

Patient Assessment & Plan of Care Report Frequently Asked Questions & Answers (Q&A)



Q: Does Spectra’s Patient Assessment and Plan of Care report meet all of the requirements set forth by the Centers for Medicare and Medicaid Services (CMS)¹?

A: Designed with the new CMS guidelines in mind, Spectra’s Patient Assessment and Plan of Care report is one tool you can use to assist with the implementation of the new CMS requirements. The report provides:

- Initial/monthly assessment
- Comprehensive patient assessment
- Patient–centric plan of care

Q: Is the Patient Assessment and Plan of Care report designed for both in-center and home dialysis patients?

A: Yes. CMS requires that an assessment and plan of care be completed for both in-center and home dialysis patients. Spectra’s Patient Assessment and Plan of Care report is designed with these patients in mind.

Q: What information is included in the report?

A: The report is an eleven page interdisciplinary document, which consists of the following information:

- Page 1 - basic patient information, current status, patient complaints, physical assessment and vital signs
- Page 2 - cardiovascular, blood pressure, and fluid management
- Page 3 - lipids and anemia
- Page 4 - bone health and nutrition
- Page 5 - diabetic management and comprehensive foot exam
- Page 6 - dialysis adequacy and vascular access
- Page 7 - infections and health maintenance (vaccinations)
- Page 8 - psychosocial
- Page 9 - patient education, transplant status, disaster plan and medication review
- Page 10 - advanced directives and patient goals
- Page 11 - interdisciplinary team member notes and signatures

NOTE: In each instance where laboratory values are important to the assessment/plan of care process, Spectra’s report includes relevant laboratory values.

Q: What data will be populated on the reports?

A: The report will include patient name, patient ID and relevant laboratory test results.

Q: What lab results will be included in the report?

A: The following tests are included:

- Lipids – LDL, HDL, Triglycerides, Cholesterol
- Anemia – Hgb, Transferrin Saturation, Ferritin
- Bone Health – Calcium, Phosphorus, Intact-PTH
- Nutrition – Albumin, Potassium
- Diabetes – HgbA1c
- Hemodialysis Adequacy – URR, Kt/V, Bicarbonate
- Peritoneal Dialysis Adequacy – Kt/V, Drain Volume, Residual Urine
- Hepatitis – HBsAb, HBsAg, HBcAb

Q: How many draws will be displayed in the report?

A: The report will contain up to *six* of the most recent results that occurred during a three month period. The three month period is based on the month that is selected when running the report.

Example: Albumin drawn monthly will have three results. Ca drawn twice a month will have six results. Hgb drawn weekly will have the last six results. PTH drawn quarterly will have one result.

Q: When completing a monthly assessment and plan of care for my unstable patients, do I need to complete all eleven pages of report?

A: A monthly assessment and plan of care is required for all unstable patients. You only need to complete the sections of the report that address the patient's unstable condition.

Example: The patient has presented an unstable condition regarding bone management. All other aspects of the patient's condition are stable. To complete the plan of care, print and complete page 1 (basic assessment), page 4 (bone health) and page 11 (interdisciplinary team member notes and signatures).

Q: How often do I need to complete an assessment and plan of care on my patients?

A: The frequency and timing of an assessment and plan of care are specific to each patient and depend on a variety of circumstances, including whether the patient is a new or continuing patient or whether the patient is stable or unstable. To learn more about the requirements for completing a patient assessment and plan of care, refer to the Centers for Medicare and Medicaid Services guidelines¹ available at:

<http://www.cms.hhs.gov/cfcsandcops/downloads/esrdfinalrule0415.pdf>

Q: Will the report include the current month's laboratory data?

A: Yes. Laboratory data is refreshed daily. The report will contain up to *six* of the most recent results that occurred during a three month period. The three month period is based on the month that is selected when running the report.

Q: Can I edit the report?

A: Yes. You can export the report to Microsoft® Word or Excel for editing purposes.

Q: Who can access and retrieve the Patient Assessment and Plan of Care report?

A: Your facility can designate the individuals who will have user access to the report.

Q: Is there a limit to how many users can have access to the reports per facility?

A: There is no limit to the number of users for each facility; however, each user will need to obtain a unique user ID and password from Spectra with an approval signature from the facility manager.

Q: How do I gain access to the report?

A: To obtain access, contact Spectra's Customer Service department:
800.433.3773 (Milpitas, CA)
800.522.4662 (Rockleigh, NJ)
You will be asked to complete and submit a User Request Form to Customer Service for your facility. Upon receipt of your User Request Form, Spectra will provide each user a unique user ID and password.

Q: Who do I contact if I forget my password?

A: You may contact Spectra's Technical Support department:
800.433.3773 (Milpitas, CA)
800.522.4662 (Rockleigh, NJ)

Q: Who do I contact if I require technical assistance or have questions on how to use the report?

A: If you require technical assistance or have questions on how to use the report, please contact Spectra's Technical Support department:

800.433.3773 (Milpitas, CA)

800.522.4662 (Rockleigh, NJ)

- 1 U.S. Department of Health and Human Services. Centers for Medicare and Medicaid Services. 2008; Medicare and Medicaid Programs: Conditions for Coverage for End-Stage Renal Disease Facilities. 42 CFR Parts 405, 410, 413, 414, 488, and 494. Available at <http://www.cms.hhs.gov/cfcsandcops/downloads/esrdfinalrule0415.pdf>.



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