

In search of a dialysis unit

An innovative approach in addressing patient placement challenges

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Whether you are a medical director, facility administrator, social worker, or admissions specialist working in a dialysis facility, it's likely that at some point a packet of information on a new patient has come across your desk and caused you great concern. Maybe it was a progress note detailing a threat made to staff, or the report of an incident involving a patient yelling and swearing. In some cases you might even see evidence of an involuntary discharge. For whatever reason, something in the packet causes you, as a dialysis professional, to consider exactly why this patient is no longer being treated at his or her previous unit. And most important, you might be concerned about the safety of your patients and fellow staff members if this individual is admitted to your facility.

Access to patient-appropriate dialysis care is a growing concern throughout the dialysis community. Patients may be denied placement in chronic outpatient dialysis units due to a history of involuntary discharge, inappropriate behavior, substance abuse, or mental health issues. In many cases it is a combination of several if not all of these factors. In order to track these cases, the Centers for Medicare & Medicaid Services has directed ESRD Networks to document these cases using the designation of "failure to place" (F2P). By

definition, a patient's case is considered F2P once all local dialysis units have denied the patient acceptance. Depending on the region, this could mean that a few units have denied access, or in some cases, it may mean that more than 100 dialysis units have not accepted the patient for admission.

Patients' medical records from previous chronic or acute settings travel with them, and they may sometimes contain alarming accounts of outbursts, threats, or other behaviors that would be considered maladaptive in the setting of a dialysis unit. With the use of electronic health record systems at large dialysis organizations (LDOs), these patients can be tracked across the country. A discharge from an LDO facility in one area could mean that all affiliated units nationwide have access to information about previous behaviors. This issue is then magnified, since the three largest dialysis organizations own approximately 70% of the units in the United States (USRDS, 2014). Additionally, units considering a new patient may call the patient's previous center to consult with staff on the patient's case, especially if they see documentation that raises concerns. This creates an ethical question: "Is it appropriate to freely speak with

someone at another facility about a patient's past behaviors?"

The reality is that patients with documented issues still require several treatments per week in order to survive and remain healthy. For patients who are unable to gain placement in an outpatient unit, the only option is to receive acute dialysis treatment through a hospital emergency department. From a continuity

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of care perspective, this method of receiving dialysis is very undesirable. Hospital emergency departments do not provide the patient with needed services that are available in the chronic outpa-

tient setting; these include standing treatment orders, a plan of care, and the careful oversight of the interdisciplinary care team. The patient may sometimes need to wait hours in an emergency department before receiving treatment, and even after waiting, may be denied treatment and asked to return in one or two days if lab results indicate that he or she is not in emergent need of dialysis. Due to the inconsistent treatment schedule, lack of clinical oversight, absence of anemia management therapy and bone mineral metabolism monitoring, these patients often become hemodynamically unstable and possibly predisposed to higher morbidity.



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Additionally, circumstances of F2P will almost always create an obstacle to kidney transplantation.

In addition to patient health concerns, there are negative cost implications for the hospital treating the patient; often claims for regular emergency department visits and ongoing acute dialysis treatment can be denied by insurers, forcing the hospital to seek reimbursement directly from the patient or to absorb the cost of the treatment provided. With hospital resources scarce and emergency treatment in high demand in many regions, patients using the acute care setting for ongoing treatment can impose hardships on hospitals. In the past many hospitals were able to place F2P cases in their satellite dialysis units. However, more and more of these units are now owned by LDOs, leaving hospitals with no alternative to having patients receive dialysis in the emergency department.

A new tool for placement

In 2014, the IPRO ESRD Network of New York reported 24 cases that met criteria for F2P in the state of New York (ESRD Network of NY, 2015), an increase from 15 cases reported during 2013 (ESRD Network of NY, 2014). It is important to keep in mind that some cases may go unreported, especially if the patient regularly travels to different hospital emergency departments to seek treatment. To address the growing problem of F2P cases, the ESRD Network implemented a pilot program in July 2015 to facilitate placement of these patients. The program was developed in collaboration with CMS and the New York State Department of Health with the following goals.

- To alleviate some of the risk that a dialysis unit assumes when it accepts a known F2P patient
- To ensure that such patients receive the elevated level of sup-

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port that may be needed to help them adjust positively to the outpatient setting.

Through the program, prospective dialysis units are offered a 30-day trial period during which they may accept a patient for treatment as if he or she is a “transient” patient. The unit accepts the patient with the understanding that there is no commitment to continue treatment after 30 days if the patient causes excessive disruption to the unit or exhibits threatening or violent outbursts. Participating units agree that if the patient refrains from these behaviors, the unit will accept the patient as permanent after the 30th day or the 12th treatment. This gives the unit staff members a chance to get to know the patient and begin to create a specific plan of care that will be implemented if the patient remains at the facility. This also gives the patient the opportunity for stability and continuity of care that is not available in the acute setting. Additionally, the patient gets the opportunity to decide if the particular dialysis unit is the right fit for him or her.

The program is structured as follows: F2P patients are identified, barriers to placement are investigated by the network, and CMS and the Department of Health are made aware of the case details. Once a patient has been identified and approved as appropriate for the program, the network collaborates with hospital social workers and discharge planners. The patient is encouraged to speak directly with a social worker from the ESRD Network, who strives to build positive rapport with the patient and gain additional facts that may prove helpful in facilitating a

placement. Network representatives contact units that have previously denied the patient; staff members at these units are then provided information about the program. If a unit accepts the terms of the program, an initial interdisciplinary meeting is held with the patient at the unit. The patient is fully informed of the terms of the 30-day trial and provided with information about patient rights and responsibilities. If mental health problems or substance abuse are apparent, the patient is encouraged to accept referrals to address these issues. Once the patient has begun treatments, the social worker at the dialysis unit provides him or her with an elevated level of support, meeting frequently to proactively address any psychosocial or treatment-related issues that may become apparent. The network follows up with the unit staff weekly to provide ongoing education and technical assistance. Additionally, in consult with the patient, the network develops a monitoring plan that generally involves weekly phone calls to discuss any issues or concerns the patient may have.

Outcomes and final thoughts

During the months of August through November 2015, three patients successfully completed 30-day trial periods without incident and were accepted as permanent patients by participating units. This success may be attributed to the extra level of support provided to these patients and/or the will and determination of patients to secure dialysis care on an outpatient basis.

During the 2015 CMS Quality Conference in Baltimore, Maryland,

the program was highlighted in a poster presentation and was also discussed during a session dedicated to addressing involuntary discharge. The ESRD Network of New York will continue to work with CMS and other stakeholders to further test the program and will explore opportunities to expand the program into other states, with aspirations of a nationwide initiative that may help to offer a second chance to patients across the country who desperately need one.

Dialysis, even under the best of circumstances, is difficult, and faced with the challenges of end-stage renal disease many of us may not be able to access the necessary coping mechanisms and at times may have difficulty expressing frustration. For the patient designated as F2P, add to that the need to visit an

emergency department several times a week. These factors, in combination with mental health or anger management issues or lack of a support system, can easily lead to a situation in which a patient finds himself or herself without a dialysis unit.

Although in today's health care environment we try to alleviate risk as much as possible, next time you have a patient whose admission packet causes you to question whether you will accept him or her in your unit, please read between the lines, and consider reaching out to your ESRD Network or State Survey Agency for help in facilitating a placement plan or a 30-day trial for the patient. Above all, try to give a second chance to a patient who needs the service you provide to stay healthy and to survive. *NN&I*

Resources

- ESRD Network of NY. (2014). 2013 Annual Report. Lake Success, NY: IPRO.
- ESRD Network of NY. (2015). 2014 Annual Report. Lake Success, NY: IPRO.
- USRDS. (2014). United States Renal Data System. 2014 USRDS annual data report: Epidemiology of kidney disease in the United States. Bethesda, MD: National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases.

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