

**Heartland Kidney Network Annual Meeting
ESRD Conditions for Coverage & State Surveyor Panel Discussion**

Question	Draft Answer
§ 494.1 Basis and scope	
None	
§ 494.10 Definitions	
None	
§ 494.20 Compliance with Federal, State, and local laws and regulations	
The interpretive guidelines are not very clear as to which adverse events are reportable to State or Network. Can you offer some clarification?	V101 states: “If a drug or device may have caused or contributed to a serious injury or illness, the facility must notify the manufacturer and the FDA using FDA’s User Facility reporting requirements. Clusters of adverse events (infectious or non-infectious) should also be reported to the appropriate State or local public health department, as required by those authorities.” V145 also requires the facility to report communicable diseases to Federal or State agencies as required. The CDC and FDA websites include information on what is reportable. V637 states that facilities should report viral hepatitis seroconversions to state and local health officials. Your State Health Department can provide information on any required reporting in your state.
Please clarify that at least in MO, anyone who is licensed (RN, dietitian, social worker, MD, DO) are all mandated reporters of abuse/neglect (not just the MSW).	This is true in many states. Know your state law(s) regarding mandated reporters.
§ 494.30 Infection control	
We have single use vials for some meds and multi-dose vials for EPO, lidocaine, etc. We use single dose for a single patient. Do we have to convert multi-dose EPO vials to single use vials?	Multi-dose vials do not have to be converted to single use. A new syringe and needle must be used for each entry into a multi-dose vial and the septum should be cleaned with alcohol before entry.
Can you use single use medications on more than 1 patient if drawn up and given immediately and not saved? We have 44 stations going at one time with several RNs pulling up meds. Seems like a huge waste if not.	No. V118 states that vials labeled for single use must be entered with a syringe and needle just once and can only be used on one patient. Facilities are given until June 2009 to comply with this for EPO to ensure an adequate supply is available.

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Do the regulations about single use vials apply to other medications with preservatives, i.e., heparin, lidocaine? Do you need a separate vial of medication per patient for these meds?	If these vials are labeled for multiple use, they may be used for more than one patient.
If the patient is sitting in their chair holding their sites, is it a violation to disinfect the surfaces of their machine while they sit next to it?	Not at this time, as long as cross contamination between the patient and the cleaned equipment does not occur. V122 states: "For each 'station' (i.e., the machine, the purified water connection, dialysate concentrate container(s) or connection(s), and the treatment chair), the completion of one patient's treatment and post-dialysis care must be separated by enough time from the initiation of the next patient's care to allow correct disinfection. If the previous patient remains in the treatment chair while the machine is prepared for the next patient, extreme caution must be employed to prevent cross-contamination."
Are we allowed to have clean supply carts in the treatment area if they are stationary?	Yes. V119 states: "If a common supply cart is used to store clean supplies in the patient treatment area, this cart should remain in a designated area at a sufficient distance from patient stations to avoid contamination with blood. Such carts should not be moved between stations to distribute supplies."
Does using the antimicrobial hand sanitizer between patients count as handwashing between patients?	Yes. V113 states: "'Hand hygiene' includes either washing hands with soap and water, or using a waterless alcohol-based antiseptic hand rub with 60-90% alcohol content. Hands should be washed with soap and water if visibly soiled. If not visibly soiled, hand hygiene with alcohol-based hand rub may be used. The CDC recommends that hand washing incorporate rubbing hands together "vigorously" for 15 seconds, and that the use of alcohol-based rubs incorporate covering all surfaces of hands and fingers, until hands are dry. According to the CDC, even with glove use, hand hygiene is necessary after glove

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	<p>removal because hands can become contaminated through small defects in gloves and from the outer surface of gloves during glove removal.”</p> <p>“Examples of when hand hygiene should be performed:</p> <ul style="list-style-type: none"> • After touching blood, body fluids, secretions, excretions, and potentially contaminated items; • Before and after direct contact with patients; • Before performing any invasive procedure such as vascular access cannulation or administration of parenteral medications; • Immediately after gloves are removed; • After contact with inanimate objects, including medical equipment or environmental surfaces at the patient station; • Before entering and on exiting the patient treatment areas; and • When moving from a contaminated body site to a clean body site of the same patient.”
§ 494.40 Water and dialysate quality	
Does the <u>actual</u> water room door have to be locked if outside access doors are locked/secured?	V184 states: “To ensure access is restricted, the delivery doors/loading dock must not be left unlocked, open and unattended. Many water systems are in the same room as stored treatment supplies; staff members who are not responsible for the water system may come into that area to retrieve supplies.” The intent is to prevent casual access and to protect patients from harm. This means doors that are unattended, like a door onto the alley behind the building, should be locked when not in use. It should not be propped open and left unattended. If the water room is in the basement of the building, and the treatment room is on another floor, the door to the water treatment room should

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	also be locked. If the water room is just off the treatment room, we would not expect the door to the water treatment area from the patient treatment area to be locked.
Hospital based unit – Unit door locked when not in use. The water room access door is inside of the unit. Therefore, only accessible when unit is unlocked and staffed. Is a separate lock to the water room required?	No. V184 requires that the delivery doors/loading dock doors must be locked.
Our water room and store room is one big room. This room can be accessed by 3 different doors inside the building/dialysis unit (patient treatment area, lab area, staff hallway). Do all of these doors need to be locked? The outside door to this room is always locked.	No. V184 requires that the delivery doors/loading dock must be locked.
How do you determine the frequency that the SPS hose needs to be disinfected? We have a nightly hot water disinfect, weekly chemical disinfect to machine. Our biomed says it is hard on the machine membrane (to disinfect it too often).	It is not expected that the hose would be disinfected each night; monthly disinfection would be sufficient. V220 states: “The machine supply line is the hose that connects the dialysis machine to the treated water outlet. This hose should be disinfected at the same frequency as the water distribution loop is disinfected, i.e., monthly.”
§ 494.50 Reuse of hemodialyzers and bloodlines	
Do reuse only techs need to be certified?	Not as a patient care technician, however, V307 states that reuse personnel should have enough education, training, or experience to understand and perform procedures outlined by the individual dialysis facility relevant to the facility’s multiple-use program. The medical director must also “certify” that the reuse technician has successfully completed the necessary training.
§ 494.60 Physical environment	
If staff prop the door to get a wheelchair patient into the hemo area from the lobby, is this held against us?	Not unless the door is left open a long time or the “prop” presents a risk for trips or falls. V401 states: “‘Safe environment’ means that there are no obstacles which would present risks for trips and falls, such

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	as loose floor tiles; no areas that would pose infection control risks, such as broken work surfaces; and no outside doors that remain propped open allowing entry of unauthorized individuals, insects, or animals or creating a hazard in the event of fire.” Propping a door from the lobby to the treatment area open just long enough to get a wheelchair through should not allow unauthorized individuals or other insects or vermin to enter that would create a potential hazard.
Does the Life Safety Code pertain to current units, i.e. do you have to have sprinkler system or the 1 hour fire wall?	<p>According to V418, these rules exempt existing dialysis facilities in operation on October 14, 2008, (i.e., that have a valid certificate of occupancy), from needing to install sprinkler systems if the facility is located in a building that was built before January 1, 2008, and if State law permits.</p> <p>According to V417, a facility that is in a mixed occupancy building must have a 1 hour firewall between it and another tenant. Facilities located in hospitals must comply with LSC regulations for hospitals which are more stringent.</p>
Will all units have to be surveyed by the State Fire Marshall at the same frequency as the Medicare survey?	V417 requires a Life Safety Code (LSC) survey to be conducted after 2/9/2009. The LSC survey will be conducted with all initial and recertification health surveys, but generally will be done separately and within a reasonable timeframe of the health survey to complete the federal requirements. Some states use State Fire Marshalls for the LSC surveys, while other states use LSC qualified state surveyors. The regulation doesn't state how often the survey will occur.
If a unit is under a redesign or update to its physical environment, do we need to notify the state office?	Yes, you should notify the State agency. Major renovation changes the Life Safety Code requirements and requires your facility to have an isolation room or waiver. Either the State Surveyor or Fire Marshal would have to come to the facility

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	to verify compliance.
§ 494.70 Patients' rights	
How often are we to ensure that "consent to treat" forms are signed for an outpatient chronic hemodialysis center?	Facility policies should define the frequency consents are to be obtained. At a minimum, consents must be signed at admission and with changes to modality of treatment.
Treatment options – How available is home dialysis especially in rural or less populated areas of the country?	A growing number of facilities are providing home dialysis options (PD and home hemodialysis). You can look up facilities that offer home options at www.homedialysis.org .
Is it OK for the patients to weigh themselves pre and post treatment without staff confirmation?	V456 states that patients should be informed about and participate, if desired, in all aspects of his or her care. Staff should train patients to observe and record their weight accurately. Unless problems have been observed related to recording weights accurately, this would be OK.
To teach a patient or spouse to cannulate only, do we need to teach all aspects of the machine and self-monitoring as well? Can it be taught by hemo staff or does it have to be home hemo staff? Does it have to be a buttonhole?	V456 states: "Self-cannulation may be performed by the patient in any facility upon receiving appropriate training and demonstrating competence, should they so choose." If the patient/spouse desires only to only learn self-cannulation, experienced in-center hemodialysis staff can teach just that. The regulations do not address the type of self-cannulation that patients should be taught. The buttonhole technique of cannulation can only be used with fistulas.
§ 494.80 Patient assessment	
Can the assessment tool and plan of care be combined into one document?	Yes.
We have a template for a combination assessment/plan of care. Can we email it to you and have you to tell us if it will be OK to use or not?	The State or CMS will not approve forms, as compliance is about the assessment and plan that is documented and provided, not about the form. Any format you choose should cover the required areas of patient assessment and plan of care. What is important here is not the form, but the accuracy of the assessment and effectiveness of the plan of care in meeting

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	the needs of the patient.
Can a nurse practitioner be part of the IDT in place of a physician?	V501 states that the facility’s interdisciplinary team consists of, at a minimum, the patient or the patient’s designee (if the patient chooses), a registered nurse, a physician treating the patient for ESRD, a social worker, and a dietitian. An NP may participate in addition to, but not in place of, a physician.
We were initially told the Comprehensive Assessments were to have the same date by all disciplines. Is it correct that the RN completes this before the patient’s first treatment, with that date, and then the other disciplines complete their sections within 13 treatments or 30 days?	<p>The “initial assessment” to be conducted prior to the patient’s first treatment is different from the comprehensive interdisciplinary assessment. It is a medical assessment by the physician, APRN or PA to develop treatment orders and identify and take action to address urgent patient medical needs. In V715 it states that this assessment can be done by a review of medical records or by consulting with the referring physician and does not require the medical staff member to “see” the patient in the facility prior to this first treatment.</p> <p>V715 also requires a nursing assessment be completed prior to initiation of that first treatment. ANNA recommends this assessment include:</p> <ul style="list-style-type: none"> • Neurologic: level of alertness/mental status, orientation, identification of sensory deficits • Subjective complaints • Rest and comfort: pain status • Activity: ambulation status, support needs, fall risk • Access: assessment • Respiratory: respirations description, lung sounds • Cardiovascular: heart rate and rhythm; presence and location of edema • Fluid gains, blood pressure and temperature pre-treatment • Integumentary: skin color, temperature and as needed, type/location of wounds
Who determines if the patient is stable?	Any member of the IDT may determine

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Does everyone on the IDT need to sign off that the patient is stable?	a patient is unstable. At V520, 4 minimal criteria for considering a patient unstable are listed. However, IDT members are able to use their professional judgment to add other assessment criteria if desired based on their unique patient population and patient characteristics. There should be communication among IDT members as patients are assessed to determine which patients fit the “unstable” criteria triggering monthly assessments and development and implementation of the plan of care within the following 15 days.
What if we do not look at “stable” vs. “unstable” and do all patients monthly? How will this be accepted with new regulations?	With the new requirements for assessment and plan of care, it will be very time consuming to try and do all patients every month. Every patient is expected to be continuously monitored, the team is expected to recognize when expected targets are not met and address that part of the plan of care. With that said, the regulations are considered minimal requirements. A facility may choose to conduct comprehensive interdisciplinary assessments and develop plans of care more often than the frequency specified in the regulations.
Regarding new patient assessment and care plans, if providers have 12 months to complete care plans on existing patients, will providers be cited if “old or prior” care plan exceeds 12 months during the 12 month transition to the new assessment and care plans?	If facility policy requires updates of the plan of care at a set frequency, the facility would be expected to follow their policy. The requirement is for the facility to have a system in place to have all assessments and plans of care in place for all existing patients by October 14, 2009. Facilities should prioritize patients, and schedule patients with problems or issues for earlier assessments.
If a transient patient only comes for 1 treatment a year or 1 time a month, do we still need a plan of care developed? Can they just bring one from their regular clinic and we keep it on file?	If a transient patient only comes for one treatment a year, the receiving facility would not need to develop a plan of care. V516 states that if an established patient transfers from one facility to another or is a transient patient and comes with a comprehensive interdisciplinary patient

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	<p>assessment and plan of care, the new facility's IDT must conduct an interdisciplinary patient reassessment within 3 months. The facility has an additional 15 days after that reassessment to begin implementing the plan of care.</p> <p>If a transfer or transient patient does not come with recent patient assessment and plan of care, IDT must conduct an assessment and begin implementing a plan of care within 30 days or 13 HD treatments.</p>
A majority of transient patients receive only 1-2 treatments per month. Would you recommend we request comprehensive assessment from their home unit for review and then complete a "focused" assessment if transient unit identifies a discrepancy in the home unit comprehensive assessment?	A comprehensive assessment is not required for a transient patient who receives 1-2 treatments in a month. You should request the patient's IDT assessment and plan of care when you are making arrangements to accept any transient patients.
Our unit occasionally has patients from other dialysis units who receive IVIG during HD once a month in preparation for transplant, i.e., transient 1-2 IVIG infusions per month. Do we have to do assessment/plans of care on these patients?	You should ask the home facility for copies of the current IDT assessment and plan of care. You would not need to develop these unless the patient stays at your facility longer than 30 days, and if you get copies from the home facility, you would not be expected to develop your own for three months.
Does the reassessment done after someone is unstable have to be the complete comprehensive interdisciplinary patient assessment?	Yes. There should be a review of all areas of the last comprehensive interdisciplinary patient assessment to assure no significant changes have occurred, with a focus on those areas where the patient was unstable.
§ 494.90 Patient plan of care	
What if the MD doesn't want patients to come to patient plan of care meetings?	The facility could be cited under V456 which states: "Patients have the right to know about and participate in their care and treatment to the extent they desire... The facility must encourage patient participation in care planning. Examples of ways to promote this participation include, but are not limited to, offering the patient the option to participate in interdisciplinary team care planning or to attend a planning

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	meeting in-person or by teleconference from home. ‘Chair-side’ review of the plan of care is also acceptable, if sufficient privacy can be provided. Patients also have the right to accept or decline to participate in their care.”
If we do care plan team meetings via teleconference phone call (because each discipline is located in different city/town – 1 in a different state), and we ask patients to participate by calling in, how will this work with HIPAA? Do you say Patient A will call in at 0900, Patient B will call in at 0910, and Patient C will call in at 0920? How will this work?	<p>One way to do this would be to notify patients like this.</p> <p>Dr. [Name] has scheduled a care planning meeting for his/her patients on [date] from [start time to end time]. He/she has asked me to ask you to participate in setting goals for your care and developing a plan to reach those goals. You can attend in person if you’d like at approximately [time] or we can call you then. Can you attend? If not, what number would be the best one for us to reach you at that time?</p> <p>Each patient would have his/her own time to attend or be called to participate to avoid any breach of HIPAA. Calling the patient also keeps him/her from paying long distance toll charges.</p>
Can you give us some examples of how centers are meeting with patients to complete the new care plan?	<p>Facilities should have been offering patients the opportunity to participate in care planning for some time since the regulatory requirement has existed since 1976.</p> <p>One approach would be to have a meeting as in the previous question. Another would be for the physician and the team to make rounds and discuss findings and develop the plan of care with those patients who agree to discuss these matters while they’re on dialysis. The Network may be able to share tips from other facilities that have successfully involved patients in care planning.</p> <p>Finally, patients have the right to choose to attend or refuse to attend. If they refuse,</p>

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	document what options the patient was given for participating in care planning and that he/she refused and why.
Regarding care plans, are you suggesting having the care plan meeting and then document–after the meeting?	The documentation of the plan of care could be done as a team during the care plan meeting or completed after the meeting. The documentation should indicate who attended the meeting.
If the POC must have the same date throughout the document, if the patient is stable and minor adjustments are made throughout the year, the dates would be different in revised areas. How crucial is this?	A POC is not expected to have the same date throughout the document. A stable patient should have a new POC annually and that plan of care should be developed during a face-to-face meeting with an opportunity for any IDT members including the patient to participate by phone if they cannot attend in person. This POC could have notes dated on different dates during the year by different IDT members as targets are met (or not met) and action plans are adjusted as needed.
Does the medical director have to attend care planning meetings?	No. The medical director may attend care planning meetings, but is only required to attend if the medical director is the patient’s treating physician.
On Plan of care, in the rural units, what if someone (RD or MSW, etc.) is either ill or unable to be there? May they do it by phone? What about the physician? Can that be done on a regular basis?	Although it is optimal for all members of the IDT to meet together to develop the plan of care, V542 states that any member of the IDT, including the patient, may meet by telecommunication.
With so much of social work care being subjective – what is the best way to set measurable goals/outcomes?	Goal-setting should be done by the patient and professional members of the IDT and take into consideration how success is to be judged. For example, if a patient has a financial problem, a measurable outcome would be the resolution of that problem and the timeline could vary depending on the severity of the problem and the availability of resources. There are objective measures social workers can use like responses and scores on patient self-report surveys (physical and mental functioning, depression, patient satisfaction, etc.). Social workers regularly report objective data on patient employment, vocational

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	rehabilitation status, and insurance. Patient interviews can include scaling questions that could be used to monitor improvement.
§ 494.100 Care at home	
A physician group practice has a home dialysis program out of their physician group practice (not the dialysis center). Are they in violation if a few of their home hemodialysis patients are receiving home hemo 5-6 days per week at the office rather than at home? The physicians are only certified by Medicare to have a home program (PD and HHD). They are not certified for in-center care.	Unless those treatments are training treatments, the facility (owned by the physicians and located in their offices) would be operating a service for which they are not certified, and risks not being eligible to be paid for those in-center treatments.
If a home hemo patient is trained and at home but needs 1-2 weeks of respite care, can this be done with home hemo equipment and the RN in-center?	If the patient is coming for respite, it would make more sense to use a facility machine (which may be used for multiple patients) rather than the facility assume the care of the patient's personal machine which can only be used for him/her. If there is training equipment in the home training department, and this equipment is used for the patient, the training room would need to be staffed so that patient is observed during his/her treatment. The patient who is trained to do home hemodialysis may do self-care in-center or may want/need facility staff to do his/her care.
How can a machine from home be brought into a unit without documentation of electrical testing or is it covered with a policy or procedure?	This would depend on facility policy. It is likely the policy for maintenance of home equipment is similar to those policies for in-center equipment.
§ 494.110 Quality assessment and performance improvement	
Will CROWNWeb data collection be required of inpatient dialysis facilities?	Not unless the inpatient dialysis facility also provides outpatient dialysis.
§ 494.120 Special purpose renal dialysis facilities	
None	
§ 494.130 Laboratory services	
My medical director wants to know. Why is there no consistency when monthly labs are drawn? Some companies draw M & T, some W-Th. The outcomes are different	The regulations are silent on when during the week blood tests should be drawn. As we go into CROWN Web and move toward value based purchasing, CMS may add

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and this is what's reported. He thinks we should all be on the same playing field. We draw M & T to see patient at their worst. Competition draws W & Th to get better outcomes. Is this taken into consideration when reporting outcomes of the units that is published?	more requirements to areas like this to ensure comparable data.
§ 494.140 Personnel qualifications	
Define "nurse manager." Does the person have to have that specific title? Can they have a "supervisory" role with a different title, such as "coordinator?"	CMS does not dictate the titles a facility uses. V684 requires the facility to have a "nurse manager" who is responsible for all nursing services. This person must be a full-time employee of the facility, an RN, and have at least 12 months of nursing experience plus 6 months of experience providing care to dialysis patients. The title a facility uses for this position is up to the facility.
If a high school diploma or GED is unavailable is a college degree acceptable for PCT certification?	Yes: evidence of a higher degree in lieu of a high school diploma or GED would be sufficient.
Can a PCT train other PCTs or does the RN need to do it.	The training program must be approved by the medical director and governing body and directed by an RN. Others can participate in the training under the direction of the RN.
We have a "machine tech" who sets up machines – no patient interventions. Does he/she need to be certified?	Yes. V692 states: "A biomedical technician or dialysis assistant would be classified as a PCT if he/she has responsibility for direct patient care or to set up machines for patient use. A technician who maintains or "takes down" machines after use without direct patient contact is not considered a PCT under these regulations."
§ 494.150 Responsibilities of the medical director	
The handout indicates a single medical director is required and states a .25 FTE time commitment. Is the .25 FTE regulatory or best practice?	The medical director has multiple responsibilities at the dialysis clinic. V711 states: "The medical director should devote sufficient time to fulfilling these responsibilities. As a guideline, the financial cost report each facility must file annually with CMS considers the medical director position to reflect a 0.25 FTE."

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Does the medical director have to be in the facility for 10 hours a week for coverage under the new guidelines? Does the RN count?	While there is no specific requirement for the time a medical director “must” spend in the facility, V711 states that the guideline in the cost report suggests 0.25 FTE for a medical director. This could be more or less than 10 hours per week. The amount of time an RN or APRN or PA spends at the dialysis clinic does not count as part of the time the medical director must spend there.
Doctors know they should sign off orders within 30 days, but they don’t get it done consistently. What can we do?	Suggest to the physicians that this practice could be cited at V715 which states: “The medical director is responsible for the implementation of the policies and procedures by all staff. This includes holding medical staff accountable for complying with facility policies and procedures, e.g., updating plans of care, signing verbal orders, being knowledgeable of the QAPI targets and working to achieve those targets in their patients.”
§ 494.160 [Reserved]	
§ 494.170 Medical records	
None	
§ 494.180 Governance	
What is the general rule for staffing in an independent clinic with 8 full chairs? How many licensed nurses and PCTs?	The federal regulations do not provide a minimal staff-to-patient ratio although state regulations may. To comply with V757, the facility must have sufficient numbers of qualified and trained staff on duty while patients are on dialysis in-center to meet the individualized needs of the patients based on their acuity and care needs (such as changes in physical or mental condition). To comply with V758, the CEO or administrator is responsible for having enough RNs, RDs, and MSWs to meet clinical needs of in-center and home dialysis patients including providing the interventions necessary to achieve the goals in the plan of care.
I believe we are not staffed to address needs of patients. How can this be addressed or how do surveyors deal with staff-to-patient ratios?	You should report your concern about staffing to your facility administrator providing as much specificity as possible. If you work for a dialysis corporation,

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<p>What about IDT meetings on non-treatment days for patients?</p>	<p>review the policies for lodging complaints. You can contact the State Survey Agency and lodge a complaint. You may choose to remain anonymous but if you do that, you will not receive a report of the outcome of any investigation. The State Survey Agency prefers complainants to provide their name to contact for more information and to send you a report of the findings. The surveyor who investigates the complaint will observe care, conduct interviews, and review medical records as appropriate to determine if staffing is provided at safe levels.</p> <p>If IDT meetings are held on non-treatment dates patients must be allowed and encouraged to participate by teleconference.</p>
<p>How many patients should/can a social worker manage on their caseload?</p>	<p>The federal regulations are silent on patient-staff ratios for any discipline. How many patients a social worker can care for depends on the social worker’s experience, patients’ acuity level and psychosocial needs, and the level of support services available to address patients’ non-clinical needs.</p>
<p>If your social worker and dietitian only come to rural units one time a month, how do you get the comprehensive interdisciplinary patient assessments and care plans all done in timeframes regulated and how to include the patients also?</p>	<p>Accomplishing the assessment and plans of care with a schedule of visiting a facility only one time a month will be a challenge. How to accomplish this would depend on the number of established patients (who require an annual assessment and plan of care only), the number of new patients (who need a full assessment and plan of care and a 3 month reassessment and plan of care), the number of unstable patients (who need a monthly reassessment and plan of care), the patient acuity of “stable” patients, and how the clinic schedules patients. The surveyor could cite V500 and V540 (Condition level) if the social worker and/or dietitian have not fulfilled their responsibilities in the timeframes required.</p>

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	And the surveyor could cite V758 if the reason why is because the patient-to-staff ratio is too high for the social worker and/or dietitian to meet the needs of patients.
Are you supposed to have dietitians and social workers there all the time patients are in the clinic (vs. 1 time a week).	The federal regulations do not require full-time RDs and MSWs. The federal regulations only require an RN to be present in a dialysis facility at all times that a patient is dialyzing. According to V758: <i>If the facility “shares” the social worker or dietitian with multiple clinics or requires professional staff to perform non-clinical tasks, it must not negatively impact the time available to provide the clinical interventions required to achieve the goals identified in the patient’s plan of care. The facility CEO or administrator is responsible to assure the professional support staff members have sufficient time available in the facility to meet the clinical needs of in-center and home dialysis patients.</i>
What about patients who are so violent or disruptive that they can only dialyze at a hospital? The hospitals don’t want to keep dialyzing them either. Ideas?	V766 states: “Involuntary discharge or transfer should be rare and preceded by demonstrated effort on the part of the interdisciplinary team to address the problem in a mutually beneficial way. The facility must have and follow written policies and procedures for involuntary discharge and transfer.” The Decreasing Dialysis Patient Provider Conflict materials should help reduce the number of patients involuntarily discharged. In fact, sometimes patients express depression as anger and feeling out of control can trigger either emotion. Staff may unintentionally escalate anger to violence. Treating depression and/or encouraging patients to assume as much control over their health and treatment as possible (perhaps even home dialysis) may reduce conflict situations. Providing training to help staff better understand patient stresses and

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	<p>coping better may help them have more tolerance and control.</p> <p>If a patient poses a severe immediate threat to the dialysis facility personnel or patients, the authorities should be called.</p> <p>Although hospitals may not want to treat violent patients, hospitals are prohibited from “dumping” patients and EMTALA requires hospitals to provide treatment to stabilize a patient in a medical emergency. Without regular treatment, a dialysis patient may present at the ER emergently.</p>
Miscellaneous	
<p>What performance indicators do you use when you measure the effectiveness of your surveyors?</p>	<p>Missouri uses the Federal Oversight Support Survey (FOSS) from CMS that evaluates surveyors onsite during a survey. Managers go with the surveyors and evaluate them onsite during a survey. State Survey Agencies also look at feedback from the providers about the survey process. The CMS Regional Offices are also charged with responsibility of oversight of the state surveyors. This includes conducting comparative (“look behind”) and collaborative surveys.</p> <p>State managers routinely review survey reports, approve or edit deficiencies, and coach surveyors.</p>
<p>Does a nocturnal program need separate certification or is it considered just a 4th shift at an existing facility.</p>	<p>No separate certification is required when adding a nocturnal in-center dialysis program. The facility should notify the state agency if it is planning to open a nocturnal shift so this service can be considered when surveys are being scheduled.</p>
<p>Does a facility have to accept an illegal alien as a patient? We lose a lot of money treating them.</p>	<p>There is no federal law that denies health services to undocumented individuals. However, the patient can be discharged if he/she is unable to pay. When V766 discusses involuntary discharge, it states that there must be evidence in the medical</p>

**Heartland Kidney Network Annual Meeting
ESRD Conditions for Coverage & State Surveyor Panel Discussion**

Question	Draft Answer
	<p>record that the facility made good faith efforts to help the patient resolve nonpayment issues prior implementing the involuntary discharge protocol.</p> <p>EMTALA would apply if the individual presented to a hospital ER and was denied treatment and the reason was due to an inability to pay. Routine dialysis treatment is not considered an emergency, but an individual presenting at an ER must be screened to rule out an emergency medical condition warranting dialysis treatment.</p> <p>Every facility is expected to have written admission policies and part of that policy may address ability to pay.</p>
Why are buttonhole and self-cannulation not included in the yearly fistula percentage?	The method of cannulation is not collected as part of the Fistula First effort.
How can we get all the handouts?	Free CDs of the presentation materials are available, but registrants need to fill out a request form. Participants won't automatically receive a CD.