Dialysis Clinic Advisory Committee Meeting Minutes

Date: 03/18/2014	**Convened:** 1:10 p.m **Adjourned**: 2:40 p.m.	**Room:** C1D	**Minutes Prepared by:** Leslie Simbai
Meeting Called By: Judy Hughes		**Facilitator:** Judy Hughes	
Purpose of Meeting: Monthly meeting of Dialysis Clinic Advisory Committee			
Stakeholder Attendees: Tracy Flitcraft, Archie Jones, Debra Hollister, Vicki Kording **CDPHE Attendees:** Judy Hughes, Carol Cambria, Cheryl McMahon, Jennie Pike (by phone), Laurie Schoder, Lorraine Dixon-Jones			

Handouts

- Copies of the minutes of February 18, 2014 meeting
- Memorandum dated March 13, 2014 regarding types of reportable events (occurrences) in other states

Discussion

- Judy Hughes convened the meeting and announced that Laurie Schoder will go before the Board of Health on 03/19/2014 to request a rule hearing. Laurie Schoder noted that the Board typically does not take testimony or questions during requests for rulemaking. Her presentation to the Board will include the proposed rules, a cover letter regarding the rules and a statement of basis and purpose and regulatory analysis.

- Tracey Flitcraft indicated that the proposed rules were not sent out through the portal. Laurie indicated that they were supposed to be sent 02/21 and she would follow-up to find out why they did not go out.

- Judy asked whether the group should meet as frequently and if so what the providers would like to discuss at future meetings. The group indicated that it still wanted to meet monthly.

- Lorraine Dixon-Jones distributed a memo outlining some of the reportable occurrences in other states and types of state agency responses. She noted that Colorado' rules are about 14-15 years old and all facilities were included. Since then various organizations have focused on patient safety issues more specifically, for various facility types. Many states have adopted the guidelines set by the National Quality Forum for hospitals, ASCs and birth centers. The types of reportable events include criminal assaults, environmental issues, falls, burns, care management, pressure ulcers and some areas that don't relate to dialysis.

- Debra Hollister said that she has a state- by- state comparison and will share this as it is specific to requirements for ESRD. Judy stated that the occurrence advisory group is currently working on what is presently being done and that this advisory group can work on what the future should look like. Dialysis already has some appropriate responses to consumer safety.

- Stakeholders asked what will be done with the data and what will be disseminated to the public. Will the data be aggregated and disseminated to facilities? Will information be shared with the Renal Network? Providers indicated the Renal Network has worked collaboratively with them in the past. Several years ago they provided technical assistance and training. Judy indicated that the training might be valuable for the department's survey staff. The need for specific guidance about what exactly is reportable was discussed. The reporting system in Texas was raised as a good example of specificity. In addition, the value of root cause analysis was noted and that a culture of safety should be focused on process improvement and be non-punitive.

- Carol Cambria indicated that occurrences can provide valuable insight into "near misses" on issues such as equipment malfunction, where the state can react with much more quickly than the FDA.

- Provider performance needs to be evaluated according to the complexity of the organization or treatment numbers not just as pure data. If you have one provider who is diligent about reporting and one who is not, it looks as if the non-compliant one is the better facility. Data needs to be disseminated to the public in a way that expresses its true meaning. Judy said part of the vision is to decrease occurrences and complaints by increasing prevention through education If there is a increase in a specific trend, the response would depend on the situation. Perhaps

the appropriate response may be to call in the experts or come up with a training plan. Maybe it would be to have a face-to-face meeting with providers or to issue a memo.

- Debra discussed the national call that was held three weeks ago. Companies in attendance were: Fresenius, DCI, Renal Ventures and Davita. She indicated it is difficult to reach the people at CMS. Staff noted that different CMS regions may interpret federal requirements differently. Often the best way to get a definitive answer is by email, since it can be easily tracked and forwarded.

- Next Meeting is scheduled for April 15th. At the next meeting:
  - Debra Hollister indicated she would bring meeting notes from the national call with other providers.
  - There will be continued discussion about what providers think the future state of occurrence reporting should be.