Comprehensive Multidisciplinary Patient Assessment (CMPA) Example Questions

Social Work-Focused Criteria

Council of Nephrology Social Workers

INTRODUCTION TO THE CMPA

The Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), published the Final Conditions for Coverage (CfCs) for End-Stage Renal Disease (ESRD) Facilities on April 15, 2008. In anticipation of the final publishing of the CfCs 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
- Three 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:
  - Extended or frequent hospitalizations
  - Marked deterioration in the health status
  - Significant change in psychosocial needs
  - Concurrent poor nutritional status, unmanaged anemia and inadequate dialysis

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 four 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 comorbid conditions
- Evaluation of the appropriateness of 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 (e.g., arteriovenous fistulas, 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 (e.g., 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 current patient 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 CfCs, 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 CfCs designate two areas to specific team members: evaluation of nutritional status to the dietitian and the 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 to ensure compliance with the CfCs and to aide 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. The master's level social worker will have to utilize additional clinical assessment tools, and modify or omit questions as clinically necessary.

The example questions are intended to address the following minimum criteria of the CMPA:

- Demographics (not officially required as a minimum criteria, but likely part of any initial assessment)
- Evaluation of psychosocial needs by a social worker
- 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 (e.g., 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 for referral to vocational and physical rehabilitation services

Patients have the right to refuse to answer questions and to participate in nonessential assessments. If a patient refuses to provide information for an assessment item, the social worker 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 should create or adjust the plan of care to address the problems identified by the CMPA. The CfCs (§ 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-based, 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, use of evidenced-based assessment tools and engagement of the patient in the assessment process.

DISCLAIMER

This document was created for educational purposes only. The assessment questions are intended to provide examples of the types of questions that facilities 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 CfCs 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 CNSW whether further information, resources or guidance has been provided on this subject. Information provided by CNSW 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 of the information provided herein.

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 his or her 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
Print name of enrolled/principal tribe:
_____
☐ Asian
☐ Native Hawaiian or other Pacific Islander
What is his or her 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 treatment at the current facility?
___ /___ /_____

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	
	■	Not able to communicate in English *Requires interpretation assistance at all times*
	■	Only able to communicate basic needs to staff *Uses single words or short phrases; requires interpretation assistance for conversations and care planning*
	☐	Able to communicate with staff in most situations *Able to carry on conversations with staff; requires occasional interpretation assistance for more complex conversations*
☐		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.)

☐	Family
☐	Friends and/or other social supports
☐	Professional interpreter
☐	Community agency
☐	Facility staff (able to communicate with the patient in his or her primary language)
☐	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
	☐	■	☐	
	☐	■	☐	
	☐	■	☐	

Advance Care Planning

Complete for each assessment.

AP1. Does patient have any of the following?

	Yes	No	Copy at facility	
Advance directive (living will, durable power of attorney for health care and health care proxy)	☐	☐	☐	Appointee:
Do not resuscitate order at facility	■	■	☐	
Do not resuscitate order in community	■	■	☐	
Court-appointed guardian	☐	☐	☐	Appointee:
Durable power of attorney for financial	☐	☐	☐	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 the 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
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
☐ 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.)

☐	Walks	☐	Taxi (self-pay)
☐	Drives self	☐	ADA transport
☐	Public bus	☐	Insurance-funded transport
☐	Family	☐	Other:
☐	Friends	☐	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:

_____

Complete for each assessment.

SB6. What is the patient's employment status?

Prior employment If initial assessment, use 6 months prior to starting dialysis If reassessment, use status at last assessment	Current employment
☐ Employed full-time	■ Employed full-time
☐ Employed part-time	■ Employed part-time
☐ Retired	■ Retired
☐ Medical leave of absence	■ Medical leave of absence
☐ Unemployed (by choice)	■ Unemployed (by choice)
☐ Unemployed (looking for work)	■ Unemployed (looking for work)
☐ Unemployed (disabled)	■ Unemployed (disabled)

SB6a. If not working, what is the patient's vocational rehabilitation (VR) 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 or 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.)	☐	☐	■
Food	☐	☐	■
Medication	☐	☐	■
Utilities	☐	☐	■
Housing/rent	☐	☐	■
Legal	☐	☐	■
Immigration	☐	☐	■
Other:	☐	☐	■
Other:	☐	☐	■

Mobility Status, Activities of Daily Living and Physical Rehabilitation

Complete for each assessment.

A1. What did the patient use in the past month: (Check all that apply.) ☐ Cane/crutch ☐ Walker ☐ Manual wheelchair ☐ Electric wheelchair ☐ Limb prosthesis ☐ None of the above

A2. Has the patient been referred for physical rehabilitation services? ☐ Yes ☐ No

A2a. If no, does the patient want to be referred to physical rehabilitation? ■ Yes ☐ No

A3. Level of assistance with activities of daily living:

☐ Independent

☐ Assistance required (indicate activities requiring assistance):

☐ Bathing	☐ Laundry
☐ Toileting	☐ Transportation
☐ Dressing	☐ Shopping
☐ Medication management	☐ Finances
☐ Meal preparation	☐ Medical appointments
☐ Housekeeping	☐ Other:_____

☐ Requires total care

If assistance or total care is required, answer the following questions.

A3a. Is there adequate support or services in place to provide assistance?
☐ Yes
■ No

A3b. 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?

☐ Owns home/condo/mobile home	■ Acute rehabilitation center
☐ Rents apartment/house	■ Shelter
☐ Assisted living	☐ Correctional facility
☐ Public housing	■ Homeless
■ Long-term care facility (nursing home)	■ Adult family home/group home

Support System and Spirituality[1]

Complete for initial assessment and at least annually.

S1. What is the patient's relationship status?
- ☐ Single
- ☐ Domestic partner
- ☐ Married
- ☐ Widowed
- ☐ Divorced
- ☐ 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 himself or herself
- ☐ Talks to family
- ☐ Talks to friends
- ☐ Prays
- ☐ Talks 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 the patient 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 *(e.g., dietary restrictions, use of blood products, etc.)?*
■ Yes ☐ No

If yes, describe:

Cognitive Patterns and Cognitive Skills for Daily Decision Making[2]

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?[2]

Confusion assessment method

Behavior	Behavior not present	Behavior continuously present, does not fluctuate	Behavior present, fluctuates (comes and goes, changes in severity)
Inattention: Did the patient have difficulty focusing attention (easily distracted, out of touch or difficulty keeping track of what was said)?	☐	■	■
Disorganized thinking: Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas or unpredictable switching from subject to subject)?	☐	■	■
Altered level of consciousness: Did the patient have an altered level of consciousness (not related to low blood pressure)?	☐	■	■
Psychomotor retardation: Did the patient have an unusually decreased level of activity (sluggishness, staring into space, moving slowly)?	☐	■	■

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
If yes, describe: _____
_____

Mental Health Status

Complete for initial assessment only.

M1. Does the patient report any past or current mental health issues, concerns or mood disturbances (feelings of depression or anxiety)?

- [x] Yes
- [ ] No
- [ ] Unknown, reason: _____

M1a. If yes, describe:

_____

_____

_____

M2. Is there any history of mental health diagnosis?

☐ Yes ☐ No

M2a. If yes, answer the following:

Diagnosis	Approximate diagnosis date

M3. Has the patient participated in counseling?

- [ ] Yes, in the past
- [ ] Yes, currently participating
- [ ] No

M3a. If yes, how does the patient describe his or her counseling experience?

_____

_____

_____

M4. 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: _____

_____

_____

_____

_____

Complete for initial assessment only.

M5. 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

M5a. If yes, complete the following:

Drug	Current use	If currently using, frequency			
		Less than monthly	Monthly	Weekly	Daily or almost daily
	☐ Yes ☐ No	☐	☐	☐	☐
	☐ Yes ☐ No	☐	☐	☐	☐
	☐ Yes ☐ No	☐	☐	☐	☐
	☐ Yes ☐ No	☐	☐	☐	☐
	☐ Yes ☐ No	☐	☐	☐	☐
	☐ Yes ☐ No	☐	☐	☐	☐

M6. Has the patient ever received drug or alcohol treatment?
☐ Yes ☐ No

M6a. If yes, describe:

_____
_____
_____

M7. Ask the patient the following questions (AUDIT questions[5]).
☐ If unable to interview patient, specify reason: _____
_____

M7a. How often do you have a drink containing alcohol?
☐ Never
☐ Monthly or less
☐ Two to four times a month
■ Two to three times a week
■ Four or more times a week

M7b. How many drinks containing alcohol do you have on a typical day when you are drinking?
☐ N/A (never drinks)
☐ One or two
☐ Three or four
■ Five or six
■ Seven to nine
■ 10 or more

M7c. Has a relative, friend, doctor or another health worker been concerned about your drinking or suggested that you cut down?
☐ No/never drinks
☐ Yes, but not in the last year
■ Yes, during the last year

Complete for each assessment.

M8. Are there signs/symptoms present for depression or anxiety problems?

- ☒ Yes
- ☐ No

M8a. 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	☐	☐	☐	☐
Decreased interest/pleasure in most activities	☐	☐	☐	☐
A problem with appetite/weight change	☐	☐	☐	☐
Significant sleep disturbance	☐	☐	☐	☐
Psychomotor retardation or agitation	☐	☐	☐	☐
Fatigue, loss of energy	☐	☐	☐	☐
Feelings of worthlessness or guilt	☐	☐	☐	☐
Poor concentration	☐	☐	☐	☐
Suicidal ideation	☐	☐	☐	☐
Panic attacks	☐	☐	☐	☐
Irritable mood	☐	☐	☐	☐
Early awakening	☐	☐	☐	☐

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 initial assessment).

M9. Has the patient started taking a psychotropic medication?

☒ Yes
☐ No

M9a. If yes, list medication(s) and effectiveness per patient's report.

Name of medication and dosage	Date started	Effective	Not effective	Adverse reaction	Effectiveness not yet determined
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐

M10. Has the patient started counseling or a support group?

☐ Yes
☐ No

M10a. If yes, describe:

_____
_____
_____

Depression screening questions (PHQ-2)[6]

M11. Say to the patient: "Over the past 2 weeks, have you often been bothered by …"

	Yes	No
1. Little interest or pleasure in doing things?	☒	☐
2. Feeling down, depressed, or hopeless?	☒	☐

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

☐ If unable to interview patient, specify reason: _____
_____

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 and Level of Participation in Care

Complete for initial assessment only.

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

	Not able to understand	Limited understanding	Adequate understanding	Excellent understanding
Chronic kidney disease	☐	☐	☐	☐
Treatment options	☐	☐	☐	☐
Dialysis vascular access options	☐	☐	☐	☐

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	☐	☐	☐	☐	☐	☐
2. Complete the full-prescribed hemodialysis treatment time	☐	☐	☐	☐	☐	☐
3. Perform every peritoneal dialysis treatment	☐	☐	☐	☐	☐	☐
4. Take medications as prescribed	☐	☐	☐	☐	☐	☐
5. Follow dietary restrictions	☐	☐	☐	☐	☐	☐
6. Follow fluid restrictions	☐	☐	☐	☐	☐	☐

SM3a. For anything that was somewhat or very difficult, what would be helpful?

_____
_____
_____

SM4. How well-controlled is the patient's:

	Not controlled	Somewhat controlled	Controlled
Phosphorus level	☐	☐	☐
Fluid gains	☐	☐	☐
Blood sugar (if diabetic)	☐	☐	☐
Blood pressure	☐	☐	☐

SM5. Does the patient assist with self-care (putting in/taking out own needles, setting up machine, etc.).
- ☐ Not permitted in facility
- ☐ Yes
- ☐ No

SM6. What is the percentage of treatments missed in the last 30 days? (Disregard treatments missed due to hospitalization/travel or other situation in which treatment was received in another setting.)

Percentage: _____

SM7. What is the percentage of shortened treatments in the last 30 days?

Percentage: _____

SM8. Does the patient take responsibility for following his or her medication schedule?
- ☐ Yes
- ☐ No

SM8a. If no, check one of the following:
- ☐ Relies on caregiver/support partner to administer meds
- ■ Not interested
- ☐ Other: _____

SM9. Does the patient take responsibility for following dietary restrictions?
- ☐ Yes
- ☐ No

SM9a. If no, check one of the following:
- ☐ Relies on caregiver/support partner to monitor diet
- ■ Not interested
- ☐ Other: _____

SM10. Does patient appear comfortable asking staff/physician questions?
- ☐ Yes
- ■ No
- ☐ N/A

SM10a. 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:

_____
_____
_____

SM11. How does patient express concerns/complaints?

_____
_____
_____
_____
_____

Preferences in Home Dialysis[3]

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 peritoneal dialysis) 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 peritoneal dialysis) within the last 12 months?
- ☐ Yes
- ■ No
- ☐ Patient doesn't recall

HD3. Does the patient want to pursue home dialysis?
- ■ Yes
- ☐ No

HD3a. If 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[4]

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 why:
☐ 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 center's 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, e-mail)
☐ 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 _____

General Narrative Comments:

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 minimum data set (MDS), which can be located at: **www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp** 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, go to **www.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 at **www.homedialysis.org/files/pdf/pros/MatchD2007.pdf**)

[4]Taken with permission from 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 CMS, Department of Health and Human Services. Available at: **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 United Nations World 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**

[6]The Physicians Health Questionnaire (PHQ)-2 is derived from the 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 **www.depression-primarycare.org/clinicians/toolkits** or **www.phqscreeners.com**

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 and Medicaid Services, to go into effect **October 14, 2008**.

You can find the entire CfCs at:

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

To best stay informed and up-to-date about the new CfCs, we encourage you to be a national member of the CNSW. Go to **www.kidney.org** or call 800.622.9010 to join today!

www.kidney.org/professionals/pdf/cnswform.pdf