End-Stage Renal Disease
Network Program

Partnering with the Network to Achieve Positive Patient Outcomes

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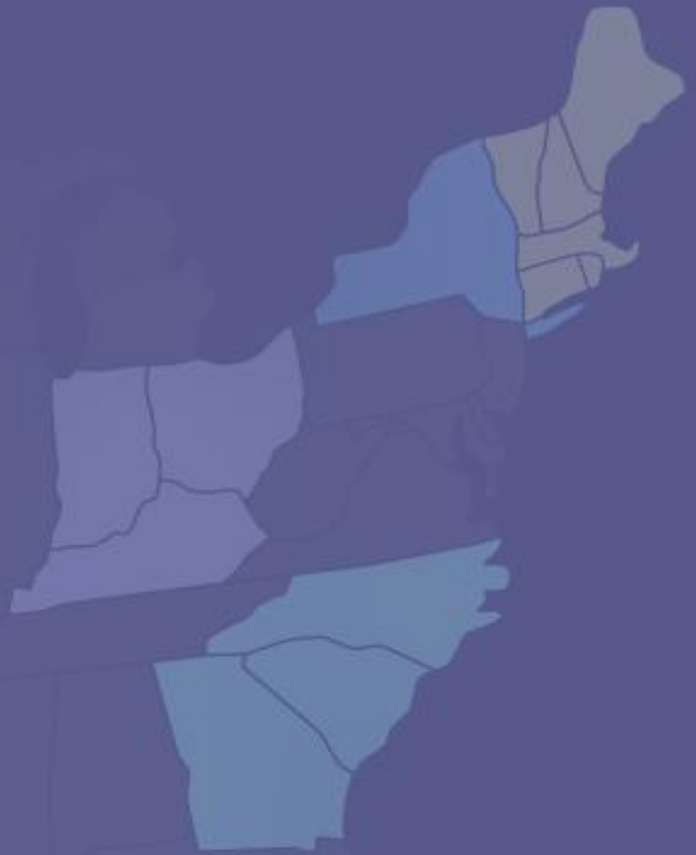
September 16, 2022

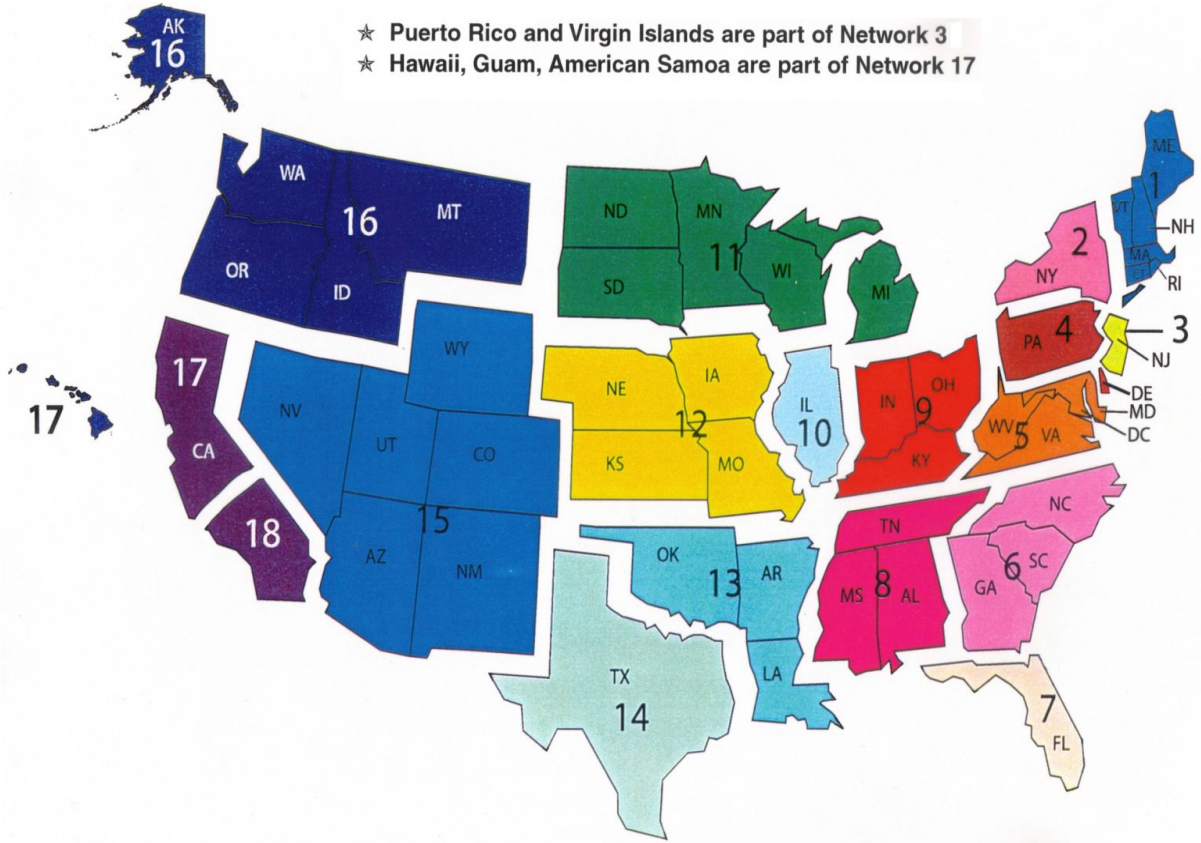
Agenda Topics

- Welcome
- ESRD Program Administration
  - Overview of CMS Statement of Work
  - Participation/Conditions for Coverage (CfC)
- Emergency Management
- Social Determinants of Health
- National Healthcare Initiatives
- Patient Services
  - Involuntary Discharge
  - Access to Care
  - Steps and Strategies to Prevention
  - De-Escalation Resources and Strategies
  - Moving Forward: It Starts with You

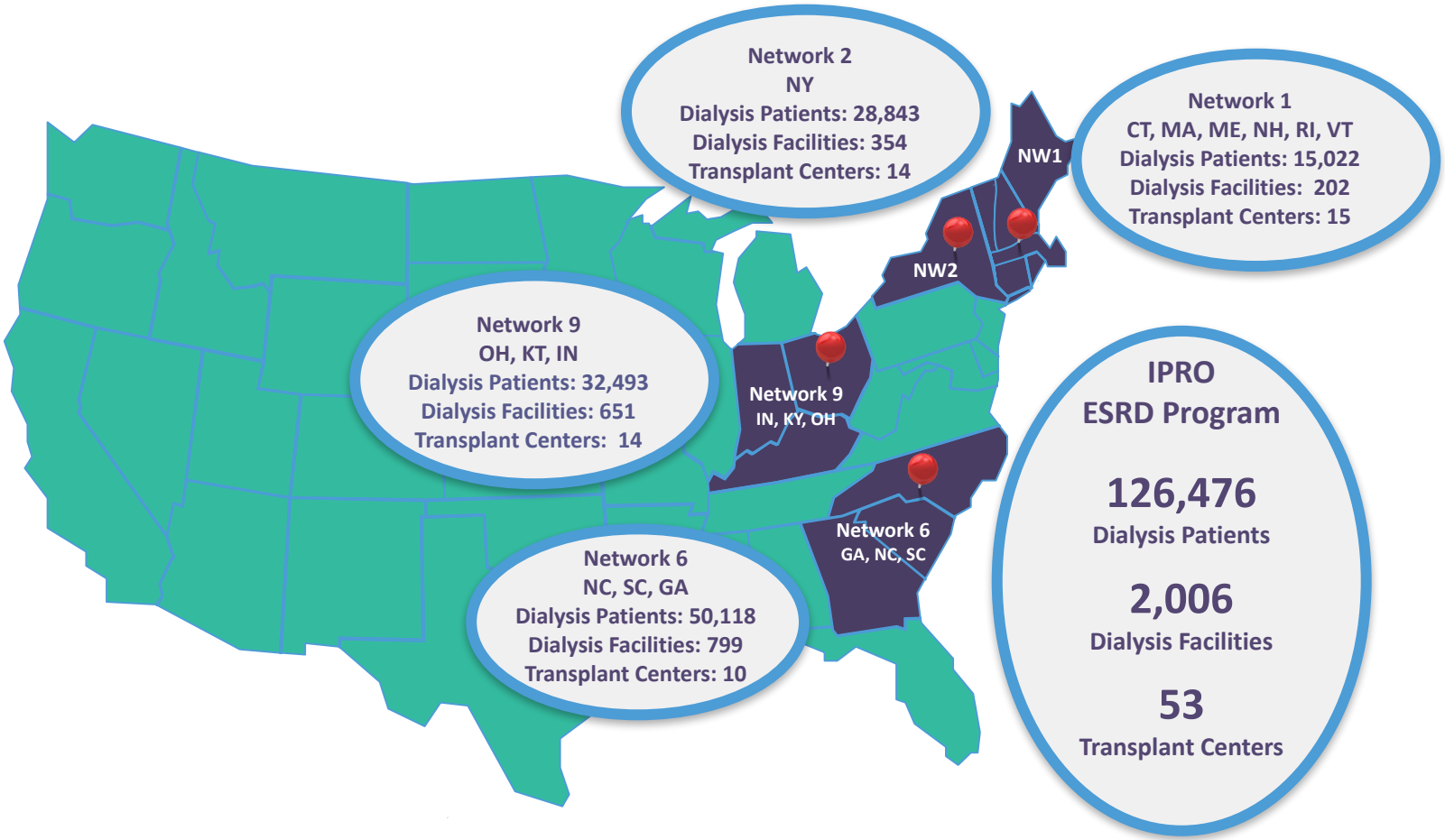
ESRD Program Administration



ESRD Networks



IPRO ESRD Network Program
Network Service Areas



Mission Statement

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:
https://esrd.ipro.org/wp-content/uploads/2020/09/ESRD-NWP_vtags-ivd_2020.pdf

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

Emergency Preparedness, Mitigation, & Response

Network Responsibilities

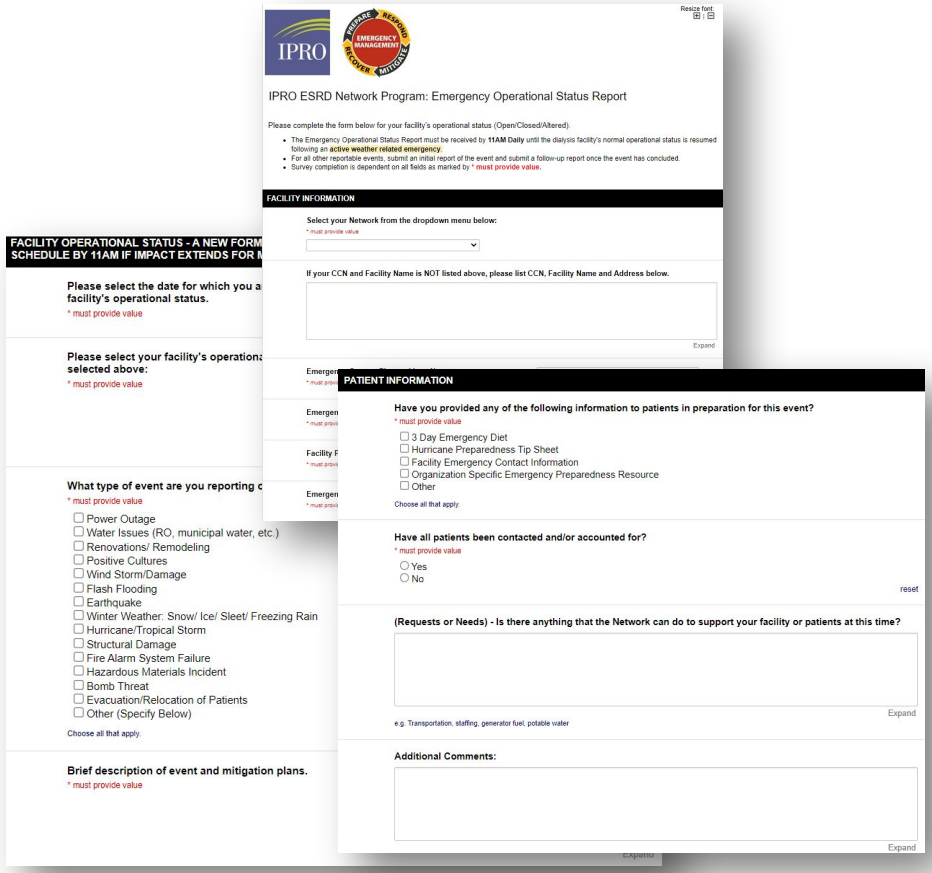
- Networks are the foundation of ESRD Emergency Management in collaboration with the Kidney Community Emergency Response (KCER) national response coordination contractor
- Networks monitor conditions that impact a facility's ability to provide service to dialysis patients
- Networks establish relationships 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

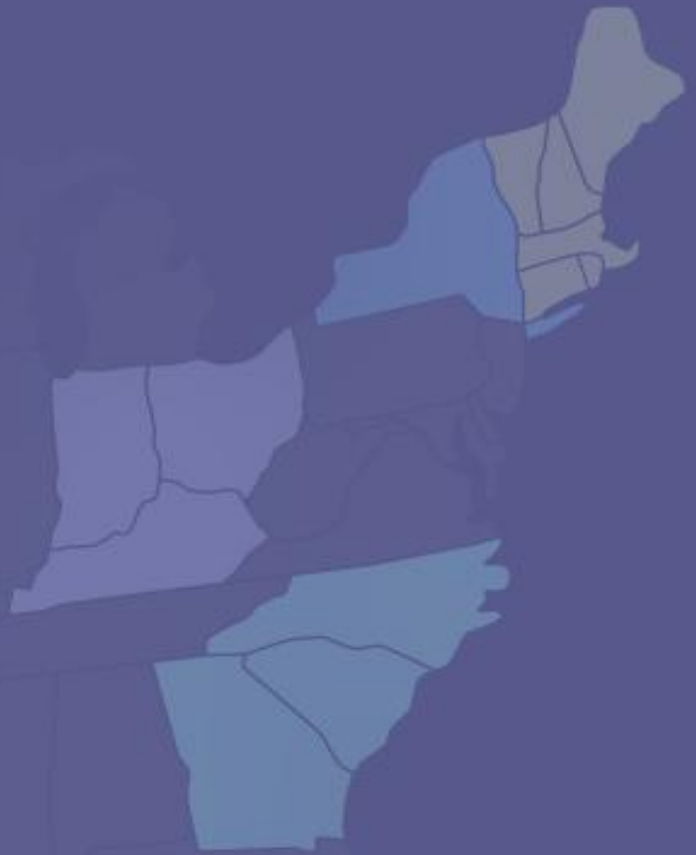
- REPORT Closed/Altered Status
- Use the Closed/Altered Reporting Link: https://redcap.ipro.org/surveys/?s=R8K7RWETHM

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

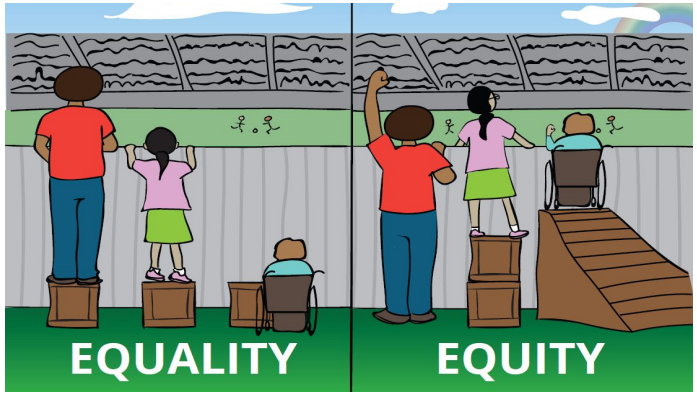


What is Health Equity?

According 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 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

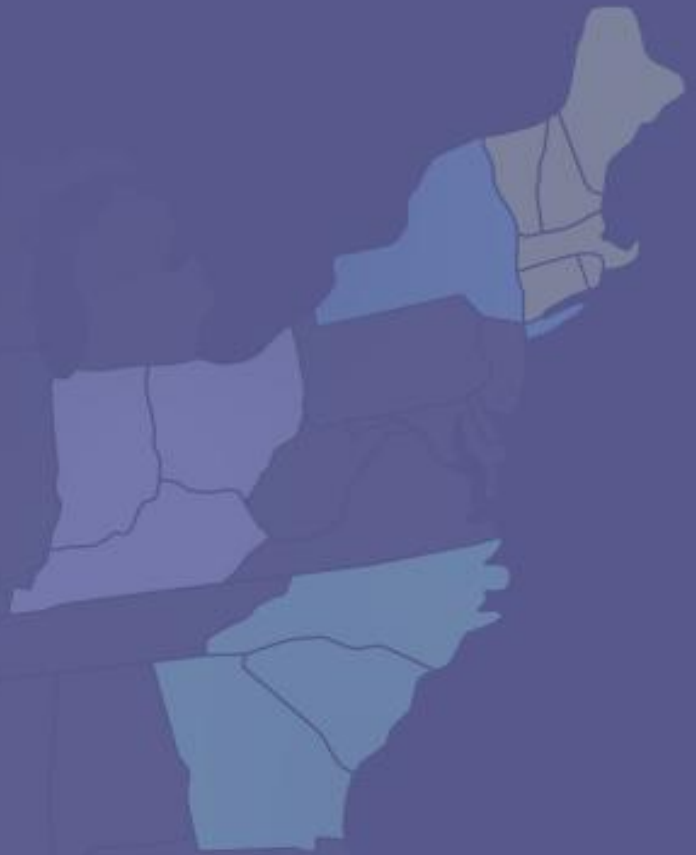
- Decrease the Rate of Blood Transfusions in ESRD Patients Dialyzing in a Nursing Home

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

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Emergency Incident Commander

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Patient Services Coordinator

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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

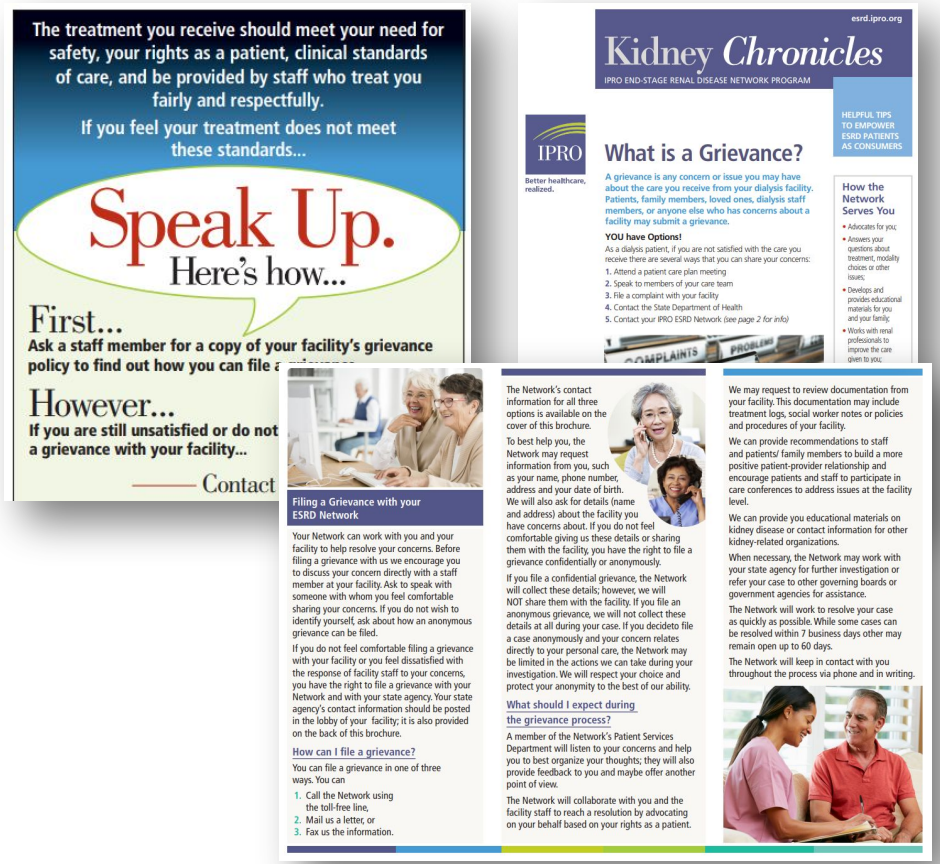
Grievance Case Management

January - August 2022

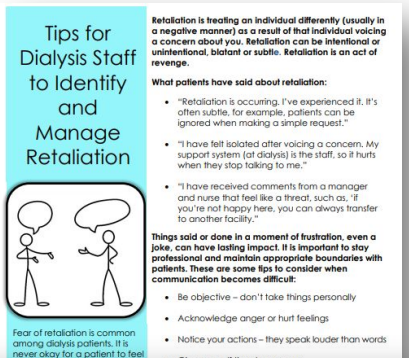
Case Categories	Network 6
Immediate Advocacy	31
General Grievance	19
Quality of Care	13
Total	63

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


Tips for Dialysis Staff to Identify and Manage Retaliation

Fear of retaliation is common among dialysis patients. It is never okay for a patient to feel

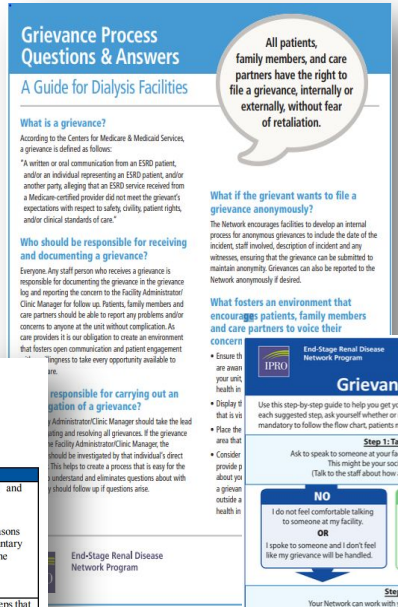
Retaliation is treating an individual differently (usually in a negative manner) as a result of that individual voicing a concern about you. Retaliation can be intentional or unintentional, blatant or subtle. Retaliation is an act of revenge.

What patients have said about retaliation:

- "Retaliation is occurring. I've experienced it. It's often subtle, for example, patients can be ignored when making a simple request."
- "I have felt isolated after voicing a concern. My support system (at dialysis) is the staff, so it hurts when they stop talking to me."
- "I have received comments from a manager and nurse that feel like a threat, such as, 'if you're not happy here, you can always transfer to another facility.'"

Things said or done in a moment of frustration, even a joke, can have lasting impact. It is important to stay professional and maintain appropriate boundaries with patients. These are some tips to consider when communication becomes difficult:

- Be objective – don't take things personally
- Acknowledge anger or hurt feelings
- Notice your actions – they speak louder than words


Grievance Process Questions & Answers

A Guide for Dialysis Facilities

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

What is a grievance?

According to the Centers for Medicare & Medicaid Services, a grievance is defined as follows:

"A written or oral communication from an ESRD patient, and/or an individual representing an ESRD patient, and/or another party, alleging that an ESRD service received from a Medicare-certified provider did not meet the grievant's expectations with respect to safety, civility, patient rights, and/or clinical standards of care."

Who should be responsible for receiving and documenting a grievance?

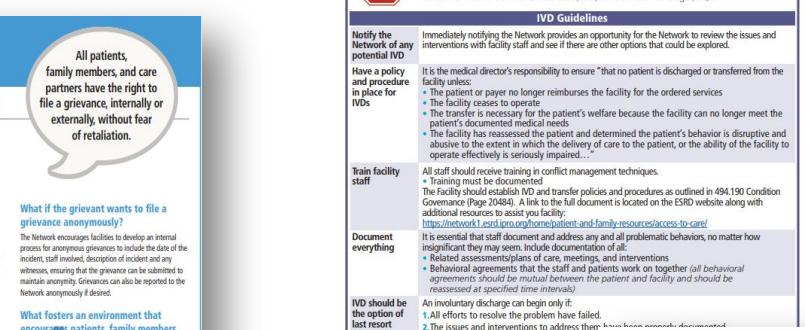
Everyone. Any staff person who receives a grievance is responsible for documenting the grievance in the grievance log, and reporting the concern to the Facility Administrator/ Clinic Manager for follow up. Patients, family members and care partners should be able to report any problems and/or concerns to anyone at the unit without complication. As care providers it is our obligation to create an environment that fosters open communication and patient engagement

What if the grievant wants to file a grievance anonymously?

The Network encourages facilities to develop an internal process for anonymous grievances to include the date of the incident, staff involved, description of incident and any witnesses, ensuring that the grievance can be submitted to maintain anonymity. Grievances can also be reported to the Network anonymously if desired.

What fosters an environment that encourages patients, family members and care partners to voice their

End-Stage Renal Disease Network Program


Dialysis Facility Involuntary Discharge Guidelines

STOP

Before considering an involuntary discharge (IVD), a facility's interdisciplinary team (IDT) should:
1. Conduct a thorough assessment of the situation
2. Develop a plan to address any problems or barriers the patient may be experiencing

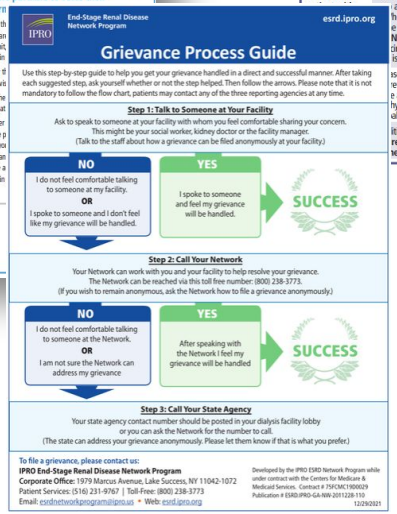
Note: *Discharging a patient for "non-compliance" is not an acceptable reason for discharge per the Centers for Medicare & Medicaid Services (CMS) Conditions for Coverage (CfC).*

IVD Guidelines	
Notify the Network of any potential IVD	Immediately notifying the Network provides an opportunity for the Network to review the issues and interventions with facility staff and see if there are other options that could be explored.
Have a policy and procedure in place for IVDs	It is the medical director's responsibility to ensure "that no patient is discharged or transferred from the facility unless: • The patient or payer no longer reimburses the facility for the ordered 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 reassessed the patient and determined the patient's behavior is disruptive and abusive to the extent in which the delivery of care to the patient, or the ability of the facility to operate effectively is seriously impaired…."
Train facility staff	All staff should receive training in conflict management techniques. • Training must be documented The Facility should establish IVD and transfer policies and procedures as outlined in 494.190 Condition Governance (Page 20484). A link to the full document is located on the ESRD website along with additional resources to assist you facility: https://network1.esrd.ipro.org/home/patient-and-family-resources/access-to-care/
Document everything	It is essential that staff document and address any and all problematic behaviors, no matter how insignificant they may seem. Include documentation of all: • Related assessments/plans of care, meetings, and interventions • Behavioral agreements that the staff and patients work on together *(all behavioral agreements should be mutual between the patient and facility and should be reassessed at specified time intervals)*
IVD should be the option of last resort	An involuntary discharge can begin only if: 1. All efforts to resolve the problem have failed. 2. The issues and interventions to address them have been properly documented
Assist the	• The facility should assist the patient with est another facility if the IVD cannot be avert Then attempting to assist the patient in tra e medical information requested by the ot **NOT** include additional documentation indica circumstances surrounding the discharge unle is considered blacklisting and will be reported ses of immediate severe threat to the health eviated IVD procedure. Per the CfC Interpretiv e a threat or physical harm. For example, if a hysical harm, this would be considered an "im al abuse is not considered to be an immediate ities must notify the State Survey Agency of al **result of immediate, severe threats, the S** **ediately.**

IPRO End-Stage Renal Disease Network Program

V-TAGS & INTERPRETIVE GUIDANCE REGARDING PATIENT INVOLUNTARY DISCHARGE
CMS End Stage Renal Disease (ESRD) Program Interim Final Version Interpretive Guidance Version 1.1

TAG NUMBER	REGULATION	INTERPRETIVE GUIDANCE
V468 (Patient Rights)	(b) *Standard: Right to be informed regarding the facility's discharge and transfer policies.* The patient has the right to – (1) Be informed of the facility's policies for transfer, routine or involuntary discharge, and discontinuation of services to patients; and	Patients must be given information about the facility policies for routine and involuntary discharges. Refer to the Condition for Governance at V766-V767 for involuntary discharge or transfer regulations and guidance, including acceptable reasons for involuntary discharge. Use those tags for failure to follow the involuntary discharge procedures. Use this tag for failure to inform patients about the transfer and discharge policies.
V469 (Patient Rights)	(2) Receive written notice 30 days in advance of an involuntary discharge, after the facility follows the involuntary discharge procedures described in § 494.180(f)(4). In the case of immediate threats to the health and safety of others, an abbreviated discharge procedure may be allowed.	The involuntary discharge procedures described at V767 identify the steps that a facility must follow prior to the involuntary discharge of a disruptive and abusive patient. After following the required procedures, a facility must give at least 30-days prior notice to any patient whom they opt to discharge involuntarily, except in the case of a patient who makes severe and immediate threats to the health and safety of others. An "immediate threat to the health and safety of others" is considered to be a threat of physical harm. For example, if a patient has a gun or a knife or is making credible threats of physical harm, this can be considered an "immediate threat." Verbal abuse is not considered to be an immediate threat. In instances of an immediate threat, facility staff may utilize "abbreviated" involuntary discharge or transfer procedures. These abbreviated procedures may include taking immediate protective actions, such as calling "911" and asking for police assistance. In this scenario, advance notice is not possible or required and there may not be time or opportunity for reassessment, intervention, or contact with another facility for possible transfer, as outlined at V767.
V716	(ii) The interdisciplinary team adheres to the discharge and transfer policies and procedures specified in § 494.180(f).	The medical director must monitor and review each involuntary patient discharge to ensure that the facility interdisciplinary team follows the discharge and transfer policies and completes the steps required under the


End-Stage Renal Disease Network Program

esrd.ipro.org

Grievance Process Guide

Use this step-by-step guide to help you get your grievance handled in a direct and successful manner. After taking each suggested step, ask yourself whether or not the step helped. Then follow the arrows. Please note that it is not mandatory to follow the flow chart, patients may contact any of the three reporting agencies at any time.

Step 1: Talk to Someone at Your Facility

Ask to speak to someone at your facility with whom you feel comfortable sharing your concern. This might be your social worker, kidney doctor or the facility manager. (Talk to the staff about how a grievance can be filed anonymously at your facility.)

NO — I do not feel comfortable talking to someone at my facility. OR I spoke to someone and I don't feel like my grievance will be handled.

YES — I spoke to someone and feel my grievance will be handled. → SUCCESS

Step 2: Call Your Network

Your Network can work with you and your facility to help resolve your grievance. The Network can be reached via this toll free number: (800) 238-3773. (If you wish to remain anonymous, ask the Network how to file a grievance anonymously.)

NO — I do not feel comfortable talking to someone at the Network. OR I am not sure the Network can address my grievance

YES — After speaking with the Network I feel my grievance will be handled → SUCCESS

Step 3: Call Your State Agency

Your state agency contact number should be posted in your dialysis facility lobby or you can ask the Network for the number to call. (The state can address your grievance anonymously. Please let them know if that is what you prefer.)

To file a grievance, please contact us:
IPRO End-Stage Renal Disease Network Program
Corporate Office: 1979 Marcus Avenue, Lake Success, NY 11042-1072
Patient Services: (516) 231-9767 | Toll-Free: (800) 238-3773
Email: esrdnetworkprogram@ipro.us • Web: esrd.ipro.org

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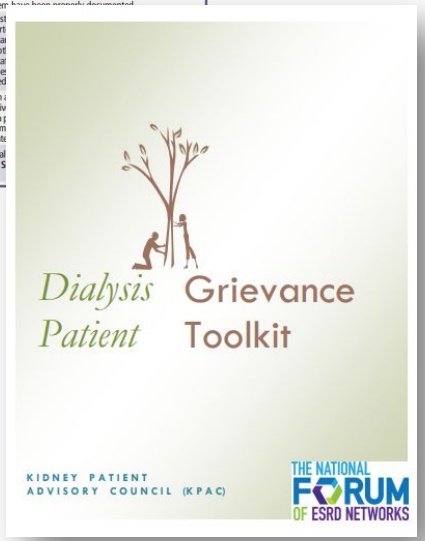
12/29/2021


Dialysis Patient Grievance Toolkit

KIDNEY PATIENT ADVISORY COUNCIL (KPAC)

THE NATIONAL FORUM OF ESRD NETWORKS

What is Access to Care?

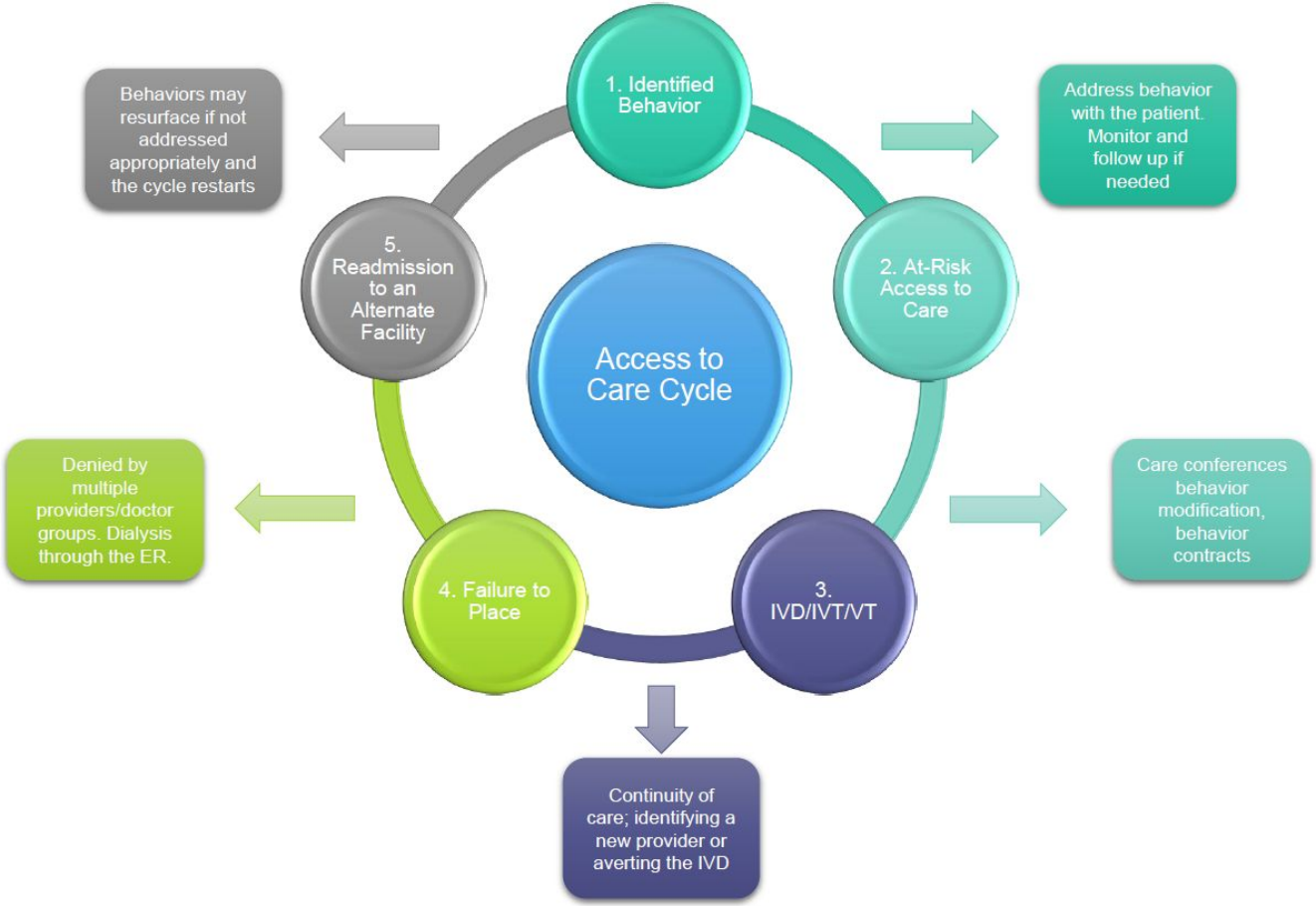
It refers to:

- 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



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:

Patient At-Risk

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.

Averted

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 a 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 extender 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

Case Categories	Network 6
Facility Concern	114
Access to Care	60
Averted Discharge	47
Involuntary Discharge	13
Failure to Place	1
Total	174

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

Case Type:	What it is:	What do you do:
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 <u>NO</u> 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

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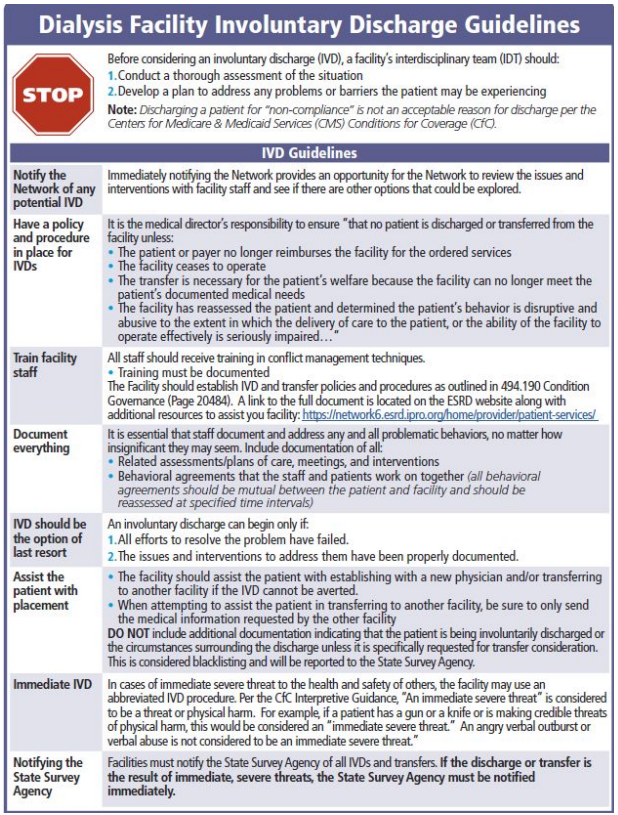


Dialysis Facility Involuntary Discharge Guidelines

STOP

Before considering an involuntary discharge (IVD), a facility's interdisciplinary team (IDT) should:
1. Conduct a thorough assessment of the situation
2. 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 of any potential IVD	Immediately notifying the Network provides an opportunity for the Network to review the issues and interventions with facility staff and see if there are other options that could be explored.
Have a policy and procedure in place for IVDs	It is the medical director's responsibility to ensure "that no patient is discharged or transferred from the facility unless: • The patient or payer no longer reimburses the facility for the ordered 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 reassessed the patient and determined the patient's behavior is disruptive and abusive to the extent in which the delivery of care to the patient, or the ability of the facility to operate effectively is seriously impaired…"
Train facility staff	All staff should receive training in conflict management techniques. • Training must be documented The Facility should establish IVD and transfer policies and procedures as outlined in 494.190 Condition Governance (Page 20484). A link to the full document is located on the ESRD website along with additional resources to assist you facility: https://network6.esrd.ipro.org/home/provider/patient-services/
Document everything	It is essential that staff document and address any and all problematic behaviors, no matter how insignificant they may seem. Include documentation of all: • Related assessments/plans of care, meetings, and interventions • Behavioral agreements that the staff and patients work on together *(all behavioral agreements should be mutual between the patient and facility and should be reassessed at specified time intervals)*
IVD should be the option of last resort	An involuntary discharge can begin only if: 1. All efforts to resolve the problem have failed. 2. The issues and interventions to address them have been properly documented.
Assist the patient with placement	• The facility should assist the patient with establishing with a new physician and/or transferring to another facility if the IVD cannot be averted. • When attempting to assist the patient in transferring to another facility, be sure to only send the medical information requested by the other facility **DO NOT** include additional documentation indicating that the patient is being involuntarily discharged or the circumstances surrounding the discharge unless it is specifically requested for transfer consideration. This is considered blacklisting and will be reported to the State Survey Agency.
Immediate IVD	In cases of immediate severe threat to the health and safety of others, the facility may use an abbreviated IVD procedure. Per the CfC Interpretive Guidance, "An immediate severe threat" is considered to be a threat or physical harm. For example, if a patient has a gun or a knife or is making credible threats of physical harm, this would be considered an "immediate severe threat." An angry verbal outburst or verbal abuse is not considered to be an immediate severe threat."
Notifying the State Survey Agency	Facilities must notify the State Survey Agency of all IVDs and transfers. **If the discharge or transfer is the result of immediate, severe threats, the State Survey Agency must be notified immediately.**

- 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

https://esrd.ipro.org/wp-content/uploads/2020/07/NW6-Dialysis-Facility-Involuntary-Discharge-Guidelines_2019.pdf

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

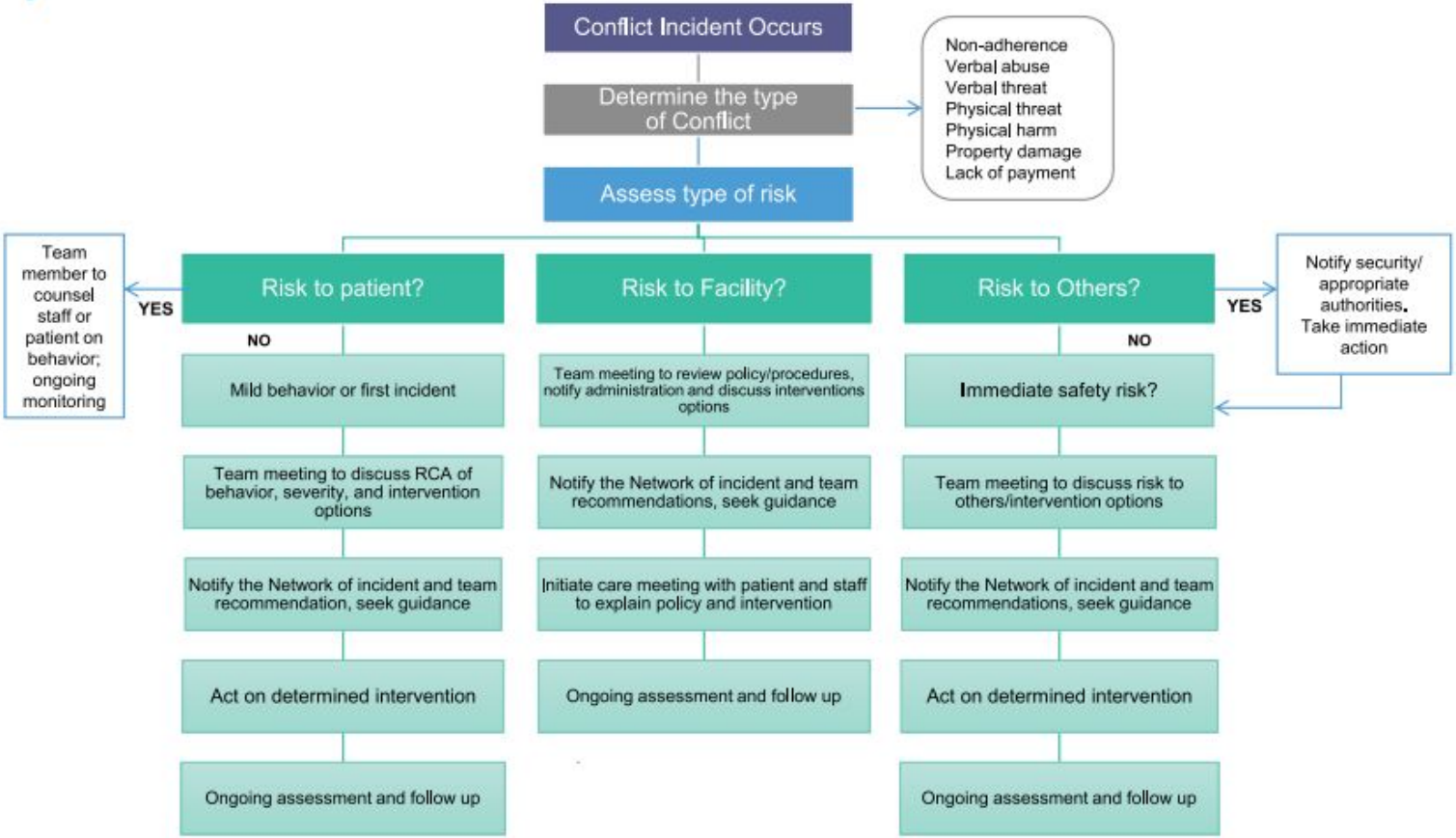
Seek Additional Guidance if Needed

- 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[1]



[1]Goldman, R. S., and Jones, E. R. (2013). "Managing Disruptive Behavior by Patients and Physicians: A Responsibility of the Dialysis Facility Medical Director." *American Society of Nephrology.*

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

Crisis Prevention Institute: 10 De-Escalation Tips

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

Techniques to address emotions, build trusting relationships and diffuse conflicts

TECHNIQUE	DO	SCRIPT	DO NOT
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.

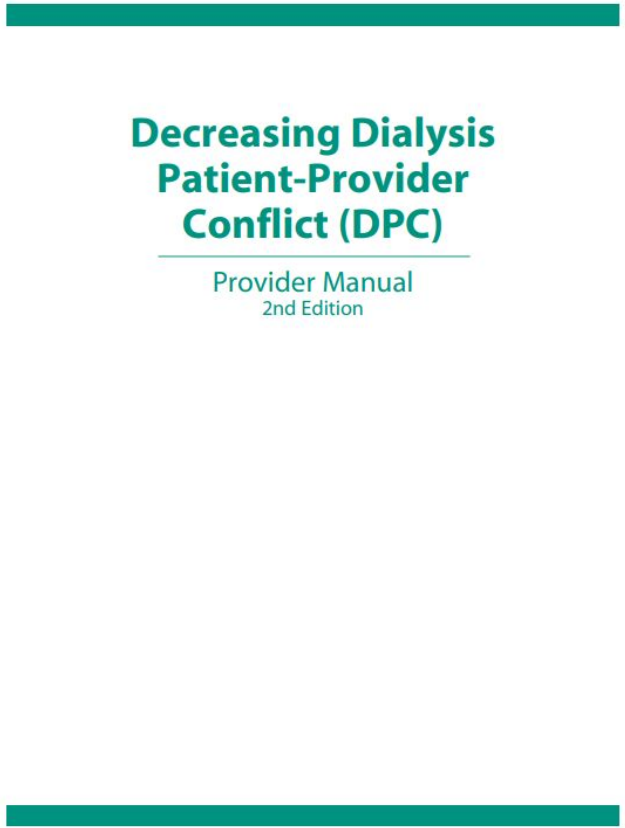
- Uses the three techniques empathy, active listening, and transparency
- Enables staff to provide support to patients who are experiencing increased emotion, worry or frustration

https://www.aha.org/system/files/media/file/2020/05/COVID-19-Addressing-Emotions-Frontlines.pdf

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 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

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