

ESRD Network 15

**Clinical Performance Guidelines
and Standards of Care for
Dialysis Facilities in
Arizona, Colorado, Nevada,
New Mexico, Utah,
and Wyoming**

2019 | V. 6.0

TABLE OF REVISIONS

The contents of this plan are subject to change without prior notice. Should revisions become necessary, written updates will be distributed to Network staff for inclusion in the plan. The Quality Improvement Director is responsible for updating the *Clinical Performance Guidelines and Standards of Care*; however, all staff are responsible for updating and knowing the actions/activities within their areas of responsibility, keeping them current, and being familiar with their content. The Network Executive Director shall ensure that all staff members are updated and current on the *Clinical Performance Guidelines and Standards of Care*.

When inserting revisions to this plan, the person revising the document shall complete the table below.

Revision #	Date	Section, Page(s)	Change	Revised By
1.0	February 2019	Initial Publication		ESRD Network 15

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CLINICAL PERFORMANCE GUIDELINES

OVERVIEW

A primary goal of Network 15 is to improve the quality of healthcare services provided to end stage renal disease (ESRD) patients. The Network's Medical Review Board (MRB) adopted the following revised Network Clinical Performance Guidelines in February 11, 2019, to align with the Kidney Disease Outcomes Quality Initiative (KDOQI) guidelines, ESRD Conditions for Coverage (CfCs) Measures Assessment Tool (MAT 2.5), and the ESRD Quality Incentive Program (QIP) measures.

The objective of these clinical guidelines is to provide guidance for dialysis providers to attain specific clinical outcomes for their adult (≥ 18 years old) patient populations on chronic dialysis.

The Condition for Patient Plan of Care (V540) reviews individual patient outcome data and addresses the goals and plans set for individual patients. When a specific target is not met, the plan of care (POC), revised after each patient assessment, should either be adjusted to achieve the target or provide an explanation in areas where the targets are not able to be achieved.

Clinical Guidelines

ESRD-specified clinical outcomes include:

- **Hemodialysis Adequacy**

Each provider should strive to attain and subsequently maintain a:

- Hemodialysis patient population achieving a spKt/V levels of ≥ 1.2 . monitored monthly.

- **Peritoneal Dialysis (PD) Adequacy**

Each provider should strive to attain and subsequently maintain a PD patient population achieving:

- Adult: ≥ 1.7 /week monitored first month and every four months thereafter.
- Pediatric ≥ 1.8 /week monitored first month and a minimum of every six months thereafter.

- **Albumin**

- ≥ 4.0 g/dl BCG monitored monthly.

- **Anemia Management**

Each provider should strive to attain and subsequently maintain a dialysis patient population (on dialysis for ≥ 90 days), on erythropoiesis stimulating agent (ESA):

- Achieving Hgb levels greater than 10 gm/dl, with target goal of 10-11 gm/dl
 - Nearing or >11 g/dl ESA dose should be tapered
 - ESA should be discontinued with HGB ≥ 12 .
 - Nephrologist should provide guidance on frequency of monitoring
- Achieving T-Sat levels of $>20\%$ or CHr >29 pg/cell.
- Ferritin (HD) >200 ng/ml
- Ferritin (PD) > 100 ng/ml

- **Vascular Access**

Each provider should strive to attain and subsequently maintain:

- A fistula rate of ≥ 66 percent.
- Graft only if a fistula is not appropriate.
- Catheter as a last choice if fistula or graft is not an option, transplant is pending or if AVF/AVG is not possible in a small adult.
- Long-term catheter (LTC) (in use ≥ 90 days) less than 10 percent

For pediatric patients:

- A permanent access in the form of a fistula or graft is the preferred form of vascular access for maintenance HD therapy.
- A catheter may be a reasonable first choice for patients <20 kg or patients >20 kg who are likely to receive a kidney transplant within one year.
- Circumstances in which a central venous catheter (CVC) may be acceptable for long-term access include:
 - Lack of local surgical expertise to place permanent vascular access in small children.
 - Patient size is too small to support a permanent vascular access.
 - Bridging HD for PD training or PD catheter removal for peritonitis.

- There is an expectation of expeditious kidney transplantation.
- If surgical expertise to place permanent access does not exist in the patient’s pediatric setting, efforts should be made to consult vascular access expertise among local adult-oriented surgeons to either supervise or place permanent vascular access in children.

- **Mineral Metabolism**

Each provider should strive to attain and subsequently maintain:

- An adult dialysis patient population achieving serum phosphorous levels between 3.5 and 5.5 mg/dl.
- A pediatric patient population with levels maintained in normal range for age.
- A dialysis patient population achieving uncorrected calcium levels less than 10.2 mg/dl.

- **Blood Pressure (BP) and Volume Management Guidelines**

Ideal BP in dialysis is not defined. When possible, BP adjustments should be made using home BP readings or ambulatory BP readings from non-dialysis days. Generally, each provider should strive to attain and subsequently maintain:

- Adult target rates:
 - Non-dialysis days: BP < 140/90.
 - Dialysis days (post-dialysis): BP < 130/80.
 - Individualized BP targets may be required in some patients.
- Pediatric target rate: Lower of 90 percent of normal for age/ht/wt or 130/80.
- An ultrafiltration (UF) rate of <13ml/kg/hr.
 - The UF rate maximum is a guideline that should prompt assessment of patients’ prescription (treatment duration) and provide opportunity for individualized counseling. It should not supersede clinical judgement of provider to appropriately manage fluid overload, including but not limited to, an increase in treatment duration and frequency and its consequences, which are also detrimental for the patients.

- **Modality**

Each provider should:

- Provide patient education so that patients can make an informed decision regarding modality.
- Document modality candidacy or reason(s) for non-referral in the patient’s plan of care.
- Focus on transitions to care for all new patients for preparation into home modalities.
- The team should make every attempt to include the family/caregiver.
- Refer patients to transplant, as appropriate.
 - Responsibility of the nephrologist.

- **Policies/Procedures/Methods**

Providers should have:

- Policies and procedures in place for specific goals.
- Protocols with appropriate interventions.
- Areas of documentation.
- Methods for tracking/trending.
 - To include an established monthly quality review with the renal team and the medical director.

- An established method for full engagement of the entire renal team for ongoing review of the patient plan of care.
 - The team should always include the patient/family member/caregiver.

Review should allow engagement of the team to:

- Review targets.
- Implement changes in plans of care appropriate for the patient.
- Allow for goal establishment and planned follow up.

STANDARDS OF CARE

Overview

The Network 15 Standards of Care have been established to address appropriate delivery of care and facility requirements. These standards include quality statements that describe the care patients should be offered and define facility requirements to assist all Medicare-certified ESRD programs in providing a high quality of treatment to their patients.

The Network 15 MRB adopted the revised Standards of Care on February 11, 2019.

Standards are established by the Network describing the provisions that should be offered, with the expectation that all ESRD facilities will comply with these provisions to deliver quality care within the renal network.

Standards

1. Appropriateness of Initiation of ESRD Care

For all patients entering a maintenance dialysis program, the medical record shall indicate that the patient has been evaluated by a physician on staff of a Medicare-approved dialysis facility. Such evaluation shall include, but is not limited to, documentation of:

- **Diagnosis**
 - Primary cause of renal failure using Internal Classification of Diseases (ICD) code terminology such as uremia, ESRD, or chronic renal failure (CRF) alone are not acceptable
- **Permanence or irreversibility of renal failure**
 - This is defined as, "that stage of renal impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life."
 - The Network recognizes the rare occurrence of recovery of renal function in this situation and considers that such patients fit the Medicare definition of ESRD.

- **Age, gender, weight, and height**

In absence of laboratory values suggestive of ESRD, the provider must maintain sufficient documentation within the medical record to justify the initiation of dialysis, including for:

- **Adult non-diabetic patients**, *one* of following:
 - MDRD GFR (glomerular filtration rate) < 10 ml/min
 - Estimated GFR:
 - 24-hour urine for urea clearance + creatinine clearance/2 \leq 10 ml/min
 - 24-hour urine creatinine clearance < 10 ml/min.
 - Uremic Symptoms
 - Patients with higher eGFR 10-15 who cannot maintain euvoolemia or blood pressure control with diuretics alone.
- **Adult diabetic patients**, *one* of following:
 - MDRD GFR < 15 ml/min
 - Estimated GFR:
 - 24-hour urine for urea clearance + creatinine clearance/2 \leq 15 ml/min
 - 24-hour urine creatinine clearance < 15 ml/min
 - Uremic Symptoms
- **Pediatric patients**, *one* of following:
 - Bedside Schwartz (2009) GFR < 15 ml/min/1.73m²
 - Estimated GFR:
 - 24-hour urine for urea clearance + creatinine clearance/2 \leq 15 ml/min
 - 24-hour urine creatinine clearance < 15 ml/min
 - Complications, including uremic symptoms, malnutrition, and growth failure

Special Note: Regular assessment of the ongoing need for continued dialysis should be maintained throughout the course of the renal replacement treatment.

2. Permanent Access

Facilities should:

- Strive to attain and subsequently maintain:
 - Fistula rate of ≥ 66 percent.
 - Grafts as alternative permanent access choice.
 - Catheter as a last resort.
 - Facilities should strive to maintain an LTC in-use rate >90 days of <10 percent.
 - A catheter may be a reasonable first choice for pediatric patients <20 kg or patients >20 kg, who are likely to receive a kidney transplant within one year.
- Have policies and procedures in place to perform monthly vascular access monitoring, as well as having methods in place to review, track, and trend results of monitoring.
- Have appropriate training plans in place for staff members, including but not limited to safe and effective:
 - Cannulation techniques.
 - Troubleshooting techniques.
 - Methods for initiation, discontinuation, monitoring, and dressing change procedures for central venous catheter (CVC) patient's infection control.

Facilities must present plans for CVC reduction and sustainability in their monthly Quality Assessment Process Improvement (QAPI) meetings.

3. Infection Control

- Every facility should have policies and procedures related to the prevention and management of healthcare-associated infections (HAIs), to include:
 - The training of staff and education of patients regarding:
 - Prevention measures
 - Participation in bloodstream infection (BSI) prevention activities
 - Review of daily operational procedures
 - Identification and treatment of infections as per stated in facility policy and procedures.
 - Use of the [Centers for Disease Control and Prevention \(CDC\) Core Interventions for Dialysis Bloodstream \(BSI\) Prevention](#) and CDC training resources and tools.
 - Staff competency upon completion of training and on a regular basis thereafter for:
 - Hand hygiene and glove use.
 - Surface disinfection.
 - Appropriate use of personal protective equipment.
 - Accessing the catheter and care of the exit site.

- Vascular access cannulation procedures.
- Medication administration procedures.
- Isolation procedures.
- Completion of infection control audits by staff and patients
- Infection control and patient safety issues should be continuously reported and discussed in QAPI meetings.
 - Actions taken to address these issues should be documented.
 - Records of infection tracking should be a part of the facility’s QAPI program.
- CMS and the Network recommend all in-center dialysis facilities report dialysis events in the National Healthcare Safety Network (NHSN) per the Dialysis Event Protocol.
- All dialysis facilities, including home units, also need to follow the guidelines and procedures for reporting in the Vaccination Module of the Healthcare Personnel Safety Component.
- The facility medical director should review all policies and procedures.

4. Safe and Effective Dialysis Treatment:

Facilities should strive to provide every patient with treatments that are high quality and safe. This requires open communication between facility staff and patients, as well as diligent monitoring and documentation in the medical record of:

- **Intradialytic vital signs**, including but not limited to:
 - Pre- and post-assessments of each patient, including standing and sitting blood pressure, temperature, weight, and pulse every treatment.
 - A patient’s condition, at least **every 30 minutes**, including, at a minimum:
 - Patient’s blood pressure and pulse.
 - Inspection of the vascular access to note blood loss or leakage.
 - Arterial and venous pressures and blood flow rate.
 - Any results outside normal limits.
 - These should be reported to the charge nurse immediately and patients should be directed, as indicated, to the appropriate level of care for evaluation.
 - Any changes in patient conditions.
 - These must be communicated to the nursing staff. The nursing staff should, at a minimum, assess the patient and contact the nephrologist, per facility policy, to give a full report and accept any changes in prescription and or additional orders.
- **Ultrafiltration rates (UFRs)**
 - The Network recommends facilities maintain an average UFR of <13 ml/kg/hr for all patients.
 - The UF rate maximum is a guideline that should prompt assessment of patients’ prescriptions and provide opportunity for individualized counseling but should not

supersede clinical judgement of provider to appropriately manage fluid overload and its consequences which are also detrimental for the patients.

- Although it is reasonable to educate the patient and document the risks of a high UF rate, it is equally important to understand that a higher UF rate ordered by a nephrologist may be due to reduced risk of fluid overload and/or hospitalization in a patient who either refuses extra treatments or is unable to reduce interdialytic weight gain (IDWG) despite counseling/routinely cut treatment time, or missing treatment. Appropriate documentation is required.
- Facilities should have clear policies and procedures in place:
 - To ensure safe and effective dialysis.
 - For staff training and competencies.
 - This would require each facility to follow the rules and regulations specific to their state, as well as CMS guidelines.
 - For patient and staff educational requirements.
- Facilities must incorporate the patient plan of care within 30 days of initiation of dialysis and then accordingly per the conditions of coverage.
- At a minimum, patient assessment by the interdisciplinary team (IDT) should include:
 - Health status/comorbidities
 - Dialysis prescription
 - BP and fluid management
 - Lab Profiles
 - Immunization and medication history
 - Anemia status
 - Renal bone disease
 - Nutritional status
 - Psychosocial needs
 - Dialysis access type and maintenance
 - Abilities, interests, preferences, goals, desired participation in care, preferred modality and setting, and expected outcomes
 - Transplant referral, if suitable
 - Family and care giver engagement
 - Physical activity level
- Facilities must incorporate water and dialysate monitoring, testing, and follow up procedures to ensure safety for patients.
- Facilities must have Quality Improvement and Risk Management programs in place.
 - Monthly meetings must be documented.

5. Vaccination Screening for Patients

Given the altered immunocompetent state of ESRD patients, the incidence and severity of certain vaccine-preventable infections are higher in this population; thus, inactivated influenza and pneumococcal vaccinations are advised. Given the increased risk of hepatitis B transmission in the dialysis process, hepatitis B vaccination should be administered to ESRD patients who are susceptible.

Every ESRD facility must have a written policy under which the currently-recommended vaccines and local sources are presented to all eligible patients. The recommended vaccinations for people on dialysis include, but are not limited to:

- **Hepatitis B**

- Hepatitis B vaccination is recommended for all susceptible chronic hemodialysis patients and dialysis unit staff. Vaccination is recommended for pre-end-stage renal disease patients before they become dialysis dependent, and for peritoneal and home dialysis patients because they might require incenter hemodialysis. “Patients with uremia who were vaccinated before they required dialysis have been shown to have higher seroprotection rates and antibody titers. The response to hepatitis B vaccination may also be better in children.
- Hepatitis B patients’ caregivers should be advised to get the hepatitis B vaccine from their provider.

- **Pneumococcal pneumonia**

- Pneumococcal Vaccine 23-Valent Pneumococcal Polysaccharide Vaccine (PPSV23)
 - PPSV23 (Pneumovax 23, Merck & Co. Inc.) contains 12 of the serotypes included in 13-valent pneumococcal conjugate vaccine (PCV13 [Prevnar 13]).
- PPSV23 is recommended for prevention of invasive pneumococcal disease (IPD) among ESRD patients ≥ 2 years of age.
 - Pneumovax 23 should be administered to all ESRD patients once (if not administered within previous five years) and again after five years.
 - Only two doses are recommended for patients 2–64 years of age.
 - Adults who received PPSV23 before age 65 should receive another dose of the vaccine at age 65 (or later) if at least five years have passed since his/her previous dose.
 - Adults who receive PPSV23 at or after age 65 should receive only a single dose.
 - PPSV23 should be administered at least eight weeks after the last dose of PCV13.
- PCV13 is recommended for ESRD patients.
 - Adults who have never received PCV13 should receive a single dose.
 - Pediatric patients should receive PCV13 per current Centers for Disease Control and Prevention (CDC) immunization schedules.
 - It is recommended to give PCV13 prior to PPSV23 administration, if possible.

- **Influenza**

Routine annual influenza vaccination is recommended for ESRD patients and dialysis

facility staff. To permit time for production of protective antibody levels, vaccination optimally should occur before onset of influenza activity in the community. Therefore, vaccination providers should offer vaccination as soon as vaccine is available. Vaccination should be offered throughout the influenza season (i.e., as long as influenza viruses are circulating in the community).

- Influenza Vaccine: Inactivated Influenza Vaccine (TIV)
- Live influenza vaccine should NOT be used in ESRD patients.

- **Pediatric**

It is recommended to assess current immunization status and collaborate with a patient's primary care provider (PCP) to keep pediatric patients up-to-date on all childhood immunizations per CDC immunization schedules

Note: Document acceptance, refusal, and administration of vaccinations in the patient medical record and the CMS-designated data collection system, Consolidated Renal Operations in a Web-Enabled Network (CROWNWeb). A separate hepatitis surveillance log should be maintained for all patients.

6. Vocational Rehabilitation (VR)

- All ESRD patients between 18 and 54 years of age, receiving a regular course of renal replacement therapy or receiving a transplant, shall be evaluated annually for VR referral, which shall be documented in the patient's medical record.
- Each provider shall identify and provide patients with the VR resources available in the geographic area, including work incentive programs.
- Facility staff will reinforce the long-term benefits of continued employment and/or going back to school.
 - The dialysis facility shall discuss with the patient a schedule suitable to maintain employment or meet scholastic demands
- The interdisciplinary team must assist the patient to achieve and sustain an appropriate level of productive activity, as desired by the patient; including the educational needs of a pediatric patient and make rehabilitation and VR referrals as appropriate. (V515, V555)

7. Patient Grievances

Grievance Definition

CMS defines a grievance as:

A written or oral communication from an ESRD patient, and/or an individual representing an ESRD patient, and/or another party alleging that a Medicare covered ESRD service did not meet recommended standards of safety or civility, or professionally recognized clinical standards of care.

Role of Facilities and the Network

All ESRD **facilities** are required by Medicare to post information in common areas about how to file a grievance. This information will explain how individuals can:

- File a grievance at the facility.
- Contact their ESRD Network and the State Health Department.
- Report unsafe practices.

Many of the dialysis corporations have 800 numbers for grievances to be handled at a higher level than the facility.

The **ESRD Network's** role in a grievance is to:

- Keep communications open between patients and ESRD facility staff on issues and problems.
- Ensure problems are solved as quickly as possible.
- Help patients feel comfortable taking their concerns to an appropriate authority without fear of mistreatment or retaliation.
- Help patients through the process.

NO PERSON SHALL BE PUNISHED OR RETALIATED AGAINST FOR FILING A GRIEVANCE.

Policies and Procedures

In an effort to ensure that patients are aware of their right to file a grievance, facilities must have **written policies and procedures** regarding how the facility will receive and address patient grievances. Policy information should include:

- Who will be in charge of receiving the grievance.
 - Individual responsible for assigning staff member for grievance resolution.
- The grievance process in its entirety.
- Expected time frame for response.
- Follow-up procedures.

Patients and facility staff need to be aware that **anyone can file grievances anonymously**.

Documentation

Each step of the grievance process should be documented. Facilities must:

- Document that patients have been informed of their rights and responsibilities, including the right to file a grievance (internally, or externally to Network 15).
- Post a copy of Network 15's contact and grievance information in a prominent location in the facility.

8. Patient Experience of Care Activities

Rationale for Activities

Patient and family engagement (PFE) activities are evidence-based practices that lead to better clinical outcomes, greater consistency of care and compliance, and higher quality of care delivery. Through engagement in their care, patients, family, and caregivers gain knowledge that gives them confidence, helping them to participate in their care decisions.

The CMS CfCs require all dialysis providers to educate patients on their modality and treatment options, including:

- The pros and cons of each treatment option.
- Information on treatment options available at the patient's current clinic.
- Referrals for additional treatment options outside of the clinic, as needed.

This education should be given **in collaboration with the patient** toward their best quality of life.

Provider Responsibilities in Project Engagement

Providers should:

- Foster open communication with their patients and families regarding personal values, modality preferences, and expressed needs.
- Assist in care partner education to help patients communicate their needs and the realities of living with ESRD, including:
 - Balancing what patients can do for themselves with when assistance is needed.
 - Fostering patient responsibility and involvement in their care.
- Encourage active patient and family participation in care through a variety of methods including, but not limited to:
 - Family care conferences.
 - Patient assisted lobby days.
 - Social activities encouraging ESRD-friendly lifestyle choices.
 - Engagement in projects and QAPI meetings.
 - Peer mentoring by experienced patients for new patients.
 - Establishment of patient councils.
 - Encouragement of patient and family member participation on Network and national committees, or other facility-specific opportunities as they arise.
 - Deploying, documenting, and reporting PFE activities as required by the Network.

Additional Requirements

Providers shall:

- Set reasonable expectations for patients as to:
 - Dialysis care team choices.
 - Concerns.
 - Engagement.
- Foster open discussion without fear of retaliation.

- Ensure posting and communication vehicles for:
 - Patient rights and responsibilities.
 - Medicare coverage.
 - Americans with Disabilities Act (ADA) information.
 - Other relevant offerings for ESRD patients.
- Deliver and document education for individual patients and family annually, including:
 - Evaluation of modalities.
 - Patient choices.
 - Description of facility efforts to meet the patient’s modality preference.
- Explain to patients the possible receipt of an experience survey and encourage them to complete the **In-Center Hemodialysis Consumer Assessment of Healthcare Providers Survey (ICH CAHPS)** to assist the clinic in their effort to provide the highest quality treatment and services for each patient seeking care.

9. FACILITY STAFFING GUIDELINES

General Criteria

Staffing levels should be commensurate with providing the care outlined in the CfCs, ensuring, at a minimum, there is a:

- Registered nurse within the facility.
- Clinical technician/patient ratio of one certified technician for each four adult patients undergoing treatment.
 - Recommended not required

In an ongoing effort to provide quality care and ensure patient safety, facilities should consider the following when developing staffing guidance for nurses, social workers, and dietitians:

- Experience level of staff.
- Size of the facility.
- Type of patients.
 - Geriatric, pediatric, home, self-care
- Co-morbidities.
- Location of facility.
 - Rural vs. urban
- Admission rate of new patients.

Pediatric Facility Criteria

Pediatric units need to observe the following special requirements for staffing/equipment:

- For a patient weighing less than 10kg/22 lb:
 - One-to-one nursing care.

- Size-appropriate equipment for dialysis.
 - Dialyzer and blood-lines
 - Dialysis machines that can:
 - Remove small fluid volumes.
 - Use low blood flow rates.
 - Use lines of varying blood volumes.
- Equipment needed for continuous monitoring of weight and vital signs, including, but not limited to:
 - Cardiac monitor.
 - Automatic doppler blood pressure equipment
 - Pediatric blood pressure cuffs
 - Continuous readout scales and/or automatic ultra-filtration control.
- For a patient weighing between 10 and 20 kg/22 and 44 lb:
 - One-to-two nursing care.
 - Size-appropriate equipment for dialysis, including:
 - Dialyzer and bloodlines.
 - Dialysis machines that can:
 - Remove small fluid volumes.
 - Use low blood flow rates.
 - Use lines of varying blood volumes.
 - Equipment needed for continuous monitoring of vital signs, including pediatric blood pressure cuffs.
 - Continuous readout scales or automatic ultra-filtration control.

10. Provision of Nutritional Services in ESRD

The evaluation of each patient’s nutritional status must be conducted by a qualified dietitian as defined in the regulations at computer identifier tag identifiers, V689 and V690. Examples of nutritional parameters to be addressed include, but are not limited to:

- Nutritional status.
- Hydration status.
- Metabolic parameters, including:
 - Glycemic control (if diabetic) and cardiovascular health;
- Anthropometric data, such as:
 - Height, weight, weight history, weight changes, volume status, and amputations.
- Appetite and intake.
- Ability to chew and swallow.
- Gastrointestinal issues.
- Use of prescribed and over-the-counter nutritional, dietary, or herbal supplements.

- Previous diets and/or nutrition education.
- Route of nutrition.
- Self-management skills.
- Attitude to nutrition, health, and wellbeing.
- Motivation to make changes to meet nutrition and other health goals.

Dietitians must:

- Hold state licensure, where applicable.
- Collaborate with the IDT to develop and implement plans of care that specify services needed to address patients' nutrition needs, including but not limited to:
 - Monthly monitoring of laboratory results and interventions to achieve:
 - Albumin ≥ 4.0
 - Calcium < 10.2
 - iPTH 150–600
 - Phosphorus 3.5–5.5 or age appropriate level for pediatric patients
 - Implementation of interventions to prevent unintended weight loss.
 - Participation in Plan of Care meetings.
 - Participation in monthly QAPI meetings.

11. Provision of Social Work Services in ESRD

General Criteria

All ESRD patients will have assistance offered to develop the coping and disease management skills necessary to adjust to his or her chronic illness. These social services will be available to all patients on a weekly basis.

Social workers practicing in a dialysis unit in the Network 15 service area must:

- Serve as a patient advocate.
- Facilitate communications between patients/patient representatives and facility administration/staff.
- Assist patients and/or their representatives with psychosocial issues encountered throughout the duration of the dialysis experience to achieve and sustain optimal psychosocial status.
- Be licensed at the level of a Master Prepared Social Worker (MSW).
- Receive new hire social worker orientation and training per individual company policy.

Social Worker Responsibilities per the CMS CfC's Interpretive Guidance

Qualified social workers in dialysis facilities will:

- Evaluate the patient's:
 - Psychological needs and ability to cope with ESRD.

- Consider a patient’s physical condition, emotional state, and cultural background. (V452)
 - Ability to meet basic needs. (V510)
 - Follow the treatment prescription. (V510)
 - Mental health history. (V510)
 - Capacities. (V510)
 - Need for counseling. (V510)
 - Substance abuse history, if any. (V510)
 - Expectations for the future and living with kidney failure and treatment. (V510)
 - Educational and employment status, concerns, and goals. (V510)
 - Home environment including current living situation. (V510)
 - Legal issues, need for advocacy with traditional and non-traditional housing, financial capabilities. (V510)
 - Access to available community resources and eligibility for federal, state, or local resources. (V510)
 - Abilities, interests, goals, and desired level of participation in plans of care. (V512)
 - Family and other support systems. (V514)
 - Physical and activity level. (V514)
- Inform the patient about:
 - His/her right to execute advance directives. (V457)
 - All treatment modalities and settings. (V457)
 - His/her facility’s internal grievance process, as well as external grievance mechanism.
 - i.e., ESRD Network and the State Survey Agency (V465, V765, V466)
- Assess unstable patients. (V520)
- Assess educational and employment status, make referral to VR, as appropriate. (V515)
- Involve the facility’s IDT to:
 - Provide necessary monitoring of social work interventions. (V552)
 - i.e., Counseling services and referrals, assisting the patient to achieve and sustain an appropriate psychosocial status. (V552)
 - Provide modalities education, referral, and follow up. (V553)
 - Provide education and training. (V652)
 - Evaluate patient appropriateness for transplantation. (V513, V554, V561)

12. Physical Environment

The facility shall meet the federal, state, local, and Network conditions and standards set forth for physical environment, including:

- The physical environment must be maintained in such a way that will ensure a comfortable, fully operational, and safe environment for all stakeholders.

- All equipment within the facility should be utilized and maintained according to the recommendations of the manufacturer
- “Dummy” drip chambers should only be utilized during the maintenance of a machine and CANNOT be utilized in the treatment area.
- Sufficient space between individual patient care areas must be provided.
- Areas of privacy must be provided when needed.
- All patients must be able to be viewed by staff at all times.
 - Video surveillance does not suffice.
- Reasonable efforts to maintain a temperature of comfort within the treatment facility must be made.

Note: Per CDC recommendations, and to prevent cross contamination, the facility should ensure the dialysis station, which includes the chair and the machine, has been fully vacated by the current patient prior to cleaning and disinfecting the station for the next patient.

13. Open Staffing Privileges

The facility shall have a written policy, which assures open staffing privileges to the area’s qualified ESRD physicians and physician extenders.

14. Access to Treatment

All Medicare-certified ESRD providers **shall provide access to treatment for patients regardless of their race, color, religion, national origin, age, sex, familial status, sexual orientation, gender identity, disability, or veteran status** per Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

Dialysis facilities must:

- Work to maintain patients in a chronic outpatient dialysis setting, regardless of treatment or other related compliance issues, in an attempt to avoid patients having to use a hospital emergency room for chronic dialysis.
- Work with patients, nephrologists, and the facility medical director to avoid involuntary discharges from the facility when a nephrologist discharges a patient from their physician practice.
 - All attempts to address issues related to the physician discharge with the patient must be documented in the patient’s medical record.
- Establish policies and procedures for admitting patients to the facility.
 - Any patient that meets the requirements of the facility admission policy should be considered, even if a patient has documented compliance issues.

- A process should be in place to work with non-compliant patients to improve compliance rather than blacklisting non-compliant patients altogether.
 - Facilities should conduct root cause analysis (RCA), provide educational resources, involve the social worker and insurance specialists.

15. Food and Drink in the Dialysis Unit

- Dialysis facilities should have policies that relate to patients eating and drinking during dialysis.
- Patients should be made aware of these policies and understand that they can talk with their nephrologist and or clinic staff management if their needs differ from the policy to see if exceptions can be made.

16. Data Submission Compliance

All Medicare-certified ESRD providers **shall** attain and maintain 100 percent compliance for the following data reporting:

- CROWNWeb
 - All required data should be entered per the [CROWNWeb Data Management Guidelines](#).
 - The Network recommends facilities always have at least one administrative and one clinical staff CROWNWeb user to ensure data accuracy and completeness.
- NHSN
 - Facilities can enroll in NHSN [here](#).
- Other CMS-designated data collection systems.

Note: All facilities identified for inclusion in a Network Quality Improvement Activity (QIA) are required to submit monthly self-reported data per QIA timelines.

17. Patient and Family Engagement—Staff Responsibilities

- Dialysis staff should be professional and use appropriate communication skills at all times to help patients feel comfortable and safe, and to establish an atmosphere of mutual trust.
 - Staff education may be needed to learn these skills
- Patients should be:
 - Educated, in a timely manner, on the importance of patient engagement, especially those new to dialysis.
 - Educated on how/continually encouraged to take responsibility for their treatment and healthcare.
 - Encouraged to come for all their treatments and stay for the prescribed time.
 - Education on the risks associated with fluid overload.
 - Encouraged to participate in the ICH-CAHPS process.

- Education should be provided so patients understand the importance of the survey and the importance of making their voices heard.
- Every member of the IDT (MD, RN, RD, MSW) should encourage/motivate patients to take an active role in their Plan of Care.
 - This necessitates a process where patient input is requested and welcomed.

18. Emergency Preparedness

All Medicare-certified ESRD providers **shall have written policies and procedures that specifically define the handling of emergencies** which may threaten the health and safety of patients. Such emergencies would exist during natural disaster (e.g., fire or hurricane) or during functional failures in equipment or utilities. Specific emergency preparedness procedures exist for different kinds of emergencies. At a minimum, the provider shall:

- Review and test the emergency preparedness plan, at least annually, and revise as necessary.
- Ensure all personnel are knowledgeable and trained in their respective roles in emergency situations.
- Ensure the availability of emergency medications, medical supplies, and equipment.
- Ensure that staff are familiar with the use of all dialysis equipment and procedures to handle medical emergencies.
- Ensure that patients are:
 - Trained to handle medical and non-medical emergencies.
 - Fully informed regarding what to do, where to go, and who to contact if a medical or non-medical emergency occurs.
 - Know how to locate additional resources related to emergency management for ESRD patients on the Kidney Community Emergency Preparedness (KCER) [website](#).
- Complete additional training and testing requirements contained in the CMS [Emergency Preparedness Rule](#).
- Notify the Network as soon as possible, but no later than 24 hours after, any facility status change that may cause the disruption of treatment schedules or any event that requires immediate/emergency actions by the facility, such as rescheduling or placement of patients at a backup provider.
- Provide the facility's open or closed status and patient location updates, at least daily, to the Network during identified emergencies or disasters.
 - This includes before and after a potential tropical storm or hurricane.

19. Transplant

The benefits of transplantation extend to ESRD patients regardless of age, gender, or ethnicity, as well as those with common comorbid conditions, including diabetes and hypertension. The intent

of transplant evaluation, referral, and coordination is to increase the percentage of ESRD patients on waitlists through:

- Annual review of treatment modality options, including renal transplant, with a focus on promoting early referrals to transplant.
- Patient education and awareness regarding barriers and myths that discourage transplant.
- Patient education and understanding of living donation options, including support with potential donor discussions.
- Collaboration with transplant centers, promoting communication and information sharing regarding patient factors positively or negatively affecting waitlisted patients.
- Quarterly assessments of suitability or contra-indications and patient progress towards waitlist.
 - Assessment frequency should be increased as deemed necessary.
- Provider and patient participation in activities that promote transplant, including but not limited to lobby days, transplant and living donor information distribution, QAPI presentations by transplanted patients, promotion/facilitation of patient peer discussions.
- Participating in Transplant QIA activities and reporting to Network 15, as required during projects.

20. Home Modalities

The MRB has established a goal of meeting or exceeding the national average of ESRD patients placed in a self-/home-care dialysis setting.

- All patients will be evaluated annually for and offered the option of home care when medically appropriate.
- There will be 100 percent documentation in all individualized dialysis patient assessments and plans of care of this option being offered or the factors that exempt the patient from this treatment modality.

21. Network Specifics

QIAs

Network 15 is contracted with CMS to conduct specific QIAs.

- CMS mandates QIA scope, goals, and selection criteria for regional facilities.
- Participation in QIAs is not optional.
 - If a facility chooses not to participate in a QIA for which they have been selected, it will be reported to CMS.
- QIA participation includes, but is not limited to:
 - Attendance to webinars.
 - Distribution of educational materials to facility staff and/or patients.

- Review of articles and/or videos with provision of feedback, poll completion, and monthly reporting in QAPI meetings.

Network Assistance with Care/Safety Concerns

Network 15 will work with all facilities and patients to achieve quality and safe care. If at any time any facility staff, patients, family, or caregivers have concerns about the quality and safety of the care a patient is receiving, they may call the Network with their concerns and or grievances.

- Contacting the Network can be done anonymously.
- Based upon the severity of the concern, Network 15 may notify the State Agency for additional investigation.

Network Assistance with Patient Access to Care

Network 15's goal is to ensure that every patient has access to the care they need. A facility should contact the Network as soon as possible if there is:

- A concern relating to the possible discharge of a patient.
 - For assistance with interventions.
- An immediate threat of harm.

Network Education Services

Network 15:

- Will assist facilities with any educational needs they may have.
 - Facilities should contact the Network for assistance.
- Works with numerous stakeholders to educate on ESRD.
- Has a Medical Review Board, Network Council, and a Patient Activity Council that actively participate in the development and overview of QIAs.
 - All boards and committees play a vital role in educational materials and support for all facilities and Network activities.