

December 16, 2013

Dear Stakeholders,

I look forward to upcoming discussions and great progress towards protecting patients from inadequate access to dialysis services in our state in the future. Each point below addresses this fundamental objective in one way or another.

Kind regards,  
Natalie Baxter PA-C

**Isolation station allocation should be + 2**

Isolation stations should not be included in utilization calculations. Isolation stations are difficult to consistently fully utilize because they are reserved for HepB patients. No HepB patient, no other use of this station. Medicare rules regarding infections and immune-status are likely to expand and granting the number chairs + 2 builds in essential isolation capacity into dialysis services for the future in Washington State.

**Home therapy training should be designated a service**

Home therapy training, designated as a service for which projection models and station allocation metrics do not apply, will encourage some very positive outcomes for patients. Home dialysis is a great way to deliver high-quality dialysis.

Demand for home therapies will rise. Historically the US has lagged behind Europe and other parts of the world in providing home therapies. This is due in part to nephrology training which tended to focus on technology-intensive hemodialysis. This trend is changing with greater focus on patient-centered outcomes. Recently there has been a 1 month waiting list for PD training at the largest dialysis unit in Vancouver because there is not enough room to train them. More space would allow this service to expand at a pace more reflective of patient need- especially if competing dialysis units could also expand their home therapies. A little competition goes a long-way in promoting access to care.

Relevant WACs should not penalize providers for capital investments in training facilities.

## **Reduced projected station need across the state to 3.2, with no special exceptions**

Current projected station need is based on 4.8 resident in-center patients for all planning areas except certain more rural counties. Several participants in this stakeholder meeting have proposed changes to this rule. The proposed changes are designed to allow facilities at capacity in a planning area to expand even if other units in the same planning area are not at capacity. This approach is problematic for 3 reasons:

1. It is not consistent with the original intent of the law to use resources efficiently as it allows unused capacity in a planning area to persist.
2. It would perpetuate and facilitate monopolistic provision of services, undesirably limiting genuine choice and limiting pressures to be competitive in quality of care.
3. It does not effectively solve the problem of time delays in provision of dialysis services in a community. Once capacity is well-exceeded then access has already been compromised. A meaningful solution anticipates need and meets it in a timely way.

A better way to improve responsiveness to need would be decrease projected station need, defined in 246-310-284 (3), to 3.2 across the state. This would allow:

1. The CN application process to proceed and conclude well in advance of crisis-level shortages
2. The projection model to reflect the change to 3.2 and lead to appropriate levels of capacity
3. Less administrative work because such a change is simple to apply

## **Distill statutory CN requirements to Yes-No criteria on DOH CN application**

Thoughtfully turning statutory criteria into a series of Yes-No questions on the DOH CN application is a high-leverage way to increase objectivity in the CN process and save money. The statutory criteria found in RCW 70.38.115 present an opportunity for clarification through rule-making.

“Certificates of need shall be issued, denied ... in accord with the provisions of this chapter and rules of the department which establish review procedures and criteria for the certificate of need program...”

Improving objectivity in CN decisions is a common theme in pre-stakeholder meeting comments and moderator Bart Eggen, in his introduction, voiced a desire that any rule changes would foster objectivity, “so that anyone applying

these rules would come up with the same decision.” In early discussion of the tie-breaker rule it was observed that “we thought we would be getting more ties” after the creation of the tie-breaker rule 7 years ago. Perhaps that too is a sign that greater objectivity is needed. Greater objectivity should make CNs easier to award and defend, make the whole process more timely and allow applicants to know with greater certainty the likelihood of application acceptability. Good for the department, good for applicants. Good for patients.

**In the case of a tie, then grant both applications**

In the case of a tie (WAC 246-310-288), grant both applicants a CN. If need exists and both applicants can be expected to provide acceptable quality of care, then CNs should be awarded to both. Approve each the number of chairs they would have been awarded as if they were the only applicant. This change to the tie-breaker rule would limit incentives to appeal or sue, decrease waste of time and money, help protect patient choice in a planning area and ensure greater capacity. Again, good for the department, good for applicants. Good for patients.