The Journal of Nephrology Social Work

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THE JOURNAL OF NEPHROLOGY SOCIAL WORK

The Council of Nephrology Social Workers (CNSW) of the National Kidney Foundation (NKF) is a professional membership organization of nearly 1000 social workers dedicated to improving the quality of psychosocial services delivered to ESRD patients, as well as supporting the profession of nephrology social work.

The Council of Nephrology Social Workers of the National Kidney Foundation

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The Journal of Nephrology Social Work is always interested in attracting CNSW members who will serve as Editorial Board members to help with the planning, solicitation, and review of articles for publication.

If you are interested in becoming a member of the Editorial Board, please contact Norma Knowles, MSW, LCSW, Dialysis Clinic Inc., 3300 Lamone Industrial Boulevard, Columbia, MO 65201-8246. E-mail: **Norma.Knowles@dciinc.org** OR Joseph Merighi, Boston University School of Social Work, 264 Bay State Road, Boston, MA 02215. E-mail: **merighi@bu.edu**

CALL FOR MANUSCRIPTS

The Editorial Board of *The Journal of Nephrology Social Work* encourages the submission of original manuscripts. The journal contains articles addressing contemporary issues/topics relevant to nephrology social work. Authors may wish to address any of the following topics, which are listed as guidelines:

- Social Work Outcomes
- Kidney Transplant
- Pediatric Issues
- End-of-Life Concerns
- Sleep Disorders
- Sexual Functioning
- Aging and Gerontological Issues
- Disaster Preparedness
- Comorbid Illnesses
- Home Dialysis Modalities
- Professional Roles
- Rehabilitation
- HIV/AIDS
- Quality of Life
- Ethics

Please e-mail manuscript to: **merighi@bu.edu** Alternatively, you may mail a hard copy to:
Joseph Merighi, Boston University School of Social Work, 264 Bay State Road, Boston, MA 02215.

INSTRUCTIONS FOR AUTHORS

The Journal of Nephrology Social Work (JNSW) is the official publication of the Council of Nephrology Social Workers of the National Kidney Foundation, Inc. Its purpose is to stimulate interest and research in psychosocial issues pertaining to kidney and urologic diseases, hypertension, and transplantation, as well as to publish information concerning renal social work practices and policies. The goal of *JNSW* is to publish original communications and research that maintain high standards for the profession and that contribute significantly to the overall advancement of the field.

The *JNSW* is a peer-reviewed publication. Manuscripts are accepted for review with the understanding that the material has not been previously published, except in abstract form, and is not concurrently under review for publication elsewhere. Authors submitting a manuscript do so with the understanding that, if it is accepted for publication, the copyright for the article, including the right to reproduce the article in all forms and media, shall be assigned exclusively to the National Kidney Foundation. The publisher will not refuse any reasonable request by the author for permission to reproduce any of his or her contributions to the *Journal*.

Exclusive Publication: Articles are accepted for publication on the condition that they are contributed solely to *The Journal of Nephrology Social Work*. Authors should secure all necessary clearances and approvals prior to submission. All manuscripts are peer-reviewed by two reviewers. Receipt of manuscripts will be acknowledged within two weeks, and every effort will be made to advise contributors of the status of their submissions within six to eight weeks.

A submitted manuscript should be accompanied by a letter that contains the following language and is signed by each author: "In compliance with Copyright Revision Act of 1976, effective January 1, 1978, the undersigned author(s) transfers all copyright ownership of the manuscript entitled ______ to *The Journal of Nephrology Social Work* **in the event this material is published."**

To qualify as an original manuscript, the article or a version of the article must not have been published elsewhere. Author(s) must inform the editor if the manuscript is being reviewed for publication by any other journals. Once accepted for publication by the editor, the author(s) cannot make revisions on the manuscript.

TYPES OF ARTICLES BEING SOUGHT

Research and Review. The *JNSW* welcomes reports of original research on any topic related to renal social work. The editors will also consider articles that document the development of new concepts or that review and update topics in the social sciences that are relevant to professionals working in the field of renal social work.

Reports and Commentary. The *JNSW* welcomes articles that describe innovative and evaluated renal social work education programs, that report on viewpoints pertaining to current issues and controversies in the field, or that provide historical perspectives on renal social work.

Reviews. Review articles—in traditional or meta-analysis style—are usually invited contributions, however, letters of interest are welcome.

Original Research. Full manuscript format should include: introduction, methods, results, and discussion of original research. Length usually should not exceed 15 double-spaced pages, including references.

Clinical/Research Briefs. Abbreviated manuscript format presents clinical practice experience, preliminary research findings (basic or clinical), or professional observations in a shortened report form. Length usually should not exceed six double-spaced pages.

Practical Aspects Section. Contributions to this section are detailed protocols, forms, or other such materials that are successfully utilized for delivery of outcomes-based clinical social work services.

Case Studies. These detailed scenarios should illustrate a patient care situation that benefited from clinical social work intervention. Typically, they should consist of a brief clinical and psychosocial history, and a detailed intervention plan with discussion of recommendations focused toward practical application.

Letters to the Editor. Letters should be restricted to scientific commentary about materials published in the *JNSW* or to topics of general interest to professionals working in the field of renal social work.

MANUSCRIPT SUBMISSION

Manuscript Format

Manuscripts should be formatted according to the rules laid out by the *Publication Manual of the American Psychological Association, Fifth Edition*. What follows is a brief synopsis of the broader style points used by the APA.

Paper and Type. Hard copy manuscripts should be submitted on standard-sized (8 1/2” x 11”), white paper. Both hard copy and electronic versions should conform to the following guidelines: Text should be double-spaced, set in 12-point type (preferably Times New Roman) and have 1-inch margins along all sides of every page. Starting with the title page, pages should be numbered in the upper, right-hand corner and should have a running head in the upper left-hand corner. The running head should be a shortened version of the manuscript's title and should be set in all uppercase letters. The first line of every paragraph in the manuscript should be indented, as should the first line of every footnote.

Order of the Manuscript Sections

- Title page
- Abstract
- Text
- References
- Appendixes
- Author note
- Footnotes
- Tables
- Figure captions
- Figures

Title Page. The manuscript's title page should contain the title of the manuscript and the name, degree, and current affiliation of each author. Authors are generally listed in order of their contribution to the manuscript (consult the *Publication Manual of the American Psychological Association, Fifth Edition,* the APA style guide, for exceptions). The title page should also contain the complete address of the institution at which the work was conducted and the contact information for the primary author. A running head (a shortened version of the manuscript's title) should be set in the upper left-hand corner of the page, in all uppercase letters. Page numbering should begin in the upper right-hand corner of this page. With the exception of the page numbers and running heads, all text on the title page should be centered.

Abstract. The manuscript's abstract should be set on its own page, with the word “Abstract” centered at the top of the page. The abstract itself should be a single paragraph with no indentation and should not exceed

120 words. All numbers—except for those that begin a sentence—should be typed as numerals. Running heads and page numbers should continue from the title page.

Text. The text (or body) of the manuscript should begin on a new page, after the abstract. The title of the manuscript should be set at the top of the first page, centered and double-spaced. Running heads and page numbers should continue from the abstract.

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Appendixes. Each appendix should begin on a new page and should be double-spaced. Running heads and page numbers should be continued from the text of the manuscript. The word "Appendix" and the identifying letter (A, B, C, etc.) should be centered at the top of the first page of each new appendix. Running heads and page numbers should continue from the references.

Author Note. If there is an author note, it should begin on a new page with the words "Author Note" centered at the top of the page. Each paragraph should be indented. Running heads and page numbers should continue from the last appendix. Consult the APA style guide for further details on the structure of an author note.

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Tables. All tables should be double-spaced and each should begin on a separate page. Tables are numbered sequentially according to the order in which they are first mentioned in the manuscript (*Table 1, Table 2,* etc.) and are given an appropriate title that is centered at the top of the page. Table Notes should be a single, double-spaced paragraph, set after the last line of data. The first line should be flush and begin with the word *Note*.

Table footnotes should be set in lowercase, superscript letters, immediately to the right of the pertinent data. The footnotes themselves should appear below the table, after the Table Notes (if any). Table footnotes should begin anew with each new table. If a table has been previously published, the author is required to submit a copy of a **letter of permission** from the copyright holder, and must acknowledge the source of the table in the manuscript's reference section. Running heads and page numbers should continue from the footnotes.

Figures. Figures are also numbered consecutively, according to the order in which they appear in the manuscript. The convention *Figure 1, Figure 2, Figure 3*, etc. should be followed. In cases where the orientation of the figure is not obvious, the word TOP should be placed on the page, well outside the image area, to indicate how the figure should be set. If any figure has been previously published, the author is required to submit a copy of a **letter of permission** from the copyright holder, and must acknowledge the source of the figure in the manuscript's reference section. Running heads and page numbers should continue from the tables.

Figure Captions. Each figure in the manuscript must have a caption, formatted as follows:

Figure 1. Exemplary formatting for all figure captions.

All figure captions should be listed on a separate page, according to the order in which they appear in the manuscript. Multi-line captions should be double-spaced.

Reference Examples

Journal Article, Two Authors

Wassner, S. J., & Holliday, M. A. (1989). Protein metabolism in chronic renal failure. *Seminar in Nephrology, 9*, 19–23.

Journal Article, Three to Six Authors

Gartner, J., Larson, D. B., & Allen, G. D. (1991). Religious commitment and mental health: A review of the empirical literature. *Journal of Psychology and Theology, 19*, 6–25.

Journal Article, More Than Six Authors

Larson, D. B., Sherrill, K. A., Lyons, J. S., Craigie, F. C., Thielman, S. B., Greenwold, M. A., et al. (1992). Associations between dimensions of religious commitment and mental health reported in the *American Journal of Psychiatry and Archives of General Psychiatry*: 1978–1989. *American Journal of Psychiatry, 149,* 557–559.

Journal Article in Press

Odaka, M. (in press). Mortality in chronic dialysis patients in Japan. *American Journal of Kidney Diseases.*

Complete Book, Edited

Levine, D. Z. (Ed.). (1983). *Care of the renal patient.* Philadelphia: Saunders.

Chapter of an Edited Book

Nixon, H. H. (1966). Intestinal obstruction in the newborn. In C. Rob & R. Smith (Eds.), *Clinical surgery* (pp. 168–172). London: Butterworth.

Article from a Journal Supplement

Paganini, E. P., Latham, D., & Abdulhadi, M. (1989). Practical considerations of recombinant human erythropoietin therapy. *American Journal of Kidney Diseases, 14*(Suppl. 1), 19–25.

Abstract

Bello, V. A. O., & Gitelman, H. J. (1990). High fluoride exposure in hemodialysis patients [Abstract]. *American Journal of Kidney Diseases, 15,* 320.

Editorial

Piantadosi, S. (1990). Hazards of small clinical trials [Editorial]. *Journal of Clinical Oncology, 8*, 1–3.

REVIEW PROCESS

Manuscripts submitted to *The Journal of Nephrology Social Work* are peer-reviewed, with the byline removed, by at least two professionals in the field of renal social work. The length of the review process will vary somewhat depending on the length of the manuscript, but generally takes two to three months. *The Journal of Nephrology Social Work* reserves the right to edit all manuscripts for clarity or length. Minor changes in style and clarity are made at the discretion of the reviewers and editorial staff. Substantial changes will only be made with the primary author's approval, prior to typesetting.

AFTER ACCEPTANCE

If a manuscript is accepted for publication, the author will be required to send the following to the editorial office:

- An electronic copy of the final version of the manuscript. All components of the manuscript must appear within a single word processing file, in the order listed previously. Any features that track or highlight edits should be turned off. Do not use automatic numbering functions, as these features will be lost during the file conversion process. Formatting such as Greek characters, italics, bold face, superscript and subscript, may be used, however the use of such elements must conform to the rules set forth in the APA style guide and should be applied consistently throughout the manuscript.
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- We would prefer a printed copy of the final version of the manuscript to be sent to verify contents.
- A copyright form signed by at least one of the authors.

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ERRATA

In **"End-of-Life Care Discussions: A Survey of Dialysis Patients and Professionals" (Spring 2008, vol. 28, p. 52)**, the following text should replace the last sentence of the introduction: "Twenty and one-half percent of people receiving dialysis treatment, or 69,990 dialysis patients, died in 2005, compared to 21% in 2004 (U.S. Renal Data System, 2006, 2007)."

In **"Rates and Correlates of Therapy Non-Adherence in Adult Hemodialysis Patients" (Spring 2008, vol. 28, p. 11)**, Julie Brown, MSW, LCSW (listed below in bold), was omitted from the list of authors in the original printing of this article. The following is the corrected authorship list.

Cynthia L. Russell, RN, PhD, Associate Professor, Sinclair School of Nursing, University of Missouri, Columbia, MO; Robert Whitlock, MSSW, MHA, LCSW, Director, Missouri Kidney Program, University of Missouri School of Medicine, Columbia, MO; Norma Knowles, MSW, LCSW, Clinical Nephrology Social Worker, Dialysis Clinics Inc., Columbia, MO; Leanne Peace, MSW, LCSW, Dialysis and Transplant Social Worker, University of Missouri Health Care, Columbia, MO; Barb Tanner, RN, BSN, Research Nurse, Sinclair School of Nursing, University of Missouri, Columbia, MO; ***Julie Brown, MSW, LCSW, Missouri Kidney Program Center for Renal Education, St. Louis, MO****; Barry A. Hong, PhD, FAACP, Professor of Psychiatry, Washington University School of Medicine, Saint Louis, MO*

A MESSAGE FROM THE GUEST EDITOR FOR THIS ISSUE

As the national chair of the Council of Nephrology Social Workers (CNSW) and guest editor of this special issue of *The Journal of Nephrology Social Work (JNSW)*, I am pleased to present "Psychosocial Aspects of the 2008 End-Stage Renal Disease Conditions for Coverage." CNSW is very excited about the new Conditions for Coverage (CfC) put into effect in every dialysis unit in the United States and its territories on October 14, 2008. We believe that they give social workers tremendous opportunities for intervention to help facilities meet these mandated conditions. CNSW created many programs and resources to help social workers and the kidney community understand and implement these new conditions, and we thank our CfCs task force for their hard work under the tireless leadership of Aaron Herold. This special *JNSW* issue was created as a permanent resource for nephrology social workers about the regulations put in place in dialysis units for many years to come and is a key component of the tools and resources that were created by CNSW and this task force. We look forward to helping you in the years to come as we all adapt to these new CfCs and are very excited about all the ways in which social workers can help their teams implement them. We hope that you find the material presented herein a valuable addition to your knowledge base, and that the information will enhance your practice and patient outcomes.

Teri Browne

Teri Browne, MSW, LSW
Assistant Professor, University of South Carolina College of Social Work, Columbia, SC

DISCLAIMER

This journal 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 for Coverage (CfCs). The implementation and interpretation of the new CfCs is anticipated to be a dynamic process. This journal reflects the information available to the kidney community as of its version date. 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 facility management before implementing any of the information provided herein.**

ACKNOWLEDGEMENTS

CNSW would like to acknowledge the following individuals for their outstanding assistance in educating social workers about the new CfCs and providing them with the tools to address the requirements of the new conditions:

- National Kidney Foundation: Gary Green, Maritza Owens
- Centers for Medicare and Medicaid Services: Judith Kari, Glenda Payne
- CNSW Conditions for Coverage Education Task Force members: Teri Browne, Deborah Collinsworth, Sandie Dean, Duane Dunn, Phyllis Ermann, Wendy Funk Schrag, Lisa Hall, Jeff Harder, Tom Lepetich, Chris Simon
- Special thanks to our Task Force Chair, Aaron Herold

Psychosocial Aspects of the 2008 End-Stage Renal Disease Conditions for Coverage

Teri Browne, MSW, LSW, University of South Carolina College of Social Work, Columbia, SC;
Chairperson, Council of Nephrology Social Workers

On October 14, 2008, practices and policies in every dialysis unit in the United States and its territories will be significantly changed with the implementation of the 2008 Conditions for Coverage (CfCs) for End-Stage Renal Disease Facilities (Office of the Federal Register, 2008). These CfCs mark the first wholesale change in the regulations for dialysis units in more than 30 years, and the Council of Nephrology Social Workers (CNSW) is making every effort to provide its members with the tools and resources they need to adapt to and adopt these new CfCs. This special issue of The Journal of Nephrology Social Work *is intended to provide members with an introduction to the sections of the CfCs that are relevant to social workers and an overview of the CfCs and relevant resources created by the CNSW.*

BACKGROUND

The Council of Nephrology Social Workers (CNSW) is encouraged that the Centers for Medicare and Medicaid Services (CMS) recognized how important psychosocial functioning is for patients with end-stage renal disease (ESRD) in the 2008 Conditions for Coverage (CfCs) for ESRD Facilities (Office of the Federal Register, 2008). A large body of literature suggests that there are many psychosocial barriers to optimal outcomes in those with ESRD, including the following challenges (see Browne, 2006, for a full literature review):

- Adjustment to and coping with the illness and treatment regime
- Depression and anxiety
- Medical complications and problems
- Issues related to pain, palliative care and end-of-life care
- Familial, social, vocational role adjustment
- Concrete needs: financial loss, insurance problems and prescription coverage
- Diminished quality of life
- Body image issues
- Sexual and reproductive functioning
- Sleeping problems
- Comorbid illnesses
- Numerous losses, such as financial security, health, libido, strength, independence, mobility, schedule flexibility, appetite and freedom with diet and fluid.

These psychosocial concerns may decrease quality of life, increase malnutrition and significantly negatively impact outcomes, such as hospitalizations, mortality and morbidity (Auslander et al., 2001; Burrows-Hudson, 1995; Hedayati et al., 2004; Kimmel et al., 1998, 2000; Koo et al., 2003; Paniagua et al., 2005). Families and social support network members of those with ESRD also have problems adjusting to the chronic disease and its concurrent psychosocial stressors (White & Greyner, 1999).

Significant psychosocial problems faced by those with ESRD and their loved ones require intervention from qualified social workers who have a master's degree in social work (MSW). An MSW has been mandated in every dialysis unit in the United States and its territories since the first CfCs were published, with limited exceptions for those who had been working in renal settings as social workers for at least a year prior to publication date (Office of the Federal Register, 1976). Since 1976, MSWs have provided interventions to those with ESRD and their family members who have decreased depression (Beder, 1999; Cabness, 2005) and improved attendance at dialysis sessions (Medical Education Institute, 2004). MSWs help reduce interdialytic weight gains (Auslander & Buchs, 2002; Johnstone & Halshaw, 2003; Root, 2005) and improve quality of life (Chang et al., 2004; Frank et al., 2003; Johnstone, 2003). Social workers can also help improve medication management and lower blood pressure (Beder et al., 2003). More than 75% of nephrology social workers mediate conflicts in dialysis units (Merighi & Ehlebracht, 2004). MSWs can also increase establishment of advance directives (Yusack, 1999). The 2008 CfCs provide social workers with a plethora of opportunities to provide clinical social work interventions to improve outcomes for patients and their families.

HISTORY

Nephrology social workers were instrumental in lobbying for the inclusion of an MSW in every dialysis and transplant facility in the 1976 CfCs. In 2005, when the notice of proposed rulemaking (proposed CfCs) was published in the *Federal Register*, the CNSW launched a long-planned effort to educate its members about the proposed CfCs, provided members with the organization's evidence-based response and encouraged members to write in support of sections they liked and to offer suggestions to modify sections where improvement was needed. Social workers were the professionals who responded most frequently to the call for comments about the proposed CfCs.

In 2007, key social workers attended an invitation-only community forum organized by CMS to provide feedback to draft interpretive guidelines for the proposed CfCs. The interpretive guidelines document explains the regulation to surveyors who must monitor facility policies, procedures and practices to ensure patient health and safety.

Throughout 2007 and 2008, a special CNSW task force created tools and resources for CNSW members that relate to the new CfCs. This included working on a multidisciplinary task force with the Council of Renal Nutrition, Council of Nephrology Nurses and Technicians and the American Nephrology Nurses Association to create a sample interdisciplinary comprehensive assessment tool for the community review to help facility interdisciplinary teams comply with the condition of patient assessment. Other CNSW activities included hosting a webinar viewed by more than 600 social workers and others about the new CfCs, distributing social work educational tools, such as the resources in this special issue, and creating a new Web page devoted to the new CfCs. Along the way, much discussion about the release and implementation of the CfCs occurred on the CNSW listserv, which can now be reviewed by members at the CNSW listserv archive Web page at **http://listserv.kidney.org/scripts/wa.exe?LOGON**

On October 14, 2008, the new CfCs will go into effect in every dialysis unit in the United States and its territories, forming the basis for all subsequent Medicare surveys. You can look forward to the CNSW continuing to produce information and resources for members about the CfCs and the interpretive guidelines in the future.

THIS ISSUE

This issue of *The Journal of Nephrology Social Work* includes a fact sheet to help social workers comply with the condition of patient plan of care for quality-of-life (QOL). Included is a sample assessment tool with recommended psychosocial components for an interdisciplinary patient assessment and a summary compilation of the psychosocial aspects of the CfCs. This issue concludes with an insightful article by Wendy Funk Schrag that explores ethics and the new CfCs.

The "Quality of Life Assessment Tools" fact sheet includes information from the condition of plan of care at §494.90(a)(6), which mandates social services include assessment of mental and physical functioning using a standardized tool. This fact sheet also provides information from the preamble, or introductory language of the CfCs, in addition to information about CMS' ESRD clinical performance measures (CPMs), including the CPM regarding QOL. This new CPM requires all dialysis facilities in the United States and its territories to report when asked how many eligible patients completed the KDQOL-36, a standardized tool that measures physical and mental functioning.

The "Comprehensive Multidisciplinary Patient Assessment (CMPA) Example Questions: Social Work-Focused Criteria" document is intended to be a sample for the community that can be used to satisfy the psychosocial components of the condition of patient assessment at §494.80, which mandates an interdisciplinary assessment of every dialysis patient. These assessment criteria are intended to be used in conjunction with nursing and dietary assessment components, and also identify potential areas for interdisciplinary care planning intervention.

The "Psychosocial Aspects of the 2008 Dialysis Conditions for Coverage" is a helpful resource to guide social workers, patients and professionals through the new CfCs, highlighting all aspects of these CfCs that have relevance to social workers. This table includes the following:

- Location: where the condition can be found in the regulations
- Condition: the number and name of the condition
- Standard: the letter and name of the related standard
- Key points, background and more information from the preamble, a lengthy introduction prior to the regulation that begins on page 20,475 of the *Federal Register*. The preamble contains background for the regulations, including public comments and CMS responses related to every section of the CfCs and, in some cases, implementation suggestions. The CNSW recommends that its members become familiar with the regulation as well as the preamble.

IMPLEMENTATION OF THE NEW CFCS

Social workers need to be educated about the new CfCs and how they affect their day-to-day practice. It is important to keep in mind that the CfCs clearly state that it is the responsibility of the governing body of each dialysis facility to ensure there are an adequate number of qualified social workers present so 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." Dialysis units need to ensure that there is a sufficient level of social work staffing to allow social workers to help with or take responsibility for the following *mandated* tasks in every dialysis unit:

- Honoring patients' rights to respect, dignity, recognition of individuality and personal needs and sensitivity to psychological needs and ability to cope with ESRD
- Informing all patients of their right to execute advance directives and the facility's policy regarding advance directives
- Working with the interdisciplinary team to honor patients' rights to receive resource information for dialysis modalities not offered by the facility, including information about alternative scheduling options for working patients
- Assessing patients' psychosocial needs; family and other support systems; patients' abilities, interests, preferences and goals, including the desired level of participation in the dialysis care process; preferred modality (hemodialysis or peritoneal dialysis) and setting (e.g., home dialysis); and patients' expectations for care outcomes.
- Developing plans of care with the interdisciplinary team and patient or representative within 30 days of admission, at 90 days and annually for stable patients or every month for patients who have significant changes in psychosocial needs or are otherwise unstable
- Providing necessary monitoring and social work interventions, including counseling services and referrals for other social services, and assisting patients in achieving and sustaining appropriate psychosocial status as measured by a standardized mental and physical assessment tools chosen by the social worker, at regular intervals or more frequently on an as-needed basis
- Assisting patients, along with the interdisciplinary team, in achieving and sustaining desired, appropriate levels of productive activity, including the educational needs of patients under age 18, and making rehabilitation and vocational rehabilitation referrals as appropriate
- Providing education and training, along with the interdisciplinary team, for patients and family members or caregivers or both, in aspects of the dialysis experience, dialysis management, home dialysis and self-care, quality of life, rehabilitation and transplantation
- Participating in the training program for patient care dialysis technicians on communication and interpersonal skills, including patient sensitivity training and care of difficult patients
- Helping to resolve conflicts before they escalate into grievances
- Helping to implement the new involuntary discharge and transfer policies and procedures.

It is clear that with the new CfCs, social workers need to maintain ongoing communication with patients, other team members and families to ensure that psychosocial needs that contribute to patient instability are assessed in a timely fashion and continue to work with the rest of the interdisciplinary team to improve other outcomes. It is also clear that social workers are unable to do these mandated responsibilities if they are overwhelmed by clerical or other inappropriate tasks or have caseloads that are too large for patient acuity. Large nephrology social work caseloads have been linked to decreased patient satisfaction and poorer rehabilitation outcomes (Callahan et al., 1998), and an inability for social workers to provide clinical interventions to patients and their families (Bogatz et al., 2005; Merighi & Ehlebracht, 2002, 2005). The CNSW recommends an acuity-based social worker-to-patient ratio that takes into consideration the psychosocial risks of patients and recommends a maximum of 75 patients per full-time dialysis social worker (CNSW, 2002).

Social workers may need to self-advocate by reminding their employers about the condition of governance at §494.180, which clearly states that every dialysis unit's "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." The new CfCs are clear that patients' clinical needs are primary, and the preamble states explicitly that facilities may use ancillary staff to help with clerical tasks, such as arranging transportation and transient treatments, getting insurance referrals, applying for financial assistance as well as tasks to benefit the facility such as copying insurance cards or resolving insurance questions and denials of payment. The preamble encourages MSWs to focus on clinical interventions.

With this new paradigm in the dialysis community, social workers will likely find themselves needing to remind employers that clerical tasks and large caseloads prevent them from complying with the new CfCs, which could lead to a condition or standard level citation and a requirement from the state survey agency to develop a plan of correction and additional monitoring. Social workers need to become comfortable telling their employer "I am sorry, but that clerical task (or this excessive patient caseload) will prevent me from fulfilling all of the mandated tasks of a qualified social worker in the new CfCs that govern this dialysis unit, placing this dialysis unit at risk of being cited by the state surveyor, which could bring negative attention to our dialysis unit. Let's talk about exploring ways that non-MSWs can help with these clerical tasks (or let's talk about hiring another social worker), so I can be sure that all of the psychosocial aspects of the new CfCs are met." The CNSW's book, *Professional Advocacy for the Nephrology Social Worker* (available from the National Kidney Foundation) is an excellent resource to help social workers advocate for themselves to ultimately improve patient outcomes.

Social workers may also find themselves overwhelmed by the prospect of performing clinical social work interventions in dialysis units after many years of focusing on non-clinical tasks. The CNSW has many tools to assist social workers in honing their clinical skills, as well as many projects that social workers can do to document their value. The CNSW also has tools and information about the recently published transplant Conditions of Participation. The CNSW was actively involved in commenting on the new transplant conditions and providing information to transplant social workers. The very active CNSW e-mail listserv and its archive are terrific tools for finding professional support and suggestions to help in implementing these new conditions.

The CNSW looks forward to helping social workers in the years to come as we adapt to these new CfCs and is excited about all the ways in which social workers can help their interdisciplinary teams assess, plan and monitor interventions to improve outcomes. Our patients deserve all that we have to offer.

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Psychosocial Aspects of the 2008 Dialysis Conditions for Coverage

Council of Nephrology Social Workers

This table was created by the Council of Nephrology Social Workers (CNSW) to help inform and educate the kidney community about the psychosocial aspects of the new Conditions for Coverage (CfCs) for End-Stage Renal Disease Facilities. The implementation and interpretation of the new CfCs 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 of the information provided herein. The CfCs were published April 15, 2008, by the Department of Health and Human Services, Centers for Medicare and Medicaid Services, to be in effect October 14, 2008, in every U.S. dialysis unit. You can find the entire CfCs at **http://edocket.access.gpo.gov/2008/pdf/08-1102.pdf**

Location	Condition	Standard	Language	Key Points, Background and More Information From Preamble
Subpart B Patient safety	494.60 Physical environment	(c) Patient care 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.	• Room temperature is a source of frequent tension in a hemodialysis facility. Generally, the sedentary patients undergoing treatment prefer a warmer room temperature, whereas staff members, who are engaged in activity and wearing protective coverings, prefer a cooler room temperature. • The intent of the new requirement is to have facilities arrive at a middle ground so that the room temperature is at least marginally acceptable to both patients and staff. Patients who continue to feel cold could use coverings or blankets. Regardless of the room temperature, patients should not be deprived of the ability to use covers or blankets. The dialysis facility may allow patients to bring their own blanket or opt to provide a cover. In either case, adequate infection control precautions must be taken considering the risk of blood spatter. Additionally, the access sites and line connections should remain uncovered to allow staff to visually monitor these areas to ensure patient safety. • We also pointed out that in situations in which there is patient body exposure, the staff should be instructed to provide temporary screens, curtains or blankets to protect patient privacy. To respond to these comments and to further strengthen the patient's right to physical privacy, we have added new provisions at § 494.60(c)(d).
Subpart C Patient care	494.70 Patients' rights	(a) Patients' rights	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. (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; (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	• Patients are entitled to be informed of their rights at the start of care, meaning within the first three treatments in the facility, which, we believe, allow patients to exercise their rights and make choices regarding their care immediately. We are not prescribing the level of detail for a patient's rights review, nor which facility staff members must perform the review. The facility has flexibility in meeting the intent of this provision, so long as the facility sufficiently informs the patient so that he or she may exercise his or her rights early in dialysis care. The professionals at the dialysis facility should determine the most appropriate time for a more detailed review of patient's rights (including discharge policy information) according to individual patient's needs. • Patients must also be informed of dialysis facility discharge policies as required at § 494.70(b)(1), and we expect all information would be provided at one time. We believe requiring a facility to provide patients' rights information within three treatments is reasonable, given that dialysis is normally performed three times per week for approximately 3 to 4 hours per session. • **Comment:** We received several comments regarding possible misinterpretations by state surveyors as to what is meant by patients being "informed" of facility policies. Response: The word "inform" simply means to communicate knowledge. We have not dictated the mode of communication. Patients' rights information may be presented to patients in writing, orally, audiovisually, etc. Because the means by which information is communicated

Location	Condition	Standard	Language	Key Points, Background and More Information From Preamble
Subpart C Patient care (con't)	494.70 Patients' rights (con't)	(a) Patients' rights (con't)	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	to the patient is not specified, facilities and their staff have the necessary flexibility to comply within the intent of the condition. **Response:** At § 494.70(a)(1), patients have the right to receive respect for their personal needs. The intent of this standard is that all facilities must respect patients and their individual characteristics or unique needs. For instance, facilities may want to develop policies for a variety of situations, such as patient restroom use during a dialysis session, to ensure that their patients' rights are protected. We do not expect that patient signatures on liability waivers are necessary or appropriate in most cases. • When a patient needs to use the restroom, that time should not be deducted from the dialysis treatment session. Facilities should schedule patients in such a way so that patients are not forced to give up prescribed services for which Medicare provides payment. In addition, CMS considers situations in which facilities fail to schedule patients appropriately and thus force patients to give up prescribed services to be a serious matter of program integrity. • The intent of the proposed rule language is to provide the facility with flexibility in meeting the requirement that it provide information in a way the patient understands. If a facility needs to obtain the use of a translator service to provide information to a patient and respond to questions, then we expect the facility to obtain that service … The information required to be provided under § 494.70 would include all the information patients need to understand their rights and participate in their care if they choose (see § 494.70(a)(5)). • **Comment:** One commenter suggested that specific language be added to state that a social worker should have the ability to assess a patient's psychological needs in a private environment. **Response:** The intention of § 494.70(a)(3) and § 494.70(a)(4) is that all facilities must respect privacy and confidentiality for all patients; therefore social worker–patient interactions that require privacy should be conducted in private. • It may be desirable that patients participate fully in their care; however, neither CMS nor a facility can demand full patient participation. Additionally, we cannot mandate the involvement of patient representatives in the care of patients. We do require that patients have the opportunity to participate in their care. Patients have the right to accept or decline to participate. Patients have the right to be involved in their care planning as part of the interdisciplinary team, which is defined at § 494.80 and § 494.90. Because patients have the right to be part of the interdisciplinary team, they have the opportunity to participate in all aspects of care, which includes, but is not limited to, care planning. The language in the final rule allows for flexibility in the way a facility demonstrates that a patient has had sufficient opportunity to participate as part of the team. Care plan meetings or conference calls that allow the patient to call in from home would allow the patient to participate. The dialysis facility must encourage patient participation in care planning. • The large number of supportive comments regarding advance directives is

Location	Condition	Standard	Language	Key Points, Background and More Information From Preamble
Subpart C Patient care (con't)	494.70 Patients' rights (con't)	(a) Patients' rights (con't)	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 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.	appreciated. We believe that it is important to include this language in the final regulation for several reasons, not the least of which is that while ESRD treatment has prolonged life, the typical patient receiving dialysis treatment is often afflicted with multiple comorbidities. We are not mandating that facilities discuss "end-of-life" options or provide advance directives planning assistance or requiring patients to complete advance directive documents. We are requiring in the final rule at § 494.70(a)(6) that facilities inform patients of their right to have advance directives and the facility's policies regarding advance directives. Patients requiring assistance in advance directive preparation should look to the facility's social workers for guidance, as social work professionals are trained to use their clinical judgment to evaluate, provide information and make referrals when necessary. The facility should address advance directives in their policies and procedures, which must be available to patients as required in the "Patients' rights" condition. We expect facilities to make patients aware of their policies about honoring properly executed advance directives. If a facility does not honor advance directives, we expect it to make the patient aware of that policy. In addition, we believe that the facility should develop a protocol for patient transfer if a facility does not intend to honor advance directives. • Individual patients always have the choice to not seek treatment. As indicated at proposed § 494.70(a)(5), patients have the right to refuse treatment. If an individual is a patient of an ESRD facility, then he or she has likely made the decision to treat his or her illness. However, the patient's medical condition may change in later months or years and there could be a time when the patient decides that dialysis treatment is no longer appropriate. Therefore, in response to this comment, we have modified our requirement so that a patient must be informed of the right to discontinue as well as refuse treatment. • Patients have the right to receive resource information for modalities not offered in their facilities. The facility may wish to create a resource information packet or provide patients with an existing list from Medicare's Dialysis Facility Compare (DFC) Web site. This resource information may include giving the patient a handout or the DFC Web site information. Doing any of these things would meet the requirement to provide the patient with resource information on where they may obtain alternate care options. • Patients currently are allowed to self-cannulate upon receiving the proper training and demonstrating competency. The patient's right to participate in aspects of his or her care is addressed at § 494.70(a)(5), and as written, is flexible enough to include self-cannulation as well as other forms of in-center self-care and home dialysis. • Dialysis patients who work or attend school should be encouraged to continue doing so and dialysis facilities should recommend the most appropriate modality and setting for dialysis. While we are not requiring a facility to provide every modality or schedule to accommodate patients' unique schedules, we

Location	Condition	Standard	Language	Key Points, Background and More Information From Preamble
Subpart C Patient care (con't)	494.70 Patients' rights (con't)	(a) Patients' rights (con't)		are now requiring that facilities inform patients where such accommodations may be obtained. We have added new language at § 494.70(a)(7) giving patients the right to receive resource information about dialysis modalities not offered by that facility, including alternative scheduling options for working patients. Accommodations for working patients may include, for example, home hemodialysis, peritoneal dialysis or extended facility hours. • Reuse is a care decision that is to be made between the patient and his or her physician. Patients also have the option to seek treatment in a facility that exclusively uses new dialyzers. • **Comment:** A few commenters suggested that regulatory language require that patients be given access to social work and psychological services, psycho-social counseling and nutritional counseling. Some commenters suggested that language be added to the "Patients' rights" condition specifying that patients would have access to, and receive counseling from, a qualified social worker and a dietitian. Some commenters recommended that patients have the right to receive a referral for mental health services, physical or occupational therapy and/or vocational rehabilitation, as needed. **Response:** The "Patient assessment" and the "Patient plan of care" conditions for coverage (§ 494.80 and § 494.90, respectively) require input by an interdisciplinary team. This team of professionals includes, at minimum, a registered nurse, physician, social worker and dietitian. The team is responsible for properly assessing and treating the patient, which would include identifying additional treatment needs, such as psychosocial counseling, etc. Therefore, we believe that expanding the language at § 494.70(a)(12) to include social work and psychological services, psychosocial counseling and nutritional counseling, as suggested by these public comments, would be redundant under the final rule. Under the final rule, following the comprehensive assessment required at § 494.80, a plan of care for each patient must be implemented, which must include care and services deemed necessary by the interdisciplinary team. The requirements for the provision of services under the "Plan of care" condition at § 494.90 do include nutritional and social services, such as psychosocial and nutritional counseling. Furthermore, the "Patients' rights" condition at § 494.70(a)(11) requires facilities to inform patients of their right to be informed of services available in the facility and the charges for services not covered under Medicare. At § 494.70(a)(12), patients have the right to receive the necessary services outlined in the patient plan of care. • **Comment:** Some commenters suggested adding language to specify that facilities must inform patients of their responsibilities, including being punctual following dietary/fluid restrictions, following treatment regimens, exhibiting appropriate personal behavior, and informing the team of scheduling problems or issues in filling prescriptions. Other commenters stated that facilities should inform patients of their responsibility to listen and ask questions when they do not fully understand their rights or responsibilities. Another commenter stated

Location	Condition	Standard	Language	Key Points, Background and More Information From Preamble
Subpart C Patient care (con't)	494.70 Patients' rights (con't)	(a) Patients' rights (con't)		that CMS should clarify patient responsibilities in the standard for patient rights. **Response:** Patient responsibilities are addressed at § 494.70(a)(13). We have retained the existing requirement found at § 405.2138(a)(1), which states that patients must be informed of the rules and expectations of the facility regarding patient conduct and responsibilities. The proposed language has been retained in the final rule. It is essential to recognize that positive patient behavior may be encouraged but cannot be regulated. • Patients are to be reassessed by the interdisciplinary team, including a master's degree social worker (MSW) at least monthly when a patient exhibits significant changes in psychosocial needs (as required at § 494.80(d)(2)(iii)), manifested by, for example, issues such as disruptive behavior that could result in discharge … As stated in the proposed rule preamble, we do not expect that a patient should be involuntarily discharged from a dialysis facility merely for failure to follow the instructions of a facility staff member. However, we recognize it may be necessary to discharge a disruptive patient in order to protect the rights and safety of other patients and staff in the facility. If, for instance, a patient physically harms, threatens or verbally abuses other patients and/or staff; brings weapons or illegal drugs into a facility; or disrupts the facility to a degree that it is unable to operate effectively, then the 30-day discharge notice policy could be abbreviated pursuant to § 494.180(f)(5). • **Comment:** One commenter recommended that we require posted patient rights to be written in English at a 7th to 9th grade level and translated into a patient's native language if possible. Many other comments suggested that we require facilities to have an "alternate method" to inform patients who cannot read posted information. **Response:** The concerns raised in these comments have already been addressed at § 494.70(a)(2). The "Patients' rights" condition requires that all patients receive information in a way they can understand. Facilities have the flexibility to provide information to patients in the most appropriate manner based on patient needs. The qualified professionals at the facility are capable of evaluating an individual patient's level of understanding and making a determination regarding the needs of that patient.
Subpart C Patient care	494.70 Patients' rights	(b) Right to be informed regarding the facility's discharge and transfer policies	(b) 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	**Comment:** One commenter requested additional clarification regarding what would constitute "discharge" (for example, "30 days after departure from a facility for any reason"). **Response:** Our intent was to describe the cessation or end of patient care services for patients who either voluntarily leave the facility or for patients who are discharged for reasons listed at § 494.180(f). To address the commenter's concern, we have added clarifying language at § 494.10 to read, "Discharge means the termination of patient care services by a dialysis facility or the patient voluntarily terminating dialysis when he or she no longer wants to be dialyzed by that facility."

Location	Condition	Standard	Language	Key Points, Background and More Information From Preamble
Subpart C Patient care (con't)	494.70 Patients' rights (con't)	(b) Right to be informed (con't)	health and safety of others, an abbreviated discharge procedure may be allowed.	
Subpart C Patient care	494.70 Patients' rights	(c) 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.	**Comment:** We received many comments in support of more patient protection requirements regarding facility internal grievance processes. Commenters supported the proposed requirement for facilities to post information on how to file a grievance. Some commenters specifically supported requiring the posting of network and state agency phone numbers and/or mailing addresses. **Response:** We agree that it would be in the best interest of patients that network and state agency mailing addresses and phone numbers be posted. Posting the additional patient rights information will not be a significant burden upon facilities. We have revised § 494.70(c) to include mailing addresses.
Subpart C Patient care	494.80 Patient assessment	(a) 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) 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 comorbid 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	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, 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.

Location	Condition	Standard	Language	Key Points, Background and More Information From Preamble
Subpart C Patient care (con't)	494.80 Patient assessment (con't)	(a) Assessment criteria (con't)	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's physical activity level. (13) Evaluation for referral to vocational and physical rehabilitation services.	

Location	Condition	Standard	Language	Key Points, Background and More Information From Preamble
Subpart C Patient care	494.80 Patient assessment	(b) 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.	**Comment:** A few commenters sought clarification on the meaning of the phrase "new patient" at proposed § 494.80(b), "Frequency of assessment for new patients." The commenters asked whether "new patient" meant a patient new to dialysis or a patient new to a particular dialysis unit. Another commenter asked if "new patient" referred to a patient receiving his or her first treatment in an outpatient dialysis unit. **Response:** In order to clarify the meaning of "new patient," we have modified the title of § 494.80(b), so that it now reads: "Frequency of assessment for patients admitted to the dialysis facility." We intend for all dialysis patients new to any particular outpatient dialysis facility to be categorized as "new patients" and have a comprehensive assessment within the specified 30-day timeframe, even if they are transferring from another dialysis facility. This standard means a comprehensive assessment must be done on all transfer patients, as well as those new to dialysis, within the first 30 days.
Subpart C Patient care	494.80 Patient assessment	(d) 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	Unstable patients must be reassessed in accordance with § 494.80(d), which specifies use of the assessment criteria at § 494.80(a)(1) through § 494.80(a)(13). Although a comprehensive reassessment for patients classified as unstable is required, it is possible that patient status may not change in all parts of the assessment. Patient status, whether changed or unchanged, should be clearly reflected in the new assessment.
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	• We recognize that patient outcomes are determined in part by factors outside of the dialysis facility's control, such as demographics, the systemic effects of the underlying renal disease and patient preferences and adherence. Further, we recognize that health care delivery is dynamic and that not all patients may be achieving, for example, the expected delivered dose of dialysis at any specific point in time. If the patient is unable to achieve the desired health outcomes, the plan of care should be adjusted to reflect the patient's condition along with an explanation, and any opportunities for improvement in the patient's health should be identified. The patient is part of the team and should be working to meet the plan of care goals. We are requiring the interdisciplinary

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Subpart C Patient care (con't)	494.90 Patient plan of care (con't)		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.	team to adjust the patient's plan of care to achieve revised goals if initial outcomes are not achieved. If a therapeutic goal is not met due to patient non-compliance, then interventions must be implemented to achieve better patient compliance. If reasonable measures have been taken and lack of patient compliance still prevents the goal from being met, the facility must document the interventions, the results of the interventions, and the plan to preserve patient health and safety within the limitations of poor patient compliance. Patient choices that create barriers to meeting the targets should be documented and addressed to a reasonable extent by the team. We are not requiring patients to meet plan of care goals as a condition for coverage of facility services. • The introductory language to the "Patient plan of care" condition calls for the establishment of "measurable and expected outcomes and estimated timetables to achieve these outcomes." This requirement will allow for individualized plans that lead to desirable outcomes for patients in all care areas listed in the patient's plan of care, including rehabilitation. Outcomes listed in the plan of care could include such targets as the return of the patient to a former occupation, attainment of a certification of education, return to normal activities within the patient's household, a certain level of functionality or any another outcome that the team has determined is appropriate for the patient. Dialysis facilities have the flexibility to choose appropriate rehabilitation outcome targets, and we will not narrowly define them in this final rule. • Advance directives were added under the "Patient's rights" and "Medical records" conditions and therefore we will not require advance directives within the plan of care. Facilities have the flexibility to address advance directives within the plan of care when they deem it appropriate. **Comment:** One commenter believes that education for all life changes associated with dialysis is an unfunded mandate that will require additional personnel skilled in this training. The commenter also stated that patient education regarding employment, rehabilitation and transplantation is beyond the scope of the dialysis center nurses and technicians. **Response:** Patient education is included in the Medicare composite rate paid for dialysis. We expect that the interdisciplinary team has the skills and expertise needed to educate dialysis patients about aspects of the dialysis experience, dialysis management, quality of life, rehabilitation and transplantation.
Subpart C Patient care	494.90 Patient plan of care	(a) Development of patient plan of care	The interdisciplinary team must develop a plan of care for each patient. The plan of care must	• **Comment:** Although most comments recommended that social services be part of the plan of care, two commenters disagreed, stating that social workers have too big a caseload and are not capable of providing professional

Location	Condition	Standard	Language	Key Points, Background and More Information From Preamble
Subpart C Patient care (con't)	494.90 Patient plan of care (con't)	(a) Development of patient plan of care (con't)	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.	counseling services. One commenter stated that until there is consensus on outcomes, CMS should not include an outcomes-based social service requirement in the plan of care. Commenters supporting social services in the plan of care submitted a lengthy list of references that highlight the importance of social services as related to improved patient outcomes. **Response:** In the previous conditions (§ 405.2162) as well as in this final rule (§ 494.180(b)), dialysis facilities are required to have adequate staff available to meet the care needs of their dialysis patients. This requirement applies to the provision of social services as well. Facilities may want to assess the caseloads of social workers to ensure adequate staff members are available to provide the appropriate level of social services, including counseling. Social workers who meet the qualifications at § 494.140(d) are capable of providing counseling services to dialysis patients. Furthermore, Medicare payment for social worker counseling services is included in the dialysis facility composite rate. • **Comment:** We received many comments regarding whether a social services component should be required in the "Patient plan of care" condition. Most of the comments recommended that social services be part of the plan of care and referred to current research regarding social work services. Commenters stated that studies have shown that social work intervention improves patients' quality of life, their adherence to the ESRD treatment regimes and fluid restrictions and improves medication compliance. Another example of improved outcomes provided by a commenter is that social work interventions can reduce patients' blood pressure and anxiety levels. Commenters suggested including emotional and social well-being criteria in the final rule. Some commenters recommended including functional status measures that they believe correlate with better survival and hospitalization rates. Other commenters recommended requirements that would specify psychosocial criteria along with MSW tasks and responsibilities, and which would require MSWs to provide information and training to patients. Some commenters suggested adding specific language that would address "measurable improvement in physical, mental and clinical health outcomes," "psychosocial status and appropriate referral for services," and would "provide the necessary care and services to achieve and sustain effective psychosocial status." Many commenters suggested that we require use of a tool to assist in measuring psychosocial status. Tools suggested include the Zung Self-Assessment Depression Scale or Hamilton Anxiety Scale and a quality-of-life tool, such as the SF-36 or SF-12 (version 2.0 tool), that commenters state are used to measure depression, functional status and predict mortality and morbidity. Commenters cited research supporting social work interventions that they believe would contribute to meeting patient care team goals. **Response:** In response to the large number of comments, and in light of current academic research supporting social service interventions to improve patient care, we are adding a social services component, called "psychosocial status" to the plan of

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Subpart C Patient care (con't)	494.90 Patient plan of care (con't)	(a) Development of patient plan of care (con't)		care requirements at § 494.90(a)(6). We are requiring that a standardized tool, chosen by the social worker, be used to monitor patient status, and that counseling be provided and referrals be made as appropriate. This new requirement reads, "The interdisciplinary team must provide the necessary monitoring and social work interventions, including counseling and referrals for 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." The standardized tool should be a professionally accepted, valid, reliable tool, such as the SF-36, and should relate to the patient's functional health and well-being. The tool must be used as a monitoring aid that assists in determining the patient's psychosocial status. The SF-36 model uses metrics that measure physical health as related to functional level and presence of pain, and mental health as related to social functioning, emotional and mental health. Reliability and validity studies have been performed for this instrument. More information about the SF-36 may be found in numerous articles or on the Web at **www.sf-36.org/tools/sf36.shtml**. The SF-12 survey form was derived from the SF-36 form and scales the 36-question survey down to a 1-page, 2-minute version. However, we are not specifying which tool must be used in order to allow flexibility and to limit the amount of burden. The choice of which standardized tool to use is best left to the facility social worker. • At § 494.80(a)(7), a social worker is required to assess the psychosocial needs of patients, and § 494.90(a)(6) of the final rule requires the plan of care to address psychosocial status using a standardized mental and physical assessment tool, chosen by the qualified social worker. As discussed previously, we are not requiring facilities to use any specific assessment tool.
Subpart C Patient care	494.90 Patient plan of care	(a) 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	• "The patient must be assessed at least annually for modality choice and level of participation in the dialysis care process … The interdisciplinary team must identify a plan for home dialysis or explain why the patient is not a candidate for home dialysis." This provision requires that, based on the most recent assessment, the plan of care must be revised to reflect modalities for which the patient is a candidate and the patient's preferences regarding modality. • Our intent is to ensure that the interdisciplinary team is aware of where the patient is in the referral and transplant evaluation process so that patients do not get "lost" along the way. We do not expect that the transplant referral tracking responsibilities borne by the dialysis facilities would be redundant with the responsibilities of the transplant center. We would expect the interdisciplinary team to be aware of whether the patient has completed the evaluation process, is waitlisted, is ineligible for waitlisting or is awaiting living donation. Moreover, the dialysis facility is expected to alert the transplant center about changes in the patient's condition that would affect whether a patient was able to receive kidney transplantation. The transplantation center

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Subpart C Patient care (con't)	494.90 Patient plan of care (con't)	(a) Development of patient plan of care (con't)	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).	conditions of participation published on March 30, 2007 (72 FR 15198), require kidney transplant centers to communicate transplant patient status to the dialysis facility at § 482.94(c)(1) and § 482.94(c)(2) so that there is two-way communication.
Subpart C Patient care	494.90 Patient plan of care	(a) 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.	• This final rule makes the interdisciplinary team responsible for the patient plan of care, including rehabilitation. Referrals may be made by the appropriate team member, which may be the physician and/or the nurse or social worker. The role of the medical director, as described in § 494.150, is to be responsible for the delivery of patient care and outcomes in the facility, which would include rehabilitation outcomes. • The patient is a member of the interdisciplinary team and, as such, should participate in team discussions regarding rehabilitation potential and goals.
Subpart C Patient care	494.90 Patient plan of care	(b) 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	• We have designated the patient as a member of the interdisciplinary team (if the patient desires) and expect that the patient would share in the goal-setting team decisions. • The interdisciplinary team definition specifically includes the patient, and has been added to the first paragraph of this condition. We have added the phrase "including the patient if the patient desires" to § 494.90(b)(1)(i) to clarify that we expect that the patient will want to participate in devising the plan of care. • The role of the patient is central to providing quality dialysis care. Paper compliance without substantive compliance is unproductive. Specifically, the patient member of the interdisciplinary team has a role in converting the comprehensive assessment into a meaningful plan of care. Whenever possible, the patient (or designee) should assist in the identification of goals and in formulating the action plan to achieve these goals. The patient must be involved in care planning and actively participate in care plan development and review. Survey tag V174, referred to by the commenter, required regularly scheduled conferences, with participation by the staff involved in the patient's

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Subpart C Patient care (con't)	494.90 Patient plan of care (con't)	(b) Implementation of the patient plan of care (con't)	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.	care, to evaluate the progress each patient was making toward the goals in their long-term care program and patient care plan. However, this final rule also allows the facility flexibility to choose the methods to ensure patient participation. One means of providing an opportunity for participation is to have the patient attend the meeting in which the plan of care is developed and updated. This final rule makes very clear that the patient is part of the care team and can participate in the assessment and the plan of care activities if the patient desires to do so. While we have not required monthly care plan meetings specifically, the facility must demonstrate that there is an opportunity for patient involvement and participation. The facility has the flexibility to design a process. The patient signature on the plan of care is not sufficient to demonstrate patient participation. The new interpretive guidelines for this regulation will include direction to surveyors regarding enforcement of this provision. • We agree that as long as the patient has been provided sufficient opportunity to participate with the interdisciplinary team, the dialysis facility should not receive a citation for noncompliance with these conditions when the patient has refused to participate or sign the plan of care. We have modified the language at § 494.90(b)(1)(ii) to indicate that the facility must document a patient's refusal to sign the plan of care, along with the reason the signature was not provided. • **Comment:** Many comments addressed proposed § 494.90(b)(4), which would require the dialysis facility to ensure that the patients are seen at least monthly by a physician providing ESRD care. Some commenters supported this provision and a few suggested that the visit could take place in the physician's office. Other commenters disagreed with the requirement but agreed with the intent, saying that physicians should see their dialysis patients at least monthly. Many commenters strongly disagreed with the provision, stating that the facility should not be accountable for physician visits. A few commenters stated that the payment G-codes provided enough incentive for facilities and that therefore this physician visit requirement was not needed. Other commenters suggested there was no evidence of any benefits that could be linked to monthly visits, and this would be especially burdensome for rural dialysis facilities. One commenter recommended that an exception be available for facilities in the Pacific Islands. Two commenters suggested that CMS had no authority to mandate monthly physician visits according to section 1801 of the Social Security Act, which prohibits the federal government from exercising any supervision or control over the practice of medicine. **Response:** We believe that it is in the best interest of the patient for dialysis facilities to ensure that a physician (or other practitioner, such as a physician assistant, nurse practitioner or clinical nurse specialist) visits each month. The Dialysis Outcomes and Practice Patterns Study (DOPPS) data demonstrate that physician contact correlates with the quality of care. The G-codes, established

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Subpart C Patient care (con't)	494.90 Patient plan of care (con't)	(b) Implementation of the patient plan of care (con't)		in the final rule, "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2004" published November 7, 2003 (68 FR 63196, 63216), provide payment to physicians in incremental amounts depending on whether the patient was seen one, two to three or four times during a given month. Although the payment G-codes provide some incentive for attending physicians to see their dialysis patients more often, physicians may still choose not to see their patients for a month or more. In this case, the patient still receives dialysis for which the facility receives payment. We do not believe that requiring monthly visits infringes on how physicians practice medicine and note that physician organizations that provided comment on the proposed rule supported the provision. We are retaining the proposed provision at § 494.90(b)(4) to ensure that patients receive face-to-face physician (or, as discussed later, "physician extender") visits at least monthly. • **Comment:** A few commenters suggested that physician assistants be allowed to perform monthly visits, while one commenter favored allowing a nurse practitioner to perform monthly visits. **Response:** In response to comments, we have added nurse practitioners, clinical nurse specialists and physician assistants as options for compliance with the provision requiring monthly visits by a physician. CMS has previously issued instructions regarding physician visits and payment via G-codes and these instructions clarify that a physician assistant, clinical nurse specialist or a nurse practitioner may provide visits to dialysis patients instead of a physician. Physicians may use nurse practitioners, physician assistants and clinical nurse specialists, who are able under the Medicare statute to furnish services that would be physician services if furnished by a physician and who are eligible to enroll in the Medicare program, to deliver some of the visits during the month.
Subpart C Patient care	494.90 Patient plan of care	(c) 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	

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Subpart C Patient care (con't)	494.90 Patient plan of care (con't)	(c) Transplantation referral tracking (con't)	there is a change in transplant candidate status.	
Subpart C Patient care	494.90 Patient plan of care	(d) 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.	• **Comment:** We received several comments supporting inclusion of the "Patient education and training" standard at § 494.90(d). Some commenters recommended the addition of other training topics, including patient education regarding arteriovenous fistulas, advance directives and more. A commenter recommended that we require documentation in the medical record that patients were informed of the risks and benefits of various types of vascular access consistent with the national "Fistula First" quality initiative and provide funding for this if needed. **Response:** We agree that it is a reasonable expectation that dialysis patients be educated regarding the risks and benefits of various access types due to the impact of a vascular access on the patient's morbidity and mortality risks. Comments on this and other sections of these conditions strongly support adding a requirement ensuring that patients must be educated regarding the risks, benefits and outcomes of various access types. These comments are in keeping with "Fistula First." Additionally, the Institute of Medicine (IOM) has encouraged the empowerment of patients to improve the quality of the health care system. Therefore, we have added new language to the "Patient plan of care" condition at § 494.90(d), "Patient education and training," requiring that the plan of care include education and training on the benefits and risks of various vascular access types. We have also added infection prevention and personal care, and home dialysis and self-care training to this provision in response to comments as discussed under the "Infection control" and "Care at home" sections of the preamble. • **Comment:** One commenter believes that education for all life changes associated with dialysis is an unfunded mandate that will require additional personnel skilled in this training. The commenter also stated that patient education regarding employment, rehabilitation and transplantation is beyond the scope of the dialysis center nurses and technicians. **Response:** Patient education is included in the Medicare composite rate paid for dialysis. We expect that the interdisciplinary team has the skills and expertise needed to educate dialysis patients about aspects of the dialysis experience, dialysis management, quality of life, rehabilitation and transplantation.
Subpart C Patient care	494.110 Quality assessment and performance improvement		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	We are also requiring at § 494.110 that the interdisciplinary team, which includes the registered nurse, social worker and dietitian, play an active role in the Quality Assurance Performance Improvement (QAPI) program. This final rule requires that the interdisciplinary team provide appropriate care to dialysis patients and improve patient care on an ongoing basis. The dialysis facility may need to evaluate staffing levels as part of their action plan for the QAPI program. In order to clarify that the adequate staffing standard applies to all clinical staff, we have added language to the requirement at § 494.180(b)(1), requiring that the registered nurse, social worker and dietitian be available to meet patient clinical needs.

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Subpart C Patient care (con't)	494.110 Quality assessment and performance improvement (con't)		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.	
Subpart C Patient care	494.110 Quality assessment and performance improvement	(a) 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	• We have modified this requirement in the final rule to make clear that the professional members of the interdisciplinary team (physician, registered nurse, social worker and dietitian) must participate in the QAPI program. The facility has the option of including facility patients when appropriate. • Facilities may use indicators and measures of their choice as appropriate and necessary to implement the data-driven QAPI program. We may update the QAPI topics as needed in future revisions of the ESRD Conditions for Coverage. Facilities may add topics to their QAPI program as needed to meet the unique needs of their facility. • The facility has the flexibility to develop and implement QAPI via processes of their own choosing, as long as the efforts result in a multidisciplinary, data-driven QAPI program that achieves improvement and meets the criteria stated in § 494.110. This might include face-to-face meetings or additional and alternate activities. We have not modified the regulatory language to specify processes or face-to-face meetings. • We are requiring that dialysis facilities include patient satisfaction as a component of their QAPI program. At this point in time we are strongly encouraging facilities to use the standardized In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) tool to assess in-center hemodialysis patient experience of care, but we are not requiring use of this instrument. As the renal community becomes more experienced with using the ICH CAHPS instrument and recognizes benefits associated with its use, we would expect to see widespread voluntary use. The IOM dimensions of patient-centered care include respect for patients' values, preferences and expressed needs; coordination and integration of care; information, communication and education; physical comfort; emotional support; involvement of family and friends; continuity and transition; and access to care. The ICH CAHPS survey instrument addresses all these areas in either the core instrument or supplemental questions. The ICH CAHPS core instrument and supplemental questions have been placed in the public domain.

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Subpart C Patient care (con't)	494.110 Quality assessment and performance improvement (con't)	(a) Program scope (con't)		Any hemodialysis facility interested in using the survey should contact Charles Darby at **charles.darby@ahrq.hhs.gov**
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. 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.	
Subpart D Administration	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 (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).	• **Comment:** Some commenters stated that it would be helpful if clinical social worker responsibilities were listed in regulation; they state that social workers are unable to provide clinical social services to patients because they are often tasked with clerical work that fills the majority of their time. **Response:** We have sought to be less prescriptive in this rule in order to allow dialysis facilities flexibility in meeting Medicare requirements. We expect that as professional caregivers, members of the interdisciplinary team are aware of their discipline's professional standards of practice and provide quality care to their patients in keeping with those standards. Under the "Patient assessment" and "Patient plan of care" conditions (§ 494.80 and § 494.90, respectively), we require that members of the interdisciplinary team complete a comprehensive assessment followed by a plan of care that identifies goals for patient care and the services that will be provided in order to meet those goals. This includes psychosocial and nutrition services to be provided by the social worker and the registered dietitian. The assessment and plan of care requirements necessitate that the registered nurse, social worker and dietitian provide appropriate professional care to each patient. Specifically, the dialysis facility must ensure that the social worker provides timely psychosocial assessments and social work interventions in accordance with the plan of care in order to meet these Conditions for Coverage. We are also requiring at § 494.140 that the interdisciplinary team, which includes the registered nurse, social worker and dietitian, play an active role in the QAPI program. This final rule requires that the interdisciplinary team

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Subpart D Administration (con't)	494.140 Personnel qualifications (con't)	(d) Social worker (con't)		provide appropriate care to dialysis patients and improve patient care on an ongoing basis. We do not agree that all the responsibilities of the entire interdisciplinary team need to be enumerated in regulation. • **Comment:** We received more than 70 comments regarding social worker qualifications. The vast majority of commenters supported the proposed social worker qualifications, which require an MSW from a school of social work accredited by the Council on Social Work Education. Commenters stated that dialysis patients have highly complex needs and require care from an MSW who has a "specialization in clinical practice" education. Commenters made the following statements in support of an MSW with a specialization in clinical practice: nephrology social workers must be skilled in assessing for psycho-social influences and their interrelatedness in predicting treatment outcomes, and must be able to design interventions with the patient, family, medical team and community systems at large to maximize the effectiveness of ESRD treatment. The additional training received by MSWs enables them to perform these complex professional tasks and ensure effective outcomes that have a direct relationship to morbidity and mortality. Master's-prepared social workers are trained to use validated tools, such as the SF-36 (the Medical Outcomes Study 36-item short-form health survey) and the Kidney Disease Quality of Life (KDQOL), to improve care and to monitor the outcomes of directed interventions. Most nephrology social workers provide psychosocial services autonomously as primary providers without social work supervision or consultation, using highly developed social work intervention skills obtained in a master's level curriculum. The MSW degree provides an additional 900 hours of specialized training beyond a bachelor's degree in social work. An MSW curriculum is the only curriculum that offers additional specialization in the bio-psycho-social-cultural, person-in-environment model of understanding human behavior. Undergraduate degrees or other mental health credentials do not offer this specialized and comprehensive training. The National Association of Social Workers Standards of Classification considers the bachelor's degree a basic level of practice, while the master's degree is considered a specialized level of professional practice and requires a demonstration of skill or competency in performance. These commenters provided references and citations along with these comments. A few commenters suggested that the MSW qualification be eliminated because it is difficult to recruit MSWs in some rural areas. A commenter stated that in California a licensed clinical social worker requires 2 years of supervision and two examinations, which makes it difficult to get a clinical social worker license. Another commenter suggested that we keep the MSW requirement but include an "exceptions process" for units that cannot hire an MSW. Some commenters stated that bachelor's-prepared social workers (BSWs) are competent as long as they are supervised by an MSW. **Response:** We appreciate the large degree of support for the MSW qualification for social workers. We have revised the MSW requirement in

Location	Condition	Standard	Language	Key Points, Background and More Information From Preamble
Subpart D Administration (con't)	494.140 Personnel qualifications (con't)	(d) Social worker (con't)		§ 494.140(d)(1) by adding "specialization in clinical practice," as specified in part 405, subpart U, as the majority of comments supported this. The consensus among the commenters is that this level of knowledge and skill is needed to deal with an increasingly older, sicker, more complex dialysis patient population. • **Comment:** One commenter recommended that we delete § 494.140(d) in its entirety or delete any preamble references to MSWs performing counseling, long-term behavioral and adaptation therapy and grieving therapy. The commenter stated that such counseling exceeds the expertise of MSWs, and that patients should be referred outside the units for this service. The commenter also claimed that an "expansion" of counseling requirements represents a potential $18 million burden to his large dialysis organization. **Response:** The "Personnel qualifications" condition for coverage at § 494.140 does not specify tasks or responsibilities for dialysis facility social workers, but only their education and qualifications. The proposed rule preamble discussion provided examples of social worker services that facilities might offer, including counseling services, long-term behavioral and adaptation therapy and grieving therapy (70 FR 6222) that would require the education and training of an MSW. The proposed rule's preamble discussion is consistent with part 405, subpart U, social worker requirements at § 405.2163(c), which state that "Social services are provided to patients and their families and are directed at supporting and maximizing the social functioning and adjustment of the patient." Social services needed for each patient should be determined during the assessment and identified in the plan of care. Only one commenter suggested deleting § 494.140(d) in its entirety, while very large number of comments supported this requirement, and the consensus was to retain MSWs in dialysis units. MSWs are trained and competent to counsel patients. The social worker professional standards of practice (**www.socialworkers.org/practice/standards/NASWHealthCareStandards.pdf**) do include patient and family counseling within the scope of services provided by a social worker. MSW services, which include counseling, are incorporated into the Medicare composite payment rate and should not be outsourced or separately billed. • **Comment:** We received a large number of comments regarding our proposed deletion of the master's degree "grandfather clause" for social workers. Many commenters agreed with eliminating the "grandfather clause" because "30 years was more than enough time for dialysis social workers to obtain master's degree." Commenters stated that MSW and BSW tasks could be broken out into separate job descriptions so that BSWs may assist MSWs. Commenters said that there was no MSW shortage. A larger number of commenters suggested that we retain the "grandfather clause" for non-MSWs so that currently employed non-MSWs working as dialysis social workers do not lose their jobs. Some commenters suggested that experienced non-MSW social workers were competent and had much to offer dialysis patients. A few

Location	Condition	Standard	Language	Key Points, Background and More Information From Preamble
Subpart D Administration (con't)	494.140 Personnel qualifications (con't)	(d) Social worker (con't)		commenters recommended that we continue the grandfather clause until the year 2015 to allow current non-MSWs who met the subpart U requirements to finish out their careers. **Response:** According to the definition of "Qualified personnel" at § 405.2102, a non-MSW may serve as an ESRD social worker (under § 405.2102(f)(2), qualified personnel) when he or she "has served for 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 paragraph (f)(1) of this definition" (that is, has completed a course of study with specialization in clinical practice at, and holds a master's degree from, a graduate school of social work). This subpart U grandfather clause only applies to non-MSWs who have been practicing social work since 1974, and any ESRD social workers who do not have 2 years of experience prior 1976 must have a master's degree. While we believe the number of non-MSWs still practicing over the past 32 years is small, we do not intend that these long-time employees should become unqualified for their jobs because of deletion of the "grandfather clause" … The grandfather clause may not be applied to social workers who do not meet the 1976 experience criterion. BSWs may function as assistants to MSWs. The MSW is the staff member who must satisfy these conditions for coverage. • **Comment:** A few commenters suggested that we eliminate the proposed § 494.140(d)(2) requirement, "Meets the practice requirements for social services in the state in which he or she is employed." **Response:** Adherence to state scope-of-practice requirements is an appropriate minimum requirement for a federal health and safety regulation. This final rule supports compliance with state regulations. The final rule provision for meeting applicable scope-of-practice board and licensure requirements for dialysis facility personnel has been moved to the beginning of § 494.140 to avoid redundancy within the standards for each of the dialysis facility staff members. • **Comment:** Several commenters suggested that we add a social worker licensure requirement to § 494.140(d)(2). **Response:** The proposed rule at § 494.20 required licensure for all staff. To prevent confusion regarding whether licensure is required under personnel qualifications, we have moved the requirement to the beginning of § 494.140, to read: "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." • **Comment:** Many social workers as well as some commenters who are not social workers suggested that a new social worker aide personnel standard be added to the final rule. The rationale given was that this new staff member could perform many of the clerical tasks (admissions, billing, transportation, transient patient paperwork, determining insurance coverage) often assigned to social workers, so that the social worker would be freed up to perform clinical social services, such as counseling, which would result in improved patient care

Location	Condition	Standard	Language	Key Points, Background and More Information From Preamble
Subpart D Administration (con't)	494.140 Personnel qualifications (con't)	(d) Social worker (con't)		and better outcomes. Many commenters stated this position should be required for dialysis facilities with more than 75 patients. **Response:** This final rule requires each facility to have adequate staff to meet patient needs. Paragraph § 494.180(b)(1) applies to all dialysis staff, including social workers. The use of ancillary staff is not precluded by this regulation. Some dialysis facilities do employ staff to assist the social worker with clerical tasks, while other facilities may employ more than one social worker. Each facility should assess their staffing needs and determine appropriate staffing levels. While we agree that using an MSW to perform clerical tasks and manage patient financial information may not be the most effective or efficient use of trained and licensed professional clinical staff, we are not requiring that dialysis facilities employ social worker aides. We encourage dialysis facilities to use staff resources in the most effective and efficient manner to provide quality care to dialysis patients. • **Comment:** Many commenters suggested that the final rule state that MSWs could not be assigned non-MSW tasks. These commenters object to the number of clerical tasks that are assigned to social workers. **Response:** Dialysis facilities have the flexibility to assess facility staffing needs and use staff as necessary. This final rule requires social workers to provide appropriate clinical services to dialysis patients under the "Patient assessment" and "Patient plan of care" conditions for coverage (§ 494.80 and § 494.90, respectively). The social worker must also participate in the facility QAPI program (§ 494.110). The facility must have a sufficient social services staff to meet dialysis patient needs as required at § 494.180(b)(1), which applies to all dialysis staff, including social workers. We would expect that any tasks assigned to the social worker would not compromise the social worker's ability to meet his or her obligations to patients and these Conditions for Coverage. We have not added restrictions regarding staff assignments to this final rule. • **Comment:** Many commenters recommended that we specify a maximum MSW caseload or an MSW-to-patient ratio. **Response:** As discussed earlier, adequate staffing is addressed under the "Governance" Condition for Coverage at § 494.180(b). Some states have implemented staff-to-dialysis patient ratios, and we defer to state provisions on this issue. Nephrology social workers should adhere to the professional standards of practice for social workers. The National Association of Social Workers published "NASW Standards for Social Work Practice in Health Care Settings" in 2005. These professional practice standards may be found at **www.socialworkers.org/practice/standards/NASWHealthCareStandards.pdf** The National Association of Social Workers and Council of Nephrology Social Workers jointly published "NASW/NKF Clinical Indicators for Social Work and Psychosocial Service in Nephrology Settings" in 1994, which may be found at **www.socialworkers.org/practice/standards/nephrology_settings.asp** In addition, the National Kidney Foundation (NKF) has published the 2003 Council of Nephrology Social

Location	Condition	Standard	Language	Key Points, Background and More Information From Preamble
Subpart D Administration (con't)	494.140 Personnel qualifications (con't)	(d) Social worker (con't)		Workers "Standards of Practice for Nephrology Social Work." These standards of practice include guidelines for clinical practice, a description of the nephrology social work role, as well as staffing information. • **<u>Comment:</u>** A commenter suggested that the final rule state that different facilities can share the same renal dietitian or social worker. **<u>Response:</u>** Neither part 405, subpart U, nor the proposed rule precludes facility sharing of renal dietitians and social workers, as long as each facility has adequate staff and staff hours to meet patient needs and provide care consistent with professional practice standards. Please refer to § 494.180(b)(1), which applies to all dialysis staff.
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.	• The proposed patient care technician training program (proposed at § 494.180(b)(5)) included the "care of patients with kidney failure, including interpersonal skills" and "possible complications of dialysis." "Care of patients with kidney failure" (proposed § 494.180(b)(5)(ii)) would include psychosocial and nutritional aspects of care. The "interpersonal skills" training would include professional conduct and interactions during challenging situations.
Subpart D Administration	494.150 Responsibili-ties of the medical director		The dialysis facility must have a medical director who meets the qualifications of § 494.140(a) to be responsible for the delivery of patient care and outcomes in the facility. The medical director is accountable to the governing body for the quality of medical care provided to patients. (b) Staff education, training and performance. (2) Ensure that— (i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers; and (ii) The interdisciplinary team adheres to the discharge and transfer policies	

Location	Condition	Standard	Language	Key Points, Background and More Information From Preamble
Subpart D Administration (con't)	494.150 Responsibilities of the medical director (con't)		and procedures specified in § 494.180(f).	
Subpart D Administration	494.180 Governance	(b) 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.	• **Comment:** Many commenters suggested a 1:75 MSW-to-patient ratio, and stated that it was impossible for MSWs to do case review and counseling with high patient ratios. Commenters stated that MSWs were assigned large caseloads of between 125 and 300 patients each, and cited a 2005 study (Bogatz et al.) in support of this contention. Some commenters recommended that we require use of a standardized acuity-based formula for adequate staff, such as the NKF Council of Nephrology Social Workers' "Professional Advocacy for the Nephrology Social Worker" (first edition, 2002, pages 9–11). One social worker stated she had 150 patients in 3 units and could therefore only triage and "put out fires." **Response:** We solicited public comment in the proposed rule regarding whether we should include a requirement for an acuity-based staffing plan. The public comments were split on the acuity-based staffing plan issue. Clearly staffing is of concern to many commenters. While commenters agreed with the intent of the proposed adequate staff provision at § 494.180(b)(1), there was discontent related to how this provision would be interpreted and enforced. First, we would like to clarify that the adequate staff standard applies to all clinical patient care staff, including nurses, technicians, social workers and dietitians who provide services to the dialysis patients. Appropriate staffing ratios are affected by a number of factors. These factors include patient acuity, level of staff expertise and skill mix, presence or absence of support staff/unlicensed personnel, available technology, distances between groups of patients served, efficiency of systems in place, scope of staff duties, degree of team work, state requirements, practice board-imposed limitations, number of meetings in which staff participation is required, paperwork demands, etc. We do not have a method available to identify and account for all of these types of characteristics in determining staff ratios that balance staff time to provide quality care and meet patient needs with the economic factors associated with dialysis facility labor costs. We are also concerned that any mandated minimum staffing ratios would be interpreted as the "maximum

Location	Condition	Standard	Language	Key Points, Background and More Information From Preamble
Subpart D Administration (con't)	494.180 Governance (con't)	(b) Adequate number of qualified and trained staff (con't)		ceiling" that must be complied with, which could lead to a decline in the number of patient care staff available. "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. We are requiring under the "Patient assessment" and "Patient plan of care" conditions (§ 494.80 and § 494.90, respectively) that members of the interdisciplinary team complete a comprehensive assessment, followed by a plan of care that identifies goals for patient care and the services that will be provided in order to meet those goals. This includes psychosocial and nutrition services to be provided by the social worker and the dietitian. The assessment and plan of care requirements necessitate that the registered nurse, social worker and dietitian provide appropriate professional care to each patient. We are also requiring at § 494.110 that the interdisciplinary team, which includes the registered nurse, social worker and dietitian, play an active role in the QAPI program. This final rule requires that the interdisciplinary team provide appropriate care to dialysis patients and improve patient care on an ongoing basis. The dialysis facility may need to evaluate staffing levels as part of their action plan for the QAPI program. In order to clarify that the adequate staffing standard applies to all clinical staff, we have added language to the requirement at § 494.180(b)(1), requiring that the registered nurse, social worker and the dietitian be available to meet patient clinical needs.
Subpart D Administration	494.180 Governance	(e) 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.	• **Comment:** One commenter suggested the final rule state (at § 494.180(e)) that the facility must accept a grievance in any form (oral or written) presented. **Response:** We agree that facilities should not limit acceptance of grievances to written grievances, and therefore, we have added the words "oral or written" at § 494.180(e) to allow patients more flexibility in how they communicate a grievance. The sentence now reads, "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." • **Comment:** Two commenters suggested we require the internal grievance process to be posted. Another commenter recommended patient involvement in the design and administration of internal grievance process. **Response:** We are not prescribing the manner in which a facility must make its grievance process known. The facility has the flexibility to inform patients of the grievance process as required under the "Patients' rights" condition at § 494.70(a)(14), using the methods of its choice. • **Comment:** One commenter recommended that we require routine reporting to the ESRD Network on the number and topics of complaints. A second commenter supported the concept of an internal grievance process, but suggested the addition of an expectation of timely investigation, documentation and resolution, along with a quality assurance requirement to prevent any recurrences. **Response:** Grievances resolved at the facility level might not need to be escalated to the ESRD Network level. Grievances are to be

Location	Condition	Standard	Language	Key Points, Background and More Information From Preamble
Subpart D Administration (con't)	494.180 Governance (con't)	(e) Internal grievance process (con't)		addressed in a reasonable fashion in a reasonable period of time. The grievance process must include a clearly explained procedure for the submission of grievances, timeframes for reviewing the grievance and a description of how the patient or the patient's designated representative will be informed of steps taken to resolve the grievance. Dialysis facilities must track grievances and patient satisfaction as part of the QAPI program in which trending and quality improvement efforts are expected (§ 494.110(a)(2)(viii)).
Subpart D Administration	494.180 Governance	(f) 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	

Location	Condition	Standard	Language	Key Points, Background and More Information From Preamble
Subpart D Administration (con't)	494.180 Governance (con't)	(f) Involuntary discharge and transfer policies and procedures (con't)	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.	

Comprehensive Multidisciplinary Patient Assessment (CMPA) Example Questions

Social Work-Focused Criteria

Council of Nephrology Social Workers

INTRODUCTION TO THE CMPA

The Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), published the Final Conditions for Coverage (CfCs) for End-Stage Renal Disease (ESRD) Facilities on April 15, 2008. In anticipation of the final publishing of the CfCs for ESRD facilities, CMS encouraged the National Kidney Foundation (NKF) and American Nephrology Nurses Association (ANNA) to establish a task force to develop resources and guidelines to assist facilities in complying with the requirement for a comprehensive, multidisciplinary patient assessment (CMPA). The CMPA replaces the requirement for individual assessments by each discipline (ref: § 494.80). The CMPA needs to be completed on the following schedule:

- The latter of 30 calendar days or 13 outpatient hemodialysis sessions, beginning with the first outpatient dialysis session for all new patients
- Three months after the completion of the initial assessment
- At least annually for stable patients
- At least monthly for unstable patients, including, but not limited to, patients with:
    - o Extended or frequent hospitalizations
    - o Marked deterioration in the health status
    - o Significant change in psychosocial needs
    - o Concurrent poor nutritional status, unmanaged anemia and inadequate dialysis

In addition to the CMPA schedule, the adequacy of the patient's dialysis prescription must be assessed as follows:

- Hemodialysis patients: at least monthly by calculating delivered Kt/V or an equivalent measure
- Peritoneal dialysis patients: at least every four months by calculating delivered weekly Kt/V or an equivalent measure

MINIMUM CRITERIA OF THE ASSESSMENT

The CMPA must consist of the following minimum criteria:

- Evaluation of current health status and medical condition, including comorbid conditions
- Evaluation of the appropriateness of dialysis prescription, blood pressure and fluid management needs
- Laboratory profile, immunization history and medication history
- 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)
- Evaluation of factors associated with renal bone disease
- Evaluation of nutritional status by a dietitian
- Evaluation of psychosocial needs by a social worker
- Evaluation of dialysis access type and maintenance (e.g., arteriovenous fistulas, grafts and peritoneal catheters)
- 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 (e.g., home dialysis); and the patient's expectations for care outcomes
- 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
- Evaluation of family and other support systems
- Evaluation of current patient physical activity level
- Evaluation for referral to vocational and physical rehabilitation services

COMPLETION OF ASSESSMENT

The interdisciplinary team is responsible for the completion of the assessment. The team, as defined in the CfCs, includes 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. Each member of the team should contribute to the completion of the assessment. The CfCs designate two areas to specific team members: evaluation of nutritional status to the dietitian and the evaluation of psychosocial needs to the social worker. It is anticipated that each facility and treatment team will individually determine who is responsible for completing the remaining criteria based on their clinical judgment, professional expertise and organizational structure. Team members should consult with each other in the process of completing the assessment in order to reach agreement on assessment points and to ensure integration.

EXAMPLE ASSESSMENT QUESTIONS

The following set of questions was created to ensure compliance with the CfCs and to aide in the development of an effective plan of care. For responses noted in shaded boxes "■," it is anticipated that the item will need to be addressed in the plan of care. The master's level social worker will have to utilize additional clinical assessment tools, and modify or omit questions as clinically necessary.

The example questions are intended to address the following minimum criteria of the CMPA:

- Demographics (not officially required as a minimum criteria, but likely part of any initial assessment)
- Evaluation of psychosocial needs by a social worker
- 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 (e.g., home dialysis); and the patient's expectations for care outcomes
- 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
- Evaluation of family and other support systems
- Evaluation for referral to vocational and physical rehabilitation services

Patients have the right to refuse to answer questions and to participate in nonessential assessments. If a patient refuses to provide information for an assessment item, the social worker should document the patient's refusal.

ASSESSMENT TO PLAN OF CARE

The CMPA is the first step in the care planning process and will generate a list of problems. The care team should create or adjust the plan of care to address the problems identified by the CMPA. The CfCs (§ 494.90) state that the plan of care must:

- Be individualized
- Specify the services necessary to address the patient's needs identified in the assessment
- Include measurable and expected outcomes
- Include estimated timetables to achieve outcomes
- Contain outcomes consistent with current, evidence-based, professionally accepted clinical practice standards

The example assessment questions have been designed in such a way to try to allow for the measurement of progress, use of evidenced-based assessment tools and engagement of the patient in the assessment process.

DISCLAIMER

This document was created for educational purposes only. The assessment questions are intended to provide examples of the types of questions that facilities and social workers may want to use to meet the requirements for a CMPA. The validity and reliability of the questions have not been confirmed. It is the responsibility of the user to verify that the use of any of the questions from cited sources does not violate any copyright laws.

The implementation and interpretation of the new CfCs 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 of the information provided herein.

Demographics

Complete for initial assessment only.

D1. What is the patient’s name?
Last name: ____________________________
Legal first name: _______________________
Preferred first name: ___________________
Middle initial: _____

D2. What is the patient’s date of birth?
___ /___ /______

D3. What is the patient’s sex?
☐ Male
☐ Female
☐ Intersex, transsexual, or other:
(Please specify)
____
____
____

D4. What is the patient’s gender identity? (Check all that apply.)
☐ Woman
☐ Transgender
☐ Man
☐ Other: ____________________________

D5. Is the patient of Hispanic or Latino origin or descent? (2728 coding)
☐ Yes

What is his or her country/area of origin or ancestry?
____

☐ No

D6. What is the patient’s race? (2728 coding)
☐ White
☐ Black or African American
☐ American Indian/Alaska native

Print name of enrolled/principal tribe:
____

☐ Asian
☐ Native Hawaiian or other Pacific Islander

What is his or her county/area of origin or ancestry?
____

D7. What is the date of the patient’s first chronic dialysis treatment?
___ /___ /_____

D8. What is the date the patient started chronic dialysis treatment at the current facility?
___ /___ /_____

Communication Status

<u>Complete for initial assessment and at least annually</u>.

CS1. Are there physical or cognitive barriers that affect the patient’s ability to communicate?

■ Yes
☐ No

CS1a. If yes, describe:

____
____
____

CS2. Are there any barriers to the patient’s ability to communicate verbally in English, exclusive of cognitive or physical barriers?

Assessment of Patient’s Ability to Communicate in English		
No limitation	Barriers present	
	■	Not able to communicate in English *Requires interpretation assistance at all times*
	■	Only able to communicate basic needs to staff *Uses single words or short phrases; requires interpretation assistance for conversations and care planning*
	☐	Able to communicate with staff in most situations *Able to carry on conversations with staff; requires occasional interpretation assistance for more complex conversations*
☐		Able to communicate in English

If a barrier is present, answer the following questions:

CS2a. What is the patient’s primary language for communicating with facility staff?

____

CS2b. When interpretation assistance is required, how does the patient communicate with the care team? (Check all that apply.)

☐	Family
☐	Friends and/or other social supports
☐	Professional interpreter
☐	Community agency
☐	Facility staff (able to communicate with the patient in his or her primary language)
☐	None of the above (care team unable to effectively communicate with the patient)

CS3. Is the patient able to read printed materials?

Language	Yes	No	Limited	Details
	☐	■	☐	
	☐	■	☐	
	☐	■	☐	

Advance Care Planning

<u>Complete for each assessment</u>.

AP1. Does patient have any of the following?

	Yes	No	Copy at facility	
Advance directive (living will, durable power of attorney for health care and health care proxy)	☐	☐	☐	Appointee:
Do not resuscitate order at facility	■	■	☐	
Do not resuscitate order in community	■	■	☐	
Court-appointed guardian	☐	☐	☐	Appointee:
Durable power of attorney for financial	☐	☐	☐	Appointee:

AP1a. If the patient does not have an advance directive, does the patient or a support person want information on advance directives?

■ Yes
☐ No, not interested
☐ No, already has
☐ Unknown

AP2. If the patient has a do not resuscitate order at the facility or in the community, does the patient have pre-funeral arrangements made?

☐ Yes
☐ No
☐ Unknown

AP2a. If yes, list name and phone number of funeral home and other details:

____

____

Social Barriers

Complete for each assessment.

SB1. Have there been any changes to the patient's insurance status since the last assessment? (If initial assessment, mark "Yes.") ☐ Yes ☐ No

SB1a. If yes, what is the patient's current insurance status?

Insurance	Active	Pending	Primary	Secondary	Other
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
☐ No insurance					

Comments: ______________________________

____

____

SB2. Is the patient's insurance status a barrier to positive treatment outcomes? ■ Yes ☐ No

SB2a. If yes, explain (examples: unable to afford co-pays, difficulty paying monthly premiums, etc.):

____

____

____

SB3. What is the patient's mode of transportation to dialysis? (Check all that apply.)

- ☐ Walks
- ☐ Drives self
- ☐ Public bus
- ☐ Family
- ☐ Friends
- ☐ Taxi (self-pay)
- ☐ ADA transport
- ☐ Insurance-funded transport
- ☐ Other:
- ☐ Other:

SB4. Does the patient have reliable transportation to/from dialysis? ☐ Yes ■ No

SB4a. If no, explain:

____

____

____

SB5. Is the patient currently a student? ☐ Yes ☐ No

SB5a. If yes, explain:

____

____

____

<u>Complete for each assessment</u>.

SB6. What is the patient's employment status?

Prior employment If initial assessment, use 6 months prior to starting dialysis If reassessment, use status at last assessment	Current employment
☐ Employed full-time	☐ Employed full-time
☐ Employed part-time	☐ Employed part-time
☐ Retired	☐ Retired
☐ Medical leave of absence	☐ Medical leave of absence
☐ Unemployed (by choice)	☐ Unemployed (by choice)
☐ Unemployed (looking for work)	☐ Unemployed (looking for work)
☐ Unemployed (disabled)	☐ Unemployed (disabled)

SB6a. If not working, what is the patient's vocational rehabilitation (VR) status?

☐ Already working with VR agency
☐ Patient referred to VR
☐ Patient has expressed interest in VR, but has not followed up
☐ Patient not interested
☐ Patient not eligible
☐ Patient looking for employment on own

SB7. Is the patient's dialysis a barrier to positive vocational outcomes? ☐ Yes ☐ No

SB7a. If yes, what barriers does the patient report that prevents him or her from working or attending school? *(Examples: missing workdays, not enough energy to perform job, not able to attend school, etc.)*

SB8. What is the patient's status with regard to the following social needs?

	No problems reported	Maximum assistance in place	Referral needed or in process
Income (wages, Social Security, welfare, etc.)	☐	☐	☐
Food	☐	☐	☐
Medication	☐	☐	☐
Utilities	☐	☐	☐
Housing/rent	☐	☐	☐
Legal	☐	☐	☐
Immigration	☐	☐	☐
Other:	☐	☐	☐
Other:	☐	☐	☐

Mobility Status, Activities of Daily Living and Physical Rehabilitation

Complete for each assessment.

A1. What did the patient use in the past month: (Check all that apply.) ☐ Cane/crutch ☐ Walker ☐ Manual wheelchair ☐ Electric wheelchair ☐ Limb prosthesis ☐ None of the above

A2. Has the patient been referred for physical rehabilitation services? ☐ Yes ☐ No

A2a. If no, does the patient want to be referred to physical rehabilitation? ☒ Yes ☐ No

A3. Level of assistance with activities of daily living:

☐ Independent

☐ Assistance required (indicate activities requiring assistance):

- ☐ Bathing
- ☐ Toileting
- ☐ Dressing
- ☐ Medication management
- ☐ Meal preparation
- ☐ Housekeeping
- ☐ Laundry
- ☐ Transportation
- ☐ Shopping
- ☐ Finances
- ☐ Medical appointments
- ☐ Other:______________________

☐ Requires total care

If assistance or total care is required, answer the following questions.

A3a. Is there adequate support or services in place to provide assistance?
☐ Yes
☒ No

A3b. Describe support or services in place. (Include persons providing assistance, barriers and/or lack of assistance.)
____
____
____
____

Living Situation

Complete for each assessment.

L1. With whom does the patient live?
☐ Lives alone
☐ Parents
☐ Spouse
☐ Child/children
☐ Significant other/friend/relative
☐ Other ___________________________

L3. Is the patient's current living situation a barrier to positive treatment outcomes?
☒ Yes
☐ No

L3a. If yes, describe barrier:
____
____
____

L2. Where does the patient reside?
☐ Owns home/condo/mobile home
☐ Rents apartment/house
☐ Assisted living
☐ Public housing
☒ Long-term care facility (nursing home)
☒ Acute rehabilitation center
☒ Shelter
☐ Correctional facility
☒ Homeless
☒ Adult family home/group home

Support System and Spirituality[1]

Complete for initial assessment and at least annually.

S1. What is the patient's relationship status?
☐ Single ☐ Domestic partner
☐ Married ☐ Widowed
☐ Divorced ☐ Separated

S2. Describe family composition *(dependent children, relatives in the home, etc.):*

S3. What is the level of involvement of family and friends on a regular basis with the patient *(visits, phone calls, emails, etc.)?*
☐ Daily
☐ Weekly
☐ Monthly
☐ Less frequently than monthly

S4. How does the patient cope with life events and daily stress? (Check all that apply.)
☐ Keeps it to himself or herself
☐ Talks to family
☐ Talks to friends
☐ Prays
☐ Talks with a professional
☐ Support group
☐ Resources on the Internet

S5. Is the patient involved in community activities, groups, social events or volunteering?
☐ Yes
☐ No

S5a. If yes, describe:

S6. What has the patient previously done for enjoyment or recreation?

S6a. Is the patient able to engage in these activities now?
☐ Yes
☒ No

S7. Does the patient report having adequate support (patient's perspective)?
☐ Yes
☒ No

S7a. If no, what support is desired:

Complete for initial assessment only.

S8. Is the patient part of a spiritual or religious community? ☐ Yes ☐ No
Describe:

S9. Are there any specific cultural or spiritual practices/restrictions the health care team should know about in providing the patient's medical care *(e.g., dietary restrictions, use of blood products, etc.)?*
☒ Yes ☐ No

If yes, describe:

Cognitive Patterns and Cognitive Skills for Daily Decision Making[2]

Complete for each assessment.

C1. Is there evidence of a change in cognitive status from the patient's baseline since the last assessment? (If initial assessment, compare to reported status 6 months prior to starting dialysis treatments.)
▣ Yes
☐ No

C2. The patient's ability to make decisions regarding daily life:
☐ Independent
☐ Modified independence (some difficulty in new situations)
☐ Moderately impaired (requires assistance in making decisions)
☐ Severely impaired (never/rarely makes decisions)

C3. Does the patient appear to have a problem with the following?

Short-term memory	▣ Yes	☐ No
Long-term memory	▣ Yes	☐ No

C3a. If yes, check all that the patient was normally able to recall during the last 5 days:
☐ Current season
☐ Day of the week
☐ Staff names and faces
☐ That (s)he is in a dialysis facility
☐ None of the above is recalled

C4. During the past 2 weeks, has the patient demonstrated any of the following behaviors?[2]

Confusion assessment method

Behavior	Behavior not present	Behavior continuously present, does not fluctuate	Behavior present, fluctuates (comes and goes, changes in severity)
Inattention: Did the patient have difficulty focusing attention (easily distracted, out of touch or difficulty keeping track of what was said)?	☐	▣	▣
Disorganized thinking: Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas or unpredictable switching from subject to subject)?	☐	▣	▣
Altered level of consciousness: Did the patient have an altered level of consciousness (not related to low blood pressure)?	☐	▣	▣
Psychomotor retardation: Did the patient have an unusually decreased level of activity (sluggishness, staring into space, moving slowly)?	☐	▣	▣

C4a. What sources of information were used in answering this section?
☐ Patient's self-report ☐ Observations of dialysis staff ☐ Social supports/family
☐ Medical records ☐ Other: ______________________

C4b. Does the patient's behavior change during dialysis treatments? ▣ Yes ☐ No
If yes, describe: ____
____

Mental Health Status

<u>Complete for initial assessment only</u>.

M1. Does the patient report any past or current mental health issues, concerns or mood disturbances (feelings of depression or anxiety)?

☒ Yes
☐ No
☐ Unknown, reason: ____

M1a. If yes, describe:

M2. Is there any history of mental health diagnosis?

☐ Yes ☐ No

M2a. If yes, answer the following:

Diagnosis	Approximate diagnosis date

M3. Has the patient participated in counseling?

☐ Yes, in the past
☐ Yes, currently participating
☐ No

M3a. If yes, how does the patient describe his or her counseling experience?

M4. Has the patient ever taken a psychotropic medication? (Possible interview question: "Have you ever taken any medication to help you relax, to help you sleep or to help you feel less sad or less angry?")

☐ Yes
☐ No
☐ Unknown

Comments:

Complete for initial assessment only.

M5. Does the patient report any history of substance use?

(Possible interview question: “Have you ever used a substance other than alcohol, such as a drug, to help you calm down, feel better, reduce pressure on yourself or just have fun?”)

■ Yes
☐ No

M5a. If yes, complete the following:

Drug	Current use	If currently using, frequency			
		Less than monthly	Monthly	Weekly	Daily or almost daily
	☐ Yes ☐ No	☐	☐	☐	☐
	☐ Yes ☐ No	☐	☐	☐	☐
	☐ Yes ☐ No	☐	☐	☐	☐
	☐ Yes ☐ No	☐	☐	☐	☐
	☐ Yes ☐ No	☐	☐	☐	☐
	☐ Yes ☐ No	☐	☐	☐	☐

M6. Has the patient ever received drug or alcohol treatment?

☐ Yes ☐ No

M6a. If yes, describe:

____

____

____

M7. Ask the patient the following questions (AUDIT questions[5]).

☐ If unable to interview patient, specify reason: ______________________________________

____

M7a. How often do you have a drink containing alcohol?

☐ Never
☐ Monthly or less
☐ Two to four times a month
■ Two to three times a week
■ Four or more times a week

M7b. How many drinks containing alcohol do you have on a typical day when you are drinking?

☐ N/A (never drinks)
☐ One or two
☐ Three or four
■ Five or six
■ Seven to nine
■ 10 or more

M7c. Has a relative, friend, doctor or another health worker been concerned about your drinking or suggested that you cut down?

☐ No/never drinks
☐ Yes, but not in the last year
■ Yes, during the last year

Complete for each assessment.

M8. Are there signs/symptoms present for depression or anxiety problems?
☒ Yes
☐ No

M8a. If yes, what are the signs/symptoms and their severity level?

Signs/symptoms	Severity level			
	Not a problem	Mild	Moderate	Severe
Depressed mood most of the day	☐	☐	☐	☐
Decreased interest/pleasure in most activities	☐	☐	☐	☐
A problem with appetite/weight change	☐	☐	☐	☐
Significant sleep disturbance	☐	☐	☐	☐
Psychomotor retardation or agitation	☐	☐	☐	☐
Fatigue, loss of energy	☐	☐	☐	☐
Feelings of worthlessness or guilt	☐	☐	☐	☐
Poor concentration	☐	☐	☐	☐
Suicidal ideation	☐	☐	☐	☐
Panic attacks	☐	☐	☐	☐
Irritable mood	☐	☐	☐	☐
Early awakening	☐	☐	☐	☐

This signs/symptoms list is derived from the Diagnostic and Statistical Manual of Mental Disorders (DSM). The list is not comprehensive and is not intended to diagnosis depression. Further assessment should be completed if signs/symptoms are present. Somatic symptoms may be due to medical causes.

Complete for each assessment (except initial assessment).

M9. Has the patient started taking a psychotropic medication?

☒ Yes
☐ No

M9a. If yes, list medication(s) and effectiveness per patient's report.

Name of medication and dosage	Date started	Effective	Not effective	Adverse reaction	Effectiveness not yet determined
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐

M10. Has the patient started counseling or a support group?

☐ Yes
☐ No

M10a. If yes, describe:

Depression screening questions (PHQ-2)[6]

M11. Say to the patient: "Over the past 2 weeks, have you often been bothered by …"

	Yes	No
1. Little interest or pleasure in doing things?	☒	☐
2. Feeling down, depressed, or hopeless?	☒	☐

If the patient responds "yes" to either question, follow up with further assessment for depression.

☐ If unable to interview patient, specify reason: ______________________________

Rehabilitation Goals

Complete for initial assessment and at least annually.

R1. What are the patient's goals (vocational, educational, personal, etc.) for the next year?

For the next 5 years?

Self-Management and Level of Participation in Care

Complete for initial assessment only.

SM1. On the following items, indicate the patient's level of understanding:

	Not able to understand	Limited understanding	Adequate understanding	Excellent understanding
Chronic kidney disease	■	■	☐	☐
Treatment options	■	■	☐	☐
Dialysis vascular access options	■	■	☐	☐

SM2. Was the patient referred to a pre-dialysis education program or session?

☐ Yes
☐ No

SM2a. If yes, did the patient attend the program or session?

☐ Yes, location: ____
☐ No, reason: ____

Complete for each assessment (except for initial assessment).

SM3. Patient interview

Say to the patient: "Over the past month, how easy or difficult has it been for you to do any of the following?" Read the options to the patient.

	N/A	Very easy	Somewhat easy	Neither easy nor difficult	Somewhat difficult	Very difficult
1. Come to each hemodialysis treatment	☐	☐	☐	☐	■	■
2. Complete the full-prescribed hemodialysis treatment time	☐	☐	☐	☐	■	■
3. Perform every peritoneal dialysis treatment	☐	☐	☐	☐	■	■
4. Take medications as prescribed	☐	☐	☐	☐	■	■
5. Follow dietary restrictions	☐	☐	☐	☐	■	■
6. Follow fluid restrictions	☐	☐	☐	☐	■	■

SM3a. For anything that was somewhat or very difficult, what would be helpful?

____
____
____

SM4. How well-controlled is the patient's:

	Not controlled	Somewhat controlled	Controlled
Phosphorus level	■	■	☐
Fluid gains	■	■	☐
Blood sugar (if diabetic)	■	■	☐
Blood pressure	■	■	☐

SM5. Does the patient assist with self-care (putting in/taking out own needles, setting up machine, etc.).
☐ Not permitted in facility
☐ Yes
☐ No

SM6. What is the percentage of treatments missed in the last 30 days? (Disregard treatments missed due to hospitalization/travel or other situation in which treatment was received in another setting.)

Percentage: ______

SM7. What is the percentage of shortened treatments in the last 30 days?

Percentage: ______

SM8. Does the patient take responsibility for following his or her medication schedule?
☐ Yes
☐ No

SM8a. If no, check one of the following:
☐ Relies on caregiver/support partner to administer meds
☒ Not interested
☐ Other: ______________________

SM9. Does the patient take responsibility for following dietary restrictions?
☐ Yes
☐ No

SM9a. If no, check one of the following:
☐ Relies on caregiver/support partner to monitor diet
☒ Not interested
☐ Other: _____________________

SM10. Does patient appear comfortable asking staff/physician questions?
☐ Yes
☒ No
☐ N/A

SM10a. If no, what factors limit the patient's comfort in asking questions?
☐ Does not know what questions to ask
☐ Cannot speak
☐ Does not speak English or any language staff speak
☐ Cognition
☐ Thinks asking questions is disrespectful
☐ Other:
____
____
____

SM11. How does patient express concerns/complaints?
____
____
____
____
____

Preferences in Home Dialysis[3]

Complete for each assessment.

HD1. Did the patient initiate dialysis at your facility within the last 12 months?
- ☐ Yes
- ☐ No
- ☐ Unknown

HD1a. If yes, did the patient's nephrologist or dialysis team provide information about home dialysis (home hemodialysis and peritoneal dialysis) within the first 30 days of treatment?
- ☐ Yes
- ☒ No
- ☐ Patient doesn't recall

HD2. Has the patient been dialyzing at your facility for more than 12 months?
- ☐ Yes
- ☐ No

HD2a. If yes, did the patient's nephrologist or dialysis team provide information about home dialysis (home hemodialysis and peritoneal dialysis) within the last 12 months?
- ☐ Yes
- ☒ No
- ☐ Patient doesn't recall

HD3. Does the patient want to pursue home dialysis?
- ☒ Yes
- ☐ No

HD3a. If no, specify why:
- ☐ Unsuitable home situation
- ☐ Medical complication
- ☐ Satisfied with in-center hemodialysis
- ☐ Other ______________________________________
- ☒ Undecided (specify why) ______________________________

HD4. Has the patient expressed interest in learning more about home dialysis options?
- ☒ Yes
- ☐ No

Comments: ____

____

Interest and Suitability for Transplant[4]

Complete for initial assessment and at least annually.

T1. Did this patient initiate dialysis at your facility within the last 12 months?
☐ Yes ☐ No

T1a. If yes, did the patient's nephrologist or dialysis team provide information about how to get a transplant within the first 30 days of treatment?
☐ Yes ☒ No ☐ Patient doesn't recall

T2. Has the patient been dialyzing at your facility for more than 12 months?
☐ Yes ☐ No

T2a. If yes, did the patient's nephrologist or dialysis team provide information about how to get a transplant within the last 12 months?
☐ Yes ☒ No ☐ Patient doesn't recall

T3. Does the patient want to be evaluated for a kidney transplant?
☒ Yes ☐ No ☐ Undecided

T3a. If no, specify why:
☐ Financial barrier
☐ Age
☐ Other ____
☐ Medical complication
☐ Satisfied with dialysis

T4. Are there any contraindications to referring patient for transplant evaluation?

T4a. If yes, contraindication identified by:
☐ Transplant center ☐ Dialysis facility
Specify contraindication(s) (as indicated by the transplant center's selection criteria):
____
____
____

T5. Has the patient been referred to a transplant center for an evaluation?
☐ Yes ☒ No ☐ Unknown

T5a. If yes, specify date _____/____/_____
Specify who referred patient:
☐ Nephrologist
☐ Patient self-referral
☐ Social worker
☐ Secretary
☐ Nurse
☐ Other_______________________

Specify how patient was referred:
☐ Written communication (letters, standard form, e-mail)
☐ Phone call
☐ Other____________________________________

T5b. If no, specify reasons for not referring:
☐ Contraindication(s)
☐ Physician judgment or refuses to refer
☐ Patient not interested/undecided
☐ Patient already on the waitlist
☐ Unknown
☐ Other ______________________

General Narrative Comments:

NOTES AND CITATIONS

[1] These are additional recommended assessment questions regarding spirituality:

- Do you consider yourself to be a religious or spiritual person?
- What things do you believe in that give meaning to your life?
- How might your beliefs influence your behavior during this illness?
- What role might your beliefs play in helping you with your kidney disease?
- What can your dialysis team do to support spiritual issues in your health care?
- Is there a person or group of people who can help support you in your illness?

[2] These questions were modified from questions on the CMS Long-Term Care Resident Assessment Instrument Version 3.0 of the minimum data set (MDS), which can be located at: **www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp** The confusion assessment method (CAM) is included in the MDS draft and is a standardized assessment tool. For additional information regarding the use of a CAM, go to **www.hospitalelderlifeprogram.org/pdf/The_Confusion_Assessment_Method.pdf** If a facility or social worker chooses to use the tool or another version of the CAM, it is the responsibility of the user to research and comply with any copyright requirements.

[3] The questions regarding "Preferences in Home Dialysis" should be complimented by the use of the "Method to Assess Treatment Choices for Home Dialysis" (MATCH-D) tool (available at **www.homedialysis.org/files/pdf/pros/MatchD2007.pdf**)

[4] Taken with permission from ESRD Special Study: Developing Dialysis Facility-Specific Kidney Transplant Referral Clinical Performance Measures, performed under Contract Number 500-03-NW09, entitled "End-Stage Renal Disease Network Organization Number 9," sponsored by the CMS, Department of Health and Human Services. Available at: **www.therenalnetwork.org/images/TransTEPfinalrpt805.pdf**

[5] These questions come from the Alcohol Use Disorders Identification Test (AUDIT), which is a free assessment tool developed by the United Nations World Health Organization. The assessment tool may be administered as an interview or as a questionnaire. The tool comes in both Spanish and English. A PDF version of the tool and manual is available for download at **http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf**

[6] The Physicians Health Questionnaire (PHQ)-2 is derived from the PHQ-9, which is copyrighted and is available in English and Spanish. To read about the PHQ-9, locate scoring instructions and register for download, go to **www.depression-primarycare.org/clinicians/toolkits** or **www.phqscreeners.com**

The Conditions for Coverage for End-stage Renal Disease Facilities were published April 15, 2008, by the Department of Health and Human Services, Centers for Medicare and Medicaid Services, to go into effect **October 14, 2008**.

You can find the entire CfCs at:

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

To best stay informed and up-to-date about the new CfCs, we encourage you to be a national member of the CNSW. Go to **www.kidney.org** or call 800.622.9010 to join today!

www.kidney.org/professionals/pdf/cnswform.pdf

Quality-of-Life Assessment Tools

Council of Nephrology Social Workers

Conditions for Coverage (CfCs): Subpart C Patient Care/Patient Plan of Care 494.90(a)(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.

Supplementary Information: Section II/Summary of the Proposed Provisions and Response to Comments on the February 4, 2005, Proposed Rule

Response: In response to the large number of comments, and in light of current academic research supporting social service interventions to improve patient care, we are adding a social services component, called "psychosocial status" to the plan of care requirements at 494.90(a)(6). We are requiring that a standardized tool, chosen by the social worker, be used to monitor patient status, and that counseling be provided and referrals be made as appropriate. The standardized tool should be a professionally accepted, valid, reliable tool, such as the SF-36, and should relate to the patient's functional health and well-being. The tool must be used as a monitoring aid that assists in determining the patient's psychosocial status. The SF-36 model uses metrics that measure physical health as related to functional level and presence of pain, and mental health as related to social functioning, emotional and mental health. Reliability and validity studies have been performed for this instrument. More information about SF-36 may be found in numerous articles or on the Web at **www.sf-36.org/tools/sf36.shtml**. The SF-12 survey form was derived from the SF-36 form and scales the 36-question survey down to a 1-page, 2-minute version. However, we are not specifying which tool must be used in order to allow flexibility and to limit the amount of burden. The choice of which standardized tool to use is best left to the facility social worker.

Phase III ESRD Clinical Performance Measures (CPMs) in Effect April 1, 2008

Assessment of Health-related Quality of Life (Physical & Mental Functioning)—Facility Level: Percentage of dialysis patients who receive a quality-of-life assessment using the Kidney Disease Quality-of-Life (KDQOL)-36 (a 36-question survey that assesses patients' functioning and well-being) at least once per year. You can read about CPMs and download the latest table of them at **www.cms.hhs.gov/CPMProject**.

DISCUSSION

Based on the above requirements in the CfCs and CPMs, a facility that uses another survey to measure physical and mental functioning will *still* need to administer the KDQOL-36 at least once per year. The KDQOL-36 includes physical and mental functioning *and* kidney-specific information, which may make it more acceptable to your patients than the generic SF-36. Don't panic! The Medical Education Institute, Inc./Life Options (**www.lifeoptions.org**) is designing an online version of the KDQOL-36 for social workers to gain practice with the tool; see the questions, subscales and norms; and get tips for how to improve low scores. A subsequent project planned for late winter will let facilities score patient *and* facility data and track it on your center's computer. Both tools will be offered for free at **www.lifeoptions.org**.

The CMS clinical performance measures state that the KDQOL-36 must be administered annually with some limited situations where it is not required, such as for those patients at the facility less than 90 days, those under 18 years old, those with cognitive impairments, those who speak languages for which there is no translation and those who refuse. See **www.qualityforum.org/projects/ongoing/esrd/index.asp** (from the menu on the left side of the page, choose "Specifications for Endorsed Measures") to download the document to your computer. JNSW

Ethics and the New Conditions for Coverage for End-Stage Renal Disease Facilities

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Social workers bring a unique perspective of values and ethical decision-making skills to their work environments. Trained in the basic values of service, social justice, dignity and worth of individuals, importance of human relationships, integrity and competence, social workers are equipped to help the health care team face ethical dilemmas and use these values to promote ethical decision making. The new Conditions for Coverage for End-Stage Renal Disease Facilities include some new guidance on current ethical dilemmas. These include the patient care environment, patient rights, advance care planning and involuntary discharge. At this critical juncture, social workers can assist their health care team in creating new processes and policies for ethically-sound practice with people on dialysis.

INTRODUCTION

For as long as there has been an organized profession, social workers have been faced with ethical dilemmas. However, ethics have evolved over time, and different aspects of ethics have been emphasized throughout the profession's history. In the late 19th century, social workers focused on ethics related to their clients more than the social work profession. When more formal training programs were established, debate centered on determining the profession's core values. In the 1970s, more educational programs added curriculum on ethics and, with the advance of technology, professional conferences began discussing ethics in relation to topics such as life support, organ transplantation and *in vitro* fertilization. Most recently, another area of ethics has evolved related to risk management. This area of ethics has focused on professional negligence and liability in response to client complaints and lawsuits (Reamer, 2006a).

Ethical Dilemmas in the Dialysis Setting

Nephrology social workers may find themselves faced with a host of ethical dilemmas. Ethics practiced in a medical setting takes many forms, including allowing patients to assume personal responsibility for their health, practicing the principle of nonmaleficence, being truthful to patients, maintaining confidentiality and bodily integrity, caring for those who cannot pay for services and allowing patients to die if therapy to counteract illness or disease imposes a severe burden upon patients (or their families) or is ineffective (Bone, 1996). In practice with dialysis patients, social workers may find themselves faced with ethical dilemmas regarding access to care, late referrals to health care resources, appropriate patient education and conflict and interpersonal relationships between patients, health care providers and others.

When faced with an ethical dilemma, an ethical decision-making framework is important to guide social workers through the process of identifying the ethical issues to helping the health care team make the most appropriate decisions. The following step-by-step process should be used when confronted with an ethical dilemma:

1. Identify the ethical issues, including conflicting social work values and duties.
2. Identify the individuals, groups and organizations likely to be affected by the ethical decision.
3. Tentatively identify all viable courses of action and the participants involved in each, along with the potential benefits and risks.
4. Thoroughly examine the reasons for and against each course of action.
5. Consult with colleagues and appropriate experts.
6. Make the decision and document the decision-making process.
7. Monitor, evaluate and document the decision (Reamer, 2006a).

When one is in the midst of a confusing situation, it can often seem overwhelming. However, breaking it down using the previous framework can provide direction to the health care team and create a more concrete approach to overwhelming situations.

The Centers for Medicare and Medicaid Services (CMS) released revised Conditions for Coverage (CfCs) for U.S. dialysis facilities in April, which will go into effect October 2008. The following areas identify common ethical situations in dialysis settings, and the new CfCs provide some guidance for the health care team in protecting the best interests of both dialysis patients and providers. Section 494.60 (Physical Environment) contains a standard to maintain a comfortable temperature within the facility and make reasonable accommodations for the patients who are uncomfortable. Although this situation may seem at first like a minor ethical dilemma, the dialysis facility temperature is often an area of low patient satisfaction, which can lead to conflicts between patients and dialysis staff. Patients are sitting for several hours at a time, whereas staff are moving and wearing personal protective equipment. Whose comfort is most important? The CfCs' preamble encourages dialysis facilities to "arrive at a middle ground so that the room temperature is at least marginally acceptable to both patients and staff. Patients who continue to feel cold could use coverings or blankets" and "should not be deprived of the ability to use covers or blankets" as long as they keep their access and line connections uncovered (CMS, 2008).

Section 494.70 (Patient Rights) includes a new area to inform patients about their right to execute advance directives and the facility's policy regarding advance directives. A study of 80 dialysis patients found that although 69% of patients thought completing an advance directive was a good idea, only 35% had followed through to complete one (Holley, 1997). While many dialysis facilities have implemented policies related to discussing advance directives with patients, the new CfCs bring this important issue to a standard of care. Dialysis health care teams should discuss the roles of each team member in advance care planning with patients and strive to provide education to both professionals and patients to increase the level of comfort in end-of-life care discussions. The dialysis community has recognized this issue as an important one and has formed the Kidney End-of-Life Coalition, which provides tools and resources on their Web site (**www.kidneyeol.org**).

A higher level of patient participation in care is expected in the new CfCs. In Section 494.80 (Patient Assessment) and Section 494.90 (Patient Plan of Care), a number of new requirements include patients in assessing problems, determining interventions, evaluating the outcomes of those interventions and determining new goals. For example, the comprehensive patient assessment must include an area designated to evaluate the desired level of patient participation in care and the patient's expectations for care outcomes. This type of patient-centered language has not been seen in the past CfCs and reflects the current practice of increased patient involvement in health care, encouraging transparency and including patients as vital members of the multidisciplinary health care team. The Patient Plan of Care condition requires individualized care plans for each patient's needs and patients be given the opportunity to participate in the care plan process. Patients cannot participate fully without knowledge, and the condition also requires documentation showing patients were educated about the dialysis experience, dialysis management, infection prevention, home dialysis and self-care, quality of life, rehabilitation, transplantation and the benefits and risks of various vascular access types.

Ethical dilemmas may arise in determining the participation level of patients in their care. Patients may refuse to participate in care planning or may be nonadherent to their treatment plan. Language barriers may exist, making a standard of education difficult to achieve for each patient. Although the CfCs recognize that patients cannot be forced to participate or adhere to their treatment plan, a higher expectation will be placed on the health care team to include patients in decisions about their care and educate them appropriately. The new CfCs attempt to move the health care team to provide a higher level of individualized, comprehensive care. As Lori Hartwell, a person living with kidney disease, states, "I've heard the phrase 'the patients' uttered countless times during my 37 years of living with renal disease. We tend to be viewed as an amorphous group. Nothing could be further from the truth. We might have lost our kidney function, but we have not lost our identities" (2006).

Involuntary patient discharge from dialysis facilities is arguably the most difficult ethical dilemma a nephrology social worker can face. This issue includes the rights of patients and the rights of dialysis providers and health care staff. Social workers also have a professional responsibility not to abandon their clients. When a patient is involuntarily discharged, the patient leaves the care of the dialysis facility, including the professional relationship with the social worker. The National Association of Social Workers (NASW) code of ethics states, "Social workers should take reasonable steps to avoid abandoning clients who are still in need of services. Social workers should withdraw services precipitously only under unusual circumstances, giving careful consideration to all factors in the situation and taking care to minimize possible adverse effects. Social workers should assist in making appropriate arrangements for continuation of services when necessary" (NASW, 1999). Termination of services must always be handled carefully to protect patients and minimize risk to patients, dialysis providers and professional liability and integrity. As Reamer states, "Clients whose services are terminated unethically may not receive the services they need and, as a result, may pose a threat to themselves and others" (2006b).

In Section 494.180 (Governance), the CfCs provide criteria for circumstances under which patients can be involuntarily discharged. These circumstances include termination of reimbursement by patient or payer, facility closing, necessary transfer for the patient's welfare and disruptive and abusive patient behavior to the extent that the delivery of care or ability of the facility to operate effectively is seriously impaired.

The process for involuntary discharge must include these steps, which must be guided by the medical director. The patient's interdisciplinary team:

1. Documents the reassessments, ongoing problem(s) and efforts made to resolve the problem(s)
2. Provides the patient and local End-Stage Renal Disease (ESRD) Network with a 30-day notice of the planned discharge
3. Obtains a written physician's order signed by both the medical director and the patient's attending physician concurring with discharge
4. Contacts and attempts to place the patient in another facility and documents that effort
5. Notifies the state survey agency and the ESRD Network that services the area of the involuntary transfer or discharge.

In the case of immediate severe threats, the facility may utilize an abbreviated involuntary discharge procedure. The CfCs' preamble includes a suggestion from CMS that dialysis facilities use materials developed by the Decreasing Dialysis Patient–Provider Conflict National Task Force to prevent conflicts and disruptive situations. These materials are available from any ESRD Network.

Clearly, a number of ethical issues arise in caring for people on dialysis because of the nature of life-sustaining therapy and the ongoing inter-relatedness of people on dialysis, the dialysis facility staff and dialysis provider companies. Social workers should employ their training in basic values of providing services and an ethical framework for decision making to help the dialysis health care team make the most appropriate decisions when confronting ethical dilemmas. The new CfCs provide some new guidance to some of these situations and encourage the dialysis health care team to provide a higher level of care focusing on patient-centeredness and involvement in decision making.

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Resources

For a copy of the 2008 Dialysis Conditions for Coverage, visit **http://edocket.access.gpo.gov/2008/pdf/08-1102.pdf**

For the Council of Nephrology Social Workers resources about the 2008 Conditions for Coverage and to watch the related webinar, visit **www.kidney.org/professionals/webinar.cfm**

For information on the End-Stage Renal Disease (ESRD) Clinical Performance Measures (CPMs), visit **www.cms.hhs.gov/CPMProject**

For information on the CPM-required Kidney Disease Quality of Life (KDQOL) tool, visit **http://gim.med.ucla.edu/kdqol**

For more information about the CPM-required patient satisfaction survey CAHPS, visit **https://www.cahps.ahrq.gov/content/cahpskit/files/509_ich_reporting_measures.htm**

or e-mail **charles.darby@ahrq.hhs.gov**

For more information about implementing the KDQOL and rehabilitation, visit **www.lifeoptions.org**

For more information about advance directives, visit **www.kidneyeol.org**

For more information on home dialysis options, visit **www.homedialysis.org**

For more information about the National Kidney Foundation (NKF) booklet *Taking Control: Money Matters for People With Chronic Kidney Disease* (includes information on rehabilitation), visit **www.kidney.org/patients/pfc/control.cfm**

For more information about transplant referrals, visit **www.therenalnetwork.org/qi/resources/TransTEPfinalrpt805.pdf**

For more information about decreasing involuntary discharges, ask your ESRD Network about their Decreasing Dialysis Patient–Provider Conflict (DPC) Program or visit **www.esrdnetworks.org/special-projects/copy_of_decreasing-patient-provider-conflict-dpc**

For more information about CNSW research grants to help show that nephrology social work works, e-mail Jeff Harder, Research Chairperson, at **jharder@u.washington.edu**

For more information about joining CNSW—the best way to stay informed about the CfCs—go to **www.kidney.org**, **www.kidney.org/professionals/pdf/cnswform.pdf** or call **800.622.9010**.

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

CNSW Research Grants Program

PURPOSE

In keeping with the overall goals of the National Kidney Foundation (NKF) and its Council of Nephrology Social Workers (CNSW), the purpose of the CNSW Research Grant Program is to further knowledge of psychosocial factors in kidney failure and to enhance clinical social work intervention with dialysis and transplant patients/families.

AREAS OF INTEREST

- Research on psychosocial factors in kidney failure
- Clinical practice research projects focusing on social work assessment and treatment strategies with patient/families or staff
- Educational programs to enhance patient/family understanding of kidney failure treatment and its psychosocial implications
- Pilot or demonstration projects which have broad applicability to nephrology social work services and/or nephrology social workers

ELIGIBILITY

Grant applications must meet the following eligibility requirements:

- Regular membership in CNSW
- Minimum of two years nephrology social work experience (CMS Guidelines)
- Approval of the department head or facility director of the organization within which the research is to be conducted
- Residence in the United States or its territories
- Applicant must meet the definition of a “qualified social worker” as stated in ESRD Federal Regulations

Preference will be given to applicants who:

- Have ACSW accreditation or are licensed by their state

Awards will be announced in March. The Review Committee reserves the right to award grants or to decline funding without stating its reasons.

GRANT REQUIREMENTS

Each grant recipient is responsible for:

- Conducting the project as set forth in the proposal and consistency with accepted, systematic research methods
- Obtaining appropriate human studies clearance within the dialysis/transplant facility and maintaining data in a confidential manner
- Completing the project within the specified time frame
- Providing financial reports as required by the National Kidney Foundation
- Acknowledging NKF/CNSW grant assistance on all publications arising out of the work done during the duration of the grant
- Submitting three interim progress reports and other requested reports, preparing a final report of the work accomplished within 60 days of the end of the grant year, and presenting a paper at the NKF Spring Clinical Meetings describing the research, results and implications for practice
- Submitting a manuscript based on the results to *The Journal of Nephrology Social Work* (and with the committee’s approval, another related journal)

FUNDING

- CNSW annually requests grant monies from NKF.
- One or more grants will be awarded. Applicants submitting to more than one granting agency will be awarded the difference between the amount awarded by the other agency and the amount applied for from CNSW.
- CNSW grants assist in defraying the cost of research and projects. They are not intended to cover the entire cost of the research (i.e., office space, basic supplies, services, overhead, administration fees).
- Funds may not be used for the purchase of equipment.
- Budgets must allocate $750.00 for airfare and one night’s accommodation to enable grantees to present their research at the NKF Spring Clinical Meetings. This amount will be withheld until *The*

CNSW Research Grants Program *(cont'd)*

Journal of Nephrology Social Work Editor receives the first draft for publication three weeks prior to the Clinical Meetings.

- Funding for CNSW research grants runs from July 1 of the year of approval through June 30 of the following year.

HOW TO APPLY

If you are interested in preparing a proposal, please submit a letter of intent to the CNSW Research Grant Program, c/o the National Kidney Foundation by **October 16**. Your letter of intent is not part of your actual application, but rather a device to assist you and the grants coordinator in identifying your research objectives and goal. The letter of intent must include the following:

1. Name of the person and organization submitting the proposal
2. Address
3. Telephone number
4. Name of the principal investigator and his/her membership number
5. Short title of the project
6. Approximate cost
7. Brief abstract under 250 words which includes:
   a. A description of the project goal
   b. How it relates to the purpose of CNSW research

Upon receipt and acceptance of your letter of intent, NKF/CNSW will send you a grant application packet.

CONSULTATION COMMITTEE

CNSW has volunteer consultants available to provide recommendations and prior review of your proposal.

Review Schedule

October 16	Letter of intent due
December 1	Grant Proposal due
January – February	Council Research Grants Committee Review
March	Awards Announced
July 2	Approved projects begin operation and continue until June 30th of the following year.

The Council of Nephrology Social Workers (CNSW) is a professional organization established by nephrology social workers in 1973. CNSW is one of three Professional Councils of the National Kidney Foundation (NKF). The functional structure of CNSW includes an Executive Committee with regional representation, standing and ad hoc committees, and local chapters.

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