

The QIP Newsletter

For Dialysis Facilities

Summer 2017

Volume 3

ALLIANT
QUALITY



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What is the QIP?

The End-Stage Renal Disease Quality Incentive Program (QIP) is a type of program known as “pay-for-performance” or “value-based purchasing”. The intent of the QIP is to promote patient health by providing a financial incentive for renal dialysis facilities to deliver high-quality patient care.

The QIP does this by setting minimum goals across a selected group of measures, and authorizes payment reductions up to 2% if a facility does not meet or exceed the minimum Total Performance Score (TPS) as set forth by the Centers for Medicare & Medicaid Services (CMS).

Your facility works to achieve the QIP clinical, safety, and reporting measures to maximize income and promote optimal dialysis-related outcomes.

How does the QIP affect me?

Poor QIP performance can lead to payment reductions to the facility, and this can affect everyone in a facility. A reduction in payments can affect profit and influence staffing.

In addition, each facility's QIP performance is publicly reported through Dialysis Facility Compare (<http://www.medicare.gov/DialysisFacilityCompare/search.html>) and mandated posting of your Performance Score Certificate (PSC) at the facility.

Patients can use the ESRD QIP to see how your facility's performance compares to the performance of facilities nationwide in the same program, and may decide to transfer to another facility that they perceive will provide better care.



Acute Kidney Injury (AKI) and ESRD Facilities

Beginning January 1, 2017, CMS will provide coverage and payment for renal dialysis services furnished on or after January 1, 2017 by an ESRD facility to an individual with AKI. The payment will be the amount of the ESRD PPS base rate, as adjusted by the wage index and drugs, biologicals, laboratory services, and supplies that ESRD facilities are certified to furnish, but that are not renal dialysis services, may be paid for separately when furnished to individuals with AKI.

What Does the QIP Measure?

The measurements taken each calendar year (CY) will affect Medicare reimbursements for the payment year (PY) that will follow two years later. For example, the first year the QIP was implemented was CY 2010, and the performance that year produced the results for PY 2012. Therefore, the performance of your facility now in CY 2017 will affect reimbursement for PY 2019.

The ESRD QIP that will measure performance for CY 2017 is comprised of seven clinical measures that constitute 75% of your facility's Total Performance Score

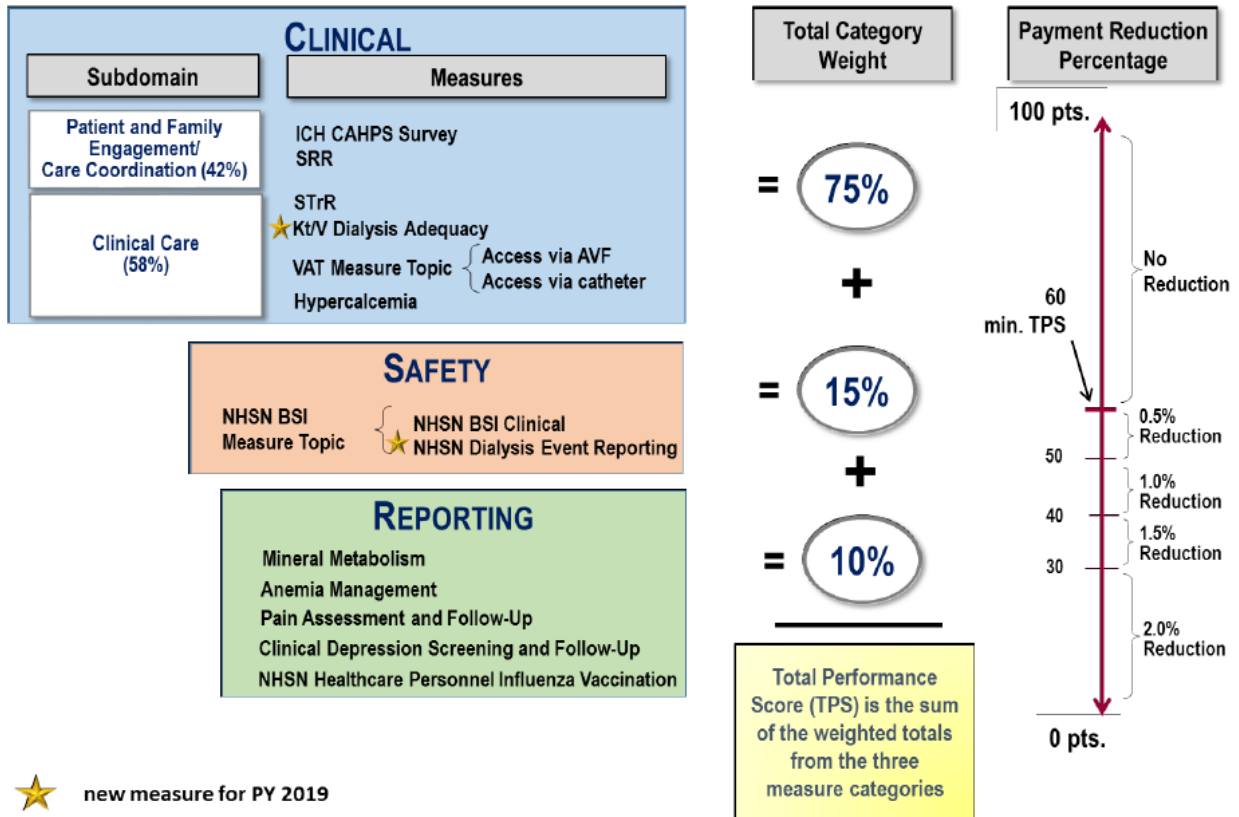
(TPS). The remaining 25% of your facility's TPS is comprised of two safety measures for 15% of your TPS and five reporting measures for the remaining 10% of your facility's TPS. Facility measures are scored by achievement (a comparison to set goals) or by improvement (a comparison to previous facility performance). The minimum Total Performance Score required for a zero payment reduction is 60 points.

(Example below is from the National Provider Call, held January 17, 2017, regarding CMS' final rule for PY 2019 and 2020: <https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2017-01-17-ESRD-QIP-Presentation.pdf>)

For more information on the QIP from CMS, visit the CMS ESRD Quality Incentive Program website:

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/index.html>

PY 2019 Scoring and Payment Reduction Methodology



★ new measure for PY 2019



Where Does the Data Come From?

CMS collects data from Medicare reimbursement claims, the National Healthcare Safety Network (NHSN), CROWNWeb, and vendors who report data for the In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS). The estimated scores and payment reductions are released in a Preview Score Report (PSR) to facilities. Then there is a 30 day Preview Period for facilities to review these calculations and submit any clarification questions or formal inquiries regarding the scores. CMS will adjust the scores where required and submit the payment reductions to the Center for Medicare (CM). Final results are typically released mid-December of the Calendar Year in a Final Performance Score Report (PSR) for facilities and a Performance Score Certificate (PSC) to be posted for patients in English and Spanish in a prominent patient area in each facility. These are downloaded from the QualityNet website and facilities will receive notices and reminders from the Network to access them when they become available.

What is your facility's score? Below is an example of the Performance Score Certificate to be posted.

The same information that appears on the PSC will also appear on the Dialysis Facility Compare website available at <http://www.medicare.gov/DialysisFacilityCompare/search.html>.

CMS updates the information posted on the Dialysis Facility Compare website each quarter.

|  | U.S. DEPARTMENT of HEALTH & HUMAN SERVICES CENTERS for MEDICARE & MEDICAID SERVICES | |  | |
|--|--|-------------------------|---|-----------------|
| | End-Stage Renal Disease Quality Incentive Program 2016 Certificate of Dialysis Facility Performance – Part 1 | | | |
| | | | Facility CMS Certification Number: 999999 | |
| ** To obtain scores and rates, CMS compares data from 2012 and 2013 to data from 2014. ** | | | | |
| A Sample Facility, City, State | | | | |
| TOTAL PERFORMANCE SCORE: 87 out of 100 National Average: 73 out of 100 | | | | |
| <div style="border: 2px solid red; padding: 5px; display: inline-block; color: red; font-weight: bold; transform: rotate(-2deg);"> Example Only </div> | | | | |
| Clinical Measures of Quality | Facility Percent in 2014 | National Median in 2012 | Facility Percent in 2013 | Facility Score |
| Hemoglobin > 12g/dL <i>(Shows how well a facility keeps red blood cell counts at an acceptable level – lower score desirable)</i> | 0% | 0% | 0% | 10 of 10 |
| Kt/V Dialysis Adequacy – Hemodialysis <i>(Shows how well a facility cleans blood during a dialysis treatment – higher score desirable)</i> | 96% | 93.4% | 93% | 8 of 10 |
| Kt/V Dialysis Adequacy – Peritoneal Dialysis <i>(Shows how well a facility cleans blood during a dialysis treatment – higher score desirable)</i> | N/A | 85.7% | N/A | N/A |
| Kt/V Dialysis Adequacy – Pediatric Hemodialysis <i>(Shows how well a facility cleans blood during a dialysis treatment – higher score desirable)</i> | N/A | 93% | N/A | N/A |
| Vascular Access Type – Fistula <i>(Compares access to a patient's bloodstream via fistula – higher score desirable)</i> | 88% | 62.3% | 86% | 10 of 10 |
| Vascular Access Type – Catheter <i>(Compares access to a patient's bloodstream via catheter – lower score desirable)</i> | 1% | 10.6% | 2% | 10 of 10 |
| NHSN Bloodstream Infection in Hemodialysis Outpatients <i>(Shows how well a facility prevented patient infections during treatment – lower score desirable)</i> | 0.296 | 0.861 | N/A | 8 of 10 |
| Hypercalcemia <i>(Shows how well a facility managed patient metabolism of calcium – lower score desirable)</i> | 4% | 1.7% | 14% | 7 of 10 |
| Quality Reporting Measures | | | Facility Performance in 2014 | Facility Score |
| Did the facility report anemia management information? | | | Yes | 10 of 10 |
| Did the facility report patient phosphorus levels? | | | Yes | 6 of 10 |
| Was the patient experience of care survey administered and delivered? | | | Yes | 10 of 10 |
| A Sample Facility Street Address City, State ZIP | _____ Facility Medical Director | | _____ /s/ Patrick Conway CMS Chief Medical Officer Deputy Administrator for Innovation and Quality | |

What are the QIP Measures?

End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP)

Facility performance in 2016 will be scored according to the PY 2018 rule and released in December 2017.

Facility performance in 2017 will be scored according to the PY 2019 rule and released in December 2018.

| | PY 2018 | PY 2019 |
|---|--|---|
| Measures | 11 Clinical NHSN BSI ICH CAHPS Standardized Readmission Ratio Kt/V Dialysis Adequacy Measure Topic (hemodialysis, peritoneal dialysis, pediatric hemodialysis, pediatric peritoneal dialysis) Standardized Transfusion Ratio VAT Measure Topic (fistula, catheter) Hypercalcemia 5 Reporting Mineral Metabolism Anemia Management Pain Assessment and Follow-Up Clinical Depression Screening and Follow-Up NHSN Healthcare Personnel Influenza Vaccination | 7 Clinical ICH CAHPS Standardized Readmission Ratio Kt/V Dialysis Adequacy (comprehensive) Standardized Transfusion Ratio VAT Measure Topic (fistula, catheter) Hypercalcemia 2 Safety NHSN BSI Measure Topic (NHSN BSI clinical, Dialysis Event reporting) 5 Reporting Mineral Metabolism Anemia Management Pain Assessment and Follow-Up Clinical Depression Screening and Follow-Up NHSN Healthcare Personnel Influenza Vaccination |
| Performance Period | CY 2016 (NHSN HCP reporting measure: 10/1/2015 – 3/31/2016) | CY 2017 (NHSN HCP reporting measure: 10/1/2016 – 3/31/2017) |
| Comparison Period | CY 2014 (achievement), CY 2015 (improvement) <i>Note: ICH CAHPS uses CY 2015 for both</i> | CY 2015 (achievement), CY 2016 (improvement) |
| Performance Standard | National Performance Rate (CY 2014); National Performance Rate (CY 2015) for ICH CAHPS | National Performance Rate (CY 2015) |
| Weighting | Clinical: 90% (Safety Subdomain 20%; Patient and Family Engagement/Care Coordination Subdomain 30%; Clinical Care Subdomain 50%) Reporting: 10% | Clinical: 75% (Patient and Family Engagement/Care Coordination Subdomain 42%; Clinical Care Subdomain 58%); Safety: 15%; Reporting: 10% |
| Minimum Data Requirements | Facility needs to qualify for at least one measure in the Clinical Measure Domain and at least one measure in the Reporting Measure Domain. | Facility needs to qualify for at least one measure in the Clinical Measure Domain and at least one measure in the Reporting Measure Domain. |
| Low-Volume Facility Score Adjustment | SRR: 11 – 41 index discharges; STR: 10 – 21 patient-years at risk; all other clinical measures: 11 – 25 cases | SRR: 11 – 41 index discharges; STR: 10 – 21 patient-years at risk; all other clinical measures: 11 – 25 cases |
| Minimum Total Performance Score | 49 points | 60 points |

Medical Review Board Recommendations

Goals for Clinical and Safety Performance Measures/Quality Indicators Calendar Year 2017/Payment Year 2019

- Network 14 endorses CMS Quality Incentive Program goals in lieu of setting additional Network-specific goals.
- Network 8 endorses the CMS Payment year 2019 Achievement Thresholds, Benchmarks, and Performance Standards (Quality Incentive Program goals) for clinical guidance.

| Clinical Performance Measures | Network 14 | | Network 8 | | |
|--|---|--------------------------|---|-----------------------------|----------------------|
| | Goals | Source | Achievement Threshold (15th percentile) | Benchmark (90th percentile) | Performance Standard |
| Kt/V Dialysis Adequacy (comprehensive) ⁺ | 97.74% | PY2019 QIP Benchmark | 86.99% | 97.74% | 93.08% |
| Hypercalcemia* | 0.32% | PY2019 QIP Benchmark | 4.24% | 0.32% | 1.85% |
| Vascular Access – Arteriovenous Fistula (AVF) | ≥ 68% | National CMS Goal | 53.66% | 79.62% | 65.93% |
| Vascular Access – Catheter ≥ 90 days* | < 10% | National CMS Goal | 17.20% | 2.95% | 9.19% |
| Standardized Readmission Ratio (SRR)* | 0.624 | PY2019 QIP Benchmark | 1.289 | 0.624 | 0.998 |
| Standardized Transfusion Ratio (STrR)* | 0.421 | PY2019 QIP Benchmark | 1.488 | 0.421 | 0.901 |
| NHSN Bloodstream Infection (BSI)* | 0.00 | PY2019 QIP Benchmark | 1.738 | 0 | 0.797 |
| ICH CAHPS – Nephrologists' Communication and Caring | 77.06% | PY2019 QIP Benchmark | 56.41% | 77.06% | 65.89% |
| ICH CAHPS – Quality of Dialysis Center Care and Operations | 71.21% | PY2019 QIP Benchmark | 52.88% | 71.21% | 60.75% |
| ICH CAHPS – Providing Information to Patients | 85.55% | PY2019 QIP Benchmark | 72.09% | 85.55% | 78.59% |
| ICH CAHPS – Overall Rating of Nephrologists | 76.57% | PY2019 QIP Benchmark | 49.33% | 76.57% | 62.22% |
| ICH CAHPS – Overall Rating of Dialysis Center Staff | 77.42% | PY2019 QIP Benchmark | 48.84% | 77.42% | 62.26% |
| ICH CAHPS – Overall Rating of the Dialysis Facility | 80.58% | PY2019 QIP Benchmark | 51.18% | 80.58% | 65.13% |
| Mortality, Hospitalization, Transplant | Facility is "As Expected" or "Better than Expected" | Dialysis Facility Report | | | |

⁺Denotes new measure for Calendar Year 2017

*On these measures, a lower rate indicates better performance

QIP Benchmark: 90th percentile of performance rates nationally during CY 2015

A Focus on Seven Clinical Measures

ICH CAHPS Survey

DATA SOURCES: ICH CAHPS, REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2744 to obtain certification date and facility type)

DESCRIPTION: Percentage of patient responses to multiple testing tools. Composite Score: The proportion of respondents answering each response option by item, summed across all items within a composite. Composites include: Nephrologists' Communication and Caring, Quality of Dialysis Center Care and Operations, and Providing Information to Patients Overall Rating: a summation of responses to the rating items grouped into 3 levels NQF #0258

This is an expanded measure that consists of three requirements:

1. Facilities must arrange to have a CMS-approved vendor administer the survey once during the spring (March, April, May) and once during the fall (September, October, November) of each year.
2. Facilities register on <https://ichcahps.org> to allow their vendors to submit data on their behalf.
3. Facilities ensure that their vendors submit results by the spring and fall deadlines.

HOW YOU CAN MAXIMIZE THIS SCORE:

- Identify a third-party vendor to conduct the survey.
- Ensure that this survey is administered during the spring and fall of each year.
- Focus on the specific needs of each individual patient
- Implement strategies to make patient centered care "real"
 - Put patient priorities first in the plan of care
 - Recognize need to bridge gaps in health literacy
 - Promote shared decision-making
 - Use proven techniques to engage patients; Motivational Interviewing, "Teach back"

ADDITIONAL INFORMATION:

1. Facilities are required to register on the <https://ichcahps.org> website in order to authorize a CMS-approved vendor to administer the survey and submit data on their behalf.
2. Facilities are required to administer the survey twice during the performance period, using a CMS-approved vendor.
3. Facilities are required to ensure that vendors submit survey data to CMS by the date specified at <https://ichcahps.org>.
4. Adult and pediatric facilities that treat fewer than 30 eligible patients during the eligibility period must attest to this in CROWNWeb in order to not receive a score on the measure; facilities that do not attest that they are ineligible will be considered eligible and will receive a score on the measure.
5. Facilities that do not administer two surveys during the performance period will receive a score of 0 on the measure.
6. Facilities that administer two surveys during the performance period but receive less than 30 completed surveys will not receive a score on the measure.

A Focus on Seven Clinical Measures (Continued)

Standardized Readmission Ratio (SRR)

DATA SOURCES: Medicare Claims, REMIS, CROWNWeb, and other CMS ESRD administrative data

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

This measure is defined to be the ratio of the number of Medicare-covered index discharges from acute care hospitals that resulted in an unplanned Medicare-covered readmission to an acute care hospital within 4–30 days of discharge for dialysis patients treated at a particular dialysis facility to the number of readmissions that would be expected given the discharging hospitals, the characteristics of the dialysis facility’s patients and the national norm for dialysis facilities.

The SRR should be considered in conjunction with the Standardized Hospitalization Ratio (SHR; NQF #1463). These two measures present two different aspects of dialysis facilities’ hospitalization use, both of which are important. The SHR gives a measure of hospitalization rates with reference to the totality of patients being served by a given facility. The SRR on the other hand uses as a denominator the number of hospitalizations for the given facility. A facility that has a very low SHR, corresponding to low hospitalization rates, together with a high SRR suggests the facility is managing patients well overall, but there appear to be some potential problems with transitions of care, such as hospital discharges. Alternatively, a facility might have a high SHR and a low SRR, indicating that there is an overall high utilization of hospital resources, but that the process of care after a discharge seems effective at reducing readmissions. (www.DialysisData.org)

HOW YOU CAN MAXIMIZE THIS SCORE:

- Start by tracking hospital admissions internally.
- Communicate with patients, especially those that recently had a hospital visit.
- Review medical records for patients recently hospitalized during QAPI meetings.
- Perform dry weight assessments and medication reconciliation post-hospitalization

ADDITIONAL INFORMATION:

1. A hospitalization is counted as an event in the numerator if it (a) occurred within 4 to 30 days of an index hospital discharge; and (b) is not considered a “planned” readmission
 2. Additional information about the measure can be found in the SRR Measure Methodology Report posted at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/061_TechnicalSpecifications.html.
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A Focus on Seven Clinical Measures (Continued)

Kt/V Dialysis Adequacy (comprehensive) New Measure for PY2019

DATA SOURCES: Medicare Claims, REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2728 to obtain the diagnosis date of ESRD and date of birth)

DESCRIPTION: Percentage of all patient months for patients whose average delivered dose of dialysis (either hemodialysis or peritoneal dialysis) met the specified threshold during the reporting period.

Adult Hemodialysis: percent of qualifying hemodialysis patient-months with $spKt/V \geq 1.2$ (calculated from the last measurement of the month)

Adult Peritoneal Dialysis: percent of qualifying peritoneal dialysis patient-months with $Kt/V \geq 1.7$ (dialytic + residual, measured within the past 4 months)

Pediatric Hemodialysis: percent of qualifying pediatric in-center hemodialysis patient-months with $spKt/V \geq 1.8$ (dialytic + residual, measured within the past 6 months)

HOW YOU CAN MAXIMIZE THIS SCORE:

- Measure your performance monthly.
- More dialysis time generally improves outcomes.
- Evaluate potential reasons for low scores.
- Dialysis prescription: time, blood, and dialysate flow rates, dialyzer, needle size.
- Patient vascular access issues (identify and eliminate circulation/flow problems)
- Error in blood sampling (what is the timing of lab draw, missing/erroneous labs, is there a process for follow up)
- Re-educate staff when indicated
- Monitor staff practices for compliance
- Increase patient's URR or Kt/V by increasing time on dialysis or increasing blood flow through the dialyzer

ADDITIONAL INFORMATION:

1. Must be calculated using UKM or Daugirdas II method.
2. Dialysis sessions per week is calculated as the number of dialysis sessions in the claim divided by the time period covered by the claim, with no rounding for the number of sessions per week. Frequent dialysis is determined by (i) calculated sessions per week is 4 or more for claims greater than 7 days, and total sessions is 4 or more for claims with 7 days or fewer; (ii) Kt/V is 8.88 on claim; (iii) Other administrative data (e.g. CROWNWeb) indicates 4 or more sessions per week.
3. The reported $spKt/V$ should not include residual renal function.
4. Patients with missing $spKt/V$ values or $spKt/V=9.99$ (not reported) are included in the denominator.
5. For Peritoneal dialysis patients, if no Kt/V value is reported for a given patient in a claim month, the most recent Kt/V value in the prior 4 months (adult) or 6 months (pediatric) is applied to the calculation for that month. For all in-center Hemodialysis patients, Kt/V must be reported during claim month. For all Home HD patients, Kt/V must be reported within 4 months of claim through date.

A Focus on Seven Clinical Measures (Continued)

Standardized Transfusion Ratio (STrR)

DATA SOURCES: Medicare Claims, REMIS, CROWNWeb, form 2728 to obtain the dialysis date of ESRD, and other CMS ESRD administrative data

DESCRIPTION: Risk adjusted facility level transfusion ratio (STrR) for all adult Medicare dialysis patients. STrR is a ratio of number of observed eligible red blood cell transfusion events occurring in patients dialyzing at a facility to the number of eligible transfusions that would be expected from a predictive model that accounts for patient characteristics within each facility.

The STrR is a ratio of the number of eligible red blood cell transfusion events observed in patients dialyzing at a facility, to the number of eligible transfusion events that would be expected under a national norm, after accounting for the patient characteristics within each facility. Eligible transfusions are those that do not have any claims pertaining to the comorbidities identified for exclusion, in the one year look back period prior to each observation window. This measure is calculated as a ratio, but can also be expressed as a rate.

HOW YOU CAN MAXIMIZE THIS SCORE:

- Review anemia management to lessen risks for transfusion
- Educate patients, families and medical providers to avoid unnecessary blood transfusions
- Focus on prevention and treatment of iron deficiency, inflammation and other causes of ESA resistance
- Monitor transfusion rates:
 - Build relationships with hospitals to get more complete and timely information
 - Medicare Hospital Conditions of Participation require transfer of discharge information prior to the next treatment
 - Educate staff to ask patients about blood transfusions post-hospitalization

ADDITIONAL INFORMATION:

1. Eligible transfusion events are those that do not have any claims pertaining to the comorbidities identified for exclusion, in the one year look back period prior to each observation window.
2. When a patient transfers from one facility to another, the patient continues to be attributed to the original facility for 60 days, at which point the patient is attributed to the destination facility.
3. A patient-month is considered eligible if it is within two months of a month in which a patient has \$900 of Medicare-paid dialysis claims or at least one Medicare-paid inpatient claim.
4. Additional information about the measure can be found in the STrR Measure Methodology Report posted at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/061_TechnicalSpecifications.html.

A Focus on Seven Clinical Measures (Continued)

VAT Measure Topic (Access via AVF)

DATA SOURCES: Medicare Claims, REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2728 to obtain the diagnosis date of ESRD and date of birth)

DESCRIPTION: Percentage of patient-months on hemodialysis during the last hemodialysis treatment of the month using an autogenous AV fistula with two needles. NQF#0257

This measure is intended to promote fistula use and penalize catheter use (infection control/patient safety). It is the percentage of patient-months for adult patients on maintenance hemodialysis (HD) during the last HD treatment of the month using an autogenous AV fistula with two needles. A patient is assigned to a facility if there is at least one claim meeting the inclusion criteria submitted by the facility during the reporting period. A patient can be mapped to more than one facility during a single patient-month. The denominator will include all patients who are at least 18 years old, have been on ESRD for greater than 90 days and who are determined to be maintenance hemodialysis patients as of the first day of the reporting month. Patients for whom access type is missing for the month are still included in the denominator. This is designed to encourage data reporting.

HOW YOU CAN MAXIMIZE THIS SCORE:

- It requires a team effort, collaboration, and trust.
- The nephrologist must play a central role.
- Make a vascular access plan for each patient.
- When possible, place fistula approximately three months before dialysis is needed.
- Establish a relationship of trust with primary care physicians and surgeons.
- Educate patients and their families.
- Start early and have a continuous education plan in place with specific “educator” roles by position (social worker, dialysis tech, nurse, dietician, etc.).
- Use simple terms and visuals/pictures.
- Stress the importance of protecting veins.
- Encourage patients referred late to consider home PD.
- Coach staff to properly cannulate fistula.
- Assign a “Vascular Access Coordinator.”
- Measure your rates and monitor to encourage changes in practice.

ADDITIONAL INFORMATION:

1. If claim indicates fistula and catheter, then only the fistula is counted.
2. The last claim of the month is used for calculation.

A Focus on Seven Clinical Measures (Continued)

VAT Measure Topic (Access via catheter)

DATA SOURCES: Medicare Claims, REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2728 to obtain the diagnosis date of ESRD and date of birth)

DESCRIPTION: Percentage of patient-months for patients on hemodialysis during the last hemodialysis treatment of month with a catheter continuously for 90 days or longer prior to the last hemodialysis session. NQF#0256

This measure is the percentage of patient-months for adult patients on maintenance hemodialysis (HD) during the last HD treatment of the month with a chronic catheter continuously for longer than 90 days prior to the last hemodialysis session. A patient is assigned to a facility if there is at least one claim meeting the inclusion criteria submitted by the facility during the reporting period. A patient can be mapped to more than one facility during a single patient-month. The denominator will include all patients who are at least 18 years old, have been on ESRD for greater than 90 days and who are determined to be maintenance hemodialysis patients as of the first day of the reporting month. Patients for whom access type is missing for the month are still included in the denominator. This is designed to encourage data reporting.

HOW YOU CAN MAXIMIZE THIS SCORE:

- It requires a team effort, collaboration, and trust (dedicated/persistent).
- The nephrologist must play a central role (share goals, facility catheter rates, strategies to increase AVF).
- Make a vascular access plan for each patient.
- When possible, place fistula approximately three months before dialysis is needed.
- Establish a relationship of trust with primary care physicians and surgeons.
- Educate patients, their families and all staff (mandatory staff meetings on the importance of reducing catheters)
- Start early and have a continuous education plan in place with specific “educator” roles by position (social worker, dialysis tech, nurse, dietician, etc.).
- Use simple terms and visuals/pictures.
- Stress the importance of protecting veins.
- Encourage patients referred late to consider home PD.
- Coach staff to properly cannulate fistula.
- Assign a Vascular Access Team (Vascular Access Coordinator/Vascular Access Manager)
- Measure your rates and monitor to encourage changes in practice.

ADDITIONAL INFORMATION:

1. If claim indicates fistula and catheter, then only the fistula is counted.
2. If a claim indicates catheter and graft, then only the graft is counted.
3. Measure uses claims data from October, November, and December of the year prior to the performance or comparison period (e.g., October – December 2016 for performance period) to determine catheter history
4. The last claim of the month is used for calculation.

A Focus on Seven Clinical Measures (Continued)

Hypercalcemia

DATA SOURCES: REMIS, CROWNWeb, and other CMS ESRD administrative data (to obtain the diagnosis date of ESRD, time at facility, and date of birth)

DESCRIPTION: Proportion of patient-months with 3-month rolling average of total uncorrected serum calcium greater than 10.2 mg/dL. NQF #1454

This measure focuses on the proportion of qualifying patient-months with three-month rolling average of total uncorrected serum calcium greater than 10.2 mg/dL.

HOW YOU CAN MAXIMIZE THIS SCORE:

- Report the serum calcium value monthly in CROWNWeb.
- Consider trends over time.
- Review patterns and temporal trends to make clinical decisions.
- Standardize clinical practices and methods of sample collections and processing.
- Dietitians counsel patients regarding phosphorus, calcium-based phosphate binders and Vitamin D analogue

ADDITIONAL INFORMATION:

1. November and December of the previous year will be used in calculating the three-month rolling average for January and February of the baseline and performance period.
2. Includes all patients (i.e., not just those patients on Medicare).
3. The last value reported in the month is used for calculation.
4. Any value reported during the two months prior to the reporting month will be used to calculate the 3-month rolling average.
5. No interpolation between uncorrected serum calcium values for peritoneal dialysis patients.
6. The uncorrected serum calcium value reported by the facility is used. The facility may obtain this value from an external source.
7. "Uncorrected" indicates albumin is not considered in the calculation.
8. Includes plasma as an acceptable substrate along with serum calcium.
9. Patient-months with missing values in the reporting month and the two months prior are included in the measure calculation to minimize any incentive favoring non-measurement of serum calcium in the three-month study period.

A Focus on Two Safety Measures

NHSN BSI Measure Topic (NHSN BSI Clinical and Dialysis Event reporting-New for PY2019)

DATA SOURCES: NHSN (for Risk-Adjusted Standardized Infection Rates), REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2744 to obtain facility type and certification date), Medicare claims and CROWNWeb (to determine patient-minimum exclusion)

DESCRIPTION: Number of hemodialysis outpatients with positive blood cultures per 100 hemodialysis patient-months. Based on NQF #1460

This is measured using a standardized number of qualifying hemodialysis outpatients with positive blood cultures per 100 hemodialysis patient-months. Facilities submit “accurately reported dialysis event data” to the Centers for Disease Control and Prevention (CDC). If a facility fails to report 12 months of data, the facility will receive zero points for this measure. Combining these two measures into a single Measure Topic balances incentives for a complete and accurate reporting along with effective clinical performance. The purpose of surveillance is to collect data uniformly so that meaningful comparisons can be made. The goal is to generate data that is useful for informing quality improvement decisions.

HOW YOU CAN MAXIMIZE THIS SCORE:

- Review the dialysis event protocol (<https://www.cdc.gov/nhsn/pdfs/pscmanual/8pscdialysiseventcurrent.pdf>) at least annually.
- Use the guides available on the NHSN website to assist in gathering data that must be reported.
- Complete NHSN trainings available on the CDC website (<http://www.cdc.gov/nhsn/training>).
- Promote infection prevention practices such as hand hygiene and immunizations.

ADDITIONAL INFORMATION:

1. Facilities are required to meet enrollment and training requirements, as specified at <http://www.cdc.gov/nhsn/dialysis/enroll.html> and <http://www.cdc.gov/nhsn/Training/dialysis/index.html>.
2. A positive blood culture is considered a new event and counted only if it occurred 21 days or more after a previously reported positive blood culture in the same patient.
3. Patients receiving inpatient hemodialysis are excluded from the measure.
4. Patients receiving only home hemodialysis or peritoneal dialysis are excluded from the measure.
5. Facilities that do not submit 12 months of accurately reported data receive zero points for the measure.
6. For more information about the methodology used to calculate risk-adjusted standardized infection rates, please see <http://www.cdc.gov/nhsn/dialysis/>.
7. Score based on number of months a facility reports data
 - 12 months: 10 points
 - 6 to 11 months: 2 points
 - 0 to 5 months: 0 points

A Focus on Five Reporting Measures

Mineral Metabolism

DATA SOURCES: Medicare Claims, REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2744 to obtain certification date, form 2728 to obtain the diagnosis date of ESRD)

DESCRIPTION: Number of months for which facility reports serum or plasma phosphorus values for each Medicare patient.

Each facility submits serum phosphorus data for each qualifying Medicare patient in CROWNWeb. The facility's score is based on the number of months it submits this data. For PY 2020, Serum Phosphorus will replace the Mineral Metabolism reporting measure. This measure is NQF #0255, which evaluates the extent to which facilities monitor and report patient phosphorus levels.

HOW YOU CAN MAXIMIZE THIS SCORE:

- Have a system to ensure review of each patient's serum phosphorus each month.
- Routinely request lab results from hospitals and transient dialysis providers.
- Review lab results and document the review in the patient record.

ADDITIONAL INFORMATION:

1. The serum or plasma phosphorus values reported by the facility are used. The facility may obtain these values from an external source.

2. The measure will be scored according to the following formula:

$$\left[\frac{\text{Number of Months Facility Successfully Reports}}{\text{Number of Months in the Performance Period Facility has CCN}} \times 12 \right] - 2$$

A Focus on Five Reporting Measures (Continued)

Anemia Management

DATA SOURCES: Medicare Claims, REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2744 to obtain certification date, form 2728 to obtain the diagnosis date of ESRD)

DESCRIPTION: Number of months for which facility reports ESA dosage (as applicable) and hemoglobin/hematocrit for each Medicare patient at least once per month.

Facilities must submit erythropoietin-stimulating agent (ESA) dosage (as applicable) and hemoglobin/hematocrit for each qualifying Medicare patient via billing claims data. The facility's score is based on the number of months it submits this data. (This is revised from PY 2015 to include home peritoneal dialysis patients.)

HOW YOU CAN MAXIMIZE THIS SCORE:

- Give special attention to hemoglobin trends.
- Investigate other causes contributing to anemia.

ADDITIONAL INFORMATION:

1. Hemoglobin value of 99.99 is not considered valid for purposes of measure. Note: we will not penalize facilities for using the default 99.99 value for a patient in his/her first month of treatment at that facility.
2. The hemoglobin/hematocrit reported by the facility is used. The facility may obtain this value from an external source.
3. No ESA dosage need be recorded if patient is not treated with ESAs.
4. ESA dosage must be reported via HCPCS codes and corresponding units, as applicable.
5. The measure will be scored according to the following formula:

$$\left[\frac{\text{Number of Months Facility Successfully Reports}}{\text{Number of Months in the Performance Period Facility has CCN}} \times 12 \right] - 2$$

A Focus on Five Reporting Measures (Continued)

Pain Assessment and Follow-Up

DATA SOURCES: REMIS, CROWNWeb, and other CMS ESRD administrative data

DESCRIPTION: Facility reports in CROWNWeb one of the six conditions below for each qualifying patient once before August 1, 2017 and once before February 1, 2018. Based on NQF #0420

CMS identified a need to incorporate a measure as part of the ESRD QIP that determines whether facilities regularly assess their patients' pain, and whether they develop follow-up plans as necessary. Authorized facility representatives are required to use CROWNWeb to report semi-annually one of six conditions (listed below under Additional Information) pertaining to the pain assessment and follow-up status of each qualifying patient.

HOW YOU CAN MAXIMIZE THIS SCORE:

- Educate staff members to this requirement
- Select a standardized tool
- Establish a record keeping system
- Set dates for the two required assessments in CY2017; reschedule any patients absent on the set dates
- Report data from first assessment data in CROWNWeb by August 1, 2017 and second assessment data by February 1, 2018

ADDITIONAL INFORMATION:

1. Facilities must report one of the following conditions for each eligible patient: a) Pain assessment using a standardized tool is documented as positive and a follow-up plan is documented b) Pain assessment documented as positive, a follow-up plan is not documented, and the facility possesses documentation that the patient is not eligible c) Pain assessment documented as positive using a standardized tool, a follow-up plan is not documented, and no reason is given d) Pain assessment using a standardized tool is documented as negative, and no follow-up plan required e) No documentation of pain assessment, and the facility possesses documentation the patient is not eligible for a pain assessment using a standardized tool f) No documentation of pain assessment, and no reason is given
 2. Conditions covering the first six months of the performance period must be reported in CROWNWeb before August 1, 2017, and the conditions covering the second six months of the performance period must be reported in CROWNWeb before February 1, 2018.
-

A Focus on Five Reporting Measures (Continued)

Clinical Depression Screening and Follow-Up

DATA SOURCES: REMIS, CROWNWeb, and other CMS ESRD administrative data

DESCRIPTION: Facility reports in CROWNWeb one of the six conditions below for each qualifying patient once before February 1, 2018. Based on NQF #0418

This measure was adopted as an opportunity to improve outcomes in patients' mental health and to promote person- and family-centered care. Under the screening, authorized facility representatives are required to use CROWNWeb to report one of six conditions (listed below under Additional Information) pertaining to the clinical depression screening and follow-up status for each qualifying patient annually.

HOW YOU CAN MAXIMIZE THIS SCORE:

- Educate staff members to this requirement
- Select a standardized tool
- Establish a record keeping system
- Set dates for the required assessment in CY2017; reschedule any patients absent on the set dates
- Report data in CROWNWeb by February 1, 2018

ADDITIONAL INFORMATION:

1. Facilities must report one of the following conditions for each eligible patient before February 1, 2018: a) Screening for clinical depression is documented as being positive, and a follow-up plan is documented b) Screening for clinical depression documented as positive, and a follow-up plan not documented, and the facility possess documentation stating the patient is not eligible c) Screening for clinical depression documented as positive, the facility possesses no documentation of a follow-up plan, and no reason is given d) Screening for clinical depression is documented as negative, and a follow-up plan is not required e) Screening for clinical depression not documented, but the facility possesses documentation stating the patient is not eligible f) Clinical depression screening not documented, and no reason is given

A Focus on Five Reporting Measures (Continued)

NHSN Healthcare Personnel Influenza Vaccination

DATA SOURCES: NHSN, REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2744 to obtain facility type and certification date)

DESCRIPTION: Facility submits Healthcare Personnel Influenza Vaccination Summary Report to CDC's NHSN system, according to the specifications of the Healthcare Personnel Safety Component Protocol, by May 15, 2017. Based on NQF #0431

CDC/NHSN encourages that HCP influenza vaccination summary counts be updated on a monthly basis and suggests that healthcare facilities update new counts within 30 days of the end of each month (e.g., all October data should be added by November 30). This is to ensure they have the greatest impact on influenza vaccination activities. However, entering a single influenza vaccination summary report at the conclusion of the measure reporting period will meet the minimum data requirements for NHSN participation.

As long as your facility is enrolled as the correct facility type, your CCN and CCN effective date are correct, and your data appear in the CMS Line Listing for the current reporting period in NHSN, no further action is required on your part. Your data will be shared with CMS following the reporting deadline established by CMS for your facility type.

HOW YOU CAN MAXIMIZE THIS SCORE:

- Performance period for this measure starts October 1 of the prior year
- Educate all personnel (everyone with potential patient contact) to this requirement
- Establish a record-keeping system
- Don't forget to include personnel starting after October 1 of the prior year
- Report your HCP influenza data by the deadline, May 15 of the current year

ADDITIONAL INFORMATION:

1. A "qualifying healthcare personnel" is defined as an employee, licensed independent practitioner, or adult student/trainee/volunteer who works in a facility for at least one day between October 1 and March 31 (designated as the "flu season")
2. NHSN Summary Reports submitted by May 15 would document actions taken during the flu season that spans October to April, and would count toward facilities' NHSN Healthcare Personnel Influenza Vaccination reporting measure scores
3. Additional information about the Protocol and Summary Report can be found at: <http://www.cdc.gov/nhsn/PDFs/HPS-manual/vaccination/HPS-flu-vaccine-protocol.pdf>.

What are the Next Steps?

The next steps are to ensure that you are part of the facility's plan to make your facility successful when it comes to the QIP. It's vital to understand what your position can do to influence each clinical and reporting measure. You may be able to directly influence all 14 measures, or maybe only two. The number of measures you can directly influence does not mean your job is any more important or less important than any other. In the team setting that is the dialysis facility, EVERYONE has, at the very least, an indirect influence over a number of things that can occur in your facility.

Stay current with the QIP measures. Be sure ALL team members (RNs, PCTs, MSWs, RDs and physicians) are aware of the QIP and the implications for payment. Remember that your facility must meet the performance standards (see Page 5) to avoid a payment reduction: AIM for MUCH HIGHER!

Training Opportunities

CROWNWeb

Facility Dashboard Training Sessions:

- * May 31 @ 1:00 pm
 - * June 7 @ 9:00 am and @ 1:00 pm
 - * June 13 @ 1:00 pm
- <http://mycrownweb.org/events/>

NHSN

Dialysis Event Surveillance Training

- * <https://nhsn.cdc.gov/nhsntraining/courses/2016/C18/>
- * Complete between January 1– September 30
- 2017 APIC Conference Live Training (June 14-16)
- * www.cdc.gov/nhsn/training/ (updates Summer 2017)

QIP Contact for ESRD Network 8

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QIP Contacts for ESRD Network 14

| | |
|-------------------------------|------------------------------|
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| QI Director | QI Specialist |
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| 469.916.3803 | 469.916.3802 |

Resources for the QIP

Centers for Medicare & Medicaid Services

www.CMS.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/

Centers for Disease Control and Prevention

www.cdc.gov/nhsn/dialysis/faq/faq-ESRD-QIP.html

ESRD Network of Texas, Inc.

www.esrdnetwork.org/professionals/qip/

Network 8, Inc.

<http://esrdnetwork8.org/dialysis-transplant-providers/quality-improvement/QI-overview.asp>

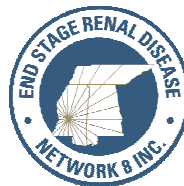
Calendar Year 2017 ESRD QIP Calendar

| January | February | March |
|--|---|---|
| <ul style="list-style-type: none"> • Post PSC PY 2016 in English and Spanish • ICH CAHPS 2016 Fall Survey Data Submission Deadline (1/25) | <ul style="list-style-type: none"> • ICH CAHPS 2017 Facility Non-Participation Form Deadline (2/28) • QDFC-Preview for April 2017 reports available (2/1) • QDFC-Preview for April 2017 comment period closes (2/15) | <ul style="list-style-type: none"> • CROWNWeb January Clinical closure • ICH CAHPS 2017 Spring Survey Vendor Authorization Deadline (3/8) • NHSN 2016 Q4 data due (3/31) |
| April | May | June |
| <ul style="list-style-type: none"> • CROWNWeb February Clinical closure • ICH CAHPS 2017 Spring Survey Pre-Notification Letters sent (4/21) | <ul style="list-style-type: none"> • CROWNWeb March Clinical closure • ICH CAHPS 2017 Spring Survey Data Collection Period (5/5-7/14) • QDFC-Preview for July 2017 reports available (5/1) • QDFC-Preview for July 2017 comment period closes (5/15) • NHSN HCP Influenza Vaccination (5/15) | <ul style="list-style-type: none"> • CROWNWeb April Clinical closure • ICH CAHPS 2017 Spring Survey Data Collection Period (5/5-7/14) • NHSN 2017 Q1 data due (6/30) |
| July | August | September |
| <ul style="list-style-type: none"> • CROWNWeb May Clinical closure • ICH CAHPS 2017 Spring Survey Data Collection Period (5/5-7/14) • ICH CAHPS 2017 Spring Survey Data Submission Deadline (7/26) • QDFC-Preview for October 2017 reports available (7/15) • FY 2018 DFR reports available (7/15) • PY 2020 Proposed Rule comment period begins • PY 2017 Preview PSR (submit formal inquiries or clarification questions) | <ul style="list-style-type: none"> • CROWNWeb June Clinical closure • ICH CAHPS 2017 Fall Survey Vendor Authorization Deadline (8/31) • QDFC-Preview for October 2017 comment period closes (8/15) • PY 2017 Preview PSR (submit formal inquiries or clarification questions) closes • Pain Assessment Screening (8/1) | <ul style="list-style-type: none"> • CROWNWeb July Clinical closure • NHSN 2017 Q2 data due (9/30) |
| October | November | December |
| <ul style="list-style-type: none"> • CROWNWeb August Clinical closure | <ul style="list-style-type: none"> • CROWNWeb September Clinical closure • QDFC-Preview for January 2018 reports available (11/1) • QDFC-Preview for January 2018 comment period closes (11/15) | <ul style="list-style-type: none"> • CROWNWeb October Clinical closure. • NHSN 2017 Q3 data due (12/31) • Post PSC PY 2017 in English and Spanish |

ESRD QIP Rulemaking: A Guide to the ESRD QIP Rules

Each year of the program, CMS writes a proposed rule, followed by a comment period and the publication of a final rule. All official CMS rules are published in the Federal Register (<https://www.federalregister.gov/>). CMS usually uses the annual ESRD Prospective Payment System rule to establish ESRD QIP rules each payment year. Below is a guide to each of the rules CMS has published about the ESRD QIP. Note that the "calendar years" (CYs) referenced in the rule titles refer to the time frames for the ESRD Prospective Payment System itself, not necessarily ESRD QIP PYs.

| Rule Title | Publication Date | ESRD QIP-specific Provisions |
|--|-------------------|--|
| ESRD Prospective Payment System Final Rule for CY 2011 | August 10, 2010 | Established general ESRD QIP provisions along with some information about PY 2012 http://edocket.access.gpo.gov/2010/pdf/2010-18466.pdf |
| ESRD QIP Final Rule (stand-alone) | January 5, 2011 | PY 2012 ESRD QIP http://www.gpo.gov/fdsys/pkg/FR-2011-01-05/pdf/2010-33143.pdf |
| ESRD Prospective Payment System Final Rule for CY 2012 | November 10, 2011 | PY 2013 and PY 2014 ESRD QIP http://www.gpo.gov/fdsys/pkg/FR-2011-11-10/pdf/2011-28606.pdf |
| ESRD Prospective Payment System Final Rule for CY 2013 | November 9, 2012 | PY 2015 ESRD QIP http://www.gpo.gov/fdsys/pkg/FR-2012-11-09/pdf/2012-26903.pdf |
| ESRD Prospective Payment System Final Rule for CY 2014 | December 2, 2013 | PY 2016 ESRD QIP (with some other future-year information) http://www.gpo.gov/fdsys/pkg/FR-2013-12-02/pdf/2013-28451.pdf |
| ESRD Prospective Payment System Final Rule for CY 2015 | November 6, 2014 | PY 2017 - PY 2018 http://www.gpo.gov/fdsys/pkg/FR-2014-11-06/pdf/2014-26182.pdf |
| ESRD Prospective Payment System Final Rule for CY 2016 | November 6, 2015 | PY 2019 ESRD QIP http://www.gpo.gov/fdsys/pkg/FR-2015-11-06/pdf/2015-27928.pdf |
| ESRD Prospective Payment System Final Rule for CY 2017 | November 4, 2016 | PY 2020 ESRD QIP https://www.gpo.gov/fdsys/pkg/FR-2016-11-04/pdf/2016-26152.pdf |



KIDNEY COLLABORATIVE



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www.esrdnetwork8.org

Phone: 601-936-9260
Fax: 601-932-4446
Patient Toll Free Line:
1-877-936-9260

Important Resources

Kidney School

www.kidneyschool.org

One of the BEST resources available for almost everything you need to know about kidney failure, dialysis and transplant. This site is organized into interactive, self-paced chapters.

Texas Department of State Health Services (TDSHS)

1-888-973-0022
www.dshs.state.tx.us

Bureau of Kidney Health

1-800-222-3986
www.dshs.state.tx.us/kidney/default.shtm

Medicare

Customer Service Line
1-800-813-8868
www.medicare.gov

United Network of Organ Sharing (UNOS)

1-800-292-9547
www.transplantliving.org

Medicare Part D

Updates and Information
<https://www.medicare.gov/part-d/index.html>

American Kidney Fund

1-800-638-8299
www.akfinc.org

American Association of Kidney Patients (AAKP)

1-800-749-AAKP
www.aakp.org

The Renal Support Network (RSN)

1-818-543-0896
www.rsnhope.org

National Kidney Foundation

www.kidney.org

Modality/Treatment Options

www.homedialysis.org

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