When Patient Disruptors Impact Quality and Operational Survival

Costs can be NETWORK Grievances ; STAFF ABUSE & TURNOVER ; QUALITY ; RELATIONSHIPS

= ?FINANCIAL / ?OPERATIONAL SURVIVAL

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** Patient discharges increasing

- Physician terminates due to behavior – not CfC
- Ongoing disruptive and abusive behavior - CfC
- Immediate and severe threat - CfC
- Medical noncompliance MD discharge – not Cfc
- Unit unable to meet medical needs –Cfc ** will grow!

** Dialysis facilities are closing (almost 1 per week) (RURAL)

- Lack of Nephrologist due to consolidation with competitor
- Labor market – Nurses and techs don't see dialysis as rewarding career
- Payor mix resulting in financial loss and projections show no positive relief from CMS, MA or Medicaid
  ** repeat – units ARE closing due to MONEY$

Quality Dialysis per CMS is QIP – here are 2023 Measures to impact your 2025 payment year. 15 Measures

10% Patient Safety = NHSN (via CDC) Infection reporting

30% Care Coordination = Hospitalizations / Readmissions / Prevalent Patients Waitlisted Transplant

35% Clinical Care = Kt/V ; Vascular Access (fistula vs catheter) ; Transfusions *

15% Patient/Family Engagement = ICH CAHPS (>30 survey eligible ICH patients treated PRIOR year) if < 30 – measure is thrown out but causes other measures to be valued higher!

10% - *NEW – 6 measures at 1.67% each=Clinical depression ; hypercalcemia Ultrafiltration Rate ; Medication Reconciliation ; NHSN event reporting ; COVID Staff vaccinations

Opportunities – The devil is in the details…

1. Where does the data come from? CLAIMS (ALL patient claims in the system) ; EQRS (CrownWeb); Enrollment Database (EDB) ; Long Term ; NHSN (CDC) infection reporting ; Other CMS ESRD data?
2. To be counted in QIP - > 18 yrs old ; NEW dialysis patients > 90 days ; patients dialyzing at YOUR facility > 60 days ; Same modality for entire month ;
3. NHSN – MUST submit every month X 12 months or 0 POINTS!
4. Hospital Readmissions – excludes facilities with <11 discharges/yr; Patient readmitted within 3 days of discharge ; Readmissions >30 days of discharge ; Readmissions with patient death ; Patient death within 30 days of discharge. Patient leaves AMA ; Patients >12 admits in 1 year ; patient off dialysis when discharged; t/f to another acute setting.
    1. Are you capturing Hospital diagnosis on ESRD claim !

5. Transfusions – They are BACK and hospitals famously put ESRD on all transfusions claims. ***Need to put REAL diagnosis on ESRD claim***: hemolytic and aplastic anemia, solid organ cancer (breast, prostate, lung, digestive tract, etc) lymphoma, carcinoma in situ, coagulation disorders, multiple myeloma, myelodysplastic syndrome; myelofibrosis; leukemia; head and neck cancer & other cancers (connective tissue, skin, etc.) metastatic cancer, & sickle cell anemia. (get these from hospital medical records or MD records).
6. Adequacy - Kt/V >1.2 and PD > 1.7 but excludes patients with RX in EQRS 2 or >3 (4 or 5). Patient assigned for entire month (no t/f or modality changes)
7. Access – Catheters =Double negative! Reduce fistula % and Increase Catheter %. Opportunity = can they have GRAFT?

Reporting Measures – DO NOT MISS 1 MONTH

1. Hypercalcemia
2. Ultrafiltration Rate
3. Medication Reconciliation – attestation it was done monthly
4. Clinical Depression Screening and follow-up
5. NHSN COVID 19 vaccination coverage for personnel

QIP scores impact the payment for the entire facility. Payment penalties range from .5% to 2% of total monthly payment. Smaller units feel this more because the smaller your census the higher impact one or two patients who don't meet clinical goals or who might be "disruptive" can impact your facility in a financial way; impact staff morale; result in Involuntary Discharge; create conflict between staff and patients /families; and many other adverse outcomes.

Environment in the dialysis facility has changed

1. Todays patient versus patient from 10 yrs ago:
   - Patients **want** more and more from staff
   - Patients want to dictate/control treatment – what chair they will sit in; what time they want to come; how much fluid we can remove; # of times they come per week or per month ; who can cannulate them ; who can "talk" to them; etc. These decisions have real life and death consequences.
   - Increase in patients with kidney failure due to addiction/opioids use – - frequent hospitalizations, near death experiences
   - Angry and in denial about their ESRD can be abusive to staff who are "trying to help"
   - > 50% of patients: won't take CKD medications; refuse to follow fluid/dietary recommendations
   - >50% of patients feel sad, nervous, scared or depressed
   - POLITICS !
   - Health Literacy is a real problem with many of our patients
   - **all of these make the 10-12 hr work day long and leave staff un-appreciated

COVID extremely hard on our staff - Compassion Fatigue

- Patient care staff didn't get to stay home, they had to come to work in uncertain times and try to keep their patients out of the hospitals and alive.
- They watched many of their patients pass away despite all their efforts (lost their resilience)
- They endured patients being angry over masking and infection control policies
- Telemedicine put extra work on unit staff who had to help facility physician rounds
- Mental state of staff: discouraged, feel they don't make a difference, feel isolated in their daily struggles, dealing with constant staffing shortages,
- Staff have Compassion Fatigue: physical, emotional & psychological impact of helping others
- Staff have no more empathy to give; They have given up on trying to HELP our patients

The disruptive patients are now "the last straw" and they can have a ripple effect on the other patients in the facility who witness & mirror these behaviors; Patients believe the disruptive patient instead of their doctors, nurses, dietitians, etc. Today we are all living the consequences:

- Our most experienced and skilled nurses are leaving dialysis and finding good replacements is proving impossible
- Our staff need counseling to help them believe they can have a positive influence again and be valued as care givers. Need to know it is OK to seek counseling / support groups.

Physician Perspective

Working harder in the hospital due to consequences of these behaviors.

- Drug Abusers and infections, low hemoglobin, low clinical values, access problems
- Frequent Flyers - Monthly or more due to fluid overload
- Hyperkalemia – medication and diet adherence ; missing outpatient treatments
- Anemia – usually not CKD – GI bleed – Infections – Surgical issues – etc. but patient not getting the treatment needed to fix the anemia root cause
- Influenza , Pneumonia , COVID, UTI – which can all be deadly and are higher in patients who refuse immunizations/vaccinations
- Acute staff are consistently called back to hospital for after hours admissions = higher cost for the labor and Acute staff suffering from same “compassion fatigue” as the chronic staff
- Physicians feel they need to protect the STAFF, because the staff are their front line; integral part of the team. Empathy is a cycle that starts from the TOP and trickles down.

Costs of the disruptive patient are significant and impact the facility in multiple areas, specifically our essential care team

1 – Quality of Care we provide and Quality of Life for both staff and patients

2 – Mental health of our dialysis team is evident – from physicians to techs

3 – Financial cost is real – facilities lack the budgets to address the increase cost of caring for patients with poor clinical outcomes but consistently miss treatments.

4 – Nationwide epidemic of nurses bailing – discouraged, not making a difference, don't feel they are giving help or hope to patients anymore; feel patients are required to be a part of solution

This will be our greatest challenge moving forward – I don't know the answer but I know these patients will continue to be discharged and units will continue to close until we acknowledge it and work together to fix it.