Fall Edition 2015

# The Lone Star Bulletin

Fall 2015

**Inside this issue:**



## From the Desk of the Executive Director

As was announced in January of this year, the End Stage Renal Disease Network of Texas, Inc. (ESRD Network 14) ushered in a new era by merging with Atlanta-based Alliant Health Solutions (AHS). ESRD Network 14 retained its mission to support equitable patient- and family-centered quality dialysis and transplant health care through patient services, education, quality improvement, and information management and to continue as the contractor for the Centers of Medicare & Medicaid Services (CMS) to assure healthcare security for end stage renal disease (ESRD) patients in Texas.

At the same time as ESRD Network 14, Southeastern Kidney Council, Inc. (ESRD Network 6) also joined AHS and the existing AHS subsidiary Network 8, Inc. (ESRD Network 8) in the newly formed Alliant Quality Kidney Collaborative (AQKC), each retaining independent boards and organizational structures. This collaborative is leveraging quality improvement capabilities and administrative infrastructure to accelerate quality improvement for patients with chronic kidney disease (CKD) and ESRD and their families.

As a subsidiary of AHS, ESRD Network 14 has retained its identity, with current staff continuing operations from the Dallas office while utilizing expanded resources provided by the Alliant merger.

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## From the Desk of the Executive Director

***Continued from page 1***

I feel confident that this has been a seamless process for the Texas facilities, professionals, and patients.

We recently submitted a proposal to CMS to continue to operate ESRD Network 14 with a new contract that will commence in 2016 and continue through 2020. Many of the current initiatives will continue while others will build upon our past work with evolving projects well into the future.

Our 2014 Annual Report is posted on the website, documenting continued growth of the ESRD program in Texas and the exciting outcomes *you* produced in our projects. We appreciate the many facilities that are partnering with us to meet the contract directives from CMS this year as we work *with you* to improve care for our patients and to increase patient and family engagement and patient-and family-centered care (PFCC). As always, we thank you for the care you provide on a daily basis and look forward to partnering with you in new and important ways.

Glenda Harbert, RN, CNN, CPHQ
ESRD Network 14 Executive Director


Patients often ask us to let their facilities know how important it is for them to hear about advances or ongoing research in kidney health and dialysis treatment options. Patients are encouraged by knowing someone is working hard to improve their care. Hope is a powerful tool in staying healthy, mentally and physically, so share some exciting news with your patients today!

## 2015 ESRD Network of Texas Goals and Objectives

At the beginning of July, the 2015 ESRD Network 14 Goals and Objectives Packets were mailed to all Texas dialysis and transplant facilities. We believe that understanding the goals and services available will benefit your facility. Also, as a Medicare-certified facility, you are required under Federal Regulation Part 494, Condition 494.180: Governance, to submit data and information for program administration and to participate in meeting Network Goals and Objectives. We ask that you share the information from this packet with appropriate staff. Also enclosed was an ESRD Network 14 MRB memo and Opinion Statements on Transplant Referral, Catheter Only, Telemedicine, and Vaccination for distribution to the **Medical Director**.

The ESRD Network 14 patient poster has been revised for 2015. There are English and Spanish versions that MUST be posted, along with the previously disseminated 2015 Patient Engagement Calendar Poster, in an area that is readily visible to all patients and families/care providers. Poster placement may be reviewed during a Department of State Health Services survey. In addition, we request that you share reports sent to you by the Network with your patients, such as Quality Reports, our Annual Report, and reports of Quality Improvement Projects. Also, please share the ***List of Services Available*** *(page five of the Goals and Objectives)* with them.

You were required to complete and return an acknowledgment of receipt form to the Network office by July 31, 2015. If you have not received your packet, please contact Debbie O'Daniel at dodaniel@nw14.esrd.net.



## 2015 Patient Engagement Learning and Action Network UPDATE

During this year's Learning Session webinars, we received great feedback from both staff and patients. Here are just a few comments from our patients and staff on their experiences:

"Patients are more willing to be involved than expected."

"Some patients need to be asked if they want to be an FPR, otherwise they will not volunteer. Patients feel honored being asked to be an FPR."

"Patients like visual learning best/visual demonstrations."

Patients learned "that we [staff] were interested in their talents and willing to use those talents."

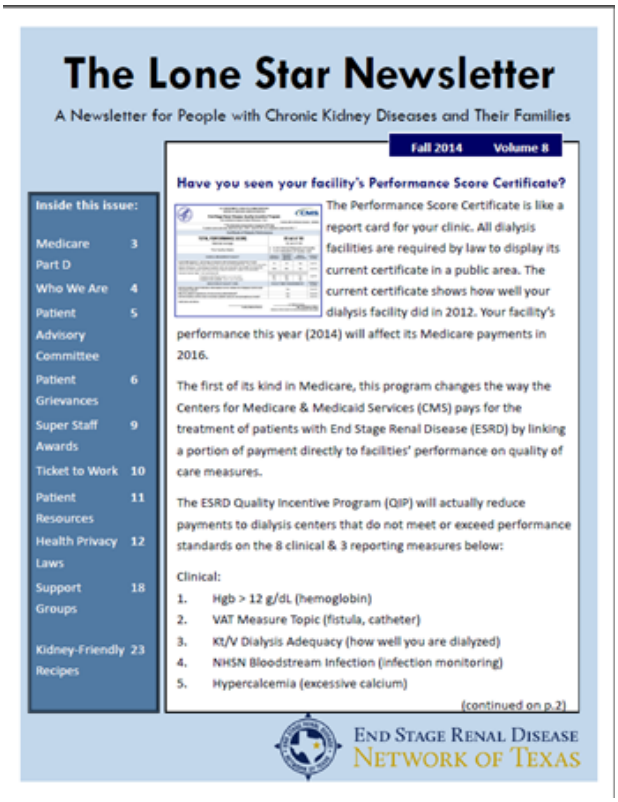
"Patients learned that we are willing to listen to their recommendations. They learned that even though they are very different and come from different backgrounds, that they are still able to work together for a common good."

"We learned that the final list of tasks needs to be tailored to the FPR's abilities."

# 2015 Patient Engagement Learning and Action Network

In January 2015, ESRD Networks 6, 8, and 14 came together to form the Alliant Quality Kidney Collaborative (AQKC). As a part of the collaboration, the ESRD Network 14's Lone Star Newsletter for patients has recently been replaced by the AQKC's Patient Newsletter. The first issue (Summer 2015) was printed and shipped to all Texas dialysis facilities.

Be on the lookout for this new and very helpful patient newsletter to share with your patients. If your facility did not receive the newsletter, you can find it on our website at: http://esrdnetwork.org/our-network/newsletters/. Scroll down to Newsletters for Patients and Families, under 2015 AQKC Patient Newsletter, and click on "Summer 2015." You are encouraged to print copies for your interested patients.



The Lone Star Newsletter

A Newsletter for People with Chronic Kidney Diseases and Their Families

Fall 2014 Volume 8

Inside this issue:



**Have you seen your facility's Performance Score Certificate?**

The Performance Score Certificate is like a report card for your clinic. All dialysis facilities are required by law to display its current certificate in a public area. The current certificate shows how well your dialysis facility did in 2012. Your facility's performance this year (2014) will affect its Medicare payments in 2016.

The first of its kind in Medicare, this program changes the way the Centers for Medicare & Medicaid Services (CMS) pays for the treatment of patients with End Stage Renal Disease (ESRD) by linking a portion of payment directly to facilities' performance on quality of care measures.

The ESRD Quality Incentive Program (QIP) will actually reduce payments to dialysis centers that do not meet or exceed performance standards on the 8 clinical & 3 reporting measures below:

Clinical:

1. Hgb > 12 g/dL (hemoglobin)
2. VAT Measure Topic (fistula, catheter)
3. Kt/V Dialysis Adequacy (how well you are dialyzed)
4. NHSN Bloodstream Infection (infection monitoring)
5. Hypercalcemia (excessive calcium)

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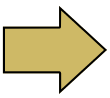
End Stage Renal Disease Network of Texas



PATIENT NEWSLETTER

ISSUE 1 JULY 2015

WHO IS AQKC?

PARTNERING TO IMPROVE THE LIVES OF PEOPLE AFFECTED BY ESRD

In January 2015, ESRD Networks 6, 8, and 14 came together to form the Alliant Quality Kidney Collaborative (AQKC). By working together, we can make a BIG difference in the lives of dialysis and transplant patients in seven states: Alabama, Georgia, Mississippi, North Carolina, South Carolina, Tennessee, and Texas! Every staff member and patient can benefit when we share what we learn with other ESRD Networks. If you would like to know more about AQKC, you can visit our website at http://aqkc.org/

ALLIANT QUALITY

IN THIS ISSUE



PREVENTATIVE CARE AND DISEASE MANAGEMENT

Studies show patients who undergo dialysis treatment have an increased risk for healthcare associated infections (HAI). The frequent use of catheters or insertion of needles to access the bloodstream puts hemodialysis patients at a high risk for infection. Dialysis patients and staff's top priority is to provide and receive safe care to avoid infectious complications.

Every visit to the dialysis facility can put you at risk for HAIs, but you can minimize that risk by following some simple steps.

1. Wash and sanitize your hands upon entering the treatment floor.
2. Wash and sanitize your hands upon leaving the treatment floor.
3. Wash and care for your access upon entering and leaving the treatment floor.
4. Speak up and request staff members to practice good infection prevention, such as:
   - Proper glove and mask use
   - Practicing hand hygiene
   - Practicing proper catheter care
5. Notifying your healthcare team if you notice any signs or symptoms of infection

The CDC recognizes the serious health implications associated with HAIs and has developed many tools to help you reduce the risk for HAIs. Work with your dialysis healthcare team to reduce infections through ongoing education and practicing positive infection prevention techniques.

Visit the Centers for Disease Control and Prevention (CDC) website for excellent resources on dialysis safety and HAIs at http://www.cdc.gov/dialysis. This website contains access education, clinical education, guidelines and recommendations, and prevention tools, such as the Patient Pocket Guide: 6 Tips to Prevent Dialysis Infections, (http://www.cdc.gov/dialysis/PDFs/Dialysis-Patient-PocketGuide.pdf).

Please visit the CDC's Dialysis Safety website, http://www.cdc.gov/dialysis/, for additional infection prevention resources, including a free continuing education (CE) activity for professionals and several observation tools, checklist tools, and protocols.

## QIP Performance Year 2016: Influenza Vaccination for Healthcare Personnel

A number of changes are coming for the ESRD QIP in Calendar Year 2016/Payment Year 2018. ICH CAHPS moves from a reporting measure to a clinical measure, where three specific areas will be tied to facility performance: Nephrologists' Communication and Caring, Quality of Dialysis Center Care and Operations, and Providing Information to Patients. Four new measures will also make their first appearance on the ESRD QIP: Standardized Transfusion Ratio, Pain Assessment and Follow-up, Clinical Depression Screening and Follow-up, and NHSN Healthcare Personnel Influenza Vaccination. Facilities should begin preparations to internal processes and systems to track and focus on these changes. Quarterly Dialysis Facility Compare Reports (QDFC) can aid in this process. However, if glaring inconsistencies are noticed between internal systems and the QDFC or the Performance Score Report (PSR) preview, how will your facility investigate?

A regular request for clarity that the Network receives from facilities regarding the QIP for 2016 is the NHSN Healthcare Personnel Influenza Vaccination measure. How is it tracked? When does it start, 2015 or 2016? What is the data source? Who qualifies? These are all excellent questions that are answered in this article.

This measure states that facilities will submit their Healthcare Personnel Influenza Vaccination Summary Report to CDC's NHSN system, according to the specifications of the Healthcare Safety Component Protocol, by May 15, 2016. This measure aims to promote influenza vaccination among facility healthcare personnel during the upcoming flu season. This flu season is defined as October 2015 to April 2016. Therefore, qualifying healthcare personnel who work in a facility for at least one day between October 1, 2015, and March 31, 2016, should be part of the summary report.

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## QIP Performance Year 2016: Influenza Vaccination for Healthcare Personnel (continued)

***Continued from page 6***

The greatest bit of confusion surrounding this measure is the term "qualifying healthcare personnel." "Qualifying healthcare personnel" is defined as an employee, licensed independent practitioner, or adult student/trainee/volunteer who works for at least one day during the designated flu season. "What if we need to hire a plumber or a contractor for repairs? Should they be included?" No. These contractors are not your employees, nor are they a student/trainee/volunteer. Most importantly, these contractors are not healthcare personnel.

The data for this, naturally, will come from NHSN. However, REMIS, CROWNWeb, and other CMS ESRD administrative data may be used to ensure that facilities do not qualify for an exclusion. For this specific measure, the only facilities that are excluded are those with a CCN effective date after January 1, 2016. Facilities certified after January 1, 2016, will not be required to participate in this measure during the Calendar Year 2016 timeframe.

**More information about the Protocol and Summary Report can be found at http://www.cdc.gov/nhsn/PDFs/HPS-manual/vaccination/HPS-flu-vaccine-protocol.pdf.**

**If there are any questions about this measure, or other QIP measures, please contact Jason Simmington, Quality Improvement Specialist with ESRD Network 14, at 469-916-3806 or jsimmington@nw14.esrd.net.**

## National Healthcare Safety Network (NHSN)

Healthcare Associated Infections (HAIs) are among the leading causes of morbidity and mortality in the United States and the most common type of adverse event in the healthcare field today. They are defined as localized or systemic adverse events, resulting from the presence of an infectious agent or toxin, occurring to a patient in a healthcare setting. By this definition, these infections are not present or incubating in the patient at the time of entry into that healthcare setting unless related to a previous admission from the healthcare facility.[1] At any given time, about 1 in every 20 hospitalized patients has an HAI, while over one million HAIs occur across the U.S. healthcare system every year; the fiscal cost of these HAIs is steep, creating an additional $28 billion to $33 billion in healthcare expenditures annually.[2]

CDC's National Healthcare Safety Network (NHSN) is the nation's most widely used HAI tracking system. NHSN provides facilities, states, regions, and the nation with data needed to identify problem areas, measure progress of prevention efforts, and ultimately eliminate healthcare-associated infections.

In addition, NHSN allows healthcare facilities to track blood safety errors and important healthcare process measures such as healthcare personnel influenza vaccine status and infection control adherence rates.

NHSN provides medical facilities, states, regions, and the nation with data collection and reporting capabilities needed to:

- Identify infection prevention problems by facility, state, or specific quality improvement project
- Benchmark progress of infection prevention efforts
- Comply with state and federal public reporting mandates

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## National Healthcare Safety Network (NHSN) (continued)

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- Drive national progress toward elimination of HAIs

Beginning decades ago with 300 hospitals, NHSN now serves over 14,500 medical facilities tracking HAIs. Current participants include acute care hospitals, long-term acute care hospitals, psychiatric hospitals, rehabilitation hospitals, **outpatient dialysis centers**, ambulatory surgery centers, and nursing homes, with hospitals and dialysis facilities representing the majority of facilities reporting data. Participation among the other facility types is expected to continue to grow in coming years.

While ensuring data security, integrity, and confidentiality, NHSN gives healthcare facilities the ability to see their data in real-time and share that information with clinicians and facility leadership, as well as with other facilities (e.g., a multihospital system) and partners like health departments or quality improvement organizations. CDC provides the standard national measures for HAIs, as well as analytic tools that enable each facility to assess its progress and identify where additional efforts are needed. In addition, NHSN is the conduit for facilities to comply with the Centers for Medicare & Medicaid Services' (CMS') infection reporting requirements.

In addition to benefiting from increased attention to HAI prevention, patients can use NHSN data posted publicly on the Department of Health and Human Services' Hospital Compare website (https://www.medicare.gov/hospitalcompare/search.html). Patients are encouraged to visit the website to see how their local facilities are doing and discuss concerns with their healthcare providers.

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## National Healthcare Safety Network (NHSN) (continued)

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NHSN data is analyzed by the CDC and others to direct actions for HAI prevention. Local, state, and national HAI trends are used to identify emerging problems and areas of concern that need intervention and to measure progress in HAI reduction against national, state, and local prevention goals.[3]

[1] McKibben L, Horan T, Tokars JI, et al. Guidance on Public Reporting of Healthcare- Associated Infections: Recommendations of the Healthcare Infection Control Practices Advisory Committee, 2005. *American Journal of Infection Control* 2005; 33:217-226.
[2] Klevens RM, Edwards J, Richards C, Et al, Estimating health care-associated infections and deaths in U.S. hospitals, 2002. *Public Health Reports* 2007; 160-166.
[3] http://www.cdc.gov/nhsn/about-nhsn/index.html

## ICH CAHPS Evolution

The fall In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) survey is just a month away. Calendar Year 2015 marks the first time that facilities are required to have this survey administered two separate times during the calendar year.

Considering that the spring survey data submission deadline is the first week of August, chances are that facilities will not have spring administration results back by the time the fall surveys roll out.

Once the fall surveys are completed, Payment Year 2016 offers an additional caveat, as facilities will be measured for ICH CAHPS in the Quality Incentive Program (QIP) not just for participation, but the rating will be tied to a summation of responses to selected question sets.

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## ICH CAHPS Evolution (continued)

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As the process of how ICH CAHPS is integrated into the QIP evolves, it is important to maintain a proper perspective on what the survey represents. The survey is much more than a tool that is used to give a facility a score on their QIP; at its heart, ICH CAHPS is simply a patient experience of care survey. While retailers utilize a "voice of the customer" survey, which is similar in nature, the ICH CAHPS is much more complex and nuanced than the reflection of a customer's singular visit to a retailer. Patients and their families spend a significant amount of time in the facilities interacting with nephrologists, facility staff, and fellow patients. Relationships, barriers, and trust are built over time; some are positive, and some are not.

Because of the relationships built in facilities, it is important to quantify the effectiveness of communications. One exception some take with this idea is that some facilities feel that only patients that may be upset are completing the survey. This exception is supplemented when a facility starts with a very low patient response rate. The recommendation to counter this challenge is to encourage all patients to participate. The best way to counter low patient response AND to offset upset patients is to increase the overall number of patients responding. Implementing a call to action for those patients who are perfectly content with their care will provide a more accurate assessment.

Accomplishing this is more than a simple conversation about the survey. Facilities should engage patients to find out why they do complete surveys, or why they decline. If a patient chooses not to, what triggers this reaction? These answers can only be found inside the facility's patient population.

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## ICH CAHPS Evolution (continued)

***Continued from page 11***

Facilities can uncover these answers with interactions as complex as discussion groups, or as simple as reflective listening. For guidance with either of these, feel free to contact the ESRD Network 14.

The ESRD Network 14 website also has excellent resources for ICH CAHPS. You can find tools that include an ICH CAHPS Resource Matrix, webinar slides, and other resources at http://esrdnetwork.org/professionals/qip/.

For any questions concerning ICH CAHPS, you can contact Jason Simmington, MHS, Quality Improvement Specialist at (469) 916-3806 or email: jsimmington@nw14.esrd.net.

## Vascular Access as a Matter of Life

Whether you are a renal patient or a healthcare professional in the ESRD field, chances are you have heard the phrase “your access is your lifeline.” There is a good explanation for the use of this phrase in the dialysis arena. The End Stage Renal Disease (ESRD) National Coordinating Center (NCC) has taken on the task of developing the Lifeline for a Lifetime program to improve outcomes for dialysis accesses. The ESRD NCC, in collaboration with the dialysis community, has developed an initiative that promotes not only choosing the right access for dialysis patients, but also sharing best practices centered around the patient’s goals and preferences.

Lifeline for a Lifetime is a guide that will help you choose, plan, track, and care for the best vascular access for each individual patient. It is designed to work as a bridge to the patient’s lifeline, a bridge the patient will not have to cross alone. The program understands that the care team, as well as the family and support systems, are important to the patient.

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## Vascular Access as a Matter of Life (continued)

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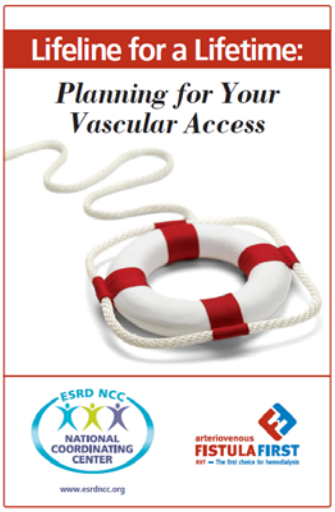


Lifeline for a Lifetime is an eight-step plan designed to meet the patients' needs where they are. By reviewing all the steps in this program, you will be able to help the patients determine where they are in the process and establish a goal for their accesses. For instance, if the patient is new to dialysis, *Step 1: Making an Access Plan* can help the Care Team and the patient choose the right access.

Together, you will be able to navigate through all steps and utilize them as a guide to establish a successful vascular access plan. It is important to mention that this initiative is also a patient-focused approach that addresses the patients' community connections, learning the basics, making lifestyle changes, maintaining adequate health, and caring for the vascular access. Living to the fullest with ESRD is very important for each patient, and it's the key to obtaining the best dialysis outcomes. Learning about the patient's vascular access needs and knowing what actions to take will help him or her stay healthier, feel better, and perhaps live longer.

"Living with ESRD can be hard…connecting with other patients or families that are going through what you're going through can help." This statement by the ESRD NCC recognizes that peer mentoring and community connections can definitely help in coping with life after being diagnosed with ESRD. Having access to a support network can help close the gaps in managing and caring for the best vascular access. The Lifeline for a Lifetime program believes in empowering the lives of patients and families through communication and community support. The Community Connections section provides myriad resources, including patient stories, motivational videos and social media tools, connecting with other patients, and establishing

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## Vascular Access as a Matter of Life (continued)

***Continued from page 13***

effective peer mentorship programs. Learning how shared experiences can effect ESRD patients will positively impact their lives and the lives of those going through the same journey.

In essence, the ESRD NCC aims to establish the optimal vascular choices through implementation of best practices, professional resources, early interventions, and patient-focused initiatives. Understanding the patient's vascular needs is a pivotal step towards establishing a successful access. Effective implementation of the Lifeline for a Lifetime program in your facility is indeed a matter of life for all ESRD patients.

Sources:
http://esrdncc.org/navigating-your-esrd-journey/lifeline-for-a-lifetime/ *My Vascular Access*
http://esrdncc.org/navigating-your-esrd-journey/lifeline-for-a-lifetime/access-planning/ *Lifeline for a Lifetime: Planning for your Vascular Access*

## Innovation of Best Practices to Reduce Bloodstream Infections (BSIs)

Healthcare-associated infections are on the rise and can be acquired anywhere care is being delivered. According to the National Action Plan to Prevent Health Care-Associated Infections: Road Map to Elimination (2009, para.2), "At any given time, about 1 in every 25 inpatients has an infection related to hospital care. These infections cost the U.S. health care system billions of dollars each year and lead to the loss of tens of thousands of lives."

One of the main goals for the U.S. Department of Health and Human Services (HHS) has been to reduce the incidence of healthcare-acquired infections by measuring, targeting, and developing best practices.

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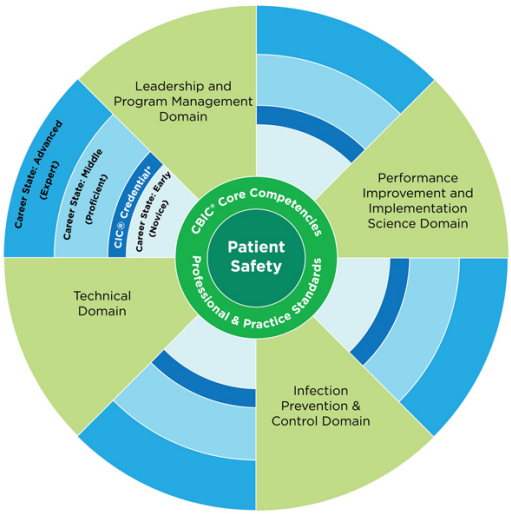
# Innovation of Best Practices to Reduce Bloodstream Infections (BSIs)

***Continued from page 14***

Innovation and continuous implementation of best practices has proven to be an effective strategy to target and reduce the impact of bloodstream infections in different healthcare settings. According to the *American Journal of Infection Control* (AJIC), there is a widespread variation among best practices to prevent infections ("Competency in infection prevention: A conceptual approach to guide current and future practice," 2012, para.1). Based on this study, a conceptual model of competency that can be applied to all practice settings was created in collaboration with the Association for Professionals in Infection Control and Epidemiology, Inc. (APIC).

The APIC Competency Model for the Infection Preventionist is a circular-shaped, color-coded chart. The main green areas in the center of the model are critical targets and are focused around "Patient Safety" as the bull's-eye. The remaining rings are built around the concepts of leadership, performance, infection control, and technical domains. The APIC Competency Model and other professional resources can be accessed on the APIC website at http://www.apic.org/Professional-Practice/Infection_preventionist_IP_competency_model.

APIC Competency Model for the Infection Preventionist




Maintaining an innovative approach in the prevention of infections also includes searching for best practices developed in other specialty areas and applying them to a different environment. As stated by physician Michael L. Rinke, MD, Assistant Professor of Pediatrics in the Division of Quality and Safety at Johns Hopkins University School of Medicine, "It's challenging to get people

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## Innovation of Best Practices to Reduce Bloodstream Infections (BSIs)

***Continued from page 15***

to change behavior they've engaged in for years and years" (Lindsey, 2012). Hence the importance of approaching practices proven to be effective in other settings and using them to assist in reshaping common policies and procedures. Having the willingness to learn and adapt to new concepts as a healthcare professional in your area of specialty can be advantageous in fighting BSIs.

In the search for innovative infection prevention practices, an array of research initiatives are currently under trial by hospitals, universities, and epidemiologists across a variety of care settings. Sharing evidence-based strategies to help reduce the incidence of healthcare-associated infections is becoming best practice among healthcare facilities. In a recent article published by *Cambridge Journals* in May 2014, Deborah Yokoe, MD, MPH, argues that prevention of HAIs is a national priority. "Although substantial progress has been achieved," says Dr. Yokoe, "Deficiencies remain in our ability to efficiently and effectively translate knowledge about HAI prevention into reliable, sustainable practice"(p.1).

Therefore, innovation and development of best practices to reduce BSIs begins by integrating new approaches in infection prevention initiatives. Collaboration among different health areas and adoption of new best practices can significantly help reduce the incidence of bloodstream infections among healthcare facilities. Implementation of advanced best practices continues to gain support as an effective avenue to reduce and eliminate bloodstream infections.

Sources:
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http://journals.cambridge.org/abstract_S0195941700035748
http://www.apic.org/Professional-Practice/Infection_preventionist_IP_competency_model

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