

MARYLAND COMMISSION ON KIDNEY DISEASE

THE CONNECTION

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MOLST: MEDICAL ORDERS FOR LIFE SUSTAINING TREATMENT

BY:

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A “Medical Orders for Life Sustaining Treatment” or “MOLST” form contains medical orders regarding life-sustaining treatments, the use of medical tests, whether to transfer a patient to a hospital, and other orders implementing the treatment preferences of patients. Unlike an advance directive, a MOLST form contains written medical orders related to a patient’s current medical condition.

The Department of Health and Mental Hygiene has adopted regulations that specify the MOLST form and its instructions. The Department’s regulations regarding the MOLST form are contained in COMAR 10.01.21.

Effective July 1, 2013, certain health care programs and facilities are required to complete a MOLST form for each newly admitted patient and must offer the patient, the health care agent, or the surrogate decision maker the opportunity to participate in the completion of the MOLST form. These health care providers include nursing homes, assisted living programs, home health agen-

cies, hospices, kidney dialysis centers, and hospitals. Hospitals are only required to have a MOLST form completed for an inpatient who is to be transferred or discharged to the care of one of these health care programs or facilities. Other health care providers may voluntarily choose to use a MOLST form. If they do so, they must offer the patient, the health care agent, or the surrogate decision maker the opportunity to participate in the completion of the MOLST form.

The MOLST form is not required for patients whose primary diagnosis is related to a current pregnancy, for children under age 18 who are unlikely to require a life-sustaining treatment, and for patients with a primary psychiatric diagnosis, except for dementia, delirium, or mental disorders due to a medical condition. Physicians or nurse practitioners caring for these patients may elect to complete a MOLST form, depending on the circumstances and the voluntary participation of the patient.

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COMMISSION MEETINGS



The Commission on Kidney Disease will meet on the following dates in 2013:

April 25, 2013

July 25, 2013

October 24, 2013

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:

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COMMISSION NEWS

CITATION FREE SURVEYS

The Commission is commending the following citation free facilities:

- Johns Hopkins Harriet Lane
- IDF Arundel Center
- Davita Home
- IDF Chestnut Center
- Good Samaritan—Frankford
- Davita Washington County

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

CONGRATULATIONS !

FACILITIES APPLYING FOR CERTIFICATION

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

- FMC Princess Anne
- Good Samaritan Future Care
- Davita Charles County
- Davita Deer Creek Home Training
- Davita PG County South

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

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.



POSITIVE CROSSMATCH AND SENSITIZED PATIENTS

About 30% of transplant patients are sensitized. This means that they have harmful antibodies which will attack foreign tissue, such as the transplanted organ from a living donor. These antibodies develop through previous exposure to foreign tissue, such as through pregnancy, previous transplants, or blood transfusions. Sensitized patients may wait three to four times longer for a compatible deceased donor kidney. To test a recipient for these antibodies, a sample of their blood is mixed with a sample of the potential donor's blood. This test is called a "crossmatch," and shows how a recipient's antibodies react with the donor's. Test results can be either positive or negative. It may seem confusing at first, but a positive crossmatch means that a donor and recipient are not compatible.

INCOMPATIBLE KIDNEY TRANSPLANTATION:

Often, patients who need a kidney transplant have a living donor. Unfortunately, many living donors may not have blood or tissue types that are compatible with their recipient. In this case, if the traditional method of transplantation were to occur, the transplant would fail. These same incompatible donor/patient pairs do have an opportunity to be transplanted by exploring Incompatible Kidney Transplant programs.

The Incompatible Kidney Transplant program (InKTP) was developed to offer kidney transplant patients the ability to receive a kidney from a live donor with a

different blood or tissue type (ABO blood group incompatible and positive cross-match). Further, this program addresses donor sensitization or the inability of recipients to receive organs from certain donors because of immune system antibodies that the recipient carries. Paired Kidney Exchange, Blood Compatibility, Positive Crossmatch and Sensitized Patients, are subspecialties of the InKTP program at Johns Hopkins Hospital.

PAIRED KIDNEY EXCHANGE:

Also known as a "kidney swap" this occurs when a living kidney donor is incompatible with their recipient and exchanges kidneys with another donor/recipient pair.

BLOOD COMPATIBILITY:

Living donors and recipients should have matching or compatible blood types to decrease the risk of organ rejection. Patients with living donors who do not have a compatible blood type can still receive a kidney transplant. The Johns Hopkins Comprehensive Transplant Center pioneered a method of removing harmful antibodies prior to transplant. This method is called plasmapheresis.

Living donors have helped meet the desperate needs of many transplant patients who have endured long waits for deceased kidney donors. Through careful protocols and specialized care treatments, Johns Hopkins has been able to desensitize and transplant 98% of the patients who had therapy with a live donor kidney. Please feel free to contact the Johns Hopkins Hospital Comprehensive Transplant Center 410-955-5045 for additional information about Incompatible Kidney Transplantation or to refer a patient for transplant evaluation.

Amy S. Morris, MHA
JHH Transplant Outreach Coordinator

The More Options the Better in Kidney Transplantation

The first kidney transplants in the U.S. occurred in the 1950s, and the surgical techniques and science have continued to improve steadily ever since. Now, roughly 17,000 kidney transplants alone are performed every year at hospitals across the country, and patients are only in the hospital four or five days after the surgery instead of several weeks. Transplant teams are working diligently to create more options for people in need of transplantation.

Studies show that kidneys from living donors have the best long-term outcomes. However, volunteering to be a living donor can be an intimidating process. Most transplant programs are able to make the process donor-friendly by having a dedicated team of living donor specialists who work closely with living donors and can help anticipate their questions and concerns.

One surgical technique is especially donor-friendly, known as the SILS technique (single incision laparoscopic surgery). Surgeons make one small incision in the donor's belly button to remove the kidney. The donor leaves the hospital with a Band-Aid on their belly button and virtually no scar from their life-saving donation.

A 2012 study published in the *Annals of Surgery* by a surgeon from the University of Maryland School of Medicine found that living donors who had a kidney removed through a single port in the belly button reported higher satisfaction in several key categories, including significantly improved satisfaction with the cosmetic outcome and the overall donation process, compared to donors who underwent traditional multiple-port laparoscopic removal.

Paired Kidney Exchange (PKE) is another initiative that can help give transplant patients more options. PKE is an option for recipients who have someone willing

to be a living donor but who are not a match with that donor. This is known as an "incompatible pair." By entering the PKE program as an incompatible pair, donors and recipients become part of several transplant registries, which allows the best kidney to be matched with the best recipient. This PKE option offers patients who could not be transplanted with their intended living donor the chance to be transplanted very quickly without having to wait for a deceased donor kidney. Nationally, there are several Paired Kidney Exchange programs in which incompatible pairs can be enrolled.

In addition, Paired Kidney Exchange programs are now offering compatible pairs (living donors and intended recipients who are a match for each other) a chance for a better match while simultaneously helping a patient, or several patients, with incompatible pairs undergo transplantation. Living donors are often a friend or family member of an intended recipient, and they may be deemed a match for that recipient. However, there may actually be an even better donor for that recipient; possibly someone who is younger or a better match. Research has shown that the closer the match, the greater the long-term success after transplantation.

So the compatible pair has two options: they can proceed with their planned donation and transplant, or they can consider exploring kidney exchange, not to be confused with Paired Kidney Exchange. In kidney exchange, the intended recipient has the option to take the kidney from their known living donor or to have the program's living donor team look for an even better donor match from other living donor pairs. The living donor will also have a chance to donate to a closer recipient match. The ultimate goal in kidney exchange is to create options for compatible pairs by giving them an opportunity to find the best donor and recipient for their needs or allow them to proceed with their planned transplant with each other. Participation in kidney exchange is completely voluntary.

Transplantation isn't an option for all patients. Many transplant surgeons specialize in providing dialysis access so that patients can continue receiving hemodialysis for as long as is necessary. Finding a surgeon who offers the latest and best access care is an important task for a patient with renal failure and should not be overlooked.

To learn more about transplantation or dialysis access within the state of Maryland, visit umm.edu/transplant or hopskinsmedicine.org/transplant.

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MOLST (Continued from Page 1)

Unless a MOLST form's order is based on the medical ineffectiveness of a treatment, an order contained in a MOLST form must be consistent with a legally effective advance directive and the known wishes of a patient, health care agent, or surrogate decision maker. A health care provider who relies in good faith on the presumed validity of a MOLST form is immune from liability for following the MOLST form's orders.

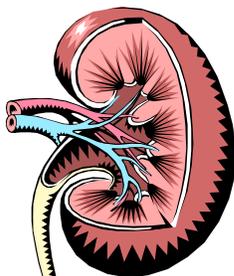
Every time a physician or nurse practitioner completes a MOLST order form, a copy of the form must be provided to a competent patient, health care agent, or surrogate decision maker within 48 hours after completing the MOLST form. The MOLST form must accompany a patient when the patient is transferred to another health care facility or program.

More information about the MOLST form is available on the website:

Marylandmolst.org.

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WE ARE ON THE WEB

www.dhmh.maryland.gov/mdckd/

MARC Offers an All-Inclusive Opportunity to Collaborate with your Network Peers to Improve Dialysis Outcomes!!

The Mid Atlantic Renal Coalition (MARC) serving as ESRD Network 5 will be facilitating two Learning and Action Networks (LAN) in 2013. These LANs are innovative initiatives that will bring together like-minded professionals to achieve rapid, wide-scale improvement. This model will be carried out through collaborative projects and online and in-person peer-to-peer interactions to facilitate shared commitment, energy and knowledge while focusing on spread and sustainability.

Among patients on hemodialysis, infection is the most common cause of morbidity and the second most common cause of death. Infections are both numerous and costly. The cost to treat one bloodstream infection was estimated several years ago to be over \$24,000. In 2010, more than 380,000 patients were treated with maintenance hemodialysis in the United States. With this knowledge, the Network will facilitate a Healthcare Associated Infections LAN with a focus on improving patient safety by reducing healthcare-associated infections in the dialysis setting. Participants will be collaborating to identify tools that can be

implemented as best practices in the promotion and elimination of infections in the dialysis population.

Patient and family engagement offers a promising pathway toward better-quality health care, more-efficient care, and improved population health. The terms Patient Engagement and Patient- and Family-Centered Care are often used synonymously to convey a vision of healthcare that includes a partnership among practitioners, patients and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care. In the Patient Engagement LAN, participants will explore ways to promote patient and family centered care in end-stage renal disease patients. This will be done through campaigns and a Quality Improvement Activity, the focus of which will be directed by patients serving as Subject Matter Experts.

These two Learning and Action Networks are an opportunity for nurses, facility administrators, providers, physicians, dialysis technicians, patients, state survey-

ors, QIO staff, hospitalists, pharmacists, dietitians, social workers, and any other community stakeholders with an interest in working with peers to improve patient safety and outcomes. It is a partnership to make dialysis safer for end-stage renal disease patients, while improving outcomes and decreasing cost. For more information or to join the HAI LAN, please contact Octavia Wynn, Quality Improvement Coordinator at owynn@nw5.esrd.net. For the Patient-Engagement LAN, you may contact Renee Bova-Collis, Patient Services Director, at rbovacollis@nw5.esrd.net. We look forward to learning, sharing and positively impacting dialysis quality of care with you!

Lindberg, Curt, et al. "Embracing collaboration: A novel strategy for reducing blood stream infections in outpatient hemodialysis centers." American Journal of Infection Control (2012): 1-7.

"Dialysis Event Protocol." February 2013. Centers for Disease Control and Prevention. 15 February 2013.

Carmen, Kristin, et al. "Patient And Family Engagement: A Framework For Understanding The Elements And Developing Interventions And Policies." Health Affairs (2013): 223-231.