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The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
P.O. Box 8010  
Baltimore, MD 21244-8010

*Re: Medicare Program; End-Stage Renal Disease Prospective Payment System, Payment for Renal Dialysis Services Furnished to Individuals with Acute Kidney Injury, End-Stage Renal Disease Quality Incentive Program, and End-Stage Renal Disease Treatment Choice Model (Proposed Rule)*

Dear Administrator Brooks-LaSure,

On behalf of the American Nephrology Nurses Association (ANNA), I write to provide comments on the proposed rule for the Medicare Program; End-Stage Renal Disease Prospective Payment System, Payment for Renal Dialysis Services Furnished to Individuals with Acute Kidney Injury, End-Stage Renal Disease Quality Incentive Program, and End-Stage Renal Disease Treatment Choice Model (proposed rule). In addition to our comments on the proposed rule, we have also highlighted important issues facing nephrology nurses to provide context.

The American Nephrology Nurses Association improves members' lives through education, advocacy, networking, and science. Since it was established as a nonprofit organization in 1969, ANNA has been serving members who span the nephrology nursing spectrum. ANNA has a membership of over 8,000 registered nurses and other health care professionals at all levels of practice. Members work in areas such as conservative management, peritoneal dialysis, hemodialysis, continuous renal replacement therapies, transplantation, industry, and government/regulatory agencies. ANNA is committed to advancing the nephrology nursing specialty and nurturing every ANNA member. We achieve these goals by providing the highest quality educational products, programs, and services. Our members are leaders who advocate for patients, mentor each other, and lobby legislators, all to inspire excellence.

We also strongly support closing the health equity gap in our country. In June 2020, the ANNA Board of Directors released a statement that read in part, "ANNA stands in solidarity with our members and the patients for whom we provide care, whose health and well-being are threatened by long-standing inequality stemming from racism and injustice. ANNA recognizes that patient populations impacted by racism and injustice often are also the same populations at an increased risk of developing kidney disease. Despite these challenges, and recently in the face of a pandemic, nephrology nurses show

up to provide compassionate and respectful care to all patients, acknowledging the inherent dignity, worth, and unique attributes of every person without prejudice.”

To commit to the call to action, ANNA created a Diversity, Equity, and Inclusion Committee with the purpose of “influencing kidney health by engaging within the communities we serve to address healthcare equity and advocate for improved access to nephrology health care and education for all.” The committee works to “build a diverse and inclusive association that will ensure that our practices and policies do not allow, condone, or result in discrimination and create an ongoing educational process to build diversity, equity, and inclusion competencies.”

ANNA believes that the demand for quality nephrology care will continue to grow, particularly considering the ongoing effects of COVID-19 on individuals experiencing acute kidney injury (AKI) and chronic kidney disease (CKD).<sup>1</sup> Nephrology nurses are in a unique position to enhance the quality of care delivered to individuals with kidney disease in a variety of settings. The challenging yet determined work of nephrology nurses during the COVID-19 pandemic, whether in-center, acute care settings, or preparing individuals for home therapies, only underscores the importance and value they bring to the care of End Stage Renal Disease (ESRD) beneficiaries. To that end, we urge you to consider the following when finalizing this proposed rule.

**I. Calendar Year (CY) 2023 End-Stage Renal Disease (ESRD) Prospective Payment System (PPS)**

***Provisions for the CY 2023 ESRD PPS Update:***

ANNA believes that the best way to address changes in the mix of goods and services in a market basket is to rebase to a more current year. We agree with CMS that using 2016 data to rebase will not reflect the current mix of goods and services adequately and we support using 2020 data to rebase the market basket. Additionally, as per Kidney Care Partners’ (KCP) comment letter, we support the proposed cap on wage index changes as they will promote predictability. However, as noted by KCP, since CMS does not have the authority to eliminate the productivity factor, we remain concerned with the continued application of that factor to cut the ESRD PPS base rate. Lastly, ANNA, along with KCP, requests that when updating the ESRD PPS base rate, CMS also update it to reflect errors in the projection use.

***Request for Information About Addressing Issues of Payment for New Drugs After Transitional Drug Add-On Payment Adjustment (TDAPA) Period Ends:***

ANNA appreciates CMS’s attention to the kidney care community’s concerns about the current blanket “no new money” policy restricting any adjustments to the ESRD PPS system rate when a new drug or biological is introduced to bundle into an existing

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<sup>1</sup> Nugent J, Aklilu A, Yamamoto Y, et al. Assessment of Acute Kidney Injury and Longitudinal Kidney Function After Hospital Discharge Among Patients With and Without COVID-19. JAMA Netw Open. 2021;4(3):e211095. doi:10.1001/jamanetworkopen.2021.1095

functional category at the end of a TDAPA period. However, add-on payment adjustments for new drugs and biologicals that fall within existing categories after the TDAPA period ends are necessary to protect access to these innovative products. To resolve this conflict, we agree with the recommendations made by KCP in their response to this RFI and urge CMS to consider those recommendations moving forward.

**Health Equity RFI:**

An estimated 37 million Americans live with chronic kidney disease and most are undiagnosed. In fact, 40% of people with severely reduced kidney function (not on dialysis) are not aware of having CKD. Every 24 hours, 360 people begin dialysis treatment for kidney failure.<sup>2</sup> These statistics are even more alarming in communities of color. The Centers for Disease Control and Prevention (CDC) reports that 16% of non-Hispanic Black adults and 14% of Hispanic adults in the United States have CKD, compared to only 13% of non-Hispanic White or Asian adults in the United States. The NIH notes that higher risk for CKD among these groups is primarily due to higher risk for other conditions such as diabetes and high blood pressure, both of which are highly prevalent among Black, Latino, and Native American patients in the United States.<sup>3</sup>

ANNA strongly believes that “Fixing health disparities begins with acknowledging their existence and understanding how the various disparities influence an individual’s health. It requires a knowledge of the social determinants of health and how they can affect each individual/patient and populations of people. To know our patients, care for them, and advocate for them, we must look beyond their blood pressures, glomerular filtration rates, and weight gains between dialysis procedures to understand the social determinants of health that preceded their kidney disease and its manifestations.”<sup>4</sup> We stand with CMS in their commitment to health equity and recommend the agency take swift action from the feedback received in this proposed rulemaking to address health disparities in ESRD patients.

To that end, we applaud CMS for the recently published Framework for Health Equity and agree with the approach outlined by the five core priority areas which will inform CMS policies and programs.<sup>5</sup> We also appreciate the various guidance CMS has developed to

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<sup>2</sup> CDC, Chronic Kidney Disease Initiative, February 28, 2022, available at <https://www.cdc.gov/kidneydisease/basics.html#:~:text=15%25%20of%20US%20adults%20are,number%20of%20red%20blood%20cells> (last visited July 21, 2022).

<sup>3</sup> Patient-Centered Outcomes Research Institute, Minority Health Month: Spotlight on Chronic Kidney Disease, April 18, 2022, available at [https://www.pcori.org/blog/minority-health-month-spotlight-chronic-kidney-disease#:~:text=Chronic%20kidney%20disease%20\(CKD\)%20disproportionately,other%20racial%20or%20ethnic%20identities](https://www.pcori.org/blog/minority-health-month-spotlight-chronic-kidney-disease#:~:text=Chronic%20kidney%20disease%20(CKD)%20disproportionately,other%20racial%20or%20ethnic%20identities) (last visited July 21, 2022).

<sup>4</sup> Stat News Look to nurses to help accelerate the transformation of health care by Lynda Benton, Robyn Begley and Debbie Hatmaker Aug. 20, 2021.

<sup>5</sup> CMS Framework for Health Equity, July 8, 2022, available at <https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/framework-for-health-equity> (last visited July 21, 2022)

advance health equity, including the *CMS Mapping Medicare Disparities Tool*, the *Rural Urban Disparities in Health Care in Medicare Report*, the *CMS Innovation Center's Accountable Health Communities Model*, the *Guide to Reducing Disparities*, and the *Chronic Kidney Disease Disparities: Educational Guide for Primary Care*.<sup>6</sup>

### 1. ANNA comments on issues raised by Technical Expert Panel

Furthermore, we commend CMS on engaging stakeholders by convening a technical expert panel (TEP) to discuss issues in health disparities related to kidney care. In response to the TEP's conclusion, we offer the following observations:

- a. **Direct Patient Care Labor Categories in Dialysis.** The TEP stated that actual direct patient care labor costs associated with providing renal dialysis services are not currently being accurately captured and additional direct patient care labor categories should be explored. We agree. Dialysis centers cannot compete with other healthcare settings such as hospitals due to wage competition. We urge CMS to examine how to accurately capture labor costs to ensure individuals still have timely access to these treatments; anecdotally, providers are reporting having to pay higher wages to attract nurses and technicians into dialysis.
- b. **Subpopulations with Observable Disparities in Treatment or Outcomes related to ESRD.** ANNA agrees with the TEP suggestion that patients who experience homelessness, are undocumented, have limited English proficiency, and those that have mental health issues should be considered a subgroup at risk. With policies pushing for individuals who need dialysis to be sent home for continued care, it is imperative to recognize that the underlying issue of homelessness must be addressed so that the policy can be realized. Additionally, we highlight that there must be a serious and sustained investment in addressing limited English proficiency. Limited English proficiency is not only an issue during treatment or training, but when an emergency may occur, and the patient may be harmed because there is a language barrier.
- c. **Payment Accuracy.** With regard to payment accuracy, the TEP stated that there were patient groups and provider types for which payments were inadequate, and we agree. As CMS is exploring appropriate reimbursement, ANNA stands ready to help in these determinations.

### 2. ANNA comments on the Request for Information on Advancing Health Equity Under the ESRD PPS

We applaud CMS' continued work to address health inequity in our country and we are especially pleased at the recognition that racial disparities affect treatment for ESRD. ANNA strongly believes that addressing social determinants of health (SDoH) is a

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<sup>6</sup> ESRD Proposed Rule, Federal Register, Vol. 87, No. 123, p. 38535.

foundational step in achieving health equity. To that end, we submit the following observations for your consideration:

- a. While refining payment policy to mitigate health disparities is an important issue, we urge CMS to increase the bundle payment to address underlying SDOHs that contribute to health disparities.
- b. The more co-morbidities an individual has, the more complex his or her care plan. These patients need more time, resources, and money to receive the care they need. We ask that CMS consider a holistic approach to care, so that an individual's co-morbidities can be appropriately managed alongside their dialysis treatments. CMS should further consider capturing data related to SDOH and using it to prevent co-morbidities. We also urge CMS to invest in educating individuals on chronic kidney disease (CKD). The CDC estimates that 40% of people with severely reduced kidney function (and not on dialysis) are not aware of having CKD.<sup>7</sup> As CKD progresses in these individuals, the more expensive their treatment becomes. Catching CKD earlier not only benefits the patient and affords them a better quality of life, but it will also help curb the cost of treatment for CKD.
- c. As CMS is aware, there is an acute lack of data related to specific patient populations. While ANNA members can provide countless anecdotes on factors that affect communities of color, we are not equipped to collect the data in a meaningful way. As CMS proceeds to discuss how to address data collection and analysis, ANNA would appreciate the opportunity to be a part of the discussion to provide the viewpoint of practicing nephrology nurses who can help understand the data and its implications.
- d. When deciding what additional data to collect, we recommend collecting data related to food insecurity, shelter insecurity, and access to transportation as this can greatly affect the quality of patient care.
- e. With regard to technology, ANNA supports new and innovative technologies in the dialysis space. However, the technology is not useful for those who do not have internet access. We urge CMS to work with Congress and other regulatory agencies to swiftly address the issue of broadband access to ensure an individual's care needs are met.
- f. When collecting self-identified demographic data, we urge caution as this collection method may perpetuate racial disparities.

“Several scholars contend that self-identified race/ethnicity does not adequately characterize the contextual aspect of race – the lived experience and

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<sup>7</sup> CDC, Chronic Kidney Disease Initiative, February 28, 2022, *available at* <https://www.cdc.gov/kidneydisease/basics.html#:~:text=15%25%20of%20US%20adults%20are,number%20of%20red%20blood%20cells> (last visited July 26, 2022)

opportunities of racial/ethnic groups. It has been argued that self-identified race/ethnicity is not sufficient to represent the individual and structural components of experiencing race in a racialized society. First, a singular reliance upon self-identified race/ethnicity may conceal intraracial heterogeneity in the experience of race and racism. Members of the same racial/ethnic group may have vastly different lived experiences based on how others perceive them. The social interactions of an individual who self-identifies as black and is perceived as white may be qualitatively different from the social interactions of an individual who self-identifies as black but is perceived as black. For example, individuals who self-identify and are socially assigned as black may have a higher likelihood of exposure to daily microaggressions and racial discrimination relative to individuals who self-identify as black and socially assigned as white. Second, there is a growing divergence between how respondents identify and how others see them. For instance, Latinx populations are frequently socially assigned to a race that is inconsistent with their self-identification. The experience of race is not static and can change for an individual as a function of social relationships, time, and context. The changing population demographics in the United States present new opportunities for understanding the complexity of race and mechanisms that produce and maintain racial inequality in an increasingly multiracial and majority-minority society. Solely relying on self-identified race to measure group membership may not be sufficient to capture the relational nature of race, particularly where racism is the central underlying mechanism.”<sup>8</sup>

- g. Additionally, CMS should consider collecting SDoH data using Z-codes to account for and report on the most common non-clinical barriers to home dialysis, including housing or financial insecurity, minimal caregiver support, other mental and certain physical illnesses, or advanced age to provide information about these barriers and develop policies to overcome them and to be able to set target rates of home dialysis adoption.
- h. In addition to our recommendations above, we also echo the recommendations made by KCP in their letter. Namely, CMS should:
  - Expand access to CKD screening;
  - Incentivize medical professionals to specialize in nephrology; and
  - Provide CKD treatment and education earlier in the progression of the disease and before an individual’s kidney’s fail.

ANNA works as a leading member of patient care for kidney disease and our nursing communities are committed to advocating for equity and inclusion on behalf of our patients. Addressing these inequities and improving patient outcomes are at the center of health care. We recognize the multifaceted needs of the nephrology patient population,

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<sup>8</sup> White, K., Lawrence, J.A., Tchangalova, N. *et al.* Socially-assigned race and health: a scoping review with global implications for population health equity. *Int J Equity Health* 19, 25 (2020). <https://doi.org/10.1186/s12939-020-1137-5>

but as you can see from our comments, we must support the nursing workforce so they can adequately support kidney patients and their individual needs and choices, and effect positive change and outcomes. Specifically, with data collection, it is prudent to recognize that staffing shortages will affect data collection as registered nurses are needed to ensure the accuracy of the data collected.

### **3. ANNA Comments on Request for Information Regarding Dialysis for Pediatric ESRD Patients**

With regard to pediatric ESRD patients, we note that this population is particularly impacted by health inequities. Home dialysis is preferred by pediatric patients due to its limited side effects, less disruptive to the school schedule, and because some children cannot tolerate hemodialysis because of their small size. Overall, we agree with and amplify the comments submitted by the American Society for Pediatric Nephrology (ASPN). Particularly, we highlight the following:

- a. SDoH of a caregiver directly affects the SDoH of a child. For patients who do have two parents as a caregivers, at least one parent or caregiver will need to provide full-time care, leading to a potential loss of income that disproportionately impacts disadvantaged populations.
- b. “Black children are significantly less likely to receive kidney transplants, wait longer to receive transplants, and are disproportionately impacted by CKD overall.<sup>9</sup> United States Renal Data System (USRDS) data show that the time to 50 percent incidence of kidney transplantation was 30 months in Black children compared to 19 months in White children.<sup>10</sup> Disparities in pediatric kidney care also extend to treatment modalities, with all racial and ethnic minorities being significantly less likely to receive home dialysis treatment than white patients.<sup>11,12</sup> Data show that a substantially higher percentage of Black children initiated hemodialysis compared with White children, 55.4 percent compared to 34.5 percent.<sup>13”</sup>
- c. There are a number of refinements that can be made to the ESRD PPS policy to mitigate health inequities in the pediatric population including

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<sup>9</sup> Laster M, Soohoo M, Hall C, et al. Racial–ethnic disparities in mortality and kidney transplant outcomes among pediatric dialysis patients. *Pediatr Nephrol*. 2017;32(4):685-695.

doi:10.1007/s00467-016-3530-2; Leonard MB, Donaldson LA, Ho M, Geary DF. A prospective cohort study of incident maintenance dialysis in children: An NAPRTC study. *Kidney Int*. 2003;63(2):744-755. doi:10.1046/j.1523-1755.2003.00788.x; Moxey-Mims M. Kidney Disease in African American Children: Biological and Nonbiological Disparities. *Am. J. Kidney Disease*, 2018;72(5):S17-S21. doi.org/10.1053/j.ajkd.2018.06.025.

<sup>10</sup> <https://adr.usrds.org/2021/end-stage-renal-disease/8-esrd-among-children-and-adolescents>

<sup>11</sup> Mehotra R, et al. Racial and Ethnic Disparities in Use of and Outcomes with Home Dialysis in the United States.

<sup>12</sup> <https://adr.usrds.org/2021/end-stage-renal-disease/8-esrd-among-children-and-adolescents>

<sup>13</sup> *Ibid*.

addressing housing instability and food insecurity and access to proper nutrition. Additionally, investments should be made to support the pediatric nephrology team since they are limited in number. As ASPN notes, there are two states without a single pediatric nephrologist and many more with fewer than one per 100,000 children.<sup>14</sup>

- d. ANNA agrees with ASPN’s recommendation “that a combination of age, weight, and pediatric-specific comorbidities be used as a proxy for composite rate costs.” ANNA also agrees with the list of co-morbidities compiled by ASPN for CMS’s consideration.
- e. CMS should consider direct patient labor categories when determining costs to provide renal dialysis services to pediatric patients because the care team for a pediatric patient requires additional training.

**II. Calendar Year (CY) 2023 Payment for Renal Dialysis Services Furnished to Individuals With Acute Kidney Injury (AKI):**

ANNA is committed to supporting home dialysis modalities for individuals living with kidney failure, including those with acute kidney injury. However, current federal policies do not allow coverage of home dialysis for AKI as reimbursement is limited to AKI treatments received through in-center dialysis. This limitation poses a barrier for patients, providers, and caregivers. As KCP notes in their comments, this is also a health equity issue; Black Americans are more likely than White Americans to experience AKI.<sup>15</sup> As a result, federal policies blocking those with AKI from selecting home dialysis modalities likely contributes to the gap in Black Americans with kidney failure not receiving the treatment they need. As such, ANNA urges CMS to eliminate this unnecessary barrier to home dialysis for individuals with AKI.

**III. End-Stage Renal Disease Quality Incentive Program (ESRD QIP)**

***Updates for the PY 2025 ESRD QIP:***

The impact of COVID-19 on the health care system has been vast and substantial, particularly for individual’s living with kidney disease as they are at risk for infection, re-infection, and experiencing complications of the disease. These complications are underscored by the nephrology nursing workforce shortage. As such, we agree with CMS’ proposal to suppress measures once again this year. However, as KCP explains in their comment letter, we also believe it is important to suspend the penalties for PY 2023 again as well.

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<sup>14</sup> <https://www.abp.org/sites/public/files/pdf/workforcedata2020-2021.pdf>

<sup>15</sup> Grams ME, Matsushita K, Sang Y, Estrella MM, Foster MC, Tin A, *et al.* “Explaining the racial difference in AKI incidence.” *25 J Am Soc Nephrol* 1834–41. (2014).



#### **IV. End-Stage Renal Disease Treatment Choices (ETC) Model**

***Proposed Updates to the ETC Model:*** ANNA appreciates CMS’s efforts to continually refine the ETC Model. However, we amplify KCP’s comments related to concerns with the proposed updates. Specifically, we highlight:

1. The underlying methodology needs to be revisited as the model shift toward the penalty phase and the success of the model is being devalued by the artificial comparison to the control group.
2. Launching the ETC and KCC Model simultaneously will confuse results and make it difficult to assess which policies led to the results.
3. While we support the flexibilities for the Kidney Disease Education (KDE) benefit, we do not support policies that narrow the benefit. To assist in better education, CMS should create comprehensive, clear, and non-branded materials tailored towards differing levels of health literacy to be used by advocacy groups.
4. The requirement to publish ETC participant performance may be confusing to stakeholders and it remains unclear how aggregation of individuals relying upon home dialysis will be accounted for in the performance publication.

#### **V. Other Issues for Consideration**

##### ***Workforce Retention and Attrition***

ANNA continues to have great concerns about ensuring an adequate, qualified, and resilient nursing workforce. This includes recruiting and retaining qualified nephrology nurses, and appropriately training, educating, and preparing nurses, patients, and caregivers for changes in dialysis treatment modalities directed by the *Advancing American Kidney Health Initiative*. It also includes the need for essential resources from stakeholders in building a nursing workforce that is supported and valued for its contributions. These resources include but are not limited to ample personal protective equipment, policies for vaccination and screening, reasonable lengths of shifts, safe nurse-patient caseloads, and an overall healthy work environment that allows for vacation time and breaks and is free of verbal and physical abuse from patients and other staff.

We further remain concerned about the increasing shortage of qualified nephrology nurses and the factors contributing to the nephrology nursing shortage and position vacancies that have expanded over time. These contributing factors include an aging workforce, a lack of adequate training, unsupportive and unsafe work environments, limited exposure to nephrology in undergraduate and graduate nursing programs, and the ongoing need of individuals needing kidney replacement treatments.

Several nurse leaders recently published an opinion editorial about the challenges facing America’s nurses since the pandemic. “One clear takeaway from the pandemic so far is that it has unlocked new momentum in the delivery of care to patients, with notable advancements powered by nurses. Examples include nurse-led command centers that deploy health system resources to treat patients more effectively, creative partnerships that connect homebound individuals to highly trained health practitioners, tighter collaborations between points of care and the academic institutions that prepare nurses to practice, and more.”<sup>16</sup> This expanded care demand requires a workforce to meet these patients’ needs and preferences.

To address the nursing shortage and resulting position vacancies, strategies to grow the pipeline of registered and advanced practice nurses and build a “nursing workforce for tomorrow’s needs should involve planning at the national level. Broader educational opportunities outside of traditional acute-care settings, as well as diversified continuing education, will help create more professional pathways for nurses, fill the expanding roles nurses will play across the health care continuum, bolster their skills, and reduce attrition. Nurses of many backgrounds, demographic identities, and skill sets are increasingly essential to meet the dynamic health needs of the U.S., now and into the future.”<sup>17</sup> As such, ANNA urges HHS and CMS to coordinate action to address these important issues.

### **1. Work Environment**

Another issue hindering workforce retention and driving attrition is the work environment for nephrology nurses. ANNA has commented previously about the connection between the work environment and the pressure on nephrology nurses to perform with limited staffing support, while managing increasingly high patient caseloads, and working an extraordinary number of hours. The result of these work conditions is a high number of nephrology nurses leaving the specialty and, in some cases, leaving the nursing profession entirely.

As the New York Times Opinion Editorial noted, “We celebrate nurses now. We call them heroes. But if we value their sacrifices and want them to be there when we need them, we must prevent a return to the poor pre-pandemic working conditions that led to high nurse burnout and turnover rates even before COVID-19.”<sup>18</sup> The focus of nephrology nurses is steadfastly focused on the health and safety of their patients. However, a nurse’s own health is equally as important, as underscored by the Code of Ethics for Nurses, which unequivocally states that nurses owe a duty to their own health, well-being, and

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<sup>16</sup> Andrew Jacobs, New York Times, August 21, 2021, ‘Nursing is in Crisis’: Staff Shortages Put Patients at Risk.

<sup>17</sup> Linda H. Aiken, New York Times, August 12, 2021, Nurses Deserve Better. So do their patients.

<sup>18</sup> Andrew Jacobs, New York Times, August 21, 2021, ‘Nursing is in Crisis’: Staff Shortages Put Patients at Risk.

safety.<sup>19</sup> Therefore, we ask HHS, CMS, and lawmakers to partner with ANNA to improve the work environment for nurses to ensure these vital frontline workers do not prematurely leave the workforce.

## 2. Workplace Violence

According to the Bureau of Labor Statistics in 2019, the incidence rate for violence and other injuries by persons in the health care and social assistance industry was 14.7 for every 10,000 full-time workers. The total rate for all industries was 4.4. The danger faced by healthcare workers ultimately may lead to a decision to leave the industry which contributes to the ongoing workforce shortage issues. ANNA supports the House-passed *Workplace Violence Prevention for Health Care and Social Service Workers Act*. The bill requires the Department of Labor (DOL) to address workplace violence in health care, social service, and other sectors. Specifically, DOL should issue an interim occupational safety and health standard that requires certain employers to take actions to protect workers and other personnel from workplace violence. ANNA encourages CMS to be vigilant in efforts to protect nephrology nurses, and all healthcare providers playing a role in the treatment of Medicare ESRD beneficiaries.

### ***Mental Health of Nephrology Nurses***

ANNA is most concerned by the extremely high level of “burnout” impacting nurses across the country, including nephrology nurses. The increased burnout has not merely resulted in nurses leaving the specialty or the profession, but it has dramatically affected their mental health and in some cases has led to an increase in nurse suicide.

When mental health is not protected and the overall well-being of nurses is strained, not only is the nurse in danger but patient care can also be jeopardized. From a 2020 issue of the *Nephrology Nursing Journal*, an article on nurse burnout shared, “In the outpatient dialysis unit, reducing nurse burnout is vital to retaining nurses and ensuring patients receive the quality of care essential to their needs (O’Brien, 2011). Burnout compromises job performance and patient safety (Gutsan et al., 2018).”

Burnout is not only a phenomenon of professional fatigue resulting in emotional, physical, and mental exhaustion. The *Nephrology Nursing Journal* article further explains, “there are many potential contributors to burnout in nurses, including lack of control, unclear expectations, dysfunctional work dynamics, extremes of activity, lack of social support, and work life imbalance.”<sup>20</sup> However, what is most striking from the journal article is the following:

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<sup>19</sup> American Nurses Association, Code of Ethics, January 2015, <https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only/> (last visited July 21, 2022)

<sup>20</sup> Prevention Strategies to Cope with Nurse Burnout (*Nephrology Nursing Journal*, November-December 2020, Vol. 47, No.6).

*“Further, suicide may be a severe consequence of clinician burnout (Davidson et al., 2018; National Academy of Medicine, 2019). Davidson and colleagues (2020), in a long-term study on nurse suicide in the United States, found that nurses are at a higher risk for suicide than the general population. In addition, while dealing with a pandemic from COVID-19, nurses are also dealing with a public health epidemic of nurse burnout, depression, and suicide.”<sup>21</sup>*

The nursing profession is in overdrive to serve patients during this public health emergency and the full impact to the nursing profession is yet to be seen. Based on this information, ANNA strongly recommends policymakers consider initiatives and reforms to support and stabilize the nursing profession.

### ***Negative Impacts of Replacing Nephrology Nurses with Other Licensed or Un-licensed Professionals<sup>22</sup>***

Since the release of HHS’ *Advancing American Kidney Health Initiative* in July 2019, ANNA has supported efforts to increase home dialysis care and services. In fact, we have routinely emphasized the essential role nephrology nurses have in providing home dialysis care and education to ensure long-term therapy success and patient safety. Given the nature of home dialysis care, it is imperative that nephrology nurses and other health providers anticipate and prepare for complications that may occur to both allow patient independence in-home dialysis therapy and to prevent failure in therapy. This requires a significant investment in educating nephrology nurses, so they have the proper skill set to train and educate patients and their caregivers for home therapy, as well as prepare additional nurses to be proficient and competent in-home dialysis training and therapy management. In addition, nephrology nurse practitioners will require additional training and education to transition in-center patients to home therapies, provide adequate dialysis prescriptions, and troubleshoot complications. ANNA has actively educated nurses about home dialysis therapies to increase patient access to these therapies. However, due to the COVID-19 pandemic and the workforce issues, nephrology nurses are leaving the profession in large numbers and it is impacting the number of nurses available to train and manage patients on home dialysis therapy.

One solution to this nursing shortage has been to try to fill the gap with other health care and non-health care providers. Nephrology nurses are uniquely situated to provide dialysis care and this type of replacement strategy may ultimately cause serious harm to the patients we serve. Additionally, we stress that the scope of practice for nephrology nurses cannot be transferred to other licensed or un-licensed professionals without serious consequence to patients. Nephrology nurses regularly assess a patient’s needs, evaluate that data, and then educate patients and their caregivers on how to execute the care plan. The consistency and quality of care suffers when these critical activities are split up amongst other licensed or un-licensed professionals.

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<sup>21</sup> Id.

<sup>22</sup> David Walz, Working with and Not ‘Around’ Nephrology Nurses, *Nephrology Nursing Journal*, Vol. 49, No.2, March-April 2022.

It is imperative that the nephrology registered nurse is involved at the inception of a patient's care as this fosters trust, familiarity, and communication between the nurse and patient. Additionally, these nurses are trained to quickly identify and troubleshoot a patient's therapy challenges; early identification of challenges and learning patient's needs is imperative to long-term therapy success and sustainability.

As such, ANNA believes the best path forward is to work in collaboration with nephrology nurses and not 'around' nephrology nurses. The expertise of nurses should be considered when making policy decisions about a role which they have expert knowledge and will therefore lead to the best patient outcomes. ANNA will continue to invest in the efforts to advance home dialysis therapies and remain an active member of the nephrology community in this effort. ANNA has established a Dialysis Home Therapies Task Force and is conducting a Think Tank to explore and identify the nephrology nurse's role in home therapies in the environment of a nephrology health care worker shortage in the effort to ensure the patient's safe and informed transition to home dialysis. We welcome the opportunity to work with HHS and CMS on this important issue.

We strongly encourage CMS to continue and expand efforts to consider the nursing work environment, mental health, equity, and diversity issues in the development of policy and regulations.

Sincerely,



Dr. Angie Kurosaka  
President  
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