ESRD Network 13:

2016 Performance Guidance
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INTRODUCTION

Network 13 Performance Guidance is intended to provide guidance for dialysis provider delivery of care to patients on chronic dialysis therapies. Annually, the Network 13 Performance Guidance is reviewed by the Network 13 Medical Review Board for continuity with the ESRD Quality Incentive Program (QIP), as well as with other established, evidence-based guidance and recommendations. Simultaneously, the Network Standards and Recommendations are annually reviewed and updated, utilizing available clinical resources and expertise in conjunction with the Network-specific analyses and their knowledge specific to our service area. The Performance Guidance is applicable to adult and pediatric ESRD patient populations and is current as of March 2016. Items in **RED** are new.

**Standards:** Established by the Network with the expectation that all ESRD facilities will comply accordingly toward the provision of quality care within the renal healthcare community. Facilities are “Accountable and can be cited.”

- Placement of Patients in Self-/Home-Care Setting
- Transplantation
- Vocational Rehabilitation
- Hemodialysis (HD) Adequacy: Performance of Care Audits
- Monitoring for Access Dysfunction
- Disaster Preparedness
- Nephrologist as Dialysis Facility Medical Director
- Facility Status Notification
- Involuntary Discharge

**Recommendations:** Although not at a “standards” level, recommendations are to be strongly considered for implementation as applicable within renal organizations.

- Adequacy of Hemodialysis
- Anemia Management in Chronic Renal Failure (CRF)
- Vascular Access Management
  - Catheters
  - Arteriovenous Fistula (AVFs)
- Continuing Education Credits in Renal Healthcare
- Mineral Metabolism in CRF
- Peritoneal Dialysis Adequacy
- Nutrition in CRF
- Management of Hyperkalemia
- Fluid Management for HD
- Fluid Management for Peritoneal Dialysis (PD)
- Advance Directives
- CMS Criteria to Determine Eligibility for the ESRD Program
- ICH-CAHPS Survey
- Patient Education Awareness
- Assessment of Health-Related Quality of Life

**Grievance Policy:** Provides a method of consideration for concerns or grievances of ESRD patients-consumers. All certified ESRD (chronic dialysis and kidney transplant) providers are required to make this policy easily accessible to all patient-consumers of the facility and annually document in their patients’ individualized plan of care that a copy of this policy has been received and understood.

**Sanction and Alternative Sanction Recommendation Policy:** This policy is to ensure ESRD facilities and providers cooperation towards meeting Network goals and requirements.
Performance Guidance 2016

PURPOSE: The following objectives are to provide guidance for dialysis provider delivery of care to patients on chronic dialysis therapy.

APPLICABILITY: Dialysis providers serving adult (≥ 18 years of age) and pediatric (< 18 years of age) dialysis patients.

NETWORK PERFORMANCE GUIDANCE BY INDICATORS:

1. ADEQUACY OF HEMODIALYSIS (HD): Each provider should strive to attain and subsequently maintain:
   • 93% of adult and pediatric HD patients with spKt/V ≥ 1.2

2. PERITONEAL DIALYSIS (PD) ADEQUACY: Each provider should strive to attain and subsequently maintain:
   • 100% performance of adequacy testing on all PD patients every four-month period
   • All Incident PD and/or new to PD patients should have their first adequacy testing done at four to six weeks following initiation of PD therapy
   • 90% of adult PD patients achieving a weekly Kt/V_urea (dialytic + residual) of at least 1.7 during a four-month period
   • 90% of pediatric PD patients achieving a weekly Kt/V_urea (dialytic + residual) of at least 1.8 during a six-month period

3. ANEMIA MANAGEMENT: Each provider should strive to attain and subsequently maintain:
   • Less than 10% of the dialysis patient population having Hgb levels < 10 gm/dL
   • Less than 1% of the dialysis patient population having Hgb levels > 12 gm/dL on ESA therapy.

   TRANSFUSION THERAPY:
   • Each provider should develop and implement as applicable a transfusion protocol. Guidelines have been developed by the AABB (formerly, the American Association of Blood Banks) and are listed below for reference: [http://www.aabb.org/Pages/Homepage.aspx](http://www.aabb.org/Pages/Homepage.aspx)
     o The AABB recommends adhering to a restrictive transfusion strategy (7 to 8 g/dL) in hospitalized, stable patients. (Grade: strong recommendation; high-quality evidence)
     o The AABB suggests adhering to a restrictive strategy in hospitalized patients with preexisting cardiovascular disease and considering transfusion for patients with symptoms or a hemoglobin level of 8 g/dL or less. (Grade: weak recommendation; moderate-quality evidence)
   • Dialysis providers must be cognizant of transfusion implications for patients on the transplant waiting list(s)

4. NUTRITION MANAGEMENT: Each provider should strive to attain and subsequently maintain:
   • 65% of the dialysis patient population achieving serum albumin (Alb) levels > 3.7 gm/dL

5. MINERAL METABOLISM: Each provider should strive to attain and subsequently maintain:
   • 50% of the dialysis patient population achieving serum phosphorus levels between 3.5–5.5 mg/dL
• 80% of the dialysis patient population achieving serum levels of corrected total calcium levels within the normal range for the laboratory used, preferably toward the lower end (> 8.4 and < 10.2 mg/dL)
• 70% of the dialysis patient population achieving serum calcium-phosphorus products at < 55 mg²/mL², if monitored for facility-aggregate outcomes
• 70% of the dialysis patient population achieving intact PTH levels between 150-600 pg/mL
Reference: Kidney Disease: Improving Global Outcomes (KDIGO™)
• Intact PTH levels need to be monitored quarterly at a minimum; and more frequently if indicated

6. VASCULAR ACCESS MANAGEMENT: Each provider should strive to attain and subsequently maintain:
• CATHETERS: Less than 10% of chronic maintenance HD patients utilizing a catheter for 90 days or longer
• ARTERIOVENOUS FISTULAE:
  o 68% of prevalent HD patients utilizing primary AV fistulas
  o Primary AVF placement in at least 50% of all new (incident) patients electing to receive HD as their renal replacement therapy
• MONITORING/SURVEILLANCE FOR ACCESS DYSFUNCTION:
  o 100% monitoring for access dysfunction in all adult HD patients utilizing AVFs or AVGs as primary vascular access
• ACCESS CANNULATION POLICIES AND PROCEDURES (P&P) addressing:
  o Staff competencies as directed by governing body and/or corporate oversight with focus on vascular access cannulation technique skills (e.g., infiltrations, > 2 sticks to achieve cannulation)
  o Monitoring and tracking of cannulation complication(s)
  o If initial cannulation not successful after second stick by staff member, cannulation to be achieved by another cannulator

7. IMMUNIZATIONS: Each provider should strive to attain and subsequently maintain:
• 90% of dialysis patient population with documented receipt of annual influenza immunizations
  o 100% of dialysis patient population with documentation in patient record of receipt or refusal of annual influenza vaccinations annually between October 1 and March 31
• 90% of dialysis patient population with documented receipt of pneumococcal pneumonia immunizations
  o 100% of dialysis patient population with documentation in patient record of receipt or refusal of pneumococcal pneumonia vaccination on schedule
• 90% of dialysis patient population with documented receipt of hepatitis B vaccination series
  o 100% of dialysis patient population with documentation in patient record of receipt or refusal of hepatitis B vaccination series on schedule
• 90% of dialysis provider staff with documented receipt of annual influenza immunizations.
  o Documentation in management meeting minutes of staff education on importance of annual influenza immunization. Personnel records should reflect receipt of or refusal of annual influenza vaccinations annually between October 1 and March 31.

8. INFECTION CONTROL: Each provider should:
• Strive to achieve zero infection control events by incorporating CDC recommendations in regards to prevention of bloodstream infections (BSIs) in dialysis patients into their daily operations and quality assessment and performance improvement (QAPI) activities
• Incorporate CDC recommendation specific to staff competencies by assessing upon hire and annually thereafter competencies specific to:
  o Gloving and hand hygiene (all staff)
  o Catheter dressing change technique (applicable staff)
  o Vascular access technique (applicable staff)
  o Safe injection/safe medication practices (applicable staff)
• Analyze rates and trends for access related infections in PD catheters
• Specific to in-center HD, utilize required participation in the CDC National Healthcare Safety Network (NHSN) dialysis event reporting to analyze aggregate infection control rates and trends for:
  o IV Antimicrobial Use
  o Positive Blood Culture(s)
  o Pus, redness, and swelling at vascular access [AVF, AVG, tunneled and/or non-tunneled catheters, other access (i.e., HeRO®)] sites

9. PATIENT SAFETY: Each provider should develop and document facility-specific goals/tracking to address:
  • Medication Errors
  • Medication Reconciliation
  • Patient Falls
  • Intradialytic Hypotension
  • Vascular Access Management / Complications

10. FLUID MANAGEMENT: Each provider should develop and document facility-specific goals/protocols and monitoring to address:
  • Blood Pressure Targets
  • Management of Fluid Gains
  • Establishment and Review of Dry Weights

Limitation Statement: With regards to Network analysis of provider performance, it is recognized that small providers/facilities could have one or two poor patient outcomes which could skew their performance scores for reasons unrelated to the quality of care they have furnished. Therefore, we will use national means (based on publically reported data) as the basis for analyzing each measure.

Data Sources for Network 13 Analysis: CROWNWeb (CW) and National Healthcare Safety Network (NHSN)

Guidance as directed by Medical Review Board, March 2016

Additional Resources:

STANDARDS
Placement of Patients in Self-/Home-Care Setting

The Medical Review Board (MRB) has developed standards and criteria for patients and providers of ESRD care that encourage participation in the self-/home-care treatment setting when medically appropriate.

**STANDARD:** 100% of patients with ESRD will be evaluated annually for and offered the option of self- and/or home-care when medically appropriate.

**CRITERIA:** The MRB has established a goal of meeting or exceeding the national average of ESRD patients placed in a self-/home-care dialysis setting. There will be 100% 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.

**EVALUATION:** The MRB requires the Network staff to evaluate facilities for compliance with this established standard and criteria. Year-end facility survey information will be utilized to trend facility self-/home-care rates.
Transplantation

The Medical Review Board (MRB) has developed standards and criteria for patients and providers of ESRD care that encourage consideration for renal transplantation.

**STANDARD:** 100% of patients with ESRD will have documentation reflecting an annual evaluation and/or consideration for renal transplantation.

**CRITERIA:** The MRB has established a goal that the Network will meet or exceed the national average of ESRD patients undergoing or preparing for a transplant. Documentation of review for transplantation is to be located in all individualized dialysis patients’ assessments and/or plans of care. Documentation should specifically include:

1. Modality option being offered as applicable with patient decision accordingly
2. Current listing for transplant
3. Contraindications to transplantation (absolute or relative) that may exempt the patient from this treatment modality. *Facility procedures should include recognition that HIV is not exclusionary criteria for a transplant.* Please note that relative contraindications should be listed and re-evaluation for transplantation may be appropriate between annual modality reviews.
4. Ongoing communications between dialysis unit and transplant provider in regards to patient’s listing for transplant, as well as updates/changes in status affecting potential transplant.

**EVALUATION:** The MRB requires the Network staff to evaluate facilities for compliance with this established standard and criteria. The Networks will trend facility transplant rates over a five-year period, utilizing the year-end facility survey for review by the MRB.
HD Adequacy: Performance of Care Audits

**STANDARD:** Each dialysis facility should be routinely monitoring their performance of delivery of care specific to prescriptions and/or protocols addressing adequacy of hemodialysis (HD), utilizing delivery of care audits.

**PERFORMANCE TARGET:** 100% of HD patient records should be reviewed at least twice a year for delivery of renal replacement therapy as prescribed. This target includes review of any home HD for adherence to prescription and delivery.

**CRITERIA:** ALL HD patients

**METHODOLOGY:** For the purposes of this standard, delivery of care audit is defined as a performance review of delivered hemodialysis adequacy factors (e.g., duration, blood flow rates, dialysate flow rates, dialyzer, and achievement of estimated dry weight).

A sample audit tool for performance of delivery of care audits specific to adequacy of HD has been developed and piloted for use in this activity. In the event that a facility has already established a delivery of care audit tool, it may be submitted in lieu of the Network provided tool, as long as the required factors are addressed.

**EVALUATION:** The MRB requires the Network staff to evaluate facilities for compliance with established standards. Where applicable within ongoing QI activities specific to adequacy of HD, the Network QI staff will request verification of delivery audits performed by dialysis management.
Monitoring for Access Dysfunction

STANDARDS:

- Permanent HD AV accesses must be monitored for access dysfunction.
- An organized monitoring approach with regular assessment of clinical parameters of the AV access and dialysis adequacy is required.

FACILITY LEVEL PERFORMANCE:

- Monitoring for Vascular Access Dysfunction through Physical Examination
- Monitoring for Vascular Access Dysfunction through Pre-Pump Arterial Pressure
- Routine Monitoring and Surveillance of Grafts for the Presence of Stenosis

RATIONALE: (K/DOQI™ Vascular Access Clinical Practice Guidelines)

MONITORING:

1. Access patency should be ensured prior to treatment before attempts to cannulate the access.
2. Access characteristics, such as pulsatility and presence of thrill, as well as flow and pressure, should be recorded and tracked in a medical record and be available to all caregivers.
3. Data should be analyzed at least monthly to evaluate access dysfunction.

MEASUREMENT/FREQUENCY:

1. With regards to AVGs, it is not clear that access flow measurements performed at a monthly frequency provide sufficient data stability to make decisions. Until additional studies are performed to determine the optimal frequency, more frequent measurements are recommended.
2. In AVGs, static pressure measurements require less technology and should be made more frequently than flow measurements. Direct measurements of static pressure ratios should be made every two weeks. Less-direct measurements should be made weekly. Dynamic pressures, if used, should be measured with each dialysis treatment, but derivation of a static pressure should be attempted, rather than using the raw numbers.
3. Thrombosis in fistulae develops more slowly than in grafts. Flow measurements performed at a monthly frequency appear to be adequate. Until additional studies are performed to determine the optimal frequency, less frequent measurements are not recommended.
4. Because static pressure measurements are inherently less accurate in detecting access stenosis in fistulae, the frequency should not be less than in grafts. Direct measurements of static pressure ratios should be made every two weeks. Less-direct measurements should be made weekly. Dynamic pressures should be measured with each dialysis. Increased recirculation can indicate reduced effective blood pump flow, resulting in inadequate dialysis.

PHYSICAL EXAM: Regular physical examination and monitoring of dialysis treatments (e.g., physical findings of persistent swelling of the arm, clotting of the access, prolonged bleeding after needle withdrawal, or altered pulse characteristics of pulse or thrill in access; and elevated negative arterial pre-pump pressures that prevent increasing to acceptable blood flow can be indications of dysfunction (i.e., stenosis).

EVALUATION: Facility-specific evaluations to be done during any onsite visit performed with review of overall vascular access management.
Disaster Preparedness

STANDARDS:

1. All Patients (dialysis and transplant) should be assisted in developing a patient/family-specific emergency (all-hazards) plan specific to their ESRD therapy. Plans should be developed in conjunction with performing an individualized disaster needs assessment. Plans must include renal dietary and fluid instructions, as well as medication instructions as applicable to the patient. Patient-specific disaster readiness planning should be documented in the patient’s individualized plan of care (POC). It is required that patient-specific disaster plans be reviewed at a minimum annually with continued documentation in the individualized POC. Note: Home-/self-care dialysis patients should be encouraged to notify their various suppliers (e.g., power, water) as to their status as necessary.

2. ESRD facilities are required to annually communicate with their local county or parish emergency operations centers (EOC). Note: As transplant centers are located within hospitals, this requirement is already addressed. The annual communication is to:
   a. Verify that the local EOC is aware of the dialysis facility and has incorporated their existence and needs in the local EOC preparedness as possible
   b. Have an identified local contact person or established communication protocol as discussed with local authorities

3. Each in-center dialysis patient and/or patient representative should be instructed on “how-to” evacuate the dialysis center as directed by the management and/or local authorities (e.g., natural gas leak, wildfires). Procedures (e.g., clamp and disconnect; clamp and cut) can be facility-specific and as directed by corporate and/or medical director. This training should also be documented in the patient individualized POC, as well as in the facility’s QAPI plan as determined by the facility.

4. Practice procedures and/or alternative methods should be utilized to determine the time required to evacuate facility.

5. This standard is not intended to supersede any other immediate evacuation facility-specific directives, but to enhance and/or provide direction during the absence of any existing directives.

6. Each dialysis and transplant provider is required to post the ESRD Network 13 Disaster Preparedness Poster in primary patient care waiting areas.

7. Remember the requirement to notify the Network of changes in facility status and personnel (SEE NETWORK STANDARD “NETWORK NOTIFICATION OF CHANGES IN FACILITY STATUS AND PERSONNEL”)

APPLICABILITY: All dialysis and transplant providers

RECOMMENDATIONS FOR ESRD PROVIDERS LOCATED WITHIN THE LOUISIANA “HURRICANE AT-RISK” DESIGNATED AREA

1. All dialysis patients who dialyze in a Network-designated “hurricane at-risk” parish should be provided copies of their dialysis medical records, pertinent to arranging transient dialysis in the event of an evacuation, prior to and periodically throughout hurricane season.

2. It is recommended that all dialysis and transplant providers located in a geographic location and timeframe in which tropical/hurricane force winds are forecasted, base their treatment and subsequent closure plans to meet the safety and evacuation needs of their patients and staff.

3. All chronic dialysis services should be suspended and chronic dialysis units closed in the event of a mandatory evacuation.

4. Following an evacuation declaration, providers should strongly consider the state of infrastructure prior to repatriating their staff/patient populations. Communication should be ongoing with
local/state emergency operations personnel to ascertain that the area has been cleared for safe return.

RECOMMENDATIONS WHEN PUBLIC/PRIVATE TRANSPORTATION IS DISRUPTED OR TEMPORARY PROVIDER CLOSURE IS NECESSARY (e.g., winter weather issues, flooding)

1. All dialysis patients should be provided copies of their dialysis medical records, pertinent to arranging transient dialysis with impending weather events (e.g., winter weather issues).
2. Following a closure due to a disaster event, providers should follow their protocols to reopen and strongly consider the state of infrastructure prior to repatriating their staff/patient populations. Communication should be ongoing with local/state emergency operations personnel to ascertain that the area has been cleared for safe return.
Nephrologist as Dialysis Facility Medical Director

STANDARDS:

1. That the complex duties and responsibilities of the Medical Director of a dialysis unit mandate the training and background inherent in the education of a physician;
2. That there is support of existing CMS personnel requirements of the Medical Director as “a physician who has completed a board approved training program in nephrology and has at least 12 months experience providing care to patients receiving dialysis”; (CfC Personnel Qualifications - §494.140)
3. That the Medical Director must supervise and be responsible for dialysis unit policies and procedures (inclusive of infection control, involuntary discharges), which address the overall medical, technical, and administrative functions of the dialysis unit;
4. That the Medical Director supervise and be responsible for the facility’s compliance with and/or adherence to Network standards and recommendations;
5. That the Medical Director provide leadership and be an active participant in dialysis unit quality improvement activities;
6. That the Medical Director provides the leadership within the interdisciplinary dialysis care team to ensure that required assessments are performed and individualized patient plans of care are developed, implemented, and revised, if not achieved; and
7. That to accomplish these duties, the Medical Director should be physically present at the facility monthly, at a minimum.

EVALUATION: The MRB requires the Network staff to evaluate for compliance with established standards. In conjunction with the Network’s ongoing QI activities, all facility-specific QI plans submitted to the Network office will be reviewed for documentation of medical direction participation.

REFERENCES:

1. RPA/ASN Position Papers, April 26, 1996: (1) The Nephrologist as Dialysis Facility Medical Director and (2) The Role of Non-Physician Medical Personnel in Delivering Nephrologic Care.
2. Federal Register / Volume 73, Number 73 / Tuesday, April 15, 2008. [Conditions for Coverage (CfC)]:

Network Notification of Changes in Facility Status and Personnel

STANDARD: The Network must maintain updated information regarding facility status (including any changes in number of stations, number of shifts, temporary closures, etc.) and key personnel for use in case of potential or actual disasters or emergencies. Updated information must also be available for use by CMS, the Network, and renal organizations; and in order to maintain updated information for the Dialysis Facility Compare website.

CRITERIA:

1. The Network 13 office is to be notified immediately of any facility status change that may cause disruption of treatment schedules or has caused disruption/changes in treatment schedules (power outages, flooding, etc.)
2. For any event that requires immediate/emergency actions by the facility staff (such as placement of patients at a backup provider or contacting patients for updated status) the Network 13 office must be notified as soon as possible but no later than 24 hours after the event.
3. The Network 13 office is to be notified within two weeks of any changes in key personnel, location, number of shifts or stations and any other facility status information that does not immediately affect patient care.

RATIONALE: The Network is required by CMS to maintain current facility specific information for use before and during potential and actual emergencies and for ongoing correspondence and contact with each facility within its service area.

The Network must maintain the ability to assist patients who may call for assistance in times of a potential or real, local or widespread, emergency or disaster. Accurate information on facility status, available services, contact, and personnel information is essential in times of emergencies as this information is shared with local, regional, and national agencies to coordinate response efforts. Accurate information is vital for patients, so up-to-date options are available and timely arrangements for continued treatments can be arranged. Timely notification of the Network by facilities of any changes in facility status or key staff members is an important component of this.

EVALUATION: The MRB requires the Network staff to evaluate facilities for compliance with this established standard and criteria. Standard evaluation will be done through tracking at the Network level.
Involuntary Discharge of Patients

STANDARD: 100% of involuntarily discharged patients will be reported to the Network 30 days prior to the discharge. Documentation of initial contact with the Network, synopsis of ongoing problem(s), reassessment, and efforts to resolve the problem(s) and documentation of provision of the ESRD Network 13 Patient Toll-Free number will be submitted along with the involuntary discharge notice to the patient.

CRITERIA: In an effort to minimize the incidence of involuntary discharges, all facilities are recommended to seek Network assistance prior to discharging a patient to ensure there is recognition among facility staff of the responsibilities listed below that accompany the action of involuntary discharge and of the potential negative outcomes for the patient.

1. NOTIFY THE NETWORK PRIOR TO AN INVOLUNTARY DISCHARGE:
   - The Network requires 30-day notification prior to the involuntary discharge of any patient to provide an opportunity for the Network Patient Services Department to review the issue(s) with facility staff, the reassessments, ongoing problem(s), and efforts that have been made to resolve the problem(s).
   - The Network Patient Services Department and facility staff can explore if other actions might be utilized to prevent the involuntary discharge.
   - The facility staff should thoroughly document the patient’s behavior: steps taken to assist the patient in addressing and modification of the problematic behavior, referral assistance provided, and outcomes of those referrals. The documentation should include:
     - Conflict management steps taken by the staff in addressing any disruptive patient situations
     - Physician and medical director’s discharge orders concurring with the discharge actions
     - Documentation indicating the patient was informed of the Network 13 Grievance Procedure and was provided the patient toll-free number
   - Any patient considered at-risk for involuntary discharge or transfer must be considered “unstable” triggering a comprehensive interdisciplinary team (IDT) patient reassessment due to “significant change in psychosocial needs.” Note that V767 requires that patients at risk for involuntary discharge be reassessed.
     - “Significant change in psychosocial needs” would include any event that interferes with the patient’s ability to follow aspects of the treatment plan.
   - The Network Involuntary Discharge Packet is completed and required documentation is submitted to the Network for review.

2. TRAIN FACILITY STAFF:
   - ESRD Network 13 requires that all facility staff receive training in conflict management techniques and this training is documented and reviewed annually. The Network reserves the right to request this documentation be submitted for review.

3. REPORT INVOLUNTARY DISCHARGES TO THE NETWORK:
   - Any discharge or transfer of a patient who has not requested such action is to be reported to the Network as an involuntary discharge regardless if the patient was transferred to another dialysis facility. While there is a mechanism in CROWNWeb for this reporting, each facility is responsible for reporting the discharge and discharge reason to the Network directly. The facility will be contacted if the discharge and reason are not reported correctly and will be required to submit the corrected information.
4. INVOLUNTARY DISCHARGE SHOULD BE THE OPTION OF LAST RESORT:
   • All efforts and options need to be put forth to prevent involuntary discharges from occurring. CMS regulations need to be followed on allowable discharges (see reference: CMS Regulations).
     o If a discharge occurs, patients are given advanced notice to ensure orderly transfer or discharge. Under most circumstances, we interpret orderly transfer or discharge to require a 30-day notice and active staff assistance in locating a new facility.
     o It is expected that a patient will not be discharged without notice and without receiving assistance in securing another unit except in cases involving physical assault, or when the patient is considered a serious threat to the safety and security of staff or other patients.
     o If an immediate termination of services is necessary to maintain a safe environment, the patient should be:
       ▪ Notified by certified letter
       ▪ Given a list of facilities in the area
       ▪ Notified of area hospitals that may provide emergency care
     o Active assistance (contacts made for the identification of available treatment space at facilities in the local geographical area, referral of patient and transmission of required medical records) for patients who have had immediate termination of services can still be provided through telephone.
     o When chronic placement is not obtained, the discharging physician and facility should work with area providers to ensure continued treatment.
     o The practice of “banning” a patient within a chain of providers is not supported.
     o Documentation of all discharge activities is required in the patient’s records.

5. NOTIFICATION OF THE STATE SURVEY AGENCY:
   • Documentation should indicate that the State Survey Agency (SSA) was notified of the involuntary discharge or transfer. Documentation should reflect the date, time, and person the involuntary discharge or transfer was reported to.

RATIONALE: The number of patients involuntarily discharged from facilities is a concern in Network 13 and throughout the country. Any ESRD patient without access to regular chronic dialysis and the necessary support services is at increased risk for morbidity and mortality. An unknown number of deaths have occurred due to lack of access to dialysis. Although the number may be small, these deaths may have been preventable. They evoke disturbing ethical questions, particularly in the case of any discharge for non-adherence.

EVALUATION: The MRB requires the Network staff to evaluate facilities for compliance with this established standard and criteria. Compliance will be accomplished by:
   A. Reports of involuntary discharges made to the Patient Services Coordinator and submission of the required documentation.
   B. Reconciliation with submitted monthly Network Patient Activity Reports indicating discharge criteria 6c.

REFERENCE: CMS regulations Section § 494.180 Condition: Governance. (f) Standard: Involuntary discharge and transfer policies and procedures.

The governing body must ensure that all staff follows the facility’s patient discharge and transfer policies and procedures. The medical director ensures that no patient is discharged or transferred from the facility unless:

1. The patient or payer no longer reimburses the facility for the ordered services
2. The facility ceases to operate
3. The transfer is necessary for the patient’s welfare because the facility can no longer meet the patient’s documented medical needs
4. The facility has reassessed the patient and determined that the patient’s behavior is disruptive and abusive to the extent that the delivery of care to the patient or the ability of the facility to operate effectively is seriously impaired, in which case the medical director ensures that the patient’s interdisciplinary team:
   a. Documents the reassessments, ongoing problem(s), and efforts made to resolve the problem(s), and enter this documentation into the patient’s medical record
   b. Provides the patient and the local ESRD Network with a 30-day notice of the planned discharge
   c. Obtains a written physician’s order that must be signed by both the medical director and the patient’s attending physician concurring with the patient’s discharge or transfer from the facility
   d. Contacts another facility, attempts to place the patient there, and documents that effort
   e. Notifies the SSA 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.*

Abbreviated involuntary discharge procedure: Discharges that occur due to serious threat or actions where it is deemed necessary to discharge the patient without the provision of a 30-day notice. Each facility should have a procedure for abbreviated involuntary discharge that indicates:

- Behaviors and/or actions will result in an abbreviated discharge (less than 30 days)
- Notification of patient in writing regarding the decision to discharge
- Placement assistance will be provided to the patient by the facility
- Provision of a listing of hospitals providing acute dialysis care for interim dialysis care until placement can be arranged
- Efforts to be made to provide the necessary security at the facility (including those made to provide ongoing dialysis care while placement efforts are undertaken)
- Notification of the Network prior to discharge (discharge is not official until written notification of discharge is provided to patient)

RESOURCES:

1. DPC Position Statement on Involuntary Discharge: Executive Summary (available on request from the Network)
# ESRD Network 13 Documentation Requirement for Involuntary Discharge

Identify reason for the Involuntary Discharge (IVD) at right and submit the requested documentation and/or information indicated by an “X” in the corresponding box.

Fax information to:
Attn: Patient Services Coordinator
405.942.6884

<table>
<thead>
<tr>
<th>Reason for Involuntary Discharge</th>
<th>Non-Payment</th>
<th>Medical Needs</th>
<th>Disruptive and Abusive Behaviors</th>
<th>Immediate Severe Threat</th>
<th>Termination by Physician</th>
<th>Facility Closure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Payment</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</tr>
<tr>
<td>Copy of discharge or transfer notice given to the patient (30-day notice is required in all cases except “immediate severe threats”). If physician discharge, a copy of the physician discharge notice is required</td>
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<td>Copy of facility’s discharge and transfer policies and procedures</td>
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<td>Documentation the patient received a copy of the Patient’s Rights and Responsibilities document</td>
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<tr>
<td>Documentation of the patient’s medical needs and reasons why the facility can no longer meet them</td>
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<td>Copies of the patient’s interdisciplinary reassessments. Including unstable assessment for potential discharge prior to discharge notice</td>
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<td>Documentation from the patient’s medical record of the ongoing problem(s) and the facilities efforts to resolve the problem(s) (Plan of Care/Assessments/Progress Notes)</td>
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<td>Documentation of the exact nature of the immediate severe threat to the health and safety of others</td>
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<td>Physician order, signed by both the Medical Director and attending nephrologist, concurring with discharge or transfer</td>
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<td>Documentation of attempts to place the patient at another facility (may be provided to the Network later in the 30 day notification period)</td>
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<td>Documentation of Annual Staff Training in Conflict Management</td>
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RECOMMENDATIONS
Adequacy of Hemodialysis (HD)

1. The dialysis prescription should specify the parameters of the hemodialysis calculated to target a single pool (sp) kinetics (spKt/V) ≥ 1.4 per hemodialysis session for patients treated three times per week, with a minimum delivered spKt/V of 1.2.

2. In patients with significant residual native kidney function (Kr), the dose of hemodialysis may be reduced provided Kr is measured periodically.

3. For hemodialysis schedules other than three times per week, a target standard Kt/V of 2.3 volumes per week with a minimum delivered dose of 2.1 using a method of calculation that includes the contributions of ultrafiltration and residual kidney function.

4. The delivered dose of hemodialysis should be calculated using urea kinetic modeling (UKM) or Daugirdas II and these methods should be performed at least monthly to assure that adequate hemodialysis is being delivered.

Anemia Management in Chronic Kidney Disease

Management of anemia in chronic kidney disease usually involves repeated administration of epoetin or darbepoetin [erythropoiesis-stimulating agents (ESAs)] to achieve and maintain desired hemoglobin value between 10.0 to 12.0 g/dL.

FACILITY LEVEL PERFORMANCE:

- **Assessment of Iron Stores**
  Measure Description: Percentage of all adult (≥18 years old) hemodialysis (HD) or peritoneal dialysis (PD) patients prescribed an ESA at any time during the reporting period, or who have a Hemoglobin (Hgb) < 11.0 g/dL in at least one month of the reporting period for whom serum ferritin concentration AND either percent transferrin saturation or reticulocyte Hgb content (CHr) are measured at least once in a three-month period for in-center HD patients, and at least twice during a six-month period for PD patients and home HD patients.

- **Hemoglobin Control for ESA Therapy**
  Measure Description: Adult HD and PD patients, with ESRD ≥ three months, who have received ESA therapy at any time during a three-month reporting period AND have achieved a mean Hgb of 10.0 – 12.0 g/dL for the three-month reporting period. The Hgb value reported for the end of each month (end-of-month Hemoglobin) is used for the calculation.

- **Monitoring Hemoglobin Levels Below Target Minimum**
  Measure Description: Adult HD and PD patients, with ESRD ≥ three months, who have a mean Hgb < 10.0 g/dL for a three-month reporting period, irrespective of ESA use. The Hgb value reported for the end of each reporting month (end-of-month hemoglobin) is used for the calculation.

REFERENCE: The Centers for Medicare & Medicaid Services (CMS) Quality Incentive Program.
Vascular Access Management - Catheters

Chronic maintenance hemodialysis patients should not be maintained on catheters as their permanent chronic dialysis access unless all other forms of access (AVF, AVG) are not clinically feasible (e.g., lack of suitable vessels, multiple failed attempts at access) or patient informed choice.

FACILITY LEVEL PERFORMANCE:

- **Minimizing Use of Catheters as Chronic Dialysis Access**
  
  Measure Description: Analysis of percentage of patients on maintenance hemodialysis during the last HD treatment of reporting period with a chronic catheter continuously for 90 days or longer prior to the last HD session.

RATIONALE:

- The use of cuffed dialysis catheters for long-term access is associated with a dramatic increase in access complications. Cuffed catheters are associated with lower blood flow rates compared to AV accesses. As a result, catheters used long-term without appropriate adjustments in treatment duration can compromise dialysis adequacy. Systemic and local infections occur more frequently with cuffed catheters than with AV accesses. Chronic catheter access is associated with a risk of central venous stenosis. Development of central venous stenosis can preclude the establishment of a permanent vascular access for hemodialysis.

- The initial success, ease-of-use, and painless access to the patient’s blood offered with a dialysis catheter may foster reluctance in the patient to consider other more permanent access options, despite the greater risk of infection and inadequate dialysis associated with chronic permanent catheter access use. Patients should be educated on these issues and strongly encouraged to allow creation of an AV fistula for permanent access where appropriate.

REFERENCE: The Centers for Medicare & Medicaid Services (CMS) Quality Incentive Program.
Vascular Access Management – Arteriovenous Fistula (AVF)

The preferred type of permanent vascular access for patients choosing HD as their dialysis modality is a primary AVF.

RATIONALE: (K/DOQI™ Vascular Access Clinical Practice Guidelines)

- Native accesses have the best 4- to 5-year patency rates and require fewer interventions compared to other access types. An increase in the percentage of native AVFs is best accomplished by early determination of the patient’s preferred dialysis modality while dialysis initiation is still months away, since primary AVF ideally should be allowed to mature three to four months before use.

- Placement of an AVF should be viewed as an integral part of an overall vascular access plan for each patient, and not as an end in and of itself. Evaluation through vessel mapping and placement of an AVF are only the first steps in providing long-term optimal vascular access. The goal is for the AVF to remain functional through proper cannulation, monitoring, and maintenance.

- In many patients, a previous native or synthetic access produces dilatation of arm veins, permitting construction of a new primary AV access at a site not previously available.

- In the patient receiving PD who is manifesting signs of modality failure, the decision to create a backup fistula should be individualized by periodically reassessing need.

- If an AVF is not useable between four to six weeks after placement, evaluation should be done regarding immediate functionality and referral to surgeon and/or interventionalist accordingly.
Continuing Education Credits in Renal Healthcare

ESRD healthcare professionals should attain at least 5.0 hours of continuing education credits and/or contact hours annually in the area of renal healthcare. Of the 5.0-hour recommendation, 2.0 hours must be approved for credit by an accredited professional healthcare organization.

Each ESRD provider should utilize continuing education verification forms for tracking purposes.

CRITERIA: ESRD healthcare professionals (nurses (RN/LPN), social workers, dieticians, and patient care technicians).

RATIONALE: To foster the highest attainable level of patient care in the ESRD setting, continuing education serves to validate ongoing qualification and knowledge for practice in a renal healthcare setting. It also encourages the maintenance of an up-to-date knowledge base in renal healthcare.

EDUCATIONAL RESOURCES:

- ESRD Network 13 Outreach/Educational Activities
- American Nephrology Nurses Association (ANNA)
- National Association of Nephrology Technicians (NANT)
- Dialysis Corporations
- Suppliers of Dialysis Supplies, Pharmaceuticals
- Internal Facility Continuing Education (in-services)
- Centers for Disease Control and Prevention (CDC)/National Healthcare Safety Network (NHSN)
- Local Colleges/Universities/Vocational Technical Schools
- National Kidney Foundation (NKF)
  - Council of Nephrology Nurses and Technicians (CNNT)
  - Council of Nephrology Social Workers (CNSW)
  - Council of Renal Nutrition (CRN)
Mineral Metabolism in Chronic Kidney Disease

1. The target range for the serum level of phosphorus should be maintained between 3.5–5.5 mg/dL. (EVIDENCE: K/DOQI™ Guidelines)

2. The serum calcium-phosphorus product should be maintained at <55 mg^2/mL^2. (EVIDENCE: K/DOQI™ Guidelines)

3. Serum levels of corrected total calcium should be maintained within the normal range for the laboratory used, preferably toward the lower end (8.4 to 10.2 mg/dL). (OPINION: K/DOQI™ Guidelines)

4. The serum calcium-phosphorus product is best achieved by controlling serum levels of phosphorus within the target range. (OPINION: K/DOQI™ Guidelines)

FACILITY LEVEL PERFORMANCE:

- **Measurement of Serum Calcium Concentration**
  Measure Description: Analysis of percentage of all adult (≥18 years of age) PD and HD patients included in the sample for analysis with serum calcium measured at least once within month.

- **Measurement of Serum Phosphorus Concentration**
  Measure Description: Percentage of all adult (≥18 years of age) PD and HD patients included in the sample for analysis with serum phosphorus measured at least once within month.

**REFERENCE:** The Centers for Medicare & Medicaid Services (CMS) Quality Incentive Program.
Peritoneal Dialysis (PD) Adequacy

1. At initiation of PD therapy, total Kt/Vurea, total Ccr, and PNA (with all its components) should be measured within the first two months and then every four months.

2. If there is a change in prescription or a major change in clinical status (e.g., hospitalization, weight loss), but in the absence of peritonitis, measurements of delivered weekly Kt/Vurea and total weekly Ccr should be performed within the next four weeks and then resume adequacy testing at four-month intervals.

RATIONALE:

- Measurements of delivered PD dose and total solute clearance are easy to perform, but require attention to detail and precision in techniques for patients and dialysis staff. It is imperative that these measurements become a routine for the patients and facility staff. The four-month interval is recommended because it strikes a balance: every four months is often enough to be clinically helpful, but not so often as to be intrusive into a PD patient’s lifestyle.

- The impact of a change in prescription should be assessed within two to four weeks in order to determine if the recommended change has actually been executed and if it has accomplished its goal. The promptness of the assessment is important because clinical events could postpone the measurement or confound the results.

FACILITY LEVEL PERFORMANCE:

- Measurement of Total Solute Clearance at Regular Intervals
  Measure Description: Analysis of percentage of all adult (≥18 years of age) PD patients with total solute clearance for urea (endogenous residual renal urea clearance and dialytic) measured at least once in a four-month period.

- Delivered Dose of PD Above the Minimum of 1.7
  Measure Description: Analysis of percentage of all adult (≥18 years old) PD patients whose delivered PD dose was a weekly Kt/Vurea of at least 1.7 (dialytic + residual) during the four-month reporting period.

REFERENCE: The Centers for Medicare & Medicaid Services (CMS) Quality Incentive Program.
Nutrition in Chronic Kidney Disease

1. Serum albumin is a valid and clinically useful measure of protein-energy nutritional status in all adult and pediatric ESRD patients.
2. The optimal target serum albumin level is $\geq 3.7$ gm/dL.

RATIONALE:

- Serum albumin levels have been used extensively to assess the nutritional status of individuals with and without chronic renal failure. Malnutrition is common in the ESRD population, and hypoalbuminemia is highly predictive of future mortality risk when present at the time of initiation of chronic dialysis as well as during the course of maintenance dialysis. It follows that nutritional interventions that maintain or improve serum albumin concentrations may be associated with improved long-term survival, although this has not been proven in randomized, prospective clinical trials. Serum albumin levels may rise with increased protein or energy intake.
- Although no ideal measure of nutritional status exists, the serum albumin concentration is considered a useful measure of protein-energy nutritional status in maintenance dialysis patients. The extensive literature in individuals with or without renal failure relating serum albumin to nutritional status, and the powerful association between hypoalbuminemia and mortality risk in the chronic dialysis population, strongly support this contention. In addition, the measurement of serum albumin levels is inexpensive, easy to perform, and widely available.
Management of Hyperkalemia

Develop and implement protocol specific to use of low K+ baths (< 2.0 mEq/L) for management of hyperkalemia, which includes:

- Prudent serum K+ monitoring to be considered at least weekly for 1.0 mEq/L bath
- Change in bath as serum K+ levels normalize
- Prudent use of low K+ baths on patients receiving cardio-tonics (e.g., digoxin, digitalis, and Lanoxin)
- Dietary consult completed and documented in the patient’s chart
- In the rare instances where K+ free dialysate is routinely utilized, care should include:
  - Serum K+ monitoring per treatment
  - Cardiac monitoring during treatment

CRITERIA: Hemodialysis patients (adult and pediatric) as applicable.

RATIONALE: Serious adverse events can occur related to the use of low potassium (K+) dialysate without timely monitoring.

PROFESSIONAL KNOWLEDGE:

- “K+ free dialysate may produce rapid K+ fluctuations along with a higher incidence of cardiac arrhythmias.”
- “K+ free dialysate should be avoided because its ability to enhance K+ removal is modest in comparison with dialysate containing 1 mEq/L K+.”
- “Patients with known cardiac disease and perhaps other patients such as those with concurrent hypomagnesemia or hypocalcemia AND those receiving Digitalis, are very likely at greater risk for hypokalemia-induced arrhythmia. The use of dialysate with a higher K+ concentrate (>2.0 mEq/L) is advisable, if possible in such patients.”

REFERENCES:

Fluid Management for Hemodialysis

Develop and implement facility goals and protocols specific to fluid management for HD, which include:

1. BLOOD PRESSURE TARGETS:
   - Patients should have post-dialysis diastolic blood pressures < 100 mmHg for half of their treatments at a minimum (e.g., in at least six out of 12 treatments)

2. MANAGEMENT OF FLUID GAINS:
   - 100% of your prevalent HD patients should have “dry” weight ordered on chart
   - The process of establishing “dry” weight in new to HD patients should occur within 30 days of admission to chronic dialysis unit
   - Protocols (or orders) to achieve “dry” weight should safely challenge to attain while avoiding symptoms
   - Once established, 100% of your HD patients should be monitored for consistent achievement of “dry” weight. Monitoring for achievement or needed change should be documented within individual patient plans of care
   - Sodium modeling, hypertonic saline, or high dialysate sodium concentration should be used with extreme caution and/or avoided
   - Patients should not gain fluid gains > 3 kg between treatments

3. ESTABLISHING “DRY” WEIGHT:
   - Achieving “dry” weight should be accomplished gradually
   - Consider use of a step-by-step approach to decrease fluid overload, lowering ultrafiltration rates (UFR) as needed for signs of fluid depletion (e.g., hypotension, cramping) until intravascular fluid volume is restored
   - Cramping is not to be used as a defining point to set “dry” weight
   - Dry weight reduction should not exceed 1 to 2 kg/week generally
   - Fluid management protocols should incorporate considerations for patients with residual renal function, compromised cardiac status, and autonomic dysfunction which impede use of general fluid removal guidelines

4. PEDIATRICS:
   - For patients weighing less than 35 kg, blood volume monitoring during HD should be available in order to evaluate body weight changes for gains in muscle weight vs. fluid overload

5. INTERVENTIONS: Medical records should reflect evidence of investigation including one or more of the following interventions when there are exceptions to the above guidance:
   - Further dietary instruction to patients/caregivers with focused instruction on sodium and fluid intake every 90 days
   - Reassessment of “dry” weight
   - Reassessment of antihypertensive medications program and/or medications that interfere with fluid removal or cause symptomology (e.g., vasodilators, pain medications, other non-steroidals, etc.)
   - Patient education and/or instructions for when to take and hold medications pre-/post-dialysis treatment
   - Change in dialysis prescription targeting control of blood pressure
   - Reassessment of sodium modeling, as applicable
   - Evaluate use of normal saline and/or hypertonic solutions
   - Psychosocial intervention
CRITERIA: All HD Patients

RATIONALE: Optimal control of fluid volume and blood pressure influences morbidity and mortality

PROFESSIONAL KNOWLEDGE:

KDOQI™ Clinical Performance Guidelines (CPG) - Hemodialysis Adequacy Guideline 5: Control of Volume and Blood Pressure indicates the use of sodium profiling or high dialysate sodium concentration should be avoided. Available evidence indicates that control of a patient's fluid volume influences outcome. Volume and blood pressure are linked; thus, it is important to optimize ultrafiltration and dry weight to control blood pressure in an effort to improve patient outcome.

KDOQI™ guidelines also state poor volume control can exacerbate hypertension and its detrimental effects on the cardiovascular system. Analysis of USRDS Waves 3 and 4, when adjusted for comorbidity, showed that weight gain between dialyses of more than 4.8% (i.e., 3.4 kg in a 70 kg person), a reflection of excessive sodium and water intake, is associated with increased mortality.

Achievement of Optimal “Dry” Weight (CPG 5.1): During dialysis, as the patient's dry weight is approached, the rate at which the vascular compartment refills from fluid in the adjacent tissue spaces is reduced. If Ultrafiltration Rate (UFR) is reduced toward the end of dialysis, the reduced compensatory refilling process may be adequate to support the patient's depleted blood volume, thereby avoiding hypotension and muscle cramping. When the blood volume is refilled and blood pressure improves, more rapid ultrafiltration can be resumed.

For a fluid-overloaded dialysis patient, this step-by-step process of identifying, or “probing,” for the true dry weight through ultrafiltration—but without inducing hypotension—should be accomplished gradually over a number of dialysis treatments (usually over four to 12 weeks, but it may require as long as six to 12 months) until evidence of fluid overload is in abeyance. For patients with diabetes mellitus (autonomic dysfunction) or cardiomyopathy, this process of approaching the optimal “dry” weight may take longer because plasma refilling can be low even in the presence of an expanded volume.

From the very beginning of the dialysis therapy, concomitant with ultrafiltration probing, dietary sodium should be restricted and use of a high dialysate sodium concentration and sodium profiling should be avoided. While decreasing the patient's fluid volume, net fluid losses ideally should not exceed 1 to 2 kg/wk, and by restricting dietary sodium and fluid intake, weight gain between dialyses should not exceed 1 kg during the week and 1.5 to 2 kg during the weekend.

REFERENCES:

1. KDOQI™ Clinical Practice Guidelines and Clinical Practice Recommendations 2006 (I. CLINICAL PRACTICE GUIDELINES FOR HEMODIALYSIS ADEQUACY GUIDELINE 5. CONTROL OF VOLUME AND BLOOD PRESSURE)
Fluid Management for Peritoneal Dialysis

Develop and implement facility goals and protocols specific to fluid management for peritoneal dialysis (PD), which include:

1. **BLOOD PRESSURE TARGETS:**
   - Patients should have a diastolic blood pressure < 100 mmHg in the majority of their clinic visits (e.g., at least five of the six most recent clinic visits)

2. **MANAGEMENT OF FLUID GAINS:**
   - 100% of your prevalent patients should have established “dry” weight ordered on chart
   - The process of establishing “dry” weight in new PD patients should occur within 30 days of admission to chronic dialysis facility.
   - Protocols (or orders) to achieve “dry” weight should safely challenge to attain while avoiding symptoms
   - Once established, 100% of your prevalent PD patients should be monitored for consistent achievement of “dry” weight. Monitoring for achievement or needed change should be documented within individual patient plans of care
   - Considerations as PD prescriptions are established and/or reviewed
   - Dialysate drain volume
   - Residual kidney function (RKF)
   - Hypertonic glucose solution should be used with caution
   - Fluid management protocols should incorporate considerations for patients with residual renal function, compromised cardiac status, and autonomic dysfunction which impede use of general fluid removal guidelines

3. **INTERVENTIONS:** Medical records should reflect evidence of investigation including one or more of the following interventions when there are exceptions to the above guidance:
   - Further dietary instruction to patients/caregivers with focused instruction on sodium and fluid intake every 90 days
   - Reassessment of “dry” weight
   - Reassessment of antihypertensive medication program and/or medications that interfere with fluid removal or cause symptomology (e.g., vasodilators, pain medications, non-steroidal, etc.)
   - Patient education and/or instructions for when to take and hold medications relative to dialysis treatment
   - Review of Peritoneal Equilibration Test (PET) results for transport status
   - Reassessment of hypertonic glucose solutions
   - Reassessment of the net peritoneal fluid absorption that frequently occurs with long duration dwells, such as the nocturnal dwell in Continuous Ambulatory Peritoneal Dialysis (CAPD) and diurnal dwell in Automated Peritoneal Dialysis (APD)
   - Psychosocial intervention

**CRITERIA:** Peritoneal Dialysis Patients

**RATIONALE:** Optimal control of fluid volume and blood pressure influences morbidity and mortality.
PROFESSIONAL KNOWLEDGE:

KDOQI™ Clinical Practice Guidelines and Clinical Practice Recommendations 2006: (I. CLINICAL PRACTICE GUIDELINES FOR PERITONEAL DIALYSIS ADEQUACY GUIDELINE 4. MAINTENANCE OF EUVOLEMIA. There is a high prevalence of coronary artery disease, left ventricular hypertrophy (LVH), and congestive heart failure (CHF) in patients with Chronic Kidney Disease (CKD) stage 5, including those on PD therapy. Cardiovascular disease (CVD) is the largest cause of death in this population. In patients with kidney failure, volume overload is widely believed to be the major contributor to hypertension. Therefore, interventions to optimize volume status (and hence blood pressure) are considered central to the management of these patients.

Circumstantial evidence from observational studies suggests that low transport status according to PET is associated with improved outcome in CAPD patients; this may reflect the beneficial effect of low transport status on peritoneal ultrafiltration and thus on clinical outcome. Greater fluid removal (peritoneal plus kidney) also was found to be a favorable predictor of outcomes in observational studies of both CAPD and APD patients.

KDOQI™ CPG state that each facility should implement a program that, each month, assesses patients' blood pressure and volume status and evaluates their drain volume, RKF, and dietary salt and water intake. To ensure good control of blood pressure and volume status in PD patients, clinical examination of the patient needs to be carried out on a monthly basis. In particular, this should involve reevaluation of the patient's target weight. Clinical examination will need to be done more frequently in the initial weeks of PD therapy when target weight is being established for the first time.

Peritoneal fluid removal can be increased by using a more hypertonic glucose solution or an alternative osmotic agent, such as icodextrin. Consistent use of hypertonic glucose solutions raises concerns about damage to the peritoneal membrane and the adverse effects of increased systemic absorption of glucose. Concerns about the role of glucose in membrane deterioration, in particular, have been supported by recent studies.

A preferred approach is to avoid long-duration dwells that often are associated with ineffective fluid removal or even net fluid resorption. In patients on APD therapy, this can be done by either shortening the day dwell and leaving the patient “dry” for a portion of the day or draining out the day dwell and replacing it with fresh dialysis solution partway through the day.

In CAPD patients, it can be dealt with by switching to APD without a long day dwell or using a night-exchange device to divide the nocturnal dwell into two shorter dwells. An alternative strategy is to use icodextrin solution for the long nocturnal dwell in CAPD patients and the long day dwell in APD patients. This was shown in randomized control trials to both increase peritoneal ultrafiltration and decrease extracellular fluid (ECF) volume. With icodextrin in place, there is no need to drain a day dwell early to optimize ultrafiltration. However, some patients may still request a shorter duration day dwell (six to eight hours) to allow for a period of day dry time, which some find more comfortable.

REFERENCES:

1. KDOQI™ Clinical Practice Guidelines and Clinical Practice Recommendations 2006 (I. CLINICAL PRACTICE GUIDELINES FOR PERITONEAL DIALYSIS ADEQUACY GUIDELINE 4. MAINTENANCE OF EUVOLEMIA
Advance Directives

1. Each dialysis facility should develop policies and procedures specific to advance directives and document patient-specific advance directives accordingly. This recommendation requires that dialysis units be familiar with their state-specific laws on advance directives.

2. Additional Planning Option for Do Not Resuscitate (DNR) Directives: Each Facility should develop policies and procedures specific to DNR. This recommendation requires that dialysis units be familiar with their state-specific laws on DNR.

3. Each dialysis facility should have written advance directives documentation on 100% of their patients’ records with annual reviews and/or as requested by patient or patient representative

RATIONALE:

- Patient Self-Determination Act recognizes, “An individual’s right under state law to make decisions concerning…medical care including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.”
- Conditions of Coverage Subpart C—Patient Care § 494.70 Condition: Patients’ Rights Be informed about his or her right to execute advance directives, and the facility’s policy regarding advance directives
- Specific to Additional Planning Option for Do Not Resuscitate (DNR) Directives
  - Dialysis units should enhance their respect of patients’ wishes not to be resuscitated in event of cardiac arrest during dialysis.
  - Dialysis unit might be legally liable if CPR is performed on patients who have valid DNR orders on file.

RESOURCES:

1. Advance directive forms for dialysis facilities (www.caringinfo.org)
2. Kidney End of Life Website (www.kidneyeol.org)
   - Forms: Funeral home information, valuables disposition
   - Quick reference card for pronouncement of death
   - Ways to provide support to staff after patient deaths
   - Teach patients about CPR
3. Robert Wood Johnson ESRD Workgroup
   (www.promotingexcellence.org/downloads/esrd_full_report.pdf)
   - Advance Preparation for Death
   - Advance Directive for DNR Order in Dialysis Unit

CMS Criteria to Determine Eligibility for the ESRD Program

1. Initiation of Renal Replacement Therapy (RRT) is determined by both glomerular filtration rate (GFR) and the presence of uremic symptoms.
2. For adult (age > 18) patients, use the Modified MDRD formula.
3. For adult dialysis patients, most will have GFR < 15 ml / min / 1.73m².
4. For adult pre-transplant patients, most will have pre-transplant GFR < 20 ml / min / 1.73m².
5. For pediatric (age ≤ 18) patients, use the Schwartz formula.
6. For pediatric dialysis and pre-transplant patients, most will have GFR < 20 ml / min / 1.73m².

**The Modified MDRD Formula for Adults**
- Based on formula for GFR used in Modification of Diet in Renal Disease study;
- Eliminates serum albumin and BUN in original formula;
- High correlation with GFR from iothalamate
- Estimated GFR (ml/min/1.73m²) = 186.3 * (sCr)^{-1.154} * age^{-0.203} * (0.742 if female) * (1.21 if African-American)

**The Schwartz Formula for Children**
- Introduced in 1980’s to estimate GFR in children from serum Creatinine and height
- More widely used by pediatricians than Counahan-Barratt formula
- Correlates with inulin clearance over 5 – 180 ml / min / 1.73m² range
- Estimated GFR (ml / min / 1.73m²) = k * Ht (cm) / sCr
  - Where k = 0.45 (age < 1.5)
  - k = 0.55 (1.5 yr. through < 13 or female)
  - k = 0.70 (age > 13 and male)

**CRITERIA:** All end stage renal disease (ESRD) patients = Stage 5 K/DOQI™ Stages of CKD.

**K/DOQI™ STAGES OF CHRONIC KIDNEY DISEASE**

<table>
<thead>
<tr>
<th>Stages</th>
<th>Description</th>
<th>GFR (mL/min/1.73 m²)</th>
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<tbody>
<tr>
<td>1</td>
<td>Kidney damage with normal or ↑ GFR</td>
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<tr>
<td>2</td>
<td>Kidney damage with mild ↓ GFR</td>
<td>60–89</td>
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<tr>
<td>3</td>
<td>Moderate ↓ GFR</td>
<td>30–59</td>
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<tr>
<td>4</td>
<td>Severe ↓ GFR</td>
<td>15–29</td>
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<tr>
<td>5</td>
<td>Kidney failure</td>
<td>&lt;15 (or dialysis)</td>
</tr>
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In-Center Hemodialysis (ICH) Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

All in-center HD patients will be provided the opportunity to participate in the In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH-CAHPS) Survey at least twice a year.

Documentation of facility’s governing body review of the ICH-CAHPS survey results as well as activities initiated secondary to ICH-CAHPS review within overall facility-specific Quality Assessment Performance Improvement (QAPI).

RATIONALE: Results of the ICH-CAHPS Survey provide documentation of the patients’ perception of delivered care received at a facility to the facility medical director and governing body. Results will assist the medical director and governing body to develop internal quality improvement activities to improve the patient perception of care delivery. The facility should be providing dialysis care in a fair, equitable, and responsive manner to patient’s needs and that should be reflected in their perception of care.

DESCRIPTION: The ICH-CAHPS is designed to assess the experiences of HD patients who receive care from dialysis facilities. It is intended to serve as a tool to measure and assist with improvement in the area of patient-centered care.

The ICH-CAHPS generates two types of results for reporting purposes:

- Global ratings, which use a scale of 0 to 10 to measure respondents’ assessment of their kidney doctors, their dialysis center, and their dialysis center staff.
- Composites, which combine results for closely related items that have been grouped together. There are three composites for this survey:
  1. Nephrologists’ communication and caring
  2. Quality of dialysis center care and operations
  3. Providing information to patients

RESOURCE: https://ichcahps.org/
Patient Education Awareness

One hundred percent of all dialysis patients will have documentation of education of modality options at least annually to include: hemodialysis, peritoneal dialysis, home hemodialysis, transplant (inclusive of identification of potential living donors), and no treatment.

The Patient Plan of Care meeting is the avenue for providing individualized patient education. The patient’s physician, registered nurse, social worker, and dietitian are required to participate in the Patient Plan of Care meeting. Documentation of required education by each member of the care team must be evident in the Plan of Care.

CRITERIA: Documentation of initial and annual education about modality options must be located in each ESRD patient’s individualized assessment and/or plan of care. Documentation shall be specific to:

- Individualized education, by each indicated care team member, on all modality options
- Documentation of patient’s preference for modality
- Documentation of facility actions to meet patient’s modality preference

RATIONALE: To ensure all patients are being educated about each treatment modality option available, the pros and cons of each treatment modality, and information on availability of the treatment modality at the facility or referral process to obtain the treatment modality.
Assessment of Health-Related Quality Of Life

All eligible dialysis patients should have an assessment of health-related Quality of Life (QoL) documented annually.

CRITERIA: There will be documentation in the individualized patients’ assessments and/or care plans of all ESRD patients’ as to:

- Completion of the KDQOL-36™ or like assessment tool
- Documentation of assessment results with the patient
- Analysis of aggregate QoL results to determine CQI activities to improve outcomes on the physical and mental scale facility mean score

RATIONALE:

- The KDQOL-36™ is a standardized assessment tool to assess the burden of kidney disease for the patient. The results indicate the impact of kidney disease on both the physical and mental functioning of the patient. Score results have been indicators of increased hospitalizations and poorer outcomes for patients.
- The analysis of the scores from the KDQOL-36™ will enable the care team to identify potential problem areas affecting the patient’s ability to function at the highest attainable quality of life level and will assist in the development of care team interventions to minimize the impact of these areas.

AVAILABLE RESOURCE: The KDQOL-36™ is a quality of life assessment tool utilized with patient to measure the impact of kidney disease on their lives. The areas measured are:

- Physical Component Score
- Mental Component Score
- Effects of kidney disease
  - Burden of kidney disease
  - Symptoms

The results should be utilized in care planning to improve outcomes and lessen the perceived burden of the disease on the patient. Lower scores have been shown to be indicators of increased hospitalizations and poorer outcomes for patients.

GRIEVANCE POLICY
ESRD Patient-Consumer Grievance Policy

This grievance process is available to provide a method of consideration for concerns, complaints, or grievances of ESRD patient-consumers.

A COPY OF THIS POLICY SHOULD BE PLACED IN A LOCATION THAT IS EASILY ACCESSIBLE TO ALL PATIENT-CONSUMERS OF THE FACILITY. Facilities are required to annually document, in all patients’ Plan of Care, that a copy of this policy has been received and understood (with assistance if necessary) by the patient. It is the right of all ESRD patient-consumers to file a grievance when the patient-consumer feels it is needed. Annually, facility staff should review this grievance policy with patients to ensure accessibility, understanding, and receipt of revisions (if any).

Patients are encouraged to utilize the facility grievance resolution process prior to filing a grievance with the Network. All facilities are required under CMS ESRD Conditions of Coverage (ESRD CfC) to have an internal grievance process that is posted and accessible to patients-consumers.

It is our policy to process all grievances in a timely, impartial, and confidential manner.

STEPS OF THE GRIEVANCE PROCESS

If an ESRD patient-consumer has a concern, unanswered question, or complaint regarding his/her treatment or quality of care, the patient-consumer may exercise their right to file a grievance by following the steps listed here:

**STEP 1** - The patient-consumer should first address his/her question, concern, complaint or grievance to the person perceived as the source of the confusion or conflict. It is anticipated that most conflict will be resolved in this step. If not resolved by direct communication at the source of the problem, or if the patient-consumer does not wish to address the other person involved, he/she may proceed to step 2.

**STEP 2** - All facilities are required under CMS ESRD CfC to have an 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:

- A clearly explained procedure for the submission of grievances
- Timeframes for reviewing the grievance
- A description of how the patient or the patient’s designated representative will be informed of steps taken to resolve the grievance

The patient-consumer is encouraged to utilize the facility internal grievance process to address concerns, complaints and/or grievance regarding his/her treatment or quality of care, staff related complaints, or environmental/cleanliness issues. The patient-consumer may consult the facility social worker to be an advocate for the patient in accessing the facility internal grievance process. If the patient-consumer wishes to remain anonymous, or appoint a personal representative as his/her spokesperson/advocate, the Social Worker should accommodate and protect the wishes of the patient-consumer.
STEP 3 - The patient-consumer may choose to by-pass steps 1 and 2, and initiate a grievance directly to the Network 13 office. This step may be taken with or without the knowledge of the facility staff involved in the grievance. The grievance may be communicated by telephone or letter. If the patient-consumer wishes to maintain anonymity, he/she should be made aware that a full investigation might not be achieved. Grievances should be addressed to:

HSAG: ESRD Network 13
ATTN: Patient Services
4200 Perimeter Center Suite 102
Oklahoma City, OK 73112-2314

OR CALL:

Toll-free: 1.800.472.8664
Local: 405.942.6000
Internal Grievance Process

If the grievant is an appointed representative of an ESRD patient, the Network will ask for documentation of the grievant’s status, obtain verbal confirmation, with documentation in the Patient Contact Utility (PCU) or other CMS-designated system, and request that the grievant complete an Appointment of Representative Form. In the event that the patient is deceased and a grievance is being filed by a patient representative, the Network will require legal authorization (e.g., Durable Power of Attorney) prior to starting any grievance investigation.

When a grievance is received at the Network office, the grievant will be contacted to discuss the concern. It is incumbent upon the Network to conduct a professional, impartial, timely, and thorough investigation. The Network shall request any documentation needed for the investigation from the dialysis facility in a timely manner, and the facility shall provide such documentation within five business days of the Network’s request. In some cases, the Network 13 staff, Medical Review Board or its adhoc committee, may also provide suggested resolution options and/or request a Corrective Action Plan or an Improvement Plan from the facility involved.

The Network shall complete all activities related to a grievance within 60 calendar days of receipt of the grievance, including the completion of an Improvement Plan if the Network has requested the dialysis facility to initiate one. All Corrective Action or Improvement Plans will utilize concepts of rapid cycle improvement with designated timelines and reports to the Network.

The Network shall provide the patient with a summary letter within three business days of completing activities. A grievant has the option to withdraw a grievance at any time. If the case is withdrawn, the Network shall provide a summary letter within three business describing Network actions up to the point when the grievance was withdrawn.
Facility or Other Source Grievances

Any facility complaint or complaint received from other sources in the renal community will be handled informally utilizing conflict resolution techniques. If the matter cannot be resolved informally, a Grievance may be filed regarding the QUALITY OF MEDICAL/HEALTH CARE PRACTICES in any ESRD facility within our service area by forwarding a letter to the Network office as previously discussed. This letter should provide facts leading to the grievance.

Upon receipt of a Grievance letter as defined above, the Network staff will conduct an investigation to determine the validity of the facts noted in the Grievance letter.

What this policy will not do:

This policy WILL NOT address, intervene, apply, or circumvent any Personnel Policies within ESRD facilities. Personnel issues or conditions of employment in ESRD facilities are separate and distinct matters, to be addressed through facility’s internal processes.

This policy WILL NOT address facility complaints or grievances against patients. There are a host of other mechanisms in place to address such concerns (i.e., application of Decreasing Dialysis Patient/Provider Conflict (DPC) model, behavioral modification agreements, physician intervention, patient referral, patient transfer, patient “rotation” or, in rare circumstances of patient violence, patient service termination). The facility should have policy and procedures for termination of services that abide by the CMS Conditions for Coverage and these should be followed under these circumstances.
SANCTION AND ALTERNATIVE SANCTION RECOMMENDATION POLICY
Sanction and Alternative Sanction Recommendation Policy

HSAG: ESRD Network 13 will:

(a) Recommend sanction to CMS for facilities/providers that consistently fail to comply with Network goals and/or are not providing appropriate medical care
(b) Provide documentation throughout the process to support the recommendation and associated investigation
(c) Track and trend dialysis facility data to monitor facility non-compliance and return to compliance
(d) Refer to the QIO or the state/jurisdiction Inspector General’s office any information collected while conducting contract activities that indicates that a physician may be failing to meet his/her obligation to provide quality care or is involved in Medicare fraud

AUTHORITY

Section §1881(c)(2)(G) of the Social Security Act (the Act) provides that a Network shall identify facilities and providers that are not cooperating toward meeting the Network goals and assist such facilities/providers in developing appropriate plans for correction. Networks are to report facilities that continue to be non-compliant and those that are not providing appropriate medical care to the Secretary via CMS.

Code of Federal Regulations (CFR) 42 CFR, Subpart U, §405.2100-405.2184, describes the Conditions for Coverage for suppliers of end stage renal disease services, and the Medicare State Operations Manual, Pub. 100-07 provides guidance for ensuring compliance by certified facilities/providers with these Conditions. At a minimum, facilities/providers are expected to provide data to the Network to assist CMS in maintaining accurate and complete data on ESRD patients, participate in Network activities, and pursue Network goals. CFR 405.2134 stipulates that a facility/provider must participate in Network activities and pursue Network goals. 42 CFR 405.2081 provides clarifications on the basis for sanction/alternative sanction, while 42 CFR 405.2182 and 2184 provide information on appeal rights for termination of coverage due to sanction/alternative sanction.

Section §1881(c)(3) provides that based upon information/data provided by the Network on a facility/provider’s consistent failure to cooperate with the Network plans or goals or to follow the recommendations of the Network Medical Review Board (MRB), the Secretary may terminate or withhold certification until a determination is made and validated that the provider/facility is making reasonable and appropriate efforts to cooperate with the Network. Based upon a facility/provider’s failure to cooperate, the Network can recommend sanction by providing supporting information/data to the Secretary’s designee, the CMS Regional Office (RO), utilizing the processes outlined in this chapter.
PROCESS

HSAG: ESRD Network 13 will inform all facilities of criteria and standards developed by the Network or the Centers for Medicare & Medicaid Services for use in the CMS ESRD Quality Incentive Program (QIP), Network Quality Improvement projects and/or other Network/CMS Quality Improvement initiatives. Notification will include a description of the nature of the participation required by the facility, the timeframe for that participation, and requirements for participation.

Facilities will also be informed of the Network’s process for addressing patients’ grievances, including the appropriate Network contact for patient inquiries, and the Network’s toll-free patient telephone number. This information will be provided to the facilities at least annually.

Network staff will maintain records of submission of all required written materials (including CMS forms, Network Patient Activity Reports, and other quality improvement project data collection forms) to the Network office.

Monitoring facility cooperation/compliance with Network goals (and, as appropriate, return to compliance) will be accomplished through the following processes:

(a) Review of Network- and facility-specific data related to QI projects/initiatives by Network Staff and Medical Review Board (MRB) quarterly or as appropriate to identify potential facility non-compliance
(b) Development, dissemination, and review of reporting to include facility-specific, regional, state and Network comparisons which will be reviewed regularly as appropriate for the specific activity
(c) Review of trend analysis of facility level grievances
(d) Other measures as appropriate including communication with the SSA as directed by CMS

If a facility is consistently late, or fails to submit required information, Network staff will make contact with the appropriate facility staff member and document all activities related to working with that facility to resolve the issue.

NOTIFICATION

HSAG: ESRD Network 13 will recommend a sanction only if the Network has worked with the facility for at least three months, has exhausted all reasonable efforts to gain facility compliance, and has fully documented that the facility:

(a) Has consistently failed to cooperate with Network plans or goals as specified in the Network’s contract with CMS; or
(b) Has consistently failed to follow recommendations of the MRB, which have been approved by CMS; or
(c) Did not permit the Network MRB, without just cause, to conduct an onsite review; or
(d) Has failed to submit data as required to prepare the Network Annual Report.

In the event the Network identifies a facility that is not consistently cooperating with the Network in meeting the goals and/or not providing appropriate medical care, the Network may consider recommending a sanction to the CMS Regional Office (RO) VI in Dallas, TX. Documentation of the details of the situation shall include actions taken by the Network and the response (or lack of response) by the facility and that the facility has been, and continues to be, out of compliance with Network goals and plan. The proposal will first be discussed with the Network’s CMS Project Officer. The CMS RO has
the responsibility for the actual implementation of a sanction or alternative sanction. The RO will make the final determination whether to sanction the facility.

Notification and documentation of non-compliance provided to the RO will include, at a minimum, the following:

(a) Evidence that the facility was notified in writing of the Network’s goals and objectives
(b) Description and details of the goal(s), objective(s) that the facility has failed to meet
(c) Actions the Network has taken to inform the facility that it was not complying with Network goals, objectives, or plans
(d) Evidence to demonstrate that the facility was given an opportunity to make corrections
(e) Description of follow-up actions taken to resolve the problem (e.g., documentation of phone calls or site visits to the facility asking for specific information) that demonstrate the Network’s attempts to work with the facility to resolve the problem
(f) Documentation of the facility's failure to submit an action plan, submission of an unacceptable action plan, or failure to carry out an approved action plan

Documentation to support the Network’s recommendation for a sanction can be in the form of copies of written correspondence between the facility and the Network, written notes, and/or dated contact reports of telephone conversations.

REFERRAL

At any time information is collected while conducting contract activities that indicates a physician may be failing to meet his/her obligations to provide quality care or may be involved in Medicare fraud, the Network will review the information with its MRB for referral to the QIO or state Office of the Inspector General.

RESOURCES

(Rev. 9; Issued: 04-18-08; Effective Date: 04-01-08; Implementation Date: 05-19-08)

The following resources can be used to clarify the sanction process and the roles of all parties involved, as outlined above:

1. Section §1881(c)(2)(G) of the Act
2. Section §1881(c)(3) of the Act
3. 42 CFR, Subpart U, §405.2100-2184