

# American Nephrology Nurses' Association

## National Kidney Foundation

### Comprehensive Multidisciplinary Patient Assessment (CMPA) Example Questions

#### Introduction to the CMPA

The Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), published the Final Conditions for Coverage (CfC) for End-Stage Renal Disease (ESRD) Facilities on April 15, 2008. In anticipation of the final publishing of the CfC for ESRD facilities, CMS encouraged the National Kidney Foundation (NKF) and American Nephrology Nurses' Association (ANNA) to establish a task force to develop resources and guidelines to assist facilities in complying with the requirement for a comprehensive, multidisciplinary patient assessment (CMPA). The CMPA replaces the requirement for individual assessments by each discipline (ref: § 494.80). The CMPA needs to be completed on the following schedule:

- The latter of 30 calendar days or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session for all new patients
- 3 months after the completion of the initial assessment
- At least annually for stable patients
- At least monthly for unstable patients, including but not limited to, patients with the following:
  - ✓ Extended or frequent hospitalizations;
  - ✓ Marked deterioration in health status;
  - ✓ Significant change in psychosocial needs; or
  - ✓ Concurrent poor nutritional status, unmanaged anemia, and inadequate dialysis.

Initial and annual assessments are anticipated to be more comprehensive in nature than other assessments. When a patient's unstable status triggers a new assessment, the reassessment will likely be more narrow in focus. However, the reassessment needs to include some review or evaluation in each of the 13 minimum criteria.

In addition to the CMPA schedule, the adequacy of the patient's dialysis prescription must be assessed as follows:

- *Hemodialysis Patients:* At least monthly by calculating delivered Kt/V or an equivalent measure
- *Peritoneal Dialysis Patients:* At least every 4 months by calculating delivered weekly Kt/V or an equivalent measure

## Minimum Criteria of the Assessment


The CMPA must consist of the following minimum criteria:

- Evaluation of current health status and medical condition, including co-morbid conditions
- Evaluation of the appropriateness of the dialysis prescription, blood pressure, and fluid management needs
- Laboratory profile, immunization history, and medication history
- Evaluation of factors associated with anemia, such as hematocrit, hemoglobin, iron stores, and potential treatment plans for anemia, including administration of erythropoiesis-stimulating agent(s)
- Evaluation of factors associated with renal bone disease
- Evaluation of nutritional status by a dietitian
- Evaluation of psychosocial needs by a social worker
- Evaluation of dialysis access type and maintenance (for example, arteriovenous fistulas, arteriovenous grafts, and peritoneal catheters)
- 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
- 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
- Evaluation of patient's current physical activity level
- Evaluation for referral to vocational and physical rehabilitation services

## Completion of Assessment

The interdisciplinary team is responsible for the completion of the assessment. The team, as defined in the CfC, includes: 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. Each member of the team should contribute to the completion of the assessment. The CfC designates two areas to specific team members – Evaluation of Nutritional Status to the dietitian and Evaluation of Psychosocial Needs to the social worker. It is anticipated that each facility and treatment team will individually determine who is responsible for completing the remaining criteria based on their clinical judgment, professional expertise, and organizational structure. Team members should consult with each other in the process of completing the assessment in order to reach agreement on assessment points and to ensure integration.

## Example Assessment Questions

The following set of questions was created as an example to ensure compliance with the CfC and to aid in the development of an effective plan of care. For responses noted in shaded boxes “,” it is anticipated that the item will need to be addressed in the plan of care.

Patients have the right to refuse to answer questions and to refuse to participate in non-essential assessments. If a patient refuses to provide information for an assessment item, the team should document the patient's refusal.

## **Assessment to Plan of Care**

The CMPA is the first step in the care planning process and will generate a list of problems. The care team will create or adjust the plan of care to address the problems identified by the CMPA. The CfC (§494.90) state that the Plan of Care must:

- Be individualized
- Specify the services necessary to address the patient's needs identified in the assessment
- Include measurable and expected outcomes
- Include estimated timetables to achieve outcomes
- Contain outcomes consistent with current evidence-base professionally-accepted clinical practice standards

The example assessment questions have been designed in such a way to try to allow for the measurement of progress, the use of evidenced-based assessment tools, and the engagement of the patient in the assessment process. This example is in no way intended as the absolute requirement. This CMPA is an example of one possibility to meet the expectations and should in no way be interpreted as a requirement to facilities. It is expected facilities will modify the CMPA based on their own documentation systems.

## **Disclaimer**

This document was created for educational purposes only. The assessment questions are intended to provide examples of the types of questions that physicians, registered nurses, dietitians, and social workers may want to use to meet the requirements for a CMPA. The validity and reliability of the questions have not been confirmed. It is the responsibility of the user to verify that the use of any of the questions from cited sources does not violate any copyright laws.

The implementation and interpretation of the new Conditions for Coverage for End-Stage Renal Disease Facilities is anticipated to be a dynamic process. This document reflects the information available to the kidney community as of its version date. Please confirm with NKF or ANNA whether further information, resources, or guidance has been provided on this subject. The information provided is not intended to establish or replace policies and procedures provided by dialysis providers to their facilities. Please check with your dialysis facility management before implementing any information provided here.

**Reason for Assessment**

**Complete for each assessment**

**R1. State Reason for Assessment**

- Initial     90 day     Annual (stable patients)     Monthly (unstable patients)

**R1a.** If monthly, choose reason for unstable status. Choose all that apply.

- Hospitalization – frequent or extended stay  
 Marked deterioration in health status  
 Change in psychosocial needs  
 Poor nutritional status and unmanaged anemia and inadequate dialysis

Other:

**Demographics**

**Complete for initial assessment only**

**D1.** What is the patient's name?

Last name:

Legal first name:

Preferred first name:

Middle initial:

**D2.** What is the patient's date of birth?

/ /

**D3.** What is the patient's sex?

- Male  
 Female  
 Intersex, transsexual, or other:  
(Please specify)

**D4.** What is the patient's gender identity?

(Check all that apply)

- Woman  
 Transgender  
 Man  
 Other:

**D5.** Is the patient of Hispanic or Latino origin or descent? (2728 Coding)

Yes

What is their country/area of origin or ancestry?

No

**D6.** What is the patient's race? (2728 Coding)

- White  
 Black or African American  
 American Indian/Alaska Native

What is the name of Enrolled/Principal Tribe?

- Asian  
 Native Hawaiian or Other Pacific Islander

What is their county/area of origin or ancestry?

**D7.** What is the date of the patient's first chronic dialysis treatment?

/ /

**D8.** What is the date the patient started chronic dialysis at the current facility?

/ /

**D9.** What is the patient's learning preference:

- Seeing     Hearing  
 Doing

## Medical History

### Complete for initial assessment only

#### N1. Cardiovascular N/A

- Cardiomyopathy:  Ischemic  Hypertrophic  Unknown  
 Ischemic heart disease:  Angina at rest  
 Angina on exertion  
 Angina on dialysis
- Heart failure:  Left  Right  Unknown  
 Dysrhythmia:  Atrial fibrillation  Ventricular dysrhythmia  
 Hypertension  
 Left ventricular hypertrophy  
 Myocardial infarction  
 Coronary artery bypass graft  
 Pacemaker  
 Internal defibrillator  
 Endocarditis  
 Pericarditis  
 Heart transplant  
 Valvular heart disease  
 Ischemic Skin Lesions  No  Yes Treatment:  
 Peripheral vascular disease  
Amputation:  Yes  No  
If yes, specify body part:  
 Aortic aneurysms  
 Renal artery stenosis  
 Dyslipidemia  
 ESA prior to dialysis initiation  Yes  No  
If yes, which type and dose if known:  
 Iron dosing prior to dialysis initiation  Yes  No  
If yes, type, dose and freq:  
 Prior transfusions  Yes  No If yes, explain:  
 Transfusion reactions  
Explanations:

#### N2. Pulmonary N/A

- Asthma  Chronic obstructive pulmonary disease (COPD)  
 Allergic rhinitis  Tuberculosis (TB)  
 Sarcoidosis  Supplemental oxygen dependence  
 Tobacco history and/or use  Exposure to second hand smoke  
 Smoking cessation education provided  
 Sleep apnea Treatment for sleep apnea  
 Other:

Explanations:

**N3. Endocrine**  N/A

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Hyperthyroidism                                  | <input type="checkbox"/> Hypothyroidism     |  |
| <input checked="" type="checkbox"/> Secondary hyperparathyroidism         |   |  |
| <input checked="" type="checkbox"/> Vitamin D insufficiency or deficiency |   |  |
| <input type="checkbox"/> Parathyroidectomy                                |   |  |
| <input checked="" type="checkbox"/> Diabetes mellitus                     |   |  |
| <input type="checkbox"/> Type I   | <input type="checkbox"/> Diet-controlled    | <input type="checkbox"/> Self-monitoring |
| <input type="checkbox"/> Type II  | <input type="checkbox"/> Insulin-controlled |  |

Explanations:

**N4. Gastrointestinal Disorders**  N/A

- |   |   |
|---|---|
| <input checked="" type="checkbox"/> Constipation  | <input checked="" type="checkbox"/> Diarrhea                    |
| <input checked="" type="checkbox"/> Poor appetite | <input type="checkbox"/> Nausea                                 |
| <input type="checkbox"/> Diverticulosis           | <input type="checkbox"/> GERD (gastroesophageal reflux disease) |
| <input type="checkbox"/> Esophageal disorders     | <input type="checkbox"/> Dysphagia                              |
| <input checked="" type="checkbox"/> Gastroparesis | <input type="checkbox"/> GI bleeding                            |
| <input type="checkbox"/> Peptic ulcer disease     | <input type="checkbox"/> Feeling of fullness (PD patients)      |
| <input type="checkbox"/> GI disease               | <input type="checkbox"/> Liver transplant                       |

Specify:

Explanations:

**N5. Neurological Disorders**  N/A

- |   |   |
|---|---|
| <input type="checkbox"/> Seizure disorder       | <input type="checkbox"/> TIA (transient ischemic attacks) |
| <input type="checkbox"/> CVA (stroke)           | <input type="checkbox"/> Dysphagia                        |
| <input type="checkbox"/> Carpal tunnel syndrome | <input checked="" type="checkbox"/> Peripheral neuropathy |
| <input type="checkbox"/> Restless leg syndrome  | <input type="checkbox"/> Parkinson's disease              |

Explanations:

**N6. Musculoskeletal**  N/A

- |  |   |
|--|---|
| <input type="checkbox"/> Osteoarthritis            | <input type="checkbox"/> Rheumatoid arthritis                     |
| <input type="checkbox"/> Osteoporosis              | <input checked="" type="checkbox"/> Metabolic bone disease of CKD |
| <input type="checkbox"/> Fractures (explain below) | <input type="checkbox"/> Joint replacements                       |
| <input type="checkbox"/> Gout                      | <input type="checkbox"/> Fibromyalgia                             |
| <input type="checkbox"/> Back Injury               |   |

Explanations:

**N7. Genitourinary**  N/A

- |  |   |
|--|---|
| <input type="checkbox"/> Residual urine  | <input type="checkbox"/> Painful urination    |
| Volume/day:                              | <input type="checkbox"/> Gynecological issues |
| <input type="checkbox"/> Prostate issues | <input type="checkbox"/> Pregnancy issues     |

Explanations:

**N8. Immune**  N/A

- Amyloidosis
- HIV/AIDS
- Scleroderma
- Other
- Systemic lupus erythematosus (SLE)

Explanations:

**N9. Mental Health**  N/A

Does the patient report any past or current mental health issues, concerns, or mood disturbances (*feelings of depression or anxiety*)?

Yes  No

- Dementia
- Anxiety disorder
- Depression
- Alcohol or substance abuse
- Post-traumatic stress syndrome
- Other
- Alzheimer's
- Bipolar disorder
- Schizophrenia

Explanations:

**N10. Cancer**  N/A

- Breast
- Gynecologic
- Lung
- Prostate
- Multiple myeloma
- Bone
- Other
- Colon
- Hematologic
- Melanoma
- Renal
- Skin
  - Squamous cell
  - Basal cell
  - Other:

Explanations:

**N11. Infection**  N/A

- Acute Hepatitis B
- Acute Hepatitis C
- Respiratory infection
- Recent exposure to communicable disease:
- History of at risk behavior (unprotected sex, IV drug abuse)
- MRSA within the last 5 years
- History of VRE or other drug-resistant bacteria
- Infected ulcers or pressure sores:
- Access related infection: Specify:
- Peritonitis
- Bacteremia or septicemia
- Other:

Vaccination Status

- Influenza  Up to date  not a candidate or refuses  needs vaccine
- Pneumococcal  Up to date  not a candidate or refuses  needs vaccine
- Hepatitis B  series completed  series in process  not a candidate or refuses  
 needs vaccine series started or booster

Explanations:

**N12. Hematologic Conditions**  N/A

- Sickle cell disease
- Bleeding disorder
- Other
- Heparin allergy
- Heparin-induced thrombocytopenia

Explanations:

**N13. Head Ears Eyes Nose Throat (HEENT)**  N/A

- Retinopathy
- Impaired vision
- Dental status
  - Good dentition
  - Poor dentition
  - Dentures
  - Difficulty chewing
  - Difficulty swallowing
- Glaucoma
- Hearing loss
- Other:

Explanations:

**N14. Miscellaneous**  N/A

**N15. Surgical History**  N/A

**Complete for each reassessment**

**N16.**  Has the patient experienced any events or developed any new conditions since last assessed, such as fall, surgery, illness, or deterioration in status? List any additions to the above co-morbid conditions. Check box if care planning needed.  
Explanations:

**Evaluation of Current Health Status**

**Complete for each assessment**

**HS1.** Other providers involved in patient's care  
(Include area of practice such as primary care, OB, etc. Telephone numbers are helpful.)  
  
Dentist  
Mental health provider

**HS2.** General Health Status  
How does the patient rate his/her health status?  Good  Fair  Poor  
Dates of most recent routine health screening  
Colonoscopy:                      PAP:  
Mammogram:                      Prostate screening:  
Dental exam:  
Other:

**HS3.** ESRD diagnosis from 2728 if available:  
Do you know what caused your kidneys to stop working?

**HS4.** Cardiac or radiologic results if available, include dates:

**HS5. Nursing Review of Systems Assessment**

Level of consciousness: Is patient alert?  Yes  No Oriented x 3?  Yes  No  
Responsive to stimuli?  Yes  No  
Explanations

Heart sounds, – rate, rhythm, abnormal sounds:

Fluid status –

chronically over  chronically under  at target weight

Neck veins:  distention  flat

Periphery – edema, perfusion, lack of skin turgor

Dry tongue  Yes  No

Chest pain  Yes  No

Palpitations  Yes  No

Dizziness or light-headedness  Yes  No

Explanations

Lung sounds:

Labored breathing  Yes  No Cyanosis  Yes  No

Cough  Yes  No Shortness of breath  Yes  No

Sputum production?  Yes  No

Does the patient use oxygen?  Yes  No

Explanations

GI:

Bowel patterns:

Abdominal distention – fluid related or motility related

Bowel sounds

Is the patient continent of bowel?  Yes  No

Constipation  Yes  No

Nausea/Vomiting  Yes  No

Diarrhea  Yes  No

Abdominal discomfort  Yes  No

Anorexia  Yes  No

Difficulty swallowing  Yes  No

Explanations

GU:

Residual urine volume:  greater than 1 cup/day  less than 1 cup/day

actual or  estimated output

Is the urine clear?  Yes  No

Pain with urination?  Yes  No

Is the patient continent of bladder?  Yes  No

Explanations

Extremities:

Edema include location and degree:

Skin integrity: Do you have any areas of broken skin?  Yes  No

Access:

What problems cause you concern? Please tell me about those.

**HS6. Medication History (including OTC)**

Allergies reviewed:  Yes  No What is patient allergic to?

Medications reviewed:  Yes  No

Do you have another provider prescribing medications?  Yes  No

Which medications and what is the provider's name?

What pharmacy do you use?

Do you have problems related to the medications you take?

**HS7. Laboratory Profile**

Lab results reviewed:

**HS8. Immunization History**

Immunization status reviewed and up to date  Yes  No

If no, what immunization(s) are due? <sup>9</sup>

**Appropriateness of Dialysis Prescription**

**DP1. Volume Status**

Blood Pressure Elevated (K/DOQI C-level Recommendation 140/90 Predialysis)

Yes  No

Blood Volume Monitoring shows refill (if available)  Yes  No

Estimated dry weight:

Chronically unable to achieve dry weight  Yes  No

**DP2. Patients on Hemodialysis  N/A**

Adequacy meeting targets:  Yes  No

If no, why:

Is Kt/V adjusted for > 3 hemo treatments/week :  Yes  No

**Adverse Intradialytic Symptoms**

Interdialytic Weight Gains:

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> Cramping                    | <input type="checkbox"/> Nausea      |
| <input type="checkbox"/> Hypertension                | <input type="checkbox"/> Hypotension |
| <input type="checkbox"/> Dizziness                   | <input type="checkbox"/> Hypoxemia   |
| <input type="checkbox"/> Cardiovascular complication |                                      |

Dialysate Chemistries

K:            Ca<sup>++</sup>:            Bicarb:            Na:            Temp:

Delivery system:

Comments:

**DP3. Patients on Peritoneal Dialysis**  N/A

CCPD  CAPD Total daily volume: \_\_\_\_\_ Kt/V  
PET results  Low  Low average  High average  High  
Usual Dextrose:  
 Icodextran Which exchange: \_\_\_\_\_

**Evaluation of Anemia Management**

**Complete for each assessment**

**A1. Anemia Evaluation**

Is Hgb 10-12?  Yes  No  
Hgb: \_\_\_\_\_ Retic: \_\_\_\_\_ CHr: \_\_\_\_\_ WBC: \_\_\_\_\_  
Ferritin: \_\_\_\_\_ Tsat: \_\_\_\_\_ Iron: \_\_\_\_\_ TIBC: \_\_\_\_\_  
Active infection?  Yes  No  
Organism: \_\_\_\_\_  
Co-morbid conditions affecting anemia:  Yes  No  
If yes, what? \_\_\_\_\_  
Recent transfusions:  Yes  No  
Predisposition to bleeding?  Yes  No  
Rapid change in Hgb?  Yes  No  
Occult blood tested?  Yes  No  
If yes, date and results: \_\_\_\_\_  
ESA name: \_\_\_\_\_ ESA dose: \_\_\_\_\_ Date of last ESA change: \_\_\_\_\_  
Iron dose: \_\_\_\_\_ Date of last iron dose change: \_\_\_\_\_  
Other: \_\_\_\_\_

**Factors Associated With Nutritional Status**

**Complete for each assessment**

**NS1. Anthropometrics**

Height: \_\_\_\_\_ Estimated dry weight: \_\_\_\_\_ BMI: \_\_\_\_\_  
Usual body weight: \_\_\_\_\_ % UBW: \_\_\_\_\_ Recent weight change?  Yes  No  
 Weight loss greater than 5% in one month  
Frame size:  Small  Medium  Large  
Reference weight: \_\_\_\_\_ % Reference weight: \_\_\_\_\_  
Adjusted body weight:  
 for obesity  
 for amputees  
Nutrition-related medications:  
 Vitamin supplement  GI medications  
 Stool softeners  Non-Rx vitamin/minerals  
 Other: \_\_\_\_\_

**NS2. Diabetes Self-Management**  N/A

Diet:

Foot checks:  Yes  No If yes, how often: \_\_\_\_\_ By who: \_\_\_\_\_

Dental care: Daily brushing?  0  1  2  3+ Daily flossing?  Yes  No

Regular check-ups?  Yes  No

Blood glucose monitoring frequency:

Device brand:

Usual blood glucose:

Hgb A1C:

Diabetes medications:  oral agent  insulin type \_\_\_\_\_ dose \_\_\_\_\_

Education:

**Diabetes Management:**

Comments:

**NS3. Mineral Bone Disorder Management**

Lab Review:

Phosphorus: Trends:  usually in goal  usually high  other

Calcium: Trends:  usually in goal  usually high  other

PTH: Trends:  usually in goal  usually high  other

Medications:  phosphorus binder Adherence  good  fair  poor

calcium supplement

vitamin D

Diet issues: Adherence  good  fair  poor

Education: Understands diet  Yes  No

Comments:

**NS4. Cultural Factors Related to Diet**

Religious food preferences:

Cultural foods:

Party responsible for purchasing and preparing food:  patient  spouse  other:

Reading ability:

Primary language for food prep:  English  Spanish  Other:

Vision:  good  glasses  contacts  blind

Hearing:  good  hearing aids  hard of hearing

Lives alone?  Yes  No

Has meals alone?  Yes  No

People with whom meals are shared:

Frequency for dining out: number of meals eaten out/week:

Types of food usually ordered:

Does patient receive food assistance?  Yes  No

If yes, source:

**NS5. Subjective Data**

Appetite:  improving  decreasing  good  fair  poor  
Typical meal pattern: morning:                      noon:                      evening:  
Usual intake (24-hour recall):  
Number of meals/day:                      number of snacks/day:  
Food preferences:  
Food allergies:  
Pica?  Yes             No    Type:  clay  dirt  starch  ice  chalk  
Other:  
Nutritional supplements, including enteral nutritional supplements, herbal, minerals,  
and vitamins not previously listed:  
Previous diets/nutrition education:  
Weight history, patient's desired weight:  
Weight changes:  planned  unplanned  loss  gain amount

**NS6. Objective Data**

Albumin:                      nPCR:                      K:  
Evaluation of nutritional intake: calories  adequate  inadequate:  
Protein  adequate  inadequate  
Variety of food groups  adequate  inadequate:  
Evaluation of nutritional status:  
 Well-nourished    Malnourished     Mild     Moderate     Severe

**Evaluation of Dialysis Access**

**Complete for each assessment**

**DA1. Hemodialysis**

Type of access:  Simple fistula     Transposed vein  
Graft:  Poly             Vectra             Other  
 Catheter (see catheter section DA8)  
Location:  
Date placed:    Surgeon:  
Previous access history:

**DA2. Average Blood Flow Rate (BFR):**

Average arterial pressure:                      Average venous pressure:  
Cannulation method:  
Buttonhole:    Rotation:

**DA3. Does patient use any preparation to limit pain with needle insertion:  Yes  No**

Lidocaine intradermal  Lidocaine cream  Lidocaine patch  
 Emla cream  Emla patch  Ethyl chloride spray  Other:  
Venous mapping done prior to placement:  Yes  No

**DA4. Anticoagulation**

Heparin dose:

Other home anticoagulation medication:  Yes  No

Explanation:

**DA5. History of infection:**  Yes  No

Hospital Acquired  Yes  No

If yes, organism

Staph aureus

Staph aureus methicillin resistant (MRSA)

Staph epi

Staph epi methicillin resistant

Enterococcus

Enterococcus vancomycin resistant (VRE)

EColi

Pseudomonas

Other:

Treatment:

Vancomycin

Cefazolin

Gentamycin

Azactam

Zinzolid

Other:

**DA6. Physical description of access:**  Straight  Curved  Loop tortuous  Aneurisms

Direction of flow:

Other:

**DA7. Access Surveillance Method**

Physical finding (persistent swelling, collateral veins, prolonged bleeding, altered characteristics of pulse or thrill)

Intra-access flow Method

Static pressure Method

Duplex ultrasound

Recirculation

Interventions required  Yes  No

Angioplasty

Date:

Where:

Surgical Revision

Date:

Where:

Declotting procedures

Date:

Where:

**DA8. Catheter**

Type of central venous catheter:  Quinton  Arrow  Other  
Temporary catheter:  Quinton  Other

**Catheter Dysfunction**

Manipulation or replacement    Date:                      Where:  
 Thrombolytic agent  Alteplase  Urokinase  Other                      Frequency  
 Reversed lines

**DA9. Peritoneal Dialysis**

Type of catheter:  Straight  Coiled  Swan neck  Cruz  Other  
Insertion date:

Thrombolytic agent  Alteplase  Urokinase  Heparin  Other  
Frequency:                      Dose:  
Catheter function:  
 Patent                       Migration                       Repositioned/replaced

**DA10. History of exit site infections:**  Yes  No

If yes, organism

- Staph aureus
- Staph aureus methicillin resistant (MRSA)
- Staph epi
- Staph epi methicillin resistant
- Enterococcus
- Enterococcus vancomycin resistant (VRE)
- EColi
- Pseudomonas
- Fungus
- Other:

Treatment

- Vancomycin
- Cefazolin
- Gentamycin
- Azactam
- Zinzolid
- Other:

**DA11. Exit site care**  Soap and water  Other:

Is antibiotic cream used:  Yes  No  
Exit site width:  
Cuff status:  
Recent trauma:

## Evaluation of Physical Activity

### Complete for each assessment

**PA1.** Activity assessment (exercise activity is equal to 30 minutes)

- Inactive (1 or less exercise activities per week)  
 Inactive light (1 to 2 exercise activities per week)  
 Active (3 to 4 exercise activities per week)

**PA2.** Type of activity

- Walking  Jogging  
 Bicycling  Swimming  
 Conditioning or weight training  Dancing  
 Home activities such as gardening or snow shoveling  
 Other activities:

**PA3.** Waist girth and waist-to-girth ratio (optional)

To calculate ratio: In a relaxed standing position, measure the narrowest point at waist and divide this by measuring the widest point of hips. A value greater than 0.8 for women and 0.9 for men have a higher risk to develop conditions such as heart disease, high blood pressure, or diabetes.

Is patient at an increased health risk:  Yes  No

**PA4.** Physical limitations:  Yes  No

Explanation:

**PA5.** Does patient desire to start or increase activity level?  Yes  No

Explanation:

Comments:

## Fall Assessment

### Complete for each assessment

**F1.** Assessment of balance score:

Assessment of gait score:

Method used: Example: Tinetti assessment <sup>7</sup>

Other assessment:

**F2.** Past history of falls:  Yes  No

**F3.** Physical limitations:

**F4.** Known or diagnosed cognitive deficits reported by patient or family:

**F5.** Medications (psychotropics/sedatives/hypnotics/antihistamines/alcohol/pain/etc.):

**F6.** Assistive devices:  None  Cane/Crutch  Walker  Manual wheelchair  
 Electric wheelchair  Limb prosthesis

**F7.** Postural hypotension:

**F8.** Do you have strategies for avoiding falls?  Yes  No  
Explanation:

**F9.** Patient risk for fall:  low  moderate  high

### **Pain Assessment**

#### **Complete for each assessment**

**P1.** Frequency of pain  
 No pain  
 Pain daily  
 Pain every other day  
 Pain weekly  
 Pain monthly  
 Pain related only to a specific activity:

Intensity of pain  
 Mild  
 Moderate  
 Times when pain is excruciating

**P2.** Location of pain:  
Character of pain:  throbbing  burning  stabbing  aching  
How long ago did you start experiencing this type of pain?  
Worst pain you ever had:

**P3.** Intensity of pain on a scale from 1-10 with 10 the worst pain you ever experienced:

**P4.** How much does pain affect your life?  
What do you do to decrease/eliminate pain?  
What makes the pain worse?

**P5.** Are you taking medications for pain?  Yes  No  
If yes, what medications:  
Does the medication provide relief?  Yes  No  
What side effects do you experience?  
Do you have other strategies for dealing with pain?  
How do you respond to pain (i.e., cry out, moan, become withdrawn or angry, etc.)?

**Communication Status****Complete for initial assessment and at least annually****CS1.** Are there physical or cognitive barriers that affect the patient's ability to communicate? Yes No**CS1a.** If yes, describe:**CS2.** Are there any barriers to the patient's ability to communicate verbally in English?  
EXCLUSIVE OF COGNITIVE OR PHYSICAL BARRIERS?

Assessment of Patient's Ability to Communicate in English		
No Limitation	Barriers Present	
	<input checked="" type="checkbox"/>	Not able to communicate in English <i>Requires interpretation assistance at all times</i>
	<input checked="" type="checkbox"/>	Only able to communicate basic needs to staff <i>Uses single words or short phrases – requires interpretation assistance for conversations and care planning</i>
	<input type="checkbox"/>	Able to communicate with staff in most situations <i>Able to carry on conversations with staff. Requires occasional interpretation assistance for more complex conversations.</i>
<input type="checkbox"/>		Able to communicate in English

If a BARRIER IS PRESENT, answer the following questions:

**CS2a.** What is the patient's primary language for communicating with facility staff?**CS2b.** When interpretation assistance is required, how does the patient communicate with the care team? (Check all that apply)

<input type="checkbox"/>	Family
<input type="checkbox"/>	Friends and/or other social supports
<input type="checkbox"/>	Professional interpreter
<input type="checkbox"/>	Community agency
<input type="checkbox"/>	Facility staff (able to communicate with the patient in their primary language)
<input type="checkbox"/>	None of the above (care team unable to effectively communicate with the patient)

**CS3.** Is the patient able to read printed materials?

Language	Yes	No	Limited	Details
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

**Advance Care Planning**

[Complete for each assessment](#)

**AP1.** Does patient have any of the following?

	Yes	No	Copy at Facility	
Advance Directive ( <i>living will, durable power of attorney for healthcare, and health care proxy</i> )	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Appointee:
Do Not Resuscitate Order at Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Do Not Resuscitate Order in Community	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Court Appointed Guardian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Appointee:
Durable Power of Attorney for Financial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Appointee:

**AP1a.** If the patient DOES NOT have an advance directive, does the patient or a support person want information on advance directives?

- Yes
- No - not interested
- No - already has
- Unknown

**AP2.** If the patient has a “Do Not Resuscitate Order” at facility or in the community, does the patient have pre-funeral arrangements made?

- Yes
- No
- Unknown

**AP2a.** If yes, list name and phone number of funeral home and other details:

**Social Barriers**

[Complete for each assessment](#)

**SB1.** Have there been any changes to the patient’s insurance status since the last assessment? (If initial assessment mark “Yes”)  Yes  No

**SB1a.** If yes, what is the patient's current insurance status?

Insurance	Active	Pending	Primary	Secondary	Other
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> No Insurance					

Comments:

**SB2.** Is the patient's insurance status a barrier to positive treatment outcomes?  Yes  No

**SB2a.** If yes, explain:

*Examples: unable to afford co-pays, difficulty paying monthly premiums, etc.*

**SB3.** What is the patient's mode of transportation to dialysis? (Check all that apply)

- |                                      |   |
|--------------------------------------|---|
| <input type="checkbox"/> Walk        | <input type="checkbox"/> Taxi (Self-pay)            |
| <input type="checkbox"/> Drives self | <input type="checkbox"/> ADA transport              |
| <input type="checkbox"/> Public bus  | <input type="checkbox"/> Insurance funded transport |
| <input type="checkbox"/> Family      | <input type="checkbox"/> Other:                     |
| <input type="checkbox"/> Friends     | <input type="checkbox"/> Other:                     |

**SB4.** Does the patient have reliable transportation to/from dialysis?  Yes  No

**SB4a.** If no, explain:

**SB5.** Is the patient currently a student?  Yes  No

**SB5a.** If yes, explain:

**SB6.** What is the patient's employment status?

Prior Employment If INITIAL – use 6 months prior to starting dialysis If REASSESSMENT – use status at last assessment	Current Employment
<input type="checkbox"/> Employed full-time	<input checked="" type="checkbox"/> Employed full-time
<input type="checkbox"/> Employed part-time	<input checked="" type="checkbox"/> Employed part-time
<input type="checkbox"/> Retired	<input checked="" type="checkbox"/> Retired
<input type="checkbox"/> Medical leave of absence	<input checked="" type="checkbox"/> Medical leave of absence
<input type="checkbox"/> Not employed - by choice	<input checked="" type="checkbox"/> Not employed - by choice
<input type="checkbox"/> Not employed - looking for work	<input checked="" type="checkbox"/> Not employed - looking for work
<input type="checkbox"/> Not employed - disabled	<input checked="" type="checkbox"/> Not employed - disabled

**SB6a.** If NOT working, what is the patient's vocational rehabilitation status?

- Already working with VR agency
- Patient referred to VR
- Patient has expressed interest in VR but has not followed up
- Patient not interested
- Patient not eligible
- Patient looking for employment on own

**SB7.** Is the patient's dialysis a barrier to positive vocational outcomes?  Yes  No

**SB7a.** If yes, what barriers does the patient report that prevents him /her from working or attending school?

*Examples: missing workdays, not enough energy to perform job, not able to attend school, etc.*

**SB8.** What is the patient's status with regard to the following social needs?

	No problems reported	Maximum assistance in place	Referral needed or in process
Income (wages, social security, welfare, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Food	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Utilities	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Housing/Rent	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Legal	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Immigration	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

**Mobility Status, Activities of Daily Living, & Physical Rehabilitation**

**Complete for each assessment**

**A1.** Has the patient been referred for physical rehabilitation services?  Yes  No

**A1a.** If no, does the patient want to be referred to physical rehabilitation?  Yes  No

**A2.** Level of Assistance with Activities of Daily Living

<input type="checkbox"/> Independent	
<input type="checkbox"/> Assistance required: (Indicate activities requiring assistance)	
<input type="checkbox"/> Bathing	<input type="checkbox"/> Laundry
<input type="checkbox"/> Toileting	<input type="checkbox"/> Transportation
<input type="checkbox"/> Dressing	<input type="checkbox"/> Shopping
<input type="checkbox"/> Medication management	<input type="checkbox"/> Finances
<input type="checkbox"/> Meal preparation	<input type="checkbox"/> Medical appointments
<input type="checkbox"/> Housekeeping	<input type="checkbox"/> Other:
<input type="checkbox"/> Requires total care	

If assistance is REQUIRED (or total care required), **answer these questions:**

**A2a.** Is there adequate support or services in place to provide assistance?

- Yes  
 No

**A2b.** Describe support or services in place: (include persons providing assistance, barriers, and/or lack of assistance):

### Living Situation

#### Complete for each assessment

**L1.** With whom does the patient live?

- Lives alone  
 Parents  
 Spouse  
 Child/children  
 Significant other/friend/relative  
 Other:

**L3.** Is the patient's current living situation a barrier to positive treatment outcomes?

- Yes  
 No

**L3a.** If yes, describe barrier:

**L2.** Where does the patient reside?

- |  |  |
|--|--|
| <input type="checkbox"/> Owns home/condo/mobile home                       | <input checked="" type="checkbox"/> Acute rehabilitation center  |
| <input type="checkbox"/> Rents apt/house                                   | <input checked="" type="checkbox"/> Shelter                      |
| <input type="checkbox"/> Assisted living                                   | <input type="checkbox"/> Correctional facility                   |
| <input type="checkbox"/> Public housing                                    | <input checked="" type="checkbox"/> Homeless                     |
| <input checked="" type="checkbox"/> Long-term care facility (nursing home) | <input checked="" type="checkbox"/> Adult family home/group home |

## Support System & Spirituality<sup>1</sup>

### Complete for initial assessment and at least annually

**S1.** What is the patient's relationship status?

- |   |                                    |
|---|------------------------------------|
| <input type="checkbox"/> Domestic partner | <input type="checkbox"/> Single    |
| <input type="checkbox"/> Married          | <input type="checkbox"/> Widowed   |
| <input type="checkbox"/> Divorced         | <input type="checkbox"/> Separated |

**S2.** Describe family composition: *Dependent children, relatives in the home, etc.*

**S3.** What is the level of involvement of family and friends on a regular basis with the patient? *Visits, phone calls, emails, etc*

- Daily  
 Weekly  
 Monthly  
 Less frequently than monthly

**S4.** How does the patient cope with life events and daily stress? (Check all that apply)

- Keeps it to him/herself  
 Talk to family  
 Talk to friends  
 Pray  
 Talk with a professional  
 Support group  
 Resources on the Internet

**S5.** Is the patient involved in community activities, groups, social events, or volunteering?

- Yes  
 No

**S5a.** If yes, describe:

**S6.** What has the patient previously done for enjoyment or recreation?

**S6a.** Is (s)he able to engage in these activities now?

- Yes  
 No

**S7.** Does the patient report having adequate support (patient's perspective)?

- Yes  
 No

**S7a.** If no, what support is desired:

**Complete for initial assessment only**

**S8.** Is the patient part of a spiritual or religious community?  Yes  No  
Describe:

**S9.** Are there any specific cultural or spiritual practices/restrictions the health care team should know about in providing the patient's medical care? *Dietary restrictions, use of blood products*  
 Yes  No Describe:

**Cognitive Patterns & Cognitive Skills for Daily Decision-making <sup>2</sup>**

**Complete for each assessment**

**C1.** Is there evidence of a change in cognitive status from the patient's baseline since the last assessment? (if initial assessment, compare to reported status 6 months prior to starting dialysis treatments)  
 Yes  
 No

**C2.** The patient's ability to make decisions regarding daily life:  
 Independent  
 Modified independence – *some difficulty in new situations*  
 Moderately impaired – *requires assistance in making decisions*  
 Severely impaired – *never/rarely makes decisions*

**C3.** Does the patient appear to have a problem with the following?

Short-term memory  Yes  No  
Long-term memory  Yes  No

**C3a.** If yes, check all that the patient was normally ABLE to recall during the last 5 days  
 Current season  
 Day of the week  
 Staff names and faces  
 That (s)he is in a dialysis facility  
 None of the above is recalled

**C4.** During the past 2 weeks, has the patient demonstrated any of the following behaviors? <sup>2</sup>

**CAM** Confusion Assessment Method

Behavior	Behavior not present	Behavior continuously present, does <u>not</u> fluctuate	Behavior present, fluctuates (comes and goes, changes in severity)
a. <b>Inattention</b> – Did the patient have difficulty focusing attention ( <i>easily distracted, out of touch, or difficulty keeping track of what was said</i> )?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
b. <b>Disorganized thinking</b> – Was the patient’s thinking disorganized or incoherent ( <i>rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject</i> )?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
c. <b>Altered level of consciousness</b> – Did the patient have altered level of consciousness ( <i>not related to low blood pressure</i> )?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
d. <b>Psychomotor retardation</b> – Did the patient have an unusually decreased level of activity ( <i>sluggishness, staring into space, moving slowly</i> )?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

**C4a.** What sources of information were used in answering this section?

- Patient’s self-report     Observations of dialysis staff     Social supports/family  
 Medical records     Other:

**C4b.** Does the patient’s behavior change during dialysis treatments?  Yes  No

Describe:

**Mental Health Status****Complete for initial assessment only****M1.** Has the patient participated in counseling?

- Yes in the past  
 Currently in counseling  
 No

**M1a.** If yes or CURRENTLY in counseling, how does the patient describe his/her counseling experience?

Describe:

**M2.** Has the patient ever taken a psychotropic medication? (*Possible interview question: "Have you ever taken any medication to help you relax, to help you sleep or to help you feel less sad or less angry?"*)

- Yes  No  
 Unknown

Comments:

**M3.** Does the patient report any history of substance use?*(Possible interview question: "Have you ever used a substance other than alcohol, such as a drug, to help you calm down, feel better, reduce pressure on yourself, or just have fun?")*

- Yes  No

**M3a.** If yes, complete the following:

Drug	Current Use	If currently using, frequency			
		Less than monthly	Monthly	Weekly	Daily or almost daily
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**M4.** Has the patient ever received drug or alcohol treatment?

- Yes  No

**M4a.** If yes, describe:

**M5.** Ask the patient the following questions, (A.U.D.I.T Questions <sup>5</sup>)

If unable to interview patient, specify reason:

**M5a.** How often do you have a drink containing alcohol?

- Never
- Monthly or less
- 2 to 4 times a month
- 2 to 3 times a week
- 4 or more times a week

**M5b.** How many drinks containing alcohol do you have on a typical day when you are drinking?

- N/A – never drinks
- 1 or 2
- 3 or 4
- 5 or 6
- 7,8, or 9
- 10 or more

**M5c.** Has a relative, friend, doctor, or another health worker been concerned about your drinking or suggested that you cut down?

- No or never drinks
- Yes, but not in the last year
- Yes, during the last year

**Complete for each assessment**

**M6.** Are there signs/symptoms present for depression or anxiety problems?

Yes  No

**M6a.** If yes, what are the signs/symptoms and their severity level?

Signs/Symptoms	Severity Level			
	Not a problem	Mild	Moderate	Severe
Depressed mood most of the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased interest/pleasure in most activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A problem with appetite/weight change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Significant sleep disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychomotor retardation or agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue, loss of energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feelings of worthlessness or guilt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal ideation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritable mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Early awakening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*This signs/symptoms list is derived from the Diagnostic and Statistical Manual of Mental Disorders (DSM). The list is not comprehensive and is not intended to diagnosis depression. Further assessment should be completed if signs/symptoms are present. Somatic symptoms may be due to medical causes.*

**Complete for each assessment (EXCEPT FOR INITIAL ASSESSMENT)**

**M7.** Has the patient started taking a psychotropic medication?

Yes  No

**M7a.** If yes, list medication(s) and effectiveness per patient's report

Name of Medication & Dosage	Date Started	Effective	Not Effective	Adverse Reaction	Not Yet Determined
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**M8.** Has the patient started counseling or a support group?

Yes  No

**M8a.** If yes, describe:

*Depression Screening Questions (PHQ-2)<sup>6</sup>*

**M9.** Questions:

If unable to interview patient, specify reason:

Say to the patient: "Over the past two weeks, have you often been bothered by:"

	Yes	No
1. Little interest or pleasure in doing things?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless?	<input checked="" type="checkbox"/>	<input type="checkbox"/>

If the patient responds "yes" to either questions, follow-up with further assessment for depression.

**Rehabilitation Goals**

**Complete for initial assessment and at least annually**

**R1.** What are the patient's goals (vocational, educational, personal, etc.) for the next year?

For the next 5 years?

**Self-Management & Level of Participation in Care**

**Complete for initial assessment only**

**SM1.** On the following items, indicate the patient's level of understanding:

	Not Able	Limited	Adequate	Excellent
Chronic kidney disease	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Treatment options	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis vascular access options	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SM2.** Was the patient referred to a pre-dialysis education program or session?

Yes  No

**SM2a.** If yes, did the patient attend the program or session?

Yes, location:

No, reason:

**Complete for each assessment (EXCEPT FOR INITIAL ASSESSMENT)**

**SM3.** Patient Interview

Say to the patient: *“Over the past month, how easy or difficult has it been for you to do any of the following?”* Read the options to the patient.

	N/A	Very Easy	Somewhat Easy	Neither Easy nor Difficult	Somewhat Difficult	Very Difficult
1. Come to each hemodialysis treatment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Complete the full-prescribed hemodialysis treatment time.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Perform every peritoneal dialysis treatment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Take medications as prescribed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Follow dietary restrictions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Follow fluid restrictions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

**SM3a.** For anything that was SOMEWHAT or VERY DIFFICULT, what would be helpful:

**SM4.** Does the patient assist with self-care (putting in/taking out own needles, setting up machine, etc.).

- Not permitted in facility
- Yes
- No

**SM5.** What is the percentage of treatments missed in the last 30 days? (Disregard treatments missed due to hospitalization/travel/or other where treatment was received in another setting)

Percentage:

**SM6.** What is the percentage of shortened treatments in the last 30 days?

Percentage:

**SM7.** Does the patient take responsibility for following their medication schedule?

- Yes
- No (If no, check one of the following)
  - Relies on caregiver/support partner to administer medications
  - Not interested
  - Other:

**SM8.** Does patient appear comfortable asking staff/physician questions?

- Yes
- No
- N/A

**SM8a.** If NO, what factors limit the patient's comfort in asking questions?

- Does not know what questions to ask
- Cannot speak
- Does not speak English or any language staff speak
- Cognition
- Thinks asking questions is disrespectful
- Other:

**SM9.** How does patient express concerns/complaints?

### Preferences in Home Dialysis<sup>3</sup>

#### Complete for each assessment

**HD1.** Did the patient initiate dialysis AT YOUR FACILITY within the last 12 months?

Yes  No  Unknown

**HD1a.** If yes, did the patient's nephrologist or dialysis team provide information about home dialysis (home hemodialysis and PD) within the first 30 days of treatment?

Yes  No  Patient doesn't recall

**HD2.** Has the patient been dialyzing at your facility for MORE than 12 months?

Yes  No

**HD2a.** If yes, did the patient's nephrologist or dialysis team provide information about home dialysis (home hemodialysis and PD) within the last 12 months?

Yes  No  Patient doesn't recall

**HD3.** Does the patient want to pursue home dialysis?

Yes

No (specify why)

Unsuitable home situation

Medical complication

Satisfied with in-center hemodialysis

Other:

Undecided (specify why):

**HD4.** Has the patient expressed interest in learning more about home dialysis options?

Yes

No

Comments:

### Interest and Suitability for Transplant<sup>4</sup>

#### Complete for initial assessment and at least annually

**T1.** Did this patient initiate dialysis AT YOUR FACILITY within the last 12 months?

Yes  No

**T1a.** If yes, did the patient's nephrologist or dialysis team provide information about how to get a transplant within the first 30 days of treatment?

Yes  No  Patient doesn't recall

**T2.** Has the patient been dialyzing at your facility for MORE than 12 months?

Yes  No

**T2a.** If yes, did the patient's nephrologist or dialysis team provide information about how to get a transplant within the last 12 months?

Yes  No  Patient doesn't recall

**T3.** Does the patient want to be evaluated for a kidney transplant?

Yes  No  Undecided

**T3a.** If no, specify:

- Financial barrier  Medical complication  
 Age  Satisfied with dialysis  
 Other:

**T4.** Are there any contraindications to referring patient for transplant evaluation?

**T4a.** If yes, contraindication identified by:

Transplant center  Dialysis facility

Specify contraindication(s) (as indicated by the transplant centers selection criteria):

**T5.** Has the patient been referred to a transplant center for an evaluation?

Yes  No  Unknown

**T5a.** If yes, specify date        /        /

Specify who referred patient:

- Nephrologist  Social worker  Nurse  
 Patient self-referral  Secretary  Other:

Specify how patient was referred:

- Written communication (letters, standard form, email)  
 Phone call  
 Other:

**T5b.** If no, specify reasons for not referring:

- Contraindication(s)  Patient already on the waitlist  
 Physician judgment or refuses to refer  Unknown  
 Patient not interested/undecided  Other:

## Notes and Citations

- 1 These are additional recommended assessment questions regarding Spirituality.  
Do you consider yourself to be a religious or spiritual person?  
What things do you believe in that give meaning to your life?  
How might your beliefs influence your behavior during this illness?  
What role might your beliefs play in helping you with your kidney disease?  
What can your dialysis team do to support spiritual issues in your health care?  
Is there a person or group of people who can help support you in your illness?
- 2 These questions were modified from questions on the CMS Long Term Care Resident Assessment Instrument Version 3.0 of the MDS (Minimum Data Set) which can be located at the following Web site: [http://www.cms.hhs.gov/NursingHomeQualityInits/25\\_NHQIMDS30.asp - TopOfPage](http://www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp-TopOfPage). The Confusion Assessment Method (CAM) is included in the MDS draft and is a standardized assessment tool. For additional information regarding the use of a CAM, see the following Web site as a resource: [http://hospitalelderlifeprogram.org/pdf/The\\_Confusion\\_Assessment\\_Method.pdf](http://hospitalelderlifeprogram.org/pdf/The_Confusion_Assessment_Method.pdf). If a facility or social worker chooses to use the tool or another version of the CAM, it is the responsibility of the user to research and comply with any copyright requirements.
- 3 The questions regarding "Preferences in Home Dialysis" should be complimented by the use of the METHOD TO ASSESS TREATMENT CHOICES FOR HOME DIALYSIS" (MATCH-D) TOOL (available <http://www.homedialysis.org/files/pdf/pros/MatchD2007.pdf>)
- 4 Taken with permission from the following: ESRD Special Study: Developing Dialysis Facility-Specific Kidney Transplant Referral Clinical Performance Measures, performed under Contract Number 500-03-NW09, entitled "End-Stage Renal Disease Network Organization Number 9", sponsored by the Centers for Medicare & Medicaid Services, Department of Health and Human Services. <http://www.therenalnetwork.org/images/TransTEPfinalrpt805.pdf>
- 5 These questions come from the Alcohol Use Disorders Identification Test (AUDIT) which is a free assessment tool developed by the UN Whole Health Organization. The assessment tool may be administered as an interview or as a questionnaire. The tool comes in both Spanish and English. A PDF version of the tool and manual is available for download at [http://whqlibdoc.who.int/hq/2001/WHO\\_MSD\\_MSB\\_01.6a.pdf](http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf).
- 6 The PHQ-2 is derived from the Physicians Health Questionnaire (PHQ-9), which is copyrighted, and is available in English and Spanish. To read about the PHQ-9, locate scoring instructions and register for download go to <http://www.depression-primarycare.org/clinicians/toolkits/> or <http://www.phqscreeners.com/>.
- 7 One example of a fall risk assessment can be found in the following reference. *Tinetti, M.E., Williams, T.F., Mayewski, R. (1986). Fall risk index for elderly patients based on number of chronic disabilities. American Journal of Medicine, 80, 429-434.*

- 8 An excellent reference for nephrology nursing standards and guidelines is the *Nephrology Nursing Standards of Practice and Guidelines for Care* (2005) edited by Sally Burrows-Hudson and Barbara Prowant. It is available from the American Nephrology Nurses' Association <http://www.annanurse.org>.
  - 9 The Centers for Disease Control and Prevention have current immunization recommendations for children and adults available on their Web site <http://www.cdc.gov/vaccines>.
- 

The Conditions for Coverage for End-stage Renal Disease Facilities were published April 15, 2008 by the Department of Health and Human Services, Centers for Medicare & Medicaid Services

To go into effect **October 14, 2008**

You can find the entire conditions for coverage at:

<http://edocket.access.gpo.gov/2008/pdf/08-1102.pdf>