MARYLAND COMMISSION ON KIDNEY DISEASE

THE CONNECTION

VOLUME 15 ISSUE 1 APRIL 2017

CHAIRMAN'S REPORT

The Commission on Kidney Disease and Transplantation represents a very important institution for the State of Maryland. Its main mission is to protect the citizens of Maryland by promoting the best possible quality health care for end-stage renal disease (ESRD). To that effect, 2016 has been a very busy year with the Commission certifying fourteen new dialysis facilities for the purposes of reimbursement from the Kidney Disease Program (KDP) and surveying 90 facilities (dialysis and transplant centers) for compliance with standards of care, addressing important corrective action plans as needed. Further in 2016, the Commission satisfactorily resolved more than a dozen patients' complaints. To achieve all of its goals, the Commission continues to work collaboratively with the Maryland Board of Nursing and the ESRD Networks, specifically Network 5 represented by Quality Insights Mid-Atlantic Renal Coalition (MARC).

Over the past several years, as a member of the Commission, I had the opportunity to review many dialysis centers surveys. Too many of these surveys cited repeatedly common problems related to "Infection Control" issues by the dialysis staff. For example, "staff member initiating the catheter patient's treatment was not wearing a mask"; or another example, "there was no clean barrier under the patient's catheter and the catheter hubs were not cleaned/disinfected prior to re-connection to the dialysis lines". To help with this vital issue of Infection Control among other issues, the Commission is organizing this Spring, in collaboration with the National Kidney Foundation of Maryland, a conference targeted at patient care technicians (PCTs). The main goal of this conference will be to teach or remind the PCTs, the important reasons behind the rules in dialysis care.

As we all know, patients with ESRD represent a vulnerable patient population. Compared to the general population, dialysis patients are at a much higher risk of mortality and morbidity. For example, hemodialysis patients have about 1.7 hospital admissions per year and this comes with a significant cost. Total Medicare ESRD expenditure in 2014 was $32.8 billion and a significant proportion of this (about 40%) was due to hospitalizations. Because in dialysis patients, more than one-third of hospitalizations result in a readmission within 30 days, the Centers for Medicare and Medicaid Services (CMS) has prioritized reduction of hospital readmissions in this population and adopted the new but still controversial standardized readmissions ratio (SRR). The SRR represents the observed number of readmissions in a dialysis facility divided by the expected number of unplanned readmissions in the dialysis facility. (The expected number of readmissions is a case-mix adjusted according to several patient characteristics). The main controversy stems from the fact that many of these readmissions occur within a week or less after hospital discharge, offering little opportunities for the dialysis centers to intervene on specific problems that might lead to a readmission within 30 days. ***Continued on Page 4***

COMMISSION MEETINGS

The Commission on Kidney Disease will meet on the following dates in 2017:

April 27, 2017

July 27, 2017

October 26, 2017

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.

COMMISSIONERS:

STAFF:

Eva H. Schwartz, MS, MT, SBB(ASCP)
Executive Director

Donna Adcock, RN
Healthcare Surveyor

Leslie Schulman, AAG
Commission Counsel

INSIDE THIS ISSUE:

COMMISSION NEWS

CITATION FREE SURVEYS

The Commission is commending a record number of facilities for achieving citation free surveys:

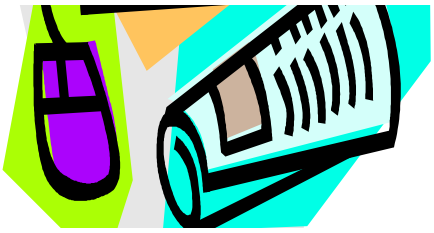
- FMC Robinwood
- Davita Washington County
- Union Memorial Outpatient Dialysis
- NxStage Greenbelt
- Davita Wheaton
- Davita Deer Creek
- IDF Allegany
- IDF Garrett
- Davita Cambridge
- University of MD Transplant
- Johns Hopkins Hospital Transplant
- Davita Berlin
- IDF Chestnut
- NxStage Baltimore North

It is an achievable goal, and should be the goal of each facility.

CONGRATULATIONS !

COMMISSION WEBSITE

www.dhmh.maryland.gov/mdckd
Find the latest Commission information: meeting dates, new facility information, complaint forms, regulations, Governor's report and past and current newsletters.



FACILITIES APPLYING FOR CERTIFICATION

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

- NxStage Baltimore North
- Davita Brandywine
- Davita Glenarden
- FMC Towson
- FMC Cross Keys
- FMC Nashua Court
- FMC Fleet Street
- FMC Caroline Street
- FMC Broadway Street
- FMC Merritt Boulevard
- FMC Greenspring Drive
- FMC Brightseat
- FMC Franklin Square Home
- Davita Kidney Home Downtown
- Davita Largo Town Center
- Davita Greenbelt Home Training
- Davita Briggs Chaney
- Davita Friendly Farms Home

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

KIDNEY DISEASE FACTS

1 in 3 American adults is at risk for kidney disease. 26 million American adults have kidney disease—and most aren't aware of it. Risk factors for kidney disease include diabetes, high blood pressure, family history, and age 60+. People of African American; Hispanic; Native American; Asian; or Pacific Islander descent are at increased risk for developing the disease. African Americans are 3 ½ times more likely, and Hispanics 1 ½ times more likely, to experience kidney failure.

The National Kidney Foundation (NKF) is the largest, most comprehensive and longstanding organization dedicated to the awareness, prevention and treatment of kidney disease. For more information about the NKF visit www.kidneymd.org.

FACILITY NURSING STAFFING

Nurse staffing ratios are not mandated in the state of Maryland. The Federal Regulations, Maryland State Licensing Regulations and Commission regulations require "staffing sufficient to meet the needs of the patients". Patient needs are not met when the nurse is unable to provide pretreatment assessments, address patient issues during treatment, administer medications, provide CNA-DT supervision and assess patients for discharge.

During surveys the Commission surveyor has witnessed nurses who are overwhelmed and unable to provide optimal care for their patients. Patients complain that the nurses are not listening to lungs, checking for edema or reviewing medications. Review of patient treatment sheets reveal that abnormal patient vital signs and findings such as shortened treatments and patients being discharged above or below their ordered goal weights are not being documented by the nurse. In addition, lack of adequate nursing staffing, has led to facilities being unable to open on time and altering patient treatment schedules.

The facility's governing body is responsible to assure adequate staffing including adequate nursing staffing. The Commission recommends that each facility's governing body assess the staffing in their facility to determine if their current staffing is truly meeting the needs and safety of the patients.

By: Donna Adcock, RN

Intradialytic Hypotension: Managing Antihypertensive Medications

Cardiovascular disease remains the most common cause of death in the chronic hemodialysis population. As in the general population, there is a "J" shaped relationship between the level of blood pressure and increased mortality. Control of high blood pressure with the use of antihypertensive agents does improve survival and has therefore is a valuable intervention. The pre- and post- dialysis blood pressure goals that have been proposed by the KDOQI working group are <140/90 mm Hg and <130/80 mmHg. Achieving these blood pressure targets in maintenance HD patients is possible, but also places patients at risk of intradialytic hypotension (IDH). What do we know about the management of antihypertensive medications in patients who experience this unintended consequence?

In dialysis patients, the selection of antihypertensive drugs should be guided by consideration of comorbidities. Overall, ACE Inhibitors, angiotensin receptor blockers (ARB), beta blockers and calcium channel blockers appear to provide similar efficacy in hemodialysis patients and all have been shown to decrease mortality. Ace -inhibitors and/or ARBs may be preferred as they preserving residual renal function in HD and PD patients, maximally decrease left ventricular mass and cause regression of left ventricular hypertrophy (LVH). They reduce sympathetic nerve activity and pulse wave velocity, improve endothelial function, and are beneficial in patients with systolic heart failure and after myocardial infarction. Hyperkalemia and diminished erythropoiesis do not appear to be clinically significant. In hemodialysis patients undergoing routine care, renin-angiotensin system blocking drugs-containing regimens were recently associated with a lower risk of death when compared with β-blockers-containing regimens.

Beta blockers are particularly effective in post MI patients and those with systolic heart failure. Calcium channel blockers are effective and well tolerated, particularly in patients who are volume overloaded. Dihydropyridine calcium blockers, as compared to non-DHPs, are associated with reduced cardiovascular morbidity and mortality. They are useful in those with LVH and diastolic dysfunction. There is emerging evidence that mineralocorticoid receptor antagonists offer a mortality benefit, but confirmatory studies are needed. Centrally acting drugs and direct vasodilators are recommended for last-line therapy, and do not have demonstrated mortality benefit in ESKD. Diuretics in the treatment of hypertension in dialysis should be reserved for those patients with substantial residual renal function.

Intradialytic hypotension (IHD) is defined as the presence of either a decrease in systolic blood pressure _> 20 mmHg or in mean arterial pressure by 10 mm Hg, which coincides with clinical symptoms or require nursing intervention. Symptoms of abdominal discomfort, nausea, vomiting, sighing, restlessness, dizziness, anxiety or restless legs are common. IDH occurs in the absence of medical conditions known to be associated with low blood pressure. The estimated prevalence in maintenance hemodialysis patients is as high as 25-50%. Recognized risk factors for IDH include a long dialysis history, high ultrafiltration rates, diabetes, LVH and diastolic dysfunction, LV systolic dysfunction, severe anemia, hypoalbuminemia, autonomic dysfunction, older age, lower pre-dialysis blood pressure, higher body mass index, female gender, Hispanic ethnicity, and high serum levels of NT-proBNP. Modifiable factors include acetate dialysate, low dialysate sodium and calcium, higher dialysate temperature and possibly pre-dialysis meal ingestion. Antihypertensive drugs used to target current BP goals are an increasingly recognized cause.

Intradialytic hypotension is associated with an increased risk of morbidity and mortality. It causes vascular access thrombosis, impaired well-being and quality of life, chronic fluid overload, cardiac arrhythmias, cardiac and cerebral ischemic events, and interferes with the delivery of adequate dialysis. IDH patients have an increased risk for mortality at 5 years that is 1.6 times greater than those patients who don't experience similar declines. The higher the interdialytic weight gain (IDWG), relative or absolute, the greater the frequency of IDH. A nadir SBP<100 mmHg is most strongly associated with increased mortality.

Initial Measures to Prevent Recurrent IDH

There are currently several strategies to guide management if IDH. All patients should be evaluated carefully and attempts made to correct simple variables. This should always start with re-evaluating the patient's dry weight. The optimal weight is often initially determined clinically by setting the goal at just above that weight which is associated with symptoms. Some centers have the capability to use modalities such as blood volume monitoring that more objectively estimate dry weight. These technologies, when available, can reduce IDH by as much as 30%.

It is important that once patients with frequent IDH have been identified, a multidisciplinary approach be instituted and a new plan of care be discussed directly with the patient. Patients should be evaluated for their underlying cardiac function and potential autonomic instability. Frequent blood pressure measurements are necessary to ensure patient safety during hemodialysis treatments. Excessive fluid accumulation between dialysis sessions should be strongly discouraged. Limiting salt, proper dosing and timing of medications, and adherence to the prescribed treatment can all reduce IDH. Staff can be educated on the detriment of automatically reducing UF or administering fluids. These rescue measures should only be done if necessary. Engaging patients with the health care team could have additional benefits in controlling interdialytic weight gain and reducing IDH episodes. Such efforts can bolster satisfaction and adherence by the patients and staff.

Whether the current strict blood pressure targets for hemodialysis patients offer a survival advantage remains controversial, particularly when IDH results. In the meantime, medication lists should be scrutinized for accuracy on a regular basis. Short acting antihypertensives and direct vasodilators should be avoided where possible. Nocturnal dosing of longer acting agents is encouraged, which may reduce the early morning surge of blood pressure and minimize intradialytic hypotension. There is limited evidence that withholding antihypertensives before dialysis reduces IDH events. If concerted measures do not improve the incidence of IDH, consideration should be given to longer treatment times or other modalities.

By: Donna S. Hanes, MD, FACP

When it Comes to Vital Organs Hearts Get all the Love—Time to "Heart Your Kidneys"

New public awareness campaign launches for March, National Kidney Month

The National Kidney Foundation (NKF) is encouraging all Americans to "**Heart Your Kidneys**" (#heartyourkidneys) today, on World Kidney Day and throughout the month of March, National Kidney Month. The new public awareness campaign seeks to lift the kidneys to the status of other, better-understood, vital organs like the heart so that people understand what kidneys do and why they are vital to sustaining life.

"When it comes to vital organs, hearts get all the love. Kidneys get the short end of the stick," said Kevin Longino, CEO, National Kidney Foundation. "But kidneys are essential to keeping you healthy—when your kidneys stop working, so do you. Trust me, I know," added Longino, who received a kidney transplant 12 years ago.

More than 26 million Americans have kidney disease, and most don't even know they have it. When kidneys fail, dialysis or a transplant are needed just to stay alive. One in three American adults is at risk for developing the disease within their lifetimes.

The foundation is encouraging anyone with diabetes, hypertension, or a family history of kidney disease to speak with their doctor this month and ask about getting tested. It only takes two simple tests at the doctor's office to check your kidney health. Even if you inherit kidney disease, you may be able to slow it down with lifestyle changes.

Join the conversation #heartyourkidneys.

UPCOMING EVENTS

***KIDNEYS: EVALUATE YOURS (KEYS) SCREENINGS**

Free screening designed to detect early markers of chronic kidney disease and identify those at risk. Includes brief medical history, measurement of weight and blood pressure, possible blood draw and medical consultation.

Saturday, April 1, 2017
Peninsula Regional Medical Center HealthFest
James M. Bennett High School
07:30 am - 12:30 pm
300 East College Avenue, **Salisbury, MD**

Saturday, September 30, 2017
Hispanic Health Festival &Resources
Heritage Community Church
10:00 am - 2:00 pm
8146 Quarterfield Road, **Severn, MD**

Saturday, October 28, 2017
Go Pink Go Blue Expo
Mount Pleasant Church & Ministries
11:00 am - 3:00 pm
6000 Radecke Avenue, **Baltimore, MD**

Greater Baltimore Kidney Walk
Sunday, April 30, 2017
9:00 am Check In; 10:00 am Walk Start
UMBC,100 Hilltop Circle Lot 22
Baltimore, MD

Southern Delaware Kidney Walk
Sunday, April 30, 2017
10:00 am Check In; 11:00 pm Walk Start
Cape Henlopen State Park, **Lewes, DE**

Salisbury Kidney Walk
Sunday, May 7, 2017
9:00 am Check In; 10:00 am Walk Start
Winterplace Park, **Salisbury, MD**

2017 Scientific Session
Thursday, May 4, 2017
6:00 pm – 9:00 pm
Johns Hopkins Bayview Asthma & Allergy Center, **Baltimore, MD**

10th Annual Beyond Dialysis Patient Conference
Sunday May 7, 2017
11:00 am—3:30pm
Hilton Garden Inn, 5015 Campbell Blvd, **Baltimore, MD**

Lessons in Dialysis Conference
Sunday, May 21, 2017
7:00 am—11:30am
John Hopkins Hospital, **Baltimore, MD**

Rappel for Kidney Health
June 3, 2017
9:00 am—5:00pm
Hyatt Regency, **Baltimore, MD**

Golf Classic
Friday, September 15, 2017
Greystone Golf Course, **White Hall, MD**

Interested in scheduling or volunteering for a screening? Please contact Jessica Quintilian, Senior Director of Field Services, jquintilian@kidneymd.org or 410.494.8545.

Chairman's Report

(Continued from Page 1)

Nevertheless, the SRR took effect at the beginning of this year as a new quality measure for all dialysis facilities.

At this point, we need to work diligently in addressing this new quality measure as best as we can to not only reduce societal cost of care but also and importantly to help improve our patients outcomes as several studies have shown that hospital readmissions have been significantly associated with higher mortality, higher morbidity (malnutrition, hospital acquired infections, …) and poor quality of life. There are several possible interventions at the level of the dialysis unit that may help reduce 30-day readmissions. The following is a suggested list of these interventions that may help when reassessing a dialysis patient after hospitalization:

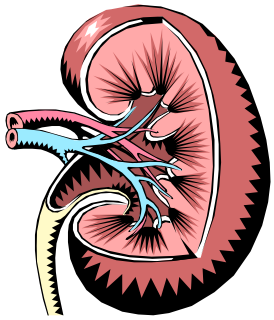
- Reassess nutritional status
- Reassess Dry Weight to avoid volume overload
- Medication reconciliation
- Treat ongoing infections: e.g., avoiding break in antibiotics coverage between the inpatient and the outpatient setting
- Reassess anemia management

Although to date, none of these interventions have been scientifically proven to lower the risk of 30-day readmissions, however, they represent good practice and common sense interventions.

By: Bernard Jaar, M.D., M.P.H.

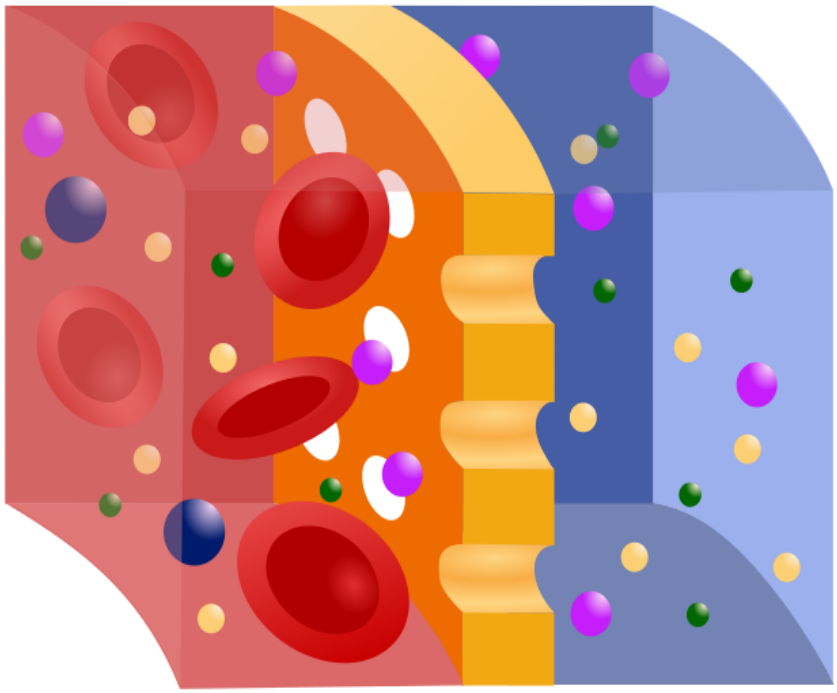
MARYLAND COMMISSION ON KIDNEY DISEASE

4201 PATTERSON AVENUE
BALTIMORE, MARYLAND 21215
TOLL FREE : 1 866 253 8461
TEL: (410) 764 4799
FAX: (410) 358 3083
EMAIL: *eva.schwartz@maryland.gov*



WE ARE ON THE WEB

dhmh.maryland.gov/mdckd/



KDP FISCAL YEAR 2016 ACCOMPLISHMENTS

The Kidney Disease Program (KDP) enhanced the Program's website with information and updates relative to the Program. The address of this website is :

http://mmcp.dhmh.maryland.gov/familyplanning/Pages/kidneydisease.aspx.

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, Billing Instructions, KDP COMAR Regulations and the KDP Drug Formulary. This website will undergo continuing development in an effort to provide the renal community with the most up to date information available with regard to the Kidney Disease Program. Enhancements and system developments to the KDP electronic claims management system (eCMS) and the Xerox 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.

ESRD providers of service continue to be granted access to the KDP Portal. Approval of the required User Agreements, necessary to grant access, has improved to a 48 hour or less processing window. The website, to gain access to the KDP portal is www.dhmheclaims.org. This portal allows providers to verify claims' status and view detailed payment information, which includes, check numbers, check dates and voucher numbers. This information assists providers in maintaining an accurate and up to date accounts receivable system and minimizes duplicate billing. In addition, providers of service may access up to date eligibility information for all ESRD patients certified with the Kidney Disease Program of MD.

The BPO approved the first option period for TPL on June 8, 2016 to include KDP in Medicaid's HMS (Health Management Services) contract to gather third party information in an effort to maximize collection efforts and ensure that KDP is truly a payer of last resort. The current period expires on June 30, 2018. Work has initiated to modify the KDP eligibility file to effectively transmit records in the proper format to HMS.

Santeon upgraded the entire eCMS platform to be compatible with newer Windows version and .Net frameworks. This upgrade has improved the security of the system. Upgrading the entire eCMS platform improved the security, reliability and performance of eCMS thus enhancing the efficiency and productivity of the system.

KDP, along with BCCDT and MADAP, has obtained a sole source contract with Santeon, the current KDP claims processing vendor, to continue the KDP claims functioning processes, financial payments and recoveries, in addition to reporting requirements. This 5 year contract covers the period of FY 2016 to FY 2021.

Customer service in the areas of patient certification, accounts payable and accounts receivable continues to improve. KDP personnel strive to assist KDP recipients, in processing applications as quickly and efficiently as possible, adjudicate claims in a timely manner, provide assistance with program participation fees, and provide education to members of the renal community to assist them in receiving the most accurate information possible.