Capital BlueCross
FREESTANDING RENAL DIALYSIS SURVEY

Provider Name: _____
CBC #: _____ **Medicare #:** _____ **Medicaid #:** _____
Accrediting Organization: _____ **Date of most recent accrediting survey:** _____
Person completing survey: _____ **Phone:** _____ **Date:** _____
Contact person (if different than above): _____ **Phone:** _____

Directions: Please complete each line with appropriate information.
Where applicable please indicate with a check mark (☐).

ADMINISTRATION

Days & Hours of operation: _____
Handicap access ☐ Yes ☐No
Number of dialysis stations: _____
Number of patients treated annually: _____
Written compliance program ☐ Yes ☐No
Compliance program officer ☐ Yes ☐No
Internal compliance audits ☐ Yes ☐No
Review of the Medicare/Medicaid sanction report ☐ Yes ☐No
Frequency of review: _____
Written policy on patient confidentiality ☐ Yes ☐No
Written policy on medical record confidentiality ☐ Yes ☐No
Written policy for release of medical records ☐ Yes ☐No
Written policy for maintenance/retention of medical Records ☐ Yes ☐No
Written patient medical emergency plan ☐ Yes ☐No
Written policy for transfer to acute care ☐ Yes ☐No
Written transfer agreement with acute care ☐ Yes ☐No
If **yes**, list facilities: _____

Written agreement with an emergency transport service ☐ Yes ☐No
Reliance on 911 system ☐ Yes ☐No
Emergency crash carts/supplies available ☐ Yes ☐No
Defibrillator ☐ Yes ☐No
Written policy for checking:
Emergency crash cart/supplies ☐ Yes ☐No
Defibrillator ☐ Yes ☐No
Policy includes frequency of checks ☐ Yes ☐No
Written on-call policy ☐ Yes ☐No
Written agreement for back-up dialysis services ☐ Yes ☐No
If **yes**, list facilities: _____

Isolation treatment area ☐ Yes ☐No
Written policy for use of isolation area ☐ Yes ☐No

QUALITY MANAGEMENT

Quality Activities

Performance Improvement Program ☐ Yes ☐No
Performance Improvement Program includes utilization review ☐ Yes ☐No
Development of improvement activities based on identified issues ☐ Yes ☐No
Performance Improvement Committee ☐ Yes ☐No
Frequency of meetings: _____
List two Current Quality Studies:
1. _____
2. _____
Written infection control policies ☐ Yes ☐No

Patient Satisfaction

Patient Satisfaction Surveys utilized ☐ Yes ☐No
Annual return rate for surveys: _____ **%**
Issues identified:
1. _____
2. _____
Results forwarded to PI committee ☐ Yes ☐No
Written patient/family complaint process ☐ Yes ☐No

Clinical Management

Written policy on addressing advance directives ☐ Yes ☐No
Written procedure for referrals from out-of-area providers ☐ Yes ☐No
Re-use hemodialyzers ☐ Yes ☐No
If **yes**, written policy for re-use ☐ Yes ☐No
Written policy for development of treatment plan updates ☐ Yes ☐No
Policy includes frequency of updates ☐ Yes ☐No

Patient Education

Patient/family education ☐ Yes ☐No
Documented in clinical record ☐ Yes ☐No
Services available for hearing impaired ☐ Yes ☐No

Provider Name:

Services available for speech impaired ☐ Yes ☐No
Services available for visually impaired ☐ Yes ☐No
Bilingual services ☐ Yes ☐No
Bilingual patient education materials ☐ Yes ☐No
Languages offered: _____

Data Collection

Nosocomial infection rate ☐ Yes ☐No
Incident reports ☐ Yes ☐No
Hospital admissions ☐ Yes ☐No
Complication rate ☐ Yes ☐No
Hepatitis B patients treated ☐ Yes ☐No
HIV positive patients treated ☐ Yes ☐No
Employees positive for infectious diseases ☐ Yes ☐No
List other data: _____

CLINICAL STAFF

Written policy for clinical competency evaluation ☐ Yes ☐No
Evaluated during probationary period ☐ Yes ☐No
Evaluated annually ☐ Yes ☐No
Written policy for verification of the following for all clinical staff:

- Certification ☐ Yes ☐No
- Education ☐ Yes ☐No
- License ☐ Yes ☐No

Number of mandatory educational programs staff is required to attend annually: _____
Written policy for routine testing of employees for infectious diseases ☐ Yes ☐No
Written policy for credentialing of physicians ☐ Yes ☐No
Written policy for recredentialing of:

- Physicians ☐ Yes ☐No
- Clinical Staff ☐ Yes ☐No
- Frequency: _____

Medical Staff

Medical Director ☐ Yes ☐No
Name: _____
Specialty: _____
Board Certified ☐ Yes ☐No
Nephrologists ☐ Yes ☐No
Board Certified in Nephrology ☐ Yes ☐No
If physician(s) not board certified, competency established through the facility's credentialing process ☐ Yes ☐No

Other Staff

Patient Care Technicians ☐ Yes ☐No
Equipment Technicians ☐ Yes ☐No
_____ Number of Registered Dietitians
_____ Number of Registered Nurses
_____ Number of LPNs
_____ Number of MSWs
_____ Clinical Staff/Patient Ratio
Written policy defining staff requiring CPR certification ☐ Yes ☐No
_____ **%** Clinical staff CPR certified
Nurse Practitioners ☐ Yes ☐No

SERVICES

Peritoneal dialysis ☐ Yes ☐No
Social Services ☐ Yes ☐No
Nutritional Services ☐ Yes ☐No
Laboratory Services on-site ☐ Yes ☐No
CLIA approved ☐ Yes ☐No

FACILITIES & EQUIPMENT

Bioengineering specialist ☐ Yes ☐No
If **no**, person responsible for maintenance of biomedical equipment ☐ Yes ☐No
Written preventive maintenance plan ☐ Yes ☐No
Written plan for equipment failure ☐ Yes ☐No
Written emergency preparedness plan ☐ Yes ☐No
Plan includes:

- Fire ☐ Yes ☐No
- Loss of Utilities ☐ Yes ☐No
- Inclement Weather ☐ Yes ☐No

Written policy for fire/disaster drills ☐ Yes ☐No
Results of drills documented ☐ Yes ☐No
Written policy for handling biohazardous materials ☐ Yes ☐No

As a reminder, please be sure to include:

- ***Facility Information Sheet***
- ***Name sheet for branch offices***
- ***Affiliate or owned services***

COMMENTS

Provider Name:

Please complete the following based upon corporate ownership of off-site business initiatives and indicate specific services performed at the office site.

Branch Offices

Name: ______________________
Services Provided: ______________________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: __________
Address: ______________________
City: ______________________
Phone: ______________________
Contact Person: ______________________
Counties Served: ______________________

Name: ______________________
Services Provided: ______________________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: __________
Address: ______________________
City: ______________________
Phone: ______________________
Contact Person: ______________________
Counties Served: ______________________

Name: ______________________
Services Provided: ______________________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: __________
Address: ______________________
City: ______________________
Phone: ______________________
Contact Person: ______________________
Counties Served: ______________________

Name: ______________________
Services Provided: ______________________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: __________
Address: ______________________
City: ______________________
Phone: ______________________
Contact Person: ______________________
Counties Served: ______________________

Name: ______________________
Services Provided: ______________________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: __________
Address: ______________________
City: ______________________
Phone: ______________________
Contact Person: ______________________
Counties Served: ______________________

Name: ______________________
Services Provided: ______________________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: __________
Address: ______________________
City: ______________________
Phone: ______________________
Contact Person: ______________________
Counties Served: ______________________

Provider Name:

HEALTHCARE FACILITY INFORMATION FORM

Provider Name:_____
Parent:_____
Affiliation:_____
Affiliation:_____

Number of Years in business:_____

Type of Control

☐**Voluntary Nonprofit**

☐**Proprietary** (Identify all individuals, members of partnership, major stockholders, etc. If 'Other' explain.)

- ☐ Individual _____
- ☐ Partnership_____
- ☐ Corporation_____
- ☐ Other_____

☐**Government**

- ☐ Federal
- ☐ State
- ☐ County
- ☐ Other, explain:_____

Additional Information Requested

Has the facility, any corporate officer, employee or any agent acting on behalf of the facility been involved in or convicted of healthcare fraud or abuse in the last five (5) years?

☐Yes, explain:_____
☐No

Have you or any of your affiliates, entered into a corporate integrity agreement with any state or federal agency?

☐Yes
☐No
If yes, provide a copy to Capital Blue Cross

Provide copies of the following:

- State Licensure certificate(s)
- List of Board of Directors
- Most recent accreditation letter
- Most recent DOH Report
- Evidence of current malpractice insurance
- Current organizational chart

COMMENTS: _____

Provider Name:

Please indicate the counties within your service area. If services are limited to only a portion of the county, please identify.

Adams ☐ _____
Berks ☐ _____
Centre ☐ _____
Columbia ☐ _____
Cumberland ☐ _____
Dauphin ☐ _____
Franklin ☐ _____
Fulton ☐ _____
Juniata ☐ _____
Lancaster ☐ _____
Lebanon ☐ _____
Lehigh ☐ _____
Mifflin ☐ _____
Montour ☐ _____
Northampton ☐ _____
Northumberland ☐ _____
Perry ☐ _____
Schuylkill ☐ _____
Snyder ☐ _____
Union ☐ _____
York ☐ _____

Other ☐ _____
_____
_____
_____
_____