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RPA News

July 2008
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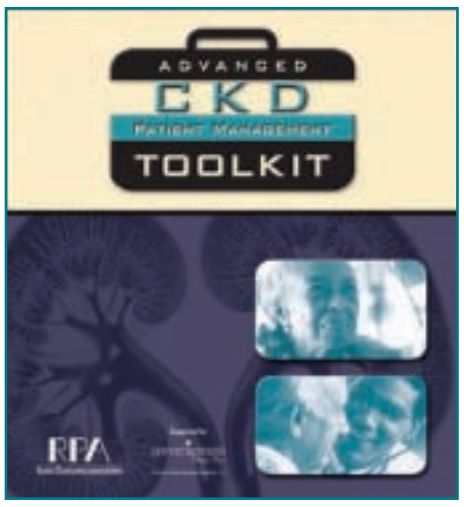
The Advocate for Excellence in Nephrology Practice

RPA Tests Effects of Toolkit Implementation on CKD Patient Outcomes

The Renal Physicians Association Advanced Chronic Kidney Disease (CKD) Patient Management Toolkit has entered its next phase of testing and evaluation. Over an 18-month period, RPA will work with the Duke University Center for Clinical Health Policy Research (Duke CCHPR) to conduct a field test of the CKD Patient Management Toolkit at ten randomly selected nephrology practices around the country. Designed to heighten awareness and provide management tools, reminders and educational materials, the toolkit is a valuable resource for nephrologists, nurse practitioners and physician assistants who treat patients with advanced CKD.



RPA developed the toolkit in 2004 through a rigorous scientific process to assist practitioners with implementing the recommendations included in RPA's third evidence-based clinical practice guideline, Appropriate Patient Preparation for Renal Therapy. The toolkit, which is organized in four main areas — assess, tailor, implement and evaluate — includes 16 categories and sets of tools for health care providers and kidney patients. Practices may choose the tools they wish to use and tailor them to meet their individual practice needs. Tools include awareness letters regarding the prevalence of CKD to share with non-nephrologists, post-consult letters, a CKD Identification and Action Plan Poster that can be displayed in exam rooms, a CKD management flow sheet, chart stickers and algorithms for treatment. The toolkit also includes a Pre-implementation Assessment Tool that gives practitioners a quick view of how they are managing CKD patients as well as a Post-implementation tool that provides a measure of performance improvement.

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It's Not Too Late to Participate in 2008 PQRI Program

For nephrology practices that have not yet started reporting quality data under Medicare's Physician Quality Reporting Initiative (PQRI), there is still time to participate in the 2008 program. The Centers for Medicare and Medicaid Services (CMS) recently established new reporting options that will make it easier for nephrology practices to participate in PQRI, though the potential 1.5 percent bonus will only apply to claims submitted between July 1, 2008 and December 31, 2008.

CMS announced new alternative reporting criteria and periods for 2008 PQRI to comply with the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), requiring the agency to establish alternative reporting periods and alternative criteria for satisfactorily reporting groups of measures as well as establish alternative criteria for satisfactorily reporting quality measures data through registries.

In addition to the current PQRI requirements, CMS created four measures groups — subsets of PQRI measures that have in common a focus on a particular clinical condition or aspect of care — allowing providers to report on one group of measures. However, providers must still report the applicable CPT II or G-code quality data codes for each measures group applicable to the patient. The four measure groups are: Diabetes Mellitus, End Stage Renal Disease (ESRD), Chronic Kidney Disease (CKD), and Preventive Care. The

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From Capitol Hill

Avoiding the Inevitable

By Dom Ruscio and Erika Miller

With five weeks set aside for campaigning and national party conventions in August and early September, Congress is running short on time to plow through legislation.

Lawmakers have yet to complete work on appropriations for a wide range of federal programs, including highways and infrastructure, medical research, college student aid, law enforcement grants and disaster relief. Indeed, Congress may only have enough time to clear two spending measures — for the Defense Department and Homeland Security — opting to postpone the remaining bills until a new, presumably more accommodating president is sworn into office.

But a new president and Congress will have a lot more to deal with in January 2009 than annual spending bills. By then, the public debt will be approaching $6 trillion, an 80 percent increase over what it was in 2001. The biggest problem will be that the federal government will be committed to paying about $200 billion a year in interest on the debt, using up funds that could be applied elsewhere. Over the next 10 years, for example, the amount the government will have to spend on interest is close to what it would take to offset the revenue lost from making the 2001 and 2003 tax cuts permanent and repealing the alternative minimum tax — problems that for the time being are considered too expensive to tackle.

Medicare physician payments

At press time, RPA and its members were still pressing Congress to stop a planned 10.6 percent cut in Medicare physician payments, scheduled to take effect July 1, 2008. Negotiations were down to the wire on a proposal crafted by Senate Finance Committee Chairman Max Baucus (D-MT) that would block the cut and increase payments 1.1 percent in 2009.

While there is bipartisan support for physician relief, at issue is how to offset approximately $20 billion the bill could cost over five years. The Baucus bill targeted the Medicare Advantage managed care program eliminating the double payment those programs now receive for care provided at teaching hospitals.

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PRESIDENT'S MESSAGE

Alan S. Kliger, M.D.
RPA President

One benefit of serving as RPA President is the vantage point from which one can observe, and sometimes participate in and influence, the political process in Washington, DC. As noted in previous issues of *RPA News*, the RPA presidency availed me the opportunity to speak before a U.S. House of Representatives subcommittee and an FDA Advisory panel in the past year, and those experiences were both enervating and memorable.

Of course, one does not just show up at Congress or the FDA and testify one day. RPA is fortunate to have seasoned public policy staff who are knowledgeable in the ways and culture of the regulatory maze surrounding Washington, as well as a relationship with legislative consultants with decades of experience regarding the processes of Capitol Hill and the pressure points that must be pushed in order to achieve a positive result for nephrology's interests. It is through efforts such as these that opportunities to provide the working nephrologists' perspective at high-profile events occur.

However, all evidence to the contrary, this month's President's Message is not about me or RPA's staff and consultants. Rather, it is about the commitment and dedication of RPA membership to the organization's effort to raise the profile of nephrology in general and RPA specifically on Capitol Hill. In the wake of the unilateral implementation of the monthly dialysis G-codes by the Centers for Medicare and Medicaid Services (CMS), as well as the publication of the Stark II final rule that established safe harbors pertaining to dialysis facility medical director reimbursement, the RPA Board of Directors made a conscious decision to increase the organization's visibility in the legislative arena.

Two of the most significant components of this effort were the decision to create the RPA Political Action Committee (RPA PAC) in 2005, and to make a strong organizational commitment to a Capitol Hill Day congressional visits program.

RPA PAC continues to grow and thrive. As of late May 2008, approximately 275 RPA members have contributed to the RPA PAC, and the total contributions exceed $167,000. The primary purpose of the RPA PAC is of course to facilitate interactions between key legislators and RPA leaders and staff, and it is through the RPA PAC that I was able to attend an event in Washington, DC, for my Congresswoman, Rep. Rosa DeLauro (D-CT) in mid-May. During this meeting Rep. DeLauro reiterated her commitment to providing not only an 18-month fix to the current Medicare physician payment shortfall but also to the broader Medicare program that would alleviate the need for organized medicine to go to Congress every year to seek a short-term solution to this annual dilemma. Rep. DeLauro also outlined her efforts to address the twin issues of childhood nutrition and obesity, toward the end of reducing the nation's diabetes patient population. (See page 12 for more details on other fundraising events attended by RPA representatives). The fact that approximately 10 percent of RPA's membership has contributed to the PAC is extremely impressive, and I would like to simultaneously thanks those who have contributed, and urge those who haven't to do so — come on in, the water's fine!

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When you see this symbol in your RPA *News*, visit the RPA website at www.renalmd.org to learn more.

EDITOR'S PERSPECTIVE

I hope that many of our members are enjoying the lazy, hazy, crazy days of summer. While July and August are popular vacation months, they are also months when RPA staff are busy planning ahead for the remainder of this year and the beginning of next year. However, like Congress, we do take a brief Fourth of July recess. After a successful Nephrology Coverage Advocacy Program (NCAP) meeting and Hill Day in late June the RPA staff have re-charged our batteries and are ready for what lies ahead. (Details regarding the NCAP meeting and Hill Day will be provided in the September issue of *RPA News*.)

Dale Singer, MHA
RPA Executive Director

As I reported in the previous issue of *RPA News*, throughout the remainder of 2008 the RPA leadership is reviewing RPA's Strategic Plan and assigning priorities to current and new initiatives that will strengthen the association and its ability to meet the needs of our membership moving forward.

RPA recently completed a review of our website, www.renalmd.org. Many of you responded to an electronic survey in which we invited your opinions about the utility and value of the RPA website. The Board is considering recommendations for improvements to the website at its Board of Directors meeting later this month. We want the RPA website to be your primary resource for timely and relevant practice-related information, and we want it to be easy for you to find the information you want and need. We will be working over the next several months to improve access to our content-rich site.

Results from the 2007 RPA Business Benchmarking Survey are being analyzed, and the report is being generated to assist our members with making decisions affecting practice operations. Thanks to those practices who took the time to respond to this very important and unique survey.

RPA embarked on two important pilot test studies this summer. RPA, in collaboration with the American Medical Association (AMA) Physician Consortium for Performance Improvement (PCPI), is pilot testing the validity and reliability of our CKD and ESRD physician performance measures that were endorsed by the National Quality Forum in three geographically diverse nephrology practices. In addition, implementation of RPA's Advanced CKD Patient Management Toolkit is being tested in 10 randomly selected nephrology practices around the country (see article on page 1).

Back by popular demand is another business course offering in collaboration with Duke University's Fuqua School of Business. The course, "The Business of Nephrology Practice," will be offered through a combined distance learning and face-to-face format. Watch your mail, the RPA website and *eNews* for program details, dates and registration information!

We hope you will join us at one of our upcoming programs. Later this month, July 17-18, we are looking forward to our Clinical Collaboration in CKD conference. This unique meeting provides nephrology-rich content to advance nurse practitioners and physician assistants working in nephrology practices. On September 12, RPA's Fall Fellows Workshop will be held in Minneapolis. We encourage all fellows to attend this session to learn about those things they don't teach in traditional nephrology training programs from seasoned and young nephrologists. This workshop is not to be missed! If you haven't attended one of RPA's nephrology billing and coding seminars in 2008, make plans to attend an upcoming seminar in September (see seminar details, dates and locations on page 13). This is an opportunity to learn how to appropriately code and document services provided to kidney patients in order to obtain appropriate reimbursement for those services.

RPA recently updated our Electronic Health Records (EHR) CD which is available from the RPA office. Originally released in March 2006, this tool will assist you with identifying your practice's needs for an electronic data capture system, crafting a Request For Proposal for an EHR for your practice, and knowing what questions to ask software vendors. Health information technology is becoming more prevalent, and RPA wants to assist our members with their efforts to go paperless. As a bit of foreshadowing, watch for more information about this as the program for RPA's 2009 Annual Meeting takes shape.

And…as I write this message, RPA's public policy staff is anxiously awaiting publication of the 2009 Medicare Fee Schedule proposed rule which will include the proposed values for the new monthly outpatient dialysis codes for ESRD services. RPA will forward specific information to you about the proposed rule upon its release.

So, while the livin' might not be easy this summer, I hope all of you enjoy some of the sights and sounds of summer — barbeques, baseball and beach time. ❖

President's Message

from page 2

On June 23rd RPA convened the largest Capitol Hill Day Congressional visits program in the organization's history. At press time, over 40 RPA members had made plans to attend the Hill Day program, with nearly 100 Senate and House offices scheduled to be visited, representing almost one-fifth of all Senate and House offices on the Hill. Beyond being RPA's largest Hill Day ever, this group may represent the largest group of nephrologists to ever march on Capitol Hill, and the entire specialty owes a debt of gratitude to those who took nephrology's concerns to our nation's elected representatives. We'll provide a detailed report to the membership on our Hill Day event in the September issue of *RPA News*.

We live in a representative democracy, which gives us all the opportunity to interact with our country's elected leaders. We nephrologists go to our legislators on behalf of our patients and our practices. I have deep appreciation for those RPA members who give of their time and expertise to come to Washington and engage with our Senators and Congressional representatives and their staffs. ❖

RPA Encourages PA Research in Nephrology

Awards Outstanding PA Kidney Abstract

More than three-quarters of physician assistants are not familiar with guidelines to detect and screen chronic kidney disease and measures recommended by the National Kidney Foundation's Kidney Disease Outcomes Quality Initiative (KDOQI). Guidelines were not being used in clinical practice, according to research results reported in an abstract selected by RPA's Clinical Practice Committee as Best Student Abstract. "A New Silent Epidemic: Are Physician Assistants Using Evidence-Based Guidelines to Screen for Chronic Kidney Disease in High Risk Patients?" by Elisha Hatfield, PA-S, also was selected by the American Academy of Nephrology Physician Assistants for presentation during its umbrella organization's, the American Academy of Physician Assistants (AAPA), annual conference in May. RPA had initiated a call for abstracts to the AAPA to help drive more interest in nephrology among students in physician assistant programs.

While a majority of respondents (87.8 percent) who completed a 10-question online survey agreed that early screening and detection was as important as that for other more prevalent diseases, 77.3 percent of respondents reported that they were not familiar with the KDOQI guidelines. This self-reporting was supported by the respondents' overall average score of only 4.98 of 11 points within the knowledge portion of the survey.

Respondents identified the most common risk factors for chronic kidney disease, but most respondents did not correctly select the recommended lab measures for initial screening or the evaluation of persistent proteinuria. Most chose either the standard urine dipstick (29.7 percent) or a serum creatinine level (25.2 percent) for initial screening rather than the recommended albumin-specific dipstick (15.0 percent).

"The results showed that there are a lot of people out there, including my fellow students, who have a lack of training on kidney disease screening," said Ms. Hatfield, a University of North Texas Health Science Center student who completed her PA requirements this spring and will complete her second Master's program in clinical research in December.

Ms. Hatfield's abstract, which currently is being submitted for publication, is part of her Master's thesis and leverages her professional experience in nephrology. Her research is a launching pad for the next phase of her career. A native of Henrietta, Texas, Hatfield worked as a clinical coordinator for Dallas Nephrology Associates for several years after graduating from Texas Tech University with a B.S. in Zoology. "I really didn't know a lot about nephrology but was interested in doing clinical research, and found a position at Dallas Nephrology," she explained. "My

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Practice Management

Planning for the Worst Ensures the Best Continuity of Care

An emergency situation hits your area, and your office cannot open — for a day, a week, or months. Are you prepared with a clear emergency plan, appropriate insurance coverage, protection of your practice's vital records and property, and plans for communications and facilitating solutions to clinical problems?

While dialysis units build systems around federally-required disaster plans, emergency clinical drills, and support of the ESRD Network and the Kidney Community Emergency Response (KCER) Coalition, physicians' practices may be flying solo as individual businesses. Practice managers must prepare for any emergency that has the power to interrupt the practice's capabilities, from a local electrical outage or other utility failure caused by weather, fire, or other situation; to "predictable" weather such as winter storms, hurricanes, or tornadoes that are the reality of a region's seasons; to an unexpected catastrophe like earthquakes, severe weather or uncontrolled wild fires. No one is immune from potential disasters.

Being unprepared can have a major economic impact on your practice and all who depend on it, including employees and their families.

Accustomed to dealing with major winter storms in Maine, Candace Walworth, M.D., a partner in Nephrology Associates of Lewiston, points to an ice storm in 1993 as the force that led her practice to look at long-term disaster preparedness. "I never thought we'd have a storm that would affect us for weeks, but an ice storm in 1993 was a colossal disaster because it knocked out power for three weeks in some parts of our community," Dr. Walworth said. While the staff tapped into resources from grateful patients to its corporate facility owner, the experience has left the practice better prepared for other potential emergencies. "Think as far ahead as you can and do the best you can when a disaster hits," she advises.

Being unprepared can have a major economic impact on your practice and all who depend on it, including employees and their families. Emergency preparedness, however, can protect the practice's property, business finances and infrastructure, and create a solid foundation for moving forward, no matter how large or small the disaster situation. "Creating emergency plans, backing up computer files, having a business interruption plan, and being able to coordinate staff and communicate with them are the major issues for practice management," said Robert Kenney, M.D., who serves as RPA's representative to the KCER Coalition and co-chairs the coalition's Physician Placement Team. "Look at the infrastructure of the operational aspects of the practice, so that after an interruption, you can resume operations almost from where you left off," he added.

Many of the key components of the CMS manual *Emergency Preparedness For Dialysis Facilities* can be translated into elements for an emergency plan for a practice as well. Foremost among them is mitigation; that is, take positive, specific steps to secure the facility, develop a disaster plan, and train all staff, so that the effects of a potential disaster are minimized.

Property Protection

A practice's property includes the physical building and equipment, as well as electronic records and business documents. Be sure the practice's attorney has original documents that are critical to the practice ownership, such as contracts, stocks, bylaws, and shareholder agreements. Other documents may include insurance policies, engineering or architectural plans, and personnel files. Be sure that partners and administrators know who maintains original documents, and how they can access copies as well.

Electronic health records, as required by the Health Insurance Portability and Accountability Act (HIPAA), must be "protected from loss or destruction." The office's practice management system, however, must have a reliable back-up to protect the practice from losing billing, scheduling, vendor information, payroll, etc. Practice management advisor Cindy Dunn, RN, FACMPE, emphasizes the importance of testing back-up tape to ensure that it's truly accessible in the event of an emergency. "Be sure you have off-site backup, which is more affordable today," said Ms. Dunn, a Senior Consultant for MGMA Health Care Consulting Group. "More importantly, ask your IT vendor or staff to test the backup tape by reinstalling it on another system, which will confirm whether or not you would be able to access the data." She recommends that practices run a backup test at least annually or perhaps as frequently as every six months, depending on the size of the practice and how much risk it carries. Many practices fail to run tests, and some, unfortunately, have been unable to recover their entire practice management systems.

Insurance coverage is a major piece of any practice's protection. Types of coverage and specific policies vary greatly, and costs can be offset by mitigation opportunities. "Always ask your provider about what local programs there are for mitigation," said Sherilyn Burris, Emergency Management Specialist for The Florida ESRD Network (Network 7) and KCER. "Depending on what's available, if you do some specific mitigation to your property, you may get a tax break or a break on your insurance policy."

The U.S. Department of Homeland Security recommends that businesses of all types create a business continuity and disaster preparedness plan.

Business interruption insurance policies are designed to offset financial damages that result from any interruption, from local utility outages, to long-term office closings that have impacted practices hit by natural disaster. In extreme cases such as Hurricane Katrina, some practices and independently-owned dialysis facilities would not survive without the cash flow that a business interruption policy may provide. Also known as business income protection, profit protection, or out-of-business coverage, business interruption insurance covers loss of income not included in property damage policies.

Creating and Implementing a Plan

When an emergency strikes, practice managers become a pivotal force in facilitating solutions for the practice, as well as dialysis units, depending on the practice's relationship with local dialysis facilities. "The buck stops with me as the [dialysis center] medical director when it comes to patient safety," explained Dr. Walworth, "but the practice manager taps into our resources and is like the sergeant of the troops getting things organized and pulling them off."

The U.S. Department of Homeland Security (www.ready.gov) recommends that businesses of all types create a business continuity and disaster preparedness plan (see checklist). Assessing potential emergency situations, using common sense and available resources to take care of staff and business infrastructures will protect the business and its functions.

Beyond securing business property, a practices' disaster plan should include local partnerships and ongoing communication with them, which would help ensure a solid working relationship should an emergency happen. In some cases, such as with hospitals and fellow providers, written agreements can be created. Municipal and state emergency management staff should be aware of specific requirements of the practice and/or an affiliated dialysis facility should water, power, or transportation, for example, become inaccessible.

"You need those business arrangements with hospitals and others, and communications can be the hardest piece during an emergency," said Vicki Peters, RN, MSN, MAEd, CPHQ

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Practice Management

from page 4

Executive Director, Southern California Renal Disease Council (ESRD Network 18). During the Northbridge earthquake in 1994, transportation turned out to be a local weakness. "A big issue, especially in outlying areas, is getting patients to other facilities. Talk to local emergency contacts to figure out how to get patients to the center, and the local government might be able to help, maybe with school buses. These are things to ask up front so that they are in your plan," she said.

Practices can be impacted by disasters either as a disaster site or as a patient refugee site; in either case, managers often must act creatively. "We learned from Katrina that practice managers need to plan for refugee management and be ready to deal with it," said Dr. Kenney. "In essence, offices treated transplant recipients who showed up at dialysis units, where they were triaged. During a disaster, hospitals limit ER access to ambulances and people with bona fide injuries," he explained, which results in chronic kidney disease patient refugees' finding their way to dialysis units wherever they're sent geographically. "It creates billing challenges, but during Katrina, CMS allowed physicians to bill for services provided to patients without assignment of benefits. People just needed service."

Other emergencies, while more localized have impacted cities for several days or weeks, and communities came together to help patients. During the 1993 Mississippi River flooding, the Des Moines water supply was contaminated. "One of our nurses had the brilliant idea to appeal to the farmers, so she got on the radio and explained the problem our patients were facing," said Prem Chandran, M.D., of Associates in Kidney Care in Des Moines. "And it was phenomenal! We started getting calls from farmers, and they came with huge rubber water containers used for irrigation, parked the trucks around our dialysis unit and pumped water into our system. Surprisingly, many of the farmers wanted nothing in return. It was the worst of life bringing out the best in human beings," he said.

The practice manager must be prepared to act as the point person communicating with community partners and municipal emergency management contacts, while managing solid communications.

"You definitely need a solid disaster plan for the business, and the second most important piece of preparedness is communication between staff and between staff and patients," said Ms. Burris.

While some of the basic elements of a communications system can seem simple, keeping them updated and accessible is critical, in cases of a minor issue affecting your building or an emergency that will impact staff and patients for an extended period. "Whether the practice is big or small, the manager needs to have personal phone numbers and a documented phone tree," said Ms. Dunn. "Document a plan as to what you would do in the event of any business interruption — big or small — and be sure you communicate the plan to your staff." Disasters, however, often result in phone outages as well as "line load control," limitations telephone utilities may use to keep systems from crashing. "During Katrina, we were able to use text [messaging]," said Dr. Kenney. "You need to have an understanding of how staff will know about reporting in and to whom during a disaster."

The keys to success, Ms. Dunn emphasized, are the practice managers' keeping records updated monthly and talking to staff about the plan often, just as clinical staff practice emergency drills. Emergency managers also urge practice managers to keep as current as possible with how others manage disasters. "We always learn something new," said Ms. Burris. "We'll never have a disaster where we don't learn something, and everyone can learn from those experiences."

RPA activates a disaster-related displaced physicians' list on its website during times of emergency. If you are a displaced physician or if you wish to volunteer to assist in an emergency, please go to www.renalmd.org/publications/report.cfm to sign up. The Kidney Community Emergency Response Coalition Report can also be viewed and downloaded from the RPA website under publications. ❖

BUSINESS CONTINUITY CHECKLIST

❑ Be Informed
Know what kinds of emergencies might affect your company.

❑ Continuity Planning
Carefully assess how your company functions, both internally and externally.

❑ Emergency Planning
Your employees and co-workers are your business' most important and valuable asset.

❑ Emergency Supplies
Think first about the basics of survival: fresh water, food, clean air and warmth.

❑ Deciding to Stay or Go
Shelter-in-place or evacuate, plan for both possibilities.

❑ Fire Safety
Fire is the most common of all business disasters.

❑ Medical Emergencies
Take steps that give you the upper hand in responding to medical emergencies.

❑ Influenza Pandemic
The federal government, states, communities and industry are taking steps to prepare for and respond to an influenza pandemic.

EMERGENCY PLANNING

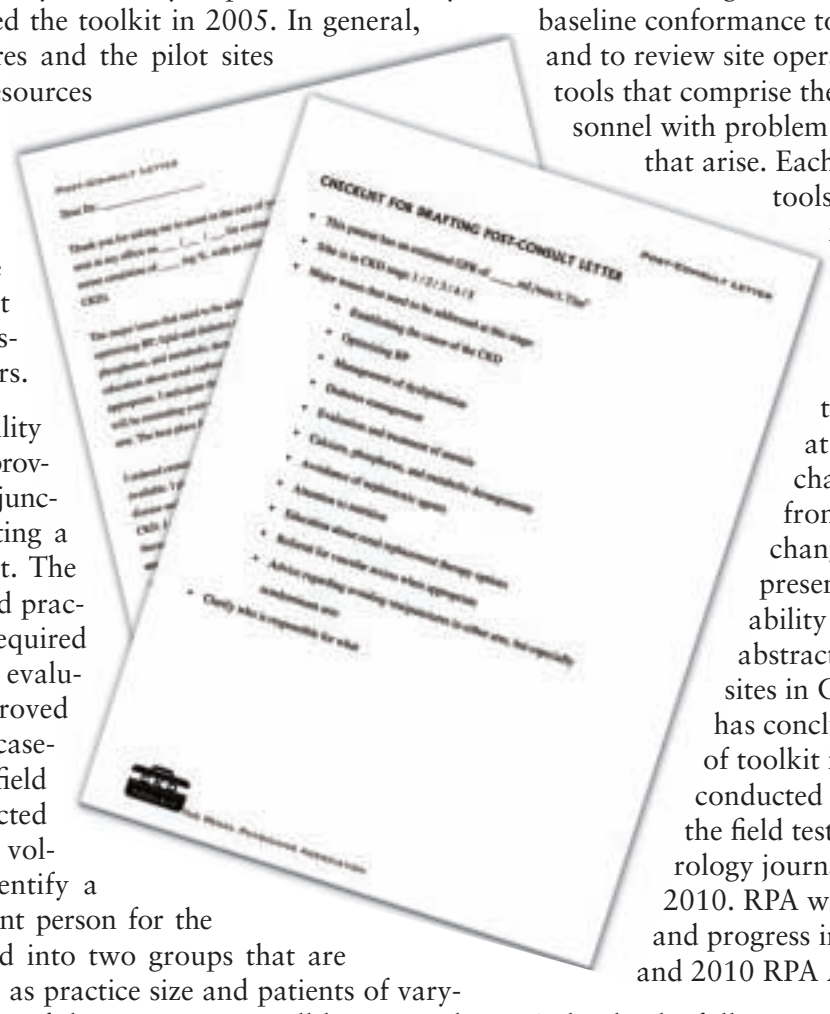
- Include emergency preparedness information in newsletters, on company intranet, periodic employee e-mails and other internal communications tools.
- Consider setting up a telephone calling tree, a password-protected page on the company website, an e-mail alert or a call-in voice recording to communicate with employees in an emergency.
- Designate an out-of-town phone number where employees can leave "I'm Okay" messages in a catastrophic disaster.
- Provide all co-workers with wallet cards detailing instructions on how to get company information in an emergency situation. Include telephone numbers or Internet passwords for easy reference.
- Maintain open communications where co-workers are free to bring questions and concerns to company leadership.
- Ensure you have established staff members who are responsible for communicating regularly to employees.
- Talk to co-workers with disabilities. If you have employees with disabilities, ask about what assistance is needed. People with disabilities typically know what assistance they will need in an emergency.
- Identify co-workers in your organization with special needs.
- Engage people with disabilities in emergency planning.
- Ask about communications difficulties, physical limitations, equipment instructions and medication procedures.
- Identify people willing to help co-workers with disabilities and be sure they are able to handle the job. This is particularly important if someone needs to be lifted or carried.
- Plan how you will alert people who cannot hear an alarm or instructions.
- Frequently review and practice what you intend to do during and after an emergency with drills and exercises.

Source: www.ready.gov

Does Toolkit Implementation Change Practice Performance?

from page1

In 2005, with technical support from the Duke CCHPR, RPA studied the use of the toolkit in two diverse nephrology practices in North Carolina over a six-month period. Duke CCHPR performed chart abstraction at the sites before and after implementation of the toolkit. They found conformance increased for all seven CKD guideline clinical topic areas (anemia, bone disease, hypertension, nutrition, lipids, education and counseling, and preparation for renal replacement therapy) after the practices utilized the toolkit. In addition, Duke CCHPR analyzed survey responses from nearly 1,000 practitioners who had received the toolkit in 2005. In general, the feedback from the questionnaires and the pilot sites revealed that toolkit users liked the resources and would recommend the toolkit to others. Recommendations from the pilot sites to increase the value of the toolkit included clarifying the instructions on how best to use the individual tools. In 2006, the toolkit was modified and re-released for dissemination to nephrology practitioners.



To demonstrate the widespread usability and value of the toolkit in improving patient outcomes, RPA in conjunction with Duke CCHPR is conducting a 10-site field test of the CKD Toolkit. The field test will assess care patterns and practices and the changes in processes required to improve care. Additionally, it will evaluate the impact of the tools on improved conformance to guidelines using a case-control design. To conduct the field test, Duke CCHPR randomly selected 10 nephrology practices from the volunteer pool. Each practice will identify a "site champion" to serve as the point person for the project. The 10 sites will be divided into two groups that are balanced on key characteristics such as practice size and patients of varying socioeconomic levels. The impact of the intervention will be assessed in both groups. Data will be collected at three points for Group I: pre-implementation, post-implementation and at a follow-up point six months later. Data will be collected at two points for Group II: pre-implementation and post-implementation. Group II sites will serve as the control group for Group I and also will be compared to their own historical performance. The study will test a number of hypotheses, including that use of the toolkit in nephrology practices both with and without an Electronic Medical Record (EMR) will result in improved care as measured by conformance to guideline recommendations and that adequacy of CKD management will increase and be sustainable six months after toolkit implementation.

The first step of the field test will be to assess current practice performance in each site by abstracting chart data. Data will be collected by a chart abstractor knowledgeable in kidney-related procedures and services. The site champion will play a key role and will begin by providing the chart abstractor with patient charts meeting specified criteria. After the charts are abstracted, data will be analyzed by Duke CCHPR. No patient-identifying information will be provided to Duke CCHPR. A feedback meeting will be held with each site to present that practice's baseline conformance to the RPA CKD guideline recommendations and to review site operations. Next, the sites will implement all tools that comprise the toolkit. Duke CCHPR will assist site personnel with problem resolution regarding implementation issues that arise. Each site will have the opportunity to tailor the tools to meet their practice's needs. The customized set of tools will then be implemented for a period of six months, during which time the site will have monthly conference calls with Duke CCHPR. The impact of the implementation will be assessed by evaluating the change in conformance to RPA guidelines at the end of the six month period via another chart abstraction. Feedback will also be obtained from the sites regarding implementation and changes in processes of care. The results will be presented to each site. In order to assess the sustainability of the implementation over time, the chart abstractor will abstract additional charts from the sites in Group I six months after the implementation has concluded. A comprehensive analysis of the effect of toolkit implementation on patient outcomes will be conducted for the 10 sites and a manuscript describing the field test will be prepared for a peer-reviewed nephrology journal following the conclusion of the project in 2010. RPA will provide updates on study developments and progress in future issues of *RPA News* and at the 2009 and 2010 RPA Annual Meetings.

RPA thanks the following practices who have agreed to serve as test sites for this project: Associates in Kidney Care (Des Moines, IA); Boise Kidney and Hypertension (Meridian, ID); Indiana Medical Associates (Fort Wayne, IN); Renal Associates of Baton Rouge (Baton Rouge, LA); Western New England Renal and Transplant Associates (Springfield, MA); Durham Nephrology (Durham, NC); Renal Medicine Associates (Albuquerque, NM); Nephrophiles, LLC (Santa Fe, NM); Long Island Hypertension & Nephrology (Port Washington, NY); and North Houston Nephrology & Diagnostic Association (Houston, TX).

Ortho Biotech has provided a grant to support the costs of this study.

For Fellows Only:

Don't Miss RPA Workshop, "Making the Transition from Training to Practice"

September 12 in Minneapolis

RPA plans two workshops during the year specifically targeted to renal fellows that address topics essential to survival in clinical practice and not offered as part of traditional fellowship training programs. RPA's September 12 workshop in Minneapolis will provide fellows with information about employment opportunities in academia, private practice and industry settings to assist them with selecting where they want to focus their job search. In addition, they will get specific tips on preparing their resume, how to present themselves in an interview and how to negotiate an employment contract. A nephrologist who recently completed fellowship training will speak to attendees about what he wished he knew before he entered practice but didn't know the right questions to ask. Fellows will get a brief, high-level overview of unique nephrology coding and billing issues. They will also gain insights into the role of the dialysis facility medical director.

Fellows who have attended this workshop have found it invaluable. All attendees receive a copy of RPA's *Guide to Nephrology Practice* to assist them as they embark on their careers. To register for the September workshop go to www.renalmd.org, educational programs, fellows workshop or call the RPA office at (301) 468-3515. Limited travel grants are available to offset costs associated with travel and lodging in Minneapolis. There is no registration fee for this workshop. Space is limited.

Funding to offset program costs has been provided by a grant from Genzyme Corporation.

Idealistic and Naïve? So Much to Do…So Little Time

By Adam Weinstein, M.D.

This is part of a series of articles aimed at describing various aspects of the transition from training to practice from Dr. Weinstein's perspective. This does not represent the views of the RPA.

The first time I saw a physician assistant rounding in a dialysis unit I was amazed to learn that my attending physician at the time, a community-based doctor in private practice, only saw his dialysis patients once a month — to review labs and complete a comprehensive monthly visit plan. After finding a tactful way, I asked how he felt about not seeing his dialysis patients more frequently, and he replied, "It doesn't matter how I feel. It is what I need to do to stay in practice and stay sane."

"On occasion, I have found the phrase 'slow down' going through my mind as I discover some important development during my rounds."

— Adam Weinstein, M.D.

Now, at the beginning of our third year in practice, my partner and I are amazed at how fast we have grown. But despite our success, I've noticed our conversations often focus on the struggle between time and money. More specifically, it seems we are always striving to provide our care as quickly as possible while maintaining our ideal level of service. And, as our practice grows, we find an increasing number of examples of time efficiency trumping our expectations of the kind of care we want to deliver.

A college history professor once told me that to understand the problems a society faced you simply have to look at the laws they enacted. Our practice is no different. Since the U.S. health care system is a volume-driven industry, it became quickly apparent how many patients we needed to see a day to make ends meet. We strongly believe that each initial visit should be given about 60 minutes, and follow up chronic kidney disease visits need 20 to 30 minutes. However, to ensure that we see the necessary volume of patients, we have developed a staggering number of rules and office policies, including: we make reminder calls to all patients two days before their visit; we charge a $25 rescheduling fee for no-shows or cancellations with less than 24 hours notice; we return only emergency patient phone calls during office hours; we call with lab and test results only if there is further action needed. In short, our office staff are taskmasters and gatekeepers — keeping our schedule full and the doctors focused and moving to see patients in the office.

Since every minute spent on documentation takes away from patient interactions, we have adopted a policy of "institutionalized revolution" with regards to physician workflow. We currently have an electronic medical record (EMR) system, but have grafted on the use of voice recognition software to speed up the documentation of our assessments and plans. In our brief time, we have also tried template-based progress notes, point-and-click EMR notes, and handwritten dialysis notes. Again, the amount of change speaks to the battle we are fighting — making the most out of the least amount of time.

Interactions with my patients have also evolved. On dialysis rounds, I find myself not asking open-ended questions. Discussions regarding salt, phosphorus, and fluid compliance get offloaded to the dietician, and anemia and bone homeostasis only get discussed when there are problems. In the hospital, I'm not as patient in gathering histories and frequently feel rushed to get through the subsequent inpatient encounters. On occasion, I have found the phrase "slow down" going through my mind as I discover some important development during my rounds.

While it is easy to ascribe all of these observations as the clash of reality in the face of the idealistic and naïve young physician, I see some patterns of concern emerging. First, there is no room for complexity. Volume-driven medicine does not allow for the flexibility of timing that an unexpectedly complex patient requires. The financial incentive seems to reward caring for a high volume of moderately ill patients. Likewise, outside of the newly implemented pay-for-performance system, there is no incentive to manage these patients with the degree of coordination or long-term planning that is often required.

There is also a huge potential for communication error — both with patients and fellow physicians. The number of useless notes from EMR-documented encounters we receive amazes me. It is clear, however, that one can have a completely compliant note that relays zero information. Likewise, in our volume-based system there is a very high failure of patient compliance — not taking medications, missing tests or appointments, etc. I find myself wondering how much of this is a failure of patient education and adequate physician teaching — often the first victim of high-volume care.

"Starting our practice has, in many ways, been about finding the limits of our ideals — the limits of our time, our financial resources, and our families' tolerance of being without us."

Lastly, there is the loss of intimacy and trust. We deal with life-altering and life-ending issues. Given how much money is spent on dialysis and end-of-life care, would it not be more cost effective to spend time educating patients as to the reality of their terminal diseases and helping them choose between quality and quantity of life? It seems many of these discussions are either not taking place or are "outsourced" to non-physician providers. While our dialysis teaching nurse is wonderful, I have rarely seen her talk someone out of dialysis.

Starting our practice has, in many ways, been about finding the limits of our ideals — the limits of our time, our financial resources, and our families' tolerance of being without us. As we hit the walls placed by our health care system, I find myself wanting change. It is painfully obvious that we have lost the flexibility and power to dictate how medicine should be practiced. Unfortunately, changing the system means political action. And though politics can be messy and frustrating, I can think of no better way to defend the ground we have left. ❖

Adam Weinstein, M.D., is a nephrologist in Easton, MD and serves the five upper counties of Maryland's eastern shore. He completed medical school, an internal medicine residency and a nephrology fellowship at the University of Maryland School of Medicine. Drs. Weinstein and Anish Hinduja, M.D. opened The Kidney Health Center of Maryland, PA, upon completing their fellowships in July 2006.

RPA's 2009 Annual Meeting *is heading back East*

Renaissance Harborplace Hotel Baltimore, Maryland • March 20–23

MARK YOUR CALENDARS

Health Care Reform: May the Best Plan Win

What would "Harry and Louise" say about the nation's health care system today?

The fictional couple who starred in TV commercials during the Clinton health care reform debate struck a nerve with the public. But once again, voters are telling pollsters that they are ready for a major overhaul of the system. In response, during this year's presidential campaign, each of the major contenders unveiled reform proposals reflecting their own approaches.

Public opinion polls have found a widening gulf among voters about what remedies they favor. Democrats are looking at building on the employer-sponsored health insurance system, using government funding to extend protection to the uninsured. Republicans, meanwhile, favor addressing the growing costs of health care and insurance, preferring instead a plan that would shift the burden of insurance from businesses to individuals, mainly through tax credits.

As a service to its members, RPA has compiled a side-by-side comparison of the candidates' reform proposals. As with anything political, specific details are hard to come by. But the following summary captures the general framework of the candidates' proposals. Wherever possible, RPA has indicated how a candidate's position might affect the practice of nephrology.

(Please note that this comparison is provided for information purposes only. RPA has not taken a position for or against any of the proposals listed.)

2008 Presidential Candidates on the Health Issues: Summary of Key Provisions

	Barack Obama	John McCain
Summary	Assumes if health care is more affordable most Americans will purchase coverage. Increases competition and requires insurers to reduce profit margins and administrative costs in order to spend more on patient care. Coverage is mandatory only for children; however, young adults up to age 25 could opt to remain under their parents' plans.	Predicated on containing spending and making all stakeholders accountable for reform – insurers, providers, hospitals, drug companies, government, and consumers. Stresses better treatment of chronic diseases and more emphasis on preventive care. Consumers are given more control of their health care dollars and increased responsibility for living healthier lifestyles (e.g. obesity prevention) and managing care.
Employer Mandate *RPA comment: this may be of benefit by having more ESRD patients in the Medicare Secondary Payer zone, where reimbursement more accurately reflects treatment costs.*	Requires employers to share in the cost of insuring workers either by offering insurance, providing premium assistance to employees, or paying a percentage of their payroll towards the costs of a national plan (play-or-pay). Exempts small businesses that meet, as yet unspecified, revenue thresholds. Offers employer health plans partial federal reimbursement for a portion of catastrophic costs above a threshold, if employers guarantee that savings would be used to reduce employees' premiums.	Opposes mandate to employers to provide coverage and mandates to individuals to purchase coverage. Would work with states to establish a Guaranteed Access Plan. One possible approach would establish a nonprofit corporation to contract with insurers to cover those denied coverage.
Medical Liability System	No information available.	Supports medical malpractice reform.
Estimated Cost	$50 billion to $65 billion annually.	No information to date.
Financing Mechanisms	Allows certain tax cuts for individuals with annual incomes greater than $250,000 to expire.	Limits employer tax deduction for health care costs. Offers tax credits — $2500 for individuals and $5000 to families — to increase incentives for insurance coverage. Allow individuals with innovative multi-year coverage plans to apply the difference to an expanded Health Savings Account. *RPA comment: may further segment insurance pool, with healthy patients opting for health savings accounts, while ESRD patients left in high-risk pool, where insurers reduce benefits, and raise premiums and co-pays.*

2008 Presidential Candidates on the Health Issues: Summary of Key Provisions (cont'd)		
	Barack Obama	**John McCain**
Public Plans *RPA comment: overall impact uncertain, depending on treatment of ESRD coverage.*	Creates a new national program available to anyone without coverage similar to Federal Employee Health Benefits Program (FEHBP); will provide comprehensive benefits, portability, guaranteed renewability and subsidies. Allows states to devise their own health care reform initiatives. Provides federal income related subsidies for individuals who do not qualify for Medicaid and the State Children's Health Insurance Program (SCHIP) to buy the new public plan or purchase private coverage.	No information to date.
Medicaid and SCHIP *RPA comment: deserves more attention. Inadequate or no reimbursement for CKD/ESRD; loss of medication benefits should be addressed.*	Expands Medicaid and SCHIP. (No details provided)	Provides states the flexibility to, and encourage them to experiment with, alternative forms of access; risk adjusted payments per episode covered under Medicaid; use of private insurance in Medicaid; alternative insurance policies and insurance providers; and different licensing schemes.
Evidence-Based Medicine	Rewards providers in public plan, the National Health Insurance Exchange (NHIE), Medicare, and FEHBP for achieving performance thresholds on physician-validated outcome measures. Establishes an independent institute to oversee reviews and research on comparative effectiveness. *RPA comment: more details required; focuses primarily on pay-for-performance.*	Requires doctors and hospitals to strengthen transparency regarding medical outcomes, quality of care, costs and prices. Requires provider compensation to be tied to performance, starting with Medicare and Medicaid; wants their reimbursements dependant on outcomes; Medicare should not pay for preventable medical errors or mismanagement. *RPA comment: appears overly punitive; fails to recognize complexities of caring for the chronically ill.*
Health Information Technology *RPA comment: candidates fail to address funding mechanism to support conversion.*	Adopts standards-based electronic health systems, including electronic health records; calls for phase in requirements of health IT systems. Ensures that patients' privacy rights are protected.	Supports adoption of health IT, use of telemedicine and community clinics where services and providers are limited.
Consumer Rights/ Transparency	Guarantees eligibility; requires plans to disclose percentage of premiums spent on direct patient care.	Portable insurance that could be carried and purchased across state lines, and multi-year coverage. Pharmaceutical transparency — requires drug companies to reveal their cost.
Insurance Pools *RPA comment: conceptually sound, but CKD/ESRD patients must be included.*	Creates NHIE to help consumers purchase private insurance plans. NHIE will establish rules and standards for participating plans to ensure coverage that is equitable, affordable, and accessible and act as a watchdog. At minimum, the benefits offered by participating plans must be comparable to public plan. Insurers will have to justify above average premium increases to NHIE.	No information to date.
Preventive Care *RPA comment: consistent with RPA goals.*	Promotes prevention through school-based initiatives and increased funding for workforce/worksite and community-based prevention programs.	Increases focus on disease prevention; wants all stakeholders to take responsibility for better preventive care and disease management.
Insurer Requirements	No information available.	No information to date.

2008 PQRI Program

from page 1

measure groups are composed of the following PQRI measures:

Diabetes Mellitus

Measure Number 1
Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus

Measure Number 2
Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus

Measure Number 3
High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus

Measure Number 117
Dilated Eye Exam in Diabetic Patient

Measure Number 119
Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients

End Stage Renal Disease

Measure Number 78
Vascular Access for Patients Undergoing Hemodialysis

Measure Number 79
Influenza Vaccination in Patients with ESRD

Measure Number 80
Plan of Care for ESRD Patients with Anemia

Measure Number 81
Plan of Care for Inadequate Hemodialysis in ESRD Patients

Chronic Kidney Disease

Measure Number 120
ACE Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy in Patients with CKD

Measure Number 121
CKD: Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone [iPTH] and Lipid Profile)

Measure Number 122
CKD: Blood Pressure Management

Measure Number 123
CKD: Plan of Care: Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)

Preventive Care

Measure Number 39
Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older

Measure Number 48
Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older

Measure Number 110
Influenza Vaccination for Patients >50 Years Old

Measure Number 111
Pneumonia Vaccination for Patients 65 Years and Older

Measure Number 112
Screening Mammography

Measure Number 113
Colorectal Cancer Screening

Measure Number 114
Inquiry Regarding Tobacco Use

Providers electing to report a group of measures must report ALL measures within that group that are applicable to either 15 consecutive — next in order by date of service — eligible patients OR 80 percent of Medicare patients for whom the measures of the measure group apply without regard to whether the patients are consecutive.

CMS has created new G-codes to identify each measure group. Providers may initiate reporting for the 15 consecutive Medicare patients beginning on or after July 1, 2008, by reporting the applicable G-code on the initial claim for a measures group. It is only necessary to submit the measures group-specific G-code one time on the initial claim. This indicates the provider's intent to report a specific measures group starting with the first patient for whom the G-code is submitted. The measure groups' specific G-codes are:

G8485 for Diabetes Mellitus

G8486 for Preventive Care

G8487 for Chronic Kidney Disease

G8488 for End Stage Renal Disease

For example, patient X presents for an office visit on July 1, 2008 with Dr. Smith with a diagnosis of CKD. Dr. Smith selects the CKD measures group as a PQRI reporting option. Dr. Smith reviews specifications for the four measures in the CKD measures group to identify measures applicable to patient X. Dr. Smith submits appropriate CPT II codes based on the measures identified as well as Healthcare Common Procedure Coding System (HCPCS) code G8487 on patient X's claim form for that July 1, 2008 visit. Dr. Smith then reports 15 consecutive patients meeting the denominator criteria starting with patient X, OR Dr. Smith reports on at least 80 percent of patients during the reporting period meeting the denominator criteria for applicable CKD measures.

Eligible providers who satisfactorily report under any of the alternatives, or report 1–3 PQRI measures through claims at a rate of at least 80 percent for the January 1, 2008–December 31, 2008 reporting period, can earn a 1.5 percent of allowed charges incentive payment with respect to services furnished during the applicable reporting period. For example, satisfactory reporting for only the July 1, 2008–December 31 2008 reporting period will qualify for the 1.5 percent bonus only for the services furnished during that reporting period.

Specific billing requirements were not available as of press time, but RPA has created a PQRI toolkit to help nephrology practices navigate the 2008 PQRI program that has been updated to include information about this new reporting alternative. For more information, please visit www.renalmd.org/pqri. For more specific guidance from CMS, please visit www.cms.hhs.gov/pqri. ❖

RPA Awards Outstanding Abstract

from page 3

interest in nephrology definitely came from all of the patients there."

Because the three-year PA program is longer than many others, students have time to focus on research, including two years to write a thesis. "It was a very long process over the two years. Part of that is a research appreciation day, which is for further training on writing abstracts, and I had a lot of support from my faculty advisor and thesis advisor," she said.

Ms. Hatfield's abstract suggests the need for more education to increase clinical awareness of the KDOQI guidelines and recommendations, and that future studies should focus on evaluating if screening measures for chronic kidney disease currently used by PAs are as adequate as those presented in the guidelines.

"Doing this study has interested me in getting more involved in educational aspects of training other PAs, especially in nephrology. I do have experience in nephrology, but I realized there's a lack of specific nephrology training for PAs. They weren't doing the right kind of screening," she said. Ms. Hatfield pointed out that in her particular Master's program, students study nephrology as part of their coursework, but clinical nephrology experience can be limited. Students choose a nephrology rotation as their one elective during their clinical rotation, although the University of North Texas program will be adding opportunities for more elective rotations.

"This research definitely got me more interested in the educational aspects of renal disease and the need to make providers more aware of what they should be doing with their patients," Ms. Hatfield said. "My goal now is to go back into nephrology, working at a university or within a group — one where I could do clinical work and also be a subinvestigator on clinical research."

RPA's July 17–18 course for PAs and nurse practitioners, "Clinical Collaboration in CKD Care," focuses on nephrology-specific issues that practitioners who work with kidney patients confront in the clinical setting. This is a unique opportunity for PAs interested in nephrology to learn about the newest approaches to care for kidney patients. The course is being held at the Ritz Carlton Pentagon City. There may be a few spots remaining. To register contact the RPA office at (301) 468-3515 or rpa@renalmd.org. ❖

From Capitol Hill

from page 1

While hopes were running high that the Medicare legislation would be adopted well before the July 1 deadline, RPA took no chances and scheduled a June 23 Capitol Hill Day, where more than 40 nephrologists took their message directly to lawmakers. At issue was whether legislation would be enacted in a timely manner, and whether the ESRD provisions would be included in the final legislation.

RPA members also urged lawmakers to use the next 18 months to come up with a fair, equitable and permanent formula — one that adequately reimburses nephrologists for the complex care they provide to the chronically-ill ESRD population.

Health IT legislation could advance

Recent developments could open the way to more widespread use of health information technology (IT) in the nation's health care system — an issue that RPA has promoted in Congress for several years.

Last summer, the Senate Health, Education, Labor and Pensions (HELP) Committee approved legislation to encourage the adoption of IT in health care. The Wired for Health Care Quality Act (S. 1693) would provide $139 million to foster health IT, establish a National Coordinator of Health IT and create a public/private partnership charged with making recommendations to the executive branch and Congress. However, the measure, which was authored by Senators Edward M. Kennedy (D-MA) and Michael Enzi (R-WY), failed to advance when several lawmakers raised concerns about privacy protections.

Senator Patrick J. Leahy (D-VT), who was among those who considered the bill's privacy provisions inadequate, has convinced Kennedy and Enzi to modify their bill, closing several loopholes, and potentially clearing the way for enactment.

Leahy's provisions would limit the ability of operators of personal health information

databases to distribute sensitive health records. The provisions also would prevent certain health care providers from using or disclosing patient health records for marketing purposes, and would require the government to submit a report to Congress containing recommendations for privacy and security protections for personal health records. Finally, patients would be given a broad right of access to inspect records held in electronic form and receive an electronic copy of the record.

If the roadblocks in the Senate can be overcome, chances are high that the House will adopt the measure, then send it to the President, who has been a strong and vocal advocate of health IT.

Comparative effectiveness research promoted

Citing a climate of ballooning health care costs that show no sign of slowing, several lawmakers are getting behind the idea of creating a national comparative effectiveness program to examine both the effectiveness and the costs of treatments.

Senators Max Baucus and Kent Conrad (D-ND) are drafting legislation that would establish a separate entity to oversee comparative effectiveness research, while Rep. Pete Stark (D-CA) is working on legislation that would incorporate this function under the existing Agency for Healthcare Research and Quality.

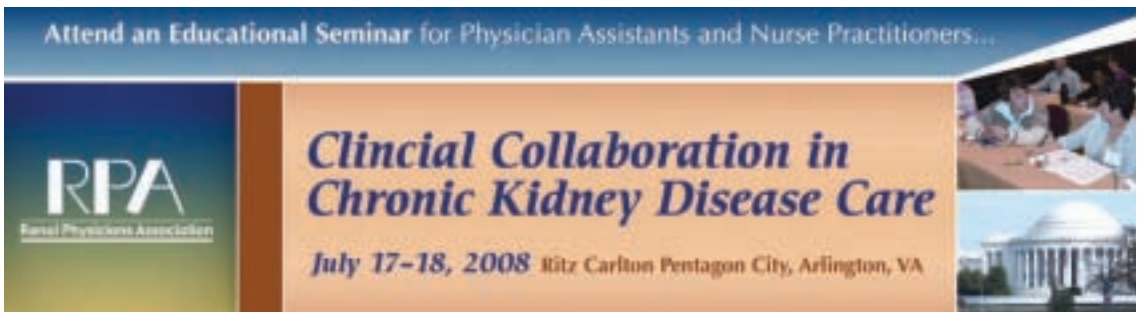
Although there is broad agreement around the basic concept of comparative effectiveness — measuring and reporting on the impact of treatments and drugs — how the research findings are used is under contention.

Some argue that to be successful and sustainable, comparative effectiveness research should focus, first and foremost, on determining clinical effectiveness. But in a position paper published in the June issue of the *Annals of Internal Medicine*, the American College of Physicians (ACP) argued that treatment costs should be studied as well.

The more that decisions "can be informed by both cost and clinical effectiveness, combined in an explicit, transparent manner…the higher the likelihood of obtaining true value and equity within the healthcare system," ACP contends. Countering concerns that the use of cost effectiveness data in reimbursement could stifle innovation, ACP argues that such data could actually encourage the development of more cost effective interventions. ACP recommends that all payers, including Medicare, should assess clinical interventions based on both comparative clinical effectiveness and cost effectiveness information, with the caveat that cost not be used as the only factor for evaluating clinical intervention.

Summary

By the time you read this article, Congress hopefully will have acted to provide some degree of relief from the impending Medicare Fee Schedule cuts, as well as enacting other provisions of benefit to the physician and ESRD communities. This will lead into what is presumed will be a quiet legislative period in deference to the national elections in the fall. Nevertheless, RPA members are encouraged to remain active participants in the advocacy process throughout the autumn months, in advance of the swearing in of a new president and the 111th Congress in 2009. ❖

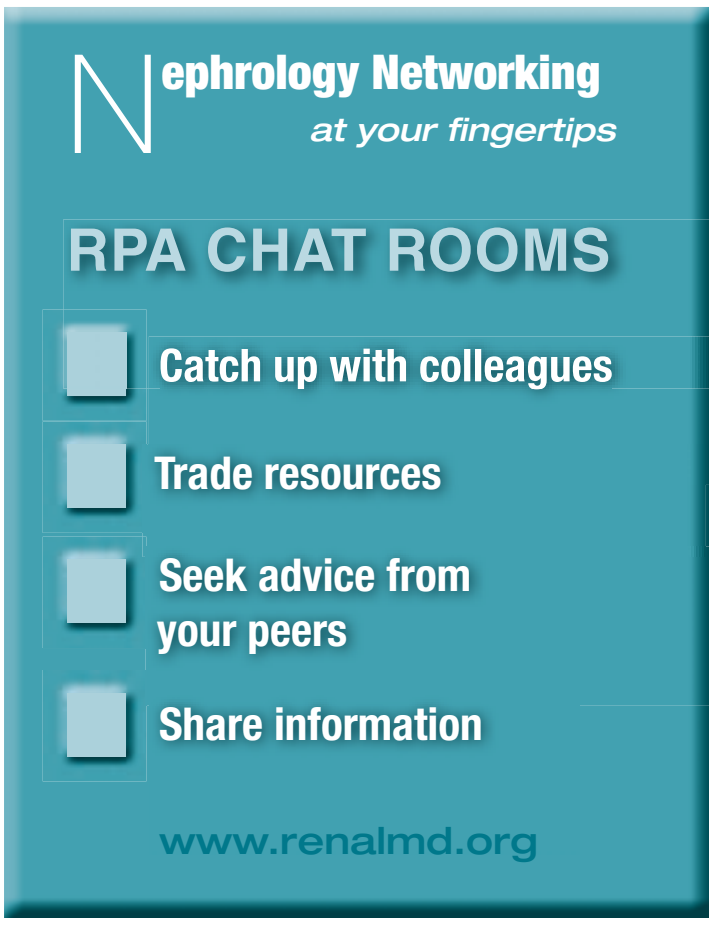


Calling all NPs and PAs

RPA's July 17–18 course for physician assistants and nurse practitioners, "Clinical Collaboration in CKD Care," focuses on nephrology-specific issues that practitioners who work with kidney patients confront in the clinical setting. This is a unique opportunity for PAs interested in nephrology to learn about the newest approaches to care for kidney patients.

There may be a few spots remaining.

To register contact the RPA office at (301) 468-3515 or rpa@renalmd.org



RPA PAC Facilitates Intimate Dialogue with Hill Leaders

RPA's decision to establish a political action committee, or PAC, in 2005 is already paying dividends.

In the months leading up to a critical decision in Congress — whether to allow a planned 10.6 percent cut in Medicare physician payments to take effect — the RPA PAC afforded the Association's leaders and staff an opportunity to personally thank lawmakers who understand and appreciate the vital role nephrologists play in our health care system, and to reiterate the issues that matter most to us.

RPA PAC contributions were made on a bipartisan basis to key lawmakers in the decision-making process, including Senate Republican Leader Mitch McConnell (R-KY), and Finance Committee members Senators John Sununu (R-NH) and Ben Cardin (D-MD). On the House side, RPA PAC contributions allowed us to personally thank key lawmakers on the House Ways and Means and Energy and Commerce Committees, including Representatives Lloyd Doggett (D-TX), Sam Johnson (R-TX), Shelly Berkley (D-NV), Chris Van Hollen (D-MD), John Shimkus (R-IL) and Fred Upton (R-MI). We also had an opportunity to meet one of the newest House members, Representative Steve Scalise (R-LA).

In addition to thanking these individuals, attendance at these events afforded to us through PAC contributions enables RPA to cultivate and nurture relationships with members of Congress, helping them better understand our issues and concerns. These events are typically informal gatherings of eight to 15 people where attendees are invited to seek the legislators' insight and counsel on matters of concern to the organization. In face-to-face gatherings, away from the hustle and bustle of the U.S. Capitol, we are also able to gain insights on where the decision-making process is heading, and what matters most to lawmakers. Additionally, these events are an excellent way of gathering insider information.

At one of these gatherings, for example, we learned how the Finance Committee planned to structure the physician pay fix, how long it would remain in effect and how ESRD provisions would be treated — all well in advance of when the information was made available to the general public.

Since this is an important election year, PAC events also offer an opportunity to hear a legislator's unvarnished views on the upcoming elections, and how the results may affect issues of importance to RPA.

The opportunities to obtain the outlook of key legislators on issues relevant to nephrologists can only occur through the ongoing support of the RPA PAC. To make a contribution to the RPA PAC, please visit the RPA PAC website at http://www.renalmd.org/members_online/members/c_pac.cfm (member login required) and click on the contribution form. Questions about the PAC should be directed to PAC Administrator Holly Owens at howens@renalmd.org or by calling (301) 468-3515. ❖

Voluntary contributions by individuals to RPA PAC will be used to support candidates for public office who demonstrate their belief in the principles to which the profession of nephrology is dedicated. Contributions from corporations and associations as well as medical practices are prohibited by federal law and cannot be accepted.

Coding Corner

by Debra Lawson, CPC

The RPA office has received numerous questions regarding home dialysis training in recent months. To address these questions broadly, the July 2008 Coding Corner Article is an update of the article on home dialysis training that was included in the July 2007 Coding Corner.

Question: *My office manager provided me with a document entitled "Medicare Part B. Nephrology and Dialysis", and in this document under the "miscellaneous dialysis procedures" there is a section called Dialysis Training. The codes listed for dialysis training are CPT code 90989-dialysis training, complete, and CPT code 90993-dialysis training, incomplete. For 90989, it says a completed course consists of 25 sessions. However, we generally do not need 25 sessions to adequately train someone. Should we bill the 90993? (Even though the training session is complete and sufficient for the patient to understand and perform the procedure.) How important is it to have 25 actual sessions to bill the full service of 90989?*

Answer: Many nephrology practices have questions regarding home dialysis training, particularly regarding the coding and billing requirements for the service. The reimbursement for dialysis training has been at times misperceived by some physicians to be a "bonus" given to providers for starting a patient on peritoneal dialysis, and that little physician work was required to bill this code. However, CMS of course does not pay "bonuses" for services that are not performed.

Another interesting point about dialysis training is that the payment was determined by Congress legislatively and was not created under the resource based relative value system (RBRVS). This means that there is a straight payment for the code, and the reimbursement is not subject to the congressionally assigned conversion factor (CF). The reimbursement is constant at the same rate that has been paid for years.

The reimbursement for a complete course of training (90989) is $500. **This information is noted in the Medicare claims processing manual, Chapter 8, Section 150, and can be found at** http://www.cms.hhs.gov/manuals/downloads/clm104c08.pdf page 114.

Frequently there is old documentation that a complete course is considered to be "25" sessions. This number is based on the reimbursement for the incomplete (by day) code (90993) reimbursed at $20 per completed session. However, it generally does not require patients 25 sessions to be adequately trained to perform home dialysis. The number of sessions a patient needs to be trained to perform home dialysis is generally left to the physician's discretion. Obviously each patient is an individual and it would be difficult for CMS to make a regulation as to the number of sessions needed. Further, the same codes (90989 – completed course) and 90993 (by day

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RPA is pleased to provide another valuable resource to the membership. The *Health Policy Handbook for Nephrology Practitioners*, mailed to all RPA members in February, is designed to make public policy advocacy more accessible to nephrology practitioners and to enable RPA members to take part in state and federal advocacy efforts affecting their practice. Unless nephrologists and their practice teams speak up for the interests of their profession, no one else will. This advocacy handbook is intended to help nephrology practices understand the legislative process by describing the players, the role of grassroots constituencies, political action committees, and associations. The handbook provides easy-to-use tips on such actions as calling, visiting, or writing to members of Congress and your state legislators, as well as working with Medicare program decision makers and contractors. RPA is the leading advocacy organization for the nephrology community, but our successful public policy advocacy is dependent on membership participation in that process. RPA hopes the information provided in the *Health Policy Handbook* will help the membership become more engaged in our advocacy efforts.

Please contact Holly Owens, RPA's Director of Legislative and Regulatory Affairs, at (301) 468-3515 or howens@renalmd.org with any questions.

Coding Corner

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for incomplete course) are used regardless of modality. The same reimbursement is paid for home training if the patient does peritoneal dialysis or the patient with a helper does home hemodialysis.

Since Medicare and most other payers reimburse dialysis training at $500 allowable, it is critical that thorough documentation to support the service is completed.

The most important thing to remember is that the physician must actively participate in the training of the patient to bill for the training. It is not enough to set up the training with the "training unit"call in the orders, and be available to talk with the training nurse as needed. The physician must see the patient during the training and actively participate. I suggest that the physician schedule his/her encounter during the last few days of training. Use this time to do the annual history and physical required by most dialysis facilities, and watch the patient do a dialysis exchange or hemodialysis procedure. After documenting the history and physical, have a discussion with the patient. Some possible topics might be maintaining sterile technique, target weights, anemia management, risks of peritonitis — what to do if the patient has a cloudy or bloody bag during the exchange, what to take to the emergency room for treatment, etc. This discussion should be documented in a separate section of the encounter. The provider should also thoroughly document who was present, what was discussed, and what conclusions were determined. Since Medicare and most other payers reimburse dialysis training at $500 allowable, it is critical that thorough documentation to support the service is completed.

Dialysis training is an important component of a patient's introduction to home dialysis. The provider is entitled to the reimbursement for home training , but careful documentation of the physician's participation in the training is important to support the billing of home dialysis training. ❖

Debra Lawson is a Certified Professional Coder and a contributor to RPA's publication, The Renal Physician Guide to Nephrology Practice. *She also conducts the RPA Nephrology Coding and Billing Seminars.*

**Editors Note: RPA consciously takes a conservative position when providing coding and billing advice to its members, since the possible unintended consequence of taking a less conservative approach could be a claims audit with the potential of doing tremendous harm to an RPA member's practice. Similar to the FAQ page on the RPA website, this column has been designed as a general information resource. It is not intended to replace legal advice. The responses to the questions submitted to the Coding Corner column have not been vetted by attorneys, and attorneys have not been consulted in the drafting of any of the replies.*

RPA Sponsors Nephrology Coding and Billing Seminars

RPA has planned 12 coding and billing seminars throughout the country during 2008 to assist nephrologists and their practice managers with understanding the physician payment requirements delineated in the 2008 Medicare Fee Schedule. Mark the remaining dates and locations on your calendar and plan to send someone from your practice so that you are armed with the latest information to properly code, bill and document nephrology services according to the latest Medicare guidelines.

September 15, Denver, CO
Denver Marriott City Center

September 17, Kansas City, MO
Hyatt Regency Crown Center

September 19, Minneapolis, MN
Marriott Minneapolis City Center

November 17, Nashville, TN
Loews Vanderbilt Hotel

November 19, Miami, FL
Doubletree Grand Biscayne Bay

Debra Lawson, CPC

The seminar leader, Ms. Debbie Lawson, is a certified professional coder and previously served as Director of Reimbursement for a practice of nine nephrologists in Southern Virginia for 14 years. She has helped author the RPA's *Renal Physicians Guide to Nephrology Practice*, has served as a member of RPA's Health Care Payment Committee, and has served as a resource to members who have difficult coding, billing and documentation quandaries. Ms. Lawson brings more than 25 years of experience to her nephrology billing, coding and documentation knowledge base.

Topics covered during the one-day program include proper use of ICD-9 diagnosis codes and CPT codes, Medicare documentation guidelines, consults vs. referrals, teaching physician requirements, the Health Insurance Portability and Accountability Act (HIPAA) compliance, Medicare fraud and abuse and more. Please contact the RPA office for registration information or register online at www.renalmd.org/seminars/index.cfm. ❖

These seminars are supported through an educational grant from Ortho Biotech Products, LP.

RPA Recognizes Corporate Patrons

The RPA corporate patrons program is designed to augment the alliance between stakeholder industries and the RPA since corporate members of the nephrology community play an important role in optimizing patient outcomes. Gifts from corporate patrons are for scientific or educational purposes.

During the year, RPA leaders meet with representatives from corporate patrons' participating companies to discuss areas of mutual concern and interest. This informal dialogue benefits the industry and the association. Potential donors should contact the RPA office to obtain additional information. Links to all of our corporate patrons' sites may be found at www.renalmd.org. Click on "About RPA" on the left side of the screen, and then click on "Corporate Patrons."

RPA is pleased to acknowledge the support provided by all of our Platinum, Gold and Silver corporate patrons in this issue of *RPA News*.

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News Briefs

NIH Publishes Study on Vascular Access

Reducing early blockages in bloodstream access for kidney failure treatment does not increase the likelihood that the access will function adequately for long-term treatments, according to a study funded by the National Institutes of Health. The study results were published May 14, 2008, in the *Journal of the American Medical Association.*

The Dialysis Access Consortium (DAC) of the NIH's National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), which funded the study, found that only 12 percent of patients developed blood clots in the fistula when treated with the clot-preventing drug clopidogrel, compared to nearly 20 percent of patients treated with placebo. Nevertheless, about 60 percent of new fistulas in each group could not be used for long-term dialysis treatments. Complications such as bleeding were similar across the study groups.

DAC studied nearly 900 patients at nine U.S. medical centers in academic and community practices in urban and rural settings. Participants received a new fistula and took an anti-platelet drug or a placebo tablet daily for six weeks to determine if the drug would maintain blood flow in fistulas and increase the number suitable for dialysis.

"Because vascular access is critical for delivering lifesaving care, we are already organizing another multi-center study to look for other ways to improve fistulas," said co-author Catherine M. Meyers, M.D., a kidney specialist in charge of DAC.

The DAC Fistula Trial is the largest multi-center trial to look at preventing blood clots in new fistulas and the first to test whether prevention would allow more fistulas to be useable for dialysis. NIDDK has funded DAC since 2000. More information on the DAC Study can be found at: http://www.nih.gov/news/health/may2008/niddk-22a.htm.

John H. Sadler Distinguished Professorship in Nephrology

The University of Maryland School of Medicine is establishing The John H. Sadler, M.D. Distinguished Professorship in Nephrology to honor and recognize a true leader in the field. In 1972 Dr. Sadler was hired as the first chief of the Division of Nephrology at Maryland and remained there for 22 years until his retirement in 1994. In 1973 Dr. Sadler was a founding member and the first President of the RPA. He received RPA's Distinguished Nephrology Service Award in March 2008 at the RPA Annual Meeting in Austin, Texas, in recognition of his significant contributions to the association and the nephrology specialty.

The University is seeking philanthropic support totaling at least $2.5 million to establish The John H. Sadler, M.D. Distinguished Professorship in Nephrology. By recognizing the best and brightest minds in academic medicine — the faculty who inspire students, expand the frontiers of knowledge, and make discoveries that change people's lives — the University intends to create an enduring legacy for a true man of science.

Gifts to support The John H. Sadler, M.D. Distinguished Professorship in Nephrology can be made outright, through pledges payable over a three to five year period, or through your estate. Checks should be made payable to The University of Maryland Baltimore Foundation, Inc. (Tax ID 31-1678679) with a note designating that the gift is intended to support the Sadler Professorship. For more information, please contact Michael Jessup in the University of Maryland School of Medicine Development Office at (410) 706-6870 or by e-mail at mjessup@som.umaryland.edu. ❖

Featuring Rob Blaser
RPA's Director of Public Policy

GOT A MINUTE?

Get up to speed on the legislative and regulatory issues affecting nephrology practitioners.

Learn how to make your voice heard on legislation and regulations that directly affect you and your practice.

Find out about RPA's latest efforts on Capitol Hill, with CMS and other federal agencies to move RPA's advocacy agenda forward.

RPA
Renal Physicians Association

Public Policy Minute

RPA, the Advocate for Excellence in Nephrology Practice, presents the Public Policy Minute each month at www.renalmd.org

Clinical Practice Opportunities

The RPA is pleased to share information about clinical practice opportunities for nephrologists. This space is reserved for members who wish to announce available positions. Please be sure to provide a contact name and phone number so that interested individuals may respond directly where the opportunity exists. Job announcements are written and submitted by RPA members and will appear in one issue of *RPA News* as space permits. Job announcements may also be posted on the RPA website. Non-members may advertise job opportunities in this section for a fee. Advertising rate information may be obtained from the RPA office.

ARIZONA

Nephrologist needed for Tucson practice. Contact Cedric Joins at (866) 931-2910 or e-mail CV to physicianjobs@davita.com.

FLORIDA

BE/BC nephrologist needed to join solo nephrologist in Clearwater. E-mail CV to Mary at vsagar7847@aol.com or via fax to (727) 734-3606.

BE/BC nephrologist or BC internist needed to join solo practitioner in Clearwater. New graduate fellows welcome. E-mail CV to Rebecca at mainstreetmed@msn.com or via fax to (727) 736-4304.

Florida-licensed nephrologist preferred for Atlantic Coast practice. Call Tammy Elzy at (866) 998-2669 or e-mail CV to physicianjobs@davita.com.

BE/BC nephrologist needed to join solo practitioner in Tampa. E-mail CV to Mary at gbkc2196@yahoo.com.

GEORGIA

BE/BC nephrologist needed to join solo practitioner in Atlanta. E-mail CV to saiedmurphy@bellsouth.net or fax it to Trovis Robertson at (404) 851-9019.

BC internist; BE/BC nephrologist needed to join six-physician practice in metro Atlanta. E-mail CV to Marietta.miller@georgiakidney.com.

Nephrologist needed to join solo practitioner in Metro City. Contact Louise Biedny at (888) 766-2242 or e-mail CV to physicianjobs@davita.com.

ILLINOIS

BE/BC nephrologist needed to join two-nephrologist practice 45 minutes SW of Chicago. Contact Anita Garcia at (815) 744-9300 or e-mail CV to a.garcia@esunhealth.com.

LOUISIANA

BE/BC nephrologist with Louisiana medical license needed to join three-physician practice in Covington. E-mail CV to gatkinson@kidhyp.com or fax it to (985) 419-9940.

MARYLAND

Nephrologist needed to join two-physician practice in suburban Maryland. Contact Cindy Cogen at (866) 399-3153 or e-mail CV to physicianjobs@davita.com.

MISSOURI

BE/BC nephrologist needed for practice that owns their dialysis facilities in Branson. E-mail CV to jwilliams@bransondialysis.com.

BE/BC nephrologist needed for two-nephrologist practice in St. Louis. E-mail CV to sloomis19@yahoo.com.

NEVADA

BE/BC transplant nephrologist needed to join 13-physician practice in Las Vegas. E-mail CV to lleblanc@nevadakidney.com or via fax to (702) 877-7141.

Nephrologist needed for new practice forming in Reno/Tahoe. Contact Cedric Joins at (866) 931-2910 or e-mail CV to physicianjobs@davita.com.

OKLAHOMA

BE/BC nephrologist needed for Oklahoma City nephrology practice in summer 2008. E-mail CV to okkidneycare@yahoo.com.

PENNSYLVANIA

Interventional nephrologist needed for Philadelphia nephrology practice. Contact Cindy Cogen at (866) 399-3153 or e-mail CV to physicianjobs@davita.com.

BE/BC nephrologist needed for suburban Philadelphia nephrology group. E-mail CV to cralmts@gmail.com or fax it to Lynn Yeoman at (610) 524-5990.

SOUTH CAROLINA

BE/BC nephrologist needed to join six-physician practice in Charleston. E-mail CV to lfloyd@charlestonnephrology.com or fax it to Lane Floyd at (843) 266-0621.

VIRGINIA

BE/BC nephrologist needed for practice in south central Virginia. J-1 waiver. E-mail CV to doctorvijaya@hotmail.com.

We want to hear your stories

RPA wants to know if posting career opportunities is a helpful service. Please let us know if you have found a job through the ads posted in ***RPA News*** or on the RPA website or if you have hired candidates that you found by announcing practice opportunities through RPA. ***We want to hear your stories***. Please e-mail rpa@renalmd.org with your name and the best way to contact you so that we may follow up and learn how we have helped you to either find a job or find a nephrologist, practice manager, nurse practitioner or physician assistant.

Thank you for your support of RPA.

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