Re: End-Stage Renal Disease Vascular Access Measure Development

To Whom It May Concern:

On behalf of the American Nephrology Nurses Association (ANNA), I appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) and University of Michigan Kidney Epidemiology and Cost Center’s (UM-KECC) proposed draft End-Stage Renal Disease (ESRD) Vascular Access measures. ANNA is supportive of CMS and UM-KECC’s efforts to improve patient mortality by developing hemodialysis vascular access measures.

ANNA promotes excellence in and appreciation of nephrology nursing so that we can make a positive difference for people with kidney disease. Established as a nonprofit organization in 1969, ANNA has a membership of approximately 10,000 registered nurses in almost 100 local chapters across the United States. We are the only professional association that represents nurses who work in all areas of nephrology, including hemodialysis, chronic kidney disease, peritoneal dialysis, acute care, and transplantation. Most of our members work in freestanding dialysis facilities, hospital outpatient units, and hospital inpatient dialysis units.

ANNA develops and updates standards of clinical practice, educates practitioners, stimulates and supports research, disseminates knowledge and new ideas, promotes interdisciplinary communication and cooperation, and monitors and addresses issues encompassing the breadth of practice of nephrology nursing.

Hemodialysis Vascular Access: Long-term Catheter Rate

ANNA applauds CMS and UM-KECC’s efforts to develop a hemodialysis vascular access long-term catheter rate measure. We are supportive of the work to build a vascular access measure that accounts for patient preference in addition to risk adjustment factors. An accurate count of the number of patients who use catheters more than 90 days as their access to hemodialysis is fundamentally important in the efforts to reduce overall utilization rates of central venous catheters (CVCs) for greater than 90
days, decrease the substantial morbidity and mortality associated with long-term catheter use, and limit the unnecessary use of health care resources.

As you are aware, there are numerous advantages to using an arteriovenous (AV) fistula (AVF) for hemodialysis as compared to a catheter or AV graft. The use of AVF 90 days after the initiation of hemodialysis has been found to be associated with reduced cardiovascular and all-cause mortality. Additionally, the use of an AVF is “recognized as the optimal type of HD [hemodialysis] vascular access for its longer patency, fewer infectious complications, and is associated with lower all-cause mortality compared with the AV graft or central venous catheter (CVC).” In those circumstances in which hemodialysis patients are unable to successfully establish or maintain an AVF, ANNA acknowledges that an AV graft is an acceptable alternative.

Moreover, we recognize that for those patients in whom kidney disease has progressed quickly, there may be insufficient time to prepare permanent vascular access before dialysis treatments are started. Choosing peritoneal dialysis as the treatment modality, rather than starting hemodialysis with a CVC catheter, has a mortality advantage of one to two years. For patients choosing peritoneal dialysis as their kidney replacement therapy, ANNA believes that urgent-start peritoneal dialysis to initiate dialysis is a superior alternative to initiating hemodialysis with a CVC for many patients. Research studies have demonstrated that the use of a CVC increases mortality risk compared with incident dialysis patients who initiated treatment with peritoneal dialysis, AVF, or an AV graft. We also would recommend that CMS recognize the potentially negative effect the CVC measure can have on small units with a larger population of peritoneal dialysis patients.

However, the proposed measure fails to allow for those individuals with ESRD who are unable to support internal access and whose only choice is a CVC. ANNA has concerns the long-term catheter rate measure, as currently drafted, will inappropriately penalize a dialysis facility that receives into its care a patient with a CVC who has transferred from a different facility or unit during the measurement period. ANNA encourages UM-KECC to consider how to account for such patients and avoid penalizing dialysis facilities and units in such circumstances.

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Hemodialysis Vascular Access: Standardized Fistula Rate

ANNA is pleased CMS and UM-KECC have created a vascular access measure that adjusts for patient-specific factors in instances when fistula placement may be difficult or not appropriate, and accounts for circumstances in which an AV graft may be the most viable option for vascular access. We are supportive of UM-KECC’s proposal to adjust for provider-driven selection bias within the standardized fistula rate hemodialysis vascular access measure. Additionally, ANNA agrees with UM-KECC’s proposed list of exclusions as well as the fistula rate model adjustments for age, body mass index (BMI), nursing home status, duration of ESRD, nephrologist care prior to ESRD, inability to ambulate/transfer, and incident and prevalent comorbidities.

ANNA is hopeful the standardized fistula rate and long-term catheter rate measures will help to improve the quality of dialysis care and urges CMS to proceed accordingly. We encourage CMS and UM-KECC to continue this work to develop a measure that will appropriately reduce the use of CVCs and increase the use of AVFs in incident dialysis patients.

Conclusion

ANNA greatly appreciates the opportunity to share our comments on the ESRD vascular access measures. As the leading professional association representing nephrology nurses, we look forward to continuing to work with you and CMS on these important issues. Should you have any questions, please contact me or have your staff contact our Health Policy Consultant, Kara Gainer (Kara.Gainer@dbr.com or 202-230-5649). We thank you for your consideration.

Sincerely,

Cindy Richards, BSN, RN, CNN
President, 2015-2016