



## 2015 *Creating a Culture of Quality* Conference Summary



### **Achieving Quality: Reconciling Competing Goals**

*Guidelines, Incentives, Patient Centered Care, Shared Decision Making...How do we judge quality?*

March 23-24, 2015 Baltimore, MD  
Forum of ESRD Networks

Unless otherwise stated, power point slides are available on the Forum Website at:  
<http://esrdnetworks.org/quality-conference-march-2015/speaker-ppt-slides>

### **Keynote: Cross Purposes or Common Ground? The Complex relationships between facility mandates and patient goals**

**Raymond Hakim, MD, PhD**, Professor, Division of Nephrology and Hypertension, Vanderbilt University Medical School (PP slides not available)

1. Dr. Hakim favors standardized mandates and publicly reported patient-centered outcomes as a mechanism to help improve outcomes as a result of competition.
2. Mortality has been improving since about 1988 when the USRDS began to publish outcomes data. Mortality still remains higher than in many diseases including diabetes, cancer or heart disease. It is highest in the first 3 months after initiation of dialysis.
3. Four areas for focus to improve outcomes:
  - Catheters: Catheter rates and complications remain high, even after years of Fistula First, and even among patients followed long term by a nephrologist pre-ESRD. Having a catheter also adversely affects the success of a subsequent AVF. He proposes financial rewards and penalties for nephrologists and surgeons, particularly for patients followed 6+ months predialysis (nephrologist) and for unsuccessful AVF's (surgeon). Dr. Hakim also recommends Medicare coverage be extended to cover access surgery for pre-ESRD patients not yet on Medicare, who may not have health insurance.
  - Nutrition: Albumin levels below 4 g/dl are exponentially inversely related to mortality and hospitalization. Nutrition suffers on dialysis days due to less food intake and to amino acid losses on dialysis. In Europe, it is common to feed patients on dialysis and studies do not show significant risks of doing so. He proposes that nutritional parameters be included in CMS quality metrics, that we eliminate restrictions to eating on dialysis, that oral nutritional supplements be provided for patients with a serum albumin of less than 4g/dL, and that the optimal patient to dietician ratio be determined.
  - Timing of dialysis initiation: Despite data that shows no benefit to starting dialysis early (eGFR ~ 12) compared to later (eGFR ~ 9.8), patients in 2011 started dialysis with higher eGFR's compared to those who started in 2000. He suggests that we use an "intent to defer" strategy with CKD patients, monitor patients very closely when the eGFR is less than 15 and initiate dialysis when there are clinical indications or an eGFR of 6 or less. Patients should be encouraged to participate in the kidney disease education benefit, and the nephrologist should have to justify starting dialysis if the eGFR is 10 or greater.
  - Rehospitalization: Rehospitalization rates are very high for ESRD patients. There is lack of communication between the inpatient and outpatient settings. A timely (within 2 treatments) post-hospitalization review of the patient data and adjustment of medication doses and dry weight by the practitioner leads to reduced re-hospitalization rates. He suggests shared responsibility for re-hospitalization between the hospital and the dialysis unit.

**Q&A and comments:**

The elderly population is difficult to address. We need to individualize CKD care for the elderly who may never need dialysis. If a patient starts dialysis with a catheter, alternate access should be obtained ASAP.

**Panel discussion following keynote address** (no power point slides)**Allen Nissenson MD, Frank Maddux MD, Doug Johnson MD, Glenda Harbert, Derek Forfang**

1. Catheter issue. There was general agreement among the panelists that practitioners must focus on the pre-ESRD patient with CKD. We need more intense education for patients and consideration of whether the patient understands what is being taught (e.g. health literacy barriers). Patients who have a failed transplant have far too similar entry vascular access characteristics to incident patients. We may need to use more AV grafts in patients who are poor AVF candidates, e.g., elderly patients who may need multiple surgeries in order to have a functional AVF. The length of time that patients have catheters is much too long. There are times when a catheter is the only realistic option for a patient, and there need to be minimum standards for catheter care and support for items such as appropriate catheter dressing to help prevent infections.
2. Eating on dialysis. There was general agreement that maintaining nutritional competence is important and one option is to allow eating on dialysis. Generally, there is consensus on the benefit of nutritional supplements and that supplements should be provided/allowed for patients at risk. This may be beneficial even when the serum albumin is up to 4g/dL. Unfortunately, U.S. providers cannot provide meals during dialysis for legal reasons. In some places patients are not allowed to eat on dialysis due to state regulations and logistics.
3. Re-hospitalization: The responsibility lies with multiple stakeholders. Preventing re-hospitalization is a difficult process. We need effective communication between hospitalists, dialysis facilities and nephrologists in order to reduce rehospitalizations; we also need to engage the patient and provide information to the patient in a way that he/she can understand is important.
4. When to start dialysis: Starting dialysis earlier than necessary often reflects a lack of communication between the nephrologist and the patient. Patients need to be educated early and monitored closely. Patient engagement is key.

**Q&A and comments:**

- Health literacy is key as is connecting to what patients want. Hope is important.
- Our current public reporting system can be distracting us from the real work of quality improvement. There is a disconnect in how we discuss issues such as nutrition with CMS to yield a more proactive nutritional support process.
- We have enough data to stratify patients according to which access is most appropriate.

**Panel: Beyond Webster: Defining What Patient and Family Centered Care Really Means to the Renal Community and the Renal Patient**

Moderator **Douglas Johnson MD** Board of Directors, DCI

**Virna Elly; patient:** What can be improved? Give patients information when they need it and how they need it. Care transitions should be improved; there are many gaps in knowledge and assumptions that are made. Patient care should be individualized – one size does not fit all. Metrics do not necessarily improve patient care – just because you are tracking outcomes does not mean you are improving care. Patients have less

choice than you might think. Unstable patients are more desperate and risk-tolerant. Patients who are stable are less risk-tolerant. We need to leverage our story telling culture; tell stories in a way that helps patients buy in and weigh in on their situations.

**Joan Wickizer, LSW;** Network Patient Services Director, NW 3: The network often gets calls from facilities regarding patients who will have a negative impact on the facility's QIP. Facility staff need to remember that an engaged patient will be more adherent. Patient engagement is multidisciplinary; the staff must put the patient at the center of the "circle".

**Douglas Johnson, MD;** BOD, DCI: What would you want if you had CKD? You would want;

- Know how to avoid being on dialysis;
- Delay the time to dialysis if it is possible;
- Know your choices and discuss them early;
- To be listed for transplant and learn how to talk to friends and family about donation;
- If dialysis is necessary, need a schedule that fits my schedule;
- Help with end of life care if the burden of dialysis is too great.

The 5 star rating does not address any of these. The QIP is a floor, but we need to look at what we can do to allow patients to have the lives they want to live.

**Shannon Wofford, RN;** DCI: Pre-ESRD education: One on one education with CKD patients is better than group education. CKD care and planning is difficult without a navigation helper. Patients should be seen multiple times, not just once. It is important to see early as well as late stage patients. Focus on what patients need when they need it and repeat it multiple times. Extremely structured programs may not meet individual patient needs. Nutrition education is critical.

#### **Q&A:**

Question for AAKP: Is patient centered care being taken seriously? Answer: For some, it is just a veneer. Some organizations are truly focused on what the patient wants. They feel the need to be on social media. Ask patients what their goals are. Tackle the issue of staying employed – this is critical.

## **The Measures Maelstrom: How to Determine the Success of a Program**

**Kate Goodrich, MD;** MHS Director of Quality Measurement and Health Assessment Group, Center for Clinical Standards and Quality, CMS

CMS is in the middle of a transition, moving from paying for volume to paying for value in a more patient centered system. Outcomes will be incentivized and there will be an emphasis on care coordination, patient engagement in shared decision making and managing the health of populations. The incentive structure entails a transition to value-based purchasing with more transparency, sustainability and coordination. Foundational to delivery system reform success is both the availability of information (such as performance on quality and cost) at the point of care as well as transparency of this information to the public at large.

CMS has a variety of quality reporting and performance programs, but the quality measures to date have been very "siloes within settings of care". There are different measures for different programs and providers. Until recently, there has not been a clear measurement strategy; process measures have been more prominent than outcomes measures. There has been a lack of a patient voice in the measurement strategy. Change in the measurement system needs to be patient centered and align with the national quality strategy priorities. Key principles for quality measurement in the new payment environment include alignment of

measures across CMS programs and with private payers, removal of measures when they are no longer appropriate because they are topped out or evidence changes. We need to focus on outcomes, especially patient reported outcomes. We need to understand what is important to patients. Evidence to date makes clear that high performance on process measures does not necessarily lead to better patient health outcomes.

Plan: Bring more patients into the measure development process from beginning to end. Monitor disparities and unintended consequences.

Some of the ways that CMS determines which measures to use are MedPAC recommendations, Technical Expert Panels (TEPs), the Measure Applications Partnership, and alignment with CMS quality strategy objectives. One of the contractors is piloting a network of patients that can be involved in measure development and public reporting. This includes training panel members, including patients, in the measure development process. Current CMS work in the ESRD space involves dialysis and transplant patients in the measure development TEPs, the Dialysis Facility Compare star ratings and Dialysis Facility Compare. CMS invites feedback on the most effective way to meaningfully include patients in these efforts.

The objectives of the ESRD Quality Measure Testing Initiative is to create a system for testing of new and previously developed measures, assess the feasibility of data collection, help establish scientific acceptability, and provide a process for ongoing testing and refinement for measure maintenance.

#### **Q&A and comments:**

- Are there plans to align methodologies across sites, e.g., hospitals, dialysis, skilled nursing facilities? A: Measures for each program are somewhat different.
- How will the success of the 5 star program be determined? A: By whether it is helping patients and families make choices. That will take time. We also believe that more effective public reporting will incentivize providers to improve.
- Dialysis Facility Compare is really used to deselect a facility rather than select a facility. Would it be better to spend the energy on engaging patients to improve their own care in the facility? A: We may need to engage patients earlier, before they have ESRD. In addition to transparency and understandability of performance information, we should collectively be working with patients to understand quality of care and to engage them in their own care.
- A bell shaped curve may not show improvement over time. A: We have heard this feedback from dialysis facilities and this topic will be discussed in the upcoming star rating Technical Expert Panel.

### **Panel: The Measures Maelstrom: So Which Metrics are Best?**

Moderator: **Klemens Meyer, MD**

**Maggie Carey, patient;** Beneficiary Advisory Committee of the Forum of ESRD Networks

4 questions:

- What is the definition of best? There are several definitions unique to individuals and what the circumstances are at the time. All of which highlight quality.
- Who determines quality and value? These are subjective and based on individual perceptions that may change over time.
- What has greatest value to patients? Patients are diverse. How does one group speak for all patients?
- The existing metrics may prevent my values from being addressed. One example is a patient who was excluded from a nocturnal dialysis program because of lack of a fistula.

Bottom line: We need to look at quality of life on dialysis. If we want patient engagement, diversity must be built into the metrics. One patient's values should not negatively impact one's provider and the provider's values cannot define and should not conflict with the patient's values. The best metrics are flexible enough to accommodate the diversity of patients' values.

**Susie Stark, Executive Director;** Network 9/10

How do we define a good measure? Unknown. Initiatives include:

- Network patient-centered metrics: Patients are the experts on what is important. Medical Review Boards have patient members who identify the issues.
- Currently the Network projects have regionalized, defined quality improvement goals but very limited time frames in which to complete CMS initiatives.
- Grievance quality improvement activities: While the CMS goal is to decrease grievances, it may be more important to address the problems, not to decrease the number of grievances.
- Vascular access activities have been a huge success and have brought together multiple stakeholders with positive outcomes.
- Health Care Associated Infection metrics; these provide great opportunities for improvement.
- Disparity reduction metrics: The 5 CMS focused initiatives in Network contracts are very good topics.

Data repositories for collecting this data are a challenge. Data integrity is suboptimal. We need accurate and complete data with standardized data definitions. The data elements should be periodically reviewed, and we need to know if there are unintended consequences of the metrics in use. We need to understand the burden that the measures place on the patient, as well as on the Network and the participating facilities. The metrics need to be prioritized to those that are most critical.

**Rebecca Schmidt, DO;** Chief of Nephrology West Virginia University School of Medicine; President Renal Physicians Association

The RPA has created the Kidney Quality Improvement Registry, A CMS-approved Qualified Clinical Data Registry (QCDR) to evaluate specified outcomes. The RPA Registry is designed for nephrology practitioners to foster performance improvement and improve outcomes in the care of patients with kidney disease. It serves as a single repository to collect, store, analyze and report on your clinical quality data. It allows for reporting on both PQRS and non-PQRS measures to satisfy CMS' PQRS reporting requirements. The registry provides continuous measure scoring, benchmarking and patient outlier lists. It gives us an opportunity to improve quality scores prior to data submission to CMS. It also links to educational resources and helps you figure out how to improve performance in your patient population. As PQRS reporting has changed into a penalty-only program and all nephrologists are now subject to the Value-Based Payment Modifier (VBM), understanding how you are doing on various quality reporting metrics – prior to reporting to CMS – becomes critical. Registry participation empowers subscribers with better control over VBM. Data can also be compared to that of others in a HIPAA compliant secure setting.

**Klemens Meyer, MD;** Professor of Medicine and Director of Dialysis Services, Tufts University School of Medicine, Past President Forum of ESRD Networks

Many performance measures are not well proven. Dr. Meyer gave the example of an ICU doctor who had to attend hospital "re-education" sessions if his patients' blood sugars were above the hospital's standard. He then showed the results of a large randomized control trial that found that keeping blood sugar control too tight in the ICU is associated with higher, not lower, mortality. Many of the metrics used to define quality have later been shown to be questionable or wrong.

Many organizations focus on meeting the metrics at the expense of neglecting other aspects of quality.

The British have found no convincing evidence that “pay for performance” improves the quality of care. Value based purchasing can be expected to disadvantage safety net hospitals.

We need to ask what the desired health outcomes are. Who desires them, how strongly, and at what personal and social cost? Is the metric a surrogate for a desired outcome? Do we all desire the same patient centered outcomes?

When a measure becomes a target, it ceases to be a good measure.

#### **Q&A and comments:**

- We must be accountable to the public. We need to revisit our understanding of what evidence-based medicine is. What is the nature of the evidence and how is it changing? The commitment to evidence-based medicine was not meant to imply a commitment to randomized control trials. It was meant to be a commitment to the best available evidence. How do we translate that into measures?
- There is a notion that evidence must be applied based on the best judgment of the medical team. However, we must take into account patient preference and desires. Currently there is not a good dialogue about how to build these concepts into the measure development.
- Guidelines do not account for the full spectrum of evidence. How do we use the evidence? Evidence-based care may not address patient values. Our guidelines are not nimble enough to keep up with the evidence.
- The problem is measuring patient preferences. Is deviation from the guidelines really responding to the patient or is it an excuse?
- Are we teaching to the test? Do we have too many measures and are we failing to prioritize them in a helpful way? There may be other issues to look at, such as reports by most patients that they have feared for their safety.
- Patients are fearful since they are vulnerable. Patient responses to questions about metrics can vary from day to day. There is no perfect answer to what the right metrics are.
- The abundance of metrics causes barriers to care for patients who do not fit into the perfect metrics picture. We need to look at this nationally. Evaluate complaints and grievances.
- Measures do help us focus on what is important to the patient, such as mortality and hospitalization. We must be accountable.

### **Data Speaks: What the Numbers Tell Us about Previous Quality Initiatives and Options for the Future**

**Allan Collins, MD;** Professor of Medicine, University of Minnesota School of Medicine/Hennepin County Medical Center: Director of the Chronic Disease Research Group: Director, Peer Dialysis Initiative  
<http://www.peerkidney.org/>

The world of public health and the regulatory world approach the subject of improving outcomes for populations differently. The public health view is to set the direction and then track the long-term progress of the country. The regulatory world compares providers’ performance. It does not assess progress over time or regional variation.

Consider the SMR and SHR (standardized mortality ratio and standardized hospitalization ratio). There are different methods of assessment such that some providers look very good with one method but not with another. Sometimes the disparities do not make sense, e.g., when the SMR and SHR do not track together. Looking at the ratios in any given year does not show trends over time. An alternative view is to assess trends

over time within providers and by geography. Providers would be their own controls. Healthy People 2020 and WHO data do show the trends.

Death rates in prevalent dialysis patients have declined over the past 30+ years. The decline has been steeper than for the general population. The ratings of facilities do not reflect that. The primary association with decreased mortality has been the increase in AVF's.

The Peer Kidney Care initiative is examining trends in outcomes, geographic variation in events and seasonal differences in major outcomes. While hospitalization rates are down in general, there are major geographic differences. In general, the east north central region has made less progress than other areas. There are also month-to-month and seasonal changes. Hospitalizations increase during influenza season; vascular access infections increase in the summer. Trends in events should be a major focus within providers and regions. It may give us clues that can change practices (e.g., flu vaccine dosing). Sudden cardiac death is highest in the first months of dialysis, and is higher in younger patients than in older patients. This should be examined in more detail.

Recommendations: Trends and targets should be the new focus of quality efforts. Providers should be used as their own controls and should be compared to their own historical data or to the region's data. We need to determine how to assess outcomes by geographic variation. We need local assessment to ensure that all populations and regions make progress.

#### **Q&A and comments:**

- We need to shift our thinking about measures for quality improvement. We need to build capacity at a local level to understand the data. We must display the data in multiple ways to get insights. The current methodology of public reporting may be distracting us from real quality improvement.
- Has the Peer Group been asked to cut the data in other ways? Answer: The data will be reported to the dialysis companies by gender, age, etc. Trends for individual units will be included.
- Local data will drive QI. The Networks are ideally positioned to lead local efforts. In the past, they were able to access the data more quickly and assess local trends.
- Access and nutrition need to be looked at by geographic regions.

**Dr. Paul Eggers:** Senior Epidemiologist at NIH for Kidney Disease and Urology. The U.S. as a whole is moving in the right direction re: mortality because improvements are made at the local level. But using SMR's that rebase yearly ensures that the same order is likely to stay in place and that there will be a certain percentage of losers. The geographic variation is the data that is most useful to local QI efforts. Dr. Eggers supports the idea of setting goals and working on them. We need to evaluate and prioritize measures. Using too many measures does not help us focus on what will make a difference. We need to look at local variations.

#### **Patients Speak: the View from the Chair**

Readings led by **Maggie Carey and Derek Forfang** based on postings online by patients (No power point slides)

This is a very small reflection of the quotes by the patient panel. Patients want to be treated like adults, with respect and dignity; they want to be heard, not just have a "fly-by" visit. They have to be tough and take problems in stride. They don't like dialysis but are glad it keeps them alive. For some patients, DML - Dialysis Means Life. Some handle it better than others and their perspectives sometimes change over time. They also have choices to make, such as going to hospice and/or discontinuing dialysis.

## **Panel: Can We Design a Show that Fits? What Would Pay for Performance Measures Look Like if They Were Designed by Patients?**

Moderator: **Jean Moody-Williams, RN, MPP**; Deputy Director of Policy, Center for Clinical Standards and Quality, CMS

Patient panel: **Virna Elly, Joe Karan and Allen Nelson**

Ms. Williams: CMS is working to engage patients and families. It will know it is successful when patients and families are truly engaged. The ESRD program has been at the forefront of patient engagement.

Foundational principles include eliminating disparities in care and enhancing infrastructure and data systems, enabling local innovations and improving engagement and self-management best practices. Patient engagement has been improved in the hospital setting.

Measure development is a rigorous process and CMS desires to include the patient voice.

Questions to the patient panel:

1. Of the measures in place, what do you like and what should be changed?
  - These are good measures because we can compare results around the country. But patients do not have control over many of the measures, including access, adequacy and even infections. It would be good to include measures that patients can control.
  - Many patients do not know what the measures mean.
2. What would you like CMS to look at regarding the experience of care, such as comfort measures?
  - What seems to be a small issue may be very important to the patient, such as chair comfort and a working TV.
  - A friendly staff member is important.
  - We need to have a common set of definitions that includes safety and comfort.
3. How do we capture the experience of care on patient surveys?
  - Everyone should be there for the patient. Talking to the patient is the most important thing.
  - Early education about dialysis is important and should start with the PCP.
  - Ask the question “are we asking you the right questions?” Ask the patient “what has happened since you were last here?”
4. Looking at care across settings (hospital, PCP, etc), what should we be looking at?
  - Look at the most prevalent diseases. We do not “scare” patients enough early on.
  - We need to start with a patient roadmap; draw the patient in the middle and show everything that is important to the patient. Seeing that may change the path that the patient will take.
  - We need to deal with nonmedical issues as well as medical ones. This includes losing a job, changes in the family, mental health issues.
5. What should we measure regarding quality of life?
  - Can you do what you did before you were ill, including work? Can you maintain your self-worth? We’re not meeting with the patient and family as much as we should be.
  - Travel is a problem, but my QOL is good.
  - We should talk about clinical measures vs practical measures. What looks good on paper may not feel good to the patient, such as getting to “dry weight”. Look at whether the treatment helps the patient meet personal goals. We need to understand personal preferences and values. One size does not fit most; all of us have different perspectives.
6. How do we include issues of value and cost in a value based system?



- Patients do not care whether the clinic is making money. What happens to the patient is more important, and they often lose their income, overall health, home, car, family and feeling of self-worth.
- We could look at patient buy-in.
- Thanks to the tax payers for keeping patients healthy.

Questions and comments from the audience and panel:

1. Recovery time could be turned into a metric with clinical and quality of life importance.
2. The estimated dry weight (EDW) involves too many variables; they need to be considered before the EDW is used as a metric.

## **Courageous Conversations: Principles of Conflict Resolution**

**Kay Ham, MHR;** Adjunct Professor, Department of Human Relations, University of Oklahoma

Supported by an educational grant from the AAKP Jenny Kitsen Safety Award Endowment

Most of us avoid conflict. We are afraid of losing control and productivity and damage to the relationship. Conflict is normal. However, if we see it in a negative light, we may make it worse. As it escalates, the chance of resolution breaks down. If we see it as a potential to work together, the interaction can be productive and outcomes can be better than hoped.

Barriers to communication may be structural, including time, resources, location, policies and regulations. There are emotional, cultural and language barriers. Conflicts can occur due to values, emotions, biases and prejudices.

Conflict resolution requires self-awareness, trust and respect. Providers must invite patients to air concerns without interrupting. Practice active, non-judgmental listening. Active listening means focusing on what the patient is saying without hearing all the stuff going on in your own head. Look at conflict as an opportunity. Explain your concerns respectfully and honestly. Keep talking and listening as long as it is productive. Consider using a 3<sup>rd</sup> party, e.g., a social worker. Even if things can't be changed, most of us can be okay with the outcome if the process was fair.

A conflict resolution workshop can be helpful. See the slide set on the Forum website for resources and references.

The top 3 issues that Network patient services personnel hear about from facilities are professionalism, lack of communication between staff and patients, and lack of autonomy.

## **Social Media: Building and Using Electronic Media to Improve Communications with Patients**

**Dori Schatell, MS;** Executive Director of the Medical Education Institute

Most social media users are under age 65. People who are disabled or on dialysis are less likely to go online, and many cannot afford computers and use smartphones. Many "lurk" on social media and do not post.

We can learn a lot about how patients feel, what bothers them, and what is important to them on social media. Patient concerns are different from those of providers; they look to social media to connect, learn, and offer and find support and understand. They want to know what it is like to live with dialysis.

See slide set for sites that are useful for patients.

**Through Each Other's Eyes "If We Could See Inside Other's Hearts"** a video produced by the Cleveland Clinic no power point slides  
Presented by **Jenny Kitsen, Independent Consultant**; Former Executive Director of ESRD Network 1  
[https://www.youtube.com/watch?v=cDDWvj\\_q-o8&feature=youtu.be](https://www.youtube.com/watch?v=cDDWvj_q-o8&feature=youtu.be)

### **Change the Lens: How Effective Role-Play Can be Brought to Your Organization**

**Donald Molony, MD**; Chair of the Forum's Medical Advisory Council; Professor of Medicine Division of Renal Diseases and Hypertension and Center for Clinical Research and Evidence-based Medicine, University of Texas at Houston Medical School

**Teresa Titus-Howard, PhD**; (Former) Director of the Division of ESRD Provider, Populations and Community Health, Center for Clinical Standards and Quality, CMS

**Kay Ham, MHR**; Adjunct Professor, Department of Human Relations, University of Oklahoma

Objective: provide evidence that supports the use of role-play, present a framework to implement role-play in the facility, present and role-play real life complex patient scenarios.

#### **Ms. Titus-Howard**

Role-play is a technique to promote learning and very helpful when there is a sense of immediacy and before addressing a complex situation. It is a testing environment for different behaviors. It creates sustained learning by practicing or teaching others about a behavior. It provides a level of self-analysis and feedback and is one of the best adult learning techniques. It is a problem-centered approach and is a powerful tool to deal with realistic, serious, complex and ambivalent situations.

Role-play can help with cognitive understanding of patient concerns. Treatment course decisions and/or corrections may be determined. Compliance/adherence may be improved because of an empathetic ear to patient concerns.

Fear is the biggest barrier to successful role-play. But it provokes less anxiety than real life. Practicing it may improve the awkwardness of talking with patients about an issue.

#### **Dr. Molony**

To be effective, role-play must be carefully planned. The facilitator must keep the session on-script – stick to the topic of the discussion.

First, decide on the goals. It can be used to teach subject matter or a procedural skill such as taking a history. It can improve communication skills and improve shared decision making. Second, develop cases. Effective cases address real issues but should not be too local or familiar. They should typically not have a single obvious answer. Participants need to have specified roles. In this situation, the players need to have legitimate reasons for their positions. There should be no evil or "bad" characters. Specify the situation but

not the specific details. Third, do background reading if appropriate. The facilitator provides instructions to the participants and provides a description of the expectations of the exercise. Call time-out if things go wrong, e.g., foul language. After the role-play, debrief.

Debriefing: the players should comment on their emotions in the role. Observers should summarize the activity without commenting on it. Identify what was successful and what can be improved.

There are challenges for facilitators. Participants may not buy-in or find it to be realistic. Discuss this issue up-front. You can flip the roles in the role-play exercise.

Role Play Example: Discussion between a patient who does not feel well on or after dialysis (Dr. Molony) and a nephrologist (Ms. Titus-Howard) who is more concerned about meeting the QIP than empathizing with the patient or exploring possible solutions. The situation was role played a second time, this time with a nephrologist who was empathetic and worked with the patient to find a solution. Observations were made by the observer, Kay Ham. Both the patient and nephrologist reported their feelings during the interactions.

## **Teach the Teacher: Share Each Other's Worlds – Learn Through Role Play**

**Donald Molony, MD** of the Forum; **Teresa Titus-Howard** formerly of CMS; **Kay Ham** University of Oklahoma

This time was occupied by having tables of audience members use provided scenarios to practice role play. A member of each table reported observations of the role play sessions and the solutions that came out of those sessions.

## **Closing Remarks**

**Dr. Jay Ginsberg**

Did we meet our goals? Our goals were to;

- discuss issues that arise from trying to meet CMS and evidence based medicine goals
- explore patient centered care and what that means for the creation of metrics
- allow the audience to provide expertise and learn from each other; we had limited time for this and will allow more time for questions, answers and comments in the next conference.

We provided actionable items to the group.

- Take home the role-play tools and the conflict resolution tools.
- Parts of this conference will be incorporated into the Forum's upcoming Patient Centered Care and Transitions of Care Toolkits.

Forum of ESRD Networks Website – MAC Toolkits for download: <http://esrdnetworks.org/mac-toolkits>

This summary will be distributed to the members of the audience and will be made available on the Forum's website: <http://esrdnetworks.org/quality-conference-march-2015/2015-creating-a-culture-of-quality-conference-summary/view>

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