Clinical Performance Guidelines and Standards of Care for Adult Outpatient Dialysis Facilities

HSAG: ESRD Network 17

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HSAG HEALTH SERVICES ADVISORY GROUP

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CLINICAL PERFORMANCE GUIDELINES

Overview

The primary goal of Network 17 is to improve the quality of healthcare services provided to patients with end stage renal disease (ESRD). The Network's Medical Review Board (MRB) adopted the following revised Network Clinical Performance Guidelines in January 2026 to align with the Kidney Disease Outcomes Quality Initiative (KDOQI) guidelines, ESRD Conditions for Coverage Measures Assessment Tool (MAT 2.5), and the ESRD Quality Incentive Program (QIP) measures. The clinical guidelines' objective is to provide guidance for dialysis facilities to attain specific clinical outcomes for adult (≥18 years of age) patients on chronic dialysis.

Dialysis facilities should review individual patient outcome data and address the goals and plans set for individual patients. When a specific target is not met, the plan of care (POC) should be revised after each patient assessment and adjusted to achieve the target or provide an explanation in the areas where the targets are not able to be achieved.

Clinical Guidelines

ESRD-specified clinical outcomes include:

Hemodialysis Adequacy

Each provider should strive to attain and subsequently maintain a:

- In-center hemodialysis patient population achieving a minimum clearance time/volume (Kt/V) level of ≥ 1.2.
- Home hemodialysis patient population achieving a single-pool Kt/V (spKt/V) level between 2.1 and 2.3.

Peritoneal Dialysis Adequacy

Each provider should strive to attain and subsequently maintain a:

- Peritoneal dialysis patient population achieving a weekly Kt/V urea of >1.7 (dialytic + residual) during a four-month period.

Anemia Management

Each provider should strive to attain and subsequently maintain a:

- Dialysis patient population (on dialysis for ≥ 90 days), on an erythropoiesis stimulating agent (ESA), achieving a hemoglobin (Hgb) level between 10.0 and 11.5 grams per deciliter (gm/dL).
- Dialysis patient population achieving transferrin saturation (TSAT) levels of ≥ 25.

Nutrition Management

Each provider should strive to attain and subsequently maintain a:

- Hemodialysis patient population achieving a preferred serum albumin (ALB) level of ≥ 4.0 gm/dL (Bromocresol Green [BCG] method).

Mineral Metabolism

Each provider should strive to attain and subsequently maintain a:

- Dialysis patient population achieving serum phosphorous levels between 3.0 and 5.5 mg/dL.
- Dialysis patient population achieving uncorrected calcium levels less than 10.2 mg/dL.

Vascular Access Management

Each patient should be evaluated to receive the most appropriate dialysis access based on medical need, patient and family choice, health status, psychosocial factors, and living environment. While a fistula is preferred, a graft is acceptable if a fistula is not possible or appropriate. If the patient is not found to be a candidate for a fistula or graft, or has exhausted all access sites, a central venous catheter (CVC) would be acceptable.

For benchmarking and goal setting purposes each provider should strive to attain and subsequently maintain a facility long-term catheter (≥ 90 days) rate less than or equal to 11.0% as determined by the ESRD Quality Incentive Program (QIP) National Performance Rate.

Standards of Care

Overview

The Network 17 Standards of Care were revised to address appropriate delivery of care and facility requirements. These standards include quality statements that describe the care patients should be offered and define facility requirements to assist all Medicare-certified ESRD programs with providing high-quality treatments to patients.

The Network 17 MRB adopted the revised Standards of Care in January of 2026.

1. Safe and Effective Dialysis Treatment

Intradialytic Monitoring

The dialysis facility must conduct pre- and post-assessments of each patient, to include standing and sitting blood pressure, temperature, weight, heart, lungs, and pulse. Assessment and monitoring of a patient's condition must be performed and documented on the treatment record at least every 30 minutes. The following minimum criteria should be included:

- Patient's blood pressure and pulse.
- Inspection of the vascular access to note blood loss or leakage.
- Arterial and venous pressures and blood flow rate.

Any results outside normal limits should be reported to the charge nurse immediately and patients should be directed, as indicated, to the appropriate level of care for evaluation.

Ultrafiltration Rate (UFR) Monitoring

The dialysis facility must maintain an average UFR of <13 milliliters per kilogram per hour (ml/kg/hr) for all patients. Any diversions from this recommendation should include an order from the nephrologist and documentation that the patient has been educated regarding the risks of large and rapid fluid removal during hemodialysis treatment.

Infection Prevention

The dialysis facility must have healthcare-associated infection (HAI) policies and procedures related to HAI prevention and management, including the education and training of staff and patients regarding prevention measures and the identification and treatment of infections. The Centers for Disease Control and Prevention (CDC) Best Practices for Bloodstream Infection Prevention in Dialysis Setting and CDC training resources and tools should be used in development of polices and for staff and patient education.

The dialysis facility must review infection control and patient safety issues as part of its Quality Assessment and Performance Improvement (QAPI) program. Additionally, the dialysis facility must follow the guidelines and procedures for reporting dialysis events and healthcare personnel vaccinations in the National Healthcare Safety Network (NHSN).

2. Vaccinations for People on Dialysis

The dialysis facility must have a written policy under which the currently recommended vaccines and local sources are presented to all eligible patients. The recommended vaccinations for people on dialysis include, but are not limited to:

- Hepatitis B
- Pneumococcal pneumonia
- Influenza
- Coronavirus Disease 2019 (COVID-19)
- Respiratory Syncytial Virus (RSV)

The dialysis facility must maintain a Hepatitis Surveillance Log for all patients and document each patient's acceptance or refusal and administration of vaccinations in the patient medical record. The dialysis facility also must document the patient's refusal reason, medical exclusion, or administration of the vaccination in the Centers for Medicare & Medicaid Services (CMS)-designated data collection system known as the ESRD Quality Reporting System (EQRS).

3. Food and Drink in the Dialysis Facility

Patients should be allowed to have food and drink during dialysis unless it is medically contraindicated. Medical contraindication is determined by the treating nephrologist, medical director, and/or governing body of the facility.

4. Facility Staffing

Dialysis facility staffing levels should be commensurate with providing the care outlined in the Conditions for Coverage (CfCs). There should be at least one nurse or patient care technician for each four adult patients undergoing treatment.

In an ongoing effort to provide quality care and ensure patient safety, facilities should consider the following when developing staffing guidance for nurses, social workers, and dietitians:

- Experience level of staff
- Size of the facility
- Type of patients (e.g., geriatric, pediatric, home, self-care)
- Co-morbidities or acuity of medical needs
- Location of facility (e.g., rural vs. urban)
- Admission rate of new patients

5. Open Staffing Privileges

The dialysis facility should have a written policy, which assures open staffing privileges to the area's qualified ESRD physicians and advanced practice providers.

6. Access to Treatment

The dialysis facility must provide access to treatment for patients. This is codified in Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. The dialysis facility also must establish policies and procedures for admitting patients to the facility. Any patient who meets the requirements of the facility's admission policy should be considered, even if a patient has documented issues with not attending treatments or not following physician orders.

A process should be in place to work with patients to improve attendance and cooperation with treatment orders rather than blacklisting patients altogether. Dialysis facilities should conduct a root cause analysis (RCA), provide education and resources, and involve the social worker and other interdisciplinary team (IDT) members to assist patients with taking an active role in their care.

Dialysis patients should be maintained in a chronic outpatient dialysis setting, regardless of treatment or other related attendance issues, to avoid patients having to use a hospital emergency room for chronic dialysis. The dialysis facility should collaborate with patients, ESRD physicians, and the facility medical director to avoid involuntary discharges from the facility when an ESRD physician discharges a patient from his/her physician practice. All attempts to address issues related to the physician discharge with the patient must be documented in the patient's medical record and reported to the ESRD Network.

7. Treatment Modalities

The dialysis facility must provide all patients or their designees with unbiased education about all dialysis modalities, settings, and transplantation. Education must include all modalities, even if they are not offered at the current dialysis facility. Dialysis facilities that do not offer one or more home modalities, must establish a relationship with a nearby home dialysis program where patients can be referred.

Modality education should be documented in the patient's medical record, including any reasons a patient may not qualify for or may refuse a particular modality. A patient's goals, preferences, and expectations should be considered in decision-making with the ESRD physician and dialysis team about treatment modalities.

To assist patients who are interested in transplant, dialysis facilities should make referrals to transplant centers on the patient's behalf. Moreover, dialysis facilities should provide patients with support and resources during the evaluation process and help patients stay "transplant ready" by monitoring patient waitlist status via the facility's EQRS Transplant Dashboard.

8. Vocational Rehabilitation (VR)

The dialysis facility must educate all patients on the benefits of continued employment and/or going back to school. The dialysis facility must identify and provide patients with the VR and work support resources available in the patient's geographic area, including work incentive programs in the community. The dialysis facility also must evaluate all patients annually for work or school interests, and VR referral and document the information in the patient's medical record.

9. Patient Grievances

The dialysis facility must ensure all patients are aware of their right to file a grievance and document that patients have been informed of their rights and responsibilities, including the right to file a grievance (internally, or externally to the ESRD Network). The dialysis facility must have written policies and procedures regarding how the facility will receive and address patient grievances and how patients can file grievances anonymously. Each step of the grievance process should be documented.

The dialysis facility must post a copy of the Network's contact and grievance information in a prominent location in the facility. The dialysis facility must also monitor and address reports of retaliation from patients and educate staff accordingly.

10. Patient Experience of Care

The dialysis facility should encourage patients to complete the In-Center Hemodialysis Consumer Assessment of Healthcare Providers Survey (ICH CAHPS®).[1] Survey results must be analyzed, and action plans must be developed and implemented at the facility level with a focus on improving the patient's experience of care. The dialysis facility should obtain patient feedback in the development of action plans, ensure ICH CAHPS results and action plans are shared with patients, and monitor ICH CAHPS results and action plans through the facility QAPI process.

11. Data Submission Compliance

The dialysis facility must have at least one administrative and one clinical staff with EQRS access to ensure data accuracy and completeness. The dialysis facility must strive to attain and maintain 100 percent compliance for the submission of CMS 2728 and 2746 forms on time per the EQRS Data Submission Stopwatch. All data must be entered in EQRS per the EQRS Data Management Guidelines and submitted by ESRD Quality Incentive Program (QIP) deadlines. The dialysis facility must enroll and submit data in NHSN to meet the CMS reporting requirements for the ESRD QIP. The dialysis facility also must submit Network Quality Improvement Activity (QIA) required self-reported data per QIA timelines.

12. Patient and Family Engagement (PFE)

The dialysis facility should invite all patients and their caregivers to POC meetings. The patient's voice should be included in all aspects of care, and the dialysis facility should implement PFE activities, including:

- Integrating patient and family/care partner feedback into the QAPI program.
- Assisting patients in developing a life plan, from which the dialysis facility develops the dialysis POC.
- Encouraging patients to engage in a peer-to-peer patient support program. Specifically, this should assist with adjustment to dialysis and increase patients' knowledge and understanding about their dialysis care.

13. Emergency Preparedness

The dialysis facility must have written policies and procedures that specifically define the handling of emergencies that may threaten the health and safety of patients. Such emergencies would exist during natural disasters (e.g., fire or hurricane) or during functional failures in equipment or utilities. Emergency preparedness procedures should meet the training and testing requirements contained in the CMS Emergency Preparedness Rule.

The dialysis facility must notify the Network as soon as possible, but no later than 24 hours after, any facility status change that may cause the disruption of treatment schedules or any event that requires immediate/emergency actions by the facility. This includes the rescheduling or placement of patients at a backup provider.

The dialysis facility must provide the facility's open or closed status and patient location updates, at least daily, to the Network and/or the EQRS Emergency Dashboard during identified emergencies or disasters (e.g., before and after a potential tropical storm or hurricane).

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).