Dialysis Station Uses
Requested Definitions
Draft 11/5/13

Goal statement: to ensure that dialysis providers can remain compliant with CN rules while preserving maximum flexibility and efficiency to meet the needs of the constituents they serve in the face of shrinking reimbursements and other changes in the delivery of health care.

1. Conventional outpatient hemodialysis. By far the most common station use, as well as the primary basis for the ESRD need projection methodology.

2. Isolation dialysis. Required by CMS for all new or expanded facilities as of 2009, isolation is affected by use of a private room for dialysis patients who are positive for hepatitis B, MRSA, or other infectious states. (If an isolation room is equipped with a private restroom, it can also accommodate c-diff positive patients who are not yet fully continent.)

    a. The most common isolation condition is hepatitis B. Providers with localized systems of care may choose to aggregate these patients at one or more facilities rather than at every facility in order to achieve economies of scale and also to better leverage core competencies; in this case a new or expanded facility may have an isolation room built and thus is able to demonstrate the capability to use it, but the facility may opt to use it as a conventional outpatient station, refer hepatitis patients to a nearby facility, and because the isolation room need not be dedicated for isolation, it should have swing status and be available for any use as needed.

    b. In smaller, probably rural, facilities where localized aggregation at one facility is not an option, the isolation room cannot be used for other uses unless it is terminally cleaned following each use, a procedure that is time-consuming, expensive and beyond the scope of most dialysis facilities. Furthermore, for hepatitis B positive patients, the CMS Conditions for Coverage prohibit use of the room for non-hepatitis patients until there are no positive patients left on the facility census.

c. In both cases, the calculation of actual station utilization in the facility is difficult because this use is not contemplated in the ESRD CN methodology. The need to isolate dialysis patients is not predicable, and thus the convention of 4.8 (or 3.2) patients per station does not work.

   Question: should isolation stations be exempt from CN?

3. Home training. Preferably done in a private room, physically separated from the conventional outpatient stations, to optimize learning. This private training is used to support several modalities, including

   a. Convention home hemodialysis
   b. Short daily home hemodialysis
   c. Slow nocturnal home hemodialysis
   d. Continuous ambulatory peritoneal dialysis
   e. Continuous cycling peritoneal dialysis
   f. Rapid peritoneal dialysis onset

   However, for any/all such training procedures, use of the training room(s) depends on demand, may not be used on a daily or regular basis, and thus should also be given swing status rather being dedicated for training.

   Question: should home training stations be exempt from CN?

4. Bedded dialysis. As with isolation and home training, the need for a bedded station cannot be predicted and a bedded station should thus also have swing status. If not needed on a given day, the bed could be stored at a surplus station or in some other part of the facility.

5. Set-up station(s). Some facilities do not rely solely on a rapid turn-around of dialysis stations between patients to optimize efficient utilization, and instead set up other stations for immediate use as soon as the dialysis treatment at the first station has been completed. This results in more physical stations being used than what is indicated in a CN award, but never for more than that number of treatments at any given time.

6. Recovery stations(s). One or more surplus dialysis stations adjacent to those in use may be used as a safe place for patients to recover following treatment.

7. Nocturnal station(s). A facility might be configured for in-center nocturnal dialysis, typically in an area of bedded dialysis stations that is different and

possibly physically segregated from the conventional outpatient stations. As with set-up stations, the provider must assure that as a nocturnal treatment is initiated at one of these stations, there is a commensurate drop in the number of other stations in use so that the number of ongoing treatments at any time does not exceed the number of CN approved stations.

8. Rinse stations. In case a dialysis machine in use develops technical problems, most providers keep one (or more) back-up machines in continuous rinse mode throughout the day so that it can be rapidly deployed as needed. Some providers have special rooms or areas away from the dialysis area for this function, but some must use surplus stations that are adjacent to the CN approved stations in use.

9. Surge capacity. Providers often over-build a new facility so that there are more built stations than needed for the number of CN approved stations, either for future use or for emergency use as surge capacity in the event of a local power outage or other disaster that affects nearby facilities. (This was in fact urged by the Head of Washington State Homeland Security in 2006.) They can also be used to accommodate any of the special functions listed above on condition that the facility never permits more treatments in progress than the number of CN approved stations.