

The Lone Star Bulletin



The End Stage
Renal Disease
Network Of Texas

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Special points of interest:

- Patient Safety Alert
- Medicare Billing Changes
- Upcoming Events 2012
- QNET 2012

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From the Desk of the Executive Director

Medical Review Board Patient Safety Alert

Recently several DSHS referrals to the Medical Review Board (MRB) have included serious instances and patterns of lack of identification of inter or intra dialytic changes in patient condition or stability coupled with failure to report to the charge nurse and or physician. Additionally, in some cases, physician standing orders have not been followed regarding physician notification, use of prn or emergency medications.

The MRB issues this alert to Medical Directors and to engage the dialysis community in a renewed awareness of the critical need for QAPI oversight to ensure that *all levels of staff from PCTs to RNs identify, report and respond appropriately to unstable situations and conditions. This is a patient safety issue of life and death importance.*

Conditions that should be recognized as unstable requiring involvement of a nurse may be based on a clinical change from the patient norm, facility protocols and physician standing orders. MRB recommendation and standard practice includes but is not limited to the following conditions that should be reported to the nurse and/or physician:

- * significant hypotension or hypertension
- * chest pain
- * bradycardia or tachycardia
- * irregular heart rate (particularly with an uncontrolled ventricular response)
- * alteration of mental status
- * diaphoresis
- * significant shortness of breath
- * weight loss or significant unusual gain between treatments
- * report of bleeding between treatments or circuit clotting
- * cyanosis, mottling, or significant color change
- * seizure activity
- * falls; in-facility or at home
- * fever or any significant changes in body temperature

Continued from pg 1:



If the condition is newly onset or abnormal for the patient, he/she should not be discharged home without charge nurse evaluation and physician notification and approval.

All licensed professionals are required under their practice acts to ensure patient safety. In the hospital setting the Joint Commission's National Patient Safety Goals apply. Additionally, under the Texas ESRD Facility Licensing Rules all levels of staff have a role and responsibility in the monitoring and reporting of the patient condition. Pertinent excerpts follow at the end of this notice.

The Network encourages all facilities to conduct an assessment to ensure that inter or intra dialytic changes in patient condition or stability are identified with appropriate reporting to the charge nurse and/or physician.

Pertinent excerpts of the Texas ESRD Facility Licensing Rules

§117.2. Definitions (10) Charge nurse--A registered nurse practicing nursing in accordance with applicable provisions of law who is responsible for making daily staff assignments based on patient needs, **providing immediate supervision of patient care, monitoring patients for changes in condition, and communicating with the physician**, dietician, and social worker regarding patient needs.

§117.45. Provision and Coordination of Treatment and Services

- (i) Medical services. (1) The medical director is responsible for:
- (B) **assuring adequate training of licensed nurses and dialysis technicians;**
 - (C) **adequate monitoring of patients and the dialysis process**

§117.62. Training Curricula and Instructors.

(a) Each training program for dialysis technicians shall develop a written curriculum with objectives specified for each section.

(b) The training curricula for dialysis technicians shall include the following minimum components:

(4) dialysis procedures to include: (D) **observing and reporting patient reactions to treatment**

(c) The supervising nurse or a registered nurse who qualifies as an instructor under §117.62(g)(2) of this title shall complete a competency skills checklist to document each dialysis technician trainee's knowledge and skills for the following allowed acts:

(12) **monitoring the patient and equipment during treatment, responding appropriately to patient needs and machine alarms, and reporting unusual occurrences to the registered nurse**



The Health Care Providers Sixth Sense

Patient sensitivity is a very familiar subject to healthcare professionals that we must consider on a daily basis and we can not be reminded of the aspects of patient sensitivity too often. ESRD patients have very complex needs and being sensitive to these needs must become second nature – your sixth sense. Patient sensitivity begins with the health care professional considering what their patient is going through. Put yourself in your patient's shoes. Whether they are newly diagnosed or experienced in their care regimen, they face many challenges. ESRD patients must adhere to strict diets, spend countless hours dialyzing, have co-morbid medical conditions, and manage many medications. Their lives and the lives of their families are changing or have changed immensely. Many patients are not able to work, are unable to care for themselves, and may feel that their freedom has been taken away. All of these factors lead to increased stress and anxiety for patients. Our job as health care professionals is to be sensitive to all of these factors and to do our best to relieve as much stress and anxiety for our patients as possible. ESRD health care professionals are a vital link to ESRD patients living as healthy lives and as high a quality life as possible. Without the sustained support of their health care providers many individuals with ESRD will not be successful in their treatment and in turn their quality of life will suffer. They need health care providers supporting them and working with them, which of course you are doing 24/7; however, at times the busyness of work can get in the way of that caring showing through to your patients!

How to tap in to your sixth sense.....your patient sense:

Always treat your patients with dignity and respect

Patients values, knowledge, beliefs, and cultural backgrounds must be incorporated into the planning and delivery of care.

Share information with your patient in a timely manner

For your patient to participate effectively in their care, they must receive timely and accurate health information. This information must be shared to them in a useful way – at a level they can understand.

Make your patient feel comfortable

If your patient is not comfortable they will be less likely to play an active role in their treatment. They must feel safe, at ease, and cared about from the moment they step in to the clinic up until the time they walk out the door.

Inform and educate your patients on –

- All aspects of their illness and treatment
- Quality of life issues
- End of life issues



Remember that patient education is an ongoing process and does not end at any stage of treatment. Patients educational needs change as diseases progress or appear, as the patient ages, and as life circumstances change. When your patient is properly educated on their condition they will be able to participate in their care. Mary Rau-Foster describes the role of a dialysis care giver as an educator, counselor, and supporter of your patient in all aspects of treatment. Continue tapping in to your sixth sense by becoming more aware of all the challenges your patients face on a daily basis.

Be a Patient for the Day!

Have you ever tried to be a patient for a day? This is a very effective way to understand in a small way the challenges that patients face. This program is a wonderful addition to your current staff orientation. It will get your patients attention and when you explain that the purpose of the program is for staff to better understand what patients go through, they may participate in the act as well.

This program demonstrates how much staff care more than words can ever say. Implementing such a program for staff is fairly simple and only involves the staff doing what the patients do from the beginning to the end of dialysis treatment:

1. Arrive at the time the first shift patients arrive and wait with them (including outside in the parking lot if the facility is not yet open for patients)
 2. Wait in the waiting room just as the patients wait
 3. Be called in as if staff were a patient, get weighed, etc, and then sit in a dialysis chair
 4. Keep your “access” arm out straight and don’t move it – using an arm board is the best way to accomplish this
 5. Stay on “dialysis” for 3-4 hours
 6. No eating or drinking if that is the facility rule
 7. Wait for transportation after dialysis just like all other patients
- And don’t forget your blanket!

Use your sixth sense to achieve the goal of having every patient experience be exceptional, every day. If you focus on reducing a patient’s anxiety more than making them happy your stress level as a health care provider will be reduced and you will feel more gratified. If you are sensitive to your patients needs your patient will be satisfied with their care and as a result, you, as a health care provider, will be satisfied.



Hours of Operation

There are times when facilities must make the daunting decision to change patient’s schedules and/or facility hours. While this is not an enjoyable task for anyone involved, it can cause an even greater inconvenience to patients and their families, regardless of necessity. It is imperative that facilities provide ample time for patients and their families make the necessary arrangements and/or adjustments to their schedules to accommodate the new requested time. Patients should be notified in writing as well as verbally. Often times, patients have a number of items on their minds and may not remember all of which is shared with them. However, if someone tells them verbally face to face and then follow up with a letter, the likelihood that they will remember has been dramatically increased.

There are times when of course you will have to involve the family as well as other’s involved in the care and transporting of the patients such as ambulance and medical transportation providers. Naturally, it is wise to ensure they have been given enough time to make the necessary adjustments to their schedules to accommodate your facility’s and the patient’s needs. When working with medical transportation companies, it is important to remember they are servicing multiple entities and patients in various settings. On average, a minimum of two weeks is considered an appropriate time frame; however, as we often request from patients, the sooner you can inform them the better. Preferably three weeks to one month ahead of time would be the most considerate.

Advance notices of facility and treatment time changes allows for respectful communication to exist between the facility staff and patients/families. Advance notice also decreases the potential for unnecessary complaints at both the facility as well as the Network levels. When patients and families understand that their time is important to you as a provider of service, they are more likely to be open to change and when problems do exist. This consideration could ensure a smoother negotiation process in the future.

New Texas ESRD Facilities



The End Stage Renal Disease Network of Texas is please to welcome the following new Medicare dialysis facilities. You may access a complete listing with addresses, telephone and fax numbers, and provider numbers from our website at www.esrdnetwork.org. Go to Provider Directory → Dialysis Facility → On right hand side of webpage → "Dialysis and Transplant facilities".

672627	FRESENIUS MEDICAL CARE DESERT MILAGRO DIALYSIS CENTER	ODESSA	4323328288	4323324715
672628	ACCESSCARE- COLORADO CITY DIALYSIS	COLORADO CITY	3257288348	3257289228
672629	FMC MOODY PARK DIALYSIS	HOUSTON	7132222513	7132222486
672630	DSI GREENWOOD HOLLY RENAL CENTER	CORPUS CHRISTI	3618507300	3618507305
672631	USRC ATASCOSA COUNTY DIALYSIS	PLEASANTON	8305693052	8305693018
672632	DAVITA CENTRAL DALLAS DIALYSIS	DALLAS	2147393004	2147393002
672633	FRESENIUS MEDICAL CARE GRAND PRAIRIE	GRAND PRAIRIE	9722663891	9722662822
672634	GREENVILLE DIALYSIS	GREENVILLE	9034559911	9034559914
672635	DUNCANVILLE DIALYSIS	DUNCANVILLE	9722964911	9722964429
672636	PLANO DIALYSIS CENTER	PLANO	9728813270	9728815086
672637	USRC TARRANT DIALYSIS WEST FORT WORTH	WHITE SETTLEMENT	8173670822	8173671520
672638	ROCKWALL DIALYSIS CENTER	ROCKWALL	9727224060	9727227491
672639	ACCESS CARE FORT STOCKTON DIALYSIS	FORT STOCKTON	4323364859	4323364894
672640	1960 DIALYSIS CENTER	HOUSTON	2814432209	8326210203
672641	DAVITA BAYTOWN DIALYSIS	BAYTOWN	2814220796	2814220961
672642	NACOGDOCHES DIALYSIS CENTER	NACOGDOCHES	9365688510	9365688517
672643	STAFFORD DIALYSIS	STAFFORD	2815689911	2815680093
672644	GESSNER DIALYSIS AND KIDNEY CENTER	HOUSTON	7137744002	7137744007
672645	EL CAMPO DIALYSIS	EL CAMPO	9795438200	9795438214
672646	MISSION VALLEY DIALYSIS	MISSION	9565833760	9565838252
672647	RENAL CENTER OF WATERTON	TYLER	9035610292	9035611896
672648	DIALYSIS SERVICES OF ALLEN	ALLEN	9729082769	9729082764

672649	RENAL CENTER OF THE HILLS	NORTH RICHLAND HILLS	8172843343	8172843448
672650	US RENAL CARE TARRANT DIALYSIS CLEBURNE	CLEBURNE	8176415530	8176415531
672651	WELLBOUND OF AUSTIN	AUSTIN	5128336695	5128336651
672652	US RENAL CARE TARRANT DIALYSIS AZLE	AZLE	8174064331	8174064332
672653	FLOYD CURL DIALYSIS	SAN ANTONIO	2105614373	2105619415
672654	RENAL CENTER FRISCO	FRISCO	2148722421	2148722426
672655	ROMANO WOODS DIALYSIS CENTER	HOUSTON	2818936300	2818936366
672656	FRESENIUS MEDICAL CARE BRYAN DIALYSIS	BRYAN	9798224613	9798227829
672657	US RENAL CARE BELLAIRE DIALYSIS	HOUSTON	7139887200	7139887201
672658	DAVITA WEST PLANO DIALYSIS	PLANO	9726081089	9726081096
672659	FRESENIUS MEDICAL CARE OF COCKRELL HILL	COCKRELL HILL	2144673788	2144673789
672660	USRC MINERAL WELLS	MINERAL WELLS	9404682704	9404682708
672661	SOUTH FORT WORTH DIALYSIS	BENBROOK	8177313652	8177314655
672662	OSO BAY DIALYSIS	CORPUS CHRISTI	3619941028	3619941829
672663	LIBERTY DIALYSIS VICTORIA	VICTORIA	3614851148	3614851158
672664	DAVITA-BINZ HOME TRAINING	HOUSTON	7135295155	7135295135
672665	VALLEY BAPTIST HARLINGEN DIALYSIS	HARLINGEN	9563642789	9564233395
672666	BAY CITY REGIONAL DIALYSIS CENTER	BAY CITY	9793230818	9793230814
672667	HOPE KIDNEY CLINIC LAKEVIEW	LAREDO	9567171600	9567171601
672668	LIBERTY DIALYSIS WAXAHACHIE	WAXAHACHIE	9723518575	9723518570
672669	CYPRESS WOODS NORTHWEST DIALYSIS	HOUSTON	2818902540	2818905376
672670	SAGEMEADOW DIALYSIS	HOUSTON	2819226136	2819226145
672671	MCKINNEY DIALYSIS	MCKINNEY	9725420495	9725429676
672672	USRC DOWNTOWN SAN ANTONIO DIALYSIS	SAN ANTONIO	2102512824	2102512635
672673	FMC GREENWAY KIDNEY CENTER	WACO	2546668826	2546662926
672674	VALLEY BAPTIST RAYMONDVILLE DIALYSIS	RAYMONDVILLE	9566899084	9566891951

For more information on opening a facility, please visit our website at www.esrdnetwork.org. Go to Provider Directory-Information for Providers—Opening Instructions for a New Facility—New Facility Welcome Packet and Forms. Complete and fax to 972-503-3219. Make sure **to allow 6-8 weeks** for processing.



Fistula First Change Package

Clinical and organizational recommendations based on best practices for increasing AV fistula use and improving hemodialysis patient outcome

1 Routine CQI review of vascular access

- Designate staff member in dialysis facility responsible for vascular access CQI (RN if feasible but can be any renal care professional). Incorporate vascular access into facility-based CQI process.
- Assemble multi-disciplinary vascular access CQI team in facility or hospital.
 - Minimally: Medical Director and VA CQI Coordinator.
 - Ideally: Representatives of all disciplines, including access surgeons and interventionalists.
- Investigate and track all non-AVF access placements and AVF failures.

2 Timely referral to nephrologist

- Primary care physicians utilize pre-ESRD/CKD referral criteria to ensure timely referral of patients to nephrologists, ideally prior to Stage 4 CKD.
 - Establish meaningful criteria for PCPs who may not perform GFR or creatinine clearance testing (i.e. serum creatinine criteria, conversion formula for GFR)
- Nephrologist documents AVF plan for all patients expected to require renal replacement therapy, regardless of RRT being considered.
- Designated nephrology staff person educates patient and family on benefits of AVF and to protect vessels, when possible using bracelet as reminder.

3 Early referral to surgeon for “AVF only” evaluation and timely placement

- Nephrologist/skilled nurse performs appropriate evaluation and physical exam prior to surgery referral.
- Nephrologist refers for vessel mapping where feasible, ideally prior to surgery referral.
- Nephrologist refers patients to surgeons for “AVF only” evaluation, no later than Stage 4 CKD (GFR<30). Surgery scheduled with sufficient lead-time for AVF maturation.
- Nephrologist defines AVF expectations to surgeon, including vessel mapping.
- If pre-ESRD placement of AVF does not occur, nephrologist ensures that patient receives AVF evaluation and placement (if feasible) at the time of initial hospitalization for temporary access (e.g. catheter).

4 Surgeon selection based on best outcomes, willingness, and ability to provide access services

- Nephrologists communicate expectations to surgeons regarding AVF placement and training in current AVF surgical techniques, based on K/DOQI Guidelines and best practices.
- Nephrologists refer to surgeons willing and able to meet AVF expectations based on K/DOQI and best practices.
- Surgeons are continuously evaluated on frequency, quality, and patency of access placements. Data collection and outcomes tracking ideally initiated and reported at the dialysis center as part of ongoing CQI process, and can be aggregated at the Network level.

5 Full range of appropriate surgical approaches to AVF evaluation and placement

- Surgeons utilize current techniques for AVF placement including vein transpositions.
- Surgeons ensure mapping is performed for any patient candidate not deemed suitable for AVF based solely on physical exam.

6 Secondary AVF placement in patients with AV grafts

- Nephrologists evaluate every AV graft patient for possible secondary AV fistula, including mapping as indicated, and document plan in patient’s record.
- Dialysis facility staff and/or rounding nephrologists examine outflow vein of all forearm graft patients (“sleeves up”) during dialysis treatments (minimum frequency=monthly) to identify patients who may have suitable upper outflow vein for elective secondary AVF conversion in upper arm. Inform nephrologist and surgeon of need to evaluate identified outflow vein for AVF conversion.
- Nephrologist refers to surgeon for evaluation/placement of secondary AVF before failure of AVG.

7 AVF placement in patients with catheters where indicated

- Regardless of prior access (e.g. AV graft), nephrologists and surgeons evaluate all catheter patients as soon as possible for AVF, including mapping as indicated.
- Facility implements protocol to track all catheter patients for early removal of catheter.

8 Cannulation training for AV fistulas

- Facility identifies and uses best cannulators and best teaching tools (e.g., videos) to teach AVF cannulation to all appropriate dialysis staff.
- Dialysis staff uses specific protocol for initial dialysis treatments with new AVFs and assigns the most skilled staff to such patients.
- Facility offers option of self-cannulation to patients who are interested and able.

9 Monitoring and maintenance to ensure adequate access function

- Nephrologists and surgeons conduct post-operative physical evaluation of AVFs in 4 weeks to detect early signs of failure and refer for diagnostic study and remedial intervention as indicated.
- Facilities adopt standard procedures for monitoring, surveillance, and timely referral for the failing AVF.
- Nephrologists, interventional radiologists, and surgeons adopt standard criteria, and a plan for each patient, to determine the appropriate extent of intervention on an existing access before evaluating and mapping for an AVF.

10 Education for care givers and patients

- Routine facility staff in-servicing and education program in vascular access.
- Continuing education for all caregivers to include periodic in-services by nephrologists, surgeons, and interventionalists.
- Facilities educate patients to improve quality of care and outcomes (e.g., prepping puncture sites, applying proper pressure at needle sites without clamps, AVF brochures, etc.).

11 Outcomes feedback to guide practice

- Networks work with dialysis providers to provide specific outcomes feedback to all decision-makers, including incident and prevalent rates of AVF, AVG, and catheter use.
- Review data monthly or quarterly in facility staff meetings. Discuss and evaluate data trended over time for incident and prevalent rates of AVF, AVG, and catheter use. Track and disseminate all vascular access-related outcomes.

12 Modify hospital systems to detect CKD and promote AV fistula planning and placement

- Hospitals develop a comprehensive plan for early identification¹ of patients with kidney disease to allow for interdepartmental coordination for protective measures programs to prevent nephrotoxicity or other causes of further kidney damage, to allow for vessel preservation, for patient and family support, and vascular access planning and/or placement.

¹ Patients with eGFR <30 - 44 (CKD Stage 3B)

13 Support patient efforts to live the best possible quality of life through self-management

- Patient achieves optimum treatment outcomes and health status through collaborative knowledge-building related to CKD progression and treatment and through effective application of self-management interventions, such as self-monitoring and decision-making.
- Health care clinicians utilize techniques and strategies for the education of those who participate in vascular access education and management that are designed to encourage, enhance, and support patient self-management. This includes motivational interviewing, health coaching, and other patient empowerment strategies and techniques.

For further information, contact your ESRD Network. A complete listing of ESRD Networks can be found at: <http://www.esrdnetworks.org/>. Fistula First is an initiative of the Centers for Medicare and Medicaid Services and the Department of Health and Human Services. Project assistance provided by the Institute for Healthcare Improvement.



Upcoming Events

- **End of Life Webinar January 24th, 2012 at 9:00 am**
- **Transplant Webinar February 7th, 2012 at 10:00 am**
- **Texas Kidney Foundation Spring Symposium-April 26th-27th, 2012 in San Antonio**

For more information on these or any future events, please reference the Network website at www.network14.org or contact Anna Koenig at akoenig@nw14.esrd.net.

Adequacy Testing Payment

MEDICARE		HEALTH INSURANCE	
SOCIAL SECURITY ACT			
NAME OF BENEFICIARY JOHN D. DOE			
MEDICARE CLAIM NUMBER 123-45-6789A		SEX MALE	
IS ENTITLED TO		EFFECTIVE DATE	
HOSPITAL INSURANCE (PART A)		1/1/95	
MEDICAL INSURANCE (PART B)		1/1/95	
SIGN HERE 			

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required the Centers for Medicare and Medicaid Services (CMS) to implement a quality based payment program for dialysis services. This payment system reduces payment to providers of services and dialysis facilities that do not meet or exceed a total performance score for standards established for certain specified measures. The changes will be effective January 1, 2012 and implemented January 3, 2012. CMS has corrected the definition of the hemodialysis Kt/V that is to be used in the calculation of the Kt/V value. Information outlined below is a summary of the claims process. Included in the changes, is a definition of the hemodialysis Kt/V to be used and the calculation of the Kt/V value. The measures are defined in the annual dialysis facility report (DFR) that each provider receives in addition to the final rule. Under the Quality Incentive Program (QIP), payments can be reduced up to 2.0 percent of payments made to ESRD facilities. The QIP will apply to payments for renal dialysis services furnished on or after January 1, 2012. The payment reduction will apply to the year involved for the ESRD facility and will not be taken into account when computing future payment rates for the facility. The ESRD Quality Incentive Program is the first Medicare program to link payments to performance based on outcomes assessed through specific quality measures.

In addition to implementing the QIP, CMS will require ESRD facilities to submit the following on all ESRD claims with dates of service on or after January 1, 2012.

Hemoglobin and/ or hematocrit values

Identify the route of administration using the JA or JB modifier code for any claim indicating the administration of erythropoiesis stimulating agents (ESAs)

Use a specified formula to calculate the Kt/V for the measurement of dialysis adequacy.

CMS is making the changes to standardize the methodology used to calculate Kt/V used to measure the adequacy of dialysis provided to ESRD patients. This change will allow CMS to meet the intent of MIPPA legislation to monitor safety and outcomes delivered by ESRD providers for the entire ESRD population as part of the Quality Incentive Program (QIP).

The calculation of the Kt/V value is based on the dialytic modality when entering Value Code D5 on ESRD claims.

Hemodialysis: For in-center and home hemodialysis patients prescribed for three or fewer treatments per week, the last Kt/V obtained during the month must be reported. Facilities must report single pool Kt/V using the preferred National Quality Forum (NQF) endorsed methods for deriving the single pool Kt/V method: Daugirdas II or Urea Kinetic Modeling (UKM). The Kt/V **should not** include residual renal function.

For patients routinely prescribed four or more dialysis treatments a week the value of 8.88 should be entered on the claim. The 8.88 value should not be used for patients who are receiving "extra" treatments for temporary clinical need.

Peritoneal Dialysis: When measured, the delivered weekly Kt/V (dialytic and residual) should be reported.

Continued on page 11....

Section 50.9 of Pub 100-04 Medicare Claims processing, titled coding for adequacy of dialysis, addresses the reporting of Urea Reduction Ratio (URR) for all hemodialysis claims. It states that effective January 1, 2012, "all hemodialysis claims must indicate the most recent Urea Reduction Ratio (URR) for the dialysis patient". Home hemodialysis and peritoneal dialysis patients may be monitored less frequently, but not less than quarterly. If a home hemodialysis patient is not monitored during a month, the last, most recent URR for the dialysis patient must be reported. HCPCS code 90999 must be reported in field location 44 for all bill types 72X. The G-modifiers to be used for each level of adequacy are as follows:

- G1 – Most recent URR of less than 60%
- G2 – Most recent URR of less than 60% to 64%
- G3 – Most recent URR of 65% to 69.9%
- G4 – Most recent URR of 70% to 74.9%
- G5 – Most recent URR of 75% or greater



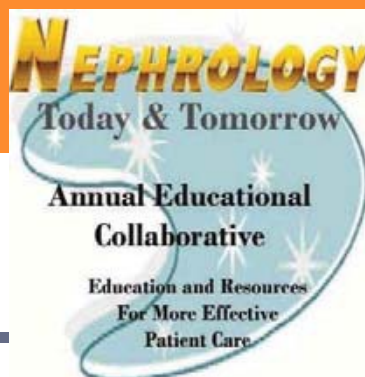
For patients that have received dialysis 6 days or less in a month, facilities should use the G6-ESRD modifier.

For services beginning January 1, 2003 and after, if the modifier is not on the claim it will be returned. These new changes will launch a new era for reimbursement of services rendered by ESRD providers.

**Don't
Forget!**

The New Year is quickly approaching and will be here before we know it!

**Be sure to mark your calendars for Network 14's
annual educational symposium
Nephrology Today & Tomorrow
June 29-30 , 2012**



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Don't forget to visit
our website:
www.esrdnetwork.org

News from QNET 2012

The ESRD Network of Texas, Inc. was one of thirteen healthcare improvement organizations recognized as a **Result Getter** at the Centers for Medicare & Medicaid Services *QualityNet* annual conference in Baltimore on December 15, 2011 and one of three ESRD Networks recognized for most improved arteriovenous fistula rate. The Result Getters are YOU in the dialysis profession, the nurses, the patient care technicians, the physicians, the social workers, the dieticians, the vascular access coordinators and others on the patient care team who are committed to providing the safest and, in most cases, most effective vascular access – the arteriovenous fistula – for the dialysis patients in Texas. In front of an audience of over 1600 healthcare improvement leaders across the nation (the largest of this type of group ever convened by the federal government), Glenda Harbert, RN, CNN, CPHQ, Executive Director for the ESRD Network of Texas, was asked to give a one-minute overview of the fistula success story in Texas! Following the stories from the recognized groups, Kathleen Sebelius, the United States Secretary of Health and Human Services, addressed the conference members, recognizing that while giant strides have been made to improve patient safety and care throughout the United States through a variety of successful improvement strategies (such as Fistula First) and many lessons have been learned and shared across agencies, facilities, organizations, there is still much work ahead of us and encouraged each of us to continue to collaborate together to break down the silos and fix systems that prevent patients from receiving the excellent care they deserve.

Listed below is Glenda's one-minute overview at the *QualityNet* conference:

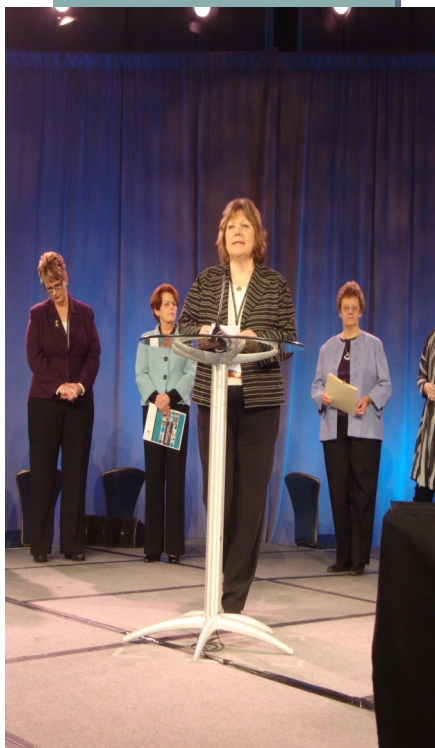
*"In the great state of Texas we have achieved a 33.5% increase in AV Fistulas, the highest increase in the nation, while decreasing less desirable accesses, the AV Graft and the evil catheters. In 60 seconds or less, how did we achieve this? I have an acronym for you- RIIP, as in **RIIP THROUGH BARRIERS!***

- *R Require accountability of medical directors*
- *Incite competition through recognition, reporting and ranking*
- *Intensively coach poor performers with required action steps*
- *Partner high and low performers in similar environments in an All Teach All Learn collaboration*

*We are ready, willing and able to share our resources and lessons learned, visit our website, or call us and we'll be glad to share strategies to help **RIIP***

***THROUGH BARRIERS!** Hey we don't tweet yet, but we may soon !"*

-Glenda Harbert, Executive Director, ESRD Network of Texas, Inc.



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