CONDITIONS for COVERAGE

OVERVIEW

• Conditions for Coverage are minimum health and safety standards.
• They are the foundation for improving care and protecting beneficiaries.
• Facilities must meet the Conditions for Coverage in order to be paid by Medicare and Medicaid.
• State Surveyors use these regulations to evaluate dialysis providers’ compliance with the laws.
Quality Assessment & Performance Improvement (QAPI)

494.110 Condition: QAPI

- Facilities **must** develop, implement, maintain and evaluate an effective, data-driven, quality assessment and performance improvement program.
- All professional members of the interdisciplinary team **must** participate.
- Program **must** reflect the complexity of the facility’s organization & services (including services provided under arrangement)
QAPI-continued

- **Must** focus on indicators related to improved health outcomes & the prevention and reduction of medical errors.
- Each facility **must** maintain & demonstrate evidence of its quality and performance improvement program for review by the surveyors for CMS.
- The facility **must** measure, analyze, and track the quality indicators it adopts or develops that reflect processes of care and facility operations.
<table>
<thead>
<tr>
<th>(V629) Adequacy</th>
<th>Kt/V, URR</th>
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<tbody>
<tr>
<td>(V630) Nutrition</td>
<td>Albumin, body weight</td>
</tr>
<tr>
<td>(V631) Bone disease</td>
<td>PTH, Ca+, Phos</td>
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<tr>
<td>(V632) Anemia</td>
<td>Hgb, Ferritin</td>
</tr>
<tr>
<td>(V633) Vascular access</td>
<td>↑Fistula, ↓catheter rate</td>
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<tr>
<td>(V634) Medical errors</td>
<td>↓Frequency of specific errors</td>
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<td>(V635) Reuse</td>
<td>↓Adverse outcomes</td>
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<td>(V636) Pt satisfaction</td>
<td>↑Survey scores</td>
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<td>(V637) Infection control</td>
<td>↓Infections, ↑vaccination status</td>
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<tr>
<td>Tag</td>
<td>Condition/Standard</td>
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<tr>
<td>V550</td>
<td>Vascular access</td>
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<td>V552</td>
<td>(6) Psychosocial status</td>
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<td>V555</td>
<td>(8) Rehabilitation status</td>
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<td>V556</td>
<td>(d) Patient education &amp; training</td>
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</tbody>
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494.110 Quality assessment & performance improvement (QAPI): The dialysis facility must develop, implement, maintain & evaluate an effective, data-driven QAPI program with participation by the professional members of the DTF. The program must reflect the complexity of the organization & services (including those under arrangement), & must focus on indicators related to improved health outcomes & the prevention & reduction of medical errors. The dialysis facility must maintain & demonstrate evidence of its QAPI program including continuous monitoring for CMS review.

V629 | (i) HD adequacy (monthly) | HD: Adult (patient with ESRD ≥ 3 mo) | Conditions for Coverage CMS CPM 4/1/2008 (all) | DFR Records |
| | (ii) PD adequacy (rolling average each patient tested ≤ 4 months) | PD: Adult | | |

V630 | (ii) Nutritional status | Unspecified in Conditions for Coverage & CPMs | Refer to parameters in Patient Assessment | Conditions for Coverage CMS CPM 4/1/2008 | DFR Records |


V632 | (iv) Anemia management | Mean hemoglobin (patient with ESRD ≥ 3 mo) | Conditions for Coverage CMS CPM 4/1/2008 | DFR Records |
| | Patients taking ESAs &/or Patients not taking ESAs | Mean hemacrit | Conditions for Coverage CMS CPM 4/1/2008 (all) | DFR Records |
| | Serum ferritin & transferrin saturation or ChE | | | |

V633 | (v) Vascular access (VA) | Cuffed catheter > 90 days | Evaluation of VA problems, causes, solutions | Conditions for Coverage CMS CPM 4/1/2008 | DFR Records |
| | AV fistulae for dialysis using 2 needles | | ESRD & chronic | DFR Records |
| | Thrombosis episodes | | | |
| | Infections per use-life of access | | | |
| | Patenty | | | |

V634 | (vi) Medical injuries & medical errors identification | Medical injuries & medical errors reporting | | Conditions for Coverage CMS CPM 4/1/2008 | Records |

V635 | (vii) Reuse | Evaluation of reuse program including evaluation & reporting of adverse outcomes | | Conditions for Coverage CMS CPM 4/1/2008 | DFR Records |

V636 | (viii) Patient satisfaction & grievances | Report & analyze grievances for trends CATHPS In-Center Hemodialysis Survey available Other surveys for pediatric & home patients | Prompt resolution of patient grievances | Conditions for Coverage CMS CPM 4/1/2008 | Records Interview |


V637 | | | Promote immunizations | | |

V638 | | | | | |

V627 | | | | | |

V628 | | | | | |

Source options: DFR=Diagnosis Facility Reports CW=CROWNWeb Chart-Patient Chart Records=Facility Records Interview=Patient/Staff Interview

Abbreviations: CFU=colony forming units; RKF=residual kidney function; CHr=reticulocyte hemoglobin; ESA=erythropoietin stimulating agent
Show Me The Progress!!

The facility must:

• Continuously monitor its performance
• Take actions that result in performance improvement
• Track to assure improvements are sustained over time
A Sound and Successful QAPI Program Provides:

- Improved patient outcomes
- Improved patient safety
- Increased customer satisfaction
- Improved staff morale
- Reduction of rework
- Cost savings
QAPI

Definitions

- Quality Assessment: A process of measuring health outcomes by tracking and analyzing quality indicators on an ongoing basis. Analyze facility processes to identify barriers to achieving desired outcomes.

- Performance Improvement: Development and initiation of facility processes of care and operations that include elements that must positively affect the desired outcomes.
QAPI

OR

QA ➔ PC ➔ PI

(planned change)

QAPCPI?
What is Change?

Change is a departure from an existing process or way of doing something, to a new process or a different way of doing the same thing.
Improving Through Change

REMEMBER:
All improvement requires change
BUT
Not all change IS improvement!
So How Do We Get Started?

- Our approach to quality improvement in healthcare needs to be focused on identifying areas for change, creating change, and measuring change.
Quality Assessment

• A process of measuring health outcomes by tracking and analyzing quality indicators on an ongoing basis.

• Analyze facility processes to identify barriers to achieving desired outcomes.
Developing your QAPI Plan

- Identify strategies
- All team members need to have a role
- Someone needs to be accountable and in charge
- Tasks need to be assigned and dates set to re-evaluate
- Plan needs to be dynamic – needs to be reviewed at least monthly
Develop a Goal Statement

• Where are we currently – why is this a problem?
  • What does our data show?
  • What is our trend?

• Where do we want to be?
  • What knowledge do we have?
  • What is our goal?
Setting Goals

- Be realistic
- Be specific
- Understand CMS or Network-set goals vs. facility or corporate-set goals
- Set both short term and long term
  - In order to reach our long term goal, what do we need to accomplish monthly, quarterly, etc. (Interim goals)
What Are We Trying to Accomplish?

Goal/Aim Statement

- Our rate for catheters >90 days is 35%
- KDOQI states that the 90 day catheter rate should be < 10%
- We will have a 25% catheter rate in 6 months
Changes Need to be...

- Evidenced Based
- Patient Centered
- System Based
Creating Change

- Evaluate processes
  - People, Policies, Procedures, Equipment
- Determine barriers to change
- Identify ways to overcome barriers
- Seek out best practices
- Create environment of collaboration
Root Cause Analysis

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.
What changes will result in an improvement: finding root causes

- Don’t stop with surface issues – go deeper
- Brainstorming to discover all root causes
  - All disciplines – all team members
- Use a root cause tool
  - Fishbone diagram
  - 5 Whys
  - Other tools
5 Whys

- Why did this occur?
- But why did that occur?
- So why did that occur?
- And then why did that occur?
- OK, so then why did that occur?
The 5 Whys is a question-asking method used to explore the cause/effect relationships underlying a particular problem. Ultimately, the goal of applying the 5 Whys method is to determine a root cause of a problem.

The following example demonstrates the basic process:

- Low AVF Rate (the problem)

4. *Why?* – Nephrologists unaware that Surgeon doesn’t understand importance of AVF as the optimal dialysis access. (fourth why)
5. *Why?* – No one has taken the time to communicate with and educate the Surgeon. (fifth why, a root cause)

The questioning for this example could be taken further to a sixth, seventh, or even greater level. This would be legitimate, as the "five" in 5 Whys is not gospel; rather, it is postulated that five iterations of asking why is generally sufficient to get to a root cause. The real key is to encourage the troubleshooter to avoid assumptions and logic traps and instead to trace the chain of causality in direct increments from the effect through any layers of abstraction to a root cause that still has some connection to the original problem.
What are the barriers?

- What are the barriers to overcoming these root causes?
- What barriers are within your control and what are not?
IHI Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What changes can we make that will result in an improvement?
Process Change

- People
- Policy
- Procedure
- Equipment
Using the Team to Drive Improvement

- Multidisciplinary
- Common Goal
- Day-to-Day Knowledge
- Physician Buy-in
The Interdisciplinary Team

- Medical Director
- Nurse Manager
- Dietitian
- Social worker
- Biomed Tech
- Others
  - Other nephrologists(?)
  - Surgeon
  - Staff members including PCTs
How will we know a change is an improvement?

Collect and trend data

- Identify sources of data
- Review and trend data monthly
- Analyze by various characteristics
- Draw conclusions with the team
How Will We Know a Change is an Improvement?

- We will collect baseline 90 day catheter rates at the beginning of the project.
- We will collect 90 day catheter data each month and trend.
- We will collect 90 days catheter data at the end of 6 months to evaluate the success of the project: Our catheter rate will be 25% or less.
Developing your QAPI Plan

**ACT**
- What changes are to be made?
- What will be the next cycle?

**PLAN**
- State the objective
- Develop a plan to carry out the cycle

**DO**
- Carry out the plan
- Document observations
- Analyze the data

**STUDY**
- Complete analysis
- Summarize what was learned

**Act**
- Plan

**Study**
- Do
Evaluate and Re-evaluate

- Review plan regularly
- Use data to determine – Are we improving?
- Are we seeing unintended consequences?
- Does the plan need revision?
- Should we bring others to the team? If so, who is the best person to help?
What do you do at the end??

- Evaluate!
  - Did we achieve our overall goal?
  - If not, why not?
  - If so, make it a permanent change
  - If not, what new strategies can we develop to try?
  - Are there best practices we can adopt?
  - Are there additional resources we need?
  - Are there new partners we can bring to the team?
Resources
Institute for Healthcare Improvement
QAPI Templates

Templates that have been developed and available on our Web site:

- Adequacy of Dialysis
- Anemia
- Vascular access
- Adverse Events, Medical Injuries and Errors
- Reuse
- Patient Satisfaction and Grievances
- Infection Control
- Transplant Referral

Templates under construction:

- Nutritional Status,
- Mineral Metabolism,

The Medical Director has operational responsibility for the QAPI program and ensures that data is used to develop actions to improve quality of care and must ensure that the facility’s program is effectively developed, implemented, maintained, and periodically evaluated.
QAPI Templates

Components Of The Templates Include:

- CQI Action Plans
- Barriers Questionnaire
- Data Collection Tools with Reports or Report Capability
- Needs Assessment Tool
Why Do QA(PC)PI?

- Because CMS says so?
- Because the Network is on my tail?
- Because we won’t get paid if our outcomes are bad?

Because it’s the right thing to do – the right care for every patient every time!
EFFECTIVE DATE

October 14, 2008
Time Flies
1 and a half years later!
Quality Assessment and Performance Improvement

Questions?