

National Kidney Foundation
CNSW
 THE COUNCIL OF NEPHROLOGY SOCIAL WORKERS



Psychosocial Aspects of the 2008 Dialysis Conditions for Coverage

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 Chairperson, CNSW
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Acknowledgements



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 - NKF: Gary Green, Maritza Owens
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 - Special thanks to: [Aaron Herold](#), Task Force Chair

CNSW would also like to especially thank member [Beth Witten](#), for her astounding work and dedication to nephrology social workers and the kidney community.


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Disclaimers

This presentation 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 for Coverage is anticipated to be a dynamic process. This presentation reflects the information available to the kidney community as of its version date.


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Disclaimers

*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.*

Webinar Objectives

- Review the psychosocial considerations of the new dialysis conditions for coverage
- “Just the facts”
 - Highlight psychosocially relevant aspects of the conditions- terrific opportunities for social workers to help facilities meet the new conditions
 - Other CNSW projects will further review implementation suggestions and provide additional tools to help social workers

Glossary

- Conditions for Coverage (CfC)
- Preamble
- Interpretive Guidelines (IG)
- Clinical Performance Measures (CPM) Project
- CNSW (Council of Nephrology Social Workers)



History

- Since 1976, same *conditions for coverage* for dialysis facilities (CMS rules and regulations that dictate the practice of dialysis)
- 1970's-1990's: Technical Updates
- 1994: Community forum meeting to begin rewrites
- 2005- Proposed updates to dialysis and transplant conditions
 - CNSW led effort = social workers responded more than any other professional

History

- 2007- CMS Community Forum about *interpretive guidelines* for the proposed conditions for coverage
- April 15, 2008 - New Conditions for Coverage published by the Department of Health and Human Services, Centers for Medicare & Medicaid Services
- To go into effect *October 14, 2008* in every U. S. (& territory) dialysis unit

What is Next?

- *Interpretive Guidelines* will come out
- New Conditions for Coverage will go into effect *October 14, 2008* in every U. S. (& territory) dialysis unit
- February 1, 2009: All units will have to *electronically submit* outcomes data to CMS
- At the same time, focus on Clinical Performance Measures (CPM's)

<http://www.cms.hhs.gov/CPMProject/>



CNSW Conditions for Coverage Education Task Force

PURPOSE

- Educate social workers about the new conditions
- Provide social workers with the tools to address the requirements of the new conditions
- To educate the broader kidney community about the CfCs as related to social work or areas of particular interest to social work

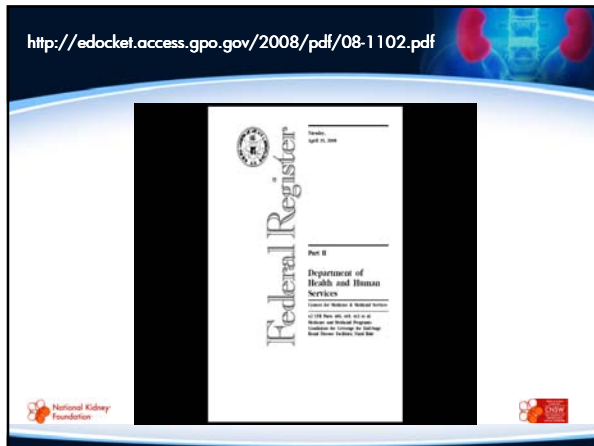
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Where do I find the new conditions?

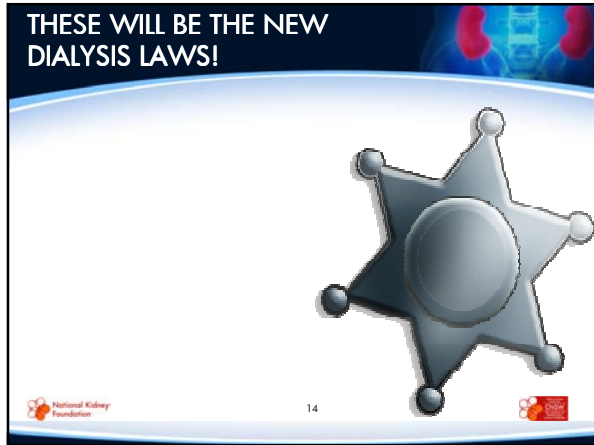
<http://edocket.access.gpo.gov/2008/pdf/08-1102.pdf>

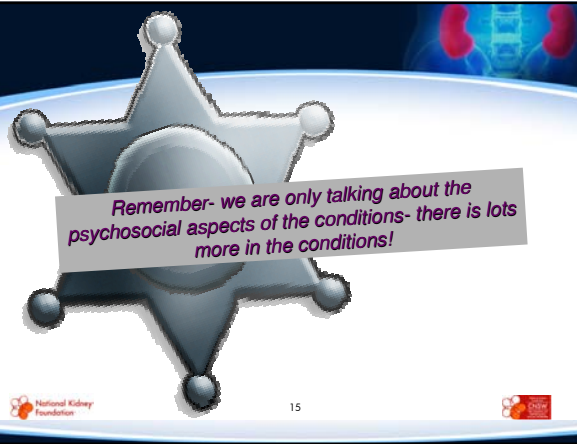
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<http://edocket.access.gpo.gov/2008/pdf/08-1102.pdf>



THESE WILL BE THE NEW
DIALYSIS LAWS!





Condition 494.60 Physical Environment

The dialysis facility must:

- (i) Maintain a **comfortable temperature** within the facility; and
- (ii) Make reasonable accommodations for the patients who are not comfortable at this temperature.
- (3) The dialysis facility must make accommodations to provide for **patient privacy** when patients are examined or treated and body exposure is required.



Condition 494.70 Patients' Rights

(a) Standard: Patients' rights. The patient has the right to:

- (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**



Condition 494.70 Patients' Rights

(a) Standard: Patients' rights. The patient has the right to:

- (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



Condition 494.70 Patients' Rights

(a) Standard: Patients' rights. The patient has the right to:

- (6) Be informed about his or her right to execute **advance directives**, and the facility's policy regarding advance directives

Condition 494.70 Patients' Rights

(a) Standard: Patients' rights. The patient has the right to:

- (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.**

Condition 494.70 Patients' Rights

(a) Standard: Patients' rights. The patient has the right to:

- (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**

Condition 494.70 Patients' Rights

- (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;
 - (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.



Condition 494.70 Patients' 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.



Condition 494.80 Patient Assessment

- 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.



Say What?!?!? The preamble tells us....

The entire interdisciplinary team is responsible for ensuring that each patient is individually assessed and his or her needs identified, as required at § 494.80. We expect all professional members of the interdisciplinary team to complete the portions of the comprehensive patient assessment that are within their respective scopes of practice. It is not necessary for each professional team member to individually complete the entire comprehensive assessment and thereby duplicate efforts. Professional interdisciplinary team members might choose to conduct one-on-one interviews with patients to complete the assessments. The team may also opt to set up team meetings, which would include the patient, in order to collect the appropriate assessment information. We expect facilities to determine the best way to manage this process, and create policies and procedures to accurately and effectively collect patient assessment information. The assessment information is used to develop the patient's treatment plan and expectations for care, and thus it is critical for the members of the interdisciplinary team to participate.

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Don't panic yet! Help is on the way, as are the interpretive guidelines

Condition 494.80 Patient Assessment

- (a) Standard: Assessment criteria. The patient's comprehensive assessment must include, but is not limited to, the following:
- (7) Evaluation of psychosocial needs by a social worker
 - (11) Evaluation of family and other support systems

Condition 494.80 Patient Assessment

(a) Standard: Assessment criteria. The patient's comprehensive assessment must include, but is not limited to, the following:

- (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



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Condition 494.80 Patient Assessment

(a) Standard: Assessment criteria. The patient's comprehensive assessment must include, but is not limited to, the following:

- (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 non-referral must be documented in the patient's medical record



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Condition 494.80 Patient Assessment

(a) Standard: Assessment criteria. The patient's comprehensive assessment must include, but is not limited to, the following:

- (12) Evaluation of current patient physical activity level
- (13) Evaluation for referral to vocational and physical rehabilitation services.



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Condition 494.80 Patient Assessment

(a) Standard: Assessment criteria. The patient's comprehensive assessment must include, but is not limited to:

- (7) Evaluation of psychosocial needs by
- (9) Evaluation of the patient's ability to meet goals, including the patient's ability to follow process; the patient's ability to understand and self-manage (e.g., medication management), and self-
- (10) Evaluation of transplantation referral, based on the patient's ability to meet the requirements of a prospective transplantation center and its referral 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.

Plus medical, nursing and dietary aspects also!

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Condition 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.

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Condition 494.80 Patient Assessment

(b) Standard: Frequency of assessment for patients admitted to the dialysis facility.

- (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.

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Condition 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.



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Condition 494.80 Patient Assessment

- ***Social workers will need to maintain ongoing communication with patients, other team members, and families to assure that they assess and address psychosocial needs that contribute to a patient's instability and that they participate with the rest of the interdisciplinary team on improving other outcomes.***



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Condition 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.



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Condition 494.90 Patient plan of care

The interdisciplinary team as defined at § 494.80 – develop and implement a written, individualized comprehensive plan of care that is necessary to address the needs identified by the comprehensive plan of care and changes in the patient's condition. The plan of care 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.

Condition 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.

Condition 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.

Kidney Disease Quality of Life (KDQOL)

gim.med.ucla.edu/kdqol

- Required by CMS in the CPMs
- Kidney Specific, Includes:
 - Mental Component Score
 - Physical Component Score
 - Burden of Disease
 - Symptoms
 - Effects on daily life



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Condition 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.



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Condition 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. (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).



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Condition 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.



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Condition 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.



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Condition 494.90 Patient plan of care

(b) Standard: Implementation of the patient plan of care.

- **“Paper compliance without substantive compliance is unproductive”**
...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.



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Condition 494.90 Patient plan of care

- (b) Standard: Implementation of the patient plan of care.
- 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).



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Condition 494.90 Patient plan of care

- (b) Standard: Implementation of the patient plan of care.
- (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.



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Condition 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.



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Condition 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.

Condition 494.110: Quality assessment and performance improvement

- Condition: Quality assessment and performance improvement. 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.

Condition 494.110: 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

Condition 494.110: Quality assessment and performance improvement

Required by CPM's:CAHPS® In-Center Hemodialysis Survey

https://www.cahps.ahrq.gov/content/cahpskit/files/509_ich_reporting_measures.htm

Any hemodialysis facility interested in using the survey should contact Charles Darby at
Charles.Darby@ahrq.hhs.gov

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Condition 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. The dialysis facility's staff (employee or contractor) must meet the personnel qualifications and demonstrated competencies necessary to serve collectively the comprehensive needs of the patients. The dialysis facility's staff must have the ability to demonstrate and sustain the skills needed to perform the specific duties of their positions.

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Condition 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. The dialysis facility's staff (employee or contractor) must meet the personnel qualifications and demonstrated competencies necessary to serve collectively the comprehensive needs of the patients. The dialysis facility's staff must have the ability to demonstrate and sustain the skills needed to perform the specific duties of their positions.

Social workers must be licensed in their states according to state social work licensure law

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Condition 494.140 Personnel qualifications

(d) Social Worker

- The facility must have a social worker who—
- (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**

Condition 494.140 Personnel qualifications

(d) Social Worker

- The facility must have a social worker who—
- (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).

Condition 494.140 Personnel qualifications

(d) Social Worker

Qualified social workers are required to have an MSW (MASTER'S IN SOCIAL WORK) unless they worked in dialysis prior to September 1, 1976 there are no exceptions!

Condition 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.



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Condition 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



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Condition 494.180 Governance

“Adequate staff” means staffing must be sufficient so that quality care is provided to dialysis patients that is consistent with the patient plan of care and professional practice standards.



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Condition 494.180 Governance

(b) Standard: Adequate number of qualified and trained staff.

- The governing body or designated person responsible must ensure that—
 - (4) All employees have an opportunity for continuing education and related development activities.

Condition 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.

Condition 494.180 Governance

(e) Standard: Involuntary discharge & transfer policies & 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;
 - (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

What's next?

- **CMS Recommends: Implementation for Facilities**
 - Read the whole document (preamble & rule)
 - Review current practice (& policies) to be sure they meet rules
 - Identify staffing, practice, equipment, & training needs
 - Develop documentation tools to match the new rules (logs, audit tools, chart forms)
- **Interpretive guidelines** still to come



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Have a question for CMS?

Submit questions pertaining to the ESRD CfCs to the CMS ESRD Final Rule Rollout mailbox at:

ESRD_Final_Rule_Rollout@cms.hhs.gov



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HELP!

- CRN, CNNT, CNSW, ANNA:
 - Comprehensive [Assessment](#) Tool Example
- Medical Education Institute: Life Options Project to help you with [KDGOL](#)
 - Coming soon!
 - www.lifeoptions.org
- Kidney End of Life Coalition: [Advance Directives](#) Information
 - www.kidneyeol.org



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HELP!

- More information about the Clinical Performance Measure (CPM) Project:
 - www.cms.hhs.gov/CPMProject
- More information on [home dialysis](#) options
 - www.homedialysis.org
- Medical Education Institute: Life Options materials to help you with [rehabilitation](#)
 - www.lifeoptions.org



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HELP!

- More information about work & rehabilitation:
<http://www.kidney.org/patients/pfc/control.cfm>

Taking Control: Money Matters For People With Chronic Kidney Disease

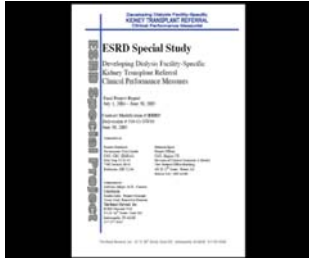


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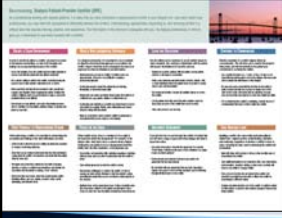
HELP!

- More information about transplant referrals
<http://www.therenalnetwork.org/qi/resources/TransTEPfinalpt805.pdf>



HELP!

- Help with decreasing involuntary discharges:
- Decreasing Dialysis Patient-Provider Conflict (DPC) Program: Understanding and Managing the Challenging Patient
- Ask your ESRD Network for more materials!
<http://www.esrdnetworks.org/dpc.htm>



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HELP!

- CNSW projects:
 - Searchable CNSW listserv archives now available!
 - More webinars
 - Tools for social workers and CNSW chapters
 - Currently working on: Sample Care Plan Ideas
 - Special issue of JNSW= compilation of tools to help with the new conditions for coverage




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Where do I find these documents?


<http://www.kidney.org/professionals/webinar.cfm>





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CNSW Research Grants



- New Conditions are a great opportunity for social workers to show their administrators that what they're doing works, and helps the unit meet the new, more stringent requirements of the CFCs.
- Number of projects that meet the needs of the entire unit that could be spearheaded by a social worker
- Apply for funding for your research project- individual or chapter research
- Contact Jeff Harder for assistance:
- jharder@u.washington.edu

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**CNSW National Membership –
how to best stay informed about the new conditions**

Ask your employer if they will fund part or all of the membership fee!

How do you join?
Go to www.kidney.org
or
Call (800) 622-9010

<http://www.kidney.org/professionals/pdf/cnswform.pdf>



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Thank You!

- This presentation and webinar will be available after this webinar on the CNSW web page

<http://www.kidney.org/professionals/webinar.cfm>
