# Network 11 Annual Meeting

## Friday, October 16, 2015

### Wisconsin Center
### Milwaukee, WI

We would like to express special thanks to
Network 11 Committee Members, Speakers and
Volunteers for your contribution in helping make today a
valuable experience for all attendees.

# Renal Network 11 Annual Meeting
# Program Agenda

## Friday, October 16, 2015
## Wisconsin Center

| Time | Session | Speaker | Room |
|---|---|---|---|
| **8:00-8:30** | President's Address | James Brandes, MD<br>Midwest Nephrology | Room 202 ABC |
| **8:30-9:15** | Using Data to Reduce Mortality and Hospitalization | Allan Collins, MD<br>Hennepin County Medical Center<br>Chronic Disease Research Group | |
| **9:15-10:00** | Reducing Preventable Hospitalizations | Andy Howard, MD<br>Metropolitan Nephrology Associates | |
| **10:00-10:25** | Break and Exhibits | | Room 201 AB |
| **10:30-11:15** | Understanding Health Disparities | Cara James, PhD<br>CMS Office of Minority Health | Room 202 ABC |
| **11:15-12:00** | Developing Personal Resilience | Jeffrey Russell<br>Russell Consulting | |
| **12:00-1:00** | Lunch | | Room 203 |
| **Breakout Session 1 1:00-1:50** | Identifying Risk for Violence in a Dialysis or Transplant Facility | Joel Lashley<br>Vistelar Conflict Prevention and Management | Room 201 CD |
| | Increasing Home Dialysis Referral | Leslie Ford LePard, MSW<br>Greenfield Dialysis | Room 202 DE |
| **1:50-2:00** | Transition Between Breakout Sessions | | |
| **Breakout Session 2 2:00-2:50** | Strategies to De-escalate Potential Violence | Joel Lashley<br>Vistelar Conflict Prevention and Management | Room 201 CD |
| | Best Practices with Infection Control | Wendy Phillips, RN<br>Purity Dialysis | Room 202 DE |
| **2:50-3:00** | Break | | |
| **3:00-4:00** | Regional Activities to Improve Care | Jonathan Segal, MD<br>University of Michigan | Room 202 ABC |
| **4:00-4:15** | Closing Remarks and Evaluation | James Brandes, MD<br>Midwest Nephrology | |

# Thank You to Our Exhibitors!

Amgen

B. Braun Medical Inc.

Central Florida Kidney Centers

Fresenius Medical Care - Pharma

Fresenius Medical Care - RTG

Hillestad Pharmaceuticals

Hospira

Infian

Keryx Biopharmaceuticals

Kidney Smart

NKF of Wisconsin

Patient Care America

Pentec Health

Physician Software System

Total Water Treatment Systems

Transonic

Visonex

Vistelar

# Renal Network 11

# 2015 Annual Meeting

# ANNA Disclosure Declaration Statement

# October 16, 2015

**Notice of requirements for successful completion:**

**Participants must indicate on the certificate which sessions were attended. Participant must certify that they attended 80% of each session indicated to receive credit for attendance.**

**Conflicts of Interest:**

**There are no conflicts of interest to report.**

**Commercial Support**

**No commercial support was received in support of any speakers**

**Non-endorsement of products**

**The presence of any product, company, or corporation at this conference in no way signifies an endorsement of the product, company, or corporation by ANCC Commission on Accreditation, ANNA, or Renal Network 11.**

**Off-Label Use**

**No off-label use of any product will be presented at this conference.**

**Vendors**

**See Exhibitor acknowledgement page.**

# 2015 Participant List

# 2015 Meeting Participants

Sarah Adams, RN
Viroqua, Wisconsin

Casie Adkins, RN, BSN, CNN
Madison, WI

Ruth Agrusa, BA, MS
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Sue Alexander, RN, CNN
Berkley, MI

Janet Anderson, RN
Sioux Falls, SD

Wendy Armstrong, RN
Belcourt, ND

Denise Balboa, RN
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Mary Baliker
Middleton, WI

Kathleen Basye
Traverse City, MI

Kathy Beckett, RN
Traverse City, MI

James Brandes, MD
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Troy, MI

Laura Buettner
Antigo, WI

Deb Buffington, RN, MSN
Willmar, MN

Maggie Carey
Harrison, MI

Robert Carter, ND
Southfield, MI

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Joanne Damon
Jamestown, ND

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Kalkaska, MI

Michelle Doro, RN
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Donna Dow
Land O'Lakes, WI

Kimberly Draeving, CCNT
Beloit, WI

Lisa Drew, RN
Delafield, WI

Robert Easton, LMSW
Flint, MI

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Calvin Ellis,
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Susan Elm, RN
Detroit, MI

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Madison, WI

Kathy Farlinger, RN
Janesville, WI

Marla Fischer, MSW
Kenosha, WI

D'Ann Fountain, CSS
Six Lakes, WI

Lavetta Fox, RN BSN
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Minneapolis, MN

Judy Gall-Fischer, RN
Fitchburg, WI

Rhonda Gendregske, RN
Alma, MI

Janelle Gonyea, RD
Rochester, MN

Darci Graves, MA, MPP
Balitmore, MD

Cheryl Greenwood, RN
Rapid City, SD

Mary Gruel, RN, CDN
Dubuque, IA

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Jan Haney, RN BSN
Platteville, WI

Renee Heder, BSN RN CNN
Green Bay, Wisconsin

Debra Herman, RN
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Juila Herzog, MSW
Ann Arbor, MI

Beverly Hicks-Wilson, MBA
Detroit, Mi

Jennifer Holcomb, RD
Bingham Farms, MI

Andrew Howard, MD, FACP
McLean, MD

Tim Jackan, RN
Watertown, SD

Cara James, PhD
Balitmore, MD

Roy Jhagroo, MD
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Lisa Jochimsen, PCT
Medford, WI

Nancy Johnson, RN CNN
Kalamazoo, MI

Mary Johnson, RN
Beloit, WI

Leena Joshi, MD
Kenosha, WI

Jennifer Kafka, RN
Janesville, WI

Richard Kammenzind, MD
Douglas, MI

Linda Kasper, RN, BSN, CNN
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Kate Kern, BSN CNN
Platteville, WI

Adeel Khan, MD
Midland,

Megan Kilps, SW
Oak Creek, WI

Karen Koivisto, CCHT, MS
Saint Croix Falls, WI

Kenna Krahmer, RN, BSN
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Joel Lashley
Milwaukee, WI

Angela Leonard, RN/BSN
Waukesha, WI

Leslie LePard, MSW
Bingham Farms, MI

# 2015 Meeting Participants

Sara Licht, R.N.
Platteville, WI

Trisha Limon
Frankfort, MI

Teresa Lockhart, RN BSN CNN
Sturgeon Bay, WI

Amy Marthenze
Wausau, WI

Crystal Martin, MD
Livonia, MI

Xinliu Meyer, RN
Fitchburg, WI

Jennifer Miller, MSW
New Hope, MN

Malarie Mobry, PCT
Medford, WI

Lori Moede, MS, BSN, RN
Appleton, WI

Emily Neibauer, MS, RN
Milwaukee, WI

Tom Nevins, MD, Professor
Minneapolis, MN

April Nizinski, MSW
West Allis, WI

Wendy Phillips, RN
Watertown, WI

Dawn Pierson, FNP-BC
Waukesha, WI

Iris Porter, RN
Milwaukee, WI

Diane Posthuma, RN, BSN
Waupun, WI

Tania Putala, RN
Sault Ste. Marie, MI

Tonja Ramthun, RN
Green Bay, WI

Becky Rehak, RNLPN
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Charles Rice, CPhT, BSBM
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Mitzi Riley,
Muskegon, MI

Anne Rismeyer, RN,CNN
Milwaukee, WI

Sue Robinson, RN
Shorewood, WI

Jackie Rozina, RN
Delafield, WI

Monica Rudiger, Practice Manager
Apple Valley, MN

Jeff Russell,
Madison, WI

Beverly Schafer, RN (retired)
New London, MN

Karen Schlageter, RN
Fitchburg, WI

Ronda Schmidt, RN
Portage, WI

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Crystal Falls, MI

Jill Shumpert, CCHT
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Mary Stapleton, GFA
Alma, MI

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Cindy Suckow, CHT
Eau Claire, WI

Tammy Surges, RN
Eau Claire, WI

Claire Taylor-Schiller, RN
Spicer, MN

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Rudolph Valentini, M.D.
Detroit, MI

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Sana Waheed, MD
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Michelle Walker, RN, BSN, CNN
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Traverse City, MI

Dave Walz, MBA, BSN, CNN
Sauk Rapids, MN

Kim Webber, RN, CNN
Pleasant Prairie, WI

Marc Weber, MD
Minneapolis, MN

Renae Wolf, RN
Mankato, MN

Ronnie Word, MD
Marshfield, MI

Stephen Zimmerman, MD
Madison, WI

Gloria Zunker, RD, MPA
Lansing, MI

# Presidential Address

**James Brandes, MD**
**Midwest Nephrology Associates**
**Milwaukee, WI**

Welcome to the 2015
Network 11 Annual Meeting

## Resources to Improve Care for People with Kidney Disease

President's Address
James Brandes, MD
Midwest Nephrology Associates
October 16, 2015

*Partnering to Improve Renal Care*

## Welcome!

Meeting participants
Speakers
Exhibitors

*Partnering to Improve Renal Care*

## Need Help today?

- See Network 11 Committee members
- Ask Network 11 staff
- Stop by the registration desk

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## Network 11 Scholarships for Continuing Education

- Continuing Education Scholarship Program
- Four scholarships for up to $1500 each for continuing education
- Winners were randomly selected from eligible 2015 Annual Meeting registrants

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## Changes and Emerging Issues In Network 11

- Changing name to Midwest Kidney Network

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## Changes and Emerging Issues In Network 11

Responding to increasing needs of 45,000 patients and 500 ESRD providers

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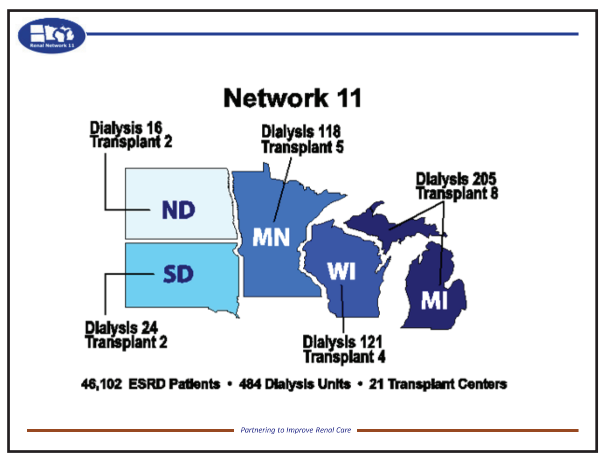


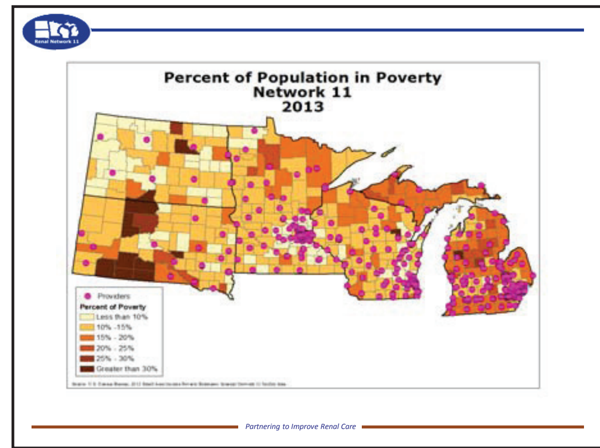


## Dialysis Facility Monitoring

- Quality Incentive Program
- Dialysis Facility Compare
- Star Rating
- National Healthcare Safety Network
- Medicare State Surveyors
- Networks
- Large Dialysis Organizations, regional chains and hospital systems

## Dialysis Facility Measures

- Standardized ratios
  - Mortality
  - Hospitalization
  - Transfusion
  - Blood stream infections
- Dialysis adequacy
- Increasing AVF
- Decreasing catheters
- Anemia management
- Bone and mineral metabolism
- Patient satisfaction (ICH CAHPS)
- Depression assessment
- Pain assessment
- Kidney transplant
- Home dialysis
- Fluid management

## National Quality Forum (NQF)

- One resource used by CMS and others
- NQF reviews and endorses measures
- In 2015, NQF reviewed 25 new ESRD Measures
- For more information:

http://www.qualityforum.org/Renal_Measures.aspx
  - View all
  - Materials
  - Draft report for voting
  - Attachment F

## 25 ESRD Measures Being Reviewed by NQF

10 on dialysis adequacy
4 on anemia management
3 on vascular access
3 on fluid management
2 on bone and mineral metabolism
1 on ACE/ARB
1 on Standardized Infection Ratio
1 on optimal start

## Measures Considered for Dialysis Facility Compare October 2016 Rollout (not for Star Rating )

- Bloodstream infection in HD outpatients (NQF #1460)
- ICH CAHPS or in In-Center Hemodialysis Consumer Assessment of Healthcare Providers Survey (NQF #0258)
- Ultrafiltration rate greater than 13 ml/kg/hr
- Pediatric peritoneal dialysis adequacy: Achievement of target Kt/V

For measure specifications, see Network 11 Resource Table and

http://www/qualityforum.org/ProjectMeasures.aspx?projectID=78016

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## Other Topics of Interest Being Considered by NQF

- Anemia management
- Fluid management
- Optimal ESRD start

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## Anemia Management Measures Being Reviewed by NQF

- Monthly hemoglobin measurements for pediatric patients
- Adult hemoglobin levels < 9 g/dL
- Pediatric hemoglobin levels < 10g/dL
- Standardized Transfusion Ratio

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## Fluid Management Measures Being Reviewed by NQF

- Percentage of patients months with ultrafiltration rate > 13 ml/kg/hr
- Avoid high ultrafiltration ≥ 13 ml/kg/hr
- Percentage of patients with an average post dialysis weight ≥ 1 kg above or below the prescribed target

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## Optimal ESRD Starts Being Reviewed by NQF

Percent of new ESRD adult patients that:

- Start treatment with a preemptive kidney transplant
- Initiating home dialysis
- Start outpatient in-center hemodialysis with an AVF or AVG

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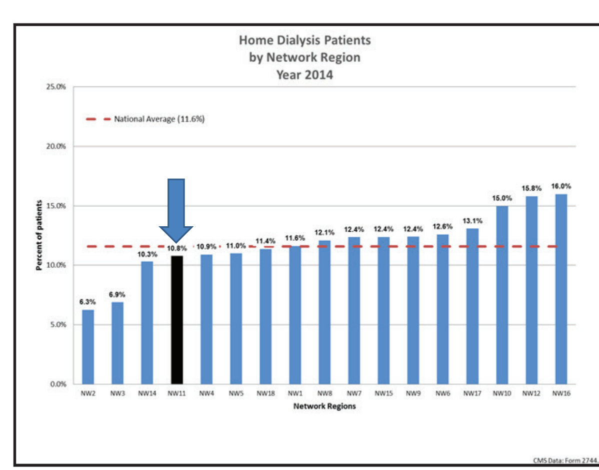
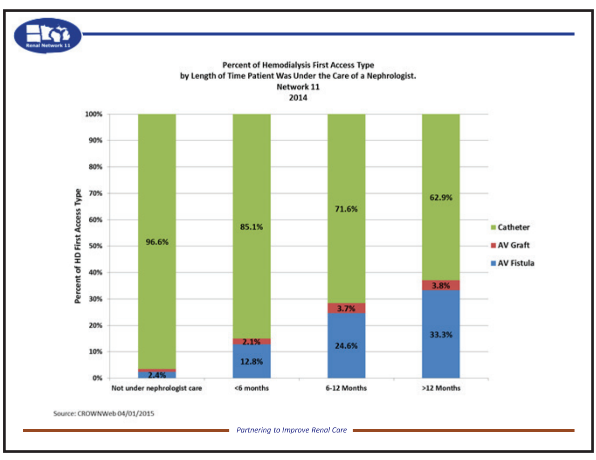




## CMS's Expectations for Networks

- More patient engagement at the Network and facility levels
- More measurement of effectiveness of activities
- More collaborations to improve outcomes
- More efficiencies

## 2016-2020 CMS Contract

**Continue Work in:**

- Access to care and patient grievances
- Vascular access
- Infection control
- Emergency management
- CROWNWeb data and system security

**New work in:**

- Patient experience of care
- Vaccinations
- Hypercalcemia
- Home referral
- Hospitalization
- Reducing healthcare disparities
- Partnerships with:
  - Quality Innovation Networks
  - Chronic Kidney Disease Providers



## Call to Action and Resources for You

- Network 11 Resource Table
  - Peer Mentoring
  - Vaccinations
  - Vascular access
  - Proposed measures for Dialysis Facility Compare
- Speakers on these topics

## Today's Plenary Sessions

- Reducing Mortality and Hospitalizations
  Allan Collins, MD
- Reducing Preventable Hospitalizations
  Andrew Howard, MD
- Addressing Disparities and Socioeconomics
  Cara James, PhD
- Developing Personal Resilience
  Jeffrey Russell
- Improving Care in Network 11
  Jonathan Segal, MD

## Afternoon Sessions

Track 1- Joel Lashley

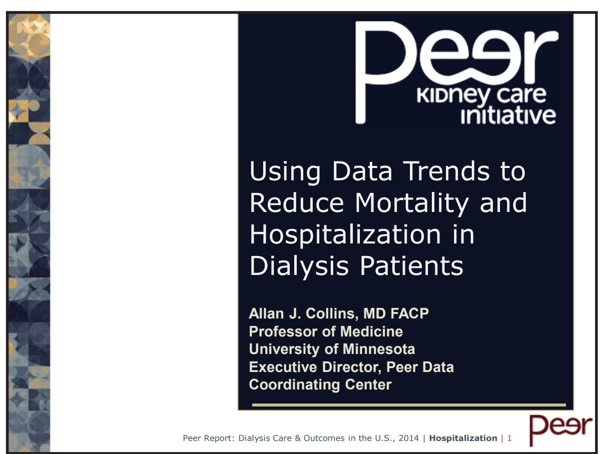
- Identifying risk of violence in a dialysis or kidney transplant center
- Strategies to de-escalate potential violence

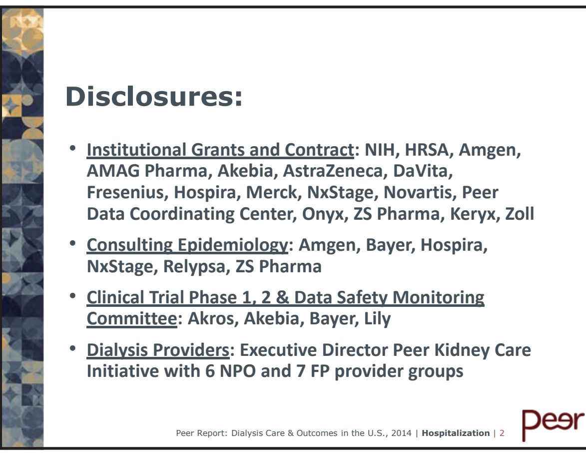
Track 2

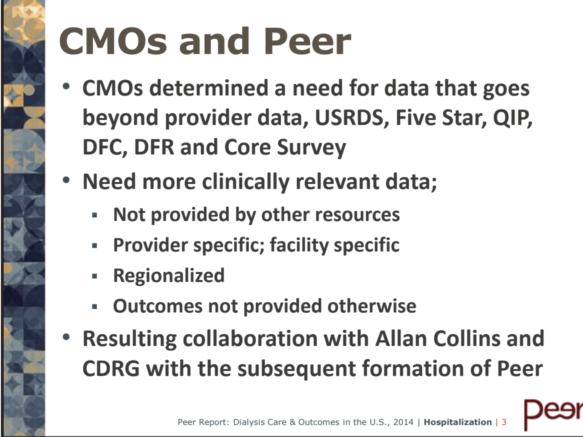
- Increasing home dialysis referral and reducing disparities by Leslie Ford LePard, MSW
- Sharing infection control best practices by Wendy Phillips, RN

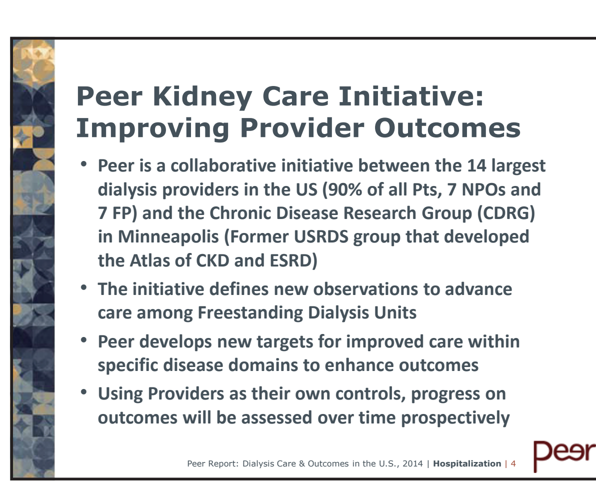
# Using Data to Reduce Mortality and Hospitalization

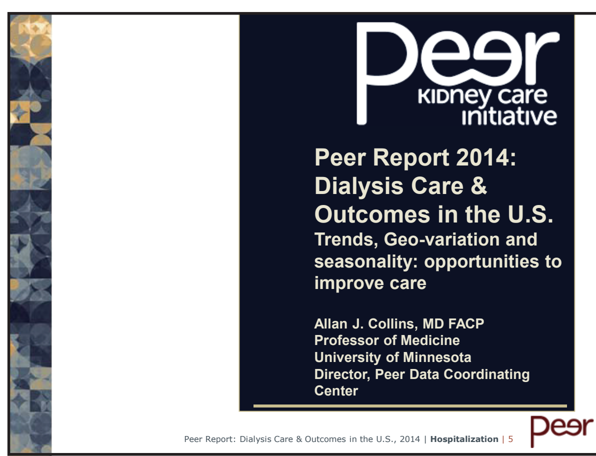
**Allan Collins, MD FACP**
**Hennepin County Medical Center**
**Chronic Disease Research Group**
**Minneapolis, MN**

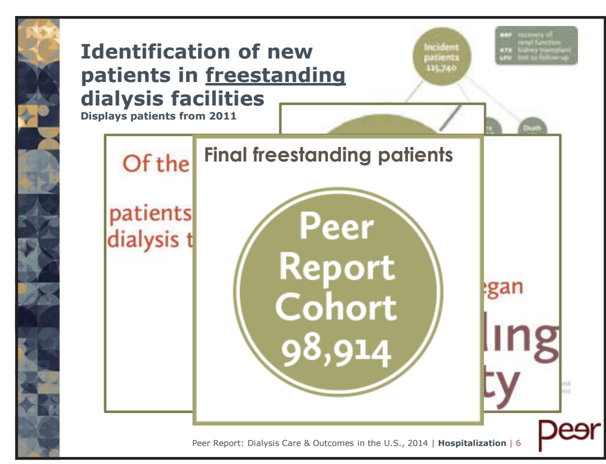

Peer
Kidney care initiative
Using Data Trends to Reduce Mortality and Hospitalization in Dialysis Patients
Allan J. Collins, MD FACP
Professor of Medicine
University of Minnesota
Executive Director, Peer Data Coordinating Center
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 1

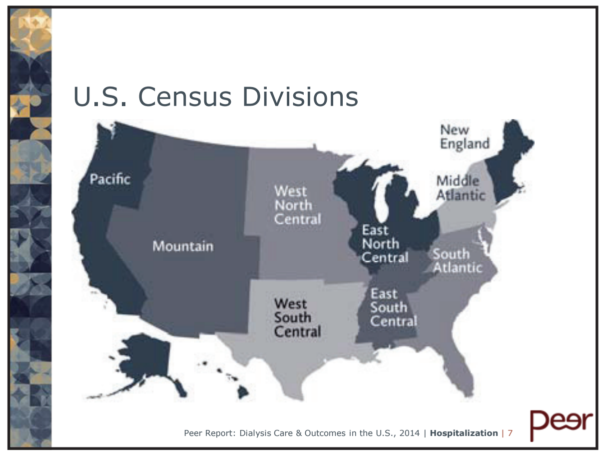

Disclosures:
Institutional Grants and Contract: NIH, HRSA, Amgen, AMAG Pharma, Akebia, AstraZeneca, DaVita, Fresenius, Hospira, Merck, NxStage, Novartis, Peer Data Coordinating Center, Onyx, ZS Pharma, Keryx, Zoll
Consulting Epidemiology: Amgen, Bayer, Hospira, NxStage, Relypsa, ZS Pharma
Clinical Trial Phase 1, 2 & Data Safety Monitoring Committee: Akros, Akebia, Bayer, Lily
Dialysis Providers: Executive Director Peer Kidney Care Initiative with 6 NPO and 7 FP provider groups
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 2

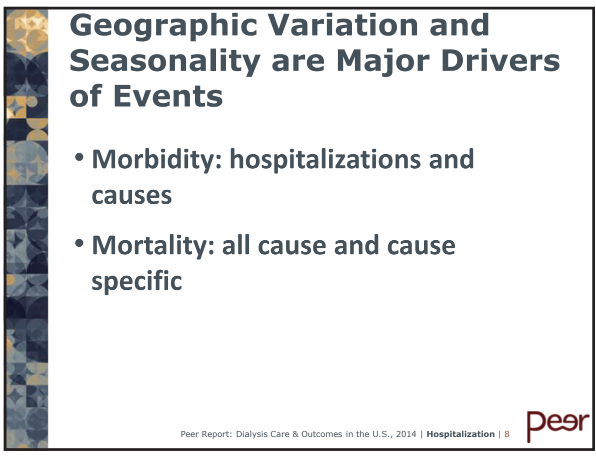

CMOs and Peer
CMOs determined a need for data that goes beyond provider data, USRDS, Five Star, QIP, DFC, DFR and Core Survey
Need more clinically relevant data;
Not provided by other resources
Provider specific; facility specific
Regionalized
Outcomes not provided otherwise
Resulting collaboration with Allan Collins and CDRG with the subsequent formation of Peer
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 3

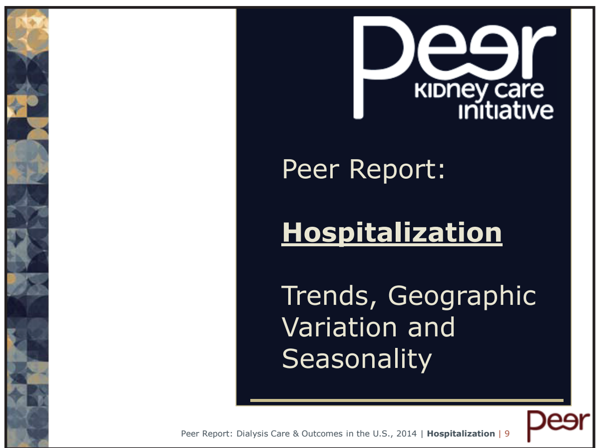

Peer Kidney Care Initiative: Improving Provider Outcomes
Peer is a collaborative initiative between the 14 largest dialysis providers in the US (90% of all Pts, 7 NPOs and 7 FP) and the Chronic Disease Research Group (CDRG) in Minneapolis (Former USRDS group that developed the Atlas of CKD and ESRD)
The initiative defines new observations to advance care among Freestanding Dialysis Units
Peer develops new targets for improved care within specific disease domains to enhance outcomes
Using Providers as their own controls, progress on outcomes will be assessed over time prospectively
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 4

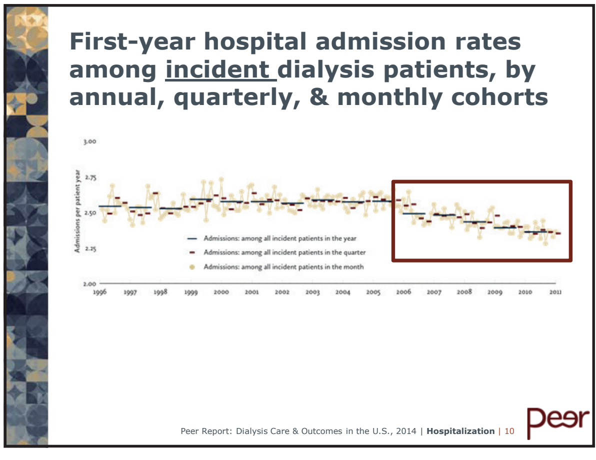

Peer
Kidney care initiative
Peer Report 2014: Dialysis Care & Outcomes in the U.S.
Trends, Geo-variation and seasonality: opportunities to improve care
Allan J. Collins, MD FACP
Professor of Medicine
University of Minnesota
Director, Peer Data Coordinating Center
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 5

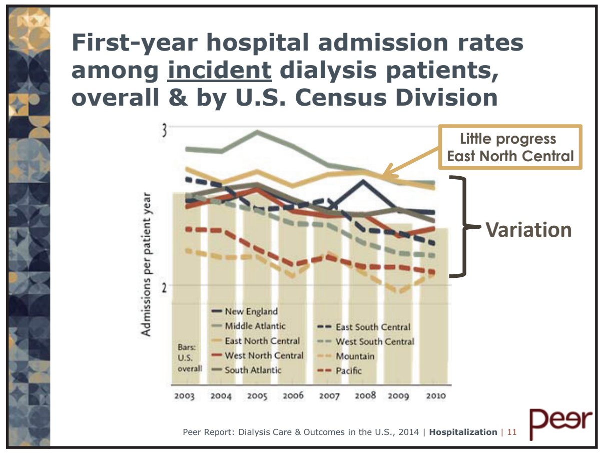

Identification of new patients in freestanding dialysis facilities
Displays patients from 2011
Final freestanding patients
Peer Report Cohort 98,914
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 6

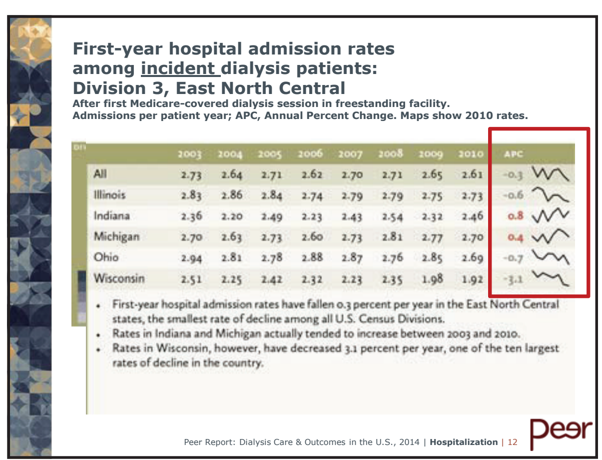


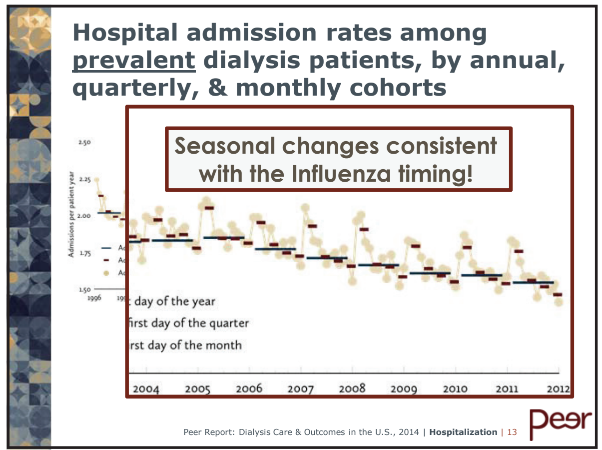



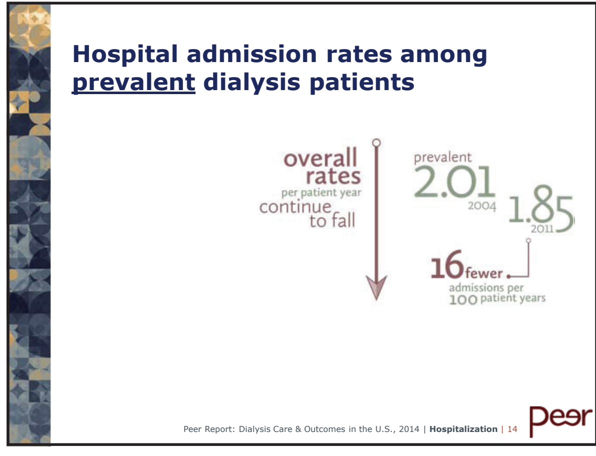



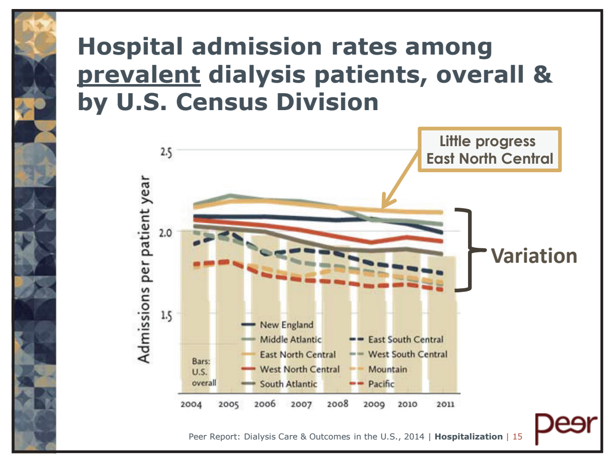



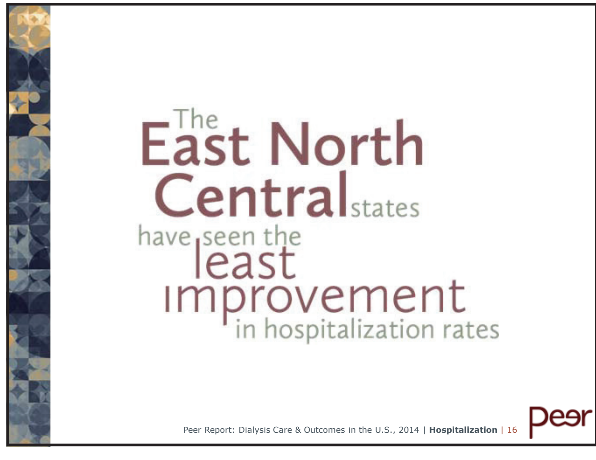

| | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | APC |
|---|---|---|---|---|---|---|---|---|---|
| All | 2.73 | 2.64 | 2.71 | 2.62 | 2.70 | 2.71 | 2.65 | 2.61 | -0.3 |
| Illinois | 2.83 | 2.86 | 2.84 | 2.74 | 2.79 | 2.79 | 2.75 | 2.73 | -0.6 |
| Indiana | 2.36 | 2.20 | 2.49 | 2.23 | 2.43 | 2.54 | 2.32 | 2.46 | 0.8 |
| Michigan | 2.70 | 2.63 | 2.73 | 2.60 | 2.73 | 2.81 | 2.77 | 2.70 | 0.4 |
| Ohio | 2.94 | 2.81 | 2.78 | 2.88 | 2.87 | 2.76 | 2.85 | 2.69 | -0.7 |
| Wisconsin | 2.51 | 2.25 | 2.42 | 2.32 | 2.23 | 2.35 | 1.98 | 1.92 | -3.1 |

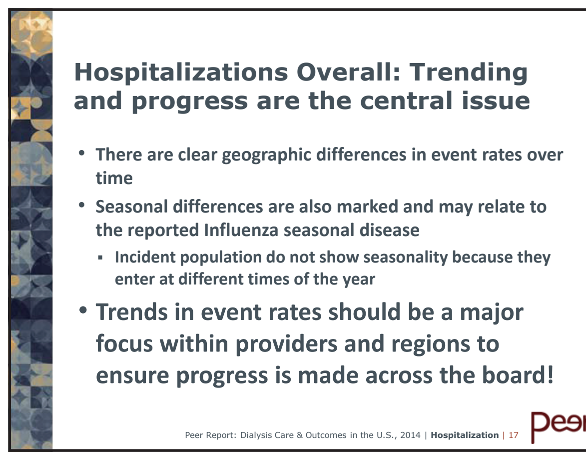
- First-year hospital admission rates have fallen 0.3 percent per year in the East North Central states, the smallest rate of decline among all U.S. Census Divisions.
- Rates in Indiana and Michigan actually tended to increase between 2003 and 2010.
- Rates in Wisconsin, however, have decreased 3.1 percent per year, one of the ten largest rates of decline in the country.

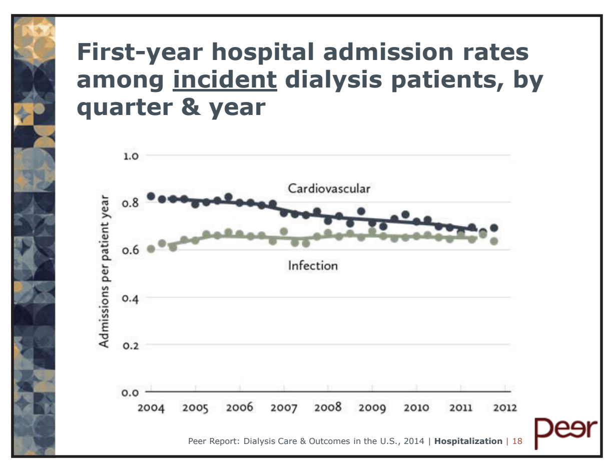

Hospital admission rates among prevalent dialysis patients, by annual, quarterly, & monthly cohorts
Seasonal changes consistent with the Influenza timing!
day of the year
first day of the quarter
first day of the month
2004 2005 2006 2007 2008 2009 2010 2011 2012
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 13
Peer

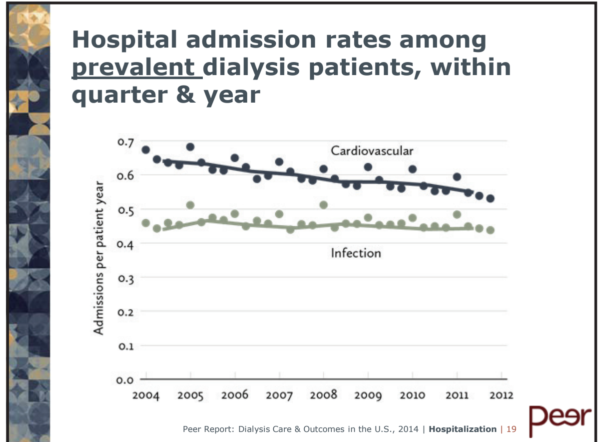

Hospital admission rates among prevalent dialysis patients
overall rates per patient year continue to fall
prevalent
2.01
2004
1.85
2011
16 fewer admissions per 100 patient years
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 14
Peer

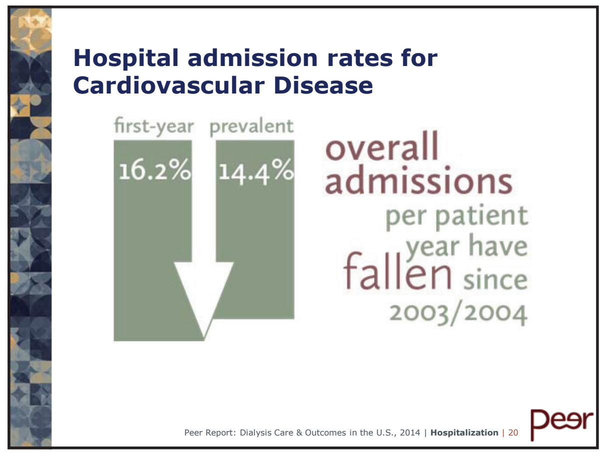

Hospital admission rates among prevalent dialysis patients, overall & by U.S. Census Division
Little progress East North Central
Variation
Admissions per patient year
2.5
2.0
1.5
New England
Middle Atlantic
East North Central
West North Central
South Atlantic
East South Central
West South Central
Mountain
Pacific
Bars: U.S. overall
2004 2005 2006 2007 2008 2009 2010 2011
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 15
Peer

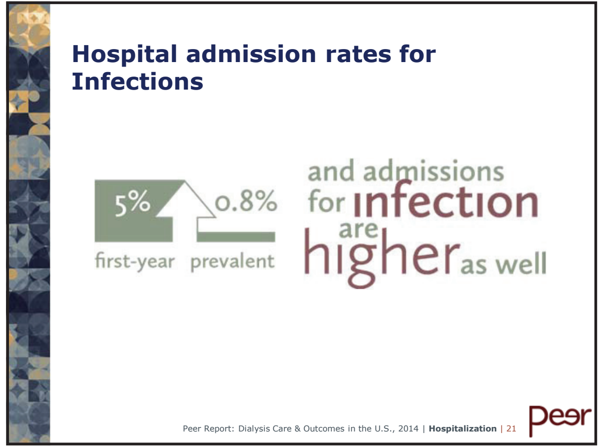

The East North Central states have seen the least improvement in hospitalization rates
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 16
Peer

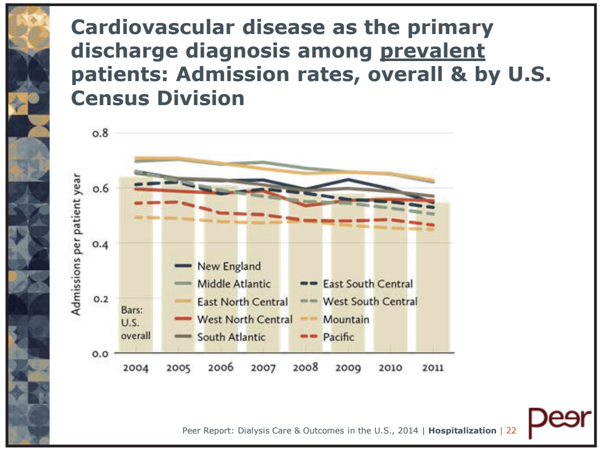

Hospitalizations Overall: Trending and progress are the central issue
• There are clear geographic differences in event rates over time
• Seasonal differences are also marked and may relate to the reported Influenza seasonal disease
▪ Incident population do not show seasonality because they enter at different times of the year
• Trends in event rates should be a major focus within providers and regions to ensure progress is made across the board!
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 17
Peer

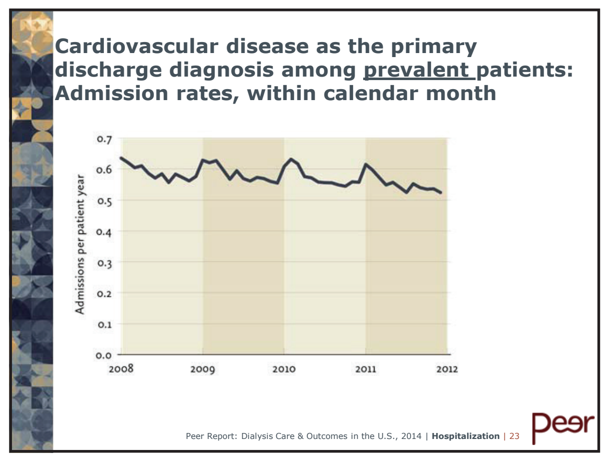

First-year hospital admission rates among incident dialysis patients, by quarter & year
Admissions per patient year
1.0
0.8
0.6
0.4
0.2
0.0
Cardiovascular
Infection
2004 2005 2006 2007 2008 2009 2010 2011 2012
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 18
Peer

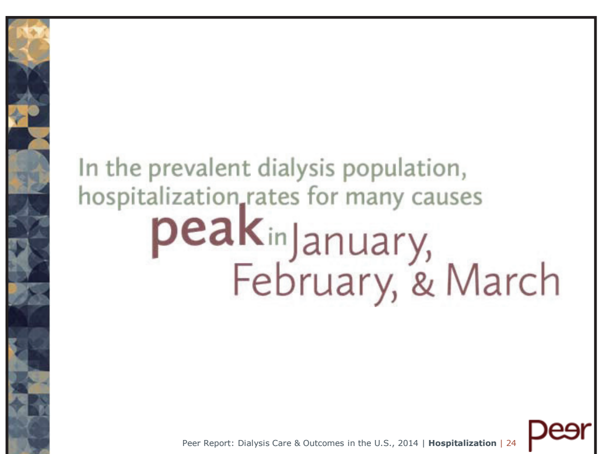

Hospital admission rates among prevalent dialysis patients, within quarter & year
Cardiovascular
Infection
Admissions per patient year
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0.0
2004
2005
2006
2007
2008
2009
2010
2011
2012
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 19
Peer

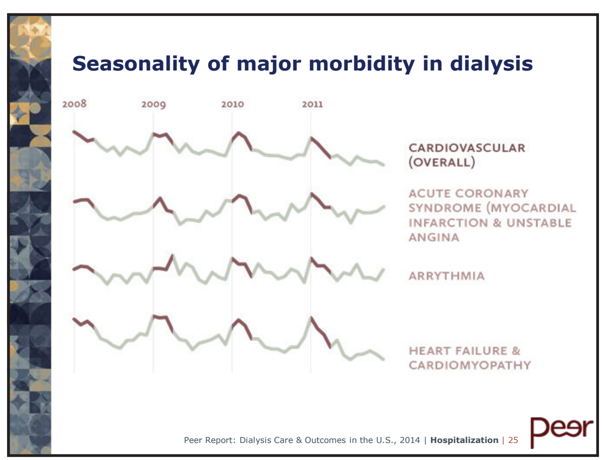

Hospital admission rates for Cardiovascular Disease
first-year
prevalent
16.2%
14.4%
overall admissions per patient year have fallen since 2003/2004
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 20
Peer

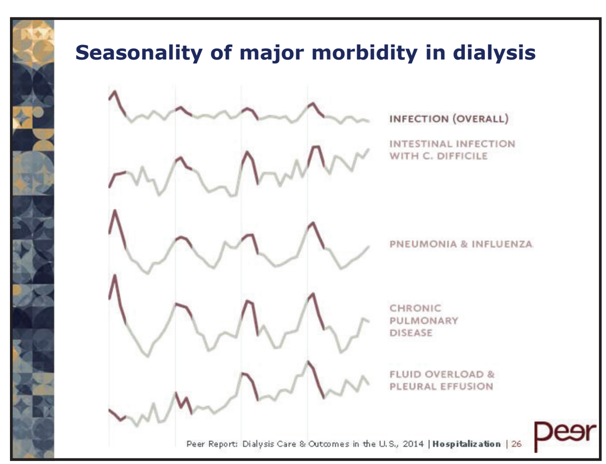

Hospital admission rates for Infections
5%
0.8%
first-year
prevalent
and admissions for infection are higher as well
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 21
Peer

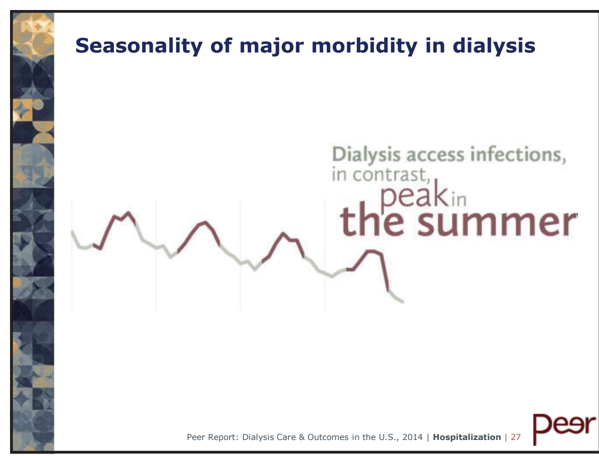

Cardiovascular disease as the primary discharge diagnosis among prevalent patients: Admission rates, overall & by U.S. Census Division
Admissions per patient year
0.8
0.6
0.4
0.2
0.0
New England
Middle Atlantic
East North Central
West North Central
South Atlantic
East South Central
West South Central
Mountain
Pacific
Bars: U.S. overall
2004
2005
2006
2007
2008
2009
2010
2011
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 22
Peer

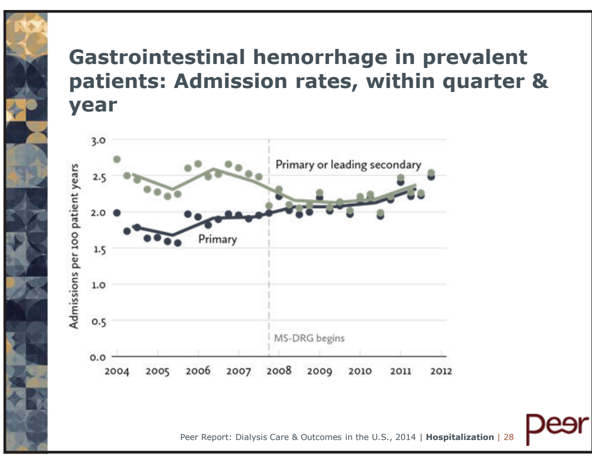

Cardiovascular disease as the primary discharge diagnosis among prevalent patients: Admission rates, within calendar month
Admissions per patient year
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0.0
2008
2009
2010
2011
2012
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 23
Peer

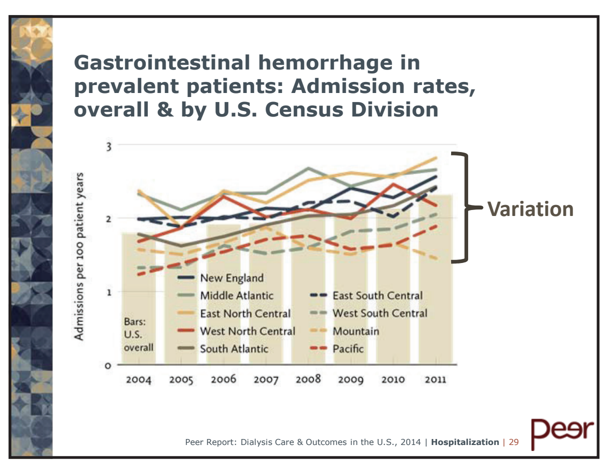

In the prevalent dialysis population, hospitalization rates for many causes peak in January, February, & March
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 24
Peer

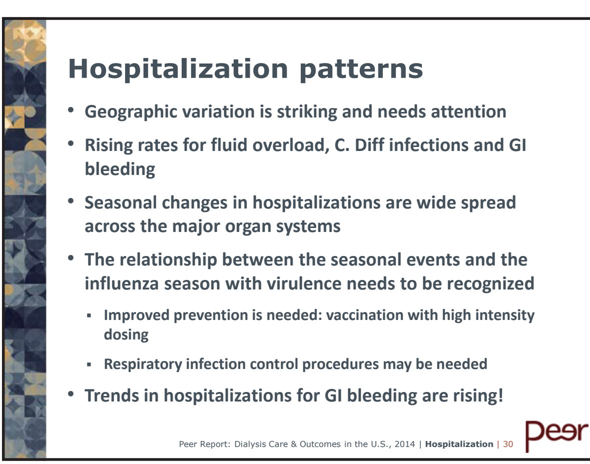

Seasonality of major morbidity in dialysis
2008
2009
2010
2011
CARDIOVASCULAR (OVERALL)
ACUTE CORONARY SYNDROME (MYOCARDIAL INFARCTION & UNSTABLE ANGINA
ARRYTHMIA
HEART FAILURE & CARDIOMYOPATHY
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 25
peer

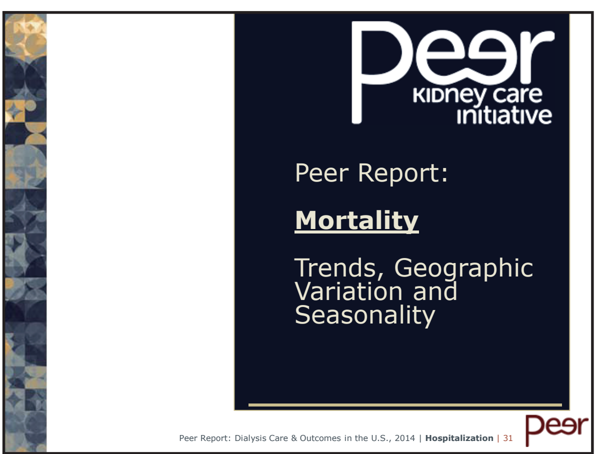

Seasonality of major morbidity in dialysis
INFECTION (OVERALL)
INTESTINAL INFECTION WITH C. DIFFICILE
PNEUMONIA & INFLUENZA
CHRONIC PULMONARY DISEASE
FLUID OVERLOAD & PLEURAL EFFUSION
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 26
peer

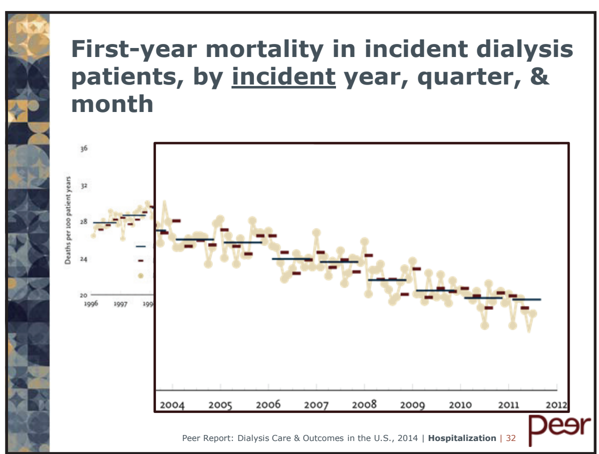

Seasonality of major morbidity in dialysis
Dialysis access infections,
in contrast,
peak in
the summer
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 27
peer

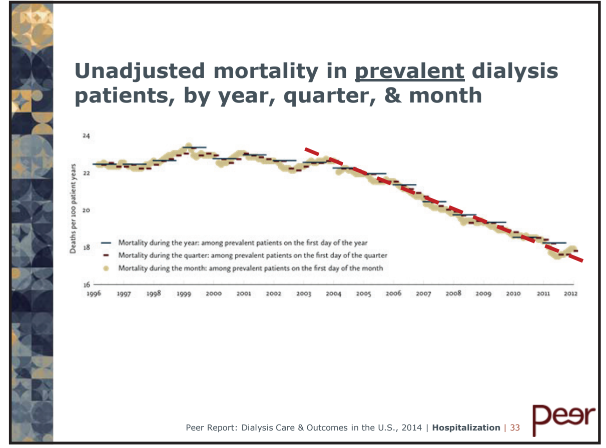

Gastrointestinal hemorrhage in prevalent patients: Admission rates, within quarter & year
Admissions per 100 patient years
3.0
2.5
2.0
1.5
1.0
0.5
0.0
Primary or leading secondary
Primary
MS-DRG begins
2004
2005
2006
2007
2008
2009
2010
2011
2012
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 28
peer


Gastrointestinal hemorrhage in prevalent patients: Admission rates, overall & by U.S. Census Division
Admissions per 100 patient years
3
2
1
0
Variation
New England
Middle Atlantic
East North Central
West North Central
South Atlantic
East South Central
West South Central
Mountain
Pacific
Bars: U.S. overall
2004
2005
2006
2007
2008
2009
2010
2011
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 29
peer


Hospitalization patterns
Geographic variation is striking and needs attention
Rising rates for fluid overload, C. Diff infections and GI bleeding
Seasonal changes in hospitalizations are wide spread across the major organ systems
The relationship between the seasonal events and the influenza season with virulence needs to be recognized
Improved prevention is needed: vaccination with high intensity dosing
Respiratory infection control procedures may be needed
Trends in hospitalizations for GI bleeding are rising!
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 30
peer


Peer
Kidney care initiative
Peer Report:
Mortality
Trends, Geographic Variation and Seasonality
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 31


First-year mortality in incident dialysis patients, by incident year, quarter, & month
2004
2005
2006
2007
2008
2009
2010
2011
2012
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 32


Unadjusted mortality in prevalent dialysis patients, by year, quarter, & month
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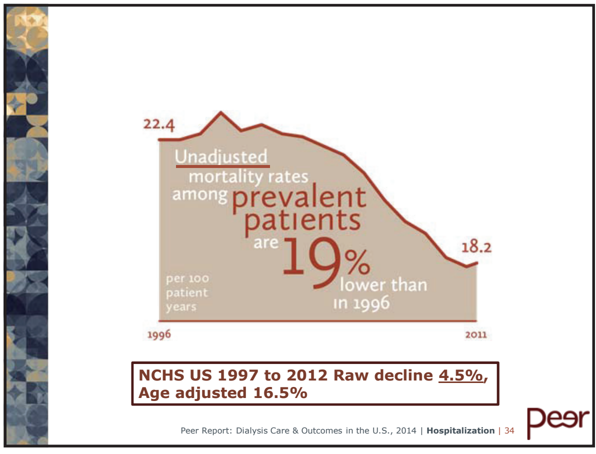
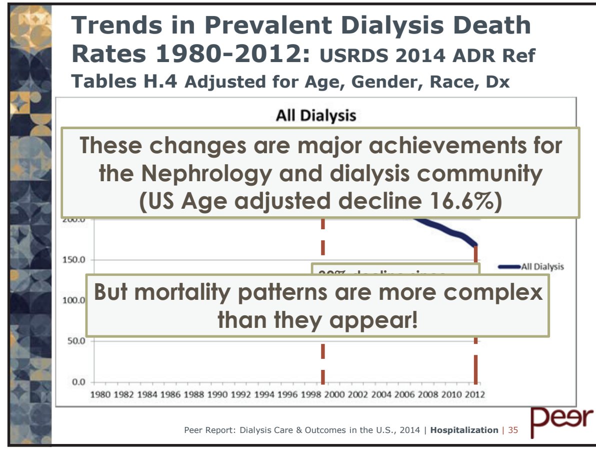
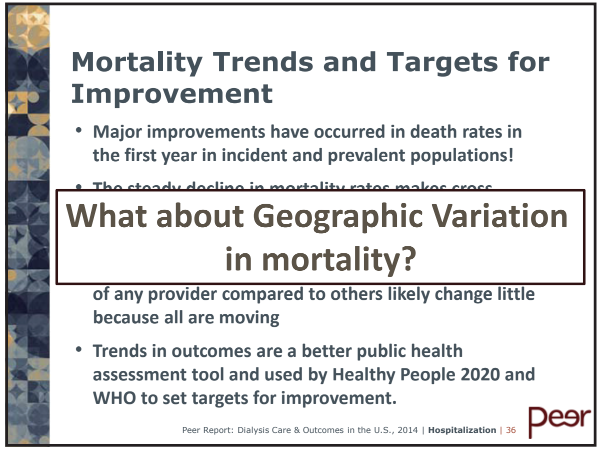
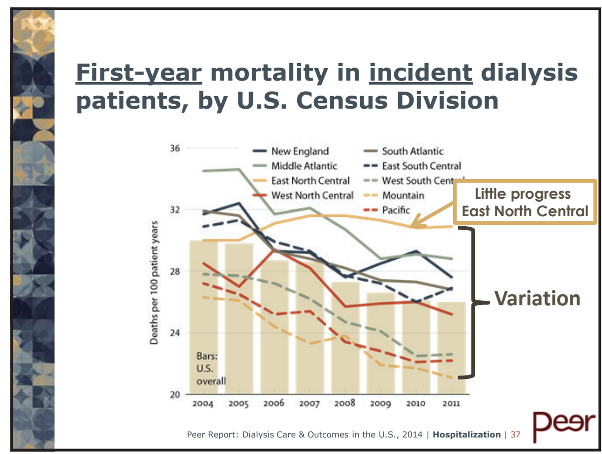
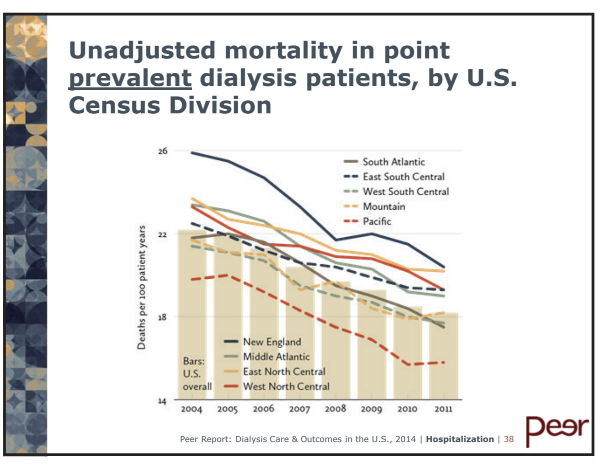
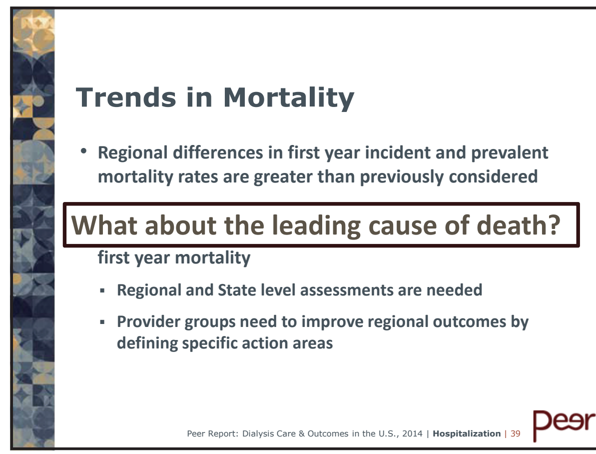

22.4
Unadjusted mortality rates among prevalent patients are 19% lower than in 1996
per 100 patient years
18.2
1996
2011
NCHS US 1997 to 2012 Raw decline 4.5%, Age adjusted 16.5%
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 34

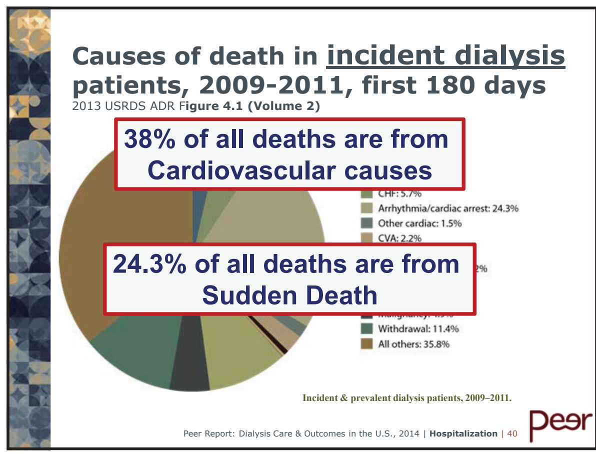

Trends in Prevalent Dialysis Death Rates 1980-2012: USRDS 2014 ADR Ref Tables H.4 Adjusted for Age, Gender, Race, Dx
All Dialysis
These changes are major achievements for the Nephrology and dialysis community (US Age adjusted decline 16.6%)
But mortality patterns are more complex than they appear!
All Dialysis
150.0
100.0
50.0
0.0
1980 1982 1984 1986 1988 1990 1992 1994 1996 1998 2000 2002 2004 2006 2008 2010 2012
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 35


Mortality Trends and Targets for Improvement
Major improvements have occurred in death rates in the first year in incident and prevalent populations!
What about Geographic Variation in mortality?
of any provider compared to others likely change little because all are moving
Trends in outcomes are a better public health assessment tool and used by Healthy People 2020 and WHO to set targets for improvement.
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 36


First-year mortality in incident dialysis patients, by U.S. Census Division
New England
Middle Atlantic
East North Central
West North Central
South Atlantic
East South Central
Mountain
Pacific
Little progress East North Central
Variation
Deaths per 100 patient years
Bars: U.S. overall
2004 2005 2006 2007 2008 2009 2010 2011
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 37


Unadjusted mortality in point prevalent dialysis patients, by U.S. Census Division
South Atlantic
East South Central
West South Central
Mountain
Pacific
New England
Middle Atlantic
East North Central
West North Central
Deaths per 100 patient years
Bars: U.S. overall
2004 2005 2006 2007 2008 2009 2010 2011
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 38


Trends in Mortality
Regional differences in first year incident and prevalent mortality rates are greater than previously considered
What about the leading cause of death?
first year mortality
Regional and State level assessments are needed
Provider groups need to improve regional outcomes by defining specific action areas
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 39


Causes of death in incident dialysis patients, 2009-2011, first 180 days
2013 USRDS ADR Figure 4.1 (Volume 2)
38% of all deaths are from Cardiovascular causes
Arrhythmia/cardiac arrest: 24.3%
Other cardiac: 1.5%
CVA: 2.2%
24.3% of all deaths are from Sudden Death
Withdrawal: 11.4%
All others: 35.8%
Incident & prevalent dialysis patients, 2009–2011.
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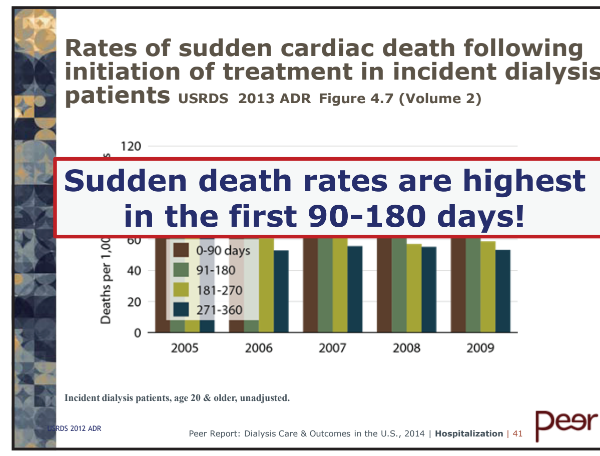
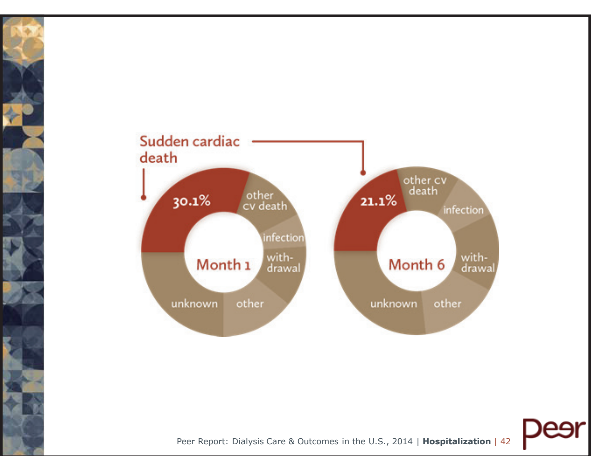
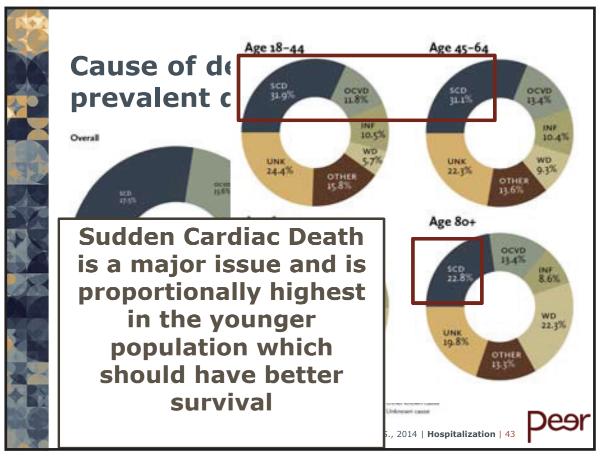
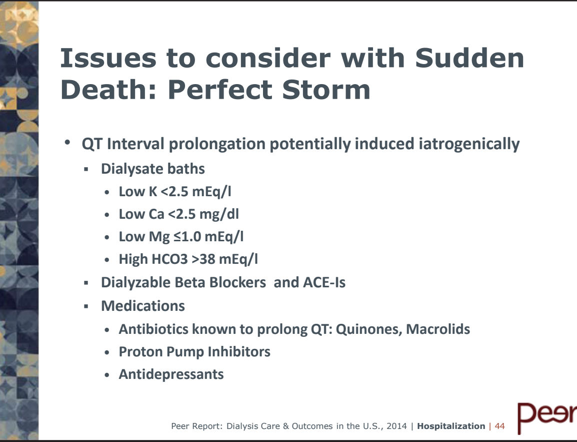
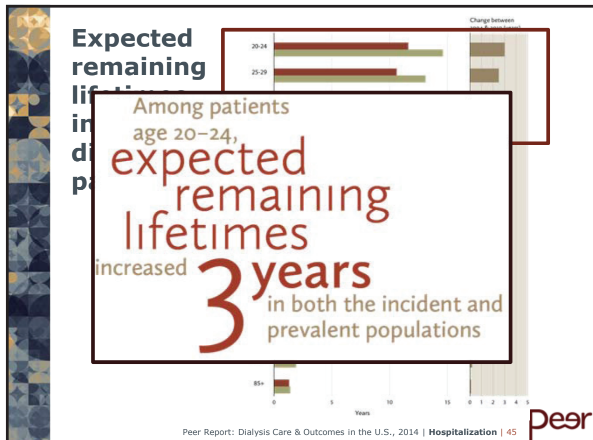
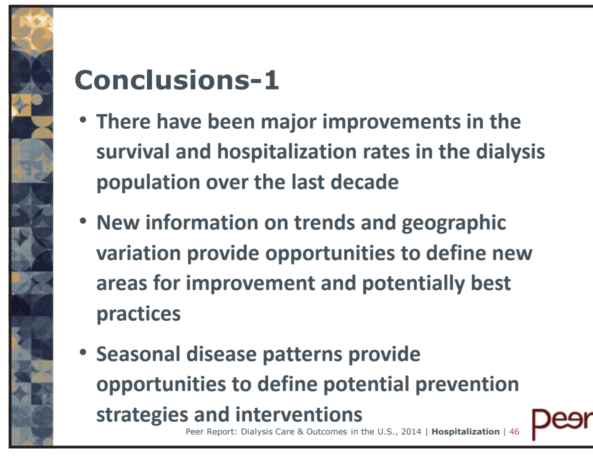

Rates of sudden cardiac death following initiation of treatment in incident dialysis patients USRDS 2013 ADR Figure 4.7 (Volume 2)
Sudden death rates are highest in the first 90-180 days!
0-90 days
91-180
181-270
271-360
2005 2006 2007 2008 2009
Incident dialysis patients, age 20 & older, unadjusted.
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 41

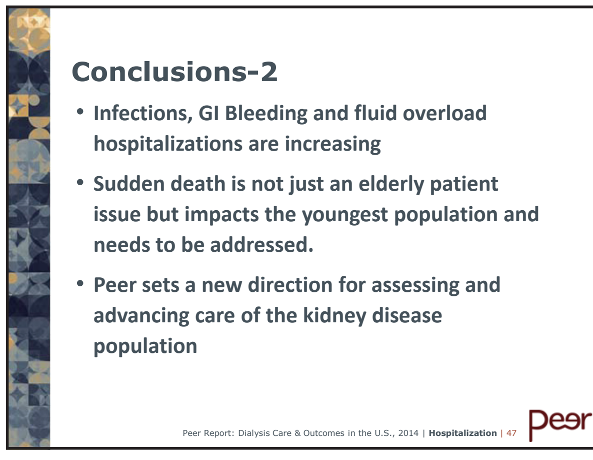

Sudden cardiac death
30.1%
other cv death
infection
with-drawal
Month 1
unknown
other
21.1%
Month 6
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 42

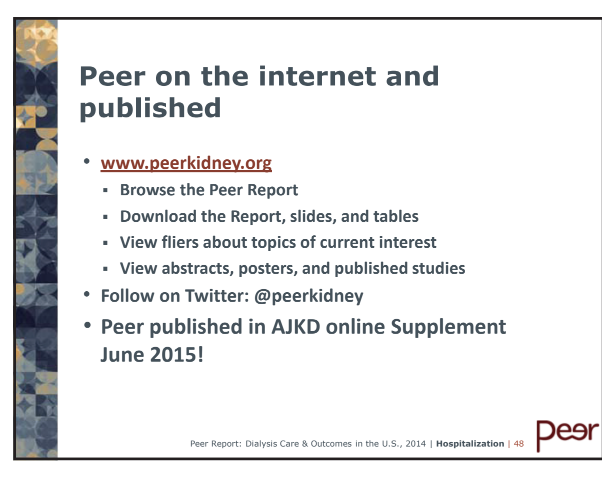

Cause of de
prevalent c
Age 18–44
Age 45–64
Age 80+
Overall
SCD 31.9%
OCVD 11.8%
INF 10.5%
WD 5.7%
OTHER 15.8%
UNK 24.4%
SCD 31.1%
OCVD 13.4%
INF 10.4%
WD 9.3%
OTHER 13.6%
UNK 22.3%
SCD 22.8%
OCVD 13.4%
INF 8.6%
WD 22.3%
OTHER 13.3%
UNK 19.8%
Sudden Cardiac Death is a major issue and is proportionally highest in the younger population which should have better survival
S., 2014 | Hospitalization | 43
Peer


Issues to consider with Sudden Death: Perfect Storm
QT Interval prolongation potentially induced iatrogenically
Dialysate baths
Low K <2.5 mEq/l
Low Ca <2.5 mg/dl
Low Mg ≤1.0 mEq/l
High HCO3 >38 mEq/l
Dialyzable Beta Blockers and ACE-Is
Medications
Antibiotics known to prolong QT: Quinones, Macrolids
Proton Pump Inhibitors
Antidepressants
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 44
Peer


Expected
remaining
Among patients age 20–24, expected remaining lifetimes increased 3 years in both the incident and prevalent populations
20-24
25-29
85+
Years
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 45
Peer


Conclusions-1
There have been major improvements in the survival and hospitalization rates in the dialysis population over the last decade
New information on trends and geographic variation provide opportunities to define new areas for improvement and potentially best practices
Seasonal disease patterns provide opportunities to define potential prevention strategies and interventions
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 46
Peer


Conclusions-2
Infections, GI Bleeding and fluid overload hospitalizations are increasing
Sudden death is not just an elderly patient issue but impacts the youngest population and needs to be addressed.
Peer sets a new direction for assessing and advancing care of the kidney disease population
Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 47
Peer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Peer Report: Dialysis Care & Outcomes in the U.S., 2014 | Hospitalization | 48
Peer

# Reducing Preventable Hospitalizations

**Andrew Howard, MD, FACP**
**Metropolitan Nephrology Associates**
**Clinton, MD**

# Reducing Preventable Hospitalizations

Andrew D. Howard, MD, FACP
Consultant, Government Affairs, FMCNA
October 16, 2015

## Who's Accountable? Standardized Readmissions Ratio (SRR)

- CMS PPS-QIP 2015 Final Rule and the PPS-QIP 2016 Proposed Rule
- NEW clinical measure for PY 2017
  - Inclusion under the Patient and Family Engagement/Care Coordination Subdomain with an individual weight of 10% for PY 2018 and PY 2019
- Areas of concern:
  - Inconsistencies with SMR and SHR
  - Impact of physician level admitting patterns
  - Reliable HIE



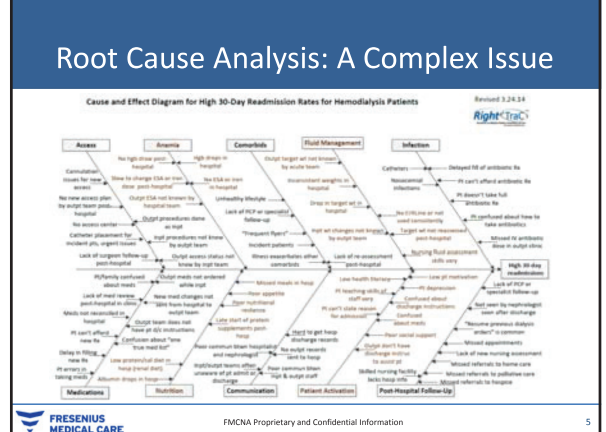
## Is the Current Metric Fair? Calculating Readmission Rates

- Per-Enrollee or Per-Admission?
  - Readmission rates usually reported on a per-admission basis
  - The readmission rate for a group of people is the number of readmissions counted (by any method) divided by the total number of admissions
- For performance benchmarking and tracking:
  - Also useful to measure readmissions on a per-person basis
- "The simplest way to reduce the risk of readmission in a population is to reduce the need for patients to be admitted to a hospital in the first place"

America's Health Insurance Plans, Policy and Research Center, March 2012



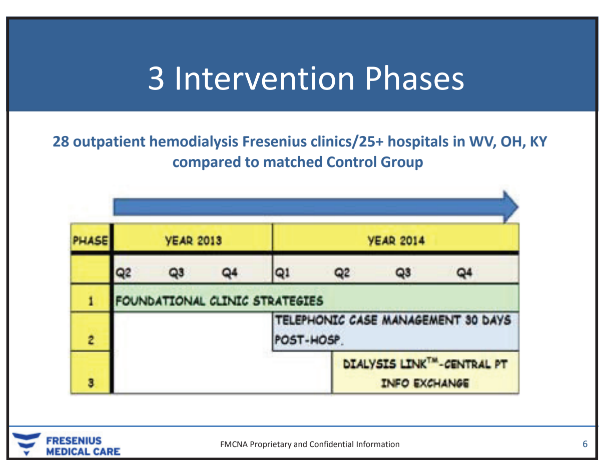
## Root Cause Analysis: A Complex Issue

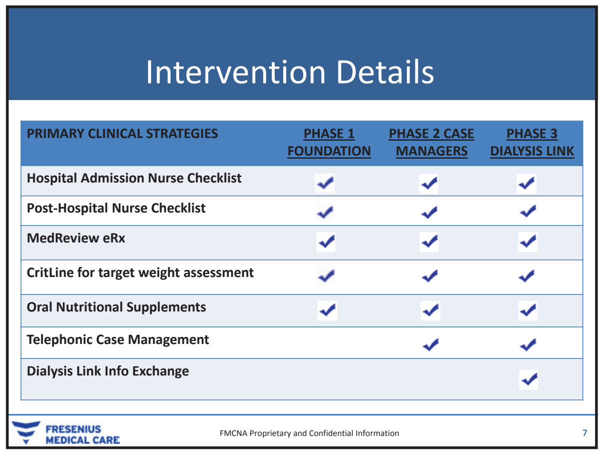





## 3 Intervention Phases

28 outpatient hemodialysis Fresenius clinics/25+ hospitals in WV, OH, KY compared to matched Control Group

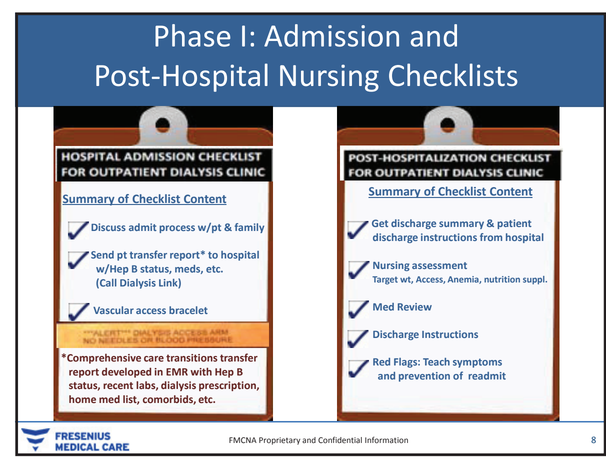


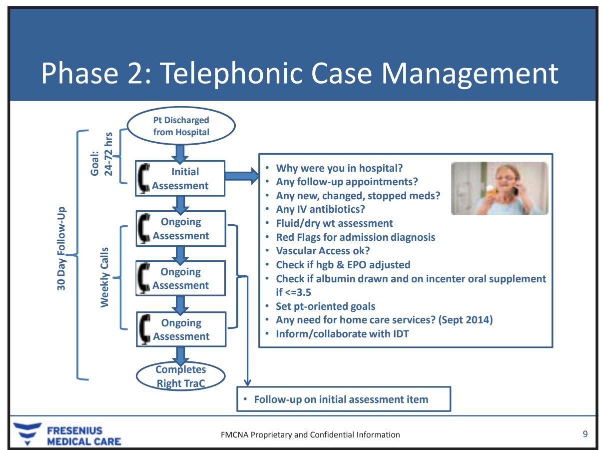


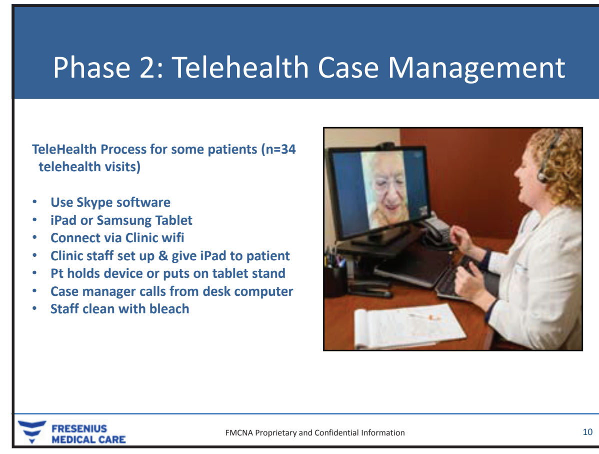
# Intervention Details

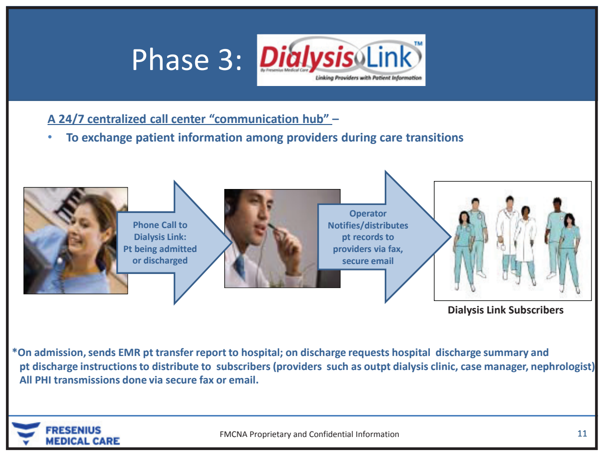
| PRIMARY CLINICAL STRATEGIES | PHASE 1 FOUNDATION | PHASE 2 CASE MANAGERS | PHASE 3 DIALYSIS LINK |
|---|---|---|---|
| Hospital Admission Nurse Checklist | ✓ | ✓ | ✓ |
| Post-Hospital Nurse Checklist | ✓ | ✓ | ✓ |
| MedReview eRx | ✓ | ✓ | ✓ |
| CritLine for target weight assessment | ✓ | ✓ | ✓ |
| Oral Nutritional Supplements | ✓ | ✓ | ✓ |
| Telephonic Case Management | | ✓ | ✓ |
| Dialysis Link Info Exchange | | | ✓ |

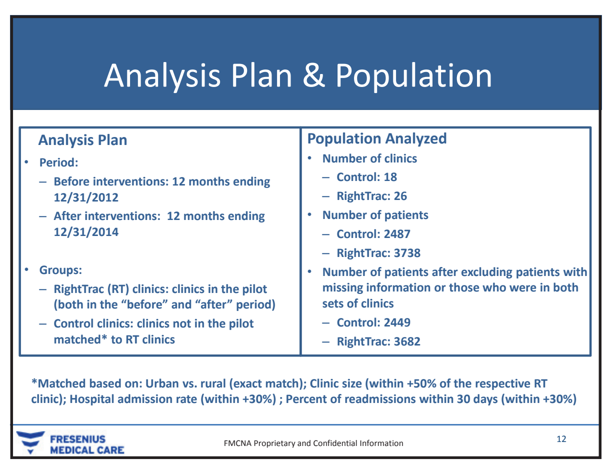
FRESENIUS MEDICAL CARE FMCNA Proprietary and Confidential Information 7

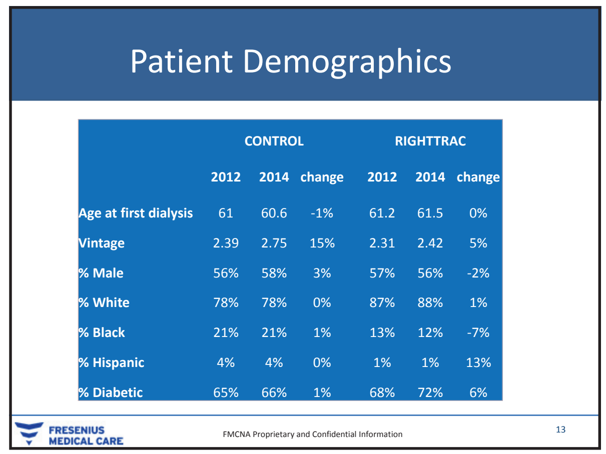


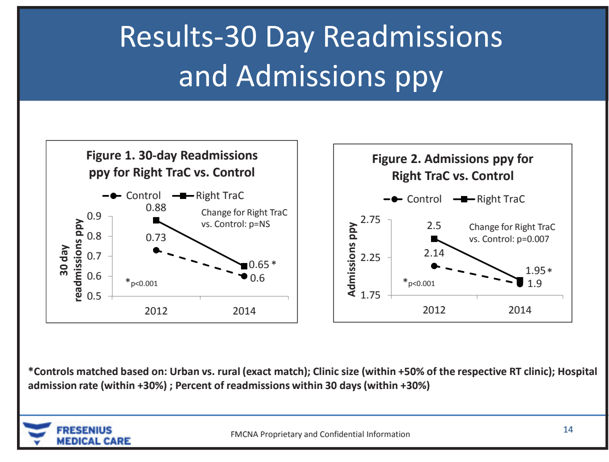





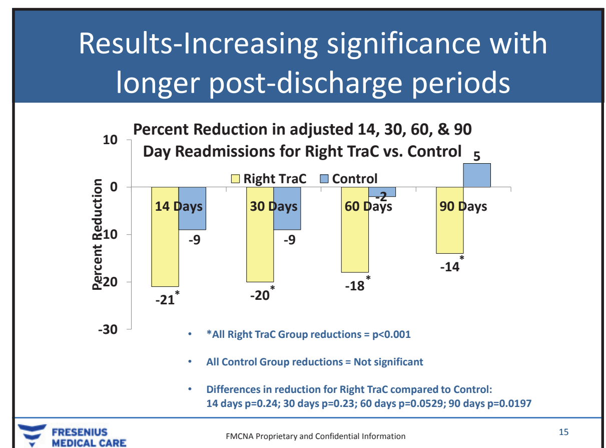
# Patient Demographics

| | CONTROL | | | RIGHTTRAC | | |
|---|---|---|---|---|---|---|
| | 2012 | 2014 | change | 2012 | 2014 | change |
| Age at first dialysis | 61 | 60.6 | -1% | 61.2 | 61.5 | 0% |
| Vintage | 2.39 | 2.75 | 15% | 2.31 | 2.42 | 5% |
| % Male | 56% | 58% | 3% | 57% | 56% | -2% |
| % White | 78% | 78% | 0% | 87% | 88% | 1% |
| % Black | 21% | 21% | 1% | 13% | 12% | -7% |
| % Hispanic | 4% | 4% | 0% | 1% | 1% | 13% |
| % Diabetic | 65% | 66% | 1% | 68% | 72% | 6% |

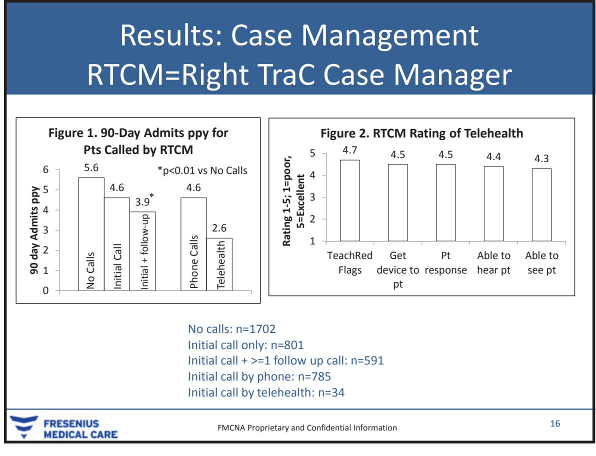








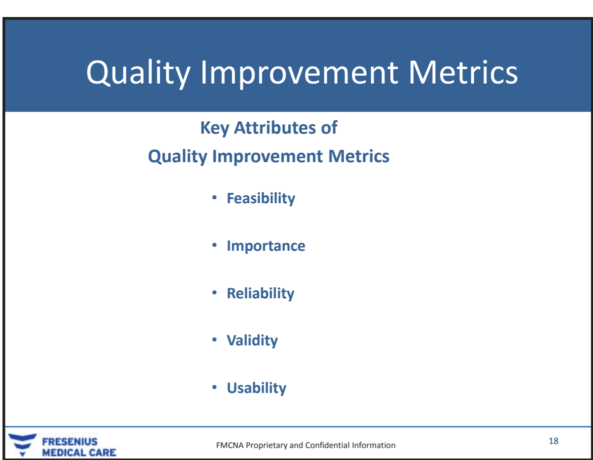



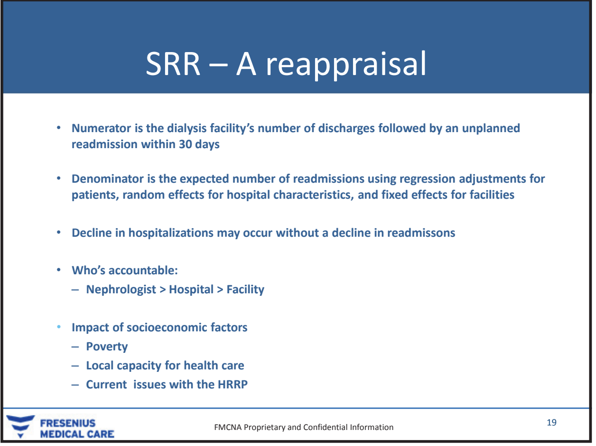


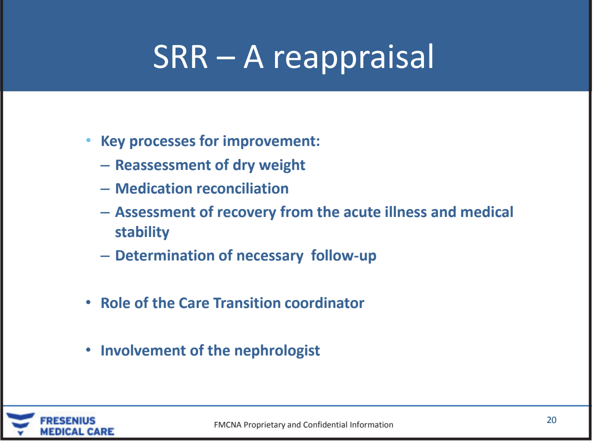

# Conclusions

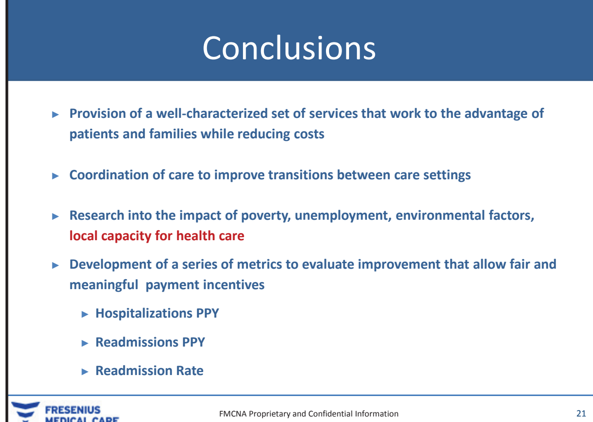
- Hospital readmissions did not decrease significantly more in the RightTrac clinics compared to controls until the 90 day time point, although total admissions did decrease at all time points
- Yet, both hospital admissions and readmissions went down significantly in the RightTrac clinics
- Specific interventions had more impact than others in these results

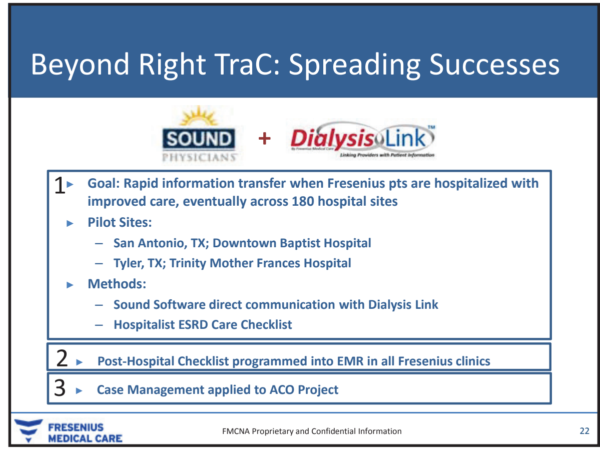







Clinical Innovation Initiatives
Overview
FMCNA

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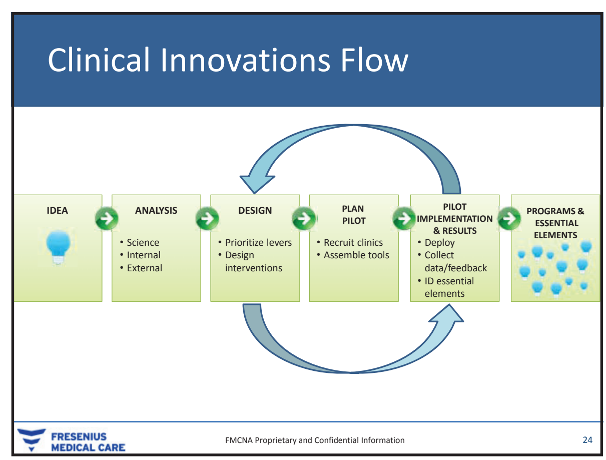

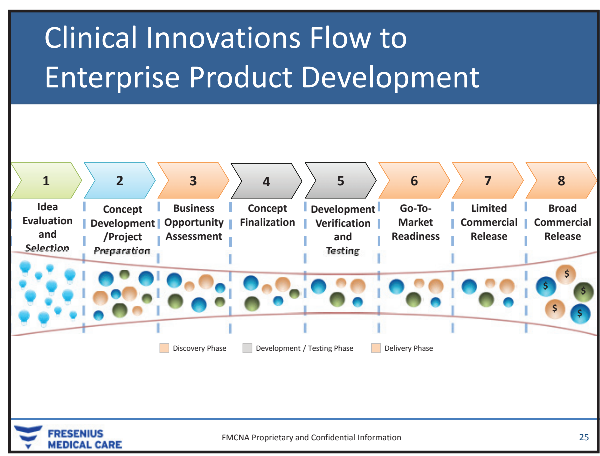
Clinical Innovations Flow to Enterprise Product Development
1 Idea Evaluation and Selection
2 Concept Development /Project Preparation
3 Business Opportunity Assessment
4 Concept Finalization
5 Development Verification and Testing
6 Go-To-Market Readiness
7 Limited Commercial Release
8 Broad Commercial Release
Discovery Phase
Development / Testing Phase
Delivery Phase
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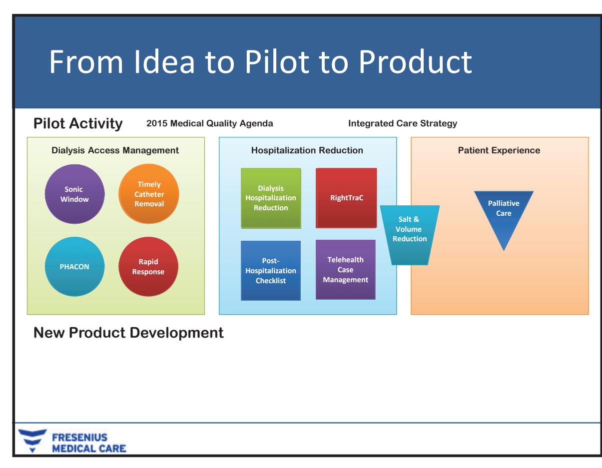
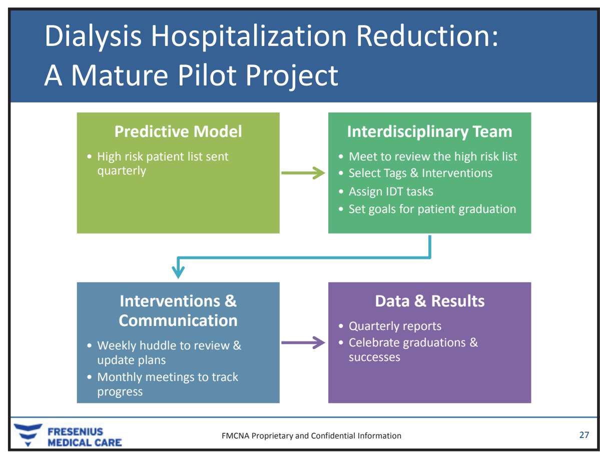

From Idea to Pilot to Product
Pilot Activity
2015 Medical Quality Agenda
Integrated Care Strategy
Dialysis Access Management
Sonic Window
Timely Catheter Removal
PHACON
Rapid Response
Hospitalization Reduction
Dialysis Hospitalization Reduction
RightTraC
Post-Hospitalization Checklist
Telehealth Case Management
Salt & Volume Reduction
Patient Experience
Palliative Care
New Product Development
FRESENIUS MEDICAL CARE


Dialysis Hospitalization Reduction: A Mature Pilot Project
Predictive Model
High risk patient list sent quarterly
Interdisciplinary Team
Meet to review the high risk list
Select Tags & Interventions
Assign IDT tasks
Set goals for patient graduation
Interventions & Communication
Weekly huddle to review & update plans
Monthly meetings to track progress
Data & Results
Quarterly reports
Celebrate graduations & successes
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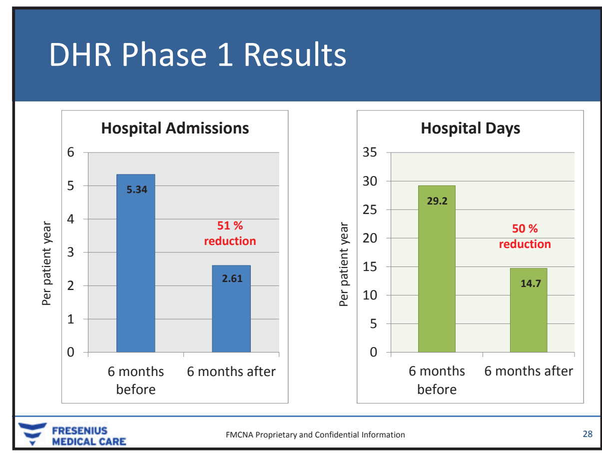
DHR Phase 1 Results
Hospital Admissions
Per patient year
5.34
2.61
51 % reduction
6 months before
6 months after
Hospital Days
Per patient year
29.2
14.7
50 % reduction
6 months before
6 months after
FRESENIUS MEDICAL CARE
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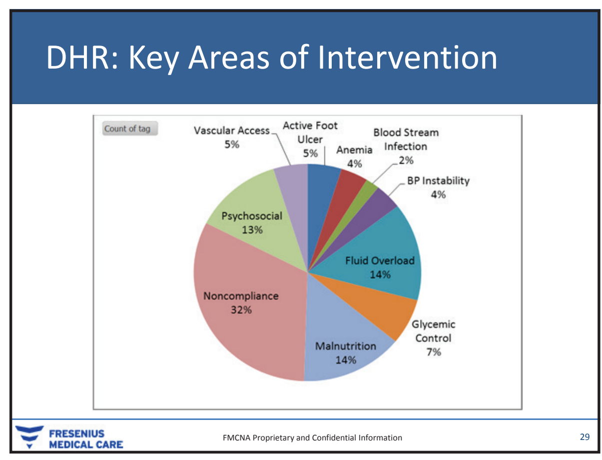
DHR: Key Areas of Intervention
Count of tag
Vascular Access 5%
Active Foot Ulcer 5%
Anemia 4%
Blood Stream Infection 2%
BP Instability 4%
Fluid Overload 14%
Glycemic Control 7%
Malnutrition 14%
Noncompliance 32%
Psychosocial 13%
FRESENIUS MEDICAL CARE
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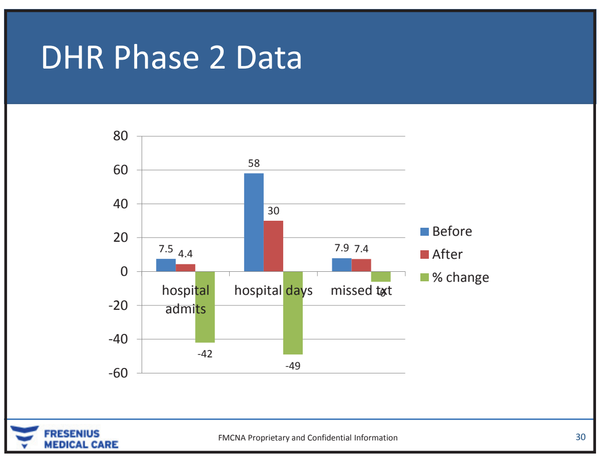
DHR Phase 2 Data
7.5
4.4
-42
58
30
-49
7.9
7.4
hospital admits
hospital days
missed txt
Before
After
% change
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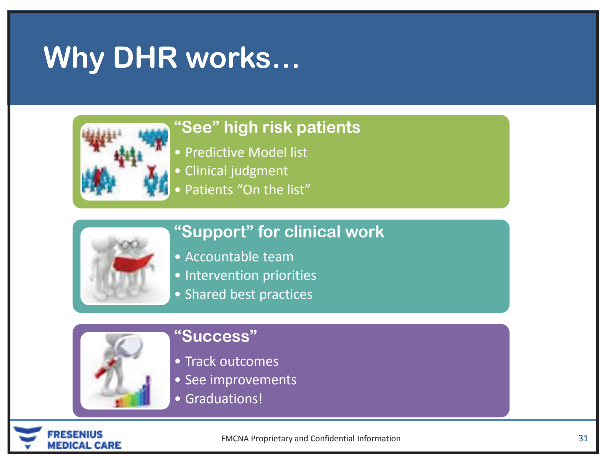
Why DHR works…
"See" high risk patients
• Predictive Model list
• Clinical judgment
• Patients "On the list"
"Support" for clinical work
• Accountable team
• Intervention priorities
• Shared best practices
"Success"
• Track outcomes
• See improvements
• Graduations!
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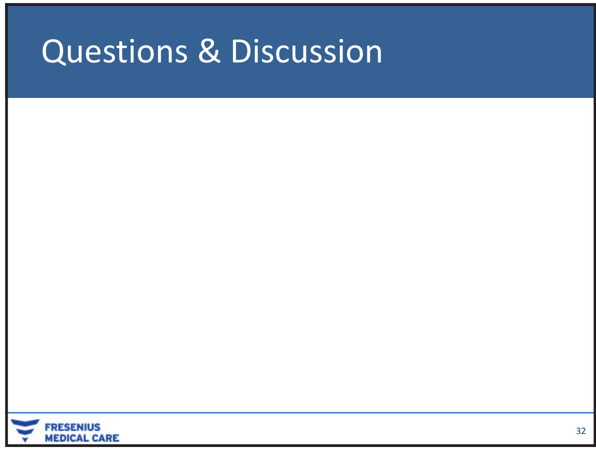
Questions & Discussion
FRESENIUS MEDICAL CARE
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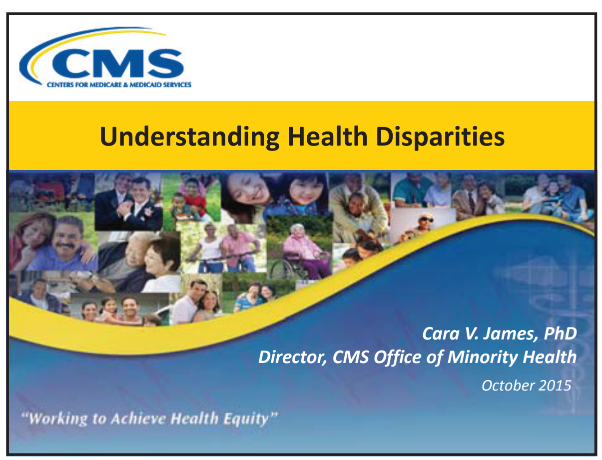
# Understanding Health Disparities

**Cara James, PhD**
**Director, Office of Minority Health**
**Centers for Medicare & Medicaid Services**

**Baltimore, MD**



## CMS OMH Mission and Vision

**Mission**

To ensure that the voices and the needs of the populations we represent are present as the Agency is developing, implementing, and evaluating its programs and policies

**Vision**

All CMS beneficiaries have achieved their highest level of health, and disparities in health care quality and access have been eliminated

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## A Quick Overview of Health Disparities

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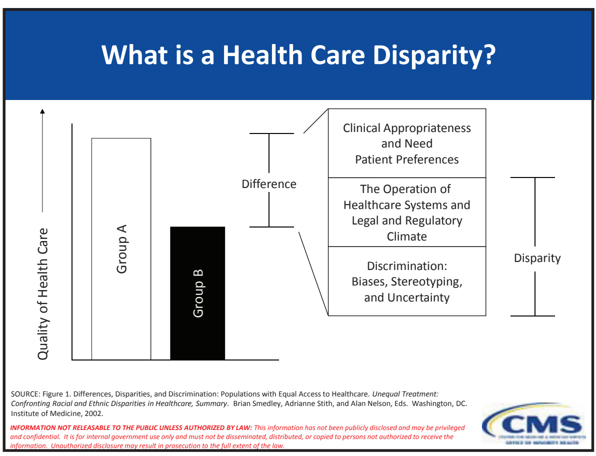


## Types of Health Disparities

- Racial and Ethnic
- Gender
- Socioeconomic Status
- Geographic
- Sexual Orientation

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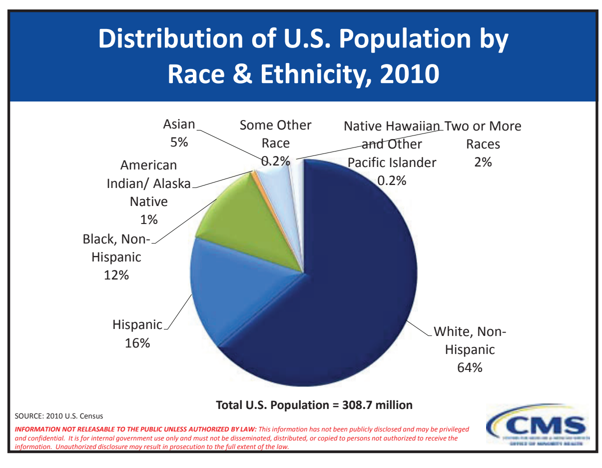
Distribution of U.S. Population by Race & Ethnicity, 2010
Asian 5%
Some Other Race 0.2%
Native Hawaiian and Other Pacific Islander 0.2%
Two or More Races 2%
American Indian/ Alaska Native 1%
Black, Non-Hispanic 12%
Hispanic 16%
White, Non-Hispanic 64%
Total U.S. Population = 308.7 million
SOURCE: 2010 U.S. Census
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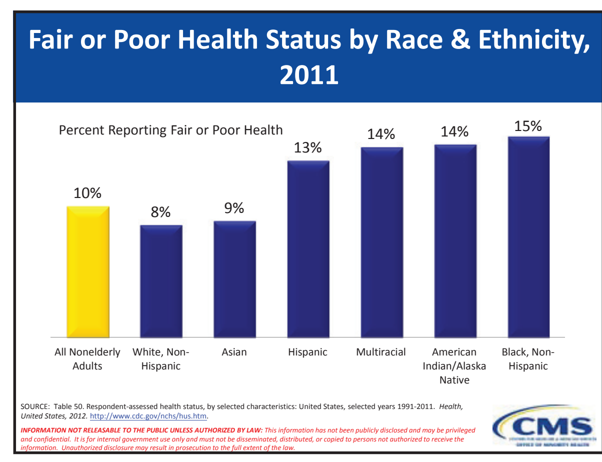
Fair or Poor Health Status by Race & Ethnicity, 2011
Percent Reporting Fair or Poor Health
10%
8%
9%
13%
14%
14%
15%
All Nonelderly Adults
White, Non-Hispanic
Asian
Hispanic
Multiracial
American Indian/Alaska Native
Black, Non-Hispanic
SOURCE: Table 50. Respondent-assessed health status, by selected characteristics: United States, selected years 1991-2011. Health, United States, 2012. http://www.cdc.gov/nchs/hus.htm.
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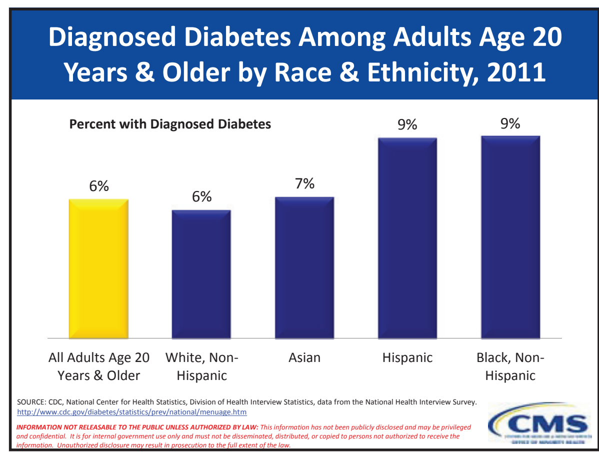
Diagnosed Diabetes Among Adults Age 20 Years & Older by Race & Ethnicity, 2011
Percent with Diagnosed Diabetes
6%
6%
7%
9%
9%
All Adults Age 20 Years & Older
White, Non-Hispanic
Asian
Hispanic
Black, Non-Hispanic
SOURCE: CDC, National Center for Health Statistics, Division of Health Interview Statistics, data from the National Health Interview Survey. http://www.cdc.gov/diabetes/statistics/prev/national/menuage.htm
INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW: This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.
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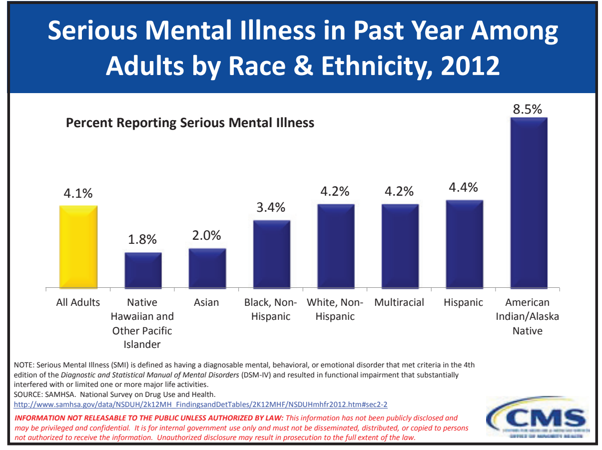
Serious Mental Illness in Past Year Among Adults by Race & Ethnicity, 2012
Percent Reporting Serious Mental Illness
4.1%
1.8%
2.0%
3.4%
4.2%
4.2%
4.4%
8.5%
All Adults
Native Hawaiian and Other Pacific Islander
Asian
Black, Non-Hispanic
White, Non-Hispanic
Multiracial
Hispanic
American Indian/Alaska Native
NOTE: Serious Mental Illness (SMI) is defined as having a diagnosable mental, behavioral, or emotional disorder that met criteria in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and resulted in functional impairment that substantially interfered with or limited one or more major life activities.
SOURCE: SAMHSA. National Survey on Drug Use and Health.
http://www.samhsa.gov/data/NSDUH/2k12MH_FindingsandDetTables/2K12MHF/NSDUHmhfr2012.htm#sec2-2
INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW: This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.
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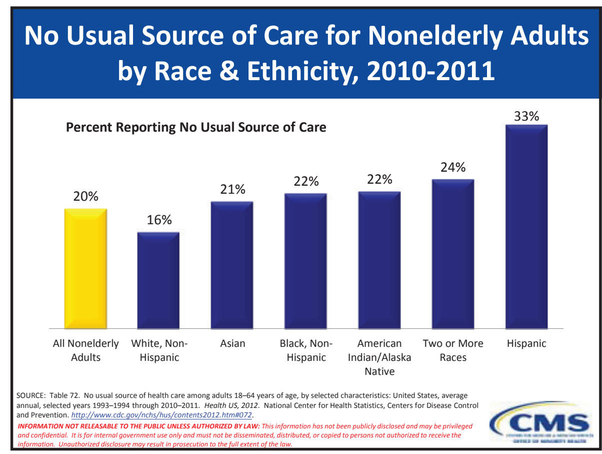
No Usual Source of Care for Nonelderly Adults by Race & Ethnicity, 2010-2011
Percent Reporting No Usual Source of Care
20%
16%
21%
22%
22%
24%
33%
All Nonelderly Adults
White, Non-Hispanic
Asian
Black, Non-Hispanic
American Indian/Alaska Native
Two or More Races
Hispanic
SOURCE: Table 72. No usual source of health care among adults 18–64 years of age, by selected characteristics: United States, average annual, selected years 1993–1994 through 2010–2011. Health US, 2012. National Center for Health Statistics, Centers for Disease Control and Prevention. http://www.cdc.gov/nchs/hus/contents2012.htm#072.
INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW: This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.
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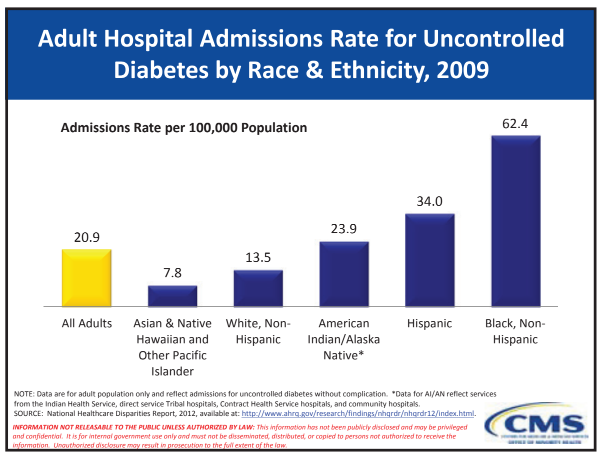
Adult Hospital Admissions Rate for Uncontrolled Diabetes by Race & Ethnicity, 2009
Admissions Rate per 100,000 Population
20.9
7.8
13.5
23.9
34.0
62.4
All Adults
Asian & Native Hawaiian and Other Pacific Islander
White, Non-Hispanic
American Indian/Alaska Native*
Hispanic
Black, Non-Hispanic
NOTE: Data are for adult population only and reflect admissions for uncontrolled diabetes without complication. *Data for AI/AN reflect services from the Indian Health Service, direct service Tribal hospitals, Contract Health Service hospitals, and community hospitals.
SOURCE: National Healthcare Disparities Report, 2012, available at: http://www.ahrq.gov/research/findings/nhqrdr/nhqrdr12/index.html.
INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW: This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.
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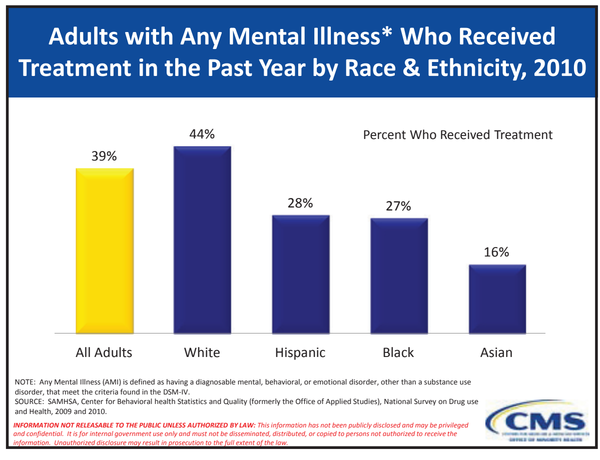
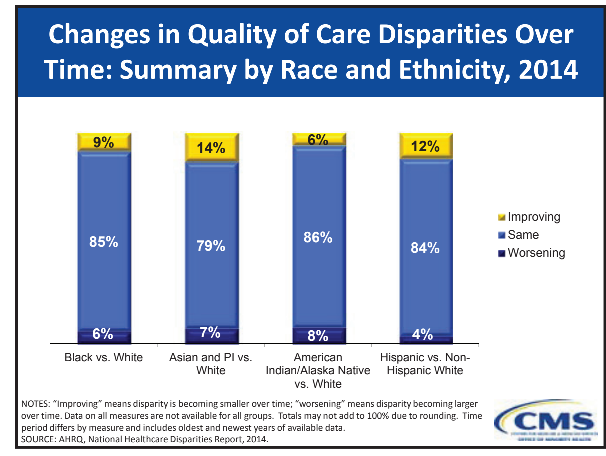
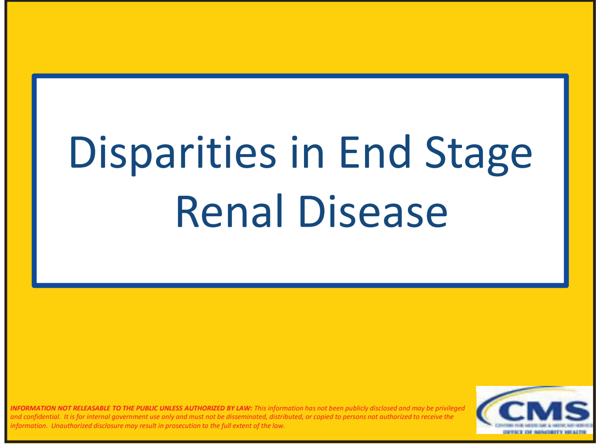
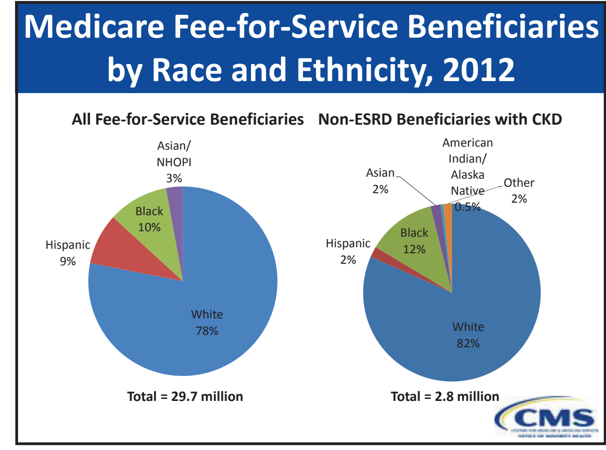
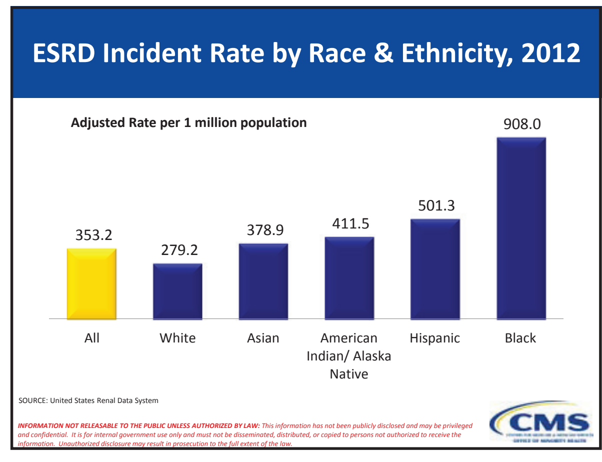
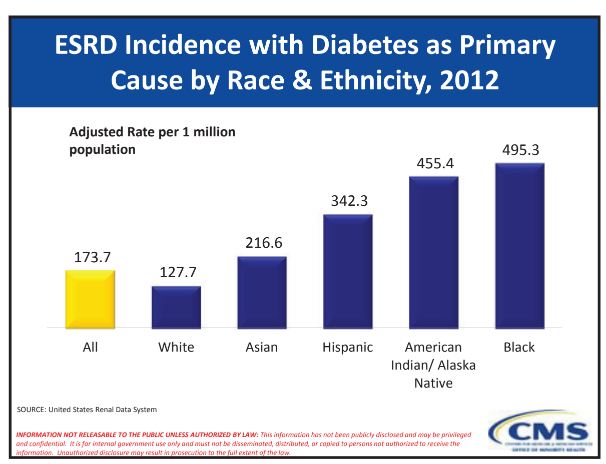

Adults with Any Mental Illness* Who Received Treatment in the Past Year by Race & Ethnicity, 2010
Percent Who Received Treatment
39%
44%
28%
27%
16%
All Adults
White
Hispanic
Black
Asian
NOTE: Any Mental Illness (AMI) is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a substance use disorder, that meet the criteria found in the DSM-IV.
SOURCE: SAMHSA, Center for Behavioral health Statistics and Quality (formerly the Office of Applied Studies), National Survey on Drug use and Health, 2009 and 2010.
CMS

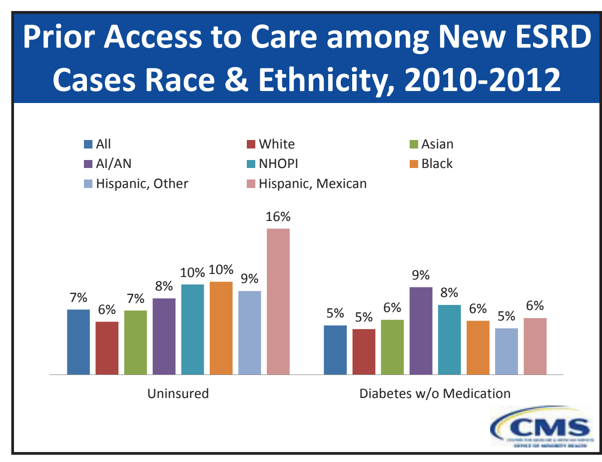

Changes in Quality of Care Disparities Over Time: Summary by Race and Ethnicity, 2014
9%
85%
6%
14%
79%
7%
6%
86%
8%
12%
84%
4%
Improving
Same
Worsening
Black vs. White
Asian and PI vs. White
American Indian/Alaska Native vs. White
Hispanic vs. Non-Hispanic White
NOTES: "Improving" means disparity is becoming smaller over time; "worsening" means disparity becoming larger over time. Data on all measures are not available for all groups. Totals may not add to 100% due to rounding. Time period differs by measure and includes oldest and newest years of available data.
SOURCE: AHRQ, National Healthcare Disparities Report, 2014.
CMS

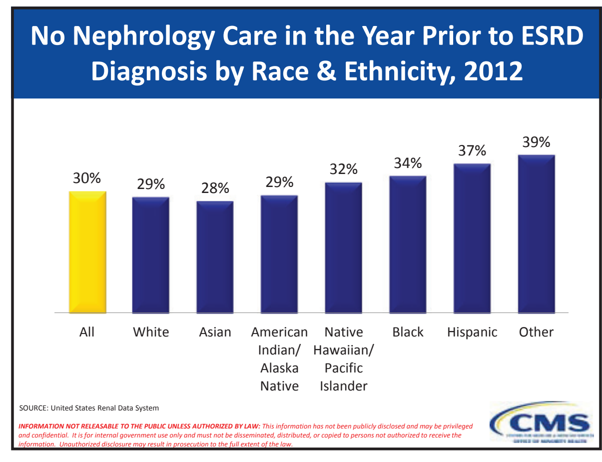

Disparities in End Stage Renal Disease
CMS

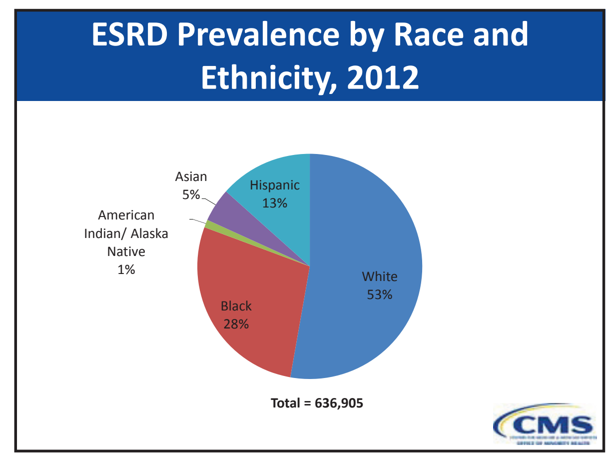

Medicare Fee-for-Service Beneficiaries by Race and Ethnicity, 2012
All Fee-for-Service Beneficiaries
Asian/ NHOPI 3%
Black 10%
Hispanic 9%
White 78%
Total = 29.7 million
Non-ESRD Beneficiaries with CKD
American Indian/ Alaska Native 0.5%
Asian 2%
Other 2%
Black 12%
Hispanic 2%
White 82%
Total = 2.8 million
CMS

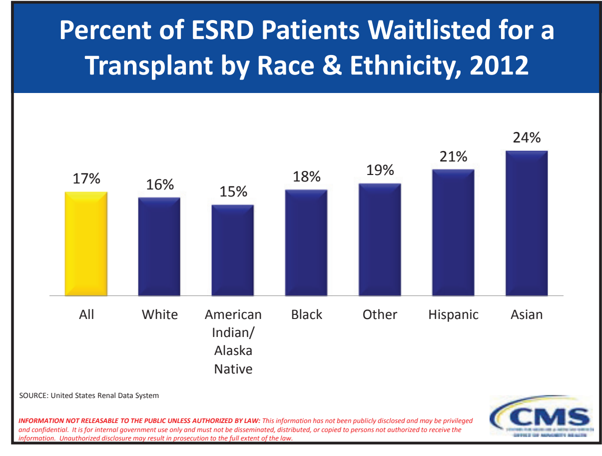

ESRD Incident Rate by Race & Ethnicity, 2012
Adjusted Rate per 1 million population
353.2
279.2
378.9
411.5
501.3
908.0
All
White
Asian
American Indian/ Alaska Native
Hispanic
Black
SOURCE: United States Renal Data System
CMS

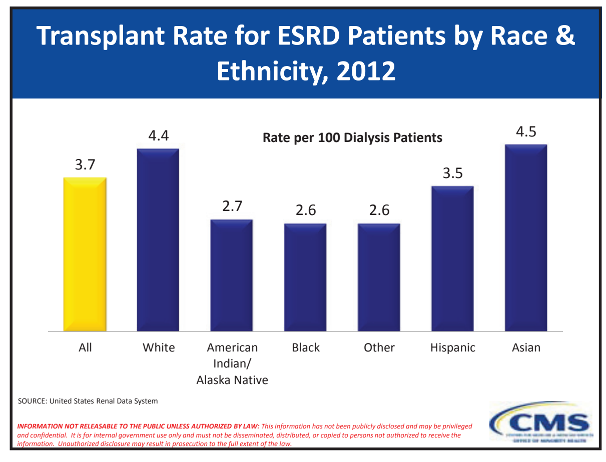

ESRD Incidence with Diabetes as Primary Cause by Race & Ethnicity, 2012
Adjusted Rate per 1 million population
173.7
127.7
216.6
342.3
455.4
495.3
All
White
Asian
Hispanic
American Indian/ Alaska Native
Black
SOURCE: United States Renal Data System
CMS

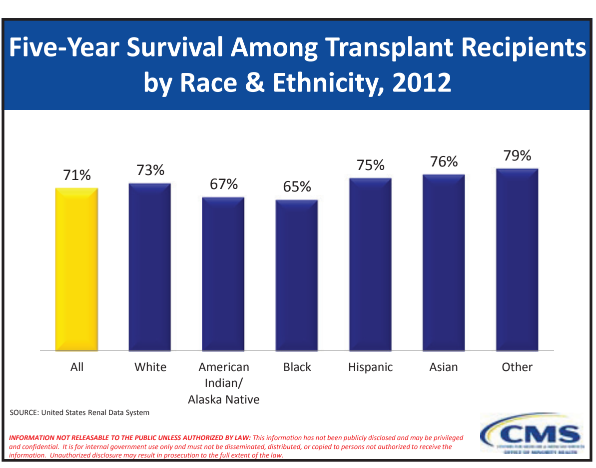

Prior Access to Care among New ESRD Cases Race & Ethnicity, 2010-2012
All
White
Asian
AI/AN
NHOPI
Black
Hispanic, Other
Hispanic, Mexican
7% 6% 7% 8% 10% 10% 9% 16%
5% 5% 6% 9% 8% 6% 5% 6%
Uninsured
Diabetes w/o Medication


No Nephrology Care in the Year Prior to ESRD Diagnosis by Race & Ethnicity, 2012
30% 29% 28% 29% 32% 34% 37% 39%
All
White
Asian
American Indian/ Alaska Native
Native Hawaiian/ Pacific Islander
Black
Hispanic
Other
SOURCE: United States Renal Data System


ESRD Prevalence by Race and Ethnicity, 2012
Asian 5%
Hispanic 13%
American Indian/ Alaska Native 1%
White 53%
Black 28%
Total = 636,905


Percent of ESRD Patients Waitlisted for a Transplant by Race & Ethnicity, 2012
17% 16% 15% 18% 19% 21% 24%
All
White
American Indian/ Alaska Native
Black
Other
Hispanic
Asian
SOURCE: United States Renal Data System


Transplant Rate for ESRD Patients by Race & Ethnicity, 2012
Rate per 100 Dialysis Patients
3.7 4.4 2.7 2.6 2.6 3.5 4.5
All
White
American Indian/ Alaska Native
Black
Other
Hispanic
Asian
SOURCE: United States Renal Data System


Five-Year Survival Among Transplant Recipients by Race & Ethnicity, 2012
71% 73% 67% 65% 75% 76% 79%
All
White
American Indian/ Alaska Native
Black
Hispanic
Asian
Other
SOURCE: United States Renal Data System

## Social Determinants of Health

- Social Gradient
- Early Life
- Social Exclusion
- Work
- Unemployment
- Social Support
- Addiction
- Food
- Stress
- Transportation
- Environment/Community
- Health Insurance
- English Proficiency
- Health Literacy

SOURCE: Richard Wilkinson and Michael Marmot, eds. *Social Determinants of Health: The Solid Facts*, 2nd Edition. Denmark; World Health Organization, 2003. Available at http://www.euro.who.int/eprise/main/who/informationsources/publications/catalogue/20020808_2.

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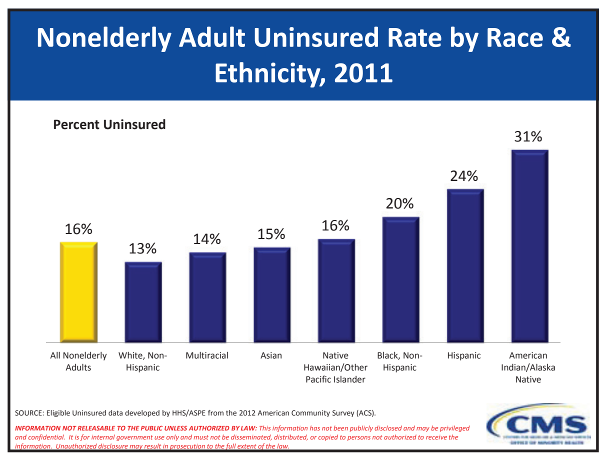


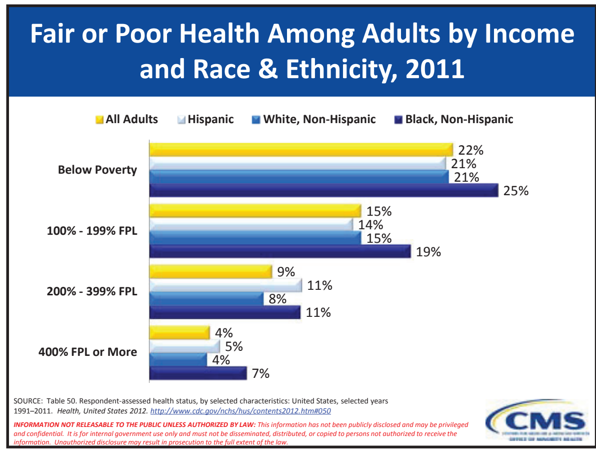


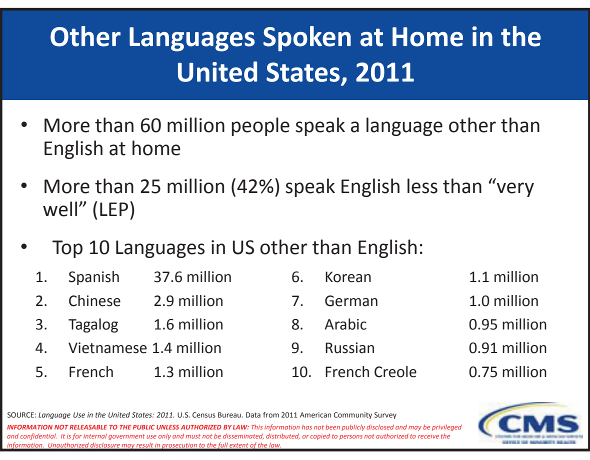


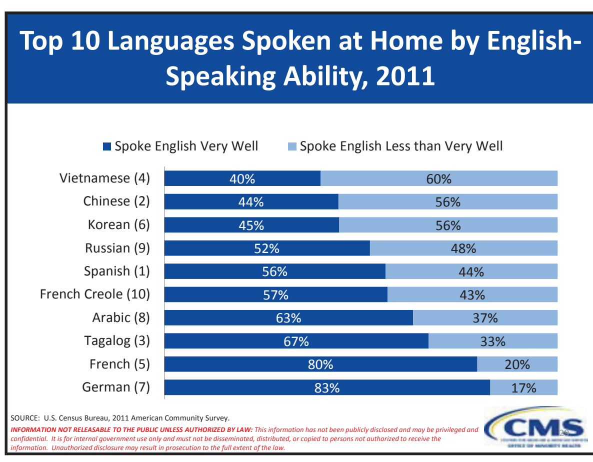


## Health Literacy

- Defined as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions." (Healthy People 2010)
- Problems particularly prevalent among elderly, minorities, immigrants and the poor.
- Health literacy problems have been linked to poor glycemic control among diabetics, increased hospitalization rates among ER patients, and other problems.

SOURCE: Health Literacy Fact Sheets. Center for Health Care Strategies, Inc. http://www.chcs.org/publications3960/publications_show.htm?doc_id=291711. Accessed June 18, 2007

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## Take Home Messages Regarding Health Disparities

1. Disparities exist in health status, access to care, quality of care, and health outcomes, there is still much we don't know, due to a lack of data.
2. Regardless of how they fair in the aggregate, all racial groups have problems.
3. Racial groups are not monolithic, and health differs within racial groups.
4. Cost of not addressing disparities is large and apt to get worse, as the population changes.
5. Many factors aside from race impact health and health care.
6. A myriad of efforts are underway to address disparities, but we still have a long way to go to eliminate disparities.

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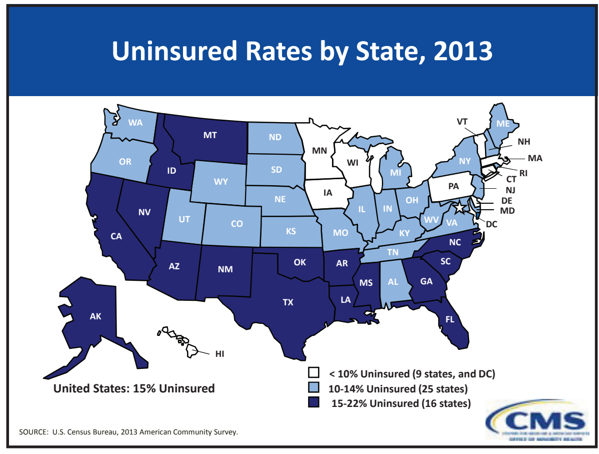


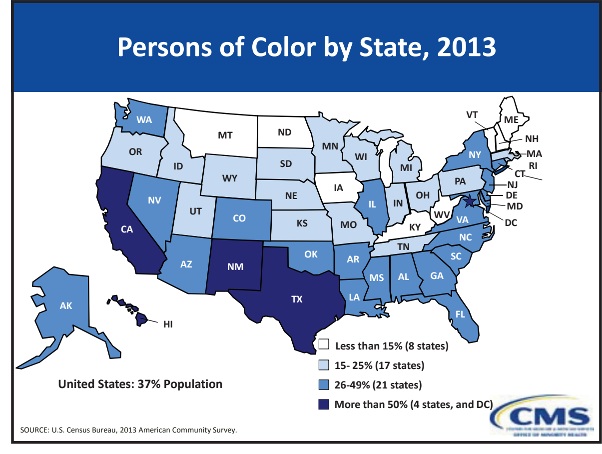


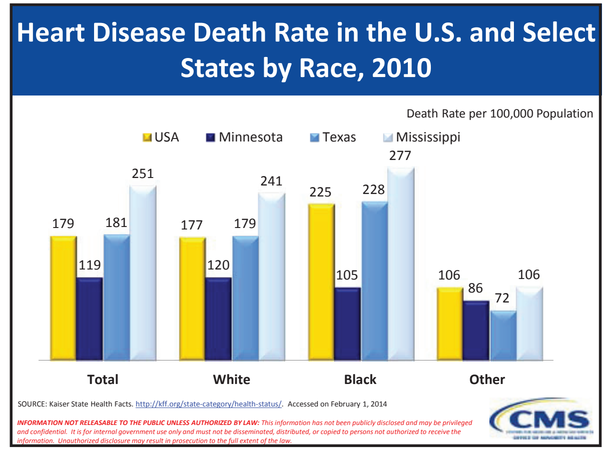


## State Policies that Can Affect Health

- Medicaid Eligibility
- SNAP and TANF Benefits, and Allowances
- Transportation and Urban Planning
- Unemployment Benefits

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## Steps for Identifying and Reducing Disparities

- Identify Performance Gaps
- Develop and Implement Initiatives Targeting the Gaps
- Increase Availability of Culturally and Linguistically Appropriate Services (CLAS)
- Increase Patient and Family Engagement
- Partner with the Community

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# Culturally & Linguistically Appropriate Services (CLAS) Standards

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## Culturally and Linguistically Appropriate Services (CLAS) Standards

- Intended to advance health equity, improve quality and help eliminate health care disparities.
- Culture includes race, ethnicity, language, geography, religion and spirituality, and biological and sociological characteristics.
- Emphasize the importance of cultural and linguistic competency at every point of contact along the health care and health services continuum.

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## National CLAS Standards

**Principal Standard**

1. Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

**Governance, Leadership and Workforce**

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources.
3. Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

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## National CLAS Standards Cont.

**Communication and Language Assistance**

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

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## National CLAS Standards Cont.

**Engagement, Continuous Improvement and Accountability**

9. Establish culturally and linguistically appropriate goals, policies and management accountability, and infuse them throughout the organizations' planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

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## National CLAS Standards Cont.

**Engagement, Continuous Improvement and Accountability**

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness.
14. Create conflict- and grievance-resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.

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## Conclusion

"A journey of a thousand miles begins with a single step." (Lao-tzu, 604 BC - 531 BC)

Together we can ensure that all Americans have access to quality affordable health coverage, and that health disparities are eliminated.

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**Thank You!!**

Contact OMH:
omh@cms.hhs.gov

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# Developing Personal Resilience

**Jeffrey Russell**
**Russell Consulting**
**Madison, WI**

*Renal Network Annual Meeting 2015*

# Developing Personal Resilience

## Strategies for Helping Navigate Life's Uncertainties

*Helping Build and Sustain GREAT Organizations!*

# Jeffrey L. Russell

Jeff Russell, co-director of ***Russell Consulting, Inc.* (*RCI*)** with his wife Linda, specializes in helping leaders build productive, supportive, and motivating work environments. *RCI* helps companies develop their leadership and strengthen team performance to achieve their great performance goals and outcomes. By guiding the exploration of key values held in common by organizational members and developing strategies and actions to express these values-in-action, *RCI* helps organizations achieve their strategic vision.

Through processes that include "visioning" retreats, Future Search conferences, process redesigns, improving decision making processes, implementing quality improvement strategies, and providing a variety of skill-building seminars, *RCI* enhances long-term organizational effectiveness and performance.

## Consulting Expertise

Jeff consults with companies in the areas of:

- Visioning and strategic planning
- Leadership development
- Leading and implementing change
- Performance management systems
- Employee engagement assessment
- Customer and employee focus groups
- Team assessment and intervention
- training needs assessment
- Organizational design
- Self-managed teams
- Problem solving and decision making

## Training Expertise

Jeff conducts an array of leadership and team development seminars on such topics as:

- Surviving difficult conversations
- Fearless performance reviews
- Leadership and strategic thinking/planning
- Leading fearless change
- Communication skills
- Dealing with difficult people
- DiSC Behavioral Profiles
- 360 leadership assessment and development
- Effective meeting management
- Decision making and problem solving
- Managing conflict and win/win negotiations
- Performance management and coaching skills
- Team building fundamentals
- Team leadership and facilitation skills
- Customer service

## Professional Background

Jeff serves as an adjunct faculty member at University of Wisconsin-Madison and UW-Milwaukee. He also teaches for the UW-Madison, UW-Eau Claire, and UW-La Crosse Small Business Development Centers.

Jeff has a bachelor's in Humanism and Cultural Change and a Masters of Science degree in Industrial Relations from UW-Madison.

Before forming RCI, Jeff served as human resource coordinator for the Wisconsin Department of Administration (DOA). At DOA, Jeff developed and coordinated their employee assistance, leadership and employee development, and equal employment opportunity/affirmative action programs.

## Conference Presenter and Author

Jeff is a sought-after speaker at state, national and international conferences. Recent presentations include:

- ASTD International Conferences — 2001 through 2011
- Jamaica Employer's Federation Conference, Ocho Rios, Jamaica, 2004, 2006, 2007, and 2009
- 2005 Minnesota Quality Conference
- Minnesota Project Management Institute, PDD 2007, 2008, 2009, 2011, 2012, and 2013
- Wisconsin SHRM Annual Conference, 2004 through 2007, 2010, 2011, 2012, and 2013
- Wisconsin Child Welfare Annual Conference, 2012
- *Leading Change*, Shanghai, China
- *Emotional Intelligence in Action*, Kuala Lumpur, Malaysia, 2012

Jeff and his business/life partner Linda have co-authored nine management books including ***Leading Change Training, Strategic Planning Training***, ***Change Basics, Strategic Planning 101, Ultimate Performance Management,*** and ***Fearless Performance Reviews*** (McGraw-Hill, 2014).

**Helping Create and Sustain *GREAT* Organizations!**

1134 Winston Drive
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*E-mail*: Jeff@RussellConsultingInc.com

# Resilience and Its Importance

## What Does it Mean to be Resilient?

Based upon the examples given and your own experience . . . identify what it means to be resilient in the face of life's challenges.

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

## Resilience is Important . . .

To our clients and customers because:______________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

To us professionally/personally because: ___________________________________

______________________________________________________________________

______________________________________________________________________

## Resilience is . . .

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

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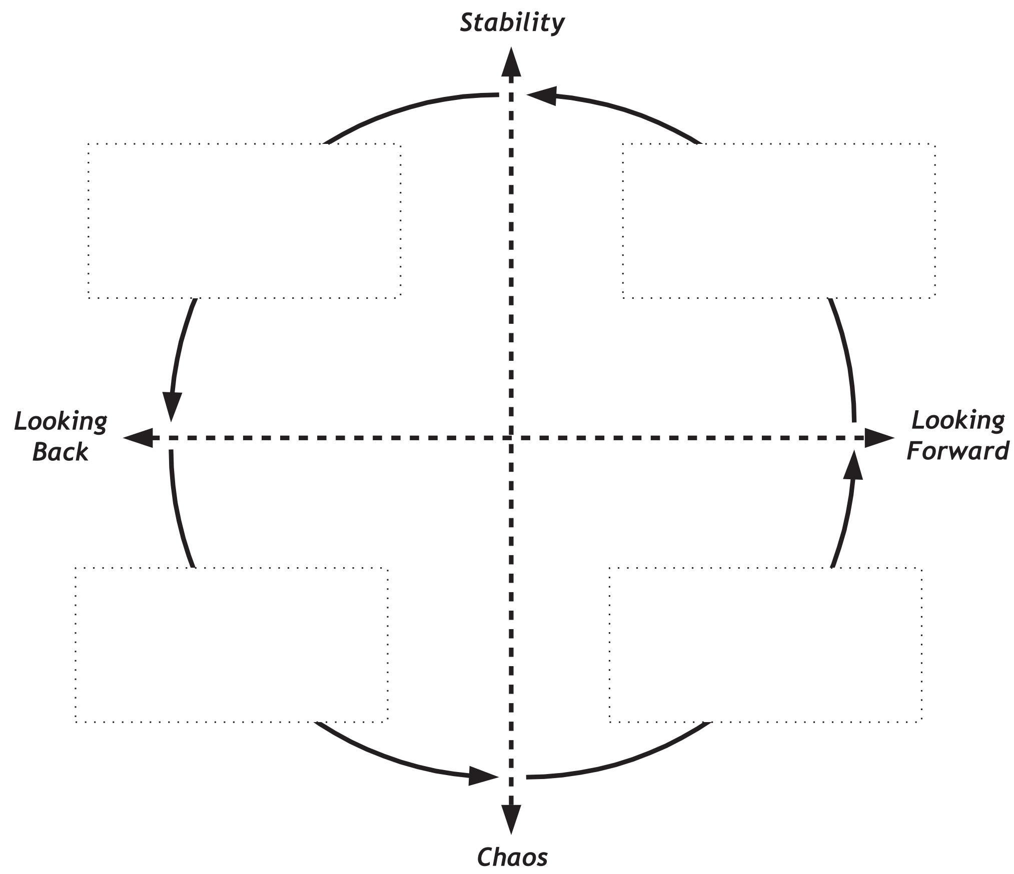
# The Importance of Resilience

When change is thrust upon us, it often pushes us out of a place of comfort, control, and complacency (**Comfort and Control** in the model below). Change introduces *instability* into this safe environment by attempting to pull apart the personal, social, and organizational structures that provide us clarity, direction, and cohesion.

When we are pushed out of this "comfort zone," we are likely to experience confusion, anxiety, self-doubt, anger, and fear. Many of the old rules, pathways, structures, and methods of the past have been taken away. Resilience gives us the capacity to more effectively deal with the uncertainty of this chaotic place (***Fear, Anger, and Resistance***). Without resilience, the anxiety that emerges can erode our personal effectiveness and job performance, create higher levels of distrust and resistance, and decrease our ability to find the "hidden opportunity" that is essential if we are to make the change work for ourselves and the organization. Resilience enables us to complete the change journey by finding integrative, forward-looking solutions (***Inquiry, Experimentation and Discovery***) and embracing the structures of the new and emerging world (***Learning, Acceptance, and Commitment***).

## A Model for Understanding the Emotional Response to Change




From **Change Basics** (ASTD Press, 2006) by Jeff and Linda Russell

# Human Nature and the *Character* of Change . . .

There are certain characteristics of being human that pose a special challenge when change — especially radical or traumatic change — occurs.

1. People find comfort in being able to maintain control over the events and circumstances of their lives. The most basic and fundamental level in Abraham Maslow's *Hierarchy of Needs* represents this core characteristic of human nature. Satisfying this basic need gives people a sense of stability, security and safety.

2. With this basic need being met, people develop self-confidence and psychological health and integration by building stable and effective relationships with others.

3. Much of our sense of control, comfort, and psychological well-being results from the degree of certainty we have about the path of our life. When our experience matches our own expectations about our future, we feel a measure of control and certainty.

4. Change disrupts our ability to predict with certainty what's in store for us tomorrow. When change threatens our capacity to envision our own future, when it seems to jeopardize our future safety and security, and when it jeopardizes our relationships with others, we can be plunged into insecurity, self-doubt, confusion, fear, anxiety, and even depression.

5. The more that a given change or set of changes disrupts our sense of self and our ability to envision our future with a degree of certainty, the more confusion, fear, anxiety, and self-doubt we are likely to experience.

6. Resilience gives us the capacity to survive — even thrive in — a radically changing environment.

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# The Characteristics of Resilient People

## The Eight Dimensions of Resilience

- ❑ ________________________________: Display a sense of security and self-assurance that acknowledges that life is complex and challenging but filled with opportunity. Develop a positive outlook about yourself, your work unit or team, the organization, and life in general.
- ❑ ________________________: Develop a clear vision of what you want to achieve or accomplish and where you want to go in your job, career, and life. Identify what you believe, what you value, and what you need to do to translate your personal and professional goals into reality. This dimension can include your faith and spirituality.
- ❑ ________________________________: Be sensitive to the forces of change. Demonstrate adaptability and flexibility in the face of uncertainty and stress. Accept the need to shift and redefine (if necessary) your direction, focus, and vision as you learn new information from the environment, peers, customers, family, and other sources.
- ❑ ________________________: Develop personalized methods, structures, and systems for organizing and managing the confusion, chaos, and ambiguity. Develop stable structures to ride out a turbulent storm. If necessary, focus on one day, one week, one project, etc. at a time.
- ❑ _______________________________: Develop the capacity to effectively think through and resolve personal and professional problems. See problems as challenges and opportunities. Fine-tune your skills of collaboration with others and such fundamental skills as critical, systemic, and creative "out-of-the-box" thinking.
- ❑ __________________________________________: Demonstrate responsiveness, empathy, and caring for others. This quality also involves communicating effectively with others, displaying a sense of humor—an ability to laugh at yourself, and valuing diverse perspectives.
- ❑ _________________________________: Build bridges and form partnerships with the people around you. Work with others to discover ways to make sense of the changing environment. Share ideas, solutions, problems, frustrations, opportunities, and accomplishments. Focus on discovering areas of common ground and answers to common problems.
- ❑ ________________________: Engage change directly rather than denying, fighting, or working against it. Accept that change is inevitable, growth is optional, and find a way to make it work FOR you. Focus on what YOU can do, not on what others are doing to you. Actively work to improve or positively influence an unwelcome change.

# Resilience Resources


American Psychological Association (various authors). *The Road to Resilience*. Washington, D.C.: Online booklet, American Psychological Association, http://helping.apa.org, 2004.

Bridges, William (1991). *Managing Transitions*. Reading, MA: Addison-Wesley Publishing Company, Inc.

Brooks, Robert, and Sam Goldstein (2004). *The Power of Resilience*: *Achieving Balance, Confidence, and Personal Strength in Your Life*. New York: McGraw-Hill, Contemporary Books.

Connor, Daryl R. (1992). *Managing at the Speed of Change.* New York: Villard Books, Random House.

Frankl, Viktor (1963). *Man's Search for Meaning*. New York: Pocketbooks, Simon & Schuster.

Reivich, Karen, and Andrew Shatté (2002). *The Resilience Factor: 7 Essential Skills for Overcoming Life's Inevitable Obstacles*, New York: Broadway Books, Random House.

Russell, Jeffrey, and Linda Russell (2006). *Change Basics*. Alexandria, VA: ASTD Press.

Russell, Jeffrey, and Linda Russell (2003). *Leading Change Training*. Alexandria, VA: ASTD Press.


**Just for Renal Network of the Upper Midwest Members:**

www.RQNetwork.org

A resource developed by Russell Consulting, Inc. and usually only available to the licensed users of the RQ. Lots of information about resilience, the RQ, and each of the eight RQ dimensions.

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# Identifying Risk for Violence in a Dialysis or Transplant Facility

**Joel Lashley**
**Vistelar Conflict Prevention and Management**
**Milwaukee, WI**

# Identifying Risk for Violence in a Dialysis or Transplant Facility

Joel Lashley - VISTELAR

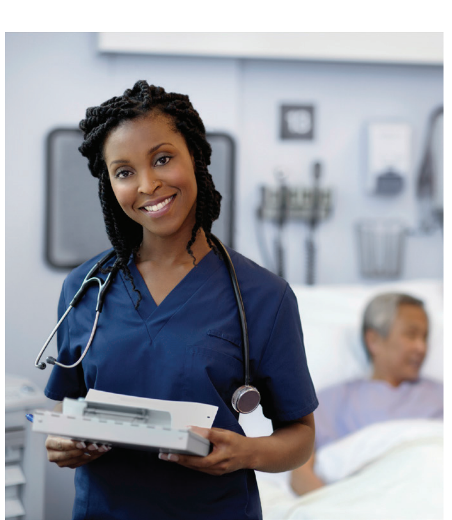
## Working in the healthcare profession should not require you to be a victim

Healthcare is by far the most violent profession. Nearly seven in every ten non-fatal assaults on American workers that are serious enough to result in time off from work are perpetrated against healthcare workers. But does it really have to be that way?

If you are a healthcare provider, this workshop will change the way you think and feel about workplace violence. More importantly, the strategies you'll learn will keep you safer.

At this 1:00 PM breakout session, Joel Lashley will share how to identify behaviors that are likely precursors to violence and specific "*non-escalation*" strategies to prevent emotional or physical violence from erupting.

Joel will walk through the process of creating environments of care that are less compatible with anti-social and aggre ssive behaviors while being more compatible with patient collaboration and better patient outcomes.



**In addition, you will learn:**

- How to form therapeutic relationships that are incompatible with violence
- How the same strategies that support peaceful environments also increase patient satisfaction
- How traditional beliefs about violence and crisis intervention strategies have actually contributed to the problem of violence in healthcare

# Recognizing Violence
# what people look and sound like before they attack

**STAMP**—pattern of behavior that indicates a patient may be escalating towards violence

- Staring and Eye Contact (conspicuously ignoring, thousand-yard stare, staring you down, Tone and Volume of Voice (yelling, cursing, angry tone)
- Anxious Behaviors (rocking, exaggerated fidgeting or "Stimming")
- Mumbling (talking under the breath or talking to self)
- Pacing (won't or can't stay seated)

(STAMP developed by Dr. Lauretta Luck, University of Western Sydney School of Nursing and Midwifery)

**Pre-Attack Postures**—how people behave just before they strike

- Blading the body (standing at an angle, shifting weight from side to side, or shifting shoulders)
- Crowding (in your space/in your face)
- Making fists (balling up the fists or clenching and unclenching the hands)
- Target glancing (looking you up and down)
- Active resistance and dead weight (resistive tension during patient moves or routine cares)

**10-5-2 Proxemics**—strategy for evaluating, approaching, or avoiding patients

- TEN FEET— evaluate for STAMP and pre-attack postures or exit the scene if necessary
- FIVE FEET—communicate using the Universal Greeting and evade if necessary

The Universal Greeting

| | | |
|---|---|---|
| 1. | Appropriate greeting | "Good morning" |
| 2. | Name and role/title | "I'm Jennifer, your technician for today" |
| 3. | Reason for contact | "I'll be assisting you with your procedure" |
| 4. | Ask a relevant question | "Did you eat breakfast this morning?" |

- TWO FEET—Operate, begin treatment and escape if assaulted

**Gateway Behaviors of Violence**—pattern of behavior that builds to a violent outcome when it is uninterrupted

Step 1…unanswered verbal disrespect leads to implied threatening….

Step 2…unanswered implied threatening leads to overt threatening…

Step 3…unanswered overt threatening leads to physical assaults…

Definitions of Gateway Behaviors:

- Verbal disrespect = yelling, cursing, and name calling
- Implied or veiled threat = "Send that nurse in here again and she'll be sorry!"
- Overt threat = "Stick me again with that thing and I'll knock you out!"
- Physical assault = shoving, spitting, hitting, kicking or worse!

**The Persuasion Sequence**—verbal strategy for gateway behavior

1. Ask
2. Tell them why
3. Offer options, not threats
4. Give a second chance
5. Take appropriate action

Ask
"Mr. Johnson, Can I ask you please not to yell and curse?"

Tell them why
"You are disturbing/frightening the other patients."

Offer options, not threats
"You have some good choices, Mr. Johnson. If you stop yelling and cursing, I can work on making you more comfortable. But if you insist on yelling and cursing, we will have to call security/police (or other appropriate action)"

Give them a second chance
"Mr. Johnson, is there anything I can say to get you to stop yelling and cursing before I have to (appropriate action)?"

Take appropriate action
(call supervisor, security, police, discharge patient, or other appropriate action depending on circumstance or level of threat)

# - NOTES -

# Vistelar

*Addressing The Entire Spectrum Of Human Conflict*

Vistelar is a global consulting and training organization focused on addressing the entire spectrum of human conflict — from interpersonal discord, verbal abuse and bullying — to crisis communications, assault and physical violence.

Training in our structured methodology reduces complaints, liability and injuries, while improving performance, morale and overall safety — with clients (customers, perpetrators, patients, students, inmates, coaches, parents, etc.), among team members and in people's personal lives.

While Vistelar's focus in on preventing conflict and managing its negative consequences at the point-of-impact — the short period of time when a tense situation can escalate to emotional and/or physical violence — our training affects a wide range of situations, from the outcome of brief encounters to the quality of long term relationships.

Vistelar's instructor-led programs are delivered in-person and online using Emotionally Safe Performance-Driven Instruction™. This proprietary "fire drill versus fire talk" training system improves retention and ensures students can actually perform the learned skills in their daily lives.

Speaking engagements, online courses and published books provide additional opportunities to learn Vistelar's proven non-escalation, de-escalation and defense strategies and tactics.

Since the early 1980s our consultants have trained hundreds of thousands throughout the world within14 market sectors below. To learn more, please visit ww.vistelar.com or call 877-690-8230

## Joel Lashley

Joel Lashley has worked in the field of public safety for over thirty years and has worked continuously in the field of healthcare security since 1991.  Mr. Lashley has extensive firsthand experience keeping the peace in hospital emergency departments, trauma centers, residential facilities and clinics, most of which were located in the very same neighborhoods where gang violence and even homicide are a feature of daily life.  His experience has led to a career developing training programs, policies, and procedures for the prevention and management of healthcare violence.

Mr. Lashley has provided training and consulting for healthcare professional organizations, crisis intervention training companies, hospitals and health systems and law enforcement agencies, all of whom are concerned with the epidemic levels of violence in healthcare.  Many of his principles of violence prevention, such as the gateway behaviors of violence and seven myths of violence in healthcare are changing the way providers and hospital administrators approach the unique problems surrounding violence in healthcare.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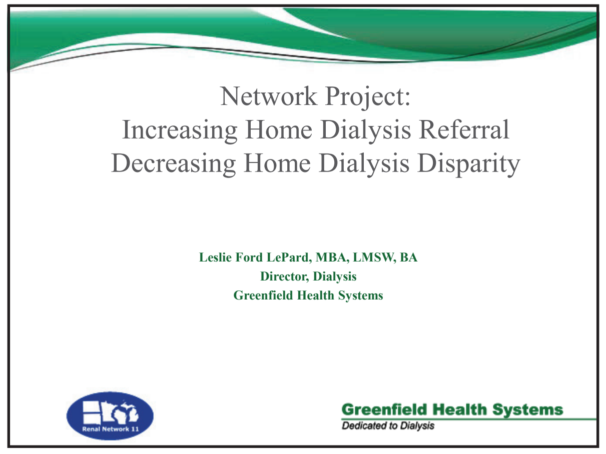
# Increasing Home Dialysis Referral

**Leslie Ford LePard, MSW**
**Greenfield Health Systems**
**Detroit, MI**




## Flow

- Brief overview of Greenfield Health Systems
- Project: Increasing Home Referrals
  Decreasing Disparity
  – Basic review of equity/disparity concepts
  – Project Background
  – Project Process
  – Project Outcomes
  – Lessons Learned
  – Next Steps

Greenfield Health Systems
*Dedicated to Dialysis*

## Overview:
## Greenfield Health Systems

Greenfield Health Systems
*Dedicated to Dialysis*

## Greenfield Health Systems

- Based in Detroit Metropolitan Area
- 11 Incenter Units with attached Home Programs
- 4 Home Only Programs
- Approximately 1800$^{+}$ patients
- Units ranging from 80 to over 300 patients
- Unit ranging from 13 to 48 stations

Greenfield Health Systems
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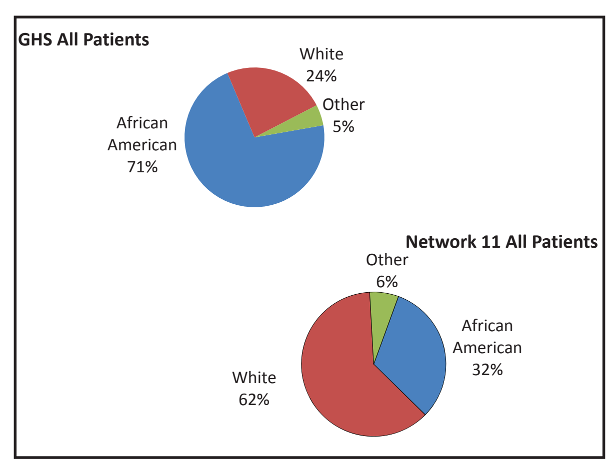


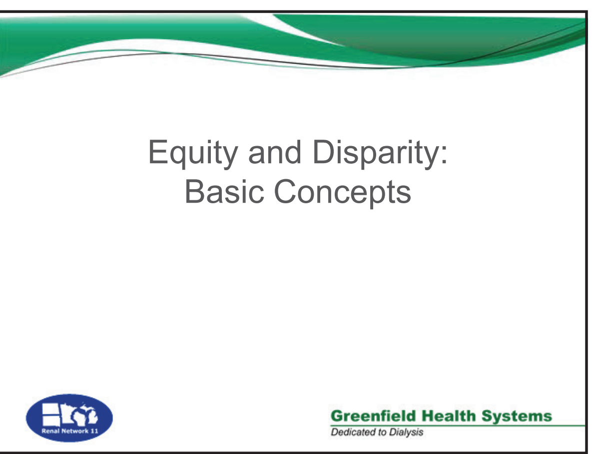

## Health Inequity

- Health inequity can be defined as the unfair and avoidable differences in health status seen within and between various populations (World Health Organization).
- For example, there may be variations in rates of disease occurrences and disabilities between populations, or differences in access to or availability of facilities and services.

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## Health*care* Inequity

- Health***care*** inequity can be defined as the differences in care quality between various populations that are not justified by differences in access, health status, or the preferences of the group (IOM).
- For example, African American men and women have a higher risk of ESRD despite presence or absence of diabetes or hypertension.
- This type of disparity relates to the project we are talking about today.

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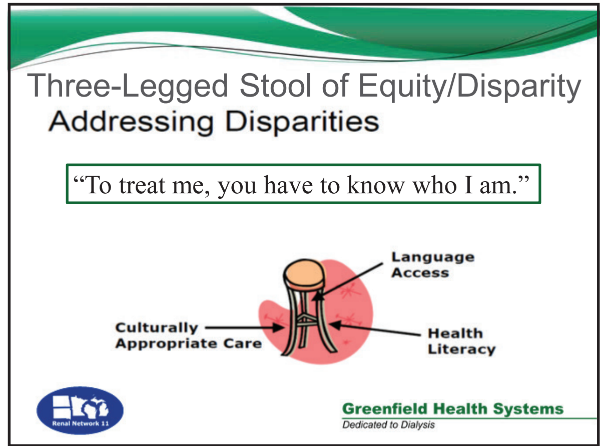


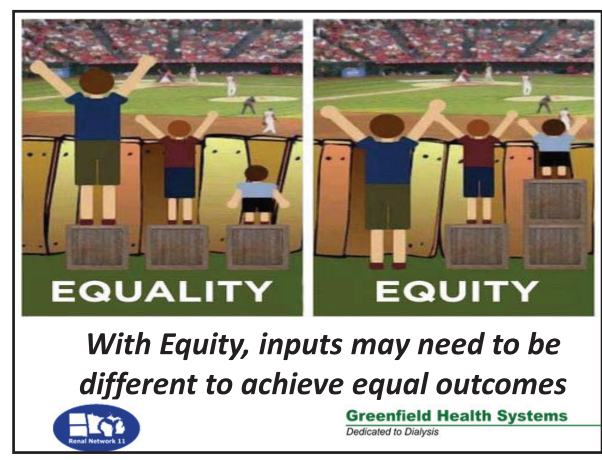


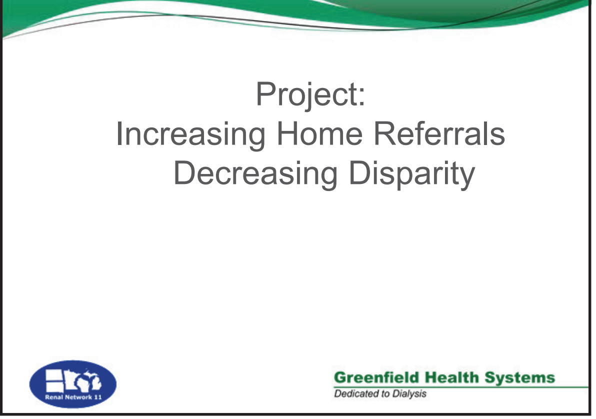

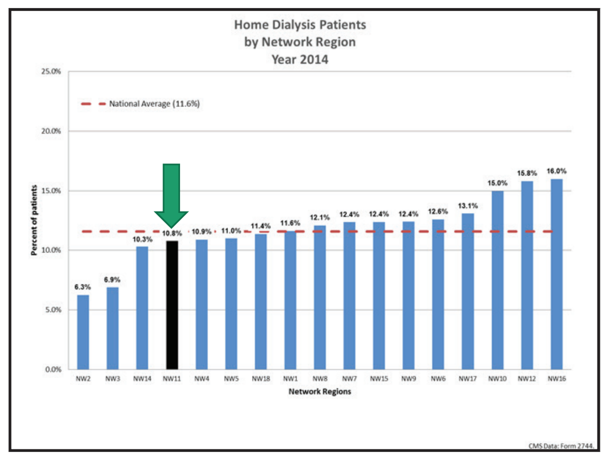


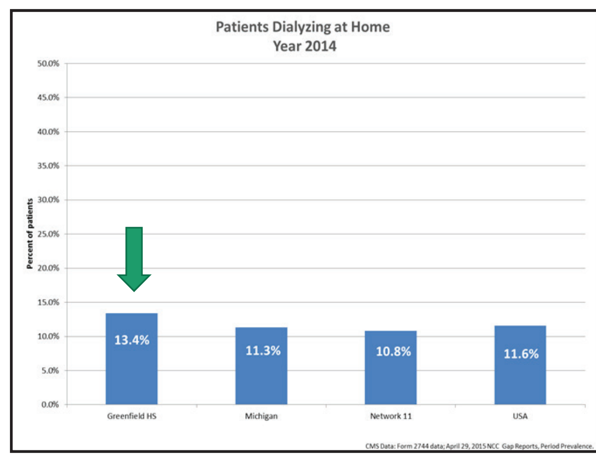


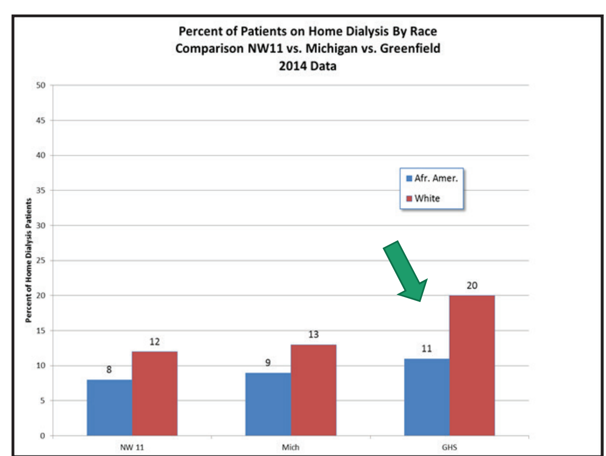


## Project Objectives

- Increase percent of patients referred for home dialysis by 5%
- Decrease disparity in referrals by 1%
- Project defines race categories as African American, White, Other
- Project defines Home eligibility as alive and on dialysis; community characteristics not considered
- Project timeline: May 2015 – September 2015

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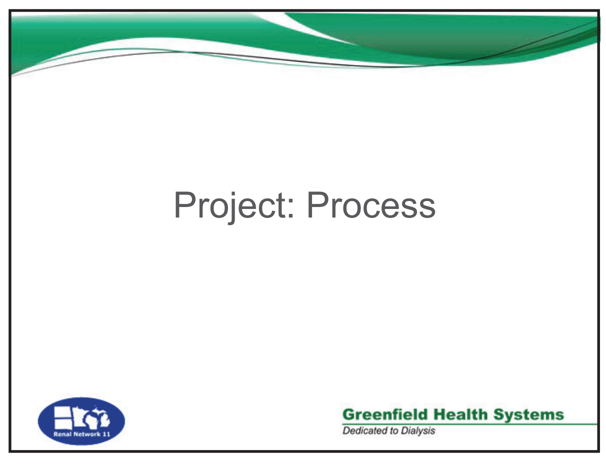


## Action Steps

- Committee
  - Network members
  - Administration
  - Social Work Manager
  - Social Worker
- Data
  - Baseline
  - Monthly
- Tools
- Education
  - Nurse Managers
  - Administrators
  - Home Nurses
  - Unit Teams
  - Incenter Patients
- Patient Focus Interviews
- Monthly “Touch Base”
- Periodic unit “Check Ins”

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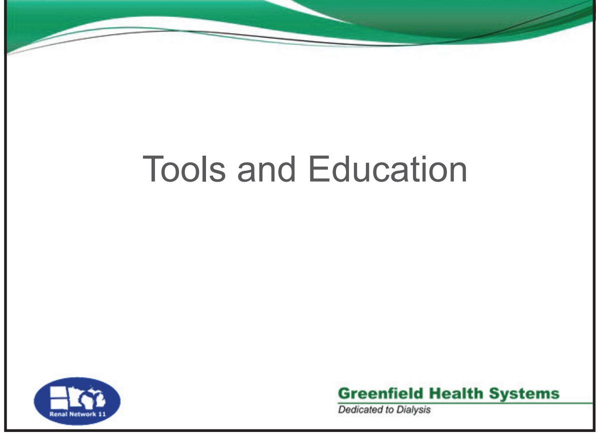


## Webinar Content

- Equity and Disparity Concepts
- Psychosocial Aspects
- Clinical Aspects
- Patient Personal Perspective

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## Scenario #1

- Young African American Male in his early 30's
- 1 failed transplant
- Relocation issues in his personal living situation
- Noncompliant
- Unreliable transportation; usually comes by bus
- Periodic bed bug issues
- Only social support is a girlfriend
- Needs a lot of assistance in life

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## Scenario #2

- White male, mid-50's
- Fluid overload, oxygen dependent
- 4 treatments/week incenter
- Extreme weakness after every treatment
- All he does is sleep
- Blood pressure issues
- Looks very frail and ill
- Has supportive wife

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## Scenario #3

- Young white male in his 30's
- Lived with his brother but brother died suddenly
- Has relative out of state who is impaired
- Unstable living circumstances
- Schizophrenic

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Would you talk with this person about Home Dialysis?

Would you make a home referral?

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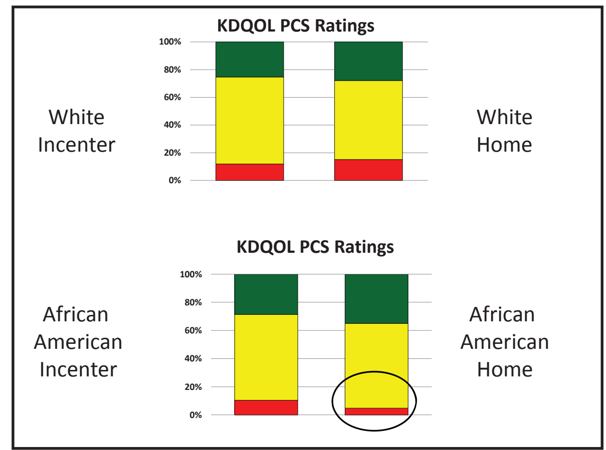
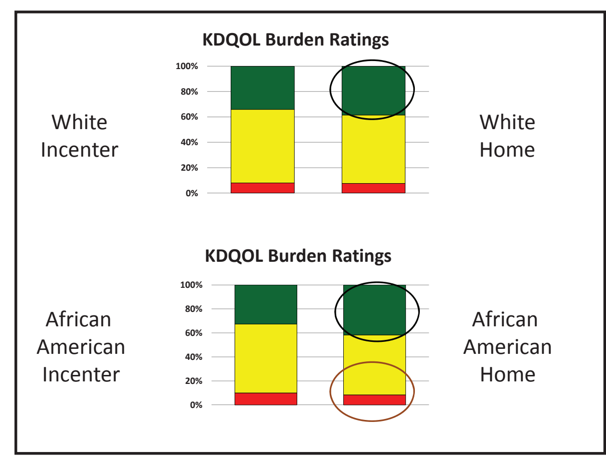
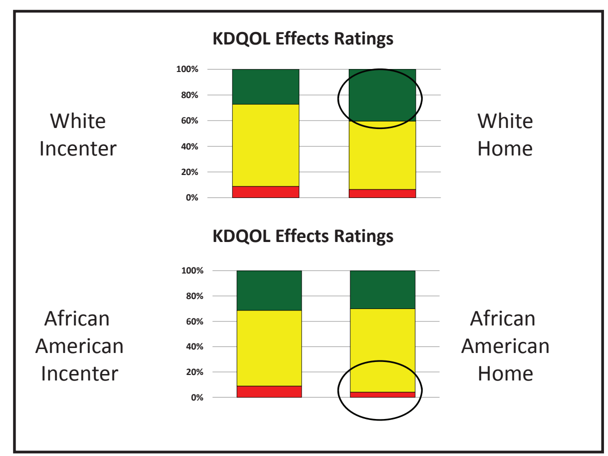
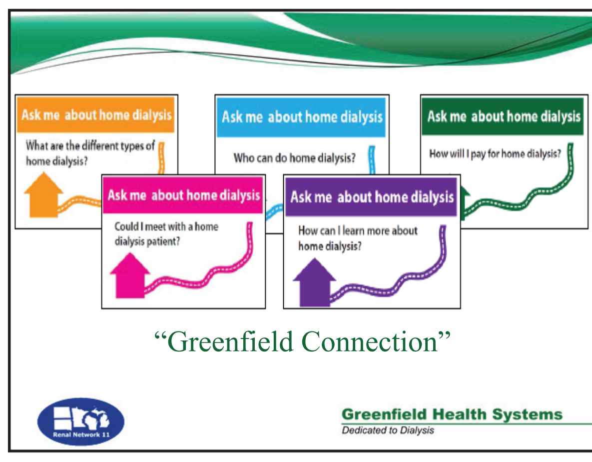
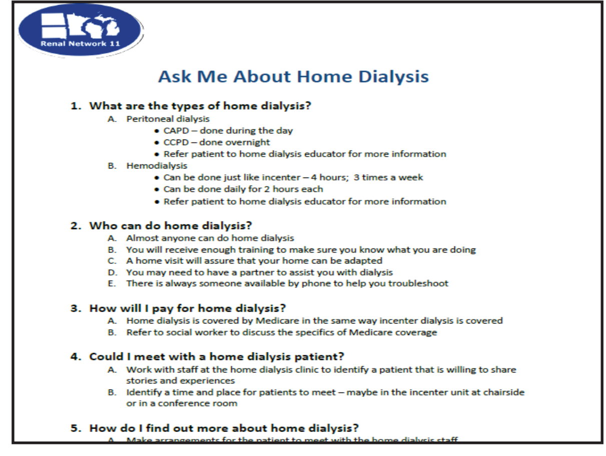


Renal Network 11

## Ask Me About Home Dialysis

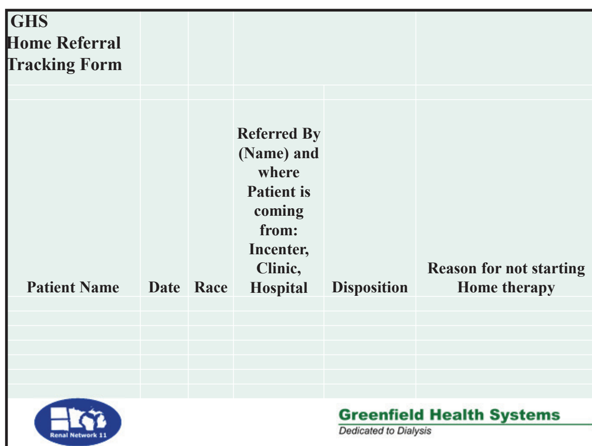
1. **What are the types of home dialysis?**
   - A. Peritoneal dialysis
     - CAPD – done during the day
     - CCPD – done overnight
     - Refer patient to home dialysis educator for more information
   - B. Hemodialysis
     - Can be done just like incenter – 4 hours; 3 times a week
     - Can be done daily for 2 hours each
     - Refer patient to home dialysis educator for more information

2. **Who can do home dialysis?**
   - A. Almost anyone can do home dialysis
   - B. You will receive enough training to make sure you know what you are doing
   - C. A home visit will assure that your home can be adapted
   - D. You may need to have a partner to assist you with dialysis
   - E. There is always someone available by phone to help you troubleshoot

3. **How will I pay for home dialysis?**
   - A. Home dialysis is covered by Medicare in the same way incenter dialysis is covered
   - B. Refer to social worker to discuss the specifics of Medicare coverage

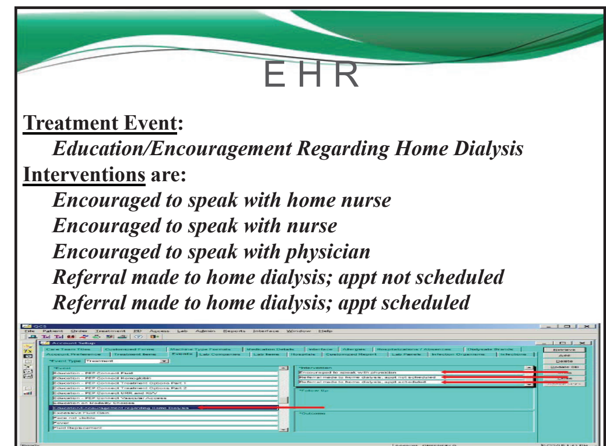
4. **Could I meet with a home dialysis patient?**
   - A. Work with staff at the home dialysis clinic to identify a patient that is willing to share stories and experiences
   - B. Identify a time and place for patients to meet – maybe in the incenter unit at chairside or in a conference room

5. **How do I find out more about home dialysis?**
   - A. Make arrangements for the patient to meet with the home dialysis staff



GHS
Home Referral
Tracking Form

| Patient Name | Date | Race | Referred By (Name) and where Patient is coming from: Incenter, Clinic, Hospital | Disposition | Reason for not starting Home therapy |
|---|---|---|---|---|---|
| | | | | | |




## Patient Focus Interviews

- Phone Interviews
  - 3 AA patients who chose Home Dialysis
  - 3 AA patients who did not choose Home Dialysis
  - 3 W patients who chose Home Dialysis
  - 3 W patients who did not choose Home Dialysis
- Members of committee and Network participated

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## Patient Focus Interviews

- Goals:
  - To understand what different "inputs" may be needed
  - To understand why they made the decision they did regarding treatment modality
  - To understand how they received information about home dialysis and from whom
  - To seek input on what we did well and/or what we could have done differently
  - To seek input on any general advice they had for us

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## Home Educational Seminar

- Our second annual educational seminar coincided with time of the project
- Target audience: inpatient and outpatient team members who work with dialysis patients but are NOT home dialysis staff
- Network member attended

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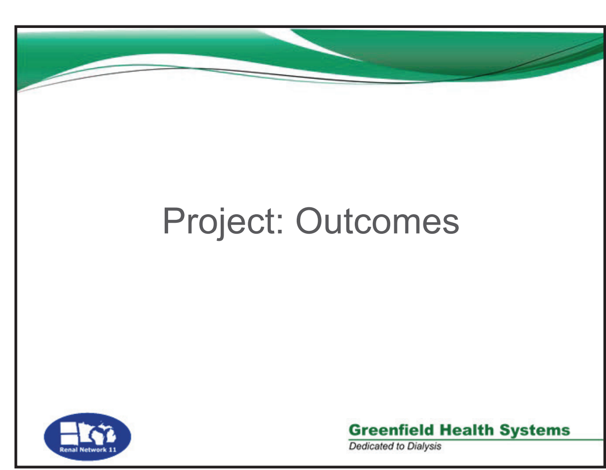

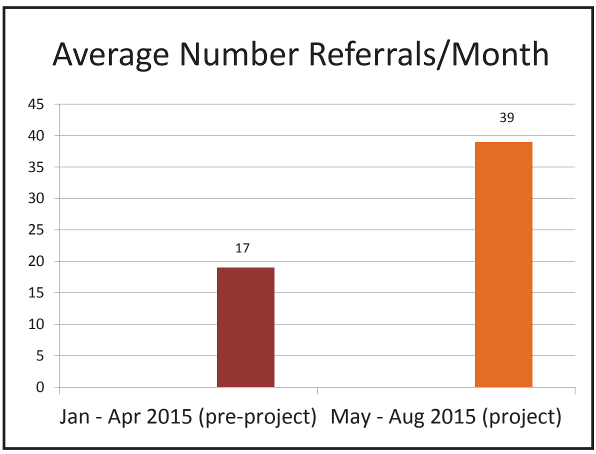


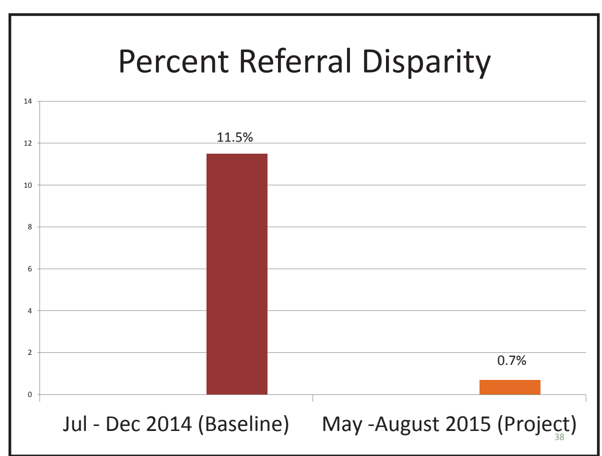


## Patient Voices

- Identified issue of non-nephrology MDs
- Recommended more focus on the burden aspect of home dialysis AND that it is simpler than it seems, especially PD
- Stress that people do better and feel better on home dialysis and that traveling is easier
- Help people separate others' experience from their own potential
- "Pre-classes" helpful

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## Patient Voices

- Did not identify a race disparity contributor; one did suggest youth as potential contributor
  - Nephrologist, social worker, clinic AP, floor clinical team, NM, RD
  - Gender, race, age
- Did identify as significant:
  - Persistence, persistence, persistence
  - Personal, individualized, caring
  - Speaking with other patients
  - Clarifying misconceptions ("end of life", "too much cleaning", "always have a partner", "catheter is size of garden hose", "can't see your same kidney MD"; "left on your own")

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## Project: Lessons Learned

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## Project: Lessons Learned

- Overall feedback from units was that the stickers made it easier to generate conversation with patients around topic of home dialysis
- Some clinical people stated they still felt uncomfortable as they were not "experts" in home dialysis
- Some reported feeling a lack of MD support
- Some expressed concern about their own job

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## Project: Lessons Learned

- Use of peer mentors/other patients is very important
- Documentation is always a challenge but valuable; queryable entries helpful in tracking compliance
- Could involve our acute programs more going forward
- More frequent "unit updates" may be helpful
- Likely need more time than project time frame

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## Project: Next Steps

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## Project: Next Steps

- Implement "auto-referral" process/new patients
- Seminar/webinar for:
  - MDs, Fellows, Advanced Practitioners
  - Home Champs
  - RDS, MSWs, RCs, Other
- Further evaluate acute role
- Continued focus on documentation process
- Deeper penetration of the peer mentor opportunities

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## Final Thoughts from Patients

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"I just went on vacation for 30 days. Home dialysis gives me freedom. I can eat different things, more than others can do. When you are on incenter dialysis, you are 'end stage'. When you are on home dialysis, you are 'end stage'. I accept that. I want to live until the end of my life. Home dialysis helps me do that and I am grateful."

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"Tell them life is short. Tell them life changes in a moment. Kidney failure does not have to be the end of enjoying your life. Grab life while it is here. Grab life while you can. Take the opportunity presented to you and go home."

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# Strategies to De-escalate Potential Violence

**Joel Lashley**
**Vistelar Conflict Prevention and Management**
**Milwaukee, WI**

# Strategies to De-escalate Potential Violence

Joel Lashley - VISTELAR

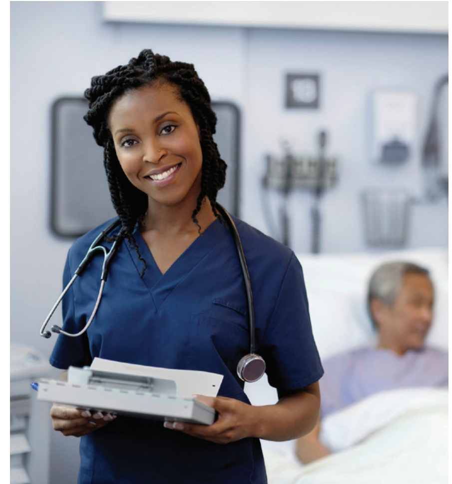
## Creating An Environment Of Care That Is Incompatible With Violence

Healthcare is by far the most violent profession. Nearly seven in every ten non-fatal assaults on American workers that are serious enough to result in time off from work are perpetrated against healthcare workers. But does it really have to be that way?

If you are a healthcare provider, this workshop will change the way you think and feel about workplace violence. More importantly, the strategies you'll learn will keep you safer.

At the 1:00 PM breakout session, Joel Lashley will discuss how to identify behaviors that are likely precursors to violence and specific "non-escalation" strategies to prevent emotional or physical violence from erupting. In this 2:00 PM breakout session, he will share how to de-escalate violence if the non-escalation strategies fail.

Joel will walk through Vistelar's *Point-Of-Impact Crisis Intervention*™ strategies which are specific to de-escalating patients who are in crisis.



**In addition, you will learn:**

- How to form therapeutic relationships that are incompatible with violence
- How the same strategies that support peaceful environments also increase patient satisfaction
- How traditional beliefs about violence and crisis intervention strategies have actually contributed to the problem of violence in healthcare

## Point-Of-Impact Crisis Intervention (PICI) - strategies for de-escalating patients in crisis

1. Reduce stimulation—fewer voices, less light and less sound
   - One voice command
   - Lowering lights to a safe level
   - Lower volumes on televisions, managing alarms, etc.
2. Separate and support—remove them from the scene or remove the scene from them
   - Provide for privacy and move if possible, or close curtains, set up screens
   - Remove unnecessary personnel and bystanders
   - Summon psych crisis personnel if available
   - Transport by EMS to more capable facility if necessary
3. Adapt communication
   - Use their name frequently
   - Confident and concerned expression
   - Reverse yelling
   - Five simple words or less/ be direct/ state the obvious
   - Pause to allow time to process questions and requests
4. Manage their urgent unmet needs
   a. Comfort
   b. Hunger/thirst
   c. Pain
   d. Toileting
   e. Urgent information
   f. Support person

# Glossary

**Adapt communication**
A trained technique comprised of the following nine tactics, intended to both de-escalate people in active crisis, as well as, communicate with people who have communications challenges: 1) cognitive engagement/distraction, 2) economy of words, 3) frequent naming, 4) if/then tactic, 5) latency directive cycle, 6) one voice command, 7) stating the obvious, 8) tactical civility, 9) tell-show-do.

**Cognitive latency**
Unusually long period of time required to react to a spoken request or command, observed when a subject may require 20 or more seconds to react when asked to do something.

**Economy of words**
The use of five simple and direct words or less, when communicating with persons who are under stress or in active crisis. Also useful for communicating with people who have cognitive or communications challenges.

**External stimulation**
Sources of stimulation that can cause stress or active crisis, e.g., sound, light, voices, reflective surfaces, excessive movement, voices and the human presence.

**Frequent naming**
A communications tactic where a speaker uses a subject's name frequently, in an effort to establish and maintain communication.

**If/then tactic**
A trained tactic used to offer choices to a subject with cognitive challenges during a persuasion sequence. [Example: "First, lie down on the gurney then we can take you home."]

**Latency directive cycle**
A trained communications tactic used to communicate with persons who may struggle with cognitive latency, in which a speaker waits 20 to 30 seconds before repeating a request or command.

**One voice command**
A spoken command intended to restore voice discipline at the scene. A non-escalation tactic used to counter verbal overload. Also a de-escalation tactic used to restore voice discipline during a crisis.

**Point of Impact Crisis Intervention (PICI)**
A crisis intervention skill set designed to de-escalate clients and subjects involved in active crisis, composed of four techniques: 1) reduce stimulation, 2) separate and support, 3) Adapt communication, 4) Meet urgent needs first

**Reduce stimulation**
A trained technique intended to reduce external stimulation during emotional crises, in an effort to de-escalate violent and/or self-destructive behavior, e.g., multiple voices, loud talking, and excessive talking; excessive light and flashing light; emergency sirens, medical alarms, handi-talkies and loud music; excessive movement, threatening/agitating persons and bystanders; excessive clutter, reflective surfaces, and attractive nuisances.

**Separate and support**
A trained technique intended to create an environment that is incompatible with crisis-related behavior, by removing the subject from the scene or removing the scene from the subject.

**Tell, show, do**
A communications tactic, in which a speaker asks someone to do something then demonstrates the required task and finally waits 20 to 30 seconds before repeating a request or command.

**Unmet needs**
Sources of internal stimulation that contribute to stress or active crisis, e.g., hunger, thirst, fatigue, fear, pain, toileting, lack of vital information.

**Verbal overload**
Sources of external stimulation involving the human voice. Examples of verbal overload are: 1.) Everyone is speaking at once, either over-lapping their voices or speaking in sequence. 2.) Frequently repeating the same request or command without pausing or paraphrasing. 3.) Talking to loud, talking too fast, or using too many words.

**Voice discipline**
A trained team tactic developed to prevent verbal overload. Use of the one voice command is used to establish and maintain voice discipline.

# - NOTES -

# - NOTES -

# Vistelar

*Addressing The Entire Spectrum Of Human Conflict*

Vistelar is a global consulting and training organization focused on addressing the entire spectrum of human conflict — from interpersonal discord, verbal abuse and bullying — to crisis communications, assault and physical violence.

Training in our structured methodology reduces complaints, liability and injuries, while improving performance, morale and overall safety — with clients (customers, perpetrators, patients, students, inmates, coaches, parents, etc.), among team members and in people's personal lives.

While Vistelar's focus in on preventing conflict and managing its negative consequences at the point-of-impact — the short period of time when a tense situation can escalate to emotional and/or physical violence — our training affects a wide range of situations, from the outcome of brief encounters to the quality of long term relationships.

Vistelar's instructor-led programs are delivered in-person and online using Emotionally Safe Performance-Driven Instruction™. This proprietary "fire drill versus fire talk" training system improves retention and ensures students can actually perform the learned skills in their daily lives.

Speaking engagements, online courses and published books provide additional opportunities to learn Vistelar's proven non-escalation, de-escalation and defense strategies and tactics.

Since the early 1980s our consultants have trained hundreds of thousands throughout the world within14 market sectors below. To learn more, please visit www.vistelar.com or call 877-690-8230

## Joel Lashley

Joel Lashley has worked in the field of public safety for over thirty years and has worked continuously in the field of healthcare security since 1991. Mr. Lashley has extensive firsthand experience keeping the peace in hospital emergency departments, trauma centers, residential facilities and clinics, most of which were located in the very same neighborhoods where gang violence and even homicide are a feature of daily life. His experience has led to a career developing training programs, policies, and procedures for the prevention and management of healthcare violence.

Mr. Lashley has provided training and consulting for healthcare professional organizations, crisis intervention training companies, hospitals and health systems and law enforcement agencies, all of whom are concerned with the epidemic levels of violence in healthcare. Many of his principles of violence prevention, such as the gateway behaviors of violence and seven myths of violence in healthcare are changing the way providers and hospital administrators approach the unique problems surrounding violence in healthcare.

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# Best Practices in Infection Control

**Wendy Phillips, RN**
**Purity Dialysis**
**Southeastern Wisconsin**

## What is NOTICE?

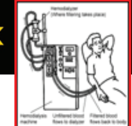
**WHAT:** **N**ational **O**pportunity **T**o **I**mprove Infection **C**ontrol in **E**SRD

**WHO:** Quality improvement project **funded by AHRQ** (Agency for Healthcare Research and Quality) and awarded to…
*HRET - Health Research & Educational Trust
*UM-KECC - Univ of Michigan & Kidney Epidemiology and Cost Center
*Renal Network of Upper Midwest & Southeastern Kidney Council
(To include 60 total dialysis facilities from NW11 & NW6)

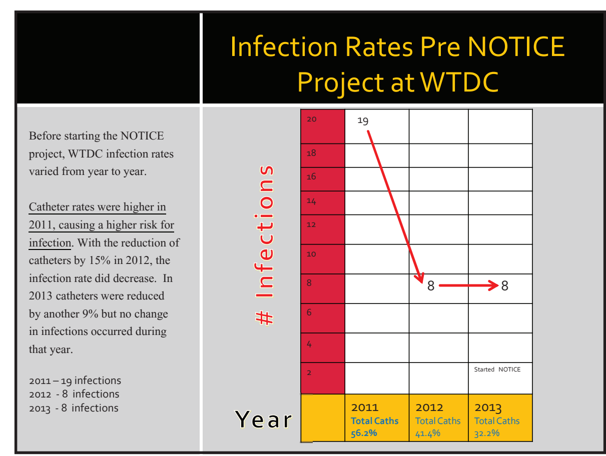
**WHEN:** Project pilot started in early 2013 and lasted 15 months

**OBJECTIVE:** **to use resources that would decrease or eliminate vascular access infections (VIA's) in dialysis facilities, which can lead to sepsis and death**

## Dialysis Patients High Risk



1) Access directly into their blood stream
2) Long-term vascular accesses create a higher risk for infection
3) Often dialysis patients are immunocompromised
4) High risk for contamination from multiple sources in their unit environment- includes staff, supplies, equipment, surfaces, and other patients




## Starting NOTICE

In preparation to start NOTICE….

- Completed a Readiness Assessment – to review what we already do vs what we need to change, and develop Plan
- I created an educational slide show for all staff showing the change in technique pertaining to Catheters and AVF/AVG and shared early to familiarize staff
- Involved our Education Department who created competencies that were then completed on all unit staff, as well as float staff
- Educational binder created for staff reference in unit during project
- Educating patients on access care including washing AVF/AVG before treatment
- Collected Culture of Safety Assessments from all staff
- Had a team meeting

## The NOTICE project involved change and CHARGE!

- **C**ulture of Safety
- **H**and Hygiene
- **A**ccess Site prep and cleansing
- **R**educe and Remove Catheters
- **G**reat Connection/Disconnection Technique
- **E**valuation of Team Infection Control Practices

## Culture of Safety

- Is key in order for change to occur with the least resistance
- Represents a 'safe' environment free from blame or punitive measures promoting open communication, MUST INCLUDE EVERYONE!
- Allows staff and patients to work as a team and bring any concerns or questions to the team to help improve outcomes together.

Examples:

- (Pt – Staff) Patient notices staff member not washing hands after picking pen off floor, pt feels comfortable enough to remind to do so before caring for them, and staff thank them for reminding them
- (Staff-Staff) Staff feel comfortable to bring up infection concerns with other staff by not belittling or reprimanding them, but by teaching and guiding them on proper technique/hand hygiene
- (Staff- Sup) Staff feel comfortable offering suggestions and bringing concerns to the Supervisor without feeling judged
- (Pt- Sup) It is also important to reassure pts they can come to sup with concerns, knowing the concern with be addressed yet kept confidential, (locked comment box also in unit)

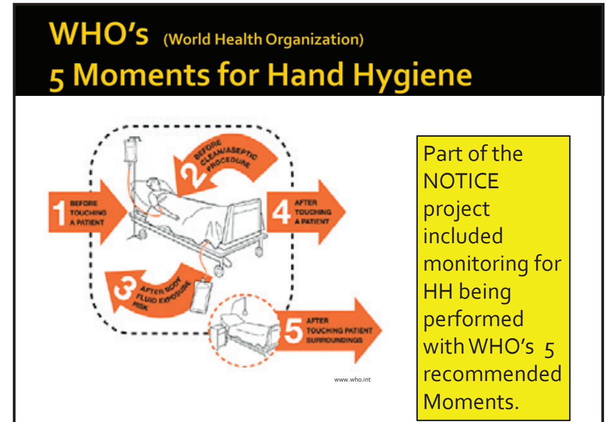
## Culture of Safety Assessments

- A 2 page anonymous assessment - staff opinions on issues that affect the overall safety and quality of care provided to pts
- It includes how they feel the unit works as a team, if they are able to speak up and are taken seriously, communication, effectiveness of changes, supervisor support, etc.
- Collected by Supervisor and reviewed, mailed into NOTICE
- Done pre, mid, and post project
- Benefit – helps Sups be aware of any issues between staff, patients, or leadership style in order to make improvements

## Hand Hygiene

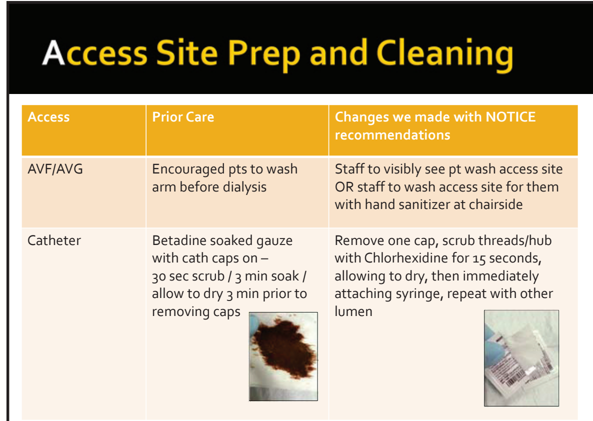
- Most effective for infection prevention!
- Everyone's responsibility (to do and make sure it is being done by others)
- Make sure to have 70% alcohol based hand sanitizer available throughout unit for easy access (staff must wash hands with soap and water minimally after every 10 uses/visibly soiled/C-Diff /etc.)
- Review proper Hand Hygiene

## WHO's (World Health Organization) 5 Moments for Hand Hygiene



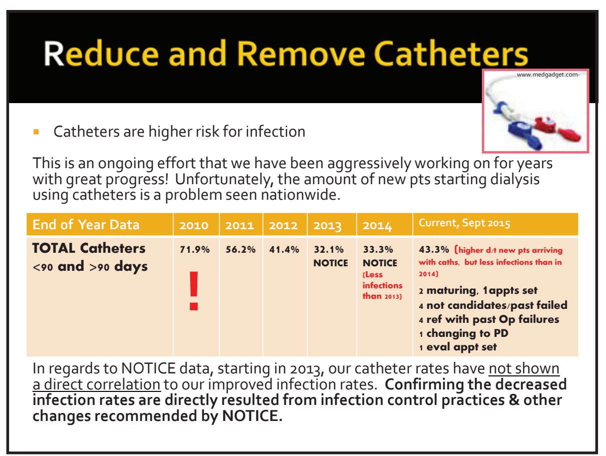

Part of the NOTICE project included monitoring for HH being performed with WHO's 5 recommended Moments.

## Access Site Prep and Cleaning



| Access | Prior Care | Changes we made with NOTICE recommendations |
|---|---|---|
| AVF/AVG | Encouraged pts to wash arm before dialysis | Staff to visibly see pt wash access site OR staff to wash access site for them with hand sanitizer at chairside |
| Catheter | Betadine soaked gauze with cath caps on – 30 sec scrub / 3 min soak / allow to dry 3 min prior to removing caps | Remove one cap, scrub threads/hub with Chlorhexidine for 15 seconds, allowing to dry, then immediately attaching syringe, repeat with other lumen |

## Reduce and Remove Catheters



- Catheters are higher risk for infection

This is an ongoing effort that we have been aggressively working on for years with great progress! Unfortunately, the amount of new pts starting dialysis using catheters is a problem seen nationwide.

| End of Year Data | 2010 | 2011 | 2012 | 2013 | 2014 | Current, Sept 2015 |
|---|---|---|---|---|---|---|
| **TOTAL Catheters <90 and >90 days** | 71.9% ! | 56.2% | 41.4% | 32.1% NOTICE | 33.3% NOTICE (Less infections than 2013) | 43.3% (higher d/t new pts arriving with caths, but less infections than in 2014)<br>2 maturing, 1appts set<br>4 not candidates/past failed<br>4 ref with past Op failures<br>1 changing to PD<br>1 eval appt set |

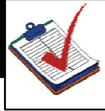
In regards to NOTICE data, starting in 2013, our catheter rates have not shown a direct correlation to our improved infection rates. **Confirming the decreased infection rates are directly resulted from infection control practices & other changes recommended by NOTICE.**

## Great Connection/Disconnection Technique

- This pertains to the total care while initiating and discontinuing dialysis

| | Cath | AVF/AVG |
|---|---|---|
| Directly before accessing | HH & new gloves, then start Scrubbing Hubs | After assessing, prewash access (if pt did not), HH, & new gloves before cleansing and inserting needles |
| Directly after accessing | Remove gloves, HH, new gloves before touching machine | Removing gloves, HH, new gloves before touching machine |
| MISC | Our unit already had been using an alcohol based chlorhexidine to clean cath exits sites when doing dressing changes- Recommended in NOTICE | After bleeding stopped from sites, apply new clean bandage to cover sites |

## Evaluation

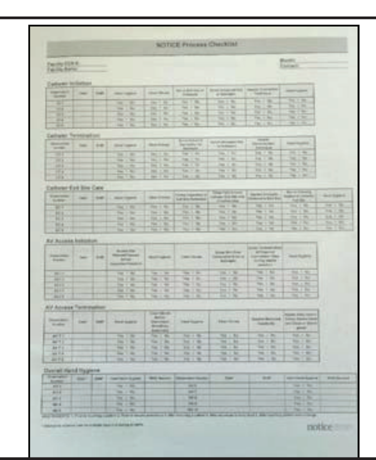


- The last part of CHARGE is the Evaluation
- In order to evaluate we used the NOTICE monthly checklists to audit staff -this assures consistency of care and technique
- If a step was missed, staff were immediately corrected and re educated in positive way
- When observed correctly staff were immediately given positive feedback

## Monthly AUDIT FORM

Staff reminded that consistency is key to maintaining proper skills and accurate data for pilot

Includes HH and steps in ....
1) Catheter Initiations
2) Catheter Terminations
3) Catheter Exit Site Care
4) AVF/AVG Access Initiation
5) AVF/AVG Access Termination
6) Overall HH / 5 WHO Moments



Example larger view of top box -

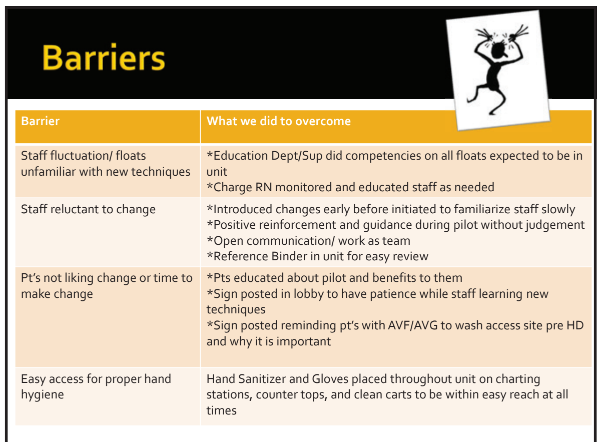
Cath initiation...
*HH pre
*Clean Gloves
*Scrub Hub correctly and timed
*Aseptic connection to lines
*HH post
(Then start HD machine)

**This is observed 5 times each month!**

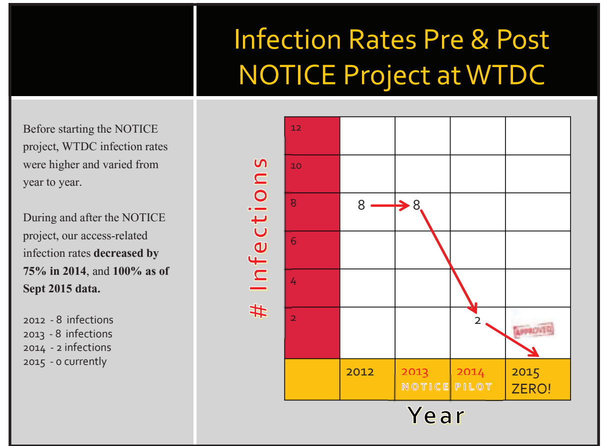
## In addition...

- Monthly team meetings in unit to review and evaluate concerns
- Monthly Content Calls –educational webinars pre and early in pilot
- Monthly Coaching calls with NW11 and NW6 units to share success, barriers, and questions
- Monthly Data entry into CDS (comprehensive data system tool) and NHSN/CDC for Networks to assess outcomes

## Barriers



| Barrier | What we did to overcome |
|---|---|
| Staff fluctuation/ floats unfamiliar with new techniques | *Education Dept/Sup did competencies on all floats expected to be in unit<br>*Charge RN monitored and educated staff as needed |
| Staff reluctant to change | *Introduced changes early before initiated to familiarize staff slowly<br>*Positive reinforcement and guidance during pilot without judgement<br>*Open communication/ work as team<br>*Reference Binder in unit for easy review |
| Pt's not liking change or time to make change | *Pts educated about pilot and benefits to them<br>*Sign posted in lobby to have patience while staff learning new techniques<br>*Sign posted reminding pt's with AVF/AVG to wash access site pre HD and why it is important |
| Easy access for proper hand hygiene | Hand Sanitizer and Gloves placed throughout unit on charting stations, counter tops, and clean carts to be within easy reach at all times |




## Purity Changes as result of NOTICE data

- As a result of the NOTICE Project data in our unit showing significant infection reduction, Purity Dialysis revised their policies for Catheter and AVF/AVG Initiation and Termination
- All 9 Purity Dialysis units in Wisconsin are using the new policy changes

## Efforts to keep what we've learned from NOTICE still in effect!

- Annual competencies on the new policies
- NOTICE Toolkit Audit Form will be used as part of the plan of correction when a rise in infection occurs to assure adherence and rule out causes
- Continue to maintain a positive Culture of Safety in our unit with open communication and consistent expectations
- Continue to attempt to reduce catheters

## NOTICE Project Huge Success!

- With an infection rate reduction of 75% in 2014, and 100% currently in 2015, we feel that all dialysis units would benefit from the information provided in the NOTICE Toolkit.

## RESOURCES

http://www.hret.org/quality/projects/improving-infection-coontrol-practices-ESRD-facilities.shtml
NOTICE Project

http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/esrd/cultureofsafety.html
Culture of Safety

http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/esrd/using-checklists.html
Checklist and Audit Tools

Thank you for participating! Wendy Phillips, RN

# Regional Activities to Improve Care

**Jonathan Segal, MD**
**University of Michigan**
**Ann Arbor, MI**

Network 11 Activities
to Improve Care for
People with Kidney Disease

Jonathan Segal, MD
Chair, Medical Review Committee
October 16, 2015

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## It's been Another Busy Year!

- 10 projects
- 475 facilities in those projects
- Approximately 22,000 patients affected by at least one of the quality improvement projects
- We still have a long ways to go and…

WE NEED YOUR HELP!

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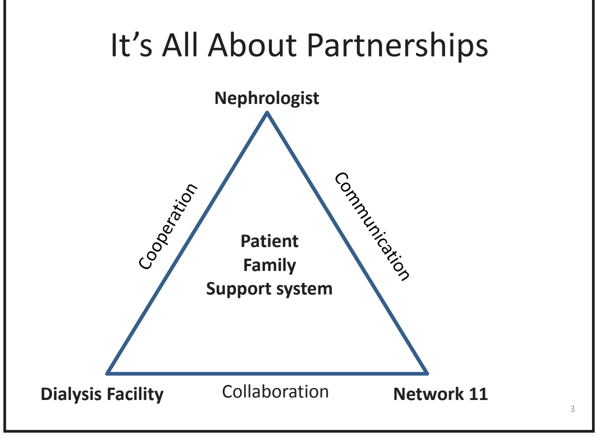
## It's All About Partnerships

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## Engaging Patients Through the EPIC Learning and Action Network **E**ngaging **P**atients to **I**mprove **C**are

During 2015:

- 1098 Incenter HD patients set a personal goal for themselves
- 2874 Incenter HD patients were given specific education regarding the advantages of home dialysis
- 45 patients with a failed transplant were given special support to assist them in the transition to dialysis

4

## Engaging Patients Through the Consumer Committee

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## Engaging Patients Through Peer Mentorship Pilot Project

- 10 facilities participated
- 31 mentors were trained
- 22 patients were mentored
- A total of 65 sessions between mentor and mentee were held
- One social worker commented:

"We will continue to use the peer mentor program as patients are enthusiastic and it benefited our patient population."

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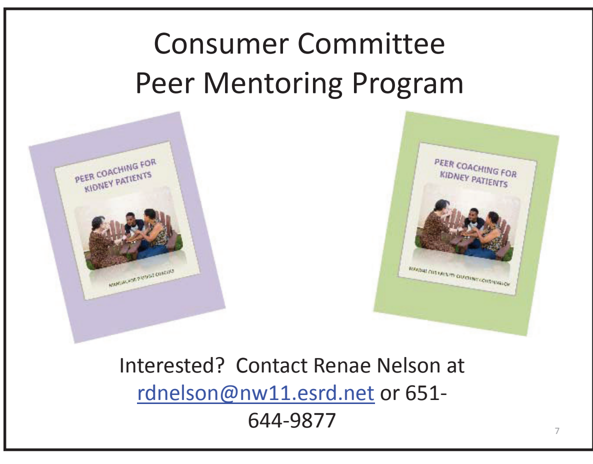


## Help for Patients Transitioning to Dialysis Following Failed Transplant

- Educational resources for patients, staff, and physicians
- Working in tandem with the EPIC workgroup
- Currently no resources available in the renal community
- Will be available for use by the end of the year

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## Engaging Patients In Network Activities

- Consumer Committee (15)
- Executive Committee (2)
- Medical Review Committee (2)
- Forum of ESRD Networks Committees (1)
- Network 11 EPIC Learning and Action Network (16)
- National Patient Learning and Action Network (3)
- Healthcare Associated Infections Workgroup (2)
- Monthly calls with NW 11's Project Officer (1)
- CMS site visit at NW 11 (2)

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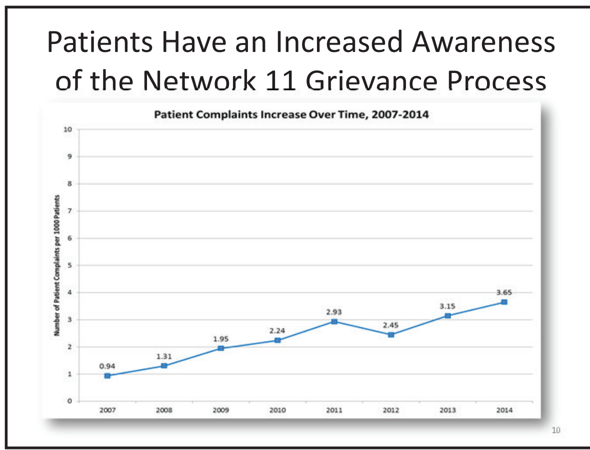


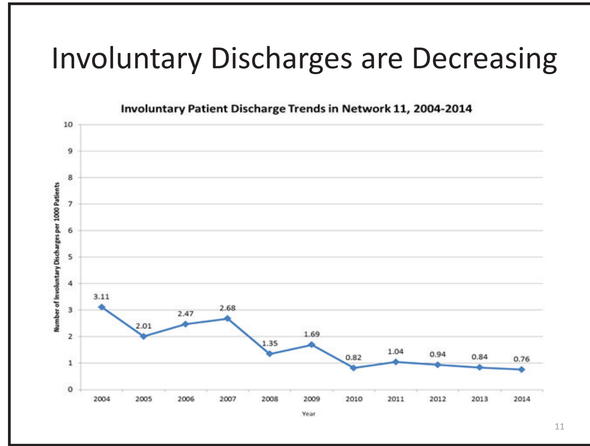


## Healthcare Associated Infections

- Using CDC Tools
- Standardizing processes
- Involving the entire team with special emphasis on developing a partnership between patients and PCTs

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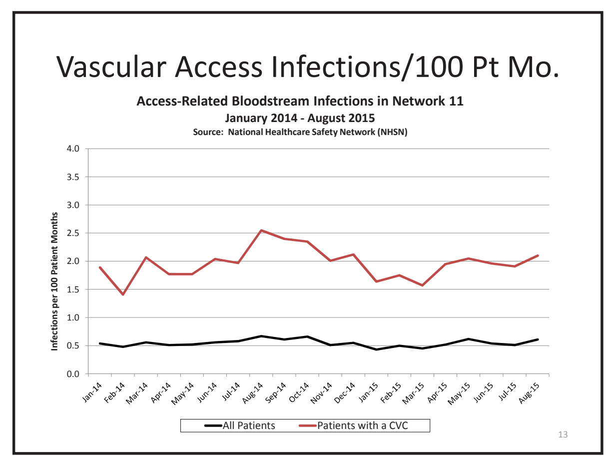


# Fistula First/Catheter Last

- Increased technical assistance
- More involvement from medical directors to drive processes
- Engaging patients in the vascular access process
- Encouraging dialysis facility-surgeon partnerships

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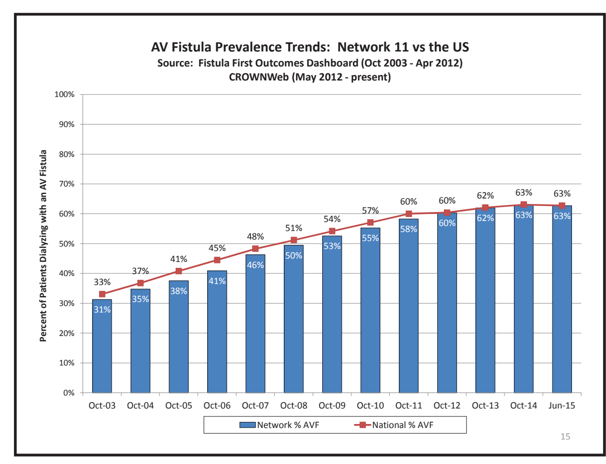
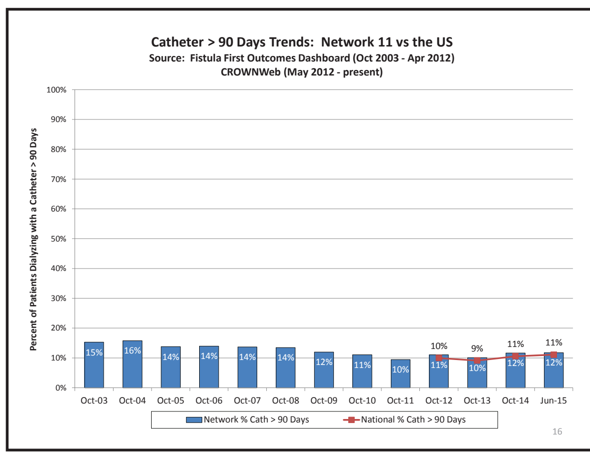
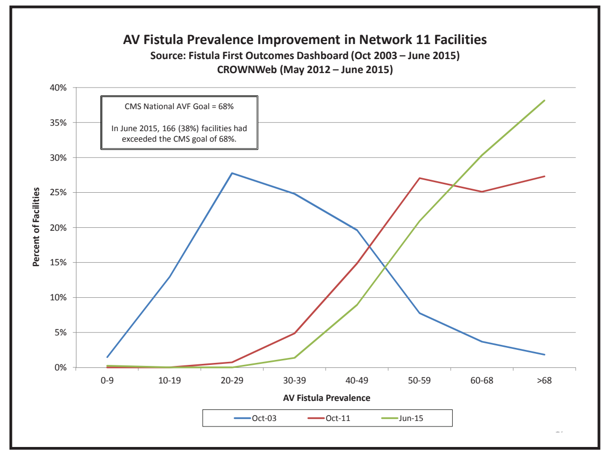
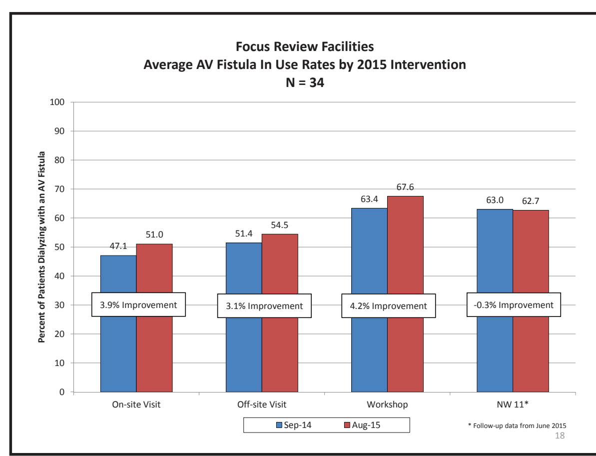


Quality Incentive Program
2016 for Payment Year 2018



## PY 2016 Payment Deductions

| Payment Deduction | # of Facilities | % of Facilities |
|---|---|---|
| 0% | 442 | 96.1% |
| 0.5% | 12 | 2.6% |
| 1% | 1 | 0.2% |
| 1.5% | 3 | 0.7% |
| 2% | 2 | 0.4% |
|  | 460 | 100% |



## PY 2018 Measures

**Safety Subdomain – 20% of Clinical Measure Domain Score**
1. NHSN Bloodstream Infection

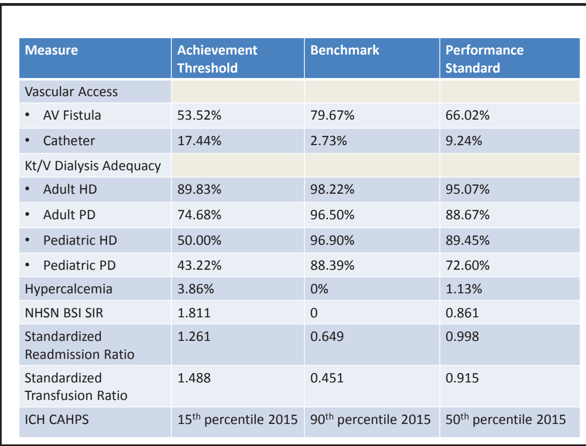
**Patient & Family Engagement/Care Coordination Subdomain – 30% of Clinical Measures Domain Score**
1. ICH CAHPS Score
2. Standardized Readmission Ratio

**Clinical Care Subdomain – 50% of Clinical Measure Domain Score**
1. Standardized Transfusion Ratio
2. Kt/V Dialysis Adequacy Measure (HD, PD, and Pediatrics)
3. Vascular Access Type Measure – AVF
4. Vascular Access Type Measure – Catheter ≥ 90 days
5. Hypercalcemia

Reporting Measures
1. Mineral Metabolism
2. Anemia Management
3. Pain Assessment and follow-up
4. Clinical Depression Assessment and follow-up
5. NHSN Healthcare Personnel Influenza Vaccination

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/Downloads/ESRDQIPSummaryPaymentYears2014-2018.pdf





| Measure | Achievement Threshold | Benchmark | Performance Standard |
|---|---|---|---|
| Vascular Access |  |  |  |
| • AV Fistula | 53.52% | 79.67% | 66.02% |
| • Catheter | 17.44% | 2.73% | 9.24% |
| Kt/V Dialysis Adequacy |  |  |  |
| • Adult HD | 89.83% | 98.22% | 95.07% |
| • Adult PD | 74.68% | 96.50% | 88.67% |
| • Pediatric HD | 50.00% | 96.90% | 89.45% |
| • Pediatric PD | 43.22% | 88.39% | 72.60% |
| Hypercalcemia | 3.86% | 0% | 1.13% |
| NHSN BSI SIR | 1.811 | 0 | 0.861 |
| Standardized Readmission Ratio | 1.261 | 0.649 | 0.998 |
| Standardized Transfusion Ratio | 1.488 | 0.451 | 0.915 |
| ICH CAHPS | 15th percentile 2015 | 90th percentile 2015 | 50th percentile 2015 |

Dialysis Facility Compare
5 Star Rating System

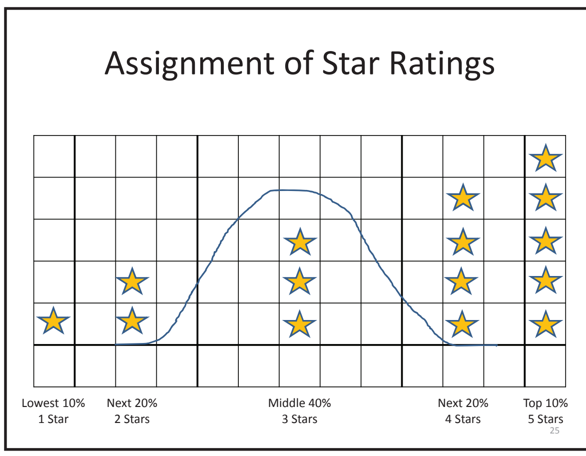


## Star Rating on DFC

- Star Rating is based on Quality Measures currently reported on DFC that assess patient health outcomes and processes of care
- Each facility given between one and five stars

★★★★★ Much Above Average
★★★★ Above Average
★★★ Average
★★ Below Average
★ Much Below Average

## Assignment of Star Ratings

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## DFC Quality Measures Used

- Standardized Ratios
  - Transfusion
  - Mortality
  - Hospitalization
- % patients (HD & PD) adequately dialyzed
- % patients with hypercalcemia (adult)
- % patients dialyzing with AVF
- % patients dialyzing with a catheter ≥ 90 days

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## 2016 Five Star Ratings for NW 11

| Star Rating | # of Facilities | % of Facilities |
|---|---|---|
| 1 | 33 | 7.8% |
| 2 | 76 | 18.0% |
| 3 | 168 | 39.7% |
| 4 | 86 | 20.3% |
| 5 | 60 | 14.2% |
| Subtotal | 423 | 91.0% |
| No rating | 42 | 9.0% |
| Total | 465 | 100% |

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## What's Ahead in 2016?

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## Healthcare Associated Infections

- Continue and expand our HAI Learning and Action Network
  - Improving communication between dialysis facilities and hospitals regarding HAIs
  - Promote reduction of BSIs in both incenter HD patients and home dialysis patients
- Reduce BSI rates by encouraging dialysis facilities to conduct CDC infection prevention audits
- Increase patient vaccinations for Hepatitis B and Pneumococcal Pneumonia

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## Vascular Access

Network 11 will continue to…

- Encourage facilities to promote AVFs whenever possible
- Decrease long term catheters
- Conduct focused reviews on outliers
- Use patient advisors to develop new strategies
- Encourage early referral for vascular access placement pre-dialysis

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## Engaging Patients to Improve Care

- Continue to develop patient-centered projects using Consumer Committee and EPIC members
- Include patients and family in the development of all QI projects
- Participate in the National Patient and Family Engagement Learning and Action Network
- Identify grievance trends and develop strategies to improve
- Improve Patient Experience of Care (ICH-CAHPS)

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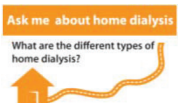
## 2016-2018 Project: Continuing Home Dialysis

- Increasing home dialysis referral AND
- Reducing disparities
- Using previous years' successes
- Increased facility and patient participation

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## Years 2019-2020: Hospitalization

- Reducing hospitalizations and reducing disparities
- National Hospital Care Coordination Project to be developed by CMS and implemented in 2019-2020
- To prepare for this, Network 11 will begin to do some preparatory work to learn more about hospitalization claims data with help from the Chronic Disease Research Group and learning from the FMC hospitalization project

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## QIP and NHSN

- Help facilities to improve QIP outcome measures
  - 2016: Improvement project to decrease percent of patients in facilities with hypercalcemia
  - Other years: To be determined by CMS
  - Potential: Fluid management, pain control, depression
- NHSN data submission
  - Improve BSI reporting rates in facilities that lack access to hospital BSI information

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## Emergency Management

- Continued emphasis on availability of dialysis resources during emergency situations
- Collaboration with Michigan Bureau of EMS, Trauma, and Preparedness to assist in identifying state-wide dialysis availability in the event of an emergency
- Additional resources are available from the Network office

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## How Will YOU Become Involved with Network 11 in 2016?

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