

## When Patients Don't Come to Dialysis

The HSAG: ESRD Network 7 Patient Services Department receives many calls from facility staff regarding patients who don't come for treatment for days or weeks at a time. Some callers ask if it is okay to discharge a patient who hasn't been in for a treatment for 30 days or longer.

In light of the Centers for Medicaid & Medicare Services' (CMS') Prospective Payment System (PPS) and the upcoming Quality Incentive Program (QIP) that ties reimbursement to patient outcomes, we wish to provide a review of the Conditions for Coverage (CfCs) to ensure that patients' rights and the facility's standing with CMS are protected.

As you know, patients have the right to refuse any aspect of their treatment plan. This right includes missing treatments. V456 in the CMS Interpretive Guidance states, "The patient has the right to be informed about and participate, if desired, in all aspects of his or her care, and be informed of the right to refuse treatment, to discontinue treatment, and to refuse to participate in experimental research." Additionally, the Interpretive Guidance indicates at V559 that the Interdisciplinary Team, "must recognize each patient has the right to choose less than optimal care when the patient determines optimal care would negatively impact his/her quality of life." **Thus, patients cannot be discharged from the dialysis facility for non-adherence.** Instead, the interdisciplinary team (IDT) is required to "focus on identifying the potential causes of the non-adherence and addressing those causes."

### Patients skip treatments for a variety of reasons such as:

- Dialysis adjustment issues, including:
  - Disliking dialysis
  - Exercising the right to self-determination
  - Not believing that dialysis is truly needed
- Avoidance of pain, discomfort or embarrassing situation (e.g., when patient has diarrhea)
- Life tasks/family obligations
- Transportation problems
- Conflict with staff
- Mental health issues
- Substance abuse

It is the responsibility of the facility to assess the barriers to treatment attendance and address those barriers with the patient. Designating the patient who chronically misses treatments as "unstable" and revising the patient's care plan would be a way to engage the entire IDT in a focused effort to identify barriers, plan interventions that address the barriers, and monitor and document outcomes. "Any member of the IDT, including the patient, may document why goals are not met or cannot be met" (V559).

There are times when staff members believe a patient is missing treatments "all the time" when, in reality, the number of missed treatments by a patient in a week or month is relatively small. Quantifying the number of missed treatments and identifying any pattern to the days of the week that treatments are missed will help determine the extent of the problem. This may also be a useful education tool for the patient.

Staff behavior can negatively influence patient adherence behavior. Staff members sometimes make the mistake of chastising a patient each and every time the patient shows up late for treatment or comes back after missing one or more treatments in a row. This is rarely an effective intervention for addressing adherence issues and is likely to create conflict between patient and staff. It may have the opposite effect on the patient's behavior than what was intended. Patients tell us that they believe staff doesn't care about them and whether they come to treatment or not; rather, they feel that the staff is more concerned about having an empty chair and a missed treatment they can't bill for. Has any patient said this to you? If so, you may want to examine staff communication and facility processes for dealing with patient adherence.

Some patients just aren't ready to commit to ongoing dialysis. Some patients believe that they don't need dialysis and have enough residual renal function to support their misperception about their health status. They show up once in a while and then disappear for days or weeks. Others may stop showing up altogether. Education falls on deaf ears and phone calls and welfare checks are considered harassment by the patient.

Some patients may not know how to tell you directly that they want to stop treatment. Other patients are clear that they don't want to come to treatment but the facility doesn't agree with the patient's decision, so staff keep calling the patient and sending out the police. Therefore, it is important that there is a discussion with the patient that discontinuing treatment is an option, what it means, and that end-of-life care can be arranged for them. Patients also need to know that if they make the decision to stop treatment now, they can change their minds and return to dialysis at your center in the future.

Depending on the underlying barriers to adherence to treatment attendance, you may want to consider negotiating with the patient a goal in the plan of care to increase attendance by one more treatment a month re-evaluate, and if the patient is successful try to negotiate attending two more treatments the following month, etc.

**It may be unrealistic to expect a patient who chronically misses treatments to attain 100% adherence, especially if there are underlying issues that the patient is unwilling to address. In these cases, the facility must modify its expectations of the patient.**

## Interventions

Below are interventions for the patient who chronically misses treatments and *is unresponsive to individualized interventions to decrease the number of missed treatments*:

- If a patient chronically no calls/no shows, consider not setting up the machine until the patient arrives. The patient will then have to wait until the machine is ready to be used and treatment time will be cut in order to minimize disruption to other patients' treatment schedules.
- Move the patient to the last shift of the day in order to minimize disruption to facility operations.
- Involve the patient's nephrologist in attempts to re-engage the patient in his care.
- Send a letter to the patient that focuses on your concerns about him and his safety and your desire to meet with the patient. The letter should not include a demand that the patient receives a

treatment in order to have a meeting. Examples of goals for meeting with the patient include assessing a catheter, reassessing barriers to treatment adherence, drawing blood to update lab results and possibly the patient's dialysis prescription, talking with the patient about discontinuing treatment, and planning for end-of-life care, if appropriate.

- If you are unable to contact the patient by phone (no working phone number; no answer to voice messages; no emergency contact information), call police for welfare check and document the outcome. If the patient is a home patient, schedule a home visit by the PD nurse and social worker in order to assess the patient.
- Contact Adult Protective Services if the patient is a vulnerable adult whose competency is questioned or who is known to be incompetent to make his own healthcare decisions and there is no known power of attorney or power of attorney is unavailable or refuses to be involved.
- Utilize emergency psychiatric services, including hospitalization for evaluation and treatment, if there is concern for immediate patient safety and patient has known or suspected mental illness.
- Thoroughly document all interventions and results. V767 states, "Facilities are not penalized if a patient or patients do not reach the expected targets if the plan of care developed by the IDT is individualized, addresses barriers to meeting the targets, and has been implemented and revised as indicated."

**Please do not hesitate to call us if you would like a case consultation.**

The protection of patient rights is the priority of the ESRD Network and we are monitoring for any unintended consequences for the patients due to the new payment rules. However, we want to acknowledge the concern we are hearing from facilities about how to balance a patient's right to refuse any aspect of the treatment plan with facility concerns about the QIP that began January 1, 2012. If you have questions about the ESRD QIP, contact CMS at [ESRDQIP@cms.hhs.gov](mailto:ESRDQIP@cms.hhs.gov). If you have questions about the ESRD bundled payment system, contact CMS at [ESRDPPSFacilityQuestions@cms.hhs.gov](mailto:ESRDPPSFacilityQuestions@cms.hhs.gov).

HSAG: ESRD Network 7  
3000 Bayport Drive, Suite 300  
Tampa, FL 33607  
813.383.1530