

Network Notes

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Network of New England
30 Hazel Terrace
Woodbridge, CT 06525
Ph: 203-387-9332
Fax: 203-389-9902
www.networkofnewengland.org

Progress on the Fistula First Project

National Vascular Access Improvement Initiative

Network of New England launched our six-state regional effort "Fistula First" vascular access improvement initiative in December 2003. Progress has been made on the development of a new database. This is a source of information developed for the purpose of direct

communication with vascular surgeons in New England. The new computerized system will enable Network educational, informational materials and comparative data reports to flow to surgeons likely to place vascular access in CKD patients. We are now on

the road to an established ongoing exchange on information with the doctors who can help us improve the rate of fistulas in New England renal patients...do you know doctors or renal professionals who should receive this information? If so, please let us know.

Fistula Success!

Do you have a fistula success story or a best practice model to share with others? We are looking for New England success stories that will help your renal colleagues to increase the number of fistulas in

their patient census. What has worked for you? How have you educated patients and staff about the benefits of fistula use? What can facilities do to decrease dependence on catheters and grafts? If you have

answers to these questions, let us know! We would like to highlight your AV Fistula success story in our next newsletter and present a storyboard to Medicare (CMS).

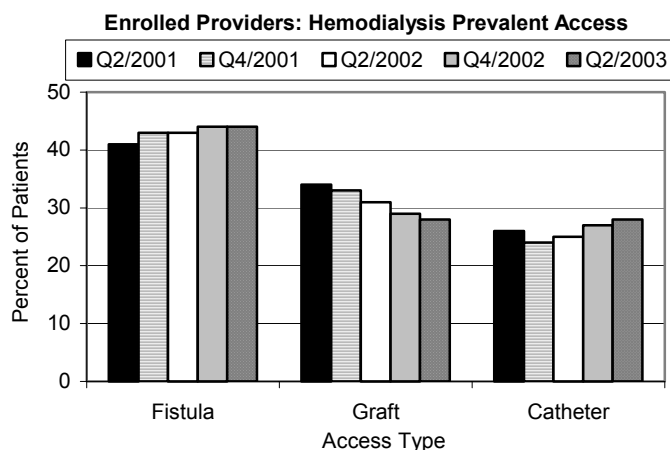
New England Snapshot: Vascular Access Data Update

Timely placement of reliable permanent vascular access is essential for hemodialysis adequacy. The K-DOQI clinical practice guidelines have emphasized the use of native anterior-venous (AV) fistula as the preferred access to decrease costly interventions and reduce access failure rates. A primary AV fistula should be the first "access of choice" placed in 50% of all new patients initiating hemodialysis, with a goal of 40% AV fistula rate in the prevalence population. The figure below shows percent (rate) of access types used by New England dialysis patients, Q2/2003 being the most recent data available. We notice AV fistula rates

in New England have remained relatively constant over the past two years.

While slight improvement has occurred since announcement of the CMS

"Fistula First" program, opportunity for improvement is evident. We are seeking higher rates of AV fistula usage, and decreased rates of catheter use for New England patients.



National Kidney Foundation Brochure

On Patients' Rights and Responsibilities Available

The National Kidney Foundation (NKF) announced availability of the long-awaited brochure entitled "Dialysis Patients' Bill of Rights and Responsibilities." The 11 page publication is available to patients, care providers and the general public by visiting

the NKF website - <http://www.kidney.org> or by calling their toll free number 800-622-9010. Most dialysis corporations and non-profit organizations providing care or service to renal patients have developed similar

documents, however this is the first such brochure from the NKF. The brochure for dialysis patients contains a list of 18 rights a dialysis patient is entitled to, along with 6 important responsibilities patients should strive to uphold.



NKF / KDOQI Nutritional Counseling and Follow-Up *

Joel D. Kopple, MD, FACP
K/DOQI Nutrition Work Group Chair

NKF-KDOQI Nutritional Guideline 18 contains the following recommendations for ESRD (CKD) patients:

RATIONALE

The high incidence of PEM and the strong association between measures of malnutrition and mortality rate in individuals undergoing MD suggests the need for careful nutritional monitoring and treatment of these individuals. Whether or not such intervention prevents or improves nutritional status has not been examined, but evidence clearly suggests that inadequate nutritional intake is an important contributor for PEM in these patients. Moreover, evidence from large multicenter trials utilizing nutrition intervention indicates that frequent nutrition counseling results in compliance with the intervention and improved outcomes. Although similar studies have not been performed in MD patients, it is reasonable to assume that similar results would occur with the ESRD patient population.

The dietitian-performed nutrition assessment includes the development of a plan of care that incorporates all aspects of the nutrition evaluation (nutritional status assessment, nutrition history, patient preferences, and the

GUIDELINE

Intensive Nutritional Counseling With Maintenance Dialysis (MD)

Every MD patient should receive intensive nutritional counseling based on an individualized plan of care developed before or at the time of commencement of MD therapy. (*Opinion*)

- during the early phase of MD care and modified frequently based on the patient's medical and social conditions.
- every 1 to 2 months and more frequently if inadequate nutrition intake or malnutrition is present or if adverse events or illness occurs that may cause deterioration in nutritional status.

nutritional prescription). These are incorporated into an active plan that is then implemented by the medical team. This care plan should be updated on a quarterly basis. The nutrition care plan should be incorporated into a continuous quality improvement plan. This plan of care should be implemented and reviewed in a multidisciplinary fashion that includes the patient and/or caregiver

(often the patient's spouse) and the physician, nurse, social worker, and dietitian. Conditions in which the patient's nutritional status may deteriorate rapidly may dictate more frequent evaluation of the nutrition care plan. Examples of such conditions are unexplained reductions in energy or protein intake, depression, deterioration in other measures of protein-energy status, pregnancy, acute inflammatory or

catabolic illnesses particularly in the elderly, hospitalization, diabetes mellitus, large or prolonged doses of glucocorticoid or other catabolic medications, and post-renal transplant allograft loss. Under these circumstances, monthly or weekly updates to the nutrition plan of care and more intensive nutrition counseling may be necessary.

* This article was reprinted with permission.

Data Questions and Answers

We often get questions in the Network office about how to fill out dialysis paperwork. It can be very confusing! Recently we talked to a dialysis staff person who inquired about when and how to file a **supplement** to the original Medical Evidence Report "2728." Her questions were; "when should I file one and what should be on it?"

This was our answer to her questions: First, a Supplemental 2728 is completed only in instances when a change has occurred in modality during the first ninety days of treatment: when a patient begins as a hemodialysis patient, but then changes to any self care modality, CCPD, CAPD, IPD, Home Hemo or kidney transplant. The data manager at the

facility would send a Supplemental 2728 to the Network in a case such as this. On the new form the word **SUPPLEMENTAL** would be written in large dark letters at the top right corner. The patient information section would be completed and the modality selection of the form would be completed to show the appropriate change. The patient and

the physician should both sign the new form and it should be sent to the Network office.

If you have data questions, please call 203-387-9332 and ask to speak with a member of our data team, we're here to help you!

The Importance of Testing for Total Chlorine

Many municipal water treatment systems add chlorine and chloramines as part of their disinfection process. Even if chloramines are not normally present in the water supply, chloramines can form naturally from chlorine combining with ammonia from decomposing vegetation. Chloramine may also be added periodically to the source water especially if those municipal suppliers are using surface water. In drinking water these additives allow us to drink water with minimal risk of becoming ill from a parasite or pathogenic bacteria. In the hemodialysis setting, both chemicals, if not removed prior to the RO system, will damage the thin film membrane. Even a short exposure to chlorine/chloramines will cause hemolysis of the patient's blood. Carbon filtration will remove both chlorine and chloramines. Two or more carbon tanks are generally placed before the R/O or D/I tanks. When the feed water passes through granular activated carbon tanks that allow at least 10 minutes of empty

bed contact time, chlorine and chloramines become absorbed into the pores of the carbon. A test for total chlorine, which tests for both "free" chlorine and "combined" chlorine or chloramine, should be performed on fresh effluent exiting the first carbon tank every day and preferably prior to every patient shift. AAMI maximum allowable limits for "Total Chlorine" is 0.1mg/L. The amount of chlorine/chloramines added to municipal water can vary from day to day and even hour-to-hour depending on the time of the year and the conditions of the water. It is always a good policy to maintain a relationship with the dialysis unit's water supplier. Most municipal water treatment suppliers will keep the dialysis facility advised of any changes in the water treatment ahead of time. The Network often receives notices from municipal water suppliers of changes in the water treatment so that we can work with them to notify the affected facilities. Dialysis facilities want to be assured that they have sufficient time to make any changes in their carbon tanks if



necessary when notified that chloramines will be added by their water supplier. Again, testing for free chlorine, prior to each patient shift to make sure the levels are 0.1 mg/L or less, will protect the patient from exposure.

Source: Excerpt from "Water Treatment for Hemodialysis, Including the Latest AAMI Standards" article written by Rebecca Amato. Nephrology Nursing Journal Dec 2001, vol.28 no. 6

Save This Date

**October 14, 2004
8:45 AM - 3:30 PM
Sturbridge, MA**

16th Annual Network of New England Education Meeting

The meeting will be held at the Sturbridge Host Hotel and Conference Center located on picturesque Cedar Lake in Sturbridge, MA. This venue has a large hall for displaying posters and exhibits in one area where participants will also be able to enjoy refreshments. In addition to the 12,000 square foot Exhibit Hall for the educational sessions, lunch will be served in the Grand Ballroom.

There is adequate parking for all attendees, and we have a range of hotels in the area to fit your budget. Registration brochures will be mailed in July, so please plan your time and registration fees now.

Network Grievance Notice Displayed?

The ESRD Network of New England is responsible under Centers for Medicare and Medicaid Services (CMS) contractual authority to receive and resolve patient complaints and grievances. Patients with complaints should first seek remedy with staff at their

provider, however there are occasions when patients prefer assistance from an outside entity. For more detailed information about the Network grievance process visit our website at <http://www.networkofnewengland.org>. All dialysis clinics and transplant

centers in New England should display the Network Grievance Policy Notification laminated card in the patient waiting area. State Surveyors usually look for the Network notification and could cite your facility if it is not displayed. Do you have

your notice posted? Do you need it in Spanish or another language? Would you like a second copy? If so, call or e-mail the Network office and request a Network Grievance laminated notice today.

POSTERS WANTED!

We want your poster/storyboards for CQI projects at **YOUR** facility. If you would like to display your project at the Network Annual Meeting in October, contact the Network office for a submission form 203-387-9332.

CMS Pushes Networks and Providers Toward: More Uniform Data Submission!

It's all in the data. You have heard it from your company, professional organizations, quality experts and now Medicare (CMS); the first step in quality improvement is looking at the data for trends. Reliable data can show us where we are doing well and where there is room for improvement. Under CMS requirements Networks must verify with

dialysis providers patient events (monthly activity: i.e. new start, transfer, discharge and death) for ESRD Medicare beneficiaries as a part of the ESRD Patient Registry and tracking system (VISION).

In an effort to streamline Network data collection processes a standardized form has been developed

for reporting patient activity each month. As of April 1st all Networks will begin using the standardized monthly patient event tracking form. Before April 1st you will receive the new form and information about how to fill it out. When your packet is received, please review carefully and call the Network office to speak with Jaya or Karen if you have questions.

End Stage Renal Disease Network of New England

30 Hazel Terrace
Woodbridge, CT 06525

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Roberta Bachelder.....Editor
Danielle Besnoff.....Designer