

ANNUAL RECONCILIATION COMING SOON!

Soon after the close of 2004 it will be time for Network 8 to "reconcile" our record of the year's patient events with your record-patient by patient.

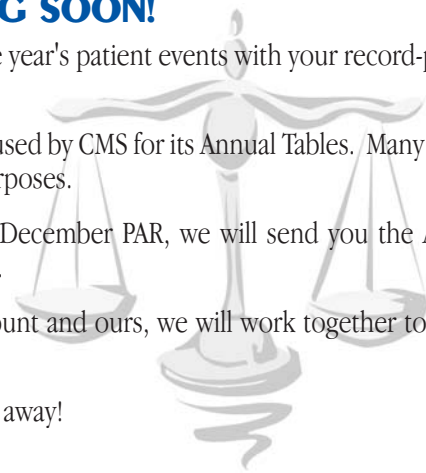
The reconciliation provides a completely accurate end-of-the-year patient census that is used by CMS for its Annual Tables. Many organizations and government departments use these counts for planning and budgeting purposes.

For those of you new to reconciliation, this is what happens. After we receive your December PAR, we will send you the Annual Reconciliation Form that counts and categorizes your patients' events for the year 2004.

You will then verify that all counts are correct. If there is a difference between your count and ours, we will work together to determine what is correct.

For you "old hands" at reconciliation-we hope you can return your balanced form right away!

We look forward to working with you. Let's get it right! jc



CLINICS WITH VISION

Twenty independent dialysis clinics in Network 8 have signed on to participate in the VISION electronic data submission project.

Training will be held in Birmingham on January 20. Immediately thereafter, these VISION clinics will begin submitting all patient events to the Network electronically.

The VISION clinic uses a new software product to enter all patient event information. The new events are then uploaded via the Internet through a secure CMS website. The Network will then download the event files, verify the accuracy, and enter the event into the SIMS computer system. The clinic and Network 8 will be in sync at all times.

Hats off to the leaders of the pack-those with VISION!!

- 013300 Children's Hospital- Birmingham, AL
- 012549 Dialysis Affiliates of South Alabama-Brewton, AL
- 012600 Atmore Dialysis Center-Atmore, AL
- 012565 South Baldwin Dialysis Center-Foley, AL
- 012607 Roanoke Dialysis Clinic--Roanoke, AL
- 012616 Landmark Dialysis Clinic-Talladega, AL
- 012614 Physicians Care Dialysis of Selma-Selma, AL
- 252502 Hattiesburg Clinic Dialysis Unit-Hattiesburg, MS
- 252510 Laurel Dialysis Unit-Laurel, MS
- 252517 Pearl River Dialysis Unit-Picayune, MS
- 252523 Columbia Dialysis Unit-Columbia, MS
- 252534 Waynesboro Dialysis Unit-Waynesboro, MS
- 252546 Wiggins Dialysis Unit-Wiggins, MS
- 252554 Bay Springs Dialysis Unit-Bay Springs, MS
- 252558 Collins Dialysis Unit-Collins, MS
- 252559 Tylertown Dialysis Unit-Tylertown, MS
- 252561 Richton Dialysis Unit-Richton, MS
- 440015 Univ of Tennessee Medical Center Pediatric Dialysis-Knoxville, TN
- 442651 Chattanooga Kidney Center-Chattanooga, TN
- 443301 Methodist LeBonheur Children's Medical Center-Memphis, TN

Other independent clinics are welcome to join us. To find out about signing up for the free software, free training-less paperwork, less faxing, less mailing, faster service to our patients, call Network 8 today. jc



ONGOING NETWORK SERVICES

Facilities with questions ranging from quality of care issues to forms processing should call us at 601-936-9260. We will do our best to help you or see to it that you are referred to a source of information for your technical assistance needs.

Patients with complaints or concerns may contact the Network by using the patients-only toll-free number: 877-936-9260. We recommend that patients first work with you directly to resolve their concerns, but we are available for first-line contact when that is the patient's preference.

Network 8, Inc.
PO Box 55868
Jackson, MS 39296-5868
Phone 601-936-9260
Email: info@nw8.esrd.net
Website: www.esrdnetworks.org/networks/net8/net8.htm

Network News - Winter 2004

Editor - Ann Pridgen, Quality Improvement Director

Articles in this edition written by:

Judy Carter, Information Systems Director

Brenda Dyson, Patient Services Coordinator

Jerry Fuller, Executive Director

Sheila Mitchell, Quality Improvement Coordinator

Ann Pridgen, Quality Improvement Director

This material was prepared under CMS contract number 500-03-NW08 and the contents may not reflect CMS policy.

NETWORK NEWS



SERVING RENAL PROFESSIONALS IN ALABAMA, MISSISSIPPI AND TENNESSEE

WINTER 2004

2004 ANNUAL MEETING WRAP-UP

Though there were no reported sightings of Elvis, and no BBQ served, the 2004 Annual Network Meeting in Memphis was deemed a success. The meeting entitled, "Putting It All Together: Increasing Knowledge and Skills to Improve Patient Care" was held in the Hotel Hilton, October 21-22. Total attendance was close to 300. We would like to thank the Network Council officers, the planning committee, Network 8 data staff, conference faculty, commercial supporters and the attendees for contributing to the success of the program.

The meeting was primarily focused on the National Vascular Access Improvement Initiative: Fistula First. A pre-conference vascular access workshop for nurses and patient care techs was presented by Debbie Brouwer, RN, CNN, a member of the Fistula First and K/DOQI work groups. A separate track was provided for physicians, entitled "Placing Fistulas First...and Successfully". This track included nationally known speakers: Larry Spergel, MD, vascular surgeon and Clinical Chair of Fistula First; Michael Allon, MD, Professor of Medicine, Nephrology Division, University of Alabama, Birmingham; William Jennings, MD, Associate Professor, Department of Surgery, University of Oklahoma College of

Medicine; and Perry Arnold, MD, Dialysis Access Specialist, Inc., Baltimore, Maryland.

The Friday session began with a presentation from Dr. Jack Reed, nephrologist from Columbus, Mississippi, who presented "The Team Approach to Fistula First." A panel consisting of an access coordinator, social worker, and dietitian joined Dr. Reed in describing their roles in improving vascular access outcomes.

Other presentations included medications for the transplant and dialysis patient, new trends in RRT, thirst, infection control and an update of the DPC, Decreasing Dialysis Patient-Provider Conflict Project. A psychosocial breakout session included information on the new Medicare drug benefit and vocational rehab.

Many of you requested that the presentation slides and/or handouts be posted on our website. We are in the process of upgrading our website, and this is under consideration. We will let you know when website updates are completed.

We appreciate your support of our annual meeting and strive to make improvements each year. The date and site selections for the 2005 Annual Network Meeting have not been finalized, but you may want to unpack the blue suede shoes and throw in a swimsuit and sunglasses to head for the coast! We'll keep you posted. AP

PARATHYROID HORMONE TESTING

In November, each facility nurse manager, medical director, and administrator received a letter from Network 8 addressing bone disease quality indicators and providing facility-specific performance outcomes. After reviewing this report, several facilities contacted the Network with various concerns about frequent PTH testing.

While each facility is encouraged to develop and follow specific protocols for bone-disease management, tools such as the K/DOQI guidelines and prescribing information for bone disease-related medications are valuable resources for such. In the event that existing protocols appear to be outdated, we encourage review and revision as necessary. Frequency of PTH testing is addressed in both K/DOQI guidelines and prescribing information for Vitamin D analogues.

In regard to PTH testing, currently there is no National Coverage Determination (NCD), i.e., policy, by Medicare. When no NCD exists, local Medicare carriers may opt to create their own coverage policy, formerly known as a local medical review policy (LMRP). In November 2003, CMS issued a final rule directing carriers to issue local coverage determinations (LCD) rather than LMRPs. According to CMS, "The difference between LMRPs and LCDs is that LCDs consist only of 'reasonable and necessary' information, while LMRPs may also contain category or statutory provisions." All existing LMRPs will be converted to LCDs by December 31, 2005.

Continued on Page 4

ITS NOT TOO LATE TO INOCULATE FLU VACCINE REMAINS AVAILABLE

The incidence of flu during this season has been low, with Tennessee reporting only sporadic acuity and Alabama and Mississippi showing no acuity. There is still time to get your patients vaccinated. They can benefit from a flu shot in January since the flu season usually lasts through March.

The Alabama Department of Public Health issued a press release in December announcing that they will be distributing an additional 35,000 doses of influenza vaccine to county health departments and have established an influenza vaccine ordering system for healthcare providers across the state. Additionally the department is identifying health care providers who may purchase approximately 54,000 doses of adult vaccine and 22,400 doses of the pediatric vaccine. Of those doses, 46,300 will be sent in January. The order form can be found on their website at www.adph.org.

The Mississippi Department of Health has announced that flu shots for adults and children in high-risk groups are now available through the county health clinics. The MSDH is also working with health care providers, including hospitals, community health centers and home health agencies to determine their flu vaccine needs.

The Tennessee Department of Health announced on December 14 that they are offering 35,000 doses of adult flu vaccine and 13,000 doses of pediatric flu vaccine for purchase by physicians for high-priority patients. They are available on a first-come, first-served basis until the supply runs out. Letters and order forms have been mailed out to let doctors know that the opportunity exists to get the vaccine for their offices. BD

VASCULAR ACCESS PRACTICES

During our annual meeting, nursing participants were asked to voluntarily complete a survey regarding their facility's vascular access (VA) practices. A copy of the 22-question survey is included in the Fistula First toolkit and reflects the recommended practices of the Fistula First Change Package. A total of 47 surveys were completed, representing 47 facilities ranging from small to large, independently to corporate owned.

The survey results indicate that facilities have adopted many of the recommended practices, but there is much room for improvement. The most widely reported practices used, and the percentages of surveyed facilities using the practices are listed below.

- ◆ Assign most skilled staff to cannulate new AVFs - 97%
- ◆ Utilize specific protocols for new AVFs (e.g. needle size, BFR, tourniquet use) - 86%
- ◆ Select surgeons based on willingness, skill and outcomes with AVFs - 81%
- ◆ Assign staff member to be responsible for monitoring vascular

- access outcomes - 78%
- ◆ Have VA plans for each patient that facilitates timely referral for complications - 76%
- ◆ Request written post-surgical procedure information from surgeons, radiologists - 73%
- ◆ Evaluate and document the status of permanent access plans within the first 3 treatments for new catheter patients - 70%
- ◆ Routinely monitor AVF and AVG flow rates/pressures for stenosis using recommended K/DOQI procedures - 70%

Less frequently reported practices used include:

- ◆ Provide routine cannulation in-services for staff - 68%
- ◆ Refer patients for vessel mapping to assist surgeon with VA placement evaluation - 65%
- ◆ Nurse/Physician collaboration to evaluate all non-AVF accesses as part of CQI process - 59%; develop and document AVF plan - 62%
- ◆ Provide written VA history information to surgeon/radiologist when patients referred for evaluation - 62%
- ◆ Surgical referrals in writing - "prefer AVF only" - 54%

- ◆ Discuss specific criteria with interventionalists/surgeons for determining degree of intervention before new access is considered - 54%

The least frequently reported practices used were:

- ◆ Trend vascular access placement by surgeon as part of routine CQI - 49%
- ◆ Offer self-cannulation option to willing patients - 43%
- ◆ Refer all "failed to mature" AVFs to surgeon or radiologist 4 weeks post-op - 41%
- ◆ Routine evaluation of all AVGs (prior to clotting) for possible conversion to secondary AVF - 30%

While some of these practices may seem more likely than others to increase AVF rates, all are important and have been proven to work. We encourage you to assess your facility's practices and determine which areas need more focus, or which practices could be adopted. For a copy of the Fistula First Facility Self-Assessment Form, contact Casey Magee, Quality Improvement Assistant, at the Network office. (Phone: 601-936-9260, Email: cmagee@nw8.esrd.net) AP

IS FISTULA FIRST SPREADING IN YOUR NEIGHBORHOOD?

In developing the Fistula First project, CMS embraced the concept of "spread theory", defined as the method for promoting broad adoption of new behaviors or techniques. It sounds simple in concept, but achieving increased rates of fistula creation remains a challenge due to the complexity of all that is involved.

Is Fistula First spreading? Word about the project most certainly is, and that is a critical starting point. Fistula First presentations are being made at every major nephrology conference and beginning to make their way into surgical and radiological conferences. Articles are appearing in medical, nursing and trade journals.

Are the initiatives being adopted? Almost all of the related professional societies, patient associations and large dialysis organizations have endorsed the project. It is difficult to argue against the benefits of increased fistula use.

Are the theories being put into action? Every ESRD Network has experienced an improvement in their prevalent fistula rates, since the project began. Not all Network 8 facilities have had the same rate of improvement, and we believe there is a close connection between improvements and adoption of recommended practices. Across the US, the fistula rate has increased 4.4% since the project began, and although Network 8 has the lowest rate at last measurement, this region has seen an increase of 4.2%. We take that as evidence that spread is taking place!

Have you adopted Fistula First and put it into action? If Fistula First has not been adopted in your "neighborhood", you should first identify the barriers, and that may include patients, staff, medical directors, administrators or surgeons.

Remember that communication is the key to overcoming barriers! Be pro-active in initiating conversations with your surgeons and hospital staff. Invite surgeons and radiologists to your QI meetings or take the meetings to them. Review the Change Package and consider introducing new practices on a small scale.

Discuss with your medical directors and administrators. Contact the Network for assistance with barriers you feel are insurmountable.

If you have put Fistula First into action, share your stories with us for publication in future newsletter editions. Fistula First goals are possible to achieve! Help us spread the word! AP

BACK TO BASICS: FOCUSING ON HEMODIALYSIS ADEQUACY

Continued from Page 6

b. Dialyzer

- ◆ Can dialyzer size be increased?
- ◆ Can dialysate flow be increased?
- ◆ Is dialyzer patent? If dialyzer is partially clotted, those fibers are not available for clearance-dialyzer is now, effectively, smaller than prescribed.
- ◆ Are dialysate hoses connected to dialyzer correctly? Only in special circumstances are hoses connected "backward" intentionally.

2) Increase time (t)

- ◆ Is patient signing off early or starting treatment late?
- ◆ Is treatment time determined by machine clock or "wall clock"?
- ◆ If treatment is interrupted, is interrupt time added back to treatment time?
- ◆ Is treatment length adequate in and of itself?

3) Volume (V)

- ◆ Again, volume "is what it is", however, if total body water is calculated based on body surface area, be sure that height and weight are correct in computer data base.

If above interventions are not helpful in improving adequacy, physicians may consider measuring residual renal function to better assess overall clearance.

Please feel free to contact Network 8 if you have any questions or need assistance in this important area of patient care. SM

MEDICATION PROJECT UPDATE

As reported in the last edition, Network 8 and the University of Mississippi School of Pharmacy are working together with CMS to determine baseline medication use in the ESRD population. An ESRD-specific drug classification scheme will be proposed, and medications to be avoided by ESRD patients will be specified.

The project began with the naming of a technical expert panel (TEP), comprised of nephrologists, nephrology pharmacists, industry representatives, and an ESRD patient. The first Network-coordinated TEP meeting was held on November 17, 2004 in Baltimore and included nine CMS staff members as well as CMS data contractors.

Next steps for the project include further data analysis followed by a summary of findings for review and comment by the renal community in February 2005. Comments will be reviewed at the second meeting of the TEP in April, and the project will be discussed before a meeting of renal community stakeholders the following day. A final project report will be completed in June 2005. JF

DID YOU KNOW...

You can help assure that your mail reaches us on time by making sure that you apply the correct postage. Mail sent to Network 8 without proper postage may be delayed several days since "postage due" notices are not always discovered on the day mail is picked up. Also, large envelopes, even those weighing less than one ounce, require more than \$.37 for first class delivery. Help improve your compliance, starting in the mailroom.



BACK TO BASICS: FOCUSING ON HEMODIALYSIS ADEQUACY

In July, each clinic received their facility-specific copy of the 2003 Elab report, obtained for the months of October through December 2003. Using the goals set by CMS for the Clinical Performance Measures, facilities were ranked based on hemodialysis adequacy, and facilities fell into one of three categories:

- ▲ Benchmark: > 90% patients with Kt/V > 1.2
- ▲ Met goal: 84-89% patients with Kt/V > 1.2
- ▲ Failed to meet goal: < 84% patients with Kt/V > 1.2

While most facilities in the Network 8 region met or exceeded goal, there were still several facilities whose patients failed to meet goal. To support the improvement efforts of these facilities and to provide information for new staff Network-wide, this article focuses on interventions to improve hemodialysis adequacy.

The original Dialysis Outcomes Quality Initiative (DOQI) workgroup for hemodialysis adequacy released guidelines for adequacy in 1997. In 2000, the workgroup, re-named Kidney Disease Outcome Quality Initiative (K/DOQI) released updated adequacy guidelines. Goals set by CMS are based on K/DOQI recommendations. Currently, the MINIMUM recommended Kt/V is 1.2 (single-pool or spKt/V). Additionally, due to variances each treatment, it is recommended that prescribed spKt/V be 1.3 so that minimum dose is consistently achieved.

What is the difference between single-pool and double-pool (equilibrated or ekt/V) measurements? With a single-pool model, urea to be removed is considered to be in one-pool, that is, outside of cells, in the bloodstream, and ready for removal. With efficient dialysis, at least 65% of the urea in this pool is removed each treatment (URR of 65%). In actuality, urea is also contained inside cells and must travel across cell walls into the bloodstream for removal. This second pool of urea is taken into account with a double-pool measurement method. In this case, urea levels rise after dialysis when urea (by diffusion) moves across cell walls. This rise, or rebound, typically occurs 30-60 minutes after treatment ends and requires post-dialysis BUN to be drawn only after this time has elapsed. For this reason, the vast majority of clinics use a single-pool model.

Having said that, exactly what does Kt/V mean?

- ▲ **K** represents clearance of urea - a function of the dialyzer. Dialyzers with a small surface area (amount of fibers) and small fiber pore size, clear less urea than do dialyzers with a larger surface area (more fibers) and larger permeability. Therefore, one avenue to increase Kt/V is to increase dialyzer size and/or dialysate flow rate, a commonly used intervention.
- ▲ **t** represents time - the length of time during which urea can be removed. Logically, longer dialysis treatments allow for more urea removal, which is why physicians may opt to increase dialysis time.
- ▲ **V** represents volume - the body volume of distribution for urea. Considered to be the same as total body water. Obese individuals have less total body water (fat tissue contains less water) while lean, muscular individuals have more total body water (muscle tissue contains more water).
- ▲ Based on the formula, a higher K or t, (the numerator) increases the product. Conversely, a higher V (the denominator) decreases the product. You may have noticed the change that volume makes in regard to young, muscular patients. Typically these patients (higher volume) must dialyze longer than patients with less muscle mass-if V is higher, either K or t must increase to yield a higher product. It is important to note, however, that volume "is what it is"-manipulating the volume for on-line clearance measurements to increase the Kt/V simply increases the number mathematically-not the actual clearance.

So, what can be done to increase Kt/V?

Before undertaking any intervention, make sure labs are drawn correctly! It may be well worth your time to review procedure with all staff, particularly if significant numbers of patients have poor adequacy outcomes. If labs are not drawn correctly and consistently correctly, adequacy numbers are worthless! Before conducting a full-blown adequacy investigation, make sure numbers are correct.

If labs are drawn correctly, the following tips may help improve adequacy.

1) Increase clearance (K)

a. Access

- ◇ Is access functioning properly? Is prescribed blood flow rate obtainable? If not, ask MD for fistulagram order. Remember, if arterial pressure is more negative than -240, the pump speed displayed is NOT the pump speed delivered!
- ◇ Is recirculation occurring because needles are too close? Needle tips should ideally be two to three inches apart.
- ◇ Are bloodlines connected to access correctly (arterial bloodline to arterial limb)? It has been estimated that as many as 40% of patients have incorrectly connected bloodlines at any point in time!
- ◇ Can blood flow rate be increased? This may require larger needles. Remember, blood flow through access must be greater than prescribed flow. Average blood flow through an AVF is 500-800 mls/min and roughly 1,000 mls/min for synthetic graft. K/DOQI guidelines recommend fistulagram for access flows < 600 mls/min.

Continued on Page 7

NEW MEMBERS INDUCTED INTO THE FISTULA FIRST 40% CLUB

Each quarter facilities will be recognized for meeting the Fistula First goal of 40% AVF prevalence. The following facilities had an average AVF prevalence rate of 40% or greater for the 3rd quarter of 2004. We congratulate these facilities for this achievement. Facilities new to the list are printed in bold. AP

ALABAMA

ADS - Oneonta

DCI - Phenix City
 FMC - Bay Minette
 FMC - Chambers
 FMC - Dadeville
 FMC - Dauphin Island Pkwy
FMC - East Mobile
 FMC - Eastern Shore
 FMC - Jackson (Tombigbee)
 FMC - Langdale
 FMC - Magnolia
 FMC - Monroeville (Whetstone)
 FMC - Opelika
 FMC - Port City Dialysis
 FMC - Tuskegee
 FMC - West Mobile
 Gambro - Birmingham Central
Gambro - Boaz
 Gambro - Eufaula
 Gambro - Russellville
Landmark D. - Nat. Renal Alliance
 Roanoke Dialysis Clinic
 South Baldwin Dialysis Center
 VA Birmingham

MISSISSIPPI

Bay Springs Dialysis Unit
 FMC - Jackson
FMC - Orange Grove SMKC
FMC - Rankin County
 Laurel Dialysis Center
RCG - Clarksdale*
 RCG - Columbus
 RCG - Greenwood
 RCG - Indianola
 RCG - Louisville
 RCG - Macon
 RCG - Starkville
 Richton Dialysis Unit

TENNESSEE

Bradley Dialysis Clinic
 Chattanooga Kidney Center, LLC
 DCI - Hixson
 FMC - Athens
 FMC - Johnson City
 FMC - Kingsport
 FMC - Morristown
 FMC - Mountain City
FMC - West Kingsport
 Gambro - Columbia
Gambro - Memphis South
 Morristown Dialysis Center
 VA Nashville



*We apologize to RCG Clarksdale, who was not recognized in the last newsletter for meeting the 40% goal in the 2nd quarter of 2004.

STRIVING TOWARD THE GOAL AND BEYOND

The following facilities have shown a 5% or greater improvement in their AVF prevalence rates in the 3rd quarter of 2004. While some have met or surpassed the 40% goal, others are closing the gap! We commend these facilities for the improvements they have made and encourage them to keep up the good work.

ALABAMA

ADS - Oneonta
 ADS - Montclair
 ADS - Shelby
 ADS - Birmingham
 DCI - Phenix City
 DCI - Birmingham
 Dialysis Affiliates of S. Alabama
 FMC - Chilton Peach
 FMC - Dallas County
 FMC - Port City Dialysis
 Gambro - Athens
 Gambro - Dothan
 Gambro - Florence
 Landmark D - Nat. Renal Alliance
 Phys. Choice Dialysis of AL, LLC - Elmore City
 RCG - Andalusia

MISSISSIPPI

Bay Springs Dialysis Unit
 Collins Dialysis Unit
 FMC - Bay St. Louis SMKC
 FMC - D'Iberville SMKC
 FMC - Rankin County
 RCG - Tunica
 Tylertown Dialysis Unit

TENNESSEE

Appalachian Dialysis Center
 DCI - Holston River Clinic
 DCI - Hixson
 DCI - Jasper
 DCI - Sevierville
 FMC - Graceland
 FMC - Mountain City
 FMC - Oak Ridge
 FMC - Roane County
 FMC - West Kingsport
 Gambro - Franklin
 Gambro - McMinnville
 Gambro - Memphis South
 TKCI - Humboldt
 VA Nashville
 Vanderbilt Dialysis Clinic East

PARATHYROID HORMONE TESTING

Continued from Page 1

Furthermore, some clinics may be confused about composite rate lab tests. Tests included in the composite rate are covered by Medicare at the specified frequency using the ICD-9 code for chronic renal failure. Any test in the composite rate can be ordered at different frequency IF MEDICALLY JUSTIFIED, which would require a code other than chronic renal failure. As an aside, PTH testing is not included in the composite rate for laboratory tests.

Specifically speaking, neither Mississippi, Alabama, nor Tennessee has a LMRP or LCD for PTH testing. Some facilities may use out-of-state laboratories whose Medicare carrier DOES have a LMRP or LCD. Contact your laboratory service provider for further information regarding coverage if necessary.

Now for the bottom line- Medicare reimburses for ALL medically necessary laboratory tests. Medical necessity is defined by CMS as "services or items reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member". Medical necessity is reflected by the ICD-9 code chosen-if the code is not specific enough to reflect the need for the test, charges may be denied. Of note, as of October 1, 2004, a new code for secondary hyperparathyroidism of renal origin (588.81) was released.

Renal bone disease is a complex complication of ESRD and one that requires on-going monitoring and intervention for optimal outcomes. Understanding coverage issues for PTH monitoring can lead to better monitoring practices and improved bone disease outcomes. It is our hope that this information will be of benefit. Please call Network 8 if further concerns arise or if more information is needed. SM

ON-LINE EDUCATION OFFERINGS

ESRD Network 5, the Mid-Atlantic Renal Coalition (MARC) has developed five web-based teaching modules for dialysis center staff. The goal of these educational offerings is to assist staff in building communication skills to promote customer service and satisfaction.

The following modules are available:

Module 1: Professionalism in Dialysis Care

The first module defines professionalism in the dialysis center and allows staff to identify ways to apply skills to increase patient satisfaction and define boundaries.

Module 2: Patient-Centered Care

This module defines patient-centered care, and helps participants apply it to their daily work.

Module 3: When Patients Have Concerns

This module allows participants to increase patient/customer satisfaction through identifying and practicing helpful communication skills.

Module 4: Fistula First

This module provides patient care staff with an understanding of the benefits of arteriovenous fistulas (AVFs), and tips for helping patients care for their AVFs.

Module 5: Caring through the End: Final Stage of Chronic Kidney Disease

This module defines palliative care and helps participants identify end-of-life issues that might arise in the facility as well as possible resources and support.

We encourage you to visit the MARC website to view these insightful modules. Modules may be accessed by clicking on "Teaching Modules" on the left side of the MARC home page: <http://www.esrdnet5.org/> SM

BUTTONHOLE INFORMATION AVAILABLE

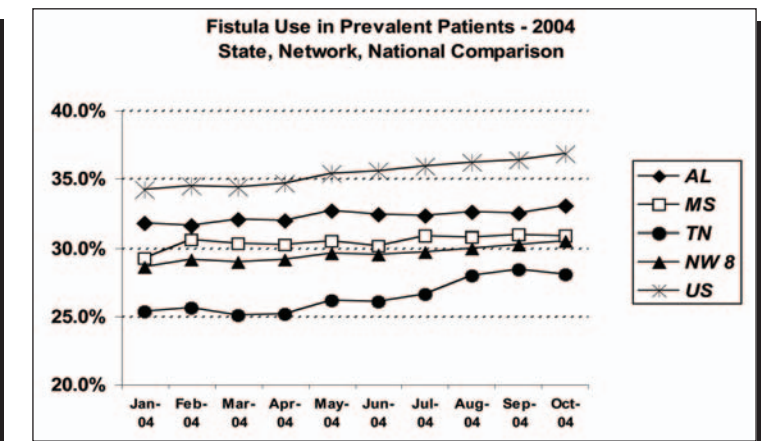
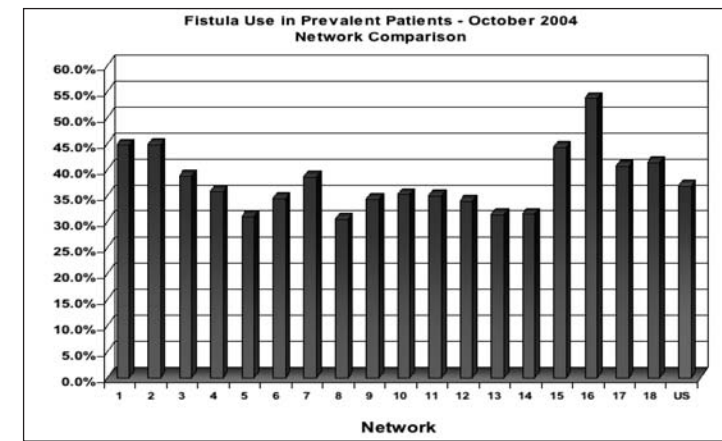
With the Fistula First focus have come numerous educational opportunities, one of which is the buttonhole technique for AVF cannulation.

First used in Europe, this technique has been utilized with success for over 25 years. With this method, the AV fistula (not to be confused with AV graft) is cannulated in the exact same spot, at the exact same angle each time. It is important to note the use of the EXACT same spot - not the same area, which is a noted cause of "one-site-itis". Using this method causes development of a scar tissue "tunnel", similar to that of pierced ears, that allows for easier cannulation of fistula with blunt-tip needles once the buttonhole tract is well established. On average, it takes roughly 6 cannulations to establish a buttonhole site.

We would encourage those of you interested to discuss this technique with your medical staff. As always, please ensure that any change in policy or procedure is approved and appropriate educational interventions have been implemented prior to change.

For more information about this technique, contact Casey Magee, QI assistant, at 601-936-9260 or e-mail cmagee@nw8.esrd.net. Additionally, information is available from Medisystems at 800-369-6334. Information will also be provided at the vascular access workshop on January 23, 2005, in Jackson, MS. SM

FISTULA FIRST DATA SNAPSHOTS



NETWORK 8, INC. & MISSISSIPPI ANNA CHAPTER TO HOST VASCULAR ACCESS WORKSHOP

Mark your calendars for the upcoming vascular access workshop in Jackson, Mississippi, hosted by Network 8, Inc. and the Magnolia Chapter of ANNA. The workshop will be held for nurses, Sunday, January 23, 2005 in the St. Dominic Hospital auditorium. Registration and lunch will be held from 11:00 a.m. - 12:00 noon, with the presentation beginning at 12:00 and concluding at 3:30 p.m.

The workshop entitled "Improving Vascular Access Outcomes: From Examination to Cannulation" will be presented by Debbie Brouwer, RN, CNN, a member on the Fistula First National Leadership Group and the K/DOQI Vascular Access Work Group. Debbie has made numerous presentations and has published articles on vascular access and cannulation.

This same workshop was held in conjunction with the Annual Network Meeting in Memphis, October 21, 2004.

Meeting brochures have been mailed to facility administrators, nurse managers and ANNA members in Mississippi. Pre-registration is preferred (by January 10, 2005) and required for those planning to eat lunch. For further information, contact the Network office.

Contact hours for continuing education in nursing have been applied for through the American Nephrology Nurses' Association, which is accredited as a provider and approver of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation.

Future workshops are being planned for Montgomery, Alabama and Nashville, Tennessee. Watch for coming announcements! AP

FOOD FOR THOUGHT - PALLIATIVE CARE FOR RENAL PATIENTS

Palliative care has been defined as interdisciplinary care for persons with life-threatening illness or injury that addresses physical, emotional, social, and spiritual needs and seeks to improve the quality of life for the ill person and his or her family.

Time constraints in the dialysis unit have kept many of these issues from being addressed, even though for individual patients, they may be equally or more important than clinical outcomes such as adequacy of dialysis and anemia management.

Dr. Michael Germain of Baystate Medical Center in Springfield, MA has studied palliative care in the dialysis center and suggests that the following components be included in a renal palliative care program:

- ✓ a palliative care focus
- ✓ pain and symptom assessment and management protocols
- ✓ systematized advance care planning
- ✓ psychosocial and spiritual support (peer counselors, SW)
- ✓ terminal care protocols (hospice, withdrawal from dialysis)
- ✓ bereavement program (includes memorial services)

Initiating programs of this kind require much dedication and work. However, small steps can be taken to improve end-of-life care for your patients. Many references and resources are available to you by request. Please contact Brenda Dyson at the Network office if you would like to receive more information. AP