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On October 14, 2008, practices and policies in every dialysis unit in the United States and its territories will be significantly changed with the implementation of the 2008 Conditions for Coverage (CfCs) for End-Stage Renal Disease Facilities (Office of the Federal Register, 2008). These CfCs mark the first wholesale change in the regulations for dialysis units in more than 30 years, and the Council of Nephrology Social Workers (CNSW) is making every effort to provide its members with the tools and resources they need to adapt to and adopt these new CfCs. This special issue of The Journal of Nephrology Social Work *is intended to provide members with an introduction to the sections of the CfCs that are relevant to social workers and an overview of the CfCs and relevant resources created by the CNSW.*

BACKGROUND

The Council of Nephrology Social Workers (CNSW) is encouraged that the Centers for Medicare and Medicaid Services (CMS) recognized how important psychosocial functioning is for patients with end-stage renal disease (ESRD) in the 2008 Conditions for Coverage (CfCs) for ESRD Facilities (Office of the Federal Register, 2008). A large body of literature suggests that there are many psychosocial barriers to optimal outcomes in those with ESRD, including the following challenges (see Browne, 2006, for a full literature review):

- Adjustment to and coping with the illness and treatment regime
- Depression and anxiety
- Medical complications and problems
- Issues related to pain, palliative care and end-of-life care
- Familial, social, vocational role adjustment
- Concrete needs: financial loss, insurance problems and prescription coverage
- Diminished quality of life
- Body image issues
- Sexual and reproductive functioning
- Sleeping problems
- Comorbid illnesses
- Numerous losses, such as financial security, health, libido, strength, independence, mobility, schedule flexibility, appetite and freedom with diet and fluid.

These psychosocial concerns may decrease quality of life, increase malnutrition and significantly negatively impact outcomes, such as hospitalizations, mortality and morbidity (Auslander et al., 2001; Burrows-Hudson, 1995; Hedayati et al., 2004; Kimmel et al., 1998, 2000; Koo et al., 2003; Paniagua et al., 2005). Families and social support network members of those with ESRD also have problems adjusting to the chronic disease and its concurrent psychosocial stressors (White & Greyner, 1999).

Significant psychosocial problems faced by those with ESRD and their loved ones require intervention from qualified social workers who have a master's degree in social work (MSW). An MSW has been mandated in every dialysis unit in the United States and its territories since the first CfCs were published, with limited exceptions for those who had been working in renal settings as social workers for at least a year prior to publication date (Office of the Federal Register, 1976). Since 1976, MSWs have provided interventions to those with ESRD and their family members who have decreased depression (Beder, 1999; Cabness, 2005) and improved attendance at dialysis sessions (Medical Education Institute, 2004). MSWs help reduce interdialytic weight gains (Auslander & Buchs, 2002; Johnstone & Halshaw, 2003; Root, 2005) and improve quality of life (Chang et al., 2004; Frank et al., 2003; Johnstone, 2003). Social workers can also help improve medication management and lower blood pressure (Beder et al., 2003). More than 75% of nephrology social workers mediate conflicts in dialysis units (Merighi & Ehlebracht, 2004). MSWs can also increase establishment of advance directives (Yusack, 1999). The 2008 CfCs provide social workers with a plethora of opportunities to provide clinical social work interventions to improve outcomes for patients and their families.

HISTORY

Nephrology social workers were instrumental in lobbying for the inclusion of an MSW in every dialysis and

transplant facility in the 1976 CfCs. In 2005, when the notice of proposed rulemaking (proposed CfCs) was published in the *Federal Register*, the CNSW launched a long-planned effort to educate its members about the proposed CfCs, provided members with the organization's evidence-based response and encouraged members to write in support of sections they liked and to offer suggestions to modify sections where improvement was needed. Social workers were the professionals who responded most frequently to the call for comments about the proposed CfCs.

In 2007, key social workers attended an invitation-only community forum organized by CMS to provide feedback to draft interpretive guidelines for the proposed CfCs. The interpretive guidelines document explains the regulation to surveyors who must monitor facility policies, procedures and practices to ensure patient health and safety.

Throughout 2007 and 2008, a special CNSW task force created tools and resources for CNSW members that relate to the new CfCs. This included working on a multidisciplinary task force with the Council of Renal Nutrition, Council of Nephrology Nurses and Technicians and the American Nephrology Nurses Association to create a sample interdisciplinary comprehensive assessment tool for the community review to help facility interdisciplinary teams comply with the condition of patient assessment. Other CNSW activities included hosting a webinar viewed by more than 600 social workers and others about the new CfCs, distributing social work educational tools, such as the resources in this special issue, and creating a new Web page devoted to the new CfCs. Along the way, much discussion about the release and implementation of the CfCs occurred on the CNSW listserv, which can now be reviewed by members at the CNSW listserv archive Web page at **http://listserv.kidney.org/scripts/wa.exe?LOGON**

On October 14, 2008, the new CfCs will go into effect in every dialysis unit in the United States and its territories, forming the basis for all subsequent Medicare surveys. You can look forward to the CNSW continuing to produce information and resources for members about the CfCs and the interpretive guidelines in the future.

THIS ISSUE

This issue of *The Journal of Nephrology Social Work* includes a fact sheet to help social workers comply with the condition of patient plan of care for quality-of-life (QOL). Included is a sample assessment tool with recommended psychosocial components for an interdisciplinary patient assessment and a summary compilation of the psychosocial aspects of the CfCs. This issue concludes with an insightful article by Wendy Funk Schrag that explores ethics and the new CfCs.

The "Quality of Life Assessment Tools" fact sheet includes information from the condition of plan of care at §494.90(a)(6), which mandates social services include assessment of mental and physical functioning using a standardized tool. This fact sheet also provides information from the preamble, or introductory language of the CfCs, in addition to information about CMS' ESRD clinical performance measures (CPMs), including the CPM regarding QOL. This new CPM requires all dialysis facilities in the United States and its territories to report when asked how many eligible patients completed the KDQOL-36, a standardized tool that measures physical and mental functioning.

The "Comprehensive Multidisciplinary Patient Assessment (CMPA) Example Questions: Social Work-Focused Criteria" document is intended to be a sample for the community that can be used to satisfy the psychosocial components of the condition of patient assessment at §494.80, which mandates an interdisciplinary assessment of every dialysis patient. These assessment criteria are intended to be used in conjunction with nursing and dietary assessment components, and also identify potential areas for interdisciplinary care planning intervention.

The "Psychosocial Aspects of the 2008 Dialysis Conditions for Coverage" is a helpful resource to guide social workers, patients and professionals through the new CfCs, highlighting all aspects of these CfCs that have relevance to social workers. This table includes the following:

- Location: where the condition can be found in the regulations
- Condition: the number and name of the condition
- Standard: the letter and name of the related standard
- Key points, background and more information from the preamble, a lengthy introduction prior to the regulation that begins on page 20,475 of the *Federal Register*. The preamble contains background for the regulations, including public comments and CMS responses related to every section of the CfCs and, in some cases, implementation suggestions. The CNSW recommends that its members become familiar with the regulation as well as the preamble.

IMPLEMENTATION OF THE NEW CFCS

Social workers need to be educated about the new CfCs and how they affect their day-to-day practice. It is important to keep in mind that the CfCs clearly state that it is the responsibility of the governing body of each dialysis facility to ensure there are an adequate number of qualified social workers present so the "patient/staff ratio is appropriate to the level of dialysis care given and meets the needs of patients, and the registered nurse, social worker and dietitian members of the interdisciplinary team are available to meet patient clinical needs." Dialysis units need to ensure that there is a sufficient level of social work staffing to allow social workers to help with or take responsibility for the following *mandated* tasks in every dialysis unit:

- Honoring patients' rights to respect, dignity, recognition of individuality and personal needs and sensitivity to psychological needs and ability to cope with ESRD
- Informing all patients of their right to execute advance directives and the facility's policy regarding advance directives
- Working with the interdisciplinary team to honor patients' rights to receive resource information for dialysis modalities not offered by the facility, including information about alternative scheduling options for working patients
- Assessing patients' psychosocial needs; family and other support systems; patients' abilities, interests, preferences and goals, including the desired level of participation in the dialysis care process; preferred modality (hemodialysis or peritoneal dialysis) and setting (e.g., home dialysis); and patients' expectations for care outcomes.
- Developing plans of care with the interdisciplinary team and patient or representative within 30 days of admission, at 90 days and annually for stable patients or every month for patients who have significant changes in psychosocial needs or are otherwise unstable
- Providing necessary monitoring and social work interventions, including counseling services and referrals for other social services, and assisting patients in achieving and sustaining appropriate psychosocial status as measured by a standardized mental and physical assessment tools chosen by the social worker, at regular intervals or more frequently on an as-needed basis
- Assisting patients, along with the interdisciplinary team, in achieving and sustaining desired, appropriate levels of productive activity, including the educational needs of patients under age 18, and making rehabilitation and vocational rehabilitation referrals as appropriate
- Providing education and training, along with the interdisciplinary team, for patients and family members or caregivers or both, in aspects of the dialysis experience, dialysis management, home dialysis and self-care, quality of life, rehabilitation and transplantation
- Participating in the training program for patient care dialysis technicians on communication and interpersonal skills, including patient sensitivity training and care of difficult patients
- Helping to resolve conflicts before they escalate into grievances
- Helping to implement the new involuntary discharge and transfer policies and procedures.

It is clear that with the new CfCs, social workers need to maintain ongoing communication with patients, other team members and families to ensure that psychosocial needs that contribute to patient instability are assessed in a timely fashion and continue to work with the rest of the interdisciplinary team to improve other outcomes. It is also clear that social workers are unable to do these mandated responsibilities if they are overwhelmed by clerical or other inappropriate tasks or have caseloads that are too large for patient acuity. Large nephrology social work caseloads have been linked to decreased patient satisfaction and poorer rehabilitation outcomes (Callahan et al., 1998), and an inability for social workers to provide clinical interventions to patients and their families (Bogatz et al., 2005; Merighi & Ehlebracht, 2002, 2005). The CNSW recommends an acuity-based social worker-to-patient ratio that takes into consideration the psychosocial risks of patients and recommends a maximum of 75 patients per full-time dialysis social worker (CNSW, 2002).

Social workers may need to self-advocate by reminding their employers about the condition of governance at §494.180, which clearly states that every dialysis unit's "governing body or designated person responsible must ensure that—(1) An adequate number of qualified personnel are present whenever patients are undergoing dialysis so that the patient/staff ratio is appropriate to the level of dialysis care given and meets the needs of patients; and the registered nurse, social worker and dietitian members of the interdisciplinary team are available to meet patient clinical needs." The new CfCs are clear that patients' clinical needs are primary, and the preamble states explicitly that facilities may use ancillary staff to help with clerical tasks, such as arranging transportation and transient treatments, getting insur-

ance referrals, applying for financial assistance as well as tasks to benefit the facility such as copying insurance cards or resolving insurance questions and denials of payment. The preamble encourages MSWs to focus on clinical interventions.

With this new paradigm in the dialysis community, social workers will likely find themselves needing to remind employers that clerical tasks and large caseloads prevent them from complying with the new CfCs, which could lead to a condition or standard level citation and a requirement from the state survey agency to develop a plan of correction and additional monitoring. Social workers need to become comfortable telling their employer "I am sorry, but that clerical task (or this excessive patient caseload) will prevent me from fulfilling all of the mandated tasks of a qualified social worker in the new CfCs that govern this dialysis unit, placing this dialysis unit at risk of being cited by the state surveyor, which could bring negative attention to our dialysis unit. Let's talk about exploring ways that non-MSWs can help with these clerical tasks (or let's talk about hiring another social worker), so I can be sure that all of the psychosocial aspects of the new CfCs are met." The CNSW's book, *Professional Advocacy for the Nephrology Social Worker* (available from the National Kidney Foundation) is an excellent resource to help social workers advocate for themselves to ultimately improve patient outcomes.

Social workers may also find themselves overwhelmed by the prospect of performing clinical social work interventions in dialysis units after many years of focusing on non-clinical tasks. The CNSW has many tools to assist social workers in honing their clinical skills, as well as many projects that social workers can do to document their value. The CNSW also has tools and information about the recently published transplant Conditions of Participation. The CNSW was actively involved in commenting on the new transplant conditions and providing information to transplant social workers. The very active CNSW e-mail listserv and its archive are terrific tools for finding professional support and suggestions to help in implementing these new conditions.

The CNSW looks forward to helping social workers in the years to come as we adapt to these new CfCs and is excited about all the ways in which social workers can

help their interdisciplinary teams assess, plan and monitor interventions to improve outcomes. Our patients deserve all that we have to offer.

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