

ESRD NETWORK #14 – MEDICAL REVIEW BOARD

2009 STANDARDS for SOCIAL WORK SERVICES IN ESRD FACILITIES

Standard 1: Professional qualifications for all ESRD settings

The nephrology social worker will be qualified to perform in the capacity assigned and mandated by the Federal Register (Federal Register / **Vol. 73, No. 73 / Tuesday, April 15, 2008 / Rules and Regulations**) and Title 25 of the Texas Administrative Code, Chapter 117—End Stage Renal Disease Facilities Licensing Rules—effective April 11, 1999.

Measurement Criteria

A. All dialysis facility staff must meet the applicable scope of practice and licensure requirements in effect in the State in which they are employed. The dialysis facility's staff (employee or contractor) must meet the personnel qualifications and demonstrated competencies necessary to serve collectively the comprehensive needs of the patients. The dialysis facility's staff must have the ability to demonstrate and sustain the skills needed to perform the specific duties of their positions. (494.140)

The Social Worker:

B. Holds a master's degree from a graduate school of social work with a specialization in clinical practice from a school of social work accredited by the Council on Social Work Education or (2) Has served at least 2 years as a social worker, 1 year of which was in a dialysis unit or transplantation program prior to September 1, 1976, and has established a consultative relationship with a social worker who qualifies under § 494.140(d)(1).

C. Has a current license to practice (LMSW) through the Texas State Board of Social Work Examiners.

D. Meets continuing education requirements mandated by the Texas State Board of Social Work Examiners to maintain licensure.

E. Has evidence of qualifications and required continuing education.

Considerations

A. A staffing ratio of between 75 to 100 patients is recommended in the ESRD setting or a ratio of 1 social worker to 125 patients when a plan, approved by the facility governing body is in place that meets the needs of the patients by delegation of ancillary tasks (administrative, financial, clerical, etc.) to another staff member.

Facilities utilizing a plan that delegates ancillary tasks to other staff should develop and implement a written plan to ensure that patient needs are being met. This plan

should include documentation of delegated responsibilities and evaluation of outcome measures.

- B. If the facility “shares” the social worker...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. (ESRD Program Interpretive Guidance 1.1 Memorandum Summary, October 3, 2008; pg. 289; <http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCletter09-01.pdf>).
- C. Sufficient, suitable space for privacy and confidentiality in working with patients is required.
- D. Orientation with a practicing nephrology social worker and other staff should include:
 - 1. Review of Federal Register, 2008, (Conditions for Coverage for End-Stage Renal Disease Facilities; Rules and Regulations)
 - 2. Review of Texas ESRD Facility Licensing Law (Health & Safety Code 251)
 - 3. Review of psychosocial considerations of ESRD patients and their families
 - 4. Review of psychosocial assessment and interventions appropriate for ESRD patients and families
 - 5. Review of major categories of problems addressed
 - 6. Overview of Renal Replacement Therapy
 - 7. Rehabilitation as a component of care of the ESRD patient
 - 8. Use of quality of life measurement in ESRD settings
 - 9. Training on cross-cultural issues, challenging staff/patient issues and use of the Decreasing Dialysis Patient Provider Conflict (DPC) toolkit

Standard 2: Major functions and services provided by the nephrology social worker

Categories include, but are not limited to:

- A. Ongoing psychosocial assessment including quality of life measurement
- B. Casework (counseling and conferences with patients, families, and support networks; crisis intervention; goal-directed counseling; discharge planning)
- C. Groupwork (education, emotional support, self-help)
- D. Interdisciplinary team care planning and collaboration
- E. Intervention with challenging staff/patient situations
- F. Facilitation of community agency referrals
- G. Resource development and advocacy on patients’ behalf within the setting and with appropriate local, state, and federal agencies, programs and programming
- H. Patient, family and staff education and support
- I. Rehabilitation assessment and intervention
- J. Advanced Care Planning

- K. Information and referral
- L. Obtain and provide staff training on cross-cultural issues

Measurement Criteria

Documentation in medical record that indicates appropriate and timely assessment and intervention has been provided by the nephrology social worker.

Standard 3: Psychosocial problem resolution

Major categories of problems to be addressed include, but are not limited to:

- A. Adjustment to chronic illness and treatment as they relate to quality of life
- B. Physical, sexual, and emotional relationship problems
- C. Educational, vocational, and activity of daily living problems
- D. Crisis and chronic problem solving
- E. Problems related to treatment options and setting transfers
- F. Resource needs, including finances, living arrangements, transportation, and legal issues
- G. Decision-making regarding advance directives and end of life care

Measurement Criteria

- A. Documentation in medical record reflects that each patient is provided psychosocial assessment on an ongoing basis to identify psychosocial problems.
- B. Documentation in medical record that psychosocial problem is identified, treatment plan made, intervention provided, appropriate staff made aware of impact of problem on patient's treatment, and evaluation of intervention effectiveness.
- C. Patient's psychosocial problems are ameliorated within 90 days of problem identification (or sooner if indicated) or documentation is made of reason that problem has not been resolved or ameliorated. (*NASW/NKF Clinical Indicators for Social Work and Psychosocial Services in Nephrology Settings, 1994*)

Standard 5: Interdisciplinary Collaboration and Teamwork

The interdisciplinary team, as defined at § 494.80, must develop and implement a written, individualized comprehensive plan of care 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. (42 CFR Part 494.80, 4/08) The outcomes specified in the patient plan of care must be consistent with current evidence-based professionally-accepted clinical practice standards.

The nephrology social worker should be involved in the early identification of problematic behaviors that develop between the patient and staff. The nephrology social worker (as part of the interdisciplinary team) should(?):

1. Provide early assessment and intervention to try to prevent the escalation of provider-patient conflict
2. Provide ongoing education to staff and patients of desired interactions and responsible behaviors
3. Provide education to staff in handling potential problem behaviors
4. Mediate and develop plans to resolve conflict as needed
5. Provide cross-cultural training
6. Assist with discharge planning as a measure of last resort

Measurement Criteria

- A. Standard: An individualized plan of care will be developed with the interdisciplinary team for each patient.
The plan of care must address, but not be limited to, the following:
 - a. Psychosocial status.
 - b. Social work interventions and monitoring of outcomes of same.
 - c. Use of a standardized mental and physical assessment tool chosen by the social worker, at regular intervals, or more frequently on an as-needed basis. (Condition 494. 90 (a)(6))
- B. Documentation in the medical record reflects nephrology social work involvement in interdisciplinary care planning and the management of challenging patients to achieve optimal treatment outcomes for all patients.

Standard 6: Patient Education

Ongoing patient education is provided by the nephrology social worker (as a part of the interdisciplinary team) to the patient and family to improve patient outcomes.

Measurement Criteria

- A. The patient/family confirms that they have been informed about:
 1. Resources available for rehabilitation
 2. Treatment options
 3. Patient's rights and responsibilities
 4. Advanced Care Planning, Advance directives and/or other end-of-life issues as indicated
 5. The relationship between following medical recommendations and treatment outcomes
- B. Documentation in the medical record that ongoing patient education is provided.

Standard 7: Ongoing Psychosocial Assessment

Ongoing psychosocial assessment is necessary to re-assess the patient's needs and circumstances so that interventions may be tailored accordingly. 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. The interdisciplinary team is responsible for providing each patient with an individualized and comprehensive assessment of his or her needs. The comprehensive assessment must be used to develop the patient's treatment plan and expectations for care. 494.80

- (a) Standard: Psychosocial Assessment criteria
The patient's comprehensive assessment must include, but is not limited to, the following:
 - (1) Evaluation of psychosocial needs by a social worker
 - (2) Evaluation of family and other support systems
 - (3) Evaluation of 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) and the patient's expectations for care outcomes
 - (4) 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 non-referral must be documented in the patient's medical record.
 - (5) Evaluation of current patient physical activity level
 - (6) Evaluation for referral to vocational and physical rehabilitation services.

- (b) Standard: Frequency of assessment for patients admitted to the dialysis facility
 - (1) An initial comprehensive assessment must be conducted on all new patients (that is, all admissions to a dialysis facility), within the latter of 30 calendar days or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session.
 - (2) A follow up comprehensive reassessment must occur within 3 months after the completion of the initial assessment to provide information to adjust the patient's plan of care specified in §494.90.
 - (3) A comprehensive reassessment of each patient and a revision of the plan of care must be conducted
 - (a) At least annually for stable patients; and
 - (b) 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 dialysis

Measurement Criteria

- A. The medical record will contain documentation of psychosocial assessment, intervention, and outcome in accordance with state and federal directives and nationally accepted standards of practice.

- B. The patient/family is able to verbalize assistance that has been provided by the nephrology social worker.

Standard 8: Case Management

The nephrology social worker will assist as indicated with:

- A. Disease management--an integrated healthcare system whose primary focus is delivery of quality care to the patient.
- B. Risk management--the evaluation of quality of care indicators to promote optimal patient outcomes.
- C. Service coordination and continuity of care management--a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services needed to meet a person's health needs including resources for non-English speaking patients.

Measurement Criteria

- A. The medical record will indicate provision of patient and family education, enhancement of patient empowerment, resource mobilization, focus on medical adherence, chronic illness counseling, information and referral.
- B. Minutes of quality management meetings will reflect nephrology social worker input in the quality improvement process.
- C. The medical record will reflect coordination of services from one organization to another and/or coordination of services within the facility that impact patient care related to psychosocial issues.

Standard 9: Review of Treatment Options

ESRD patients should be aware of all treatment options, i.e. hemodialysis, peritoneal dialysis, transplant, no treatment and discontinuation of treatment. Patients should be aware of hospital choices for transplant, types of transplant, the transplant evaluation process, how to initiate a change in treatment modality and pros and cons of treatment options. The social worker, in collaboration with the treatment team, should be able to assist the patient in understanding possible choices.

Measurement Criteria

Documentation in medical record will reflect review of treatment options with patient and work with the patient to achieve their goal.

Standard 10: Rehabilitation

Rehabilitation status “The interdisciplinary team must assist the patient in achieving and sustaining an appropriate level of productive activity, as desired by the patient, including the educational needs of pediatric patients (patients under the age of 18 years), and make rehabilitation and vocational rehabilitation referrals as appropriate” 494.90 (8)

Nephrology social work services support and maximize the psychosocial functioning and adjustment of ESRD patients and their families. "Renal rehabilitation is the process of helping dialysis patients resume productive activities, including independent living." (*Building Quality of Life*, 1997) Rehabilitation includes vocational, psychological and emotional functioning.

All patients between 18 and 54 will be informed of the Department of Assistive and Rehabilitative Services that are available to them. All patients, regardless of age, will be encouraged to set a rehabilitation goal that may or may not be related to employment.

Measurement Criteria

- A. Medical record documentation will include a review of patient's rehabilitation status and goal at least annually and note that information has been provided about Texas DRS to age appropriate patients (18-55)
- B. Medical record documentation will reflect a review of patient's functional status and the opportunity to improve functional status as indicated.
- C. If the expected outcome is not achieved, the interdisciplinary team must adjust the patient's plan of care to achieve the specified goals. When a patient is unable to achieve the desired outcomes, the team must adjust the plan of care to reflect the patient's current condition (494.90 (8) (3)(i).

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References

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