Provider Panel Presentations

Larry C. Buckelew
Deborah Harvey
Joe Mello

We asked representatives from the three largest providers of dialysis services to sit on a panel to give the Summit participants the provider view of the nursing shortage and potential solutions. Their presentations follow.

Panel Participants:

- Larry C. Buckelew, President and CEO of Gambro Healthcare/U.S.
- Deborah Harvey, President, East Business Unit, Fresenius Medical Care
- Joe Mello, COO, DaVita

Larry C. Buckelew, President and CEO, Gambro Healthcare/U.S.

Larry C. Buckelew *is President and CEO of Gambro Healthcare/U.S., and Chairman of the Renal Leadership Council (RLC).*

Deborah Harvey *is the President, of the East Business Unit for Fresenius Medical Care. Deborah has been a nurse for 24 years and in the dialysis industry for 21 years.*

Joe Mello *is the Chief Operating Officer for DaVita.*

Larry C. Buckelew *is President and CEO of Gambro Healthcare/U.S., a major dialysis provider with nearly 13,000 employees–over 8,000 caregivers–who provide life-saving hemodialysis, peritoneal and acute services to over 42,000 patients.*

In January 2003, Buckelew became chairman of the Renal Leadership Council (RLC), an organization comprised of major for-profit dialysis companies.The Council represents the interests of dialysis providers in public policy issues and serves as an information resource to federal policy makers. Buckelew also is spearheading efforts to form an industry-wide coalition–Kidney Care Partners–with a goal of helping the dialysis industry speak with a single voice about the need for an annual Medicare update to the composite reimbursement rate.

I want to thank the first two speakers for everybody in this room for doing two things. One, if I think about Beth's presentation and comments, if there's anything we need, and we need it every week, we need to be able to go to work every Monday morning and have some new ideas and new tools for making the dialysis segment of health care a better place to work. I loved hearing about some of the opportunities for improvement, ideas for engaging caregivers and making their days more enjoyable as well as more productive. When I think about some of the key points that Charlotte made, I'll tell you the one that rang loud in my ears. She talked about different areas of care. Talk about a war for talent, we're here talking about the availability of caregivers and how engaged and motivated are they.

The Speeding Bullet

As I shift into a couple of things that I'd like to share, I want to give an analogy that may be helpful. Listening today to the valuable data that we've heard and input has been for me a little bit like taking a picture of a speeding bullet.

Recent data would suggest that all is well in the dialysis industry. No segment of health care has been more deliberate and more successful in improving the care of patients. But the sad fact is that a speeding bullet is heading straight for the heart of the dialysis segment of health care. If we aren't successful in deflecting this bullet, it may mean that, despite the great progress we've already made, the dialysis industry's best days could already be behind us.

First the good news. Even though dialysis patients have grown older and sicker since 1990 (see Table 1), with 50% of new patients having three or more major co-morbid conditions, statistics show that these patients continue to do better. One important measure of dialysis treatment adequacy (quality) uses Urea Reduction Ratio (URR) values. Since 1993, the percent of adult dialysis patients with URR values greater than 65% has virtually doubled, from 43% to 82% in 2000, according to the 2000 Annual Report of the Department of Health and Human Services (HHS) ESRD Clinical Performance Measures Project (see Table 2). In fact, even the federal Office of the Inspector General (OIG), within the DHHS, noted that the major dialysis corporations "encourage their facilities to use performance measures to foster improvements in dialysis care…(and) look to facilities to conduct quality improvement projects" (see January 2002 report entitled, "Dialysis: Building on the Experiences of the Dialysis Corporations").

But the bad news is that these ESRD patients, who are becoming

Table 1
We are Treating Older and Sicker Dialysis Patients

Year	Average Age	Percent Diabetic
1990	58.6	34.4%
1991	59.1	36.1%
1992	59.5	36.6%
1993	9.9	36.4%
1994	59.8	38.4%
1995	59.6	40.5%
1996	60.2	41.8%
1997	61.1	44.4%
1998	62.2	46.4%
2000	63.0	47.0%

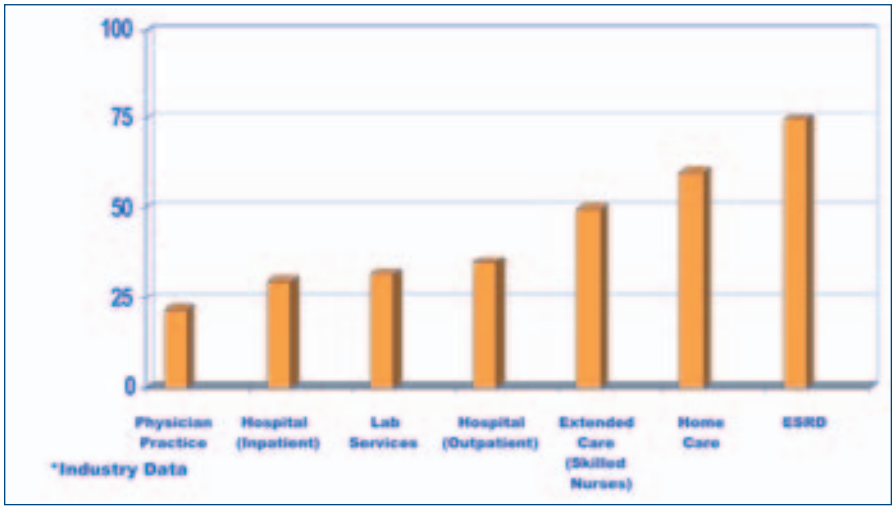
Source: United States Renal Data System (USRDS). (2001). USRDS Annual Report.

Table 2
Dialysis Patients Are Doing Better

Year	Percent of Adult Patients With URR >65%
1993	43%
1994	49%
1995	53%
1996	68%
1997	72%
1998	74%
1999	80%
2000	82%

Source: Department of Health and Human Services. (2000). 2000 Annual Report, ESRD Clinical Performance Measures Project, DHHS.

Figure 1
U.S. Healthcare Provider Segment Payment Analysis - % Medicare/Medicaid



Source: Department of Health and Human Services. (2000). 2000 Annual Report, ESRD Clinical Performance Measures Project, DHHS.

older and sicker every year–more complex, more difficult and more challenging to care for–are mostly financed through government programs, Medicare and Medicaid. The dialysis segment of health care has a higher percentage of Medicare and Medicaid patients than any other segment–75% (see Figure 1). Compare that to just over 25% for the hospital segment, 50% for the extended care (skilled nursing) segment, and 60% for the home care segment. The demographics don't favor the dialysis segment. In fact, for a number of reasons, these demographics are a speeding bullet coming directly towards the dialysis segment of health care.

Medicare Changes Through Time

First, let's consider the history behind Medicare coverage of ESRD patients. Back in 1972, Congress made an important commitment to ESRD patients by establishing the Medicare ESRD Program. In 1983, Congress adopted the "composite rate" as the prospective payment mechanism for outpatient dialysis services. The rate was designed to include all nursing services, supplies, equipment, and certain drugs associated with a single dialysis session. However, unlike all of the subsequent prospective payment systems, the ESRD reimbursement did not include an updating mechanism. Because Congress has not reformed the methodology, it remains grounded in 1983 medical standards and technology.

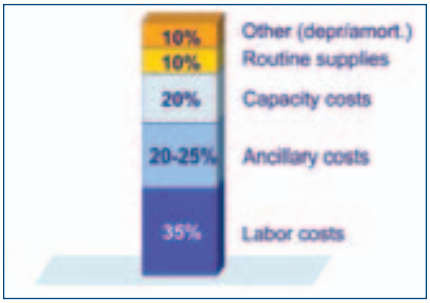
Just because the cost of treatment for ESRD patients increases doesn't mean that the amount of Medicare reimbursement keeps pace. Congress must grant each increase. Our industry was fortunate to receive small increases in Medicare reimbursement in 2000 and 2001 when the federal budget enjoyed rare surpluses. But since 1996, the Consumer Price Index (CPI) has cumulatively increased 16.3% and the CPI Medical Care Component has increased 21.8%. During the same time, we've seen the Medicare Hospital Operating Update increase by 11.25%, but the ESRD Composite Rate has increased just 3.6% since 1996 (see Table 3).

On occasion, Congress has taken note of new drug treatments to improve patient outcomes, such as intravenous Epogen, and iron and vitamin D supplements, by creating special payment rules–additions to the composite rate, commonly referred to as separately billable items. Over the years, dialysis providers have used the additional reimbursement from these separately billable drugs to help offset the losses on the composite rate reimbursement. But this is no longer a viable option. A 2002 study conducted by Abt Associates,

Table 3
Percent Changes in Price/Reimbursement

Year	CPI	CPI Medical Care Component	Medicare Hospital Operating Update	ESRD Composite Rate
1996	3.0%	3.0%	1.5%	0.0%
1997	2.3%	2.8%	2.0%	0.0%
1998	1.6%	3.4%	0.0%	0.0%
1999	2.2%	3.7%	0.5%	0.0%
2000	3.4%	4.3%	1.1%	1.2%
2001	1.6%	4.7%	3.4%	2.4%
2002	na	na	2.75%	0.0%
Average Annual Increase	2.4%	3.7%	1.6%	0.5%

Figure 2
Distribution of Costs Per Treatment (Gambro Healthcare)



Source: Gambro Healthcare.

Inc., a health and environmental research firm, concluded that "the profits made on separately billable items were not large enough to cover the increasing losses on composite rate services." In short, even with Medicare reimbursement for separately billable intravenous drugs, the composite rate remains woefully inadequate as dialysis costs continue to increase.

The bottom line for the dialysis segment is that in 2003, Medicare will cover, on average, just 94% of the costs of delivering dialysis services to Medicare beneficiaries. It means that everyone in the industry loses $10 for each dialysis treatment provided to a Medicare patient this year. That's a fact. Try to picture losing $10 every time you do a treatment–on 75% of your business.

Cost increases in the dialysis industry are due not only to inflation, but to several other factors. These are the factors that give velocity and direction to this speeding bullet heading directly for the dialysis segment of health care. Let's take a look at what these factors are and how they are affecting and will continue to affect delivery of quality care to ESRD patients. I'm sorry to tell you that this is not good news. Because of these factors, we are in a crisis.

Increasing Costs In Key Areas

Let's start with an overview of our costs in the dialysis segment. The following figures are for Gambro Healthcare (see Figure 2), but I spend quite a bit of time doing benchmarking data comparisons and I believe that the cost structures of most in this segment don't look much different. Our most precious asset in providing care for ESRD patients is our caregivers. Labor is 35 % of our cost of service. Another 20% to 25 % are ancillary costs. The majority of that is Epogen. Somewhere between 50% and maybe 60 % of the cost of service is labor and ancillaries. Now think about supply and demand.

We are dealing with the most serious shortage of nursing care in the history of this country and it's getting worse every day. Nurses are the backbone of the dialysis industry and they are continually more crucial to our operations – the most important reason being the increase in the number of dialysis patients. This number has doubled in the decades 1980-1990 and 1990-2000. We can't afford not to have excellent caregivers, and yet, financially, we can barely afford it. And supply and demand means that our most precious asset–nurses–can walk away.

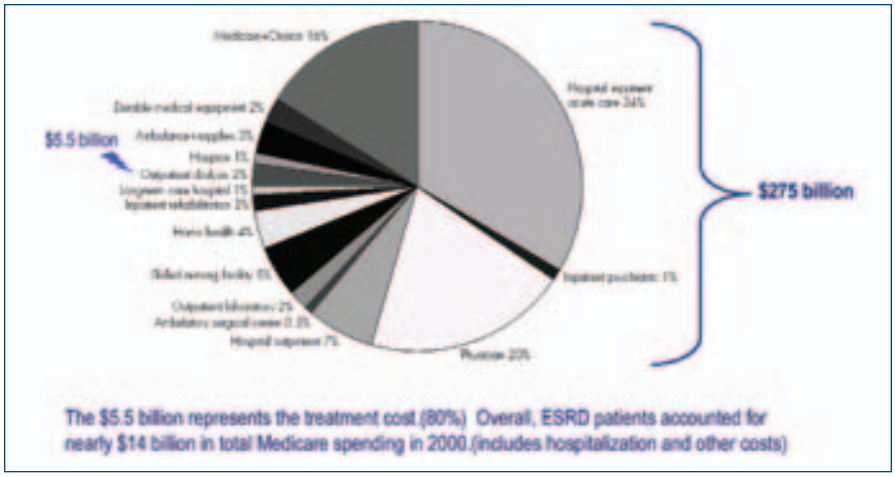
Over the past 28 years, I've worked in businesses where your assets were often bolted to the floor of a manufacturing facility. But that's not the case in the dialysis industry. In this business your most precious asset is people.

We understand and support the concerns and needs of nurses. However, in terms of our labor costs, nursing costs have nearly tripled over the past 10 years, and in the last 3 years have increased in the range of 18% to 36%. In addition, because nephrology nurses are very specialized nurses, they require more training and education from the hiring company, adding to the labor cost.

Pleading for Change

Now, remembering that every healthcare segment but the dialysis segment gets a market update according to real costs of labor, pharmaceuticals, overhead, and all related costs, let's look at the Medicare reimbursement updating system for hospitals. Increases for hospitals, because of the indexed system, have approached almost 2% per year. Looking at the ESRD composite, you may wonder how it has ever gone up when there is no legislation. Every single year, people in the dialysis segment like me have gone on Capitol Hill to plead for help. We have to do this because dialysis is the only health care segment that doesn't have an automatic inflationary factor. But only in 2000 and 2001, when the country enjoyed budget surpluses, were we for-

Figure 3
Distribution of Medicare Spending by Service Setting, 2000



Source: MedPAC's Report to Congress, March 2002.

Table 4
Dialysis Costs Are Going Up

- Longer treatment times
- More expensive dialyzers
- Increasing labor costs - nurses, dieticians, social workers, etc.
- Increasing drug costs after EPO 3.9% increase in 2001 and 2002
- Cost rising faster than Medicare reimbursement

tunate enough to receive increases. The likelihood that our nation will experience additional surpluses anytime soon seems remote. Now you begin to see why the data look like they do and why that speeding bullet seems to be heading with such inevitable velocity toward the dialysis segment of health care.

In addition to composite concerns, many services that greatly benefit patients have not been included in reimbursement schedules. In terms of criteria for Medicare coverage decisions, the first step in determining a medical benefit is deciding whether there is sufficient evidence demonstrating that the service is medically beneficial for a defined population. For dialysis patients, it was only last year that CMS determined that dietary management met the criteria.

Perfect Alignment: Patient Care And Financial Care

How did we get into this mess? Compared to other segments of health care, we're the little guy. It's hard to have a big voice when you're the little guy. Outpatient dialysis care represents only 2% of Medicare's expenditures (see Figure 3). What's extraordinary is that we think these ESRD patients represent $14 billion of the picture and that there are all kinds of costs and expenses associated with dialysis that impact hospitals. And hospitals get annual rate increases. But our segment represents just 2% of the costs. And we get annual rate increases only in extraordinary times.

I love this dialysis segment of health care for one key reason. When the patients get better, the financials get better. This is a perfect alignment for those of us who are dedicated to patients as well as to shareholders who invest in this segment. When you improve patient care outcomes, mortality rates, reduce co-morbidities, reduce hospitalizations, the patient gets better and the financials get better. It's a direct correlation.

But dialysis costs are going up (see Table 4) beyond our ability to do what it takes to help patients get better. We're estimating today that 50% to 60% of the costs are going up somewhere between 5% and 10% every 12 months and the customer won't pay more. The math doesn't work.

And that's why we need to deflect that speeding bullet coming directly at our segment. Earlier at this ANNA summit conference, you heard a glowing report about what it is like for a nurse to work at a Magnet hospital. I'm sorry to say that working as a nurse at a dialysis clinic is not on an even footing with working at a Magnet hospital. The big difference is funding. While just 25% to 30% of patients in Magnet hospitals have their care paid by Medicare or Medicaid, about 75% of patients in dialysis clinics are Medicare or Medicaid patients (see Figure 1). And Medicare's reimbursement rate has become inadequate (see Table 4). And to make matters worse, because of a poor economy and record state budget shortfalls, nearly every state in the country has reduced or is seeking to reduce Medicaid reimbursement as well.

The impact of continued underpayment is substantial. It is impeding our ability to recruit and retain the best staff for our facilities.

Lack of Access

The Renal Leadership Council (RLC) represents a big group. We are for-profit which is what 70% of this segment is. We are committed to working collaboratively with the government and being held accountable. But the results are tragic. They are the beginning of the speeding bullet hitting home. Collectively, RLC members, representing probably 50% of all dialysis clinics, had to close about 50 dialysis clinics in 2001. The trends are getting worse. These facilities shared a common characteristic. They had an above-average proportion of Medicare beneficiaries. If your mix of Medicare patients is too high, you cannot survive. It is the most tragic thing. We are having to close units. And where is it happening?

Passage of H.R. 1784
Dialysis Industry Supports

Virtually all companies in the U.S. dialysis segment of health care are supporting House Bill 1784 and its identical counterpart in the Senate, S 1098—the Medicare Renal Dialysis Payment Fairness Act of 2003—which seeks to establish an annual update in the renal dialysis composite rate for Medicare.
Under the bill, an annual update in Medicare reimbursement for dialysis treatment would be considered based on an "ESRD market basket" percentage change that considers:

- Labor costs
- Drug, supply and lab fees
- Overhead, including Medical Director fees, temporary services, general and administrative costs, interest rates and bad debt
- Capital, including rent, real estate taxes, depreciation, utilities, repairs and maintenance

In addition, increases could be considered based on adoption of scientific and technological innovations, changes in the manner of delivering dialysis services, productivity improvements in the provision of dialysis service and other relevant factors.

Renal Dialysis Partners
The Renal Leadership Council (RLC)

The Renal Leadership Council represents four of the largest renal dialysis providers in America—DaVita, Gambro Healthcare, Renal Care Group Inc., and National Nephrology Associates. Together, RLC members provide renal replacement therapy services to 40% of all dialysis patients in America (about 110,000 individuals). Member provider companies provide services to ESRD patients in more than 1,350 dialysis facilities in 42 states and the District of Columbia).

Kidney Care Partners

Kidney Care Partners is a coalition of companies in the dialysis industry whose goal is to speak with a single voice about the need for a mechanism that provides an annual Medicare update to the composite reimbursement rate for the ESRD health care segment.

Larry Buckelew, President and CEO of Gambro Healthcare, is currently chairman of the Renal Leadership Council. He and leaders of other RLC companies have encouraged all providers and companies that offer dialysis services and products to join, including Fresenius, Amgen, Baxter and Abbott, as well as such associations as the National Kidney Foundation and physician, nursing, administrator and patient groups.

Attracting and Retaining Quality Nursing Staff
The cost of attracting and retaining a quality nursing staff goes beyond salary.

Some of the ways that a company can meet the criteria most important to nurses are to:

- Maintain a competitive benefits package
- Offer a high level in quality of patient care.
- Provide sign-on bonuses
- Offer more flexible shifts
- Pay relocating cost
- Cover new employee's insurance until company benefits take effect.

Source: Gene Houchins, Management Recruiters, a firm specializing in renal professionals.

In the center cities and rural areas.

Nephrologists are the other crucial component to patient care. According to Martin H. Osinski, of American Medical Associates, a firm that specializes in recruitment of nephrology professionals, the need for nephrologists will continue to grow and the supply will very likely decrease. Improved reimbursement is one suggestion for attracting residents to the nephrology specialty area, Osinksi says. And he notes that continued lobbying on the Congressional level for improvements is a good plan of action. If the number of physicians entering nephrology does not increase, the quality of medical care will be reduced. And once again, it is the most needful patients who will be affected.

We can look at what might have been if our nation were not in a budget deficit and facing other issues. Just to keep up with inflation, the dialysis segment needed a 2.6% increase. It will not happen. Our only answer is the creation of an annual market basket inflation formula. That is our only answer if we are to survive and be an attractive place to work, recruit and retain the best caregivers and create a positive work environment.

That's why we are trying to build a coordinated coalition of voices through Kidney Care Partners that focuses on all of Congress, every government agency, and every person who can influence this situation and turn this speeding bullet away from the dialysis segment of health care. Because we won't be able to continue improving the lives and outcomes of ESRD patients until this segment levels the playing field, until we are on an even footing with the Magnet hospitals of the world or with any hospital or any other segment of health care. The outlook is very bleak for this segment until it is not treated so differently and discriminated against–until it has a structure for realizing costs and adjusting Medicare reimbursement every year. That's the single goal of Kidney Care Partners, and we'll continue to work until we meet the goal, because the very survival of the dialysis segment depends upon it.

Deborah Harvey, President, East Business Unit, Fresenius Medical Care

***Deborah Harvey** is the President, of the East Business Unit for Fresenius Medical Care. Fresenius, a major dialysis provider with over 24,000 employees, provides dialysis services for over 79,000 patients. Deborah is also a nurse. She has been a nurse for 24 years and in the dialysis industry for 21 years.*

As I was listening to the presentations this morning, a couple of things struck me. Something that became very obvious to me was that we really need to improve how we communicate. I heard that loud and clear in Beth's and Charlotte's presentations. We think we're communicating with our employees, but obviously they aren't hearing what we're telling them. Over the years, I've learned that you may think you are a good communicator, but you have to be a good listener too. Frankly, as an industry, I'm not sure we're doing that as well as we need to. Also, I think we need to really work on developing our nurse managers to become better leaders. They are obviously struggling with what we're doing today.

I took a little bit different tack to this presentation than Larry did. I think he made some very strong points. When I was asked to do this, I began thinking about how and what I would present to you. As I said earlier, I am a nurse. I've worked in dialysis units. It's one of the only jobs I've ever had where the longer I worked in dialysis caring for patients, the more I found to do. When I first started in dialysis, my primary focus was learning how to work the machine. I had worked in ICU. I had done a lot of the same things many of you have done in the past. I took care of patients on respirators who were critically ill. I wore the scrub suit and had the best stethoscope. I responded to the codes and started the IVS everywhere in the hospital. It was a very glamorous kind of job.

When I worked at Emory University Hospital in Atlanta, I went to a presentation given by a psychiatric nurse she said something that I thought was incredibly profound. She said, "Think of spending 8 hours a day trying to pin jello to a wall and make it stick. That's what being a psychiatric nurse is all about." Sometimes, being a dialysis nurse feels like that as well. It's trying to get people to take care of themselves so that when they come into the dialysis unit, you can give them the best possible treatment. A lot of these patients don't understand that they are actually killing themselves with their behaviors. That's particularly frustrating to a nurse and to health care people in general because our job is to make people feel better. What Larry said is very true. It's not a very glamorous place to work. It can be very hard. It can be very frustrating. We have to work on that with our employees.

Fresenius Medical Care is the largest provider of dialysis services in the world. In the U.S. and Puerto Rico, we have 1,083 facilities and we care for over 79,000 patients. I have a brief overview of the operational impact the nursing shortage has had on us. Our advertising costs associated with hiring RNs have gone up more than two times since 2000. Our temporary agency costs have increased three times since then. Our RN salary costs increased 8% last year. The RN bonuses that we paid in 2002 totaled $2 million, which is a 40% increase over 2001. That's staggering.

I looked at this challenge through the eyes of three different groups of people – myself and my peers as senior managers; a group composed of operations managers, administrators, regional managers, and vice presidents; and then the nurse managers – people I've known for a number of years who have hired a lot of nurses in their time. I talked with them and asked them what's different now. These are the results of my unofficial survey.

Senior Managers' Results

Certainly, as senior management, our goals are to maintain and improve the quality standards and not just to achieve the standard, but to go above and beyond the standard (see Table 1). But we all realize to do that requires nursing time. To help us achieve our goals, it is absolutely essential that nurses have critical thinking skills. Certainly, we're very concerned about regulatory compliance. That's something we all face everyday and it's becoming more and more stringent. We also want to ensure that we don't see a decrease in our customer satisfaction. Patients need and want the nurses' attention. The physicians want staff they can trust. With the nursing turnover, that's becoming more difficult as well. Higher personnel costs are an issue. Staff turnover is extremely expensive. You have increased training costs, rising salary rates, and we must pay bonuses to attract people.

From my perspective as a senior manager, I'm hiring more ancillary staff because I want to make sure that the licensed personnel in the facilities are able to do what they need to, to meet our quality standards and the regulatory guidelines, and this increases the costs of care. Fresenius is a company driven off technology and trying to implement new initiatives takes a lot of selling and convincing on the part of the managers to help the staff see that it's a good thing for the patients and will make their jobs easier. When you're short staffed and you're a nurse on the floor caring for patients, the last thing you want to do is learn something new. Just implementing single use last year proved to be very challenging. You would think that would be a wonderful thing to do, but people required training regarding the differences in managing a patient on single use vs. the patient on reuse.

We also have to acknowledge, and as Larry alluded to in his presentation,

Table 1
Senior Managers' Perspective

Maintain and Improve Quality Goals and Standards
Regulatory Compliance
Decrease in Customer Satisfaction
Higher Personnel Costs
- Staff Turnover
- Increased Training Costs
- Rising Salary Rates and Bonuses
- Require more Ancillary Staff for Oversight
More Difficult to Implement Initiatives
Decreased Patient Access

Table 2
Operations Managers' Perspective

Maintain and Improve Quality Goals and Standards
Regulatory Compliance
Decrease in Customer Satisfaction
Personnel Interaction
Higher Personnel Costs
- Staff Turnover
- Decreased Leadership Development
- Increased Training Costs
- Rising Salary Rates and Bonuses
More Difficult to Implement Initiatives

Table 3
Nurse Managers' Perspectives

Stress on Existing Personnel to Maintain Quality Goals and Standards
Stress Resulting in "Eat Their Young Syndrome"
More Training is Required
More Supervision is Needed
Paperwork Requirements
Compromised Employee Selection Standards
Decrease in Professionalism
More Difficult to Implement Initiatives
Higher Patient Acuity
Physician Frustration
Exhausts Nurse Leadership Skills

we may face decreased patient access. Whenever we are planning a new dialysis facility, we have to ask ourselves many critical questions. 'Can we actually staff this unit? Do we have the people needed to care for the patients? Do we have a nurse manager who can manage the clinic? Is it a safe location for our patients and staff to travel to? Does the current reimbursement structure and the demographics of the patients allow us to pay the bills?' As this nursing shortage gets worse, and if the reimbursement rate remains where it is today, I'm afraid, as Larry said, that is a bullet headed toward us. We're going to find ourselves with less access to care. We're going to find that our patients must travel further for treatment. We all know that as patient demographics get older, it's more difficult for the patients to drive. I don't know how many times I've had a patient say to me, 'my wife doesn't want to drive into the city.' It's a very difficult thing we're facing.

Operations Managers' Results

I spoke to several operations managers and got their perspectives (see Table 2). A lot of the issues are the same for them, but perhaps on a smaller scale, but they deal with the challenges daily. They certainly are concerned about maintaining and achieving the quality standards. Certainly, regulatory compliance is near and dear to their hearts as well. They worry about decreasing customer satisfaction. They are the people on the front line who hear the complaints and have to find solutions. One of the critical issues they face is personnel interaction. When people are tired and stressed, they tend to be less tolerant and the operations managers find themselves spending more of their time dealing with personnel issues. They are accountable to budgets. They're dealing with high personnel costs with staff turnover and training issues. They struggle with these issues every day. It is also more difficult for them to implement initiatives. As I said earlier, they find it difficult to get the staff to do new and different things.

Nurse Managers' Results

The last group that I spoke to was the nurse managers, and the one thing that I heard overwhelmingly from all of them was how stressed they felt (see Table 3). Stress, stress, and more stress. They get very frustrated. They work very hard and they feel like they're not doing their jobs as well as they need to. One of the points that they raised to me was the stress on existing personnel to maintain quality goals and standards. They absolutely understand and support the goals, and they know we all care about quality, but they find it very difficult to maintain the quality levels. They feel very, very responsible. As we heard this morning, the stress the staff feels often results in the "Eat Their Young Syndrome." I have seen this for years, and I do not understand it. New staff come into the unit and it's like they're being initiated. They are tested and, if they can make it through the test, they will be accepted. I was told when I started working, "If you can make it for a year, you'll make it forever." A lot of people get frustrated and leave in that first year and the cycle is started all over again.

Nurse Managers believe that more training is required. Those I spoke to told me the students coming out of the nursing schools today just aren't as well trained as they need to be. They often lack critical thinking skills. I think we heard that this morning from Beth and her work with the new graduates. They need more clinical training.

The paperwork requirements are also an issue – not just internal, but external. As we all know, there's more and more paperwork being required every day. They're being asked to chart, as we heard, four, five and six different places.

The nurse managers feel compromised in their employee selection standards. One told me that she used to look for nurses who had strong medical-surgical backgrounds or critical care, ICU or cardiac care, but that they are just not available anymore. She said

"I'm just glad to get someone with a nursing license." That's a sad statement to make in this day and time. Nurse managers feel like there's a decrease in professionalism in the work force, and that is very frustrating to them. Most have been in this profession for 10-15 years, they have a high level of professionalism, and they also have a very high level of commitment. They struggle with how to manage those that lack the same.

Additional Concerns

Another thing that we haven't mentioned yet is higher patient acuity. With the DRGs and the insurance companies' criteria for hospitalization, people do not stay in hospitals as long anymore.

Also, physicians share our frustrations. All of us have worked with physicians over the years and understand that it's very difficult for them because they entrust the care of their patients with nurses; however, if they feel like these people aren't equipped for the responsibility then that becomes very frustrating for them. Last, but not least, we exhaust our nursing leadership. They're tired. They spend their days trying to motivate and improve morale. One question I heard was "Who's going to help us improve our morale? We're tired."

I appreciate the opportunity to come and speak to you today. I think that I bring a unique perspective in that I've been a nurse for a long time and have spent my entire management career in nephrology. It's a subject very near and dear to my heart. I hope you take this information how it was intended as constructive. Thank you.

Joe Mello, COO, DaVita

***Joe Mello** is the Chief Operating Officer for DaVita, a major dialysis services provider with over 13,000 employees who provide care for about 46,000 patients.*

I feel like I'm here today representing a couple of groups of people. First of all, I am representing our industry. Maybe more importantly, I am representing the 3,000 Registered Nurse teammates we have within DaVita. They are the folks who we need to make sure sustain ourselves so we can do what is most important – take care of our patients. That's what we are all here for. That's why we are all taking the time to be here today to talk about this very acute problem facing our industry.

I hope to cover three questions today. First of all, what do I see as the issues regarding the nurse shortage? What can we do as an industry? And then, what support do we need to make sure we can be successful? I want to focus on three specific areas that I believe are going to be the most leveraged for us in trying to solve this as an issue. The first is attracting talent. The second is the professional nursing role, and the third is the structural disadvantages we have as an industry.

Attracting Talent

First, in attracting talent, we talked a lot about that this morning and just where the state of the industry is – as it relates to getting new folks interested in nursing as a profession and the challenges and barriers we currently face in making that happen. Second, and where we need to spend the most amount of time, is how we get more nurses interested specifically in dialysis. We have many strengths that we are currently not exploiting. Beth Ulrich pointed out a number of these this morning. There are strengths around the way we schedule. There are strengths, perhaps more importantly, around the continuity of care that we have the opportunity to provide to our patients – 3½ to 4 hours a visit, three visits a week, for a long period of time.

I too have worked in health care for all of my career. My first job in health care was at 16 when I was an orderly in a hospital and had the distinct opportunity to be supervised by nurses. Some would say now, with Gail Wick on our team, that I still have that opportunity. I worked evening shifts. I was the only male orderly in a 120-bed hospital so you know what I did most of the shift. It was very good in character building, but more importantly very good in understanding the impact that effective nursing care has on taking care of patients. I just moved into the dialysis industry about 3 years ago. One of the things that profoundly impacted me when I moved into this specialty is how different the caregivers are in dialysis compared to any place else. People have a passion. People who are nurses in dialysis have a specific passion that is distinct among nursing care providers, and I believe this is because of that continuity. That linkage that you create with the patients is so different than we see anywhere else. As an industry, that's not something we talk very much about. That's a missed opportunity that we have in promoting ourselves and making ourselves look different.

The third aspect of attracting talent is our current education process, which is close to being broken right now in the United States. In the last statistics I saw, somewhere around 4,000 to 5,000 people were turned away from nursing schools last year. That is a significant problem. Nursing educators just aren't available. They're making less than you can make as a staff nurse in a hospital in a hospital or dialysis center. That is a functional problem that we must fix. In addition, the basic dialysis rotation just isn't enough to get people interested in

our specialty. Blowing through a unit for a short amount of time is not going to give people enough exposure to understand how we're different and how we can come across as a different opportunity. In addition to the nice hours we have compared to a hospital, think about the continuity of care and the impact we can have on patients by being able to have that continuity of care over time. So we're missing a great opportunity here and as we look over the next day and a half as we're together and we brainstorm on different opportunities and areas to focus on, we have to think about how we link with the education process in a much more effective way so that we get ahead of the curve and get a disproportionate share of the new graduate nurses coming out.

Professional Nurse Role

If you look at the professional nurse role, it's an area that's very difficult for us as a specialty. Larry did an exceptional job in pointing out the structural disadvantages. I'll talk about these and emphasize a little bit more on just the cost standpoint and our ability to make ends meet, given the fact that our biggest customer doesn't give us annual increases. But it also forces us into a couple of very difficult boxes from an operational standpoint, the first of which is understanding this issue of a professional nurse and the difference between tasks and assessment. Unfortunately, too frequently now, the nurses in our dialysis units pass meds and take care of catheters. They are not using the assessment skills they have. They are not holistically participating in care the way they can and are educated to. We need to fix that as an industry.

Second is the issue between experienced and new nurses. If you look at the current hiring practices, when I go out and talk to our facility administrators who are looking to hire nurses today, none of them want to hire brand new nurses because they have zero dialysis experience. And structurally, if you look at our units, there are very few nurses in our units compared to other environments where nurses would work, such as hospitals. As a consequence, there's not a lot of opportunity for mentoring and day-to-day and shoulder-to-shoulder training that you have in other situations. So there's a real dilemma here in the education process with respect to nurses who are new graduates.

Last year I had the opportunity to visit a number of our facilities around the country. I usually plant myself in the break room to talk to people when they come on break because that's where you can talk to folks to find out what's going on. I talked to a number of nurses and a number of nurses who are relatively young in their careers who are not getting the right kind of training from a leadership skills standpoint in nursing school. As a consequence, what they say to me is that they are intimidated to tell a PCT what to do. They say the PCT has been here 24 years, and they only been in dialysis 2 or 3 years. I say, wait a minute. Your job is to supervise these individuals. This is your role. You have to be able to feel comfortable being a leader and a supervisor, being able to direct activities and tasks.

We're just not getting enough leadership training in our education process. The critical piece of leadership, and maybe the one that's even more critical, is that the vast majority of the leaders of our dialysis centers come from a clinical background. If there's anything I intend to do in the running of our company is to make sure this stays that way. That's what we need - good clinical leaders running our line units. We've got to make sure that those good clinical leaders have exceptional leadership and management skills. The burden right now is on us as the providers to be able to provide those leadership skills and those management skills. As an industry, we need to do a better job to ensure that those skills get built during continuing education and during their basic education in nursing. If you look at turnover and nurses who want to leave, the vast majority of those want to leave have lost respect for the person leading them at the local level. We look at it with our own internal turnover data. We have centers that can be in the same geographic area with one having zero turnover and one with 60% turnover competing for the same pool of nurses. What's that all about? That's about leadership.

Structural Disadvantage

The final thing I want to bring up is the fact that we have this structural disadvantage. We have crazy competitors. Hospitals are our biggest competitors and we lose nurses to hospitals. Most of the time, we lose nurses to hospitals, not because nurses don't like working in dialysis, not because nurses don't like working in our company, but most of the time because something has forced them to decide they have to do it for their family. The dollars are too compelling. When you couple the fact that we don't get an annual increase and that the vast majority of patients come from the government, and that hospitals do get an annual increase and the vast majority of their patients don't come from the government, that is difficult for us. Larry showed you the specific numbers – an annual increase of $^1/_2$ of 1% on average makes it hard to stay competitive.

Then we have this secondary problem which I call scale and density. As I mentioned earlier, there aren't a lot of RNs in a dialysis unit because they are relatively small little businesses. A lot of the time when there are multiple nurses in a unit, they aren't there at the same time because they're covering different shifts. We don't have the opportunity to create density or to create a local program like a hospital can. So we do have these structural disadvantages that we have to get help to work through and figure out more creative solutions. As an industry, we are more cohesive and smarter and we can come up with ways to fix these things if we work together, but we've got to be able to do that.

Summary

To wrap up the three big items – attracting talent, the professional nurse role, and our structural disadvantages – I would offer the following take-away thoughts:

- We ought to do what we can to get our disproportionate share of RNs out of the health care system to work in dialysis. If we work togeth-

er, we have a shot at making that happen.

- As an industry, we must exploit our strengths. We have to exploit the pride that comes in the services and the care that we provide. We need to create in a very visual way that difference for nurses who are considering which area of specialty to go into and where to create their careers.
- We, as providers, have a huge opportunity to create the right environment for our nurses. That's something we own. We have to fix it. We have to create a better place to work for nurses than any place else. We must create a more enriching place for nurses than anywhere else. That's up to us. I know a lot of us on the provider side are doing tons of things to make that happen and we need to keep driving that.
- We need a level playing field. We've proven the fact that we can deliver clinical outcomes with the best. Now we need help from our biggest customer to make sure we can compete for the resources that are necessary to sustain and improve those clinical outcomes on an ongoing basis.