2017 Quality Incentive Program (QIP)
Quality Improvement Activity (QIA)

Improving Kt/V Comprehensive Measure Score

Tish Lawson Team Leader
February Kick Off Meeting
Overview

• Facility Selection
• QIP-QIA Project
• How to improve
  – IHI - Model for Improvement with Patient Environment
    • RCA
    • PDSA Cycles
  – Improvement Plan
  – Improvement Goals
  – QIP-QIA Tool-kit

• Kt/V Metrics
• Next steps
Why you are here today

- QIRN4 was awarded its second CMS - ESRD in 2016
- We are in the second year of this 5 year contract
- CMS requires QIRN4 to conduct eight Quality Improvement Activities (QIA’s)
- These QIA’s are geared toward assist Network 4 Dialysis facilities meet CMS's three AIMs (also known as the Triple Aim):
  - Better Care through Patient Engagement
  - Better Health for ESRD Patients
  - **Reduced Cost of ESRD Care by Improving Care**
- CMS requires us to have QIP-QIA
  - 2016 Network 4 Improved Hypercalcemia in 14 facilities
  - 2017 Network 4 is working to improve Kt/V Comprehensive Score for 8 facilities based on July, August and September 2016 CROWNWeb Data
  - Facilities chosen have the most opportunity for improvement

  and

are not already selected for two other Network QIA’s
What is the Kt/V

• Kt/V measures the removal of water-soluble urea
• Considered to be a useful metric to measure dialysis adequacy
  – Are patients getting enough dialysis
Why is Kt/V Important

- Hemodialysis patients receiving adequate Kt/V leads to better health outcomes
- Patients who receive a greater Kt dose than recommended have reduced mortality and hospitalization risk

www.kidney-international.org; F Maduell et al
Kt/V is a QIP Measure

- CY 2017; PY 2019
- Comprehensive Kt/V is a New Measure for 2017

**Clinical Measure Domain – 75% of TPS**
- Patient and Family Engagement/Care Coordination Subdomain – 42% of Clinical Measure Domain score
  1. ICH CAHPS
  2. Standardized Readmission Ratio (SRR)
- Clinical Care Subdomain – 58% of Clinical Measure Domain score
  1. Standardized Transfusion Ratio (STrR)
  2. Kt/V Dialysis Adequacy (comprehensive)
  3. Vascular Access Type (VAT) Measure Topic – Arteriovenous Fistula (AVF)
  4. VAT Measure Topic – Catheter ≥ 90 days
  5. Hypercalcemia

**Safety Measure Domain – 15% of TPS**
- 1. NHSN Bloodstream Infection (BSI) Measure Topic – NHSN Bloodstream Infection Clinical
- 2. NHSN BSI Measure Topic – NHSN Dialysis Event Reporting

**Reporting Measure Domain – 10% of TPS**
- 1. Mineral Metabolism
- 2. Anemia Management
- 3. Pain Assessment and Follow-Up
- 4. Clinical Depression Screening and Follow-Up
- 5. NHSN Healthcare Personnel Influenza Vaccination
Which patients are included in this measure?

- All patients at your facility who:
  - Received Peritoneal Dialysis
  - Received Hemodialysis
    - Received dialysis 3 times per week
    - At facility or on HH for > 90 days
What is the Kt/V Comprehensive Measure

• Combines both Dialysis Modalities
  – HD
  – PD
• Comes up with one score
What is the Score to Achieve?

• From the 2018 Achievement Thresholds, Benchmarks and Performance Standards: The individual standards are:
  – Adult Hemodialysis Standard
    • 97.24%
  – Adult Peritoneal Dialysis Standard
    • 89.47%
• Combined Standard
  – Both HD and PD
    • 93.08%
What can be done to improve Kt/V?

• Each facility may have different reason for not achieving the standard for Kt/V

• For this project, each facility must determine what is their root cause for low Kt/V Comprehensive Measure Score

• Three possible root causes:
  – Data related
  – Blood draw related
  – Treatment related
Examples of Data Related Root Causes

• Data in CROWNWeb is not accurate
  – Entered correctly
  – Batched correctly

• Do not have a process to assure the data
  – No one verifies the data
Examples of Lab Draw Related Root Causes

• What is the timing of lab draw?
• Are patients not getting their labs drawn?
• Is there a process to follow up on missing or erroneous lab draws?
What if it is a Treatment Related Root Causes

• The patient and the nephrologist need to discuss ways to improve it. Since the $V$ value is fixed, $Kt/V$ can be improved either by increasing $K$ or $t$.
  – Increase Blood Flow through the Dialyzer
    • Changes in PD or HD prescriptions
  – Increase Time on Dialysis or Dwell/Cycle Time
  – Identify and Eliminate Circulation/Flow Problems
What needs to be achieved

• Come up with an improvement plan that will increase your facility Kt/V comprehensive scores in CROWNWeb based on your RCA

• Continue working to improve your Kt/V results that are recorded in CROWNWeb to achieve:
  – 25% Relative Improvement from Baseline
  – Sustain for 3 months (rolling average)

• Once achieved improvement goal met and sustained 3 months, facility will Graduate from QIA
How to Improve and Graduate?

All facilities will use

Institute for Improving Healthcare

Methodology for Improvement

Standard for the Healthcare Industry
Pre work – Prior to Webinar

• Everyone was asked to view 4 You Tube Videos
  – Introduction to Quality Improvement by the IHI
  – Drilling down on a Problem using the “5 Why” method
  – RCA cause and effect analysis - Fishbone Diagram
  – What is a PDSA cycle and how to use it

• Sets the stage for the activities to be done for this QIA
List of You Tube Videos

http://www.ihi.org/resources/Pages/AudioandVideo/MikeEvansVideoQIHealthCare.aspx
Introduction to Quality Improvement – 8:09 Minutes

https://www.youtube.com/watch?v=B-M3YI2A2K9
Drilling down on a Problem using the “5 Why” method – 2:02 Minutes

https://www.youtube.com/watch?v=BW4qvULMJjs
Step by step review of how to perform a RCA cause and effect analysis – 3:08 minutes

https://www.youtube.com/watch?v=szLduqP7u-k
What is a PDSA cycle and how to use it – 3:12 Minutes

(This is not a required video but you may choose to watch it as well)
https://www.youtube.com/watch?v=ceS9Ta820
Example of PDSA cycle via the IHI 4:45 Minutes
Step One:

• Pull your treatment team together
  – Include a patient representative

• Together: Brainstorm and determine **What is your current process surrounding the monitoring Kt/V**
  – How and who schedules lab draws?
  – How and who draws the labs?
  – How and who is submitting Kt/V Values into CROWNWeb?
  – Do you have any way to QA the results in CROWNWeb?
  – What do you do when a patient has a low Kt/V results?
Step Two:

Root Cause Analysis Basics

Symptom of the problem. “The Weed”
Above the surface (obvious)

The Underlying Causes
“The Root”
Below the surface (not obvious)

The word root, in root cause analysis, refers to the underlying causes, not the one cause.
Root Cause Analysis

Once you agree on process:

• Brainstorm on what can go or DOES go wrong with your current process
  – Identify what are the current problems or potential problems with your care planning process as it is today
  – What can or does go wrong with the care planning process
  – What and who interference with the care planning process
  – What are the barriers in the care planning process

• Document your findings on the RCA form found in your tool kit
List all barriers and problems in Categories

Data Issues

Blood Draw Issue

Treatment Related Issues

Patient Related Issues

Staff Related Issues

Effect: Reduced Kt/V results

If you have any questions about filling this out please call me at 610-265-2418 x2841
Please email to Flawson@mw4.esrd.net or FAX to 1-610-783-0374 by COB on 3-29-17
Step Three:

• After your RCA, create an **initial** improvement plan
  – Build a plan that makes it **easy to do the right thing and hard to do the wrong thing**
    • Every system (process) is perfectly designed for the results it gets
    • Build your system (process) to meet your aim
  – Should involve a hard wired System Redesign

• Document your initial plan on the form in your tool kit

• **But how do you build a plan?**
Building your Improvement Plan

• Use the IHI Model for improvement - PDSA cycles to build your plan
  - Allows your team to Plan and “test” interventions that will lead to an improvement

• Allows you to find out if what you proposed to do works!

• Your Plan allows you to examine each step of the process
Use Rapid Cycle Process Improvement
Complete one full cycle

- ACT
  - What changes are to be made?
  - Next cycle?

- PLAN
  - Objective
  - Questions and Predictions (why)
  - Plan to carry out the cycle (who, what, where, when)

- STUDY
  - Complete the analysis of the data
  - Compare data to predictions
  - Summarize what was learned

- DO
  - Carry out the plan
  - Document problems and unexpected observations
  - Begin analysis of the data
Continue each month to achieve improvement

Building Knowledge with PDSA Tests

Evidence and Data

Theories And Best Practices

Very small scale

Follow up test

Test under new condition

Wide scale tests of change

Breakthrough Results
PDSA in Review

• Allows you to test your theory
• It may take several PDSA cycles and several months to get your process manageable
• That’s OK!
• Failure always teaches you something and is just as valuable as success
Quality Improvement is a *Process*, not an *Event*
Monthly Reporting and Network Monitoring

• Each month, continue to work on PDSA cycles  
  – Document your work  each month  on the PDSA Monthly Progress Report
    • Report will be submitted on line (see tool kit for instructions)
  – Document the number of patients who have Kt/V below 1.2 (HD) or 1.7 (PD)

• Monthly report will be due by the  COB on the 25th  (starting April)
  – *If the 25th is a weekend, please submit by the following Monday*
TAKE THE FIRST STEP
Better Kidney Health Begins With What You Know
Have you been diagnosed with kidney disease? Do you know that a kidney transplant is an option?
Gain control today by learning more about your treatment options.

PATIENTS & FAMILIES
Take an active role in the quality of your renal care. Quality care begins with you.

PROVIDERS
Browse resources and information for dialysis providers, clinicians and others.

REPORTING
Access Quality Insights Renal Network 4 reporting tools.

NEW PATIENT MATERIALS
Access the New Patient Orientation Packet from the National Coordinating Center.
**Facility Information**

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**Contact Information**

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**WARNING: DO NOT ENTER PHI / PII ON THIS FORM.** No PHI / PII in the following fields. Examples of PHI include patient name or initials, birthdate, SSN, etc.

Next Step: Enter Root Cause Analysis
Root Cause Analysis (RCA)

What are the top two failure modes (reasons) that you believe prevent your patients from achieving a personal treatment goal at your facility? (this will be the Focus of your monthly PDSA cycles)

Failure Mode (Reason) 1: 

Failure Mode (Reason) 2: 

Next Step: Monthly PDSA Cycle
Monthly PDSA Cycle Documentation

**Plan:** Describe your monthly plan to improve at least one identified failure mode(s) (include details such as Who, What, When)?

**Do:** Describe the interventions you did this month and what did you observe?

**Study:** Did you achieve your goal? Yes / No

What did you learn about the effectiveness of the interventions?

What are your lessons learned?

What Barriers (if any) did you discover? (Enter NA if none)

What new successes did you discover? (Enter NA if none)
Next PDSA Cycle Documentation

**Act:** What are you going to do for your next PDSA cycle?

**Metrics**

Number of patients who achieved their treatment goal by the reporting month:

Facility Census as of the last day of the month:

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Range

(50 - 250)

(50 - 250)
Monthly Data Collection Process

- Found at the bottom of the PDSA on line report

- **Numerator**
  - Number of HD patients with Kt/V < 1.2
  - Number of PD patients with Kt/V < 1.7

- **Denominator**
  - Number of patients in your facility at the end of each month
Review of Next Steps

• Pull together a work team: Provider, FA, SW, PCT, RN and Patient Representative
  – If no Patient Representative, attempt to appoint one

• Then using initial project forms in your tool kit to:
  1. Use work sheet to help brainstorm on current Kt/V Process provided in tool kit.
  2. Next, brainstorm on what can go wrong with that process that may be leading to patients having a low Kt/V. Use the Fishbone Diagram form provided in the tool kit to document these barriers and defects in your process.
  3. Then, using what you learned from step two, document your initial plan to improve these barriers or defects on the PDSA form provided in the tool kit
    • Create your first intervention that you theorize will lead to an improvement

Email or fax these two documents to the QIP-QIA Team Lead by no later than COB Wednesday March 29th, 2017
How to ensure success?

Facility Tool Kit; will be sent and include improvement tools

1. How to Improve: Articles and Links
   − QIRN4 Introductory Presentation
   − Web Links to Quality Improvement Training Videos
   − Improvement related Articles

2. Reporting Forms/Tools – and due dates (if applicable)
   − Current Process for Kt/V monitoring worksheet
   − QIP-QIA Fishbone Template (RCA) (due 3-29-17)
   − Initial PDSA Plan (due 3-29-17)
   − Monthly PDSA (Online or Fax) Reporting Instructions (due the 25th of each month starting April)

3. Kt/V Resources (articles, videos and presentations)
   − Kt/V Research
   − Related Articles
   − PY2019 Finalized Kt/V Comprehensive QIP Measure
If you get stuck....

- Review videos in the tool kit
- Call the Network Team Lead!!
QIRN 4’s Support

- QIRN4’s commitment to facility support
  - Provide Tool Kits after completion of Webinar
  - Provide Coaching
    - Email or phone calls as needed or site visit
Questions/Feedback

• Contact Tish Lawson RN MSN
  • 610-264-2418 ext. 2841
  • plawson@nw4.esrd.net