

# Patient Assessment and Patient Plan of Care: for Physicians and Nurses

Glenda M. Payne, RN, MS, CNN  
ESRD Technical Advisor  
CMS, Dallas & Atlanta

# Objectives for This Session:

- Describe the purposes of the **MAT**
- Demonstrate understanding of the expectations for physicians and nurses related to the requirements for the Conditions for Patient assessment & Patient plan of care

# ESRD Clinical Practice Standards

- Developed by renal community workgroups & coalitions; e.g.
  - National Kidney Foundation Kidney Disease Outcomes Quality Initiative (NKF KDOQI) Guidelines
  - National Quality Forum (NQF): Clinical Performance Measures (CPM)
- Address management of complications of ESRD

# Measures Assessment Tool (MAT)

- The MAT is a tool developed for ease of reference to these Clinical Practice Standards
- Deliberately developed the MAT for ease in updating
- If an individual patient does not meet a goal on the **MAT**, the plan FOR THAT ASPECT of care must be revised

# Patient Assessment and Patient Plan of Care

These 2 Conditions:

- Are interrelated (“can’t have one without the other”)
- Address patient assessment & care delivery requirements in “care areas” associated with complications of ESRD

# These Conditions Place High Expectations on Facilities for...

- **Interdisciplinary** approach for **continually** assessing **individual** patient's care needs, & for planning & implementing the care.
- Outcome goals that meet **current professionally-accepted clinical practice standards**

# Interdisciplinary Care vs. Multidisciplinary Care

<b>Interdisciplinary</b>	<b>Multidisciplinary</b>
Work collaboratively	Work sequentially
Communication by regular discussions about patient status & the evolving plan of care	Medical record is the chief means of communication

# The Interdisciplinary Team

Includes at a minimum:

- The patient or his/her chosen designee
- A registered nurse
- A physician treating the patient for ESRD
- A social worker
- A dietitian

Required for both:

- Patient assessment

## § 494.80 Patient Assessment

- The IDT must provide each patient an individualized comprehensive assessment
- 14 assessment “criteria”
- Initial comprehensive assessment completed w/in 30 days/13 tx
- Reassessment within 3 months
- “Unstable patients” require a comprehensive reassessment monthly
- “Stable patients” = reassess annually

## § 494.90 Patient Plan of Care

- The IDT must develop & implement a written, individualized comprehensive patient plan of care
  - POC is based upon the comprehensive assessment & addresses each patient's care needs
- Outcome goals in accordance with clinical practice standards: MAT
- Frequencies, revisions defined

## In Between Assessments...

Every patient must be continuously monitored. If a “stable” patient’s outcomes do not meet the care plan goals in an area, the facility must recognize and address *that aspect* by revising the plan of care for that aspect between comprehensive reassessments.

# Correlation of PA & POC

<b>PA</b>	<b>POC</b>
Current health status (V502) Lab profile (V505) Medication/immunization history (V506)	Incorporated into all POC tags
Appropriateness of dialysis prescription (V503)	Provide adequate clearance (V544)
BP/fluid management needs (V504)	Manage volume status (V543)
Assess anemia (V507)	Manage anemia (V547) Home pt ESA (V548) ESA response (V549)
Assess renal bone disease (V508)	Manage mineral metabolism (V546)

# Correlation of PA & POC

<b>PA</b>	<b>POC</b>
Nutritional status (V509)	Effective nutritional status (V545)
Psychosocial needs (V510)	Psychosocial counseling/referrals/ assessment tool (V552)
Evaluate family support (V514)	
Access type/maintenance (V511)	VA monitor/referral (V550) Monitor/prevent failure (V551)
Evaluate for self/home care (V512)	Home dialysis plan (V553)
Transplantation referral (V513)	Transplantation status: plan or why not (V554)
Evaluate current physical activity level & voc/physical rehab (V515)	Rehab status addressed (V555)

## For Each of the Care Areas

- IDT must assess each patient, develop & implement POC to achieve established targets
- Establish a goal based on current clinical practice standards-**MAT**
- If expected outcomes are not achieved in any area, IDT must recognize and address that aspect
- Adjust the plan/implement the changes

# Care Area: Health Status & Co-morbid Conditions Assessment

- Medical & nursing histories & physical exams
- APRN or PA may conduct medical areas of assessment if allowed by your state
- Must include etiology of kidney disease & listing of co-morbid conditions

Plan of care is addressed in other care areas

# Care Area: Blood Pressure & Fluid Management Assessment

- BP on & off dialysis
- Interdialytic fluid gains
- Intradialytic symptoms
- Expected target weight

# Blood Pressure & Fluid Management: POC

- Establish target weight
- Ongoing monitoring of interdialytic fluid gains, intradialytic fluid management & BP control-MAT
- Symptomatic drops in BP during treatment require plan revision
- Continued hypertension during dialysis requires plan revision



# Care Area: Immunization Management & Medication History

# Immunization Assessment

- IDT to evaluate the patient's immunization history/status for hepatitis , influenza, pneumococcus
- Know Hepatitis B status at admission, or treat as positive
- Tuberculosis screening
- Evaluate Anti-HBs on all vaccinees

# Medications Assessment

- Initial review of current medications & allergies
- Ongoing assessment of home medications

# Immunization: POC

## CDC recommendations for dialysis patients

- Be tested for at least once for baseline tuberculin skin test results, retest if exposure is suspected
- Be offered influenza & pneumococcal vaccines
- Vaccinate all susceptible patients for Hepatitis B

# Immunization POC

- Record of testing & immunizations
- Documentation of immunity or acknowledgement of absence of immunity
- Documentation of further action planned if required

# Care Area: Dialysis Access: Assessment

- Assessment for most appropriate access for the patient: AVF, AVG, CVC, PD catheter
- Must consider co-morbid conditions/risk factors, patient preference

# Dialysis Access: Assessment

- Evaluation for/of HD access:
  - Communication with radiologist, interventionalist, vascular surgeon as indicated
  - Venous mapping, vascular access surveillance, new access placement as indicated
- Evaluation of PD access
  - Absence of infection (exit site/tunnel, peritonitis)
  - Patency & function

# Dialysis Access: POC

In evaluation for access:

- Patient evaluation as candidate for AVF
  - If CVC >90 days, action plan for a more permanent vascular access or rationale for continued use
- Access sites chosen to preserve future sites, for long term patient survival
- Monitoring to ensure capacity to achieve & sustain adequate dialysis treatments

# Dialysis Access: POC

Evidence of:

- Vascular access surveillance
- Early detection of failure
- Timely referrals for interventions

# Care Area: Dialysis Adequacy: Assessment

In addition to the IDT comprehensive assessment of the adequacy of the patient's dialysis prescription, this regulation requires:

- HD patient- assess initially & monthly Kt/V (or equivalent measure, URR)
- PD patient- assess initially & at least every 4 months Kt/V (or equivalent measure, none currently)

# Adequacy: POC

Achievement of target:

- Kt/V of **at least** 1.2 (3 x/week HD; different for more frequent treatments) or
- 1.7 (PD) (MAT)
  - Alternative equivalent (URR for HD), currently none for PD

**OR**

# Adequacy: POC

- Modification of the dialysis prescription
  - HD: change dialyzer size, time on dialysis, BFR, DFR, type of access
  - Efficacy of the vascular access can also affect adequacy
  - PD: change number of exchanges, volume (ml), dialysate dextrose content (%), dwell time; consider membrane integrity, infections (peritonitis)

**OR**

- Rationale for not achieving the expected target

# Care Area: Anemia Management: Assessment

- IDT to evaluate the patient's laboratory values (Hct, Hgb, serum ferritin, transferrin saturation)
- Evaluate co-morbid conditions which might affect anemia management
- Evaluate for ESA &/or iron therapy

# Anemia Management: POC

- Hgb/Hct and iron studies must be reviewed at least monthly
- **MAT** specifies current clinical practice standards for Hgb, Hct, & iron studies
- Medication adjustment (may use algorithms/ESA protocols)
- Home patients: evaluate ESA administration & storage

# Care Area: CKD Mineral & Bone Disorder: Assessment

- IDT to evaluate the patient's laboratory values (calcium, phosphorous, PTH)
- Evaluate use of medications for management of bone disease (phosphate binders, vitamin D analogs, calcimimetic agents)
- Evaluate relevant dietary factors

## CKD-MBD: POC

- Calcium, phosphorus results reviewed at least monthly/PTH at least q 3 months
- MAT specifies targets for calcium, phosphorous & intact PTH
- Medication adjustment as indicated: may use guidelines/algorithms
- Dietary education/consultation as indicated

# Care Area: Modality Choice

## Assessment:

- Evaluate for self/home care
- Referral for transplantation

## Plan of Care

- Home care plan (or why not)
- Transplantation referral (or why not)

# Care Area: Functional Status

## Assessment:

- Evaluate current physical activity level & vocational and physical rehab

## Plan of Care:

- Address rehab status

# Timelines: All Began 10/14/08

## Initial comprehensive interdisciplinary assessments for new patients:

- PA=30 days/13 treatments whichever is later
- POC implemented within this same timeline

## Comprehensive reassessment for new patients:

- 3 months after initial assessment completed
- POC updated & implemented within 15 days of reassessment

# Then What?

- Stable patients = Annual comprehensive interdisciplinary reassessment
  - POC updated & implemented within 15 days
- Unstable patients = monthly comprehensive interdisciplinary reassessment
  - POC updated & implemented within 15 days
- All patients: Continuous monitoring = any aspect of care where the target is not met = revise that aspect of POC

# Who Is “Unstable?”

Includes but is not limited to:

- Extended (any stay >15 days) or frequent hospitalization (>3 hospitalizations in a month)
- Marked deterioration in health status
- Significant change in psychosocial needs
- **Concurrent** poor nutritional status, unmanaged anemia & inadequate dialysis

# What About Current Patients?

As of October 14, 2008:

- Have a plan to implement this new system
- Complete some assessments/POCs each month until all are done
- All current patients should be included in the new system by 10/14/09
- Three month reassessments for current patients are NOT expected
- Any aspect of care that does not meet targets must have an updated POC

# Questions?

[ESRDSurvey@cms.hhs.gov](mailto:ESRDSurvey@cms.hhs.gov)