NETWORK 13 NEWSLETTER

NEWS YOU CAN USE...

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Involuntary Discharge: When Is It Appropriate and When Is It Not?

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Dialysis staff and management are increasingly facing challenging situations with patients that are leading to difficult choices being made regarding continued care to those patients. Involuntary discharges are occurring with patients as a result, some are justified and some are not. When is an involuntary discharge appropriate and when is it not? What steps need to be taken prior to an involuntary discharge? The Centers for Medicare & Medicaid Services (CMS) and the dialysis community identified involuntary discharge as a concern. In October 2003 a National Consensus Conference was held and the Dialysis Patient-Provider Conflict (DPC) toolkit was created. (Http://www.esrdnetworks.org/dpc.htm)

Managing Challenging Situations:

Challenging situations occur when needs or expectations are not being met. Few of these situations occur in isolation but are a culmination of past interactions, behaviors and expectations that have not been consistently addressed. Management of challenging situations occurs from the very start of a patient's introduction to the dialysis facility. The facility staff needs to be very clear about the rules, policies and procedures, expected behavior, patients' rights and responsibilities and the complaint process. The review of this information needs to occur when the patient is cognizant enough to process the information; not just at admission and reviewed annually. All staff should be trained during their orientation and annually in some type of conflict resolution model such as DPC. The staff needs to provide a consistent message about behavioral expectations with all patients. Patients are aware of the inconsistencies that occur. They gain more insight about a facility's operations by observing how the staff interact with patients, their professionalism and how they respond to request and concerns, than by what is written. The culture and tone of a facility will influence how a patient interacts with the staff. How and if a concern or complaint is addressed will influence future interactions between patients and staff.

When issues do arise with patients they must be addressed at that time. If the staff does not take the time to address the issue, the message received by the patient is their needs or concerns are not considered important by the staff. The patient is faced with several choices when faced with this response. The patient may decide not to voice their concerns and issues and bottle up their emotions until the time comes when they have had enough and a confrontation results. The patient may choose to withdraw and may begin to miss and shorten treatments, negatively impacting their health and the facility's outcomes. Another choice is the patient may feel they must amplify their need to be heard and engage in behavior that will force the staff to address them. Unfortunately, none of these outcomes benefits the patient or staff. It creates distance and allows for the labeling of the patient as disruptive or non-adherent. These labels follow the patient and can unfairly influence other healthcare providers in determining their ability to provide care for the patient. It is pertinent that more patients are actively involved in their care planning. Patient education is a tool that can assist both patients and staff in addressing concerns expressed by patients. The more educated the patient is about their care, the more responsive they can be to their own needs, and the greater understanding they have about what is occurring to them.

Identify Barriers:

It is important that staff take the time to dialogue with patients to identify the barriers present that contribute to the challenging situations. It is a detriment to the staff and patient to assume what the barriers are. Some of the barriers to explore are substance abuse, mental health issues, (particularly the influence of depression), changes in availability or reliability of transportation, loss of benefits, changing family obligations, changes in medical conditions, changes in employment obligations and end of life issues. Until the barriers are identified, movement towards resolution and improvement in care cannot take place. It takes investment in the patient to have the dialog necessary to uncover the potential barriers influencing the challenging situation.

Making Improvement:

After the barriers have been identified, improvements can be made. Goals need to be small, accomplishable, and shared by patient and staff. Patients can build on successes with the support of the staff. Communications and relationships can improve when the focus is on making positive progress; a win-win situation.

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What's in This Issue:

If All Efforts Fail:
The facility and nephrologist need to thoroughly document the challenging situation and all efforts made to address and resolve the situation. All efforts to alleviate the challenging situation should be exhausted and all referrals for assistance attempted before an involuntary discharge occurs. Consultation with the Network will assist in exploring potential solutions and referrals.

Transfer:
Facilities, whether in large or small dialysis organizations, must not ban patients from their other facilities and should attempt to establish intra-organization placement of patients, as some behaviors can be eliminated by a change in environment and establishment of new relationships with staff at another facility. A new facility may be a better fit for a patient. The only exception to this recommendation is for a patient with a history of physical violence.

In the event of a transfer to another facility, the patient must be given the right to review the documentation to be forwarded to the facility. It is inappropriate to have a patient sign a release of information consent without identifying what records will be dispersed. The patient has a right to submit a statement to be included in the records to be transferred if they disagree with what is written in their record.

It is the position of the DPC Task Force that terminating the patient/provider relationship on the basis of behaviors that place *only the patient at risk* is unjustified. In the limited instances where the behaviors are so pervasive as to create significant *financial &/or operational risk to the facility*, consideration could be given to employing an approach wherein the "privilege" of a regular outpatient appointment slot is withdrawn after advance notice and informed consent. Then the patient can be assigned to dialysis by vacancies that arise when other patients are hospitalized, absent or dialyzing elsewhere. This approach may be successful in continuing to offer dialysis and provide appropriate support services while allowing regular assignments to adherent patients, and eliminating the financial burden of repetitive "no-show" behavior. In such a treatment plan, if the patient demonstrates compliance with regular treatment, a regular slot can be offered when available and a treatment contract employed. If the patient is in emergent need of dialysis when no spot is available, the patient would be directed to the Emergency Room.

Nephrologist's Role in Discharge of a Patient:
Physicians are not obligated to accept any patient. Physicians have no legal or ethical obligation to continue a relationship with an uncooperative patient. However, once a relationship has been established between the physician and patient, a legal and ethical obligation exists to continue that relationship until it is formally terminated or until the patient voluntarily withdraws from care. These ethical obligations are not absolute and providers should clearly consider the safety and well being of others when weighing this decision. A physician may not abandon his/her patient. The physician must give notice (a minimum of 30 days) and the patient must have an ample opportunity to secure another physician. It is the responsibility of the physician, not the dialysis facility staff, to assist with the transfer of the patient to a new physician. In cases when no other nephrologist either practices in the geographic area where the patient is treated or no other nephrologist will accept the patient, the physician has a duty not to abandon his/her patients.

Facility's Role in Discharge of a Patient:
The facility must **actively** be involved in the transfer process of the patient and all attempts to assist with a transfer need to be documented and include the results. The facility is required by CMS regulation to transfer basic records within one business day. The facility must continue to assist in identifying resources available to the patient to assist in an orderly transfer.

Involuntary discharge should be the action of last resort taken with a patient. It is never appropriate to be utilized for a non-adherent patient who has the right to determine their consent or refusal of medical treatment and whose choices place only them at risk. Facility staff have an obligation to be trained in a conflict model, such as DPC, so they have the skills and knowledge to effectively address challenging situations and to work in conjunction with the patient to resolve these situations so the needs of both the patient and facility can be mutually met. Investment of time in forming mutually beneficial relationships with patients and being responsive to concerns will pay dividends by minimizing the time utilized in the management of challenging situations.

If an involuntary discharge is required, all efforts need to be made to ensure the facility staff and physician are actively involved in assisting the patient in transferring their care to another health care team. It takes time and investment to eliminate challenging situations and involuntary discharges. The effort is worth it in lives saved and improved outcomes. □

Disaster Preparedness Planning Resource: 2006

All ESRD facilities are required to develop policies and procedures for emergency/disaster preparedness. To meet the unique needs of ESRD patients and providers and to minimize the effects of an emergency, one must plan ahead to be prepared BEFORE an emergency strikes.

Federal guidelines [subpart U Section 405.2140(d), Section 405.2160 (A), and Section 405.2139 (b)] emphasize that policies must be written, drills be conducted (at least annually), and that staff and patients be trained in emergency procedures. Patients who are undergoing dialysis must be aware of procedures for disconnecting themselves from the dialysis equipment in case of fire or other natural disaster. Drills are essential in maintaining assurance that responses will be automatic when an emergency does occur. Because of the nature of the

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ESRD patients being artificially restrained by means of the dialysis mechanism, certain facility requirements for drills are pertinent. Drills are to test the efficiency, knowledge, and response of personnel. The regulatory requirement is that procedure for different types of emergencies be tested annually. Supplemental training and drills are encouraged.

It is strongly recommended that consideration be given to establishing a local affiliation (back-up unit), as well as a distant affiliation (back-up unit), in the event that a catastrophic event affects a broad area. This may not be as critical for corporate dialysis facilities, but it is paramount with independent dialysis facilities. It is important to realize that just because your facility is not considered at risk during a disaster or emergency, your proximity to facilities that can or are affected could affect your operations if the impaired facility needs to transfer patients.

Network 13's Facility Information Handbook: http://www.network13.org/disaster.asp has tools that can assist your facility in preparing for disasters. An updated CD version of the Facility Information Handbook will be coming to your facility soon. ☐

BE ALERT: Changes are Coming with Regards to Network 13's Standards and Recommendations of Care

The Network standards and recommendations are currently under review for potential revision and will be distributed shortly. Until then, the current standards and recommendation are in effect. Here is a glimpse of some of the proposed revisions or new standards/ recommendations.

Adequacy of Hemodialysis (Revised Standard)
The dialysis prescription should specify the parameters of the hemodialysis calculated to achieve a URR $\geq$ 65% (Kt/V $\geq$ 1.4) and confirm that adequate dialysis is being delivered at least monthly. The Network 13 performance target is to strive to attain and maintain 90% of incenter HD patients with URR $\geq$ 65%, or 94% of incenter HD with Kt/V $\geq$ 1.3.

Performance of Delivery of Care Audits (New Standard)
Network 13's Performance of Delivery of Care Audits states, "Each dialysis facility should be routinely monitoring their performance of delivery of care specific to prescriptions and/or protocols addressing adequacy of hemodialysis (HD) utilizing delivery of care audits". All (100%) of in-center HD patient records should be reviewed at least twice a year for delivery of renal replacement therapy as prescribed.

Delivery audit is defined as a performance review of delivered hemodialysis adequacy factors (e.g., duration, blood flow rates, dialysate flow rates, dialyzer, and achievement of estimated dry weight). A sample audit tool for performance of delivery of care audits specific to adequacy of hemodialysis has been developed and piloted for use in this activity.

AV Graft (AVG) Stenosis Monitoring (Revised Standard)
AVG's should be monitored for hemodynamically significant stenosis. Each facility will have an organized monitoring approach. Prospective monitoring using dynamic or static venous dialysis pressures detects outflow stenosis. Trends in either dynamic or static venous dialysis pressures measurements are more predictive of access stenosis than any single pressure measurement. Regular assessment of physical findings may supplement and enhance an organized monitoring program to detect access dysfunction.

The Medical Review Board requires the Network staff to evaluate facilities for compliance with established standards. As part of the 2006 CPM QI work plan, the Network will be requesting copies of facility-specific policies and/or procedures specific to monitoring vascular access for stenosis in all AVG's.

Mineral Metabolism in Chronic Renal Failure (PROPOSED New Standard)

STANDARDS:

1. The target range for the serum level of phosphorus should be maintained between 3.5-5.5 mg/dL. (EVIDENCE)
2. The serum calcium-phosphorus product should be maintained at <55 mg^2/mL^2. (EVIDENCE)
3. The target range of intact plasma PTH for patients on dialysis is 150-300 pg/mL. (EVIDENCE)

RECOMMENDATIONS:

1. Serum levels of corrected total calcium should be maintained within the normal range for the laboratory used, preferably toward the lower end (8.4 to 9.5 mg/dL). (OPINION)
2. The serum calcium-phosphorus product is best achieved by controlling serum levels of phosphorus within the target range. (OPINION)
3. The target range of biointact (whole molecule) PTH for patients on dialysis is 75 – 150 pg/mL (OPINION)
4. Recommended frequencies of measurement of PTH, Calcium and Phosphorus are provided here:

PTH	Calcium	Phosphorus
Every 3 months	Every month	Every month

"Louisiana Hurricane Preparedness" (PROPOSED New Recommendation)

- All dialysis patients should be provided copies of their dialysis medical records, pertinent to arranging transient dialysis in the event of an evacuation, prior to and periodically through hurricane season.
- Patients should be assisted in developing an emergency plan for continuation of their chronic dialysis in the event an evacuation becomes necessary. It is recommended that these plans be reviewed at a minimum annually.
- It is recommended that all dialysis and transplant providers located in a geographic location and timeframe in which tropical / hurricane force winds are forecasted, base their treatment and subsequent closure plans to meet the safety and evacuation needs of their patients and staffs.
- All chronic dialysis services should be suspended and chronic dialysis units closed in the event of a mandatory evacuation. □

Home Dialysis Central Updates Home Hemodialysis Coverage Maps

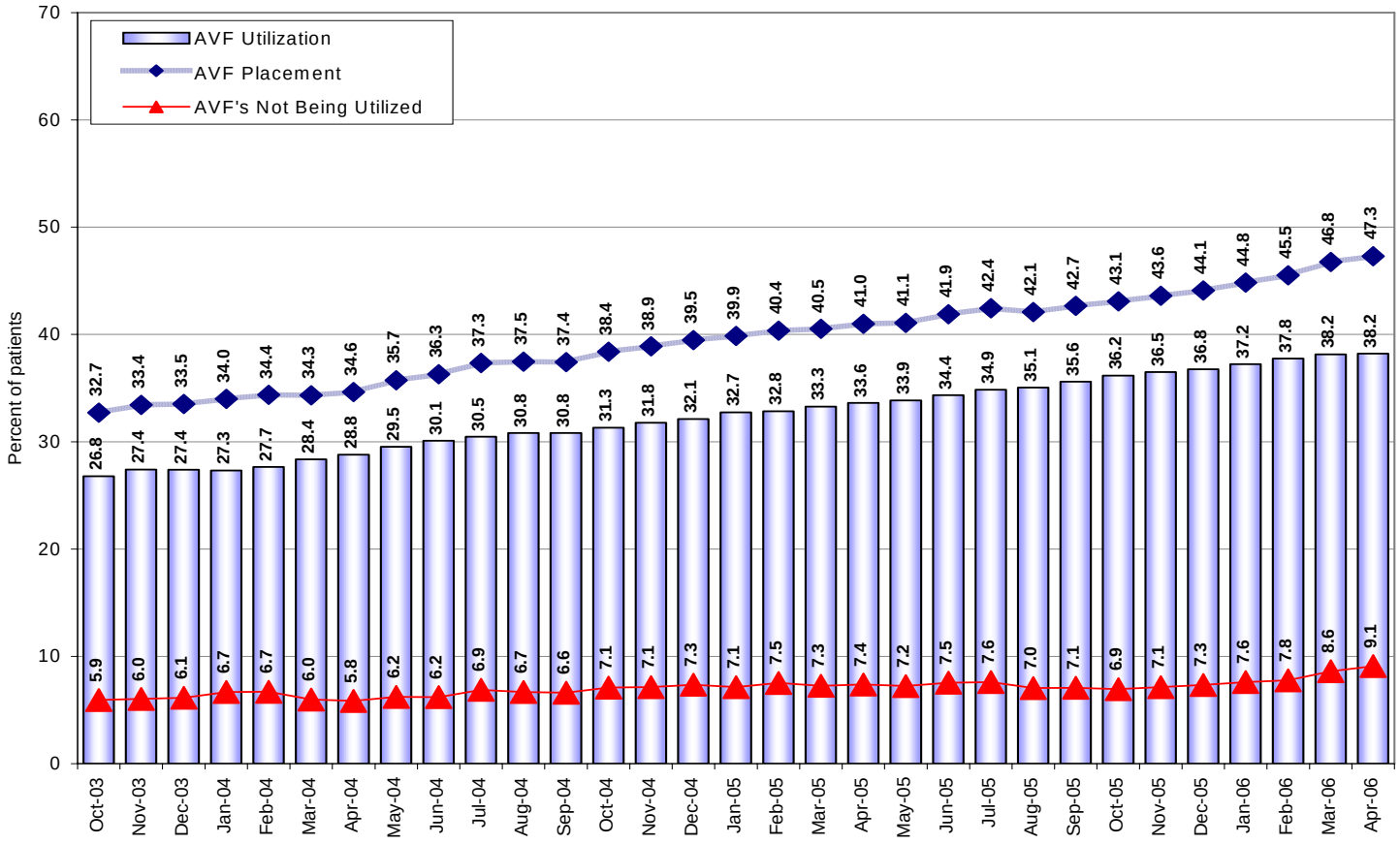
The non-profit Medical Education Institute (MEI) has updated the daily and nocturnal home hemodialysis coverage maps for 2006 on its Home Dialysis Central website. The new maps-and the previous versions- can be viewed and downloaded at http://homedialysis.org/v1/types/maps.shtml.

The maps show dialysis centers from the Home Dialysis Central database that are actively training patients. Each dot on the map represents a 120-mile radius (about a 2-hour drive) around each site of care. New maps were needed because the number of daily home hemodialysis centers increased by 106% (From 47 to 97) and nocturnal home hemodialysis centers by 39% (From 71 to 99), since June 2005.

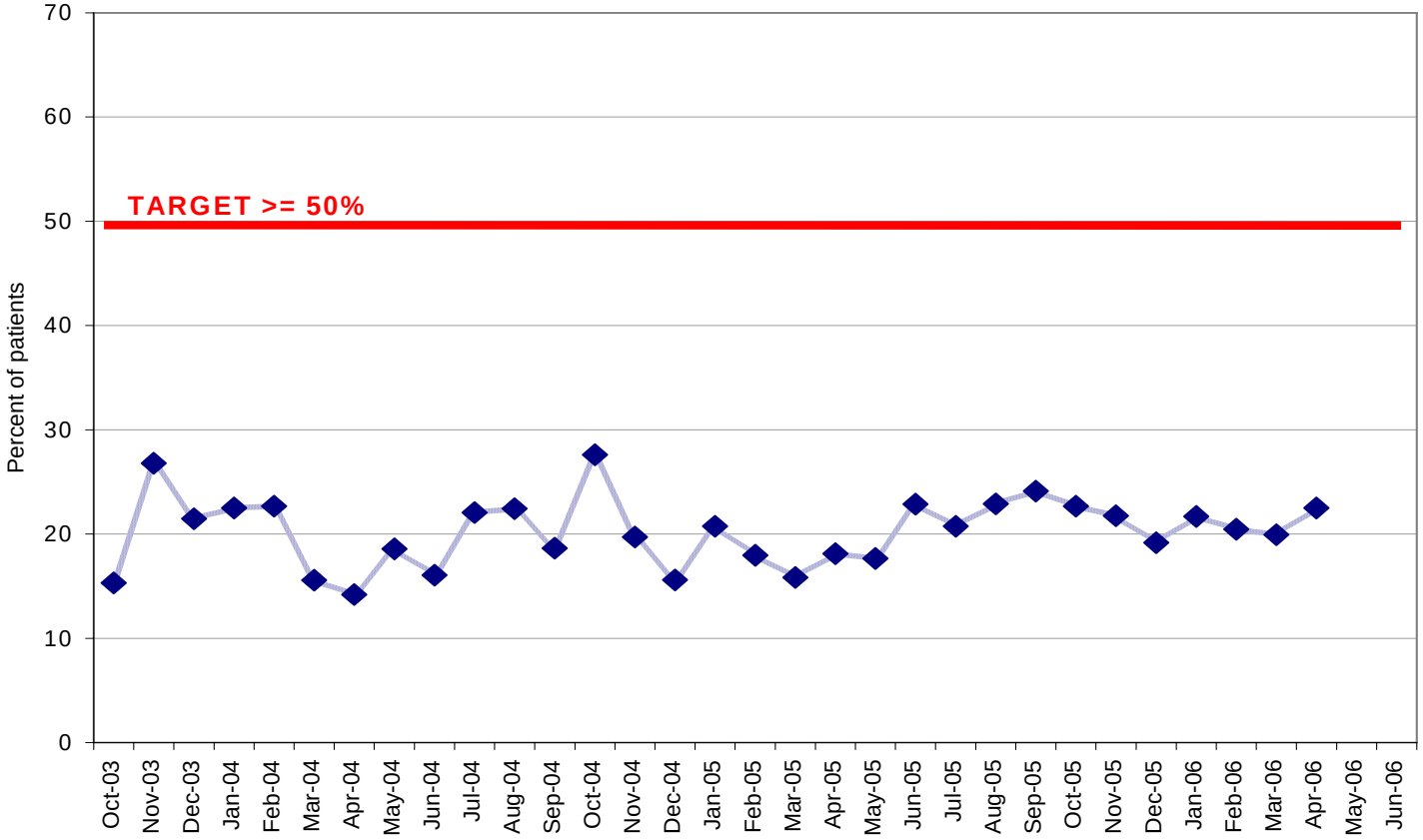
Users can search the Home Dialysis Central database by center name, city, state, treatment, or owner (e.g., company, hospital, or doctor). MEI encourages visitors to Home Dialysis Central to check their center information and submit changes using the on-line form. □

FISTULA FIRST UPDATE:

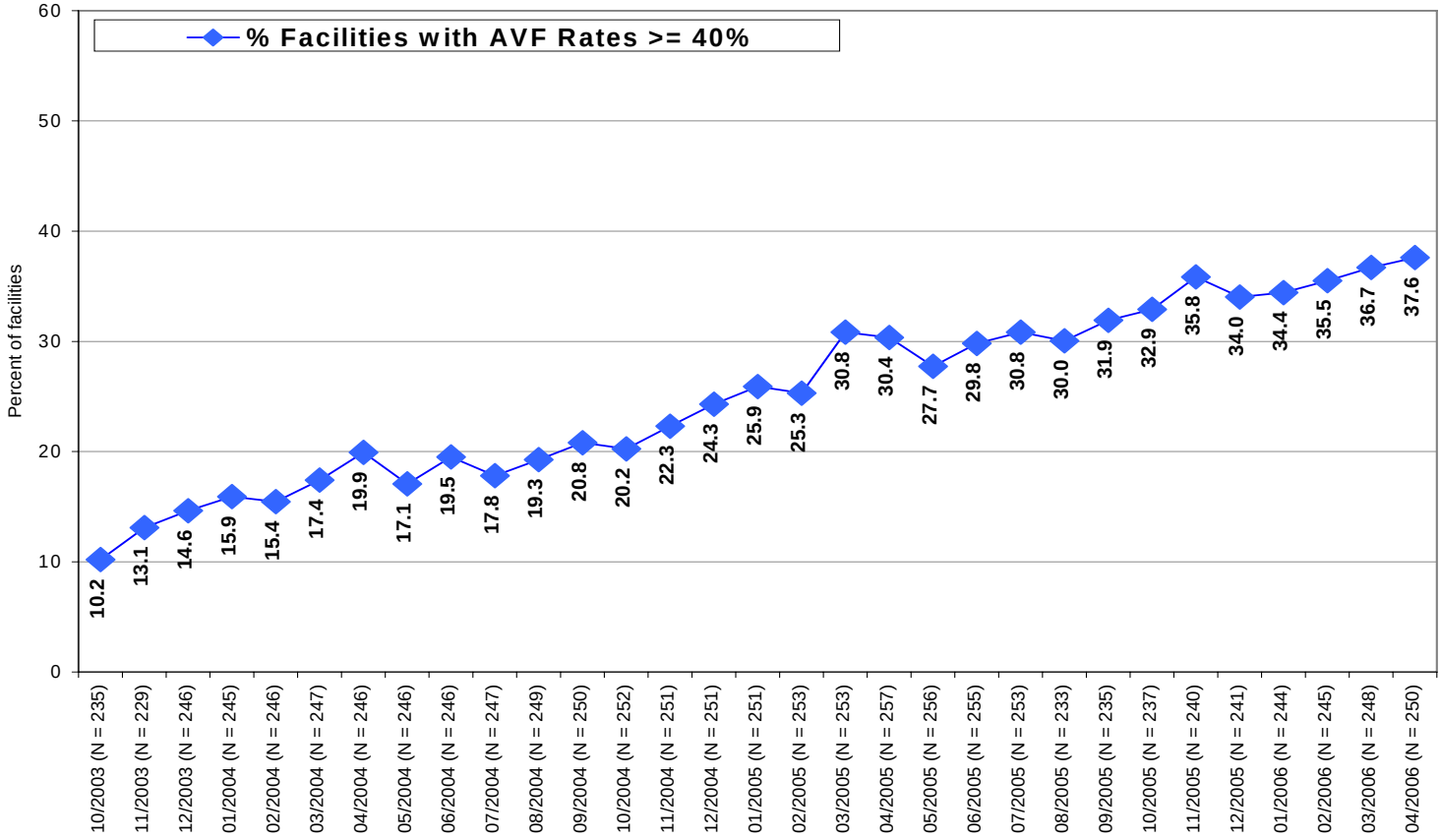
Comparison of Prevalent AVF Placement and Utilization Rates by Network with Percent (%) of AVF's Not Being Utilized



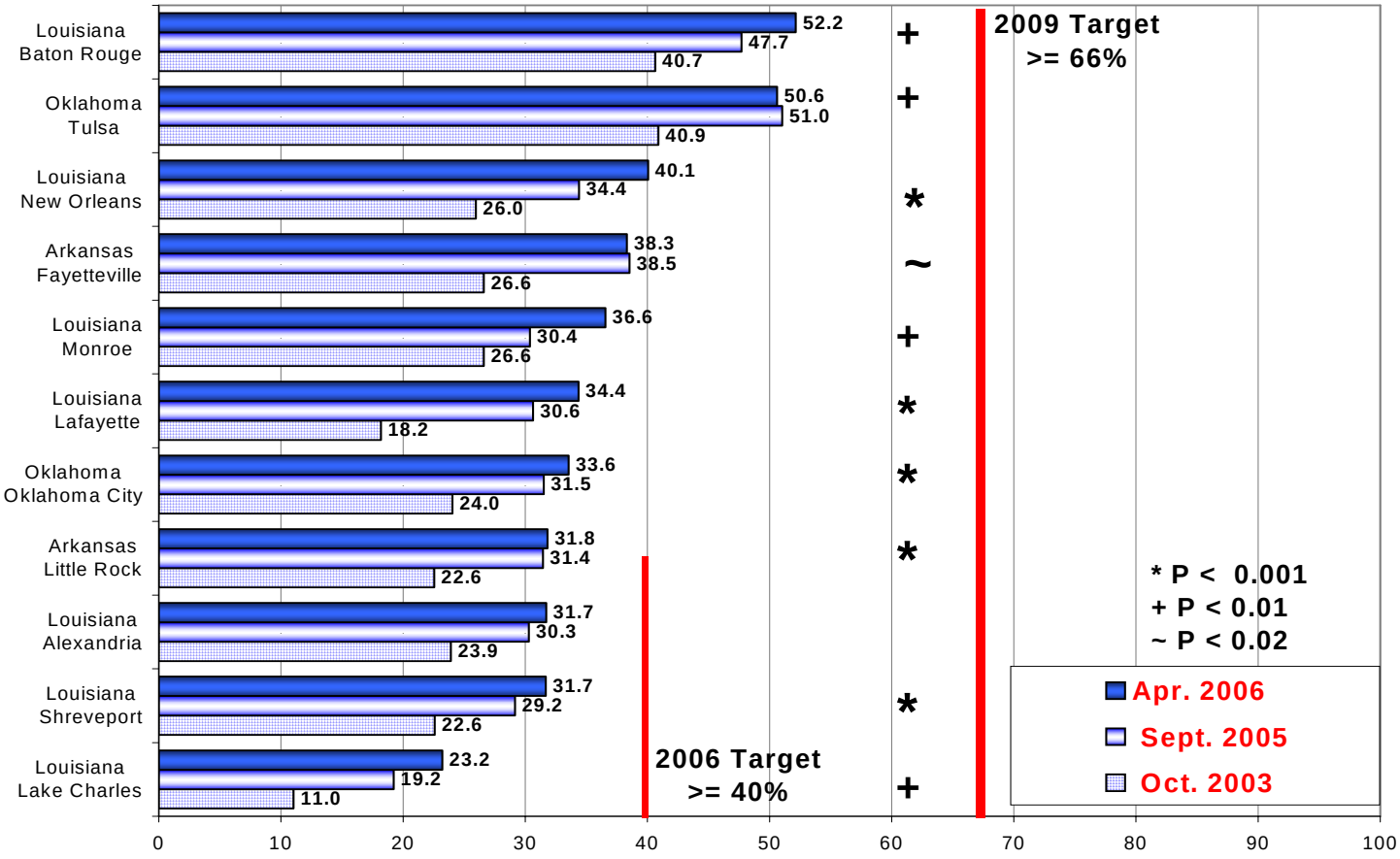
Incident Hemodialysis Patients Reported with AV Fistula Placement Rates



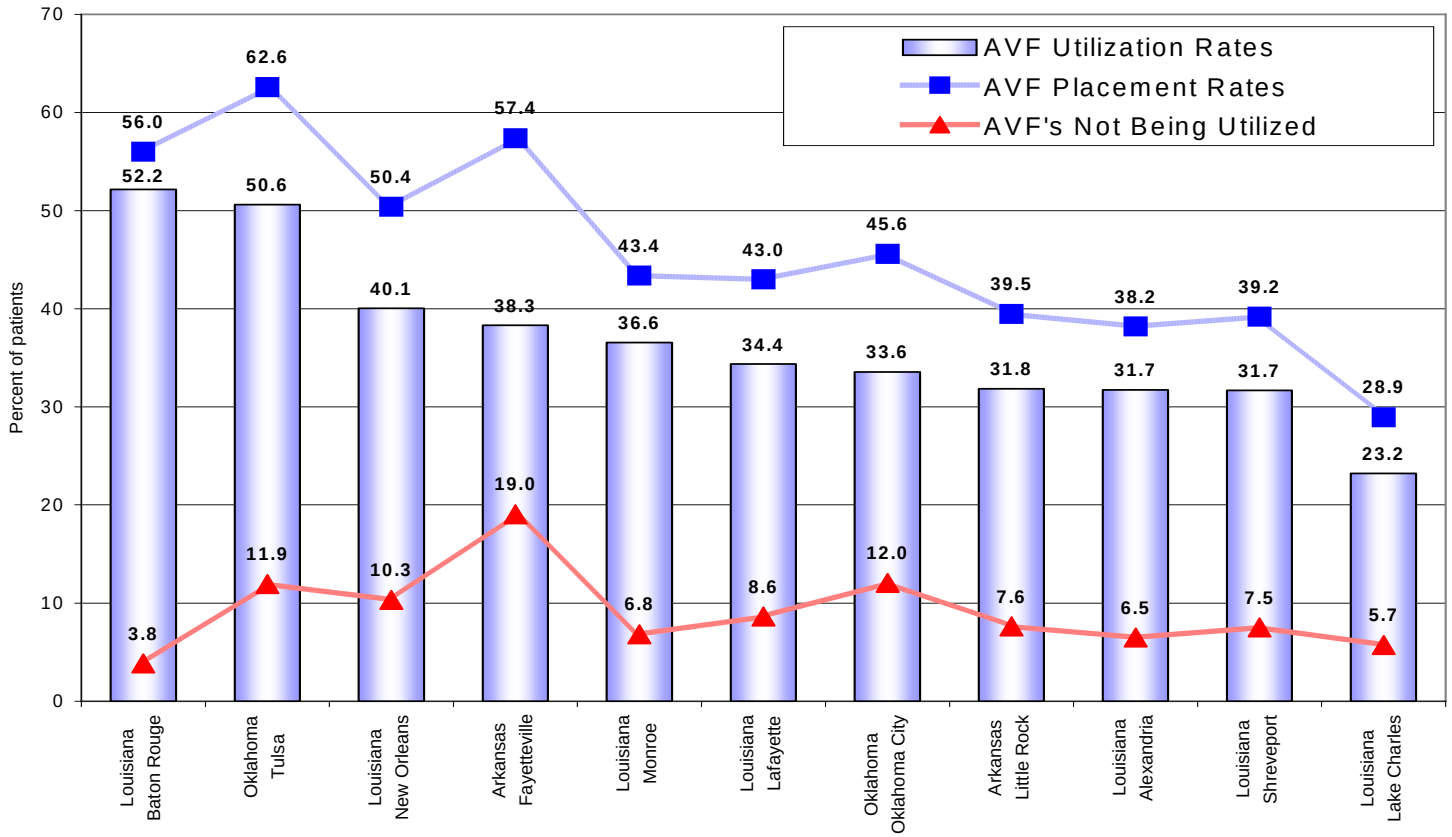
Percent of Facilities with AVF Rates >= 40%



Comparison of Prevalent AVF Utilization Rates by Urban Area in Rank Order, Baseline (10/03) to Current (04/06)



Comparison of Prevalent AVF Placement & Utilization Rates by Urban Area, Ranked by Utilization Rates with Percent (%) of AVF's Not Being Utilized, April 2006



WHAT YOU "**KNOW**" ABOUT THE "**FLOW**" IS REALLY IMPORTANT WITH REVERSE FLOW AVF's SUCH AS PROXIMAL RADIAL ARTERY FISTULAS

William Jennings, MD, FACS / Lynda Ball, RN, BSN, CNN, Network 16 /
Linda Duval, RN, BSN, Network 13

Reverse flow AVF's such as the Proximal Radial Artery arteriovenous fistula (PRA-AVF) creation is relatively new to most patient care staff. The anastomosis is located just below the elbow area and surgeons typically disrupt adjacent valves in the forearm vein allowing AVF blood flow toward the hand (retrograde) in the forearm. A PRA fistula permits use of forearm dialysis sites as well as the upper arm for cannulation and it minimizes the occurrence of steal syndrome.

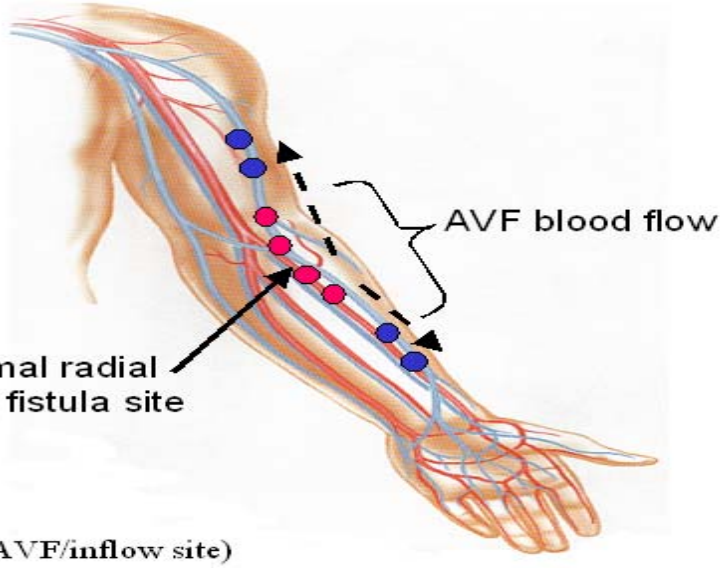
An important point in reverse flow AVF's (such as PRA-AVF's) is that blood flow will often develop in two different directions at the same time (see picture). If both needles are to be placed in the forearm, the venous needle should be placed *downstream* (i.e., retrograde) toward the hand, because that is the direction of the venous blood flow. If you use the upper arm for venous return, the flow goes toward the heart, so the needle would be *upstream* (i.e. antegrade) toward the shoulder.

It is ***IMPORTANT*** that prior to any AVF cannulation, everyone knows…

1) What ***TYPE*** of AVF has been placed;
2) The ***DIRECTION*** of blood flow for a specific access site; and
3) If a reverse flow AVF (such as a PRA-AVF) has been created, blood flow direction dictates ***PLACEMENT*** of the arterial and venous needles.

Direction of Flow

- Some fistulae have flow in the opposite direction
- Get drawing post surgery
- Compress fistula in the middle and auscultate



- Arterial puncture sites (closer to the AVF/inflow site)
- Venous puncture sites ("down stream" from the AVF/inflow site)

Food For Thought!!

Have you ever thought about Periodontitis being an occult source of inflammation and hyporesponse to Epogen™? A study conducted in Diyarbakir, Turkey studied 41 hemodialysis (HD) patients who were on erythropoietin therapy. The study evaluated the association between C-reactive protein (CRP) levels and the periodontal status of HD patients. Hematologic and biochemical parameters and CRP levels were recorded along with plaque index, gingival index, probing pocket depth and periodontal disease index.

The patients were divided into 2 groups. High CRP and Normal CRP. After periodontal therapy the mean CRP level and erythrocyte sedimentation rate declined and the hemoglobin level increased in both groups. The study concluded periodontitis is an important occult source of chronic inflammation and increases the CRP levels in HD patients. Periodontitis can cause hypo-responsiveness to erythropoietin treatment and decrease the hemoglobin levels.

National Nephrology Nurses Week: September 2006

September 10-16, 2006 has been designated as "National Nephrology Nurses Week." Employers and others may take this opportunity to recognize and reward nephrology nurses for their work and dedication. The theme chosen for this year's celebration: "Caring for a lifetime, It's who we are…It's what we do." For more information about Nephrology Nurses Week or to download the online toolkit, visit www.annanurse.org/NNW.

The Professional Newsletter is published quarterly by the staff of ESRD Network 13. The next edition is scheduled for Fall/October 2006. If you are interested in contributing to this newsletter, please call us at **405.942.6000**, fax us at **405.942.6884** or send any articles, materials and/or ideas to:

News You Can Use
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