

Network Patient  
Activity  
Reports  
...page 2



Describe Your  
Facility  
...page 3



Emergency  
Preparedness  
...page 5



Patients' Need  
for Protein  
...page 6



Volume IV, Issue 2

# FMQAI Access

The Florida ESRD Network

## PLANNING EFFECTIVE EDUCATION PROGRAMS IN DIALYSIS CLINICS

*By Lori Steinmeyer MS, RD, LD*

The Health Belief Model (HBM) is a psychological model used to understand health behaviors and possible reasons for non-compliance with recommended health actions (Becker and Rosenstock, 1984). This model provides guidelines for health education development by illuminating the multiple reasons for non-compliance. The HBM is based on the understanding that a person will follow recommended health actions if they believe that a disease can be avoided, that by taking the recommended health action they will avoid the disease and that he/she can successfully take a recommended health action. The model is constructed on four major dimensions for compliance with recommended health action: perceived susceptibility of the disease, perceived severity of the disease, perceived barriers to compliance with health actions and perceived benefits of compliance to the recommended health actions. An added concept, cues to action, is behavior that activates the client to initiate the health action. And finally a concept added by Rosenstock in 1988, self-efficacy, is the level of confidence a client has

in his ability to successfully perform the recommended health action.

In a National Institute of Health publication, "Theory at a Glance: A Guide of Health Promotion Practice" (Glanz 1997), a table defining these HBM concepts and how they are applied is presented. As Renal Professionals, we can further develop this table to apply to issues of compliance/non-compliance in the dialysis clinics. For example, in my 20-year experience as a renal dietitian, I have found non-compliance to dietary restriction of phosphorus and phosphorus binders to be a common issue. Let's apply this model to phosphorus binder and diet non-compliance to direct us in the development of educational strategies that improve compliance.

Table developed from table in "Theory at a Glance: A Guide for Health Promotion Practice" (Glanz 1997)

*continued on page 4*

# Network Patient Activity Reports



This is a form that all Networks are using for collecting information on patient events. There are a few things we would like to point out.

- You need to enter date of birth and gender for each patient, especially those patients that do not have a social security number (SSN). If the patient is new to ESRD, we cannot create a record for them without that data. In the case of patients that have no SSN, that is often the only way to discern which of many similarly named patients you are referring to.
- The zip code needs to be entered. The form does not have room for complete addresses like the Quarterly Rosters do, but this will allow us to at least get the city, county and state into the initial record. In addition, when the zip code is different from what we have on file, we will know it is possible that the patient has moved, so we will not be sending mailings to the wrong address.
- It is crucially important that you enter a date for each event. Without a date, we cannot enter the event you are reporting into our data system.
- Along with the date, you must enter the modality of the patient at the time of the event. Modality is no longer noted with a number code. Just describe the modality (In-Center Hemo, Home Hemo, CAPD, CCPD, Frequent In-Center Hemo, etc.). You can also use the words to describe the event if that would be easier for you.

Here are a couple of other things we would like to remind you about. These are not new, but since **we are** talking about the report, it is a good time to revisit these issues.

- The reports are due by the 10<sup>th</sup> of each month for the previous month.
- Send us a blank form saying “No Updates,” when you do not have anything to report to avoid being listed as delinquent.
- The most commonly forgotten fields are the SSN, the date of birth and the date of the event. Please make sure you enter those for every record.

As always, you can get a copy of the instructions, a blank form or additional tips from our website at <http://www.fmqai.com/ESRD/> or contact the Network office. If you are using the Excel spreadsheet, thank you! It really reduces problems reading handwriting! If you do not have Internet access and would like to receive the Excel version, please contact the Network office and we can email it to you or send it on a diskette.

## Facility Survey Update

We would like to thank all of you for making this year’s Facility Survey data collection the best one yet. There were fewer records that needed to be researched before mailing and fewer call backs than ever before. This is thanks to the hard work of the facility staff in keeping us updated on what is going on with your patients.

We are hoping that next year will be even better. Moreover, with your help, it can be. At the end of each quarter, we send you a compiled list of the events relating to your patients for that quarter. This will give you a chance to send us any events that may have been missed or entered incorrectly and to update any missing information.

## Getting Blank Forms

Many of you contact the Network each month trying to get blank forms. We are your source for blank 2746 (Death Notification Forms). If you need 2746s, please send a fax with your name, the facility name & provider number and the address to which you would like the forms sent.

The Social Security Administration is the source for the 2728 (Medical Evidence Forms). You must contact your local Social Security office to obtain those forms.

*We do not require* that you submit the government printed forms, as long as the ones you submit look exactly like the approved form, other than the color of the paper. If you are running short of either form, you can make a copy of a blank form and use the copy. If you have run out of blank

*continued on page 4*



# FISTULA FIRST

**MAKE A DIFFERENCE!**  
*Adopt Fistula First Change Concepts and Tools.*  
[www.fmqai.com/ESRD/FistulaFirst/FFT/](http://www.fmqai.com/ESRD/FistulaFirst/FFT/)

## “Describe Your Facility Right Now!”

Which of the sentences below best describes your dialysis facility right now?

Description	Suggestions
<p><b>Jubilation:</b>            “Our facility is really making progress! We are above 60% AVFs!”</p>	<ul style="list-style-type: none"> <li>• Keep up the good work!</li> <li>• Spread the word; share your “best practices!”</li> <li>• Continue to encourage new patients to have AVFs.</li> <li>• Ensure catheters are removed as soon as possible.</li> <li>• Work on converting AV grafts to secondary AV fistulas.</li> </ul>
<p><b>Innovation:</b>            “We are trying new approaches at our facility and have raised our % of AVFs because of it.”</p>	<ul style="list-style-type: none"> <li>• Keep up the good work!</li> <li>• Involve the entire team in brainstorming new ideas.</li> <li>• Cultivate your relationship with your vascular surgeons and interventional radiologists.</li> <li>• Share your ideas with others!</li> </ul>
<p><b>Frustration:</b>            “We are trying to increase our AVFs, but haven’t even made it to 40% yet!”</p>	<ul style="list-style-type: none"> <li>• Continue to encourage new patients to have AVFs.</li> <li>• Ensure catheters are removed as soon as possible.</li> <li>• Consider converting AV grafts to AV fistulas.</li> <li>• Discuss the vascular access goals at the next CQI meeting.</li> <li>• Develop / update your vascular access quality improvement plan.</li> </ul>
<p><b>Depression:</b>            “We have a lot of AVFs, but they don’t work very well.”</p>	<ul style="list-style-type: none"> <li>• Request the medical director speak to your surgeons.</li> <li>• Consider cannulation training for staff members.</li> <li>• Ask the surgeons to join CQI meetings.</li> <li>• Cultivate your relationship with your surgeons and interventional radiologists.</li> <li>• Consider referring patients to different surgeons.</li> </ul>
<p><b>Aggravation:</b>            “My facility is at 20% AVFs or below – I am pulling my hair out!”</p>	<ul style="list-style-type: none"> <li>• Have a serious discussion with the medical director.</li> <li>• Review the Fistula First Change Concepts.</li> <li>• Discuss the vascular access goals at the next CQI meeting.</li> <li>• Read the KDOQI Guidelines for vascular access.</li> <li>• Visit the ESRD Network website at <a href="http://www.fmqai.com">www.fmqai.com</a> or the Fistula First website at <a href="http://www.fistulafirst.org">www.fistulafirst.org</a>.</li> <li>• Develop / update your vascular access quality improvement plan.</li> <li>• Contact the ESRD Network for 1:1 assistance.</li> </ul>
<p><b>Confusion:</b>            “We don’t even understand why AVFs are better than other vascular accesses.”</p>	<ul style="list-style-type: none"> <li>• Visit the Fistula First website at <a href="http://www.fistulafirst.org">www.fistulafirst.org</a>.</li> <li>• Review the Fistula First Change Concepts.</li> <li>• Discuss the vascular access goals at your next CQI meeting.</li> <li>• Read the KDOQI Guidelines regarding vascular access.</li> <li>• Contact the ESRD Network for 1:1 assistance.</li> </ul>

## PLANNING EFFECTIVE EDUCATION PROGRAMS IN DIALYSIS CLINICS ...continued from page 1

CONCEPT	DEFINITION	APPLICATION: DIALYSIS CLINIC
Susceptibility	One's opinion of chances of getting renal bone disease.	Demonstrate risk by showing pictures of metastatic calcifications; Explain the relationship between the symptoms of itching and high phosphorus.
Severity	One's opinion of the seriousness of renal bone disease.	Use a variety of pictures showing the degrees of renal bone disease.
Benefits	One's belief in the efficacy of the advised health action.	Define the time & administration of the prescribed binders; Review dietary restrictions of phosphorus at the patient's literacy level.
Barriers	One's opinion of the tangible and psychological costs of compliance.	Identify financial barriers, use reassurance, assistance and incentives to overcome them.
Action	Strategies to motivate compliance.	Use bulletin boards and other educational material in formats that stimulate action.
Self-Efficacy	Confidence in one's ability to take action.	Encourage even small steps of success in phosphorus control using incentives and praises. Prevent a patient from feeling completely defeated when they fail.

The HBM has been applied to a broad range of health behaviors and populations, including compliance with recommended medical regimes. In our ongoing development of educational programs in the dialysis clinics, we should strive to increase the perceived severity, perceived susceptibility, perceived benefits, self-efficacy and cues to action concepts while decreasing perceived barriers. As a result, compliance should improve in the area this model is applied. As a consequence, we should achieve better outcomes and provide optimal patient care in our dialysis facilities.

### **References:**

Becker, M. H. and Rosenstock, I. M. (1984). Compliance with medical advice. In A. Steptoe and A. Matthews (ed.), Health Care and Human Behavior. London: Academic Press. Pp. 135-152.

Glanz, K., (1997). Theory at a Glance: A Guide for Health Promotion Practice. National Institute of Health.

---

### **Data-Link – Network Patient Activity Reports ...continued from page 2**

forms and you have Internet access you can download the forms from CMS's website or the Network website.

**Quick Links – Network Website**  
<http://www.fmqai.com/ESRD.aspx>

**Download 2728, 2746 and 2744 forms and instructions directly from CMS.**

<http://www.cms.gov/CMSForms/CMSForms/list.asp>  
 and do a search for items containing the word ESRD.

# Emergency Preparedness: There is Always Room for Improvement

The 2004 and 2005 hurricane seasons highlighted issues of concern around the country in addressing the need for community planning and relief efforts in the event of a major disaster. The Network asks that you consider the following information as you prepare your families, facilities and patients for the 2007 hurricane season. Remember, disasters, both natural and man-made, are not limited to hurricanes. Therefore it is critical that you plan for **year-round readiness** to respond to any emergency situation with little or no notice.

At a minimum, your facility should have written disaster policies and procedures in place. All personnel should be trained in their role in emergencies and all patients should be fully informed of where to go, what to do and who to contact. It is important to assist not only patients, but staff as well, with their personal plans.

A strong emergency plan is not limited to working within your own facility structure, but includes **collaboration** with others in the community, such as other providers (independent and corporate), local emergency responders, transplant centers, nursing homes, hospitals and other key partners. Plan within your community how you will provide emergency dialysis for patients, including:

- ✓ Space to do the treatment;
- ✓ Electricity to run the equipment;
- ✓ Dialysis machines;
- ✓ Potable water for use in the treatment (each treatment requires a minimum of ~ 100 gallons of pressurized water);
- ✓ Water treatment equipment (carbon filtration and either reverse osmosis or deionization);
- ✓ Supplies (dialyzers, blood lines, saline, medications, etc.);
- ✓ Personnel qualified to perform dialysis; and
- ✓ Medical records including the prescription for dialysis.

During times of disaster, the Network tracks facility status (e.g. open, closed, damaged, loss of power, water, phone, or access to the premises) and coordinates efforts with the State of Florida Department of Health (DOH). The status of dialysis facilities is communicated by the DOH

to all County Emergency Management Offices via the state's ESS database. This information is also posted on the Network's website. Therefore, early communication to the Network regarding your facility's status, pre and post-event, is key to response efforts toward restoration of normal operations.

For technical assistance with disaster planning, contact the Network office at 813-383-1530, ext. 3883.

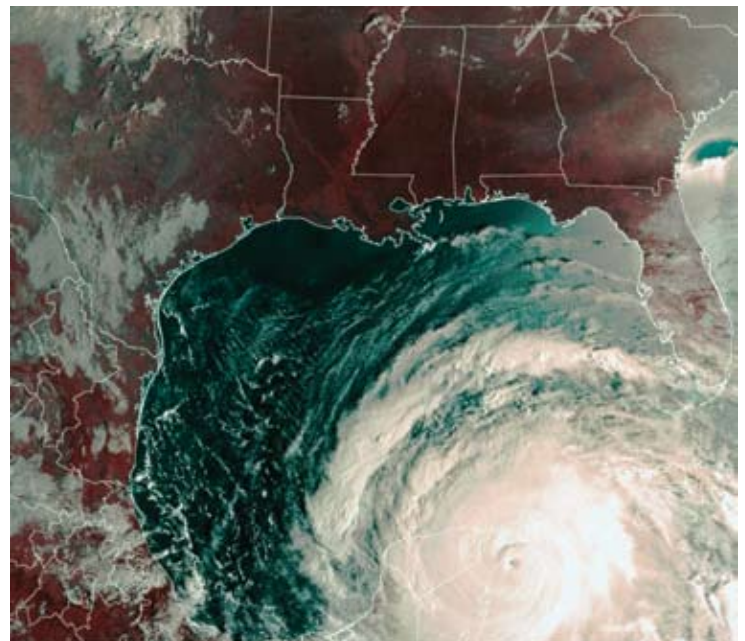
## Tools and Resources

Network 7 Emergency Information (Dialysis Facility Compare, Patient Education Tools, Boil Water Advisory and more) <http://fmqai.com/ESRD/>

Link to County Emergency Management Offices  
[http://www.floridadisaster.org/County\\_EM/county\\_list.htm](http://www.floridadisaster.org/County_EM/county_list.htm)

Link to Emergency Guide for People on Dialysis  
<http://www.medicare.gov/Publications/Pubs/pdf/10150.pdf>

Link to Emergency Preparedness Guide for Dialysis Facilities  
<http://fmqai.com/ESRD/pdf/CMSDisasterPlanningGuide.pdf>



## Q

# Quality Corner

## Dialysis Patients' Need for Protein

*An interview with Maureen McCarthy, MPH, RD, CSR, LD*

*“Reprinted with permission of the Medical Education Institute, Inc. from Life Options ([www.lifeoptions.org](http://www.lifeoptions.org))”*

**Q: Why do so many ESRD patients fail to get enough protein in their diet?**

**A:** For many, the problem begins before they start dialysis. In Stage 4 CKD, patients often experience a spontaneous decline in protein intake. If, in addition, they overdo recommendations to restrict dietary protein, they arrive at dialysis already undernourished. The problem is likely to worsen in the first few weeks on dialysis because patients lose protein during treatments, but do not regain their appetites for at least 6 – 8 weeks. Even when a taste for food returns, it may be hard to eat enough protein to reestablish good nutritional status.

**Q: What should dialysis caregivers show about serum albumin and dietary protein?**

**A:** Many articles in the literature identify serum albumin as the strongest predictor of hospitalization and death in dialysis patients. However, dialysis staff members should recognize that lab values for serum albumin are affected by many factors, including access problems, hospitalizations, infections and more. Nutrition is important, of course, but we must consider a variety of factors when we interpret serum albumin values. Too often, we scold our patients about food choices and eating habits, when there may be other reasons patients fall short of meeting goals for serum albumin values.

It is estimated that about 40% of all dialysis patients are malnourished. Severe calorie malnutrition is not common in the U.S. Every dialysis staff member should be alert to the signs and symptoms of declining nutrition—a drop in intake, sudden changes or absence

of interdialytic weight gains, unplanned weight loss, lack of interest in food and others.

**Q: What is the most important for patients to know about getting enough protein?**

**A:** Probably the biggest thing for patients to know is their own personal goal for protein intake and calories needed. Patients should be sure their dietitian helps them translate the general KDOQI guidelines into specific, personal goals so they know exactly what they are aiming for each day. In addition, patients should work closely with their dietitians to make realistic choices for the best, high-quality protein sources based on their needs, budget and preferences.

**Q: What is the best way to help patients get all the protein they need?**

**A:** There is no substitute for monthly, one-on-one sessions with the renal dietitian. She or he can help patients understand goals, but can also work with them to understand why lab values may be up or down. There may be a reason(s) other than diet alone. Dietitians can also provide specific guidance about the best food choices for an individual patient, including the use of nutritional supplements, if necessary. Creative suggestions for food preparation and selection, especially on dialysis days when patients may be too tired to put much effort into cooking, can be a big help.

**Q: Does dialysis treatment modality make a difference?**

**A:** Hemodialysis (HD) patients seem to do a little better than peritoneal dialysis (PD) patients in terms of

*continued on page 10*

# Fistula First Champion Surgeons

## Congratulations

The Network would like to congratulate the following surgeons who have been nominated by one or more “Champion Facilities” (during October 2006 thru January 2007) for playing a critical role in their ability to achieve high AVF rates. FMQAI: The Florida ESRD Network thanks you for your outstanding efforts to increase the utilization of AVF for vascular access and improving the quality of care for Florida dialysis patients.

Surgeon	Nominated By
Dr. Sanford Altman	Miami Artificial Kidney Center
Dr. Ron Arison	Universal Kidney Center, Inc.
Dr. Moshe Ashkenazi	Memorial Regional Hospital
Dr. James Bartek	RAI Punta Gorda
Dr. Robert Blais	Pinnacle Dialysis
Dr. Victor Bowers	NRI Tampa, Watson Clinic Kidney Ctr.
Dr. Bert Bowers	Sarasota Physicians Dialysis
Dr. Gordon Burch	Bonita Springs Dialysis
Dr. James Burkes	Miami Artificial Kidney Center
Dr. Charles Neustein	Ocala Regional Kidney Center - East
Dr. Delos Clift	BMA East Orlando
Dr. Joseph Coletta	Pinnacle Dialysis
Dr. Eugene Constantine	Broward Dialysis
Dr. John C. Dali	North Okaloosa Dialysis Renal Care Group - Destin
Dr. Utpal Desai	New Smyrna Beach Dialysis
Dr. Douglas Dorsay	Venice Kidney Center, NRI Lakewood, Sarasota Physicians Dialysis
Dr. T. Patrick Fitzgerald	Sarasota Physicians Dialysis
Dr. James Fogelman	Sarasota Physicians Dialysis
Dr. Steven Halbreich	Sarasota Physicians Dialysis
Dr. Michael Harrington	New Smyrna Beach
Dr. Howard Hermans	NRI Lakewood
Dr. Thomas Huber	Pinnacle Dialysis, Ocala Regional Kidney Center - East
Dr. Gary Janko	VAMC - Bay Pines Healthcare
Dr. Mamoon Jarrah	RAI Punta Gorda
Dr. Chaminda Jayanetti	Miami Artificial Kidney Center
Dr. John Driscoll	VAMC - Bay Pines Healthcare
Dr. Fernando Kafie	Santa Rosa Dialysis
Dr. Steven Kang	Miami Artificial Kidney Center
Dr. Matthew Klein	Pinnacle Dialysis
Dr. Krishna Swaminathan	Ocala Regional Kidney Center - East
Dr. Harold Kulman	NRI Lakewood, Sarasota Physicians Dialysis
Dr. Michael Lepore	NRI Lakewood, Sarasota Physicians Dialysis
Dr. Bradley Litke	New Smyrna Beach Dialysis

Surgeon	Nominated By
Dr. Donald Minervini	South Beach Dialysis
Dr. John Motta	Pinnacle Dialysis
Dr. Eugene Murphy	St. Petersburg Dialysis
Dr. John Nora	Sarasota Physicians Dialysis
Dr. Russell Novak	Sarasota Physicians Dialysis
Dr. Arthur Palamara	Memorial Regional Hospital
Dr. Fuad Ramadan	North Melbourne Dialysis, Melbourne Kidney Center, Palm Bay Kidney Center, Harbor City Dialysis
Dr. Roland Reeves	North Okaloosa Dialysis
Dr. Ronald Reise	Miami Artificial Kidney Center
Dr. Robert Gallinaro	Ocala Regional Kidney Center - East
Dr. Patricia Rosa	Broward Dialysis
Dr. Mark Rosenbloom	North Melbourne Dialysis, Melbourne Kidney Center, Palm Bay Kidney Center, Harbor City Dialysis
Dr. Antonio Revilla, Jr.	Universal Kidney Center, Inc.
Dr. John Royalty	Crystal River Dialysis
Dr. Russell H. Samson	Venice Kidney Center, NRI Lakewood, Sarasota Physicians Dialysis
Dr. Horacio Schlaen	Memorial Regional Hospital
Dr. Harry Sendzischew	South Beach Dialysis
Dr. David P. Showalter	Venice Kidney Center, Sarasota Physicians Dialysis
Dr. Steven Silverman	NRI Lakewood, Sarasota Physicians Dialysis
Dr. Bryan L. Smith	Venice Kidney Center
Dr. Lawrence Sowka	Watson Clinic Kidney Center
Dr. Marwan Tabarra	Universal Kidney Center, Inc.
Dr. Frank Toub	New Smyrna Beach Dialysis
Dr. Stephen Unger	South Beach Dialysis
Dr. Joseph Wasselle	North Melbourne Dialysis, Melbourne Kidney Center, Palm Bay Kidney Center, Harbor City Dialysis
Dr. John Wideroff	Pinnacle Dialysis
Dr. Alan Wladis	BMA East Orlando
Dr. David Wulkan	Pinnacle Dialysis
Dr. Jonathan Yunis	Sarasota Physicians Dialysis



## FROM THE PROJECT DIRECTOR

July 1<sup>st</sup> started the new contract year for Network 7 – and the work continues to focus on improving independence and quality of life for ESRD patients. Many of our projects, like Fistula First, Clinical Performance Measures and Catheter Reduction, will also be continuing forward. These activities are key to advancing the care of ESRD patients. However, another issue will be in the spotlight – the Conditions for Coverage.

The ESRD Conditions for Coverage are a set of minimum health and safety standards that are the foundation for improving care and protecting beneficiaries. The Conditions must be met in order for dialysis facilities to be paid by Medicare and Medicaid. Currently, dialysis providers nationwide are working under Conditions that have not been updated in their entirety since 1976.

On February 4, 2005, the Federal Register published an ESRD Notice of Proposed Rule Making (NPRM) to update the existing Conditions for Coverage. The NPRM is considered to be patient centered, updates the Conditions and supports quality improvement. Comments were solicited for a period of 90 days and are considered during development of the Final Rule. CMS reported that hundreds of individuals, organizations and companies submitted thousands of comments on the Proposed Rule. As required by the Medicare Modernization Act, the Final Rule must be published on or before February 4, 2008. Until the Final Rule is published – the old rules (1976) still apply.

There are many changes incorporated into the Proposed Rules. Here is a brief comparison:

### **Current Rule (1976)**

- ✓ 11 Conditions for dialysis
- ✓ Water, machines, infection control in 1 Condition
- ✓ No quality assurance language except for reuse
- ✓ 2 special Conditions for kidney transplantation

### **Proposed Rule**

- ✓ 17 Conditions for Dialysis
- ✓ Water, machines and infection control are separate Conditions
- ✓ 1 Condition for Quality Assessment and Performance Improvement
- ✓ Requirements for Kidney Transplant moved

Some of the major revisions identified in the Proposed Rule included:

- ✓ Physical Environment
  - Defibrillators required
  - Comfortable unit temperature
- ✓ Patient Rights
  - Advanced directives required

- Discharge and transfer policy – 30 day notice provided to the patient
- ✓ Quality Assessment and Performance Improvement
  - Measure, analyze & track adequacy, anemia, nutrition, medical errors, injuries, access, reuse, patient satisfaction and grievances
  - Prioritize improvement activities

Once the rules are published as final, an effective date will be established for facilities to meet compliance. It could be as few as 30 days. The Network 7 goal is to assist facilities with implementation of the new Conditions for Coverage when they are released; and as always, the Network staff will be available to provide technical assistance to the Florida providers.

But remember ... the proposed rules are only proposed! Until the Final Rule is published in the Federal Register, the dialysis community will continue to operate under the 1976 Conditions. If you would like to view a copy of the complete Proposed Rules, they were published in the

*continued on page 9*



## From the Project Director ...continued from page 8

Federal Register, Volume 70 (2005). You can download a copy at <http://www.gpoaccess.gov/fr/index.html>. The document will be listed as “Medicare Program; Conditions for Coverage for End Stage Renal.”

If you have any questions, please contact the Network at 813-383-1530. Thank you for your time and dedication to the Florida renal community.

*Kelly M. Mayo, MS*

---

## NETWORK 7 IS INITIATING A TRANSPLANT LIAISON PROGRAM!

### **WHAT ARE THE GOALS OF THIS PROGRAM?**

- Increase the number of transplant referrals in the state of Florida.
- Maximize synergies between dialysis facilities, the transplant team and the Network.
- Enhance provider community involvement in achieving ESRD Network goals.
- Assure the evaluation for transplant medical suitability of all patients at the initiation of ESRD treatment or during the pre-end stage evaluation.
- Implement learned process to enhance renal transplant referrals in the state of Florida.

### **WHAT ARE THE NETWORK’S RECOMMENDATIONS CONCERNING THE TRANSPLANT LIAISON’S ROLE?**

- Facilitate communication between patient, nephrologist and transplant team.
- Refer all potential candidates to a transplant center.
- Provide patients with information on transplant options to include living / deceased donations.
- Reinforce need for patient to maintain overall wellness including annual screenings.
- Act as patient and family educator and advocate.
- Assure transplant candidacy evaluation at initiation of treatment and annually thereafter.

### **WHAT WILL HAPPEN IF THESE RECOMMENDATIONS ARE FOLLOWED?**

#### ***THE LIAISON WILL:***

- Enhance knowledge of transplant centers’ selection criteria / referral process.
- Have open and prompt communication with the transplant team.
- Follow-up with monthly labs and annual immunizations.
- Provide patient wellness updates to transplant center.
- Explore the potential for living donor candidates.
- Accept that delivery of transplant services is a continuously evolving process.

***CONSIDER APPOINTING A TRANSPLANT LIAISON  
IN YOUR FACILITY TODAY!***

# SELF CARE AND THE OPTIONS AVAILABLE FOR RENAL REPLACEMENT THERAPY

The number of patients with end stage renal disease (ESRD) requiring renal replacement therapy (RRT) is increasing steadily. According to the United States Renal Data System (USRDS), an annual growth of 4% has been noted. Therefore, the ESRD population is projected to grow to more than 650,000 by 2010.

Currently there are three RRT options:

1. Renal transplantation
2. Hemodialysis (HD)
3. Peritoneal dialysis (PD)

The aim of RRT should be to restore patients to as normal a level of health as possible and to ensure full social and physical rehabilitation. As you know, none of the available therapies offers a cure for renal failure and each has its problems. PD, for instance, can partially replace renal excretory function but clearly does not in any way substitute for the normal endocrine activities of the kidney. Since by definition RRT must be life long, it is important to consider not only survival but also the quality of life the various therapies offer.

The challenge for all of us working with the ESRD patient is to use each of the therapies to its greatest advantage and thus to maximize the quality of care and the longevity of RRT. Having said that, it is crucial for us to promote the self-care capabilities of the ESRD

patients to improve their quality of life and prevent complications.

It is important to remember that our patients need to maintain sufficient self-care behaviors to be able to cope with the disease process. Several studies have showed that there is a relationship between the level of self-care, compliance with therapy, and health promotion behaviors. It is important to keep in mind that the patient's perception about the importance of taking responsibility for his or her own care affects compliance with disease therapy.

According to Orem's theory, self-care is characterized by a patient's deliberate actions to regulate his or her own functioning and development for health and well-being. That means that self-care is a learned behavior. This is well aligned with the proposition that patients should have free choice regarding therapy options, assuming the appropriate resources are available. It is also important that physicians offer all three types of

RRT. It is possible that each form of therapy could potentially be an option during the lifetime of a patient with renal failure.

One factor that influences RRT options and consequently affects self-care is the time of referral. Planning for RRT should begin in stage IV CKD to allow patients and families to understand the treatment options, thereby, allowing an adequate preparation for self-care and a dialysis appropriate access.

Although many educational efforts have taken place, more intense and broad education involving hospital workers and physicians must occur for this measure of early referral to become applied and consistently effective. Patients and their families should be educated and counseled about self-care activities regularly, in individual or group programs. In addition, they should be given support in handling these self-care capabilities.

---

## Dialysis Patients' Need for Protein *(continued from page 6)*

meeting goals for serum albumin levels, but there's lots of room for improvement. This happens because PD patients lose more protein with daily treatments. Of course, daily HD also increases protein losses, but improved appetite often allows a better intake to balance things out.

In one study (Galland et al. *Semin Dial* 17 (2), 2004), 17 conventional HD patients who converted to short daily HD showed significant increases in daily protein intake,

daily energy intake, serum albumin levels and body weight. The authors suspected that "increased frequency was more important than increased dialysis dose," and concluded that "short daily HD appears to be a suitable method to improve nutritional status in dialysis patients." In my own experience, short daily HD patients feel so much better that their appetites are enhanced, and they simply eat better.

# FREE CEU OFFERINGS!

## **Implementation and Use of the DCP Toolbox - 1 Free CEU**

The Decreasing Patient / Provider Conflict (DPC) Toolbox was created by the ESRD community as a resource for dialysis and transplant centers. Using the DPC Toolbox assists providers of dialysis and transplant services to better cope with the issue of conflict. This class “trains the trainer” to use the DPC Toolbox and implement the three training steps of the DPC project.

## **Water Treatment for Dialysis - 1 Free CEU**

This course examines the need for pure water and the function of a water treatment system necessary to produce hemodialysis quality water. This course can be taken by nurses, technicians, physicians, social workers and administrators that are involved with dialysis patient care. The emphasis will be to provide the individual with a brief overview of why water quality is important. It also identifies and explains the key components that are contained within a water treatment system.

## **Ethical Decision Making and Professional Boundaries in Social Work – 1 Free CEU**

This course is approved for social workers and nurses. The objectives of the course include: 1. Examine applied social work ethics in ESRD settings; 2. Increase knowledge of strategies for resolving ethical dilemmas in the workplace; 3. Demonstrate ethical competence through the analysis of ethical dilemmas; 4. Understand ethical and legal boundaries in ESRD settings.

## **Improving Adequacy of Hemodialysis – 1 Free CEU**

After completing this course you will: have a better understanding of DOQI Guidelines for adequacy of dialysis, learn strategies for improving adequacy of treatment for your patients and ensure that you are completing blood sampling based on DOQI Guidelines. This knowledge will assist you in teaching your patients about adequate dialysis, thereby decreasing the risk of premature death.

## **Renal Transplantation – 2 Free CEUs**

The renal transplantation course will provide the participant with the necessary skills and knowledge to understand the need for increased kidney donation in order to improve the possibility for kidney transplantation in ESRD patients. In addition, participants will acquire knowledge that will enable them to determine candidates meeting criteria as a recipient of organ transplantation and organ donation.

## **Vascular Access & Prevention and Treatment of Catheter and Port Complications – 1.5 CEUs**

By the end of this course the learner will be able to: 1. List five methods to decrease vascular access complications and increase vascular access performance; 2. Describe nursing best practices for aseptic technique during catheter care; 3. Examine three causes of early catheter dysfunction; 4. Describe treatment considerations for infected hemodialysis catheters.

Access these online education courses at:

<http://learning5.flqio.org/>



**FMQAI: The Florida ESRD Network**  
5201 West Kennedy Boulevard  
Suite 900  
Tampa, Florida 33609

**ACCESS**

**ACCESS**

is written, designed and distributed by FMQAI: The Florida ESRD Network.

This newsletter is published while under contract with the Centers for Medicare and Medicaid Services, Baltimore, Maryland  
Contract #  
HHSM-500-2006-NW007C

# Save The Date...



## FMQAI: The Florida ESRD Network

*Presents...*

### 2007 NETWORK 7 ANNUAL FORUM

November 14 - 16, 2007

Hilton – St. Petersburg Bayfront  
St. Petersburg, Florida



# Save The Date...