The Three Minute Read™

Insights from the Healing American Healthcare Coalition™

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HEALING AMERICAN HEALTHCARE COALITION

From the Editor: The only article summarized in this SPECIAL EDITION highlights the hazards of home medical devices. January's third issue included Modern Healthcare's reporting on the CMS End Stage Renal Disease (ESRD)Treatment Choices Model that was launched in 2021 to incentivize providers to move dialysis treatments to the home (*"Safety net dialysis centers hit with CMS payment cuts"*). ESRD cost Medicare $37 billion in 2019, and in-home dialysis saves about $50.00 per treatment. Uptake has been disappointingly slow, and the model's *"carrot and stick"* approach has resulted in reimbursement cuts to dialysis centers serving mostly Black and Hispanic patients.

TMR's Publisher, Ed Eichhorn, spent much of his professional career working with dialysis centers and weighs in with his thoughts on the matter.

ECRI: Home medical device use a top hazard in 2024, by Mari Devereaux, Dianne Estabrook, Modern Healthcare, 2/1/24

TMR Topline – As more individuals opt to receive care at home, devices like infusion pumps and ventilators are increasingly being used outside of the clinical settings for which they were designed. The non-profit patient safety organization ECRI lists major technology hazards to look out for in 2024. *"From medication errors related to infusion pumps to skin injuries caused by cardiac monitors, there are life-threatening risks associated with using complex, specialized equipment as an inexperienced layperson,"* said Dr. Marcus Schabacker, ECRI's CEO. ECRI recommends providers educate patients on all medical technology being used in their homes, and only give out equipment compatible with the educational level, environment and cognitive and physical abilities of patients or caregivers. At-home care can be more personalized and comfortable, but still has a ways to go until it reaches zero preventable harm. The CMS hospital-at-home program has more stringent medical device safety protocols and less freedom in how the equipment is set up and treatment is administered.

Dialysis at Home? It's not for Everyone!

by Edward C. Eichhorn, Publisher, **TMR**

As Director of Research for a dialysis product manufacturer, then co-founder of a medical testing service for dialysis patients, I spent 15 years working on kidney dialysis issues. The medical testing service worked with dialysis centers in 38 states before we sold the company.

During those 15 years I spent a significant amount of time in dialysis centers working to improve our products and services for nephrologists, nephrology nurses and their patients. It is from this perspective that, with great interest, I read the 2019 Advancing American Kidney Health Initiative home care goal.

The initiative's announced goal is to have 80% of the newly diagnosed patients with kidney failure receive home dialysis or kidney transplants as their first treatments by 2027. The announced goal at that time said it *"aimed at reducing the burden of dialysis on patients and improving their quality of life."* Clearly. receiving a transplant would improve the quality of life for these patients if a donor kidney were available.

Some new patients are good candidates for peritoneal dialysis. Their treatment is normally done at home. For the patients who begin their treatment on hemodialysis dialysis, I believe the real goal of this initiative was more to reduce cost than for the quality of patient lives. Today, 726,000 Americans have End Stage Renal Disease (ESRD). Roughly 88% of those who require treatment are

dialyzed in centers and 12% are treated at home. Approximately 125,000 Americans develop kidney failure every year. About half of them are over 65.

Efforts to increase in-home treatment are falling short in minority communities where there is a higher incidence of kidney failure. Black Americans have three times the incidence of kidney failure when compared with whites. Latinos have twice the incidence when compared with whites as reported in the US Renal Data System.

Home dialysis reduces costs by an estimated $50.00 per treatment by eliminating most of the staff cost for in-center treatment. CMS initiated a payment model that encourages more home dialysis. Facilities that do not meet their targets for home dialysis can receive as much as a 5% reduction in reimbursement while centers that have met their targets for increasing home treatment can receive as much as a 4% increase in reimbursement.

Nationally, about 7% of Black and Latino ESRD patients are dialyzed at home while over 9% of white ESRD patients dialyze at home. As a result, most of the dialysis centers that have been penalized are in low-income communities and most of the centers that have been rewarded are in white communities. The initiative's goal and its bonuses and penalties are inherently unfair. It does not consider the basic requirements for home dialysis. For example:

- Does the patient the space for a dialysis machine?
- Do they have a recliner and the ability to store as many as 45 boxes of supplies?
- Does the patient have a partner who is trained and understands the dialysis treatment who will be with the patient during treatments?
- Is there a backup staff member at the dialysis center who is available to answer questions that may come up during the treatment procedure?
- Does the patient have the cognitive ability to do the procedure outside of a dialysis center?

There is an upside to this initiative that I think helps all new dialysis patients. Today, more patients receive care as their kidneys are slowly failing than in past years. When newly diagnosed ESRD patients seek care early in the occurrence of their kidney disease, the patients and their families have the time to adjust to this life change. They can determine if they have the space and the fortitude to undertake home dialysis. In the past it was more common for patients to show up at a doctor's office after their kidneys failed and their care choices had to be made while the patient was traumatized and hospitalized.

While expanding home dialysis is a reasonable goal, it is not reasonable to suggest that a large percentage of new hemodialysis patients can be thoroughly trained and supported for home dialysis. The treatment goal for ESRD patients should remain as it has been since the program was established more than 50 years ago. That is, to find the very best treatment modality for every patient.

If the available modality options suggest that home dialysis is the best modality for the patient ***and*** they have the support structure for home care ***and*** are willing to take on this challenge, they should be trained to do it. On the other hand, if they don't have the required space, cognitive ability or support needed for home dialysis, they should be treated in a dialysis center. The center should not be penalized in any way for the makeup of their in-center population.

Despite the initiative's lofty goal of having 80% of the patients dialyzed at home by 2027 and the effort that has been put into achieving this goal, the percentage of patients dialyzing at home today is about the same as it was before the goal was established in 2019. It's good to have goals in healthcare, but they just need to be established after consideration of all the relevant factors. I don't think that was done in this case. As a result, dialysis centers in low-income communities are being unjustly penalized for their inability to attain unattainable goals.

TMR's Take: There's no question that in-home care is best for patients and their families when feasible. However, as the ECRI report indicates, use of home medical devices can be hazardous to a patient's health. Operating such equipment requires thorough training and support. It's not for everyone.