



DIALYSIS DIALOGUE

CONDITIONS FOR COVERAGE FOR ESRD SERVICES

Welcome to this edition of *Dialysis Dialogue*, a newsletter published by the North Dakota Department of Health, Division of Health Facilities. *Dialysis Dialogue* is designed to help dialysis departments stay up-to-date on various issues. Please share with your dialysis staff.

The new Conditions for Coverage for ESRD Services went into effect Oct. 14, 2008. The new ESRD regulations are structured into four parts:

- A. General:** (1) basis and scope; (2) definitions; and (3) compliance with federal, state and local laws and regulations.
- B. Patient Safety:** (1) infection control; (2) water and dialysate; (3) reuse of hemodialyzers and bloodlines; and (4) physical environment.
- C. Patient Care:** (1) patients' rights; (2) patient assessment; (3) patient plan of care; (4) care at home; (5) Quality Assessment and Performance Improvement (QAPI); (6) special purpose renal dialysis facilities; and (7) laboratory services.
- D. Administration:** (1) personnel qualifications; (2) responsibilities of the medical director; (3) medical records; and (4) governance.

This newsletter will focus on two Conditions of Participation in Part C — Patient Care:

- Patient Assessment (V501)
- Patient Plan of Care (V542)

Inside this issue:	
Conditions for Coverage	1-4
A Big Thank You	4
Q&A	5, 6



*These two conditions are interrelated . . .
Like love and marriage,
“you can’t have one without the other”*

The new regulations emphasize:

Interdisciplinary Care

Team members work collaboratively. Communication is by regular discussions about patient status and the evolving plan of care.



VS.

Multidisciplinary care

Team members work sequentially or parallel to each other. Chief means of communication is through the medical record.

It is the process not the paper!

(Continued on Page 2)

(Continued from Page 1)

CONDITION: PATIENT ASSESSMENT

The Interdisciplinary Team (ITD) includes at a minimum:

- The patient or designee (if the patient chooses).
- A registered nurse.
- A physician treating the patient for ESRD.
- A social worker.
- A dietitian.

The ITD 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.

“Individualized” means each assessment is unique to a particular patient and addresses that patient's needs. “Comprehensive” means the assessment covers and addresses all issues that are actionable by the dialysis facility.

STANDARD: Assessment criteria

The comprehensive assessment must include but is not limited to evaluation of:

1. Current health status and medical condition, including comorbid conditions.
2. Appropriateness of the dialysis prescription, blood pressure and fluid management needs.
3. Laboratory profile, immunization history and medication history.
4. Factors associated with anemia, such as hematocrit, hemoglobin, iron stores, and potential treatment plans for anemia, including administration of EPOs.
5. Factors associated with renal bone disease.
6. Nutritional status by a dietitian.
7. Psychosocial needs by a social worker.
8. Dialysis access type and maintenance.
9. Patient's abilities, interests, preferences, and goals, including the desired level of participation in the dialysis care process; the preferred modality and setting; and the patient's expectations for care outcomes.

10. 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. Family and other support systems.

12. Current patient physical activity level.

13. Referral to vocational and physical rehabilitation services.

STANDARD: Frequency of assessment for patients admitted to the dialysis facility

An initial comprehensive assessment must be conducted within the latter of **30 calendar days** or **13 hemodialysis sessions**, beginning with the first dialysis session. This applies to all new dialysis patients, without regard to the modality of treatment. Patients returning to dialysis from a failed transplant or changing modalities (from PD to hemo) are also considered “new” patients. A follow-up comprehensive reassessment must occur **within three months** after the completion of the initial assessment.

STANDARD: Assessment of treatment prescription

Assessment of treatment prescription for hemodialysis patients must be done **at least monthly** by calculating delivered Kt/V or an equivalent measure.

Assessment of treatment prescription for peritoneal dialysis patients must be done **at least every four months** by calculating delivered weekly Kt/V or an equivalent measure.

STANDARD: Patient reassessment

Patient reassessment (and a revision of the plan of care) must be conducted at least **annually** for stable patients and is due 12 months after the three-month reassessment.

(Continued on page 3)

Continued from Page 2)

For unstable patients, the reassessment must be conducted at least **monthly**.

Unstable patients include, but are not limited to, patients with the following:

- Extended or frequent hospitalizations.
- Marked deterioration in health status.
- Significant change in psychosocial needs.
- Concurrent poor nutritional status, unmanaged anemia and inadequate dialysis.

IDT members have the flexibility to use their professional judgment to develop **more stringent** policies regarding the definition of “unstable.”

CONDITION: PATIENT PLAN OF CARE

This condition reviews individual patient outcome data and addresses the goals and plans set for individual patients. Facilities should use the Measures Assessment Tool (MAT) to establish targets for individual patient’s clinical outcomes. The MAT is a reference for current professionally accepted clinical practice standards, guidelines and CMS Clinical Performance Measures (CPM). The standards in the MAT are targets — each patient should be treated individually. Goals for some patients may need to be initially different from these targets and then incrementally changed to the standard target value as the patient outcome improves. When a target is not met, the plan of care should either be adjusted to achieve the target or an explanation should be provided by the IDT as to why the target is not able to be achieved. The plan of care includes all of the care, services and treatment interventions the IDT determines to implement to meet the specific needs of the patient.

The plan of care must include at minimum:

- Problem(s) identified at assessment/reassessment.
- Measurable goals/outcomes.
- Planned interventions for achieving the goals.
- Timetables and reassessment date(s).

*Timelines for meeting targets should be based on setting **reasonable** targets for the individual patient. The timelines also should be appropriate to the*

severity of the problem and the extent of the planned interventions

The written plan of care may be one document or composed of separate sections, but it must reflect the integration of the comprehensive assessments contributed by all members of the IDT.

STANDARD: Development of the patient plan of care

The interdisciplinary team must develop a plan of care for each patient. The plan of care must address, but is not limited to, the following:

- Dose of dialysis.
- Nutritional status.
- Mineral metabolism.
- Anemia.
- Vascular access.
- Psychosocial status.
- Modality.
- Rehabilitation status.

STANDARD: Implementation of the patient plan of care

The patient’s plan of care must be completed by the IDT, including the patient if the patient desires. The patient’s plan of care must be signed by the 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.

Implementation of the initial plan of care must begin within the **latter of 30 calendar days** after admission to the dialysis facility, **or 13 outpatient hemodialysis sessions** beginning with the first outpatient dialysis session.

Implementation of **monthly or annual updates of the plan of care** must be performed **within 15 days** of the completion of the additional patient assessments.

(Continued on Page 4)

(Continued from Page 3)

If the expected outcome is not achieved, the IDT must adjust the patient's plan of care to achieve the specified goals. If the patient is unable to achieve the desired outcomes, the IDT must:

- Adjust the plan of care to reflect the patient's current condition.
- Document in the record the reasons why the patient was unable to achieve the goals.
- Implement plan of care changes to address the issues identified.

All dialysis patients must be seen by a physician, nurse practitioner, clinical nurse specialist or physician's assistant providing ESRD care at **least monthly**.

STANDARD: Transplantation referral tracking

The IDT must track the results of each kidney transplant center referral and monitor the status of any facility patients who are on the transplant waiting list. The IDT must communicate with the transplant center regarding patient transplant status at least annually and when there is a change in transplant candidate status.

STANDARD: Patient education and training

The patient plan of care must include education and training for patients and family members and/or caregivers in aspects of:

- The dialysis experience.
- Dialysis management.
- Infection prevention and personal care.
- Home dialysis and self-care.
- Quality of life.
- Rehabilitation.
- Transplantation.
- Benefits and risks of various vascular access types.

THANK YOU to everyone who helped fellow colleagues and the ESRD patients we serve during the recent blizzard and flood emergencies. We are all truly blessed to work with such amazing people!

*Yesterday the twig was brown and bare;
To-day the glint of green is there;
Tomorrow will be leaflets spare;
I know no thing so wondrous fair,
No miracle so strangely rare.
I wonder what will next be there!*

~L.H. Bailey



Questions and Answers (Q&A) Compiled by CMS

CMS provides specialized technical ESRD training courses for state surveyors, as well as an annual ESRD update. During these training courses, surveyors from across the country ask CMS staff members questions regarding the survey process. Although the questions and answers do not represent official CMS policy, they contain valuable information regarding the survey process. The Q&A is a regular feature of the Dialysis Dialogue newsletter.

Do transfer patients and transient patients need an initial comprehensive interdisciplinary assessment in 30 days or 13 treatments?

Each patient new to dialysis must have an initial comprehensive interdisciplinary assessment within 30 days or 13 treatments after admission. This requirement applies to all new dialysis patients, without regard to the modality of treatment. If the comprehensive assessment and plan of care for an experienced dialysis patient transferring from one dialysis facility to another is received with the patient transfer, the receiving patients IDT must conduct a reassessment within three months of the patient's admission to the new facility. This same provision (i.e., completion of a reassessment within three months of admission) applies to transient patients who are received with the sending facility's comprehensive assessment and plan of care.

Discuss the expectation for “compliance with a year.” Does this mean “don't cite” for one year?

Allowing facilities up to a year from Oct. 14, 2008, to come into compliance with these two conditions for current patients does not mean “don't cite” these requirements for a year. Patients new to dialysis (or returning from transplantation, or changing modalities) are expected to have an assessment within 30 days/13 treatments of admission, and a Plan of Care (POC) immediately implemented. When a transferred patient is received with a Patient Assessment/Plan of Care (PA/POC) from the transferring unit, the receiving unit is expected to reassess the patient within three months of admission. The requirements discussed above are expected to be “met” at the time of surveys during the first year of implementation. In addition, the facility should have a plan for completing PA/POC for all current patients within the year and have begun accomplishment of that plan.

Does an acute patient who dialyzes in an outpatient facility require the full assessment and care plan process? This patient has been discharged from a hospital and is coming to the outpatient facility until kidney function is regained.

Every patient is expected to receive the same level of care. If an “acute” patient is treated in the outpatient facility longer than 13 treatments/30 days, the PA/POC would be expected to be completed.

Discuss the mechanism of updating an assessment; what would the document look like, a series of assessments?

If a patient is stable but does not achieve or maintain the goal for one or more areas in the POC, the facility would need to update that portion of the POC. This could be done on the assessment form or in the progress notes of one or more of the IDT members. The form of the documentation is not specified.

Are facilities required to hold care plan meeting with all disciplines and patients at the same time as opposed to passing around the document and each person signing off on it?

The patient assessment and POC are required to be developed by the IDT, which includes the patient. These can be accomplished many ways; best practice would have to be face-to-face meetings of the team including the patient; other options would be to accomplish part of the assessment/POC during chair-side rounds or having each discipline work with the patient and collaborate with their findings. The POC must

(Continued on page 6)

(Continued from page 5)

Questions and Answers (Q&A) Compiled by CMS (Cont'd)

demonstrate collaboration and congruence, which is not likely to happen if a piece of paper is just passed around among the team.

When the IDT develops the POC, is it expected that all the members be present and document their presence?

The IDT members are expected to interact and share information for the comprehensive assessment and to develop the POC. This may be accomplished in an IDT conference or you may use another mechanism to ensure the development of an integrated plan. A substitute mechanism for a team conference should facilitate discussion, sharing and collaboration among team members.

If a stable patient does not meet one quality indicator in the POC, does the entire team need to reassess or can only one member of the team update and revise the POC?

If the patient does not meet the expected goal, the IDT must reassess that specific area. POC does not “require” a patient to meet every goal. Any member of the team including the patient may document why goals are not met. In some areas (such as rehabilitation, volume status and nutritional status) the majority of the actions taken might be developed by one team member.

What if the patient misses or shortens treatment time or gains excessive fluid between treatments resulting in an inability to achieve an “adequate” dialysis?

The IDT is responsible for ensuring that each patient understands the consequences of his/her behavior in terms of treatment results. In addition, the staff should work with the patient to address behaviors that result in poor treatment results, such as missing and shortening treatments. Ultimately, the patient can choose to continue behaviors that result in lessened treatment results. With documentation of educational efforts, the patient’s choice can be an explanation on a plan of care for not receiving standard treatment results.

If the patient does not wish to participate in the IDT, what documentation is expected in their medical record?

The patient has a right to refuse to participate in the IDT discussions about his/her care, and the IDT should document their attempts to include the patient in such discussions and the refusal. Because the patient’s situation and/or outlook may change, the IDT should continue to make and document good faith attempts to include the patient in the IDT discussions.

**If your facility would like
to receive
Dialysis Dialogue
electronically,
please send your e-mail
address to
bweidner@nd.gov**



*Dialysis Dialogue is published by:
Division of Health Facilities
North Dakota Department of Health
600 E. Boulevard Ave., Dept. 301
Bismarck, N.D. 58505-0200
Phone: 701.328.2352
Fax: 701.328.1890
Web: www.ndhealth.gov*

*Terry Dwelle, M.D., M.P.H.T.M., State Health Officer
Darleen Bartz, Ph.D., Chief, Health Resources Section
Bruce Pritschet, Director, Health Facilities
Bridget Weidner, Program Manager
Cathy Myrvik, ESRD Surveyor
Cindy Kupfer, Newsletter Design*