Partnersing with the Network to Achieve Positive Patient Outcomes

Danielle Daley, MBA
Executive Director

Brooke Andrews, MSW
Patient Services Coordinator

September 16, 2022
Agenda Topics

• Welcome

• ESRD Program Administration
  o Overview of CMS Statement of Work
  o Participation/Conditions for Coverage (CfC)

• Emergency Management

• Social Determinants of Health

• National Healthcare Initiatives

• Patient Services
  o Involuntary Discharge
  o Access to Care
  o Steps and Strategies to Prevention
  o De-Escalation Resources and Strategies
  o Moving Forward: It Starts with You
ESRD Program Administration
ESRD Networks

Puerto Rico and Virgin Islands are part of Network 3
Hawaii, Guam, American Samoa are part of Network 17
IPRO ESRD Program
Network Service Areas

Network 1
CT, MA, ME, NH, RI, VT
Dialysis Patients: 15,022
Dialysis Facilities: 202
Transplant Centers: 15

Network 2
NY
Dialysis Patients: 28,843
Dialysis Facilities: 354
Transplant Centers: 14

Network 3
IN, KY, OH
Dialysis Patients: 32,493
Dialysis Facilities: 651
Transplant Centers: 14

Network 6
NC, SC, GA
Dialysis Patients: 50,118
Dialysis Facilities: 799
Transplant Centers: 10

Network 9
OH, KT, IN
Dialysis Patients: 15,022
Dialysis Facilities: 202
Transplant Centers: 15

IPRO ESRD Program
126,476
Dialysis Patients
2,006
Dialysis Facilities
53
Transplant Centers
The Mission of the IPRO End Stage Renal Disease (ESRD) Network Program is to promote health care for all ESRD patients that is safe, effective, efficient, patient-centered, timely, and equitable.
CMS Priorities, Goals, and QIAs

ESRD Statement of Work (SOW)

• Contract Cycle: June 1, 2021 – April 30, 2026
• Priorities and goals align with NQS and CMS initiatives designed to result in improvements in the care of individuals with ESRD
• Quality Improvement Activities (QIAs) incorporate one or more of the CMS 16 Strategic Initiatives
  https://www.cms.gov/About-CMS/Story-Page/unleashing-innovation
• Networks deploy interventions that target patients, dialysis/transplant providers, other providers, and/or other stakeholders
• QIAs incorporate a focus on rural health, health equity, and vulnerable populations
• Grounded on the concepts and design of Section 1881 of the SSA, HHS Secretary’s Priorities, Executive Order to launch Advancing American Kidney Health (AAKH), ESRD Treatment Choices (ETC) Payment Model, and the ETC Kidney Transplant Learning Collaborative
ESRD Conditions for Coverage (CfC)

- The CMS Federal Register cites Network-specific goals and the dialysis facility’s responsibility toward achieving these goals.
- State Survey Agencies utilize these goals and initiatives as a guideline for evaluations.
- Goals are achieved through the implementation of Quality Improvement Activities (QIAs) to be launched at the dialysis facility level, which are tracked and reported to CMS.
- Participation in Network activities is a condition of approval to receive Medicare reimbursement for the provision of End Stage Renal Disease services.
- Failure to comply may result in sanctions by CMS.

V-Tags and Patient Involuntary Discharge:
CfCs and Involuntary Discharges

• The CMS Conditions for Coverage are the federal regulations by which the ESRD Dialysis facilities and all staff, including physicians, are governed.

• Among the other functions of the CfC’s, are those related to the Involuntary Discharge (IVD) of dialysis patients (sections V766 and V767).

• Dialysis facilities are required to report IVD’s to the State Agency and the Network within 1 business day of their occurrence; ESRD Networks track and work to resolve these Access to care cases as promptly and successfully as possible.
Involuntary Discharges (V766-V767)

• The Conditions for Coverage (CfCs) permit four (4) conditions for which a dialysis patient may be involuntarily discharged (V766):
  • The patient or payor no longer reimburses the facility for ordered services
  • The facility ceases to operate
  • The facility can no longer meet the patient’s medical needs
• And per V767:
  • The facility has determined that the patient’s behavior is disruptive and/or abusive to point that medical care cannot be completed
Emergency Management
Network Responsibilities

• Networks are the foundation of ESRD Emergency Management in collaboration with the Kidney Community Emergency Response (KCER) national response coordination contractor

• Networks monitor conditions that impact a facility’s ability to provide service to dialysis patients

• Networks establish relationships with state emergency management officials and healthcare coalitions

• During an emergency, Networks:
  • Work to identify challenges and barriers impacting patients and facilities
  • Collaborate with emergency response stakeholders at the local level to re-establish interrupted services
Emergency Preparedness, Mitigation, & Response

- REPORT Closed/Altered Status
- Use the Closed/Altered Reporting Link: https://redcap.ipro.org/surveys/?s=R8K7RWETHM

Why?
- Network reports to CMS, State and local OEMS during events
- Assists in placing patients as needed
- Provides Situational Awareness in an emergency
Health Equity
What is Health Equity?

According to the World Health Organization (WHO) health inequalities are systematic differences in healthcare outcomes.

- **Health equity** is achieved when everyone can attain their full potential for health and well-being.

- **Health inequities** are differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age.
Social Determinants of Health

According to the World Health Organization (WHO), health inequalities are systematic differences in healthcare outcomes.

- **Social Determinants of Health (SDOH):** conditions in places where individuals live, learn, work, and play that affect a wide range of health and quality of life, risks and outcomes.
  - Economic Stability
  - Education Access and Quality
  - Healthcare Access and Quality
  - Neighborhood and Built Environment
  - Social and Community Context

- **Examples of SDOH:**
  - Safe housing, transportation, and neighborhoods
  - Racism, discrimination, and violence
  - Education, job opportunities, and income
  - Access to nutritious foods and physical activity opportunities
  - Polluted air and water
  - Language and literacy skills
Social Determinants of Health - Access to Care

- Large urban and rural counties see lower percentages of patients receiving pre-ESRD nephrologist care compared to suburban and medium/small urban counties (Yan et al., 2013).

- Females, whites, non-Hispanics, and older patients are more likely to receive pre-ESRD nephrology care (Hao et al., 2015).

- Low socioeconomic status and low educational attainment (fewer than 12 years) are associated with a higher prevalence of ESRD (Quiñones, 2020).

- Low educational attainment, African American race, poverty, and unemployment are all associated with lower rates of kidney transplantation (Hao et al., 2015).
Quality Improvement
National Clinical Objectives and Key Results (OKRs)

Goal 1: Improve Behavioral Health Outcomes
• Increase Remission of the Diagnosis of Depression

Goal 2: Improve Patient Safety and Reduce Harm
• Reduce catheter infection rate in patients receiving home dialysis within nursing homes

Goal 3: Improve Care in High Cost/Complex Chronic Conditions
• Home and Transplant modality, telemedicine and vaccinations
National Clinical Objectives and Key Results (OKRs)

Goal 4: Reduce Hospital Admissions, Readmissions, and Outpatient Emergency Visits

• Reduction in all areas

Goal 5: Improve Nursing Home Care in Low-Performing Providers

• Decrease the Rate of Blood Transfusions in ESRD Patients Dialyzing in a Nursing Home
Strategic Program Requirements: Improve Patient and Family Engagement

Improve Patient and Family Engagement at the Facility Level

- Increase the number of facilities that successfully integrate patients and families concerns into Quality Assurance and Performance Improvement (QAPI)
- Increase the number of facilities that successfully assist patients to develop a life plan
- Increase in the number of facilities that successfully develop and support a peer-mentoring program
Improve the Patient Experience of Care

Brooke Andrews, MSW
Patient Services Coordinator
National Initiatives

Improve the Patient Experience of Care by Resolving Grievances/Access to Care Issues

• Educate patients and dialysis facility staff about the role of the Network in resolving grievance and access to care issues
• Provide a focused audit of all grievance and access to care cases
• The Network’s case review responsibilities include investigating and resolving grievances filed with the Network and addressing non-grievance access to care cases.
Patient Services Team Phone: 516-231-9767

Danielle Daley, MBA
Executive Director, Network 6
Emergency Incident Commander

Agata Roszkowski, LMSW
Patient Services Director

Shezeena Andiappen, MSW
Patient Services Coordinator

Brooke Andrews, MSW
Patient Services Coordinator
(Network 6 Primary Point of Contact)

Elizabeth Lehnes, MSW
Patient Services Coordinator

Julia Dettmann, BSW
Patient Services Coordinator
Emergency Coordinator
Brooke’s Why?

• Grandfather was a dialysis patient for 3 years
• Second generation nephrology professional
• Grandfather & Uncle are both recipients of Organ Donations
Network Role in Patient Experience of Care

The Network may assume one or more of the following roles in addressing a grievance filed by an ESRD patient, an individual representing an ESRD patient, or another party:

- **Facilitator**: Mediate concerns raised by patients and facilities.
- **Expert Investigator**: Investigate concerns raised by patients.
- **Educator**: Provide patients and facilities with tools and resources to improve the patient experience of care.
- **Advocate** for the access to care of all ESRD patients.
- **Referral Source**: Provide patients and facilities on all sources to report concerns.
- **Quality improvement Specialist**: Support the improvement of facility processes to improve the overall quality of care for all patients.
Grievances

Upon the receipt of a grievance, the Network will classify the case as one of the following:

- **Immediate Advocacy**: Concerns that are non-clinical in nature and do not require a complex investigation; resolved in 7 days or less

- **General Grievance**: Concerns that are non-clinical in nature but require complex investigation and review of records; resolved in 60 days or less

- **Clinical Quality of Care**: Concerns that involve clinical or patient safety issues and requires a clinical review of records by an RN and/or the Medical Review Board (MRB); resolved in 60 days or less
# Grievance Case Management

## January - August 2022

<table>
<thead>
<tr>
<th>Case Categories</th>
<th>Network 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Advocacy</td>
<td>31</td>
</tr>
<tr>
<td>General Grievance</td>
<td>19</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>13</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>63</strong></td>
</tr>
</tbody>
</table>
Patient Education and Support

- As required by the conditions for coverage, all patients must be educated on the grievance process and the various options when filing a grievance.

- Provide ongoing individualized education as well as displaying the Network "Speak Up!" poster in a common area that patients and visitors have access to (such as the unit lobby).
Grievance and Access to Care
Educational Resources

Grievance Process Questions & Answers

All patients, family members, and care partners have the right to file a grievance, internally or externally, without fear of retaliation.

What is the grievance?
A grievance is a written complaint made by a patient, their family member or a care partner.

Why is a grievance important?
A grievance is an opportunity to improve the outcomes and care for you or your loved one.

What should I do if I have a problem?
If you have a problem with your care, file a grievance.

How do I file a grievance?
To file a grievance, you need to provide certain information for us to investigate the issue.

What happens after I file a grievance?
The complaint is reviewed and an appropriate response is issued.

What is the complaint process?
The complaint process involves the following steps:

Stop: Reviewing the Care

Steps:
1. Stop the problem from continuing.
2. Report the issue to the appropriate staff.
3. Schedule a meeting to discuss the grievance.
4. The staff will investigate the complaint.
5. A resolution will be offered.
6. A plan of action will be developed.

Involuntary Discharge

If you believe you were discharged involuntarily, you may file a complaint. The nurse manager will review the complaint and determine if the discharge was appropriate. If the nurse manager determines that you were discharged involuntarily, you may file a grievance.

Tips for Dialysis Staff to Identify and Manage Retention

1. Be an active listener.
2. Build rapport with patients.
3. Encourage patients to share their concerns.
4. Discuss any changes in treatment plan.
5. Provide consistent care.

Patient Experience of Care

End Stage Renal Disease
Network Program

VAGS & INTERPRETIVE GUIDANCE REGARDING PATIENT INVOLUNTARY DISCHARGE

CMS End Stage Renal Disease (ESRD) Program Interim Final Version Interpretive Guidance Version 1.1

TAG NUMBER

TAG INTERPRETATION

TAG INTERPRETIVE GUIDANCE

VAGS & INTERPRETIVE GUIDANCE REGARDING PATIENT INVOLUNTARY DISCHARGE

CMS ESRD Program Interim Final Version Interpretive Guidance Version 1.1

TAG NUMBER

TAG INTERPRETATION

TAG INTERPRETIVE GUIDANCE

VAGS & INTERPRETIVE GUIDANCE REGARDING PATIENT INVOLUNTARY DISCHARGE

CMS ESRD Program Interim Final Version Interpretive Guidance Version 1.1

TAG NUMBER

TAG INTERPRETATION

TAG INTERPRETIVE GUIDANCE

VAGS & INTERPRETIVE GUIDANCE REGARDING PATIENT INVOLUNTARY DISCHARGE

CMS ESRD Program Interim Final Version Interpretive Guidance Version 1.1

TAG NUMBER

TAG INTERPRETATION

TAG INTERPRETIVE GUIDANCE

VAGS & INTERPRETIVE GUIDANCE REGARDING PATIENT INVOLUNTARY DISCHARGE

CMS ESRD Program Interim Final Version Interpretive Guidance Version 1.1

TAG NUMBER

TAG INTERPRETATION

TAG INTERPRETIVE GUIDANCE

VAGS & INTERPRETIVE GUIDANCE REGARDING PATIENT INVOLUNTARY DISCHARGE

CMS ESRD Program Interim Final Version Interpretive Guidance Version 1.1

TAG NUMBER

TAG INTERPRETATION

TAG INTERPRETIVE GUIDANCE

VAGS & INTERPRETIVE GUIDANCE REGARDING PATIENT INVOLUNTARY DISCHARGE

CMS ESRD Program Interim Final Version Interpretive Guidance Version 1.1

TAG NUMBER

TAG INTERPRETATION

TAG INTERPRETIVE GUIDANCE

VAGS & INTERPRETIVE GUIDANCE REGARDING PATIENT INVOLUNTARY DISCHARGE

CMS ESRD Program Interim Final Version Interpretive Guidance Version 1.1

TAG NUMBER

TAG INTERPRETATION

TAG INTERPRETIVE GUIDANCE

VAGS & INTERPRETIVE GUIDANCE REGARDING PATIENT INVOLUNTARY DISCHARGE

CMS ESRD Program Interim Final Version Interpretive Guidance Version 1.1

TAG NUMBER

TAG INTERPRETATION

TAG INTERPRETIVE GUIDANCE

VAGS & INTERPRETIVE GUIDANCE REGARDING PATIENT INVOLUNTARY DISCHARGE

CMS ESRD Program Interim Final Version Interpretive Guidance Version 1.1

TAG NUMBER

TAG INTERPRETATION

TAG INTERPRETIVE GUIDANCE
What is Access to Care?

It refers to:

• Dialysis patients having permanent and stable access to their dialysis treatments with continuity of care from an interdisciplinary healthcare team

Why is it important to preserve it?

• Dialysis is life-saving treatment for the ESRD community
• Without an outpatient facility, patients are forced to dialyze emergently at the hospital removing regular continuity of care
• Mortality rates are increased for patients without access to regular dialysis.
  • Patients who go to the hospital expecting immediate treatment or better care not knowing they will not receive dialysis unless their labs show elevated lab values
Access to Care Cycle

1. Identified Behavior

2. At-Risk Access to Care

3. IVD/IVT/VT

4. Failure to Place

5. Readmission to an Alternate Facility

Behaviors may resurface if not addressed appropriately and the cycle restarts.

Address behavior with the patient, monitor and follow up if needed.

Denied by multiple providers/doctor groups. Dialysis through the ER.

Care conferences, behavior modification, behavior contracts.

Continuity of care, identifying a new provider or averting the IVD.
Access to Care Cycle - Steps 1 & 2

Identified Behavior

• Address the behavior with the patient
• The behavior will be monitored and follow up will occur as needed

Identified Behavior

• Address the behavior with the patient
• The behavior will be monitored and follow up will occur as needed
At Risk Access to Care

• The patient is in danger/at-risk of losing their admission status at an outpatient facility
• Cases are followed until evidence is presented demonstrating the case is averted meaning the patient is no longer at-risk for discharge

Examples:

The facility social worker contacts the Network to report a patient has been making inappropriate remarks and advances toward staff. The behavior has been ongoing for three months. A care conference is being held to present and discuss a behavior agreement.

After 90-days of following the patient there are no further occurrences of the above behaviors. The team resumes follow ups on an as needed basis.
Access to Care

Upon the receipt of an access to care concern, the Network will classify the case as one of the following:

- **At Risk Involuntary Discharge**: Concerns related to possible patient discharge.
- **Involuntary Discharge**: Immediate or 30 day IVD. Volume monitored by the Network
  - Patient is informed in writing their treatment will be terminated from their current facility

Two types of IVD cases:
- 30 Day Termination
- Immediate Termination
Cases for Immediate Discharges

Threats of Harm of Violence

- Verbal and physical
- Could be towards staff or other patients
- Should not be isolated incidences

How to Respond

- Report to the direct managers, regional management and Medical Directors
- Involve local police enforcement
- Reach out to mobile crisis for mental health cases
- Communicate with any social work managers and risk departments
Access to Care

Before considering an involuntary discharge (IVD), a facility’s interdisciplinary team (IDT) should:

• Conduct a thorough assessment of the situation

• Develop a plan to address any problems or barriers the patient may be experiencing

Note: Discharging a patient for “non-compliance” is not an acceptable reason for discharge per the Centers for Medicare & Medicaid Services (CMS) Conditions for Coverage (CfC).
IVD Guidelines

• Notify the Network PRIOR to discharge any potential IVD and notice provided to patient
• Have a policy and procedure in place for IVDs
• Train facility staff
• Document everything
• IVD should be the option of LAST resort
• Assist the patient with placement
• Notifying the State Survey Agency
Involuntary Transfer (IVT)

• Patient is given written notice they will be transferred to an alternate facility

Reasons for the IVT

• Patient’s nephrologist no longer will provide care and acquires an alternate nephrologist who rounds at a different facility

• Patient’s facility is no longer in-network with their insurance

• The facility can no longer meet the patient’s medical need

• Improper coding in EQRS
Failure to Place (F2P)

• A patient who does not have an outpatient facility for an extended period of time
• Dialyzing emergently through the hospital emergency room or has been hospitalized for an extend period of time

Examples
• Previously involuntarily discharged for aggressive behavior
• Extreme history of non-adherence
• Previously Lost to Follow Up
• Discontinued treatment
## Access to Care Case Management

### January - August 2022

<table>
<thead>
<tr>
<th>Case Categories</th>
<th>Network 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Concern</td>
<td>114</td>
</tr>
<tr>
<td>Access to Care</td>
<td>60</td>
</tr>
<tr>
<td>Averted Discharge</td>
<td>47</td>
</tr>
<tr>
<td>Involuntary Discharge</td>
<td>13</td>
</tr>
<tr>
<td>Failure to Place</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>174</strong></td>
</tr>
</tbody>
</table>
Voluntary Discharge vs. Lost to Follow Up

Voluntary
• A patient has not shown for treatment for an extended period of time. The facility continues to have ongoing contact with the patient.
• May also be considered Discontinue or Withdraw from treatment

Examples
• The patient has not verbalized explicit desire to discontinue treatment however continues to not participate in their treatment
• The patient has express not returning for treatment

Lost to Follow Up
• A patient has not come to treatment for 30 days/13 treatments consecutively. All attempts to make contact have not yielded any results. The facility has had NO contact with the patient during this extended period of time.

Examples
• Patients who are homeless or experiencing inconsistent housing
• Patients who have mental health diagnosis or substance use who may not be able to prioritize dialysis
## Case Comparison: IVD vs. LTFU vs. VD

<table>
<thead>
<tr>
<th>Case Type:</th>
<th>What it is:</th>
<th>What do you do:</th>
</tr>
</thead>
</table>
| **Involuntary Discharge (IVD)**  | Patient is given a 30 day notice or discharged immediately and will no longer be permitted to receive treatment in his/her current facility | • Review your facility’s IVD policy and the CMS Conditions for Coverage to ensure you are adhering to the correct policy and procedure  
• Utilize the Preventing the Involuntary Discharge of Dialysis Patients Facility Guide and Checklist to ensure all appropriate steps have been taken including a root cause analysis  
• Contact your legal department if applicable  
• Notify the Network state surveyor agency if case escalates to an IVD |
| **Lost to Follow Up (LTFU)**     | The facility has had NO contact with the patient. Patient has not come to treatment for 30 days/13 treatments. All attempts to make contact have not yielded any results | • Review your facility’s LTFU policy  
• Contact your legal department if applicable  
• Document all efforts to contact the patient including their identified emergency contacts, local hospitals, completed wellness checks, and letters of concern  
• Notify the Network |
| **Voluntary Discharge (VD), Discontinue of Treatment** | A patient has not shown for treatment for an extended period of time. The facility continues to have ongoing contact with the patient. The patient has not verbalized desire to discontinue treatment however continues to not participate in their treatment | • Complete a root cause analysis with the patient to identify barriers to treatment  
• Contact the Network to discuss the voluntary discharge procedure provided by CMS  
• Send the letter of intent to patient (see template)  
• Notify your state surveyor agency  
• Document all efforts to contact patient and any other contact with patient and/or family |
Steps and Strategies to Prevent Access to Care Barriers
Preventing the Involuntary Discharge of Dialysis Patients: Facility Guide and Checklist

- Check your organization's process for specific guidance
- It is to be used as an example or guide for work that should be documented prior to consideration of an IVD
- Necessary documents may be adjusted to meet the specific needs of the facility, patient, and reason for discharge

Finding the Compromise

- Conduct your own investigation
- Educate team on communication and appropriate conversation
- Listen and apologize
- Think creatively
Step One: Identify an Area of Concern

• Determine the specific behaviors: verbal abuse and vague threats
• Identify a mental health history if applicable and the patient’s level of understanding and ability to comprehend the severity of her actions
• Are these behaviors new? Has the patient ever treated any other staff member this way?
• Find the “WHY.” Identify any triggers leading to the behaviors. Dig deep
• Review the Medicare Conditions for Coverage (CfC) V766 and V767. Are these behaviors consistent with their policy and procedures?
• What is your company’s policy and procedure?
Step Two: Identify Issues with Team and Patient

- Talk with your staff about the patient’s behaviors including triggers, de-escalation techniques, and how management can intervene
- Meet with the involved staff member/s one-on-one to gauge their emotions and how they are coping with the scenario
  - Provide training for staff an alternative methods of address said situation
- Schedule a care conference with the patient and their chosen support person and IDT team to discuss and mitigate
- Outline the patient’s concerns. Focus on trying to identify a solution or compromise for each concern
Step Three: Create a Plan of Action

- Mark the patient unstable and complete an assessment
  - Focus on the root cause of the disruptive behavior and plan interventions
- Provide additional education to the staff as needed
- Generate referrals to external resources if applicable
- Document all parts of the action plan including:
  - Issues and concerns related to the ongoing problem
  - Every attempted intervention and the patient’s response
  - Progress made towards the outcome/goal
- Consider involving social work manager about behavioral agreements
- You can remove the patient from the unstable category once risk is no longer present but continue to follow up with patient
Seek Additional Guidance if Needed

• Contact your lead social worker and regional management
• Reach out to your risk management personnel for additional guidance
• Refer back to your grievance and involuntary discharge policy as well as the CMS Conditions for Coverage
• Call your ESRD Network for technical assistance
  • Recommendations on alternative approaches
  • Refer to the Quality Improvement Team for clinical assistance
  • Facilitate conference calls
  • Act as a liaison
  • Give additional resources
De-Escalation Resources and Strategies
Decreasing Patient-Provider Conflict
A Pathway to Resolution

Conflict Incident Occurs

Determine the type of Conflict

Assess type of risk

Non-adherence
Verbal abuse
Verbal threat
Physical threat
Physical harm
Property damage
Lack of payment

Risk to patient?

YES

Team member to counsel staff or patient on behavior; ongoing monitoring

NO

Mild behavior or first incident

Team meeting to discuss RCA of behavior, severity, and intervention options

Notify the Network of incident and team recommendation, seek guidance

Act on determined intervention

Ongoing assessment and follow up

Risk to Facility?

Team meeting to review policy/procedures, notify administration and discuss interventions options

Notify the Network of incident and team recommendations, seek guidance

Initiate care meeting with patient and staff to explain policy and intervention

Ongoing assessment and follow up

Risk to Others?

Immediate safety risk?

Tean meeting to discuss risk to others/intervention options

Notify the Network of incident and team recommendations, seek guidance

Act on determined intervention

Ongoing assessment and follow up

YES

Notify security/appropriate authorities, Take immediate action

---

Crisis Prevention Institute: 10 De-Escalation Tips

1. **Be empathic and nonjudgmental**
   Start where the patient is. Their feelings are real to them

2. **Respect personal space**
   Do not crowd around the patient to confront them on their actions

3. **Use non threatening nonverbal language**
   Be mindful of tone, stance, gestures, and facial expressions

4. **Avoid overreacting**
   Remain calm, rational, and professional. You control your own reaction even if you can’t control the patient’s

5. **Focus on feelings**
   Even in tough situations, use supportive words and avoid accusatory phrases
6. Ignore challenging questions
   Keep the focus on the issues at hand

7. Set limits for the patient
   Offer clear, simple, and enforceable limits. Give concise and respectful choices and consequences

8. Choose wisely what you insist upon
   Offer options and flexibility to avoid unnecessary altercations. Determine what is and isn’t negotiable

9. Allow silence for reflection
   Allow the patient to reflect on the situation which has just occurred. Then proceed to the next action

10. Allow time for decisions
    Do not rush the patient. Hold space for them to allow them to think about what you just said
American Hospital Association: Addressing Emotions on the Front Lines

<table>
<thead>
<tr>
<th>Techniques to address emotions, build trusting relationships and diffuse conflicts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TECHNIQUE</strong></td>
</tr>
</tbody>
</table>
| Empathy | • Acknowledge the emotions your patients disclose.  
• Practice empathy. Empathy is sharing in the feelings of another. Although we might not understand their exact situations, we can understand the emotions they are experiencing. | • “This information would make me nervous as well, but we are going to do everything we can.”  
• “You are raising your voice, and this seems to me you might be frustrated. I am here to help, and I want to work together to make a plan. Are you willing to work on this with me?” | • Avoid saying, “I know exactly how you feel.”  
• “Don’t worry” and  
• “You’ll be fine.” |
| Active Listening | • Use nonverbal cues including head nodding and open body language.  
• Rephrase or reflect what our patients have said to demonstrate that we are listening and understand their concerns. | • “Thank you for sharing your concerns with me. I want to make sure that I understand you correctly. From what I am hearing, you are concerned that there is not a clear plan in place for you to receive your CT scan.” | • Try not to respond defensively; be patient as you listen and remain calm.  
• Avoid saying, “All of our patients are feeling this way.” |
| Transparency | • Be transparent. Patients and their families can ask difficult questions and request answers that we may not have; it is important to let them know our limitations. | • “I do not have an answer for that question right now. I anticipate we will get that answer in two days and we can discuss next steps then. Until then, we will watch the chest X-rays to help guide care.”  
• “I do not know when a bed will become available, but, in the meantime, we will do everything possible to care for you here.” | • Do not make promises that cannot be kept.  
• Do not provide false or incorrect information. |

- Uses the three techniques empathy, active listening, and transparency
- Enables staff to provide support to patients who are experiencing increased emotion, worry or frustration

Moving Forward:
It Starts with You
Internal Grievances / Facility Concerns

- Utilize company policy and procedures
- Utilize Risk Management
- Utilize Decreasing Dialysis Provider Conflict Manual (DPC) [Decreasing Patient-Provider Conflict (DPC)]
- If above are not clear seek guidance from the Network
Your Facility: The Best Place for Prevention

• Review the patient rights and responsibilities at admission, annually and as needed
• Have open communication with staff members
• Care Conference with Support

BE PROACTIVE, BE TRANSPARENT
What is Your Responsibility?

Build a Structure

• Safe space for treatment for patients and staff
• Open door communication
• Who to contact
• Listen
• Empathize
• Support
What is Your Responsibility?

To create a team of staff that:

• Professional
• Respectful
• Knows Policy & Procedure
• Knows the appropriate de-escalation strategies when caring for a difficult patient
• Documents and informs necessary leadership
Create an Atmosphere of Transparency

- Facility Leadership Contact
- State Surveyor Contact
- Network Contact
- Be professional but honest and clear when talking to the patient about their behavior concerns
Just a Reminder

• The goal is to aim for the patient and staff to coexist within the facility while maintaining the safety of themselves, fellow patients, and staff
• Consistent communication and documentation
• Check in with patients routinely
Preventing Discharges: How We All Win

- Patients will feel respected and will share openly due to mutual trust
- The entire team will have a shared responsibility for a positive patient experience of care
- Discharges can be decreased and/or prevented allowing the patient to have continuity of care more of a chance of success
Brooke Andrews, MSW Contact Information

Primary Network 6 Patient Services Coordinator

**Brooke Andrews, MSW**
Brooke.Andrews@ipro.us
Direct: 919-463-4523
Fax: 516-231-9767
Patient Toll-free Hotline: 1-800-238-3773 (ESRD)

Need help? Go to the IPRO ESRD Helpdesk at [http://help.esrd.ipro.org](http://help.esrd.ipro.org) to submit a ticket.
Thank You

For more information about the IPRO ESRD Network Program, go to https://esrd.ipro.org/

Department Phone and Fax Lines:
Patient Services: 516-231-9767
Data Management: 516-268-6426
Administration: 516-686-9790

Toll-Free Patient Line: 800-238-3773 (ESRD)
IPRO Knowledge Base/FreshDesk: https://help.esrd.ipro.org/support/home