HSAG HEALTH SERVICES ADVISORY GROUP

ESRD Network 13

Quality Improvement (QI) and the ESRD Quality Incentive Program (QIP)

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Thursday, May 10
1:00–1:30 p.m.

Let's Talk about the Processes of Quality Improvement

Definition of § 494.110: QAPI

- The dialysis facility must ***develop***, ***implement***, ***maintain***, and ***evaluate*** an effective, data-driven **Quality Assessment and Performance Improvement (QAPI)** program with participation by the professional members of the interdisciplinary dialysis team (IDT).
- The program must ***reflect*** the complexity of the organization and services (including those under arrangement), and must ***focus*** on indicators related to improved health outcomes and the prevention and reduction of medical errors.
- The dialysis facility must ***maintain*** and ***demonstrate evidence*** of its QAPI program including continuous monitoring for Centers for Medicare & Medicaid Services (CMS) review.

QAPI IDT Involvement

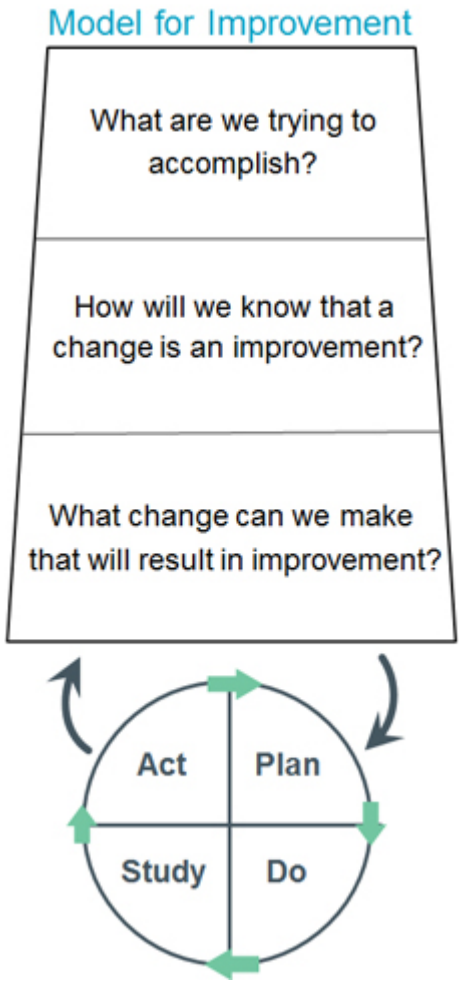
- Use a sign-in sheet.
  - Who attended?
- Documentation should reflect IDT members (i.e., Medical Director, Nurse, Dietitian, Social Worker) input and should include:
  - Specific contributions/discussion from each member from their discipline's perspective.
    - Dietitian suggests new educational idea to increase patient knowledge of the importance of protein for wound healing.
    - Medical Director requests data collection of attending clinicians' performance for analysis on a clinical indicator
      - i.e., Surgeon—AVF/AVG functionality
  - Patient engagement/contributions.
      - Consider adding specific contributions/discussion from a patient from his or her perspective.

Is Your Dialysis Unit Providing Optimal Delivery of Dialysis Care to Your ESRD Patients?

How do you know?

- So you have proof/documentation?
- What processes are working?
- What processes need improvement?
- What are your facility's strengths/weaknesses?
- Is your patient population any more challenging than any other dialysis unit?
  - If yes, how is it documented and addressed in your QAPI?
- If staffing is an issue?
  - How is staffing addressed in your QAPI?

Model for Improvement



Setting Aims

The aim should be time-specific and measurable; it should also define the specific population of patients or other system that will be affected.

Establishing Measures

Teams use quantitative measures to determine if a specific change actually leads to an improvement.

Selecting Changes

Ideas for change may come from those who work in the system or from the experience of others who have successfully improved.

Testing Changes

The Plan-Do-Study-Act (PDSA) cycle is shorthand for testing a change in the real work setting—by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method adapted for action-oriented learning.

Source: Institute for Healthcare Improvement

Reviewing Your Current QAPI Documentation

Monthly QAPI review required QI indicators (i.e., vascular access), including:

- Goals
- Trends
- Prioritization of QI indicators
- Needed action plan(s)
  - If an action plan is needed, was action plan(s) discussion documented?
  - Did documentation include IDT involvement?

Quality Indicators

Is your IDT reviewing *ALL* of the following Quality Indicators?

- Hemodialysis (HD) Adequacy
- Peritoneal Dialysis (PD) Adequacy
- Anemia
  - Hemoglobins < 10 gm/dL
  - Transfusions
- Nutrition
- Mineral Metabolism
- Fluid Management
- **Vascular Access**
  - Catheters, Arteriovenous Fistulas (AVFs), Arteriovenous Grafts (AVGs)
  - Monitoring for dysfunction
  - Cannulation Policies and Procedures (P&P)
- Immunizations
- Infection Control
- Patient Safety

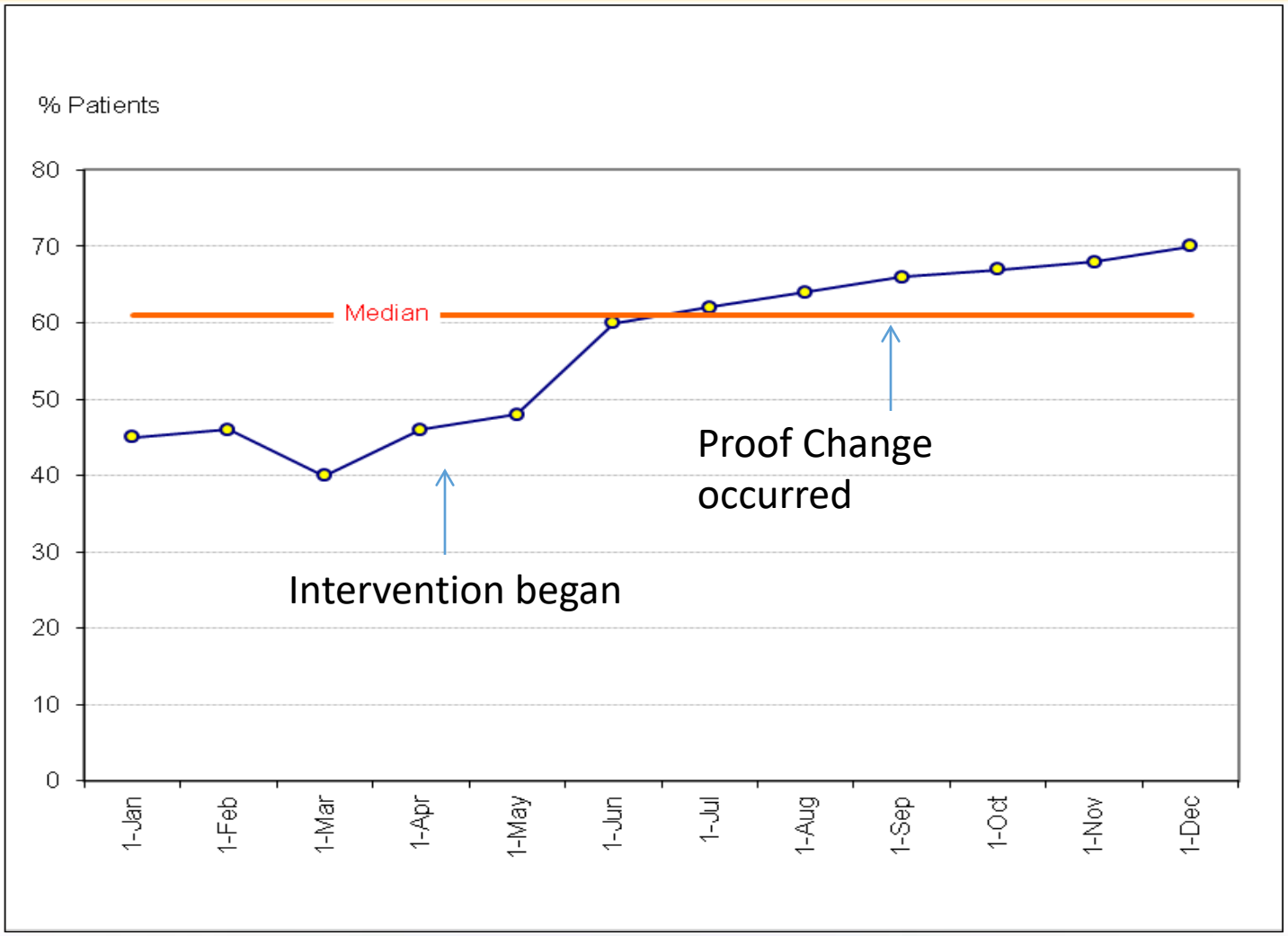
How do you set *Facility-Specific Goals?*

- CMS/Network 13
  - Performance targets (CMS)/guidance (NW 13)
  - Currently, national goals are for vascular access
- Compare Clinical Outcomes
  - National/state/region/affiliation
  - Network 13
  - Your organization
- Your organization's standards and goals
- Do you set thresholds?
  - = CRITICAL point where action is taken

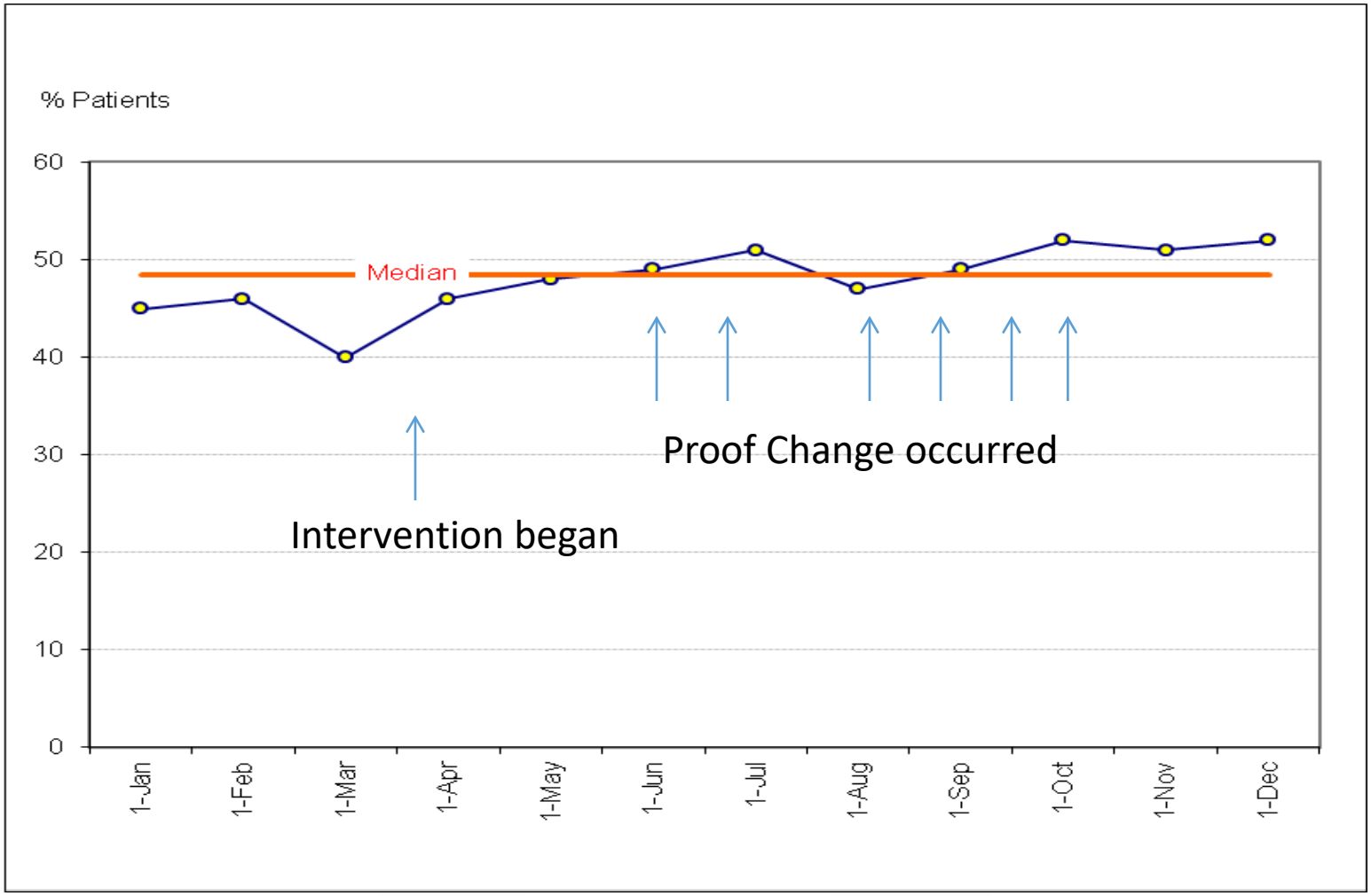
Trend Review

- Review at least a three–six month data set.
  - Many facilities are only looking at prior month vs. current month data.
- Variations will occur.
  - Are outcomes stable, trending up or down?
  - How do you know if a change has occurred?
- Consider using a Run Chart to look at trends.
  - Trends = 5 consecutive ascending or descending data sets.
  - Shifts six data sets above or below the median.

Trends = Five Consecutive Ascending or Descending Data Sets Reflects a Change



Shifts = Six Data Sets Above or Below the Median Shows a Change



Prioritization

- What is the *PRIORITY* area needing improvement in your facility?
- How do you determine priority levels?
- Was there IDT discussion on what Indicator needs the team's focus?
  - How do you document this discussion?
- How do you determine when an action plan is needed?

Action Planning

- Is an action plan needed?
- Was there discussion regarding needed areas of improvement?
  - Who was involved in the discussion?
- How are patients/families engaged?

Action Planning

- Describe Problem
- Set Goal and keep it:
  - Simple
  - Achievable
  - Measurable
    - Current Status
- Set time frame
  - Think rapid cycle
- Determine team
- Complete a root cause analysis (RCA) using measurement
- Develop action plan using QI tools such as:
  - Cause & Effect
  - Fishbone
  - PDSA

RCAs

THE weakest area in action plans reviewed by the Network is the RCA.

- Barriers/root causes are listed but not analyzed.
  - Measure the % of patients with each barrier.
  - Focus on the barrier where…
    - You get the most impact for your efforts (biggest bang for your buck!)
    - Area that is easiest to impact (quick reward)
- Test interventions/process changes on a small scale
  - i.e., 1st shift MWF
- Listing *"reasons/excuses"* is *NOT* root cause analysis!

PDSA—Action Plan—Following Up

- Use PDSA to test interventions/process changes.
  - Re-measure and document:
    - Did the action steps/interventions work?
    - What improvement was seen and sustained?
    - Will you implement the process changes facility-wide or try something different?
- Include any discussion regarding your action plan in your monthly QAPI meeting documentation.

Note: "*Will monitor*" is not an intervention

Available Tools/Documents

- QI tools
  - Sample action plans
  - Fishbone diagram
  - PDSA
  - Run chart
- Patient education materials

ESRD QIP

ESRD QIP Promotes High-Quality Care

CMS Payment for treatment of dialysis:

- Links a portion of payment directly to facilities' performance on established quality care measures.
- Reduces payments to ESRD facilities that do not meet or exceed performance standards.
  - Clinical, safety, and reporting measures are used to establish the facility's Total Performance Score (TPS).

CMS ESRD QIP: Finalized Payment Year (PY) 2020 Performance Standards Values

Measure	Achievement Threshold (15th percentile)	Benchmark (90th percentile)	Performance Standard (50th percentile)
VAT Measure Topic			
• AVF	53.95%	79.90%	65.98%
• Catheter*	17.22%	3.11%	9.40%
Kt/V Dialysis Adequacy	91.09%	98.56%	95.64%
Hypercalcemia*	2.41%	0.000%	0.86%
NHSN BSI*	1.598	0.000	0.740
SRR*	1.273	0.629	0.998
STrR*	1.444	0.429	0.889
SHR*	1.249	0.670	0.967

* On this measure, a lower rate indicates better performance.

PY 2020—Finalized Payment Reductions

The PY 2020 payment reductions will apply to a facility according to the following scale:

Facility TPS	Payment Reduction Percentage
100 – 59	0%
58 – 49	0.5%
48 – 39	1.0%
38 – 29	1.5%
28 – 0	2.0%

Overview of PY 2021 Measures

Clinical Measure Domain – 75% of TPS

Patient and Family Engagement/ Care Coordination Subdomain –
40% of Clinical Measure Domain score

1. ICH CAHPS
2. SRR

Clinical Care Subdomain –
60% of Clinical Measure Domain score

★1. STrR
2. Kt/V Dialysis Adequacy (comprehensive)

VAT Measure Topic:

★3. Standardized Fistula Rate
★4. Long-Term Catheter Rate
5. Hypercalcemia
6. SHR

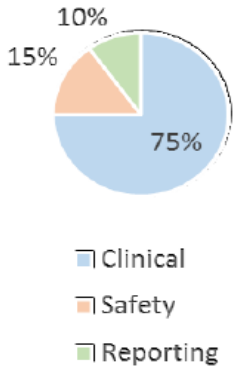
Safety Measure Domain – 15% of TPS

NHSN BSI Measure Topic:

1. NHSN Bloodstream Clinical
2. NHSN Reporting

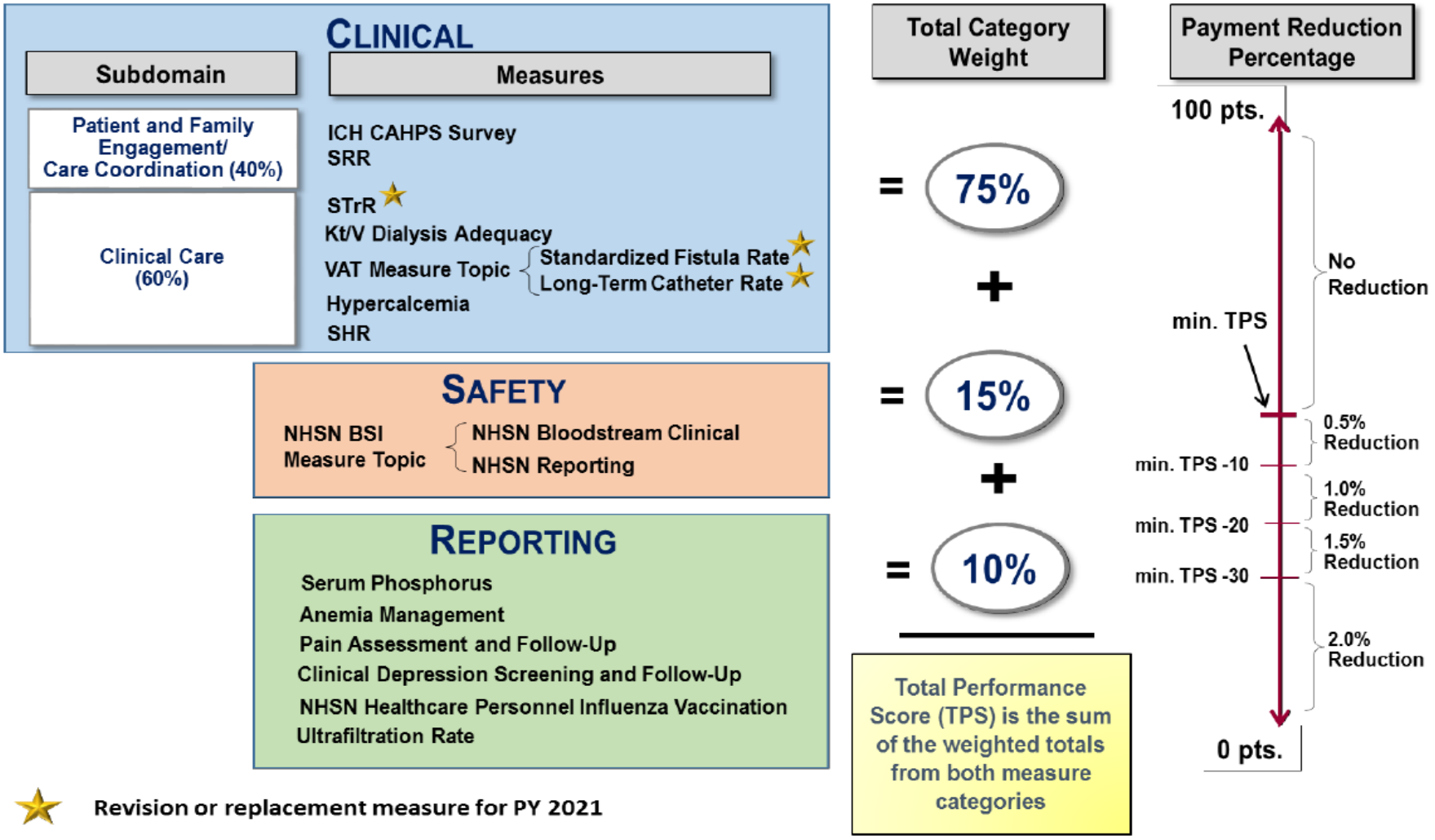
Reporting Measure Domain – 10% of TPS

1. Serum Phosphorus
2. Anemia Management
3. Pain Assessment and Follow-Up
4. Clinical Depression Screening and Follow-Up
5. NHSN Healthcare Personnel Influenza Vaccination
6. Ultrafiltration Rate



★ **Revision or replacement measure for PY 2021**

PY 2021 Scoring/Payment Reduction Method



Resources

- **ESRD QIP Section of CMS.gov**
  - Link: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/index.html
  - Technical Specifications for PY2021. Link Below:
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/Downloads/PY-2021-Technical-Measure-Specifications_Nov-17.pdf
- **ESRD QIP Section on QualityNet. Link below:**
  - https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic/Page/QnetTier2&cid=1228776130562
- **Dialysis Facility Compare**
  - **Link:** https://www.medicare.gov/dialysisfacilitycompare/
- **CMS ESRD QIP staff:** ESRDQIP@cms.hhs.gov

Disclaimer

- This presentation was current at the time it was developed. Medicare policy changes frequently so links to the source documents have been provided for your reference.
- The ESRD QIP information provided is only intended to be a general summary. Participants should review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Questions

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Thank you!

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