



National Kidney Foundation Council of Nephrology Social Workers

Comprehensive Interdisciplinary Patient Assessment (CIPA) Example Questions *Social Work Focused Criteria*

Introduction to the CIPA

The Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), published the Final Conditions for Coverage (CfC) for End-Stage Renal Disease (ESRD) Facilities on April 15th, 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, interdisciplinary patient assessment (CIPA). The CIPA replaces the requirement for individual assessments by each discipline (ref: § 494.80). The CIPA needs to be completed on the following schedule:

- The latter of 30 calendar days or 13 treatments beginning with the first outpatient dialysis session for all new patients, without regard to the modality of treatment. Patients changing modalities are also considered “new” patients.
- 3 months after the completion of the initial assessment and within 3 months for an established dialysis patient transferring from one dialysis facility to another
- At least annually for stable patients – due 12 months after the 3-month reassessment or 15 months after the patient’s admission to the facility
- At least monthly for unstable patients including, but not limited to patients with the following:
 - ✓ Extended or frequent hospitalizations- defined as a hospitalization greater than 15 days and/or more than three hospitalizations in a month
 - ✓ Marked deterioration in the health status;
 - ✓ Significant change in psychosocial needs, which includes any patient considered at risk for involuntary discharge or transfer; or
 - ✓ Concurrent poor nutritional status, unmanaged anemia, and inadequate dialysis.

In addition to the CIPA 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 CIPA 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 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 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 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 the 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 CfC 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, modify questions, or omit questions as clinically necessary.

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

- 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, (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 for referral to vocational and physical rehabilitation services

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 social worker should document the patient's refusal.

Assessment to Plan of Care

The CIPA 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 CIPA. 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
- And 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, the use of evidenced-based assessment tools, and the 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 CIPA. 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 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 information provided here.

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

Print 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?

___ / ___ / _____

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 type="checkbox"/>	<input checked="" type="checkbox"/>	Not able to communicate in English <i>Requires interpretation assistance at all times</i>
<input type="checkbox"/>	<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"/>	<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"/>	<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:

Complete for each assessment

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

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

<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:**

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
 Rents apt/house
 Assisted living
 Public housing
 Long-term care facility (nursing home)

Acute rehabilitation center
 Shelter
 Correctional facility
 Homeless
 Adult family home/group home

Support System & Spirituality¹

Complete for initial assessment and at least annually

S1. What is the patient's relationship status?

- Domestic partner Single
 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 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-making²

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

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. Inattention – 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. Disorganized thinking – 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. Altered level of consciousness – Did the patient have altered level of consciousness (not related to low blood pressure)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
d. Psychomotor retardation – 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. Does the patient report any past or current mental health issues, concerns, or mood disturbances (*feelings of depression or anxiety*)?

Yes No

Unknown – reason: _____

M1a. If YES, describe:

M2. Is there any history of mental health diagnosis?

Yes No

M2.a If YES, answer the following:

Diagnosis	Approximate Date of Diagnosis

M3. Has the patient participated in counseling?

Yes in the past

Currently in counseling

No

M3a. If YES or CURRENTLY in counseling, how does the patient describe his/her counseling experience?

Describe: _____

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
	<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"/>

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

M6a. If YES, describe:

M7. Ask the patient the following questions, (A.U.D.I.T Questions ⁵)
 If unable to interview patient, specify reason: _____

M7a. 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

M7b. 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

M7c. 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

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	<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)

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 & 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"/>

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

Yes No

M10a. If YES, describe:

Depression Screening Questions (PHQ-2) ⁶

M11. 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. How well controlled is the patient's:

	Not Controlled	Somewhat Controlled	Controlled
Phosphorus level	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Fluid gains	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Blood sugar (if diabetic)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Blood pressure	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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 where 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 their medication schedule?

- Yes
- No (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 (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 Dialysis³

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 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:

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 _____

- 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.
- 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/>.

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>

**To best stay informed and up-to-date about the new conditions,
we encourage you to be a national member of CNSW-
Go to www.kidney.org, or Call (800) 622-9010 to join today!**

<http://www.kidney.org/professionals/pdf/cnswform.pdf>