



QUALITY IMPROVEMENT

Why Is It Important?

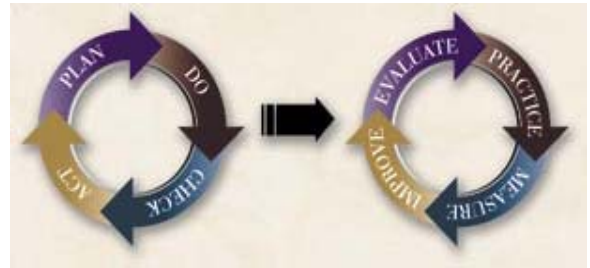
In this day of modern technology and advanced gadgetry, the words “**Quality Improvement**” are heard in the workplace everyday. It is increasingly evident in the healthcare industry that **the main goal of the provider is to deliver the highest quality of care to the patients served.** So, why is “Quality Improvement” so important?

It is vital to maintain the highest level of care possible and this can only be accomplished by routine surveillance and measurement of the patient care delivered.

Quality is defined as, “The degree to which health services for individuals and populations increase the likelihood of desired outcomes and are consistent with current professional knowledge”. Achieving the highest level of quality of care and continuously improving its delivery to all patients served must become an absolute priority for all healthcare organizations. Promoting quality improvement initiatives can lead to many positive outcomes, which may lead to enhanced overall patient safety and satisfaction.

Why stop at providing the “best” care if you can give “great” care? If achieving 99.9% is good, then is missing 0.1% acceptable in the following scenario?

continued on Page 5



Modified Shewhart Planning Cycle

Noel De Ocampo

Network #17 Director of
Quality Improvement



“Quality improvement processes, as well as employee and patient education programs, are vital in improving outcomes and overall patient satisfaction.”

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WEBSITE CORNER

www.esrdnet17.org

Visit the Network #17 Website for recent updates on:

Vocational Rehabilitation

Patient Support Groups

Fistula First

RESOURCES FOR STAFF AND PATIENTS!

PATIENT SERVICES

Vocational Rehabilitation

A packet of VR resources was mailed to all facility social workers in December 2007. Facilities may contact Patient Services if it was not received.

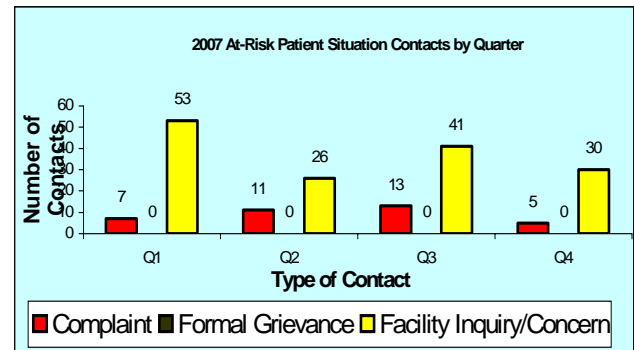
The CMS VR Survey followed in January 2008 asking all facilities to report all VR patient activity that occurred in 2007.

Visit the Network website at www.esrdnet17.org/vocrehab.htm to view the following VR resources and/or links:

- Network Vocational Rehabilitation Survey Results 2004-2006
- Dialysis Facilities with Late Shifts (after 5:00 PM)
- Vocational Rehabilitation Offices contact information
- Your-Ticket-To-Work program information
- Working with CKD Rehabilitation and Employment brochure
- Keeping Your Job When You Need Dialysis article
- CKD and Job Retention brochure
- Life Options Rehabilitation Program booklets
- Red Book Guide to Work Incentives
- California One-Stop Career Centers
- Vocational Rehabilitation Best Practices Worksheet
- Vocational Rehabilitation patient posters and handouts
- Vocational Rehabilitation Tracking Tool 2008

Resolving Conflict

The Network provides technical assistance in the resolution of patient, provider, and/or facility complaints and grievances by providing education, facilitating solutions, and/or making referrals. Concerns may be communicated to the Network by phone, fax or email.



Providers call Patient Services at (415) 897-2400 x116 while patients and loved ones call (800) 232-ESRD or (800) 232-3773. No PII (Personal Identifiable Information), which includes patient name, date of birth and Social Security number, is permitted on any email communication per CMS regulations.

QUALITY IMPROVEMENT: Fistula First

QI Activities and Projects — Western Pacific Renal Network continues to participate in collaborative activities to improve the services for each ESRD beneficiary. Partners include the National Kidney Foundation, Renal Support Network, California Dialysis Council and Lumetra (Quality Improvement Organization). Clinical and patient education projects that are currently being developed include a Vascular Access Conference.



Fistula First — As of December 2007, Network #17's fistula rate stands at 54.2%, a 4.5% increase in the last 12 months. Currently, Western Pacific Renal Network has the third highest fistula rate among 18 ESRD Networks across the country. CMS' goal is to increase the fistula rate to 66% nationwide by 2009. Through collaboration with the Fistula First Coalition and Network providers, Network #17 is making great strides to reach this goal.

The **Fistula First Subcommittee** continues to plan interventions that assist the low performers as well as further improve the Network's overall fistula rate. Quality improvement and educational materials developed by this subcommittee will be shared with all Network #17 ESRD providers.

Watch for the next Network **Fistula First Newsletter** in March 2008. It will highlight Fistula First "best practices" and the accomplishments of facilities that previously were among the lowest performers in the Network. Also included will be a feature on the Fistula First facilities who have shown a continuous upward trend in fistula rates and how those improvement rates are sustained.

NW #17 Fistula Prevalence Rate
54.2%
(As of Dec '07)

Network #17 Patient Leadership Committee Takes Shape

Northern California Group — The foundation for the Network's first Patient Leadership Committee (known as the PLC) has been established as evidenced by the creation of the following documents:

Mission Statement - "The mission of the PLC is to improve communications and services between patients and caregivers in improving the renal care experiences, and to represent and advocate the patient's point-of-view within the Network"

Goal Statement - "The overall goal of the PLC is to strive to assist patients in receiving the highest quality care every time"

Values Statement - "The PLC values every ESRD patient's life and their ability to lead an optimum lifestyle"

Statement of Purpose - includes the Purpose, Goals, and Membership guidelines, and can be located on the Network website at www.esrdnet17.org.

The newly formed **Steering Committee** consists of the PLC Chair, both Co-Vice Chairs, a Project Coordinator (involved in membership) and a member-at-large. It will take on the responsibility of planning PLC activities and insuring all documentation is kept updated. Other positions within the PLC include an Historian responsible for documenting the PLC's story, a Parliamentarian, and an Outreach Coordinator. PLC membership is a two-year commitment that begins each June

The PLC functions in an advisory capacity and was instrumental in naming the patient newsletter "Kidney Connection". The PLC also functions in an advocacy role currently working on an education initiative aimed at increasing the level of healthcare knowledge and treatment participation of new dialysis patients.

PLC meetings will be held quarterly in 2008 with the next one scheduled for March in Salinas, CA.

Pacific Island Group — The Network has already received Interest Forms from patients located in the Pacific Islands applying for membership. The first meeting of the Steering Committee of the Pacific Island PLC is planned for fall of 2008 in Honolulu. **Interest Forms** will be redistributed to all social workers in the upcoming Annual Mailing of resources who can then make them available to their ESRD patients.



LaRonda
is a Co-Chair of the Network #17
Patient Leadership Committee.
She has been an ESRD patient since 1989
and currently receives in-center hemodialysis
in California.

Photo by Shar Carlyle

Medical Review Board

The Network #17 Medical Review Board meets quarterly to evaluate the quality and appropriateness of care delivered to ESRD patients. Per CMS regulations, membership is composed of representatives from each of the professional disciplines (physician, registered nurse, social worker, and dietitian) and at least one patient. Recent meetings have been held on November 9, 2007 and January 30, 2008. Discussion was held regarding the following:

- **Quality Improvement Work Plan**
- **Vascular Access Conference**
- **Fistula First Breakthrough Initiative**
- **Use of Buttonhole Technique in facilities**
- **Lab Data Collection**
- **Clinical Performance Measures**
- **Immunization and New Vascular Access DVD Projects**
- **Network Orientation PowerPoint Project**



Addressing Conflict: DPC Staff In-Services

Continued from previous facility staff newsletter

The **Decreasing Patient-Provider Conflict (DPC)** project was designed by the DPC National Task Force for the dialysis provider to supply resources to better cope with the conflicts that occur at facility level. The DPC project is a joint effort funded by the Centers for Medicare & Medicaid Services (CMS), undertaken by a majority of key ESRD stakeholders, and coordinated through the Forum of ESRD Networks.

The **DPC Toolbox** was distributed to all major dialysis organizations within Network #17 in 2005 for its dissemination to all individual dialysis facilities. Subsequently, individual orders placed directly to the Network offices have been addressed by having a Toolbox mailed directly to the requesting unit.

If your facility is in need of a Toolbox, notify the Network #17 Patient Services Department.

The **DPC Toolbox is multifaceted** with instructions, exercises, training software and master handouts for patient care staff. For planning and implementation purposes, it is carried out in three consecutive steps.

Step I was reviewed in last quarter's issue of the Network facility staff newsletter (August 2007).

Step II consists of staff orientation and training utilizing classroom activities and an interactive software program. This staff training component utilizes two approaches: independent individual software training and group training sessions using several key educational strategies to facilitate critical thinking and encourage staff discussion. It is recommended that an initial staff meeting be conducted to introduce the program, followed by the software training for each staff member, then eight group sessions completed by a final staff meeting to assess implementation.

By the end of Step II, staff will be able to:

- Discuss effective use of the DPC model of conflict resolution in their practice through role-play and critical thinking;
- Demonstrate, through group discussion, an understanding of the rationale behind the concepts of the program, and how they can operate to achieve the highest quality patient care;
- Correctly utilize the DPC Taxonomy & Glossary for completion of DPC forms and discussions of DPC situations.

Step III comprises ongoing quality improvement activities and includes the training of all future staff.

By the end of Step III, the following will have been completed:

- All new staff will receive DPC training during initial orientation;
- DPC data will be reviewed monthly in routine Quality Improvement activities;
- When indicated by the DPC data, Quality Improvement activities will be initiated.



DPC

Six Steps to Resolving Conflict

Step 1: Share your feelings - Focus on describing how you feel about the situation or the other person's behavior; use "I" statements; you cannot work toward a resolution if you don't understand how the other person feels.

Step 2: Define the problem - Determine if the situation is a disagreement, a misunderstanding, or a conflict of interests; both of you may see a different problem, so the conflict cannot be resolved until real problem is brought to the surface; describe the conflict as a mutual problem; ask the person to state the problem from his or her point of view; restate what you heard utilizing "If I understand you correctly, this is how you see the situation..."; state the problem from your perspective.

Step 3: Explore options. Look for possible solutions to the problems of both parties - Brainstorm solutions -- think of ideas together; consult with each other -- don't dictate; sit beside each other to create a feeling of partnership; start with easy issues and then move on to more difficult ones; tell the other person what outcome you want and ask what he or she wants; offer to negotiate differences.

Step 4: Select and negotiate one option to work on - Both people must agree that the chosen solution is worthwhile; plan how the solutions will be implemented; even if you don't come to an agreement, agree to work toward a resolution that benefits everyone, and schedule a follow-up meeting.

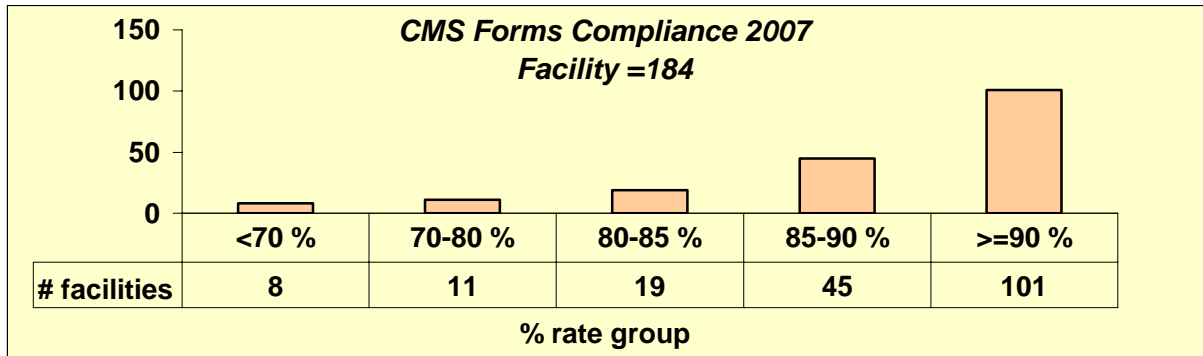
Step 5: Take action - The conflict cannot be resolved unless you put the plan into action; make a commitment to work on it; if you run into trouble, don't stop working on your plan until you get back together to review progress.

Step 6: Get feedback - Thank the person for stating his or her concerns; make sure the plan is working and both parties are still comfortable; schedule time to get back together to discuss the specific problem and how things are working.

DATA COLLECTION

CMS Forms Compliance for 2007 — The Network is processing the forms compliance results for 2007 for CMS 2728 (Medical Evidence) and 2746 (Death Notification). Preliminary results indicate that 52% of the facilities met the CMS standard of 90% for all forms submitted on time and accurately. An additional 16% were within 5 percentage points of meeting that goal. The Network goal for 2008 is to increase the number of facilities meeting the CMS threshold. The Network average was 89.2% for 2007. We're hoping to improve to 90%+ by June of 2008!

How did your facility rank in forms compliance for 2007?:



CMS Facility Survey — The CMS Facility Survey for 2007 is underway! This survey captures a snapshot of all dialysis patients receiving care on 12/31/2007 by modality as well as the following:

- facility staffing as of 12/31/2007
- additions and losses to the dialysis population during 2007
- referrals to vocational rehabilitation, employment and school for dialysis patients between the ages of 18 and 54 years
- treatment counts
- the number of transplants during 2007 by donor type.

The snapshot of patients on 12/31/2007 is the basis for demographic profiling at both local and national level, and is an important piece of CMS program planning.

Important!

Confidential PHI
(Patient Health Information)
should be sent **only**
to the following
Data Fax line:
(415) 897-2443

QUALITY IMPROVEMENT: Why Is It Important? *Continued from Page 1*

Those who received these incorrect services would agree that these are unacceptable and intolerable results:

- 12 babies given to the wrong patients each day
- 12,200 incorrect prescription every month
- 18,322 pieces of mail mishandled in one hour.

Healthcare organizations must provide the best care possible by doing the right thing in the right way 100% of the time. This may be difficult to achieve, but utilizing Continuous Quality Improvement programs will take you a step closer towards achieving that goal.

Western Pacific Renal Network, LLC will have many quality improvement programs and activities for 2008. Please watch for our mailings.

Thank you very much for your participation.

Examples of the many benefits from Continuous Quality Improvement:

- Improved patient outcomes
- Compliance with regulatory requirements
- Enhanced quality of patient services
- Identification of opportunities for improvement
- Patient and employee satisfaction
- Decreasing healthcare disparity
- Decreasing healthcare costs

Western Pacific Renal Network

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The mission of Western Pacific Renal Network is to facilitate improvement of quality of care provided to ESRD patients.

Darlene Rodgers, BSN, RN, CNN, CPHQ
Executive Director

Allison Kregness, RN, CNN
Director of Operations

Susan Tanner
Director of Information Services

Noel De Ocampo, MSN/ED, RN
Director of Quality Improvement

Vernon Silva, MSW
Director of Patient Services

Peter Traub
Community Outreach Coordinator

Anne Brush
Data Specialist

Western Pacific Renal Network, LLC
is currently searching for a
Quality Improvement Coordinator

based at the Network #17 office in Novato, California. Requirements include a Bachelors Degree in a health related field, preferably in nursing, with 5 years of progressively responsible experience in renal/CKD programs. Certification in Nephrology Nursing is preferred. Experience in Quality Improvement is helpful.

The Quality Improvement Coordinator assists the QI Director in the development and maintenance of quality improvement programs implemented by Network #17 and mandated by CMS to improve the quality of care given to end-stage renal disease (ESRD) patients. An understanding of ESRD, its impact on patients, and the system for delivery of care, is necessary for this position.

For more information and complete job description, please contact the Network #17 office at (415) 897-2400.

ESRD Network #17 Quarterly Update

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Network #17 "CKD Care" Coalition Update

After its formulation meeting in June 2007, the Network Coalition's two workgroups proceeded onward in pursuit of each group's respective goals. The **CKD Management / CKD Clinic** workgroup is working on the creation of a focused interview document to be utilized for surveying existing CKD clinics. The **CKD Early Intervention / Prevention** workgroup is working on having the eGFR (estimated glomerular filtration rate) included as standard for all blood draw panels.

Coalition membership has reached a new high with 20 members enlisted in each workgroup. However, variable participation by individual members has resulted in some inconsistent progress. The good news is that each new additional member appears to be participating enthusiastically and becoming a key figure. Recruitment continues - if you are interested in finding out more about the Coalition and what part you could play in making a difference in early detection of CKD, call the Network office at (415) 897-2400. Meetings are typically held via conference call and a face-to-face event is being planned.

The Mission of CKD Care Coalition is to work on early identification of CKD.

The Vision is to stop progression of CKD.

The Goal is to raise awareness, provide education, develop resources, and increase health screenings and prevention.

The workgroups respective goals are

- 1) to facilitate the automatic reporting of GFR on lab work
- 2) to develop algorithms that will facilitate appropriate referral and treatment.