Transition Challenges and Considerations: Pediatric to Adult Health Care
News from Capitol Hill

Change in Allocation Policy Could Affect Likelihood of Transplant

Dolph Chianchiano, JD, MPA
NKF Senior Vice President for Health Policy and Research

Due to a regulation that was finalized on April 2, 1998, the Organ Procurement and Transplant Network/United Network for Organ Sharing (OPTN/UNOS) has revised its policies for the allocation of livers and lungs, and has instituted a process to determine if its kidney allocation policy should be changed. The principles under consideration for kidney allocation could alter care planning for individuals with kidney failure or late-stage progressive kidney disease.

According to the regulation, allocation of deceased donor organs shall be based on sound medical judgment; shall seek to achieve the best use of donated organs; shall be designed to avoid wasting organs, to avoid futile transplants, to promote patient access to transplantation and to promote the efficient management of organ placement; and shall not be based on the candidate’s place of residence or place of listing.

As the result of five years of deliberations and extensive data analysis, OPTN/UNOS is considering three concepts that would work together to determine a candidate’s Kidney Allocation Score (KAS) and, thus, his or her priority for transplantation with a deceased donor kidney.

1. Life Years from Transplantation (LYFT) is an estimate of the length of time a recipient of a specific kidney may be expected to survive, as opposed to survival remaining on dialysis.

2. Dialysis Time (DT) allows candidates to gain priority based upon the length of time they have had kidney failure. (Conversely, the current policy provides points for time on the waiting list.)

3. Donor Profile Index (DPI) provides a continuous measure of organ quality based on clinical information.

The NKF has endorsed the concept of the Donor Profile Index. Donor families want to avoid wastage of donated organs. Currently, 20 percent of all kidneys recovered are not transplanted, and 30–40 percent of Expanded Criteria Donor (ECD) kidneys are discarded. DPI could foster an ECD utilization rate closer to a rate commensurate with the scientific assessment of the usefulness of ECD kidneys for transplantation, thereby increasing the number of kidney patients who are transplanted.

 Conversely, an allocation system incorporating LYFT concepts may make it more difficult for older candidates with diabetes to receive a transplant. Similarly, individuals requiring re-transplantation may not have high LYFT scores. An allocation system recognizing Dialysis Time provides a bridge between utility and equity. However, using dialysis time to assign priority for kidney transplantation does not promote NKF’s strategic goal of facilitating early transplantation and the improved outcomes derived from early transplantation.

An NKF ad hoc committee continues to monitor the deliberations of OPTN/UNOS on future policy for kidney allocation. It is chaired by NKF President, Bryan Becker, MD, and includes representatives from the National Donor Family Council and the transAction Council. Rose D’Acquisto, Past Chair of the National Donor Family Council, presented NKF’s response to the KAS concepts during an OPTN/UNOS public forum on kidney allocation policy held in St. Louis, MO, on January 26, 2009. Her statement was developed by the ad hoc committee and also reflects input from the Council of Nephrology Social Workers.
Transition Challenges and Considerations:
Pediatric to Adult Health Care
Debbie Kagan Brady, LCSW, ACSW, Arkansas Children’s Hospital

When care for chronic kidney disease (CKD) in children initially began, life expectancies were limited. As with other chronic illnesses, nephrology teams took care of their patients without concern for eventual transition to adult settings. Advances in health care, however, have led to longer lives and the need to develop new protocols and practices. With the increase of CKD in children, it is no longer feasible for pediatric providers to keep patients into adulthood. Because health care workers are trained to provide specialized care, pediatric patients need to transition to adult care. Furthermore, government regulations and individual facility policies that impact nephrology health care will often mandate transition.

Transitioning the pediatric kidney patient to the adult health care system can be a challenge for the entire team. A transition will require time and sensitivity to the fears and concerns the patient and family may have. Physicians, nurses, social workers, dietitians, child life workers, schoolteachers, the patient, family and other team members all play a role in supporting a positive transition, and they must all work together to make this change successful.

Transition to adult care can be easier in larger medical settings where adult care and pediatrics are joined. Communication between these groups increases understanding of the care pediatric patients had as children. As a result, adult care providers are more able to anticipate concerns and help the patient and family set new expectations and goals. Developing relationships between adult care and pediatric providers can be challenging for a variety of reasons, including geography, patient acuities, fewer choices or too many choices. Utilizing resources offered from the National Kidney Foundation, ESRD Networks, pharmacy representatives and seeking out educational opportunities for networking can help groups become acquainted with materials available to ease transitions.

Challenges of Childhood Kidney Disease

Unlike kidney disease in adults, the cause of childhood CKD is seldom due to lifestyle choice. More common diagnoses include congenital anomalies and focal segmental glomerulosclerosis (FSGS). Some children are diagnosed after what appears to be an acute illness, and other families may spend years successfully postponing the onset of dialysis and/or transplantation. Some children require dialysis as infants. Others may be diagnosed with a chronic medical condition, but have infrequent visits until puberty and a big growth spurt puts a strain on kidney function. Initially, parents bring their child to the doctor with hope, looking for a simple diagnosis or a cure. By the time they realize there is no cure and only treatment, patients, their families and health care providers have already established relationships.

Since a young adult between the ages of 18–21 is able to register for the draft, vote, complete an advance directive and graduate high school, transitioning to the adult health care system may seem to be a logical expectation. Nevertheless, health care teams face great difficulties trying to determine the best ways and/or the most appropriate time to transfer care. Individual patients and families, as well as their health care teams, tend to show readiness at different times. While some patients and families may be eager to move on, many remain attached to the more individualized and nurturing roles of the pediatric providers. In addition to individual practice, external factors such as pregnancy, full-time employment, high-risk behavior and other adult behaviors may be reasons to transition a patient sooner. Transitioning the patient may be unavoidable and will likely increase stress for the admitting facility, as well as for the patient. Young adults with significant developmental delay will eventually require transition as well.

Establishing Transition Protocols and Practices

Given these challenges and the possibility of unexpected developments, it is important to establish transition plans and policies well before patients begin exhibiting adult behaviors that require the expertise of adult-trained practitioners. As children move from childhood into adolescence, discharge planning should be addressed by the pediatric health care team. When clear expectations are expressed early on, the team can work together to enhance planning and coping skills. When each team member introduces his or her

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own role to the pediatric patient, it is important to discuss this relationship with the understanding that it is only expected to last until the child becomes a young adult.

Health care providers can use written tools, such as developmental checklists, booklets or information sheets detailing medications or insurance information, to introduce the idea of transition at developmentally appropriate ages, with consideration given to cognition, emotion and family function. Available technology such as portable computer memory devices (flash drives, CDs, etc.) can allow patients to take their personal health care information with them.

Health care providers need an organized, uniform procedure for transition that will fit most patients, but can also be tailored for individual patients. Favored patients cannot continue to receive care while other patients are required to move on. Inconsistency in transitioning patients from pediatric to adult settings is often fostered by patients and families who compare and contrast experiences with other patients and families informally outside of the clinical setting. Given developmental differences, some variability is inevitable in transitioning procedures. Therefore, giving families the opportunity to explore what has worked for other families can be helpful. In addition to written information in the dialysis or transplant manuals, an educational day for families may provide an informative and enjoyable way to do this. In areas where transition options are limited, pediatric and adult groups in the clinical setting could share information about their programs. Where there are more choices, groups in the clinical setting could compare and contrast experiences with other family members. Parents often think that caring for their child is their most important role, but learning how to promote independence in their child and deal with their own feelings can help the family see other roles. Practicing the transition from manager to cheerleader, or other similar analogies, prior to the transition to adult care may help parents encourage responsibility and changing roles.

When a transition plan is in place, each member of the health care team must also find ways to encourage families to promote independence so that patients are prepared for the transition. These strategies must be developmentally appropriate. Gaining greater independence begins in preschool and changes as the child grows. Helping families develop successful home care routines depends upon their understanding and acceptance of the child’s age, cognitive ability, emotional maturity and the family system itself. At times, families expect young children to assume more or less responsibility than they can adequately handle. Given their familiarity with sophisticated medical terminology, young patients may appear more developmentally ahead of their peers. However, limited experiences with socialization within their peer groups and missed school days may negatively impact development. Prior to transitioning to the adult health care system, patients need to be able to talk about their diagnosis, list medications and their use, know how to order medications and supplies, indicate emergency contact information and develop personal goals.

### Engaging Parents in Appropriate Ways

Having the pediatric patient seen alone by the team in the early teen years without a parent or guardian sets the stage for dealing with privacy. The physician, nurse, social worker, dietitian and child life worker can engage the patient in discussions about topics important to his or her developmental stage and can review care within that same framework. Team members can then review the visit with other family members. Parents often think that caring for their child is their most important role, but learning how to promote independence in their child and deal with their own feelings can help the family see other roles. Practicing the transition from manager to cheerleader, or other similar analogies, prior to the transition to adult care may help parents encourage responsibility and changing roles.

### Team Members Transition Too

Family members often express the view that members of the health care team are part of their family. Some of them may spend more time with the staff than they do with their extended family and feel that the team understands and knows them better. Such thoughts are certainly an honor for health care team members. Team members must acknowledge feelings of attachment and indispensability to particular patients, if they exist, but understanding professional boundaries and reinforcing the importance of other family roles can help the health care worker understand and live within the limits of the professional relationship.

While the decision to transition ultimately rests with the physician, other team members are important collaborators in the process. Accepting the challenges involved with change and promoting transition as an important, healthy milestone are vital points for all team members. The ultimate goal is to transition independence to the patient, and this requires much preparation and well-choreographed teamwork.

### Suggested Readings and Web sites:

- North American Pediatric Renal Trials and Collaborative Studies, NAPRTCS 2008 Annual Report Renal Transplantation Dialysis Chronic Renal Insufficiency
- Shimer’s Hospitals for Children Northern California Adolescent Health Transition Project: [www.depts.washington.edu/healthtr/](http://www.depts.washington.edu/healthtr/)
- SickKids Good 2 Go: [www.sickkids.ca/good2go](http://www.sickkids.ca/good2go)
Case Study in the Pediatric Hemodialysis Clinic:
Managing Hyperkalemia While Addressing Failure to Thrive
Danielle Milman, RD

The patient is 14-month-old Baby M, diagnosed with kidney failure secondary to polycystic kidney disease (PKD), which requires hemodialysis three days per week. Previously a bottle-fed, peritoneal dialysis patient, she was diagnosed with peritonitis. After having been intubated for several months, Baby M's doctors decided she must continue to receive formula through a nasogastric tube, as she would need to learn to eat from a bottle again. Although in this case it was necessary for survival, long-term enteral nutrition for infants and young children has been proven to reverse weight loss or growth retardation in children aged two months or younger.1 It is during the infant period of growth where the most amount of height can potentially be lost. It is also during this period of time where the most “catch-up growth” can be achieved through nutrition intervention.2 Baby M’s weight gain was a main concern for this reason, as well as determining if she would be a transplant candidate.

In November 2008, at almost a year old, Baby M weighed 6.5 kg. Based on the Center for Disease Control (CDC) growth charts, she was at less than the third percentile for length-for-age and weight-for-age, but was at the 90th percentile for weight-for-length. This suggested failure to thrive.3 Her physicians hoped she would gain weight, as she would be ineligible for transplant until she reached 8 kg. Baby M was fed continuously through a nasogastric tube using the formula Similac PM 60/40, 27 cc per hour, at a concentrated amount for adequate calories and to decrease her chance of becoming volume overloaded. The dietitian requested to increase her rate to 30 cc per hour to provide adequate calories and protein, but the mother refused because Baby M had been previously fed at that rate and it resulted in diarrhea. When asked if her baby had experienced diarrhea when she was on IV antibiotics, the mother, as well as Baby M’s nurses, stated that she had been on and off IV antibiotics many times and therefore could not definitively determine if the diarrhea was related to the feeding or the antibiotics.

On Baby M’s hemodialysis days, she would receive a bolus before and after treatment to make up for time spent away from the feeding. Her mother stated that she suspected Baby M experienced some stomach pains upon receiving the bolus and, as a consequence, she would occasionally stop the bolus after her daughter received only 3/4 of the amount. This caused concern because the bolus was necessary to provide adequate calories and protein for “catch-up growth.” At this point, Baby M’s needs were, based on 6.5 kg body weight, 1000 calories/day, 12 g protein (both calorie and protein needs estimated using catch-up growth formula), 507 mg potassium and 436 mg phosphorus. Using the concentrated formula, an attempt was made to deliver more calories and protein, while keeping Baby M’s fluid intake at a minimum. Unfortunately, the formula resulted in hyperkalemia.

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Baby M became hyperkalemic on numerous occasions, despite the renal formula she was receiving. The decision was made to switch her from the infant formula Similac PM 60/40 to 3/4 strength Suplena at 14 months of age per recommendation of her dietitian who had followed her from birth. During this hospitalization, Baby M’s weight increased from 6.5 kg to more than 7 kg and her serum potassium level stabilized, likely due to the change in formula. It is important to note that the Pediatric Nutrition Handbook of the American Academy of Pediatrics suggests that a formula should be chosen based on a patient’s weight. Unfortunately, there is little evidence-based data to support this practice. The National Kidney Foundation recommends that a child’s age should determine the type of supplementation.4

Although her mother stated that she was experiencing some diarrhea, it is normal for babies to do so when adjusting to a new formula. At 6.5 kg, Baby M’s daily calorie requirement was again 1000 kcal, but her previous formula provided only 770 kcal, and increasing her tube feeding rate was not an option. Her new formula ordered her to have two cans a day of Suplena (each can mixed with 2.5 oz water), which provided less potassium and a total of 850 kcal. This provided more kcal than the previous formula, but still less than the desired amount.

After having been discharged for a few weeks, Baby M’s weight stabilized at 7.4 kg, although fluid gains must be taken into consideration. After discontinuing the nasogastric tube, her doctor had initially requested intensive therapy so that she could learn to eat by mouth and had instructed her mother to try to feed her some low potassium baby food. After a few frustrating trials, as well as some weight loss, the nasogastric tube had to be replaced. To make up for the difference in calories, the dietitian recommended adding 1/2 cup Duocal daily, which is a high calorie, protein-free liquid supplement. A week later, Baby M continued to tolerate the Duocal and Suplena.

The hope for all involved in the case is for Baby M to reach 8 kg, at which point she may be eligible for a kidney transplant.

REFERENCES
Managing the Transition to Adult Care

Vern Ramos, CCLS

As a Certified Child Life Specialist, I have had the opportunity to share my life experiences with patients, along with the motto “Knowledge is Power” in helping young adults transition into adult health care settings. I was a chronically ill teenager myself, so I understand the gravity of having to cope with illness while still dealing with the everyday nuances of teenage-hood. It is not an easy feat, but with the correct knowledge and support it can be accomplished (and, in fact, accomplished well). Think of it as coaching a child to succeed—the purpose is to appropriately teach while providing an encouraging environment in which to flourish. I was fortunate enough to have a wonderful support team of family, friends and health care associates. This is the key to effective transition.

Typically, many adult generalists are unfamiliar with standards of practice in the childhood setting. The environment is different in the adult setting and we as pediatric practitioners should take note of this. “Children with special health care needs born today have a 90% chance of surviving into adulthood, making their transition to adult systems of care an issue that will affect almost all physicians.”1 The more we empower our patients with knowledge, the easier the transition will be for the patient and the whole health care team. However ambivalent a patient may be, we can help to provide the tools for a smooth transition.

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REFERENCE

SCM09 REVIEW

SCM09 drew over 2,200 participants from all disciplines, and there were 188 nurses and technicians in attendance. On Thursday, a joint Council session on lessons learned from kidney survivors was held. We heard from some great speakers who are living with kidney failure and gained insight from their experiences under our care. A session on dealing with dialysis water took participants through the components of the water treatment system, and then discussed how important it is to strive for ultrapure water to minimize inflammation in dialysis patients. We learned from the experience of a nephrologist who has eliminated grafts from his facility and has a greater than 90 percent fistula rate. Back by popular demand was a session on how to use the buttonhole technique to improve the longevity of fistulas.

Friday morning opened again with a joint Council session on a multidisciplinary approach to disasters, where we heard about preparing a facility for a disaster, learned about our patients’ dietary needs in a disaster and about the need of patients and staff in coping with the stress after a disaster. We had courses in cannulation, managing resources and waste, and managing a dialysis clinic.

Last year at CM08, Glenda Payne and Judith Kari announced that the new CMS Conditions for Coverage had been published. This year they came back to give us an update on how the implementation of these policies is going. Saturday’s presentations included sessions on preventing complications in dialysis, emerging technologies, managing fluid in patients during dialysis and a study review course for attendees taking the certification examination. I would like to give a big thank you to Marianne Neumann who stepped in at the last minute to present half of the study review class when our other speaker had to cancel.

We are already beginning to work on making SCM10 even better, so please plan to join us in Orlando! For topic suggestions or to help plan SCM10, please contact Program Chair Sheila Deziel [sdeziel@cox.net].

The Executive Committee at work.

The 2009–2010 CNNT Executive Committee

Photos: Rodney Choice
Welcome to Music City! Nashville welcomed over 200 nephrology social workers for another strong year of clinical learning and networking opportunities. The program offered a pre-conference workshop on motivational interviewing, which was well-attended by social workers, dietitians and nurses. Attendees were eager to learn about this client-centered approach to elicit behavioral change.

NKF Councils joined together to welcome keynote speakers from the Renal Support Network. Wendy Rogers gave an inspirational talk about how to instill HOPE in our patients and, along with her colleagues, provided a panel discussion on how to make a difference in our patients’ lives.

The CNSW Networking Luncheon once again showcased a diverse selection of new award winners. Judith Kari, MSSW, CISW, was presented with the Robert W. Whitlock Lifetime Achievement award and provided a fun-filled look back at the roots and at the future of CNSW. Congrats to all the award winners!

Gary Petingola, RSW, gave an insightful presentation on introducing relaxation therapy into social workers’ practices. Gary won an award for his poster presentation at CM07 on this very topic. Gary’s fellow Canadian colleagues, Julie Burnett, RSW, and Amy Canter, MSW, CSW, started off the day with “Let’s Talk about Sex,” a session highlighting the impact of CKD on sexuality and how professionals can address these issues with patients.

Sessions were offered for both new and experienced social workers, addressing issues affecting dialysis, transplant and pediatric practitioners. Highlights included: “Preventing Suicide,” by Jane Kwaticher, LCSW, and Matt Stricherz, EdD; “Communicating with People Who Have Dementia,” by Melissa Fry, CAPSW, a multidisciplinary panel on adolescents; and a new session entitled “Nephrology Social Work 101,” presented by Teri Brownlie, PhD, LSW, and Stephanie Stewart, LICSW, MBA. The last session offered both new and advanced social workers an overview of the roles of a dialysis and transplant social worker. It’s no surprise that a room full of social workers were eager to hear Beth Witten, ACSW, LCSW, and Dori Schateil, MS, review the KDQOL and related quality of life issues.

Please contact me at ageiman@umich.edu if you would like to speak at SCM10 or to offer any topic or speaker ideas. See you in Orlando!

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Almost 300 registered dietitians (RD) and dietetic technicians, registered (DTR) traveled to Nashville to take advantage of the exceptional educational sessions and fun networking opportunities offered at SCM09. The CRN program offered up to 31.5 CEUs related to the management of the chronic kidney disease (CKD) patient.

Topics included experience and lessons learned from kidney survivors, management of hypertension in each stage of CKD, diabetic nephropathy cardiovascular risk and metabolic syndrome, medical nutrition therapy, inflammation and wasting syndrome, micronutrient and electrolyte homeostasis and physical assessment, and alternate careers for renal dietitians, to name a few. In an effort to encourage more RDs and DTRs to get involved in research, this topic was given special attention in an A-to-Z series of captivating sessions.

The preconference workshops included tracks for both new renal and non-renal dietitians, as well as seasoned practitioners. “Motivational Interviewing and Health Coaching to Improve Health Outcomes” was a much-sought-after all-day workshop. Nationally recognized leaders in the field of renal nutrition presented advanced concepts in physical assessment, nutrition care process and standardized language, and research for the renal dietitian. Being able to link the appropriate nutrition assessment data to a specific problem and then write an accurate nutrition diagnosis is a skill required to implement the Nutrition Care Process.

There were abundant networking opportunities for attendees to mingle with professionals from across the country and international locations. The CRN Networking Luncheon was a huge success, with Dr. Paul Teschan giving a riveting and memorable presentation on the history of hemodialysis that drew a standing ovation.

We would like to thank the NKF staff, Program and Host committees for their exceptional dedication and efforts. The meetings wouldn’t have been possible without them. We are already preparing for SCM10. If you have suggestions for the program, please contact SCM10 Program Chair Marianne Hutton (finelyfit2005@yahoo.com).

SAVE THE DATE!

NKF 2010 Spring Clinical Meetings
April 13—17, 2010
Walt Disney World Swan and Dolphin
Orlando, FL
This Is a Time for Reflection

Jim Hafner, MSW, LSCSW, LCSW

I often refer back to this quote from the movie Remember the Titans, as it seems quite timely and appropriate: “This is a time for reflection.” History took a giant step forward on January 20, 2009, with the inauguration of our first African-American president. The renal community also took a giant step forward with the enactment of the new CMS Conditions for Coverage (CfCs) on October 14, 2008. What both momentous events have in common is the fact that the journey to these points in time came about over many years of hard work, dedicated determination and a zeal for what was right and best for all. Now, as this hurdle has been surmounted, we are still faced with the reality of the events and demands that both situations have placed before us.

Change comes hard. We are challenged by the new direction for clinical practice that the mandated CfCs have commissioned our profession to provide, as well as the structures within which we work to allow for the level of professionalism and clinical scope that our patients need. Let us look back toward our ancestors in social work health care. Dr. Richard Cabot commissioned social workers in health care to view the patient in his or her social context and to focus on the structures of medical education and health care services. His colleagues disparaged his focus on human well-being. Today, we are similarly challenged by those who would have our clinical skills and competency be directed toward nonclinical tasks that do little to enhance patient resilience.

Today, there is much internal frustration and puzzlement over these many challenges. How do we keep our jobs, but present ourselves in a way that portrays our professionalism? How do we set boundaries within our management regarding insignificant demands that corporate health care would have us perform? First, we must have the courage to affirm our image of clinical social work and choose how we want to practice. Just as there are many divergences in social work practice, there seems to be an equal number of us who perceive our roles differently.

As our professional predecessors have been beacons of light that have guided us in the past, we must now affirm our present leadership. These will continue to be challenging times requiring that we all march arm in arm in our journey for what we know is in the best interests of our patients. We must remember that advocating for others begins with being able to advocate for ourselves.

We must also remember that activism is not a dirty word, but is embedded in the halls of our history. Just as Dr. Martin Luther King, Jr. espoused “I Have a Dream,” we too must resonate with that same clarity of purpose. His march for civil rights did not begin with hundreds of thousands of supporters, but instead with a handful of the faithful and spread throughout the land. We too must start with one patient to demonstrate the value of clinical social work and the positive outcomes that come from our interventions, practices and skills. Our employers will again learn to turn to us for assistance in molding environments that allow patients and staff to not only flourish, but to blossom in maintaining healthy self-care management.

As these new economic times bring about greater challenges to health care, we must not lose sight of our own “dream.” We must remain resolute in listening to our voices as they echo throughout the renal community: “I Have a Dream!” Years from now, as our dreams become a reality, we will look back on these days and feel a sense of pride in paving the way for the improved quality of care that future dialysis and transplant patients will embrace.
As I come to the end of my term as Chair, I am looking forward to serving as Past Chair, where my focus will not only be on supporting our incoming Chair, but also on membership. During my tenure, CNNT focused on four action items, in addition to increasing membership and involvement, continued support of research and support of the national office goals and the renal community as a whole. Below is our progress:

**Action Items:**

1. **Transplantation Tool:** CNNT’s Web site will be updated to include links that will assist nurses and technicians in providing education to patients regarding transplantation.

2. **Infection Control Tool:** Still in early development. It will be specifically designed for use in dialysis clinics and will incorporate the Conditions for Coverage guidelines.

3. **Conversion Chart:** In the final stage of development and will be an online chart accessible on the CNNT Web site and, in the future, will be a pocket tool.

4. **E-GFR for Acute Care:** It was felt that this was not an area to be addressed at this time and therefore the project was not completed.

**Research:** With the support of the national office, we have been able to increase the amount of funds to support CNNT member-initiated scientific research.

**Membership:** In support of our members, we had the privilege to give eight $500 educational stipends to support members’ attendance at SCM09.

**Legislation:** The Executive Committee was active in the process of review and commented on the Interpretive Guidelines, as well as participated in the CMS Open Door Forum. The Medicare Improvements for Patients and Provider Act (MIPPA) will impact what we do and how we do it. The Committee will continue to help develop NKF’s comprehensive patient education plan, “Your Treatment, Your Choice,” which will serve as a model for educating CKD patients under the MIPPA provisions.

**Collaboration:** Thanks to Sheila Deziel and members of CRN and CNSW for a wonderful job collaborating with ANNA in the development of the Comprehensive Interdisciplinary Patient Assessment (CIPA), which meets the needs of the community in complying with the Conditions for Coverage. Looking back at the year behind me I feel that much work has been done, but there is still much more to do. As I pass the baton to incoming Chair Becky DeLaCruz, RN, BSN, CNN, I look forward to great things in the coming year.

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Beverly Sneed, RN, BSN  
CNNT

In March of this year, I took over as your CNSW Chairperson. I am proud and honored to serve such an outstanding group of social work professionals! We have been hard at work on many projects during the tenure of Teri Browne, PhD, such as informing and adapting to the new CMS Conditions for Coverage (CIC), developing nephrology social work certification, liability insurance and expanded CE opportunities. My goal is to ensure that CNSW will keep working for you to provide education, professional development, advocacy and training. Our current projects include rewriting our Standards of Practice as an online toolkit, creating an online QAPI manual, providing Webinars with CEUs and updating CNSW tools to reflect the new CICs.

We can’t take these projects on and do them well without your input. The CNSW Executive Committee relies on member feedback to help us focus our efforts. We get some of this feedback from the CNSW listserv, and you have given us many great ideas through your thoughtful comments.

As the Executive Committee plans for the coming years, now is a good time to let us know your priorities for CNSW. Do you need additional training on the CICs? What areas of your professional practice are most challenging? CNSW does periodic surveys of members to get feedback on member needs, but you don’t need to wait for a survey to let us know your thoughts. On our Web site, you will find a list of Executive Committee members and our contact information. Don’t hesitate to contact any one of us with your questions, concerns and ideas.

These are trying economic and professional times, and all of us are affected to one extent or another. But, my hope is that by working together as a professional organization, CNSW can play a part in making your professional role more satisfying. Let your voice be heard!
As I step into the role of CRN Chairperson, I would like to acknowledge the tremendous work, dedication and leadership Maria Karalis provided during her term as CRN Chairperson. Her vision has brought a new emphasis on promoting nutrition research within the renal RD community, while her leadership and energy has kept CRN on track in achieving its strategic goals.

I currently work at Barnes Jewish Dialysis Center at Washington University School of Medicine in St. Louis, MO. I joined the CRN Executive Committee in 1999 when I became Region III Representative and Renalink Editor, and have served in various roles during my seven years on the CRN Executive Committee. As I move into the Chair position for the next two years, my goal is to keep CRN at the forefront of providing support and direction to our members while we adjust to the new Conditions for Coverage, as well as encourage development of professional and patient education materials that will help us in the workplace. CRN will continue to be very proactive in addressing regulatory and legislative issues that impact the renal dietitian and the CKD patient.

We continue to work on joint projects with ADA-RPG. The Standards of Practice and Standards of Professional Performance is in the home stretch of development, and the update of the Clinical Guide to Nutrition Care in Kidney Disease is underway. I have returned as Co-Editor, along with Laura Byham-Gray, PhD, RD, and we welcome Jean Stover, RD, as a Co-Editor for this new edition.

I would like to thank the outgoing members of the CRN Executive Committee for all their work and volunteer time over the past two years. I welcome and look forward to working with our newly-elected board members.

In closing, I encourage members to contact me with ideas, opinions or suggestions for current or future projects. What can CRN do to better serve you or help you in your practice? You may contact me at kwiesen@dom.wustl.edu or 314.286.0832. I look forward to working with and for the CRN membership during the next two years.

As I complete my term as Chair, we are 2,295 members strong—an increase of 4.6 percent for this past year. Members are RPG’s greatest resource. The efforts of RPG could not have been accomplished without the dedication and hard work of all the volunteers.

Last year, RPG aligned with ADA’s Organizational Identity on all print and electronic media. The new identifier incorporates colors of healthy foods like leafy green, apple red and plum purple, as well as the strong, positive phrase that has long been associated with ADA: “Eat Right.”

CRN and RPG have collaborated on the development of Standards of Practice (SOP) and Standards of Professional Performance (SOPP) for RDs in Nephrology Care. Both organizations are also partnering on the revision of the 2nd edition of A Clinical Guide to Nutrition Care in Kidney Disease.

RPG leadership responded to member needs from the Membership Survey and offered two one-day seminars: a CSR review course was held in Nashville and a Medical Nutrition Therapy workshop was held in Chicago. Free CPEUs were offered via the quarterly publication Renal Nutrition Forum (RNF). Visit www.renalnutrition.org for current and archived files of RNF issues.

The ADA Evidence Analysis Library (www.adaevidencelibrary.com) is another excellent free member benefit. The original evidence-based guideline on CKD was published in 2001 and a revision is currently underway. In 2008, two evidence-based questions on fish oils and physical activity and CKD were posted online. Another helpful resource for the Renal RD is the release of the Emergency Preparedness Task Force report, posted in May 2008.

As we embark on a new era, public policy and reimbursement initiatives will be critical. ADA’s policy agenda for 2009 will be under the umbrella of work associated with health care reform. To stay well positioned, ADA/RPG must continue the grassroots efforts across the nation. This past February, the 2009 Public Policy Workshop was provided in an electronic format that allowed all 68,000 ADA members to participate free of charge.

It has been my pleasure and honor to serve as Chair of RPG this past year. It has been a great experience for me to be able to meet many of you and work with exceptional dietitians. I know that RPG will remain strong with the forward-thinking leadership from our 2009–2010 Chair, Pat Williams, and her experienced Executive Committee. The time to get involved is now. You can make a difference.
Managing Changes and Challenges

Marcia Sawyer, ACSW, LMSW
CNSW Membership Chair

“It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity, it was the season of Light, it was the season of Darkness, it was the spring of hope, it was the winter of despair; we had everything before us, we had nothing before us.” -Charles Dickens

Nephrology social work is experiencing, to paraphrase Charles Dickens, ‘the best of times’ and ‘the worst of times’ at once. We have everything before us with new federal mandates to provide the social work clinical services we trained for. At the same time, we have nearly nothing before us, as essential resources disappear and needs rise, along with conflicting work place demands and responsibilities.

As a profession, we need the support and advocacy of other nephrology social workers to cope with these changes and challenges. CNSW continues to be committed to providing this support and advocating for the nephrology social worker. Our Listserv provides 24-hour access to the expert advice of our national (and international) membership. Many of our ongoing educational programs, such as the documents we created to help navigate the new Conditions for Coverage, are offered online to reach wider audiences. CNSW continues to develop new member supports, including the Nephrology Social Work Certification (NSW-C) program and professional liability insurance coverage through Healthcare Providers Service Organization (HPSO).

We are over 1,000 strong, but we still need your involvement. Tell colleagues about CNSW. Speak up about national CNSW membership in local CNSW Chapter meetings. Let us know how we can best serve you. Together, we can make this the ‘best of times’ for nephrology social workers.

The Pocket Guide to Nutritional Assessment of the Patient with Chronic Kidney Disease, 4th Edition Is Now Available!

This invaluable dietitian resource provides specific chapters based on KDOQI recommendations and guidelines for nutrition, peritoneal dialysis, hemodialysis, diabetes, dyslipidemias, use of antihypertensive agents, CVD in dialysis, anemia and CKD, and Pediatric Nutrition Guidelines published in 2009.

CURRENT NKF-CRN MEMBERS receive a one-time, complimentary copy. Any new NKF-CRN members joining after February 2009 will receive a one-time, complimentary copy with their welcome packet materials. Additional copies can be purchased at the member price of $30.

NON-MEMBERS can purchase a copy through the NKF’s Materials Resource Department (800.622.9010) or by visiting the new NKF Store (www.kidney.org/store). The cost is $50 (plus $10 for shipping and handling).
2009 RESEARCH GRANT RECIPIENTS

NKF Professional Councils are pleased to announce research grant recipients, who will begin their research in July of 2009 and present their findings at the NKF 2011 Spring Clinical Meetings.

CNSW
CNSW has granted funds to three researchers for the upcoming year:

- Susan Walker, MSW, Beaumont Hospitals: “The Effect of Peer Mentors on Prospective Kidney Transplant Patients”
- Mary Beth Callahan, ACSW, LCSW, Dallas Transplant Institute: “Kidney Transplant Patient Employment: Vocational Training and Intervention”
- Teri Browne, PhD, MSW, University of South Carolina: “The Creation of a Model Program for Dialysis Social Work Field Placements”

CRN
The CRN Research Grant Selection Committee is pleased to announce the 2009–2010 CRN Research Grant recipient. Jerrilynn Burrowes, PhD, RD, CDN, from C.W. Post Campus of Long Island University, Brookville, NY, has been awarded $12,900 for her research entitled, “Is There an Association Between Nutritional Status and Self-Reported Sleep Quality or Sleep Duration in the HEMO Study Cohort?”

CALL FOR RESEARCH GRANT APPLICATIONS

October 15, 2009
Letter of intent to NKF

December 1, 2009
Grant proposal due to NKF

Jan & Feb 2010
Council Research Grants Committee review

March 2010
Awards announced

July 1, 2010
Approved project begins through June 2011

CNNT
Beverly Sneedd, RN, BSN

Through the support of the NKF, CNNT is able to provide funding for research as it relates to nephrology nursing. All correspondence should be submitted through the NKF. Information on suggested topics and the request for an application can be found on the CNNT Web site at www.kidney.org/professionals/CNNT

If you have any questions, contact the Immediate Past Chair, Beverly Sneedd, at bevyan1@sbcglobal.net

CNSW
Stephanie J. Stewart, LICSW

Every year, CNSW grants funds for research in nephrology social work. Have you worked to decrease the no-show rate at your unit or started a new program to resolve an ongoing unit issue? If you are doing any type of CQI project, you already have research results. Tracking any type of intervention and showing the results is research. We all do research of some sort on a daily basis when we work with clients and document what we do. Research is the key step in showing that nephrology social work works!

CNSW is now calling for applications for our 2010–2011 CNSW Research Grants. Your ideas and request for funding can be small or grand. Check the CNSW Web site for application details. If you want more information or want to talk with one of our research mentors, contact the CNSW Research Chair, Stephanie Stewart, at stewart.stephanie@mayo.edu

CRN
Laura J. Holden, MBA, RD, CSR

CRN continues to encourage and support the wide range of research activities and interests of our membership. Now is the time to start planning a research project for the coming year. Qualified renal dietitians who are national NKF-CRN members in good standing are invited to submit proposals for a CRN Research Grant. Areas of interest include:

- Basic or applied research in the area of renal nutrition
- Nutrient supplementation pertinent to renal disease
- Development and evaluation of education programs or teaching tools to enhance patient/family understanding of chronic kidney disease (CKD) treatment and its nutritional implications
- Collaborative National Research Questions using multiple sites that can be applied to a randomized sample of a large population of patients with CKD

The first part of the application process is to send a letter of intent to the CRN Research Grant Program, c/o the NKF. The letter of intent is reviewed to identify appropriateness of research objectives and goals. It must include the following: 1) Name of the person and organization, 2) Mailing address and e-mail, 3) Telephone number, 4) Name of the principle investigator and his or her CRN membership number, 5) Short title of the project, 6) Name of the project, 7) Brief abstract under 250 words, which includes a description of the project goal and how it relates to nutrition in renal disease.

Upon receipt and acceptance of the letter of intent, NKF-CRN will send a grant application packet.

Questions? Contact me at lholden@dsi-corp.com
NKF’s Professional Councils are now taking nominations for the fall elections. Nominees must be regular members in good standing, and terms for newly-elected positions will begin at the NKF 2010 Spring Clinical Meetings. Serving on a Council is a way to enhance your professional growth and it gives you the ability to impact the lives of kidney patients through advocacy and support. Please consider taking on a leadership role or nominating a fellow member today!

**CNNT**
CNNT is taking nominations for Vice Chairs for Regions II, III and IV and Chair-Elect. Both positions require attendance at two meetings each year. Any CNNT member can be nominated for the Vice Chair position, which has a term of two years. Chair-Elect is a three-year term—the first serving as Chair-Elect, then as Chair and finally as Immediate Past Chair. Chair-Elect requires having served at least one year on the Executive Committee in another position.

For more information, contact Beverly Sneed, RN, BSN, at bevyann1@sbcglobal.net

**CNSW**
CNSW is taking nominations for Region Representatives for Regions I, III and IV and Membership Chair. Region Representatives are the primary contact between CNSW and local Chapters. These are two-year terms. All submit quarterly activity reports, attend two meetings per year, participate in regularly scheduled conference calls and are involved in various ad hoc committees and projects.

For more information, contact Teri Browne, PhD, MSW, at teri.browne@gmail.com

**CRN**
Nominations for Regions I, III and V Representatives and Alternate Representatives and Chair-Elect are being accepted for the 2010–2011 CRN Executive Committee. Chair-Elect must have been a voting member of the Executive Committee for a minimum of two years, will serve as Chair-Elect for one year, then transition to Chair and Immediate Past Chair for the following two years of a three-year term. Region Representatives and Alternates serve a two-year term. If you are interested in any of these positions, contact your Region Representative to make a nomination.

For more information on elections, contact Ann Beemer Cotton, MS, RD, at abcmsrd@yahoo.com

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**CALL FOR 2010 AWARD NOMINATIONS**

**September 15, 2009 – Nominations Due**

**CNNT**
Nominations are being accepted for the **Distinguished Service Award** and **Leadership Award**. These awards recognize individuals for their contributions to the renal community. Nominees must be members of CNNT and must show service or leadership at the local, regional or national level.

For further information, visit our Web site or contact Beverly Sneed (bevyann1@sbcglobal.net).

**CNSW**
The following awards are given to commend excellence in our field: **Merit Award** (more than two years in renal), **New Worker Award** (less than two years in renal), **Social Worker in a Transplant Setting**, **Social Worker in a Pediatric Setting**, **Social Worker in the International Setting** and **Recognized Chapter**. A social worker from each of the five CNSW Regions also receives special recognition.

We each have contact with remarkable social workers who serve as role models who demonstrate excellence. Please take the time and effort to nominate these individuals for recognition. Criteria and applications can be found on the CNSW Web site. Contact teri.browne@gmail.com for further information.

**CRN**
Criteria and application instructions can be found on the CRN Web site under “Research and Awards.” Contact your Region Representative to make a nomination.

The **Recognized Renal Dietitian (RRD) Award** is given to an outstanding renal dietitian who has demonstrated exceptional abilities in leadership, creativity and public involvement in the practice of renal nutrition. The **Regional Recognized Renal Dietitian (RRRD) Award** is given to an outstanding renal dietitian demonstrating the above criteria within a particular region.

The **Susan Knapp Excellence in Education Award** recognizes a renal dietitian who has demonstrated exceptional contributions to the field of renal nutrition, specifically as it pertains to education.

The **Joel D. Kopple Award**, initially presented to Joel D. Kopple in 2001, honors an individual who has made significant contributions to the field of renal nutrition.

The **Outstanding Service Award (OSA)** recognizes promotion of CRN and its goals through financial support, lobbying, counseling, patient and professional education materials, providing community support and/or promoting renal nutrition research.
Constituent Council Connection

People Like Us is a growing movement to empower, educate and encourage people to become effective advocates. It includes:

- The Patient and Family Council (PFC), which works to ensure that kidney patients receive the best care possible and supports family members and caregivers;
- the National Donor Family Council (NDFC), which supports donor families and works to increase the sensitivity and effectiveness of the organ recovery process;
- the transAction Council, which promotes a better quality of life for transplant recipients;
- and living donors and potential living donors, for whom the NKF is a leading source of information and support.

People Like Us Advocates Visit Capitol Hill for World Kidney Day 2009

On March 12, 2009, members of NKF’s People Like Us participated in the 4th Annual World Kidney Day patient advocacy training and fly-in to Washington, D.C. Thirty-three transplant recipients, people with chronic kidney disease (CKD), living donors and donor family members used the power of their personal stories to raise awareness on Capitol Hill about CKD, donation and transplantation. People Like Us advocates mingled with lawmakers at a Capitol Hill reception and met with over 100 Members of Congress to educate them on the importance of early detection, the need to extend the Medicare coverage of immunosuppressive medications for transplant recipients and other issues. For more information about People Like Us, including instructions for joining its Take Action Network electronic advocacy group, go to www.nkfpeoplelikeus.org.

Patients and Professionals Praising People Like Us Coffee House Conversations™ Telephone Series

Since launching in November 2008, hundreds of patients, donors, recipients, family members and loved ones have been empowered through the People Like Us Coffee House Conversations™ telephone series. Participants are singing the praises of these FREE monthly calls, which feature presentations from patient and professional experts about CKD, dialysis, organ and tissue donation and transplantation. Calls are interactive, allowing participants to support, empower and educate themselves and each other by asking questions and sharing information. One call participant, Mike, shared that after listening to the call about safety in the dialysis unit, he had enough confidence to be an advocate for his care. “At my current center I noticed that while staff frequently changed gloves, the sink was never used.” As a result of bringing this to the attention of the appropriate individuals, “hand-washing is a subject of weekly in-service training.” Mike feels that because of his advocacy, patient safety has improved in his dialysis unit. To hear previous sessions or to register for future Coffee House Conversations™, please visit www.kidney.org/coffeeshouse, send an e-mail to CoffeeHouse@Kidney.org or call 888-JOIN-NKF.

New Publication for Organ and Tissue Donation Advocates

A new online resource, Be A People Like Us Advocate for Organ and Tissue Donation, is now available to educate and encourage people who want to get involved. Originally published as How to Be An Ambassador for Organ and Tissue Donation, this 40-page updated publication provides empowering messages to reinforce how influential a personal story can be to motivate others into action, presents public speaking strategies and gives tips for providing peer support. It provides information on how to advocate for legislative and public policy change to improve the lives of living donors, donor families, kidney patients and transplant recipients through the People Like Us Take Action Network (www.kidney.org/takeaction). The publication also gives suggestions for how to initiate a discussion with family members about becoming an organ and/or tissue donor after death. Download it or read it online at www.kidney.org/patients/plu/chc.cfm under END THE WAIT!
UPCOMING EVENTS AND ANNOUNCEMENTS

**July 13:** NKF of West Texas will hold a symposium for patients in Lubbock, TX. For more information, go to [www.nkfwt.org](http://www.nkfwt.org)

**July 25:** NKF of West Texas will hold a symposium for patients in Midland, TX. For more information, go to [www.nkfwt.org](http://www.nkfwt.org)

**Fall 2009:** Kansas City Metro CRN’s annual Fall Meeting is currently in the planning stages. For information about this meeting, e-mail the current Council Chair Rebecca Bauer at rbauer@dsi-corp.com

**September 24–27:** NKF of Georgia’s Nephrology Update will take place at the Westin Hilton Head Island Resort & Spa in Hilton Head, South Carolina. For more information please e-mail Lori Cassity Murphy at lori.murphy@kidney.org or call 770.452.1539 ext 18.

**October 22:** The West Michigan Renal Symposium, sponsored by the NKF of Michigan, will be held in Grand Rapids, MI. The symposium is made up of renal professionals from major dialysis facilities and local hospital organizations. For further information and volunteer opportunities, contact Beth Bowers at bbowers@nkfm.org

**October 29:** The 2009 CRN of Northern California & Nevada Symposium, “An Overview of Current Nutritional and Medical Needs for CKD Patients from Diabetes to Nutritional Vitamin D,” will take place at the Palm Event Center at Casa Real in Livermore, CA. For more information, visit [www.crn-norcal.org](http://www.crn-norcal.org)

**Educational Tools**
Understanding Your Renal Diet and Renal Diet Bingo are now available for purchase from the Virginia CRN. Information and order forms are available on their Web site: [www.vacrn.org](http://www.vacrn.org)

Virginia CRN is developing an educational material with the Mid-Atlantic Renal Coalition Network 5 Project group. It is in the final approval process and information can be accessed through the network’s home page: [www.esrdnet5.org](http://www.esrdnet5.org)

**KIDNEY WALKS**
Register for any of the Walks taking place across the country at [www.kidneywalk.org](http://www.kidneywalk.org)

**KIDNEY EARLY EVALUATION PROGRAMS (KEEP)**
To obtain more information on KEEP and for a listing of screenings taking place in your area, visit [www.KEEPonline.org](http://www.KEEPonline.org)

MEMBERSHIP AND ELECTIONS/AWARDS

**Region I**

- **New York**’s new President is Regina Avner and new Vice-President is Sharyn Kreitzer.

**Region III**

- **Michigan**: Jennifer Bruns is serving on the CNSW Certification Board and Erica Perry was awarded the CNSW Region III Award at SCM09.
- **Upper Midwest**: Diane Perry, LISW, served on the SCM09 Program Committee this year, and Bethany Roberts, LICSW, presented “Strengthening Adherence.” Also at SCM09, Michelle Mayo, LISW, received the CNSW Merit Award and Carrie Blesener, LGSW, received the New Worker Award. Congratulations to Stephanie Stewart, LICSW, who is the newly-elected incoming Chair-Elect of the CNSW Executive Committee!

**Region V**

- **Rocky Mountain**: Elections were held and Nikki Teger, MSW, was elected Chapter Chair. Megan Prescott, LCSW, will continue as Co-Chair.

**Region I**

- **Maryland** CRN-Baltimore Chapter officers for 2009 are: Chair Pamela S.B. Fagen, MS, RD, LDN ([pamela.fagen@DaVita.com](mailto:pamela.fagen@DaVita.com)), Chair-Elect Christine Leadler, MS, RD, LDN; Secretary Sharon Kennedy, MS, RD, LDN; and Treasurer Carol Seletos, MS, RD, LDN.

**Region II**

- Several Middle Tennessee CRN members served on the Host Committee for the 2009 NKF Spring Clinical Meetings at the Gaylord Opryland in Nashville, including: Lindy Burns, Rita Dimmitt, Cathy Folk, Jane Greene, Mary Lollar, Sandra Miller, Kathy Reynolds, Mary Sundell, Pat Williams and Kelley Yandell.
Mary Sundell was also a member of the CRN Program Planning Committee.

**Middle Tennessee** CRN elected the following officers for 2009: Chair Mary Sundell, Chair-Elect Kelley Yandel, Program Planning Susan Coonce, Treasurer Mary Lollar and Secretary Kelly McCasland.

**Region III**

**Illinois** CRN’s (ICRN) newly-elected officers are President-Elect Gayle Both and Secretary Susan Masselter.

**Region IV**

Nadiya Lakhani, RD, LD, resigned her position as Chapter Chair of the North Texas CRN to take on a new role as national NKF-CRN Region IV Representative. Susan Smith, RD, LD, CDE, is now the new Chair Chair.

**South Plains** CRN would like to congratulate Louise Clement, MS, RD, CSR, LD, on her fourth place finish in the poster competition at the NKF Spring Clinical Meetings. Her poster was titled “Supplementation with Over-the-Counter Cholecalciferol Increases Serum 25-Hydroxy Vitamin D Levels in Hemodialysis Subjects.”

CRN of Southeast Texas (CRNSET) has added a quarterly member spotlight in an effort to acknowledge the many achievements and contributions our members make. Our March newsletter featured our first member spotlight on Alice Chan, who was one of the founding members of CRNSET.

**Region V**

**Northern Arizona** CRN member Laura Holden, MBA, RD, CSR, received the Regional Recognized Renal Dietitian Region V award at the NKF Spring Clinical Meeting in Nashville.

Nancee VanderPluym, MS, RD, and Kay Atkins, MS, RD, of the Northern Arizona CRN published an article in the winter 2009 issue of Transplant Chronicles titled “Road of Detours: Bariatric Surgery.” You can read this article by pasting the following link into your web browser: [www.kidney.org/transplantation/transaction/chroniclesArchive.cfm](http://www.kidney.org/transplantation/transaction/chroniclesArchive.cfm) and clicking on “Winter 2009.”

Kudos to several CRN of Northern California and Nevada members! Linda McCann, RD, CSR, LC, was honored at the NKF Champions of Hope awards dinner.

Chhaya Patel has gone to India twice as part of the Bridge of Life program and has presented “Adopting Cultural Foods in the Renal Diet” at the American Kidney Fund’s “Empowering Patients to Overcome Barriers to Adherence” regional conferences in Chicago and in Phoenix. Kathleen Hunt presented “Beyond the Basics: Nutrition for Peritoneal Dialysis” at the 29th Annual Dialysis Conference in Houston, TX.

CRN of Oregon member Jessie Pavlinac, MS, RD, CSR, LD, was elected President of the American Dietetic Association and begins her term in June 2009.

Esther Teerman, RD, LD, from CRN of Oregon received the local NKF Volunteer of the Year Award.

CRN of Oregon members Jessie Pavlinac, MS, RD, CSR, LD, and Maureen McCarthy, MPH, RD, CSR, LD, are participating in a CRN/ADA task force for Standards of Practice and Standards of Professional Performance for Registered Dietitians in Nephrology. Maureen has also been the principal author of a series of articles appearing in the Renal Nutrition Forum on Standardized Language and the Nutrition Care Process. Co-authors of these articles include OCRN members Cheri Bates, RD, CSR, LD; Leslie Dilley, RD, CSR, LD; Denise Asbell, RD, LD; and Jessie Pavlinac, MS, RD, CSR, LD.

Elections for the CRN of Utah were held and new officers are as follows: Chairperson Marcia Whitaker, RD, CD; Education Chair Nancy Bybee, MS, RD, CD; and Secretary/Treasurer Sonia Neele, MS, RD, CD, CDE.

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**CNNT Council Updates**

**Region I**

The Centers for Medicare and Medicaid Services (CMS) selected four networks to participate in phase one of the implementation of CrownWEB. On February 1, 2009, eight facilities were up and running nationwide. Network 3 was selected from the Northeast with two participating facilities—one Small Dialysis Organization (SDO) and one Large Dialysis Organization (LDO).

The second phase of implementation is slated for the spring/summer of 2009. The three large dialysis organizations were given the opportunity to batch submit the data. All others are challenged with the time-consuming, labor-intensive task of manual entry, although many have the ability to batch submit.

As of January 1, 2009, hospital dialysis facilities will no longer be paid more by Medicare than the free-standing facilities. The Medicare Improvements for Patients and Provider’s Act (MIPPA) will implement a site-neutral composite rate. Hospital-based clinics have been paid $4 more on average than free-standing clinics. In addition, MIPPA will bring a 1 percent composite rate increase to dialysis providers in 2009 and 2010. Bundling will be phased in by 2010.

This equal playing field will generate more austerity programs to better manage operations. The new Conditions for Coverage require all dialysis technicians to be certified.
by January 2010, and the race is on to schedule training classes and prepare the current PCT workforce to successfully test and obtain certification. Pay for Performance is in view and has generated an urgency to streamline costs and optimize efficiencies. Professionals in our region are clearly focused and working very hard to meet these challenges.

**Region II**
The NKF of North Carolina has received its largest gift ever—a $150,000 sponsorship from Harrah’s Cherokee Casino & Hotel to support the Kidneyville Cruiser. The cruiser is a 48-foot mobile education and screening unit that travels the state educating people about CKD.

**Virginia:** Kidney Ambassador kick-off meetings were held throughout the state. Participants received training and tool kits that will help assist them in educating the public about CKD, as well as increasing CKD awareness.

The NKF of Kentucky was awarded the Most Improved NKF Signature Event for the NKF Golf Classic at the 2008 General Assembly awards luncheon in New Orleans. The award was presented to NKF of Kentucky Executive Director Lisa Allgood.

**Region III**
A spring meeting was sponsored by Illinois CNNT, ICRN, ICSW and the NKF of Illinois. Topics included “Psychosocial Implications of Chronic Illness,” “Nursing and PCT Certification,” “Pediatric Nephrology” and the Conditions for Coverage. Mark Conard, PhD, kidney transplant recipient, volunteered to speak to the renal professionals, which commemorated the 10th anniversary of his transplant. Four contact hours were awarded. Plans are being made for the 10th Annual Multidisciplinary Clinical Conference held in the fall. For information, contact Diane Hollingsworth at dhollingsworth@nkfi.org

**Region IV**
North Texas: The first KEEP of 2009 was held at Concord Missionary Baptist Church, where approximately 75 patients were screened. Based on the KEEP screening summary report for our division for the time period of 2000–2007, 66 percent of the 2,639 participants learned for the first time that they may have kidney disease. The generous support of time and talent enable us to continue offering this important service to the community.

The NKF Serving South and Central Texas has opened a satellite office in the Valley area. Texas is a BIG state. Serving an area from Temple to Brownsville can be quite a challenge, so they are thrilled to announce the opening of the new office in Brownsville. Amanda Krippel will be assisting with NKF programs and events in the Valley and southern Texas. Visit www.kidneytx.org for more information.

**Region V**
Kidney Health Australia will launch a national awareness campaign to OUT hypertension today at the Kidney Health Australia Annual Golf Day, held at the Kingston Heath Golf Course in Melbourne. The campaign stresses the importance of sport, lifestyle, exercise and taking time out to relax to combat hypertension.

**California:** The Pediatric Nephrology Educational Conference was held at Disneyland in Anaheim, CA. The conference was a full-day event, designed to provide information and support to children and families affected by kidney disease. Leading pediatric nephrologists and renal professionals presented educational sessions on dialysis, transplantation, nutrition, lifestyle and psychosocial issues with selected sessions in English and Spanish. Childcare, meals and program materials were all provided at no cost to the families in attendance.

**CNSW COUNCIL UPDATES**

**Region I**
**Western New York:** At a meeting, Anne McCooey, Executive Director, and Julie Maranca, Outreach Director from the NKF provided a demonstration on the programs available for patients and staff. Programs include a continuing education program that will be highlighted as part of a future Patient Education Day and The Risk Management Program. A new Transportation Fund will be set up for patients so that in an emergency they will be able to secure the fare for transportation to the hospital or doctor’s office from the unit.

**Connecticut:** At our first meeting of the year, a presentation was given by Hartford Hospital’s transplant team, including one of their transplant surgeons and two social workers. A social work student presented on a difficult patient with barriers to transplant. A recent conference available to the public included CEUs. Presenters were Dr. Ingeborg Haug, a professor at Fairfield University, who serves as a manuscript reviewer, and Dr. Debra Greenberg, a senior social worker specializing in gerontology at Montefiore Medical Center in New York City. Future meetings will include presentations by a psychiatric APRN and another on cognitive behavioral therapy.

**New York:** Dr. Robert Lynn, from Bronx Dialysis Center, recently presented on “New Dialysis Modalities and Settings—Contact our Web site at www.kidneyla.org or call 504.861.4500 for specific details. Kidney Walks are scheduled in Baton Rouge and New Orleans. We encourage all dialysis and transplant centers to start building their Walk Team now, so they can be the Winning Walk Team. Our Cadillac Invitational golf tournaments will be held between May and November. We are looking for volunteers and support for all of the Louisiana special events and invite you to join us for one or all of the events.
The Road Ahead,” and Dr. Paula Marcus, from Montefiore Medical Center, presented on “Psychosocial Issues in ESRD.”

**Region II**

**Kentucky** [Sally Rice, LCSW, DCD, Chair] meets twice a year. A recent meeting featured a State Surveyor and discussion of the new Nephrology Social Work-Certified program.

**South Florida** [Susan Witzel-Kreuter, LCSW, Chair] held joint meetings with the local NASW Chapter to celebrate Social Work Month.

**East Tennessee** (Kimberly Minton, LCSW, Chair) meets quarterly in Knoxville, and ethics in the dialysis setting was the topic of a recent meeting.

**Florida Gulf Coast** (Suzy Brabant, LCSW, Chair) meets every other month. Recent meetings featured a speaker from Social Security, a review of NKF Direct Aid grant requests and an elder law attorney on end-of-life issues.

**Central Virginia** (Renee Bova-Collis, MSW, LCSW, Chair) meets monthly with recent topics: “Creating Measurable and Time Frame Oriented Goals and Plans of Action for Social Work Plans of Care,” "the Virginia Transplant Program on “Living Donor Program and Transplant Preparedness” and a celebration of Social Work Month.

**Georgia** (Diana Laing, LMSW, Chair) holds quarterly meetings. The Chapter provides crisis intervention/prevention programs in partnership with the NKF of Georgia.

**Valley of Virginia** (Lois Kelley, MSW, ACSW, Chair) meets quarterly and features educational topics and networking.

**North Carolina** CNSW is back! The first meeting included speakers on “Coping with Change in the Workplace,” an update on NKF and using antidepressants with dialysis patients. For more information contact Bradley.Manton@fmcna.com

**Region III**

**Michigan**: In recent meetings, Holly Riley presented on KDQOL and Erica Perry presented “Young Adults and CKD.” The 10th Annual MCNSW Symposium included topics such as “Mindfulness, Acceptance and Resilience: Key Ingredients to Coping with Pain” and “Complementary Medicine and the Chronic Pain Patient.”

**Iowa**: Bev Chodur, LMSW, recently presented on the topic of end-of-life planning and having difficult conversations with patients and staff. Mike Wagner, LMSW, presented a review of the Heartland Kidney Network.

**Wisconsin** held a conference titled “Financial Updates: Medicare, Supplements, Etc.,” which included a presentation by Donna Bryant, Lead Advisor for the state Medigap Hotline. Teverlyn Allen, RN, BSN, Nurse Consultant, Acute Care Compliance Section, presented “Surveys and the New Conditions for Coverage.”

**Nebraska**: Mary Lou Buss, LCSW, recently presented on her research project “Self-Efficacy and Dialysis Adherence.”

**Eastern Missouri and Metro East** had a presentation regarding social security issues. Other meetings focused on in-home help for people with dementia and featured a presentation by the non-emergency medical transportation provider for the state of Missouri.

**Region IV**

**North Texas**: Dallas members received CEUs for monthly meetings. Topics included: “What About Those Super Bugs?”

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**Key to the Regions**

Region I – CT, DE, ME, MA, NH, NJ, NY, PA, RI, VT, Africa, Canada (New Brunswick, Newfoundland, Nova Scotia, Prince Edward Is.)

Region II – AL, DC, FL, GA, KY, MS, NC, SC, TN, VA, WV, Bahamas, Caribbean, Europe, Puerto Rico

Region III – IL, IN, IA, KS, MI, MN, MO, NE, ND, OH, SD, WI, Canada (Manitoba, Saskatchewan)

Region IV – AR, LA, NM, OK, TX, Mexico, Central America, South America

Region V – AK, AZ, CA, CO, HI, ID, MT, NV, OR, UT, WA, WY, Asia, Australia, Canada (Alberta, British Columbia, Yukon Territory), Middle East

**CNSW**

Region I: Christopher Simon, LCSW-C
Region II: Dawn Wilson, ACSW, LCSW
Region III: Norma J. Knowles, MSW, LCSW
Region IV: Surveen Klein, LCSW, MPH
Region V: Aaron M. Herold, MSW

**CNNI**

Region I: Eileen MacFarlane, RN, BSN, CNN
Region II: Deborah A. Glidden, ARNP, BC, CNN
Region III: Patricia Vaughan, BSN, RN, CNN
Region IV: Nancy Nardelli, RN, CCRC
Region V: Danilo B. Concepcion, CHT, CCHT

**CRN**

Region I: Elizabeth Kirk, RD, CDN
Region II: Patricia Weber, MS, RD, CSR, CDE
Region III: Catherine M. Goeddeke-Merickel, MS, RD, LD
Region IV: Nadiya Iskhani, RD, ID
Region V: Laura J. Holden, MBA, RD, CSR
“Healing with Humor” and “Mental Illness: Ethical Dilemmas in Health Care.” The Chapter’s Legislative Representative attended the Texas ESRD stakeholder’s meeting to advocate for dialysis clinic patient ratios per social worker and submitted a letter to the Texas Department of Health Services. Chapter Chair Lisa Pratka (lisa.pratka@hcahealthcare.com) volunteered on a patient education seminar planning committee sponsored by NKF of North Texas.

The Central Texas Chapter held their annual seminar providing 0.6 CEUs, including 0.3 CEUs of ethics. Barbara Anderson presented “The Long Haul: Ethical Leadership and Social Work Practice” and Sue Gallego spoke on “Cultural Diversity in the Health Care Setting.” Chapter Chair is Kristi Robinson (kristi.robinson@davita.com).

South Texas hosted presentations from the Social Security Administration, the Texas Department of State Health Services/Kidney Health Care and an ethics presentation from faculty at the University of Texas Health Science Center in San Antonio. Chapter Chair is Barbara Faller (Barbara.Faller@uhs-sa.com).

Oklahoma: Members attended NKF SCM09 and continue meeting with local NKF while working on membership growth and networking development opportunities. Chapter Chair is Angie Smith (angela.s.smith@davita.com).

Louisiana: Elections for officers were held during a Chapter meeting. New and former members are encouraged to attend meetings. Chapter Chair is Joy Glorioso (joy.glorioso@dcinc.org).

Arkansas: New members and former members are encouraged to contact Chapter Chair Debbie Brady (BradyDR@archildrens.org).

Region V
Hawaii is attempting to invite state surveyors to one of its meetings to discuss the new Conditions for Coverage. The Chapter recently participated in the University of Hawaii’s practicum fair and shared information on nephrology social work to both bachelor’s and master’s level social work students.

Northwest hosted its annual two-day educational conference, which included presentations on “The New Conditions for Coverage,” “Transplant Issues,” “Mental Health and Working with Challenging Situations on the Dialysis Unit” and “Peritoneal Dialysis.”

Northern California held elections for officers. Recent meetings included presentations on social work and dietitian collaboration, HICAP for insurance resources and kidney transplant (CMS guidelines).

Greater Los Angeles held a conference that included a presentation on KDQOL by Beth Witten and a state surveyor who spoke about what they are looking for regarding social work documentation.

Inland Empire celebrated World Kidney Day with an educational meeting, including presentations on “Changes in Transplant Regulations—The Impact on the Evaluation Process,” “Getting Ready for Kidney Transplant,” “Village Health—A Medicare Part C ESRD Medi-Gap HMO,” “Changes to the Involuntary Discharge Process” and “Empowering Patient Goals and Success in the Renal Community.” The Chapter will hold elections at its September meeting and has decided to alter its meeting structure from four half-day meetings to two full-day meetings per year.

Rocky Mountain: Kathy Hernandez, Joanne Arebalo and Kathy Suarez from the Denver Social Security Administration presented on disability work incentives for SSDI and SSI recipients.

CRN COUNCIL UPDATES

Region I
Educational Offerings
CRN of Greater NY held their Renal Nutrition conference at Beth Israel Medical Center in NYC. Topics included: “Salt as a Uremic Toxin,” by Nathan Levine, MD; “Modern Nutrition Management of HIV and CKD Co-Infection,” by Alan Lee, RD, CDE, CDN, CFT; and “Wound Healing and Nutrition,” by Nancy Collins, PhD, RD, LD/N, FAPWCA. A debate on “Tight Glucose Control is Appropriate in CKD—Pro and Con,” was presented by Richard Amerling, MD, and Jerome Tolbert, MD. CRN of Long Island offered “Gastroparesis and Motility Disorders,” presented by Dorothy Petito, MPH, RD, CD/N.

Maryland CRN-Baltimore recently offered the following educational opportunities: “The Clinical Rationale for Treating Secondary Hyperparathyroidism (SHPT) in Diabetic Patients with Declining Kidney Function,” by Mohamed Atta, MD, from Johns Hopkins University School of Medicine, and “Hidden Sources of Phosphorus,” by Lisa Gutekunst, MSEd, RD, CD.

Network 4 CRN Council held their Spring Education Meeting at the Doubletree Guest Suites Hotel in Plymouth, PA. Presentations included: “Nutritional Management for Patients with ESLD,” by Mariannne Aloupis, MS, RD, CNSD, LDN; “Cinacalcet and Improved Management of SHPT in Dialysis Patients,” by Joseph Brezin, MD, FACP; and “Food and Medication Interactions with Emphasis on Renal Disease,” by Zaneta M. Pronsky, MS, RD, LDN, FADA, and Sr. Jeanne P. Crowe, PharmD, RPh.

CRN of Western NY (Buffalo, NY) held a meeting to discuss staffing difficulties and the new care plans. “Inflammation in ESRD” was presented by Trisha Fuhrman, RD, at another meeting.

Region II
Educational Offerings
Middle Tennessee CRN continues to meet quarterly (first Thursday of January, April, July and October). Contact
Region III
Educational Offerings
The Cincinnati/Dayton CRN held a business meeting and enjoyed a presentation by Ali Abu-Alfa MD, FASN, entitled “Treatment of Chronic Kidney Disease—Mineral and Bone Disorder.”

Eastern Missouri and Metro East CRN held an educational program and business meeting at the local NKF office. The following topics were presented: “BMI and its Effect on Renal Transplant,” by Nancy Culiberk, RN, BSN, Transplant Coordinator at St. Louis University Hospital Transplant Services, St. Louis, MO; and “A Discussion on CKD and Secondary Hyperparathyroidism,” by Kathryn Norwood, MS, RD, LD, of Chromalloy American Kidney Center, St. Louis, MO.

Illinois CRN President Terrie Rydzon and President-Elect Sara Martin volunteered for the launch of NKF’s new campaign “Love Your Kidneys!” at Navy Pier in Chicago, IL. Volunteers took blood pressures, calculated BMI scores, counseled on nutritional management and educated the public about vital functions of the kidney and who is at risk for CKD. The campaign spread the theme across NBC TV, the Chicago Tribune newspaper and local radio stations. The goal is to incorporate one basic message and bring consistency to NKF’s communication nationwide.

The Kansas City Metro CRN bi-annual full-day educational seminar, “Beyond Bone Management,” offered 6 CEUs to dietitians, social workers, nurses and patient care technicians. The topics presented were as follows: “Exercise and the Dialysis Patient,” by Patricia Painter PhD; “Herbals and the Dialysis Patient,” by Camille Wissman, Pharm D; “Vitamin D Therapy,” by Marcos Rothstein, MD, FACP; “Gastric Bypass and the Dialysis and Transplant Patient,” by Barbara Weis-Malone, RN, CFNP, MSN; and “Phosphate Additives Outcome on the Dialysis Population,” by Lisa Guntekunst, MSEd, RD, CSR, CDN. The annual spring meeting featured an update from the 2009 NKF Spring Clinical Meetings in Nashville by Chapter members Tammy Rew, RD, LD, and Kim Munsterman, RD, LD.

The Northern and Eastern Ohio CRN (NEOCRN) meeting was held to show the audio presentation, “Inflammation as the Key Interface of the Medical and Nutrition Universe,” which was originally presented during the national ASPEN conference in 2006.

Sunflower CRN held their first meeting of the year and heard a presentation on “Cinacalcet and Improved Management of SHPT in Dialysis Patients,” by Dr. L. Darryl Quarles, MD, from the University of Kansas Medical Center.

Region IV
Educational Offerings
Recent monthly meetings for Fort Worth CRN provided the following educational opportunities: “Diabetes and CKD,” by Susan Smith, RD, LD, CDE; and “Cinacalcet: Improving Access for Your Secondary HPT Patients on Dialysis,” by Debbie Lindsey, RD, LD.

North Texas CRN held monthly meetings. The educational offerings at these meetings included “CKD Bone and Mineral Disorders,” by Peter McCullough, MD; “Early Intervention in Secondary Hyperparathyroidism Associated with CKD Stages 3 and 4,” by Ramesh Saxena, MD; and “Fun with IDPN Basics,” by Susan B. Smith, RD, LD, CDE.

CRN of Southeast Texas members attended a networking field trip to the John P. McGovern Museum of Health and Medical Science to see their “Amazing Body Exhibit.” Members attending The Steven Z. Fadem Update Professional Symposium heard lectures on key issues related to kidney disease and the professionals involved in these patients’ care. Bridgette Schiller, MD, gave an educational lecture on “Laboratory Monitoring in ESRD Patients: Pearls and Puzzles.”

South Plains CRN met for a presentation titled “Coaching Patients for Success—Strategies to Enhance Dialysis Patients Education through Motivational Interviewing,” given by Beverly Sneed, RN, BSN.

Region V
Educational Offerings
Over 175 people attended the 10th Annual Southwest Nephrology conference, organized by the Arizona Kidney Foundation.

At the April Northern Arizona CRN meeting, Beth Spanier, RD presented “Vitamin D—Keeping Levels Consistent to Improve Outcomes in CKD.”

A quarterly meeting for CRN of Utah was held and hosted Diana McGuire who presented “Experiences of a 40-Year Kidney Transplant Recipient.”

Legislative News
Many Northern California and Nevada members were able to attend the most recent Public Policy Day in Sacramento, CA, to legislate for expansion of California’s Business and Professions Code and to start the approval process to initiate a state licensure board.
There is an ongoing and urgent need to increase the number of organs available for transplantation in the United States. To address this complex problem, the National Kidney Foundation has developed a comprehensive action plan to increase the number of transplants for kidney patients—and to END THE WAIT!

This groundbreaking program will serve as a road map to implementing tested and proven strategies that will effectively end the wait for kidney transplants in 10 years.

By collaborating with many organizations, government agencies and individuals, END THE WAIT! will eliminate barriers, institute best practices across the nation, improve the transplant system, cover the cost of donating an organ, reduce regional and ethnic disparities and increase living and deceased donation throughout the United States.

Recommendations focus on four key areas, including the following:

1. Improving outcomes for recipients, reducing the need for multiple transplants:
   - Cover the cost of immunosuppressant medications for the life of the transplant
   - Educate chronic kidney disease stage 4 patients about early transplantation and treatment options

2. Increasing deceased donation by:
   - Covering all donation-related costs
   - Recovering and utilizing organs from Expanded Criteria Donors and from donors who have experienced cardiac death

3. Increasing living donations by:
   - Ensuring all donation-related expenses are covered, including lost wages
   - Offering donors state-of-the-art medical procedures, ensuring the quickest recovery time
   - Expanding matching and paired donor programs

This initiative will end the long wait for a transplant that has subjected too many patients to deteriorating health, poor quality of life and even premature death. By working together and focusing on the big picture and real needs of our patients, we will have a dramatic impact on the health of kidney patients across the country.

Learn more about END THE WAIT!
Read NKF’s Position Statement, full list of recommendations, comments and reactions, and keep up with the latest initiative news at www.kidney.org/endthewait