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CORPORATE COMMUNITIES:
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DaVita is proud to be the largest independent provider of dialysis services in the United States, and we’re proud of our superior clinical outcomes. But for us, being the best isn’t just about resting on what we’ve done. We recognize the responsibility that comes with being a big player in the health care industry, and we take our responsibilities as a corporate citizen very seriously. We want to be the greatest dialysis company the world has ever seen, and to us, that means a dedication to our vision of corporate communities.

We have dedicated ourselves to creating a new paradigm for renal care, one that is socially active and civic-minded inclined. For our patients this means providing the best care possible, demanding service excellence and continuous improvement. For our teammates, we aim to create a work environment that fosters productive and rewarding careers; and as for the world in which we live, DaVita strives to make it a better place.

CARING FOR OUR PATIENTS

DaVita wants to provide our patients with the highest-quality, most comprehensive care. We’ve worked hard to develop programs that address their unique needs as chronic-care patients and that optimize care by focusing on clinical outcomes and quality of life.

DaVita has invested extensively in chronic kidney disease (CKD) education and resources and has founded a nonprofit organization with the specific aim of working to prevent end-stage renal disease (ESRD). Our Kidney Education and You (KEY) Connections program has educated over 100,000 people, both those at risk for CKD and health care providers who work with CKD patients. We believe it is our duty to slow down the growth of Stage 4 renal disease in America.

However, we know we can’t wipe out ESRD. And so we also believe it is our duty to give personalized care to our dialysis patients. To that end, DaVita is affiliated with Lifeline Vascular Access™, a chain of outpatient...
vascular access centers. DaVita’s partnership with Lifeline makes it easier for both doctors and patients to manage access, while reducing costs and creating better compliance. We also have an affiliation with VillageHealth™, a disease management company that encourages preventative and coordinated care.

DaVita Rx™ is a specialized pharmacy specifically designed to meet the unique needs of patients with kidney failure. Before DaVita Rx, a physician prescribing medications for an ESRD patient rarely had access to information on all of that patient’s diagnoses or complete medication records. DaVita Laboratory Services™ is also critical to coordinating care; it features the latest in ESRD-specific methodology and technology to deliver high-quality test results for optimal patient care.

But improving ESRD isn’t just about implementing new ways to coordinate and refine care; it’s also about coordinating and refining our body of knowledge about kidney disease and dialysis. DaVita Medical Informatics is a new program that will help us better track and use medical data. DaVita Clinical Research (DCR) is a Phase I-IV clinical trial site and the nation’s largest renal research network. DCR is dedicated to providing and supporting clinical data research. It’s a leader in renal and renal-related drug and device research for approval by the U.S. Food and Drug Administration.

At DaVita, care isn’t just clinical. That’s why we have Patient Greeting Cards. Teammates can order these birthday, get well, or sympathy cards for their patients or patient family members.

Unfortunately, no matter the quality of care, many of our patients and their families face end-of-life issues. DaVita has created Circle of Life™, a program established to address these issues for patients, their families, and their caregivers. When a DaVita patient passes away, DaVita will make a donation to a nonprofit organization known as the Kidney TRUST in honor of that patient.

CARING FOR OUR TEAMMATES
At DaVita, we take the Village seriously. Our teammates know that we are all members of the same community, and that means we help each other out, invest in each other’s successes, and lend a hand when things aren’t going well.

The DaVita Village Network helps teammates with financial aid during times of crisis, such as natural disasters or life-threatening emergencies. Monies are donated by teammates on a voluntary basis. For every dollar a teammate contributes, the company will take 1 dollar from shareholder profits and match the award.

The DaVita Children’s Foundation is a charitable foundation that provides scholarships to children and grandchildren of teammates who are enrolled in college or in 12th grade and preparing for college entry. Selections are based on leadership, community service, and other application components. The KT Family Foundation provides scholarships to children and grandchildren of teammates who are in grades 6 through 11. Chief executive officer Kent Thiry; his wife, Denise O’Leary; and close friends privately fund this foundation. Scholarships from both organizations range from $1,000 to $3,000. The RN Scholarship program helps teammates foster their skills, while aiding in nurse recruitment.

DaVita also offers almost a dozen training and educational opportunities for teammates. These include leadership training at DaVita University and MBA scholarships from DaVita Redwoods. Reality 101 brings executives into the centers to train as patient care technicians.

Star Troopers is DaVita’s way of reaching out to those serving in the armed forces, whether they are teammates or teammates’ family members. Through the program, stateside teammates and their families in the Village are able to correspond with those actively serving overseas.

CARING FOR OUR WORLD
The positive sustainable changes DaVita strives to create aren’t limited to our patients and their families or to our teammates and their families. We want to help provide change for all families and communities in need.

The Kidney TRUST is a nonprofit organization founded by DaVita to increase kidney disease awareness through
education and testing. Its pilot programs include low-cost CKD screening and financial assistance for privately insured dialysis patients. The TRUST holds Kidney Awareness Time (KAT) Walks throughout the country to raise money for its programs and bring awareness to local communities. In September, DaVita sponsored the Tour DaVita, a 230-mile bike ride that benefited the Kidney TRUST. These events raised over $1M for kidney education this year.

DaVita also founded and donates money toward Bridge of Life, a nonprofit organization that brings dialysis to developing nations. DaVita is providing technical support, equipment, supplies, training, and thousands of teammate hours to build dialysis facilities in Cameroon and Ecuador, and other African, Latin American, and Asian countries are next. To facilitate DaVita teammate participation in this important effort, teammate job duties are covered during their travel abroad, and their expenses are paid in full by DaVita with contributions made by executives. Many DaVita-affiliated physicians have also participated in Bridge of Life.

The KT Community (KTC) Foundation, funded by Thiry and O’Leary, allows DaVita teammates, their families, and their neighbors the opportunity to contribute time and skill toward a community project. The KTC Foundation provides a financial grant for the materials, equipment, tools, and supplies necessary to plan and complete the project. Teammates have tutored children in reading, provided low-income children with bicycles, and taught leadership workshops for inner city children.

Village Service Days facilitate large-scale service projects planned and executed by groups of teammates. In early 2007, for instance, dozens of teammates worked together to make over a Lions Club center for the blind. Similar projects have taken place in Texas and Pennsylvania, with many more in the planning stages.

Most recently, DaVita has launched DaVita Village Green, which aims to cut the carbon and waste produced and water used by our centers. Providing dialysis doesn’t have to be wasteful or environmentally harmful, and Village Green will target reuse and biowaste disposal and implement several initiatives to reduce paper waste.

**A NEPHEROLOGIST’S PART**

DaVita wants to work with nephrologists to redefine renal care in the United States. But the government must play a hand as well. DaVita is committed to political action on behalf of all kidney patients, nephrologists, and dialysis providers. DaPAC, our political action committee, donated over $200,000 in 2007 for the benefit of the kidney care community. This includes supporting the Kidney Care Quality and Education Act, which dedicates resources to education about and prevention of kidney disease.

We’ve also created a patients’ political action group called DaVita Patient Citizens that now boasts over 20,000 members. More recently, we founded the DaVita Nephrology Alliance (DNA), a physicians’ political action group that works in tandem with the Renal Physicians Association. Our objective with DNA is to form a unified front of nephrologists who will help shape public policy. The group provides its members with updates on kidney care policy via its Web site and newsletter. Its members advocate for responsible policy and have met with lawmakers and Capitol Hill staff members to promote their goals.

So what does DaVita’s new paradigm in corporate care mean for you? It means we’re your partner in providing the best possible care for patients and in trying to slow the CKD epidemic that makes your job more difficult every year. It means that our teammates are satisfied and turnover is lower, so you’re working with better partners. It means that you’re working with a company that does what it says it will and cares about more than just profits and growth. We care about kidneys, and we care about people.
INCIDENT MANAGEMENT OF PATIENTS:
Managing the First 90 Days

By John Robertson, M.D., and Pooja Goel M.H.A.

IMPACT (Incident Management of Patients, Actions Centered on Treatment), also called the First 90 Days Project, is an effort designed to reduce mortality for incident patients, primarily in the first 3 months of dialysis, when these patients are most vulnerable. The program is aimed at patients who have never received dialysis treatment in an outpatient clinic.
These at-risk patients are often overlooked. Because they are transitioning to a new treatment, they often need more interventions initially. Therefore, they need to be reassessed more often, and thus their treatment must be more flexible and customizable. The IMPACT program is designed to focus on predictive key indicators known to be associated with lower mortality: access, anemia, adequacy, and albumin. The program also takes bone and mineral management and fluid control into consideration.

This project is an important one because it standardizes the care provided to new patients when they start dialysis. It also maintains a sharp focus on these patients throughout their initial 90-day period on dialysis.

**HIGHER MORTALITY RATES**

Incident patients are more vulnerable in the first 90 days for several reasons. These new patients are often unaware of their clinically silent kidney disease until they are uremic and require emergent hospital care and acute hemodialysis. In some parts of the country, over half of new dialysis patients have never seen a nephrologist. Furthermore, new and previously untreated patients are often facing significant comorbidities, such as severe anemia, accelerated hypertension associated with their disease and fluid overload, secondary hyperparathyroidism associated with severe hyperphosphatemia, and no preparation for a life that requires dialysis to sustain it.

Lack of preparation and no permanent vascular access requires that temporary and often tunneled-cuff dialysis catheters be placed, greatly enhancing the risk of underdialysis and catheter-induced infection. At DaVita, the majority of patients new to dialysis start with some type of vascular catheter as their dialysis access. Thus the incident patient new to dialysis is often sicker compared to the prevalent patients, and is also usually unprepared for a life requiring many new medications, dietary restrictions, and an adherence to a treatment regimen that is likely to require not only surgery but alterations of all their usual life activities.

The table below reflects DaVita’s current mortality rates as they pertain to incident patients only. Although our patient mortality rate is better than other dialysis service providers’ reported mortality, we feel we can improve. Our goal is to reduce our 90-day mortality rate.

**PREDICTIVE INDICATORS**

Many clinical factors contribute to an increased risk of death in incident patients, although some have a higher correlation than others. In particular, we believe these are anemia, adequacy, albumin, and access. Of these, albumin and access were found to have the most impact on driving mortality reduction.

In designing an approach to on-boarding new patients, these factors were emphasized in the development of multiple tools and resources.

**COMPREHENSIVE REASSESSMENT**

Reassessment is vital for high-risk incident patients in the first 90 days. IMPACT provides tools designed to make actions customizable, transitional, and comprehensive.

Our objective was to have an approach pliable enough to cover the type of condition the patient presents while still following a careful clinical protocol that delivers the best outcomes at the end of 90 days.
THE IMPACT PROCESS AND TOOLS
DaVita convened a workgroup of teammates to define an approach to on-boarding patients new to dialysis, focusing on obtaining the best clinical outcomes with an overarching goal of 90-day mortality reduction. In addition, a focus group of facility administrators was recruited to provide feedback on existing tools and standard approaches to care currently in use for incident patients in their facilities.

Our first step was to survey nephrologists and facility administrators. Was there a process in place that we weren’t aware of? Could we benefit from existing practices and share this knowledge throughout DaVita Village?

Furthermore, we asked our survey participants what, in their view, were the most critical elements to address. As we pored over the results, it became clear there were 4 critical components that had to be addressed in new patient on-boarding:

1. Structured New Patient Intake
2. Patient Education
3. 90-Day Management Pathway
4. Monitored Patient Outcome Data for the First 90 Days on Dialysis

OPPORTUNITIES

Structured New Patient Intake
Intake of new patients is generally assigned to the business office within each dialysis facility. The administrative assistant collects information about the new patient from the referring source and begins the admission process. This involves collecting demographic and insurance information. The patient is scheduled and brought on board for treatment. All relevant information is entered into clinical and registration systems.

There were several opportunities to improve the intake process. The information collected up front did not have a strong clinical focus. While basic information was gathered, there was no comprehensive collection effort in place to capture a true clinical sense of the new patient up front. In addition, data entry was inaccurate or haphazardly reported. For example, the field “First Date of Dialysis” (FDOD) is essential to have from a clinical and billing perspective, but was not regularly entered. There was rarely sufficient communication around a new patient’s arrival; either the notification about a new patient was short or there was no mechanism in place to communicate the news in advance at all. Often, the attending physicians were unaware of new patient admissions to their dialysis shifts. Not infrequently, new patients received their dialysis orders from another physician covering the attending physician, and there was no communication between the two about clinical information for the new patient. Could the facility somehow enhance communication between all the caregivers to allow the team time to address the significant needs of this new patient more acutely?

Patient Education
Our survey results indicated that over 65% of all facilities began education for new patients within the first week of dialysis. Although plenty of resources were available to them, there was no clear way to tie this all together for the incident patient. Additionally, many of the materials that did exist were not designed for the new patient.

Another factor to consider is that not all new patients are ready to learn about dialysis right at the start. While some may be under the care of a nephrologist when they begin, others “crash” into dialysis, previously unaware that they had kidney disease and not prepared for the journey they are about to take.
The 90-Day Management Pathway

Facilities were already on-boarding new patients; over time they had developed their own mechanisms for transitioning patients to dialysis. But the process was not organized and certainly not standardized. Survey results indicated that facility administrators wanted a pathway to follow, with specific action items and time-frames, with each task delegated to a specific teammate.

Monitored Patient Outcome Data for the First 90 Days on Dialysis

Because FDOD was only sporadically entered into the system, there was no way to give teammates an automated reminder to focus care for these new patients in their 90-day process. While teammates generally had a sense that a particular patient was new, the new patient became absorbed too quickly into the general population. In addition, all clinical reports industry-wide excluded pre–90 day patients. This was primarily because Medicare often becomes effective only after 90 days on dialysis. Because of the recognized gaps in predialysis care for new patients, reported dialysis provider outcomes generally excluded these patients’ outcomes during this initial period on dialysis.

Facilities were requesting a way to tease out these patients so that they could be followed more closely.

TOOLS

Structured New Patient Intake

The IMPACT team recognized that to standardize intake, the orders needed to capture all the elements of care necessary for incident patients. Over time, many order templates were developed internally but were not designed with the incident patient in mind. The new orders had to be comprehensive and list common methodologies, but also allow for deviation from standard protocol. A standardized order form was created in conjunction with members of the Physician Council, nurse leaders, and biomedical experts. It was designed to be consistent with Snappy™, DaVita’s clinical software, for future electronic order set creation, utilizing drop-down menus to select options as needed. The main impetus for creating such a detailed order form was the need for a complete set of admission orders, and by having such, we hope to better capture all the necessary order data elements once they are interfaced with an electronic medical record.

Several resources were developed for the business offices at the facilities. The IMPACT Checklist was among the first. This was a checklist that combined demographic, billing, and clinical elements all into one. The form is intended to prompt the administrative assistant to ask for all information listed, from a copy of the insurance card to the patient’s vaccination history. It allows the facility to truly get a comprehensive look at the patient before he or she starts dialysis.

The next piece developed was focused on increasing notification for new patients. Ideally, the physician’s office should call the facility in advance when sending a new patient for admission. However, this does not always happen, or it happens with very short notice, impacting the facility teammates’ ability to prepare for the new patient appropriately. The second referral source is hospitals, from which it is almost impossible to receive advance information. To address both of these issues, we created distinct fax forms for each referral source. The facility will fax the form each month to its referring physicians and social workers/discharge planners. If either source plans on admitting patients to our dialysis facility that month, they give us the patient’s name and anticipated FDOD. The facility will then begin the admission process, with more time from notification to admission.

To address the issue of teammates being unaware of a new patient’s arrival, we also generated a new patient announcement form. This is a 1-page colorful announcement designed to tack up on a break room board or other venue that is teammate-specific. The flyer lets the facility’s teammates know that a new patient is joining the DaVita Village, who this person is, when they will arrive, and any other special notes. The flyer also allows the facility to assign a teammate buddy to the new patient—one their first day, check in with them periodically, and be available in case the patient has questions.

Parallel to giving the facility more time to prepare for a new patient, we also wanted to afford the new patient the same preparation time. To this end, we created a welcome letter. The letter states that we are expecting the patient, indicates the anticipated FDOD, and lists what to expect and what the patient should bring on the first day.
It offers the patient the chance to tour the facility in advance of their FDOD, meet the facility teammates, and complete any necessary paperwork so that they do not have to add to their time on their first day of treatment.

In order to stress entry of the FDOD into clinical systems, IMPACT adds an enhancement to the monthly facility outcomes report. Working with our information technology teammates, we created a subsection on the report that would report out incident patients by name each month. If the FDOD falls within 90 days of the report being issued, the name will be listed. It will also include patients whose FDOD is blank. This will prompt each facility to keep careful track of FDOD.

To tie this all together, we created guidelines and talking points a facility’s teammates can all walk through together. It lists each resource provided and why the teammates should consider using each of the tools.

**Patient Education**

Because the incident patient population presents its own set of issues, fears, and concerns, it was imperative to develop an education guide specific to this population. The guide focuses on all key predictive indicators, including bone and mineral metabolism, fluid control, modality education, and key information about starting dialysis.

To help facilities keep track of educational efforts, a checklist was created to accompany the guide. It lists each section of the handbook, the suggested timeframe for educating the patient, and a space to note the teammate who completed each session. To help make the guide transitional and customizable, pieces are removable, allowing teammates to work at different paces with different patients. These materials will also be available in Spanish. At the conclusion of the training, the patient and his/her caregiver (if applicable) sign and date the checklist and take the materials home.

**The 90-Day Management Pathway**

The same checklist concept was applied to the management pathway. Specific action items are grouped by predictive indicator with suggested timeframes. The facility can decide who is responsible for completing each item. The pathway is currently being converted into one of our clinical systems so that the process can be automated.

**Monitored Patient Outcome Data for the First 90 Days on Dialysis**

To ease the facility’s ability to assess the incident patient’s transition to dialysis, the IMPACT team created a number of reports. The current standard lab report, which goes out to each facility monthly, lists lab values by patient name but does not distinguish between incident and prevalent patients. The report is being reformatted to make this distinction.

In addition, the IMPACT team designed an outcomes report similar to DaVita’s current DaVita Quality Index (DQI) measure for prevalent patients. This new measure tracks incident patient progress by each predictive indicator over the 90-day period. The hope is that this report will spark a desire at our facilities to improve incident patient performance well before the 90-day timeframe.

Another component being tested in IMPACT is the administration of a quality-of-life (QOL) survey. Research has shown that higher QOL scores have been associated with lower mortality. For the pilots, IMPACT is collecting some data to test this theory further.

Finally, for selected facilities IMPACT will provide nutrition supplements and monitor the impact of these supplements on nutritional adequacy and its surrogate, albumin.

**CRITICISMS OF IMPACT**

Response to the tools developed thus far has been generally positive. With the pilots, the IMPACT team hopes to test these tools further to ensure that what we have built achieves the process improvement aimed for. However, there has been some skepticism around whether the tools developed will truly reduce our 90-day mortality rate, given that factors other than clinical indicators contribute to mortality.

The IMPACT team recognizes that there are other factors at play and that our program will not address all the mortality contributors initially. The current
program is a first step toward a comprehensive approach. Pilot sites will help guide us as we refine these tools using the collected data. We also believe that this focus on incident patients may help us look upstream to better management of chronic kidney disease as a whole.

**PILOTS**

We intend to roll out our IMPACT process in 40 facilities across the United States. The facilities were chosen based on specific criteria: high incident patient volume and differing 90-day rates on mortality. The pilots are expected to begin in October 2007. The IMPACT team has enlisted the support of DaVita’s medical directors, since this process cannot be successful without physician participation. Each month, surveys will be sent to all teammates and physicians participating in the process. The intent of the pilots is to test the tools, process, and ability to measure outcomes long-term.

**CONCLUSION**

Time will tell if IMPACT has the right components to reduce 90-day mortality rates. We look forward to pilot execution and the testing of our theories. Long-term mortality measures will help us determine if this process is really impacting patients in the intended way, resulting in longer lives and better outcomes.

**REFERENCES**

The Beneficial Effects of Cool Dialysate on Sleep

Among hemodialysis (HD) patients, 50-85% complain of insomnia and excessive daytime sleepiness. Primary sleep disorders such as sleep apnea (SA) and periodic limb movement disorder (PLMD) are common, and the prevalence of restless legs syndrome (RLS) is also high. Few studies, however, have focused on either the subjective or the polysomnographic features of sleep on the night before versus the night following treatment. The results of those done to date have been equivocal. Nonetheless, dialysis may induce treatment-associated sleep changes because of its potential adverse effects on sleep regulatory processes.

By Kathy P. Parker, Ph.D., R.N., F.A.A.N., James L. Bailey, David B. Rye, Donald L. Bliwise, and Eus J. W. Van Someren
The rhythm of body temperature (BT) is very important in the regulation of sleep. A decline in core BT (increase in skin temperature) is typically associated with and may precede nocturnal sleep onset. Furthermore, sleep initiation is hastened and the amount of wakefulness during sleep is decreased when BT is declining at its maximum rate. In contrast, sleep offset and wakefulness are associated with a core BT increase.

Our previous work indicated that the heat load induced by HD may play a role in disrupting sleep following treatment, as the increase in BT that often results appears to persist for several hours and may alter the dissipation of heat from the skin that occurs during normal sleep. Increases in core BT are thought to be caused by increased sympathetic activation and decreased ability to dissipate heat due to the intense peripheral vasoconstriction that accompanies fluid removal. As little as a 1-2°C decrease in dialysate temperature helps to reverse these changes by increasing central arteriolar and venous tone, venous return, and cardiac output. In this study, we tested the hypothesis that decreasing heat load and improving hemodynamic stability during and after HD by using cool dialysate would facilitate blood flow to the skin during the night, improve heat dissipation, and have other beneficial effects on nocturnal sleep the night following treatment.

**SUBJECTS AND METHODS**

**Subject Selection**

Patients with major chronic conditions associated with changes in sleep or BT were excluded. Because of potential drug-related effects on sleep and wakefulness and thermoregulation, patients routinely taking medications known to modulate central nervous system state or alter BT were also excluded. Finally, potential subjects were screened via a structured interview to exclude those with a previous diagnosis of sleep apnea syndrome, periodic limb movement disorder, or restless legs syndrome. The final sample consisted of 7 clinically stable, well-dialyzed HD patients recruited from university-affiliated dialysis units.

**Study Design**

The 3-phase study was conducted using a randomized, single-blind, crossover design. HD was provided in the hospital’s dialysis unit, in the same building, eliminating the need to expose subjects to any major environmental temperature changes. The independent variable was dialysate temperature, which was administered in 2 conditions: warm (37°C) and cool (35°C).

The major variables were (1) axillary skin temperature (T\textsubscript{ax}; a measure of proximal skin temperature) and (2) polysomnogram (PSG) measures of nocturnal sleep. Tympanic BTs (used as an estimate of core BT—subjects refused direct core measurements) were recorded every 30 minutes during HD until “lights out”. In addition, the staff recorded the ambient temperature displayed on the room thermometer just before “lights out” and just after “lights on”. Dialysis flow sheets were collected for all subjects to obtain data on intradialytic complaints and blood pressure (BP) measurements.

During Phase I, subjects were admitted to the center for 1 night in order to familiarize them with the study equipment and procedures to reduce first-night effects. During Phases II and III (approximately 1 week apart), subjects were readmitted to the center at 1800 hours the night before HD and discharged at approximately 1200 hours 2 days later. During these 2 phases, HD was administered the morning after admission in 1 of 2 two conditions, warm (dialysate bath temperature 37°C) or cool (dialysate bath temperature 35°C), in random order. Continuous T\textsubscript{ax} and PSG recordings were made throughout the nights preceding and following treatment from “lights out” until “lights on”. In all phases of the study, subjects slept in hospital gowns and were permitted 1 sheet and 1 hospital blanket throughout the night.

**RESULTS**

**Demographic and Clinical Features of the Sample**

The mean (± standard error [SE]) age was 46.1 ± 4.2 years. Three subjects were male and 4 were female. All were African American. The mean Kt/V was 1.5 ± 0.1, indicating that subjects were well dialyzed. The mean tympanic BT during HD in the warm condition was significantly higher than in the cool condition (36.3 ± 0.1 versus 35.5 ± 0.2; z = –2.4, P = 0.018).

The mean tympanic BT, taken every 30 minutes for the period following HD until “lights out,” was also significantly higher in the warm condition (36.9 ± 0.1 versus 36.2 ± 0.1; z = –3.18, P = 0.001), demonstrating that tympanic BT continued to remain higher beyond the
intradialytic period. There were no reports of shivering noted on the dialysis flow sheets, and none of the subjects withdrew from the study.

**Effect of Dialysate Temperature on the Course of Proximal Skin Temperature (T\text{ax})**

The grand mean of T\text{ax} over all time points and subjects was 35.9 ± 0.2°C (mean ± SE). Figure 1 gives a graphic representation of the best-fitting curves following the cool, warm, and baseline conditions. As can be noted, T\text{ax} declined more during the night following the warm dialysate than during the baseline nights or the night following treatment with cool dialysate. This greater decline resulted in temperatures below the ranges observed in both the baseline and the cool conditions in the early morning. Although the main effect of dialysate temperature on T\text{ax} did not reach significance, the course of T\text{ax} was significantly affected by the interaction of time and condition for the first-, second-, and third-order terms (all P < 0.000001), showing the greater drop in T\text{ax} especially in the early morning following treatment with warm dialysate.

**Effects of Dialysate Temperature and Proximal Skin Temperature on Sleep**

There was an increased probability of nocturnal wakefulness, especially in the early morning, after receiving the warm dialysate. The (multilevel) overall probability of being awake at any given time of night was P = 0.19 (confidence interval [CI] = 0.09-0.35). The odds of nocturnal wakefulness were significantly greater (odds ratio [OR] = 1.61, CI = 1.01-2.58, P < 0.05) following warm dialysate than during the baseline nights and nights following cool dialysate. In contrast, the cool dialysate did not affect the odds of being awake (OR = 0.78, CI = 0.47-1.27, P = 0.32). The mean probability of being awake following warm dialysate was P = 0.25, versus P = 0.17 for the baseline and cool nights. This increased wakefulness in the warm condition appeared to be mainly at the cost of Stage 1 sleep, which showed a trend toward decreasing (OR = 0.67, CI = 0.42-1.08, P = 0.10). No effect of warm or cool dialysate on the probability of any of the other sleep stages was found.

Regression analyses were also used to determine whether the within-night T\text{ax} profile was associated with the probability of occurrence of wakefulness and
sleep stages. For every 1°C increase in Tₘ, the OR for the occurrence of wakefulness decreased by 0.40 (CI = 0.37-0.45, P < 0.00001). Every 1°C increase in Tₘ increased the OR for the occurrence of Stage 1 by 1.08 (CI = 0.98-1.19, P = 0.12), though this was not significant. Every 1°C increase in Tₘ increased the OR for the occurrence of Stage 2 by 1.45 (CI = 1.35-1.56, P < 0.00001), of SWS by 1.61 (CI = 1.41-1.85, P < 0.00001), and of REM by 1.24 (CI = 1.15-1.34, P < 0.00001).

There were no significant differences in standard measures of nocturnal sleep among the 3 conditions (baseline, warm, and cool). However, the sleep of subjects during the baseline and cool conditions was very similar and markedly different from sleep in the warm condition (see Table 1). When 2-group comparisons were conducted (Mann-Whitney U test) between the cool and warm conditions, subjects fell asleep significantly earlier in the cool condition (21:17 ± 2.2 versus 24:15 ± 0:19; z = -1.9, P = 0.032). Although the differences were not significant, subjects in the cool condition tended to have longer total sleep times (37.1 ± 25.6 versus 307.6 ± 38.4; z = -1.4, P = 0.09) and shorter REM latencies (70.8 ± 5.6 versus 119.7 ± 29.6; z = -1.4, P = 0.088). No statistically significant gender-based differences in sleep measures were observed within or between the baseline, warm, or cool conditions.

DISCUSSION AND CONCLUSIONS
There numerous mechanisms via which HD may adversely affect sleep the night following treatment. For example, excessive sleep both during and after HD, a phenomenon that has been long described, can decrease the underlying drive for sleep, causing problems with the initiation of nocturnal sleep and sleep fragmentation. Decrement in central nervous system arousal and overall fatigue associated with the rapid fluid, electrolyte, and acid-base changes and the production of cytokines may also play a role. HD may also influence several circadian variables such as the

**TABLE 1:** Nocturnal sleep parameters (means ± SE) for the nights (pooled) prior to HD and the nights following the two HD conditions

<table>
<thead>
<tr>
<th>SLEEP PARAMETER</th>
<th>NIGHT BEFORE HD BASELINE</th>
<th>NIGHT AFTER HD WARM CONDITION 37 DEGREES C</th>
<th>NIGHT AFTER HD COOL CONDITION 35 DEGREES C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time of Sleep Offset</td>
<td>7:43 ± 0:17</td>
<td>07:13 ± 0:15</td>
<td>7:35 ± 0:31</td>
</tr>
<tr>
<td>Sleep latency (min)</td>
<td>16.4 ± 3.0</td>
<td>62.2 ± 33.8</td>
<td>22.1 ± 8.0</td>
</tr>
<tr>
<td>REM latency (min)**</td>
<td>98.7 ± 15.5</td>
<td>119.7 ± 29.6</td>
<td>70.8 ± 5.6</td>
</tr>
<tr>
<td>Stage (min)</td>
<td>55.4 ± 17.7</td>
<td>35.7 ± 8.6</td>
<td>50.7 ± 19.4</td>
</tr>
<tr>
<td>Stage 2 (min)</td>
<td>228.1 ± 22.0</td>
<td>169.8 ± 21.5</td>
<td>164.6 ± 31.3</td>
</tr>
<tr>
<td>Stage SWS (min)</td>
<td>34.8 ± 19.3</td>
<td>47.9 ± 21.0</td>
<td>36.2 ± 21.3</td>
</tr>
<tr>
<td>REM (min)</td>
<td>62.9 ± 10.9</td>
<td>54.3 ± 11.9</td>
<td>56.7 ± 12.7</td>
</tr>
<tr>
<td>NREM (%)</td>
<td>84.3 ± 2.4</td>
<td>83.7 ± 2.9</td>
<td>82.5 ± 2.9</td>
</tr>
<tr>
<td>REM (%)</td>
<td>15.7 ± 2.4</td>
<td>16.3 ± 2.9</td>
<td>17.5 ± 2.9</td>
</tr>
<tr>
<td>Nocturnal Total Sleep Time (TST, min)***</td>
<td>381.2 ± 26.3</td>
<td>307.6 ± 38.4</td>
<td>371.7 ± 25.6</td>
</tr>
<tr>
<td>Nocturnal Sleep Efficiency (SE, %)</td>
<td>74.4 ± 5.7</td>
<td>65.8 ± 10.7</td>
<td>73.5 ± 5.5</td>
</tr>
<tr>
<td>WASO &gt; 120 seconds (minutes)</td>
<td>88.1 ± 32.1</td>
<td>109.5 ± 53.9</td>
<td>85.8 ± 30.4</td>
</tr>
<tr>
<td>WASO &lt; 120 seconds (minutes)</td>
<td>23.5 ± 3.5</td>
<td>24.1 ± 3.1</td>
<td>31.0 ± 7.4</td>
</tr>
</tbody>
</table>

Two groups comparisons between warm and cool conditions (Wilcoxin Match Pairs-Sign Rank Test)

* p=0.032

** p=0.090

*** p=0.088
production of melatonin, social and physical activities, and light exposure, all of which are important cues to help synchronize body rhythms.

Although the effects of dialysis-induced thermoregulatory abnormalities on cardiovascular and intradialytic blood pressure stability have recently been reviewed, the effects of these changes on nocturnal sleep have never been examined. Yet temperature and sleep are interrelated processes. To our knowledge, however, this is the first study to examine the effects of experimentally induced blood temperature changes on these phenomena in chronic HD patients.

A major finding was that, in the warm condition, the interaction of condition and time significantly altered the course of T_{ax}. In particular, there was a notable decrease in T_{ax} in the early morning hours in the warm condition. In contrast, in both the baseline and cool conditions, T_{ax} remained higher during the same period. The mechanism underlying these observations may be the same as that believed responsible for the beneficial effects of cool dialysate on intradialytic blood pressure; that is, improved hemodynamic stability via an increase in cardiac output that could facilitate nocturnal shunting of blood to the skin. The higher T_{ax} noted in the baseline condition may have resulted from recovery vascular refilling.

A strong positive relationship was also observed between sleep propensity and T_{ax}; a small increase in T_{ax} was associated with decreased probability of being awake and increased probability of being in Stage 2, SWS, or REM sleep. This observation is consistent with a recent study of healthy subjects, which showed that very mild warming of the proximal skin area within the thermoneutral zone increased sleep propensity. Mild skin warming has also been shown to affect sustained vigilance adversely and promote the deeper stages of sleep. Not surprisingly, then, the odds of nocturnal wakefulness were significantly higher in the warm condition than in the baseline and cool conditions.

There were no significant differences in measures of nocturnal sleep among the baseline, cool, and warm conditions. However, the sleep measures in the baseline and cool conditions were quite similar to each other and different from those characterizing the warm condition. When a 2-group comparison of warm versus cool conditions was made, subjects fell asleep significantly earlier in the warm condition and showed a trend toward longer total sleep times and shorter REM latencies. These observations were likely related to factors that increased sleep propensity: the decreased heat load experienced in the cool condition (as reflected in the lower tympanic temperatures following HD), the warmer T_{ax} observed throughout the night, and the associated increased probability of both sleep and REM sleep in the cool condition. Unfortunately, the small sample limited the power of these analyses to detect other significant differences.

The results of this study suggest that HD may adversely affect sleep the night following treatment, possibly from a treatment-associated heat load. The use of cool dialysate may be a reasonable, cost-effective way to reverse this effect. Our results also support the growing body of scientific evidence that skin temperature provides important peripheral signals to central systems that modulate sleep/wake propensity. Further research is warranted to examine this promising sleep-promoting intervention more closely. For more details regarding this study, please refer to the original article.

This study was funded by the U.S. National Institutes of Health (National Institute of Nursing Research RO1 NR04340 and P20 NR007798, National Center for Research Resources M01 RR00039).

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REFERENCES

15. Raymann RJEM, Van Someren EFJW. Time-on task impairment of psychomotor vigilance is affected by mild skin warming and changes with aging and insomnia [submitted 2006].
Providing for Patients Today
Protecting the Environment for Tomorrow

LIVE THE DIFFERENCE
Reprocessing dialyzers prevents 62 MILLION POUNDS of biohazardous medical waste per year from being thrown into community landfills.*

*Based on 2006 USRDS data and if all treatments used reprocessed dialyzers.

For more information, contact Minntech at livethedifference@minntech.com
The medical staff bylaws have been approved by the DaVita Physician Council. The bylaws will be presented to the entire medical staff by the end of the year. This article is a summary of the most important aspects of these bylaws and highlights the sections that will most affect individual practice in DaVita dialysis facilities.

After the integration of Gambro Healthcare with DaVita, new bylaws were needed to replace the 2 sets of bylaws that governed medical practice to provide consistency and efficiency. The new bylaws, which were recently passed by the Physician Council, take the best of the previous bylaws and will provide the rules and regulations that govern medical practice in all DaVita dialysis facilities.
The bylaws will be distributed to the clinics and the medical directors by the end of the year and medical staff can obtain a copy from their local clinic. The purpose of this article is to highlight the significant provisions of the bylaws that provide for membership of the medical staff and that guide conduct and practice in DaVita’s facilities.

If a physician is a member of the DaVita medical staff, then he/she is a member of at least 2 different medical bodies. The DaVita medical staff is composed of all physicians who have been granted privileges to practice in a DaVita facility. Thus, it is a national body. After being approved for inclusion on the national DaVita medical staff, the physician can apply for privileges that allow him/her to practice at a DaVita facility. The facility’s governing body grants the privileges given to the physician at that facility. The governing body consists of the medical director, the facility administrator (FA), and the regional operations director (ROD). In some facilities, a fourth member may be a licensed nurse, if neither the FA nor the ROD is a licensed nurse. The physician then becomes a member of the facility’s medical staff.

This duel membership may raise some questions. Membership in the DaVita medical staff does not guarantee membership of any particular facility’s medical staff.

Privileges may differ at different facilities. The governing body at each separate facility approves the privileges for that facility. Clinical privileges at one facility do not confer any or the same privileges at any other facility. It is also possible for a physician to be credentialed by the DaVita medical staff and not obtain privileges on a particular facility’s medical staff. If this should occur, there is a review and appeal process in the bylaws that would resolve this issue.

The medical staff serves important purposes that are supported in the bylaws. Promotion of quality medical care obviously has the highest priority. The collegial cooperation of all physician members is important in providing optimal care. Communication between a medical staff member and members of the facility’s governing body, as well as between that staff member and other physicians, is expected. Participation in facility committees, peer review, and other activities that improve the care of the dialysis patient is a requirement of the bylaws that support the purposes of the facility and DaVita.

With membership come responsibilities. Twenty-eight separate responsibilities are enumerated in the bylaws. These can be grouped into 3 categories. The first responsibility is to provide optimal medical care. The practice of evidence-based medicine is expected. Regular rounding on patients, at a minimum on a monthly basis within the facility, with appropriate record keeping is required. Note that this requirement of monthly rounds in the dialysis facility is part of the proposed Conditions of Coverage now under review by the Centers for Medicare and Medicaid Services (CMS) at the U.S. Department of Health & Human Services.
The second category includes responsibilities that encourage or require the medical staff member to work within the facility structure to promote quality care and the safety of all patients in the facility. This may require participation on facility committees, discussion with teammates about patient care plans, and attendance at other meetings.

The third group of responsibilities addresses the individual conduct of the physician. The physician must always act in an ethical manner; abide by facility, local, state, and national rules; and act in a cordial, respectful, and collegial manner.

The qualifications for membership and clinical privileges are outlined in the bylaws. These qualifications are similar to requirements for membership on most hospital medical staffs and should not require further elaboration here. The application process is clearly laid out in the bylaws and should provide some clarity for any physician seeking privileges at a DaVita facility.

Two important points, however, require comment. By applying for membership, the applicant agrees to several requirements; one is that he/she not directly or indirectly solicit any patient not currently his/her own patient to discontinue treatment by the patient’s current physician. While many state regulations forbid the solicitation of other physicians’ patients, this clause was included in the bylaws because the improper solicitation of patients disrupts the collegial practice of physicians in the facility and can cause patients significant anxiety and stress.

The applicant also agrees that he/she will not make disparaging statements regarding DaVita or any DaVita facilities to patients, other interested parties, or the public. Again, this requirement is in the bylaws to promote the collegial operation of the medical staff and facility, which is necessary to promote the optimal care of patients. The bylaws provide clear channels for communication with the facility’s governing body and other medical staff members, so that any concerns or disputes can be properly addressed.

The actual credentialing process is initially done by DaVita’s Credentialing Department, which collects and reviews the physician’s application and credentials submitted. The Credentialing and Peer Review Committee, a subcommittee of the DaVita medical staff, gives the actual final approval for staff membership. Again, inclusion on the DaVita medical staff does not mean that facility-level privileges have been granted. The facility’s governing body must approve privileges at the facility level.

Appointment to the medical staff is for 2 years. The reappointment process is outlined in the bylaws. In addition to active medical staff privileges, other categories for medical staff privileges and the prerogatives they entail are outlined in the bylaws. These categories include temporary, coverage, and consulting specialist privileges, as well as privileges for renal fellows and physicians who provide medico-administrative services. Provisions for allied health professionals to practice at DaVita facilities are included.
Article VIII of the bylaws provides for 3 entities that direct medical staff governance. A facility’s medical director has a key role and important duties. He/she is a member of the governing body. The duties and responsibilities of the medical director are many, and include ensuring that all applicable DaVita rules and regulations and state, federal, Medicare, and End-Stage Renal Disease Network policies and standards are followed. Many of these duties are stipulated in the Medicare Conditions of Coverage for dialysis facilities. The medical director is responsible for policies concerning safety, infection control, water quality, staff training, and other areas of dialysis operations. Additionally, he/she is responsible for ensuring that care plans are maintained, proper transplant education and referrals are given, and advanced directives are complied with. The medical director is also required to engage in conference and committee work to improve patient care and facility operations.

The DaVita Physician Council, a national entity, has an important role with regard to DaVita’s entire medical staff. The bylaws provide for geographically regional representation on the council, making future communications easier and ensuring that the council is aware of regionally specific issues. This body reviews, revises, and approves DaVita’s clinical policies, procedures, and programs that affect patient care. Standards for the quality of care and staff performance are also in the council’s domain. The Physician Council had the responsibility of reviewing and approving the new bylaws and did so at its meeting in July. Future revisions of the bylaws will require council approval. Thus, it is important that medical staff members and medical directors communicate with and discuss important issues with the Physician Council.

While the Physician Council frequently discusses important issues concerning the treatment of ESRD patients at the facilities, the medical staff must meet to be effective at promoting optimal patient care. However, it is recognized that a meeting of the entire medical staff nationally is not feasible. Thus, local meetings of facility medical staff are required on at least a semiannual basis. Attendance at and participation in these staff meetings and other facility committee meetings is expected.

As stated above, the medical staff strives to provide for the collegial organization of DaVita’s physicians and promote quality medical care as well as other goals. Unfortunately, full compliance with these bylaws and other regulations is unlikely. Thus, corrective measures are also stipulated in the bylaws. Behavior likely to initiate corrective action is obvious and includes conduct detrimental to patient care or safety; disruptive behavior; and failure to abide by these bylaws, contractual obligations, or other regulations, policies, or laws. An investigative process will precede corrective action. The governing body initially has the responsibility of reviewing any allegation that a medical staff member has violated the bylaws. The governing body can issue a warning, a letter of reprimand, and/or other remedies. The bylaws provide an appeal process that involves review by the Credentialing and Peer Review Committee of allegations made and any action taken by the governing body.
The Credentialing and Peer Review Committee can limit, suspend, or revoke medical staff membership. Another possible corrective action is to impose monetary fines. Though the structure to ensure uniformity of fines for similar offenses is not yet in place, the possibility of fines demonstrates the seriousness with which DaVita and the Physician Council view the importance of these bylaws in creating and maintaining a cohesive, cooperative, and collegial medical staff.

The corrective actions proposed have the potential for loss of privileges. There is a Fair Hearing Plan available to the physician when his/her membership and/or privileges are restricted or revoked. This process involves timely notice to the physician of the proposed corrective action, the requirement that the physician request a hearing, the composition of the Hearing Committee, and what may be presented as evidence to the committee. The initial burden of proof for the claim and proposed corrective action lies with the DaVita committee who recommended the corrective action. The physician then must provide proof that rebuts the claim. The governing body or the Credentialing and Peer Review Committee shall take final action.

Much time and effort was put into the creation of these bylaws by their authors and by the lawyers and Physician Council who reviewed them. The main purposes of the bylaws are to promote optimal care for the dialysis patients that we treat and to help ensure that the care is provided in a spirit that benefits patients, physicians, other health care providers, and DaVita.
Zemplar® (paricalcitol) Injection

Zemplar should not be given to patients with evidence of vitamin D toxicity, hypercalcemia, or hypersensitivity to any ingredient in this product (see WARNINGS).

W I N G S

% of patients were male, 52% were Caucasian and 45% were African-American. On hemodialysis and nearly all had received some form of vitamin D prior to the study. Seventy-placebo-controlled study of 29 pediatric patients, aged 5-19 years, with end-stage renal disease. The safety and effectiveness of Zemplar were examined in a 12-week randomized, double-blind, placebo-controlled, double-blind, multicenter studies, discontinuation of therapy due to any adverse event occurred in 6.5% of 62 patients treated with Zemplar (dosage titrated as tolerated) and 2.0% of 51 patients treated with placebo for 1 to 3 months. Adverse events occurring with greater frequency in the Zemplar group at a frequency of 2% or greater, regardless of causality, are presented in the following table:

Adverse Event Incidence Rates For All Treated Patients

<table>
<thead>
<tr>
<th>Adverse Event</th>
<th>Zemplar (n=60)</th>
<th>Placebo (n=51)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>71%</td>
<td>78%</td>
</tr>
<tr>
<td>Body as a Whole</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chills</td>
<td>5%</td>
<td>0%</td>
</tr>
<tr>
<td>Feeling unwell</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Fever</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>Nausea</td>
<td>13%</td>
<td>8%</td>
</tr>
<tr>
<td>Vomiting</td>
<td>8%</td>
<td>8%</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palpitation</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td>Digestive System</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dry mouth</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Gastrintestinal bleeding</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>Nausea</td>
<td>13%</td>
<td>8%</td>
</tr>
<tr>
<td>Vomiting</td>
<td>8%</td>
<td>8%</td>
</tr>
<tr>
<td>Respiratory System</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phlebothrombosis</td>
<td>5%</td>
<td>0%</td>
</tr>
</tbody>
</table>

A patient who reported the same medical term more than once was counted only once for that medical term. Safety parameters (changes in mean Ca, P, Ca x P) in an open-label safety study up to 13 months in duration support the long-term safety of Zemplar in this patient population. Potential adverse events of Zemplar Injection are, in general, similar to those observed with vitamin D analogs. Consumption of vitamin D analogs with reduced renal function may result in increased serum calcium levels.

OVERDOSAGE

Overdosage of Zemplar may lead to hypercalcemia, hypercalciuria, hyperphosphatemia, and over suppression of PTH. (See WARNINGS.)

TREATMENT OF OVERDOSAGE

The treatment of acute overdosage should consist of general supportive measures. Serial serum electrolyte determinations (especially sodium), rate of urinary calcium excretion, and assessment of electrocardiographic abnormalities due to hypercalcemia should be obtained. When serum calcium levels have returned to within normal limits, Zemplar may be reintroduced at a lower dose. If persistent and markedly elevated serum calcium levels occur, there are a variety of therapeutic alternatives that may be considered. These include the use of drugs such as phosphates and corticosteroids as well as measures to induce diuresis. Also, one may consider the removal of calcium from the body by dialysis.

GENERAL

Specific interaction studies were not performed with Zemplar Injection. Paricalcitol is not expected to inhibit the clearance of drugs metabolized by cytochrome P450 enzymes CYP1A2, CYP2A6, CYP2B6, CYP2C9, CYP2C19, CYP2D6, CYP2E1, or CYP3A4. Paricalcitol is not an inducer of drug metabolism by CYP2B6, CYP2C9 or CYP3A4. Specific interaction studies were not performed with Zemplar Injection.

In a 104-week carcinogenicity study in CD-1 mice, an increased incidence of uterine leiomyoma when digitalis compounds are prescribed concomitantly with Zemplar. Adynamic bone lesions are defined by 2 consecutive iPTH levels > 700 pg/mL and greater than baseline after 4 weeks of Zemplar treatment.

Zemplar-treated patients and 2 of the 14 (14%) placebo-treated patients completed the trial. Ten of the 15 (67%) Zemplar-treated patients and 2 of the 14 (14%) placebo-treated patients completed the trial. Ten of the 15 (67%) Zemplar-treated patients and 2 of the 14 (14%) placebo-treated patients completed the trial.

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Important Safety Information

• ZEMPLAR is contraindicated in patients with evidence of vitamin D toxicity, hypercalcemia, or hypersensitivity to any product ingredient

• Chronic administration may place patients at risk for hypercalcemia, elevated Ca × P product, and metastatic calcification. Adynamic bone lesions may develop if PTH is oversuppressed. Acute overdose may cause hypercalcemia and may require immediate medical attention

• Hypercalcemia may potentiate digitalis toxicity; use caution with these types of patients

• Withhold phosphate or vitamin D related compounds during treatment with ZEMPLAR

• PTH should be monitored at least every three months and more frequently at initiation and dosage changes. Calcium and phosphorus should be measured at least monthly and more frequently at initiation and during dosage changes. If clinically significant hypercalcemia develops, the dose should be reduced or interrupted

• Adverse events with greater than 5% frequency with ZEMPLAR vs placebo, regardless of causality, were nausea (13% vs 8%), vomiting (8% vs 4%), and edema (7% vs 0%)

References:

Please see adjacent brief summary of full Prescribing Information. For more information, please contact your Abbott Renal Care representative or visit www.zemplar.com.

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Our Village. DaVita Inc.

We manage over 1,300 outpatient dialysis centers and acute units in over 700 hospitals. We are located in 42 states and the District of Columbia and serve approximately 103,000 patients.

We are proud to be the largest independent provider of dialysis services in the United States. With that distinction also comes responsibility and DaVita takes our responsibilities as a corporate citizen very seriously. We owe it to our patients, our teammates and our world. We want to be the greatest dialysis company the world has ever seen. And we’re accomplishing this through a shared commitment to our mission and values.

The DaVita Village is comprised of thousands of patients and DaVita teammates, all who have the same goals in mind: service excellence, integrity, teamwork, continuous improvement and accountability.

One for All & All for One