



New Proposed Conditions of Coverage

The Centers for Medicare and Medicaid Services (CMS) has released proposed revisions to the Medicare Conditions for Coverage for End Stage Renal Disease Facilities. Facilities must meet these requirements in order to participate in Medicare and Medicaid programs. The proposed rules were published in the Federal Register on February 4, 2005. The requirements were last revised in their entirety in 1976.

One section of the proposed rules addresses Discharge and Transfer Policies and Procedures (Proposed 494.180 (f)). The conditions propose “that the facility’s discharge and transfer policy be designed to ensure that no patient, including disruptive or noncompliant patients, is discharged or transferred from the facility unless one of the following situations applies:

- The patient or payor will no longer reimburse the facility for covered services;
- The facility ceases to operate;
- The transfer is necessary for the patient’s welfare because the facility can no longer meet the patient’s documented medical needs;
- The facility has determined the patient’s behavior is so disruptive or abusive that the facility is unable to deliver care to the patient or to operate effectively.

The proposal continues that the medical director has “the responsibility to monitor and review every patient discharge of an abusive or disruptive patient to ensure that the patient’s interdisciplinary team has reassessed the patient and documented the ongoing problem(s) and efforts to resolve the problem(s); obtained a written physician’s order which must be signed by the medical director and the patient’s attending physician; and that a documented attempt has been made to place the patient in another

facility.” Furthermore, “the State survey agency and the ESRD Network must be notified of the involuntary discharge of any patient.”

In addition, the proposed rule would require a facility to provide 30 days notice in advance of terminating services except in cases of immediate threat to other patients or staff or if the patient is verbally abusive and disruptive to the degree the facility is unable to operate effectively.

Another section states the facility “social worker is responsible for counseling the patient and family, assisting the patient with the emotional adjustment to ESRD and dialysis treatment, performing crisis intervention,” ... etc.

“The social worker has an important role in addressing patient behavior that may be challenging or disruptive.”

In recent years, the number of calls the Network has received regarding the involuntary discharge of a patient, as well as calls concerning noncompliant, abusive and disruptive patients, has risen dramatically. One reason for such an increase may be the evolution of dialysis over the years particularly related to facility financial realities and staffing issues. Another reason may be

simply that more facilities are notifying us, or calling for advice.

Facility staff may find it easier and less costly to discharge a difficult patient rather than attempting to deal with the problems. The issue of discharging a patient raises many ethical dilemmas. CMS does not support the discharge of a patient for noncompliance or failure to follow the instructions of a facility staff member.

In light of the rise in involuntary discharges and the new proposed rules, SCRDC would like to suggest some alternatives for handling complex and difficult patients. We hope you find the information in this brochure useful. SCRDC will continue to provide resources for dialysis facilities on related topics in the future.

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February 2006

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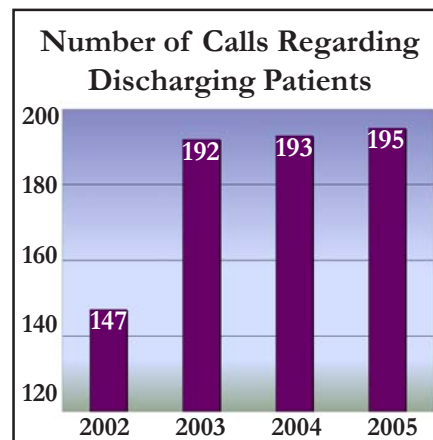
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Put Yourself in Their Shoes



Bob is a 38-year-old in-center hemodialysis patient. He developed renal failure from hypertension – a condition he was unaware he had. Prior to starting on dialysis he ran a successful computer software business. He is married and has one small child.

The dialysis staff has become frustrated with Bob. He is frequently late for his treatment and sometimes signs off early. He seems to have a short fuse, and gets very angry with the staff when they have trouble with his needles or the machine. Sometimes they hate to be assigned to his station because of the angry outbursts.

Recently, the social worker was trying to interview Bob while he was on dialysis and inquired whether he needed her assistance. Bob yelled at her to “leave him the f...alone...he didn’t need her help or anyone else’s for that matter.” The social worker was very upset about the incident and told her manager about it. She said she was afraid of him and did not feel comfortable around him since he often

yelled at her. She did not have time to “deal” with him.

Does this type of patient scenario sound familiar? Why does there seem to be so many angry dialysis patients? Try to put yourself in their shoes. What if you suddenly found yourself on dialysis? Think about it. You are being told when to come in for treatments, ordered to spend around 15 hours every week at the dialysis center. You have to endure the insertion of large bore needles into your arm. You are at the mercy of staff you don’t even know. You are being told what you can and cannot eat and drink. You are told to take numerous medications. You don’t feel good. You lack the energy to do housework let alone hold down a job. You don’t feel well enough to play with your kids. You and your spouse seem to always be at odds, after all her (his) life has changed drastically also. Do you think if you were a patient maybe you might be a little angry too?

Dialysis patients are faced with many emotional and social issues. They face

a loss of independence, changes in their self-image, changes in financial security, possible change in role within their home, lifestyle changes, dietary changes, as well as the anxiety and discomfort with the dialysis treatment itself. This list only partially covers it. Can you imagine why they may respond angrily to all the changes in their lives let alone facing their own mortality? Any angry individual needs some intervention. They need to be able to express their feelings with someone they are comfortable with, whether it be a social worker, a nurse or a psychologist. They need help adjusting to all the changes in their lives, and they need to know that it is normal to be angry without being threatened to be discharged. We need to find ways to help our patients rather than discharging them and passing their problems off to someone else.

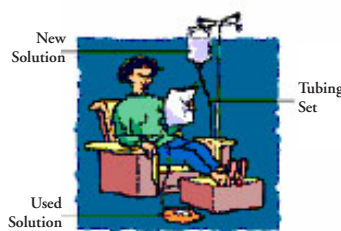
It is Network 18’s goal that the following scenarios will present alternative solutions to discharge.

How About Trying Peritoneal Dialysis?

In the above scenario, Bob was used to being the independent bread winner of the family. He was having a difficult time adjusting to the very dependent atmosphere of incenter hemodialysis. He lashed out at everyone.

Bob’s social worker arranged a face to face meeting to talk to Bob about alternatives to incenter hemodialysis. The nurse manager and Bob’s nephrologist also attended the meeting. Other treatment options were presented to Bob such as home hemodialysis, peritoneal dialysis and transplantation.

Bob’s caretakers thought he might do better on a modality where he had a little more control, a little more independence. Bob expressed an interest in trying peritoneal dialysis.



His nephrologist felt he was a good candidate and had no contraindications. Bob was attracted to the idea of the nighttime cyclor so he could have his days free to work.

A peritoneal catheter was inserted and training initiated. In the meantime, he continued on incenter hemodialysis. He remained rather short-tempered but the goal of being off hemodialysis helped both him and the staff get through the tense times. Bob learned

how to operate the cyclor and to do manual exchanges quickly. He was able to resume working during the day and dialyzed every night. He only had to see his physician at monthly clinic visits so he did not feel quite as “sick” as he did on hemodialysis. Bob was able to regain his sense of control over his life and felt like a more productive person.

Bob also discussed the possibility of receiving a transplant. Although this was an option to be pursued in the future, he chose to still change to PD for now.

Another alternative for Bob could have been home hemodialysis. For patients with a partner, the flexibility of home hemodialysis may be attractive. Patients can dialyze at any time during the day that is convenient for them.

The Chronically Late Patient

Clara is a 32-year-old who has been on hemodialysis for 2 years. She is frequently late for dialysis, and occasionally does not show up at all. The staff take her off at her scheduled time but because she arrives late, she rarely gets her full treatment time. Her URR averages 63% and her Kt/V is 1.1. This morning the patient arrived a few minutes late and then socialized in the waiting room telling other patients that she had just finished having her nails done at the beauty salon. The nurse manager overheard the conversation and became angry with Clara. This was the last straw. She crafted a letter to Clara giving her 30 days to find another dialysis facility.



Being late to dialysis IS NOT a reason to discharge a patient!

Here are some other ideas on how to handle this type of situation:

- Have a team meeting and identify the reasons the patient is frequently late. (Perhaps the patient needs to

maintain some control in her life by doing the same activities she is used to doing.)

- Offer assistance to the patient as needed, including time management;
- Review if the patient is a candidate for home dialysis where she will have more options and more flexibility in her treatments;
- Attempt to change the patient's scheduled time to better meet her needs;
- Have the patient sign a form releasing the facility from liability for not completing her prescribed treatment (similar to AMA form);
- Instruct the staff to not prime her machine until she arrives;
- Transfer the patient to the 3rd shift if available (or the last shift of the day);
- Dialyze the patient for as long as possible (until the last patient comes off);
- Do not allow the patient's noncompliance to affect the hours the

staff work or other patients' scheduled times;

- Develop a behavioral agreement/contract with the patient;
- Document your interventions and reasons the patient is not adequately dialyzed;
- Compromise with the patient one small step at a time;
- Help her have some control over her situation, offer some choices;
- Have a competition between shifts for the best adequacy, best compliance, etc;
- Create rewards, prizes, motivations to encourage compliance;
- Above all, LISTEN to your patients!

Remember, it is written in the federal conditions of coverage that "all patients are treated with consideration, respect, and full recognition of their individuality and personal needs...". It is also within their rights to refuse treatment, no matter how frustrating it is for the staff.

Paranoia?

James is 45 years old and has been on hemodialysis several years. He is divorced with a 16-year-old son. He has been described as being mildly mentally retarded and/or schizophrenic. He is compliant with his dialysis treatments and generally has no complaints. Recently, however, he has felt the dialysis staff are out to get him. He frequently experiences muscle cramping during his treatment and he believes certain staff like to see him suffer. He has started to complain to either the social worker or the nurse manager after nearly every treatment. He has also mentioned his complaints to his doctor who supported the staff. Recently he observed a tech and a charge nurse talking in the corner and laughing. Although he could not hear what they were saying, he believed they were making fun of him.

Frustrated with his constant complaining, the nurse manager told the patient if he was this unhappy he should consider transferring to another unit. The patient did not pursue a

transfer, saying he was hurt that they just wanted to get rid of him. The social worker encouraged him to get counseling. However, the patient did not believe anything was wrong with him, so he refused. Finally the facility became so frustrated with his constant complaining and inability to trust any of them, they gave him a letter saying he needed to find another unit and would no longer be allowed to dialyze at their facility after 30 days. Staff frustration and patient complaining ARE NOT reasons to discharge a patient.

How else could they have handled this situation?

- The staff and doctor could meet to discuss the muscle cramping and develop a plan to identify the causes and to help decrease the patient's pain.
- Have a face-to-face meeting with the patient and the health care team; develop a plan of action to address his complaints.
- Acknowledge the reasons he is upset with the staff.

- Encourage staff to chat briefly with him when he is not complaining as a way to build rapport and to let him know he will be acknowledged even if he does not complain.
- Provide one-on-one counseling at the facility with the patient and help him to take responsibility for what he can do to make his situation better.
- Temporarily transfer him to another facility (within group if possible) to give the patient and the staff a break.
- While the patient is gone, counsel the staff on how to restore the patient's trust.
- Hold inservices on professionalism, compassion, paranoia, mental illness.
- Consider the option for the patient to do self care.
- Offer the patient other treatment options such as home hemodialysis, peritoneal dialysis, or pursue a transplant.
- Involve the local mental health center.
- Educate staff on communicating with paranoid, mentally ill patients.

Staff Frustration

The dialysis facility presents new challenges and new situations daily. There is a lot of responsibility on the staff to provide adequate, quality care in a timely, courteous, and respectful manner. Patients' lives are entrusted to the staff to keep them alive and to prevent complications. What a tall order!

Patients who complain, are disrespectful to staff, arrive late, leave early, or do not show up at all present additional challenges to staff. Besides the frustration of knowing that the patients compromise their health when they do

not receive their full treatment, staff may get frustrated by the extra work of setting up a machine for a no-show and being yelled at to take them off the machine early. Being disrespected by being called names, cursed at, being called incompetent, etc, can be demoralizing.

However, to work in a dialysis unit, staff need to know how to handle their frustration and have outlets for it. When staff and patients are stressed and frustrated at the same time, it can easily become a no-win situation. It is important to hear and listen to the

patient, but to not take their yelling, name calling, etc. personally.

Staff need effective coping methods and stress reduction techniques too. It can be very helpful to offer in-service training programs in areas such as learning how to reduce their own stress, learning appropriate skills for working with challenging patients, learning how to de-escalate conflict, learning how their attitude and the patient's attitude affect their interactions, and learning a safety plan/approach for patients they deem threatening. All of these skills will increase their confidence in handling difficult situations.

Decreasing Dialysis Patient-Provider Conflict

In October of 2003 a national conference was held by the Forum of ESRD Networks to explore dialysis patient - provider conflicts. Renal stakeholders and CMS participated in the conference. CMS then funded a national project titled Decreasing Dialysis Patient- Provider Conflict (DPC project). A national task force and subcommittees were formed to examine the legal, ethical and regulatory issues of entitlement and to produce a statement for national consideration.

Your facility should have received its DPC Poster on Conflict and hopefully you have decided to display it in your unit. You also have received, or will receive shortly, the DPC Toolkit. Within the toolkits booklet "Conflict Resolution Resources for the Dialysis

Professional" is the task force's position statement on involuntary discharge. The statement includes the following positions:

1. Medicare beneficiaries with ESRD are entitled to partial government payment to providers for chronic dialysis treatments under the Social Security Act.
2. Providers have legal authority to refuse to treat patients who are acting violently or are physically abusive thereby jeopardizing the safety of others.
3. The use of contracts to facilitate effective and efficient use of facilities is permissible.
4. Although a patient may unilaterally terminate the patient-physician relationship, the physician may terminate the physician-patient relationship only after taking steps necessary to fulfill ethical obligations and to avoid legal abandonment of patients.
5. A certified facility cannot provide dialysis without a treating physician and thus must discharge a patient if the treating nephrologist terminates

the patient-physician relationship, unless the patient's care is transferred to another treating nephrologist within that facility. However, both the physician and the facility are obligated ethically, legally and by regulation to assist the patient in securing life saving treatment with another facility and/or nephrologist.

6. It is unethical for patients to be left without treatment based solely upon non-adherent behaviors that pose a risk only to themselves, i.e. nonadherence to medical advice.
7. Groups of providers should not exclude patients from acceptance and treatment from all their facilities or other physicians, except for irreconcilable cases of verified verbal/written/physical abuse, threats or physical harm. These groups should endorse and act on the ethical obligation to transfer patients to others within their group. An important purpose of transfer is to ensure that personality, language, or cultural issues particular to an individual patient, professional or facility are not significant causes of the problem behavior of the patient.



This material was prepared by Network 18 under a contract with the Centers for Medicare and Medicaid Services (CMS). The contents do not necessarily reflect CMS policy.