

Extra! Extra! Read All About It!

NOVEMBER 18th, 2008

## Western Pacific Renal Network, LLC



# SPECIAL EDITION 2008

## NEW CONDITIONS FOR COVERAGE ISSUED!

In April, the Centers for Medicare & Medicaid Services (CMS) issued a final rule establishing the new Conditions for Coverage (CfC) that dialysis facilities must meet to be certified under the Medicare program. Facilities had until October 14, 2008 to be in compliance with the new rules. Below is the summary taken from the beginning of the CfCs.

**“SUMMARY:** This rule finalizes the February 4, 2005 proposed rule entitled ‘*Medicare Program; Conditions for Coverage for End-Stage Renal Disease Facilities.*’ It established new

conditions for coverage that dialysis facilities must meet to be certified under the Medicare program. This final rule focuses on the patient and the results of care provided to the patient, establishes performance expectations for facilities, encourages patients to participate in their plan of care and treatment, eliminates many procedural requirements from the previous conditions for coverage, preserves strong process measures when necessary to promote meaningful patient safety, well-being, and continuous quality improvement. This final rule reflects the advances in dialysis technology and standard care

practices since the requirements were last revised in their entirety in 1976.”

Highlights from the new CfC can be found in this newsletter; you may also read the document in its entirety from a link on the Network #17 website:

[www.esrdnet17.org](http://www.esrdnet17.org)

On October 10, 2008 CMS released the most current version of the Interpretive Guidelines. These Interpretive Guidelines provide instruction to the State Survey Agency as they apply the new Conditions for Coverage to the survey process. You may access a copy of the Interpretive Guidelines on the Network #17 Website.

### Volume 1, Issue 1



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## CfC REQUIRES USE OF CROWNWeb by 2/1/09

When CMS published the updated Conditions for Coverage in the Federal Register, the final rule required the submission and maintenance of electronic patient and provider records for all dialysis facilities in the United States (§494.180(h)). This requirement takes effect on February 1, 2009.

To support this mandate, CMS created **CROWNWeb**, a web-based software application. **Use of CROWNWeb for data submission by February 1, 2009 is mandatory** to support CMS’s goals of quality improvement and performance assessment, as well as to ensure prompt claims processing and reimbursement.



Continued on page 2

## CROWNWeb Overview cont.

CMS designed **CROWNWeb** to collect patient records, clinical performance measures (CPMs), and facility data. It will include all ESRD facilities within each Network, as well as employees and patients within each facility. The dialysis facility chosen by the patient is responsible for their treatment and patients may transfer from a facility to another if necessary. The primary facility will create CMS-2728 and CMS-2746 forms using the **CROWNWeb** system, and copies of these forms will need to be printed for Social Security before submitting the data electronically to CMS. In addition, **CROWNWeb** will generate reports to assist in maintaining required records and ensuring that Social Security receives required information.

Dialysis facilities will have ac-

cess to **CROWNWeb** once the facility completes a verification and authorization process. This verification process will require proper ID and a notarized application. Each facility began the verification process in October 2008.

### Training

CMS will provide **CROWNWeb** training for facilities with online and face-to-face training at two locations to include:

- **Honolulu - January 5, 2009**
- **San Francisco - January 8, 9,12,13,14, 2009**

Online training is available via a central website 24 hours a day, 7 days a week at no cost to the facility. The core **CROWNWeb** training program will consist of a series of

online courses totaling approximately two hours and will cover the main functions of **CROWNWeb**. Additional training modules will be available soon.

CMS recommends that facility staff attend the face-to-face training whenever possible and has made it available for those who prefer this method of instruction. While dialysis facilities are responsible for any travel costs, there is no fee to attend. Training is currently scheduled to begin in December 2008 and continue through early March 2009.

For more information regarding **CROWNWeb** training including facility dates and locations go to:

[www.fmqai.com](http://www.fmqai.com)

(ESRD Network #7)

## Updating Personnel Changes for the Network

All dialysis facilities experience staff turnover on a consistent basis and personnel changes are inevitable. The Network needs to be updated as to what key positions are currently filled. The six "key" positions are:

**Medical Director**  
**Facility Administrator.**  
**Head Nurse/Clinical Manager**  
**Social Worker**

**Dietitian**  
**Data Contact (person**  
**who completes the**  
**monthly PAR)**

Please select a person to notify the Network Office when personnel changes are made as soon as possible. Mailings and phone conversations will be much more effective if we match the right per-

son with his/her current position.

Call the **Network Office (415-897-2400)** when a new employee joins your facility staff. Your facility profile in the Network database will be updated so the appropriate personnel can be contacted.

**Thank you!**

## Strategies For Addressing Non-compliance

The Patient Services Department at Network#17 is developing a series of tip sheets addressing strategies to deal with non-compliance. The first two tip sheets to be sent out will address patient assessment and health literacy. Both topics are critical in

identifying barriers to compliance before a problem arises.

The goal is to develop a collaborative working relationship to assist patients in identifying and working toward goals, and will have a positive impact on patient/provider relations.



# Highlights From the New Conditions for Coverage 2008

## § 494.100 Condition: Care at Home

Separate condition for home therapies.  
Must equal quality of care provided to in-center patients.  
Patient training described in detail.  
Water treatment/dialysate separately addressed, including newer technologies.

## § 494.90 Condition: Plan of Care

Individualized.  
Initial: within 30 days of admission or 13 outpatient HD treatments.  
Update within 15 days of each reassessment.  
No expectation for a long term program and no signature of transplant surgeon needed.  
Requirement for patients to be informed of all modalities (transplant & therapies not offered at their current clinic) are addressed under:  
-Patients' Rights  
-Patient Assessment  
-Plan of Care

## §494.40 Condition: Water Treatment and Dialysate Quality

Specific rules for mixing, distributing, and using dialysate have been added.  
Specific rules for water treatment equipment and testing are incorporated.  
Incorporates specific ANSI/AAMI water standard e.g., RD52: 2004; RD47:2002; and RD47:2002/A1:2003.

## §494.110 Condition: Quality Assessment and Performance Improvement (QAPI) Required

Condition level. [See §494.110 (a)-(c)]  
Interdisciplinary team.  
Process continuous & on-going.  
Outcome focused: use community accepted standards as targets.  
Include patient satisfaction, infection control, medical injuries & medication errors.  
Plan/Do/Check/Act.  
Medical Director is responsible for the QAPI program at each facility.

## §494.70 Condition: Patients' Rights

To be treated with respect & dignity and to:  
Receive information on all modalities, including those not provided at the current facility.  
Receive alternative scheduling options (from other facilities) for working patients.  
Receive necessary services listed in the Plan of Care  
Be informed of the right to have an advance directive.  
Be informed about all transfer & discharge policies.

## §494.110 (a)-(c) Condition: Quality Assessment and Performance Improvement QAPI Program must include but not be limited to:

Adequacy of dialysis  
Nutritional status  
Mineral Metabolism and renal bone disease  
Anemia Management  
Vascular Access  
Medical injuries and medical errors identification  
HD reuse  
Patient satisfaction and grievances  
Infection control including:  
Analyzing and documenting incidence of infection to identify trends and establish baseline information.  
Develop action plans to minimize infection transmission, promote immunization.  
Take action to reduce future incidents.

## §494.60

### Condition: Physical Environment

All facilities must have an AED or a defibrillator (& ACLS qualified staff).  
All equipment should be maintained & operated according to manufacturer's directions.  
Emergency preparedness for staff & patients, including disaster prep - get to know your local Emergency Operations Center (EOC).



## Important Dates from the Conditions for Coverage

Condition/Regulation	Effective Date	Additional Notes
The Conditions for Coverage were published on April 15th, 2008	180 days to be in compliance with the new rules by <b>10/14/08</b>	Download a copy at: <a href="http://www.cms.hhs.gov/C/FCsAndCoPs/downloads/ESRDdisplayfinalerule.pdf">www.cms.hhs.gov/C/FCsAndCoPs/downloads/ESRDdisplayfinalerule.pdf</a> . Or <a href="http://www.cms.hhs.gov/C/FCsAndCoPs/13ESRD.asp">www.cms.hhs.gov/C/FCsAndCoPs/13ESRD.asp</a>
<i>Part 494, Subpart B: Patient Safety § 494.30</i>  <i>Condition: Infection Control</i> Isolation room for HbsAg + Patient	300 days from the date of publication <b>02/09/09</b>	<ul style="list-style-type: none"> <li>Adopts CDC's 2001 Recommendations for Prevention of Infections in Dialysis</li> <li>Adopts CDC's 2002 Guidelines for the Prevention of Catheter-Related Infections</li> </ul>
<i>Part 494, Subpart B: Patient Safety §494.60</i>  <i>Condition: Physical Environment</i>	300 days from the date of publication <b>02/09/09</b>	Life Safety Code (LSC) Requirements <ul style="list-style-type: none"> <li>Meet provisions of NFPA 2000</li> <li>Grandfather clause for current facilities in non-sprinklered buildings if built prior to 01/01/80</li> <li>State fire safety code may be used in lieu of LSC</li> <li>Specific provisions of LSC may be waived in some cases</li> </ul>
<i>Part 494, Subpart C: Patient Care §494.80</i>  <i>Condition: Patient Assessment</i>	New pts: Within 30 calendar days or 13 outpatient HD sessions, 3 month reassessment	Reassessment: <ul style="list-style-type: none"> <li>Annually for stable patients</li> <li>Monthly for unstable patients</li> </ul> Required components include anemia, adequacy, access, bone disease, nutrition, psychosocial status, home dialysis, transplant status, functional status, voc rehab
<i>Part 494, Subpart C: Patient Care §494.80</i>  <i>Condition: Patient Assessments</i> Adequacy of Dialysis	HD: Monthly  PD: Every 4 months	Please review additional requirements listed under this section as well as under plan of care.
<i>Part 494, Subpart D: Administration §494.140</i>  <i>Condition: Personnel Qualifications Certification of Pt. Care Technicians hired after 10/14/2008</i>	18 months from hire	<ul style="list-style-type: none"> <li>Must have a high school diploma or equiv</li> <li>Complete a (defined) training course, approved by the Medical Director &amp; Governing Body, under the direction of an RN</li> <li>Be certified by a state or national program</li> </ul>
<i>Part 494, Subpart D: Administration §494.140</i>  <i>Condition: Personnel Qualifications</i> Certifications of existing Technicians	24 months, i.e., 04/15/10	Same as above
<i>Part 494 Subpart §494.180 (h) Information Management</i>  <i>Electronic Data Submission</i>	<b>February 1, 2009</b>	See article on pages 1 & 2

# Dialysis Facility Relationships & Responsibilities

Below are excerpts taken from the new Conditions for Coverage

## Relationship with the ESRD Network

- The dialysis facility receives and acts upon recommendations from the ESRD Network.
- The dialysis facility must cooperate with the ESRD Network in fulfilling the terms of the Network's current Statement of Work (SOW).
- Each facility must participate in ESRD Network activities and pursue Network goals, e.g., Fistula First, CPM.

## Data Submission to CMS

- Facilities must submit data and information electronically to CMS in a format specified by the Secretary of Health and Human Services at intervals specified by the Secretary.
- Cost Reports must be furnished to CMS.
- Facilities must provide patient survival information.
- Existing Clinical Performance Measures (and any new measures that might be developed in the future) must be submitted for 100% of patients.

## Data Submission to the State Survey Agency

- Facilities must report all ownership interests of five percent or more to its State Survey Agency.
- Facilities must notify the State Agency of involuntary patient discharges and/or involuntary transfers.
- Facilities must report any injury or serious illness related to drugs or medical device usage to State Survey Agency as well as to FDA/CDC and to the ESRD Network.

*This resource adapted with permission from ESRD Network #12.*

## How can facilities ensure that they are in compliance with the new CfCs?

- Read the whole document (preamble & rule)
- Review current practice (& policies) to be sure they meet rules
- Identify staffing, practice, equipment, & training needs

## AAMI Water Standards



The new Conditions for Coverage (\$494.40) refer to meeting the water and dialysate quality standards and equipment requirements found in the Association for the Advancement of Medical Instrumentation (AAMI) publication, "Dialysate for Hemodialysis," ANSI/AAMI RD52:2004 (as well as several other standards).

To order this publication, go to: <http://www.aami.org/publications/standards/dialysis.html>.

The **AAMI Standards on CD - Dialysis Edition** includes all AAMI dialysis standards. This CD is currently undergoing a revision to include two new amendments to RD52, a revised edition of RD47, and a reaffirmation of RD5.

- Order Code: **DSBK08**

- Price/Member Discount Price: \$325/\$195

- **NOTE:** Advanced orders must be made by calling 877-249-8226

## Conditions for Coverage

### *Patient Grievances & Involuntary Discharges*

Below are excerpts from §494.70 (Patients' Rights) and §494.180 (Governance) of the new Conditions for Coverage. Please read them carefully and become familiar with the new Conditions. Failure of a supplier of ESRD services to meet one or more of the Conditions for Coverage set forth in part 494 of the regulations may result in termination of Medicare coverage of the services furnished by the supplier (§488.604).

#### **The Dialysis Facility Must:**

- Prominently display a copy of the patients' rights in the facility, including the current State Survey Agency and ESRD Network mailing addresses and telephone complaint numbers, where they can be easily seen and read by patients.
- Inform the patient of facility rules and expectations for patient conduct and responsibilities.
- Inform the patient about the facility internal grievance process.
- Have an internal grievance process which includes a clear procedure for submission of the grievance, time frames for review, and a description of how the patient or patient's designated representative will be informed of the steps taken to resolve the grievance.
- Inform the patient about the ESRD Network and State Survey Agency, and how to contact both.
- Inform the patient of his/her right to file internal or external grievance without reprisal or denial of services.
- Inform the patient of his/her right to file a grievance personally, anonymously, or through a representative of the patient's choosing. Inform the patient of facility policies for transfer, routine or involuntary discharge, and discontinuation of services to patients.
- Provide the patient and the ESRD Network with 30 days advance notice of an involuntary discharge.
- Follow the involuntary discharge procedures described in §494.180(f)(4) before making a decision to involuntarily discharge a patient who exhibits abusive or disruptive behaviors in the facility. The 30-day advance notice still applies in these situations. A credible immediate jeopardy (IJ) to the health and safety of others may allow for an abbreviated discharge procedure.

- The governing body must ensure that all staff follow the facility's patient discharge and transfer policies and procedures.

#### **The Medical Director Must:**

Ensure that no patient is involuntarily discharged or transferred from the facility unless:

1. The patient or payer no longer reimburses the facility for the ordered services;
2. The facility ceases to operate;
3. The transfer is necessary for the patient's welfare because the facility can no longer meet the patient's documented medical needs or;
4. §494.180(f)(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:
  - Documents the reassessments, ongoing problems (and efforts made to resolve the problems) and enters this documentation into the patient's medical record;
  - Provides the patient and the local ESRD Network with a 30-day notice of the planned discharge
  - 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
  - Contacts other facilities, attempts to place the patient, and documents that effort; and
  - Notifies the State Survey Agency of the involuntary transfer or discharge.



*\*This resource adapted with permission from ESRD Network #12*

## Challenging Patient Situations-Tools to Assist You

Network #17 is required by CMS to track and trend facility-specific patient complaints, grievances, and involuntary discharges. The Patient Services Department is committed to providing case-specific and technical assistance to facilities to help resolve challenging patient/provider situations. A **Behavioral Agreement** can be useful in specific situations. It is a formal tool used to engage a patient in a behavior change process while continuing to provide treatment in the facility. **Behavioral Agreements** should be:

- Based on a problem behavior that is observable, measurable, and persistent.
- Time limited, behavior specific, and should include consequences *other than involuntary discharge*.
- Collaborative with the patient as much as possible and be used **only when other interventions have failed**.

Agreements should not be used as a means for discharging a patient. The Network is opposed to the use of a generic “behavior contract” that is not individualized to a specific patient, specific behavior, and has involuntary discharge as the only consequence. The new Conditions for Coverage (CfC) include procedures that all facilities must follow prior to making a decision to discharge a patient involuntarily. Additionally, the following comments appear in the CfC’s preamble:

- “We believe that every dialysis facility has the resources and responsibility to work with every patient, including patients perceived to be disruptive or challenging.”
- “Patient care technicians must have completed a facility training program...with particular sensitivity to the management of difficult patients.”
- “We believe that a registered nurse can be very effective in...demonstrating good interpersonal skills when dealing with patients, including disruptive or challenging patients.”
- “The social worker is uniquely qualified to provide counseling, anger management, and emotional support services to patients with ESRD.”
- “The social worker has an important role in addressing patient behavior that may be challenging or disruptive”.

In light of these comments, Network #17 recommends that facilities utilize the training program *Decreasing Dialysis Patient-Provider Conflict (DPC)*. This resource was sent to all facilities on CD in September 2008. This program can be used to teach staff how to deal more effectively with challenging situations in the facility, and can be implemented over a period of weeks or months. The *DPC* program will help staff work better – not harder – and the Network believes that the time spent in *DPC* training will pay off in many positive ways for staff and patients. This is illustrated in the article on page eight, *DPC Success Story*, of a pediatric dialysis program.

## Dialysis Technician Certification

As described in the new Conditions for Coverage, Dialysis Technicians who provide patient care must:

- Meet the requirements of the applicable State for education and training, including requirements related to practice standards, certification or registration
- Have a high school diploma or equivalency
- Have completed a training program that is approved by the medical director and governing body, under the direction of a registered nurse
- Be certified under a State certification program (including standardized tests, which reflect the content listed in the regulation, administered in a proctored environment by an independent examiner) or a national commercially available certification program

### Commercial Testing Websites:

[www.nncc-exam.org/CCHT/index](http://www.nncc-exam.org/CCHT/index)  
[www.BONENT.org](http://www.BONENT.org)  
[www.ptcny.com](http://www.ptcny.com)

If you have any questions regarding Hemodialysis Technician Certification requirements, please contact the Network #17 office at 415-897-2400.

## DPC (*Decreasing Dialysis Patient Provider Conflict*) Success Story

Karen is the primary social worker for the Pediatric Dialysis and Outpatient Unit and also responds to the needs of other units in the hospital. She led the DPC training for the dialysis and outpatient unit over a period of six months. She also presented Module 2 – *Open Yourself Up to Understanding Others* and Module 3 – *Need a Nonjudgmental Approach* to department managers and charge nurses for Sunrise Children’s Hospital. Here are some key points from Karen starting with why it’s worth the investment of time and energy in using the DPC training program.

### Outcome of DPC Training

As a result of DPC training, staff are able to mediate conflict situations and prevent them from escalating. Staff appear to be more patient, tolerant and are better trained to handle these situations individually. Karen reports she is not called as often to the unit for crisis intervention.

### Staff comments about the DPC Individual Module training program

*“The structure allowed time for you to think and process and I didn’t feel rushed.”*

*“The time allotted is enough time (30 – 45 minutes). It made it easier to grasp and understand.”*

*“It made us aware of the things we were doing.”*

*“Realized we could do better with handling conflict. I liked the relaxation (Create a Calm Environment).”*

*“Gives us a different perspective in the care of the kids we take care of. We are the clinical aspect and the training gives us the social aspect.”*

*“It was a good training, didn’t see anything negative. Honestly it was very good. It really hit me that they are kids and they are being denied of their childhood. It helps me empathize.”*

### Everyone wants to work in a facility with less stress & less conflict, so how do you get there?

**Organization** – Allow time for planning. Karen worked with her department manager, dialysis unit manager, charge nurse, health education manager, and IT department during the initial planning phase. In order to have everything prepared for each training module, Karen kept a calendar of training dates and a checklist that denoted who was responsible for each task along with deadlines for completion. Karen also posted the date of each training session and reminders about upcoming sessions in places where staff would be sure to see it. All the tools needed to do this are in the DPC resource kit. *Each module took only 30-45 minutes to complete.*

**Flexibility** – Initially one module was scheduled every 2 weeks. However, it was decided that training sessions would be canceled if any of the three nurses or administrative assistant weren’t available. There were times when training sessions had to be re-scheduled due to holidays or staff unavailability which extended the overall time commitment to complete the training.

**Accountability** – Karen reports that it was very important to follow through with the planning and training even though there were always many other responsibilities in the workday. Initially, staff had difficulty keeping track of the dates of upcoming training sessions because the calendar with training dates was placed in staff mailboxes. Karen then followed staff suggestions that she write announcements and reminders on the daily patient schedule and the white board in the staff lounge.

**Create Buy-in** – In this situation, RNs received 6 CEUs for completing all modules of the DPC training. All modules had to be completed in order to receive any CEUs. Karen states that they also worked the training sessions into the workday (i.e., first thing in the morning before patients came in) so staff didn’t have to commit time after hours. Using real facility examples during the interactive portion of training sessions created a shared context and enhanced learning.

*\*This resource adapted with permission from ESRD Network #15*

# General Guidelines

## THE INVOLUNTARY DISCHARGE (IVD) PROCESS

### Background:

The Network frequently receives calls regarding the process of involuntarily discharging a disruptive or abusive patient. It is important to emphasize that involuntary discharge (IVD) should be an option of last resort, remembering that discharged patients are at a higher risk for increased morbidity and mortality. Facilities should train staff in conflict management techniques and work to remove any barriers that patients may be facing. In the event that all options have been exhausted, the Network has several recommendations for the involuntary discharge process. Since this is a common concern, the Network feels it would be helpful to provide all facilities with these general guidelines and an ***Involuntary Discharge Checklist*** detailing the required steps. A copy of the checklist is included.

- **Notify the Network *prior* to an involuntary discharge:** This provides an opportunity for the Patient Services Department to review the issues and interventions with facility staff and see if there are other options that can be explored.
- **Train facility staff:** The Network recommends that all staff receive training in conflict management techniques (DPC) and that this training is documented.
- **Documentation:** It is ***essential*** that the facility staff document and address any problematic behavior, no matter how insignificant it may seem. This should include documentation of all meetings, interventions, and behavioral agreements that the staff and patients work on together.
- **IVD should be the option of last resort:** If all efforts to resolve the problem have failed, and if the behavioral issues and interventions made to attempt to solve them have been properly documented, then an involuntary discharge may be initiated. The specifics of this process are discussed in more detail in the checklist. The discharge should be reported as a **6c** on the Network Patient Activity Report (NPAR).
- **Have a policy and procedure in place for involuntary discharges:** It is the Medical Director's responsibility to make sure "that no patient is discharged or transferred from the facility unless:
  1. The patient or payer no longer reimburses the facility for the ordered services;
  2. The facility ceases to operate;
  3. The transfer is necessary for the patient's welfare because the facility can no longer meet the patient's documented medical needs; or
  4. The facility 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..." ('494.180 (f) Standard: Involuntary discharge and transfer policies and procedures; Conditions for Coverage for End Stage Renal Disease Facilities).

This document and the checklist was designed to help clarify the involuntary discharge process. If you have any further questions or concerns, please contact the **Network #17 Office at 415-897-2400.**

*\*This resource adapted with permission from ESRD Network #18*

## Involuntary Discharge Checklist For Dialysis Facilities

If you have made the decision to involuntarily discharge a patient due to **disruptive and abusive** behavior make sure that the following have been covered in accordance with the **Conditions for Coverage §494.180 (f)**:

- Notify** the Network of the potential Involuntary Discharge.
- Document** in patient's medical record the ongoing problem.
- Document** the impact of behavior on other patients/staff.
- Document** all steps to resolve the problem (including behavioral agreements and patient/staff meetings) and adherence to the facility policy regarding **disruptive/abusive** behavior.
- Document** patient response to each step taken and the reassessment of the situation.
- Obtain a **written** physician's order signed by **both** the Medical Director **and** the patient's attending physician agreeing with the patient discharge.
- Send all documentation to the Network including; agreements, letters of notification of discharge, other written communication with the patient regarding the problem.
- Attempt to place the patient in a new facility, and document your efforts.
- Notify the State Survey Agency of the involuntary discharge (numbers at bottom of page).
- In cases of immediate jeopardy (IJ) or severe threats to the health and safety of others, the facility may use an abbreviated involuntary discharge procedure.
- Report the patient as an IVD (6c) in the monthly NPAR. Patients that are involuntarily transferred out due to lack of payment should also be reported as a 6c.

If you have any further questions regarding this process, please contact ESRD Network #17 at  
(415) 897-2400

### Department of Health Services - Northern California Counties

Alameda, Contra Costa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Monterey	East Bay District Office 1-800-554-0352
Butte, Colusa, Nevada, Shasta, Sutter, Tehama, Yuba, Humboldt, Lake, Mendocino, Napa, Solano, Sonoma, Marin, Sacramento, San Joaquin, Stanislaus, Tuolumne, Yolo, Placer, Calaveras, El Dorado	Redwood Coast District Office 1-866-784-0703
Fresno, Madera, Merced	San Bernardino District Office 1-800-344-2896

### Department of Health Services - Hawaii

Hawaii, American Samoa, Guam, CNMI (Saipan)	1-808-692-7420
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## CfC Emergency Preparedness

The standards related to emergency preparedness are more specific in the new CfC and are summarized below. For more information and resources related to emergency preparedness, visit our web site at [www.esrdnet17.org](http://www.esrdnet17.org) and [www.kcercoalition.com](http://www.kcercoalition.com), the web site for the Kidney Community Emergency Response Coalition (KCER). You will find helpful resources for your facility such as “*The Four Keys to Being Prepared for a Disaster*” and the “*Dialysis Facility Disaster Plan Template*” which is a list of action items recommended for facilities to take in order to prepare a comprehensive disaster plan.

### Emergency Preparedness [§494.60 (d)]

The dialysis facility must implement policies and procedures to manage medical and nonmedical emergencies that are likely to threaten the health or safety of the patients, the staff, or the public. These emergencies include, but are not limited to; fire, equipment or power failure, care related emergencies, water supply interruption, and natural disasters likely to occur in a facilities area.

### Emergency Preparedness for Staff and Patient Training [§494.60 (d)(1)(2)]

The dialysis facility must provide appropriate training and orientation in emergency preparedness to all staff. Staff training must be provided and evaluated at least annually and include the following:

Ensuring that the staff can demonstrate a knowledge of emergency procedures, including informing patients of:

- What to do?
- Where to go, including instructions for occasions when the geographic area of a dialysis facility must be evacuated?
- Whom to contact if an emergency occurs while the patient is not in the dialysis facility. This contact information must include an alternate emergency phone number for the facility during instances when the dialysis facility is unable to receive phone calls due to an emergency situation, unless the facility has the ability to forward calls to a working number under such emergency conditions.
- How to perform the “quick disconnect” or the “clamp & cut” procedure from the dialysis machine if an emergency occurs.

Ensuring that at a minimum, patient care staff maintain current CPR certification. If the facility has chosen to use a defibrillator rather than an AED, documentation is required concerning the ability of professional staff to recognize arrhythmias and about their knowledge of protocols to properly use the defibrillator (ACLS certification).

Ensuring that nursing staff is properly trained in the use of emergency equipment and emergency drugs.

### Emergency Equipment [§494.60 (d)(3)]

Emergency equipment includes, but is not limited to: oxygen, airway suction, defibrillator/AED, artificial resuscitator, and emergency drugs, must be on the premises at all times and immediately available.

### Emergency Plans [§494.60 (d)(4)]

The facility must:

- Have a plan to obtain emergency assistance when needed
- Evaluate at least annually the effectiveness of emergency and disaster plans and update them as necessary
- Contact local disaster management agency at least annually to ensure that such an agency is aware of the dialysis facility needs in the event of an emergency.



**American Red Cross**  
Bay Area Chapter

1-877-773-7229  
WWW.REDCROSSBAYAREA.ORG

EMERGENCY CONTACT CARD    EMERGENCY CONTACT CARD

Working in Partnership with  
Western Pacific Renal Network  
1-800-232-3773  
www.esrdnet17.org



Network #17 distributed a disaster resource packet in September 2008. This packet included valuable information to assist you in preparing for emergencies within Network #17. If you are unable to locate this information sent to your facility, please contact the Network office at 415-897-2400.

## Quality Assessment and Performance Improvement (QAPI) for ESRD Medical Directors

Medical Directors set the course for their dialysis center. Patients and staff members rely on the Medical Director to lead effectively. The new Conditions for Coverage have updated the responsibilities of ESRD facility Medical Directors. As Pay for Performance (P4P) becomes a reality, it is increasingly important for facilities to achieve and sustain clinical performance targets in order to receive reimbursement. Medical Directors are encouraged to read carefully and become very familiar with the new Conditions.

The Medical Director has operational responsibility for the QAPI program and ensures that program data are used to develop actions to improve quality of care and must ensure that the facility's QAPI program is effectively developed, implemented, maintained, and periodically evaluated. The dialysis facility must maintain and demonstrate evidence of its QAPI program for review by the Centers for Medicare & Medicaid Services (CMS).

Patient Clinical Outcomes	Reuse & Water Treatment	Patient Safety & Satisfaction	Staff Training	Involuntary Discharge of Patients *	Oversight of Attending Physicians	Biohazard & Infection Control	Facility Policies & Procedures
Adequacy of dialysis	Reuse program	Medical injuries	Ensure that staff receive appropriate education and training to competently perform job	Written and signed order from both Med. Dir. and attending physician prior to discharge  (Note: The new *discharge/transfer process is very lengthy, specific, and progressive.)	Inform medical staff of facility P&P including QAPI  Written and signed order from both Med. Dir. and attending physician prior to pt discharge  Assure the attending physicians adhere to P&P	Adverse events  Infection control issues	Participate in developing P&P  Assure the attending physicians & other staff adhere to P&P
Nutritional status	Deviations from AAMI standards (corrective action plan)	Medical errors					
Mineral metabolism		Patient satisfaction					
Anemia management	Water treatment equipment	Grievances					
Vascular access	Pt did not reach target weight						

*\*This resource adapted with permission from ESRD Network # 12*

### QAPI Team Members-Interdisciplinary Team:

- Medical Director
- Administrator
- Nurse Manager
- Dietitian
- Social Worker
- Other Staff including:
  - Nurses
  - Patient Care Technicians
  - Reuse and Water Technicians

### QAPI Team is Responsible for:

- Tracking
- Tending
- Analyzing
- Formulate strategies
- Intervene
- Set Goals
- Set Timelines
- Document your efforts
- Celebrate your successes



## Quality Assessment and Performance Improvement (QAPI)

### Action Step Plan

<b>Actions</b>	<b>By Whom?</b>	<b>With What Other Sectors?</b>	<b>By When?</b>	<b>Resources &amp; Support Needed/Available</b>	<b>Potential Barriers or Resistance</b>	<b>Communication</b>
<i>What needs to be done?</i>	<i>Who will take this action?</i>	<i>What other sectors will work with you?</i>	<i>By what date will the action be done?</i>	<i>What financial, human, political and other resources are needed? Are available?</i>	<i>What individuals and organizations might resist? How?</i>	<i>Who needs to be informed about these actions?</i>

Source: Adapted from Fawcett S. et al., Preventing Adolescent Pregnancy: An Action Planning Guide for Community Based Initiatives, Work Group, University of Kansas, 1992.

*\*This resource adapted with permission from ESRD Network # 12*

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## **A Special Thank You**

Western Pacific Renal Network #17 wishes to thank Networks #12, #15 and #18 for their contributions to this newsletter. It is the hope of the Network to provide you with essential information from the Conditions for Coverage (CfC) which took effect on October 14th, 2008.

WPRN is always available to support and assist our facilities in the transition to the new CfCs in particular the upcoming CROWNWeb project beginning February 1, 2009. The Data personnel are always available by phone or email should you have questions or concerns particularly when facilities begin the data entry process.

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