Testimony of James E Kintzel M.D.
House Democratic Policy Committee Public Hearing
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Good afternoon, members of the House Democratic Policy Committee. My name is James E Kintzel M.D. I am a nephrologist in my home town of Allentown, Pennsylvania where I opened my practice in 1969 after completing a Renal Disease Fellowship at the Hospital of the University of Pennsylvania where I graduated from medical school in 1964. I am board certified in both internal medicine and nephrology and have served as the director of the acute dialysis unit at Lehigh Valley Hospital and directed the home hemodialysis and home peritoneal training programs. I am presently the medical director of the Fresenius Outpatient Dialysis Clinic in East Stroudsburg, which I opened in the summer of 1986.

I am here today to ask you to work on legislation that would recognize Registered Dietitians as providers in all healthcare plans in Pennsylvania and thus reduce barriers to nutritional care.

I have seen the care of patients with chronic kidney disease (CKD) evolve over the past 42 ½ years. When I first opened my practice there was no financial support for these patients and they had to learn how to do their own hemodialysis treatments at home with a co-trainee during a 3 times a week 10 week training program utilizing their own health insurance. Once the training was completed, the Lehigh Valley Kidney Foundation provided financial help paying for 50% of their monthly lab costs and 10% of their dialysis supplies.

In 1971 the Pennsylvania Chronic Renal Disease Program began offering financial support for home hemodialysis. One of my patients moved on to Philadelphia, found a place to live on a park bench and became the first patient to receive state support at the outpatient dialysis center at Hahnemann Hospital which was his only treatment option.

In 1972 the federal government provided funding through its Medicare End Stage Renal Disease program. Care shifted away from home dialysis, which was not suitable for everyone. Before we opened an outpatient clinic in Allentown, our patients had to hire a driver to take them to 34th and Market streets in Philadelphia to dialyze on the midnight shift. We opened a dialysis clinic in Allentown in March of 1974 with 14 patients and by Oct 1975 when we opened a clinic in Bethlehem, we had 95 patients in Allentown dialyzing round the clock. Today there are over 1000 dialysis patients receiving treatment in the greater Lehigh Valley and close to 16,000 patients in the state of Pennsylvania costing $250/Rx (treatment) 156 Rx treatments/year x 16,000 patients which comes to an expenditure of $608 million a year.

If chronic kidney disease can be detected early and treatment begun in a timely fashion we can often delay the progression to end state renal disease and reduce the medical complications that accompany it. End Stage Kidney Disease requires expensive dialysis treatments usually three times per week. Early intervention can also dramatically reduce the initial hospitalization costs by a factor of 5 when the patient finally starts on dialysis.

Early intervention includes controlling blood pressure and protein wasting in the urine with DIET and medications, controlling secondary hyperparathyroidism with dietary phosphorous

restriction and medications. Restricting dietary protein is known to reduce urinary protein wasting early in CKD and later in the disease it can reduce the urea burden (protein waste products) that the kidney has to excrete. Potassium excretion becomes impaired as kidney function declines and patients must be taught what foods to avoid especially fruits and vegetables.

The prevalence of Diabetes Mellitus is increasing in the United States and damages the kidney's filtering membrane leading to protein in the urine, which leads to sclerosis, and scarring. In 1974 a study in Minneapolis showed that juvenile diabetics with protein in the urine were all dead within 5 years. Indeed protein in the urine is associated with a loss of 10% of kidney function per year compared to less than 1% in the normal population. In 2009 44% of patients starting on dialysis had diabetic kidney disease as the cause of their ESRD.

Dietitians are the most important members of the diabetic health care team teaching patients to control their sugar and other carbohydrate intake to lower their blood sugar. Elevated blood sugars lead to kidney damage with protein wasting and retinopathy in the eye leading to hemorrhages and blindness. Controlling fat intake to reduce elevated cholesterol and triglyceride levels to prevent atherosclerosis is equally important.

In my practice I utilize a three person healthcare team to treat patients with CKD. The physician coordinates treatment and prescribes medication. The dietitian educates the patient to grasp complicated aspects of the renal diet emphasizing sodium, potassium and phosphorous restriction, and the nurse educates the patients about their medications and ESRD treatment options. Since patients with chronic kidney disease have as much as a 5-10 fold increase in coronary disease they often die of their heart disease before they reach dialysis, so early nutritional intervention is essential. As a physician I am often unable to utilize one third of that team in the under 65 year age group because of inconsistent private insurance coverage for Medical Nutrition Therapy. Without the dietitians in the therapeutic loop there is no loop!

We as physicians in a very busy practice have neither the time nor the expertise to discuss the intricacies of specialized diets such as the renal diet. We spend significant amounts of time explaining the pharmacology of a variety of medications, the seriousness of their illness and the inevitability of chronic dialysis in the future. At one time we employed a dietitian to come to the office to sit and explain food choices and dietary principles to our patients but we ran out of space and her obligations elsewhere ended the service. With the increased number of dietitians being denied recognition as preferred providers of Medical Nutrition Therapy, patients are not being adequately cared for. There are not enough specialized dietitians listed as preferred providers that physicians can refer to. Today it is more important than ever to utilize a dietitian's services to see our office patients who present with multiple co-morbidities such as hypertension and obesity, both of which aggravate their chronic kidney disease.

As a practicing physician the most frustrating part of caring for patients with chronic kidney disease is the lack of consistent dietitian intervention services. I know if we can intervene early we can make a difference. In Pennsylvania we need the proactive pioneering spirit that we showed in 1971 when we were one of the first states to provide funding for treatment of end stage chronic kidney disease ESRD. We need consistent uniform dietitian services for all

patients of all ages with all stages of CKD that often have other risk factors that ultimately contribute to the worsening of this debilitating and costly disease.