

Dialysis Patient-Provider Conflict Reduction: An ESRD Network Quality Improvement Project

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Trending of complaints and grievances in End Stage Renal Disease (ESRD) Network 5 revealed that a cluster of dialysis units consistently had complaints/grievances in consecutive years. A conflict reduction project aimed at improving conflict management was initiated. Soon after implementation, it became apparent that facilities were struggling with basic quality improvement (QI) concepts, applications and tools. The project's primary focus shifted to assisting facilities in building those skills. Despite variations in competency, each facility improved its QI skill level and all but one experienced a decrease in complaints to the Network. More training and guidance is needed to ensure that facilities are meeting the Quality Assessment and Performance Improvement requirements of the Medicare Conditions for Coverage, thereby potentially increasing satisfaction among patients and staff.

INTRODUCTION

Conflict management is a learned skill that, when adequate, can diffuse or even prevent conflict from occurring. The customer service industry understands the importance of training employees to effectively handle difficult or uncomfortable situations with customers, present oneself as caring and communicate well, with the overall goal being to increase satisfaction and prevent conflict from occurring in the first place.

Trending of complaints and grievances in End Stage Renal Disease (ESRD) Network 5 revealed that a cluster of dialysis units consistently had complaints/grievances in consecutive years. It is uncommon for complaints against units to be brought to the Network's attention and highly unusual for a unit to receive such complaints year after year.

At the time the project began, the current ESRD Conditions for Coverage were pending implementation. A conflict reduction project provided an opportunity for facilities to establish a quality improvement (QI) initiative directed at their complaints and patient satisfaction, which was an anticipated Quality Assessment and Performance Improvement (QAPI) requirement of the new regulations.

This project aimed to improve conflict management among eight identified units, thereby reducing by 50% the mean number of complaints per facility received by the Network. The primary question addressed was, "Will the number of complaints received by the Network decline as a result of facilities engaging in QI activities directed at patient concerns?" In addition, the Network was interested to know whether facilities perceived benefit from participating in the project and the materials and resources provided were viewed as helpful.

LITERATURE REVIEW

Studies in the last 10 years regarding staff training, communication and patient satisfaction were researched. A lack of staff skills and need for ongoing staff education and training

on proper interactions with patients is repeated throughout the nephrology literature (Bartlow, 2005; Department of Health and Human Services [DHHS], 2008; Goldman, 2008; Kane, 2009; King & Moss, 2004; Leebov, 2007; Rau-Foster, 2001; Renal Physicians Association & American Society of Nephrology, 2000; Sukolsky, 2003). However, little quantitative research to support this assumption was found. A demonstration project in QI utilizing the In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH-CAHPS) tool obtained results showing some positive improvements in participating dialysis facilities, but there were insufficient data to allow for any strong conclusions (Agency for Healthcare Research and Quality, 2007). A computer interactive session at a national meeting conducted by King and Moss (2004) showed that, of the 71% of respondents who indicated frequent involvement in situations with difficult or disruptive patients, only 50% indicated that they were adequately trained to manage the situation.

It is suggested that much of the conflict that occurs in a dialysis unit can be traced to staff communication problems and lack of professionalism (Bartlow, 2005; Goldman, 2008; Leebov, 2007; Sukolsky, 2003; Williams & Kitsen, 2005). Throughout the country, Networks report that the primary areas of concern in patient complaints are related to the patient's perceptions of quality of care and interactions with staff. The Decreasing Patient-Provider Conflict (DPC) National Task Force Position Statement on Involuntary Discharge emphasizes that "... [t]echnicians may inadvertently exacerbate the potential for conflict because they have not had the formal education or professional training of licensed caregivers" (p. 92) and may not be as proficient at diffusing potentially explosive situations (Centers for Medicare & Medicaid Services [CMS], 2008).

It is believed that patients' perceptions of how caring staff members are play an important role in their satisfaction with care, which can lead to conflict when satisfaction is not

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achieved. Poor communication contributes to patient resentment, fear, mistrust and non-adherence (Ambady, LaPlante, Nguyen, Rosenthal, Chaumeton, & Levinson, 2002; Kane, 2009; Williams & Kitsen, 2005). Better rapport can make the patient treatment visit more gratifying for both patient and staff. The creation of a “patient friendly” and “customer-oriented” environment, established with ongoing staff training and QI practices, can lead to improved patient and staff rapport and increased satisfaction (Bartlow, 2005; Rau-Foster, 2001; Schwartz & Batson, 2000; Sukolsky, 2003). With ongoing staff training and development, staff can increase their skill level and gain comfort and competence in dealing with conflict situations, thereby approaching these situations in a more professional manner (CMS, 2008; DHHS, 2008; Goldman, 2008; Kane, 2009; Sukolsky, 2003). When staff members have the ability to prevent and manage conflict, patients gain a greater sense of security and confidence in their care.

METHODS

To protect facility confidentiality, all participants on conference calls and webinars were provided with a unique code, which made them unidentifiable to other participants. E-mail communication was conducted by blind-copying all recipients. Facilities were also instructed not to return patient-specific information on their reporting to the Network. The project

did not require or undergo review by an institutional review board, nor was there reason to secure patient informed consent because research was not being conducted on patients. As a QI activity, the project did not satisfy the definition of “research” as defined by DHHS 45 CFR 46.102(d), which is “... a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge ...” Therefore, the regulations for the protection of human subjects did not apply. (See <http://www.hhs.gov/ohrp/qualityfaq.html#q2>.) The Network required targeted facilities to participate under §494.180(i) of the Conditions for Coverage for End-Stage Renal Disease Facilities, which states, “The dialysis facility must cooperate with the ESRD network ... in fulfilling the terms of the Network’s current statement of work. Each facility must participate in ESRD network activities and pursue network goals.”

The project included eight dialysis units from Washington, DC ($n = 1$), Maryland ($n = 1$) and Virginia ($n = 6$) that had at least one annual complaint in 2005, 2006 and 2007. Other units ($n = 16$) that had complaints in the last 2 consecutive years were invited to voluntarily participate if desired. One of these actively participated, bringing the total number of facilities to nine. Nearly 40% of the related complaints were from repeat complainants. Of those, 56% were unique concerns for the complainant (see Table 1).

Table 1. *Complaint Characteristics*

Unit	Total Number Complaints (Number Consecutive Years)	Percent Same Patient	Areas of Concern	Percent Male (Female, Unknown)	Percent African American, (White, Other, Unknown)	Average Age (Range)
A	3 (3)	66.7	Staff Quality of care Professionalism	100.0	100.0	78.7 (74–81)
B	4 (3)	75.0	Staff Quality of care	100.0	100.0	67 (30–80)
C	5 (4)	40.0	Quality of care Professionalism Transfer/discharge	100.0	80.0 (20.0, 0.0, 0.0)	53.8 (52–56)
D	16 (8)	18.8	Staff Quality of care Transfer/discharge Reimbursement Transient Other	37.5 (62.5, 0.0)	81.2 (6.3, 12.5, 0.0)	50.4 (28–71)
E	5 (3)	40.0	Staff Quality of care Other	40.0 (60.0, 0.0)	100.0	49.8 (42–62)
F	5 (5)	40.0	Quality of care Transfer/discharge	0.0 (80.0, 20.0)	80.0 (0.0, 0.0, 20.0)	59.5 (48–66)
G	15 (5)	46.7	Staff Quality of care Professionalism Transfer/discharge Physical environment	53.3 (33.3, 13.4)	73.3 (0.0, 13.3, 13.4)	60.6 (47–84)
H	10 (6)	40.0	Staff Quality of care Transfer/discharge Physical environment	40.0 (60.0, 0.0)	50.0 (50.0, 0.0, 0.0)	61.2 (45–80)
V	3 (2)	66.7	Staff Quality of care Transfer/discharge	66.7 (33.3, 0.0)	100.0	66.7 (52–74)

As shown in Table 2, of the nine units participating, seven were members of large dialysis organizations, one was a member of a small dialysis organization and one was an independent facility. The number of dialysis stations in the units ranged from 15 to 40. Only one facility was located in a rural area, and it was the second largest facility in the study.

Table 2. Facility Characteristics

Unit	Ownership	Geographic Makeup	Number of Stations
A	LDO	Urban	20
B	LDO	Urban	15
C	LDO	Rural	36
D	LDO	Urban	41
E	SDO	Urban	31
F	LDO	Urban	32
G	LDO	Urban	26
H	LDO	Urban	20
Volunteer	Independent	Urban	17
LDO, Large dialysis organization; SDO, Small dialysis organization			

The unit administrators were identified as the lead for their unit team. Each unit was expected to assemble a multidisciplinary team of relevant staff. It was anticipated that the team would, at a minimum, consist of the unit administrator, social worker and head nurse.

The project's focus was to provide staff with an understanding of their roles in conflict and to help them develop skills for better management of themselves and the conflict situation. The Network provided technical assistance to participating facilities in the form of QI training (Appendix A), resources, data feedback and individual consultation.

Each unit was provided with unit-specific data, giving as much detail as allowable regarding the complaints/grievances received by the Network, as well as a DPC toolkit (a resource available through all ESRD Networks, developed under a special study CMS contract with the Network Coordinating Center that includes staff in-servicing modules, an interactive training CD-ROM, quality tracking tools and other resources to help staff build and enhance conflict management skills), conflict change statement sheet (Appendix B) and resource list. Because all of the facilities experienced complaints related to quality of care (which are often treatment-related and involve interactions with staff) and all but two experienced staff-related issues, units were encouraged to provide staff training on conflict management techniques, which include effective communication skills, recognition of triggers in self that exacerbate ability to manage conflict, listening skills, professionalism and maintenance of boundaries and resources for continued staff training and conflict monitoring.

Each unit was to assemble a team and develop an aim statement based on review of its initial data, which may have been the information provided by the Network or internal records the unit had already been keeping. The units tracked and trended internal complaints and were instructed to apply QI approaches discussed during webinar sessions. Monthly, each unit provided a report to the Network describing its rapid cycle process, including an annotated run chart demonstrating progress over time and adjustments to processes that were made accordingly. The Network reviewed the submitted reports and provided feedback and guidance with regard to the QI process and the interventions implemented by the facilities.

This project was a one-group pretest-post-test design. Monthly aggregate rates of complaints received by the Network on the participating facilities were tracked and plotted in a run chart. In addition, a questionnaire, which was distributed at the project's conclusion, was designed to determine the usefulness of communication vehicles and project materials provided by the Network.

The quality indicator used to measure the project's success was the average number of patient complaints per facility (mean patient complaints) received at the Network, defined as:

- Numerator: annual number of patient complaints received by the Network and associated with facilities included in the denominator.
- Denominator: number of facilities participating in the conflict reduction project.

In addition, individual dialysis facilities chose quality measures unique to their situations that they tracked and shared with the Network in the monthly reporting.

The baseline period was calendar year 2007, during which time the 8 identified units incurred 15 complaints for a baseline mean patient complaint measure of 1.9. This measure did not change when recalculated to include the addition of 1 volunteer facility, which increased the number of incurred complaints to 17.

Although the stretch goal was for participants to reduce complaints received by the Network to zero, the immediate goal was to improve their conflict resolution skills, thereby reducing complaints by 50% in the annual period that began 2 months into the project and ran for 1 year (May 2008–April 2009). The Network's goal was to receive seven or fewer complaints per eight units for a mean patient complaint measure of 0.9.

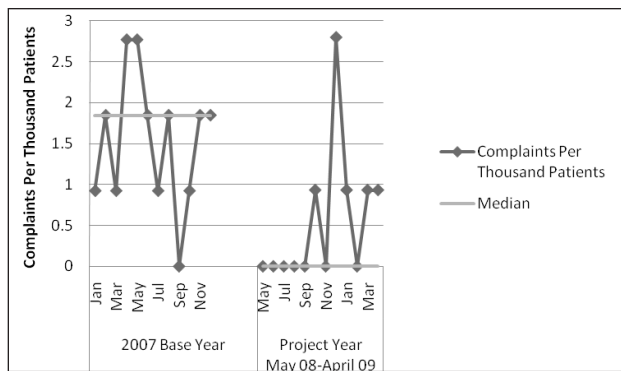
RESULTS

Soon after the project's implementation, it became apparent that facilities were having difficulty with basic QI concepts, application and tools. The project's primary focus shifted. The goals became to provide facilities with a working knowledge of QI process, establish tracking/trending mechanisms and apply these mechanisms in a plan-do-study-act (PDSA) cycle. (PDSA is a methodology for making changes

to improve. It is based on breaking down change into smaller pieces and then testing the change on a micro level and analyzing the results to validate improvement before implementing the process throughout the entire organization.) The original goal of 50% reduction in complaints remained, but became secondary to assisting facilities in putting these QI systems in place.

The number of patients remained stable throughout the study period. During the 2007 baseline period, the participating units had 17 complaints lodged with the Network for a baseline mean patient complaint measure of 1.9. During the 2008 study period (May 2008–April 2009), the number of complaints to the Network dropped to nine (mean = 1). This rate failed to meet the original project goal of a 50% reduction (≤ 0.9). Despite the shortfall, and recognizing the barriers to pursuing the project in its original format, the decline in complaints was viewed positively. Figure 1 illustrates the change in rate of complaints to the Network during the project year among the nine participating facilities.

Figure 1. Change in the Median Rate of Complaints Between Base Year 2007 and the Project Year



Facilities evaluated their participation in the project favorably (87.5% response rate, see Table 3). Interventions rated as most effective were related to increasing skills in root cause analysis and developing and implementing a plan of change. Facilities were least confident in graphing quality measures and understanding the QI process, and this was observed by the Network. Most of the participating facilities had data tracking systems in place by the first reporting month. However, the ability to clearly articulate the goals and measures of the interventions took several reporting periods to develop.

DISCUSSION

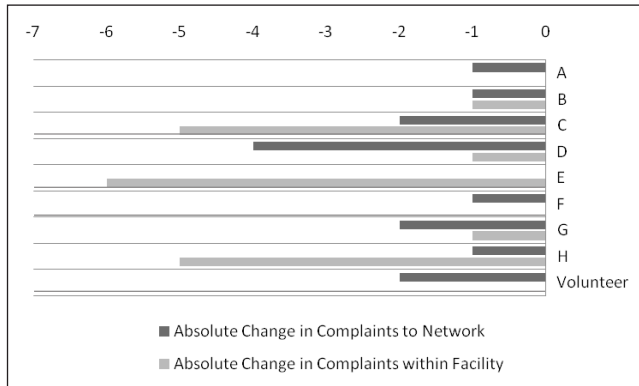
With the implementation of the new Medicare Conditions for Coverage looming on top of an already stressed system (staffing shortage, budget constraints, paper work requirements, etc.), the targeted facilities expressed discontent with being required to participate in this project. It was viewed as burdensome and punitive. There was also a knowledge

Table 3. Project End Facility Evaluation

As a result of participating in this project ...	Strongly Agree		Neutral		Strongly Disagree	
	5	4	3	2	1	
I have a greater understanding of conflict in my facility.	4.42					
I am better able to identify the root causes of conflict in my facility.	4.57					
I have increased my skill in developing a plan of change.	4.43					
I have increased my skill in implementing a plan of change.	4.43					
I understand how to define a quality measure.	4.00					
I have increased my skill in graphing quality measures over time.	3.86					
I have a better understanding of the Quality Assessment and Performance Improvement (QAPI) process.	4.00					
I obtained resources throughout the project from the Network that were helpful.	4.42					

deficit with regard to QI application among all the facilities, which necessitated ongoing teaching, an unanticipated time-resource commitment for both the Network and participants. Additionally, participants struggled with the monthly reporting template, which was based on the PDSA cycle and utilized QI language (e.g., baseline data and aim statement). Narrative instruction was included with each section and feedback on monthly reports was provided to assist with completion.

It is interesting to note the comparison between the number of complaints received by the Network and those observed within the facilities. For example, Units E and G both had the highest percentage of complaints to the Network among the participating facilities (23.1% each). Although Unit E had the greatest numerical decrease in complaints within its own project, there was no change in complaints received by the Network. Unit G, by comparison, reduced by half both the complaints within its own project and those received by the Network (see Figure 2). The difference may indicate that Unit E had not mastered

Figure 2. Change in Complaints

None of the units had an increase in complaints either to the Network or internally. All but one experienced a decrease in rate of complaints to the Network.

data collection or was under-reporting, or that the area targeted for improvement was not sensitive enough to affect the concerns that were reaching the Network level.

Despite the barriers, participants demonstrated improvement in their understanding and application of the QI process overall. Eight out of nine units had a decrease in the number of complaints received by the Network, and six made significant progress with their own internal goals. The majority of the participants reported that project participation was helpful in preparing for the demands of the newly released ESRD Conditions for Coverage and gained confidence in their ability to recognize and impact issues within their facility.

LIMITATIONS

The project's main limitations were self-reporting and threats to internal and external validity due to use of a quasi-experimental design that lacked both a comparison group and random selection of facilities for inclusion in the treatment group. With regard to the latter, the study involved a group of facilities that were complaint outliers. Consequently, the results may not be generalizable to all dialysis facilities. Without a comparison group, it cannot be assumed that complaints would not have decreased without the intervention.

No exclusions were given to repeat complainants. There was also no distinction made between repeat complainants within the same year or throughout the noted years. Had these exclusions occurred, it is likely that two of the facilities would not have been targeted for participation. Future endeavors of this kind may wish to establish more rigid criteria for inclusion of such complaints.

Facilities were expected to select their own goals and were trusted to report accurately and completely their activities and findings. The project's design was chosen to capitalize on the QAPI requirements of the new Medicare Conditions

for Coverage. It empowered facilities with the ability to apply the principles to their own real and unique issues of conflict and patient satisfaction.

Because conflict resolution is a learned skill, the observable gains made by these participants may weaken if facilities do not maintain the processes that they have put in place. Clearly, the new regulations expect that facilities will establish these practices and implement QI processes appropriately when indicated.

The Network incorrectly assumed that all facility administrators had the appropriate training and background knowledge to conduct and report on QI. This error required an unanticipated demand of resources for necessary training, which delayed the initiation and progression of the project. Social workers are in a position to take a leadership role on QI within their units. As part of the required curriculum, the Master's-prepared social worker has demonstrated research skills, which include developing goals, establishing measures and reporting findings at a level acceptable for publication.

Future endeavors of this kind would benefit from spending more time initially in one-on-one discussions with participants to determine their knowledge of QI, examine the systems already in place in each facility that can be expanded or improved and assist in overall preparation for the facility's participation. Preparation may further include determining additional training or education needs and planning for resources to address those needs. Involvement of facilities' corporate resources might be solicited for additional tutoring when facilities are determined to have limited comprehension of QI application.

CONCLUSION

The project did not achieve its goal, but did make important improvements. All but one facility experienced a decrease in complaints to the Network. Despite the variation in competency, each facility improved its QI skill level and established complaint tracking logs, which most did not have previously. This experience underscored the Network's concern that facilities did not have adequate QI processes in place. The Network underestimated the QI knowledge base of facility administrators enrolled in this project, and the project was not feasible without this knowledge and the ability to apply it. Consequently, the project's focus had to change with an unanticipated cost in time resources for ongoing training.

Facilities perceived benefit from project participation. Interventions rated as most effective were related to increasing skills in root cause analysis and developing and implementing a plan of change. Facilities reported being least confident in graphing quality measures and understanding the QI process, but demonstrated improvement in application. Participants also viewed the materials and resources that the Network provided throughout the project as helpful.

QAPI is a requirement of the ESRD regulations and must focus on several indicators, including patient satisfaction and complaints (ref: §494.110(a)(2)(viii)), and facilities must address identified deficiencies. Determining how to affect change requires facilities to actively identify issues and look closely for root causes to better select interventions. Repeat patient complainants should not be summarily discounted without full evaluation of legitimacy. Dialysis organizations would benefit from assessing facility QI knowledge and skill sets, and providing more QI training and guidance where indicated. With processes in place to track and impact undesirable trends, satisfaction among patients and staff is increased.

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APPENDIX A

QAPI Training Agenda

QAPI processes

- Developing an “aim statement”
- Utilizing rapid cycle improvement
- Determining root causes
- Understanding measures

Tools (found in the DPC toolkit)

- Conflict log
- Taxonomy
- Glossary
- Interactive CD-ROM

Techniques

- Annotated run chart

Resources and references

- DPC toolkit (provided to each of the participating units)
- www.wendyleebov.com
- www.fosterseminars.com
- Mid-Atlantic Renal Coalition staff in-service modules (<http://esrdnet5.org/in-service.asp>)
- PDSA worksheet (<http://www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/Tools/Plan-Do-Study-Act+%28PDSA%29+Worksheet.htm>)
- Conflict management change concepts

APPENDIX B

Conflict Management Change Concepts

Change Ideas: Recommended change strategies that can be employed for decreasing conflict in the dialysis unit.

Routine QAPI review of patient complaints/incidents

- Assemble multidisciplinary team.
- Conduct root cause analysis (inclusion of staff in this exercise will increase ownership of process).
- Designate staff member in dialysis facility responsible for recording reported complaints and incidents of conflict (facility administrator if feasible, but can be any renal care professional). Incorporate into facility-based QAPI process.
- Obtain retrospective data and conduct future collection, reporting and review.
- Track/trend complaints (DPC QI tools are recommended).
- When indicated by data, improvement activities will be initiated.
- Facilities adopt standard practice for staff reporting of complaints/incidents.

Routine staff training

- Designate staff member(s) in dialysis facility responsible for providing staff training in conflict management (ideally the facility administrator or clinical educator, but can be any renal care professional in authority and with favorable presentation skills and knowledge base). Incorporate into facility-based staff training process.
- Staff utilizes DPC taxonomy and glossary.
- Staff receives training in areas such as customer service, communication skills, professionalism/boundaries and patient-centered care.
- Staff receives training in conflict management and conflict resolution skills with utilization of the DPC C-O-N-F-L-I-C-T model.

Enhance patient–provider relationships

- Multidisciplinary team reviews and identifies facility culture related to areas such as patient autonomy, patient centeredness, conflict and facility policies (zero tolerance, grievance policy, treatment rescheduling, patient comforts, care planning and responses to patient non-adherence).
- Staff receives education in areas such as cultural competency and triggers/escalation of conflict.
- Data feedback is shared with all staff as an educational tool to facilitate buy-in and ownership.
- Staff is provided debriefing following all unusual conflict incidents to review what happened, what was done well, what could have been done differently/better and what is to be done going forward.
- Patients receive education in areas such as cultural competency, changes in unit policy and procedure and the unit grievance process.
- Patients are encouraged to participate in care planning.
- Patients are encouraged to participate in self-care.