

Conditions for Coverage (CfC) Checklist for Social Workers

- Inform Patient's of their Rights:** The interdisciplinary team (IDT) * must inform patients (or their representatives) of their rights (including their privacy rights) and responsibilities when they begin their treatment (i.e. within the first six treatments after admission to the facility) and must protect and provide for the exercise of those rights. ("Inform" could include providing verbal explanations, audiovisual presentations, and/or written materials. Documentation should confirm that this information is provided.) The IDT needs to consider any communication problems (vision, hearing, speech, including non-English speaker/reader) in providing patients information about their rights/responsibilities. It should be documented in the patients medical record what the IDT did to address communication problems and how they confirmed that the patient understood the information.
- Individualized Comprehensive Assessments:** The (IDT) * is responsible for providing each patient with an individualized and comprehensive assessment of his or her needs. The evaluation of psychosocial needs in the assessment must be conducted by a qualified social worker (see below). The comprehensive assessment must be used to develop the patient's treatment plan and expectations for care. The comprehensive patient assessment must demonstrate a congruent integration of the evaluations completed by each team member, identifying the patient's individual needs and allowing for planning for necessary care and services. The IDT should do a patient assessment (PA) and plan of care (POC) within 30 days if the patient comes without a recent comprehensive PA/POC.
- Frequency of assessments for patients admitted to the dialysis facility:**
 - An initial comprehensive assessment must be conducted on all new patients (that is, all new admissions to a dialysis facility), within the latter of 30 calendar days or 13 hemodialysis sessions beginning with the first facility dialysis session.
- Standard: Patient reassessment.** a comprehensive reassessment of each patient and a revision of the POC must be conducted—
 - At least annually for stable patients; and
 - At least monthly for unstable patients including, but not limited to, patients with the following:
 - (i) Extended or frequent hospitalizations;
 - (ii) Marked deterioration in health status;
 - (iii) Significant change in psychosocial needs; or
 - (iv) Concurrent poor nutritional status, unmanaged anemia and inadequate dialysisIf the comprehensive patient assessment and POC for an experienced dialysis patient transferring from one dialysis facility to another is received with the patient in transfer, the receiving facility's IDT must conduct a reassessment within three months of the patient's admission to the new facility.
- Evaluation of psychosocial needs by a social worker.**

Examples of psychosocial parameters to be addressed by the qualified social worker include, but are not limited to:

 - Cognitive status and capacity to understand;
 - Ability to meet basic needs(Activities of Daily Living);
 - Ability to follow the treatment prescription;

A * indicates that the Conditions for Coverage allow for any members of the Interdisciplinary Team (IDT) to perform the task, not specifically social workers.

- Mental health history, capacities, and needs for counseling;
- Substance abuse history, if any;
- Current ability to cope with and adjust to dialysis;
- Expectations for the future and living with kidney failure and treatment;
- Educational and employment status, concerns, and goals;
- Home environment including current living situation;
- Legal issues (e.g., court appointed guardian, advance directive status, and health care proxy)
- Need for advocacy with traditional (nursing home) and nontraditional housing (e.g., homeless shelters, group homes);
- Financial capabilities and resources;
- Access to available community resources; and
- Eligibility for Federal, State, or local resources

The IDT* must Evaluate the Patient's:

- abilities, interests, preferences, and goals, including the desired level of participation in the dialysis care process;
- the preferred modality (hemodialysis or peritoneal dialysis), and setting, (for example, home dialysis)
- expectations for care outcomes.

Transplantation Referral *: Evaluation of suitability for a transplantation referral, based on criteria developed by the prospective transplantation center and its surgeon(s). If the patient is not suitable for transplantation referral, the basis for nonreferral must be documented in the patient's medical record.

Evaluation of family and other support systems *

This evaluation should start with an interview of the patient. If one or more members of the IDT need to seek additional protected health information about the patient from family or other supporting individuals, they must obtain the patient's permission to discuss these topics with those individuals. It is not a breach of HIPAA privacy requirements for staff to ask family or other caregivers for information they may know about a patient to help the IDT provide care for the patient. HIPAA does not prohibit a staff member from educating a family member or other support person about how to help the patient with diet, medications, and cope with kidney failure. Ideally, it is best to seek approval from the patient. Educating the patient with family or other caregiver(s) (when possible) assures that everyone receives the same information. Areas which would be included in this evaluation include family composition and history, the patient's willingness to ask for help; spiritual or religious support systems; etc. Some or all portions of this evaluation may overlap with the requirements for the psychosocial assessment described at V510. Pediatric patients present special situations. Facilities that treat pediatric patients must have policies that address the need to evaluate the family and other support systems of the pediatric patients

Evaluation of current patient physical activity level *

These requirements are not intended to indicate that the IDT is responsible for fully assessing each patient's activity level/physical capabilities. It is expected that the IDT would be able to evaluate each patient's activity level to the extent necessary to determine whether the patient is a candidate for referral to the appropriate professional(s) for further evaluation and possible rehabilitation services. A member of the IDT should interview the patient/designee about the patient's current level of "physical activity," ability to perform activities of daily living, and/or barriers to independence. The assessment should include observation of the patient's ability to ambulate, transfer, and other physical activities pertinent to the dialysis environment (e.g. holding needle sites, etc).

Evaluation for referral to vocational and physical rehabilitation services *

- The social worker should be aware of the availability of community referral options for physical and vocational rehabilitation services and educational resources for all patients. The IDT should have a plan and procedure for making referrals for rehabilitation. The IDT must provide and document assistance (e.g., education, encouragement) and referrals, if indicated, which were

aimed at enabling patients to maintain or return to their desired level of functioning at work, school, home and in their community.

- **Plan of Care:** The IDT * must develop and implement a written, individualized comprehensive POC that specifies the services necessary to address the patient's needs, as identified by the comprehensive assessment and changes in the patient's condition, and must include measurable and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the patient POC must be consistent with current evidence based professionally-accepted clinical practice standards. The PA and the POC should always be linked.
 - Implementation of the initial POC must begin within the latter of 30 calendar days after admission to the dialysis facility or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session.

- **Psychosocial status.** The interdisciplinary team must provide the necessary monitoring and social work interventions. These include counseling services and referrals for other social services, to assist the patient in achieving and sustaining an appropriate psychosocial status as measured by a standardized mental and physical assessment tool chosen by the social worker, at regular intervals, or more frequently on an as-needed basis.
 - While this regulation allows the social worker to choose a "standardized mental and physical assessment tool," the tool selected by the National Quality Forum and the CMS CPMs for adult patients is the KDQOL-36 assessment survey. In the future, the percentage of patients taking this assessment survey annually will need to be reported electronically to CMS. Facilities may choose to use the KDQOL-36 from the implementation date of these regulations in order to have more comparable data once the KDQOL-36 is mandated. Pediatric patients should be assessed using an age appropriate assessment tool. As part of the assessment process, the IDT may determine and document that not all patients are able to complete the KDQOL-36 survey (such as people with dementia, those with language barriers and those who refuse).
 - "At regular intervals" means that the assessment survey is administered by the time of the first reassessment (i.e., within 4 months of initiating treatment), and repeated at least annually. Examples of an "as needed basis" would include repeat use of the survey with the patient who has a significant life changing event (e.g., loss of spouse, loss of job, recent move to a nursing home) or a change in health status.
 - The social worker must have a system for routine use of the assessment survey, evaluation of the results, and incorporation of the survey results into the development and updating of the psychosocial portion of the POC.

- **Advance Directives:** The patient has the right to be informed about his or her right to execute advance directives, and the facility's policy regarding advance directives. The standard does not require that all patients have an advance directive. Advance directives establish in writing an individual's preference with respect to the degree of medical care and treatment desired or who should make treatment decisions if the individual should become incapacitated and lose the ability to make or communicate medical decisions. Advance directives include written documents such as living wills and durable powers of attorney for health care decisions (also called a health care proxy or medical power of attorney) as recognized by State law. Many states have enacted laws requiring patients' advance directives and "do not resuscitate" (DNR) preferences to be honored. Facilities are required to know and comply with such state laws. If state law does not address this facet of health care, and the facility's policy does not allow the honoring of a patient's advance directive, there must be a protocol in place for facilitating the patient's transfer to a facility that will honor the advance directive, if the patient so chooses