

In this edition of Vision I would like to share with you portions of a letter from a patient that I hope brings as much concern to you as it did the Network office. We deal with a vulnerable population who rely on the dialysis staff for their needs. It is paramount that a patient gets the care to ensure the highest quality of life possible. An essential part of that care is patient education. It is through education that a patient becomes more knowledgeable about their disease and the treatment of their disease. Studies have shown that the patients who understand and participate in the treatment of their ESRD do better, have better quality of life and decreased complications.

If this is the case, why would any center not want to strive to make patient education a major part of the treatment process? The Network does have a number of exemplary facilities that do an excellent job of addressing the needs of patient education. The problem is we have some facilities that do not educate and prompt letters from patients such as this: "The nature of kidney disease is that you have question after question to put it all together. There should be education times but the center does not make this a priority. It puts it on the patient to catch all these people. I find this highly uncomfortable and stressful, worse than the disease itself. Once when I asked the doctor a question, he told me he was shocked that a patient was asking questions as most patients never ask anything. I was shocked that he said this. This is how bad my center is in the education aspect. And as I said, no one wants to make appointments because they are so busy they don't want to give 1 on 1 education."

Whose responsibility is it to educate the patient? The whole care team, from doctor to technician. Each member of the care team has a function in the treatment process and the responsibility to educate the patient about that function, from needle sticking to being educated about lab results and psychosocial issues. Education is also more than handing out materials to the patient and telling them to read it. The material should be reviewed, questions exchanged between the caregiver and patient and some type of evaluation to ensure the material was understood.

You can educate individually or in groups, it can be on-going or you can dedicate education times (shifts), just do it. If possible, a family member or significant other should be involved so they can have the knowledge and can provide support for the patient. The common complaint of not having enough time needs to be explored. How much time and energy is currently spent dealing with "problem patients" and "non-compliant patients"? Education can significantly reduce this time. The more the patient knows, the more control they have over their disease. The likelihood of good outcome increases with the knowledge level of the patient. As health care continues to be driven by outcomes, the significance of educated patients will increase.

Educational resources can be obtained from many sources. The Network has a clearinghouse, AAKP, AKF, NKF, CDC, LORAC, dialysis vendors, professional journals and organizations and the Internet are all available resources for education.

The challenge is to make a commitment to the education of your patients and develop a plan to accomplish this. Being a new dialysis patient is hard enough without having to feel that getting educated is more stressful than having the disease.

THE BEST PRACTICE NETWORK

Through my interactions with the American Association of Critical-Care Nurses (AACN), I have had the opportunity to participate with an organization known as the Best Practice Network. As mentoring is part of our QI mission, I would like to share some background information about this organization with each of you now. The Best Practice Network has given us permission to share with you “A Guide to Benchmarking and Best Practice Terminology” which is in my opinion “a nice QI starting point and/or reference”.

PURPOSE: The purpose of the Best Practice Network is to promote information sharing in healthcare by nurses, physicians and other healthcare professionals. The Best Practice Network facilitates the exchange of ideas, encourages collaboration in results-oriented problem solving, and enables healthcare professionals to learn from one another, best practices that will positively impact patient care and community well-being.

HISTORY: In January 1996, nationally recognized opinion leaders from the world of nursing participated in an unprecedented effort to proactively shape a vision for the future of healthcare, and to strategize an action agenda in which nursing leadership collaboratively promoted optimal patient care delivery. In May 1996, professional organizations joined the initial Summit participants to further define an agenda of initiatives and assumptions. The spirit of the Summit is captured in the predominant goal, which emerged as a result of those initial efforts:

To develop realistic and sustainable healthcare initiatives, which promote optimal patient care and have immediate and system-wide impact.

Thirteen organizations, the Founders, have provided financial and clinical support for the initiatives derived from the Summit, among them Best Practice Initiatives. Spearheaded by the American Association of Critical-Care Nurses, the Best Practice Initiatives called for the creation of the Best Practice Network and Directory and a national conference, the Showcase for Innovation and Best Practices. In November 1996, AACN appointed Mary E. Kingston, RN, MN, to direct the Best Practice Initiatives. The Advisory Board, comprised of representatives from the contributing organizations, guides the development and implementation of the Best Practice Network website www.best4health.org, the Best Practice Directory, and the Showcase for Innovation and Best Practices. The Best Practice Network is a not-for-profit entity. It is supported by the Founders and other organizations, which have donated clinical expertise and financial backing. Our vision is to provide a place where innovative solutions and best practices can be shared among nurses and other healthcare practitioners to promote healthy communities and provide optimal patient care.

A Guide to Benchmarking and Best Practice Terminology

For those with little time, but a BIG need to know about benchmarking and best practices, the Best Practice Network presents key concepts and terminology from the experts in an abbreviated format.

What is the difference between benchmarks and benchmarking?

Benchmarks are the actual measurements used to gauge the performance of a function, operation or business relative to others. [1] While benchmarking is the continual and collaborative discipline of measuring and comparing the results of key work processes with those of the best performers. It is learning how to adapt best practices learned through the benchmarking process that promotes to breakthrough process improvements and builds healthier communities. [2] The objective of benchmarking is to identify best practices so that an organization can set higher goals and improve performance. [3] This can be done by comparing benchmarks.

What is a best practice?

A best practice is a service, function, or process that has been fine-tuned, improved and implemented to produce superior outcomes. [4] “Best” is used in a contextual sense. [5] It means “best for your patients or your community” – in the context

of your regional health environment, your health system's strategies and mission, your organizational or community culture, or your practice systems. Best practices are those practices that result in benchmarks that meet or set a new standard.

Why should we seek best practices?

- To improve clinical patient outcomes.
- To improve administrative efficiencies.
- To reduce costs in healthcare.
- To provide supportive data in growing market share and contracting. [6]

How does benchmarking relate to best practices?

Benchmarking is understood to be a process, a structured approach, and a discipline that is continuing or ongoing. It involves measuring, evaluating and comparing both results and processes that produce the best results. [2] From those identified best results, we strive to learn about the strategies and practices that produced those best results. Those practices are known as best practices. The overall goal of benchmarking is to identify best practices that can be implemented to produce improvements that are at least at the same level of the best.

What is meant by evidence-based practice?

Evidence-based practice uses available evidence to ensure clinically effective and cost-effective treatment of patients, thereby increasing the proportion of clinical care shown by that evidence to be effective. [7] Ideally, the evidence needs to be drawn from systematic research and detailed evaluations of health care interventions. It is also recognized that clinical expertise and patient preferences have a part to play. [8]

What is the difference between evidence-based practice and a best practice?

Evidence base practice involves rigorous scientific evidence to demonstrate clinical effectiveness. Best practices can be evidence based, but can also be innovative, meaning a new way of doing something. An example of this may be the development of a program to teach children asthma self-management through the use of a computer game. The information in the game is evidence based and supported through scientific research, but the modality for delivering the information is innovative. If the use of computer games to teach asthma management techniques results in better compliance, fewer emergency department visits and a more informed consumer, then this may be considered a best practice in teaching asthma management.

Are best practices research-based?

Best practices can be research-based. Overall, benchmarking for best practices is more of a clinical or administrative improvement process that does not profess to be as rigorous or scientific as research.

What is a protocol?

A protocol is an organized method of analyzing and dealing with a disease process or symptom complex. A protocol may be highly organized and directive, as in some algorithms, or it may be more general and flexible. The type selected for development and use will depend on the clinical practice situation, the education and experience of those who will be using the protocol and the availability of physician support. A minimally trained person who has limited physician availability will require a protocol that is very explicit, whereas, a more highly trained professional may require only general guidelines. [9]

What is a guideline?

A guideline reflects the state of current knowledge, as published in healthcare literature, regarding the effectiveness and appropriateness of procedures or practices. [10] The goal of guidelines is to describe a recommended course of action for a specific condition, procedure, or patient population. [11]

What are standards?

A standard is a statement that defines the performance expectations, structures, or processes that must be substantially in place in a healthcare organization to enhance the quality of care. [12]

What are clinical pathways?

A clinical pathway is a tool designed to optimally sequence and coordinate events or interventions to reduce delays, promote efficient resource use, and improve quality or performance. [13]

What is an outcome?

An outcome is a result of care. [14]

Are best practices the same as protocols, guidelines, standards, clinical pathways, or outcomes?

Each of these can be considered a best practice IF...

- It has been implemented and produces superior results.
- Leads to efficient and exceptional performance in cost, quality and speed or is innovative.
- Satisfies key stakeholders (patients, clinicians, etc.)
- Is recognized either internally or externally as being a best practice (an award or presentation in publication, by an expert, by a consortium, etc.) [15]

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THINK PREVENTION!!!

One of Network 13's responsibilities is to focus facilities' attention to areas of prevention (i.e., vaccinations, mammograms, etc.) that are routinely covered by Medicare. Fall / early winter are the times to be thinking immunization. HCFA would like to see the immunization rates for Medicare beneficiaries steadily increasing. So we are providing some data analysis for your review to assist in developing or implementing prevention programs in your facility.

Influenza / Pneumococcal Vaccinations

1. In the United States, influenza causes an average of 20,000 deaths per year; 90% of these deaths are among persons aged ≥ 65 years.
 2. Pneumococcal disease accounts for more deaths than any other vaccine-preventable bacterial disease.
 3. WHY??? One reason is that vaccinations aren't being received and that is of some concern from a prevention standpoint.
- Reasons reported by Medicare Beneficiaries for NOT receiving influenza & pneumococcal vaccinations, United States 1996

The results printed here are from the CDC MMWR October 9, 1999 article. This report presents an analysis of responses to the 1996 Medicare Current Beneficiary Survey (MCBS) to describe self-reported vaccination status and reasons for not receiving influenza and pneumococcal vaccinations.

Table: Percentage of Medicare beneficiaries in the MCBS (≥ 65 yrs) who reported reasons for not receiving influenza vaccination during winter 1995-1996

Reasons For NOT Receiving Flu Shot	%
"I did not know the flu shot was needed"	19.4
"Did not think of / missed it"	14.6
"Thought the flu shot could cause the flu"	13.9
"Thought the flu shot could have side effects"	13.7
"Didn't think it would prevent the flu"	11.2
"Thought I was not at risk of catching the flu"	6.8
"Don't like shots or needles"	5.9
"Doctor recommended against the flu shot"	5.7
"Doctor did not recommend the flu shot"	5.6
"Unable to get to the location"	2.3
"Had the flu shot before, did not need it again"	0.8
"Cost of the shot not worth the money"	0.2

**1997 INFLUENZA / PNEUMOCOCCAL VACCINATIONS
ESRD BENEFICIARIES, ALL AGES**

INFLUENZA	# of beneficiaries	% vaccinated
Arkansas	2186	41.4
Louisiana	5235	49.0
Oklahoma	2480	49.6

PNEUMOCOCCAL	# of beneficiaries	% vaccinated
Arkansas	1704	7.16
Louisiana	4230	4.85
Oklahoma	1802	8.27

This information was presented at the National Adult Immunization Conference "Adult Immunization: Closing the Gap". Dallas, TX - June 21-22, 1999

Estimates of the source of vaccination were calculated based on type of Medicare claim and administrative data. Don't forget that the Network has immunization materials including roster-billing information available through the Clearinghouse Library.

NEW MEDICAL REVIEW BOARD OFFICERS AND MEMBERS

At the October meeting of the Board of Directors, a new Chairperson and Vice-Chairperson of the Medical Review Board (MRB) were elected.

MRB CHAIRPERSON

Thomas Kenkel, MD
TRC-Central Tulsa Dialysis
Tulsa, OK

MRB VICE-CHAIRPERSON

Dana Rabideau, MD
Fort Smith Regional Dialysis
Fort Smith, AR

NEW MEMBERS OF THE MRB ARE:

Sameh Abulezz, MD
University of Arkansas
Little Rock, AR

Jack Work, MD
LSU
Shreveport, LA

VIGILANCE: ("Outbreak due to contamination of vials of erythropoietin (EPO)")

CDC investigated an outbreak involving 21 patients, 13 of whom had positive blood cultures for *Serratia liquefacines* that occurred at a dialysis center during June-July 1999. Vials of EPO intended for single use were being used on multiple patients and residual EPO was pooled into a common vial for further use. The EPO apparently became contaminated during multiple punctures of the vials, especially during pooling. To prevent similar outbreaks, center personnel are advised to follow manufacturer's guidelines regarding single vs. multiple use of medications; to use careful aseptic technique when withdrawing medications from vials; and not to pool residual medication from multidose vials into a common vial.

Matthew J. Arduino, Dr.P.H., R.M., Hospital Infections Program, CDC
(404) 639-2318, Email: mja4@cdc.gov

December 1999

- January-March Facility Activity Reports (FARs) blanks mailed to facility data liaison
- 2-3 National Association of Nephrology Technicians/Technologists (NANT) Regional Symposium, "Essentials of Dialysis", Regency Plaza Hotel, San Diego, CA. Contact NANT (877) 607-6268 or (937) 586-3705
- 10 November FAR reports due in the Network office**
- 10 Y2000 Facility Agreements Due in the Network office**
- 24-27 Christmas holiday (**Network offices closed**)
- 31 New Year's Eve holiday (**Network offices closed**)

January 2000

- Patient newsletter, Kidney Concerns, mailed to facility social worker for distribution
- CDC questionnaire on infectious diseases mailed to facility head nurse for completion
- Facility Survey (validation of information for the HCFA-2744) activities begin
- 10 December FAR reports due in the Network office**

February 2000

- CDC questionnaire due in the Network office
- Facility Survey (HCFA-2744) validation activities completed
- Network Standards review activities begin
- Semi-annual (July-Dec) forms compliance reports mailed to facility administrator
- 10 January FAR reports due in the Network office**
- 10-11 National Association of Nephrology Technicians/Technologists (NANT) Regional Symposium, "Essentials of Dialysis", Imperial Palace Hotel, Las Vegas, NV. Contact NANT (877) 607-6268 or (937) 586-3705

March 2000

- 1999 annual forms compliance reports mailed to facility administrator
- 1999 Standard Mortality Ratio reports mailed to facility administrator
- April-June Facility Activity Report blanks mailed to facility data liaison
- Vocational rehabilitation questionnaire mailed to facility social worker
- Professional newsletter, The Vision, mailed to all facility personnel
- 10 February FARs due in the Network office**
- 25-27 Renal Physician Association (RPA/REF) annual meeting, The Renaissance Mayflower Hotel, Washington, DC. Contact the RPA (301) 468-3515

April 2000

- Facility Information Packet mailed to facility head nurse
- Vocational rehabilitation questionnaire due in Network office
- Patient newsletter, Kidney Concerns, mailed to facility social worker for distribution
- 8-10 Annual meeting, National Association of Nephrology Technicians/Technologists (NANT), "Nephrology Practitioners in the 21st Century", Opryland Hotel Convention Center, Nashville, TN. Contact NANT (877) 607-6268 or (937) 586-3705
- 9-12 American Nephrology Nurses' Association (ANNA), Opryland Hotel Convention Center, Nashville, TN. Contact ANNA (609) 256-2320
- 10 March FARs due in the Network office**
- 12-16 Annual National Kidney Foundation (NKF) Clinical Nephrology meetings, Hyatt Regency, Atlanta, GA. Contact NKF (800) 622-9010 or (212) 889-2210

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The Vision NEEDS YOU!

The Professional Newsletter is published quarterly by the staff of ESRD Network 13. The next edition is scheduled for Spring/March 2000. If you are interested in contributing to this newsletter, please call us at (405) 843-8688, fax us at (405) 842-4097 or send any articles, materials and/or ideas to:

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