



Psychosocial Aspects of the 2008 Dialysis Conditions for Coverage SHORT VERSION

No information from the preamble of the document

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To go into effect October 14, 2008 in every U. S. dialysis unit

You can find the entire conditions for coverage at: <http://edocket.access.gpo.gov/2008/pdf/08-1102.pdf>

This packet was put together by the Council of Nephrology Social Workers (CNSW) to help inform and educate the kidney community about the psychosocial aspects of the new conditions. The implementation and interpretation of the new Conditions of Coverage for End-stage Renal Disease Facilities is anticipated to be a dynamic process. This document reflects the information available to the kidney community as of its version date. Please confirm with CNSW whether further information, resources, or guidance has been provided on this subject. Information provided by CNSW is not intended to establish or replace policies and procedures provided by dialysis providers to their facilities. Please check with your dialysis facility management before implementing any information provided here.

**To best stay informed and up-to-date about the new conditions,
we encourage you to be a national member of CNSW-
Go to www.kidney.org, or Call (800) 622-9010 to join today!
<http://www.kidney.org/professionals/pdf/cnswform.pdf>**

Location	Condition	Standard	Language
Subpart B Patient Safety	494.60 Physical Environment	(c) Patient care environment	<p>The dialysis facility must:</p> <ul style="list-style-type: none"> (i) Maintain a comfortable temperature within the facility; and (ii) Make reasonable accommodations for the patients who are not comfortable at this temperature. <p>(3) The dialysis facility must make accommodations to provide for patient privacy when patients are examined or treated and body exposure is required.</p>
Subpart C Patient Care	494.70 Patients' rights	(a) Patients' rights	<p>The dialysis facility must inform patients (or their representatives) of their rights (including their privacy rights) and responsibilities when they begin their treatment and must protect and provide for the exercise of those rights.</p> <p>(a) Standard: Patients' rights. The patient has the right to—</p> <ul style="list-style-type: none"> (1) Respect, dignity, and recognition of his or her individuality and personal needs, and sensitivity to his or her psychological needs and ability to cope with ESRD; (2) Receive all information in a way that he or she can understand; (3) Privacy and confidentiality in all aspects of treatment; (4) Privacy and confidentiality in personal medical records; (5) 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; (6) Be informed about his or her right to execute advance directives, and the facility's policy regarding advance directives; (7) Be informed about all treatment modalities and settings, including but not limited to, transplantation, home dialysis modalities (home hemodialysis, intermittent peritoneal dialysis, continuous ambulatory peritoneal dialysis, continuous cycling peritoneal dialysis), and in-facility hemodialysis. The patient has the right to receive resource information for dialysis modalities not offered by the facility, including information about alternative scheduling options for working patients; (8) Be informed of facility policies regarding patient care, including, but not limited to, isolation of patients; (9) Be informed of facility policies regarding the reuse of dialysis supplies, including hemodialyzers; (10) Be informed by the physician, nurse practitioner, clinical nurse specialist, or physician's assistant treating the patient for ESRD of his or her own medical status as documented in the patient's medical record, unless the medical record contains a documented contraindication; (11) Be informed of services available in the facility and charges for services not covered under Medicare; (12) Receive the necessary services outlined in the patient plan of care described in § 494.90; (13) Be informed of the rules and expectations of the facility regarding patient conduct and responsibilities; (14) Be informed of the facility's internal grievance process; (15) Be informed of external grievance mechanisms and processes, including how to contact the ESRD Network and the State survey agency; (16) Be informed of his or her right to file internal grievances or external grievances or both without reprisal or denial of services; and (17) Be informed that he or she may file internal or external grievances, personally, anonymously or through a representative of the patient's choosing.

Subpart C Patient Care	494.70 Patients' rights	(b) Standard: Right to be informed regarding the facility's discharge and transfer policies	(b) Standard: Right to be informed regarding the facility's discharge and transfer policies. The patient has the right to— (1) Be informed of the facility's policies for transfer, routine or involuntary discharge, and discontinuation of services to patients; and (2) Receive written notice 30 days in advance of an involuntary discharge, after the facility follows the involuntary discharge procedures described in § 494.180(f)(4). In the case of immediate threats to the health and safety of others, an abbreviated discharge procedure may be allowed.
Subpart C Patient Care	494.70 Patients' rights	(c) Standard: Posting of rights	The dialysis facility must prominently display a copy of the patient's rights in the facility, including the current State agency and ESRD network mailing addresses and telephone complaint numbers, where it can be easily seen and read by patients.
Subpart C Patient Care	494.80 Patient assessment	(a) Standard: Assessment criteria	The facility's interdisciplinary team consists of, at a minimum, the patient or the patient's designee (if the patient chooses), a registered nurse, a physician treating the patient for ESRD, a social worker, and a dietitian. The interdisciplinary team is responsible for providing each patient with an individualized and comprehensive assessment of his or her needs. The comprehensive assessment must be used to develop the patient's treatment plan and expectations for care. (a) Standard: Assessment criteria. The patient's comprehensive assessment must include, but is not limited to, the following: (1) Evaluation of current health status and medical condition, including co- morbid conditions. (2) Evaluation of the appropriateness of the dialysis prescription, blood pressure, and fluid management needs. (3) Laboratory profile, immunization history, and medication history. (4) Evaluation of factors associated with anemia, such as hematocrit, hemoglobin, iron stores, and potential treatment plans for anemia, including administration of erythropoiesis- stimulating agent(s). (5) Evaluation of factors associated with renal bone disease. (6) Evaluation of nutritional status by a dietitian. (7) Evaluation of psychosocial needs by a social worker. (8) Evaluation of dialysis access type and maintenance (for example, arteriovenous fistulas, arteriovenous grafts, and peritoneal catheters). (9) Evaluation of the patient's abilities, interests, preferences, and goals, including the desired level of participation in the dialysis care process; the preferred modality (hemodialysis or peritoneal dialysis), and setting, (for example, home dialysis), and the patient's expectations for care outcomes. (10) Evaluation of suitability for a transplantation referral, based on criteria developed by the prospective transplantation center and its surgeon(s). If the patient is not suitable for transplantation referral, the basis for nonreferral must be documented in the patient's medical record. (11) Evaluation of family and other support systems. (12) Evaluation of current patient physical activity level. (13) Evaluation for referral to vocational and physical rehabilitation services.
Subpart C Patient Care	494.80 Patient assessment	(b) Standard: Frequency of assessment for patients admitted to the dialysis facility.	(1) An initial comprehensive assessment must be conducted on all new patients (that is, all admissions to a dialysis facility), within the latter of 30 calendar days or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session. (2) A follow up comprehensive reassessment must occur within 3 months after the completion of the initial assessment to provide information to adjust the patient's plan of care specified in § 494.90.

Subpart C Patient Care	494.80 Patient assessment	(d) Standard: Patient reassessment	In accordance with the standards specified in paragraphs (a)(1) through (a)(13) of this section, a comprehensive reassessment of each patient and a revision of the plan of care must be conducted— (1) At least annually for stable patients; and (2) At least monthly for unstable patients including, but not limited to, patients with the following: (i) Extended or frequent hospitalizations; (ii) Marked deterioration in health status; (iii) Significant change in psychosocial needs; or (iv) Concurrent poor nutritional status, unmanaged anemia, and inadequate dialysis.
Subpart C Patient Care	494.90 Patient plan of care		The interdisciplinary team as defined at § 494.80 must develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient's needs, as identified by the comprehensive assessment and changes in the patient's condition, and must include measurable and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the patient plan of care must be consistent with current evidence-based professionally-accepted clinical practice standards.
Subpart C Patient Care	494.90 Patient plan of care	(a) Standard: Development of patient plan of care.	The interdisciplinary team must develop a plan of care for each patient. The plan of care must address, but not be limited to, the following: (6) Psychosocial status. The interdisciplinary team must provide the necessary monitoring and social work interventions. These include counseling services and referrals for other social services, to assist the patient in achieving and sustaining an appropriate psychosocial status as measured by a standardized mental and physical assessment tool chosen by the social worker, at regular intervals, or more frequently on an as-needed basis.
Subpart C Patient Care	494.90 Patient plan of care	(a) Standard: Development of patient plan of care.	The interdisciplinary team must develop a plan of care for each patient. The plan of care must address, but not be limited to, the following: (7) Modality. (i) Home dialysis. The interdisciplinary team must identify a plan for the patient's home dialysis or explain why the patient is not a candidate for home dialysis. (ii) Transplantation status. When the patient is a transplant referral candidate, the interdisciplinary team must develop plans for pursuing transplantation. The patient's plan of care must include documentation of the— (A) Plan for transplantation, if the patient accepts the transplantation referral; (B) Patient's decision, if the patient is a transplantation referral candidate but declines the transplantation referral; or (C) Reason(s) for the patient's nonreferral as a transplantation candidate as documented in accordance with § 494.80(a)(10).
Subpart C Patient Care	494.90 Patient plan of care	(a) Standard: Development of patient plan of care.	The interdisciplinary team must develop a plan of care for each patient. The plan of care must address, but not be limited to, the following: (8) Rehabilitation status. The interdisciplinary team must assist the patient in achieving and sustaining an appropriate level of productive activity, as desired by the patient, including the educational needs of pediatric patients (patients under the age of 18 years), and make rehabilitation and vocational rehabilitation referrals as appropriate.

Subpart C Patient Care	494.90 Patient plan of care	(b) Standard: Implementation of the patient plan of care.	(1) The patient's plan of care must— (i) Be completed by the interdisciplinary team, including the patient if the patient desires; and (ii) Be signed by team members, including the patient or the patient's designee; or, if the patient chooses not to sign the plan of care, this choice must be documented on the plan of care, along with the reason the signature was not provided. (2) Implementation of the initial plan of care must begin within the latter of 30 calendar days after admission to the dialysis facility or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session. Implementation of monthly or annual updates of the plan of care must be performed within 15 days of the completion of the additional patient assessments specified in § 494.80(d). (3) If the expected outcome is not achieved, the interdisciplinary team must adjust the patient's plan of care to achieve the Specified goals. When a patient is unable to achieve the desired outcomes, the team must— (i) Adjust the plan of care to reflect the patient's current condition; (ii) Document in the record the reasons why the patient was unable to achieve the goals; and (iii) Implement plan of care changes to address the issues identified in paragraph (b)(3)(ii) of this section. (4) The dialysis facility must ensure that all dialysis patients are seen by a physician, nurse practitioner, clinical nurse specialist, or physician's assistant providing ESRD care at least monthly, as evidenced by a monthly progress note placed in the medical record, and periodically while the hemodialysis patient is receiving in-facility dialysis.
Subpart C Patient Care	494.90 Patient plan of care	(c) Standard: Transplantation referral tracking	The interdisciplinary team must— (1) Track the results of each kidney transplant center referral; (2) Monitor the status of any facility patients who are on the transplant wait list; and (3) Communicate with the transplant center regarding patient transplant status at least annually, and when there is a change in transplant candidate status.
Subpart C Patient Care	494.90 Patient plan of care	(d) Standard: Patient education and training	The patient care plan must include, as applicable, education and training for patients and family members or caregivers or both, in aspects of the dialysis experience, dialysis management, infection prevention and personal care, home dialysis and self-care, quality of life, rehabilitation, transplantation, and the benefits and risks of various vascular access types.
Subpart C— Patient Care	494.110 Condition: Quality assessment and performance improvement	(a) Standard: Program scope.	(2) The dialysis facility must measure, analyze, and track quality indicators or other aspects of performance that the facility adopts or develops that reflect processes of care and facility operations. These Performance components must influence or relate to the desired outcomes or be the outcomes themselves. The program must include, but not be limited to, the following: (viii) Patient satisfaction and grievances
Subpart C Patient Care	494.110 Quality assessment and performance improvement	(a) Standard: program scope	The dialysis facility must develop, implement, maintain, and evaluate an effective, data-driven, quality assessment and performance improvement program with participation by the professional members of the interdisciplinary team. The program must reflect the complexity of the dialysis facility's organization and services (including those services provided under arrangement), and must focus on indicators related to improved health outcomes and the prevention and reduction of medical errors. The dialysis facility must maintain and demonstrate evidence of its quality improvement and performance Improvement program for review by CMS. (1) The program must include, but not be limited to, an ongoing program that achieves measurable improvement in health outcomes and reduction of medical errors by using indicators or performance measures associated with improved health outcomes and with the identification and reduction of medical errors. (2) The dialysis facility must measure, analyze, and track quality indicators or other aspects of performance that the facility adopts or develops that reflect processes of care and facility operations. These performance components must influence or relate to the desired outcomes or be the outcomes themselves. The program must include, but not be limited to, the following: (viii) Patient satisfaction and grievances.
Subpart D Administration	494.140 Personnel qualifications		All dialysis facility staff must meet the applicable scope of practice board and licensure requirements in effect in the State in which they are employed.

2008 Dialysis Conditions for Coverage- CONDITIONS WITH PSYCHOSOCIAL RELEVANCE

Subpart D Administration	494.140 Personnel qualifications	(d) Social Worker	The facility must have a social worker ho— (1) Holds a master's degree in social work with a specialization in clinical practice from a school of social work accredited by the Council on Social Work Education; or (2) Has served at least 2 years as a social worker, 1 year of which was in a dialysis unit or transplantation program prior to September 1, 1976, and has established a consultative relationship with a social worker who qualifies under § 494.140(d)(1).
Subpart D Administration	494.140 Personnel qualifications	(e) Patient care dialysis technicians	Patient care dialysis technicians must— (3) Have completed a training program that is approved by the medical director and governing body, under the direction of a registered nurse, focused on the operation of kidney dialysis equipment and machines, providing direct patient care, and communication and interpersonal skills, including patient sensitivity training and care of difficult patients.
Subpart D Administration	494.180 Governance	(b) Standard: Adequate number of qualified and trained staff.	The governing body or designated person responsible must ensure that— (1) An adequate number of qualified personnel are present whenever patients are undergoing dialysis so that the patient/staff ratio is appropriate to the level of dialysis care given and meets the needs of patients; and the registered nurse, social worker and dietitian members of the interdisciplinary team are available to meet patient clinical needs; (4) All employees have an opportunity for continuing education and related development activities.
Subpart D Administration	494.180 Governance	(e) Standard: Internal Grievance Process	The facility's internal grievance process must be implemented so that the patient may file an oral or written grievance with the facility without reprisal or denial of services. The grievance process must include: (1) A clearly explained procedure for the submission of grievances. (2) Timeframes for reviewing the grievance. (3) A description of how the patient or the patient's designated representative will be informed of steps taken to resolve the grievance.
Subpart D Administration	494.180 Governance	(f) Standard: Involuntary discharge and transfer policies and procedures	The governing body must ensure that all staff follow the facility's patient discharge and transfer policies and procedures. The medical director ensures that no patient is discharged or transferred from the facility unless— (1) The patient or payer no longer reimburses the facility for the ordered services; (2) The facility ceases to operate; (3) The transfer is necessary for the patient's welfare because the facility can no longer meet the patient's documented medical needs; or (4) The facility has reassessed the patient and determined that the patient's behavior is disruptive and abusive to the extent that the delivery of care to the patient or the ability of the facility to operate effectively is seriously impaired, in which case the medical director ensures that the patient's interdisciplinary team— (i) Documents the reassessments, ongoing problem(s), and efforts made to resolve the problem(s), and enters this documentation into the patient's medical record; (ii) Provides the patient and the local ESRD Network with a 30-day notice of the planned discharge; (iii) Obtains a written physician's order that must be signed by both the medical director and the patient's attending physician concurring with the patient's discharge or transfer from the facility; (iv) Contacts another facility, attempts to place the patient there, and documents that effort; and (v) Notifies the State survey agency of the involuntary transfer or discharge. (5) In the case of immediate severe threats to the health and safety of others, the facility may utilize an abbreviated involuntary discharge procedure.



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