

OPENING STATEMENT OF CHAIRMAN GRASSLEY

I want to begin by thanking my fellow Members for taking time out of their busy schedules to attend this important hearing. In addition, I want to thank the witnesses for being here today. Your testimony today will assist the Committee greatly in determining how best to address the quality of care that kidney dialysis patients receive.

This hearing focuses on the quality of care of close to 300,000 patients on kidney dialysis throughout the country. In spite of the excellent care many dialysis facilities provide, the Committee's investigation has found evidence of poor treatment, as well. Shoddy treatment of people with poor kidneys under any condition is inhumane. Bleeding to death is NEVER acceptable, like John Floyd Martin of Florida, who was left to bleed to death when a technician went to take a phone call and failed to properly connect him to the dialysis machine. It's important that taxpayers receive quality care in exchange for their dollars. But most important is quality and safety of patient care and quality of patient life.

As the chart over there shows these 300,000 or more ESRD patients represent 0.8 percent of the Medicare population but 5.2 percent of the total Medicare outlays, or \$12.8 billion dollars annually.

The largest portion of dialysis patients are those people who are 65 and up. Of concern to this Committee is the fact that the this population continues to increase at a rate of 7-8 percent per year. This is largely due to the growth in the elderly American population. While it is gratifying that more and more people are living longer, there are increasing concerns about the ability to serve this growing dialysis population and serve it well.

Although each kidney dialysis patient is extremely vulnerable, I am particularly concerned about the elderly. They are the most vulnerable and least able to recover financially or emotionally or medically, if they do not receive the best quality of care that medical science has to offer. Our first witness, Dr. Bays, will describe the differences in his quality of life on dialysis, depending on the care he received. With less dialysis, Dr. Bays was sick everyday, had no quality of life, and was resigned to dying in 3 years. Now on nocturnal home dialysis, he has regained his life and expects to live a full and complete life.

The next witness, Mr. Smith, will describe his experience with dialysis and transplants over a 23-year period. He will describe the marked decline in the skill of dialysis staff and how this almost cost him his life. The Committee staff has interviewed numerous other dialysis patients with similar stories, but too many to tell this afternoon.

Today, this hearing will examine several issues related to quality of care for kidney dialysis patients. First, we will examine the role of the Health Care Financing Administration, or HCFA, and the 18 Networks Organizations, and how well each carries out their responsibility to oversee the kidney dialysis program, also referred to as the End Stage Renal Disease (ESRD) program. As of 1999, HCFA surveyed only 12% of the existing dialysis facilities. This is a dramatic drop from 1993 when more than half of the facilities were surveyed. It is extremely important that the delivery of care is reviewed periodically to ensure that patients receive the best possible care.

Next, we will review several quality issues, including adequacy of dialysis, reuse of dialyzers, and training of technicians. Other than some voluntary guidelines that exist, there is a distinct lack of rules addressing these issues and other dialysis issues. The Committee recognizes that medical science and research are at the heart of many of these issues. However, one purpose of this oversight hearing is to determine the extent of the medical research and consensus on these issues. Also, the purpose of this Committee's investigation is to encourage a consensus on dialysis issues. Much research has been

conducted over the years with little resolution. It may be time to ensure that the proper research is conducted that will expedite resolution of these important health care issues.

"Adequacy of dialysis" refers to the amount of time that patients spend on dialysis. This is the period in which the patient's blood is circulated out of the body, through the dialyzer for cleansing, and returned to the body free of toxins. Many patients have raised concerns that they are subjected to a "jiffy lube" approach where they are rushed through dialysis. In other words, some patients believe that longer dialysis can produce increased quality of life and longer life. It has been suggested that some facilities are driven by the profit motive and have little concern for patient health. It is suggested that these facilities schedule as many patients as possible to collect the Medicare payments. Let me hasten to add, at this point, that I recognize that there are many excellent providers of dialysis in this country. I have an Iowa constituent who has told me of the wonderful care he has received at a facility in Iowa. However, this Committee has reviewed numerous studies worldwide about adequacy of dialysis. Although there are many studies that address this issue, there is no clear, definitive work. Moreover, there are no clear standards enforced by HCFA or the Networks. These are serious matters that we must address.

Another important issue is reuse of dialyzers. The United States is the only industrialized nation that reuses dialyzers to a large extent. One report shows that approximately 85% of all dialysis facilities reuse dialyzers. The dialyzer, which acts as the patient's artificial kidney, is critical part of the dialysis process. To the extent that the dialyzer is unsafe in anyway, patients are at risk. Again, there is no clear, definitive consensus on this issue in the United States. We encourage that consensus as soon as possible.

In addition, much evidence exists about the decline in skilled staff who work with kidney dialysis patients everyday. Approximately 20 years ago, registered nurses were the primary caregivers in dialysis clinics. Today, most of the staff are made up of lesser-skilled technicians. As a result, it is imperative that adequate training is provided to these technicians who are dealing directly with patient lives. Once again, there are no established requirements nationwide with regard to the level and the content of training for dialysis staff. Patients like Professor Robert Sollud, Professor of Psychology at Cleveland State University, who is a dialysis patient, have had to resort to putting up signs just to get minimum safety. I have a copy of Professor Sollud's sign over there that he keeps at his dialysis station just to remind staff to wash their hands.

In summary, there is a lack of oversight of the dialysis industry. This coupled with serious quality issues that remain unresolved in the United States, leaves a vulnerable kidney dialysis population at risk. It is with these thoughts in mind that the Committee convenes these hearings. My hope is that these hearings will be constructive. I look forward to hearing the testimony today to address these issues.

Before I introduce the witnesses, I want to thank the Committee's Ranking Member, Senator Breaux, for his strong support throughout this investigation and yield to him for an opening statement.

CLOSING STATEMENT OF CHAIRMAN GRASSLEY

I want to thank the witnesses who testified today. Your testimony has been very helpful in focusing the issues of importance to dialysis patients. Moreover, your testimony will help this Committee determine how best to approach solutions to quality of care issues.

I intend to look for common sense solutions to the issues raised today. It strikes me that a conclusion to some of the medical research on several quality issues is something clearly needed. Specifically, I am referring to issues like "adequacy of dialysis" and "reuse of dialyzers." It appears that it might be advisable to ask the National Institute of Health, or some other appropriate body, to resolve some of this

debate with its research, on an expedited basis. I am quite surprised that this debate has gone on so long in this country. The quality of life of too many patients depends on it.

The GAO and the HHS-Inspector General have made it clear that the oversight is lacking. This lack of oversight leaves a vulnerable population even more unprotected. I will continue to oversee and work with HCFA and the Networks as we strive to improve the quality of care kidney dialysis patients receive . In addition, I will review the recommendations of the GAO and the HHS-Inspector General to determine if legislation is necessary.

I will leave the record open for two weeks to receive additional statements or information in the record. Thank you again for being here.