

**DPC POSITION STATEMENT
ON INVOLUNTARY DISCHARGE:
EXECUTIVE SUMMARY**

Decreasing Dialysis Patient-Provider Conflict

National Task Force Position Statement on Involuntary Discharge

Executive Summary

The Task Forceⁱ believes that there is a substantial need to give providers guidance regarding the Ethical, Legal and Regulatory issues related to the involuntary discharge of ESRD patients by either the nephrologist or a certified dialysis center or facility. Most ESRD patients are covered by the Medicare ESRD Program and as such are entitled to receive a payment subsidy to their ESRD providers by the federal government for the life saving chronic treatments they require. Dialysis facilities become certified for this purpose and accept Medicare funding to provide these treatments and other services to Medicare Beneficiaries. When conflicts arise related to patient behaviors that are deemed unacceptable by the providers, then questions arise as to the rights and obligations of both the patient and provider in the Medicare entitlement system. This paper sets forth the following positions:

- Medicare beneficiaries with ESRD are entitled to partial government payment to providers for chronic dialysis treatments under the Social Security Act.
- Providers have legal authority to refuse to treat patients who are acting violently or are physically abusive thereby jeopardizing the safety of others.
- The use of contracts to facilitate effective and efficient use of facilities is permissible.
- Although a patient may unilaterally terminate the patient-physician relationship, the physician may terminate the physician-patient relationship only after taking steps necessary to fulfill ethical obligations and to avoid legal abandonment of patients.
- A certified facility cannot provide dialysis without a treating physician and thus must discharge a patient if the treating nephrologist terminates the patient physician relationship, or transfer the patient's care to another treating nephrologist within that facility. However, both the physician and the facility are obligated ethically, legally and by regulation to assist the patient in securing life saving treatment with another facility and/or nephrologist.
- It is unethical for patients to be left without treatment based solely upon non-adherent behaviors that pose a risk only to them i.e., nonadherence to medical advice.
- Groups of providers should not exclude patients from acceptance and treatment from all their facilities or other physicians, except for irreconcilable cases of verified verbal/written/physical abuse, threats or physical harm. These groups should endorse and act on the ethical obligation to transfer patients to others within their group. An important purpose of transfer is to ensure that personality, language or cultural issues particular to an individual patient, professional or facility are not significant causes of the problem behavior of the patient.

Background

In the early years of dialysis, those fortunate enough to have access to the treatment followed closely the recommendations of their providers. However, an increase in dialysis patients in recent years and a shift in the demographics of the patient population have changed that pattern. Staffing issues have also contributed to the situation. Once nurses served on the front lines of dialysis care, spending time tending not just to the disease's physical demands but emotional ones as well. As dialysis has evolved and financial pressures have outpaced facility reimbursement increases, facilities, aiming to streamline operations for financial efficiency, now rely on technicians to do the jobs nurses once performed. Technicians may inadvertently exacerbate the potential for conflict because they have not had the formal education or professional training of licensed caregivers. Technicians may not be as proficient licensed caregivers in defusing potentially explosive encounters. If situations escalate out of control, dialysis units – faced with monetary and staffing constraints – may find it easier to dismiss problem patients rather than thoroughly assessing and responding to their complex problems. All these factors combine to set the stage for conflict.ⁱⁱ

In the years 1999 & 2000 the ESRD Networks (NWs) perceived an increase in the number of contacts and complaints regarding disruptive and abusive patients. The number of involuntary discharges of patients both with and without placement in a new facility increased for various reasons including nonadherence (non-compliance) to treatment regimens. A workgroup organized by the **FORUM OF ESRD NETWORKS** designed a Centers for Medicare & Medicaid Services (CMS) approved national project with the purpose and goal of beginning to quantify the number of HD/PD patients involuntarily discharged, gain an understanding of the reason(s) for the discharges, describe the characteristics of the involuntarily discharged patient population and identify placement outcomes for these involuntarily discharged patients. Over 70% of ESRD facilities and patients in the US in 2002 were included in the project. Of the 285,982 patients included in the project, 458 (0.2%) were reportedly involuntarily discharged. Treatment non-adherence was the leading reason for discharge nationally at 25.5% (117 patients), followed by verbal threat at 8.5% (39 patients). Other reasons for discharge were lack of payment at 5.2% (35 patients), combinations of verbal abuse, verbal threat and physical threats at 5.2% (24 patients) and verbal abuse at 5% (23 patients).

The Task Force noted that discharged patients are at high risk for morbidity and mortality. Any ESRD patient without access to regular chronic dialysis and the necessary support services is at increased risk. An unknown number of deaths have occurred due to lack of access to dialysis. Although the numbers are thought to be small, these deaths may have been preventable. They evoke disturbing ethical questions, particularly in the case of any discharge for nonadherence (resulting only in a danger to self rather than a danger to others) when the patient has exercised his/her legal and ethical right to consent to or refuse medical treatment.

The **FORUM OF ESRD NETWORKS** convened a national consensus conference in October of 2003 to explore dialysis patient provider conflict. Renal stakeholders and CMS participated in the conference during which action options were identified to address these issues. CMS subsequently funded a national project titled Decreasing Dialysis Patient-Provider Conflict (DPC project) to act

upon several of the action options, including the need to clarify the rights and obligations of patients and providers in an entitlement system. A national **TASK FORCE** was formed for this project and a subcommittee activated to examine the legal, ethical and regulatory issues of entitlement and to produce a statement for national consideration.

This statement addresses three levels of behavior:

1. Behaviors, physical acts, nonphysical acts or omissions by a patient that result in placing his/her own health, safety or well-being at risk (frequently referred to as non-adherence to medical advice).
2. Behaviors, actions, or inactions by patients and/or family, friends or visitors perceived to put the safe and efficient operations of the facility at risk (for example frequent “no-show” for treatment or non-payment, frequently referred to as non-adherence to facility policy and procedures).
3. Behaviors, actions or inactions by patients and/or family, friends or visitors that are perceived to place the health, safety or well-being of others at risk (commonly referred to improper behaviors that impinge on the rights of others).

Discussion

Ethical & Legal Issues

Physicians cannot be, nor should they be, forced to accept a particular patient into their care. Physicians have no legal or ethical obligation to sustain or maintain a relationship with an uncooperative patient. However, once a relationship has been established between the physician and patient, a legal and ethical obligation exists to continue that relationship until it is formally terminated or until the patient voluntarily withdraws from care. These ethical obligations are not absolute and providers should clearly consider the safety and well-being of others when weighing this decision^{iii,iv}. If a situation arises where neither party can provide what the other needs, the relationship may be terminated; however, a physician may not abandon his/her patient. The physician must give notice and the patient must have an ample opportunity to secure the presence of other medical attendance^v. A minimum of 30 days notice has been recognized in case law and good faith assistance of the physician is recommended. In cases when no other nephrologist either practices in the geographic area where the patient is treated or no other nephrologist will accept the patient, the physician has a duty not to abandon his/her patients and should make a concerted effort to work out an acceptable treatment program.

Treatment Issues

Referral to an alternate provider may be impossible due to refusal of other providers to accept the patient or due to a lack of alternate providers in the area. In such cases, aggressive steps are needed to continue treating the patient. These steps include but are not limited to the following:

- Evaluation of the role of metabolic side effects of treatment, endocrinopathies and medications on patient behaviors.

- Focused interventions by each member of the interdisciplinary team including a complete assessment of needs and planned interventions together with referral to a mental health specialist that may result in beneficial changes^{vi} or consultation with an Ethics Committee^{vii}
- Isolation of the patient during treatment or moving the patient to another shift
- Psychiatric evaluation as required by facility for continued treatment; in some cases this may involve a court-order
- Attendance of family members/significant others during treatment to contain patient behavior; in some cases this may involve a court-order
- Cases that involve physical attack or other violent conduct where others are placed at risk are best handled by referral to the appropriate law-enforcement agency

Providers should thoroughly document inappropriate patient behavior and provider efforts to assist patients achieve more appropriate conduct. If the decision is made to discharge a patient involuntarily, there should be clearly documented evidence that the patient's rights have been protected, that aggressive measures to modify inappropriate conduct have been attempted and been unsuccessful. Finally, as stated by CMS to ESRD Networks a) providers are "required to assist with alternate placement" b) "(placement) is not the responsibility of the Network" c) "whenever possible the patient's nephrologist should be involved in the discharge and transfer planning"^{viii}. Earnest attempts to accomplish an orderly transfer^k to another provider must be fully documented.

Protocols should be adopted that make available, where possible, the intra-corporate placement of discharged patients whose behaviors *place themselves at risk* since some behavioral problems may be resolved by the characteristics of a new environment and new treatment team. These protocols should include an alternate provision for placement consultation with providers from different organizations in cases where transfer within the same corporation is not possible. Prohibition on intra-corporate transfers is inappropriate except in well-documented cases when a patient places *others at physical risk*.

While the use of "Zero-Tolerance" policies is adopted in some settings, these policies are very often inappropriately and inconsistently enforced and open to broad subjective interpretation. The use of Zero Tolerance Policies is supported only for behaviors that place *others at physical risk*. Aggressive measures should be attempted to resolve conflicts involving other inappropriate non-violent behaviors.

It is the position of this Task Force that terminating the patient/provider relationship on the basis of behaviors that place *only the patient at risk* is unjustified. In the limited instances where the behaviors are so pervasive as to create significant *financial &/or operational risk to the facility*, consideration could be given to employing an approach wherein the "privilege" of a regular outpatient appointment slot is withdrawn after advance notice and informed consent and the patient assigned to dialysis by vacant spots that arise when other patients are hospitalized, absent or dialyzing elsewhere. This approach may be successful in continuing to offer dialysis and provide

appropriate support services while allowing regular assignments to adherent patients, and eliminating the financial burden of repetitive “no-show” behavior. In such a treatment plan, if the patient demonstrates compliance with regular treatment, a regular slot can be offered when available and a treatment contract employed. If the patient is in emergent need of dialysis when no spot is available, the patient would be directed to the Emergency Room for acute services, as is routine in ESRD care.

Effects on Outcome Data

Under Congressional mandate, Networks evaluate the quality of care rendered by ESRD providers. This oversight function may lead some providers to regard patients *whose behaviors place themselves at risk* as liabilities to their facility’s quality indicator profiles. In other words, nonadherent patients could be viewed as a ‘risk to the facility’ by worsening the facility’s outcome measures. Although current data systems do not allow for case mix adjustment or censoring of patient data with poor outcomes due to nonadherence, it is the position of this Task Force that no negative conclusions should be drawn about practitioner or facility quality of care based upon data for patients who do not cooperate with the prescribed regimen. The NW Medical Review Boards, therefore, in their quality oversight role should not hold providers responsible for aberrant quality indicators in such cases, since patients cannot and should not forcibly be made to receive dialysis therapy as prescribed, nor comply with other aspects of the treatment program, including diet and medication orders, if they choose otherwise. The Networks should request further information from providers in cases where facility outcomes appear as outliers, allowing facilities the opportunity to justify outcomes that are directly related to the continued care of patients who do not cooperate with the treatment regimen.

Recommendations

1. When discussions regarding discharging a patient arise, the interdisciplinary care team should consider the ethical, legal, and regulatory obligations toward the patient who requires life-sustaining treatment.
2. Treatment should continue without bias or discrimination towards patients whose behaviors place only them at risk.
3. Although current data systems do not allow for case mix adjustment or censoring of patient data with poor outcomes due to non-adherence, it is the position of this Task Force that no negative conclusions should be drawn about practitioner or facility quality of care based upon data for patients who do not cooperate with the prescribed regimen. We recommend that the Network Medical Review Boards and other quality oversight agencies consider the effect of non-adherence on aberrant quality indicators, since patients cannot and should not forcibly be made to receive dialysis therapy as prescribed, nor comply with other aspects of the treatment program, including diet and medication orders, if they choose otherwise. It is recommended that further information be requested from providers in cases where facility outcomes appear as outliers, allowing providers the opportunity to justify outcomes

that are directly related to the continued care of patients who do not cooperate with the treatment regimen.

4. All members of the renal health care team should receive training in conflict resolution and develop skills in this area.
5. Each facility should develop a comprehensive, multidisciplinary policy for intensive intervention that recognizes the rights of both patients and staff and includes early consultation with provider support services and the ESRD Network, to resolve conflicts among patients, renal care team professionals, and the facility.
6. Consideration of potential contributing clinical side effects of treatment, endocrinopathies and medications on patient behaviors should be documented.
7. In the rare event a decision is made to terminate the physician/provider- patient relationship for behaviors which put the facility or others at risk, multidisciplinary renal care team good faith attempts at intensive interventions should have occurred over a reasonable period of time prior to the decision. Treatment should be continued until the patient-provider relationship has been legally and appropriately terminated. This includes advance notice and directly contacting other nephrologists and dialysis facilities to obtain alternate care. It is recommended that transfer within provider groups be facilitated if required to ensure continued treatment.
8. In addition to the provision of a list of other nephrologists and dialysis facilities the discharging facility has an ethical responsibility to the patient with a life threatening condition to actively participate in a well documented, good faith effort to obtain dialysis placement to ensure continuity of care. This involves:
 - a. Active involvement of the patient's nephrologist
 - b. Provision of accurate medical records and information to prospective providers in accordance with HIPAA and/ or the Federal Privacy Act including the reason for discharge
 - c. Informing the patient of his/her rights under HIPAA to:
 - i. Review records for transfer AND
 - ii. Submit a statement in a reasonable time prior to the transfer for inclusion in medical record if not in agreement with the record
 - d. Prospective providers have an ethical obligation to earnestly consider accepting patients who have been discharged by other providers. This may require:
 - i. A face to face meeting with the potential provider, patient and family
 - ii. Use of treatment trials and behavior contracts
9. When chronic placement is not obtained, the discharging physician and facility should work with area providers to ensure continued treatment.

This position statement was adopted by the DPC National Task Force on January 14, 2005

The statement has been endorsed by the following renal stakeholders:

American Association of Kidney Patients
American Nephrology Nurses Association
Gambro Healthcare
National Association of Nephrology Technicians/Technologists
National Renal Administrators Association

ⁱ Decreasing Dialysis Patient Provider Conflict Project National Task Force: Center for Medicare & Medicaid Services representatives- Ida Sarisis, Gina Clemons, Condict Martak, Brady Augustine, MS, Barry Straub, MD; Richard S. Goldman, MD, Co-Chair; Glenda F. Harbert, RN, CNN, CPHQ, Co-Chair; Karin Anderson-Barrett, BSN, RN, JD (DCI); Elaine Colvin, RN, BSN, MEPD (ANNA); Sandie Guerra Dean, MSW, LICSW (FMC); Cammie Dunnagan (eSource); Brenda Dyson (AAKP); Wendy Funk-Schrag, LMSW, ACSW (CNSW & RCG); Clifford Glynn, CHT (NANT); Kay Hall, BSN, RN, CNN (GHC); Barry Hong, PhD, ABPP(psychologist); Liz Howard, RN, CNN (Davita); Denise Rose, JD; Ann Stivers (NRAA); Mark Meier, MSW, LICSW; Arlene Sukolsky; Lisa Taylor, BSN, RN; Sandra Waring, MSN, CNN, CPHQ (Forum of ESRD Networks); William Winslade, PhD, JD (medical ethicist).

ⁱⁱ Report of the Dialysis Patient-Provider Conflict (DPPC) A Consensus Project with the Participation of the Community of Stakeholders Final Report. 2003.

ⁱⁱⁱSection 5 (a) (1) of the OSHA Act "Each employer shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees." OSHA Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers.

^{iv} OSHA Safety and Health Program Management Guidelines (Federal Register 54 (16:3904-3916, January 26, 1989). OSHA Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers.

^v American Medical Association Council on Ethical and Judicial Affairs states that a "physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable notice and sufficient opportunity to make alternative arrangements for care."

^{vi} ESRD Network of TX, Inc. Intensive Intervention With The Non-Complaint Patient Booklet

^{vii} Renal Physicians Association/ American Society of Nephrology Clinical Practice Guideline Shared Decision Making in the appropriate Initiation and Withdrawal from Dialysis

^{viii} Centers for Medicare & Medicaid Services ESRD Network Organization Manual 130.11

^{ix} Subpart U Conditions for Coverage of Suppliers of ESRD Services 405.2138