MARYLAND COMMISSION ON KIDNEY DISEASE

THE CONNECTION

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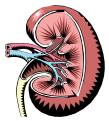

MESSAGE FROM THE CHAIRMAN

During the past year, the Maryland Commission on Kidney Disease and Transplantation has been very active in assuring that patients undergoing renal dialysis or transplantation have received high quality care. Commission members have reviewed and commented on facility surveys and in some cases, individuals from dialysis facilities have appeared in closed executive session before the Commission to explain and correct serious deficiencies noted on the surveys. While the Commission firmly believes that punitive action is not its primary role, there is close cooperation between the Commission and the Office of Health Care Quality (OHCQ) to protect patients' welfare and safety through immediate intervention when necessary. The Commission members primarily serve to assist renal professionals and patients by providing the expertise necessary to assure that dialysis and transplantation services in Maryland are being implemented in compliance with both Federal and State regulations.

As most of you are aware, significant changes in Federal regulations were finalized last October and have caused some facilities to change their internal operations in order to comply with the new standards. We are also in the process of drafting revisions to our existing State regulations to conform to these regulatory changes as well. It is our desire that all of the regulatory changes result in improved outcomes for Maryland ESRD patients.

Finally, the Commission has also been actively involved with issues such as emergency preparedness, as in the Boiled Water Advisories after a water main break in Montgomery County, facility discharge practices and continuity of care issues, resolving patient grievances, educating the renal community regarding the new ESRD Conditions for Coverage, and assisting patients and facilities with reimbursement issues.

During 2009, it is expected that the ESRD population in Maryland will continue to grow and that new treatment facilities will be established to meet the anticipated need for care. Dialysis modalities, such as home hemodialysis and peritoneal dialysis, may also play an increasing role in dialysis care in the future. The Commission is ready to meet all challenges in the coming year to assure that medical and patient safety issues, both old and new, are satisfactorily managed.

Roland Einhorn, M.D. Chairman

COMMISSION MEETINGS

The Commission on Kidney Disease will be meeting on the following dates in 2009:

July 23, 2009

October 22, 2009

The Commission meets at the Department of Health and Mental Hygiene, 4201 Patterson Avenue Baltimore, MD 21215.

The Open Session of the meeting begins at 2:00pm and is open to the public. For further information regarding these meetings, please contact the Commission office at (410) 764-4799.

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Donna Adcock, RN
Healthcare Surveyor

Leslie Schulman, AAG
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COMMISSION NEWS

CITATION FREE SURVEYS

The Commission is commending the following citation free facilities:

- Davita Southern Maryland
- Renal Care of Seat Pleasant
- Davita Baltimore Geri Center
- Good Samaritan at Lorien Frankford
- DCA N. Baltimore
- Davita Bel Air
- DCA Rockville

It is an achievable goal, and should also be the goal of each facility.
CONGRATULATIONS for a job well done!

FACILITIES APPLYING FOR CERTIFICATION

The following facilities have applied for certification with the Commission, for KDP reimbursement purposes:

Frederick Renal Care

Davita Northwest

Kidney Home Center

The above stated facilities have been certified and are in good standing with the Commission.

INFECTION CONTROL

The new Conditions for Coverage contain nineteen pages and over thirty infection control Vtags. If you have been surveyed since October 14, 2008 you already are aware of the surveyors' attention to infection control measures in the facility during survey. Facility Administrators and Charge Nurses should be routinely monitoring patient care staff, conducting unannounced infection control audits and educating staff when infection control issues are identified. These measures should improve infection control and minimize risk of cross contamination.

OFFICE OF HEALTH CARE QUALITY: NEW REGULATIONS

The Office of Health Care Quality has released a copy of COMAR 10.05.04, revised effective November 17, 2008. Highlights of the revisions include:

- Definitions for Facility Administrator, CNA-DT and CEO
- Governing Body responsibilities
- Waiver requirements for centers operating an Administrator- in- Training program
- Quality Assurance program updates including staffing exception reporting
- Clarifications of staffing ratios including the requirement for a charge nurse that is not included in the staffing ratio when there are more than nine patients per shift
- Water standards expanded to include treatment system safeguards

PATIENT ADVOCACY GROUP

Pearl Lewis, President

Mobility: As many of you know there has been a great deal of trouble with Mobility, the paratransit service covering the Baltimore metro-area.

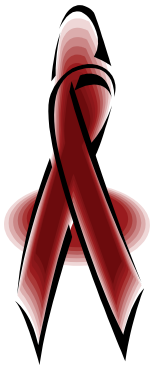
Several years ago we reached an agreement with Mobility which included a dedicated dialysis line and a grace period which allows patients immediate access to Mobility without the 21 day certification period. Richard Reiches and I have been collecting problems from social workers, passing them along to our advocates in the General Assembly especially Sen. Delores Kelley and Del. Shirley Nathan-Pulliam. They have asked the MD Health Care Commission (Bruce Kozlowski) to review the situation and report his findings and to suggest a solution.

Richard and I met with Mr. Kozlowski and provided him with background information necessary to give him the facts required to meet the needs of our and similar populations - a dedicated critical care paratransit system. Other patient populations felt the current system created a system that was not on a level playing field. To address that issue we suggested that the Mobility system become all inclusive serving dialysis patients as well as other similarly affected populations. I suggested using the Rare and Expensive (REM) Case Management program as a template. Using 3-4 medical criteria to identify those eligible for the Critical Care Paratransit we would implement a program that would assure these patients of timely access to and from treatment.

We are currently awaiting the suggestions of MHCC. The Maryland Disability Law Center (MDLC) has been intimately involved in advocating for our, as well as other similarly afflicted populations.

We will up date you by email as soon as a decision has been made. In the meantime please continue to provide MPAG, Pearl Lewis at yetapearl@marylandpag.org with Mobility issues.

This article is printed at the request of the Maryland Patient Advocacy Group and is not to be construed as the opinion of the Commission.



TRANSPLANT NEWS

CONTINUED HOPE FOR PATIENTS WITH KIDNEY DISEASE

This year marks the tenth anniversary of the first Blood Type Incompatible kidney transplant performed at The Johns Hopkins Hospital. Over the past decade many positive changes have occurred resulting in innovative ways to increase transplant options for patients waiting on dialysis for a kidney transplant. Transplantation of patients who have a blood or tissue incompatibility with a live donor, as well as paired donations with other "incompatible" recipients and live donors is now being offered at many transplant centers.

Along with Hopkins, there are several centers that utilize plasmapheresis and immunoglobulin therapy to reduce tissue and blood type antibodies prior to an incompatible live donor transplant with great success! Other centers are administering high dose immunoglobulin for those who have no donor, but have been waiting for years on the deceased donor list due to a high antibody level. This has increased their chance of matching with a kidney from a deceased donor. In addition, there has been a multicenter movement for the kidney paired donation program. Recipients come forward with a donor who is not compatible. The recipient may not want to go through the rigorous treatment of plasmapheresis or they have multiple antibodies that are not amenable to the treatment. These recipients and donors will be paired in an exchange where the donor will give to a recipient that is compatible, and the other recipient will receive a kidney from that person's intended donor. This has proven to be very successful and has given hope and new life to individuals who felt they were destined to spend the rest of their lives on dialysis.

Patient education and communication is the key to patient success in dealing with their illness and treatment choice. Whether it is transplant or dialysis, the patient is taught that these are only treatment options for their kidney disease, not a cure.

Transplantation gives a patient a chance at a new life, but it too comes with many challenges for both the patient and their families. A comprehensive team approach comprised of surgeons, nephrologists, social worker, dietitian, pharmacist, various consultants as well as the transplant nurse coordinator work with the patient and their family both pre and post transplant to achieve the goal of a successful transplant.

The goal of transplantation is not only to treat kidney disease effectively but to also improve quality of life. People who have been unable to obtain a transplant through traditional programs and who are referred to an Incompatible Transplant Program may have additional burdens and pressures beyond those assumed by patients whose treatment may be more routine. Travel may be required and costs of transportation and local lodging may strain resources already affected by chronic illness. Social support is an important component of successful transplant. Support may be limited or unavailable away from home. Extended hospitalizations and complications requiring longer local stays are not uncommon among patients in incompatible transplant protocols, and these complications can quickly exhaust the social support and financial resources that have been available in advance. Separation from familiar supports is temporary, but can affect coping and adjustment to transplant. Education and preparation are key for successful transplants. The transplant team will assess financial and social resources, as well as the need for education, and will help patients problem solve and develop action plans.

Advancements in the field of transplantation have given hope to those waiting for kidneys. In addition, plans are in the works for a national paired kidney exchange program. Continued research, pushing the boundaries, while maintaining safety for the patient will open new doors for the future of patients with kidney disease.

KIDNEY DISEASE PROGRAM

The Kidney Disease Program (KDP) has been successful in developing a website with information and updates relative to the Program. The address of this website is http://www.dhmh.state.md.us/healthcare/medhealthins.htm. This website includes helpful information such as: KDP Notices of updates/changes, Information Resources, Web Links, Phone Numbers, E-Mail Address for Questions about KDP and Billing Instructions. This website will undergo continuing development in an effort to provide the renal community with the most up to date information available in regards to the Kidney Disease Program. Enhancements and system developments to the KDP electronic claims management system (eCMS) and the ACS pharmacy point-of-sale system (POS) continue in an effort to provide more efficient and timelier processing of claims. These systems continue to allow KDP to accept and return HIPAA compliant transactions from Medicare trading partners and all participating providers.

TIPS FOR A SUCESSFUL SURVEY

The facilities and surveyors all strive for successful survey outcomes. Listed below are tips to help dialysis facilities achieve a successful survey:

- Facility Administrators should be aware of all applicable laws and assure compliance.
- Name tags must be worn by everyone in the facility with name and position identified.
- Care to patients must be provided in a sanitary environment.
- Staff must wear appropriate PPE.
- Staff must participate in infection control training and education.
- Items taken into the patient station must be discarded or disinfected prior to being removed or used by another patient. Blood pressure cuffs, clipboards, TV's etc. must be wiped down with disinfectant. The dialysis chair must be opened up to be properly cleaned.
- Hepatitis testing must be completed on patients and staff. Vaccines must be offered and administered as required.
- AAMI chemical analysis must be completed at least annually and should be reviewed and signed by the Medical Director.
- Monthly water system/ dialysate cultures are required. The Q/A team must review the results. Each facility should designate a person who will be responsible to follow up on water testing at the alert or action level. Don't wait until the last day of the month to send water tests.
- The facility must disinfect the water system monthly.
- The facility's water system must be appropriately labeled. See V 187 Interpretive Guidance for examples.
- The facility's water system operators must be appropriately trained. Periodic audits of the operator's compliance must be documented.
- The water room should be secured/ restricted.
- Dialysate conductivity and pH must be verified at each patient station every shift.
- Reuse staff must be knowledgeable about the process. The facility must provide care in a safe, functional environment. Area must be clean and free from clutter with sufficient space.
- Staff must be CPR certified and trained for emergencies.
- Annual evaluation of emergency/disaster plans is required. Mock codes should be performed.
- Emergency preparedness plans must be reviewed; staff and patients should be able to demonstrate their knowledge of the plans.
- Patients must be informed about reuse.
- Quality assurance audits for reuse must be completed.
- Patients must be informed of their rights and responsibilities and of the facility's internal and external grievance mechanisms.
- Patients must be informed about their right to execute advanced directives and the facility's advanced directive policy.
- Patients must be informed about all treatment modalities and settings.
- Patients must be informed regarding the facility's discharge and transfer policies.
- The facility's interdisciplinary team must provide patients with individualized and comprehensive assessment; the assessment is used to develop the patent's treatment plan. The physician, as a member of the interdisciplinary team, must document their assessment of the patient. The interdisciplinary team must develop and implement a written, individualized comprehensive plan of care. This plan of care must be updated and documented appropriately.
- The facility's home program must meet the Federal requirements for training, monitoring, coordination of care and provision for back-up services.
- Provision of care to the home patient must be at least equivalent to care provided to in-facility patients.
- The trainer must be a RN. Patient comprehension of training must be documented.
- Home records must be reviewed at least every 2 months (should be done monthly during office visits).
- Home adaptation/visits must be documented for home patients (PD, Home hemo).
- Facilities are responsible for the monitoring of water quality for the home hemodialysis patients.
- The dialysis facility's quality assurance program must meet Federal requirements including monitoring performance improvement. All modalities must be included. The facility should set goals and adjust those goals as they are attained. The program must demonstrate measurable improvements in health outcomes and the reduction of medical errors. These improvements must be sustainable. The Measurement Assessment Tool (MAT) tool lists expected outcomes. The facility should document quality assurance meeting minutes and include old and new business in the documentation. Action items must be documented and followed up upon each meeting. The interdisciplinary team must attend the meetings. The meetings should be monthly. Grievance and hospitalization logs must be maintained and reviewed. Review of reuse and water quality must be included. Prioritize improvement activities. Must immediately correct any patient safety issues.
- The Medical Directors must be aware of their responsibilities to the facility.
- The Medical Director is responsible for the QAPI program, staff education, training and performance, policies and procedures including COMPLIANCE. The Medical Director is also responsible to assure that the team adheres to discharge and transfer policies.
- Any involuntary patient discharge must be ordered and documented by the physician and signed by the Medical Director. Approval must be obtained from the Commission.

The CEO/Administrator is responsible for: staff appointments, fiscal operations, QAPI, staffing ratios that meet patient needs, availability of a RN, LCSW and RD for patients, staff orientation and ongoing education, medial staff credentialing, grievance processes, physician roster availability, and agreements and disclosure of ownership.