Involuntary Discharge: Alternative Strategies to Address Behaviors

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The number of patients involuntarily discharged from facilities is a concern throughout the country. Many of these individuals become displaced, with no facility willing to accept them. These patients are forced to go to hospital emergency rooms for treatment, thus contributing to an already over-burdened system, and receive little or no continuity or coordination of care. Any end-stage renal disease (ESRD) patient without access to regular chronic dialysis and the necessary support services is at increased risk for morbidity and mortality.

The new ESRD Conditions for Coverage mandate that facilities inform patients of their right to file a grievance without reprisal or denial of services. Further, patients must be informed of the facility's policies for transfer, routine or involuntary discharge, and discontinuation of services. Patients must receive a 30-day written notice of an involuntary discharge, and the facility must follow specific involuntary discharge procedures. A patient being involuntarily discharged must have an order for discharge signed by the facility's medical director and the patient's attending physician. An abbreviated discharge procedure is allowed only in the case of immediate severe threats to the health and safety of others. The medical director has specific responsibilities and accountability to the governing body for patient care and outcomes and is responsible for ensuring that the interdisciplinary team adheres to discharge and transfer policies.

With these new regulations in place, the challenge for providers is to find creative solutions to work more effectively with difficult and special needs patients.

Regulations

Careful review of the new Conditions for Coverage (42 CFR Part 494 Conditions for Coverage for ESRD Facilities) pertaining to the topic of involuntary discharges, as well as the corresponding Interpretive Guidance (IG) related to the Conditions, is recommended (*Table I*).

The Conditions for Coverage require facilities to notify both the ESRD Network and the State Survey Agency of involuntary discharges and transfers. The Network must be provided with a 30-day notice of the planned discharge, and the State Survey Agency must be notified. The interpretive guidelines (V766) specify that involuntary discharge or transfer should be rare and preceded by a demonstrated effort on the part of the interdisciplinary team to address the problem in a mutually beneficial way. Efforts must be made to resolve the problems, and the interdisciplinary team must reassess the patient with an intent to identify any potential action or plan that could prevent the need for discharge or transfer of the patient involuntarily. The reassessment must focus on identifying the root causes of the disruptive or abusive behavior and result in a plan of care aimed at addressing those causes and resolving unacceptable behavior.

TABLE I. ESRD federal regulations and guidelines that address involuntary discharge or transfer of patients.

Subpart C–Patient Care 494.70 Condition: Patient's rights.

(a) Standard: Patient's rights. [14-17; V465-467]
(b) Standard: Right to be informed regarding the facility's discharge and transfer policies. [1-2; V468-469]

Subpart C–Patient Care 494.110 Condition: Quality assessment and performance improvement.

(a) Standard: Program scope. [1; V627]

Subpart D–Administration 494.180 Condition: Governance.

(e) Standard: Internal grievance process. [1-3; V765]
(f) Standard: Involuntary discharge and transfer policies and procedures. [1-5; V766-767]

Understanding the Patient's Perspective

Coping is the cognitive and behavioral effort to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person. True coping requires a person to give up previously held secure states of mind and adapt to changes in circumstances. In response to lifestyle changes related to ESRD, many dialysis patients exhibit changes in behavior. Waiting to get on the dialysis machine, physical pain of cannulation, and other treatment-related intrusions may cause unhappiness, lack of cooperation, and complaining. While a patient may be perceived as difficult, the patient's behaviors should be considered in the context of his or her adjustment phase. Social and emotional needs that are not addressed can manifest in numerous problems, including acting out behavior. Masters-prepared nephrology social workers have the clinical skills to assist with behavioral concerns, including:

- Assessment of the root cause of behaviors and factors which may affect the patient's functional capacity;
- Determination of the patient's usual coping mechanisms;
- Determination of whether the unacceptable behavior is an isolated incident or a pattern of coping;
- Identification of patient strengths and available support systems that can help achieve improvement;
- Provision of counseling or referral if needed; and

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Resources

- ESRD Networks: www.esrdncc.org/index/index
- *Decreasing Dialysis Patient-Provider Conflict (DPC)*: www.esrdncc.org/index/decreasing-dialysis-patient-provider-conflict
- *CMS Regulations*. www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCletter09-01.pdf. This site includes the Survey & Certification letter sent to State Agencies on October 3, 2008. With the letter is a 2-page *Measures Assessment Tool (MAT),* which summarizes and provides standards associated with Conditions of Patient Assessment, Patient Plan of Care, and Quality Assessment and Performance Improvement (QAPI); and the *Interpretive Guidance* for the *Conditions for Coverage for End-Stage Renal Disease Facilities* (42 CFR Part 494). There is a table of contents for the IGs that lists the page number of the IG document for the first page of each Condition and the V-tag range (a computer identification system for the individual regulations) for that Condition. Note that the MAT recommends that facilities report and analyze grievances for trends.
- *Clinical Performance Measures (CPM) Project*: www.cms.hhs.gov/CPMProject
- *Kidney School Module Fourteen: Patient Rights and Responsibilities*–Exercising patient rights and responsibilities: www.kidneyschool.org/pdfs/KS-Module_14.pdf
- *The Consumer Assessment of Healthcare Providers and Systems In-Center Hemodialysis Survey*; Survey tool and instructions: www.cahps.ahrq.gov/cahpskit/ICH/ICHchooseQX.asp. Includes a survey instrument, which is a standardized experience of care assessment tool appropriate for in-center hemodialysis patients. Effective April 1, 2008, CMS endorsed the use of this tool to measure in-center HD patient satisfaction as a CPM.
- Measure/developer instrument website: www.cahps.ahrq.gov
- Reporting measures: www.cahps.ahrq.gov/content/cahpskit/files/509_ich_reporting_measures.htm

- Evaluation of adjustment and reinforcement of accomplishments.

Benefit of the doubt should always be given to patients who have not previously exhibited difficult behavior. If the patient has no history of problematic behavior, something out of the ordinary has likely occurred and reassessment of the patient's social and emotional functioning is required. Questioning should focus on determining the cause of the aberrant behavior. As behavior is changed toward the positive, staff should reinforce the desired changes with recognition and praise. In other words, "catch them doing good."

The strengths-based perspective makes several assumptions about the human condition. One assumption is that all people have strengths that enable them to move forward. Another assumption is that people are more motivated to move toward things they want than away from things they don't want. People are also more motivated to work toward a goal they have set for themselves than one that an "expert" has set for them. Self-determination—allowing individuals to determine their own destiny—is a very powerful thing. The strengths model also assumes that people have the capacity to change. It does not promise, however, that all will change or will change as someone else wishes. To support effective coping:

- Support functional coping behaviors;
- Include the patient and/or patient representative in treatment planning;
- Encourage the patient to communicate feelings and concerns to the healthcare team and significant others;
- Convey acceptance that "bad days" can be expected but do not necessarily hinder effective coping;
- Encourage strategies for promoting mental health, such as stress management, the importance of diversional and recreational activity, use of support systems, and so forth;
- Encourage continued rehabilitation, for example, a return to activities enjoyed before illness;
- Provide patient education; and
- Utilize the social worker's expertise in assessment and care planning.

Many facilities use "behavior contracts" with patients. Meeting with the interdisciplinary team and hearing about one's "behaviors" can result in a patient feeling intimidated, isolated, and misunderstood. Agreements about expectations of both the patient and facility should be reviewed at the start of treatment and again periodically, rather than presented to a patient during a crisis situation for signature under duress.

Helping the Patient Adapt

While it is acknowledged that each patient situation is unique, there are proactive steps that facilities can take. Challenging situations occur when needs or expectations are not being met. Few of these situations occur in isolation, but are a culmination of past interactions, behaviors, and expectations that have not been addressed. Management of challenging situations occurs from the very start of a patient's introduction to the dialysis facility. The facility staff needs to be very clear about the rules, policies and procedures, expected behavior, patients' rights and responsibilities, and the complaint process. Taking the time to involve patients actively in the planning and delivery of their care is a proactive approach. When the support of staff is apparent and dialysis care is perceived as a partnership, it is a win/win situation for all.

It is not unusual to have complaints from patients. The goal is to address and resolve the concerns before they become grievances. Keep in mind that not having any complaints or grievances may mean either your facility is doing a terrific job of taking care of patients, or your patients are too afraid to complain or are unaware of how to file an internal or external grievance.

Much conflict that occurs in a unit can be traced to problems with patient-staff communication and professionalism. The way a patient asks a question or points out a concern can trigger staff defensiveness. The nephrology social worker can teach patients ways to communicate with staff to reduce the potential for conflict. At the same time, staff should be held accountable for their behavior that may adversely impact the patient's behavior or adjustment. Staff can be taught to manage their own reactions to a patient's behavior. Train facility staff in conflict management techniques. When staff gains comfort

and competence in dealing with conflict, patients have a greater sense of security and confidence in their care.

Conflict can also be triggered when a patient feels out of control. Offering patients the opportunity to do as many aspects of their care as possible, including self-care in-center or home dialysis, and teaching them how to do those aspects of care safely is another way to reduce problem behaviors.

Decreasing Dialysis Patient-Provider Conflict (DPC) is a program developed by the ESRD Networks through a national task force, and provides proactive techniques to resolve concerns and prevent the need for involuntary discharge. Each dialysis facility has received a copy of this interactive program, which includes grievance tracking tools for CQI (now called quality assessment and performance improvement or "QAPI") reporting. Obtain training in the use of DPC tools by contacting your area ESRD Network.

ESRD Networks are a great resource for tools to assist with facility concerns. Notify the Network regarding patient behaviors outside the norm—before these behaviors escalate to crisis. Acting early provides a time to review issues and try various interventions, all with the hope of allowing options other than discharge.

Any instance where the patient leaves the dialysis facility against his/her will is considered involuntary. While the primary goal of the facility should be for the patient to adapt in their present setting, it is recognized that healthcare providers are often torn between their duty to an individual patient and their duty to provide a safe environment. When involuntary discharge is determined to be the only course of action, the physician and facility are obligated to assist the patient in securing life-sustaining treatment and continuity of care with another facility and/or nephrologist. Groups of providers should not exclude patients from treatment at all of their facilities or by other physicians in the group. The large dialysis organizations have agreed with CMS that there should be no "black listing" or banning of patients within a physician group or chain of providers. Behaviors can be eliminated by a change in environment, a change in treatment type, and establishment of new relationships with staff at another facility. Patients who are transferred to a new chronic facility and/or physician have the opportunity to present different behaviors than were experienced in the previous facility, as facility rules, the culture, language, and personality of facility staff can vary from one setting to another.

Facility staff must be cognizant of HIPAA requirements and share only factual data from medical records and not hearsay, rumor, or personal opinions of patients with another facility when seeking placement for patients being involuntarily discharged. Referring patients to the hospital emergency room for dialysis should be the last resort. While hospitals may not turn away patients requiring emergent care, hospitals may (and do) have policies that stipulate certain thresholds that dialysis patients must meet in order to be eligible for treatment. Patients who have been involuntarily discharged usually will not have the ability to have dialysis in the hospital as frequently as they did in a chronic outpatient center. If the patient does end up dialyzing in a hospital due to involuntary discharge, the issues that led to the involuntary discharge need to be addressed while the patient is in the hospital. If the patient shows improvement in the acute setting, this information should be shared with potential admitting nephrologists and/or facilities.

When each member of the interdisciplinary team works proactively together, optimal care and successful adjustment for patients can result. Your local ESRD Network is interested in serving as a resource to both patients and providers to discuss difficult situations and help to resolve issues and hopefully prevent such concerns from escalating to an involuntary discharge.

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