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Empowering Kidney Care: An ANNA-ASN Conference with Nurse-Physician Partners – Quality and Safety

Jennifer Payton, MHCA, BSN, RN, CNN, FANNA, Jennifer Vavrinchik, MSN, RN, CNN, Michael Kraus, MD, FACP, and Naveed Masani, MD, FACP, FASN

Mary Haras: Good morning. Welcome to Session 313, Quality and Safety. My name is Mary Harris, and I'm the chair of the ANNA Publications Committee and a member of the *Nephrology Nursing Journal* Editorial Board. It's my pleasure to introduce you to our panel.

Our first panel presenter is Michael Kraus, MD, FACP. He is a dedicated nephrologist with extensive experience in clinical practice and medical leadership. Dr. Kraus completed his nephrology fellowship at the University of Iowa, remained in academic nephrology practice at Iowa, and later was for 25 years at Indiana University. Dr. Kraus was the Clinical Chief of Nephrology and the Chief Medical Officer of Adult Dialysis and Stressed Quality Care and Quality Surveillance. He later became Associate Chief Medical Officer for NxStage and later for Fresenius Kidney Care. He is presently the Chief Medical Director at the Indiana Donor Network, the organ procurement organization for Indiana, and Professor Emeritus at Indiana University.

Our second panelist is Naveed Masani, MD, FASN. Dr. Masani serves as Medical Director of Dialysis Services at NYU Langone Hospital in Long Island and is the Assistant Clinical Professor of Medicine at the Grossman Long Island School of Medicine. He also serves as the Vice Chair of Morbidity and Mortality in the Department of Medicine. Dr. Masani has published in multiple peer-reviewed nephrology journals and served as the Chair of the Education Committee of the New York Chapter of the American College of Physicians, from 2015 through 2024. He also had the privilege of serving as Chair of the Clinical Practice Subcommittee of the Renal Physicians Association.

Our third panelist is Jennifer Payton, MHCA, BSN, RN, CNN, FANNA. Jennifer is the Chief Compliance Officer with National Dialysis Accreditation Commission (NDAC). She has been a nephrology nurse for 27 years. In her current role, she is proficient in the CMS rules and regulations that govern dialysis. Jennifer is a past president of ANNA and the Associate Editor of the *Nephrology Nursing Journal.*

Our final panelist is Jennifer Vavrinchik, MSN, RN, CNN. Jennifer is a seasoned nephrology nurse leader with over 30 years of experience in kidney care and advanced practice. She's the co-founder and Chief Operating Officer of the National Dialysis Accreditation Commission (NDAC). Before founding NDAC, she led clinical services for Spectra Laboratories and owned a consulting firm, Nephrology Clinical Solutions. In addition to her leadership at NDAC, she serves as the health policy and advocacy committee chair-designate for ANNA, acts as the best practice advisor for the Administrative Specialty Practice Network (SPN), and serves as ANNA's liaison with AAMI.

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Michael Kraus, MD, FACP is Chief Medical Director, Indiana Donor Network, and Professor Emeritus, Indiana University, Bloomington, IN.

Naveed Masani, MD, FACP, FASN, is Medical Director of Dialysis Services and Nephrologist, NYU Langone Health; and Assistant Clinical Professor of Medicine, Grossman Long Island School of Medicine, Long Island, NY; and is the Vice Chair of Morbidity and Mortality for the Department of Medicine.

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Editor-in-Chief's Note

On September 27, 2025, the American Nephrology Nurses Association (ANNA) and the American Society of Nephrology (ASN) collaborated on a one-day meeting at ANNA's 2025 Nephrology Nursing Summit to bring nurses and physicians together to discuss important issues in nephrology. This article is based on the panel discussion on quality and safety. The recorded version of the panel discussion is available in ANNA's Online Library (https://library.annanurse.org/p/s/quality-and-safety-26209).

Keywords:
Quality, safety, nephrology, nurse-physician collaboration.

Jennifer Vavrinchik: We have the privilege of discussing quality and safety with you. That is a broad umbrella, and we could all talk about quality and safety all day, but we have chosen a couple of topics to kick off this session. We are going to discuss quality and safety for a few minutes and then move on to solutions and strategies to help you leave with some valuable concepts to apply in your facilities. Jennifer and I do have the privilege of going around the country and getting a glimpse of dialysis facilities, and they are amazing. We have great facilities and some facilities that have opportunities for improvement. One of the first things we look at is culture of safety. We review this throughout the entire survey process. You really can feel a culture when you walk into the building. We go in large, small, independent, for-profit, and not-for-profit units. There is not one type that is consistently better than the others. Corporations undertake high-quality initiatives, and they are wonderful. However, excellence in quality and safety is achieved at the local level, and it starts with us, as nurse managers, and with our medical directors. And it is that engagement that as surveyors, we evaluate to see how engaged you are because that starts the ripple effect across the staff in your facility. If they see you all striving for excellence, they will want to strive for excellence. That is my take from a culture perspective and what we are seeing out in the field. And I will turn it over to Jennifer to get her perspective.

> We have to have a situation where we're all on the same page, we're all looking at the same things, and we're all trying to do what's right for the patients.

Jennifer Payton: We see culture of safety issues in facilities sometimes when the nurse manager and the staff are not communicating with the medical directors. We have to have a situation where we're all on the same page, we're all looking at the same things, and we're all trying to do what's right for the patients. Dr. Masani, how do you see that collaboration in the facilities that you're in?

> One of the most important pieces of puzzle is escalation – how you communicate, how you escalate, when you escalate, and with what information.

Naveed Masani: We talk about quality and safety first of all. I want to make this comment to start with. Metrics are great. They help you and give you a feel for an overview of your unit. But that day-to-day care, the moment-to-moment care, is really what sets it apart. Because numbers are one thing, but we all understand in this room that it is about the one person in front of you who you're taking care of at that moment in time, and that's key. Every unit has opportunities to do better. You come to the table saying, what can we do better? Here's where we are, here's where we want to get to. We'd love to be 100% in patient outcomes. Numbers! Numbers! You want to be 100% in patient outcomes that matter to get your patients to the point of getting transplanted and getting off of dialysis. That's what we would love for everyone. You want that culture where everyone's looking at everyone and saying, okay, why aren't you listed? Why don't you have a fistula? Have you considered home? Do the things that you need to do to get their quality of life better because you're here so that they can live. I was stunned to hear that only 20% of patients post-transplant go back to work. It tells you a lot about how important the care leading up to that is so important. And on the day-to-day level, you mentioned nurse managers and medical directors. It goes even beyond that to me. Think of how many people in any given situation are there at that moment in time. Techs, LPNs, RNs, APPs, nephrologists, nurse managers, medical directors. There can be so many people in a thread, and therefore, I think one of the most important pieces of puzzle is escalation – how you communicate, how you escalate, when you escalate, and with what information. Not just, oh, so-and-so is not feeling well today. No, communicate it in an SBAR sort of a way so that the communication is driven by how are we going to make a meaningful conversation and decision-making so we get the best outcome today in what's happening in front of us?

I think those are some of the challenges. Looking at these patients uniquely and individually, and not just that rote feeling of, oh, you came to dialysis three times a week. One quick example is people who come back post-transplant with their grafts not functioning right away. The patient with delayed graft function should be viewed very uniquely compared to your standard patient or even compared to themselves the way they were pre-transplant. They are now, configuration-wise, a different patient, right? And what sort of policies and procedures and protections do you have in place to communicate that? Dr. Kraus, your thoughts?

Michael Kraus: Quality is an interesting thing. It is about culture, and it is mostly about inclusivity. And Dr. Naveed's right, there's individual quality. The care I deliver to you as a patient at the bedside and at the dialysis chair is exceedingly important. This process requires collaboration, communication, understanding the patient, and thinking – not just walking past looking at blood pressure or hemoglobin. But you can't skip the importance of the safety net, the QAPI of why we do things. It is important that as a unit, we have standards. And I think as I look, the better units that have better quality look at QAPI differently. If QAPI is just clicking numbers, dots, and points,' it's terrible. QAPI should be an open meeting, so first there must be inclusivity. It's not just the nurse manager and the medical director, it's everybody. Open the doors! If you're a bedside tech and you're interested in quality, come to QAPI. Technically, we're asked to have patients come to QAPI, but it makes us nervous. Figure out how to make it happen – open the doors! Make it as inclusive as possible. Help the patients understand what they're at QAPI and how to be a participant. The other thing I always hate when I looked at other people's QAPI, is the lack of participation of a medical director. So as a nurse manager, a nurse leader, APP in your unit, you have to help get that fire in the medical director. QAPI isn't about "I'm calling it in." "I'm driving in." "I couldn't make it today. I've got six things. I'm really busy." "I'm a doctor. I'm busy." QAPI is important. Make the medical director come to the unit. Have the medical director lead the QAPI, not sit in the back on the phone, texting, emailing, doing whatever. Be a participant. That's how we get better. And it's not just the numbers. It's what we do with the numbers. It's setting up what can we do better. Everybody's good. We understand that. But everybody can be better. So I think as we look at quality, that's what you want – participation of leadership at the bedside (and that we tend to get), but also, yes, at how we get to where we need to be. If Dr. Montgomery just worried about transplanting kidneys, this would be a different world, right? It's how is he going to get that next step? That's the point. It's thinking how we make things better.

Jennifer Vavrinchik: I'm going to lean into what you just said. When we graduate from nursing school or you graduate from medical school, we often do not receive any formal leadership training. We get that when we go back for our master's degrees and our doctorates. I remember coming out as a baby nurse, and I took on my first leadership role; the medical director was young, too. And so, we leaned on one another. We would ask each other, "Do you know what you are doing?" '"No." "Okay, so we are going to work on this together." It was such a great partnership. However, regarding your point about QAPI, we recognize that if one person calls in to QAPI, other individuals from the interdisciplinary team may also call in. They are less effective. There is no question. So if you have a physician missing from QAPI, you said, "Tell the medical director that they have to attend the QAPI meeting." How do we engage in that dialogue with one another? And it could be the nurse manager missing, too. How do we engage with one another to build that excellence and make it mandatory to be present for a QAPI meeting?

Naveed Masani: One of the things you have to do is hold each other accountable, and you just said it. You and the medical director that you worked with said – we're going to figure this out together. You hold each other accountable. This is the meeting. One of the first things you have to do is take away the WebEx option. It's a subtle, yet direct ,way of saying you're coming to the meeting, everyone's here, this is how we're doing this. And you don't want to take it away completely, I get it at times, but sometimes, if you're really having that problem, and I will say this, and I'm fairly certain Dr. Kraus not only agrees, we'll probably set the standard, there's no excuse for the medical director to routinely not be at QAPI or the nurse administrator or the managers. The people who need to be there, need to be there onsite.

Jennifer Payton: We need the whole team there. You need the social worker, the dietician, you need the nurses, you need people who are out directly working with the patients. We need all these people so we have an effective meeting, and we're tracking and trending everything that's going on in that facility, and we're looking at all of these things and working as a team together to improve these things. You have to have the whole team there, and everyone has to be focused on what you're doing because it's the quality of the care we're giving, and we need to look at all of those things together.

Michael Kraus: And going back to your question then, how do you get Dr. Kraus to get there and participate? You suck up, right? You work on this. You say, "We're having some issues. I'm not quite sure we are where we need to be, and we need your input to get there. We need your leadership. I need you to show my team how important this is. And I want them to look up to you and be part of it." If that fails, then you look at their leadership, right? And whether you're a small unit, but you're part of a DO, you go to the DO leadership and say, "Somebody needs to speak to Dr. Kraus, get him there." And hopefully, somebody in that background has the ability to have that discussion as well. But first, just start with explaining the importance because as you said, we're not taught leadership skills in medical school. We're not even taught how to communicate to our patients, and we're certainly not taught how to handwrite, although nobody does that. So you've got to

help them. You've got to help them get leadership. And maybe you talk about going to leadership education. I'm old, so I've been through a lot of different leadership education, some very good, some frankly not so good. I learned something from all of it. When I was young, I would have thought you were crazy, right? But work on those things. We need you to step up to make this unit even better. We want you to lead, so help us help you.

Jennifer Payton: What questions do the audience have related to that interaction between the staff and the medical director? What questions do you have or what suggestions do you have, especially related to culture of safety or to QAPI?

Audience Question/Comment: There are a lot of issues that strike people. One thing that struck me as you were talking, Michael, was the way you talked about the medical director and the team in the dialysis unit, as if those are two distinct things. We can't have the medical director or the nephrologists in the unit being a different team than the nurses and techs who are taking care of the patient. It's all one team. And if we have a culture where there's a separation of those, then we have a problem. We have to build the culture within the facility that the team is everyone. The team includes the medical director, the other nephrologists, the APPs, the nurses, the techs, the social worker, the dietician, and most importantly, the patients. They are part of the team, and we need to empower our patients to be able to speak up and say, this is not right. You're not putting on your gloves. You didn't disinfect your hands, or other deviations from what they know to be the standard that they should be receiving.

Michael Kraus: That's precisely right. That's that inclusivity that we need, right? You've got to be able to include everybody in the conversation and bring them up to the level of quality. If you want to build a team, I believe the culture of quality is the place to build it. And that gets everybody involved. You and I remember the old days. The surgeon walked into the room, the nurse stood up. I don't want that. I want to be part of a team. We also remember surgeons walking into the ICU and never talking to the nurse. Like she wasn't there; she was just another IV pole. I remember as a young nephrologist, I'd turn to the nurse and say, "What is it I can do for you? Are there any concerns you have?" And it just opened up an epiphany and set in that the conversation, communication, teamwork that's absolutely critical. So we have to break those silos. You want to promote the physician to become a leader, not just be the doctor. And I absolutely agree in having patients included because they matter. Quality isn't QAPI; quality is every day as you discussed. I can't tell you the number of times I would tell techs, if the doctor walks in and doesn't wash his or her hands first thing, stop them. Teach them that quality is everyone's job.

Naveed Masani: You've got to empower everyone to audit, self-audit everybody, and look out for each other, keeping in mind that we're here for the patient at the end of the day. And in that moment in space and time, this is what you're here to deliver – the best care possible. And

that doesn't always happen; there are always instances when you feel you could have done better. Full disclosure as a medical director: So many times over the past years, you look at different meetings you've been at, whether it's a safety meeting or a QAPI meeting, and you say, "I should have said something, I shouldn't have said that, or I could have said this better." You self-reflect a lot, right? Because it's not easy. It's not easy doing what we all do every day, trying to get the best out of each other and for our patients. And I think especially when things go wrong, when there are opportunities for peer review for morbidity and mortality. Taking opportunities when they happen, huddling, and pulling people in together, are really important opportunities to have and say, hey, we could have all done better here, and it's okay to admit that and move forward with it.

Audience Question/Comment: I really appreciate that you're doing this. My name's Deb Hain. I have been in nephrology for a long time as first a dialysis nurse. And I came from the days when doctors came in the room, and we had to get up out of the chair and let them sit. And they did not discuss anything with us. And it got to a point where they said, "You've got to get up when the doctor comes in," and I said, "no, I'm not going to do that," because we're equal. He has knowledge or she has knowledge I don't have, and I have knowledge she doesn't have. So we have to work together to really not be in that submissive role and we need to teach everybody about that.

I'm a professor in at a College of Nursing in Florida, and we do a lot of interprofessional education. I'm also on the Forum Medical Advisory Board. One of the focuses is how do we teach our fellows? How do I teach our fellows to be leaders? How do we teach our fellows to work in a team? And I've trained several nephrology fellows in dialysis, and the first thing I did is say we work as a team. We work together and teach them everybody's role. You know, this is the water room, go with that person that day. Go here, go there, and see, because one day you'll be a medical director, and you're going to have to know all of this and how to work with people. So I think that starts from the education.

We have a big program at FAU for geriatrics. We bring nursing, medicine, pharmacy, and social work together. We all work together to learn how to work as a team, truly as a team, and then be able to deliver the care.

I think we need to think of that in nephrology. We're all looking at team-based care across the United States. We've always had a team, but we've never functioned as a team. You know, we're supposed to have those rounds. How many times have I worked as a nurse practitioner and we don't have rounds unless I would initiate it. You know – let's talk about this patient and bring the patient in. Truly shared decision-making is where you say, these are options, what do you think you can do? What do you think is right for you? What matters most to you? And we all as a team work together to deliver that, to do the best we can. And I think that's where you're going with this. And I appreciate and applaud you for that.

One last thing I have to say is in our College of Nursing, we come from a philosophy of caring. It's not the act of caring, it's the philosophy. And we have in our tile, when you walk in our college, the dance of caring persons. And that means everybody is in the dance together as a team. One person has a rhythm that is out, and the team doesn't function, the dance is off. And that's just a basic thing, but that's basically why the patient's also in that dance. We're all in this dance together. I'm so happy that you're actually here to join us in that dance. Thank you.

Michael Kraus: I think those are excellent points. The bottom line is how do we teach? We lead by example. I remember when I was a junior medical student, a long time ago, and the urology resident said something wrong to the attending about a patient who I'd just spent two hours with at three in the morning or whatever. And I corrected him in a polite way. I said, "This is what's going on with the patient." He pulled me aside and – I can't use the language he used. He read me the riot act to never contradict him to the attending. And I knew from that moment, that's not how you teach, that's not how you lead.

When you round in teams, there's a huge team, right? Make sure the medical students hear when you talk. First and foremost, you talk to the patients. You talk to the patients, you listen, you ask the questions, like you said, because it is complete decision-making, right? You talk to the nurses, you ask the residents what their plan of action is and why. And even if it didn't agree with mine, I'd say, "Look, it's a little bit different than what I would do. Let's do it your way and let's see what happens and go from there." It's about leading by example. Frankly, when I would leave a patient's room and we would have a conversation with nurse or whomever, I would sit down with medical students. I would explain that I wanted them to learn how to interact and communicate with the patients, their families, and the nurses. If you learn nothing else from your month with me, I want you to understand that's what's important about medicine."

Jennifer Vavrinchik: One of the questions I want to ask the audience: How many of you make these beautiful action plans in QAPI? How many of you share the action plans with your entire frontline staff? Raise your hands—a few of you. If you do not take them out of the QAPI meeting and deliver them to the frontline workers, who by the way are the ones implementing the action plan, you are going to fail. And we, as surveyors, will ask the patient care tech, the registered nurse, and the LPN, "So how are you involved with QAPI?" Most of the time, we hear, "We're not involved." You just made your QAPI ineffective. A couple of pearls we have seen are that the physician and the nurse hold a 'take-five' huddle with the staff. They quickly review QAPI, focusing on major items that are important and likely related to specific quality metrics. That makes a huge difference. And when we see an improvement in whatever quality initiative program they are working on, that is a great strategy because what we see is that both of you are taking responsibility and delivering that message to your staff, as they are the ones who will make or break your quality initiatives.

Jennifer Payton: The top question from our online audience is about QAPI again. How do we get clinics away from just looking at numbers and truly doing a root cause analysis of where the facility is and where the facility wants to be and how the facility is going to get to the goal?

Naveed Masani: Such an easy question! That's the crux of it. You've got numbers. You can do better. Many times, you've got to do better for the obviousness of not just the numbers because you see a true problem that the numbers reflect. The numbers reflect patient care, and you know inherently, "Wait a minute, something's not right here." And that is the development of that action plan in a multidisciplinary way. Even take something we see every day of our lives, like vascular access. It's so much more than connecting patients with a surgeon. It is transportation. It is getting to that visit. It is the post-hospital discharge flow. It is saying, okay, wait a minute, who's going to do what? What is the medical clearance like? Now they've got an appointment for the cardiologist to go to. So they've got three times a week dialysis as it is, chewing up 15 hours of their lives, and now they've got to do all these other pieces of the puzzle. Coordinating the care, making sure that once that access is in place, who's looking at it, who's assessing it – there's your tech, LPN model, RNs, everyone at the daily bedside. When that fistula is cannulated, who's arranging the catheter removal now, and what's that communication look like? That action plan and being transmitted down like you just said, that's huge, right? We all struggle with this. You need to be able to get these things done, and you want to do it in concert. But everybody's got to be on the same page for these things. My answer to that question is it's a struggle to do that. You've got to have that communication piece and you've got to have some way to effectively disseminate the information in communicating with the patient. Because the patient's got to be the one who ultimately owns this.

A goal without a plan is a wish.

Michael Kraus: It boils down to strong leadership. Because if you remember learning, going through nursing school or medical school, you had levels. The lowest level

is the reporter. That's the junior student, and before we had computers, I had to go to everybody's bedside, get the vitals, do all the things, go look at the X-rays, and I would report those things. I didn't know what to do with it. If QAPI turns into, which it frequently does, just reporting numbers, that's what you're going to get. And then the problem is you've got a plan, but don't disseminate it or discuss it. It goes nowhere.

We're really good with the P of PDSA, but you've got to do the rest. You've got to measure the numbers, you've got to understand the numbers, you've got to set goals, but a goal without a plan is a wish. You can say you want to do this, but if you don't plan to do it, measure where you're at, make changes, and be appropriate, you'll never get there. So you've got to plan, you've got to measure, you got to think, but you've got to set your QAPI up and the way you run your dialysis unit or your OR or whatever else you're doing in life with the fact that this is where our errors are, this is how we're going to move forward and improve. We measure that, we respond to that measurement, and we use leadership. We don't just report numbers.

Jennifer Payton: When we do those action plans, those action plans should be living and breathing. We should disseminate them to everyone. But if we've got an action plan and nothing's going anywhere, you've gone two, three months and nothing's changing, you need to look at that action plan, you need to revise that action plan, and everyone needs to be involved in the root cause analysis and how we're going to change that action plan because what we're doing is not working.

You're allowed to try something and fail at it.

Naveed Masani: I think that's so important that you can, you're allowed to try something and fail at it. You are. It's okay to say, hey, listen, we're going to take this path. We really don't know which way to go with this. We're going to try and decide as a group, we're going to take this path forward, and we're going to reassess on a regular basis, whether that's monthly, quarterly, however you decide to do it, whatever the measure is, and say, hey, if we're not getting where we need to get to, it's okay to go back to the drawing board and think about it again. That's tremendously important.

Jennifer Vavrinchik: We make better leaders when we experience some failures.

Jennifer Payton: Yes. The next question is – how do we objectively assess culture in a facility?

Jennifer Vavrinchik: You can usually walk into a facility and sense the culture. We consider culture throughout the entire survey, evaluating factors that help us determine culture, such as quality metrics. Are they improving? Are they declining? What do the staff say? The staff and patients tell us a lot. And it is through them that we typically can hone in and figure out what the problem is with culture. Unfortunately, it often starts at the top and trickles down. We recently conducted a survey in which we identified a condition due to the culture, as the nurse manager was allegedly belittling and bullying their staff and patients, and was also yelling at them. There is no excuse for that. But that is an easy example. Sometimes it's subversive. As leaders, you really need to examine your culture and determine what is going on; conduct that root cause analysis.

Michael Kraus: And you can measure that in multiple ways, right? It's engagement. You walk into a unit, people are smiling. There's a culture that's positive, right? If you look and see retention and it's horrible, that's a culture that's failing. So understanding retention, understanding how the people communicate and collaborate with each other, and making sure they do that teamwork we've been talking about. At the end of the day, it's a sandbox, and you can either play in it or piss in it. So you want to make sure we're playing together in the sandbox. If you're not, find out what the problem is.

Naveed Masani: I think you mentioned objectively, right? It's very hard as a medical director to objectively know that. I'm a big believer – and there are no regulations to this – that a medical director should have patients in their unit and should round in their unit. That's one of the ways you kind of know the feel. And I think the comfortableness of everyone to go to each other, particularly, and this happened to me last week at fourth shift, tired, long day. I was a little fast rounding, and then one of the patients, I think they obviously still had some more questions. And their LPN came to me and said, "Hey, Masani, can you come back here? They still have more questions." Totally on me. I'm glad the LPN felt comfortable to come to me and actually say that.

I think the empowering goes both ways. What happens here? We prescribe a treatment, we leave the bedside, we depend on nurses to deliver and critically think and escalate and report back. Right there, what dialysis represents is an incredible opportunity, far different than anything else and anyone does in any other specialty in that regard. We prescribe a procedure entirely, walk away, and leave it to a nurse to deliver it. When you do that, and when we tell our fellows, "Listen, you need to trust each other." So when the nurse tells you something's not right, you've got to wake up and dig in on that. The nurse wants a responsive physician, someone who trusts and understands that hey, listen, when I speak up, even if I don't have every-

thing, but if I speak up to you and tell you something's not right, I need you to listen. Well, we need trusted nurses who can critically think when we walk away that when there's a change, you escalate that. And that's got to work. That trust has to develop, build, develop, build. And it's an ongoing thing. You can't just have it and walk away. Nurse managers and medical directors, we need to hear from each other. It's not one way, either way, but we need to hear from each other, and we need to trust each other that when one tells the other, "Hey, I don't like this" or "I'm concerned about this," that's a starting point for discussion.

Audience Question/Comment: I want to talk about the leadership and the teamwork thing. I think a big limiting factor is that, and Jennifer, you mentioned this, nurses don't get a lot of leadership training. Well, the doctors don't either, but even if you get leadership training, being a subject matter expert doesn't make you a leader. And I think one of the things that I think any experienced or even new nephrology nurse will tell you is that they notice the little things. So a lot of it is about how, not only as a medical director, but as a nephrologist, you build and value those relationships. I remember rounding one of our units and people were saying, you know, the garbage is always piling up and whatever. And so we need to hire better EBS people, right? And I remember walking up to the EBS person going, hey, listen, it's super important what you're doing. I appreciate it. I know you're busy, but this is so important for us to prevent infections. And the patients notice and the nurses notice when stuff piles up. So could you make sure that this gets done? And you know something? The next week, he's like, hey, Dr. Wong, guess what? I changed all that stuff. And he was excited because you know something? Me as a medical director, I valued what he was doing. And that made him feel much more valued. So that's one thing.

The second thing I think is that we as nephrologists and physicians in general are very hesitant and uncomfortable holding each other accountable. So guess what? You know, most of the stuff that I deal with when I talk to my nurse managers or other nursing leaders is, yeah, my medical director isn't present. Or the worst thing you can do as a medical director is walk in there and say, I didn't read that new protocol, and I don't believe in it. We're going to do it this way. It just drives people nuts. I think one of the things that we have to be comfortable with as nephrologists is holding each other accountable as peers, but especially if you're in a leadership position, talking to the nurses, social workers, dieticians, etc. and asking, How could this be better? If there is an issue, to go to that directly. I've heard so many medical directors say, "You know something? I know we have a problem with this, but someone's going off protocol for everything. You know, I'm not going to challenge anyone." And I'm like, that is the wrong thing to do. You've got to be able to do that respectfully and manage conflict and then treat each other as equals in terms of quality and safety. And that, I think, talking about culture, when you walk in and people are able to problem solve together instead of avoiding problems, I think that's a sign of a really good safety culture.

Michael Kraus: I think that's right. As a physician and as a leader, you have to learn to listen first. And trust me, that's hard for me. But you listen first. And when you have decisions and explanations, you also discuss the why. Don't just tell people to do things. Understand the why with even simple things. Because if I teach you the why, you will remember the hows. And that's how I grew home dialysis – I taught why. That's how I change things in my present job. I teach why. And the people on the other end of the phone, you can hear the epiphanies. So it's very important that we treat each other well. The way I would look at it is you round as if your mother's behind you. And you better make her damn proud!

Audience Question/Comment: I just want to make a quick comment about what Jennifer was talking about when it came to QAPI. I really agree with disseminating the information to the frontline staff, but also if you have multiple physicians and APRNs who are also rounding your facility, I find that there is a gap between what we decide in QAPI and if that information is being disseminated to the other physicians and the other APRNs who are also rounding on their physicians in the same facility. And then when it comes to root cause analysis, one thing that I feel is really underutilized is that a lot of our root cause analyses are done behind closed doors by one or two people and the frontline staff are not being included. So I just wanted to encourage everybody to ask your staff, ask your nurses, ask your techs, ask them, your biomed technician. Why? So you're not just assuming you know the reason why, but gather the information from people who are actually in the unit all the time to ask them why things are happening, and you'll get a much more robust root cause analysis.

Audience Question/Comment: My question is – QAPI is designed for outpatient facilities. As a leader in acutes, I struggle with what metrics are most appropriate to actually incorporate into our QAPI. So I'd like to hear from you all what metrics we can/should be looking at and which ones we can dismiss since most of our patients maybe get one or two treatments in the hospital before moving on.

Jennifer Vavrinchik: Metrics are essential in the acute setting, typically focusing on infections and catheters. One big one that I love to introduce is starting modality education right then and there for incident patients. It is something we do not always do, and it is simple to implement. NYU begins initial training in the hospital, which is amazing. All the metrics are vital, but that is a great one for our incident patients. It is something I'm passionate about, and I will turn to the rest of the panelists to discuss metrics. If you are not doing education in your acute program, you need to be doing it.

Naveed Masani: First, I think it's a great question. Second, it's a huge challenge and opportunity at the same time, right? The outpatient has the conditions of coverage. You've got that Bible. It's very prescriptive. The inpatient

becomes like the wild, wild west a little bit, and I believe this panel would argue you probably do need some guidelines and regs and stuff developed for acute units. You're not going to look at KT/V in the acute inpatient setting. That's not where it belongs. On the other hand, infection and vascular access modality education are some things that we look at. There are some practical elements we look at while at the bedside and how many people you bring to the room. You look at how many temporary non-tunnel catheters versus time to tunnel catheter placement and time to permanent access placement. You can look at your hepatitis B, making sure that there are no hep B unknowns crossing into your acute unit, and then make sure we track all our hepatitis B-positive patients, make sure we report every month how many there were, were they isolated? Were the infection control procedures followed? We also look at transfusions.

We do a patient safety meeting aside from the quality meeting. It gives us a forum and space to talk it out more. QAPI is tough because it is very much prescriptive. And everyone's rushed for time. You need a forum and a space. Now, that could be at QAPI or it could be separate, but you need a forum and a space where you can openly discuss things. And what comes out of RCAs? More things that you track sometimes. You get burned, you make improvements, you track it. That's kind of how this goes. Quality is a continuously improving dynamic variable target that you're looking at. And you want to be engaging in those discussions. And out of that comes things you want to measure. In that way, the acute unit's an opportunity. You can do things, you can see it as a landscape.

One of the challenges I will say with education in the acute setting is the condition the patients are in and their state of mind to hear that education. The combination of uremia, multiple procedures, sedation, anesthesia, and trying to come out of that and hearing you have kidney failure all of a sudden on your crash starts, that's tough, but I do agree it's a starting point. So when they hear it repetitively, I believe it puts your outpatient personnel in a better spot to succeed, if the patients have heard it once or twice going in.

Michael Kraus: It's an interesting thing, the acute unit issue. You may have to choose what's important for your unit, which may be different than what's important for Dr. Naveed's unit. But I find in the acute unit, especially when I started, the answer was, well, it's never our fault. The first part of acute unit quality is we have to fight the mindset of loss of control and understand that you do have a part to play in process and quality. It may be for your acute unit how you move patients in and out in an efficient process so you can continue to take care of as many patients as possible. And maybe you measure lines and blood flow rates and ultrafiltration rates and episodes of hypotension in your unit, or perhaps you monitor how long it takes to get to the ICU, or how long your CRKT system stays patent. Certainly measuring hepatitis B serology is a huge one. But it's a matter of, again, just engaging. There are lots of things you can choose. So do the right thing.

And I will say one thing about education in the acute unit. It's absolutely critical. That's what I taught our acute nurses to do. They spent more time educating on home dialysis than anything else. And as a nephrologist rounding, I knew six doctors talked to the patient about his pneumonia today. He didn't need a seventh to say it, so I talked to him about home dialysis, right? And it's like everything else, you lay seeds, you put water, you fertilize, and eventually, things grow. And you'd be surprised at the number of people who would come to our tertiary care center as in-center patients came in for myeloma or whatever else that would leave asking questions about home dialysis when they went back to their incenter unit. I think that opportunity is frequently missed, and I just wanted to throw that in there because that's been a passion of mine for most of my life.

Audience Question/Comment: I thoroughly have enjoyed hearing the fact that QAPI is not just about numbers, that numbers have faces. And I've been so delighted over the years to hear the term patient-centered care and firmly believe that if we can keep that at the forefront of our minds, that the patient is the most important part of that team. And it's what I liked your thing about the why, Dr. Kraus, because it's the patient's why that we really have to get to and explore and make a plan to meet their why. It may be a very simple why. I want to get to see my granddaughter graduate or something like that, to live. But one of the things that occurred to me as I was listening to this, there was an article back in 2001 by Roberta Curtin and Donna Mapes[1] in the *Nephrology Nursing Journal* about long-term survival and interviewing, doing a quality study on why these patients outlived their expectancy – their why. And I think that's what we need to engage with every patient, is to find out what it is you want, not just to feel better, etc., but what is the meaning of your life and what you want out of it. I've always believed in partnering with patients and self-management, but knowing their why, you've got to know their why if they're going to be able to self-manage at all. A lot of our patients can't do a lot of self-management, but we still need to make sure that it's the patient who's the center of our attention.

Michael Kraus: I think that's wonderful, because again, now I'm in the procurement world, so we always start almost all meetings with a why and a story of somebody that's done great with transplant or success after procurement, how the family's recovered and gotten better and are happy. Think about doing that in your in-center dialysis unit. You know, you guys sent Mrs. Smith to the home unit six months ago. Let's tell you about Mrs. Smith today. Or even bring Mrs. Smith in to tell you or someone that's been transplanted and is grateful for the care you gave in the in-center unit and the quality you delivered. I don't know if you can do that every month. But that's that culture you talked about, that engagement that brings people in. Because we all work for reasons, right? We all want to get paid and get the bennies. But that's not why we go to work. We go to work because we want to be appreciated and listened to. That's that inclusivity we talked about. And we want to know that we're doing good. And that's

where that why really plays in. I really like that idea and trying to bring that into in-center dialysis as well.

Jennifer Vavrinchik: I do want to address one point you made, Leslie. When we [surveyors] interview individuals on dialysis, one of the first questions I ask is, "What's important to you?" And do you know that most patients will say, "I've never been asked that"? And it may change what is important to them in the next month. So we need to start our questions that way. What is important to our patients?

Audience Question/Comment: The other thing I found is a great source of information over the years is patients might not tell nurses even what their why is. Patient care technicians have been some of the most valuable sources of information for me because they get to talk to them. They spend actually more hands-on time with these patients than the nurses do. And it's incredible what information you can get secondhand through a PCT about a patient.

Michael Kraus: And that leads back to that collaboration we talked about, right? After you get that as the nurse, and you've seen the physician walk by the chair too fast, you grab him and say, "Hey, wait a second, did you know that Mrs. Jones has this going on?" I would teach the nurses – I shouldn't say this – I would teach the nurses to grab the doctor if they were performing "drive-by" rounds, to make up a murmur, and say, "You know, I'm not so good, but I swear I heard a loud murmur on Jennifer. Do you mind going back and listening to her for me?" Doctors – we're wonderful people. And don't get me wrong, I'm not doctor bashing. But we're busy and we think and we forget the whys. So bringing us information and centering us, particularly when we walk in the unit, is incredible. So yes, understanding the patient's story and then sharing it, I think is important.

Naveed Masani: Absolutely happens, guilty as charged, it's happened to me. I think what you're describing is advocacy too, right? That person delivering the care can be a tremendous advocate for their patient, right? And it's got to go up somewhere, something's got to be done about it so they feel heard and they feel there was a point in doing that. It starts with the person taking care of them, like you said, and they have a tremendous opportunity to hear that patient out. They spend the most time with them. Same thing with an acute unit nurse delivering education. There is a ratio that's favorable there that you can absolutely leverage for education purposes.

Audience Question/Comment: One of the themes that I keep hearing comes back to this question of communication and how do we empower people, how do we teach, and how do we provide the leadership to develop that communication? There are a lot of tools out there. I want to plant a seed. When we talk about safety, oftentimes, we refer to the airline industry and the things the airline industry has done over the years since the disasters that occurred in Tenerife and some of the other major crashes. And in many of those, the root causes were loss of communication within the cockpit. It unfortunately required a generational change within the airline industry, but tools were developed known as crew resource management, which, when translated into the medical environment, have been rebranded as clinical team training. I was fortunate that I met a nurse who had been a nurse, became a pilot for Northwest Airlines, and then after Northwest was acquired by Delta, lost their job, came back to nursing, and was appalled at the fact that the attention to safety and quality in medicine was nowhere near what it was in the airline industry. There are a number of books on using these tools. It requires teaching these tools to everyone from the medical director to the cleaning staff within the unit. When I round and a nurse starts talking to me, saying, "Dr. Palevsky, what I see…, what I am concerned about…, what I want…," I know that this means I haven't been listening. That is a tool that is taught. I would ask, "How many of you in this room have gone through clinical team training or crew resource management training?" I see a couple hands, not many. And one of the problems is this is also not something that is a one and done because there is drift. You go through training, and even if you're committed to it, you go back to your bad habits. It's something that has to be reinforced periodically. In designing systems to improve quality and safety, we have to make these commitments. And unfortunately, in health care, we haven't bought into that. There are tools that work and we don't use them.

Michael Kraus: Or we don't use them correctly, right? We come from a culture where we're really damn smart and we don't want to be told what to do. And you know a checklist to some of us is unfortunately just that – I walked in the room, did it, and then I go back and I check, check, check the boxes, so I could bill or do whatever else. A pilot doesn't do that. A checklist is important, and it's important every single time they fly because they know one mistake is 150 lives including their own. So that culture of safety is more ingrained and everybody's got the pause. And yes, we talk about that in medicine, but we have to figure out how to make it work and make sure that we set up the processes. Because processes are quality and safety no matter what.

That's not the way as a physician I was grown up. I heard this the other night. I called a doctor to explain the standards and needs for care, and he said, "I don't want to hear those rules, that's just some guy driving a desk." Well, no they aren't. These are thoughtful guidelines based on clinical experience and evidence. It was about safety in the world from taking an organ from one person and giving it to another. You want that person to do really well and survive. That's why we have guidelines. That's why we have the culture. We as physicians have to change, we as nurses have to change, and understand there are reasons behind it.

Jennifer Vavrinchik: I appreciate someone mentioning empowerment. We all have the right to empowerment. And it's not happening overnight, to your point. We have to work on this. And it is in those meetings or huddles. You ask the staff, "What do you think?" and "What do you think?" That empowers them. It is not saying, "I'm giving

you permission or empowerment." No. It is asking the question, "What do you think?" That is a great strategy.

Jennifer Payton: We have a staffing question from someone online – I have issues in staffing. Advocating for nurses and technicians, what is the panel's opinion on the increasing workload that the frontline team are experiencing that might affect the quality of care that we deliver?

Michael Kraus: That's a fascinating and important question. The bottom line is, I got to say this so I don't get in trouble. We live in a world that is top down. Quality happens at the bedside. The work happens at the bedside. The stress happens at the bedside. And if I don't have the right people or enough people, I don't care what my goals are, what leadership thinks is going to happen, if I'm not staffed properly. Now, that doesn't mean we can overstaff and we make jobs too easy, but we have to listen to the people at the bedside. And any way you can improve a problem, you should start at the bedside. I often see, in all the work I've done from early academics to organizations to where I'm at today, I make a decision how to fix a problem as a leader. That rarely works. You've got to bring the people at the bedside in, and hopefully, they'll come to a similar decision that you thought was right. But you've got to listen and you've got to make sure there's enough bedside personnel to do things safely.

Jennifer Payton: Questions that I ask medical directors when we're doing surveys is, how is the staffing at your facility? Do you know how the staffing is? Are you working with the management? Are you working with the nurse manager? Are you speaking to the staff? Is there a high turnover rate? What is your role in this? And many times I get an answer that I'm not real happy with – that their role is they leave that up to other people and don't believe that's part of their role. What do you think about that?

Naveed Masani: It goes to that bi-directional communication. It doesn't mean you can solve every instance of understaffing. I think nephrology is a profession from LPNs, techs, to RNs, managers, APPs, nephrologists, etc., we are staff-challenged across the board. And I will say this, one thing that kind of struck me about checklists and about volume and speed, we are moving faster than ever before. Medicine was not meant to go this fast. Things that slow you down, and as much as the conditions of coverage irk you, sometimes they do. One great rule is you have to clean that and you can't start cleaning that station until the patient has left, until the next one comes. It slows you down. There's a good purpose behind it. It slows you down. We need to slow down, and I think checklists are fine, but checklists without critical thinking are dangerous. A lot of times root cause analysis goes, Oh, well, I did X, Y, and Z. Yeah, but you didn't interpret A, B, and C over here and escalate that. So I think that there are dangers. There are traps all over the place. You look at, and – this is just my own paranoia – I think paranoia keeps you alive – you walk into a dialysis unit, I just see risk. I see risk in traps. I see great care. I see all of us trying very hard, but I see an area and a world of risk where things can go wrong. That doesn't get to the answer, though, of the staffing issue. I think that every day, I know our unit struggles, I know many units struggle, and I think even coming from a place when you have resources that doesn't mean that on a daily level, someone somewhere is not struggling with staffing. I think it's part of our environment. You have to be able to talk about it, address it, but know that there's no permanent cure for it, at least not from where I stand.

We need to work on workflow processes and how we can take better care for our staff and our patients.

Jennifer Vavrinchik: How many of you talk to each other, the medical director and nurse managers, about staffing issues? As nurses, we may feel afraid, or we may think that it is just in our lane, that it is our total responsibility, and it is not. It is everybody's responsibility. And so, if I had Mike or Masani as medical directors, let's talk about workflow factors. We know we have a staffing issue. We have ads out there. We are doing what we are supposed to be doing, but we have an immediate problem. We need to have a dialogue on how we can change the workflow process to better engage and protect our staff and our patients. That's what I recommend for staffing. Can we fix the staffing? We are trying. ANNA is working very hard with the [National Student Nurses Association], working upstream, and I love the work we are doing. But immediately, we need to work on workflow processes and how we can take better care for our staff and our patients.

Michael Kraus: And I think you've got to be brave enough to pull back if you don't have what it takes to be running a full service. We sometimes say we've got to push it and we probably shouldn't. We've got to be brave enough. And to your point, Jennifer V, I've seen both things happen, right? The doctor doesn't care about staffing and they're passive. I've also seen the doctor not want to be passive and have the DO say, stay in your lane. And the medical director's lane is that, and the medical director has to understand that. But you have to understand what's driving that culture.

Audience Question/Comment: I just love this conversation. What's important is we need everybody's support for that. We can't just as nurses do this. We need physicians. We really need the support of the physicians to be involved in this. And we need more voices together – more voices together are louder than just one. Why do we need that? When I started dialysis, we had three to one. Now we're four to one. What else are we doing? So we really need support. And I appreciate you for what you've said because I agree with 100% what you're saying. One last thing is we need to teach communication. I heard that conversation. Communication's not easy. You have to have the intent to

listen, not just hear, but truly listen. So I think we need to teach people who are in leadership how to communicate, give them all the skills, the toolbox to do this. So I appreciate everything you're doing. It's really great.

Jennifer Payton: Communication is very important. We frequently find a breakdown of communication in facilities, and when we get complaints, we go into a facility, and it's a breakdown of communication between the patient and the staff, and it's frequently a culture of safety issue when we go in. That's what it all boils down to.

We have to invest in becoming a leader just like we invested in becoming an excellent clinician.

Audience Question/Comment: Good morning, and thank you for being here and leading this discussion for us today. This is very important. I'm Judy Kaufman. I'm from the University of Virginia, and one of my passions is helping to develop and mentor leaders. Because most of us, whether we're nurses or physicians, we have come up through the clinical pathway. And then we're plopped into this new role where we think we are a leader. So I think for us, we have to flip our script. We are now a novice leader, and we have to learn and we have to invest in becoming a leader just like we invested in becoming an excellent clinician. So that's one of my passions. I do a lot of teaching with new nurses, older nurses, and how we can become leaders. I'm in the process. I have a medical director who is onboarding. And one of the first things she said to me is, can you teach me how to be a leader? And I said, absolutely, we're going to do this together because we are dyad partners. We're in this together. She and I are actually starting a leadership institute program together at the University of Virginia next month. We're going to do it together because, again, we're partners. Hopefully, something is going to come out of it that's going to benefit our program.

And just another note around quality in an acute unit. One of the things we do on a daily basis is our daily huddles, our visual management boards. That visual management board includes what's top priority in our quality – what it is, who's responsible, and by when. We're looking at this daily. And one of the things within our culture is that it is bottom up and not top down. Our team members know they are invested, they are empowered, and they are committed. And I think that makes all the difference. Me as the leader, it's my job to remove the barriers and get out of their way and let them do their job. So again, thank you all for being here and leading.

Audience Question/Comment: Something just to share with the audience – I don't know if any of you all work with Darlene Rogers, but I had the privilege of working with her. And one of the things she taught me was the importance of Just Culture as we're talking about things. And not just because of the construct, but it's actually a really good communication tool with your staff. Something that I do with my physician leaders and everyone I supervise, we actually have the Just Culture algorithm. And we say, this is something that we're all accountable to this. It's really helpful because when some friction or conflict arises in the unit, you know, we're all human beings. So it's not just like, well, that person's difficult, or this is that, or that person's inexperienced. It's sitting down as a team and when we do an after action review and say, something didn't happen well, let's go through this and let's see. It actually helps people because what it does is it increases transparency and it builds that thing that says, if someone actually had a slip, they made a mistake. We don't punish them for that. And when you start being able to talk constructively and people are like, if I made a mistake based on Just Culture, I shouldn't be punished. In fact, let's work together on making this better. And that's when a lot of the stuff people don't want to talk about when it comes to staffing, when it comes to this, and stuff that we, as medical directors, can actually help with the dialogue. You've got to get that because you've got to get the frontline PCT, dialysis technicians, people to be able to contribute to the conversation.

Michael Kraus: I think that's important. When you look at root cause analysis and those discussions about quality, it's not about who. It's about why. And it's about five whys is what they teach. So you want to run it that way, and everybody needs to understand.

Naveed Masani: Make it about process, not about the individual. Absolutely, 100%.

Audience Question/Comment: So I have a one-minute commercial for an article in the *Nephrology Nursing Journal* last year[2] on the challenges of implementing a safety culture. And a lot of what we've been talking about here is addressed in that article. Bonnie Greenspan is the primary author, and I would really direct you to that.

Jennifer Vavrinchik: We could go on all day, and we genuinely appreciate your comments. I am very passionate about health policy and advocacy, and this continuing dialogue needs to occur between the physicians and nurses. We appreciate our physician colleagues being with us.

You are all leaders in this room, whether you think you are or not; seek it out. We have to be better at what we do. We have to be passionate. It is not just a job. We are ultimately responsible for our patients on dialysis and with transplants.

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