

Information for the Dialysis Professional

AAKP DEVELOPS NUTRITION ELECTRONIC NEWSLETTER

Tampa, Fla. – The American Association of Kidney Patients (AAKP) announced today it has developed a new nutrition electronic newsletter. *AAKP Diet Tips & Bits* is a free electronic newsletter that will feature recipes, news and nutrition information.

AAKP Diet Tips & Bits will provide patients with practical ideas that will enable them to properly manage their eating habits. Proper nutrition helps patients feel better and avoid problems linked to bad nutrition such as fluid overload, high potassium levels and weight gain. AAKP encourages all kidney patients to take action and take control of their health.

“One of AAKP’s objectives is to help kidney patients be the leader of their healthcare team,” says AAKP CEO/ Executive Director Kris Robinson. “I know personally how difficult the renal diet can be and look forward to sharing tips, recipes and nutrition information with fellow patients.”

AAKP Diet Tips & Bits, the fifth electronic newsletter provided by AAKP, is sponsored by a generous grant from Shire. The other newsletters include: *Kidney Beginnings: The Electronic Newsletter*, *Renal Flash*, *Kidney Transplant Today* and *Public Policy Briefing*. Subscriptions to all AAKP electronic newsletters are **FREE**.

The electronic newsletters are transmitted once a month. *AAKP Diets Tips & Bits* will begin distribution in April 2007. It will be delivered the second Tuesday of each month. To learn more about all of the AAKP electronic newsletters, log onto www.aakp.org or call the National Office at (800) 749-AAKP.

AAKP is the voluntary patient organization which for more than 35 years, has been dedicated to improving the lives of fellow kidney patients and their families by helping them deal with the physical, emotional and social impact of kidney disease. The programs offered by AAKP inform and inspire patients and their families to better understand their condition, adjust more readily to their circumstances, and assume more normal, productive lives in their communities. ■

DATES TO REMEMBER Spring, 2007 ESRD Workshops

LOUISIANA - THURSDAY, MAY 17, 2007

SHERATON BATON ROUGE CONVENTION CENTER

102 FRANCE STREET

BATON ROUGE, LA 70802

PHONE NUMBER: 225.242.2600

ARKANSAS - THURSDAY, MAY 31, 2007

EMBASSY SUITES

11301 FINANCIAL CENTRE PARKWAY

LITTLE ROCK, AR 72211

PHONE NUMBER: 501.312.9000

PROJECT MANAGEMENT OPENING

Due to retirement of incumbent in early 2008, we are seeking an Executive Director [ED] for a not-for-profit, government-funded organization.

The ED will provide overall supervision and direction of Network goals and objectives into administrative action. The ED will be responsible for: (1) supervision of staff; (2) preparation of the Network’s work plan and budget; (3) coordination of the contract requirements between the Network and the Centers for Medicare & Medicaid Services [CMS]; (4) planning and development of special statewide projects pertinent to the Network goals and interests; (5) providing advice and assistance to the Board of Directors, Medical Review Board and the ESRD Council; (6) providing direct liaison with CMS national and regional offices; and, (7) interfacing and cooperating with state agencies and other renal-related organizations.

Masters Degree in Health Administration or a health-related area preferred but not required. At least five years progressively responsible experience in the health care field is mandatory, including management and supervisory experience.

Submit applications and resume NO LATER THAN MAY 31, 2007 to:

Patricia Philliber

ESRD Network 13

4200 Perimeter Center Drive # 102

Oklahoma City, OK 73112

or

pphilliber@nw13.esrd.net

What's the big deal with Phosphorus?

Lora R. Winchester RN, MSN, CNN

Anyone who has been in the world of dialysis for very long is familiar with the patient complaint of "itching all over". It seems that the dialysis nurse spends at least half the day administering diphenhydramine and giving the well rehearsed lecture, "If you would stop eating so much phosphorus and take your binder, you wouldn't have this problem!" But the problem of hyperphosphatemia goes far beyond this incessant and annoying itching problem. This article will discuss the resulting issue of hyperparathyroidism and its affect on our dialysis patient population. The objectives of this commentary are to help the reader to:

- Identify the basic physiology behind renal osteodystrophy
- Identify the problems associated with high serum phosphate and PTH levels.
- Recognize interventions that will assist the patient in reaching healthy phosphorus and PTH levels.

The problem that we each face is straightforward: General patient non-compliance with a phosphorus restricted diet, phosphorus binder regimen, and lack of education regarding the phosphorus-parathyroid hormone-renal osteodystrophy connection. The solution is equally as straightforward: We must **EDUCATE!** Start with the staff and spread the knowledge to each patient.

The major players in this cycle are as follows:

Parathyroid Hormone- PTH- bones use the amount of PTH in the system to decide to release or store calcium.

Phosphorus- vital to energy production and storage, modifies enzymes, component of mineralized crystals of bone.

Calcium- most abundant cat-ion, forms thrombin, helps form the rigid mineralized structure of bone.

We must first understand the basic physiology of renal osteodystrophy. The contributing factors include:

- Hyperparathyroidism
- Acidosis
- Low vitamin D levels
- Suppressed PTH activity after dialysis treatment.

The Key to Renal Bone Disease Is Hyperparathyroidism!

Hyperparathyroidism is a complex problem:

- Caused by failure of the kidney to synthesize 1.25 dihydroxyvitamin D3, or calcitrol, which is the active metabolite of Vitamin D.
- Without this mechanism, the parathyroid makes too much PTH. Leading to...an endless cycle...
- Decreased intestinal calcium absorption- hypocalcaemia-increased PTH synthesis.
- Increased PTH action on skeleton releasing calcium and phosphate, thereby restoring plasma calcium levels toward normal.

Phosphate retention is also complex. It is described as:

- Increased phosphate levels lead to decreased calcium levels lead to increased PTH secretion.
- Decreased formation of 1.25 vitamin D3 by enzymatic inhibition.
- Directly reduce sensitivity of parathyroid gland to hypocalcaemia (i.e. raised calcium level causes less inhibition of PTH synthesis)

This cycle has detrimental effects on our patients.

Unfortunately, symptoms usually do not develop until an *advanced stage* of renal bone disease. Some of the symptoms that we see are:

- *Pruritis-* calcium phosphate deposition under skin
- *Soft tissue calcification-* leading to tender lumps under skin.
- *Calcification of tendons-* leading to acute joint problems.
- Symptoms of *hypercalcaemia-* N/V, confusion.
- *Joint Pain-* usually mild and widespread.
- *Aching Bones*
- *Osteomalacia-* fractures usually of pelvis with Vitamin D Deficiency.

So, What's the Big Deal With Phosphorus?

- Soft tissue and vascular calcification- if in coronary arteries causes ischemic heart disease (found in 40% of maintenance hemodialysis patients).
- Evidence of reduced survival on dialysis
- Metastatic calcification- may occur in dialysis patients when phosphorus and Ca x P product are too high- calcium deposits form in a variety of body locations.

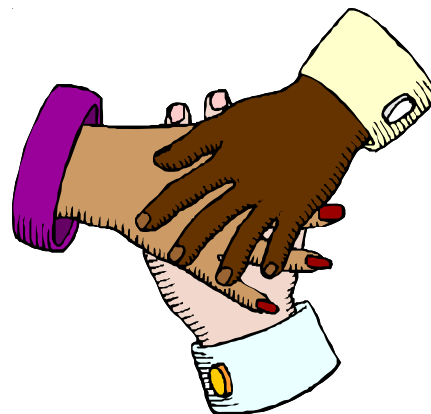
What can we do?

- Ensure adequate dialysis treatments
- Encourage dietary compliance
- Aggressive use of phosphate binders
- Judicious use of Vitamin D analogs

The Plan

- Encourage dietary compliance.
- Encourage phosphate binder compliance.
- Encourage treatment compliance.
- Follow written protocols regarding vitamin D analog dosing and administration.
- Be available for questions.
- **Let the patient be involved with their plan of care** ■

EDUCATION + UNDERSTANDING = COMPLIANCE.



Teamwork - together we can make a difference.

How To Create A Quality Improvement Plan

A Quality Improvement Plan (QIP) is an ACTION PLAN. Much like a nursing care plan, a QIP should be created to target a specific problem area in patient care. Unlike a nursing care plan, which is patient specific, a QIP is a plan of action to determine problem areas and measure actions and/or interventions initiated to improve the overall facilities patient outcomes.

Any plan of correction needs to include certain criteria to be measurable.

Identify Opportunity for Improvement:

- Describe specific issue where improvement is needed.

Define Root Cause:

- Develop a team to brainstorm underlying problems.
- Define causes and barriers relating to specific issue.
- Use tools to quantify barriers to determine which areas are of highest weight. (If any particular area is severe, a separate QIP may be needed for that specific problem)
- Determine which causes and barriers have the greatest impact on outcomes, and document them as the root causes.

Set Specific goal for Improvement:

- Document what goal to achieve.
- Goals must be measurable.
- Gradual stair step goals may be used, but should be documented that goals will increase in steps as prior goal is achieved.

Identify Interventions:

- Have a team meeting to discuss root causes and decide what interventions will be used, and how they will be carried out.
- Document intervention(s) to be initiated **for every cause or barrier that will be addressed.**
- Update after each review (ie. monthly/quarterly). Add any new or modified interventions if changes are made to *interventions*.

Identify Person(s) responsible:

- Identify persons on team.
- Identify persons who will initiate interventions.
- Identify persons who will review and update QIP.

Date Process began:

- Document date when QIP was created.

Date/Frequency of Re-measurement:

- Document how often the data will be reviewed and measured. (ie. monthly/quarterly).

Outcomes-Measurement results:

- Enter measurable results. Update after each review.
- Document after each review if interventions are achieving results and will be continued, or not achieving results and will be modified. Add any new or modified interventions under interventions above. ■

Do You Know - Infection Control? Can We Fight Back Against Antibiotic Resistant Bacteria?

Facts

- Staphylococcus aureus has become increasingly resistant to first-line antimicrobial agents in health-care settings.
- Dialysis patients are especially vulnerable to infections, frequently those caused by antimicrobial-resistant organisms, including methicillin-resistant *Staphylococcus aureus* (MRSA).
- Persons receiving dialysis are at *high risk* for infection with invasive MRSA compared with the general population.
- In 2005, the incidence of invasive MRSA infection among dialysis patients was 45.2 cases per 1,000 population.
- The primary risk factor for bacterial infections among dialysis patients is vascular-access type. *Risk is highest for catheters*, intermediate for grafts, and lowest for native arteriovenous fistulas.
- Findings underscore the need for continued surveillance and infection-control strategies *aimed at reducing infection rates and preventing additional antimicrobial resistance* among persons receiving dialysis.
- Despite higher rates of bacteremia among patients with catheters, the percentage of U.S. dialysis patients with an indwelling hemodialysis catheter increased substantially from 1995 to 2002.
- The most basic strategy to prevent catheter-related bacteremias, including invasive MRSA infections among hemodialysis patients, is minimizing the use of catheters for long-term vascular access.
- Health-care providers should follow published guidelines for judicious use of antimicrobials, particularly vancomycin, to reduce selection for antimicrobial-resistant pathogens (CDC's resource on the prevention of infections and patient-to-patient transmission of infections in dialysis settings *Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients*) <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5005a1.htm>.
- Recommendations for the prevention of antimicrobial resistance are available from CDC's 12-step Campaign to Prevent Antimicrobial Resistance Among Dialysis Patients <http://www.cdc.gov/drugresistance/healthcare/patients.htm> - dialysis.
- For more information visit http://www.network13.org/facility_handbook.asp - section6. ■



“Doubt is a pain too lonely to know that faith is his twin brother.”

—Kahlil Gibran

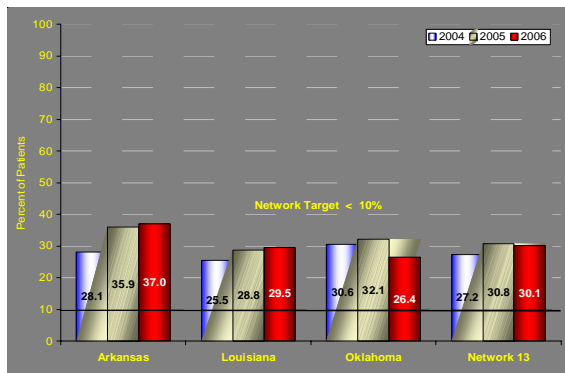
“Quality is never an accident; it is always the result of high intention, sincere effort, intelligent direction and skillful execution; it represents the wise choice of many alternatives.” William Foster

What Can I do to Prevent Infections?

- Educate patients on vaccinations, infection control, and access care; teach them how to wash their AVG/AVF site prior to treatment.
- Provide frequent training for staff members on infection control.
- Practice safe draw procedure when entering medication vials, dispose of unused medication; do not pool medications.
- Wash hands frequently or use a waterless hand rub, especially in between patient care.
- Clean dialysis machine and surfaces with disinfectant (1:100 dilution of bleach) between patient uses, and discard any supplies not used which have come in contact with potentially contaminated surfaces.
- Prep access site per aseptic technique, assuring the disinfectant remains on the allotted duration for optimal disinfection.
- Disinfect dialysis machine on schedule with your unit's policy, replace transducers when wet and after each treatment.
- Check reuse dialyzers to assure adequate sterilant is present and needed duration has been met.
- Use PPE; ensure Standard Precautions are used on all patients.
- Keep records and monitor infections monthly.
- Keep accurate water and dialysate records.
- For more information visit

http://www.network13.org/facility_handbook.asp - section6

Hemodialysis catheter rates are listed among the highest risks for bacterial infection. See graph below for Network 13 catheter rates.



Palliative Care in the Dialysis Center

In keeping with the CMS' goal for high-value health care, there exists an opportunity to improve access to hospice care for dialysis patients. The American Society of Nephrology and Renal Physicians Association recently published a clinic practice guideline and position statement that directly endorses hospice care for patients who have ESRD and are at the end of life. Approximately 25% or 80,000 dialysis patients die each year. We know that hospice care for dialysis patients is associated with lower-end-of-life care costs and higher quality care. Despite this, only 13.5% of dialysis patients use hospice benefits according to a recent study, and 73% die with distressing pain, severe dyspnea, and other symptoms.

Case Scenarios Kidney End of Life Coalition

Case 1 ESRD patient with terminal lung cancer still benefiting from and wishing to continue dialysis. Dialysis and services related to dialysis would be covered by ESRD benefit. Services related to lung cancer care would be recovered by Hospice benefit.

Case 2 ESRD patient with end-stage heart failure from previous heart attacks wishes continued dialysis while "tying up affairs." Dialysis and services related to dialysis would be covered by ESRD benefit. Services related to heart failure care would be recovered by Hospice benefit.

Case 3 ESRD patient, whose cause of renal failure is renal atherosclerotic vascular disease and who has severe peripheral vascular occlusive disease resulting in a gangrenous foot. The patient refuses amputation but wishes to continue dialysis.

Dialysis and services related to dialysis would be covered by ESRD benefit. Services related to peripheral vascular disease (including pain control) would be recovered by Hospice benefit.

Resources to Assist Your Patients' Return To Work

The Social Security Administration (SSA) awarded 99 cooperative agreements to a variety of community organizations called Work Incentive Planning and Assistance (WIPA) projects. These WIPA projects have Community Work Incentive Coordinators (CWICs) to provide all SSA beneficiaries with disabilities (including transition-to-work aged youth) access to benefits planning and assistance services.

What is a WIPA?

Local organizations that have arranged with Social Security to provide work incentive and planning services for Social Security and SSI beneficiaries

These local organizations have people who have been specially trained to help your patients.

What can they do for your patients?

Answer questions about the SSA work incentives

Help you create a PASS plan

Plan how work incentives and other federal, state, and local assistance plans can help your patient return to work

Answer your questions about the Ticket to Work

Help you find an Employment Network for your patients

What if there aren't any local organizations in my area?

SSA has arranged for work incentives planning and assistance services for beneficiaries who reside in the areas where there is currently no WIPA project and for beneficiaries who reside in areas where the WIPA does not have staff trained under the Benefits Planning, Assistance and Outreach programs.



This service will be provided by an experienced WIPA project, Imagine Enterprises, in Texas (known as the "Transitional WIPA"), via a toll-free telephone line.

The toll-free number is 866-426-1132. It is now in operation; the hours are 9am—7pm Eastern Time.

ARKANSAS

Sources for Community Independent Living—Project

AWIN

1918 Birch
Fayetteville, AR 72703
1-888-284-7521 Toll Free
479-442-5192 FAX

www.arsources.org/awin.html

Serving the entire state

LOUISIANA

LSUHSC Human Development Center

1900 Gravier Street, 10th Floor
New Orleans, LA 70112
888-942-8104 Toll free
504-568-6761 FAX

[E-Mail: ldemer@lsuhsc.edu](mailto:ldemer@lsuhsc.edu)

Hours of Operation:

9am—4pm

Serving the Parishes of—Acadia, Allen, Avoyelles, Beauregard, Bienville, Bossier, Caddo, Calcasieu, Caldwell, Cameron, Catahoula, Claiborne, Concordia, De Soto, East Carroll, Evangeline, Franklin, Grant, Iberia, Iberville, Jackson, Jefferson Davis, La Salle, Lafayette, Lincoln, Madison, Morehouse, Natchitoches, Ouachita, Pointe Coupee, Rapides, Red River, Richland, Sabine, St. Landry, St. Martin, St. Mary, Tensas, Union, Vermillion, Vernon, Webster, West Baton Rouge, West Carroll, and Winn.

Advocacy Center

Louisiana Work Incentive Planning And Assistance Coalition

Address: 1010 Common Street,
Suite 2600,

New Orleans, Louisiana 70116
504-522-2337; 1-800-960-7705 Telephone
504-522-5507 FAX

[E-Mail address: dgallegos@advocacyla.org](mailto:dgallegos@advocacyla.org)

[AC Website: www.advocacyla.org](http://www.advocacyla.org)

Hours of operation:

9am—5pm

Contact Person: David Gallegos, LAWIPA Project Director

Serving the Parishes of—Ascension, Assumption, East Baton Rouge, East Feliciano, Jefferson, Lafourche, Livingston, Orleans, Plaquemines, St. Bernard, St. Charles, St. Helena, St. James, St. John the Baptist, St. Tammany, Tangipahoa, Terrebonne, Washington, and West Feliciano.

OKLAHOMA

University of Oklahoma

Jill Burgess
OWIPA Project Director
106 Constitution Building 158
Norman, OK 73072
405-325-8130
405-325-1632 FAX

NEWS FROM THE DATA DEPARTMENT

By Cindy Smith, Data Manager

2006 Annual Compliance Reports

The 2006 annual compliance reports have been mailed. As mandated by the Centers for Medicare & Medicaid Services (CMS), the Networks must track all mandatory forms received by each provider for timeliness and accuracy and report this information back to you for comparison to statewide rates and CMS' expectations. CMS expects a 90% compliance rate annually for timeliness and accuracy. While the Network compliance rate is still above 90%, the compliance rates dropped significantly this year. This means that the facilities in our "**Club 100**" and "**Gold Club**" are particularly exceptional this year.

Each year, we recognize our "**Club 100**" facilities. These facilities have maintained a 100% compliance rate for timeliness and accuracy. In this newsletter you will find a list of the 32 facilities that met this goal for 2006.

In addition, there are 7 facilities that qualified for our prestigious "**Gold Club**". These are facilities that have maintained 100% compliance rate for 3 consecutive years starting in 2004. We are extremely proud of these facilities. They will be receiving a special plaque for the facility in recognition of their efforts.

We're always looking for new members for both of these clubs! A special "Thanks" to all who have maintained a 90% or higher annual rate.... we appreciate your efforts.

Here are a few tips on completing the revised 2728 for those of you that had problems with your compliance rates. By far, the most common error was field 18.

- Field 8 – Ethnicity - If you checked Hispanic or Latino, you must complete field 9. **Indicate in field 9 the country/culture with which the patient most closely identifies.**
- Field 10 – Race — If you checked Asian as one of the race codes in field 10, you must complete field 9. **Indicate in field 9 the country/culture with which the patient most closely identifies.**
- Field 15 – Primary Cause of ESRD – **We cannot accept narrative in this field. You must use ONLY the codes on the back of the form.**
- Field 18 – Prior to ESRD Therapy – All fields must be completed!!!!
- **18 a, b & c – if you answer YES – you must indicate the time period (if < 6 months please write on the form. Do not leave blank)**
- **18 d – If not AVF – you MUST complete the next 2 questions (*This applies to graft question even if your answer was graft*)**

FIELD 18 IS THE MOST COMMON ERROR ON ALL 2728s COMPLETED! →

Article continued on page 7. Please see page 6 for the winners of this year's Gold Crown and 100 Club. Thanks for all you do! Working together, we can provide ESRD patients with the best care possible.

Club 100 - 100% Compliance in Accuracy and Timeliness For One Full Year

Provider Number	Facility Name	State	Total Form Rec'd	2006 Compliance Rate
042501	FT SMITH REGIONAL DIALYSIS CTR	AR	115	100%
042534	NRI - OSCEOLA	AR	16	100%
042535	JACKSONVILLE DIALYSIS CTR	AR	12	100%
042547	MIDTOWN DIALYSIS CTR	AR	31	100%
042555	PRESCOTT DIALYSIS CTR	AR	3	100%
042563	HEMPSTEAD COUNTY DIALYSIS UNIT	AR	9	100%
042569	HOPE DIALYSIS CENTER	AR	6	100%
190006	UNIVERSITY MED CTR	LA	3	100%
190048	LADY OF THE SEA DIALYSIS CTR	LA	15	100%
190098	LSU HEALTH SCIENCES CTR-DIALYSIS-SHREVEPORT	LA	7	100%
192515	CHALMETTE DIALYSIS CTR	LA	5	100%
192548	MORGAN CITY DIALYSIS CTR	LA	23	100%
192554	DAVITA-NEW ORLEANS	LA	4	100%
192567	DVA RENAL HEALTHCARE - GRETNAL DIALYSIS	LA	1	100%
192589	FMCNA-PICARDY KIDNEY CTR	LA	43	100%
192590	DAVITA-CRESCENT CITY DIALYSIS CTR	LA	1	100%
192602	FMCNA-NEW ROADS	LA	12	100%
192637	FMCNA-DIALYSIS SERVICES AVONDALE	LA	20	100%
192641	FMCNA-COUSHATTA	LA	11	100%
192652	FMCNA-FELICIANAS DIALYSIS CTR	LA	19	100%
192662	DCI - HOMER	LA	5	100%
192675	DC I- PERITONEAL DIALYSIS	LA	6	100%
192682	METAIRIE KIDNEY CTR	LA	2	100%
370035	UNIVERSITY HOSPITAL-DIALYSIS	OK	2	100%
370037	ST ANTHONY HOSP-DIALYSIS	OK	3	100%
372500	FMCNA-MEDICAL PLAZA DIALYSIS	OK	46	100%
372532	FMCNA-OKLAHOMA CITY	OK	38	100%
372533	FMCNA-SHAWNEE	OK	41	100%
372547	DAVITA - TRI-STATE DIALYSIS	OK	15	100%
372552	FMC - PONCA CITY	OK	19	100%
372563	BLACK HILLS DIALYSIS	OK	14	100%
372564	MCALESTER REGIONAL DIALYSIS CTR	OK	46	100%

Gold Club - Three Year's in a row with 100% compliance

Provider Number	Facility Name	State	Total Forms Rec'd 04 - 05 - 06	Compliance Rate Years 04 - 05 - 06
190048	LADY OF THE SEA DIALYSIS CTR	LA	34	100%
192637	FMCNA-DIALYSIS SERVICES AVONDALE	LA	59	100%
192652	FMCNA-FELICIANAS DIALYSIS CTR	LA	65	100%
370037	ST ANTHONY HOSP-TRANSPLANT	OK	7	100%
372500	FMCNA-MEDICAL PLAZA DIALYSIS	OK	46	100%
372532	FMCNA-OKLAHOMA CITY	OK	184	100%
372564	MCALESTER REGIONAL DIALYSIS CTR	OK	127	100%

State	Total Forms Received	% (#) on Time	% (#) Accurate	Compliance Rate
Arkansas	1893	93.6% (1,771)	91.5% (1,732)	92.5%
Louisiana	4143	92.9% (3,848)	90.1% (3,733)	91.5%
Oklahoma	2217	92.9% (2,060)	88.4% (1,960)	90.7%
Network Total	8253	93.0% (7,679)	90.0% (7,425)	91.5%

Field 19 Lab Values - All acceptable lab values for items 19a through 19c MUST be within 45-days PRIOR to the date in field 24 (Date regular dialysis began) for dialysis patients or field 28 (Transplant Date) for transplant patients. The Lipids must be within one year.

The only mandatory lab value is 19b-Serum Creatinine. We must have this value to calculate the GFR to determine ESRD eligibility.

If you don't have any lab values prior to the date in field 24 (or 28) - please enter the labs you have. Indicate in the remarks that these are the only labs available and why. Please attach any supporting documentation that you have. These forms will have to be handled manually by the Network.

Field 26 – Has Patient been informed of kidney transplant options: If you answer “NO”, you MUST complete field 27. ■

Free CME/CE Activity

Visit www.kidney.org/KLS for education on “Teaming Up for Peak Performance: Early Identification and Optimal Management of CKD-Related Anemia.” A new continuing education activity from the National Kidney Foundation's Kidney Learning System (KLS)TM based on a symposium which took place at NKF Spring Clinical Meetings 2006 in Chicago. This activity is a free, on demand interactive presentation that can be accessed online at www.kidney.org/KLS or on a CD-ROM. Participants are able to view a self-directed slide presentation with accompanying audio. At the conclusion of this activity, participants will complete an evaluation and post-test to receive a certificate of completion. The estimated time for completion is two hours.

To further improve knowledge and understanding of chronic kidney disease, NKF offers continuing education activities that are accredited for physicians, physician assistants, nurses, nurse practitioners, dietitians, pharmacists, social workers, and dialysis technicians on an array of topics in varied formats for the user.

[Managing Bone and Mineral Metabolism: A Case Study Approach](#) is also available on the website noted above. If you need CME's or CE's and are interested in learning the

latest on kidney disease visit www.kidney.org/KLS.

Supported by an Educational Grant from Roche

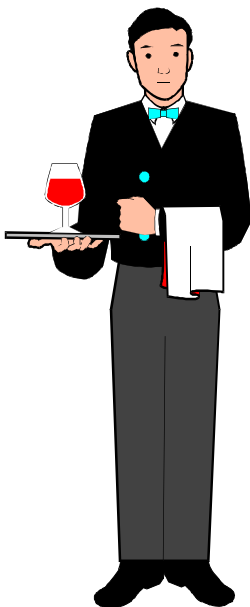
“There are three things that if a man does not know, he cannot live long in this world: what is too much for him, what is too little for him and what is just right for him.” --Swahili Proverb

Dietary Protein Intake (DPI) for Chronic Peritoneal Dialysis (CPD) NKF K/DOQI Guidelines

The recommended DPI for clinically stable CPD patients is 1.2 to 1.3 g/kg body weight per day. Protein losses into peritoneal dialysate are almost invariably higher than are protein losses into hemodialysate. Peritoneal protein losses average about 5 to 15g per 24 hours, and during episodes of peritonitis, dialysate protein may be considerably higher. At least 50% of the dietary protein should be of high biological value. Patients who do not have an adequate DPI should receive dietary counseling and education.

Failure to eat an adequate amount of protein and/or calories results in the body cannibalizing its own protein for energy and to generate new protein.

A thorough assessment of dialysis patients' appetites is critical, not only to assess protein intake but also adequate dialysis. Instead of asking patients if their appetite has increased or decreased, be specific. Ask your patient, “if I invited you to dinner how many hamburgers would you eat; would you eat an entire hamburger or 1/2 of a hamburger?” This will put it in perspective for you and allow for a better understanding. Remember, your idea of a good appetite and your patient's idea may be totally different. ■



Top Ten Things You Will Never Hear A Dialysis Patient Say

- 10) Boy, that needle really went in nicely and didn't hurt.
- 9) It's really warm in here, do you think we could get some air?
- 8) No thanks, I don't want anything to drink.
- 7) It's fine if you get me on a little late today, I know how hard you all work!
- 6) Oh good, here comes the dietitian with results of my monthly lab work!
- 5) I see my doctor way too often, why doesn't he take a day off.
- 4) I don't care who puts me on today, anyone will do, they are all so good.
- 3) I enjoy watching every drop of fluid I put in my mouth.
- 2) I really want to run my whole time, I love to sit in this chair for four whole hours.
- 1) **And, the number one thing you will never hear a dialysis patient say, “This renal diet is really awesome, in fact, I want to share it with my friends.”**

Patient Perspective Patient Advocacy Committee

By Heather Powell, PAC Member

The **Patient Advocacy Committee** (also known as the PAC) is made up of kidney patients and caregivers from Network 13. It was started in the 1990s. Network 13 has one Medical Review Board covering the states of Louisiana, Oklahoma, and Arkansas. Within that Board is the Grievance, Patient Advocacy, and Quality Improvement subcommittees made up of patients and professionals. We get our directives from Medicare and work with the facilities that provide care to kidney patients.

I have been a member of the PAC since 1999. The PAC desires to bring about positive changes in the quality of care that those living with kidney disease receive.

Our mission is to express our opinions and those of other kidney patients in our Network. We promote positive improvements in the quality of care being a "voice" for all patients. There are three different sub-committees that a PAC member can serve on. As patients, we serve on these different committees so that we have input as educational tools are being developed, quality of care issues occur, and regulations change. We help to keep the kidney patient perspective in mind. We want to advocate for patients' concerns and issues regarding their care. One committee is the Kidney Concerns Newsletter. Please help see that patients receive this newsletter. We use this as a means to communicate important information to patients. The educational articles, surveys, and helpful tips are designed with patients in mind. Kidney Concerns is a great place for patients to write in to tell their story, concerns, and successes. Another committee is the Speaker's Bureau. PAC members speak at Network 13 conferences and other meetings to present a patient's perspective to the professionals. The final committee is the Quality Improvement Committee. This committee provides feedback on Quality Improvement activities and the impact on patients. Committee members review patient education materials utilized in the Quality Improvement activities

The PAC is charged with the task of providing input to Network 13 about the concerns and needs of kidney patients. While we are patients ourselves, everyone is different and we understand this. If you know a patient with a concern or need, please ask them to write or call and let the PAC know. It truly is our desire to serve everyone's interests. We want improve the life for the ESRD patient by improving the quality of care they receive.

If you know a patient that might be interested in being considered as a PAC member, contact Network 13 at www.network13.org. It has been my pleasure to serve on the PAC. We hope to have a positive impact in in the care that kidney patients receive and make lives better for one and all. Please encourage patients to take advantage of this terrific venue. Their voice can make a difference in the lives of other patients. Foster an awareness among patients and encourage them to call or write and let their voice be heard! Helping patients help themselves! Working hand-in-hand with each other makes us all stronger!



"A man would do nothing if he waited until he could do it so well that no one could find fault."
.....Marilyn Moats Kennedy

Medicare Reviewing Erythropoiesis Stimulating Agents In Response to FDA's Recent Black Box Warning

The Centers for Medicare & Medicaid Services (CMS) announced today it is closely reviewing all Medicare policies related to the administration of Erythropoiesis Stimulating Agents (ESAs) in light of the Food and Drug Administration (FDA) recent issuances of new warnings regarding the use of ESAs.

"We pay close attention to FDA black box warnings because the safety of our Medicare beneficiaries is paramount," said CMS Acting Administrator Leslie V. Norwalk. "We will carefully examine the effect of these labeling changes on Medicare's policies and we encourage treating physicians to review the warnings and to take them into account when prescribing ESAs for their patients."

CMS also announced today the opening of a National Coverage Analysis (NCA) on the use of ESAs for the conditions other than end-stage renal disease (ESRD). This is the first step toward issuing a National Coverage Determination (NCD).

"We will review the scientific evidence to determine the appropriate use of ESAs for multiple clinical indications. It is important to provide the correct coverage of ESAs for each specific clinical indication," said Barry Straube, MD, Chief Medical Officer for CMS.

ESAs are anti-anemia biologics, distributed as Epogen®, Procrit®, and Aranesp®. They are man-made versions of erythropoietin, a hormone that is produced in the kidney and stimulates the bone marrow to make more red blood cells. ESAs are FDA approved for the treatment of anemia in chronic kidney failure patients, in patients with cancer whose anemia is caused by chemotherapy, in patients with human immunodeficiency virus that are using Zidovudine (also known as AZT) and to reduce the number of transfusions in patients scheduled for major surgery (except heart surgery).

In addition, CMS is currently reviewing its Erythropoietin (EPO) monitoring policy for patients with ESRD, and who are dialyzed in renal facilities. The Medicare benefit policy is consistent with the National Kidney Foundation and current kidney disease industry guidelines to maintain a target hemoglobin level in the range of 10 g/dl to 12 g/dl (or hematocrit level of 30 – 36 percent). Under the EPO monitoring policy, CMS initiates a payment reduction if the hemoglobin exceeds 13 g/dl (or hematocrit level of 39 percent) unless the provider provides information with the claim that the dosage has already been reduced.

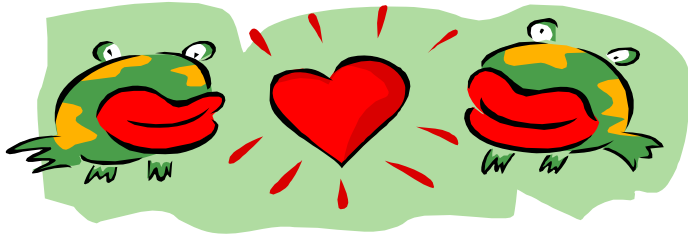
Additional information on the National Coverage Analysis (NCA) can be found at:

<http://www.cms.hhs.gov/mcd/viewtrackingsheet.asp?id=203>
FDA information on Erythropoiesis Stimulating Agents (ESAs) can be found at: <http://www.fda.gov/bbs/topics/NEWS/2007/NEW01582.html>

You play a special role in the lives of your patients. They look to each of you as experts and trust you with their lives. If you have any questions about this important issue please look at the aforementioned Websites or call the Network office.

Dialysis From the Heart

Do you have a story to share? As dialysis professionals, you hold a unique position in health care and with the patients you serve. Often times you see the patients more often than you see your families. Think back to when you became a nurse, a technician, social worker, dietitian or when you were learning all the details of dialysis. The hard work, the stress and at times, frustration. What were your goals back then? What was it that drove you to keep going? Each day, whether you realize it or not, you touch lives and make a difference in the lives of people you come in contact with. If you have a story of encouragement you would like to share with fellow dialysis professionals, please e-mail it to me at svaladez@nw13.esrd.net or mail it to the Network 13 office. Your stories or words of encouragement will be in the next issue of News You Can Use. You may have something to brag about for you or somebody else. Please share these stories. ■



Stenosis Monitoring - Is Here To Stay

Catheter reduction, Fistula First, stenosis monitoring! Will it ever end? Chances are no - with infection on the rise and health care costs going through the roof and the well being of our patients being compromised, there is no good reason for Fistula First to disappear! With the high risk of infection it is easy to see why catheter reduction is now at a critical high. CMS has charged Network 13 with the task of making certain that 100% of patients with AVG's or AVF's are currently being monitored for signs of stenosis.

For additional information please visit the ESRD Network 13 Website at: <http://www.network13.org> and look in the Facility Information Handbook.

Requests for CMS - 2728 Forms By Cindy Smith, Data Manager

We receive many requests for copies of CMS – 2728 ESRD Patient Registration forms. There are many reasons for these requests. You may need a copy of the CMS – 2728 for patients that transferred to you from another facility. With the onset of spring, many of our patients get the yearning to travel. Many facilities require a copy of the CMS – 2728 to treat a patient transiently. If you do not have a copy of the 2728 or the copy you have is illegible, you may request a copy from the Network office. This will be an electronic copy. We do not have the originals available to copy and fax.

If you did not initiate this form, we **require** a copy of a medical release of information signed by the patient prior to sending these to you. Most facilities have a standard medical release that they use routinely to request information. The Network can accept these for CMS – 2728 requests, too. If you do not have a standard release form, we have developed a medical release form specifically for the CMS – 2728 requests. A sample of this form can be found on the Network Website under the data tab.



Don't pull your hair out - if you have any questions please contact the Network Office.

Dialysis Facility Compare (DFC)

An important tool is available for you on the Web at <http://www.medicare.gov/dialysis/home.asp>. This resource gives you detailed information about Medicare-certified dialysis facilities, and lets you compare facilities in your area. The information helps you compare facility characteristics and quality measures.

Dialysis Facility Characteristics include:

- The name, address and telephone number of the facility
- The date the facility first got Medicare certification
- Shifts starting at 5:00 PM or later
- The number of treatment stations
- The types of dialysis offered.

Quality Measures include:

- The percent of patients at a facility who get adequate hemodialysis
- The percent of patients at a facility treated for anemia, and whose anemia was adequately managed
- Patient survival information.



Quality is how well the facility treats its patients. Good quality dialysis care means doing the right thing at the right time, in the right way for the right person--and getting the best possible results. Each quality measure is explained in detail. The DFC Website will tell you how the information is gathered and calculated. You can also read about what these quality measures mean to a person getting dialysis.

“Victory is in the quality of competition, not the final score.”

...Mike Marshall

ESRD Network 13 News You Can Use
Give us your Feedback

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Oklahoma City, OK 73112

**“Thorough preparation makes
its own luck.”
...Joe Poyer**

Disaster Preparedness

Does the clinic you work in have a disaster preparedness plan? Do you know what to tell your patients to do should a disaster occur? Emergency circumstances warrant our use of professional and clinical judgement to ensure that Federal requirements, effective in normal circumstances, do not impede access and quality of care in extraordinary circumstances. Under an emergency situation, the HIPAA Privacy Rule allows covered entities to share patient information to assist in disaster relief efforts and to assist patients in receiving the care they need. This information will likely be available in special bulletins which can be readily accessed from the "What's New" column on the OCR website, <http://www.hhs.gov/ocr/hipaa/>.

Please take time before a disaster strikes to visit the Network 13 Website. You will find important information for staff and patients. The Website address is <http://www.network13.org/disasterresources.asp>. Network 13 also has a poster available to place in clinics with steps for dialysis patients and families to consider in disaster planning. Please call the network office and request a disaster poster if you do not have one. You can also download a smaller version of the poster from the Network Website listed above. ■

On March 30, 2007 the Department of Health and Human Services (DHHS) established regulation authorizing the survey and certification of transplant programs. The Centers for Medicare & Medicaid Services (CMS) is the federal agency responsible for monitoring compliance with the Medicare conditions of participation. All hospital transplant programs covered by the regulation, whether currently approved by CMS or seeking initial approval, must submit a request for approval under the new regulations to CMS by December 26, 2007 (180 days from the effective date of the regulation.)

See the CMS Website for additional information

<http://www.cms.hhs.gov>



As a patient, it's important for you to be prepared with questions. As you can see, there is only limited time with Health Care Professionals.

by Lori Hartwell

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[Cartoon reprinted with permission from the Renal Support Network, November 2006.]

Introducing An Innovative New Program to Educate and Empower People on Dialysis

Hope StreetSM is the first "reality series" of, by, and for the dialysis community.

Developed by the National Kidney Foundation, Hope Street uses an educational and entertaining graphic novella format to tell the story of a group of patients and their healthcare team in a typical dialysis center. It encourages patients and healthcare professionals to discuss important issues regarding dialysis. It will help promote understanding and education with all the tools you will need.

"We are creating valuable educational tools for both healthcare professionals and patients. For the first issue of Hope Street, we've developed a special package containing:

Hope Street Poster—the inaugural issue of the innovative graphic novella dedicated to dialysis! This 24" x 36" poster may be hung on the walls of a dialysis unit or physician's office. It will be printed in English on one side and Spanish on the other.

Introduction to Hope Street—provides a valuable overview of the Hope Street program for healthcare professionals, with information on how best to use the program with patients.

Healthcare Professional Teaching Tool—offers valuable tips on ways to stimulate dialogue with patients regarding the issues discussed in each issue of Hope Street.

Patient Learning Tool—a handy 8.5" x 11" pad with tear-off sheets that gives patients a greater understanding of the messages communicated in each issue of Hope Street.

The NKF will publish Hope Street six times per year. For each issue, we will develop new packs that contain the latest Hope Street graphic novella and the related Healthcare Professional Teaching Tool and Patient Learning Tool.

What's more, we're also creating a website dedicated to Hope Street where you will find additional information and ways you can participate in the program."

Want to know more? Visit www.nkfsneakpeek.org.

Watch for Hope Street—and all the tools that go with it—on your street!

30 East 33rd Street, New York, NY 10016

800.622.9010 www.kidney.org



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News You Can Use **NEEDS YOU!**

The Professional Newsletter is published quarterly by the staff of ESRD Network 13. The next edition is scheduled for Summer/2007. If you are interested in contributing to this newsletter, please call us at **405.948.2250**, fax us at **405.942.6884**, email to: Svaladez@nw13.esrd.net or send any articles, materials and/or ideas to:

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This material was prepared by Network 13 under contract HHSM-500-2006-NW013C with Centers for Medicare & Medicaid Services (CMS). The contents presented do not necessarily reflect CMS policy.

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