intrinsic motivation to proceed with fistula creation and use. Improving patient motivation requires an interdisciplinary dialysis team approach. For example, the team can support the choice to have a fistula by:

- calming fears. Address needle fear with hypnosis referral, instruction to squeeze leg and non-access arm muscles during cannulation (prevents syncope), and by offering pain relief. Topical lidocaine (EMLA®, Topicaine®, LMX®, and Less-N-Pain® avoid additional needles, but must be applied one to two hours prior to treatment.
- addressing body image concerns. Acknowledge that dialysis causes losses to be grieved. Some patients choose to view their accesses as “battle scars.” The Buttonhole Technique may reduce unattractive aneurysms and reduce needle pain (3).
- educating patients. The interdisciplinary team knows that fistulas provide optimal outcomes, but patients may not. Start by asking them to tell you what they know about access, so you can correct myths and start a dialog.

In the end, the responsibility of helping patients overcome their concerns about getting or using an AVF cannot be left to one member of the dialysis team. Nephrologists, in collaboration with social workers, nurses, patient care technicians, and dietitians, can provide a unique solution to this multifactorial problem. Understanding the patient’s perspective is central to improving the U.S. fistula success rate.

Dori Schatell is executive director of Medical Education Institute in Madison, WI. Joseph Merighi, PhD, is associate professor of human behavior at Boston University School of Social Work.

References
Kidney Disease Patient Education Classes Now Reimbursable by Medicare

By Caroline Jennette

Kidney Disease Education (KDE) classes are now reimbursable by Medicare. Patient education services were mandated by the Medicare Improvements for Patients & Providers Act of 2008 and became effective January 1, 2010.

Who is allowed to administer KDE classes?
KDE services may be delivered by a physician, physician assistant, nurse practitioner, clinical nurse specialist, or if in a rural area (defined by Metropolitan Statistical Area), KDE services may be provided by a hospital, critical access hospital, skilled nursing facility, outpatient rehabilitation facility, home health provider, or hospice. Under no circumstances can a dialysis unit provide or bill for Medicare KDE sessions, even if it resides within a hospital.

Who is eligible for KDE services?
Medicare Part B beneficiaries with stage 4 chronic kidney disease can be referred for KDE classes. Beneficiaries with an estimated glomerular filtration rate of under 15 or over 30 are ineligible for services.

Is there a set curriculum for the KDE classes?
There is no standardized curriculum except that sessions must cover all topics listed in the regulations (see Table 1). The National Kidney Foundation has developed a curriculum that fits the regulations and is available for free from www.kidney.org/YTYC.

How will KDE classes be measured for effectiveness?
There is not a standardized tool for outcomes measurement yet, but the Department of Health and Human Services is “considering working with organizations that are developing outcomes assessments as they work to develop a standardized assessment tool.” However, outcomes assessments are supposed to be administered to the beneficiary during a KDE session and available to CMS by request.

How are the classes supposed to be formatted?
Sessions may be done individually or in a group, and each beneficiary may receive a maximum of six sessions. Sessions are billed at one hour. Group sessions may accommodate two to 20 people. All sessions must be “face to face.”

How are the classes billed?
Two separate billing codes can be used depending on whether the sessions are done individually or in groups:
- HCPGS G0420 (CPT 97082): face-to-face, educational services related to the care of chronic kidney disease; IN-DIVIDUAL, per session, per one hour
- HCPGS G0421 (CPT 97804): face-to-face educational services related to the care of chronic kidney disease; GROUP, per session, per one hour

Caroline Jennette is legislative liaison at the University of North Carolina Kidney Center.

Table 1. Content standards for Kidney Disease Patient Education Services

<table>
<thead>
<tr>
<th>Management of comorbidities including for the purpose of delaying the need for dialysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention and treatment of cardiovascular disease</td>
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<tr>
<td>Prevention and treatment of diabetes</td>
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<tr>
<td>Hypertension management</td>
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<tr>
<td>Anemia management</td>
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<tr>
<td>Bone disease and disorders of calcium and phosphorus metabolism management</td>
</tr>
<tr>
<td>Symptomatic neuropathy management</td>
</tr>
<tr>
<td>Impairments in functioning and well-being</td>
</tr>
<tr>
<td>Prevention of uremic complications</td>
</tr>
<tr>
<td>Information on how the kidneys work and what happens when the kidneys fail</td>
</tr>
<tr>
<td>Understanding if remaining kidney function can be protected, preventing disease progression, and realistic chances of survival</td>
</tr>
<tr>
<td>Diet and fluid restrictions</td>
</tr>
<tr>
<td>Medication review, including how each medication works, possible side effects and minimization of side effects, the importance of compliance, and informed decision-making if the patient decides not to take a specific drug</td>
</tr>
<tr>
<td>Therapeutic options, treatment modalities, and settings, including a discussion of the advantages and disadvantages of each treatment option and how the treatments replace the kidney</td>
</tr>
<tr>
<td>Hemodialysis, both at home and in-facility</td>
</tr>
<tr>
<td>Peritoneal dialysis (PD), including intermittent PD, continuous ambulatory PD, and continuous cycling PD, both at home and in-facility</td>
</tr>
<tr>
<td>All dialysis access options for hemodialysis and peritoneal dialysis</td>
</tr>
<tr>
<td>Transplantation</td>
</tr>
</tbody>
</table>

Opportunities for beneficiaries to actively participate in the choice of therapy and to help tailor it to meet their needs including |
| Physical symptoms |
| Impact on family and social life |
| Exercise |
| The right to refuse treatment |
| Impact on work and finances |
| The meaning of test results |
| Psychological impact |
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The primary preparatory course for ABIM’s initial certification and MOC examinations in nephrology

And the premier update for the practicing nephrologist
The second annual ASN In-Training Exam (ITE) was given on April 8 and 9, 2010, at 122 different institutions nationwide. The ITE is an Internet-based test administered by the National Board of Medical Examiners that closely mimics the American Board of Internal Medicine’s initial certifying exam in nephrology. The results of the exam allow nephrology training program directors (TPDs) to compare their fellows both internally and with all other fellows in the country who took the exam. It also allows TPDs to identify subject areas that are lacking and need further attention as well as individual fellows who may need more direction in a certain subject.

For fellows, ITE offers an opportunity to assess their knowledge about all areas of nephrology. The exam was created and is maintained and updated by a subgroup of the ASN Training Program Directors Executive Committee led by Mitch Rosner, MD, associate professor of medicine at the University of Virginia.

ASN saw a substantial increase in registrants in one year—from 689 in 2009 to 754 in 2010. This number includes almost every first and second year nephrology fellow in the country. The test consists of 150 multiple-choice questions and takes about six hours to complete.

The exam, open to any nephrology fellow who is a member of ASN, will be an annual event. For more information, please contact ASN Senior Policy Coordinator Susan Owens at sowens@asn-online.org or (202) 416-0668, or visit the ITE Frequently Asked Questions website at http://asn-online.org/training/ite-faq.aspx. The results of the exam will be mailed to TPDs approximately six weeks after the test date.
High Rate of AKI Even in Non-Severe Pneumonia

Acute kidney injury occurs in up to one-fourth of patients with uncomplicated pneumonia, in association with increased mortality and an elevated immune response, according to a study in *Kidney International*.

The prospective study included 1836 hospitalized patients with community-acquired pneumonia (CAP). The overall rate of AKI in CAP patients was 34 percent. Fifty-two percent of the patients with AKI had severe sepsis, while 48 percent had non-severe sepsis. In 63 percent of cases, AKI was already present at the time of hospital admission.

Among patients with non-severe CAP, the rate of AKI was 16 to 25 percent, depending on subgroup classification. Patients with AKI were older, more likely to be white, and had more preexisting comorbidity and more severe CAP. They also had increased levels of biomarkers, including interleukin-6, tumor necrosis factor, and D-dimer—even in the absence of severe sepsis.

The risk of death associated with AKI was highest in the first 100 days after presentation. However, the increase in mortality remained significant through one-year follow-up. For non-severe CAP, hospitalization; or hospital-acquired hyponatremia worsened during the hospitalization; or hospital-acquired hyponatremia, in which community-acquired hyponatremia worsened during hospitalization; or hospital-acquired hyponatremia, in which serum Na+ was normal at baseline but fell to less than 138 mEq/L in the hospital.

About 38 percent of patients had CAH. This group was at increased risk of in-hospital death, adjusted odds ratio (OR) 1.52. Patients with CAH were also more likely to be discharged to a long-term or short-term care facility, OR 1.12; and had a 14 percent increase in length of hospital stay.

Hospital-associated hyponatremia occurred in 5.7 percent of patients who had hyponatremia at admission. The OR for in-hospital mortality was 2.30 for this group, compared to 1.46 for patients with CAH but no further decrease in serum Na+.

Of patients who stayed in the hospital for more than one day and had an admission serum Na+ of 138 to 142 mEq/L, 38 percent developed hospital-acquired hyponatremia. This group also had increased in-hospital mortality, OR 1.66; and increased risk of discharge to a facility, OR 1.64. Patients with hospital-acquired hyponatremia also had a 64 percent increase in length of stay. The consequences of hyponatremia tended to be greater at lower Na+ levels.

The adverse prognostic impact of hyponatremia is well known, but few studies have included the full range of patients with hospital-associated hyponatremia or examined outcomes other than mortality. This large, unsel ected series finds that both CAH and hospital-acquired hyponatremia are common conditions associated with increased in-hospital mortality and increased resource use.


Across eGFRs, Proteinuria Linked to Increased Mortality

Proteinuria is an independent predictor of mortality and progressive kidney disease at all levels of estimated glomerular filtration rate (eGFR)—including normal kidney function, according to a report in *The Journal of the American Medical Association*.

Alberta laboratory registry data were used to evaluate relationships among eGFR, proteinuria, and adverse clinical outcomes. The analysis included more than 920,000 adults who had at least one outpatient serum creatinine measurement between 2002 and 2007 and were not receiving renal replacement therapy at baseline. Proteinuria was assessed by both dipstick and albumin-to-creatinine ratio (ACR).

Eighty-nine percent of patients had a normal eGFR (60 mL/min/1.73 m2 or greater). On adjusted analysis, all-cause mortality was higher in patients with lower eGFR or higher proteinuria. Adjusted mortality per 1000 person-years was 7.2 for patients with heavy dipstick-measured proteinuria but normal eGFR, compared to 2.9 for those with decreased eGFR (45 to 59.9 mL/min/1.73 m2) but normal protein excretion. Proteinuria measured by ACR showed a similar effect on mortality. Heavy proteinuria was also independently associated with progressive kidney disease, including end stage renal disease and doubling of serum creatinine, and with acute myocardial infarction.

Current guidelines for kidney disease staging rely on eGFR but do not address the presence or severity of proteinuria—an important CKD marker that is also associated with adverse outcomes. Many patients with low eGFR do not have proteinuria, and vice versa.

This study shows increased rates of death and other adverse outcomes in patients with heavy proteinuria, regardless of eGFR. In fact, outcomes appear worse for patients with normal eGFR and heavy proteinuria than for those with decreased eGFR but normal proteinuria. “These findings suggest that future revisions of the classification system for CKD should incorporate information from proteinuria,” the researchers write [Hemmelgarn BR, et al. Relation between kidney function, proteinuria, and adverse outcomes. *JAMA* 2010; 303:423–429].

Hospital-Associated Hyponatremia: High Costs and Consequences

Hyponatremia, whether community- or hospital-acquired, is a common problem that is associated with increased mortality and resource utilization, according to a report in *Archives of Internal Medicine*.

The cohort study included more than 53,000 adult hospitalizations at one tertiary care hospital between 2000 and 2007 for which an admission sodium level was available. The researchers analyzed the rates and outcomes of community-acquired hyponatremia (CAH), defined as an admission serum Na+ of less than 138 mEq/L; hospital-aggravated hyponatremia, in which community-acquired hyponatremia worsened during hospitalization; or hospital-acquired hyponatremia, in which serum Na+ was normal at baseline but fell to less than 138 mEq/L in the hospital.

About 38 percent of patients had CAH. This group was at increased risk of in-hospital death, adjusted odds ratio (OR) 1.52. Patients with CAH were also more likely to be discharged to a long-term or short-term care facility, OR 1.12; and had a 14 percent increase in length of hospital stay.

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Letters

*ASN Kidney News* accepts letters to the editor in response to published articles. Please submit all correspondence to kidneynews@asn-online.org
FDA and NIH Collaborate to Bring New Treatments to the Public

American Society of Nephrology (ASN) public policy staff recently participated in a briefing on a new partnership between the U.S. National Institutes of Health (NIH) and the Food and Drug Administration (FDA). The two agencies will work together to improve the processes for bringing new drugs and treatments through the approval process, thus making new therapies publicly available and improving public health.

NIH Director Francis Collins, MD, and FDA Commissioner Margaret Hamburg, MD, established the Joint NIH FDA Leadership Council, which will work to improve regulatory tools, make regulatory considerations part of biomedically research planning, and integrate the latest science into the regulatory review process.

NIH and FDA also issued a Request for Applications to encourage research in regulatory science on February 24, 2010. According to Health and Human Services Secretary Kathleen Sebelius, “much more can be done to speed the progress from new scientific discoveries to treatment for patients. Collaboration between NIH and FDA will go a long way to foster access to the safest and most effective therapies for the American people.”

ASN enthusiastically supports this collaboration. The society’s major legislative priorities include funding medical research in kidney disease and improving the success of kidney transplants. Designing research studies with a proactive approach to navigating the regulatory process, and improving the ability to carefully and efficiently evaluate the efficacy of new treatments, will help address the significant needs of millions of Americans who suffer from chronic kidney disease.


Patients in the Public Safety Net: A Blind Spot in Medical Care?

Addressing profound health care disparities is a major legislative priority of ASN in 2010. As part of its commemoration of World Kidney Day on March 11, ASN highlighted the recently published work of Yoshio Hall, MD, Andy Choi, MD, Glenn Chertow, MD, and Andrew Bindman, MD. Their study, titled Chronic Kidney Disease in the Urban Poor (Clinical Journal of the American Society of Nephrology, doi 10.2215/C JN.09011209), emphasizes the need to better understand and address the burden and progression of chronic kidney disease (CKD) in underserved populations. Safety net medical settings provide care to millions of Americans who cannot afford medical care or are not eligible for health insurance.

Hall and his colleagues examined data from 15,353 adults with nondialysis-dependent CKD stages 3 to 5 who were cared for in safety net settings in San Francisco. The patients were followed for periods ranging from 12 months to 9.4 years. The vast majority were indigent (73 percent had annual incomes less than $15,000), 8 percent were homeless, and 46 percent unemployed. Forty percent were uninsured or enrolled in Medicaid, and one-third spoke a primary language other than English. The vulnerable populations studied are highly underrepresented in prior U.S.-based studies of kidney disease.

In this public health care setting, the study authors found that moderate to severe CKD afflicted a large fraction of younger adults, most of whom were members of racial-ethnic minority groups. They further observed that poor minority adults with moderate to severe CKD were two to four times more likely to progress to kidney failure than non-Hispanic whites. The authors concluded that additional research is vital to assess the extent and burden of kidney disease in other safety net settings, particularly as the nation contemplates how to enhance access to effective care for uninsured and underinsured Americans.

World Kidney Day and Beyond: ASN Advances Key Priorities in Kidney Care

World Kidney Day is a global health awareness campaign designed to inform lawmakers and the public about the prevalence of kidney disease and the importance of improving the lives of millions who suffer from kidney disease worldwide.

ASN leaders gathered in Washington, DC, on Thursday, March 11, 2010, and visited members of Congress and their staff. In visits to congressional offices and a series of radio interviews with national media, ASN leaders reviewed the four major legislative priorities for ASN in 2010:

• Address Profound Health Care Disparities
• Improve the Success of Kidney Transplants
• Fund Medical Research that Improves Kidney Health
• Fix the Flawed Sustainable Growth Formula

Several ASN leaders were invited to more informal sessions hosted by U.S. senators and representatives and discussed with them the issues noted above and the effect of kidney disease on individuals and their caregivers.

In collaboration with the National Kidney Foundation and Dialysis Patient Citizens, ASN hosted a reception for members of Congress, patient advocates, and kidney professionals at which speakers discussed how kidney disease affects Americans and what is being done in the professional and public arenas to address this growing health threat.

Throughout the year, ASN advocates for these important legislative goals. For example, ASN recently joined with 14 other organizations representing professionals in organ donation and transplantation to urge President Obama and Congress to extend Medicare funding for immunosuppressive drug coverage. The current 36-month limit on Medicare coverage of these drugs often causes patients to reduce or stop using them, and can result in transplant failure. Extended coverage would prolong the lives of millions of transplant recipients, reduce taxpayer costs, and allow more dialysis patients to consider transplant.

ASN President Sharon Anderson, MD, FASN, recently wrote U.S. Senate Majority Leader Harry Reid urging him to rescind the 21 percent Medicare physician payment cut. Millennials of seniors and military veterans rely on government-supported health care, and drastic physician payment cuts affect the ability of clinics and hospitals to sustain operations to care for these individuals. At press time, the House of Representatives and Senate were working to address this issue.

ASN urges its members to visit the policy section of the ASN website and learn how to become involved in supporting these important priorities in kidney care.

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The FDA imposed a Class I recall on Baxter's HomeChoice and HomeChoice PRO peritoneal dialysis (PD) cyclers because the cyclers could overfill a patient's abdominal cavity, a condition referred to as increased intra-peritoneal volume (IIPV). The FDA noted that although Baxter is not removing the HomeChoice and HomeChoice PRO from the market, "clinicians should weigh the risks and benefits to continued use of these devices by their patients versus other forms of dialysis therapy." The FDA suggested that clinicians also review the prescription settings for patients who continue to use the devices.

Baxter said on its website that it had received serious injury reports, and at least one notice of death considered to be linked to IIPV. The company sent notices to clinicians and patients to inform them of the FDA recall and is identifying steps that should be enacted to reduce the risk of harm associated with IIPV. As for the signs and effects of IIPV, Baxter noted that children and non-verbal patients may be at increased risk because of their smaller size or inability to communicate. The company recommends increased monitoring of these patients, and others who may be vulnerable, including critically ill patients and patients with pulmonary and hemodynamic instability.

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