

# Dialysis Clinic Advisory Committee Meeting Minutes

<b>Date:</b> 11/19/13	<b>Convended:</b> 1:15 p.m. <b>Adjourned:</b> 3:00 p.m.	<b>Room:</b> C1D	<b>Minutes Prepared by:</b> Nancy Brown
<b>Meeting Called By:</b> Judy Hughes		<b>Facilitator:</b> Judy Hughes	
<b>Purpose of Meeting:</b> Monthly meeting of Dialysis Clinic Advisory Committee			
<p><b>Stakeholder Attendees:</b> Halaina Bruckman, Tracy Flitcraft, Archie Jones, Cathy Meyer, Stuart Senkfor, Deb Sizer (by phone), Jason (by phone), Debra Hollister, Darlene Rogers, Tamyra Warmack</p> <p><b>CDPHE Attendees:</b> Carol Cambria, Judy Hughes, Cheryl McMahon, Jennie Pike, Laurie Schoder, Lorraine Dixon-Jones</p>			

## Handouts

- Minutes of October 17, 2013 meeting were approved as presented.
- Agenda for November 19, 2013 meeting

## Introductions

## Discussion

- October 17, 2013 minutes were approved as presented.
- Proposed regulation in response to new law: The Department reviewed the revised statutory language in 25-1.5-108, Authorization to Serve Non-ESRD Patients. The public hearing for consideration of the proposed amendments to Chapter XV – Dialysis Treatment Clinics (6 CCR 1011-1) is scheduled for May. In order to meet the May meeting deadline, a draft version of the proposed regulation must be ready by January 2, 2014. Based on the results of today's committee meeting, a substantially completed draft of the proposed regulation wording will be developed and hopefully finalized at the December 17, 2013 committee meeting. The draft will be developed and distributed by e-mail to all committee members with the meeting minutes. Committee members were asked to respond to the draft by marking red-line changes and send the e-mail "reply to all." The committee will first concentrate on the language needed to include treatment for acute patients and later will work on other necessary changes to other parts of the chapter. The Department noted that there are not many specifics currently in the licensing rules for dialysis clinics so this committee will be establishing a bar. As the committee develops a draft, language in the regulation may apply across the board to both acute and chronic patients. The Department noted a concern that no language be included in the state regulation that conflicts with CMS regulations. The need to address peritoneal dialysis was also raised.

Statutory language ".....without a referral for treatment from a board-certified or board-eligible nephrologist licensed as a physician in Colorado." This wording could be an issue for out-of-state nephrologists who see clients in towns close to the Colorado border who may not be licensed in Colorado. There was also a question as to whether this language refers to the hospital or to the facility nephrologist.

- Discussion – Policies and Procedures: Differences between acute and chronic patients. Currently there is no differentiation between the policies and procedures for the provision of care for chronic and acute patients; all care is dependent upon physician orders. Physician orders for an acute patient will differ in that the goal for an acute patient is to retain existing renal function requiring a more individualized treatment approach and more awareness of the overall patient condition. Regarding care planning, an acute patient is considered more unstable but they will be cared for based on a multidisciplinary monthly care plan developed by dieticians, social workers, etc. The determination of when a patient moves from acute to chronic status is physician (nephrologist) driven and depends on the situation and the condition of the patient prior to the injury. Acute patients account for a very small percentage of total dialysis patients currently treated. There is a 30 day requirement to start an initial assessment for a chronic patient, but that time-frame may not be realistic for an acute patient who may not be seen for a 30-day period. The initial plan for the patient should determine the immediate needs of the patient, such as transportation. Most of the standing orders for chronic patients are applicable to acute patients, although a few issues may need to be adjusted.

- Discussion - Education for patients and staff:  
Education for acute patients centers around diet, blood pressure control, emergency information, and other short-term issues that also apply to chronic patients. However, some issues, such as transplant information, will not be applicable. Education provided will depend on how healthy the patient is and whether or not he/she is cognitively ready to receive the information. If at all possible, a caretaker or family member should be present when the patient receives this information. Putting specifics into regulation would be difficult as all patients are different and individual patient's needs vary. There are no specific additional training requirements for staff when dealing with acute patients except to stress that accurate assessment is critical for acute patients. Training is on-the-spot rather than formalized. National training for technicians is required to maintain certification and this training covers acute care. Archie Jones, a dialysis treatment consumer, noted that all dialysis patients have mental health (depression) issues. To educate a new patient, it is crucial to involve a family member or caretaker in the process on behalf of the patient. As it is always difficult to change lifestyle, a caregiver is vital for support. Fresenius has a good booklet that talks to the caretaker rather than the patient.

- Discussion - Type of dialysis patients that clinics can serve:  
Not all patients are good candidates for outpatient dialysis services. Any dialysis facility considering admission for an acute patient will consider the patient's acuity level and determine if it is safe for staff and other patients to admit the patient. All nurses are told not to go beyond the scope of practice. Some patients may be good candidates for outpatient dialysis after just two hospital treatments while other patients are not.

The Department noted the need to include verbiage that would allow for treatment of patients whose needs can be met, but given the anticipated trend of accepting higher acuity levels, also protect dialysis facilities from being pushed by hospitals to accept patients that the dialysis facility is not equipped to serve safely.

- Discussion – Patient assessment and admission:  
The nephrologist who treated a patient in the hospital may not be the same nephrologist overseeing care at dialysis facility. The nephrologist accepting a patient should review records, consider parameters, and discuss the case with the referring nephrologist. Both parties must agree to the acceptance of a particular patient. As not all facilities have the same structure, the Department noted that the appropriate clinical nurse and referring physician should be the individuals agreeing to an acute patient's admission. If in doubt, the clinical nurse should consult with the facility's medical director. Acute patients may require more psycho-social work assessment, especially with traumatic injury cases.
- Discussion - Staffing:  
The ability to take care of non-dialysis issues such as wound care and behavioral management raises the question of adequate facility staffing. Safety and care concerns must be addressed with existing staff, so the facility's staffing model may prohibit a facility from accepting a higher needs patient. Cases that are more serious, such as persons in need of trachea care, should not be seen in a dialysis facility; they will be in long-term rehabilitation or nursing home facilities.
- Next meeting is scheduled for Tuesday, December 17, 2013, 1:00 p.m. in Room C1D.