WE ARE ALL IN THIS TOGETHER
OBJECTIVES

- Who is the ESRD Network of Texas
- Medicare ESRD Quality Incentive Program (QIP)
- Tools and Resources
- Current and Future QI Projects
YOUR PARTNERS

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We support equitable patient- and family-centered quality dialysis and kidney transplant health care through the provision of patient services, education, quality improvement, and information management.
Six Domains of Quality Measurement Based on the National Quality Strategy

1. **Treatment and Prevention of Chronic Disease**
   - Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease

2. **Patient and Family Engagement**
   - Ensuring that each person and family are engaged as partners in their care

3. **Care Coordination**
   - Promoting effective communication and coordination of care

4. **Population/Community Health**
   - Working with communities to promote wide use of best practices to enable healthy living

5. **Affordability**
   - Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new healthcare delivery models

6. **Safety**
   - Making care safer by reducing harm caused in the delivery of care
TRANSITIONS OF PATIENTS WITH CKD

- Hospitalized more often and re-hospitalized
- Multiple medications and multiple health problems
- See many healthcare providers
- Unique nutritional needs
- Special medication needs
“Dialysis patients continue to have substantially higher mortality, and fewer expected remaining life years, compared to the general population and Medicare populations with cancer, diabetes, or cardiovascular disease.”

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[https://www.usrds.org/2016/view/v2_06.aspx](https://www.usrds.org/2016/view/v2_06.aspx)
Patients with CKD and ESRD experienced rehospitalization rates of 21.4% and 34.6%, respectively as compared to only 15.3% of older Medicare beneficiaries without a diagnosis of kidney disease (Figure 5.6). This held true for the combined outcomes of post-discharge death and/or rehospitalization—experienced by 27.6% of CKD patients and 40.1% of those with ESRD, versus only 19.8% of patients without diagnosed kidney disease.”

Figure 5.6
Proportion of patients aged 66 & older discharged alive from the hospital who either were rehospitalized or died within 30 days of discharge, by kidney disease status, 2014


https://www.usrds.org/2016/view/v2_05.aspx
Proportion of hemodialysis patients with cause-specific rehospitalizations within 30 days of discharge, by cause of index hospitalization, 2014

Data Source: Special analyses, USRDS ESRD Database. Period prevalent hemodialysis patients, all ages, 2014, unadjusted. Includes live hospital discharges from January 1 to December 1, 2014. Cause-specific hospitalizations are defined by principal ICD-9-CM codes. See Vol. 2, ESRD Analytical Methods for principal ICD-9-CM diagnosis codes included in each cause of hospitalization category. Abbreviations: CVD, cardiovascular disease; ESRD, end-stage renal disease; rehosp, rehospitalization; VA, vascular access.
DIALYSIS PATIENT READMISSIONS & HEPATITIS C

Figure 1. Rates of Hospital Admissions and 30-Day Readmissions in the First Year of Dialysis in Patients with and without a Hepatitis C Infection

- Hospital Admissions: HCV Negative (1.96), HCV Positive (2.47)
- 30-Day Hospital Readmissions: HCV Negative (0.6), HCV Positive (0.9)
# QIP Clinical Measure

## Standardized Readmission Ratio (SRR)

### Description

Ratio of the number of observed unplanned 30-day hospital readmissions to the number of expected unplanned 30-day hospital readmissions.

### Numerator

Number of unplanned 30-day hospital readmissions

### Denominator

The expected number of unplanned 30-day hospital readmissions in each facility, which is derived from a model that accounts for patient characteristics, the dialysis facility to which the patient is discharged and the discharging acute care or critical access hospitals involved.

### Exclusions

The measure excludes readmissions in the numerator that:
1. Occurred more than 30 days after the index discharge
2. Are considered “planned”
3. Occur within the first three days following discharge from the acute care hospital

The measure excludes index hospital discharges from the denominator that:
1. End in death
2. Result in a patient dying within 30 days with no readmission
3. Are against medical advice
4. Include a primary diagnosis for certain types of cancer, mental health conditions or rehabilitation
5. Occur after a patient’s 12th admission in the calendar year
6. Are from a PPS-exempt cancer hospital
7. Result in a transfer to another acute care or critical access hospital on the same day, or the day after the discharge date
8. Result in a readmission occurring within the first three days following discharge from the acute care hospital

Started in 2015
## QIP CLINICAL MEASURE

### STANDARDIZED HOSPITALIZATION RATIO (SHR)

**LOWER IS BETTER**

<table>
<thead>
<tr>
<th>Description</th>
<th>Risk-adjusted standardized hospitalization ratio of the number of observed hospitalizations to the number of expected hospitalizations NQF# 1463</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of inpatient hospital admissions among eligible patients at the facility during the reporting period.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Denominator</th>
<th>Number of hospital admissions that would be expected among eligible patients at the facility during the reporting period, given the patient mix at the facility.</th>
</tr>
</thead>
</table>

| Denominator Exclusions | 1. Patients on chronic dialysis for 90 days or less.  
2. Patients treated at the facility for less than 60 days.  
3. Patients who receive a transplant. (Exclusion begins 3 days prior to the date of transplant)  
4. Patients who have not been treated by any facility for a year or longer. |

**Will start in 2018**
**COMMUNICATION FORM**
**DIALYSIS TO HOSPITAL**

![Dialysis Unit to Hospital Transfer Summary form](image)

**Patient Information**
- **Name / ID:**
- **DOB:** / / 
- **Chronic Dialysis Unit Name:**
- **Primary Renal DX:**
- **Nephrologist:**
- **Unit Phone:**
- **Nephrologist Phone:**

**Hepatitis B**
- **Antigen:**
- **Antibody:**
- **Date:** / / 

**Allergies:**

**Current Vascular Access**
- **Primary:**
  - CATH
  - AVF
  - AVG
  - Other
- **Secondary (if any):**
  - CATH
  - AVF
  - AVG
  - Other
- **Access Location:**
- **Access Surgeon:**
- **Needle Size:**
- **Average bleeding time:**
- **Buttonhole cannulation:**
- **Vascular Access Infection:** (within last 30 days):
  - NO
  - YES
- **Positive Blood cultures:**
  - NO
  - YES
- **If Yes - name antibiotic(s) given:**

**Dialysis Prescription**
- **TX per week:**
- **Duration:**
- **Schedule:**
- **Dialysate = Na:**
- **K:**
- **Ca:**
- **Bicarb setting:**
- **DFR rate:**
- **BFR Rate:**
- **Weight:**
- **Heparin:**
  - Load:
  - Hourly:
  - MId Tx bolus:
  - Dialyzer:
- **Treatment tolerance:**
  - Well
  - Fair
  - Poor
  - Details:

**Reason for Admission**
- **Hospital Name:**
- **Date of Admission:** / / 

**Competent to Sign Consents**
- Yes
- No

Other Instructions:
## Hospital to Dialysis Unit Transfer Summary

**Patient Information**

<table>
<thead>
<tr>
<th>Name / ID:</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Renal DX:</td>
<td></td>
</tr>
</tbody>
</table>

**Hepatitis B**

<table>
<thead>
<tr>
<th>Antigen:</th>
<th>Antibody:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Date:** / /  

**Allergies:**  

<table>
<thead>
<tr>
<th>Code Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full</td>
</tr>
</tbody>
</table>

**Other Instructions:**  

**Competent to Sign Consents**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Hospital Information**

<table>
<thead>
<tr>
<th>Hospital:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit:</td>
</tr>
<tr>
<td>Phone:</td>
</tr>
</tbody>
</table>

**Admission Date:** / /  

**Inpatient Attending Nephrologist(s):**  

**Discharge Date:** / /  

**Discharging Physician:**  

### Outpatient Dialysis

#### Unit Accepting Transfer

<table>
<thead>
<tr>
<th>Facility:</th>
<th>Phone:</th>
<th>Contact:</th>
</tr>
</thead>
</table>

### Current Vascular Access

- Tunnelled Catheter
- AVF
- AVG
- Other

### Any changes this admission:

- Clotting
- Declotting
- Revision
- New Placement – Please describe:

### Vascular access infection:

- No
- Yes

### Positive blood cultures:

- No
- Yes – Name of antibiotic(s) given:

### Organism Type:

### Anemia Management

#### ESA's given during the admission:

- None
- Epogen®
- Aranesp®
- Procrit®

<table>
<thead>
<tr>
<th>Last Dose / Date Received:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### IV IRON Therapy

- Venofer®
- Ferrlecit®
- Feraheme®
- Infed®
- Dextraferum®
- Other

<table>
<thead>
<tr>
<th>Last Dose / Date Received:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### Hb prior to transfusion(s) gm/dl

- Most recent:
  - Hgb:
  - Date: / /  
  - Hct:
  - Date: / /  

### Miscellaneous

- Date of last HD prior to discharge: / /  
- Changes to EDW:
- Medication changes:

### Notice:

- Compliance with this form is mandatory. The Nephrology Department shall discontinue service for non-compliance.
- The completed form shall be reviewed by the Nephrology Department. Additional forms shall be completed for any changes to the above information.
- This document is also available online:

#### Online Access:

- Website URL:

#### Contact Information:

- Phone:  
- Email:  

#### Additional Resources:

- PDF Download:
- FAQ:
- Support:

#### Legal Notice:

- Compliance:
- Confidentiality:
- Privacy Policy:

#### Acknowledgement:

- acknowledgment
Transitions of Care Toolkit
Developed by the Forum of ESRD Networks’ Medical Advisory Council (MAC)

This toolkit for health providers and practitioners is a reference tool that gives information about challenges in transitions of care and suggestions to help create solutions.

Forum Medical Advisory Council (MAC)
The Forum of ESRD Networks
First Publication: 12/01/2015
Revised: 01/09/2017
Transitions Toolkit Fundamentals

- Target audience = the dialysis facility staff and practitioners.
- The dialysis team needs to “own” the transitions – the team cannot wait for hospitals and primary care providers to reach out.
- The dialysis team includes dialysis staff, practitioners and patients. Patient perspectives are critical in evaluating processes and outcomes.
Transitions Included in the Toolkit

• First dialysis treatments
• Changes in dialysis staff/new clinic staff
• Change in treatment modality, including to and from transplant and to palliative care or hospice
• Transitions between settings (hospital, dialysis unit, skilled nursing)
• Pediatric- to adult-focused dialysis
## Patient Engagement

### Self Management Plan for Renal Failure

<table>
<thead>
<tr>
<th>Green Zone: All Clear</th>
<th>Green Zone Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• No shortness of breath</td>
<td></td>
</tr>
<tr>
<td>• No swelling</td>
<td></td>
</tr>
<tr>
<td>• Urinating with no problems</td>
<td></td>
</tr>
<tr>
<td>• Watching intake of foods/fluids</td>
<td></td>
</tr>
<tr>
<td>• No pain</td>
<td></td>
</tr>
<tr>
<td>• Not tired or weak</td>
<td></td>
</tr>
<tr>
<td>• Monitoring foods with potassium, protein and salt</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yellow Zone: Caution</th>
<th>Yellow Zone Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increased swelling</td>
<td></td>
</tr>
<tr>
<td>• Increased tiredness with any activity</td>
<td></td>
</tr>
<tr>
<td>• Decreased urine output</td>
<td></td>
</tr>
<tr>
<td>• Nausea and vomiting</td>
<td></td>
</tr>
<tr>
<td>• Loss of appetite</td>
<td></td>
</tr>
<tr>
<td>• Headache</td>
<td></td>
</tr>
<tr>
<td>• Muscle aches</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Red Zone: Medical Alert</th>
<th>Red Zone Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increased shortness of breath - breathing faster</td>
<td></td>
</tr>
<tr>
<td>• Heart rate faster</td>
<td></td>
</tr>
<tr>
<td>• Fatigued - unable to stay awake</td>
<td></td>
</tr>
<tr>
<td>• Increased swelling</td>
<td></td>
</tr>
<tr>
<td>• Increased pain</td>
<td></td>
</tr>
<tr>
<td>• Increased nausea and vomiting</td>
<td></td>
</tr>
<tr>
<td>• Fever</td>
<td></td>
</tr>
<tr>
<td>• Unable to urinate at all</td>
<td></td>
</tr>
</tbody>
</table>

### GFR Zone

GFR stands for glomerular (glow-MAIR-you-lure) filtration rate. A blood test checks your GFR, which tells how well your kidneys are filtering.

It's important to know your GFR if you are at risk for kidney disease. A urine test will also be used to check your kidneys.

**GFR is reported as a number.**

- A **GFR of 60 or higher** is in the normal range.
- A **GFR below 60** may mean you have kidney disease.
- A **GFR of 15 or lower** may mean kidney failure.
PATIENT ENGAGEMENT

Professional Resources for Access Monitoring

Lifeline for a Lifetime
Planning for Your Vascular Access

If you and your dialysis care team decide that hemodialysis is the best choice for you, you will need to have a vascular access made. This is important because an access is your lifeline for a lifetime. Take the proper steps to plan your access.

Professional Resources for Access Planning

Video for the "One Minute Access Check"
Video that outlines the steps for the "One Minute Access Check".
The biggest misconception about communication is that it has occurred.
We support equitable patient- and family-centered quality dialysis and kidney transplant health care through the provision of patient services, education, quality improvement, and information management.

- **Current QIAs**
  - Grievance QIA
  - ICH CAHPS QIA
  - Long Term Catheter QIA
  - Blood Stream Infection (BSI) QIA
  - Vaccinations QIA
  - Home Referrals QIA
  - Hypercalcemia QIA
  - NHSN Data Quality QIA
Background

- Facilities are required to report infections identified in the facility as well as those that occurred on the 1st and 2nd day of hospital admission
- Gaps in BSI reporting to NHSN
- Insufficient/lack of communication between hospital and dialysis facility

Aims of NHSN Data Quality QIA

- Improve communication between hospitals and dialysis facilities
- Ensure appropriate, sufficient and timely information exchange occurs between the hospitals and dialysis facilities
- Demonstrate an increase over baseline, in the number of Positive Blood Cultures reported to NHSN that occurred on the 1st or 2nd day of hospital admission
 SCOPE OF PROJECT

- QIA includes
  - Three cohorts of ≥20 dialysis facilities and ≥5 corresponding hospitals during a period of 5 years
  - For each cohort, the QIA will consist of
    - 1 year of planning
    - 1 year of implementation
    - Up to 3 years of monitoring
  - Five hospitals that receive patients from the dialysis facilities in the project

- First Cohort 2016-2017
  - Selected facilities based on:
    - Degree of difficulty in obtaining hospital information / access to information
    - Location (North Texas region)
    - High Catheter rates and low BSI rates

Supporting Quality Care
Implementation year for each cohort include:

- Facilities will perform a root cause analysis to identify the root causes for under-reporting of blood stream infections

- Facilities will address the root causes using PDSA cycle with the aim of:
  - improving communication between hospitals and dialysis facilities
  - Capturing blood stream infections identified in hospitals

- Goal of the project: Increase the reporting of blood stream infections identified in hospitals by 2% from baseline

- Baseline Reporting rate is 20.6%
## Root Cause Analysis

<table>
<thead>
<tr>
<th>Root Causes</th>
<th>Number of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Facility Factors</strong></td>
<td></td>
</tr>
<tr>
<td>No/limited knowledge of the structure and function of the hospital EMR</td>
<td>4</td>
</tr>
<tr>
<td>No or limited knowledge of the role and responsibilities of different...</td>
<td>10</td>
</tr>
<tr>
<td>No designated hospital personnel to contact to retrieve information on PBC</td>
<td>17</td>
</tr>
<tr>
<td>Key information of PBC and specifically the day of collection following the...</td>
<td>13</td>
</tr>
<tr>
<td>Retrieval of information from EMR is difficult</td>
<td>12</td>
</tr>
<tr>
<td>No / limited access to hospital electronic medical records (EMR)</td>
<td>18</td>
</tr>
<tr>
<td><strong>NHSN Factors</strong></td>
<td></td>
</tr>
<tr>
<td>Lack of facility data validation into NHSN</td>
<td>4</td>
</tr>
<tr>
<td>Reporting is time consuming</td>
<td>5</td>
</tr>
<tr>
<td>There is a learning curve for NHSN application of NHSN Dialysis Events...</td>
<td>11</td>
</tr>
<tr>
<td>Individual dialysis staff access to NHSN through SAMS registration...</td>
<td>12</td>
</tr>
<tr>
<td><strong>Organization Factors</strong></td>
<td></td>
</tr>
<tr>
<td>Not involving patients in the design, development and implementation of...</td>
<td>3</td>
</tr>
<tr>
<td>Lack of incentives for communicating with hospital and ED staff</td>
<td>8</td>
</tr>
<tr>
<td>There is no clear designation of NHSN roles for facility personnel</td>
<td>9</td>
</tr>
<tr>
<td>No process for validating the data reported to NHSN</td>
<td>7</td>
</tr>
<tr>
<td>No tracking system for monitoring PBC and reporting in NHSN</td>
<td>7</td>
</tr>
<tr>
<td>There is no protocol for asking and documenting the patients about...</td>
<td>6</td>
</tr>
<tr>
<td>There is no protocol for hospital/ ED record retrieval process</td>
<td>8</td>
</tr>
<tr>
<td><strong>Patient Factors</strong></td>
<td></td>
</tr>
<tr>
<td>Patient/Family unaware of importance of communicating transitions of...</td>
<td>20</td>
</tr>
<tr>
<td>Cultural differences</td>
<td>4</td>
</tr>
<tr>
<td>Language barrier</td>
<td>10</td>
</tr>
<tr>
<td><strong>Facility Factors</strong></td>
<td></td>
</tr>
<tr>
<td>General misconception that reporting guidelines for NHSN and...</td>
<td>8</td>
</tr>
<tr>
<td>Not following protocol and/or no protocol</td>
<td>4</td>
</tr>
<tr>
<td>Lack of staff knowledge regarding the DE protocol and application of the...</td>
<td>8</td>
</tr>
<tr>
<td>Lack of follow-up from dialysis facility on getting information from the...</td>
<td>12</td>
</tr>
<tr>
<td>Lack of follow-up from dialysis facility on getting information from the...</td>
<td>11</td>
</tr>
<tr>
<td>Lack of staff training on how to retrieve information from the hospital/ ED</td>
<td>7</td>
</tr>
<tr>
<td>Time constraints</td>
<td>5</td>
</tr>
<tr>
<td>Staffing issues: Short staffed, stress, turnover, Not enough staff who are...</td>
<td>7</td>
</tr>
</tbody>
</table>

**Number of Responses**

**N = 22**
No / limited access to hospital electronic medical records (EMR)
Retrieval of information from EMR is difficult
No designated hospital personnel to contact to retrieve information on PBC
Key information of PBC and specifically the day of collection following the hospital admission is not routinely...
No or limited knowledge of the role and responsibilities of different departments in hospital
No / limited knowledge of the structure and function of the hospital EMR

Number of Responses
N = 22
QUESTIONS?
THANK YOU