Rapidly Growing and Complicated

By Suresh Samson, MD, FASN

On August 10, 2018, the Centers for Medicare & Medicaid Services (CMS) published updated regulations for dialysis facilities (1). The CMS guidance encompasses several modalities, with a focus on the locations where dialysis services are provided.

The new guidance reaffirmed CMS’ recognition of dialysis in a nursing home setting, making revisions to the State Operations Manual (Chapter 2, ESRD Facilities), adding section 2271A, titled “Dialysis in Nursing Homes.” This action affirmed that Medicare-approved ESRD facilities may provide dialysis services to skilled nursing facility (SNF) residents in the nursing home within an approved home training and support modal. These new requirements include operational, logistical, physical, and staffing guidelines for nursing home dialysis. What follows is a summary of the nursing home dialysis model.

First, let us briefly frame the term “subacute care dialysis” (SACD), which includes dialysis provided in SNFs. Dialysis patients in such facilities may receive hemodialysis or peritoneal dialysis. Hemodialysis in these facilities in nursing homes is unclear. However, using data from the U.S. Renal Data System and CMS, reliable estimates place the number at about 10% of the broader nationwide dialysis population—at approximately 70,000 (2, 3). With the rapid increase in the number of new ESRD patients in the >65 years age group, this number is sure to increase in the coming years.

**SACD: the logistics**

The framework under which SACD is provided is simple: The nursing home chooses the space in its building to convert into a hemodialysis unit, and it bears the expense of constructing the unit. If conventional thrice-weekly dialysis is sought, a nursing home dialysis unit has many of the physical characteristics of a standalone outpatient unit—just in miniature form. It will have its own water treatment system, dialysis equipment, and traditional dialysis supplies. The nursing home would contract with a home dialysis provider to provide services. CMS guidelines indicate that the ESRD facility can only provide home dialysis services to a nursing home resident under a written agreement with the home, and that the nursing home is charged with maintaining direct responsibility for the dialysis-related care over that patient. Moreover, the quality of such services must remain consistent with the ESRD Conditions for Coverage requirements, as well as the terms of an applicable agreement with the nursing home. The agreement itself must clearly delineate the responsibilities of the ESRD facility and the nursing home regarding the care of the resident before, during, and after dialysis treatments (1).

The new guidance emphasizes the need for communication and collaboration between the dialysis provider and nursing home. There must be a constant, uninterrupted flow of information between the dialysis unit and the nursing home staff, through systematic processes. Unlike traditional in-center dialysis facilities, a nursing home dialysis provider must establish defined mechanisms to ensure that respective staffs are exchanging information.

As someone overseeing these processes, my recommendation is that the agreement between the two entities clearly set forth each entity’s responsibilities and build in weekly and monthly meetings between appropriate members of the respective interdisciplinary teams to address any nonmedical/clinical needs, general medical/clinical needs, and each patient to assess plans of care and potential problems or issues that could hamper treatment goals.

**SACD from a physician’s perspective**

In most states, a hemodialysis patient admitted to a nursing home must be transported to a regular dialysis unit three-times weekly. The provision of dialysis in-house eliminates the need for the patient to endure such travel, which carries multiple risks, particularly in cold-weather states. Receiving in-house dialysis treatment, on the other hand, allows patients to spend more time receiving therapy and working to improve their condition and to work toward discharge home.

More time is also afforded for physician visits and recreational time. Whether in-house dialysis reduces the length of nursing home stay is yet to be seen. This model is a great advantage for the patient and his or her family.

**SACD from a patient’s perspective**

Physicians must be versed with this model to appropriately care for their patients. First, they will naturally be required to have privileges with the dialysis provider to see patients in the dialysis unit. Because of the need for a significant amount of coordination of care with the nursing home and its staff, however, it would behoove physicians to obtain privileges with the nursing home as well. Given that patients have multiple comorbidities and a higher acuity than the average in-center patient, their medication regimen often changes with more frequency, increasing the utility of having access to both the dialysis provider and nursing home’s systems for better control and management of such patients.

Of note, CMS considers SNFs to be the patient’s home (4). Therefore, these patients are required to be seen at least once a month as is the case with conventional home dialysis patients. This is an important distinction between SACD and the in-center setting. Although patients can be scheduled to see physicians in their own clinics, my recommendation is to do the monthly physician examination in the nursing home—and not necessarily during dialysis. This offers the physician the opportunity to better coordinate the patient’s care and facilitates a discussion of care plans with the interdisciplinary team.

Physicians may also discover opportunities to serve as medical directors with nursing home dialysis providers. Because each dialysis unit has a small capacity, this may include overseeing care at multiple nursing home dialysis units. Physicians may use such opportunities to build relationships with area nursing homes and hospitals, while also assisting nursing homes with the crafting and implementation of their policies and procedures, which are essential for the proper care of dialysis patients.

**General pitfalls to avoid**

- Ensure that your name is entered on the nursing home patient’s chart as the nephrologist, with your contact details.
- Obtain privileges with both the dialysis provider and the SNF. You will be unable to provide orders directly if you do not have SNF privileges.
- Familiarize yourself with both electronic medical record (EMR) systems.
- Owing to the high proportion of patients with drug-resistant infections, familiarize yourself with infection control policies of both the dialysis provider and SNF.
- Communicate with the interdisciplinary team for both the dialysis provider and the SNF.
- Evaluate patients monthly. It is not required that you
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**NephSAP**

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References


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