Network 18 Goals & Clinical Performance Measures 2020

Comagine Health
ESRD ALLIANCE | NETWORK 18

Category	Definition/ Justification	Network Goal
Coordination of Care: Electronic Medical Record or Health Information Exchange	The Network spent three years working to reduce both admission and readmission to the hospital. The most effective intervention was electronic medical records (eMR) or health information exchange (HIE) access that allowed the dialysis facility to know why the patient was hospitalized.	100% of Network facilities will have either eMR access or HIE access to their primary admitting hospital.
Home Modality	Among prevalent ESRD cases on December 31, 2017, 7.1% of patients treated using peritoneal dialysis and 1.9% of patients treated using home hemodialysis. (USRDS 2019) The Advancing American Kidney Health initiative has a goal of having 80% of new ESRD patients in 2025 either receiving dialysis at home or receiving a transplant.	Increase the number of dialysis patients on a home modality by 4% in 2020 and push toward 80% of incidents patients on a home modality.
Transplant Waitlist	The Advancing American Kidney Health initiative has a goal of having 80% of new ESRD patients in 2025 either receiving dialysis at home or receiving a transplant. A measure focusing on the waitlisting process is appropriate for improving access to kidney transplantation for several reasons. First, waitlisting is a necessary step prior to potential receipt of a deceased donor kidney (receipt of a living donor kidney is also accounted for in the measure). Second, dialysis facilities exert substantial control over the process of waitlisting. This includes proper education of dialysis patients on the option for transplant, referral of appropriate patients to a transplant center for evaluation, assisting patients with completion of the transplant evaluation process, and optimizing the health and functional status of patients in order to increase their candidacy for transplant waitlisting. (ESRD Measures Manual)	Increase the percentage of dialysis patients under the age of 75 who are on the transplant waitlist to at least 20%. (National average 18.8% DFR 2019)

Category	Definition/ Justification	Network Goal
Long Term Catheters (LTC)	CMS goal of 10% or less. Sepsis is the second leading cause of death among ESRD patients. Reducing use of Central Venous Catheters (CVCs) is a vital component of all facilities' infection prevention efforts as these patients are up to ten times more likely to contract a bloodstream infection (BSI). This measure reflects the clinics' ability to communicate, coordinate, and execute a comprehensive patient plan of care in a timely and effective manner. Facilities are measured on patients who only rely on a catheter for treatment; the catheter is considered 'long-term' if placed more than 90 days prior.	The facility should maintain a long-term (greater than 90 days) catheter rate less than 10%.
Ultrafiltration Rate (UFR)	The UFR measure is intended to guard against risks associated with high ultrafiltration (i.e., rapid fluid removal) rates for adult dialysis patients undergoing hemodialysis. Despite the majority of dialysis patients achieving targets for urea removal, the mortality rate among hemodialysis (HD) patients has remained unacceptably high. Published literature suggests that higher UFR is an independent predictor of mortality. Faster UFR (depending on the magnitude of interdialytic fluid loss and the duration of dialysis session) may lead to higher frequency of intradialytic hypotension (IDH), which currently occurs at high frequency and has been associated with higher mortality. Phenomena such as repetitive 'myocardial stunning,' recurrent central nervous system, bowel, and other organ-perfusion related damage could result if large volumes of fluid are removed rapidly during each dialysis session, with deleterious consequences for the patient, both in the short and longer term. (ESRD Measures Manual)	-The ultrafiltration rate should be <10-13 ml/kg/h for all in-center hemodialysis treatments. -Generous use of oral diuretics while RRF is still present (urine volume >150 ml/d). -Do not stop diuretics for Incident Hemodialysis patient when dialysis is initiated. Can prescribe during off hemodialysis days. -For Prevalent Hemodialysis patient, consider continuing oral diuretics as long as daily urine volume is >150 ml/d. -Continue dietary compliance to avoid excessive weight gain or increase frequency of hemodialysis sessions/week as needed.

Category	Definition/ Justification	Network Goal
Medication Reconciliation	With dialysis patients having a high pill burden, as well as multiple healthcare providers - who are not under the same electronic medical record potentially using different pharmacies – prescribing medication, dialysis patient are at high risk for medication errors. (ESRD QIP)	Medication Reconciliation will be completed for 100% of the facilities' patients each month and within two treatments after a hospitalization.
Hospitalization	Hospitalization rates are an important indicator of patient morbidity and quality of life. On average, dialysis patients are admitted to the hospital nearly twice a year and spend 11.2 days in the hospital a year. Hospitalizations account for approximately 40% of total Medicaid expenditures for ESRD patients. (ESRD Measures Manual)	Reduce hospitalizations to a rate of ≤ 1.5 time per year per patient.
Mortality Ratio	ESRD patients are an especially vulnerable population. Mortality measurement provides a generalized picture of each facility's patient population. In general, this ratio should trend down. (ESRD Core Survey Manual MAT)	Standardized mortality ratio (1.0 is average, >1.0 is worse): Reduce the facility standardized mortality ratio to less than the national average. Facilities with a rising mortality ratio should work to reverse the upward trend.
Emergency Reporting Requirements	By the Statement of Work (SOW) the Network is to educate facilities and patients on the actions to take during emergency and disaster situations. Emergency status reporting will be submitted using the KCER Emergency Situational Status Report (ESSR) and its associated Standard Operating Procedure (SOP). The Network is required to provide KCER with complete information regarding facility operational status, using the ESSR, as often as requested by KCER/CMS, but not less than daily.	To notify the Network of a facility closure, facilities complete the **Facility Temporary Closure / Interruption in Service Form**. This should be completed by a facility any time patients cannot make it to the facility due to an emergency/disaster situation, or the facility is closed for a full shift or more.

Category	Definition/ Justification	Network Goal
Chronic Kidney Disease, Dietary and Behavioral Health Education	Behavioral health is a vital component to supporting dietary education in individuals diagnosed with chronic kidney disease (CKD). Being diagnosed with CKD, at any stage, can be devastating to individuals and their family members. Often, individuals may not conceptualize the long-term impact of their condition due to lack of physical symptoms or the common defense mechanisms. Individuals often lack basic knowledge of health-promoting foods, or they live in a geographical area where the availability of such foods is scarce – such as in a food desert. Individuals diagnosed with chronic kidney disease may also have cognitive or mental health challenges that may interfere with their ability to fully comprehend the impact of the long-term health ramifications of improper diet and need for lifestyle changes. Providing evidenced-based interventions would not only support the patient but also provide education and relief to their family. Interventions that would work best with patients diagnosed with CKD include Motivational Interviewing and Cognitive Behavioral Therapy. Goals of behavioral health interventions to support patients diagnosed with CKD: • Decrease the progression of CKD to End Stage Renal Disease (ESRD) • Provide dietary and psycho-social education to improve every aspect of a patient's lifestyle • Provide culturally appropriate education • Be aware of mental health, financial, personal, career or housing concerns that may impact a patient's ability to follow education provided • Be aware of an individual's perceptions that may impact their ability to accept and make necessary changes • Fosters an individual's self-awareness to help them manage their own care.	To partner with local nephrologists, primary care providers, and patient groups to support and promote CKD education.