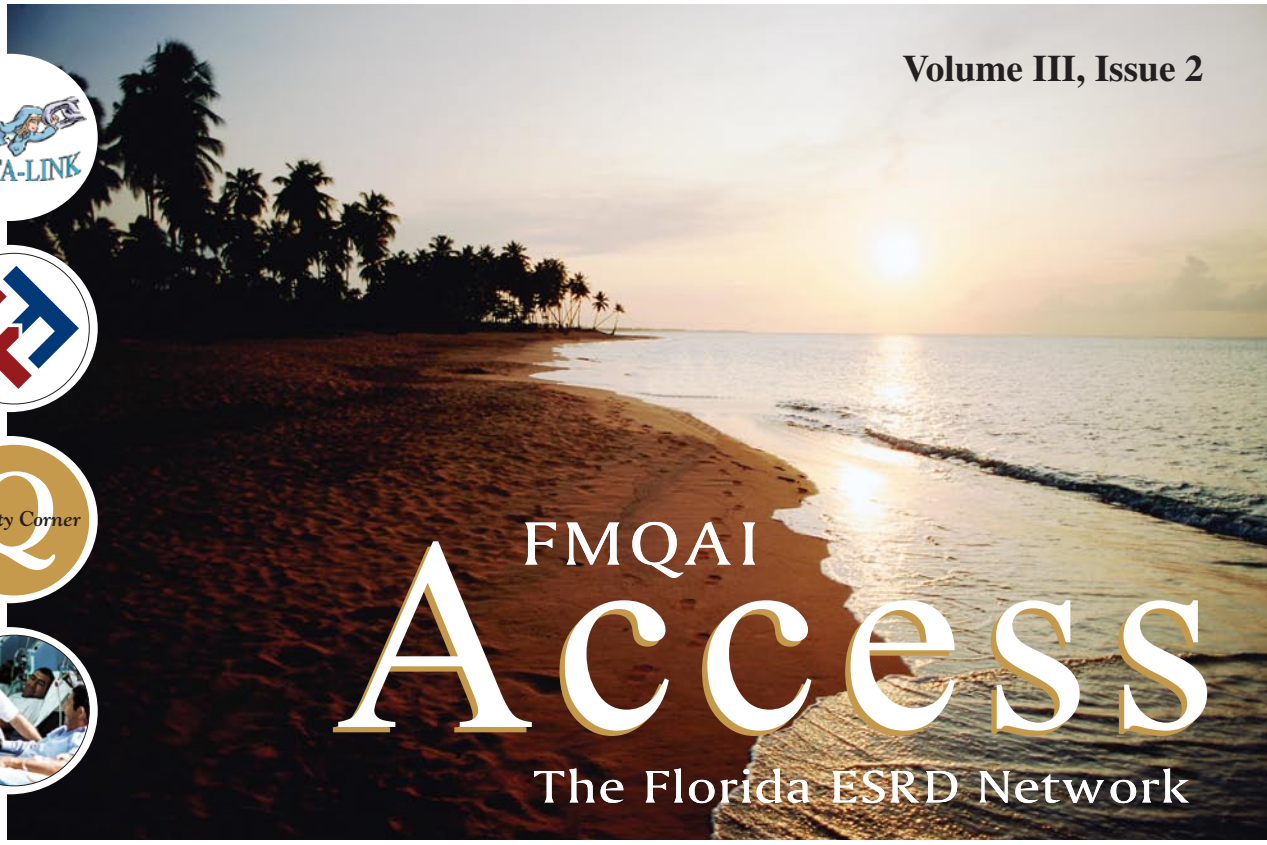

Volume III, Issue 2

FMQAI Access

The Florida ESRD Network

Emergency Preparedness: There is Always Room for Improvement

The 2004 and 2005 hurricane seasons highlighted issues of concern around the country in addressing the need for community planning and relief efforts in the event of a major disaster. The Network asks that you consider the following information as you prepare your families, facilities and patients for the 2006 hurricane season. Remember, disasters, both natural and man-made, are not limited to hurricanes. Therefore it is critical that you plan for **year-round readiness** to respond to any emergency situation with little or no notice.

At a minimum, your facility should have written disaster policies and procedures in place, all personnel should be trained in their role in emergencies and all patients should be fully informed of where to go, what to do and who to contact. It is important to assist not only patients, but staff as well, with their personal plans.

A strong emergency plan is not limited to working within your own facility structure, but includes **collaboration** with others in the community, such as other providers (independent and corporate), local emergency responders, transplant centers, nursing homes, hospitals and other key partners. Plan within your community how you will provide emergency dialysis for patients, including:

- ✓ Space to do the treatment;
- ✓ Electricity to run the equipment;
- ✓ Dialysis machines;
- ✓ Potable water for use in the treatment (each treatment requires a minimum of ~ 100 gallons of pressurized water);
- ✓ Water treatment equipment (Carbon filtration and either reverse osmosis or deionization);
- ✓ Supplies (dialyzers, blood lines, saline, medications, etc.);
- ✓ Personnel qualified to perform dialysis; and
- ✓ Medical records including the prescription for dialysis.

During times of disaster, the Network tracks facility status (i.e. open, closed, damaged, loss of power, water, phone, or access to the premises) and coordinates efforts with the State of Florida Department of Health (DOH). The status of dialysis facilities is communicated by the DOH to all County Emergency Management Offices via the state's ESS database. This information is also posted on the Network's website. Therefore, early communication to the Network regarding your facility's status, pre and post-event, is key to response efforts toward restoration of normal operations.
For technical assistance with disaster planning, contact the Network office at 813-383-1530, ext. 3883.

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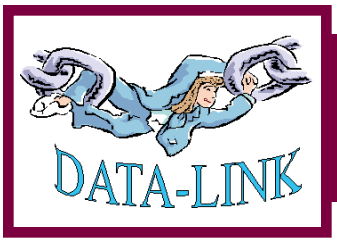

Network Patient Activity Reports

The current Network Patient Activity Reports (NPARs) were rolled out last May. This is a form that all Networks are using for collecting information on patient events. Now that we have a years worth of experience with the form, there are a few things we would like to point out.

- ❑ You need to enter date of birth and gender for each patient, especially those patients that don't have a social security number. If the patient is new to ESRD, we cannot create a record for them without that data. In the case of patients that have no social security number, that is often the only way to discern which of many similarly named patients you are referring to.
- ❑ The zip code needs to be entered. The form does not have room for complete addresses like the Quarterly Rosters do, but this will allow us to at least get the city, county and state into the initial record. In addition, when the zip code is different from what we have on file, we will know it is possible that the patient has moved, so we will not be sending mailings to the wrong address.
- ❑ It is crucially important that you enter a date for each event. Without a date, we cannot enter the event you are reporting into our data system.
- ❑ Along with the date, you must enter the modality of the patient at the time of the event. Modality is no longer noted with a number code. Just describe the modality (In-Center Hemo, Home Hemo, CAPD, CCPD, Frequent In-Center Hemo, etc.).

Here are a couple of other things we would like to remind you about. These are not new, but since we are talking about the report, it is a good time to revisit these issues.

- ❑ The reports are due by the 10th of each month for the previous month.
- ❑ Send us a blank form saying "No Updates," when you do not have anything to report to avoid being listed as delinquent.
- ❑ The most commonly forgotten fields are the social security number, the date of birth and the date of the event. Please make sure you enter those for every record.

As always, you can get a copy of the instructions, a blank form or additional tips from our website at http://www.fmqai.com/ESRD/DataManagement.htm or contact the Network office. If you are using the Excel spreadsheet, thank you! It really reduces problems reading handwriting. If you do not have Internet access and would like to receive the Excel version, please contact the Network office and we can email it to you or send it on a diskette.

Facility Survey Update

We would like to thank all of you for making this year's Facility Survey data collection the best one yet. There were fewer records that needed to be researched before mailing and fewer call backs than ever before. This is thanks to the hard work of the facility staff in keeping us updated on what is going on with your patients.

We are hoping that next year will be even better. Moreover, with your help, it can be. At the end of each quarter, we send you a compiled list of the events relating to your patients for that quarter. This will give you a chance to send us any events that may have been missed or entered incorrectly and to update any missing information.

Forms Tips

Getting Blank Forms

Many of you contact the Network each month trying to get blank forms. We are your source for blank 2746 (Death Notification Forms). If you need 2746's please send a fax to the Network office at 813-354-1514. Please provide your name, the facility name & provider number and the address to which you would like the forms sent.

The Social Security Administration is the source for the 2728 (Medical Evidence Forms). You must contact your local Social Security office to obtain those forms.

We *do not require* that you submit the government printed forms, as long as the ones you submit look exactly like the approved form, other than the color of the paper. If you are running short of either form, you can make a copy of a blank form and use the copy. If you have run out of blank forms and you have Internet access, you will find a link to download the form from the Network website at http://www.fmqai.com/ESRD/ESRD.htm.

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FISTULAFIRST
National Vascular Access Improvement Initiative

FISTULA FIRST: UPDATE

MAKE A DIFFERENCE!
Adopt Fistula First Change Concepts and Tools.
www.fmqai.com/ESRD/FistulaFirstToolKit.htm

AV Fistula – The Optimal Choice for Hemodialysis Access

Today, approximately 41% of patients in the United States dialyze with a fistula instead of a prosthetic tube (graft) or a plastic catheter, despite overwhelming evidence that they are safer, cheaper and more effective than grafts and catheters. Patients with fistulas develop fewer infections, require fewer hospitalizations, have fewer problems with clotting and have a greater blood flow for better treatment. Fistulas last for years, compared to weeks or months for other access types. Despite this evidence, fistula rates remain lower in the United States than in Europe and Japan. Currently, more than 80% of patients living in Europe and Japan are dialyzing with an AV fistula.

Fistulas have been used since the 1960s, but when synthetic grafts became available in the mid-1970s, surgeons started to prefer them because they came in different sizes, were easy to place, and could be used almost immediately. However, over the passage of time, problems associated with the use of catheters and grafts became obvious. Now the medical community is faced with the challenge of reversing several decades' worth of medical practice and correcting this unfortunate practice pattern of excessive use of grafts and catheters. Although there are situations where a graft or catheter will be the appropriate vascular access for a given patient, the use of a graft or catheter should be avoided wherever an AV fistula is feasible. The cost associated with caring for a patient with a fistula is thousands of dollars less annually.

Medicare spends about one billion dollars a year for repairs to grafts and catheters. That number is expected to increase because of the anticipated rise in the number of diabetic patients--the number one cause for end stage renal disease. In 2003, it cost Medicare an average of $52,751 to care for a patient with a fistula, compared with $61,929 for those using a graft and $69,893 for those with a catheter.

The reasons why more patients don't benefit from a fistula are complex:

- Many patients cannot have a fistula because their veins are not strong enough to withstand the procedure or because of other existing medical conditions.
- Many times patients are not referred to a surgeon early enough for a fistula to mature before a first treatment. Therefore, a graft or catheter is placed.
- Many patients prefer catheters even though there is a higher likelihood that they will develop a potentially deadly infection.
- Many patients prefer catheters because they fear the pain associated with the large gauge needles that must be inserted at each treatment.
- On average, a surgeon receives $714 for a graft but only $560 for a simple fistula. That is because Medicare's reimbursement system is based on the time and resources needed to do a procedure, not on the outcome.

The goal of the Fistula First Breakthrough Initiative is to increase fistula use to 66% by the year 2009. The initiative includes widespread educational outreach that could lead to changes in the way the government pays for dialysis care, providing incentives for surgeons placing fistulas instead of grafts or catheters. Ultimately, every patient receiving hemodialysis should have the opportunity to have a native AVF, the optimal vascular assess, whenever possible.

For more information on the Fistula First initiative, please contact FMQAI: The Florida ESRD Network at (813) 383-1530 X5 or visit www.fmqai.com or www.fistulafirst.org.

Reference: Gaul, Gilbert M. "For Kidney Patients, Another Failure." Washington Post, 6 Dec. 2005; Pg HE01.

Quality Corner

Functional Ability of Patients on Dialysis: The Critical Role of Anemia

By Randee Breiterman-White, MSN, RN, CNN

Functional ability describes the extent to which people are able to live their lives, provide for their own needs and fulfill their expected roles as active members of society. When medical professionals hear the term "functional ability," they typically think of activities of daily living (ADL), including both basic and instrumental functions of life. Basic ADL comprise fundamental tasks such as eating, walking, dressing and using the bathroom. Instrumental ADL encompass more advanced skills such as driving, shopping, paying bills, exercising lightly, doing housework, volunteering and working. While ADL are the basis of assessments of functional ability, other factors may also have to be evaluated depending on the patient population.

Anemia negatively influences a broad range of parameters that can significantly decrease functional ability in patients on dialysis. Conversely, partial correction of anemia to maintain hemoglobin levels at 11 to 12 g/dL, as recommended by the National Kidney Foundation's Kidney Disease Outcomes Quality Initiative (NKF-K/DOQI), has been shown to improve functional status.

By the time patients reach end stage renal disease, many have experienced a downward spiral in functional ability caused by a combination of disease, deconditioning and disability. While maintaining hemoglobin (Hgb) in the NKF-K/DOQI target range is vital to partially reversing this deterioration, there are physiological limits to the benefits of anemia correction alone. Indeed, in addition to anemia, other factors such as age, deconditioning, gender, body mass, cardiac dysfunction and other comorbid conditions, metabolic disturbances, impairment of cardiac autonomic control, defects in muscle oxidative metabolism and skeletal muscle atrophy can also affect functional capacity in patients on dialysis.

While some of these factors may not be correctable, considerable attention has been focused on reversing physical deconditioning by means of a consistent exercise program. The mechanisms by which an exercise program and Epoetin alfa therapy affect exercise capacity are different. Epoetin alfa raises Hgb levels, thereby leading to improvement in the oxygen-carrying capacity of the blood. Partial correction of anemia with Epoetin alfa therapy may make patients more willing to participate in an exercise program and enable them to perform higher intensity exercise. By contrast, exercise leads to improvement in oxygen uptake of the ability of cells to use oxygen they receive. Studies indicate that adding an exercise training program to a patient's regimen can increase exercise tolerance by up to 25%. Further, the combination of exercise and Epoetin alfa is synergistic, thereby facilitating even greater improvements in functional capacity.

Care plans at many dialysis facilities include anemia management to maintain Hgb levels at 11 to 12 g/dL, in conjunction with an exercise training program, referrals for physical therapy and /or in-center exercise. Nurses are typically responsible for monitoring and managing the anemia management protocol to ensure Hgb levels remain in the target range. However, nurses should also be aware that improvements in functional capacity often depend on the encouragement from the nephrology team. Therefore, improvements in functional ability can be greatly enhanced when nurses regularly tell patients that they are expected to adhere to both the anemia management prescription and the exercise program.

Anemia is a devastating consequence of ESRD that can contribute to deterioration in functional ability. Clinical data indicate that patients who maintain Hgb levels in the target range of 11 to 12 g/dL typically experience significant improvements in many facets of functional ability. Nurses are influential in ensuring that target Hgb levels are achieved and maintained, while at the same time encouraging patients to participate regularly in activities that improve physical conditioning and functional ability.

This is an excerpted portion of an article first published in Nephrology Nursing Journal, January-February 2005, Vol. 32, No. 1 - *Reprinted with permission from Amgen*

TOP 10 CMS SURVEY DEFICIENCIES

By Marsha Lisk, CMS Surveyor

You are assisting your dialysis facility to prepare for a recertification survey. The Quality Assurance Committee has reviewed the Facility Data Report and has been working on plans to improve your numbers. But what else can you and your staff do to ensure a good survey? What are the most common deficiencies cited in Florida?

The top 10 deficiencies to date for fiscal year 2006 are:

1. V0266 Policies/Procedures for Preventing/Controlling Infection. This was cited in 20.63% of the surveys. Why? Patients were observed holding their own access sites without wearing gloves, not washing their hands after holding their sites and then touching door handles on the way out. Patient Care Techs were observed leaving the treatment area without removing personal protective equipment, not washing their hands or using a hand sanitizer between touching patients, catheter sites, IV lines, other machines, charts or keyboards. Staff was observed going back and forth between patients and a common medication cart preparing and administering medications. The door to an isolation room was left open during a treatment. Staff were observed going from the general population to isolation and out again without washing their hands. Staff didn't follow the facility's policy for cleansing the patient's access site.
2. V0258 Electrical and Other Equipment Maintained Free of Defects. This was cited in 14.29% of surveys. It was cited because of a lack of preventative maintenance on machines, not doing safety checks and not following facility policy on documenting equipment problems.
3. V0261 Water for Dialysis Analyzed Periodically. This was also cited at 14.29%.
4. V0196 Care Plans Reviewed Monthly for Unstable Condition. This was cited in 11.11% of surveys.
5. V0431 Registered Nurse. This was cited in 11.11% of surveys. The registered nurse was cited because access sites were covered with a blanket, therefore, the staff could not assess the sites for bleeding. Nurses were also cited for lack of documentation post treatment of vital signs and weight; having expired meds available and outdated post disinfection strips.
6. V0263 Bacteriology of the dialysate. The facility was not testing or monitoring dialysate as required or in accordance with their written policies.
7. V0256 Building and Equipment. This was cited for unsecured oxygen cylinders.
8. V0265 Favorable Environment for Patients.
9. V0227 Grievance Mechanism. This was cited for lack of a process to report and resolve patient/family complaints.
10. V0192 Patient Care Plan.

Numbers 6-10 were all cited at 9.52%.

Stand back and objectively observe the care that is being provided in your facilities. This will assist you to see what the surveyors are seeing. Making staff more aware of these ten commonly cited deficiencies can only improve care for your patients.

ANEMIA MANAGEMENT ON-LINE CE PROGRAM

This is an educational activity designed to increase awareness of anemia as a risk factor in special populations, as well as to discuss evidence-based strategies for improving patient function and quality of life. Following completion of this program, you will be awarded 1.2 Type I CEUs. Log onto www.princetoninstcme.com and register between April 12, 2006 and October 12, 2006. CE information and program materials can also be downloaded from this site.

FROM THE PROJECT DIRECTOR

In December 2003, not long after the Network 7 contract was awarded to FMQAI, a highly qualified and unique individual was hired to serve as the Quality Improvement Coordinator for the Florida ESRD Network. Her name was Susan V. McGovern, MS, ARNP.

She didn't arrive with direct experience regarding ESRD, but had an intense desire to learn and make a difference in the renal community. What she did bring was unmatched quality improvement knowledge and an exceptional ability to teach others. With all of these tools, Susan elevated the Network's capacity to serve the renal community to a new level.

Her efforts not only impacted the Network staff, but the entire Florida renal community. Through her work with dialysis and transplant providers, and other key stakeholders, Susan strived to improve fistula and adequacy rates, taught quality improvement techniques, collaborated for disaster preparedness and developed partnerships to improve quality care.

As some of you know, she began battling breast cancer in early 2004. With deep sadness, the Network staff would like to inform you that Susan passed away on Saturday, May 20th. Susan made a tremendous difference to our staff and to our community. She will be greatly missed. We will go forward without her – but not without the skills, knowledge and memories she left behind.

Kelly M. Mayo, MS

Newsletter Submittals

TELL US WHAT YOU'RE DOING!

Are you implementing any QI projects that are having a positive impact on patient outcomes or internal processes? Let us showcase your successes in our newsletter.

Contact **Cindy Woodward**, QI Community Services
By phone: 813-383-1530 x3882 or E-mail: cwoodward@nw7.esrd.net

Join AAKP at its 33rd Annual Convention!

This four-day event is the largest national meeting where kidney patients can interact on a person-to-person basis with fellow patients and healthcare professionals.

Renaissance Orlando Resort at Sea World

August 31 – September 3, 2006 – Orlando, Florida

Please visit www.aakp.org for more information
or call (800) 749-2257

Network Patient Activity Reports *...continued from page 2*

VISION

While we are on the subject of the difficulties of acquiring blank forms, we would like to offer a way for you to generate, electronically, as many forms as you need, whenever you need them, *and* give you a way to avoid the need to submit monthly NPARs. Plus, you get the added bonus of improving both forms accuracy and timeliness! Interested?

VISION, which stands for Vital Information System to Improve Outcomes in Nephrology is a software product developed by CMS to reduce data collection and reporting problems faced by facility personnel. Participation is open to independent and regional chain facilities (those not a part of any of the Large Dialysis Organizations). You will need access to a computer and the Internet to participate. For more information, you may visit the VISION website at http://www.esource.net/vision.php. You can also fill out an Online Training Request form if you are interested in participating.

If you are one of the more than 30 facilities already participating in VISION, we would like to take this opportunity to thank you.

The next time you get together with your peers, please share your experiences with them. We would also like to encourage anyone who can, to participate in the VISION Users Group. They are the people who have direct contact with the VISION developers and provide leadership and guidance as the product evolves. Minutes of previous meetings are also posted to the VISION website; membership is open to all VISION users.

Quick Links

Network Website
http://www.fmqai.com/ESRD/ESRD.htm

VISION Website
http://www.esource.net/vision.php

Download 2728, 2746, and 2744 forms and instructions directly from CMS
http://www.cms.gov/CMSForms/CMSForms/list.asp
and do a search on the keyword ESRD.

EMERGENCY PREPAREDNESS *...continued from Page 1*

Tools and Resources

Network 7 Emergency Information (Dialysis Facility Compare, Patient Education Tools, Boil Water Advisory and more)
http://fmqai.com/

Link to County Emergency Management Offices
http://www.floridadisaster.org/County_EM/county_list.htm

Link to Emergency Guide for People on Dialysis
http://www.medicare.gov/Publications/Pubs/pdf/10150.pdf

Link to Emergency Preparedness Guide for Dialysis Facilities
http://fmqai.com/ESRD/pdf/CMSDisasterPlanningGuide.pdf

The Network Grievance Process

All ESRD facilities are required to have steps in place to handle concerns or complaints. Patients are encouraged to use the system in their clinic first. If this does not work, patients can call Network 7's toll-free helpline at 800-826-3773. The Network is authorized by the Centers for Medicare & Medicaid Services (CMS) to receive, investigate, and when possible, resolve complaints and grievances made by or on behalf of ESRD patients. Complaints can be made anonymously. The Network will ask the patient to describe the concern and will collect information to determine the nature and extent of a problem and/or whether the services received meet medically acceptable standards. When quality of care concerns are identified, Networks can:

- Work directly with the facility to correct the problem;
- Ask the Agency for Healthcare Administration (AHCA) to investigate; or
- Ask the Quality Improvement Organization (QIO) to look into the problem and take appropriate action.

ESRD Providers: Please be certain that your patients are made aware of information on how to contact Network 7 to voice their concerns. This information should be shared with all patients at least annually, and we recommend it be documented in the patient's medical record. Network Grievance Posters (both in English and in Spanish) should be posted in the lobby of your facility with the correct contact information for Network 7.

Should you need more information about how the Network complaint and grievance process works, talk with your facility social worker or call the Network at 800-826-3773.

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ACCESS

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