Caring for CKD / ESRD patients who are undocumented or homeless and other unique populations
Renal Physicians Association
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Disclosures

- Speakers bureau participation: Sanofi, Amgen, Fresenius Medical Care, Relypsa

- Nothing to disclose related to this topic.
Unique Populations

- **Undocumented**
  - Long-time residents - Largely younger and most commonly from Mexico and Central America
  - Recent arrivals – Elderly; parents of US residents – South America, South Asia, West Africa

- **Homeless Patients**

- **Violent or aggressive patients**
Initial RPA position on Uncompensated Kidney Care was adopted by RPA Board of Directors in July 1998: “Dialysis for Non-Citizens”.
- Published in 2000: Clinc Nephrol 54(3)

Most recent revision of RPA position approved by RPA Board of Directors January 2015.
RPA Position on Uncompensated Kidney Care

- **RPA position:**
  - “…Federal Government has a responsibility to provide care for all patients within the borders of the United States, and that the financial burden of uncompensated care provided to both citizens and non-citizens is both Federal and State responsibility.”
  - “…health care professionals and health care systems have an ethical obligation to treat the sick…”
Facts about unauthorized immigrants in US
(Pew Research Center)

- 11.3 million unauthorized immigrants living in US by 2013
- Growth of unauthorized immigrants have stabilized
- Rise in the median length of stay.
- Texas up to 1.7 million unauthorized immigrants by 2013.
FIGURE 1

Growth in Unauthorized Immigration Has Leveled Off

In millions

Note: Shading surrounding line indicates low and high points of the estimated 90% confidence interval. White data markers indicate that the change from the previous estimate shown is statistically significant (for example, for 1995 change is significant from 1990). Data labels are for 1990, odd years from 1995-2011, 2012, 2013.


PEW RESEARCH CENTER
Unauthorized Immigrant Population, by State, 2012

Note: Population figures are rounded.

Source: Pew Research Center estimates for 2012 based on augmented American Community Survey data from Integrated Public Use Microdata Series (IPUMS)
Facts about Unauthorized Immigrants in US
(Pew Research Center)

● Six States account for 60%:

● States have shown increase:
  ● Florida, Idaho, Maryland, Nebraska, New Jersey, Pennsylvania, Virginia
Uncompensated Kidney Care

- Description of group of patients at risk for uncompensated care:
  - US Citizens:
    - No third party insurance
    - Patients below or above 133% federal poverty levels
    - Options: public coverage, Medicaid, ACA of 2010 & Exchanges
Uncompensated Kidney Care

- Non-Citizens:
  - Legal Residents
  - Undocumented Residents

- Limited options:
  - Emergency care (EMTALA)
  - Medicaid
  - Federal Qualified Health Centers
  - Exchanges?
Affordable Care Act (ACA) 2010

- Requiring US residents and legal residents to have health insurance
- Established Exchanges
- Expanded Medicaid benefits.
  - But Supreme Court ruling 2012, Medicaid expansion under ACA was made optional for states. Many states declined.
- These benefits limited to “lawful residents”
RPA Position Paper
Ethical and Legal Issues

- Patients with kidney disease among the sickest and most vulnerable
- Is it ethical for nephrologist to provide dialysis services only on emergency basis and deny outpatient dialysis support?
- Is it ethical for dialysis provider to deny outpatient dialysis services?
- Is nephrologist and/or provider responsible to report information to government?
- Legal consequences with providing “free” services at ESRD facility.
RPA Position Paper
Other Concerns

● Financial concerns of providing uncompensated care
  ● Fiscal viability of facilities specially in high intensity immigration areas

● Impact to the other (paying) patients

● Would providing uncompensated care improve better use of the scarce resources and decrease unnecessary ED visits or hospitalizations.
RPA Position Paper
Uncompensated Kidney Care

- Principles:
  - All professionals and health care systems have an ethical obligation to treat the sick
  - Federal Government has the ethical and fiscal responsibility to provide care for patients in US
  - Financial burden of ESRD patient should be a national and state responsibility
  - All citizens and non-citizens with ESRD should be eligible for federal funding if they do not have insurance or resources to pay for renal-related care
  - Nephrologists should not be expected to report undocumented patients to federal agencies, due to confidentiality and fiduciary reasons.
Current landscape of care for ESRD patients who are undocumented

- National Options
  - Coverage of outpatient hemodialysis through Medicaid and other government programs
  - Coverage of emergency care only
  - Hybrid programs (Texas)

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Harris County Experience

- Previously emergency care only for the majority of patients:
  - Two models
    - single treatment when patients meet certain criteria for emergency treatment
    - Multiple treatments to treat uremia over a 2-3 day period
  - No difference in apparent outcomes of patients under each model but never studied in an unbiased fashion. No evaluation of impact on need for acute care hospitalization and use of ICU services.

- A select few patients were treated in a single small chronic dialysis facility with access mostly limited to patients from certain county clinics and zip codes.
Consequences of emergency only care policy and responses

- Patients admitted to the hospital for emergency dialysis accounted for >25% of all admissions to the internal medicine teaching services thereby denying needed hospital beds and skewing the teaching service experience.

- Move to have more patients treated as emergency room patients without admission to the hospital. Non-admitted patients to the teaching services.

- Patients only admitted if treatment required for conditions other than dialysis (infection, cardiovascular events, other non-related conditions)
Additional care provided by Community Hospitals
2016 Trends and Actual Cost of Care -1

- 168 patients in chronic hemodialysis facility
  - Medicare / Texas DSHS oversight
  - Medications and access provided by county safety net system
- > 205 unique ESRD patients still treated through the emergency departments.
- Newest program providing CAPD (no CCPD)
- Vascular access programs / PD catheter program
- Funding largely through county safety net programs; very minimal availability of Medicaid emergency funds
2016 Trends and Actual Costs of Care -2

- Emergency Room care:
  - $255,000 (LBJ General Hospital) – $280,000 (Ben Taub General Hospital) / year / patient

- Chronic Hemodialysis Unit Care
  - $35,000 / year / patient

- CAPD
  - $15,000 / year / patient

- Estimates of cost do not include hospitalizations, medications, access creation and maintenance.

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Barriers to provision of chronic scheduled care

- Limitations in funding; varies by state and is largely politically driven
- Political view that funding of adequate care would drive more patients seeking care.
  - Most of the undocumented ESRD patients are long-term residents of the US
  - Provision of full care in states such as California and New York have not lead to an increase in the number of patients seeking care in those states compared to Texas and other states of first entry without such coverage.
  - Myth that many patients are migrants because of lack of care in their home countries.
Costs of current care model of emergency care only.

- Significant inefficient utilization of emergency resources.
- Maintenance of patients in a sicker state.
- Barriers to patients being able to work and pay taxes (sales taxes support the public safety net in Texas and elsewhere).
- Moral dilemma for teaching services where students and residents are modelled care that is not equitable or justified by best evidence. The provision of less than adequate care is generally confined to the most vulnerable populations in society.
- No accounting for environmental, social, or economic justice.

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Homeless patients; Unique challenges

- Lack of a permanent address precludes home modalities. Some patients continue PD while homeless.
- Homeless patients can not protect their medications and other medical devices.
- Transportation to and from clinic appointments can be difficult to arrange.
- No resources for adequate nutrition etc.
- Some homeless patients have unaddressed mental health needs.

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US Cohort of Homeless Dialysis Patients

- 100% men; all single; all had Medicare coverage for dialysis.
- Average age 46 years old;
- Mean number of months on dialysis 46.
- Place of domicile: community shelter, Salvation Army, personal automobile.
- Similar characteristics to a Canadian cohort.
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<th>Issue</th>
<th>Management strategy</th>
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| Medication adherence                       | Use long-acting preparations of antihypertensives  
Dispense medications and administer after dialysis  
Treat infections with IV after dialysis (rather than outpatient p.o.)  
Fax prescriptions to pharmacy and have delivered to shelter |
| Clinic appointments                        | Arrange for patient to be accompanied by shelter volunteer or family member  
See homeless patients as soon as they arrive in waiting room; do not make them wait  
Always reschedule missed appointments |
| Contact information                        | Identify and write all possible shelter numbers in chart, as well as number for case worker and family/friends  
Obtain Medic Alert bracelet for patient |
| Denial of end-stage kidney disease         | Establish therapeutic alliance with patient, improve understanding, explain treatments.                                                               |
| Late to dialysis                           | Schedule dialysis for last shift  
Early involvement of social work to help with transportation |
### Strategies to improve adherence to appointments, dialysis and therapy

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| Difficult or disruptive patients | Explain expectations to patient  
Use nonjudgmental approach, establish mutual respect  
Educate patient in terms comprehensible to patient  
Negotiate behavior contract; abuse not to be tolerated |
| Alcohol addiction            | Pre-treat with benzodiazepines before appointments or dialysis to prevent withdrawal                                                              |
| Pain syndromes               | Use nonopiates (acetaminophen), coanalgesics (gabapentin, amitriptyline)  
Use IV opiates on dialysis only as per guidelines  
For p.o. prescriptions, chose long-acting meds over short-acting; less chance of diversion for sale  
Treat anxiety, depression as these often present as pain syndromes |
| Diet adherence               | Team approach, involve shelter                                                                                                                       |
Programs to address the ESRD homeless patient

- National VA programs to address homelessness with more permanent housing options
- Coordination of care with shelters; joint healthcare clinics with safety net providers
- Volunteer Community-based Medical Services to individuals in shelters
ESRD of the abusive or violent patient

- ESRD network provide support to find ways to reduce involuntary discharges
- Toolkits to address aggressive behaviors and to reduce voluntary discharges.
- Patients who file grievances are not abusive patients by definition.
- New toolkit to help provider establish a safe environment for patient feedback and grievances.

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Certain types of patients present unique challenges for clinicians attempting to provide care that is optimal and evidence-based. These patients include the undocumented immigrant, the homeless patient, and the patient deemed to be disruptive.

Care for the undocumented patient is often fragmented and incomplete and most commonly designed to address short-term emergency needs and not the attainment of long-term optimal health.

Both economic arguments and moral imperatives support strategies to provide optimal full-care for ESRD patients in these populations.

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