



The 30-90 Day Period of Dialysis

By **Thomas Lepetich**, MSW, LCSW

Now that you have been a dialysis patient for 30 days, there are more requirements that you and the dialysis facility must fulfill, as stated by the federal government. The Centers for Medicare & Medicaid Services (CMS) guides both the facility and you, the patient, in what must happen to keep you safe and to help you have the best quality of life. This is done through a process called Conditions for Coverage (<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCletter09-01.pdf>).

Within the first 30 days or 13 treatments of you initiating outpatient dialysis, the interdisciplinary team (treating physician, registered nurse, dietician, social worker, and yourself or a designee) does an “individual” assessment of your medical, dialysis, nutritional, emotional and situational needs.

Compliance with this Condition is determined by observation of practices; interviews of patients, personnel and medical staff; and review of medical records.

INITIAL ASSESSMENT AND PLAN OF CARE: To be completed within 30 days of first treatment in unit.

90 DAY ASSESSMENT AND PLAN OF CARE: To be completed 90 days after Initial Assessment.

KDQOL: Quality of Life (QOL) survey due with 90 Day Assessment, then, completed yearly after that.

Dialysis is both life-saving and life-altering. It changes patients’ eating, sleeping, medication use and daily activities at home and in the community. Dialysis and associated symptoms can reduce the ability to work (50 percent of new patients each year are working-age). The degree of lifestyle change needed—following prescribed diet/fluid limits and medications and managing symptom burdens—depends considerably on the modality chosen and affects patients’ day-to-day health-related quality of life. Per the Centers for Disease Control and Prevention, health-related quality of life is the impact of a chronic disease and its treatment on patients’ perceptions of their own physical and mental function. Amongst people on dialysis, Kidney Dialysis Quality of Life scores are both a critical outcome and a predictor of hospitalization and death.

DEPRESSION SCREENING: Done after 90 days from first treatment in unit, then, completed yearly after that.

Depression is the most common psychiatric illness in patients with end-stage renal disease (ESRD). The reported prevalence of depression in dialysis population varied from 22.8 percent (interview-based diagnosis) to 39.3 percent (self- or clinician-

administered rating scales). Such differences were attributed to the overlapping symptoms of uremia and depression. Systemic review and meta-analysis of observational studies showed that depression was a significant predictor of mortality in dialysis population.

PAIN ASSESSMENT: Done after 90 days from first treatment in unit, and then, completed semi-annually after that.

Pain is one of the most common symptoms in patients with ESRD. Based on this fact, and the findings of other clinical studies, CMS identified a need to incorporate a measure that determines whether facilities regularly assess their patients' pain and whether they develop follow-up plans as necessary. CMS believes that a measure such as this offers the possibility of improving the health and well-being of patients with ESRD.

QOL/Depression/Pain: Together with your care team, your dialysis social worker uses the results of these instruments to form your Plan of Care. The goal of the plan is to address any negative responses that you have had to your dialysis regimen, as indicated by these surveys. Research has shown that patients with high Quality of Life scores and low depression/pain scores are more active and involved in their lives and medical treatments and stay out of the hospital more and live longer.

V500 § 494.80 Condition: Patient Assessment.

V501 The facility's interdisciplinary team, consists of, at a minimum, 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. The interdisciplinary team is responsible for providing each patient with an individualized and comprehensive assessment of his or her needs. The comprehensive assessment must be used to develop the patient's treatment plan and expectations for care.

("Interdisciplinary teams" work collaboratively with regular meetings to discuss patient status and the evolving plan of care. Working as a team allows for working toward common goals, pooling of expertise and a forum for problem solving.)

("Individualized" means each assessment is unique to a particular patient and addresses that patient's needs. "Comprehensive" means the assessment covers and addresses all issues that are

actionable by the dialysis facility; this could include referrals to specialists for assessments that are beyond the capacity of a dialysis facility.)

V502 (a) Standard: Assessment criteria. The patient's comprehensive assessment must include, but is not limited to, the following: (1) Evaluation of current health status and medical condition, including co-morbid conditions.

V503 (2) Evaluation of the appropriateness of the dialysis prescription,

(A hemodialysis (HD) prescription includes the number of treatments per week, length of treatment time, the dialyzer, specific parameters of the dialysis delivery system (e.g., electrolyte composition of the dialysate, blood flow rate, dialysate flow rate), anticoagulation and the patient's target weight. An appropriate HD prescription is individualized to meet the dialysis needs of the patient.)

(A peritoneal dialysis (PD) prescription must take into consideration the peritoneal transport rate determined by peritoneal equilibration testing [PET], residual renal function, total body surface area, certain medical conditions and personal preference. The PD prescription includes the number of exchanges or cycles to be done each day, the volume of fluid to be used with each exchange, whether fluid is always present in the peritoneal cavity (except for brief periods between draining and reinfusion of dialysate), and the concentration of glucose or other osmotic agent to be used for fluid removal (which may vary according to a prescribed sliding scale.)

V504 Blood pressure, and fluid management needs.

Because of the adverse effects of ESRD, many patients experience dramatic changes of blood pressure and fluid management, the management of which may require reassessment of medication needs, adjustments in target weight and changes to the plan of care (POC).

V505 (3) Laboratory profile.

Laboratory work-up should include, but not be limited to, comprehensive metabolic testing, dialysis adequacy, complete blood count, iron studies and screening for the Hepatitis B virus.

V506 Immunization history and medication history.

“Immunization history” should include whether the patient has received standard immunizations (pneumococcal, hepatitis and influenza) and has been screened for tuberculosis. The immunization record is expected to include at least the patient’s immunization history as of the effective date of this regulation.

V507 (4) 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).

V508 (5) Evaluation of factors associated with renal bone disease.

(Disturbances in mineral and bone metabolism are common in patients with ESRD, often resulting in hyperparathyroidism and chronic kidney disease (CKD) mineral and bone disorder if not managed effectively.)

V509 (6) Evaluation of nutritional status by a dietitian.

V510 (7) Evaluation of psychosocial needs by a social worker.

V511 (8) Evaluation of dialysis access type and maintenance (for example, arteriovenous fistulas, arteriovenous grafts and peritoneal catheters).

The efficacy of the HD patient’s vascular access and the PD patient’s peritoneal catheter correlates to the quality (adequacy) of their dialysis treatments and is of vital importance to their overall health status.

V512 (9) Evaluation of the patient’s abilities, interests, preferences and goals. This includes 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.

V513 (10) 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 non-referral must be documented in the patient’s medical record.

V514 (11) Evaluation of family and other support systems.

V515 (12) Evaluation of current patient physical activity level.

V515 (13) Evaluation for referral to vocational and physical rehabilitation services.

Vocational rehabilitation referrals may be appropriate for older youth and adult patients who desire to return to work and/or improve independent living skills.

V516 (b) Standard: Frequency of assessment for patients admitted to the dialysis facility. (1) An initial comprehensive assessment must be conducted on all new patients (that is, all admissions to a dialysis facility), within the latter of 30 calendar days or 13 hemodialysis sessions beginning with the first dialysis session.

V517 (2) A follow-up comprehensive reassessment must occur within three months after the completion of the initial assessment to provide information to adjust the patient’s plan of care specified in § 494.90.

Patients new to dialysis and/or a new dialysis setting frequently need time to adjust and adapt to the treatment. The three-month comprehensive reassessment enables the interdisciplinary team (IDT) to re-evaluate how well patients follow their treatment plan; their educational, psychosocial, rehabilitation and nutritional needs; their current adjustment to the dialysis regimen and coping; and the accuracy and appropriateness of patients’ plans of care.

V518 (c) Standard: Assessment of treatment prescription. The adequacy of the patient’s dialysis prescription, as described in § 494.90(a)(1), must be assessed on an ongoing basis as follows: (1) Hemodialysis patients. At least monthly by calculating delivered Kt/V or an equivalent measure. (2) Peritoneal dialysis patients. At least every four months by calculating delivered weekly Kt/V or an equivalent measure.

V519 (d) Standard: Patient reassessment. In accordance with the standards specified in paragraphs (a)(1) through (a)(13) of this section, a comprehensive reassessment of each patient and a revision of the plan of care must be conducted—(1) At least annually for stable patients; and

V520 (2) At least monthly for unstable patients including, but not limited to, patients with the following: (i) Extended or frequent hospitalizations; (ii) Marked deterioration in health status; (iii) Significant change in psychosocial needs; or (iv) Concurrent poor nutritional status, unmanaged anemia and inadequate dialysis.

V540 § 494.90 Condition: Patient plan of care.

The Condition is directly related to the Condition for Patient assessment, as the plan of care is built upon the patient assessment. The individual plan of care is revised after each patient assessment, and portions of the plan of care must be updated if the target goals for each area are not achieved or not sustained.

The concept of patient-centered care has gained increasing prominence in recent years as a key aim of the U.S. health care system. Patient and family engagement offers a promising pathway toward better quality health care, more efficient care and improved population health.

YOU know how you feel and what you need better than anyone else. Attending Plan of Care meetings empowers YOU and your family to help make decisions about your care. When you understand all of your choices, YOU have more control over your own health.

V541 The interdisciplinary team as defined at § 494.80 must develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient's needs, as identified by the comprehensive assessment and changes in the patient's condition, and must include measurable and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the patient plan of care must be consistent with current evidence-based professionally-accepted clinical practice standards.

V556 (b) Standard: Implementation of the patient plan of care. (1) The patient's plan of care must (i) Be completed by the interdisciplinary team, including the patient if the patient desires; and (ii) Be signed by the team members, including the patient or the patient's designee; or, if the patient chooses not to sign the plan of care, this choice must be documented on the plan of care, along with the reason the signature was not provided.

V557 (2) Implementation of the initial plan of care must begin within the latter of 30 calendar days after admission to the

dialysis facility or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session.

V558 Implementation of monthly or annual updates of the plan of care must be performed within 15 days of the completion of the additional patient assessments specified in § 494.80(d).

V560 (4) The dialysis facility must ensure that all dialysis patients are seen by a physician, nurse practitioner, clinical nurse specialist or physician's assistant providing ESRD care at least monthly, as evidenced by a monthly progress note placed in the medical record, and periodically while the hemodialysis patient is receiving in-facility dialysis.

V561 (c) Standard: Transplantation referral tracking. The interdisciplinary team must (1) Track the results of each kidney transplant center referral, (2) Monitor the status of any facility patients who are on the transplant wait list and (3) Communicate with the transplant center regarding patient transplant status at least annually and when there is a change in transplant candidate status.

Requiring the facility to track patients' transplant referrals and their status on the transplant wait list is intended to enhance the communication and coordination between the transplant center and the dialysis facility so that patients do not get "lost" along the way in the transplant referral, work up and waiting period.

V562 (d) Standard: Patient education and training. The patient care plan must include, as applicable, education and training for patients and family members or caregivers or both, in aspects of the dialysis experience, dialysis management, infection prevention and personal care, home dialysis and self-care, quality of life, rehabilitation, transplantation, and the benefits and risks of various vascular access types.

The dialysis facility must provide patients and their family members/caregivers with education and training in these listed areas, at a minimum.

Out of all the deaths experienced by patients in the first year of dialysis, 40 percent occur within the first 90 days. You and your family's input and participation are the most important things you can do for your health. With everyone working together on The Assessment and Plan of Care, they can become your roadmap to obtain the most beneficial results from your dialysis regimen. ■