ESRD Beneficiary Focused Learning Network Special Project

Environmental Scan Report
Environmental Scan

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Prepared By: Dolores Perez
Background and Scope of Work

This environmental scan provides a systematic overview of the external factors that are relevant to Beneficiary Experience. The goal of this environmental scan is to review various media related to the beneficiary experience and to increase the understanding of the beneficiary’s view of dialysis care.

Areas of Focus

- Beneficiary satisfaction and sources of dissatisfaction
- Hospitalizations
- Care transitions and coordination of care
- Maintenance dialysis experience
- Beneficiary understanding about care options including vascular access, dialysis modality and location
- Self-management issues
- Beneficiaries’ and family engagement knowledge of ESRD and skills related to the care of ESRD
- Decision making preferences
**Environmental Scan through Blog Analysis**

Table 1

<table>
<thead>
<tr>
<th>Website:</th>
<th><a href="http://www.hemodoc.com">www.hemodoc.com</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>November 1, 2011 through November 30, 2011</td>
</tr>
<tr>
<td></td>
<td>4 blog postings</td>
</tr>
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</table>

The data in Table 1 was extracted from four blog postings available on www.hemodoc.com. Thirty-nine (39) keyword instances appeared in the blogs for the month of November, 2011.

In the area of satisfaction, the data revealed concerns about Medicare costs. “The fact that Medicare now includes anemia management in with their routine payment (along with the other formerly separately billable services) doesn't change the math. Additionally, to calculate the average per year per beneficiary allowed reimbursement you'd need to know the average number of treatments per year, per beneficiary. I think for beneficiaries who start and finish the year using dialysis, they average about 148 treatments a year. Thus, 148 x $250 x .8 gives the average per year, per beneficiary cost to Medicare for someone who uses dialysis.”

According to one blog post, “**Home hemodialysis**, the preferred renal replacement **modality** prior to the beginning of the ESRD... is re-emerging today by the power of individual patients seeking a viable alternative to conventional **in-center hemodialysis**.” A conclusion from a study posted in this blog found that “Patients and family caregivers highly value treatment that enhances survival and can be performed at home. Future planning of dialysis services could better reflect these priorities through provision of increased home dialysis support services and planned respite for caregivers.”
Conflicting views in the area of modality exists among bloggers. “The question of what dialysis modality would nephrologist use is predicated on the assumption that transplant is not an option.” “…the question is who will really benefit from more aggressive and prolonged daily dialysis. The answer to this question is vital if we are to make those modalities credible so that the resources will be directed towards the people who will really benefit from it.”

Table 2

<table>
<thead>
<tr>
<th>Satisfaction</th>
<th>Hospitalization</th>
<th>Transitions and Coordination of Care</th>
<th>Dialysis Experience</th>
<th>Vascular Access</th>
<th>Modality</th>
<th>Knowledge of ESRD</th>
<th>Self Management (care)</th>
<th>Self Management (decision making)</th>
<th>Bundling</th>
<th>Anemia Management</th>
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The New York Times allows blog posts in their ‘Health’ section. The data in Table 2 was extracted from twenty-one (21) blog postings available on the well.blogs.nytimes.com/ website. One hundred fifty-eight (158) keyword instances appeared in the blogs for the month of November, 2011. The majority of blog posts focused on satisfaction and dialysis experience. Those individuals who post indicate a commanding knowledge of ESRD.

Patients and physicians post on this blog. Physicians acknowledge, “The CKD epidemic is only worsening as people are living longer with more and more comorbidities.” One patient expressed his knowledge and interest in research in this area stating, “For medical statisticians it would be relatively easy to check the population of CKD patients who have had a biopsy to see if there was a statistically significant change in kidney function for the better or worse!” “Diabetes is the leading cause of end-stage renal disease (ESRD), causing nearly 40 percent of all cases of kidney disease. Given those percentages, it’s important for all people living with diabetes and those who have been told they have prediabetes to understand how diabetes can lead to kidney disease.”

ESRD patients post blogs that indicate declining states of mental health, fear, and PTS. “One of the greatest barriers to successful long term treatment with dialysis and transplant is under treated depression and post traumatic stress that is endemic to the CKDS
population. “My biggest struggle is the fight with Medicare and my secondary insurance. You HAVE to have Medicare after 33 months on dialysis and they are the WORST!! Fighting with them is the LAST thing anyone should endure.”

A medical doctor posts on this blog and states, “In my practice, I help maintain the veins and catheters that are used for the dialysis treatments. During my career I have seen Medicare and private insurance whittle away at the reimbursements for dialysis dependent patients. These patients are a silent, though growing, group without a strong unified voice. Their care is expensive, but life saving. In this time of even more economic hardship, beware of more and more cut-backs for this politically helpless group.”

Patients post about a deep sense of gratitude when they become a transplant recipient. “After 3 years on dialysis my 21 year old daughter was able to get a kidney transplant due to the generosity of an altruistic donor we met through the internet. Dialysis is life support and we are grateful for it – but the difference in well being and energy cannot be compared to a transplant. There are not enough deceased organ donors to meet the need. Living donors make miracles happen. Potential donors can learn more about what is involved by going to Living Donors Online. This is a support forum for living donors. God bless everyone who steps up to help a kidney patient.”

Table 3

| Website: | http://www.billpeckham.com/from_the_sharp_end_of_the/ |
| Date:   | November 1, 2011 through November 30, 2011 |
|         | 6 blog postings |

<table>
<thead>
<tr>
<th>Keyword Tracking</th>
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<td>Satisfaction</td>
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<td>Anemia</td>
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<tr>
<td>Management</td>
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</table>

| 0 | 0 | 1 | 0 | 0 | 2 | 2 | 0 | 0 | 0 | 2 | 0 |

The data in Table 3 was extracted from six blog postings available on www.billpeckham.com/from_the_sharp_end_of_the. Seven (7) keyword instances appeared in the blogs for the month of November, 2011. Blog entries focused on ‘every-other-day’ schedules for patients. Erythropoietin (EPO) hormone evidence and its effects were addressed in an EOD scenario. For example, “The biggest financial effect may be D’s [patient] EPO profile before and after skipping. In general let's assume D will need the same yearly dose of EPO whether dialyzing 156 times a year or 130, D will need 624,000 units of EPO (likely D would need a higher yearly dose due to
skipping). If D runs 156 times the EPO dose will be 4,000 units per treatment. If D runs 130 times the EPO dose will need to be 4,800 units per treatment. D's skipping makes each treatment less lucrative, over and above any QIP withhold.”

Table 4

| Website: | http://www.fbkidneydisease.info/kidney-disease |
| Date:    | November 1, 2011 through November 30, 2011 |
|          | 18 blog postings |

<p>| | | | | | | |</p>
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The data in Table 4 was extracted from eighteen blog postings available on www.fbkidneydisease.info/kidney-disease. Individual posts discuss several issues relating to personal or someone they know with ESRD. Discussions rarely identify any of the keywords listed. Posts contain recommendations on diet, lifestyle, and recommendations on how to deal with this disease.
## Environmental Scan through Academic/Medical Journal Analysis

<table>
<thead>
<tr>
<th>Academic/Journal Articles</th>
<th>Journal of Human Nutrition &amp; Dietetics (0952-3871)</th>
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<tbody>
<tr>
<td>Title:</td>
<td>A qualitative study exploring patients' perspective of adhering to recommended behavior change in the pre-dialysis stage of kidney disease.</td>
</tr>
<tr>
<td>Authors:</td>
<td>James, H.; Burns, A.; Walker, R. James.</td>
</tr>
<tr>
<td>Abstract:</td>
<td>An abstract of the article &quot;A qualitative study exploring patients' perspective of adhering to recommended behavior change in the pre-dialysis stage of kidney disease,&quot; by R. Walker, H. James and A. Burns is presented.</td>
</tr>
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</table>

<table>
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<tr>
<th>Academic/Journal Articles</th>
<th>Journal Of Advanced Nursing (1365-2648)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title:</td>
<td>Self-reported adherence to a therapeutic regimen among patients undergoing continuous ambulatory peritoneal dialysis.</td>
</tr>
<tr>
<td>Authors:</td>
<td>Lam LW; Twinn SF; Chan SW.</td>
</tr>
<tr>
<td>Year/Issue:</td>
<td>2010 Apr. Vol.66,Iss.4;p.763-73</td>
</tr>
<tr>
<td>Abstract:</td>
<td>This paper is a report of a study conducted to examine self-reported adherence to a therapeutic regimen for continuous ambulatory peritoneal dialysis.; Studies of patients' adherence during dialysis have primarily focused on hemodialysis and have frequently yielded inconsistent results, which are attributed to the inconsistent tools used to measure adherence. Levels of adherence to all four components of the therapeutic regimen (i.e. dietary and fluid restrictions, medication, and the dialysis regimen) among patients receiving peritoneal dialysis have not been examined, especially from a patient perspective.; A total population sample was used. A cross-sectional survey was carried out by face-to-face interviews in 2005 in one renal clinic in Hong Kong. A total of 173 patients undergoing peritoneal dialysis (56% of the total population) participated in the study.; Patients perceived themselves as more adherent to medication (83%; 95% confidence interval 77-88%) and dialysis (93%; 95% confidence interval 88-96%) prescriptions than to fluid (64%; 95% confidence interval 56-71%) and dietary (38%; 95% confidence interval 30-45%) restrictions. Those who were male, younger or had received dialysis for 1-3 years saw themselves as more non-adherent compared with other patients.; Healthcare professionals should take cultural issues into consideration when setting dietary and fluid restriction guidelines. Additional attention and support are required for patients who identify themselves as more non-adherent. To help patients live with end-stage renal disease and its treatment, qualitative research is required to understand how they go through the dynamic process of adherence.</td>
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</tbody>
</table>
**Title:** Mexican American women's adherence to hemodialysis treatment: a social constructivist perspective.

**Authors:** Tijerina MS; Tijerina MS.

**Year/Issue:** 2009 Jul. Vol.54, Iss.3; p.232-42

**Abstract:**
Mexican Americans have as much as a six-times greater risk of end-stage renal disease (ESRD) than non-Hispanic white Americans, and women show a faster rate of decline in diabetic renal functioning. The leading treatment for ESRD is hemodialysis, an intensive, complex treatment regimen associated with high levels of patient non-adherence. Previous studies of patient adherence have adopted a biomedical, practitioner-oriented approach focused on performance of fixed behaviors and ignoring contextual and motivational factors. The author describes a social constructivist approach to understanding how female Mexican American dialysis patients experience their disease, the treatment regimen, and the consequences of that experience. Mexican American women's perceptions and psychosocial factors were examined to understand what these women viewed as important to their realities as dialysis patients. Poverty, longer treatment history, and immigrant status emerged as factors that appeared to influence treatment non-adherence. Perceived identity losses, heightened awareness of mortality and family dysfunction emerged as themes that participants viewed as preeminent in their day-to-day lives. A social constructivist perspective is highly compatible with social work principles of person-in-environment and starting where the client is. This perspective provides a valuable framework for informing social work practice with this special population of Mexican American dialysis patients.
Findings

Approach
The environmental scan presented here is based on a review of the identified dialysis patient blogs as well as a review of literature gathered through the application of keyword search for the period of November 1 – 30, 2011. As reported in an earlier project status meeting, the selected keywords were grouped according to the areas of interest identified for this special project. Data extracted from the blogs are summarized for each blog individually with a table showing keyword tracking and followed by a general summary statement for that individual group of blog entries with specific illustrations to highlight findings.

Highlights
The following table summarizes the keyword tracking table and indicates the top areas of interest as: Satisfaction, Dialysis Experience and Knowledge of ESRD.

<table>
<thead>
<tr>
<th></th>
<th>Satisfaction</th>
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<th>Dialysis Experience</th>
<th>Vascular Access</th>
<th>Modality</th>
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<th>Self Management (decision making)</th>
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</table>

A review of the project key words, however, reveals considerable overlap between the areas of Satisfaction and Dialysis Experience and between Dialysis Experience and Knowledge of ESRD. As a consequence, keyword analysis of individual blog entries has generated counts for multiple areas of interest. The most notable finding is made in reference to Table 4. “Individual posts discuss several issues relating to personal or someone they know with ESRD. Discussions rarely identify any of the keywords listed. Posts contain recommendations on diet, lifestyle, and recommendations on how to deal with this disease.” Another interesting finding is made in reference to Table 4, noting that the greatest number of keyword instances was found in a general health blog for the New York Times Health section.
Conclusion

Although this environmental scan report covers only the period of November 1 – 30, 2011, the number of blog postings totals only 49 entries.

It is believed that keyword mismatch noted in the discussion of Table 4 may account for some underrepresentation of the beneficiary perspective. Keyword extraction-based detection of beneficiary blog entries can only be effective if there is a certain level of consistency between keywords and descriptions.

The greatest congruence of keywords occurred in the NYT Health blog where blog entries reflected both professional and beneficiary response as well as reflecting “a commanding knowledge of ESRD.” As these posts were in response to a specific topic addressed in the Health section, it would be expected that responses would be closely related to the topic and be couched in similar terminology. It is not unexpected that NYT bloggers would tend to respond at an advanced level of understanding as their publication tends to be written at a higher than average reading level and attracting a more informed readership.

The second greatest congruence of keywords appeared in Hemodoc blog (Table 2). A review of the actual blog entries reveals a high level of sophistication and discussion lead by patient/doctor writing from “a patient’s perspective.” This blog as well as the blog represented in Table 3 are written by patient advocates who enjoy a high level of recognition and proficiency of issues within and affecting the ESRD community. Although the blog entries in Table 3 did not reflect a high number of keyword instances, a review of the blog entries (Appendix C) reveals an elevated level of discussion related to every other day dialysis (EOD). The blog entries include discussion of research findings, the QIP, advanced shareholder interests and MAC/FIs. Although written by patients, the advocate perspective of these blogs would appear to be more directed at industry and regulatory entities rather than other patients.

The patient – to – patient bloggers is represented by Table 4. The 18 blog entries captured in this environmental scan reflect concerns with symptoms of CKD, the renal diet and other lifestyle questions. Information and support are the basic themes of these entries. The concern is that none of the entries tracked with the keywords currently in use. The challenge is how to capture and quantify such entries as many of them reflected a lack of knowledge of ESRD and self-management issues. Another challenge is how to capture question regarding CKD when bloggers/posters do not yet consider themselves kidney patients. To address some of these questions, a review of keywords and meta headers for each of the identified patient blog sites will be undertaken to determine how to expand the current environmental scan and capture additional relevant information.
Appendix A Environmental Scan through Blog Posts

www.hemodoc.com
“Bill Peckham Responds to Dr. Ishak's Kidney Doctor Opinions and Hemodoc Rebuttal”
By Bill Peckham (DSEN)

Why would you use $160 as the Medicare allowed cost? There is no situation under which Medicare pays $160. The base allowed rate is $230, the average is $250. The fact that Medicare now includes anemia management in with their routine payment (along with the other formerly separately billable services) doesn’t change the math.

Additionally, to calculate the average per year per beneficiary allowed reimbursement you’d need to know the average number of treatments per year, per beneficiary. I think for beneficiaries who start and finish the year using dialysis, they average about 148 treatments a year. Thus, 148 x $250 x .8 gives the average per year, per beneficiary cost to Medicare for someone who uses dialysis.

The cost to Medicare is the same, whether the person dialyzes at home or incenter, whether the person dialyzes for 3 hours or 5. Medicare’s dialysis cost increases only with frequency. However, Medicare can lower the cost of a beneficiary using dialysis by looking at the Part A side. And in fact there is a lot of money to be saved on hospitalizations. As much as Medicare spends on dialysis, it spends an equal amount on hospitalizations and skilled nursing.

D. Ishak, in your http://www.thekidneydoctor.org/2011/10/dialysis-unplugged-waiting-for-godot.html?showComment=132081785323#c4408236234879080109 original comment to Dr. Singh’s Waiting for Godot post you made the claim that, aside from a select group of dialyzers (represented improbably by myself and Rich B) higher dose dialysis would only benefit “The new Amsens and their agents!!”

You continue ”There is a whole new industry for home dialysis and the more patients they have the more machines they will sell and the more treatments per patient the more supplies they will sell.” (you point to the “home dialysis” industry but since PD has not been part of this discussion I will assume that you meant home hemodialysis). That is a false equivalency.

Prior to the expanded bundle the way to maximize EPO revenue (and profits) was to increase people’s dose of EPO without increasing their hemoglobin. That is bad enough but combined with concerns about high EPO induced hemoglobin’s, or perhaps, with high doses of EPO, in and of themselves, there is reason to believe reimbursement led to medical harm. Tell me where the analogous dynamic is at work in home hemodialysis (HHD)?

Unlike EPO, HHD has a constraint built in: the dialyzer’s willingness to perform the treatment. If someone feels well dialyzing every other day then that is the schedule they will freely select, leaving another dialyzer, another individual, to dialyze seven days a week, over night. Each person is perfectly able to identify their preferred dose, striking their own balance between pros and cons.

The other glaring difference between EPO and HHD, is that HHD, unlike EPO, evinces no evidence of harm. Indeed, as most recently spelled out in September by http://www.nejm.org/doi/full/10.1056/NEJMoa1103313 a paper in the New England Journal of Medicine, there is evidence of harm associated with the conventional three day a week schedule. If there had been evidence of harm associated with a ‘Hgb less than 10’ the situation would be analogous to HHD, instead the situation is exactly opposite.

If people want to dialyze at home they should be supported in that choice. If they want to dialyze more frequently than 3 times a week they should be supported in that choice as well. The FHN study was not powered to differentiate the benefit of HHD among various comorbidities, but it did demonstrate the absence of harm.

The question of what dialysis modality would nephrologist use is predicated on the assumption that transplant is not an option. In fact not being eligible for transplant is the only characteristic given: if you were among those who must use dialysis because a transplant is not being pursued, what modality would you choose? Nephrologist would choose to dialyze more frequently.
Since the not pursuing transplant group includes tens of thousands current Medicare beneficiaries, using a conventional incenter dialysis schedule, that are as healthy as an average nephrologists, how do you explain this dissonance?

The Nephrology Oral History project is a great resource. Dr Maddux interviews a nephrology luminary and reports their answer. On page 27 of the Gotch interview transcript (PDF link http://www.voiceexpeditions.com/assets/media/ohfag/gotch.pdf ), Dr. Maddux asks a great question. If you needed dialysis [a transplant not being an option] what would you choose?

I thought Gotch's answer was very revealing. He says he isn't sure he'd choose to dialyze at all but you can hear his approach to the question in his answer... that he'd want dialysis to take as little time as possible, that he'd want to feel well enough to still be able to do things that mattered to him, for example, going on a favorite hike, and that he'd want to evaluate the short daily dialysis option to see if it was a better choice in his case. He'd want to see how well he did, how well he felt and then decide.

It's a perfectly reasonable answer - find the best renal replacement to fit your life and then decide if it is worth the trouble. That's what we wish for everyone. The reason Gotch's answer stings, though, is that it is at odds with what he advocated during his long professional career boosting the importance of urea.

It is not enough to say Nephrologists wouldn't do what we routinely prescribe because nephrologists are special. It turns out that nephrologists are just like everyone else; everyone else deserves a nephrologist's level of informed consent.

www.hemodoc.com
Dr. Ishak Rebputtal: “Extra Cheese Dialysis” or the Gold Standard?
By Noshi Ishak, MD

Dr. Laird, let me explain few issues so that your enthusiasm and energy can be directed the right way. First, let me reiterate what I said in my first response which is that there is no doubt that home Hemo and more frequent dialysis are superior to traditional 3x/week dialysis to many, exactly like transplant is superior to traditional dialysis, BUT, the question is who will really benefit from more aggressive and prolonged daily dialysis. The answer to this question is vital if we are to make those modalities credible so that the resources will be directed towards the people who will really benefit from it. You can’t, for example, give a transplant to a patient with lung cancer whose has less than 2 years life expectancy. Likewise, will it be right to put a patient like this on a 30 hrs/week dialysis!! Or will you be taking away from him very precious time with no benefit....well, may be “Extra Cheese”!!

Now, in regards to the issue of mortality of nocturnal dialysis, we all know that FHN is a credible study, and that study did compare apples to apples. The study compared patients with multiple co-morbidities doing their frequent home Hemodialysis to their peers with similar co-morbidities doing the traditional 3x/week in-unit dialysis. The study proved that both groups had equal mortality. In a sense, what you are trying to do is compare the mortality rate of transplant candidates with the mortality rate of non transplant candidates. But this makes no sense because the non transplant candidates have an obvious reason that will limit their prolonged survival chances. You cannot just compare apples and oranges. That’s why even the study you quoted Survival among nocturnal home hemodialysis patients compared to kidney transplant recipients honestly compared the selected group on nocturnal dialysis with kidney transplant recipients, they did not compare them with the general dialysis population. In other words, they compared relatively healthy patients to relatively healthy patients. Their conclusion was “ this intensive dialysis modality may be a bridge to transplantation or even a suitable alternative in the absence of LTX in the current era of growing transplant waiting lists and organ shortage.” This only confirms and supports what I said, and which you yourself quoted, which is that “For transplant candidates with expected prolonged wait for an organ and patients who failed their transplants, a more intensive dialysis such as daily dialysis or daily nocturnal dialysis is recommended.”

In regards to the second issue which has to do with cost, I have no doubt that home dialysis is cheaper than in center dialysis. That’s why all the LDO’s are scrambling to develop home programs. The story is completely different when it comes to in-center short daily or nocturnal daily dialysis, because, in this case, the cost will be prohibitive, and those are the kind of treatments that we have to be very selective and offer only to patients who will get real benefit not just “Extra Cheese”. Let me also clarify the real cost of dialysis...
for Medicare, because I keep seeing different number tossed around that have no bases. For example, I read that “in-center patients averaged around $29,000” in 70’s. I also read that “the new expanded bundle - per year amount to, on average, about $36,000 of which Medicare pays about $30,000.” To my knowledge, Medicare only paid $120.00/dialysis in the 70’s through 2000. Multiplying this $120 x 13 treatments/month x 12 month = $18,720.00 From what Medicare paid 80%, which means the total of Medicare payment was $14,976.00/year per patient. With the new bundle, Medicare pays about $160.00 for the dialysis treatment only. Multiplying the 160x13x12x80% = $19,968/ year (current yearly cost of dialysis for Medicare). This at a time where Medicare pays $130.00 to a hospital for a nurse to supervise IV infusion of medication for 1 hour, and which does not include the price of the drug or the supplies used. So, whereas Medicare pays that for a nurse to supervise IV infusion in a hospital setting, Medicare allows $160.00 for 4 hours of dialysis including nursing supervision, supplies, dialyzer, Heparin, dietician......What a deal! No wonder then even the Non Profit Major Medical Centers sold their dialysis units to LDO’s. None of them was able to sustain a financially viable dialysis unit. What a shame... All the potential innovations of the medical and nursing staff of our best institutions are being chocked by the cook books of the LDO’s. Thanks to all the people who kept whining about their doctors or hospitals making money from dialysis, they did all the work for the LDO’s and the day the last Non-profit dialysis unit to be sold for an LDO is not far away. On that day the LDO’s will have a celebration and all their whining partners will have access for free Hot Air Balloon rides and free buffet, All You Can Eat Cheese. Also thanks to our politicians and their priorities, the same year our taxpayers paid $5 billion for dialysis treatments, they paid $2billion for Epogen alone. Yes for every $10 spent towards a dialysis treatment they gave Amgen $4. What a shame. I wish I can hear what our politicians were telling their brokers about Amgen!!

Further, when you say, “Thirdly, Dr. Ishak advised selected use of frequent home hemodialysis to those with limited co-morbidities and transplant eligibility,” you gave examples of patients you think will benefit from aggressive dialysis. The examples you gave are exactly as the ones I was suggesting, so we are in complete agreement here. I don’t see how or from where you get the idea that I will pull the plug on them!!!! Dr Laird this is nothing but a flawed misreading of my assessment, I recommend you go back and re-read what I wrote!!

Bill Peckham had a failed transplant and Rich Berkowitz had an MI that he recovered from, which is a limited co-morbidity. Those are exactly examples of the kind of patients I support for aggressive therapy. But for the patients who have severe cardiomyopathy, vascular disease and other significant co-morbidities, aggressive dialysis will make no significant difference in their outcome. For example you need to prove to me that a patient with an Ejection Fraction of 20% will benefit by being converted from CKD 5-4 to CKD 4-3? This patient will die from his cardiac disease even if you give him a transplant. You cannot give him false hope. And you better not use this patient as an excuse to bill for more dialysis unless you have Solid Evidence that your extra dialysis will really give him real benefit, other than the“Extra Cheese”. This patient has precious limited time and you don’t want to waste it on a dialysis machine just for “Extra Cheese”.

You also add,“Dr. Ishak should also include one more group in his flawed assessment, the American nephrologist who overwhelmingly chooses NHHD when they themselves are in need of renal replacement therapy”.

Dr. Laird, here you go again, you keep missing the point, the majority of the American Nephrologists are transplant candidates and if they cannot get their transplant on a timely manner, they will choose NHHD or daily hemo. No doubt about that. I will, too. They fit exactly in the criteria of patients I have always recommended for the daily Home Hemo. But when I am a 70 years old with few stents in my legs and heart and few other things I will tell you, No Thanks I’ll Skip the Cheese!

www.hemodoc.com
Patient Demand Leads Boom in Home Hemodialysis
By Peter Laird, MD

Home hemodialysis, the preferred renal replacement modality prior to the beginning of the ESRD http://hemodoc.typepad.com/.a/6a0133f61818b7970b0162fd76748e970d-popupprogram in 1973 here is re-emerging today by the power of individual patients seeking a viable alternative to conventional in-center hemodialysis. This is evident in a graph (here) provided by Dori Schatell of the Medical Education Institute and Home Dialysis Central that compiled the number of dialysis centers offering home hemodialysis options over the last eight years. The greatest growth is in those centers offering short daily hemodialysis facilitated by the ease and popularity of the NxStage System One portable hemodialysis machine. Evaluating the reasons behind the renewed interest in home hemodialysis is revealed in an Australian study that asked patients and care partners why they chose home hemodialysis:
Characteristics of dialysis important to patients and family caregivers: a mixed methods approach

Results. Thirty-four participants from two Australian hospitals attended six ‘nominal group’ focus groups between September 2009 and February 2010. Two groups involved predialysis patients (total n = 8), two involved peritoneal and hemodialysis patients, respectively (n = 9) and two involved caregivers of dialysis patients (n = 17). We identified 28 characteristics of dialysis important to patients and caregivers. Patient groups agreed that the most important characteristics were (i) survival, (ii) convenience of dialysis at home and (iii) dialysis-free days. For caregivers, the most important were (i) convenience of dialysis at home, (ii) respite and (iii) the ability to travel.

Conclusions. Patients and family caregivers highly value treatment that enhances survival and can be performed at home. Future planning of dialysis services could better reflect these priorities through provision of increased home dialysis support services and planned respite for caregivers. Improved survival came highest on the list of variables that attracted patients to home hemodialysis options in Australia. While the pundits of dialysis hierarchy here in America continue to contest the merits of “non-conventional” dialysis, informed patients are not waiting for them to place the imprimatur of America’s academic nephrology elite. The market place and patient demand for travel, survival benefit and convenience is bypassing what in my opinion is the stodgy behemoth industry infested academic nephrology community that continues instead to rubber stamp the American dialysis holocaust while waiting for the holy grail RCT that likely will never come.

As the evidence mounts, the truth that we have abandoned the right path over forty years ago at the hands of the business of dialysis is the inevitable conclusion. The blood of dialysis patients bathes this for-profit dominated industry that continuous it’s gluttonous rape of patients trust and hopes for continued life to only instead receive a counterfeit death sentence filled with the pain and anguish of short, rapid and violent sessions while suffering with nausea, vomiting, severe cramps and syncope in inflexible cattle call dialysis units across America. We can do better. We should do better.

www.hemodoc.com
EPO: Lighting the Fires of Cancer
By Peter Laird, MD

Erythropoietin (EPO) is a natural hormone that mediates the production of red blood cells (RBC’s) that is primarily produced in the renal cortex and small amounts in the liver. Studies over the last decade evaluated the effects of EPO in diverse populations at risk of anemia outside of the renal dialysis patients, especially in patients undergoing chemotherapy for a variety of cancers. Unfortunately, these studies revealed adverse survival with more rapidly progressive cancers and shortened survival. In addition, in the CKD population, patients were more likely to experience cardiovascular events and death bringing the CHOIR study to an early close as well. The TREAT trial followed shortly with a higher risk of stroke for patients treated with EPO for CKD related anemia.

Many patients sustained with EPO for years on dialysis vocally protested the new FDA labeling changes and the removal of minimum Hb levels in the QIP. Despite the increased risk of cardiovascular outcomes with EPO and the suspected increased cancer risk for chemotherapy trials, the correction of anemia for many patients overcame the potential risks. However, a new study highlighted by Gary Peterson of RenalWEB sheds light on the role of EPO not only in promoting cancer, but it is actually involved in the development of cancers as well:

PDGF-BB modulates hematopoiesis and tumor angiogenesis by inducing erythropoietin production in stromal cells
At the molecular level, we show that the PDGF-BB=PDGFR-b signaling system activates the EPO promoter, acting in part through transcriptional regulation by the transcription factor Atf3, possibly through its association with two additional transcription factors, c-Jun and Sp1. Our findings suggest that PDGF-BB-induced EPO promotes tumor growth through two mechanisms: first, paracrine stimulation of tumor angiogenesis by direct induction of endothelial cell proliferation, migration, sprouting and tube formation, and second, endocrine stimulation of extramedullary hematopoiesis leading to increased oxygen perfusion and protection against tumor-associated anemia.

Blood protein EPO involved in origin and spread of cancer
Angiogenesis is the formation of new blood vessels from pre-existing ones, and is one of the most important research fields in the treatment of such diverse conditions as cancer, metastases, obesity, heart disease, stroke, diabetes and chronic inflammation. The process is also important in healthy individuals for wound healing, the menstrual
cycle and other normal processes. Professor Yihai Cao and his team are researching into angiogenesis and its links to cancer and other diseases, and in the present study show the significant role played by a growth factor, PDGF-BB.

"It's a member of the PDGF family and significantly contributes to blood vessel development, which is one of the characteristic signs of cancer, says Professor Yihai Cao. Our preclinical findings suggest that PDGF-BB causes systemic effects in the body, which is to say that rather than being active locally it goes into the blood and interferes with the function of several organs so that the entire body is affected."

As a cancer survivor in addition to my IgA nephropathy and dialysis, I have been very leery of EPO right from the time I first started on dialysis in 2007. My first confrontation with my health care team at dialysis came about when I refused to continue EPO shortly after beginning dialysis. In retrospect of current guidelines, I never needed EPO with a Hb over 12.0 with only iron infusions alone. The issue of adverse cardiovascular outcomes and now this new basic science information that EPO is involved in cancer formation leaves dialysis patients with hard choices. EPO prevents the need for blood transfusions and their associated complications, but at what price?

The for-profit dialysis industry made billions of dollars pushing higher and higher dosages of EPO to their patients prior to the bundle. The cardinal duty of physicians is to first do no harm. As we evaluate each and every aspect of dialysis care in America, it keeps coming up short every time. The irony is that we are spending billions of dollars for a genetically engineered medicine that is supposed to reduce pain, suffering and enhance our lives. Instead, the evidence is mounting on the dangers of EPO. The debate will continue especially since many dialysis patients fail to respond to iron supplementation alone. Blood transfusions for many are an unacceptable rescue method. In an era of uncertainty, EPO may be too risky to justify it's continued use. Adding the risks of cardiovascular disease and cancer together may render the issue of informed consent between doctor and patient on whether to use EPO instead in the hands of the FDA and further black box warnings.
Appendix B  Environmental Scan through Blog Posts  
http://well.blogs.nytimes.com/2009/03/05/the-voices-of-kidney-disease/  

After my mother received a kidney transplant 2 years ago, friends and family members expected her to be her old, healthy self again. They weren't there to watch her take her carefully timed cocktail of drugs each day, or to see her disinfect everything around her, or to carefully monitor her sodium intake to keep her blood pressure low. People often act offended when she recoils from a hug or a handshake, not realizing that the everyday germs we all carry on our bodies could potentially kill her. As an earlier commenter noted, transplants are indeed a treatment, not a cure. My mom looks healthy and puts on a brave front, so people expect a lot from her. I think her life would be much easier if people realized the struggles she goes through just to make it through each day.  
— anonymous

One of the greatest barriers to successful long term treatment with dialysis and transplant is under treated depression and post traumatic stress that is endemic to the CKD5 population. If you have CKD5 or a loved one with the disease, please put as much effort into supporting their mental and emotional health as you are into supporting their physical health. After almost two years on Dialysis, one at home with the NxStage, I realize that my greatest challenges are in maintaining my mental health and healthy relationships.  
— Brian Steele-Sierk

I am coming up on the 4th anniversary of the day I started dialysis. I will never tell anyone it is easy, because it is not. It is necessary for me to live. I still work full-time and on D days I am out of my house from 7am till 11pm. My off days.....tue, thur, sat & sun are my “normal” days, the days I try to recover from being so tired. By the time the weekend rolls around I am ready to collapse. I keep pushing myself, working keeps me away from depressing thinking. My daughter offered me a kidney, but she is too young, never married and really I cannot accept such a gift from my daughter. My biggest struggle is the fight with Medicare and my secondary insurance. You HAVE to have Medicare after 33 months on dialysis and they are the WORST!! Fighting with them is the LAST thing anyone should endure. That’s what the new President can do for me…..OVERHAUL MEDICARE! It is the worst, and the drama you have to deal with over your bills is the last thing any of us should endure.  
— Dawn

HIP HIP HOORAY for my craptastic suckersick life on dialysis! 40 years old going on 5 years! Friends abandoned me like rats from a sinking ship. Don’t date any more (SWM likes fine dining, long walks on beach, Has all blood sucked from body 3 times per week!) No energy to do anything, but go to my silly-ass job which I can’t leave because it is not like any other employer would touch me with a 10 foot pole.: So I’m either at treatment, the office, or home in bed. FUN FUN FUN! Small talk from nurses, people “how are you feeling” every 5 minutes and let us not forget all the wonderful drugs! Honestly, sometimes I wish the illness would just get on with it.  
— Dialysis Dude

I have had CKD for about 15 years and have about 35% kidney function. I recently had a change of nephrologist and he suggested that I have a biopsy. I had the biopsy a few days ago and apart from being slightly sore, I feel better than before I had the biopsy. I have slept better, I seem to have less foam on my urine and strangely my allergy to dust mites seems to be reduced. My medication has not changed. Perhaps this is temporary and due to endorphins from the trauma of the biopsy, but it occurred to me – could it possibly be due to the acupuncture effect of the biopsy? I almost feel like asking for a biopsy on the other kidney! Has anybody noticed this effect before or is it just my imagination?  
For medical statisticians it would be relatively easy to check the population of CKD patients who have had a biopsy to see if there was a statistically significant change in kidney function for the better or worse!  
A possible PhD thesis?
Graeme, England

My friend belonged to an HMO and was on a transplant list. I suggested he sell his car and stocks and go overseas to buy a kidney there. He didn’t. He put up with poor quality (two day a week dialysis) for years. And when he was in the hospital, after a horrifically botched attempt to put stents in his arteries (by a retread doctor, cross training from another specialty) and with a huge hematoma in his groin to get rid of, he still was only getting two days of dialysis a week. He spent six months in the hospital at the end, dying.
Better you should go overseas, buy a kidney, and buy insurance for the person you bought the kidney from. (So that if their kidney fails, they can also buy a kidney transplant. It is a small probability so the insurance shouldn’t be very expensive.) — JCA

Dialysis patients have not only kidney problems, but usually suffer from many other health issues, some of which have led to their renal failure. Their lives become focused on at least three half-days spent on the dialysis machine with the rest of those days spent recovering from the exhaustion that they experience from the dialysis treatment.
The non-dialysis days are sandwiched with other doctor appointments, not to mention trying to maintain some type of normal life, including shopping, buying food, trying to interact with family and friends.
For those very few lucky enough to receive a transplant they get their lives back, but for the unlucky majority it is a daily struggle.
In my practice, I help maintain the veins and catheters that are used for the dialysis treatments. During my career I have seen Medicare and private insurance whittle away at the reimbursements for dialysis dependent patients. These patients are a silent, though growing, group without a strong unified voice. Their care is expensive, but life saving. In this time of even more economic hardship, beware of more and more cut-backs for this politically helpless group.
— Jeffrey Lautin, MD

I was on dialysis for 2-1/2 years. I have a genetic disorder – Polycystic Kidney Disease. In 2003 I received a telephone call that dramatically changed my life. A kidney match was found! Post operation, I found it fascinating that the majority of people were under the impression I would be able to live 100% “normally”. This is a popular misconception. In fact, the anti-rejection medications have very serious side effects. We all understand that nothing is perfect and these are the trials we have to learn to live with. However, I feel very strongly that the positive attitude I have tried to maintain, throughout my illness, has a great deal to do with my day-to-day health. I am not a religious person, but each day the moment I awake, I automatically thank God for receiving this miracle! I urge everyone to sign the organ donor card. There is no greater gift, you can give to someone, so desperately in need, than to give them back their life.
— Joan Chisling

Last week I was forwarded an email about a 26-year-old in need of $130,000 for a kidney transplant. I am a cancer patient (thyroid not kidney) and just wrote a guidebook for 20 and 30-something patients navigating healthcare systems. I contacted the patient’s sister (a perfect donor match) and we have emailed daily brainstorming hit and miss tactics for convincing their university teaching hospital to schedule the transplant regardless of finances. Yesterday we struck administrative gold and the transplant has been scheduled.
It was an incredibly eye opening week learning about the different financial rules that apply specifically to transplants. I wish all of you with financial barriers awaiting kidney transplants the best fortitude and a strong pair of boots when kicking down the door!
Blog: http://everythingchangesbook.com/
— Kairol Rosenthal

After 3 years on dialysis my 21 year old daughter was able to get a kidney transplant due to the generosity of an altruistic donor we met through the internet. Dialysis is life support and we are grateful for it – but the difference in well being and energy cannot be compared to a transplant. There are not enough deceased organ donors to meet the need. Living donors make miracles happen. Potential donors can learn more about what is involved by going to Living Donors Online. This is a support forum for living donors. God bless every one who steps up to help a kidney patient.
— Karol

On behalf of all of those who have CKD or care for someone with CKD, and who were offended by comment #32, please allow me, as a professional caregiver, to apologize for such callous remarks. There are many reasons why people with CKD or any other medical condition may be less than compliant with diet or medication or behavior— which other people for some reason feel righteously free to judge. Sadly, this seems to be its own chronic condition in our country at the moment—we have far more complaints about our fellow human beings than compassion. However, such remarks from a caregiver, if that person is either paid or professional, are intolerable. If, on the other hand, the caregiver has simply been placed in a situation not of their own choosing (and in the case of #32, clearly not of her own liking), perhaps some respite care from a volunteer organization is in order. At one time or another I have been in all of the roles—patient, nurse, and loved one caring for a seriously and chronically ill person. I’ve discovered that each role can be maddening, demanding, rewarding, and even amazing. Being the SOLE caregiver is quite a task, and would certainly exacerbate the stress, but using words like contempt and soul-sucking about patients offends me too. I’m torn between thinking that “caringg” is not the accurate word for what this person offers, or that she is overwhelmed and needs some care for herself.
— Kathryn Monahan

I had a double nephrectomy in 2004. I was on pd for 8yrs and now hemo for 2,almost 3yrs. 3dys a week.3half hrs. i have developed addisons diseases, high density bone disease, a digestive problem, where it takes longer than it should for my food to digest, there is a name for it!. My legs hurt so very badly..the pain is unbearable. I’m taking indocet. it works but lowers my bp. lately i feel like I’m in my last days on this earth. I have people around me that love me, but i feel so very alone. are there stages to this disease?.how do i know when I’m in the last stage? i have been on the transplant list now for about 1yr maybe 2 now. this is a bad, bad disease. I’d like to know what stage I’m in or do we just drop dead at anytime. My diagnosis is idiopathic. I just feel so bad. yes my kt/v is good. still i do not believe that i have very long to live. I feel so very alone.
— katrinaferguson

6 years ago, at 35, I was diagnosed with ESRD. My kidneys had completely shut down (less than 5% function), I had lost about 100 pounds in the previous 6 months (I was about 300 at 6’5?) and was in sad shape. When my family finally had me carted off to the hospital, I was told that I was within 6 hours of expiring. After 2 weeks in the hospital, I came home ill, depressed, tubes embedded in my chest, and on an anew schedule of 3 times a week dialysis. That was the bottom. The one great thing about being on the bottom, though, is there is only one direction you can go.
I started exercising, very little at first, but gradually increasing the distances on my bicycle, and the weight on my barbells. I started watching what I would eat, now that my appetite had returned, I went back to work. Things in my life are hardly perfect. I have the occasional bad day (days when I work and have treatment are the worst), bad treatment, and a pronounced fistula on my arm, but all being considered, things can be worse.
— Larry A., Seaford

My mother was a dialysis patient for almost a year. Going 2 days/week she would be wiped out,couldn’t eat,only wanted to sleep and take sips of water.It was her decision to stop her dialysis treatments but it also killed a part of me as I was her daughter and caregiver. It has been 3 years since her death and I am still grieving over her loss. I am a donor on my drivers license God forbid I should die and not be able to donate whatever organ is needed.
— LIZZ

This is a wonderful column and I thank you for running it. In 1995 I became very ill and was told that I was in renal failure. I recovered but was diagnosed with chronic kidney disease. Needless to say I was in shock since I had never had a sick day in my life. I did not have hypertension nor diabetes. I was referred to a nephrologist who did the million dollar work up and said we would see where I was in 10 years. By the summer of 2003 he and I had a discussion about the types of dialysis that are available and which type I might like to do.
I opted to do peritoneal dialysis which I could do myself, had fewer dietary and fluid restrictions and was generally easier on the body. I did that for 3 years, never regretted it and highly recommend it to anyone who might be in a similar situation.
I had myself listed for a transplant and spent quite a few moments feeling sorry for myself. Ultimately I decided I had to make myself the healthiest sick person I could be and try to live a life. Three years ago I was lucky enough to receive a cadaver kidney and I am here to tell you that I feel wonderful. Yes, I take lots of pills every day at proscribed times. No. I will never eat sushi again. I will never sit in the sun again. There are lots of things I won’t do again but it is all fine. I have gone back to work. I am earning a living. I feel great and I enjoy every day. I am very grateful. Many of us never think about those 2 bean shaped organs until it is too late. This is a wake up call for many.

— Lorinda Klein

I am so glad to have found this forum. I have an adult son who is blind because of diabetes and now suffers from ESRD with total kidney failure. He is only 39 years old, but is holding up well considering the tremendous taxing of his body by the dialysis process. He is currently on social security disability and that is his only income and he is quickly running out of $ to make the Medicare 20% co-pays and we don’t know how he will ever be able to have a transplant unless he qualifies for Medicaid in NC. He is going through the evaluation process and everything looks good for a pancreas/kidney transplant except for the finances. I have tried on multiple occasions to call the Dept of Social Services in his county (150 miles away) to just get an idea of if he will qualify.. He has about $2000 to spend before he meets the reserve, but I need to know now, as I fear he will not qualify and whether he does or not, he may have to move home with me. I have been through dozens of websites and do know that if he qualifies, he will have a very large spend down since you are only allowed an income of $867 to fully qualify for Medicaid and his SS income pre-Medicare deductions is $1125 a month. Does anyone out there know anything about what is taken into consideration when figuring out qualification. His dialysis treatments cost about $500 a month out of pocket, plus other medical expenses, so once his funds are depleted, I can’t see how he can even afford dialysis.

I myself am facing being laid off from my job and my daughter is already living with me because of losing her job, and my husband only has social security. I really need some help! Medicaid will only talk to us when we file the application and because his reserves are above the $2K, now, we sit in the dark.. wondering if he will live or die because of lack of care.

Help.. please

— Mindy

I ran 4-5 miles 5 days a week, ate healthy, and took care of myself. I mysteriously wound up with ESRD in 2002 after having flu like symptoms for several days. My doctor drove to my house to tell me I was in kidney failure after reviewing my lab tests. Nothing could have shocked me more. I spent 13 months on dialysis during which time I worked full-time and purse a hemo over peritoneal dialysis because I had such an aversion to having friends and family see me in a weakened state. I was transplanted with complications 3 days post-op and the drug treatment for the rejection almost killed me. I am still here but have had devastating bouts of stomach flu for months at a time. I do not hesitate to tell people I am not a hugger, kiss or toucher when they are not close friends or family. My life is 100% better than on dialysis but it is not what it used to be, for sure. Even though I am a nurse and have always been healthy, I want everyone to know that, really, there are no guarantees. To this day they do not know the cause of my renal failure, not uncommon for those afflicted at a younger age.

— SR

I’m a nurse who has worked in outpatient hemodialysis for over 20 years. I was once at a seminar at which a social worker had us write down names of our SO/spouse, children, other family members and friends, favorite things to do with those people, hobbies, occupation, favorite foods, favorite vacation spots and so on — and then showed us how every one of those were affected by a diagnosis of CKD. Really, those were only the tip of the iceberg. I remember a sweet little lady telling me that she wouldn’t wish what was happening to her on her worst enemy. Anna Bennett is right when she says, “...people aren’t realizing that modification of their diets and being on top of your hypertension and diabetes could save you from dialysis, could save your kidneys.” Being aware of those numbers and taking medications to help regulate them is important, but the lifestyle changes you can make to help control them are equally as important. It might seem like a major inconvenience, but it’s nothing compared to sitting in that chair at dialysis 3 times a week for 3-4 hours at a time and having nearly every aspect of your life significantly altered.

Prepared By: Dolores Perez
Several years ago I read that 70 diabetics start dialysis each day. Based on what I see, I’m sure that number has increased. But that’s enough to open at least 1-2 new dialysis centers each week. There’s so much we can do to prevent this — not only CKD, but hypertension, Type 2 diabetes (the two leading causes of CKD), other cardiovascular diseases and cancers.

Take care of yourselves!
— SSK

I just got a kidney transplant, after being on the waiting list about 3 years. Of the 3 years I was on the waiting list, I was able to avoid dialysis, except for the 2 1/2 months before I finally got the transplant. The reason I think I was able to avoid dialysis for so long (most people are on dialysis for many years before receiving a transplant) is that I followed Dr. McKenzie Walser (of Johns Hopkins University)’s book: Coping with Kidney Disease: A 12-Step Treatment Program to Help You Avoid Dialysis. The 2 punch lines of this book are: (1) Minimize eating protein (especially meat protein)– best to become a vegetarian (while minimizing high protein vegetables like beans); and (2) take essential amino acids (you can get them from Calwood Nutritional products which makes a product especially for Kidney patients following Dr. Walser’s diet) because you need them if you don’t eat much protein. The book presents a bunch of recipes, but I didn’t use any of them. I’m Chinese, so I cooked and ate mostly Chinese food, except with only tiny, tiny amounts of meat and fish used as flavoring (e. oyster sauce, etc.). After transplant, I can and do eat more meat (I now really appreciate the taste of well cooked meat and fish!), but I still try to cut down on the amount of meat I eat, because I’m pretty sure that this helps prolong the life of my new kidney. Great book. All those with kidney failure problems should read it.
— Steve

By TARA PARKER-POPE
1. My father is currently experiencing ESRF and I left my job over four years ago to be his caregiver. When I first met with his doctors they projected the need for dialysis in twelve to eighteen months. We have been on a quarterly, recently monthly, program of blood tests to try to safely defer the procedure as long as possible. Through (very) careful diet, liquid and medication (especially diuretics) management we have postponed the need for dialysis for almost three years past what his doctors originally believed would be the time dialysis would be necessary. The restrictions are not easy for my father but it has allowed him the have a good quality of life without the need for dialysis. Along the way I have become quite adept at menu preparation, nutritional analysis and factors contributing to kidney health. I have also become disenchanted with most national chain restaurants that seem to go to great lengths to distort or all together refuse to publish nutritional information on their websites. Even the fast food industry has done a much better job than the eat -in chains. His current blood work notes we are very close to the point we can no longer delay dialysis, but I feel great satisfaction that I was able to give my father three more years dialysis free.
We have chosen at home PD over in clinic HD because we feel the likely effects of HD will be a significant reduction in energy, mobility and (perhaps most importantly) depression. It is not something we look forward to, but we will find a way to make the best of the situation. Thank you for The Voices series that help illustrate the many issues facing our health care issues.

My kidney disease was first diagnosed in 1984, nephrotic syndrome, and progressed slowly until 2008. I started dialysis Dec 28, got my fistula re-worked on March 17 and got the transplant call the day after my birthday on Mar 27. Surgery on March 28 and I went home on April 1. Except for a bout with CMV things have gone well. Now the pressure comes from keeping employed with decent insurance to cover the medicine costs. I am still pretty lucky with the limited time on dialysis but still have HCV and Crohns disease to manage. Life is a gift and every story is different.
— Tom M in Chicago

Prepared By: Dolores Perez
Appendix C  Environmental Scan through Blog Posts

http://www.billpeckham.com/from_the_sharp_end_of_the/

1.
Offering an EOD schedule is the best response to patients skipping treatments
By Bill Peckham

At the risk of becoming The Bruce Dikinson of the dialysis industry, when I read the JASN abstract that connects skipping dialysis with URRs below 65%, and thus a 1% payment withhold under the QIP, I think the only prescription is more cowbell! dialysis! Offering Every Other Day (EOD) schedules is the best response to control the cost of skipping.

The JASN paper only addresses the costs associated with being subject to a 1% withhold under the QIP; this understates the cost to the unit of skipping. Think of a person who comes every treatment, who dialyzes 156 times a year, who we'll call G ... compared to someone who tends to skip twice a month and at the end of the year has dialyzed 130 times, who we'll call D.

First, one reason a person may skip regularly is that they don't feel very well when they do dialyze three times a week; if you're going to feel unwell if you do or you do not go to dialysis, you'll be more likely to not go. EOD schedules, when followed, would increase the person's chance to feel well, thus their ability and willingness to accommodate regular dialysis. But we're talking money, skipping and costs.

On the cost front, consider G's financial impact. Each dialysis payment under the expanded bundle is made up of fractional payments. Lab tests are in the bundle; each one of G's 156 reimbursements include some amount intended to cover lab tests. If G dialyzes 13 times in the month it means that the unit received 13 fractional payments intended to cover the cost of labs.

In addition with each payment the center received fractional payments to cover other monthly services and fractional payments for services that are delivered quarterly or yearly. All sorts of services required by the Conditions for Coverage are paid for a little at a time out of each individual, treatment, reimbursement e.g. the cost of care planning, iron, social worker support, PTH tests, Hepatitis tests, nutritionist support are all paid for a little at a time, by each treatment even though they don't necessarily happen each treatment.

Now consider D's financial impact. Labs still need to be done each month but at the end of the month there are only 11 fractional payments available to pay the cost of running the tests. D, just through skipping, generates 16% less revenue to pay for services delivered at frequencies less than each treatment. The biggest financial effect may be D's EPO profile before and after skipping. In general let's assume D will need the same yearly dose of EPO whether dialyzing 156 times a year or 130, D will need 624,000 units of EPO (likely D would need a higher yearly dose due to skipping). If D runs 156 times the EPO dose will be 4,000 units per treatment. If D runs 130 times the EPO dose will need to be 4,800 units per treatment. D's skipping makes each treatment less lucrative, over and above any QIP withhold.

EOD schedules fix the financial side of this problem. Skipping in and of itself is a clinical problem, and as the JASN authors note there are as many reasons for skipping as the mind can imagine. But skipping shouldn’t mean not having access to dialysis and units shouldn’t be trapped into a needless financial drain. I don't think D is thinking: I only need to dialyze 11 times this month, more likely, about twice a month, D has a sense that: I need a break.

With an EOD schedule D would receive the 13/month medical minimum number of treatments - enough dialysis to avoid expensive hospitalizations and keep URRs above 65%; the unit would have received the number of payments anticipated by the bundle to pay for formerly separately billable services; and D would have had two breaks during the monthly grind. Win. Win. Win.

D should be given an EOD schedule and expected to call the unit as soon as the intention to skip is known.

Every Other Day (EOD) incenter dialysis schedules can be done (Part I); EOD schedules would improve clinical outcomes and support patient choice (Part II); EOD schedules are implicitly supported by MAC/FIs (Part III); EOD schedules would improve the clinic's finances and may lower overall Medicare costs per
person, per year (Part IV); EOD schedules would increase the clinic's value (Part V). And, EOD schedules are a sensible clinical and financial response to patients who routinely skip treatments.

2. Shareholders should demand patient access to Every Other Day incenter dialysis schedules
By Bill Peckham

This is Part Five, the last in a five part DSEN series making the case that Every Other Day (EOD) incenter dialysis schedules can be done (Part One); EOD schedules would improve clinical outcomes and support patient choice (Part Two); EOD schedules are implicitly supported by MAC/FIs (Part Three); EOD schedules would improve the clinic’s finances and [edit; equivocation] may lower overall Medicare costs [edit] per person, per year (Part Four); EOD schedules would increase the clinic’s value (Part Five).

Let me say from the outset that I don’t usually spend a lot of time on dialysis industry equity prices and the concerns of shareholders. I own no stock related to the provision of dialysis. However, as Peter’s comment today nicely illustrated, the owners of the capital need to be part of the discussion. I think the case that the seventh treatment would be financially lucrative, is strong. But that is not quite the same thing as value. Today’s shareholder is most interested in value. Would EOD schedules increase the clinic’s value? Certainly. Shareholders should be EOD schedules' biggest proponents.

It is easy to think that value to a shareholder relies entirely on net income and ultimately it is true an equity share price has to correlate to net income. But it is net income as it is expected for that industry, for that business, for that business at this point in its life cycle. Dialysis as an industry is at the mature stage of its business life cycle. Most of the dialysis in the United States is provided by two large dialysis organizations that are for profit companies with equity shares available to the public and are generally understood to be at the mature stage of their business life cycles.

Being at the mature stage leads investors to have expectations of what it means to serve X number of patients or operate X number of facilities. This is why changes in insurance reimbursement are such a big deal to the dialysis industry - whether it is regular inflation adjustments to Medicare's payment (+), or two percent cuts to per treatment funding (-), or the new role of the exchanges (+/-) it's a big deal because it changes the value of the companies. If average reimbursement goes down, for whatever reason, 100,000 patients are not going to be worth what 100,000 patients were worth the day before. In the world of equity traders what a patient is worth ultimately determines what a dialysis provider is worth.

The good news is we're worth quite a bit to these equity traders, over $85,000 a piece if recent sales are our guide (here, here). We're being sold not as people but as dialyzers. Buying/valuing an established dialysis provider would be like buying/valuing an airline. Sure you pay something for the planes but mostly you're paying for the right to the routes and the airline's frequent fliers. The units are the routes and dialyzers are the frequent fliers. To a shareholder the fact that dialyzers, unlike most frequent fliers, are largely captive of their proximate service provider is a feature not a bug. Providing dialysis and being in position to provide dialysis in the future, has equity value.

EOD schedules increase that value. If patients are worth $85,000 dialyzing six days every two weeks, they're worth more dialyzing seven. EOD schedules increase the value of the provider because they increase the expected value of serving a patient. EOD schedules advance shareholder interests. Providing every other day incenter dialysis schedules would increase the value of the provider.

3. Do EOD schedules offer financial benefits to Payers and Providers?
By Bill Peckham

This is Part Four of the unheralded five part DSEN series making the case that Every Other Day (EOD) incenter dialysis schedules can be done (Part One); EOD schedules would improve clinical outcomes and support patient choice (Part Two); EOD schedules are implicitly supported by MAC/FIs (Part Three); EOD schedules would improve the clinic’s finances and [edit; equivocation] may lower overall Medicare costs [edit] per person, per year (Part Four); EOD schedules would increase the clinic’s value (Part Five).
schedules would improve the clinic’s finances and may lower overall Medicare costs per person, per year (Part Four); EOD schedules would increase the clinic’s value (Part Five).

At their simplest clinic finances are the average reimbursement per treatment vs. the average cost per treatment. EOD schedules manifest as one extra treatment every two weeks and compared to the conventional treatments, that treatment would have a higher average per treatment reimbursement and a lower average per treatment cost.

The seventh treatment, the extra treatment of an EOD schedule, would have higher average reimbursement per patient because use of EOD schedules would skew towards people who drive themselves to dialysis, and as a group, people who drive themselves to dialysis have better insurance than people who rely on funded transportation.

The seventh treatment would also have lower non-labor costs. Services such as EPO, iron and labs are fully funded after 6 treatments, meaning in effect the seventh treatment would carry a ~$70 premium. This gain would have to be weighed against the wage premium and possible tenant costs associated with opening on Sunday, but the higher average reimbursement and lower non-labor costs suggests EOD schedules would be viable with relatively few patients.

Beyond the straight revenue/cost analysis EOD schedules would be a financial plus if it keeps patients out of the hospital. Dialysis units pay a price when their patients are hospitalized, and they will benefit if EOD schedules keep their patients in their chairs, dialyzing. Thus, it is an important, fundamental question — will EOD schedules keep patients out of the hospital?

The answer is yes. Would the decrease in hospitalization cover the added cost of EOD schedules? I think so but, on reflection (hence the edits to the position statement) I can’t make a very solid case. It is not a simple question to answer. The added cost for Medicare of EOD schedules would be about $5,000 (80% allowed $ x 26) per patient per year and there looks to be $5,000 to be saved in hospitalization cost. On average in 2008 (most recent data year) people who use hemodialysis spent 14.5 days in the hospital, at a cost to Medicare north of $30,000.

However, the people who choose EOD schedules might not have average hospitalization profiles, if they are healthier than average it means there is less hospitalization costs to save. And if EOD schedules improve survival, if EOD schedules extend people’s lives, that will increase total Medicare spending.

And, it does give one pause that incenter EOD schedules are provided no where on Earth. All routine incenter schedules include the dialysis weekend, no matter if the dialysis is being provided through for profit system or a centrally planned, state owned hospital. You would think that if EOD schedules saved their cost that systems that fully paid for both the dialysis and hospitalization would offer EOD schedules. They don’t, so maybe EOD schedules wouldn’t lower total spending (though I am not convinced, groupthink would be an alternative explanation), but even if EOD schedules don’t lower total Medicare healthcare spending they should still be offered.

The dialysis weekend represents a cost shift of sorts. Not getting regular dialysis is risky but patients are instructed in how to decrease the risks through strict dietary control. The added dietary restrictions are a cost. The dialysis weekend increases risk and increases the cost of care to the patient. That doesn’t sound like a system that is up to our standards.

EOD schedules would improve the clinic’s finances. EOD schedules lower overall Medicare costs EOD schedules may lower the overall Medicare costs per person, per year.

4.

Would Medicare routinely reimburse EOD dialysis schedules?

By Bill Peckham

This is Part Three of a five part DSEN series making the case that incenter Every Other Day (EOD) dialysis schedules can be done (Part One); EOD schedules would improve clinical outcomes and support patient choice (Part Two); EOD schedules are implicitly supported by MAC/FIs (Part Three); EOD schedules would
improve the clinic’s finances and [edit; equivocation] may lower overall Medicare costs [edit] per person, per year (Part Four); EOD schedules would increase the clinic’s value (Part Five).

The question has to be asked - would EOD schedules receive routine reimbursement from Medicare, in the same way that conventional schedules receive routine reimbursement? My review of the documents online leaves me to conclude that Medicare support of EOD schedules is implied though not plainly expressed. It is possible that, short of a National Coverage Decision (that anyone can initiate) it may be necessary to fight for routine EOD dialysis reimbursement but that is a fight worth having and on this ground it is a fight dialysis unit administrators can win.

Medicare Administrative Contractors (MACs) are entities, created by 2003 legislation, that are contracted to pay claims on behalf of Medicare. The country is divided into 15 regions and each region has a MAC (I think there will eventually be 5 MACs, possibly 10 but it is confusing; current list here (PDF LINK)). When a dialysis unit submits a claim, that claim is submitted to their MAC, who then rejects, or authorizes and pays, the claim.

The Medicare Benefit Policy Manual has little, but not nothing, to say about coverage related to hemodialysis treatment frequency, Chapter 11 - End Stage Renal Disease (ESRD), (PDF LINK):

30.1 - Frequency of Dialysis Sessions
(Rev. 1, 10-01-03) A3-3112.6, A3-3166.2

Hemodialysis and peritoneal dialysis are covered at the frequencies shown below under the composite rate. Additional composite rate payments may be made when they are medically justified. three sessions weekly, and these may be covered routinely. If the ESRD facility bills for any sessions in excess of this frequency, the intermediary shall consider requiring medical justification.

MACs are guided by the Medicare Benefit Policy Manual when making claim decisions. According to the claims manual additional dialysis treatments can be reimbursed when they are medically justified but if additional hemodialysis treatments are provided it is up to the MAC whether medical justification is required.

One way MACs communicate their understanding of what is and is not covered or required for coverage, is through Local Coverage Determinations (LCD). As published in CMS IOM 100-08, Section 13.5.1 (PDF LINK), to be covered under Medicare, a service shall be reasonable and necessary. It is the MACs job to ensure LCDs for the service in question is considered reasonable and necessary under Section 1862(a)(1)(A) of the Social Security Act. Basically, MACs will consider a service to be reasonable and necessary if the MAC determines that the service is (my emphasis):

Safe and effective.
Not experimental or investigational (with exception).
Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient’s condition or to improve the function of a malformed body member.
Furnished in a setting appropriate to the patient’s medical needs and condition.
Ordered and furnished by qualified personnel.
One that meets, but does not exceed, the patient’s medical need.
At least as beneficial as an existing and available medically appropriate alternative.

Two of the current MACs have LCDs regarding hemodialysis treatment frequency: First Coast (FL, PR, VI) and Trailblazer (CO, NM, OK, TX). First Choice directs that:

HEMODIALYSIS sessions which exceed the frequency of three sessions per week must be medically reasonable and necessary.
Trailblazer directs that:
Hemodialysis and peritoneal dialysis performed or billed more than three times per week is reasonable and medically necessary for hyperkalemia, pregnancy, fluid overload, acute pericarditis, congestive heart failure, pulmonary edema or severe catabolic state when these conditions are refractory to dialysis three times per week.

The Trailblazer LCD doesn't preclude payment under other circumstances, but it does suggest that payment for four or more treatments in a week would not be routinely granted. But what about three and half treatments a week?

An EOD schedule (3.5 treatments per week) uniquely meets the directive that duration and frequency of service be "One that meets, but does not exceed, the patient’s medical need."

There is very good research, most recently a NEJM paper, but the data has been consistent since the 1960s: routinely taking two days off from dialysis increases the risk of mortality and hospitalization. The NEJM paper found that the incidence of death increased during two days off from dialysis vs. during the remainder of the week when treatment is every other day:

- All-cause mortality (22.1 vs. 18.0 deaths per 100 person-years, P<0.001),
- Mortality from cardiac causes (10.2 vs. 7.5, P<0.001),
- Infection-related mortality (2.5 vs. 2.1, P=0.007),
- Mortality from cardiac arrest (1.3 vs. 1.0, P=0.004),
- Mortality from myocardial infarction (6.3 vs. 4.4, P<0.001),
- Admissions for myocardial infarction (6.3 vs. 3.9, P<0.001),
- Congestive heart failure (29.9 vs. 16.9, P<0.001),
- Stroke (4.7 vs. 3.1, P<0.001),
- Dysrhythmia (20.9 vs. 11.0, P<0.001),
- And any cardiovascular event (44.2 vs. 19.7, P<0.001).

In order to meet a patient's need, in order to have 18.0 deaths per 100 person-years, instead of 22.1, patients have to adhere to an EOD schedule. Dialysis on an EOD schedule is reasonable and necessary.

EOD schedules are implicitly supported by MAC/FIs.

5. EOD schedules would improve clinical outcomes, and support patient choice

By Bill Peckham

This is Part Two of a five part DSEN series making the case that Every Other Day (EOD) incenter dialysis schedules can be done (Part One); EOD schedules would improve clinical outcomes and support patient choice (Part Two); EOD schedules are implicitly supported by MAC/FIs (Part Three) EOD schedules would improve the clinic’s finances and [edit; equivocation] may lower overall Medicare costs [edit] per person, per year (Part Four); EOD schedules would increase the clinic’s value (Part Five).

I haven’t seen, compared to a conventional schedule, the clinical benefits of an EOD schedule disputed. That the dialysis weekend is risky is well known. Most recently a NEJM paper reviewed the evidence but the data has been consistent since the 1960s. Routinely avoiding the weekend should routinely lead to better clinical outcomes.

The tougher questions to answer are concerns that patients would not want to switch from conventional three day a week schedules to EOD schedules, that patients prefer three day a week schedules.

Unless there is a choice it can not be said that there is a preference. For patients who want to dialyze incenter there is little access to higher frequency dialysis. Incenter patients do not have agency to decide their dialysis frequency. I believe that if there was a choice and the risks that are inherent in the dialysis weekend were well understood a significant number of patients would choose the safer schedule.

Some patients due to transportation issues would not be able to use an EOD schedule. Some patients would prefer the set weekly schedule allowed by conventional three day a week dialysis. Some patients seeing EOD schedules as requiring more from them would feel like they are doing all they can and they just aren’t able, at this time, to do any more. This is all to be expected and accommodated.
However, some number of patients would want to use the safer schedule and would choose to dialyze EOD. How many is not a number I can give. Each patient would have to make their own personal cost benefit analysis but I think there is reason to believe that most patients would reckon EOD schedules to be a good value.

We're not use to thinking in terms of weekly dose of dialysis, let alone the biweekly dose of dialysis, but I think we should. Talking about treatment duration alone obscures dangerous anomalies like the dialysis weekend. One way to quantify the impact of the weekly dose of dialysis is the HemoDialysis Product (HDP). The HDP assigns an impact value to various weekly dialysis schedules (D&T just republished the Scribner classic) using a simple formula: HDP = (hrs/dialysis session) x (sessions/wk)2.

My experience supports using HDP as a way to understand the impact of various schedules; how various schedule would make me feel as compared to other schedule options. In order to decide if I would use an EOD schedule I would want to weigh the benefits against the cost. Would I feel better, would the burden of CKD5 be less vs. spending more time dialyzing and taking into account the net effect of additional time getting to and from the clinic and the time spent recovering from the dialysis treatment. The costs are easier to reckon then the benefits, the HDP provides a way to quantify the expected benefits.

A conventional three day a week, four hours per treatment schedule has a HDP=36; keeping treatment length the same but dialyzing once every two weeks, i.e. going to an EOD schedule, brings the HDP up to 49. Thus, increasing the amount of time dialyzing by 16.6% - from 6 days every two weeks to seven days every two weeks - will increase the impact of therapy by over 36% - from 36 to 49.

Another way to say it is that going from 12 to 14 hours of treatment per week, in effect, in this way, through frequency, increases the HDP 13 points. If instead you increased your weekly time to 14 hours while keeping frequency the same, i.e. doing four hour forty minute runs three times a week, your HDP would be 41.94, a six point gain. Frequency gives more dialysis 'bang' for a dialyzer's 'buck', paid in time.

The EOD schedule is the better value. There is every reason to believe that if EOD schedules were offered, EOD schedules would be a popular choice. Think of the very good financial advise to pay your mortgage every two weeks instead of every month. If you pay every month you will make the 12 payments and four times during the year you get an extra week of income between payments. Having an extra paycheck between mortgage payments is pretty great. But if you pay every two weeks you end up taking years off of your mortgage, saving lots of money and you don't really notice that you made a 13th monthly payment during the year. An EOD schedule would be like agreeing to pay your mortgage every two weeks instead of every month. It's the smart move. Offering EOD schedules improves clinical outcomes. Offering EOD schedules supports patient choice.

6.

The Every Other Day Dialysis Clinic
By Bill Peckham

My contribution to the excellent discussion taking place on The Kidney Doctor (spring boarding off the Atlantic article) puts forward incenter every other day dialysis schedules as one of the solutions needed to improve the clinical outcomes of those who use dialysis. I am an advocate for incenter every other day dialysis (e.g. the petition, here, here), I have not heard anyone dispute that this would be better clinically but some might question this, the push back I have heard has been that it is impractical. Not that it shouldn't be done, but that it can't be done. Or it can only be done at too high a financial cost.

I say that Every Other Day (EOD) incenter dialysis schedules can be done (Part One); EOD schedules would improve clinical outcomes and support patient choice (Part Two); EOD schedules are implicitly supported by MAC/FIs (Part Three); EOD schedules would improve the clinic's finances and [edit; equivocation] may lower overall Medicare costs [edit] per person, per year (Part Four); EOD schedules would increase the clinic's value (Part Five).

I will make my case in five parts. Part I -
EOD incenter dialysis schedules can be done along side conventional schedules
The most specific concern that I have read is that you couldn't do EOD dialysis schedules for some patients but not others. "You can't be a little bit pregnant" the skeptics remind, contending that a unit would have to go entirely to an EOD schedule to offer anyone an EOD schedule. "They'd have to be 100% in or 100% out", "What clinic can accommodate its entire pt population for an additional treatment day?".

I would not advocate switching entire incenter populations over to EOD schedules but I think all patients should be offered EOD schedules. Transportation to the unit, specifically funded transportation, is an issue outside the control of units and represents a real barrier to EOD schedule access. I don't see EOD schedules being used by a majority of patients but I do believe it would be a popular choice if it was widely available.

What follows is an example of how a unit could operate with some patients using an EOD schedule, while other patients, the majority of patients continue to use a conventional three day a week schedule.

Consider a 24 station unit - operating six shifts Monday through Saturday at 80% capacity, a unit with 115 patients dialyzing 3x/week on average for 3.5 hours. The unit would have to have in mind the minimum number of patients they would need to have dialyzing on Sunday to open the unit (the unit conventionally runs Mon to Sat). And then double that number to find how many patients the unit would need to start EOD schedules. It's a question of staffing.

Staffing a Sunday shift would be more costly than an average conventional shift but the treatments provided would carry more reimbursement. There would be different staffing requirements for different units, depending on case mix among other factors. For ours the number is 12, the unit would need 12 patients to make opening the unit on Sunday viable. Thus, the unit needs 24 patients to want EOD schedules for it to make sense to start their EOD program.

36 patients have agreed to switch to EOD schedules (there will need to be another post on how it might come to pass that a third of a unit’s census would agree to switch but it would start with buy in from the patient’s MCP physicians).

The first step to make this work is to divide the EODers into two groups of 18 (a number well over the 12 patient threshold). Instead of calling them MWF and TTS we'll call them Group 1 (G1) and Group 2 (G2). At this unit the interest in EOD skewed to the evening shift.

To accommodate the EODer’s shift preferences the unit manager has to have 8 stations on the evening shift (16 wanted EOD) and 5 stations on both the morning and mid day shifts (10 patients on each wanted EOD schedules). As the EOD census grows or contracts G1 and G2 have to stay in balance, just as the shifts generally have to remain in balance. However, unlike MWF & TTS, G1 & G2 are indistinguishable from the dialyzer’s point of view so switching between the groups should not represent a problem but it will mean that there will be times when patients have to shift from G1 to G2 or vise versa - as long as the number of patients on G1 and G2 is greater than 24 (12+12) the program remains viable at this unit.

Day One

It’s Monday and G1’s turn to dialyze. The patients get themselves to treatment and arrive at their appointed times, receiving their treatments normally. If they use ESAs they receive their dose. This continues through the day. From an operational standpoint it should look like any other Monday even as this tectonic shift in the provision of dialysis is taking place.

Day Two

G2 comes in for their dialysis. As with G1 this looks like any other Tuesday from an operational standpoint. Unless you looked at their charts you wouldn’t be able to tell G2 patients from the conventional TTS patients. But as a group they do skew towards the units younger and healthier patients. Many of the unit’s older and sicker patients rely on funded transportation to get to and from dialysis and it has not yet been worked out how to make funded transportation compatible with EOD schedules. This reality does mean that as a group the EODers are younger, healthier and have better insurance than the unit’s patients generally.

Day Three to Six

The unit would continue to operate per usual, without any unique staffing requirements. In gathering supplies and preparing stations, staff would know they were getting ready for Wednesday and G1 or Thursday and G2. If it was time for labs they’d be drawn, iron would be given, visits with doctors and staff, nutritionists and social workers would take place normally.

Day Seven
On Sunday G1 would come in for dialysis. From the patient's point of view Sundays would be different. On every other day of the week you'd come in at your normal time but if dialysis fell on a Sunday you'd come in, most likely, at a different time. Having a special Sunday time for dialysis, different from dialysis on conventional days, is what allows EOD schedules to embed in a unit with a majority of patients using conventional schedules. It might be that on Sunday G1 and G2’s dialysis is always during a window from 8AM to 2PM or it could be that G1’s Sunday is from 10AM to 6PM and G2’s is from 8AM to 2PM. The options would need to be evaluated based on patient and staff preferences and availability but ultimately most patients would need to accommodate a time outside their conventional time. Until the EOD census grows it will be necessary to operate the unit for just part of the day on Sunday. Additionally by operating the unit for only six or eight hours the unit would still be available for maintenance tasks typically done during off hours.

It's 10AM, G1 arrives in waves of four, 20 minutes apart. The four techs and one nurse get 18 patients dialyzing by noon. At the height of operation the unit operates 18 stations at once with a slightly higher staff/patient ratio than their conventional standard, since no medications, labs or ongoing education is taking place and there are no deliveries and few phone calls. The patients have event free treatments, they are generally healthier than the average unit patient and they have not had two days off. Note that no formerly separately billable services are provided on Sunday but payment is the same, resulting in the ~$70 included in the bundle for formerly separately billable services to be available for increased staffing costs.

Day Eight
G2 comes in for dialysis. From an operational perspective it should look the same, setting up treatments based on a patient’s prescription. Staff would know to set up for Monday and G2. The only difference I would expect to be apparent is that G2 would not show the effects of taking two days off while the conventional Monday patients would continue to show the symptoms associated with the break in their routine renal replacement.

Day Nine to thirteen
Lather, rinse, repeat.

Incenter every other day dialysis can be done along side conventional dialysis schedules.

Appendix D  Environmental Scan through Blog Posts
http://www.fbkidneydisease.info/kidney-disease
1. 62y/o female with 16% kidney function, diabetes, HTN, Hypothyroidism, heart disease, and Chrones disease…?
I think that you must educate yourself on each disorder separately, then take an honest look at how all these conditions put together contribute to her health and well being.
When you finish your research, then you will be able to discern how all of these disorders contribute to a toxic cocktail in the body...Dialysis is not a ‘cure’ by any means, it’s function is to help her body rid of toxins that build up, which should help her feel much better. The frequency of the procedure, and type of procedure will be determined by her physician.
Good Luck!

sounds like my father.
First and foremost, you should talk to a doctor.
However, once the Kidney function is gone it takes about 2 weeks for a person to die from the build up of toxins in the blood. They will start to fill sicker and more lethargic, and eventually they will fall asleep and die. At the end, I am told that it is relatively peaceful, but they will be unconscious when they die. Once a patient goes on dialysis the risk of heart attack or stroke increases tremendously. The risk of heart attack or stroke while having dialysis or shortly afterwards skyrocket. I believe once someone goes on dialysis their previously life expectancy is cut in half. I think it’s worth it though, she’ll feel better than she has in a long time after dialysis treatments.
Also the diet for a kidney/diabetes patient is only possible with strict portion control. 

And just a heads up. With heart disease with next major organ to fail are the kidneys. Dialysis is the only option. The organ that fails after that, are the large intestines. For this there is no cure.

What is my mother’s prognosis with dialysis?

2.

Does end-stage renal sickness cause gastrointestinal difficulties?

It can. Higher blood urea nitrogen, which is elevated in end-phase renal sickness can cause vomiting and even gastric bleeding. Chat to the medical doctor about this.

Hi, I am a Homeopath and I can help you remedy both your renal sickness and your gastroenteritis. But to do that I need your specifics precisely the way you really feel in your own words as well as your healthcare background. Remember to give full facts so I can prescribe an acceptable remedy for you.

Homeopathic Medication treats you the particular person so figuring out all about you is much more critical then anything else in healing and curing you one hundred%. Please post your particulars for a proper and proper answer.

Consider care and God Bless you!

3.

kidney failure or chronic kidney disease there are foods you cannot eat is that true?

Yes, it's definitely true. The one that seems to be hardest for people (and all patients with renal failure must adhere to this) is strict restriction of sodium; basically, no more salt in foods. Your kidneys are responsible for getting rid of excess sodium and water to maintain the proper volume of body water, so when they don't work, there has to be strict sodium and fluid restriction to prevent fluid overload. Phosphate generally must be limited too, so no colas/’dark’ sodas, certain meats and dairy products, etc. Potassium is also restricted, and finally, the amount of protein is regulated depending on the stage of renal disease. The kidneys are incredibly important to the body, so it unfortunately is really tough to manage, both medically and on a day-to-day basis, when they fail.

Yes, some foods must be avoided or limited. I have been on dialysis. Some foods I was not supposed to eat included tomatoes, potatoes, cheese and dark colas. The colas were the worst because I love Diet Pepsi. (It was the first thing I asked for following my transplant)

I have included a link to a dialysis provider’s page regarding diet info.

And some one was saying if you have kidney failure or chronic kidney disease there are foods you cannot eat is that true.

4.

Kidney issues or nerve dilemma??? Support?

yep, it really is now in your kidneys. see a nephrologist, I hope your doctor asked for a urine tradition. You need to know what kind of bacteria, it is not usually E. coli... You need to have to be seen ASAP, consume plenty of h20, cranberry, grape. notify your document about the meds and your sx got worse. It’s not a uti any more, it really is a kidney infection.... and do a urine tradition after the next round of antibiotics to make sure it really is cleared up. numerous docs will not do that. basic lazy...

I am 23 y/o. No diseases or sicknesses. Around four months, I observed that I urinated much more in frequency. Til very last month when I was urinating at practically every hour. I considered it to be a uti not realizing how prolonged I have had it. I as recommended eight days of Bactrim to very clear the infection. By the time I obtained the medication, my decrease back to higher back again was in really undesirable soreness with warming sensations on my back in which
kidneys are put it so considerably even with contact i had gentle fevers, severe joint pains and numbness in legs, significant fatigue nausea and vomiting stress and discomfort in bladder when trying to urinate. After finishing the antibiotics, the signs or symptoms were not as serious but inside 3 days following the signs are again. I have no appetite now. I am not positive if this is a nerve factor of a kidney infection/uti. Make sure you help me with any data that it could be.

Further Specifics

Also the pain is now along my spinal cord place, it can be like a burning feeling type of pain. also have had flank discomfort. Doesn’t harm also a lot as it did a few days ago

5. My father has Chronic Kidney Disease, along with type 2 diabetes. His kidneys function at 20%, but he has?

He is a ticking time bomb... those kidneys could shut down at any time... especially for someone who is diabetic.

My friend has the same problem But him hes kidneys are functioning at 29 percent Hes watching everything he eats and hes doing find Your father can live a long time with just 20 percent

i got diabetes when i was 7 i had total kidney failure when i turned 30 i went on dialysis. but i lived with only one working about half the time for about 9 years.

they just need to keep close watch on his kidney functions. have you asked your doctor about dialysis?

stated that they have been that way for 10 years...Is that possible? I mean, to actually have been living for 10 years with such compromised kidneys....also, any idea of how long he can live with kidneys functioning at 20%? Thank you.

My father does NOT want dialysis, unfortunately, he has stated that he would rather die....

6. My uncle has said he has stage 4 kidney disease, was there a way to have known ahead of time this was coming?

I don’t think he could have known unless it was in the family and he tested himself for it frequently. The symptoms he might have confused with something else. I’m sorry, but I don’t know what you should do now, since I’m not an expert on kidney disease. You should really consult your doctor. He would know the best thing to do.

Try davita.com/kidney-disease for information. His nephrologist (kidney doctor) will decide what treatment he should have. The doc might also suggest he see a dietician.

Very often people will have little or minimal symptoms – unless he had bleeding or the Doc had some reason to do a blood test, they often will not know until it’s too late. And sometimes blood tests don’t even show anything definitive.

Sorry for your Uncle, and good luck to him.

The 3 most common causes for kidney failure are:

1. Diabetes
2. High BP
3. Infection of the kidney (glomerulonephritis)

Since he has the 2 top causes, it should have been mentioned by his doctor at some point. The difficulty is that these 2 conditions also lead to other things. The lab results to detect for kidney failure are specific, and are not part of the regular labs you might get drawn at your doctor. Sometimes the progression is slow and can be seen coming, and other times it comes without warning and no one could have caught it.

He should see a nephrologist at this point, and he will be instructed on how to maintain the kidney function that’s remaining. The thing that probably caused the kidney disease (uncontrolled diabetes and uncontrolled bp) is the same thing that will make it worse. In addition there are other diet changes to make.
The nephrologist will be doing the necessary labs to track the disease process. Take it one step at a time. But yes, if he reaches the next stage (end stage kidney failure), he will need dialysis. Good luck!

Would his lab results have shown that he was in Stage 4? What happen to the other stages of this disease? Did he just ignore the signs/symptoms that the doctors told him? He is diabetic and has high blood pressure. I want to know how this disease got this far into his health and nobody knew about it. Will this condition lead to heart failure as well as kidney failure? nWhat should he do now? have dialysis/transplant/diet change? Help me please understand this.

7.
What health insurance company does not disqualify people with kidney disease in family history?
She’s facing a rough road ahead when it comes to qualifying for medical coverage.
The only answer I can think of is to find employment with a company that has a good benefits package.
Sorry to hear of her plight. I hope things work out for her.
If you are looking for individual insurance, I would say look for a high risk pool in Ohio. These are administered by a company (in Texas, its Blue Cross) and underwritten with state funds. They are required to accept everyone and while incredibly expensive, the coverage is good.
The other option is group coverage. She goes on your employer plan as your spouse. If you have an HMO option, there would be no pre-existing condition, if she goes on the PPO (or anything besides an HMO) there will be an 18 month exclusion on the bi-polar, but if she has never been treated or seen on the kidney issue, there would be no pre-exclusion for that.
Health Insurance typically does not ask for a family history and it’s not the kidney issue that will keep her from getting coverage, but the bi-polar diagnosis. The kidney issue would cause coverage problems for life insurance.
Hope this helps and congrats on your engagement!
OK, she’s not going to have a problem with kidney disease, because she doesn’t HAVE it yet.
Her problem, is that she’s DISABLED, AND, she’s bipolar. Either one of them is going to disqualify her.
But, if she IS disabled, on SSDI, she should qualify for MEDICARE, welfare health insurance for those on SSDI, and that’s probably the only place that is going to take someone disabled, who is bipolar.
Sorry to hear of what might come.
You need to check out this site: www.deliveringonthepromise.com/mkeys
The company is AmeriPlan. They are not insurance but a discount program and they have coverage for the entire household whether they are related or not. There are no pre-existing condition no paperwork no waiting and the plans are very affordable. Just check them out they may be able to help and if she has the total health plan and has to go into the hospital they will work with her and the hospital to give her a HUGE discount on her total bill (ex. 30k down to 5 or 10k) hopes this helps and good luck with everything.
State Farm Insurance is probably your best hope ( i don’t work there). If they say no, you can go to one of the small local agencies who charge triple the normal rate. If she has no claims for 3 years, her rate will go down..
My girlfriend is 37, non-smoker, living with parents in Geauga County, Ohio. There is history of kidney disease in her family. She runs the risk of having this later in life. She is on Social Security Disability for bi-polar, but works part-time. Her current health insurance is limited to one Cleveland hospital that requires she pay 80%. She is otherwise, the picture of health. 5’6, 130 lbs.
She needs health insurance that will not disqualify her for disease that may or may not materialize.
Jack, did you answer the question just to get a Yahoo credit? My only response is..Duh! And if yahoo gives you credit for a best answer, I will fight the credit.

8.
What are the early warning signs of diabetes-related kidney disease?

none

some diabetes signs are blurred vision, sore that won’t heal, the munchies, thirsties, and leakis. It all means have to go to the bathroom a lot for leakis, have to eat a lot for munchies, and have to drink a lot for thirsties. I would say none. Happy holidays!

p.s. I’m 14 years old and I know this

Early warning signs would be seen on your blood work and urine studies….while you would be completely asymptomatic. On your blood work, you kidney function test (creatinine) may start to rise. On your urine studies, you may have protein (microalbumin) in your urine. Also, eye disorders caused by diabetes tend to occur at the same time as diabetes-related kidney damage. So things like blurry vision and other signs of retinopathy may be indicative of concurrent kidney damage. Usually patients will be asymptomatic from the diabetes-related kidney damage until the damage is very advanced. Your doctor can see the damage much sooner via your blood and urine studies.

None of the four. Heightened response to insulin, increased microscopic proteinuria, macroscopic proteinuria and increased serum creatinine are the earliest signs of diabetic nephropathy.

What are the early warning signs of diabetes-related kidney disease?

1>. Painful urination
2>. Indigestion
3>. Bloody stools
4>. None

9. What are the possibilities of kidney failure that has only 16% of equally kidneys doing work?

My wife’s grandpa is stage four kidney failure and my daughter has a birth defect exactly where she may well have to have a kidney transplant afterwards on in existence.

The a single issue I seen about my in-laws (wife’s grandma) is that she controls his diet program drastically to support his kidneys as much as achievable. I feel bad for the male, but it has kept his kidneys from finding worse. Also, preserve his method flushing, I was advised by my daughter’s pediatrician to make pure cranberry juice a part of her diet program, not that crap that truly just isn’t juice, the true unpleasant things. I sweeten it for her with loads of sugar till it is bearable. I want you luck, it is going to be ok with your father.

The following, I identified the brand that we use: http://www.mountainsun.com/products/juice.php

You have to be a brave person to consume this basic, lol. The bottle is kinda tiny for the price, but it is value the cash to retain him nutritious.

E-mail me for questions/assistance. I will not head. E-mail me if you want me to request what his diet regime is specifically. I would have to phone and ask…… the dialysis is the remedy for this, and which is fairly a lot the only thing that will assist other than a transplant. 16% isn’t a lot, hate to be the bearer of bad information, but he is eventually heading to need to have a transplant simply because dialysis is only a temp resolve and his kidneys will preserve failing until finally he dies if he doesn’t get one particular.

Very best needs and prayers…

I would say really excellent chance, I’m confident a transplant is up coming to come. My father had a coronary heart transplant and did extremely well for 13 yrs. Before getting a transplant Remember to have your father request about also acquiring bone marrow from the donor as to keep away from anti rejection meds. This is a new method that holds a lot of guarantee. Very good luck
My dad was diagnosed to have kidney failure both of them has sixteen % working. it implies he have to go an dialysis. Is there any way we could treat him? pls wonderful advice ....i am so anxious about my dad. thanks in advance. I know its a wrong part ill take my probabilities here with men and women who has the same problem as my father.

10. What are the signs of kidney disease? Yellow urine?
If you have dark brown or bloody urine, be concerned. Yellow urine covers the gamut from almost clear to dark yellow, and is mainly the result of normal pigment varied by the amount of water being put out by the kidneys.
You cannot see the protein in the urine, but if there is cloudy appearance, you may be looking at crystalline matter or white cells. Only microscopic examination can be sure.
You would be concerned only if there are symptoms of pain on urination, blood in the urine, dark brown urine color, incontinence or other unusual symptoms.
You are better off just listening to your doctor, instead of trying to find things to worry about. Only a fool has himself for his doctor.
Try eating foods that don’t strain your kidneys so much. Eating a bunch of meat and dairy can lead to serious kidney problems. Of course, it could be something else, no way to know unless you go to a doctor. Just eat more balanced meals and exercise.
wait a second...didn’t you say you went to the doctor?
so, you didn’t ASK him anything?? Even after he told you that that was a sign of kidney disease?
Couldn’t you have asked him what the other signs were? Not that it matters. They did some kind of test that measured your protein content in your urine.
Something that you probably couldn’t do at home. And THAT was a sign of kidney disease.
Shouldn’t you be asking us what might work as a cure?
Just a thought...vitamin C is responsible for supporting your immune system. Start taking 3000 mg a day for a month and see what happens.
You don’t take any now, do you? OR maybe you take 200 mg once a week when you remember to take vitamins.
It’s not enough. Don’t pay any attention to what the government says about minimum daily dosage. Do you want your kidneys to be healthy or not? Then don’t listen to our goddamned government. They’re all just a bunch of liars.
I’d say the minimum is 1 gram a day. If you might be sick, you might consider taking 6 grams a day. There IS no upper limit. I’ve read about people taking 20 grams a day. No adverse side effects.
This is a bad sign. You should drink more water, and there is a dietary change you can make.
This site I saw had a great discussion on kidney issues:
http://epidemiologyandpublichealth.blogspot.com/2009/03/yellow-peas-are-that-good.html
Its run by some epidemiologist who’s an expert in the field. check it out.
The best thing for now is to drink water, and watch your blood pressure...more tips can be found at
http://epidemiologyandpublichealth.blogspot.com/2009/03/yellow-peas-are-that-good.html
I went to the doctors and they said that i have 500+ protein in my urine. They said its an early sign of Kidney disease. What are some other signs of Kidney disease? If your urine is really yellow, what does that mean? not enough water? Please help me!

11. What do you do without health insurance? I have Polycystic Kidney Disease and I am in need of medical help?
Look and see if your community has a “Free Clinic”. Most communities do. Also look to see if you have a United Way Agency.....call them....they often act as First Call for Help from people in need!!!
What about free clinics and catholic hospitals who usually don’t turn anyone away. Any in your area. Sorry you are so sick and I hope you find some help.

Hi,

I presume you are in America.

My suggestion pack your bags and move to the Northern Ireland, our health service will look after you.

Better you come than scroungers from the Eastern Countries.

Skip

I don’t know what state you live in, but some are much better than others.

Here in Massachusetts, students at college are required to have health insurance. Most students pay for this out of their student loans. I had a job with the federal government (the VA system) and the health insurance was excellent, even when I was just a nurse’s aide. State jobs also provide good benefits as do certain unions like the Teamsters. Keep looking. You might have to move to another state, but there’s a solution for you somewhere.

Oh, I wished we had National Health Care like many other progressive countries. I feel for you. These are your choices:

1. Don’t work and collect welfare. Usually, you will then be entitled to medical care.
2. Move in with your parents. Attend college full time through financial aid. Usually, colleges provide health benefits.
3. Don’t go to college, and get a full time job. If you end up losing your job, then move in with your parents and pay for Cobra insurance for 12 months.
4. Maybe you can get free medical care by moving to Canada. I don’t know what the rules are in Canada.
5. Try to get a job at Starbucks. They provide their part time employees with health insurance benefits.
6. If you are heterosexual, focus on finding someone to marry. Maybe he will have health insurance where he works.
7. And, definitely vote for Hillary Clinton if she ends up being the Democratic candidate. She is for National Health Care.

Wow that was intense you need to stick to your job long enough to get health insurance through that company.

All jobs provide it and its against the law if they don’t. So stick with it and also your community college as health options for you, go to the admin desk and talk to them. I didn’t have insurance and always went to the er because of my kidney’s so you might be able to afford without but try not to.

Go to www.deliveringonthepromise.com/Trent

Every one with pre-existing conditions is accepted.

Good luck.

Hi ..I’m 23 years old. I inherited Polycystic Kidney Disease ..was diagnosed at age 14. A year later the disease spread to my ovaries. Up until I turned 21, the government has helped me.. I had medical benefits...however, I lost them when I turned 21. I have applied numerous times but I am always denied. Once, while I was unemployed, they denied me because they said you needed some income. Then, I got a job making minimum wage...applied again and was denied because they said I was making TOO much money. I pay rent and have bills just like everyone else so I have to work, of course. It’s hard to find a job where benefits are offered for these reasons:

I’m currently attended a community college so it’s been hard to find a job that offers benefits that willing to work around my school schedule. Also, sometimes it’s hard for me to hold onto jobs because I end up having health problems and having to take considerable amounts off...I am having a lot of health problems and I am very scared.

12.

my dad has 9% kidney function, COPD, diabetes, does not want dialysis, how long can he go on?

I would suggest your father take digestive enzyme supplements with every meal. Enzymes are essential for all body functions. I watched a video about it and the narrator gave her grandfather enzymes which prevented him from going onto dialysis. Vitamin B12 deficiency is very prevalent at your father’s age so upping B12 levels can help. I’m not sure how long your father has to live, but I have read case studies that the Gerson Therapy can reverse chronic disease.
have him check to see if he has altimers. many people when they get older they forget things. we do not know that answer. dialysis is a death sentence to diabetic. my friend went thu with it it was a nightmare. diabetic all ways trier when they sugar level are too high or too low. remember that he live a good life and should be remember that way. many people live without dialysis. or one kidney but take him to the doctors for memory loss.
dad has 9% kidney function he is 83, mobility very limited, (few steps before he has to rest). He has chronic COPD, diabetes. He has lost 5 stone in 6 months, he is very breathless with the COPD like i say only a few steps before he has to rest. He has decided not to have dialysis and the hospital are happy with his decision, I do not have a problem with this.
He is tired all the time, he also gets a little confused or forgetful at times. Has anyone any idea how much longer he can survive with kittle kidney function.
many thanks B

13.
Chronic Kidney Disease?
The best source for lifestyle changes in your specific case is your doctor and I recommend that you talk to him/her about it. Meanwhile, a little research on webmd.com or nih.gov could be useful.
Good luck.
My son has Kidney Reflux disease and he is 15. It has caused severe atrophy and scarring to one of his kidneys, because it went undiagnosed for so long. He will be having surgery on the affected kidney, but we won’t know what kind of surgery until later this month. Hopefully after the surgery he will be fine.
As for lifestyle changes there arent to many we had to make. He is currently on antibiotics and he drinks more water. We eat pretty healthy and gets lots of exercise.
The worst thing about any disease, especially when you are young is that we predict the worst possible outcome. Once you have gone to a kidney specialist and he/she lets you know what your options are, you will find that usually the worst possible outcome is not the one that happens.
Good luck to you and remember the waiting for all the referrals and tests and finally finding out what treatment will be used is the worst part.
Chronic Kidney Disease, CKD, is an all too common phenomenon amongst the US population and its two most common causes are Essential Hypertension and Diabetes. Hypertension that is not well controlled, i.e., keeping the blood pressure at or less than 140/80, has been shown in multiple studies to be a strong predictor of hypertension related comorbidities such as CKD.
The actual serum creatinine should be interpreted in light of your age, body build, physical activity and very importantly your total body muscle mass. Creatinine actually results from the turnover or metabolism of muscle protein. Many things affect its level in the serum.
Parameters necessary to completely answer your question and further discuss it are:
1. What was your baseline serum creatinine at diagnosis of your hypertension?
2. At the time of diagnosis, did you have any proteinuria?
3. Is the GFR (glomerular filtration rate) you mention a measured value or one calculated from your age, weight and serum creatinine?
4. What are the GFR and total protein excretion in a 24 hour urine collection? These are fairly accurate measurements of renal function.
5. What is your serum HC03; i.e., do you have any degree of metabolic acidosis?
6. If you are overweight, how far above your ideal body weight are you, exactly? Obesity plays a negative role in the treatment and outcome of hypertension.
7. Is your blood pressure well controlled?
8. Have you been assessed for Renal Artery Stenosis (RAS)? In your age group if you have significant HTN that is somewhat or very difficult to control Secondary causes of hypertension must be sought. These include RAS, endocrine disease, pheochromocytoma, etc.
I would strongly recommend you have a nephrologist evaluate you. Not only does a nephrologist specialize in renal disorders, of which there are several primary glomerulopathies which may afflict you, they are also experts in the evaluation and treatment of hypertension. Don’t wait for further evaluation and treatment. Hypertension does its damage over time and the longer you wait the more damage will occur, not just to your kidneys but other organs as well, especially the cardiovascular system.
I hope this is helpful to you.
DrEarp
I wanna see you smile first to compete this illness! becarefull on some ways of that monster:
- Tiredness
- Backache
- Kidney’s ache
- your Urin changed colour
- Thirsty most the times
There are the mean aspects that develop easily into a very serious chronic disease.
Take care, hope you all best
Hey guys! I’m 31, slightly overweight but active, with chronic high blood pressure that I have been taking medication for several years. In my annual blood test, it shows that glomerular filtration rate is weakening and the creatinine rate is increasing. The doctor is saying that I am developing chronic kidney disease. Has anyone else been diagnosed with this so young? If so, what lifestyle changes have you had to do to help combat it?
Thanks!

14.
Early signs of kidney disease? Need advice? 
Hi, just wait til you see your specialist. try not to stress they will tell you what to do.
ask your family and relatives- but also keep in mind modern medicine gets more advanced every year.
I’m 24 years old and lately I have been really worried that I’m developing kidney disease. I have a strong family history of kidney problems and have had a lot of problems myself in the last 2 months. In the last 2 months, I have had a UTI, a kidney stone removed, and 2 kidney infections. I also had a CAT scan a week and a half ago and was told that my left kidney looked pretty swollen. The symptoms I’ve had for the last 2 months are: noticeable blood in my urine, bubbly or foamy looking urine, severe pain in my left side which radiates to my back, nausea almost all the time, weight loss, feeling cold all the time, very itchy skin, craving more salty foods and feeling worn out all the time even when I haven’t done anything. I have read a little bit about kidney disease and have read that all of these things can be symptoms. I’m worried that with my family history and all of these symptoms that I might be developing kidney disease. I do have a follow-up appointment with my urologist next week. I plan to ask him about all of this since none of it is getting better. If anyone has any experience with kidney disease, what were your first symptoms? Does this sound like kidney disease or could it be something else? I would really appreciate any personal experiences or advice. Thanks!

15.
I have stage 3 chronic kidney disease (CKD). What should my diet consist of?
Eat whatever you want cus you gonna die anyway!
Generally, a low sodium, low protein diet—
Here is a link with food choices for CKD patients.
Good Luck!
http://www.aakp.org/newsletters/KB-The-Magazine/Diet-Tips-&-Bits/CKD-Food-Choices/
Other answer tell your diet, only I want to tell you that you are not going to die because in case all your kidneys not working you can depend on renal dialysis and continue to live, or if lucky you get kidney transplant, then you can live almost normally.
There are lots of kidney and dialysis patients that can help answer this question at http://www.ihatedialysis.com – go to the forum and post a question – it’s a really great group of people with experience and knowledge to share.
My doctor hasn’t helped. I am trying to find another doctor. I want to know what I should and shouldn’t be eating.

16.
Is there any life insurance plan/policy available for Chronic Kidney Disease patient?
lifeinsurance.awardspace.info – try this one. I have their insurance and, as remember, they can provide such a service.
My friend has CKD stage 4 and looking for 100k policy! @ companies declined insurance because of health condition! He is fine and under nephrologist care! Is there any insurance company who’ll provide life ins.? may be 50k?

17.
Is there any charity or any foundation which can help my sister with kidney disease?
Check out the website www.kidney.org
It is the National Kidney Foundation. There should be somebody on there that you can contact that might lead you in the right direction
I have a sister who is in India. She is 29 years old. She has polycystic kidney and also liver failure. Presently she is surviving with dialysis. She need multiple organ transplant which can be done successfully only in USA. Is there any charities which can help her to get medical help in USA or in India?

18.
if someone goes into stage 5 of Chronic Kidney Disease, what happens to them?
They move way up on the donor availability list
they will be in hospital because if the kidneys don’t work the body starts to shut down and after about a week should give up – blood poisoning probably because its not getting cleaned out.
the likely hood of a transplant for this person is very small (due to blood type etc) & they have already decided to refuse dialysis when the time comes. I know they die but what actually happens, the symptoms leading up to it? and will they be in hospital by this point or at home? will it be sudden? will they be in pain?