

December 11, 2020

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in a Quality Council Committee meeting at 7:00AM on Thursday, December 17, 2020, in the Kaweah Delta Lifestyle Center, Conference Room A, 5105 W. Cypress Avenue, or via GoTo Meeting from your computer, tablet or smartphone. <https://global.gotomeeting.com/join/881426077> or call (224) 501-3412 - Access Code: 881-426-077.

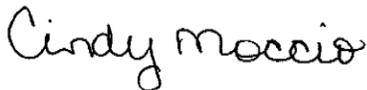
The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:01AM on Thursday, December 17, 2020, in the Kaweah Delta Lifestyle Center, Conference Room A, 5105 W. Cypress Avenue, pursuant to Health and Safety code 32155 & 1461. Board members and Quality Council closed session participants will access closed meeting via Confidential GoTo Meeting phone number provided to them.

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Quality Council Committee meeting at 8:00AM on Thursday December 17, 2020, in the Kaweah Delta Lifestyle Center, Conference Room A, 5105 Cypress Avenue, or via GoTo Meeting via computer, tablet or smartphone. <https://global.gotomeeting.com/join/881426077> or call (224) 501-3412 - Access Code: 881-426-077.

All Kaweah Delta Health Care District regular board meeting and committee meeting notices and agendas are posted 72 hours prior to meetings in the Kaweah Delta Medical Center, Mineral King Wing entry corridor between the Mineral King lobby and the Emergency Department waiting room.

Due to COVID 19 visitor restrictions to the Medical Center - the disclosable public records related to agendas can be obtained by contacting the Board Clerk at Kaweah Delta Medical Center – Acequia Wing, Executive Offices (Administration Department) {1st floor}, 400 West Mineral King Avenue, Visalia, CA via email: cmoccio@kdhcd.org, via phone: 559-624-2330 or on the Kaweah Delta Health Care District web page <http://www.kaweahdelta.org>.

KAWEAH DELTA HEALTH CARE DISTRICT
David Francis, Secretary/Treasurer



Cindy Moccio
Board Clerk, Executive Assistant to CEO

DISTRIBUTION:
Governing Board, Legal Counsel, Executive Team, Chief of Staff
<http://www.kaweahdelta.org>

**KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
QUALITY COUNCIL**

Thursday, December 17, 2020

5105 W. Cypress Avenue

The Lifestyle Center; Conference Room A

Call in option: 1-224-501-3412 Access Code: 881-426-077

ATTENDING: Board Members; David Francis – Committee Chair, Mike Olmos; Gary Herbst, CEO; Keri Noeske, RN, BSW, DNP, VP & CNO; Anu Banerjee, PhD, VP & Chief Quality Officer, Byron Mendenhall, MD, Chief of Staff; Monica Manga, MD, Professional Staff Quality Committee Chair; Daniel Hightower, MD, Secretary/Treasurer; Harry Lively, MD, Past Chief of Staff; Lori Winston, MD, DIO & VP of Medical Education; Tom Gray, MD, Quality and Patient Safety Medical Director; Sandy Volchko DNP, RN CLSSBB, Director of Quality and Patient Safety; Ben Cripps, Chief Compliance Officer, and Michelle Adams, Recording.

OPEN MEETING – 7:00AM

1. **Call to order** – *David Francis, Committee Chair*
2. **Public / Medical Staff participation** – Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves at this time. Members of the public or the medical staff may comment on agenda items after the item has been discussed by the Committee but before a Committee recommendation is decided. In either case, each speaker will be allowed five minutes.
3. **Approval of Quality Council Closed Meeting Agenda – 7:01AM**
 - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Monica Manga, MD, and Professional Staff Quality Committee Chair;*
 - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Anu Banerjee, PhD, VP & Chief Quality Officer*
4. **Adjourn Open Meeting** – *David Francis, Committee Chair*

CLOSED MEETING – 7:01AM

1. **Call to order** – *David Francis, Committee Chair & Board Member*
2. **Quality Assurance pursuant to Health and Safety Code 32155 and 1461** – *Monica Manga, MD, and Professional Staff Quality Committee Chair*
3. **Quality Assurance pursuant to Health and Safety Code 32155 and 1461** — *Anu Banerjee, PhD, VP & Chief Quality Officer*

4. Adjourn Closed Meeting – David Francis, Committee Chair

OPEN MEETING – 8:00AM

1. Call to order – David Francis, Committee Chair

2. Public / Medical Staff participation – Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves at this time. Members of the public or the medical staff may comment on agenda items after the item has been discussed by the Committee but before a Committee recommendation is decided. In either case, each speaker will be allowed five minutes.

3. Update: Clinical Quality Goals - A review of current performance and actions focused on the FY 2020 clinical quality goals. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*

4. Written Quality Reports – A review of key quality metrics and actions associated with the following improvement initiatives:

- 4.1. [Value Based Purchasing](#)
- 4.2. [Renal Services Report](#)
- 4.3. [Subacute & Transitional Care Unit](#)
- 4.4. [Infection Prevention Quarterly Dashboard](#)

5. Follow Up From Previous Meetings

- 4.1. Healthgrades
- 4.2. Bathing

6. [Hospital Acquired Pressure Injuries \(HAPI\) Quality Focus Team \(QFT\) Report](#) – A review of current performance and key improvement strategies from the recent Rapid Improvement Event. *Mary Laufer, DNP, RN, NE-BC, Director of Nursing Practice.*

7. [Handoff Communication Quality Focus Team \(QFT\) Report](#) – A review of measures and plan to enhance handoff communication between departments. *Kassie Waters, RN, MHA, CPHQ, Director of Cardiac Critical Care Services*

8. Adjourn Closed Meeting – David Francis, Committee Chair

In compliance with the Americans with Disabilities Act, if you need special assistance to participate at this meeting, please contact the Board Clerk (559) 624-2330. Notification 48 hours prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to the Kaweah Delta Health Care District Board of Directors committee meeting.



Value Based Purchasing Fiscal Year 2021

Quality Council – December 2020

Dr. Tom Gray, Medical Director Q&PS / Evelyn McEntire, QI Manager

Abbreviations

- CMS: Centers for Medicare and Medicaid Services
- DRG: Diagnosis Related Groups
- FY: Fiscal Year
- CY: Calendar Year
- TPS: Total Performance Score
- VBP: Value Based Purchasing
- CHA: California Hospital Association
- CAUTI – Catheter Associated Urinary Tract Infection
- CLABSI – Central Line Associated Blood Stream Infection
- COPD – Chronic Obstructive Pulmonary Disease
- MRSA - Methicillin-resistant Staphylococcus aureus

VBP Payment Method

- *“The Hospital VBP Program is funded by a 2% reduction from participating hospitals’ base operating diagnosis-related group (DRG) payments for FY 2018.*
- *Resulting funds are redistributed to hospitals based on their Total Performance Scores (TPS).*
- *The actual amount earned by each hospital depends on the range and distribution of all eligible/participating hospitals’ TPS scores for a FY.*
- *It is possible for a hospital to earn back a value-based incentive payment percentage that is less than, equal to, or more than the applicable reduction for that program year.”*

CMS Quality Patient Assessment Instruments



Value Based Purchasing Measures Fiscal Year 2021

- Payment adjustment effective for discharges from Oct 1, 2020 and Sept 30, 2021
- For outcomes reported in CY 2019 (Safety, Efficiency and Engagement Domains) and July 1, 2016 through June 30, 2019 for Clinical Care Domain

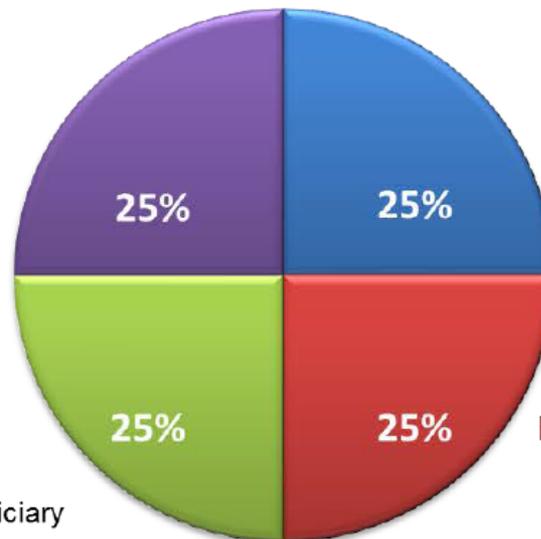
Safety

1. **CDI:** Clostridium difficile Infection
2. **CAUTI:** Catheter-Associated Urinary Tract Infection
3. **CLABSI:** Central Line-Associated Bloodstream Infection
4. **MRSA:** Methicillin-Resistant *Staphylococcus aureus* Bacteremia
5. **SSI:** Surgical Site Infection Colon Surgery & Abdominal Hysterectomy

Efficiency and Cost Reduction

1. **MSPB:** Medicare Spending per Beneficiary

Domain Weights



Clinical Care

1. **MORT-30-AMI:** Acute Myocardial Infarction (AMI) 30-Day Mortality Rate
2. **MORT-30-HF:** Heart Failure (HF) 30-Day Mortality Rate
3. **MORT-30-PN:** Pneumonia (PN) 30-Day Mortality Rate
4. **THA/TKA:** Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Complication Rate

Person and Community Engagement

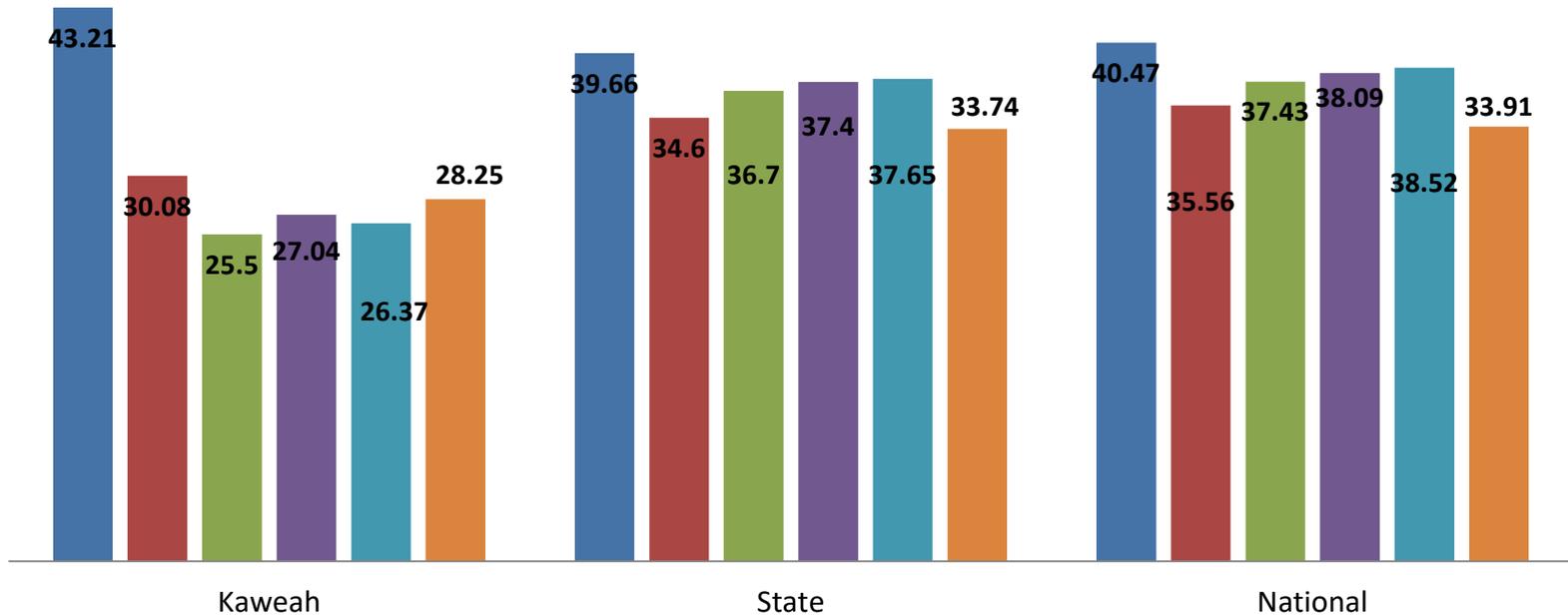
HCAHPS Survey Dimensions

1. Communication with Nurses
2. Communication with Doctors
3. Responsiveness of Hospital Staff
4. Communication about Medicines
5. Cleanliness and Quietness of Hospital Environment
6. Discharge Information
7. Care Transition
8. Overall Rating of Hospital

Kaweah Delta Performance - FY 2021 Payment Performance

Actual VBP Total Performance Score

■ FY 2016 ■ FY 2017 ■ FY 2018 ■ FY 2019 ■ FY 2020 ■ FY 2021



| FY 2021 CHA <u>ESTIMATED</u> VBP Cost Analysis | |
|---|---------------------|
| Contribution | Payment Percentage |
| 2% = \$1,889,800 | 1.48% = \$1,397,900 |
| (\$491,900) → | |

FY 2021 actual performance was slightly better than CHA's estimated performance. Actual VBP cost calculations are not available, but we expect to pay a slightly reduced VBP cost (less than \$491,900).

FY 2021 Actual VBP Points by Domain

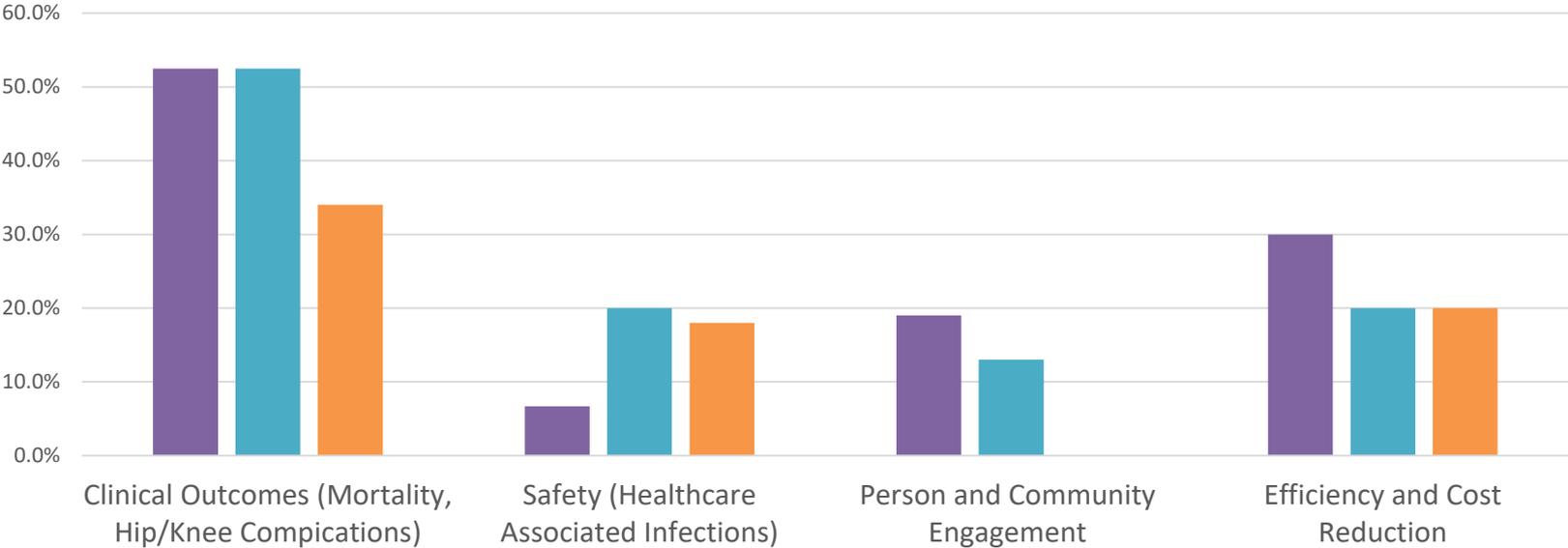
| Domains | FY 2021 (Points out of 10 Possible) |
|--|---|
| Clinical Outcomes - Domain Score (% of all points possible for this 25% of VBP) | 48% |
| Acute Myocardial Infarction | 7 |
| Heart Failure | 4 |
| Pneumonia* | 3 |
| COPD | 3 |
| Complication elective Total Hip/Knee | 7 |
| Safety - Healthcare Associated infections - Domain Score (% of all points possible for this 25% of VBP) | 38% |
| CLABSI - Per 1000 line days* | 0 |
| CAUTI - Per 1000 catheter days* | 0 |
| SSI Surgical Site Infection | 5 |
| SSI Colon - Rate Per 100 procedures | 5 |
| C. difficile - Per 10,000 patient days | 7 |
| MRSA - Per 10,000 patient days | 2 |
| Person and Community Engagement - Domain Score (% of all points possible for this 25% of VBP) | 15%** |
| Communication with Nurses | 0 |
| Communication with Doctors | 0 |
| Responsiveness of Hospital Staff | 1 |
| Communication about Medicines* | 0 |
| Cleanliness of Hospital Environment | 0 |
| Quietness of Hospital Environment* | 0 |
| Discharge Information | 0 |
| Care Transition | 0 |
| Overall Rating of Hospital* | 0 |
| Efficiency and Cost Reduction-Domain Score (% of all points possible for this 25% of VBP) | 20% |
| Medicare Spending per Beneficiary | 2 |

*Largest opportunity for Improvement

**Consistency Score

FY Comparison for VBP Domain Scores % of all Points Possible for the 25% Domain

FY 2019 Actual FY 2020 Actual FY 2021 Actual



Action Plan & Teams

Mortality

- Mortality committee meets once month and has identified the largest improvement opportunity is earlier palliative care. Disease-specific resource effectiveness teams are also working on best practices.

Hip & Knee Complications

- Orthopedic service line reviews all complications to assess if complications are true (re-code) and identify opportunities for improvement. Initiating Enhanced Recovery After Surgery (ERAS) program in 2020 which aims to reduce complications and decrease length of stay through implementation of evidenced-based care pathways.

Infection Prevention

- Infection prevention committees implement best practices for each measure. CAUTI and CLBASI Kaizen Events (Rapid Improvement) in Jan and Feb 2020 with robust action plans implemented. IV safety team continues round on all lines and monitor expired IVs. Hand Hygiene (HH) monitoring system (Biovigil) currently rolling out on a number of units with HH rates greater than 98%.

Patient Experience

- Continued implementation of “Operation Always” with department specific action plans, increased leader patient rounding, and use of new survey vendor in July 2019.

Medicare Spending

- Resource Effectiveness Committee and teams in place and reorganizing structure to maximize heightened focus on biggest opportunities to reduce costs.

Questions?



Kaweah Delta Dialysis Quality Report

The dialysis facility quality program consists of both internal data and external reviews and scores.

The Quality Assessment And Performance Improvement committee is a multidisciplinary committee that meets monthly and reviews data generated internally from the dialysis information system, Midas reports, facility maintenance and water quality reports and results of internal audits. We also periodically review external scores such as are presented below. The patient outcome data is a review of data that records measures of each parameter on 100% of patients, and is compared with external benchmarks such as from the USRDS, Medicare quality incentive program, KDOQI, ESRD network 18, etc. The result of this medical outcome data analysis is formulated changes in procedures or policies in order to drive the outcome to goal. Attached is the latest QAPI report for the facility (divided into hemodialysis and peritoneal dialysis).

Also attached are reports from outside agencies that use data collected either via claims or a reporting mechanism required of dialysis facilities to upload data to crown web. These reports include the dialysis facility report, dialysis facility compare, quality incentive program from CMS, and ICH CAH PS survey results.

A major focus of ongoing efforts based upon these reports are related to vascular access: a long-term issue that is been pernicious. Small gains only have been made over the last 2 years. The goal is to have as many arteriovenous fistulas as we can and reduce the use of long-term tunneled catheters. The former has less vascular infection and is a better long-term access.

Summary of external reports:

dialysis facility compare, 3 star rating (average) up from 2 stars last year

ICH CAH PS: most ratings in the 80 to 90%

CMS QIP: full payment for next year

dialysis facility report: no specific scoring methodology list data that we also track internally

Explanation of abbreviations:

ESRD: end-stage renal disease

KDOQI: kidney disease outcomes quality initiative

USRDS: US renal data systems

QIP: quality incentive program

QAPI: Quality Assessment And Performance Improvement

Quarterly Dialysis Facility Compare -- Preview Report for October 2020 Release

- **This Quarterly DFC Preview Report includes data specific to CCN(s): 050057 053506**

- **Purpose of the Report**

This report provides you with advance notice of the updated quality measures for your facility that will be reported on the Dialysis Facility Compare (DFC) website (<https://www.medicare.gov/dialysisfacilitycompare/>).

- **Overview**

This report was created for all Medicare certified dialysis facilities that are operating according to DFC in July 2020. The measures included in the report are based primarily on Medicare-paid dialysis claims, CROWNWeb, and other data collected for CMS. This report contains seven tables that summarize the patient outcomes and treatment patterns for chronic dialysis patients. Unless otherwise specified, data refer to all dialysis patients combined (i.e., hemodialysis and peritoneal dialysis, adult and pediatric). The measures reported in the Table "Quarterly Dialysis Facility Compare Preview", beginning on page 3, will be reported on the DFC website and available in the DFC downloadable databases at <https://data.medicare.gov> in October 2020.

Description of the methodology for all measures and the star rating in this report can be found in the *Guide to the Quarterly Dialysis Facility Compare Report* and the *Technical Notes on the Dialysis Facility Compare Quality of Patient Care Star Rating Methodology for the October 2018 Release*, both of which are available on the DialysisData website at www.dialysisdata.org.

- **What's New This Quarter**

The annual standardized ratio measures reported in Table 1 (Standardized Mortality Ratio, Standardized Hospitalization Ratio, Standardized Readmission Ratio, Standardized Transfusion Ratio, Standardized First Kidney Transplant Waitlist Ratio for Incident Dialysis Patients) have been updated this quarter using data during 2016-2019 for SMR, 2016-2018 for SWR, and January - December 2019 for the other standardized measures. The quarterly standardized measures (Standardized Fistula Rate and Percentage of Prevalent Patients Waitlisted) have also been updated using data during January - December 2019.

The Standardized Infection Ratio reported in Table 2 has been updated this quarter using data during January - December 2019.

The quarterly measures in Table 3 (hemoglobin) and Table 4 (hypercalcemia, serum phosphorus concentrations, Kt/V, long-term catheter rate, and nPCR) have been updated by one quarter, using data during January - December 2019.

ICH CAHPS patient experience of care measures in Table 5 have been updated this quarter.

The DFC quality of patient care star rating has been updated this quarter.

- **How to Submit Comments**

This preview period will be held during **July 15, 2020 - August 15, 2020**. As part of a process to encourage early requests of patient lists to allow sufficient time for facility review and inquiry during the preview period, patient list requests must now be made **within the first ten days** of the preview period. During the entire preview period, you may submit comments to CMS on the measures included in this report. Your comments will be shared with CMS but will not appear on the DFC website. Please visit the www.dialysisdata.org website, log on to view your report, and click on the **Comments & Inquiries** tab. If you have questions after the comment period is closed, please contact us directly at dialysisdata@umich.edu or 1-855-764-2885.

**Prepared by
The University of Michigan Kidney Epidemiology and Cost Center (UM-KECC) under contract with the
Centers for Medicare & Medicaid Services**

Quarterly Dialysis Facility Compare Preview: The following table displays measures for this facility as they will appear on the DFC website. Please refer to Table 1 for more information on hospitalization (admissions and readmissions), death, transfusion, fistula rate, transplant waitlist ratio, or percentage of patients waitlisted, Table 2 for infection, Table 3 for hemoglobin, Table 4 for mineral and bone disorder, dialysis adequacy and nutritional status measures, and long-term catheter reported in CROWNWeb, Table 5 for patient experience of care, and Table 6 for the quality of patient care star rating calculation. The quality of patient care star rating, Standardized Mortality, Hospitalization, Readmission, Transfusion, Waitlist, and Infection Rates/Ratios are updated annually in October; Patient Survey Results are updated semi-annually in April and October; all other measures are updated quarterly in January, April, July, and October. For a complete description of the methods used to calculate the statistics in this report, please see the *Guide to the Quarterly Dialysis Facility Compare Report*. The *Guide* is available on the Dialysis Data website at www.dialysisdata.org.

| Measure Name | This Facility |
|--|---|
| 1 Quality of Patient Care Star Rating (2016-2019, Table 6) | ★ ★ ★ ☆ ☆ Average |
| 2 Quality of Patient Care Table | |
| Avoiding hospitalizations and deaths (Table 1) | |
| 2.1 Frequency of patient death ¹ (2016-2019) Lower Confidence Limit (2.5%), Upper Confidence Limit (97.5%) Classification Category ² Number of included patients | 27.8 (per 100 patient-years) 23.3, 33.0 Worse than Expected 690 |
| 2.2 Frequency of hospital admission ¹ (2019) Lower Confidence Limit (2.5%), Upper Confidence Limit (97.5%) Classification Category ² Number of included patients | 162.5 (per 100 patient-years) 118.8, 235.0 As Expected 165 |
| 2.3 Frequency of hospital readmission ¹ (2019, percentage of hospital discharges) Lower Confidence Limit (2.5%), Upper Confidence Limit (97.5%) Classification Category ² Number of hospital discharges | 21.9% 15.0% , 30.2% As Expected 182 |
| Avoiding unnecessary transfusions (2019, Table 1) | |
| 2.4 Rate of Transfusions ¹ Lower Confidence Limit (2.5%), Upper Confidence Limit (97.5%) Classification Category ² Number of included patients | 9.3 (per 100 patient-years) 3.5, 29.5 As Expected 151 |
| Transplant waitlist (Table 1) | |
| 2.5 Transplant waitlist within a year of dialysis initiation (2016-2018) Lower Confidence Limit (2.5%), Upper Confidence Limit (97.5%) Classification Category ⁴ Number of included patients | 2.85 1.71, 4.45 Better than Expected 116 |
| 2.6 Patients who were on the kidney or kidney-pancreas transplant waiting list ³ (2019) Lower Confidence Limit (2.5%), Upper Confidence Limit (97.5%) Classification Category Number of included patients | 29.3% 18.3%, 43.2% Better than Expected 166 |
| Preventing bloodstream infections (2019, Table 2) | |
| 2.7 Preventing bloodstream infections: Standardized Infection Ratio Lower Confidence Limit (2.5%), Upper Confidence Limit (97.5%) Classification Category ² | 1.94 1.35, 2.69 Worse than Expected |

(continued)

Quarterly Dialysis Facility Compare Preview (continued):

| Measure Name | | This Facility |
|---|---|---|
| Using the most effective access to the bloodstream³ (2019) | | |
| 2.8 | Rate of fistula (Table 1) | 58.2% |
| | Lower Confidence Limit (2.5%), Upper Confidence Limit (97.5%) | 45.3%, 70.2% |
| | Classification Category ⁴ | As Expected |
| | Number of included patients | 184 |
| 2.9 | Adult patients who had a catheter (tube) left in a vein for at least three consecutive complete months, for the regular hemodialysis treatments (Table 4) | 29% |
| Removing waste from blood and nutritional status³ (2019, Table 4) | | |
| 2.10 | Adult patients who had enough waste removed from their blood during hemodialysis | 98% |
| 2.11 | Adult patients who had enough waste removed from their blood during peritoneal dialysis | 94% |
| 2.12 | Children who had enough waste removed from their blood during hemodialysis | Not Available |
| 2.13 | Children who had enough waste removed from their blood during peritoneal dialysis | Not Available |
| 2.14 | Children who had a monthly normalized protein catabolic rate (nPCR) measured during in-center hemodialysis | Not Available |
| Keeping a patient's bone mineral levels in balance³ (2019, Table 4) | | |
| 2.15 | Adult patients who had too much calcium in their blood | 1% |
| 3 | Survey of Patients' Experiences Table⁵ (Spring - Fall 2019, Table 5) | % of Always (Yes) Responses Star Rating |
| 3.1 | Kidney doctors' communication and caring | 73% ★★★★★☆ |
| 3.2 | Dialysis center staff care and operations | 72% ★★★★★☆ |
| 3.3 | Providing information to patients | 84% ★★★★★☆ |
| 3.4 | Rating of kidney doctors | 71% ★★★★★☆ |
| 3.5 | Rating of dialysis center staff | 89% ★★★★★★ |
| 3.6 | Rating of dialysis facility | 95% ★★★★★★ |
| 3.7 | Overall star rating | n/a ★★★★★☆ |

n/a = not applicable

[1] The facility rate was calculated by multiplying the facility ratio by the national rate. National rates for mortality, hospitalization, readmission, and transfusion are 22.4, 190.7, 27, 20.7, respectively. Calculation of rates using values in report may not equal actual rates shown due to rounding of values.

[2] If the facility SMR (SHR, SRR, STrR, or SIR) is less than 1.00 and statistically significant (p<0.05), the classification is "Better than Expected". This classification is based on the measure ratio, not the rate. If the ratio is greater than 1.00 and statistically significant (p<0.05), the classification is "Worse than Expected". Otherwise, the classification is "As Expected" on DFC. Please note that the SMR is not reported on DFC if it is based on fewer than 3 expected deaths. Similarly, the SHR and STrR are not reported if they are based on fewer than 5 or 10 patient years at risk, respectively. The SRR is not reported if the facility experienced fewer than 11 index discharges. The SIR is not reported if there are fewer than 12 months of reporting in NHSN and/or <= 131 eligible patient-months.

[3] Percentages based on fewer than 11 patients will be reported as "Not Available" on DFC.

[4] If the facility SFR (or SWR) is greater than national SFR (or SWR) and statistically significant (p<0.05), the classification is "Better than Expected". If the rate is less than national rate and statistically significant (p<0.05), the classification is "Worse than Expected". The classification is "Not Available" if a facility has fewer than 11 eligible adult HD patients for SFR (fewer than 11 patients or less than 2 expected events for SWR). Otherwise, the classification is "As Expected" on DFC.

[5] Survey results based on 29 or fewer completed surveys over the two survey periods will be reported as "Not Available" on DFC.

TABLE 1: Mortality, Hospitalization, Readmission, and Transfusion Summaries for Medicare Dialysis Patients, Fistula Use and Transplant Waitlist Summary for All Dialysis Patients¹

The mortality summaries reported in the first part of the table include all Medicare dialysis patients treated at your facility during 2016-2019. The hospital admission and transfusion summaries include all Medicare dialysis patients treated at your facility in 2019. The hospital readmission summaries include all Medicare-covered hospitalizations that ended in 2019 for all patients in your facility. The fistula use summaries include all adult hemodialysis patients treated at your facility in 2019. The transplant waitlist summaries include incident dialysis patients who are younger than 75 years old treated at your facility during 2016-2018. The transplant waitlist percent summaries include dialysis patients who are younger than 75 years old treated at your facility in 2019. State and national averages are included to allow for comparisons. SMR, SHR, SRR, STrR, and SWR are updated annually in October; SFR and PPPW are updated quarterly in January, April, July, and October.

| Measure Name | This Facility | Regional Averages ² , per Year | |
|--|------------------|---|------------------|
| | | State ⁸ | U.S. |
| Standardized Mortality Ratio (SMR) | 2016-2019 | 2016-2019 | 2016-2019 |
| 1a Medicare patients (n=number) ³ | 690 | 78.9 | 68.6 |
| 1b Patient-years at risk (n) | 476 | 50.0 | 41.2 |
| 1c Deaths (n) ³ | 133 | 10.7 | 9.2 |
| 1d Expected deaths (n) ³ | 107 | 10.6 | 9.2 |
| 1e Standardized Mortality Ratio ⁴ | 1.24 | 1.01 | 1.00 |
| Lower Confidence Limit ⁵ (2.5%) | 1.04 | n/a | n/a |
| Upper Confidence Limit ⁵ (97.5%) | 1.47 | n/a | n/a |
| 1f P-value ⁶ | 0.016 | n/a | n/a |
| 1g Mortality Rate (per 100 patient-years) ⁷ | 27.8 | n/a | 22.4 |
| Lower Confidence Limit ⁵ (2.5%) | 23.3 | n/a | n/a |
| Upper Confidence Limit ⁵ (97.5%) | 33.0 | n/a | n/a |
| Standardized Hospitalization Ratio (SHR): Admissions | 2019 | 2019 | 2019 |
| 1h Medicare patients (n) | 165 | 80.1 | 64.8 |
| 1i Patient-years at risk (n) | 123 | 49.8 | 41.3 |
| 1j Total admissions (n) | 192 | 90.5 | 77.7 |
| 1k Expected total admissions (n) | 225.4 | 91.8 | 78.6 |
| 1l Standardized Hospitalization Ratio (Admissions) ⁴ | 0.85 | 0.99 | 1.00 |
| Lower Confidence Limit ⁵ (2.5%) | 0.62 | n/a | n/a |
| Upper Confidence Limit ⁵ (97.5%) | 1.23 | n/a | n/a |
| 1m P-value ⁶ | 0.446 | n/a | n/a |
| 1n Hospitalization Rate (per 100 patient-years) ⁷ | 162.5 | n/a | 190.7 |
| Lower Confidence Limit ⁵ (2.5%) | 118.8 | n/a | n/a |
| Upper Confidence Limit ⁵ (97.5%) | 235.0 | n/a | n/a |
| Standardized Readmission Ratio (SRR) | 2019 | 2019 | 2019 |
| 1o Index discharges (n) | 182 | 82.4 | 70.7 |
| 1p Total readmissions (n) | 38 | 21.5 | 19.1 |
| 1q Expected total readmissions (n) | 46.7 | 21.9 | 19.5 |
| 1r Standardized Readmission Ratio ⁴ | 0.81 | 1.02 | 1.04 |
| Lower Confidence Limit ⁵ (2.5%) | 0.56 | n/a | n/a |
| Upper Confidence Limit ⁵ (97.5%) | 1.12 | n/a | n/a |
| 1s P-value ⁶ | 0.206 | n/a | n/a |
| 1t Readmission Rate (Percentage of hospital discharges) ⁷ | 21.9% | n/a | 27.0% |
| Lower Confidence Limit ⁵ (2.5%) | 15.0% | n/a | n/a |
| Upper Confidence Limit ⁵ (97.5%) | 30.2% | n/a | n/a |

(continued)

TABLE 1: Mortality, Hospitalization, Readmission, and Transfusion Summaries for Medicare Dialysis Patients, Fistula Use and Transplant Waitlist Summary for All Dialysis Patients¹ (continued)

| Measure Name | This Facility | Regional Averages ² , per Year | |
|---|------------------|---|------------------|
| | | State ⁸ | U.S. |
| Standardized Transfusion Ratio (STrR) | 2019 | 2019 | 2019 |
| 1u Adult Medicare Patients (n) | 151 | 70.4 | 55.4 |
| 1v Patient-years at risk (n) | 104 | 40.5 | 32.4 |
| 1w Total transfusions (n) | 10 | 8.2 | 6.5 |
| 1x Expected total transfusions (n) | 22.2 | 8.2 | 6.6 |
| 1y Standardized Transfusion Ratio ⁴ | 0.45 | 0.99 | 1.01 |
| Lower Confidence Limit ⁵ (2.5%) | 0.17 | n/a | n/a |
| Upper Confidence Limit ⁵ (97.5%) | 1.43 | n/a | n/a |
| 1z P-value ⁶ | 0.191 | n/a | n/a |
| 1aa Transfusion Rate (per 100 patient-years) ⁷ | 9.3 | n/a | 20.7 |
| Lower Confidence Limit ⁵ (2.5%) | 3.5 | n/a | n/a |
| Upper Confidence Limit ⁵ (97.5%) | 29.5 | n/a | n/a |
| Standardized Fistula Rate (SFR) | 2019 | 2019 | 2019 |
| 1ab Eligible adult HD patients (n) | 184 | 112.2 | 79.4 |
| 1ac Patient-months at risk (n) | 1,786 | 1,012.3 | 685.9 |
| 1ad Total fistula-months (n) | 1,005 | 683.5 | 431.6 |
| 1ae Standardized Fistula Rate ⁴ | 58.2% | 66.6% | 62.7% |
| Lower Confidence Limit ⁵ (2.5%) | 45.3% | n/a | n/a |
| Upper Confidence Limit ⁵ (97.5%) | 70.2% | n/a | n/a |
| 1af P-value ⁶ | 0.438 | n/a | n/a |
| Standardized First Kidney Transplant Waitlist Ratio for Incident Dialysis Patients (SWR) | 2016-2018 | 2016-2018 | 2016-2018 |
| 1ag Eligible patients (n=number) ³ | 116 | 13.6 | 10.3 |
| 1ah Patient-years at risk (n) | 100 | 12.1 | 9.2 |
| 1ai Transplant waitlist events or receipt of a living-donor transplant (n) ³ | 19 | 1.6 | 1.0 |
| 1aj Expected number of transplant waitlist or living-donor transplant events (n) ³ | 6.7 | 1.3 | 1.0 |
| 1ak Standardized Waitlist Ratio ⁴ | 2.85 | 1.17 | 1.00 |
| Lower Confidence Limit ⁵ (2.5%) | 1.71 | n/a | n/a |
| Upper Confidence Limit ⁵ (97.5%) | 4.45 | n/a | n/a |
| 1al P-value ⁶ | <0.01 | n/a | n/a |
| Percentage of Prevalent Patients Waitlisted (PPPW) | 2019 | 2019 | 2019 |
| 1am Eligible patients (n) | 166 | 96.3 | 69.1 |
| 1an Patient-months at risk (n) | 1,646 | 840.1 | 578.4 |
| 1ao Total waitlisted months (n) | 474 | 230.8 | 107.4 |
| 1ap Percentage of prevalent patients waitlisted ⁴ | 29.3% | 28.9% | 18.1% |
| Lower Confidence Limit ⁵ (2.5%) | 18.3% | n/a | n/a |
| Upper Confidence Limit ⁵ (97.5%) | 43.2% | n/a | n/a |
| 1aq P-value ⁶ | 0.044 | n/a | n/a |

n/a = not applicable

[1] See Guide, Section V.

[2] Values are shown for the average facility, annualized.

[3] Sum of 4 years (SMR) or 3 years (SWR) used for calculations; should not be compared to regional averages.

[4] Calculated as a ratio of observed deaths (or admissions/readmissions/transfusions/transplants waitlisted) to expected deaths (or admissions/readmissions/transfusions/transplants waitlisted) (1c to 1d for deaths, 1j to 1k for admissions, 1w to 1x for transfusions, 1ai to 1aj for waitlist), an adjusted rate of fistula use, or an adjusted percentage of patients waitlisted. Not shown if there are fewer than 3 expected deaths for SMR, fewer than 5 or 10 patient-years at risk for SHR or STrR, fewer than 11 index discharges for SRR, fewer than 11 eligible adult HD patients for SFR, fewer than 2 expected waitlisted events or fewer than 11 eligible patients for SWR, or fewer than 11 eligible patients for PPPW, respectively.

[5] The confidence interval range represents uncertainty in the value of the SMR, SHR, SRR, STrR, SFR, SWR, and PPPW due to random variation.

[6] A p-value less than 0.05 indicates that the difference between the observed and expected deaths (or admissions/readmissions/transfusions/transplants waitlisted), the difference between the fistula rate for your facility and the overall national fistula rate, or the difference between the percentage of prevalent patients waitlisted for your facility and the overall national percentage (PPPW) is probably real and is not due to random chance alone. A p-value greater than or equal to 0.05 indicates that the difference could plausibly be due to random chance.

[7] The facility rate was calculated by multiplying the facility ratio by the national rate. National rates for mortality, hospitalization, readmission, and transfusion are 22.4, 190.7, 27, 20.7, respectively. Calculation of rates using values in report may not equal actual rates shown due to rounding of values.

[8] State values not reported when < 3 Medicare-certified dialysis facilities exist in the state.
Produced by The University of Michigan Kidney Epidemiology and Cost Center (June 2020)

TABLE 2: Facility Bloodstream Infection Summary for Hemodialysis Patients based on National Healthcare Safety Network (NHSN) (January-December 2019)¹

This table displays bloodstream infection information for dialysis facilities as collected from the National Healthcare Safety Network. The measure is updated annually in October.

| Measure Name | | This Facility |
|---|---|---------------|
| Standardized Infection Ratio (SIR) | | 2019 |
| 2a | Eligible patient-months (n=number) | 1,762 |
| 2b | Observed bloodstream infections (n) | 33 |
| 2c | Predicted bloodstream infections (n) | 17.1 |
| 2d | Standardized Infection Ratio ² | 1.94 |
| | Lower Confidence Limit ³ (2.5%) | 1.35 |
| | Upper Confidence Limit ³ (97.5%) | 2.69 |

n/a = not applicable.

[1] See *Guide, Section VI*.

[2] Calculated as a ratio of observed infections to expected infections (2b to 2c for infections); not shown if there are fewer than 12 months of reporting in NHSN and/or <= 131 eligible patient-months.

[3] The confidence interval range represents uncertainty in the value of the SIR due to random variation.

TABLE 3: Facility Hemoglobin for Medicare Dialysis Patients based on Medicare Dialysis Claims (January-December 2019)¹

Anemia management is reported by quarter and for a one-year period. One-year state and national averages are included to allow for comparisons. The quarterly values are provided in order to allow for you to evaluate facility time trends and will not appear on DFC. This measure is based on all Medicare dialysis claims reported under the CCN(s) included in this report and is updated on DFC quarterly in January, April, July, and October.

| Measure Name | This Facility | | | | | Regional Averages ² | |
|----------------------------------|----------------------|----------------------|----------------------|----------------------|-------------------------|--------------------------------------|------------------------|
| | Q1 Jan'19--Mar'19 | Q2 Apr'19--Jun'19 | Q3 Jul'19--Sep'19 | Q4 Oct'19--Dec'19 | Q1-Q4 Jan'19--Dec'19 | State ⁴ Jan'19--Dec'19 | U.S. Jan'19--Dec'19 |
| Hemoglobin³ | | | | | | | |
| 3a Eligible patients (n=number) | 106 | 111 | 116 | 107 | 112 | 44.4 | 36.3 |
| 3b Hemoglobin < 10g/dL (% of 3a) | 15.1 | 18.9 | 23.3 | 16.8 | 10.7 | 15.1 | 19.6 |
| 3c Hemoglobin > 12g/dL (% of 3a) | 2.8 | 0.0 | 0.0 | 0.9 | 0.0 | 0.4 | 0.2 |

[1] See *Guide, Section VII*.

[2] Values are shown for the average facility. Measure values will be missing if there are no eligible patients/patient-months.

[3] Among patients with at least 1 eligible claim/quarter and 4 eligible claims/year: eligible claims include ESA-treated dialysis patients with ESRD for 90+ days at this facility.

[4] State values not reported when < 3 Medicare-certified dialysis facilities exist in the state.

TABLE 4: Facility Dialysis Adequacy, Nutritional Status, Long Term Catheter Use, and Mineral and Bone Disorder for Dialysis Patients based on CROWNWeb (January-December 2019)¹

Hypercalcemia, serum phosphorus concentrations, Kt/V, long term catheter, and nPCR are reported by quarter and for a one-year period. One-year state and national averages are included to allow for comparisons. The quarterly measures are provided in order to allow you to evaluate facility time trends and will not appear on DFC. These measures are based on CROWNWeb data and are updated on DFC quarterly in January, April, July, and October.

| Measure Name | This Facility | | | | | Regional Averages ² | |
|---|----------------------|----------------------|----------------------|----------------------|-------------------------|--------------------------------------|------------------------|
| | Q1 Jan'19--Mar'19 | Q2 Apr'19--Jun'19 | Q3 Jul'19--Sep'19 | Q4 Oct'19--Dec'19 | Q1-Q4 Jan'19--Dec'19 | State ⁹ Jan'19--Dec'19 | U.S. Jan'19--Dec'19 |
| Hypercalcemia | | | | | | | |
| 4a Eligible adult patients (n=number) | 180 | 186 | 184 | 180 | 209 | 117.5 | 82.6 |
| 4b Eligible adult patient-months (n) ³ | 515 | 523 | 529 | 505 | 2,072 | 1,062.7 | 723.1 |
| 4c Average uncorrected serum or plasma calcium >10.2 mg/dL ⁸ | 1.4 | 1.9 | 0.6 | 0.8 | 1.2 | 1.8 | 1.7 |
| Serum Phosphorus Concentrations | | | | | | | |
| 4d Eligible adult patients (n) | 193 | 195 | 184 | 185 | 215 | 122.3 | 86.9 |
| 4e Eligible adult patient-months (n) ³ | 550 | 546 | 536 | 502 | 2,134 | 1,093.2 | 747.1 |
| 4f Serum phosphorus categories (% , sums to 100%) | | | | | | | |
| <3.5 mg/dL | 11.3 | 9.5 | 10.4 | 7.6 | 9.7 | 7.7 | 7.9 |
| 3.5-4.5 mg/dL | 28.9 | 27.1 | 27.8 | 25.1 | 27.3 | 24.3 | 24.1 |
| 4.6-5.5 mg/dL | 26.7 | 27.3 | 28.7 | 29.5 | 28.0 | 32.2 | 30.9 |
| 5.6-7.0 mg/dL | 25.6 | 28.9 | 26.9 | 30.1 | 27.8 | 21.5 | 22.4 |
| >7.0 mg/dL | 7.5 | 7.1 | 6.2 | 7.8 | 7.1 | 14.3 | 14.7 |
| Kt/V⁴ | | | | | | | |
| 4g Eligible adult hemodialysis (HD) patients (n) ⁵ | 138 | 147 | 145 | 130 | 162 | 101.1 | 72.1 |
| 4h Eligible adult HD patient-months (n) ^{3,5} | 389 | 402 | 406 | 369 | 1,566 | 869.8 | 606.7 |
| 4i Eligible patient-months with Kt/V missing or out of range (n) | 3 | 1 | 0 | 3 | 7 | 10.4 | 7.8 |
| 4j Adult HD: Kt/V >=1.2 (% of 4h) | 96.9 | 96.8 | 98.5 | 98.6 | 97.7 | 97.0 | 97.1 |
| 4k Eligible adult peritoneal dialysis (PD) patients (n) | 27 | 28 | 28 | 31 | 37 | 36.6 | 22.1 |
| 4l Eligible adult PD patient-months (n) ³ | 76 | 75 | 74 | 90 | 315 | 300.8 | 172.7 |
| 4m Eligible patient-months with Kt/V missing or out of range (n) | 3 | 4 | 0 | 1 | 8 | 15.7 | 6.3 |
| 4n Adult PD: Kt/V >=1.7 (% of 4l) ⁶ | 88.2 | 90.7 | 98.6 | 96.7 | 93.7 | 89.4 | 91.3 |
| 4o Eligible HD pediatric patients (n) ⁵ | 0 | 0 | 0 | 0 | 0 | n/a | n/a |
| 4p Eligible HD pediatric patient-months (n) ^{3,5} | . | . | . | . | . | n/a | n/a |
| 4q Eligible patient-months with Kt/V missing or out of range (n) | . | . | . | . | . | n/a | n/a |
| 4r Pediatric HD: Kt/V >=1.2 (% of 4p) | . | . | . | . | . | 85.8 | 92.8 |
| 4s Eligible PD pediatric patients (n) | 0 | 0 | 0 | 0 | 0 | n/a | n/a |
| 4t Eligible PD pediatric patient-months (n) ³ | . | . | . | . | . | n/a | n/a |
| 4u Eligible patient-months with Kt/V missing or out of range (n) | . | . | . | . | . | n/a | n/a |
| 4v Pediatric PD: Kt/V >=1.8 (% of 4t) ⁷ | . | . | . | . | . | 62.7 | 73.1 |

(continued)

TABLE 4: Facility Dialysis Adequacy, Nutritional Status, Long Term Catheter Use, and Mineral and Bone Disorder for Dialysis Patients based on CROWNWeb (January-December 2019)¹ (continued)

| Measure Name | This Facility | | | | | Regional Averages ² | |
|---|----------------------|----------------------|----------------------|----------------------|-------------------------|--------------------------------------|------------------------|
| | Q1 Jan'19--Mar'19 | Q2 Apr'19--Jun'19 | Q3 Jul'19--Sep'19 | Q4 Oct'19--Dec'19 | Q1-Q4 Jan'19--Dec'19 | State ⁹ Jan'19--Dec'19 | U.S. Jan'19--Dec'19 |
| Long Term Catheter Rate | | | | | | | |
| 4w Eligible adult HD Patients (n) | 165 | 163 | 156 | 151 | 184 | 112.2 | 79.4 |
| 4x Patient-months at risk (n) ³ | 468 | 459 | 447 | 412 | 1,786 | 1,012.3 | 685.9 |
| 4y Long-Term Catheter Rate ⁸ | 29.3 | 31.8 | 29.5 | 24.5 | 28.9 | 12.1 | 12.9 |
| nPCR | | | | | | | |
| 4z Eligible pediatric in-center HD patients | 0 | 0 | 0 | 0 | 0 | n/a | n/a |
| 4aa Eligible pediatric in-center HD patient-months ³ | . | . | . | . | . | n/a | n/a |
| 4ab Percentage of pediatric in-center hemodialysis patient-months with documented monthly nPCR measurements | . | . | . | . | . | 92.1 | 91.6 |

[1] See *Guide, Section VIII*.

[2] Counts are shown for the average facility. Counts will be missing if there are no eligible patients/patient-months.

[3] Patients may be counted up to 12 times per year.

[4] Missing or out of range Kt/V values are supplemented with Medicare dialysis claims.

[5] HD Kt/V summaries are restricted to patients who dialyze thrice weekly.

[6] Adult PD Adequacy uses the most recent value over a 4-month look-back period.

[7] Pediatric PD Adequacy uses the most recent value over a 6-month look-back period.

[8] Missing values are included in the numerator.

[9] State values not reported when < 3 Medicare-certified dialysis facilities exist in the state.

TABLE 5: Patient Experience of Care based on ICH CAHPS (April 19, 2019 – July 12, 2019 and October 18, 2019 – January 10, 2020)¹

ICH CAHPS survey results are reported for three composite measures and three global items. Linearized score and star rating for each composite measure and an overall star rating are also shown. The data include the two most recent semi-annual surveys. State and National averages are included to allow for comparisons. These measures are updated semi-annually in April and October.

| Measure Name | This Facility | Regional Statistics ² | |
|---|-------------------------|----------------------------------|-------------------------|
| | | State | U.S. |
| ICH CAHPS³ | Spring-Fall 2019 | Spring-Fall 2019 | Spring-Fall 2019 |
| 5a Number of Completed Surveys | 64 | 26,815 | 195,123 |
| 5b Response Rate (%) | 27 | 29 | 30 |
| Composite Measures³ | | | |
| 5c Percent of Patients reporting- Kidney doctors' communication and caring | | | |
| Always | 73 | 69 | 68 |
| Sometimes | 9 | 14 | 14 |
| Never | 18 | 17 | 18 |
| Linearized Score | 83 | 82 | 81 |
| Star Rating | ★★★★☆ | n/a | n/a |
| 5d Percent of Patients reporting- Dialysis center staff care and operations | | | |
| Always | 72 | 65 | 63 |
| Sometimes | 13 | 19 | 19 |
| Never | 15 | 16 | 18 |
| Linearized Score | 84 | 81 | 80 |
| Star Rating | ★★★★☆ | n/a | n/a |
| 5e Percent of Patients reporting- Providing information to patients | | | |
| Yes | 84 | 82 | 81 |
| No | 16 | 18 | 19 |
| Linearized Score | 84 | 82 | 81 |
| Star Rating | ★★★★☆ | n/a | n/a |
| Global Items³ | | | |
| 5f Percent of Patients- Rating of kidney doctors | | | |
| Most favorable | 71 | 62 | 61 |
| Middle favorable | 19 | 26 | 25 |
| Least favorable | 10 | 12 | 14 |
| Linearized Score | 88 | 86 | 85 |
| Star Rating | ★★★★☆ | n/a | n/a |
| 5g Percent of Patients- Rating of dialysis center staff | | | |
| Most favorable | 89 | 67 | 64 |
| Middle favorable | 9 | 24 | 25 |
| Least favorable | 2 | 9 | 11 |
| Linearized Score | 94 | 88 | 86 |
| Star Rating | ★★★★★ | n/a | n/a |

(continued)

TABLE 5: Patient Experience of Care based on ICH CAHPS (April 19, 2019 – July 12, 2019 and October 18, 2019 – January 10, 2020)¹ (continued)

| Measure Name | This Facility | Regional Statistics ² | |
|---|------------------|----------------------------------|------------------|
| | | State | U.S. |
| Global Items ³ | Spring-Fall 2019 | Spring-Fall 2019 | Spring-Fall 2019 |
| 5h Percent of Patients- Rating of dialysis facility | | | |
| Most favorable | 95 | 72 | 69 |
| Middle favorable | 2 | 19 | 20 |
| Least favorable | 3 | 9 | 11 |
| Linearized Score | 95 | 89 | 87 |
| Star Rating | ★★★★★ | n/a | n/a |
| 5i Overall Star Rating | ★★★★☆ | n/a | n/a |

n/a = not applicable

[1] See *Guide, Section IX*.

[2] Values are shown for the average facility except for Number of Completed Surveys which is a total value.

[3] Not shown if there are 29 or fewer completed surveys over the two survey periods.

TABLE 6: Quality of Patient Care Star Rating Calculation¹

This star rating is based on the measures reported in the QDFC-Preview Report for the October 2020 Release and is updated annually each October on DFC. The time period for SMR in this table is 2016-2019; all other measures are 2019. Further description of the methodology can be found in *Section X* of the *Guide to the Quarterly Dialysis Facility Compare Report*.

| Calculation Definition | This Facility |
|--|---------------|
| 6a Standardized Outcomes Domain Score (average of 6c, 6e, 6g, and 6i) ² | 0.09 |
| 6b Standardized Mortality Ratio (SMR) ³ | 1.24 |
| 6c Measure Score: SMR ⁴ | -1.17 |
| 6d Standardized Hospitalization Ratio (Admissions) (SHR) ³ | 0.85 |
| 6e Measure Score: SHR ⁴ | 0.32 |
| 6f Standardized Readmission Ratio (SRR) ³ | 0.81 |
| 6g Measure Score: SRR ⁴ | 0.45 |
| 6h Standardized Transfusion Ratio (STrR) ³ | 0.45 |
| 6i Measure Score: STrR ⁴ | 0.76 |
| 6j Other Outcomes 1 Domain Score ⁵ (average of 6l and 6n) ² | -1.52 |
| 6k Standardized Fistula Rate (SFR) ⁶ | 58.17 |
| 6l Measure Score: SFR ⁴ | -0.45 |
| 6m Long Term Catheter Rate ⁶ | 28.89 |
| 6n Measure Score: Catheter ⁴ | -2.58 |
| 6o Other Outcomes 2 Domain Score (average of 6u and 6w) ² | 0.50 |
| 6p Adult HD: Percentage of patients with Kt/V \geq 1.2 ⁶ | 97.70% |
| 6q Adult PD: Percentage of patients with Kt/V \geq 1.7 ⁶ | 93.65% |
| 6r Pediatric HD: Percentage of patients with Kt/V \geq 1.2 ⁶ | Not Available |
| 6s Pediatric PD: Percentage of patients with Kt/V \geq 1.8 ⁶ | Not Available |
| 6t Overall: Percentage of patients with Kt/V \geq specified threshold ⁷ | 97.02% |
| 6u Measure Score: Kt/V ⁴ | 0.48 |
| 6v Percentage of patients with uncorrected serum or plasma calcium $>$ 10.2 mg/dL ⁶ | 1.16% |
| 6w Measure Score: Hypercalcemia ⁴ | 0.51 |
| 6x Final Score (average of 6a, 6j, 6o)^{8,9} | -0.3104 |
| 6y Quality of Patient Care Star Rating | ★ ★ ★ ☆ ☆ |

[1] See *Guide, Section X*.

[2] The Domain Score is the average of the measure scores within that domain. If there is at least one measure in the domain, the missing measures in that domain are imputed with the average of the measure score to limit the non-missing measures from being too influential. If all measures in a domain are missing, then the domain score is not calculated.

[3] Calculated as a ratio of observed deaths (or admissions/readmissions/transfusions) to expected deaths (or admissions/readmissions/transfusions); not included in star rating calculation if there are fewer than 3 expected deaths for mortality, fewer than 5 or 10 patient-years at risk for admissions or transfusions, or fewer than 11 index discharges for readmissions, respectively.

[4] If a measure is Not Available, its measure score will be imputed with the average of the measure score to limit the non-missing measures from being too influential in calculation of the domain score.

[5] Facilities that serve only PD patients will not have any measures in this domain since their patients do not have fistulas or catheters. For these facilities, this domain was not included in the star rating calculation.

[6] Percentages based on 10 or fewer patients are shown in this table but will be reported as 'Not Available' on DFC.

[7] For improved ability to compare Kt/V in facilities with different types of patients in terms of modality or pediatric status, the adult and pediatric HD and PD Kt/V measurements were pooled into one measure. The percentage of patients that achieve Kt/V greater than the specified thresholds for each of the four respective patient types (adult PD patients, adult HD patients, pediatric HD patients, and pediatric PD patients) was weighted based on the number of patient-months of data available. If the overall Kt/V percentage is based on 10 or fewer patients, then it is reported as 'Not Available' in this table.

[8] Final score is the average of the 3 domain scores. If all measures in a given domain are missing, then there is no final score and no star rating computed with the exception of PD only facilities. PD only facilities are not eligible for Other Outcomes Domain 1 (SFR and catheter), therefore, they are only scored on the Standardized Outcomes Domain and Other Outcomes 2 Domain if they have at least one measure value in each of these two domains.

[9] The final score value has been truncated for display purposes.

Dialysis Facility Report for Fiscal Year (FY) 2021

Purpose of the Report

The *Dialysis Facility Report (DFR) for FY 2021* is provided as a resource for characterizing selected aspects of clinical experience at this facility relative to other caregivers in this state, ESRD Network, and across the United States. Since these data could be useful in quality improvement and assurance activities, each state's surveying agency may utilize this report as a resource during the FY 2021 survey and certification process.

This report has been prepared for this facility by the University of Michigan Kidney Epidemiology and Cost Center (UM-KECC) with funding from the Centers for Medicare & Medicaid Services (CMS) and is based primarily on data reported in CROWNWeb, Medicare claims and data collected for CMS. It is the twenty-fifth in a series of annual reports. This is one of 7,920 reports that have been distributed to ESRD providers in the U.S.

This DFR includes data specific to CCN(s): 050057 053506

Overview: This report includes summaries of patient characteristics, treatment patterns, and patient outcomes for chronic dialysis patients who were treated in this facility between January 2016 and December 2019. Mortality, hospitalization, transplantation, and waitlist statistics are reported for a three- or four-year period. Regional and national averages are included to allow for comparisons. Some of the summaries of patient mortality, hospitalization, transplantation, waitlist, vascular access, and anemia management are adjusted to account for the characteristics of the patient mix at this facility, such as age, sex and diabetes as a cause of ESRD. Unless otherwise specified, data refer to hemodialysis (HD) and peritoneal dialysis (PD) patients combined.

Selected highlights from this report are given on pages 2 through 5. For a complete description of the methods used to calculate the statistics in this report, please see the *Guide to the Dialysis Facility Reports for FY 2021*. The *Guide* may be downloaded from the methodology section of the Dialysis Data website at www.DialysisData.org.

What's New This Year: As part of a continuing effort to improve the quality and relevance of this report for your facility, the following changes have been incorporated into the DFR for FY 2021: Medicare Advantage patients are now excluded from the following measures:

- Standardized Hospitalization Ratio (SHR) for emergency department visits (Table 4)
- Influenza summaries (Table 7)
- Transfusion summaries (Table 8)
- Access-related infection summaries (Table 11)

How to Submit Comments

Between July 15, 2020 and August 15, 2020, facilities may submit comments to their state surveyor or UM-KECC by visiting www.DialysisData.org, logging on to view their report, and clicking on the **Comments & Inquiries** tab. Questions or comments after the comment period is over may be submitted to us directly at DialysisData@umich.edu or 1-855-764-2885.

- (1) **State Surveyor:** Select “**DFR: Comments on DFR for State Surveyor**” from the drop down list to submit comments regarding this report for the state's surveyor(s). Any comments submitted will be appended and sent to the state's surveyor(s) in September 2020. Please do not include questions for UM-KECC using this option.
- (2) **UM-KECC:** Select “**DFR: Comments on DFR for UM-KECC**” to submit questions or suggestions to improve the DFR to UM-KECC. These comments will not be shared with CMS or your state surveyor.

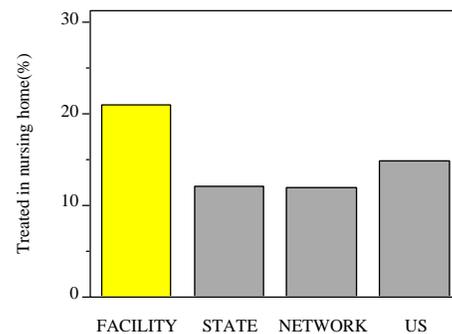
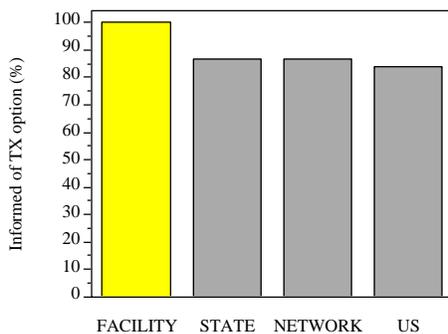
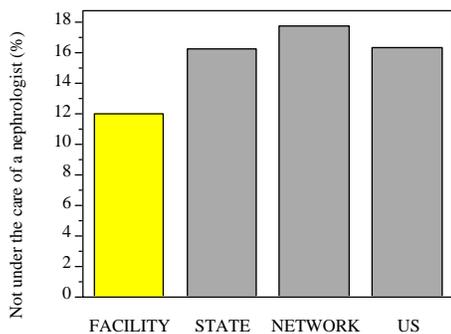
Facility Highlights

Bar charts in this section are displayed as a percentage for all measures reported and highlight the facility's value compared to the state, network, and US.

The line charts in this section are displayed for all standardized measures. The markers show the values of the corresponding standardized measure for this facility, state, network, and US. The bolded horizontal line shows the range of uncertainty due to random variation (95% confidence interval; significant if it does not cross the 1.0 reference line). Regional and national values are plotted above the dotted line to allow for comparisons to facility values.

Patient Characteristics (Tables 1 and 2):

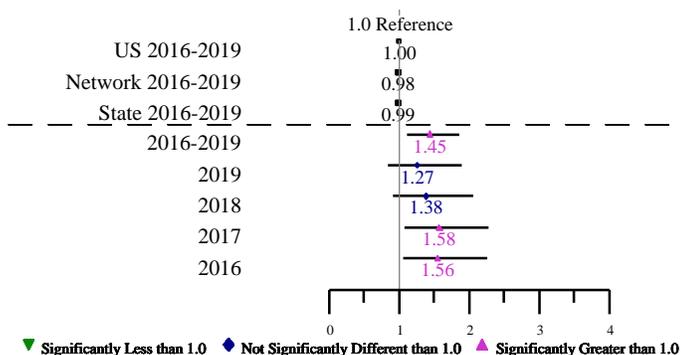
- Among the 25 incident patients with Medical Evidence Forms (CMS-2728) indicating treatment at this facility during 2019:
 - 12% of these patients were not under the care of a nephrologist before starting dialysis, compared to 16% in your State, 18% in your Network, and 16% nationally.
 - 100% of these patients were informed of their transplant options, compared to 87% in your State, 87% in your Network, and 84% nationally.
- Among the patients treated at this facility on December 31, 2019, 21% were treated in a nursing home during the year, compared to 12% in your State, 12% in your Network, and 15% nationally.



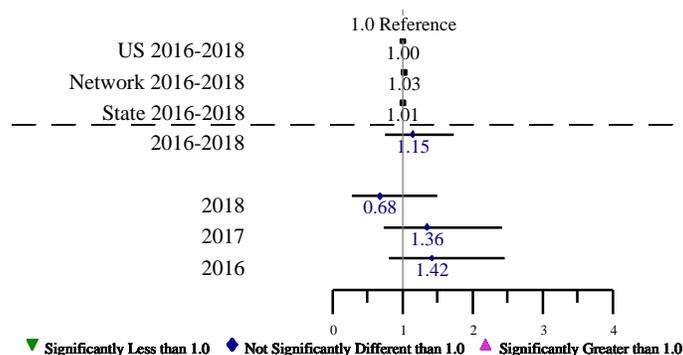
Standardized Mortality Ratio (SMR) (Table 3):

- At this facility, the 2016-2019 SMR is 1.45, which is 45% more deaths than expected at this facility. Among all U.S. facilities, 92% of facilities had a four-year SMR lower than 1.45. This difference is statistically significant ($p < 0.05$), so this higher mortality is unlikely to be due to random chance and probably represents a real difference from the expected mortality in the nation. The 2016-2019 SMR of observed to expected deaths is 0.99 and 0.98 for your State and Network, respectively.
- At this facility, the 2016-2018 first-year SMR of observed to expected deaths is 1.15, which is 15% more deaths than expected at this facility. Among all U.S. facilities, 66% of facilities had a first-year SMR lower than 1.15. This difference is not statistically significant ($p \geq 0.05$), so this higher mortality could plausibly be just a chance occurrence. The first-year SMR (2016-2018) of observed to expected deaths is 1.01 and 1.03 for your State and Network, respectively.

2016-2019 SMR



2016-2018 First-Year SMR



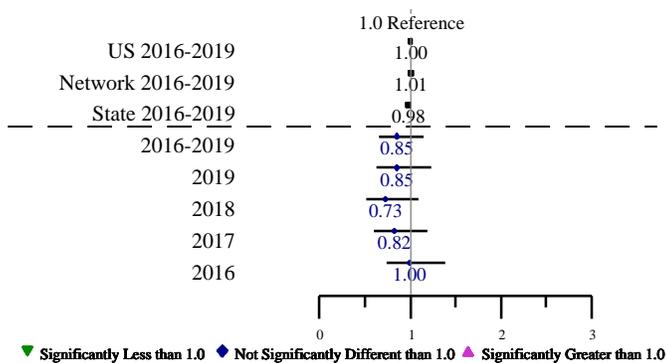
Dialysis Facility Report for Fiscal Year (FY) 2021

KAWEAH DELTA VISALIA DIALYSIS CENTER State: CA Network: 18 CCN: 053506

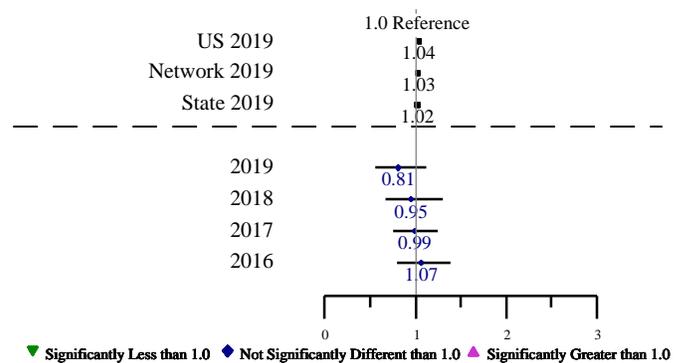
Hospitalizations and Readmissions (Table 4):

- The 2016-2019 Standardized Hospitalization Ratio (SHR-Admissions) at this facility is 0.85, which is 15% fewer admissions hospitalized than expected. This difference is not statistically significant ($p \geq 0.05$), so this lower hospitalization could plausibly be just a chance occurrence. The 2016-2019 SHR (Admissions) for your State and Network is 0.98 and 1.01, respectively.
- The 2019 Standardized Readmission Ratio (SRR) at this facility is 0.81, which is 19% fewer admissions than expected. This difference is not statistically significant ($p \geq 0.05$), so this lower number of readmissions could plausibly be just a chance occurrence. The 2019 SRR for your State and Network is 1.02 and 1.03, respectively.

2016-2019 SHR-Admissions

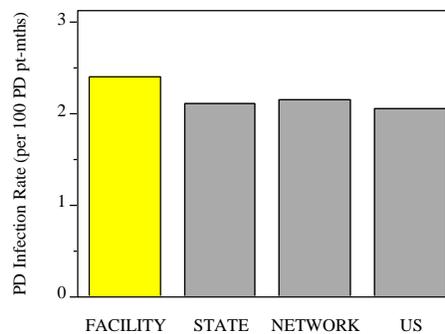
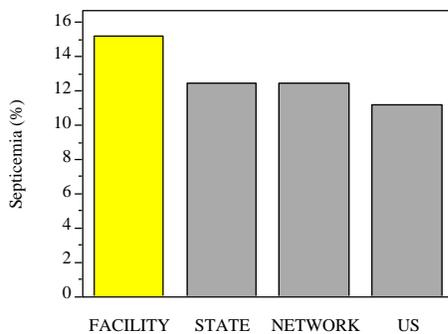


2016-2019 SRR



Infection (Tables 4 and 11):

- The percentage of Medicare dialysis patients at this facility hospitalized with septicemia during 2016-2019 is 15%, compared to 12% in your State, 12% in your Network, and 11% nationally.
- The 2019 rate of PD catheter-related infection was 2.4 per 100 PD patient-months, compared to 2.1 in your State, 2.2 in your Network, and 2.1 nationally.

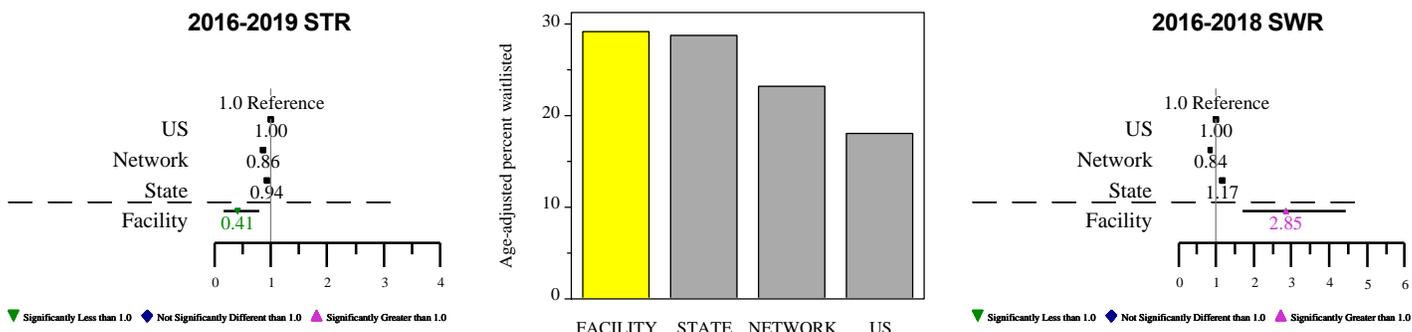


Transplantation (Table 5):

- The 2016-2019 Standardized 1st Transplantation Ratio (STR) of observed to expected number of patients transplanted for this facility is 0.41, which is 59% lower than expected for this facility. This difference is statistically significant ($p < 0.05$) and is unlikely to be due to random chance. The 2016-2019 STR for your State and Network is 0.94 and 0.86, respectively.

Transplant Waitlist (Table 6):

- The 2019 age-adjusted percent waitlisted at this facility is 29.3%, which is 11% higher than the national adjusted percentage. This difference is statistically significant ($p < 0.05$) and is unlikely to be due to random chance. The age-adjusted percent waitlisted in your State and Network is 28.9% and 23.2%, respectively.
- At this facility, the 2016-2018 Standardized Waitlist Ratio (SWR) is 2.85, which is 185% more patients on the waitlist and living donor transplants than expected at this facility. This difference is statistically significant ($p < 0.05$) and is unlikely to be due to random chance. The 2016-2018 SWR for your State and Network is 1.17 and 0.84, respectively.

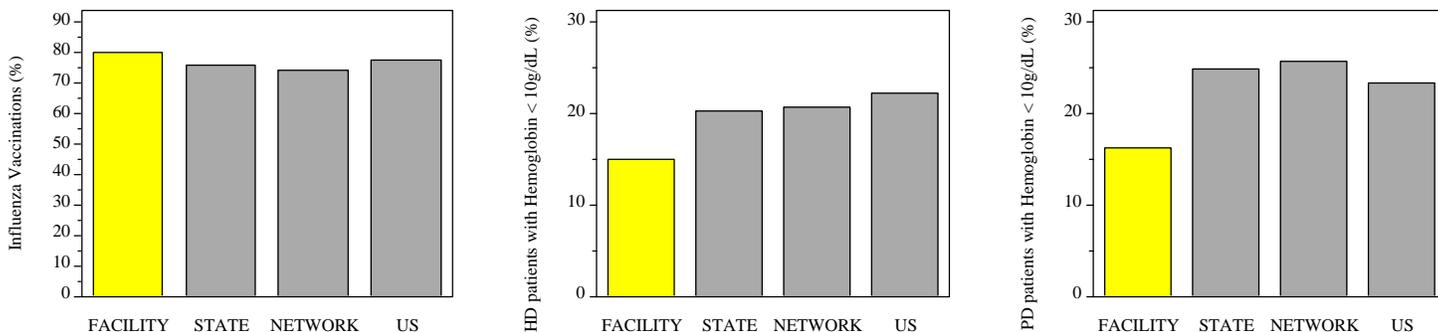


Influenza Vaccination (Table 7):

- Among the 106 Medicare dialysis patients treated at this facility on December 31, 2019, 80% were vaccinated between August 1 and December 31, 2019 compared to 78% nationally. This difference is not statistically significant ($p \geq 0.05$) and is plausibly due to random chance. The percentage of patients vaccinated in your State and Network is 76% and 74%, respectively.

Anemia Management (Table 8):

- In 2019, 15% of eligible hemodialysis patient-months had a hemoglobin value below 10 g/dL, compared to 20% in your State, 21% in your Network, and 22% nationally.
- In 2019, 16% of eligible peritoneal dialysis patient-months had a hemoglobin value below 10 g/dL, compared to 25% in your State, 26% in your Network, and 23% nationally.



Dialysis Adequacy (Table 9):

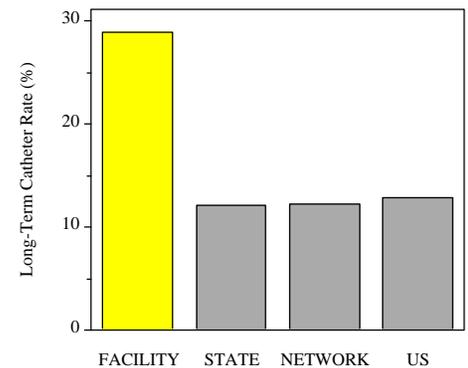
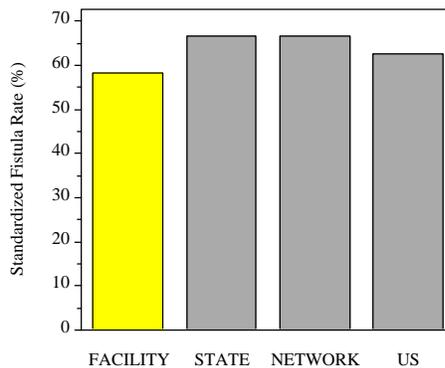
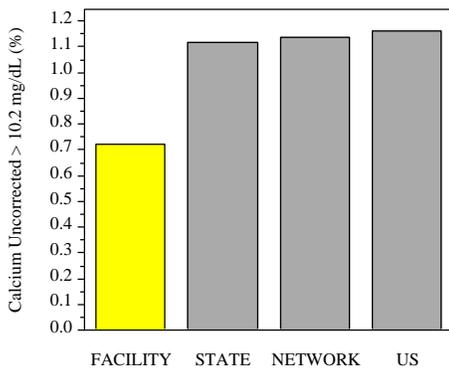
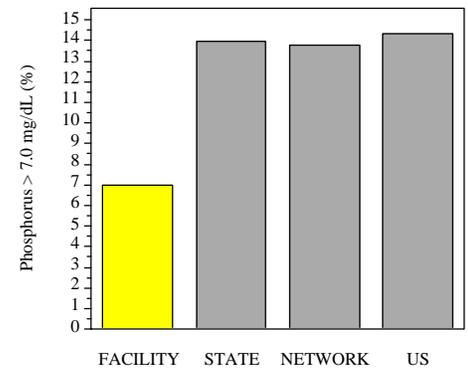
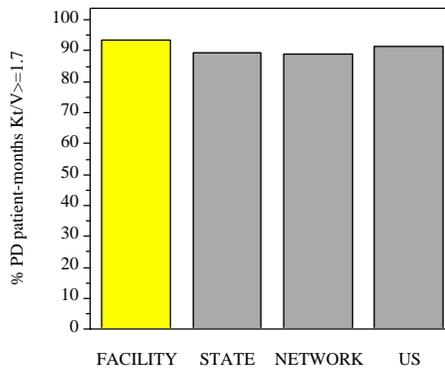
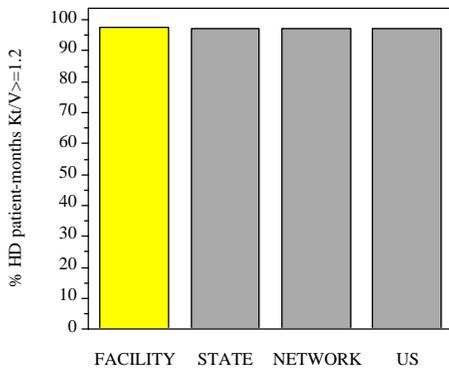
- In 2019, 98% of eligible hemodialysis patient-months had a Kt/V ≥ 1.2 reported, compared to 97% in your State, 97% in your Network, and 97% nationally.
- In 2019, 94% of eligible peritoneal dialysis patient-months had a Kt/V ≥ 1.7 reported, compared to 89% in your State, 89% in your Network, and 91% nationally.

Mineral Metabolism (Table 10):

- In 2019, 7% of eligible patient-months had a serum phosphorus value >7.0 mg/dL, compared to 14% in your State, 14% in your Network, and 14% nationally.
- In 2019, 0.7% of eligible patient-months had calcium uncorrected value >10.2 mg/dL, compared to 1.1% in your State, 1.1% in your Network, and 1.2% nationally.

Vascular Access (Table 11):

- This facility's 2019 Standardized Fistula Rate (SFR) for prevalent patients is 58%, which is 4% lower than the national SFR. This difference is not statistically significant ($p \geq 0.05$) and could plausibly be due to a chance occurrence. The SFR in your State and Network is 67% and 67%, respectively.
- Of the prevalent patients receiving hemodialysis treatment at this facility in 2019, the long-term catheter rate was 29%, compared to 12% in your State, 12% in your Network, and 13% nationally.



Dialysis Facility Report for Fiscal Year (FY) 2021

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TABLE 1: Summaries for All Dialysis Patients Treated as of December 31st of Each Year^{*1}, 2016-2019

| Measure Name | This Facility | | | | Regional Averages ^{*2} , 2019 | | |
|--|---------------|------|------|------|--|---------|------|
| | 2016 | 2017 | 2018 | 2019 | State | Network | U.S. |
| 1a Patients treated on 12/31 (n) | 165 | 151 | 174 | 167 | 92.3 | 99.7 | 63.1 |
| 1b Average age (years) | 62.3 | 64.0 | 62.4 | 61.8 | 63.2 | 63.0 | 62.7 |
| 1c Age (% of 1a; sums to 100%) | | | | | | | |
| < 18 | 0.0 | 0.0 | 0.0 | 0.0 | 0.2 | 0.2 | 0.2 |
| 18-64 | 53.3 | 46.4 | 50.6 | 51.5 | 50.2 | 51.0 | 51.4 |
| 65+ | 46.7 | 53.6 | 49.4 | 48.5 | 49.6 | 48.8 | 48.4 |
| 1d Female (% of 1a) | 46.1 | 47.0 | 47.1 | 44.9 | 40.9 | 40.8 | 42.6 |
| 1e Race (% of 1a; sums to 100%) ^{*3} | | | | | | | |
| African American | 3.0 | 2.6 | 3.4 | 4.8 | 13.6 | 12.7 | 34.2 |
| Asian/Pacific Islander | 2.4 | 2.6 | 2.9 | 4.2 | 17.8 | 14.6 | 6.3 |
| Native American | 0.6 | 0.0 | 0.0 | 0.0 | 0.4 | 0.3 | 1.2 |
| White | 93.3 | 94.0 | 93.1 | 90.4 | 67.3 | 71.6 | 57.8 |
| Other/Unknown/Missing | 0.6 | 0.7 | 0.6 | 0.6 | 0.8 | 0.8 | 0.4 |
| 1f Ethnicity (% of 1a; sums to 100%) | | | | | | | |
| Hispanic | 66.1 | 68.2 | 67.2 | 66.5 | 43.0 | 50.1 | 18.8 |
| Non-Hispanic | 33.9 | 31.8 | 32.8 | 33.5 | 56.5 | 49.5 | 80.7 |
| Unknown | 0.0 | 0.0 | 0.0 | 0.0 | 0.4 | 0.5 | 0.4 |
| 1g Primary Cause of ESRD (% of 1a; sums to 100%) | | | | | | | |
| Diabetes | 58.8 | 58.9 | 59.8 | 62.3 | 53.1 | 53.6 | 46.6 |
| Hypertension | 17.6 | 17.2 | 14.9 | 14.4 | 26.0 | 26.8 | 30.0 |
| Glomerulonephritis | 9.1 | 9.9 | 9.8 | 9.6 | 9.2 | 8.8 | 9.9 |
| Other/Unknown | 14.5 | 13.9 | 14.9 | 13.8 | 10.9 | 10.1 | 12.8 |
| Missing | 0.0 | 0.0 | 0.6 | 0.0 | 0.7 | 0.8 | 0.7 |
| 1h Average duration of ESRD (years) | 4.7 | 4.8 | 4.4 | 4.5 | 5.2 | 5.2 | 5.0 |
| 1i Years since start of ESRD (% of 1a; sums to 100%) | | | | | | | |
| < 1 | 17.6 | 15.2 | 24.7 | 12.0 | 14.4 | 14.3 | 15.6 |
| 1-2 | 16.4 | 17.9 | 14.4 | 28.1 | 15.8 | 15.4 | 16.8 |
| 2-3 | 12.7 | 11.9 | 13.2 | 12.0 | 13.2 | 13.0 | 13.6 |
| 3-6 | 27.3 | 28.5 | 24.7 | 22.2 | 27.4 | 27.4 | 26.6 |
| 6+ | 26.1 | 26.5 | 23.0 | 25.7 | 29.2 | 29.8 | 27.3 |
| 1j Nursing home patients (% of 1a) ^{*4} | 18.2 | 10.6 | 18.4 | 21.0 | 12.1 | 11.9 | 14.8 |
| 1k Modality (% of 1a; sums to 100%) | | | | | | | |
| In-center hemodialysis | 89.7 | 86.1 | 85.1 | 80.2 | 85.6 | 86.1 | 86.3 |
| Home hemodialysis | 0.0 | 0.0 | 0.0 | 0.6 | 1.2 | 1.0 | 2.2 |
| Continuous ambulatory peritoneal dialysis | 0.6 | 0.0 | 0.6 | 1.2 | 1.7 | 1.4 | 1.4 |
| Continuous cycling peritoneal dialysis | 9.1 | 12.6 | 14.4 | 18.0 | 11.3 | 11.3 | 9.8 |
| Other modality ^{*5} | 0.6 | 1.3 | 0.0 | 0.0 | 0.2 | 0.2 | 0.3 |

n/a = not applicable

[*1] See *Guide, Section IV*.

[*2] Values are shown for the average facility.

[*3] 'Asian' includes Indian sub-continent. 'Native American' includes Alaskan Native. 'White' includes Middle Eastern and Arab.

[*4] Includes patients who were also treated by a nursing facility at any time during the year. The source of nursing facility history of patients is the Nursing Home Minimum Dataset.

[*5] Other modality includes other dialysis, uncertain modality, and patients not on dialysis but still temporarily assigned to the facility (discontinued dialysis, recovered renal function, and lost to follow up).

Dialysis Facility Report for Fiscal Year (FY) 2021

KAWEAH DELTA VISALIA DIALYSIS CENTER State: CA Network: 18 CCN: 053506

TABLE 2: Characteristics of New Dialysis Patients^{*1}, 2016-2019 (Form CMS-2728)

| Measure Name | This Facility | | | | Regional Averages ^{*2} , 2019 | | | |
|--------------------------------|--|------|------|------|--|---------|------|------|
| | 2016 | 2017 | 2018 | 2019 | State | Network | U.S. | |
| Patient Characteristics | | | | | | | | |
| 2a | Total number of patients with forms (n) | 51 | 52 | 70 | 25 | 19.6 | 21.1 | 15.6 |
| 2b | Average age (years [0-95]) ^{*3} | 66.2 | 66.1 | 61.2 | 59.3 | 64.2 | 64.1 | 63.9 |
| 2c | Female (% of 2a) | 41.2 | 48.1 | 34.3 | 48.0 | 40.4 | 40.8 | 41.8 |
| 2d | Race (% of 2a; sums to 100%) ^{*4} | | | | | | | |
| | African-American | 2.0 | 1.9 | 7.1 | 12.0 | 11.3 | 10.9 | 26.6 |
| | Asian/Pacific Islander | 3.9 | 7.7 | 7.1 | 12.0 | 18.1 | 15.9 | 5.9 |
| | Native American | 0.0 | 0.0 | 0.0 | 0.0 | 0.5 | 0.3 | 1.1 |
| | White | 94.1 | 90.4 | 85.7 | 76.0 | 69.6 | 72.4 | 66.1 |
| | Other/Unknown | 0.0 | 0.0 | 0.0 | 0.0 | 0.5 | 0.5 | 0.3 |
| 2e | Hispanic (% of 2a) | 47.1 | 55.8 | 60.0 | 60.0 | 37.4 | 43.7 | 16.1 |
| 2f | Primary cause of ESRD (% of 2a; sums to 100%) | | | | | | | |
| | Diabetes | 43.1 | 53.8 | 57.1 | 72.0 | 53.7 | 55.1 | 48.7 |
| | Hypertension | 27.5 | 17.3 | 10.0 | 16.0 | 25.9 | 26.5 | 29.4 |
| | Primary glomerulonephritis | 5.9 | 9.6 | 5.7 | 4.0 | 6.3 | 5.8 | 6.5 |
| | Other/Unknown | 23.5 | 19.2 | 27.1 | 8.0 | 14.2 | 12.5 | 15.5 |
| 2g | Medical coverage (% of 2a; sums to 100%) | | | | | | | |
| | Employer group only | 5.9 | 9.6 | 5.7 | 16.0 | 12.0 | 11.9 | 12.2 |
| | Medicare only | 25.5 | 26.9 | 15.7 | 24.0 | 27.1 | 27.3 | 34.8 |
| | Medicaid only | 23.5 | 17.3 | 24.3 | 16.0 | 21.2 | 22.9 | 13.3 |
| | Medicare and Medicaid only | 19.6 | 21.2 | 30.0 | 28.0 | 17.2 | 18.0 | 12.2 |
| | Medicare and other | 23.5 | 23.1 | 12.9 | 4.0 | 11.0 | 9.5 | 15.7 |
| | Other/Unknown | 2.0 | 1.9 | 10.0 | 12.0 | 10.6 | 9.5 | 7.4 |
| | None | 0.0 | 0.0 | 1.4 | 0.0 | 1.0 | 0.9 | 4.3 |
| 2h | Median body mass index ^{*5} (Median; Weight/Height ²) | | | | | | | |
| | Male | 27.5 | 27.3 | 28.0 | 28.6 | 27.1 | 27.0 | 28.1 |
| | Female | 29.8 | 28.4 | 29.6 | 31.3 | 27.6 | 27.5 | 29.1 |
| 2i | Employment ^{*6} | | | | | | | |
| | Six months prior to ESRD treatment | 40.0 | 19.0 | 32.4 | 50.0 | 40.8 | 41.6 | 36.5 |
| | At first ESRD treatment | 13.3 | 0.0 | 5.9 | 0.0 | 26.7 | 25.4 | 25.6 |
| 2j | Primary modality (% of 2a; sums to 100%) | | | | | | | |
| | Hemodialysis | 94.1 | 90.4 | 87.1 | 80.0 | 84.1 | 84.8 | 87.9 |
| | CAPD/CCPD | 5.9 | 9.6 | 12.9 | 20.0 | 15.9 | 15.2 | 12.1 |
| | Other/Unknown | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| 2k | Number of incident hemodialysis patients (n) | 48 | 47 | 61 | 20 | 16.5 | 17.9 | 13.7 |
| 2l | Access used at first outpatient dialysis (% of 2k; sums to 100%) | | | | | | | |
| | Arteriovenous fistula | 4.2 | 0.0 | 6.6 | 0.0 | 17.1 | 14.5 | 14.8 |
| | Arteriovenous graft | 0.0 | 0.0 | 1.6 | 0.0 | 3.6 | 2.9 | 3.0 |
| | Catheter | 95.8 | 100 | 91.8 | 100 | 79.1 | 82.4 | 81.8 |
| | Other/Unknown/Missing | 0.0 | 0.0 | 0.0 | 0.0 | 0.2 | 0.2 | 0.3 |
| 2m | Arteriovenous fistula placed (% of 2k) | 8.3 | 6.4 | 8.2 | 0.0 | 27.9 | 25.2 | 27.8 |

(continued)

Dialysis Facility Report for Fiscal Year (FY) 2021

KAWEAH DELTA VISALIA DIALYSIS CENTER State: CA Network: 18 CCN: 053506

TABLE 2 (cont.): Characteristics of New Dialysis Patients^{*1}, 2016-2019 (Form CMS-2728)

| Measure Name | This Facility | | | | Regional Averages ^{*2} , 2019 | | |
|---|---------------|------|------|------|--|---------|------|
| | 2016 | 2017 | 2018 | 2019 | State | Network | U.S. |
| Average Lab Values Prior to Dialysis^{*3} | | | | | | | |
| 2n Hemoglobin (g/dL [5-20]) | 9.2 | 9.2 | 9.3 | 9.5 | 9.4 | 9.4 | 9.3 |
| 2o Serum albumin (g/dL [0.8-6.0]) | 3.0 | 3.0 | 3.1 | 3.2 | 3.3 | 3.3 | 3.3 |
| 2p Serum creatinine (mg/dL [0-33]) | 5.6 | 5.0 | 5.7 | 5.6 | 6.3 | 6.3 | 6.4 |
| 2q GFR (mL/min [0-30]) | 11.8 | 12.5 | 11.8 | 11.7 | 10.6 | 10.6 | 10.8 |
| Care Prior to ESRD Therapy | | | | | | | |
| 2r Received ESA prior to ESRD (% of 2a) | 19.6 | 11.5 | 17.1 | 12.0 | 19.8 | 16.6 | 16.1 |
| 2s Pre-ESRD nephrologist care (% of 2a; sums to 100%) ^{*7} | | | | | | | |
| No | 41.2 | 40.4 | 22.9 | 12.0 | 16.3 | 17.8 | 16.4 |
| Yes, < 6 months | 3.9 | 13.5 | 27.1 | 44.0 | 19.4 | 19.6 | 16.7 |
| Yes, 6-12 months | 35.3 | 40.4 | 37.1 | 28.0 | 20.4 | 18.9 | 20.4 |
| Yes, > 12 months | 13.7 | 1.9 | 10.0 | 8.0 | 28.6 | 25.8 | 32.3 |
| Unknown/Missing | 5.9 | 3.8 | 2.9 | 8.0 | 15.3 | 17.9 | 14.2 |
| 2t Informed of transplant options (% of 2a) | 100 | 100 | 100 | 100 | 86.6 | 86.9 | 84.0 |
| 2u Patients not informed of transplant options (n) | 0 | 0 | 0 | 0 | 2.6 | 2.8 | 2.5 |
| 2v Reason not informed (% of 2u; may not sum to 100%) ^{*8} | | | | | | | |
| Medically unfit | . | . | . | . | 20.4 | 16.9 | 17.4 |
| Unsuitable due to age | . | . | . | . | 19.4 | 20.0 | 13.2 |
| Psychologically unfit | . | . | . | . | 1.3 | 1.4 | 1.5 |
| Patient declined information | . | . | . | . | 1.8 | 2.6 | 1.1 |
| Patient has not been assessed | . | . | . | . | 62.6 | 68.4 | 69.9 |
| Comorbid Conditions | | | | | | | |
| 2w Pre-existing comorbidity (% yes of 2a) ^{*9} | | | | | | | |
| Congestive heart failure | 39.2 | 32.7 | 34.3 | 40.0 | 25.0 | 25.1 | 29.6 |
| Atherosclerotic heart disease ^{*9} | 9.8 | 0.0 | 0.0 | 0.0 | 10.0 | 9.1 | 13.1 |
| Other cardiac disorder ^{*9} | 45.1 | 69.2 | 58.6 | 44.0 | 16.4 | 16.7 | 21.6 |
| CVD, CVA, TIA | 9.8 | 11.5 | 18.6 | 20.0 | 6.6 | 6.4 | 9.1 |
| Peripheral vascular disease | 11.8 | 5.8 | 14.3 | 12.0 | 6.4 | 6.6 | 9.5 |
| History of hypertension | 92.2 | 94.2 | 95.7 | 100 | 87.7 | 88.6 | 88.7 |
| Diabetes ^{*9} | 64.7 | 76.9 | 77.1 | 80.0 | 66.5 | 67.9 | 65.1 |
| Diabetes on insulin | 52.9 | 51.9 | 58.6 | 52.0 | 40.6 | 41.0 | 44.2 |
| COPD | 11.8 | 11.5 | 8.6 | 12.0 | 5.2 | 4.9 | 9.5 |
| Current smoker | 11.8 | 7.7 | 11.4 | 8.0 | 3.6 | 3.1 | 7.1 |
| Cancer | 13.7 | 13.5 | 5.7 | 4.0 | 5.1 | 4.7 | 7.4 |
| Alcohol dependence | 11.8 | 5.8 | 5.7 | 0.0 | 1.7 | 1.6 | 1.8 |
| Drug dependence | 3.9 | 1.9 | 5.7 | 0.0 | 1.6 | 1.3 | 1.6 |
| Inability to ambulate | 9.8 | 9.6 | 8.6 | 0.0 | 6.9 | 7.8 | 7.0 |
| Inability to transfer | 9.8 | 7.7 | 4.3 | 0.0 | 4.1 | 5.0 | 3.7 |
| 2x Average number of comorbid conditions | 4.0 | 4.0 | 4.1 | 3.7 | 2.9 | 2.9 | 3.2 |

n/a= not applicable

[*1] See *Guide, Section V*.

[*2] Values are shown for the average facility.

[*3] For continuous variables, summaries include only responses in range indicated in brackets.

[*4] 'Asian' includes Indian sub-continent. 'Native American' includes Alaskan Native. 'White' includes Middle Eastern and Arab.

[*5] The median BMI is computed for adult patients at least 20 years old with height, weight, and BMI values in acceptable ranges. Acceptable range for height, weight, and BMI are 122-208 cm, 32-318 kg, and 10-55, respectively.

[*6] Full-time, part-time, or student (% of 18-60 year olds).

[*7] Values may not sum to exactly 100% because of patients that received nephrology care but duration unknown (0.003% in US in 2019).

[*8] Values may not sum to exactly 100% because of patients for which multiple reasons are selected, or when other or no reason is selected.

[*9] 'Atherosclerotic heart disease' includes ischemic heart disease (coronary artery disease) and myocardial infarction. 'Other cardiac disorder' includes cardiac arrest, cardiac dysrhythmia, and pericarditis. 'Diabetes' includes patients with diabetes as the primary cause of ESRD.

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KAWEAH DELTA VISALIA DIALYSIS CENTER State: CA Network: 18 CCN: 053506

TABLE 3: Mortality Summary for All Dialysis Patients (2016-19) & New Dialysis Patients (2016-18) *1

| Measure Name | This Facility | | | | | Regional Averages *2 | | |
|--|---------------|-------------|-------------|-------------|------------------|----------------------|------------------|-------------|
| | 2016 | 2017 | 2018 | 2019 | 2016-2019 | State | Network | U.S. |
| All Patients: Death Counts | | | | | | 2016-2019 | | |
| 3a Patients (n=number) | 220 | 217 | 231 | 219 | 887 *8 | 119.7 | 129.5 | 92.0 |
| 3b Patient-years (PY) at risk (n) | 157.9 | 157.5 | 164.7 | 177.7 | 657.8 *8 | 89.2 | 96.8 | 62.3 |
| 3c Deaths (n) | 42 | 44 | 36 | 38 | 160 *8 | 13.4 | 14.3 | 10.9 |
| 3d Expected deaths (n) | 26.9 | 27.8 | 26.0 | 30.0 | 111 *8 | 13.6 | 14.5 | 10.9 |
| 3e Withdrawal from dialysis prior to death (% of 3c) | 33.3 | 36.4 | 27.8 | 28.9 | 31.9 | 21.0 | 18.2 | 26.2 |
| 3f Death due to Infections (% of 3c) | 4.8 | 11.4 | 11.1 | 7.9 | 8.8 | 10.5 | 10.1 | 10.5 |
| Death due to Cardiac causes (% of 3c) | 52.4 | 31.8 | 5.6 | 21.1 | 28.8 | 51.0 | 55.6 | 45.6 |
| Death due to Liver disease (% of 3c) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 1.3 | 1.4 | 1.5 |
| 3g Dialysis unrelated deaths *3 (n; excluded from SMR) | 0 | 0 | 0 | 0 | 0 *8 | 0.1 | 0.1 | 0.1 |
| All Patients: Standardized Mortality Ratio (SMR) | | | | | | | | |
| 3h SMR *4 | 1.56 | 1.58 | 1.38 | 1.27 | 1.45 | 0.99 | 0.98 | 1.00 |
| 3i P-value *5 | 0.025 | 0.020 | 0.108 | 0.211 | <0.01 | n/a | n/a | n/a |
| 3j Confidence interval for SMR *6 | | | | | | | | |
| High (97.5% limit) | 2.26 | 2.28 | 2.06 | 1.90 | 1.87 | n/a | n/a | n/a |
| Low (2.5% limit) | 1.06 | 1.08 | 0.92 | 0.85 | 1.12 | n/a | n/a | n/a |
| 3k SMR percentiles for this facility *7 | | | | | | | | |
| In this State | 95 | 93 | 88 | 80 | 94 | n/a | n/a | n/a |
| In this Network | 95 | 93 | 87 | 80 | 93 | n/a | n/a | n/a |
| In the U.S. | 91 | 91 | 84 | 77 | 92 | n/a | n/a | n/a |
| New Patients: First Year Death Counts | | | | | | | | |
| | 2016 | 2017 | 2018 | | 2016-2018 | | 2016-2018 | |
| 3l New patients (n=number) | 51 | 52 | 70 | | 173 *8 | 21.3 | 22.5 | 15.8 |
| 3m Patient-years (PY) at risk (n) | 43.7 | 44.7 | 65.5 | | 154 *8 | 19.2 | 20.2 | 14.0 |
| 3n Deaths (n) | 17 | 14 | 8 | | 39 *8 | 3.4 | 3.7 | 2.9 |
| 3o Expected deaths (n) | 11.9 | 10.2 | 11.7 | | 34.0 *8 | 3.3 | 3.6 | 2.8 |
| 3p Withdrawal from dialysis prior to death (% of 3n) | 41.2 | 28.6 | 37.5 | | 35.9 | 22.3 | 19.5 | 28.7 |
| 3q Death due to Infections (% of 3n) | 5.9 | 21.4 | 0.0 | | 10.3 | 9.2 | 8.7 | 9.7 |
| Death due to Cardiac causes (% of 3n) | 41.2 | 14.3 | 12.5 | | 25.6 | 43.7 | 46.7 | 41.4 |
| Death due to Liver disease (% of 3n) | 0.0 | 0.0 | 0.0 | | 0.0 | 2.6 | 2.8 | 2.6 |
| New Patients: First Year Standardized Mortality Ratio (SMR) | | | | | | | | |
| 3r SMR *4 | 1.42 | 1.36 | 0.68 | | 1.15 | 1.01 | 1.03 | 1.00 |
| 3s P-value *5 | 0.182 | 0.281 | 0.431 | | 0.457 | n/a | n/a | n/a |
| 3t Confidence interval for SMR *6 | | | | | | | | |
| High (97.5% limit) | 2.47 | 2.43 | 1.50 | | 1.73 | n/a | n/a | n/a |
| Low (2.5% limit) | 0.81 | 0.73 | 0.28 | | 0.75 | n/a | n/a | n/a |
| 3u First Year SMR percentiles for this facility *7 | | | | | | | | |
| In this State | 75 | 71 | 34 | | 65 | n/a | n/a | n/a |
| In this Network | 76 | 70 | 33 | | 62 | n/a | n/a | n/a |
| In the U.S. | 75 | 72 | 37 | | 66 | n/a | n/a | n/a |

n/a = not applicable

[*1] See *Guide, Section VI*.

[*2] Values are shown for the average facility, annualized.

[*3] Defined as deaths due to street drugs and accidents unrelated to treatment.

[*4] Calculated as a ratio of deaths to expected deaths (3c to 3d for all patients, 3n to 3o for new patients); not shown if there are fewer than 3 expected deaths.

[*5] A p-value less than 0.05 indicates that the difference between the actual and expected mortality is probably real and is not due to random chance alone, while a p-value greater than or equal to 0.05 indicates that the difference could plausibly be due to random chance.

[*6] The confidence interval range represents uncertainty in the value of the SMR due to random variation.

[*7] All facilities are included in ranking, regardless of the number of expected deaths.

[*8] Sum of 4 years (all patients) or 3 years (new patients) used for calculations; should not be compared to regional averages.

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TABLE 4: Hospitalization Summary for Medicare Dialysis Patients^{*1}, 2016-2019

| Measure Name | This Facility | | | | | Regional Averages ^{*2} , per Year, 2016-2019 | | | |
|-------------------------------------|---|-------------|-------------|-------------|-------------|--|-------------|-------------|-------------|
| | 2016 | 2017 | 2018 | 2019 | 2016-2019 | State | Network | U.S. | |
| Medicare Dialysis Patients | | | | | | | | | |
| 4a | Medicare dialysis patients (n) | 175 | 175 | 175 | 165 | 690 ^{*3} | 78.9 | 84.3 | 68.6 |
| 4b | Patient-years (PY) at risk (n) | 117.7 | 117.9 | 117.5 | 122.7 | 475.7 ^{*3} | 50.0 | 52.6 | 41.2 |
| Days Hospitalized Statistics | | | | | | | | | |
| 4c | Total days hospitalized (n) | 1,698 | 1,404 | 1,476 | 1,425 | 6,003 ^{*3} | 593.6 | 662.0 | 570.8 |
| 4d | Expected total days hospitalized (n) | 1,741.0 | 1,832.1 | 1,648.2 | 1,671.8 | 6,893.1 ^{*3} | 667.5 | 711.8 | 571.1 |
| 4e | Standardized Hospitalization Ratio (Days) ^{*4} | 0.98 | 0.77 | 0.90 | 0.85 | 0.87 | 0.89 | 0.93 | 1.00 |
| 4f | P-value ^{*5} | 0.980 | 0.289 | 0.743 | 0.608 | 0.555 | n/a | n/a | n/a |
| 4g | Confidence interval for SHR (Days) ^{*6} | | | | | | | | |
| | High (97.5% limit) | 1.51 | 1.22 | 1.45 | 1.39 | 1.27 | n/a | n/a | n/a |
| | Low (2.5% limit) | 0.67 | 0.52 | 0.60 | 0.57 | 0.64 | n/a | n/a | n/a |
| 4h | Percentiles for this facility (Days) ^{*7} | | | | | | | | |
| | In this State | 65 | 33 | 54 | 47 | 49 | n/a | n/a | n/a |
| | In this Network | 57 | 28 | 49 | 39 | 41 | n/a | n/a | n/a |
| | In the U.S. | 56 | 30 | 46 | 40 | 40 | n/a | n/a | n/a |
| Admission Statistics | | | | | | | | | |
| 4i | Total admissions (n) | 224 | 196 | 160 | 192 | 772 ^{*3} | 88.3 | 96.7 | 77.2 |
| 4j | Expected total admissions (n) | 225.1 | 238.6 | 220.4 | 225.4 | 909.4 ^{*3} | 90.5 | 95.9 | 77.2 |
| 4k | Standardized Hospitalization Ratio (Admissions)^{*4} | 1.00 | 0.82 | 0.73 | 0.85 | 0.85 | 0.98 | 1.01 | 1.00 |
| 4l | P-value ^{*5} | 0.929 | 0.318 | 0.127 | 0.446 | 0.313 | n/a | n/a | n/a |
| 4m | Confidence interval for SHR (Admissions) ^{*6} | | | | | | | | |
| | High (97.5% limit) | 1.39 | 1.18 | 1.09 | 1.23 | 1.14 | n/a | n/a | n/a |
| | Low (2.5% limit) | 0.74 | 0.60 | 0.51 | 0.62 | 0.66 | n/a | n/a | n/a |
| 4n | Percentiles for this facility (admissions) ^{*7} | | | | | | | | |
| | In this State | 56 | 26 | 15 | 31 | 28 | n/a | n/a | n/a |
| | In this Network | 49 | 22 | 14 | 25 | 22 | n/a | n/a | n/a |
| | In the U.S. | 54 | 27 | 16 | 32 | 26 | n/a | n/a | n/a |
| 4o | Diagnoses associated with hospitalization (% of 4a)^{*8} | | | | | | | | |
| | Septicemia | 17.7 | 14.3 | 14.3 | 14.5 | 15.2 | 12.5 | 12.5 | 11.2 |
| | Acute myocardial infarction | 8.0 | 8.0 | 8.0 | 5.5 | 7.4 | 5.3 | 5.6 | 5.1 |
| | Congestive heart failure | 30.3 | 26.9 | 26.9 | 27.3 | 27.8 | 23.8 | 23.7 | 25.1 |
| | Cardiac dysrhythmia | 20.0 | 17.7 | 18.9 | 20.0 | 19.1 | 15.8 | 15.3 | 16.6 |
| | Cardiac arrest | 1.7 | 2.3 | 0.6 | 3.6 | 2.0 | 2.1 | 2.2 | 2.2 |
| 4p | One day admissions (% of 4i) | 7.1 | 7.1 | 5.0 | 6.8 | 6.6 | 10.7 | 10.9 | 9.6 |
| 4q | Average length of stay (days per admission; 4c/4i) | 7.6 | 7.2 | 9.2 | 7.4 | 7.8 | 6.7 | 6.8 | 7.4 |

(continued)

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TABLE 4 (cont.): Hospitalization Summary for Medicare Dialysis Patients^{*1}, 2016-2019

| Measure Name | This Facility | | | | | Regional Averages ^{*2} , per Year, 2016-2019 | | | |
|---|--|-------------|-------------|-------------|-------------|--|-------------|-------------|-------------|
| | 2016 | 2017 | 2018 | 2019 | 2016-2019 | State | Network | U.S. | |
| Emergency Department (ED) Statistics | | | | | | | | | |
| 4r | Total ED visits (n) | 355 | 340 | 230 | 306 | 1,231 ^{*3} | 127.3 | 128.6 | 122.7 |
| 4s | Expected total ED visits (n) | 362.5 | 382.5 | 366.8 | 394.2 | 1,506.0 ^{*3} | 140.8 | 146.4 | 122.9 |
| 4t | Standardized Hospitalization Ratio (ED) ^{*4} | 0.98 | 0.89 | 0.63 | 0.78 | 0.82 | 0.90 | 0.88 | 1.00 |
| 4u | P-value ^{*5} | 0.949 | 0.649 | 0.042 | 0.233 | 0.298 | n/a | n/a | n/a |
| 4v | Confidence interval for SHR (ED) ^{*6} | | | | | | | | |
| | High (97.5% limit) | 1.44 | 1.32 | 0.99 | 1.15 | 1.16 | n/a | n/a | n/a |
| | Low (2.5% limit) | 0.71 | 0.64 | 0.43 | 0.56 | 0.61 | n/a | n/a | n/a |
| 4w | Percentiles for this facility (ED) ^{*7} | | | | | | | | |
| | In this State | 68 | 49 | 12 | 30 | 34 | n/a | n/a | n/a |
| | In this Network | 69 | 52 | 14 | 31 | 36 | n/a | n/a | n/a |
| | In the U.S. | 52 | 38 | 8 | 22 | 22 | n/a | n/a | n/a |
| 4x | Patients with ED visit (% of 4a) | 64.0 | 62.3 | 49.1 | 57.0 | 58.1 | 51.2 | 49.6 | 54.1 |
| 4y | ED visits that result in hospitalization (% of 4r) | 54.4 | 52.1 | 53.9 | 47.4 | 51.9 | 45.4 | 47.8 | 42.9 |
| 4z | Admissions that originate in the ED (% of 4i) | 86.2 | 90.3 | 77.5 | 75.5 | 82.8 | 65.4 | 63.6 | 68.1 |
| Readmission Statistics | | | | | | | | 2019 | |
| 4aa | Index discharges (n) | 217 | 214 | 166 | 182 | | 82.4 | 89.5 | 70.8 |
| 4ab | Total readmissions (n) | 68 | 63 | 40 | 38 | | 21.5 | 23.3 | 19.1 |
| 4ac | Expected total readmissions (n) | 64 | 64 | 42 | 47 | | 21.9 | 23.5 | 19.5 |
| 4ad | Standardized Readmission Ratio (SRR)^{*4} | 1.07 | 0.99 | 0.95 | 0.81 | | 1.02 | 1.03 | 1.04 |
| 4ae | P-value ^{*5} | 0.712 | 0.811 | 0.661 | 0.206 | | n/a | n/a | n/a |
| 4af | Confidence interval for SRR ^{*6} | | | | | | | | |
| | High (97.5% limit) | 1.38 | 1.24 | 1.30 | 1.12 | | n/a | n/a | n/a |
| | Low (2.5% limit) | 0.80 | 0.75 | 0.66 | 0.56 | | n/a | n/a | n/a |

n/a = not applicable.

[*1] Based on patients with Medicare as primary insurer; see *Guide, Section VII*.

[*2] Values are shown for the average facility, annualized.

[*3] Sum of 4 years used for calculations; should not be compared to regional averages.

[*4] Standardized Ratios are calculated as a ratio of actual to expected events (4c/4d for days, 4i/4j for admissions, 4r/4s for ED visits, and 4ab/4ac for readmissions). SHRs are not shown if there are less than 5 patient years at risk. SRR is not shown if fewer than 11 index discharges in the year.

[*5] A p-value less than 0.05 indicates that the difference between the actual and expected event is probably real and is not due to random chance alone, while a p-value greater than or equal to 0.05 indicates that the difference could plausibly be due to random chance.

[*6] The confidence interval range represents uncertainty in the value of the standardized hospitalization and readmission ratios (SHRs and SRR) due to random variation.

[*7] All facilities are included in ranking, regardless of the number of patient years at risk.

[*8] Includes diagnoses in any position on a hospital inpatient claim.

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TABLE 5: Transplantation Summary for Dialysis Patients under Age 75^{*1}, 2016-2019

| Measure Name | This Facility | | | | | Regional Averages ^{*2} , per Year, 2016-2019 | | | |
|--|---|-------|-------|-------|-----------|---|-------------|-------------|-------------|
| | 2016 | 2017 | 2018 | 2019 | 2016-2019 | State | Network | U.S. | |
| All Transplants | | | | | | | | | |
| 5a | Eligible patients (n) | 165 | 161 | 181 | 176 | 683 ^{*10} | 93.3 | 101.5 | 73.1 |
| 5b | Transplants (n) | 2 | 2 | 2 | 4 | 10 ^{*10} | 2.9 | 2.9 | 2.1 |
| 5c | Donor type (sums to 5b) ^{*3} | | | | | | | | |
| | Living donor (n) | 0 | 1 | 0 | 2 | 3 ^{*10} | 0.6 | 0.6 | 0.5 |
| | Deceased donor (n) | 2 | 1 | 2 | 2 | 7 ^{*10} | 2.3 | 2.3 | 1.7 |
| First Transplants | | | | | | | | | |
| 5d | Eligible patients (n) | 160 | 155 | 173 | 168 | 656 ^{*10} | 87.3 | 95.2 | 67.7 |
| 5e | Patient years (PY) at risk (n) | 118.4 | 115.1 | 122.2 | 137.3 | 493.0 ^{*10} | 65.4 | 71.7 | 46.1 |
| 5f | First transplants ^{*4} (n) | 2 | 1 | 2 | 3 | 8 ^{*10} | 2.5 | 2.5 | 1.9 |
| 5g | Expected first transplants (n) | 4.6 | 4.4 | 4.7 | 5.8 | 19.6 ^{*10} | 2.6 | 2.9 | 1.8 |
| Standardized 1st Transplantation Ratio (STR)^{*5} | | | | | | | | | |
| 5h | STR^{*6} | | | | | 0.41 | 0.94 | 0.86 | 1.00 |
| 5i | P-value ^{*7} | | | | | <0.01 | n/a | n/a | n/a |
| 5j | Confidence interval for STR ^{*8} | | | | | | | | |
| | High (97.5% limit) | | | | | 0.80 | n/a | n/a | n/a |
| | Low (2.5% limit) | | | | | 0.18 | n/a | n/a | n/a |
| 5k | STR percentiles for this facility ^{*9} | | | | | | | | |
| | In this State | | | | | 13 | n/a | n/a | n/a |
| | In this Network | | | | | 15 | n/a | n/a | n/a |
| | In the U.S. | | | | | 21 | n/a | n/a | n/a |

n/a = not applicable.

[*1] See *Guide, Section VIII*.

[*2] Values are shown for the average facility, annualized.

[*3] Values may not sum to 5b due to unknown donor type.

[*4] Among first transplants that occurred after the start of dialysis from 2016-2019, 3.3% of transplants in the U.S. were not included because the transplant occurred fewer than 91 days after the start of ESRD and 1.1% were not included because the patient was not assigned to a facility at time of transplant.

[*5] This section is calculated for the 4-year period only and not reported if there are fewer than 3 expected transplants.

[*6] Standardized 1st Transplantation Ratio is calculated as a ratio of actual (5f) to expected (5g) transplants.

[*7] A p-value less than 0.05 indicates that the difference between the actual and expected transplants is probably real and is not due to random chance, while a p-value greater than or equal to 0.05 indicates that the difference is plausibly due to random chance.

[*8] The confidence interval range represents uncertainty in the value of the STR due to random variation.

[*9] All facilities are included in ranking, regardless of the number of expected transplants.

[*10] Sum of 4 years used for calculations; should not be compared to regional averages.

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TABLE 6: Waitlist Summary for All Dialysis Patients (2016-2019) & New Dialysis Patients (2016-2018) under Age 75^{*1}

| Measure Name | This Facility | | | | Regional Averages ^{*2} , 2019 | | |
|---|---------------|-------------|-------------|------------------|--|-------------------------------|-------------|
| | 2016 | 2017 | 2018 | 2019 | State | Network | U.S. |
| All Dialysis Patients | | | | | | | |
| 6a Eligible patients (n) | 186 | 179 | 201 | 166 | 95.8 | 103.4 | 67.8 |
| 6b Patient-months at risk (n) ^{*3} | 1448 | 1418 | 1614 | 1646 | 835.4 | 907.1 | 567.3 |
| 6c Patient-months on the waitlist (% of 6b)^{*3} | 34.3 | 36.2 | 30.0 | 28.8 | 27.5 | 23.0 | 18.6 |
| 6d Patient-months on the waitlist by subgroup (%) ^{*3 *4} | | | | | | | |
| Age < 40 | 38.6 | 47.3 | 31.1 | 26.3 | 42.7 | 37.7 | 28.9 |
| Age 40-74 | 33.7 | 35.0 | 30.0 | 29.0 | 25.8 | 21.3 | 17.4 |
| Male | 33.0 | 37.2 | 32.9 | 32.1 | 28.9 | 24.3 | 19.8 |
| Female | 35.8 | 35.1 | 26.9 | 24.9 | 25.2 | 21.1 | 16.7 |
| African American | 53.2 | 63.9 | 37.7 | 33.7 | 23.4 | 19.0 | 17.5 |
| Asian/Pacific Islander | 65.5 | 45.5 | 36.6 | 19.0 | 36.2 | 28.2 | 27.5 |
| Native American | 0.0 | 0.0 | . | . | 22.0 | 17.9 | 11.9 |
| White, Hispanic | 35.2 | 36.4 | 31.1 | 30.6 | 26.7 | 23.1 | 20.2 |
| White, non-Hispanic | 23.2 | 32.8 | 26.3 | 25.1 | 25.2 | 22.1 | 17.4 |
| Other/unknown race | 7.1 | 14.3 | 0.0 | 0.0 | 31.6 | 26.7 | 22.7 |
| Diabetes | 32.0 | 35.1 | 26.1 | 21.3 | 23.1 | 18.3 | 15.0 |
| Non-diabetes | 37.3 | 37.6 | 35.5 | 40.8 | 32.4 | 28.5 | 21.6 |
| Previous kidney transplant | 46.7 | 75.0 | 62.5 | 63.6 | 36.0 | 31.1 | 31.8 |
| No previous kidney transplant | 33.9 | 34.6 | 28.7 | 27.1 | 26.9 | 22.5 | 17.5 |
| < 2 years since start of ESRD | 16.8 | 19.1 | 14.2 | 21.3 | 17.5 | 12.4 | 14.0 |
| 2-4 years since start of ESRD | 39.5 | 41.8 | 34.4 | 27.5 | 32.4 | 28.0 | 23.1 |
| 5+ years since start of ESRD | 45.4 | 50.8 | 49.7 | 40.0 | 32.2 | 27.9 | 19.1 |
| 6e Age-adjusted percentage of patient-months waitlisted^{*5} | 34.4 | 36.4 | 30.6 | 29.3 | 28.9 | 23.2 | 18.1 |
| 6f P-value ^{*6} | 0.028 | <0.01 | 0.034 | 0.042 | n/a | n/a | n/a |
| 6g Confidence interval for percent waitlisted ^{*7} | | | | | | | |
| High (97.5% limit) | 49.4 | 51.7 | 44.8 | 43.2 | n/a | n/a | n/a |
| Low (2.5% limit) | 22.0 | 23.5 | 19.4 | 18.3 | n/a | n/a | n/a |
| New Dialysis Patients | | | | | | | |
| | 2016 | 2017 | 2018 | 2016-2018 | | 2016-2018^{*2} | |
| 6h Eligible patients (n) | 31 | 33 | 52 | 116 | 13.6 | 14.6 | 10.3 |
| 6i Patient-years (PY) at risk (n) | 27 | 27 | 45 | 100 | 12.1 | 13.2 | 9.2 |
| 6j First waitlist events (n) ^{*8} | 5 | 5 | 9 | 19 | 1.6 | 1.3 | 1.0 |
| 6k Expected 1st waitlist events (n) ^{*8} | 1.5 | 1.7 | 3.3 | 6.6 | 1.3 | 1.4 | 0.9 |
| 6l Standardized Waitlist Ratio (SWR) ^{*8 *9} | | | | 2.85 | 1.17 | 0.84 | 1.00 |
| 6m P-value ^{*6} | | | | <0.01 | n/a | n/a | n/a |
| 6n Confidence interval for SWR ^{*7} | | | | | | | |
| High (97.5% limit) | | | | 4.45 | n/a | n/a | n/a |
| Low (2.5% limit) | | | | 1.71 | n/a | n/a | n/a |

n/a = not applicable.

[*1] See *Guide, Section IX*.

[*2] For "All Dialysis Patients" section, values are shown for the average facility. For "New Dialysis Patients" section, values are shown for the average facility, annualized.

[*3] Eligible patient-months (6b) include patients assigned to the facility on the last day of each month. A patient may be counted up to 12 times per year.

[*4] The waitlist percentage for each subgroup is calculated as a rate of waitlisted patient-months to patient-months at risk in each subgroup. A missing value indicates that there were no eligible patients in the subgroup.

[*5] Age-adjusted percentage of prevalent patients waitlisted is not shown if there are fewer than 11 eligible patients in this facility.

[*6] A p-value less than 0.05 indicates that the difference between the observed and expected waitlist events (SWR), or the difference between the age-adjusted percent waitlisted for your facility and the overall national percentage is probably real and is not due to random chance alone. A p-value greater than or equal to 0.05 indicates that the difference could plausibly be due to random chance.

[*7] The confidence interval range represents uncertainty in the value of the SWR or age-adjusted percent waitlisted due to random variation.

[*8] An event is defined as a waitlisting or living-donor transplant.

[*9] SWR is calculated as a ratio of observed waitlisted events to expected waitlisted events (6j/6k); not shown if a facility has less than 2 expected waitlisted events or less than 11 eligible patients.

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TABLE 7: Influenza Vaccination Summary for Medicare Dialysis Patients Treated on December 31st of Each Year^{*1}, Flu Seasons August 2016-December 2019

| Measure Name | This Facility | | | | Regional Averages ^{*2} | | |
|--|---------------|-------------|-------------|-------|---------------------------------|-------------|-------------|
| | 2016 | 2017 | 2018 | 2019 | State | Network | U.S. |
| | | | | | | | 2019 |
| 7a Eligible patients on 12/31 (n) | 122 | 120 | 115 | 106 | 45.0 | 46.1 | 38.5 |
| 7b Patients vaccinated between Aug. 1 and Dec. 31 (% of 7a) | 77.0 | 85.0 | 80.9 | 80.2 | 75.9 | 74.2 | 77.6 |
| 7c P-value ^{*3} (for 7b compared to U.S. value ^{*4}) | 0.221 | 0.034 | 0.292 | 0.309 | n/a | n/a | n/a |
| | | | | | | | 2018 |
| 7d Patients vaccinated between Aug 1 and Mar 31 of following year (% of 7a) | 77.9 | 85.0 | 80.9 | | 78.6 | 77.7 | 79.0 |
| 7e P-value ^{*3} (for 7d compared to U.S. value ^{*5}) | 0.224 | 0.057 | 0.358 | | n/a | n/a | n/a |
| | | | | | | | 2019 |
| 7f Patients vaccinated between Aug 1 and Dec 31 by subgroup (%) ^{*6} | | | | | | | |
| Age < 18 | . | . | . | . | 57.9 | 58.3 | 57.4 |
| Age 18-39 | 80.0 | 100 | 75.0 | 50.0 | 68.2 | 66.9 | 70.6 |
| Age 40-64 | 76.4 | 84.9 | 80.4 | 84.1 | 73.2 | 71.5 | 75.9 |
| Age 65-74 | 61.3 | 75.8 | 84.6 | 75.7 | 77.7 | 76.3 | 79.3 |
| Age 75+ | 93.5 | 93.5 | 76.9 | 85.7 | 80.3 | 78.6 | 81.1 |
| Male | 77.8 | 84.7 | 81.4 | 76.8 | 75.4 | 74.1 | 77.4 |
| Female | 76.3 | 85.2 | 80.4 | 84.0 | 76.5 | 74.4 | 77.9 |
| African American | 60.0 | 75.0 | 100 | 66.7 | 64.6 | 60.6 | 74.4 |
| Asian/Pacific Islander | 60.0 | 100 | 83.3 | 100 | 80.8 | 78.4 | 78.8 |
| Native American | . | . | . | . | 68.6 | 62.2 | 78.8 |
| White | 78.4 | 84.7 | 80.6 | 80.2 | 76.8 | 75.8 | 79.5 |
| Other/unknown race | 100 | . | . | . | 73.9 | 69.2 | 74.0 |
| Hispanic | 80.5 | 86.5 | 80.6 | 79.4 | 77.9 | 76.7 | 79.5 |
| < 1 year since start of ESRD | 50.0 | 94.4 | 76.2 | 55.6 | 61.6 | 58.6 | 64.0 |
| 1-2 years since start of ESRD | 77.1 | 77.8 | 75.0 | 76.3 | 74.6 | 72.9 | 76.7 |
| 3+ years since start of ESRD | 86.2 | 86.4 | 85.5 | 86.4 | 79.3 | 77.8 | 81.0 |

n/a = not applicable

[*1] Based on patients with Medicare as primary insurer; see *Guide, Section X*.

[*2] Values are shown for the average facility.

[*3] A p-value greater than or equal to 0.05 indicates that the difference between percent of patients vaccinated at the facility and national percentage is plausibly due to random chance.

[*4] Compared to the U.S. value for that year and time period (8/1-12/31): 73.6% (2016), 77.9% (2017), 78.3% (2018), 77.6% (2019).

[*5] Compared to the U.S. value for that year and time period (8/1-3/31): 74.4% (2016), 78.8% (2017), 79.0% (2018).

[*6] A missing value indicates that there were no eligible patients in the subgroup.

TABLE 8: Anemia Management Summaries for Adult Dialysis Patients^{*1}, 2016-2019

| Measure Name | This Facility | | | | Regional Averages ^{*2} , 2019 | | |
|---|---------------|-------|-------|-------|--|---------|-------|
| | 2016 | 2017 | 2018 | 2019 | State | Network | U.S. |
| Hemoglobin and ESA for Adult Hemodialysis (HD) Patients | | | | | | | |
| 8a Eligible patients (n) | 184 | 177 | 185 | 178 | 107.7 | 116.9 | 75.3 |
| 8b Eligible patient-months (n) ^{*3} | 1,686 | 1,600 | 1,612 | 1,744 | 977.8 | 1,064.1 | 659.0 |
| 8c Average hemoglobin ^{*4} (g/dL) (average of 8b) | 10.8 | 10.9 | 11.0 | 10.8 | 10.8 | 10.8 | 10.7 |
| 8d Hemoglobin categories (% of 8b; sums to 100%) | | | | | | | |
| <10 g/dL | 14.5 | 13.1 | 9.3 | 15.0 | 20.4 | 20.8 | 22.3 |
| 10-<11 g/dL | 40.9 | 39.9 | 38.5 | 41.1 | 36.5 | 36.5 | 35.1 |
| 11-12 g/dL | 33.7 | 37.2 | 37.5 | 32.9 | 30.1 | 29.7 | 29.0 |
| >12 g/dL | 8.8 | 8.4 | 10.0 | 9.9 | 11.3 | 11.2 | 11.7 |
| Missing/Out of range | 2.0 | 1.4 | 4.6 | 1.1 | 1.8 | 1.7 | 1.9 |
| 8e ESA prescribed (% of 8b) | 87.1 | 86.8 | 84.1 | 85.0 | 73.4 | 78.0 | 75.2 |
| Hemoglobin and ESA for Adult Peritoneal Dialysis (PD) Patients | | | | | | | |
| 8f Eligible patients (n) | 22 | 25 | 30 | 37 | 36.6 | 35.9 | 22.1 |
| 8g Eligible patient-months (n) ^{*3} | 171 | 217 | 278 | 315 | 300.8 | 300.7 | 172.7 |
| 8h Average hemoglobin ^{*4} (g/dL) (average of 8g) | 10.6 | 11.2 | 10.9 | 11.0 | 10.8 | 10.7 | 10.9 |
| 8i Hemoglobin categories (% of 8g; sums to 100%) | | | | | | | |
| <10 g/dL | 37.4 | 23.0 | 19.4 | 16.2 | 25.0 | 25.8 | 23.4 |
| 10-<11 g/dL | 29.2 | 24.0 | 29.5 | 40.0 | 31.7 | 31.1 | 29.4 |
| 11-12 g/dL | 15.2 | 29.0 | 35.3 | 29.5 | 25.4 | 24.8 | 26.0 |
| >12 g/dL | 16.4 | 23.5 | 13.3 | 11.7 | 14.8 | 15.1 | 18.0 |
| Missing/Out of range | 1.8 | 0.5 | 2.5 | 2.5 | 3.2 | 3.3 | 3.2 |
| 8j ESA prescribed (% of 8g) | 81.9 | 78.3 | 83.1 | 80.3 | 56.0 | 59.7 | 56.1 |
| Standardized Transfusion Ratio (STrR) | | | | | | | |
| 8k Eligible adult Medicare patients (n) | 141 | 140 | 141 | 132 | 56.2 | 57.5 | 47.2 |
| 8l Patient years (PY) at risk (n) | 94 | 97 | 99 | 99 | 36.4 | 37.1 | 30.0 |
| 8m Total transfusions (n) | 25 | 29 | 22 | 28 | 9.0 | 9.9 | 9.3 |
| 8n Expected total transfusions (n) | 33.5 | 33.5 | 33.7 | 33.7 | 11.4 | 11.6 | 9.5 |
| 8o Standardized Transfusion Ratio ^{*5} | 0.75 | 0.87 | 0.65 | 0.83 | 0.79 | 0.85 | 1.01 |
| Upper Confidence Limit (97.5%) | 1.50 | 1.64 | 1.33 | 1.55 | n/a | n/a | n/a |
| Lower Confidence Limit (2.5%) | 0.41 | 0.50 | 0.36 | 0.49 | n/a | n/a | n/a |
| 8p P-value ^{*6} | 0.461 | 0.744 | 0.264 | 0.641 | n/a | n/a | n/a |

n/a = not applicable

[*1] See *Guide, Section XI*. Transfusion summaries include adult Medicare Dialysis Patients only.

[*2] Values are shown for the average facility.

[*3] Patients may be counted up to 12 times per year.

[*4] Based on in-range values; see *Guide* for range values.

[*5] Calculated as a ratio of observed to expected transfusions (8m to 8n); not shown if there are fewer than 10 patient-years at risk (8l). The confidence interval range represents uncertainty in the value of the STrR due to random variation.

[*6] A p-value less than 0.05 indicates that the difference between the actual and expected transfusion is probably real and is not due to random chance alone, while a p-value greater than or equal to 0.05 indicates that the difference could plausibly be due to random chance.

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TABLE 9: Dialysis Adequacy Summaries for Adult Dialysis Patients^{*1}, 2016-2019

| Measure Name | This Facility | | | | Regional Averages ^{*2} , 2019 | | |
|--|---------------|-------|-------|-------|--|---------|-------|
| | 2016 | 2017 | 2018 | 2019 | State | Network | U.S. |
| Hemodialysis (HD) Adequacy | | | | | | | |
| 9a Eligible adult HD patients (n) | 184 | 177 | 185 | 178 | 107.7 | 116.9 | 75.3 |
| 9b Eligible adult HD patient-months (n) ^{*3} | 1,686 | 1,600 | 1,612 | 1,744 | 977.8 | 1,064.1 | 659.0 |
| 9c Average serum albumin (g/dL) (average of 9b) | 3.7 | 3.7 | 3.7 | 3.7 | 3.9 | 3.9 | 4.7 |
| 9d Serum albumin categories (% of 9b; sums to 100%) | | | | | | | |
| < 3.0 g/dL | 3.9 | 4.7 | 4.2 | 4.0 | 2.3 | 2.3 | 2.6 |
| 3.0-<3.5 g/dL | 16.1 | 19.6 | 17.6 | 17.9 | 9.3 | 9.2 | 10.3 |
| 3.5-<4.0 g/dL | 44.5 | 50.8 | 51.4 | 50.1 | 41.9 | 41.7 | 42.7 |
| >=4.0 g/dL | 17.9 | 23.4 | 24.7 | 26.9 | 43.9 | 44.2 | 41.7 |
| Missing | 17.7 | 1.6 | 2.1 | 1.2 | 2.7 | 2.6 | 2.8 |
| 9e Serum albumin<4.0 g/dl(% of 9b) | 64.4 | 75.1 | 73.2 | 71.9 | 53.4 | 53.2 | 55.5 |
| 9f Ultrafiltration rate average ^{*4} (ml/kg/hr) (average of 9b) | 9.3 | 8.8 | 9.0 | 9.0 | 8.1 | 8.1 | 7.6 |
| 9g Ultrafiltration rate categories (% of 9b; sums to 100%) | | | | | | | |
| <=13 ml/kg/hr | 73.3 | 78.1 | 76.8 | 76.9 | 83.1 | 83.0 | 85.1 |
| >13 ml/kg/hr | 14.7 | 13.5 | 15.1 | 16.6 | 10.3 | 10.3 | 7.8 |
| Missing/Out of range | 12.0 | 8.4 | 8.1 | 6.4 | 6.6 | 6.8 | 7.1 |
| 9h Eligible adult HD Kt/V patients (n) ^{*5} | 165 | 166 | 171 | 162 | 101.1 | 110.1 | 72.1 |
| 9i Eligible adult HD Kt/V patient-months (n) ^{*3 *5} | 1,494 | 1,469 | 1,456 | 1,566 | 869.8 | 949.8 | 607.0 |
| 9j Average Kt/V ^{*4} (average of 9i) | 1.6 | 1.5 | 1.5 | 1.5 | 1.6 | 1.6 | 1.6 |
| 9k Kt/V categories (% of 9i; sums to 100%) | | | | | | | |
| <1.2 | 3.7 | 4.4 | 1.2 | 1.9 | 1.8 | 1.6 | 1.6 |
| 1.2-<1.8 | 72.9 | 80.7 | 84.7 | 86.0 | 72.2 | 71.7 | 70.7 |
| >=1.8 | 20.9 | 13.4 | 13.0 | 11.7 | 24.8 | 25.6 | 26.4 |
| Missing/Out of range | 2.5 | 1.5 | 1.1 | 0.4 | 1.2 | 1.2 | 1.3 |
| Peritoneal Dialysis (PD) Adequacy | | | | | | | |
| 9l Eligible adult PD patients (n) | 22 | 25 | 30 | 37 | 36.6 | 35.9 | 22.1 |
| 9m Eligible adult PD patient-months (n) ^{*3} | 171 | 217 | 278 | 315 | 300.8 | 300.7 | 172.7 |
| 9n Average weekly Kt/V ^{*4 *5} (average of 9m) | 2.2 | 2.4 | 2.2 | 2.2 | 2.2 | 2.2 | 2.2 |
| 9o Weekly Kt/V categories (% of 9m; sums to 100%) ^{*5} | | | | | | | |
| <1.7 | 7.0 | 4.6 | 9.0 | 3.8 | 5.4 | 5.4 | 5.0 |
| 1.7-<2.5 | 64.3 | 57.6 | 56.5 | 73.3 | 68.7 | 68.2 | 67.9 |
| >=2.5 | 20.5 | 35.5 | 30.9 | 20.3 | 20.7 | 20.7 | 23.4 |
| Missing/Out of range | 8.2 | 2.3 | 3.6 | 2.5 | 5.2 | 5.7 | 3.7 |
| 9p Average serum albumin (g/dL) (average of 9m) | 3.3 | 3.4 | 3.5 | 3.4 | 3.6 | 3.6 | 3.6 |
| 9q Serum albumin categories (% of 9m; sums to 100%) | | | | | | | |
| < 3.0 g/dL | 19.9 | 18.9 | 8.3 | 11.1 | 6.7 | 7.1 | 7.6 |
| 3.0-<3.5 g/dL | 39.2 | 35.5 | 39.2 | 38.4 | 25.0 | 25.2 | 25.1 |
| 3.5-<4.0 g/dL | 31.0 | 35.5 | 36.7 | 40.6 | 43.0 | 42.9 | 43.0 |
| >=4.0 g/dL | 7.6 | 9.7 | 12.9 | 7.0 | 21.9 | 21.3 | 21.2 |
| Missing | 2.3 | 0.5 | 2.9 | 2.9 | 3.4 | 3.5 | 3.2 |
| 9r Serum albumin <4.0 g/dL(% of 9m) | 90.1 | 89.9 | 84.2 | 90.2 | 74.8 | 75.2 | 75.7 |

n/a = not applicable.

[*1] See *Guide, Section XII*. Unless otherwise noted, all summaries are based on data reported in CROWNWeb and the patient must be on HD (or PD) for the entire reporting month to be included in patient counts and summaries.

[*2] Values are shown for the average facility.

[*3] Patients may be counted up to 12 times per year.

[*4] Based on in-range values; see *Guide* for range values.

[*5] Kt/V summaries are supplemented with Medicare claims if missing in CROWNWeb. HD Kt/V summaries are restricted to patients who dialyze thrice weekly. See section of *Guide* titled "Determination of Thrice Weekly Dialysis" for more information. The most recent value over a 4-month period is selected for PD Kt/V.

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TABLE 10: Mineral Metabolism Summaries for All Adult Dialysis Patients^{*1}, 2016-2019

| Measure Name | This Facility | | | | Regional Averages ^{*2} , 2019 | | |
|---|---------------|-------|-------|-------|--|---------|-------|
| | 2016 | 2017 | 2018 | 2019 | State | Network | U.S. |
| 10a Eligible adult patients (n) ^{*3} | 206 | 199 | 213 | 209 | 117.5 | 126.0 | 82.5 |
| 10b Eligible adult patient-months (n) ^{*3 *4} | 1,858 | 1,823 | 1,894 | 2,072 | 1,062.8 | 1,145.2 | 722.7 |
| 10c Average phosphorus ^{*5} (mg/dL) (average of 10b ^{*6}) | 5.2 | 5.0 | 5.1 | 5.1 | 5.4 | 5.4 | 5.4 |
| 10d Phosphorus categories (% of 10b; sums to 100%)^{*6} | | | | | | | |
| <3.5 mg/dL | 11.9 | 13.3 | 9.7 | 9.6 | 7.5 | 7.7 | 7.7 |
| 3.5-4.5 mg/dL | 26.4 | 29.3 | 28.0 | 26.8 | 23.7 | 24.0 | 23.5 |
| 4.6-5.5 mg/dL | 26.5 | 25.0 | 28.2 | 27.5 | 31.4 | 31.4 | 30.1 |
| 5.6-7.0 mg/dL | 21.9 | 21.0 | 26.1 | 27.4 | 20.9 | 20.7 | 21.8 |
| >7.0 mg/dL | 11.3 | 9.9 | 5.8 | 7.0 | 14.0 | 13.8 | 14.3 |
| Missing/Out of range | 2.1 | 1.4 | 2.2 | 1.7 | 2.5 | 2.5 | 2.6 |
| 10e Average calcium uncorrected ^{*5} (mg/dL) (average of 10b) | 8.9 | 8.9 | 8.8 | 8.8 | 8.9 | 8.9 | 8.9 |
| 10f Calcium uncorrected categories (% of 10b; sums to 100%) | | | | | | | |
| <8.4 mg/dL | 14.8 | 17.8 | 18.7 | 21.1 | 18.2 | 18.5 | 19.2 |
| 8.4-10.2 mg/dL | 67.7 | 80.0 | 78.0 | 76.7 | 78.5 | 78.2 | 77.3 |
| >10.2 mg/dL | 1.3 | 0.8 | 1.0 | 0.7 | 1.1 | 1.1 | 1.2 |
| Missing/Out of range | 16.2 | 1.4 | 2.3 | 1.4 | 2.2 | 2.2 | 2.3 |
| 10g Average uncorrected serum or plasma calcium > 10.2 mg/dL ^{*5 *7} | 2.6 | 1.0 | 1.5 | 1.2 | 1.8 | 1.7 | 1.7 |

[*1] See *Guide, Section XIII*. Summaries are based on data reported in CROWNWeb and the patient must be assigned to the facility the entire month to be included.

[*2] Values are shown for the average facility.

[*3] Includes patients on ESRD more than 90 days who switch between HD and PD during the month and patients for whom modality is unknown.

[*4] Patients may be counted up to 12 times per year.

[*5] The acceptable range for phosphorus and calcium is 0.1 – 20 mg/dL. Values outside of this range are considered missing, which are counted towards the numerator.

[*6] Eligible patients included in the phosphorus summaries differ slightly from what is reported in 10b since it includes patient-months within the first 90 days of ESRD.

[*7] Hypercalcemia is averaged from uncorrected serum or plasma calcium values over a rolling 3-month period. Eligible patients included in the hypercalcemia summary differs slightly from what is reported in 10b since patients must be 18 as of the first day of the 3-month period.

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TABLE 11: Vascular Access Information for All Dialysis Patients and Access-Related Infection Summaries for All Medicare Patients^{*1}, 2016-2019

| Measure Name | This Facility | | | | Regional Averages ^{*2} , 2019 | | | |
|--|---|-------------|-------------|-------------|--|-------------|-------------|-------------|
| | 2016 | 2017 | 2018 | 2019 | State | Network | U.S. | |
| Vascular Access | | | | | | | | |
| 11a | Prevalent adult hemodialysis patients (n) | 197 | 190 | 207 | 184 | 112.2 | 121.9 | 79.5 |
| 11b | Prevalent adult hemodialysis patient-months(n) ^{*3 *4} | 1,729 | 1,632 | 1,764 | 1,786 | 1,012.3 | 1,100.3 | 686.3 |
| 11c | Vascular access type in use (% of 11b; sums to 100%) | | | | | | | |
| | Arteriovenous fistula | 62.1 | 60.9 | 55.2 | 56.3 | 67.5 | 67.6 | 62.9 |
| | Arteriovenous graft | 5.6 | 7.0 | 7.3 | 8.6 | 14.9 | 14.7 | 17.8 |
| | Catheter | 29.3 | 29.3 | 35.3 | 32.1 | 15.9 | 16.0 | 17.4 |
| | Other/Missing | 3.0 | 2.8 | 2.3 | 3.0 | 1.7 | 1.7 | 1.9 |
| 11d | Standardized Fistula Rate (SFR) ^{*5} | 63.6 | 63.1 | 57.7 | 58.3 | 66.6 | 66.7 | 62.5 |
| 11e | P-value ^{*6} | 0.939 | 0.955 | 0.369 | 0.453 | n/a | n/a | n/a |
| 11f | Confidence interval for SFR ^{*7} | | | | | | | |
| | High (97.5% limit) | 50.0 | 49.2 | 44.7 | 45.3 | n/a | n/a | n/a |
| | Low (2.5% limit) | 76.0 | 75.7 | 69.6 | 70.2 | n/a | n/a | n/a |
| 11g | Long-Term Catheter Rate^{*8} | 25.3 | 24.3 | 27.5 | 28.9 | 12.1 | 12.2 | 12.9 |
| Vascular Access at First Treatment | | | | | | | | |
| 11h | Incident hemodialysis patients (n) | 58 | 55 | 68 | 25 | 18.5 | 19.8 | 14.6 |
| 11i | Vascular access type in use (% of 11h; sums to 100%) | | | | | | | |
| | Arteriovenous fistula | 5.2 | 0.0 | 5.9 | 0.0 | 16.6 | 14.2 | 14.1 |
| | Arteriovenous graft | 0.0 | 0.0 | 1.5 | 0.0 | 3.9 | 3.1 | 3.3 |
| | Catheter | 94.8 | 98.2 | 92.6 | 100.0 | 73.4 | 76.4 | 77.3 |
| | Other/Missing | 0.0 | 1.8 | 0.0 | 0.0 | 6.1 | 6.3 | 5.2 |
| 11j | Arteriovenous fistulae in place (% of 11h) ^{*9} | 5.2 | 0.0 | 5.9 | 0.0 | 17.2 | 14.9 | 15.1 |
| Infection: Peritoneal dialysis (PD) | | | | | | | | |
| 11k | Eligible PD patients (n) | 14 | 19 | 24 | 27 | 15.6 | 15.3 | 14.6 |
| 11l | Eligible PD patient-months ^{*4} | 120 | 148 | 191 | 249 | 118.1 | 115.2 | 102.2 |
| 11m | PD catheter infection rate per 100 PD patient-months ^{*10} | 4.17 | 0.68 | 3.14 | 2.41 | 2.12 | 2.15 | 2.06 |
| 11n | P-value ^{*11} of 11m (compared to U.S. value) ^{*12} | 0.195 | 0.105 | 0.338 | 0.581 | n/a | n/a | n/a |

n/a = not applicable

[*1] See *Guide, Section XIV*. Vascular Access type is based on data reported in CROWNWeb. For the prevalent summaries (rows 11a-11g), the patient must be assigned to the facility for the entire calendar month to be included. The PD infection summaries are based on Medicare Dialysis claims.

[*2] Values are shown for the average facility.

[*3] Patient months with a catheter that have limited life expectancy, including under hospice care in the current reporting month, or with metastatic cancer, end stage liver disease, coma or anoxic brain injury in the past 12 months, were excluded.

[*4] Patients may be counted up to 12 times per year.

[*5] Includes patients with an autogenous arteriovenous (AV) fistula as the sole means of vascular access. SFR is calculated as an adjusted rate of AV fistula in use reported in 11c; not shown if fewer than 11 eligible adult HD patients.

[*6] A p-value less than 0.05 indicates that the difference between the fistula rate for your facility and the overall national fistula rate is probably real and is not due to random chance alone.

[*7] The confidence interval range represents uncertainty in the value of the SFR due to random variation.

[*8] Includes patients using a catheter continuously for three months or longer. Patients with other or missing access types (11c) are also counted as catheter in use in the numerator.

[*9] Includes all patients with fistulae, regardless of whether or not they received their hemodialysis treatments using their fistulae.

[*10] The ICD-9 PD catheter infection code for PD patients is 996.68 which is effective thru 9/30/2015 and the ICD-10 PD catheter infection code for PD patients is T8571XA which is effective beginning 10/1/2015.

[*11] A p-value greater than or equal to 0.05 indicates the differences between the percent of patients with infection at the facility and national percentage is plausibly due to random change.

[*12] Compared to U.S. value for that year: 2.89 (2016), 2.65 (2017), 2.65 (2018), and 2.06 (2019).

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TABLE 12: Comorbidities Reported on Medicare Claims for Medicare Dialysis Patients Treated as of December 31st of Each Year^{*1}, 2016-2019

| | Measure Name | This Facility | | | | Regional Averages ^{*2} , 2019 | | |
|-----|--|---------------|------|------|------|--|---------|------|
| | | 2016 | 2017 | 2018 | 2019 | State | Network | U.S. |
| 12a | Medicare dialysis patients on 12/31 (n) | 129 | 122 | 127 | 126 | 57.1 | 60.6 | 45.5 |
| 12b | Comorbidity (% yes of 12a) | | | | | | | |
| | Infections | | | | | | | |
| | AIDS/HIV positive | 0.0 | 0.0 | 0.0 | 0.0 | 0.8 | 0.7 | 1.7 |
| | Intravascular/implanted device-related ^{*3} | 23.3 | 13.1 | 11.8 | 13.5 | 7.2 | 7.4 | 8.5 |
| | Hepatitis B | 1.6 | 0.8 | 0.8 | 0.0 | 1.8 | 1.7 | 1.4 |
| | Hepatitis other | 2.3 | 4.1 | 3.1 | 3.2 | 4.6 | 4.4 | 4.8 |
| | Metastatic | 5.4 | 2.5 | 3.1 | 3.2 | 2.7 | 2.7 | 3.2 |
| | Pneumonia | 9.3 | 9.0 | 10.2 | 7.1 | 9.5 | 9.5 | 10.5 |
| | Tuberculosis | 2.3 | 0.8 | 0.8 | 0.0 | 0.7 | 0.8 | 0.6 |
| | Other | 47.3 | 33.6 | 34.6 | 36.5 | 33.8 | 33.8 | 35.0 |
| | Cardiovascular | | | | | | | |
| | Cardiac arrest | 1.6 | 1.6 | 0.0 | 1.6 | 1.6 | 1.6 | 1.7 |
| | Cardiac dysrhythmia | 34.1 | 31.1 | 32.3 | 32.5 | 37.2 | 36.5 | 38.2 |
| | Cerebrovascular disease | 21.7 | 25.4 | 28.3 | 27.0 | 23.8 | 23.5 | 24.5 |
| | Congestive heart failure | 55.0 | 51.6 | 54.3 | 49.2 | 52.3 | 52.2 | 54.7 |
| | Ischemic heart disease | 53.5 | 54.1 | 50.4 | 52.4 | 47.2 | 46.9 | 49.6 |
| | Myocardial infarction | 11.6 | 10.7 | 9.4 | 10.3 | 11.5 | 11.9 | 11.3 |
| | Peripheral vascular disease ^{*4} | 65.1 | 58.2 | 49.6 | 50.8 | 46.4 | 46.3 | 44.6 |
| | Other | | | | | | | |
| | Alcohol dependence | 2.3 | 4.1 | 3.9 | 0.0 | 3.2 | 3.3 | 3.1 |
| | Anemia | 32.6 | 92.6 | 90.6 | 88.1 | 9.6 | 10.3 | 10.6 |
| | Cancer | 8.5 | 4.9 | 7.1 | 8.7 | 9.6 | 9.6 | 11.5 |
| | Chronic obstructive pulmonary disease | 35.7 | 39.3 | 26.0 | 25.4 | 26.6 | 25.2 | 31.7 |
| | Diabetes | 84.5 | 82.0 | 78.7 | 81.7 | 72.7 | 73.7 | 68.3 |
| | Drug dependence | 4.7 | 2.5 | 1.6 | 1.6 | 3.4 | 3.5 | 3.8 |
| | Gastrointestinal tract bleeding | 7.0 | 3.3 | 3.1 | 3.2 | 4.0 | 4.0 | 4.4 |
| | Hyperparathyroidism | 75.2 | 74.6 | 78.0 | 78.6 | 87.2 | 84.6 | 87.3 |
| 12c | Average number of comorbid conditions | 5.8 | 6.0 | 5.8 | 5.7 | 5.0 | 4.9 | 5.1 |

n/a = not applicable

[*1] Based on patients with Medicare as primary insurer on 12/31 each year. See *Guide, Section XV*.

[*2] Values are shown for the average facility.

[*3] This category includes bloodstream and other infections related to intravascular access and other implanted devices, not limited to dialysis access.

[*4] Peripheral vascular disease includes venous, arterial and nonspecific peripheral vascular diseases.

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TABLE 13: Facility Information ^{*1} , 2019

| Measure Name | This Facility 2019 | Regional Averages ^{*2} , 2019 | | |
|---|--------------------------------------|---|---------|-------|
| | | State | Network | U.S. |
| 13a Organization | INDEPENDENT | | | |
| 13b Ownership | Non-profit | | | |
| 13c Initial Medicare certification date | 08/22/1977 | | | |
| 13d Number of stations | 26 | | | |
| 13e Services provided | Hemodialysis and Peritoneal Dialysis | | | |
| 13f Shifts after 5:00 pm | Yes | | | |
| 13g Dialyzer Reuse | . | | | |
| 13h CMS Certification Numbers (CCN) included in this report | 050057 053506 | | | |
| 13i National Provider Identifier (NPI) ^{*3} | 1245291558 | | | |
| Long Term Care (LTC) ^{*4} | | | | |
| 13j Dialysis facility located in a Skilled Nursing Facility (SNF) | No | | | |
| 13k Services provided in LTC facility by non-SNF based facility | None | | | |
| Patient Placement | | | | |
| 13l Patients treated during year from AFS Form-2744 (n) | 230 | 145.6 | 157.4 | 101.5 |
| 13m Transferred into facility (% of 13l) | 4.3 | 13.2 | 12.9 | 15.9 |
| 13n Transferred out of facility (% of 13l) | 5.7 | 13.8 | 13.5 | 15.9 |
| 13o Patients treated on 12/31 (n) | 174 | n/a | n/a | n/a |
| 13p Medicare eligibility status (% of 13o; sums to 100% ^{*5}) | | n/a | n/a | n/a |
| Medicare | 79.3 | 66.3 | 65.5 | 74.6 |
| Medicare application pending | 0.6 | 0.9 | 1.0 | 0.8 |
| Non-Medicare | 20.1 | 32.7 | 33.5 | 24.6 |
| Survey and Certification ^{*6} | | | | |
| 13q Date of last survey | 02/24/2017 | | | |
| 13r Type of survey | Recertification | | | |
| 13s Compliance condition after survey | Does Not Meet Requirements | | | |
| 13t Number of CFC deficiencies cited | 2 | 0.4 | 0.5 | 0.2 |
| 13u Number of Standard deficiencies cited | 20 | 8.2 | 9.3 | 4.9 |

n/a = not applicable

[*1] See *Guide, Section XVI*. Information based on data reported in CROWNWeb as of May, 2020. If missing, data were not available.

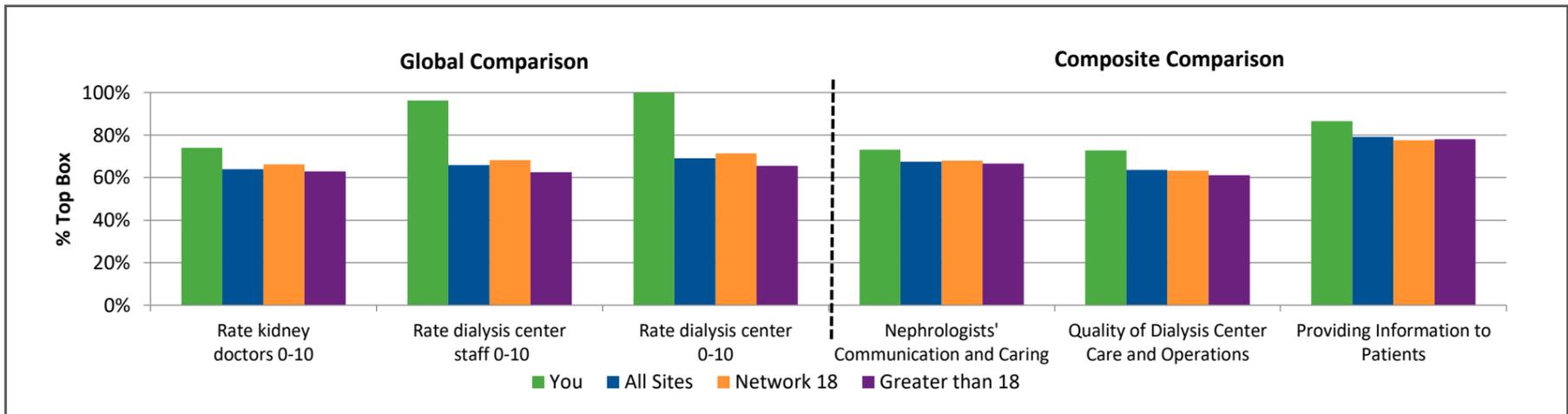
[*2] Values are shown for the average facility.

[*3] 'NPI' obtained from CROWNWeb as of March 2020. If missing, data were not available.

[*4] LTC information obtained from CMS Form-3427 submitted during most recent survey.

[*5] Values may not sum to exactly 100% because of unknown Medicare status.

[*6] Data on this section are from the facility's latest survey since January 2009 according to information reported in QIES as of early June 2020. If your facility has not been surveyed since January 2009, facility-level data on this table will be missing.



| Kaweah Delta Visalia Dialysis | Current n | Your Top Box Score | | | All Sites N=2,792 | Network 18 N=84 | Greater than 18 N=920 |
|---|-----------|------------------------|-----------------------|---|-------------------|-----------------|-----------------------|
| | | Previous % May19-Jul19 | Current % Nov19-Jan20 | | | | |
| Composite Question | | | | | | | |
| Rate kidney doctors 0-10 | 27 | 78.4% | 74.1% | ▼ | 76 | 77 | 82 |
| Rate dialysis center staff 0-10 | 27 | 88.6% | 96.3% | ▲ | 99 | 99 | 99 |
| Rate dialysis center 0-10 | 27 | 91.4% | 100.0% | ▲ | 99 | 99 | 99 |
| Nephrologists' Communication and Caring | | 75.0% | 73.2% | ▼ | 69 | 69 | 76 |
| Doctors listen carefully to you | 28 | 73.7% | 71.4% | ▼ | 68 | 68 | 73 |
| Doctors expl in way you understand | 28 | 71.1% | 60.7% | ▼ | 41 | 40 | 43 |
| Doctors treat with respect | 28 | 78.9% | 82.1% | ▲ | 80 | 88 | 87 |
| Doctors spend enough time with you | 28 | 60.5% | 60.7% | ▲ | 72 | 72 | 80 |
| Doctors cared about you as a person | 28 | 73.7% | 67.9% | ▼ | 52 | 58 | 56 |
| Doctors informed and up-to date | 26 | 91.9% | 96.2% | ▲ | 88 | 96 | 95 |
| Quality of Dialysis Center Care and Operations | | 70.8% | 72.9% | ▲ | 84 | 95 | 94 |
| Staff listen carefully to you | 28 | 73.7% | 67.9% | ▼ | 65 | 65 | 76 |
| Staff expl in way you understand | 28 | 71.1% | 75.0% | ▲ | 84 | 95 | 93 |
| Staff treat with respect | 28 | 68.4% | 75.0% | ▲ | 76 | 84 | 88 |
| Staff spend enough time with you | 27 | 68.4% | 66.7% | ▼ | 75 | 82 | 87 |
| Staff cared about you as a person | 28 | 78.9% | 75.0% | ▼ | 78 | 88 | 90 |
| Staff make you comfortable | 28 | 92.1% | 82.1% | ▼ | 87 | 90 | 95 |
| Staff keep info about you private | 28 | 91.7% | 89.3% | ▼ | 26 | 21 | 26 |
| Comfortable asking staff about care | 28 | 97.3% | 96.4% | ▼ | 70 | 80 | 79 |
| Staff insert needle w/ little pain | 17 | 39.3% | 58.8% | ▲ | 86 | 98 | 96 |
| Staff check as closely as wanted | 28 | 77.1% | 78.6% | ▲ | 90 | 99 | 98 |
| Staff manage prob during dialysis | 2 | 50.0% | 100.0% | ▲ | 99 | N<7 | 99 |
| Staff behave in professional manner | 27 | 86.1% | 85.2% | ▼ | 87 | 95 | 96 |
| Staff discuss what to eat and drink | 27 | 94.4% | 96.3% | ▲ | 77 | 81 | 86 |
| Staff expl test results clearly | 27 | 66.7% | 74.1% | ▲ | 82 | 95 | 90 |
| On machine within 15 min of appt | 27 | 31.4% | 37.0% | ▲ | 38 | 19 | 47 |
| Dialysis center clean as could be | 27 | 82.9% | 81.5% | ▼ | 79 | 85 | 91 |
| Satisfied with handling of problems | 2 | 33.3% | 0.0% | ▼ | 1 | N<7 | N<7 |
| Providing Information to Patients | | 82.0% | 86.5% | ▲ | 85 | 99 | 94 |
| Take care graft, fistula, catheter | 28 | 97.3% | 92.9% | ▼ | 59 | 75 | 68 |
| Staff give info re: patient rights | 26 | 88.2% | 84.6% | ▼ | 34 | 48 | 40 |
| Staff review patient rights | 26 | 81.8% | 92.3% | ▲ | 91 | 99 | 97 |
| Staff give info re: problem at home | 27 | 85.7% | 96.3% | ▲ | 92 | 99 | 98 |
| Staff discuss emergency disconnect | 26 | 91.4% | 88.5% | ▼ | 48 | 44 | 51 |
| Doctor/staff discuss best treatment | 27 | 82.4% | 96.3% | ▲ | 94 | 99 | 99 |
| Expl why ineligible for transplant | 6 | 62.5% | 83.3% | ▲ | 89 | 99 | 99 |
| Dr/staff talk re: peritoneal dialys | 27 | 57.6% | 59.3% | ▲ | 49 | 57 | 49 |
| Involved in choosing treatment | 27 | 90.9% | 85.2% | ▼ | 40 | 62 | 48 |

| Items Correlated to Rate Dialysis Center 0-10 | | | |
|---|-------------|----------------|-------------|
| Order | Survey Item | All Sites Rank | Correlation |
| Insufficient Data | | | |

The priority index combines information about your organization's performance and the relative importance of each question to respondents' overall rating. Higher priority is given to those issues that are relatively more important to respondents (higher correlation coefficients) and relatively lower performing (lower percentile rank) for your organization. Questions are listed in decreasing priority.



**Quality Assessment & Performance Improvement (QAPI)
KD Visalia Hemodialysis & KD Visalia Peritoneal Dialysis**

**Meeting Date: October 29, 2020
Reporting Period: September 2020**

Renal Services Medical Director: Roger Haley, MD, FACP
Director of Renal Services: Amy Baker, MSN, BSHA, RN, CMSRN

Location: GoToMeeting Teleconference
Facilitator: Nicole Rhodes

Members Present via GoToMeeting Teleconference: Sign in sheet documented via roll call

| Topic | Discussion | Action | Status |
|---|---|--|--|
| Welcome/Call to Order/Roll Call | | Meeting was called to order at 12:33pm | |
| Approval of Previous Meeting Minutes | Minutes were approved as written. | | |
| Celebrations Recognitions | <i>All</i> <ul style="list-style-type: none"> SW's for completing 175 depression screenings by the end of September | | |
| Hemodialysis Outcomes | | | |
| Census | Visalia Hemo – 140 patients (September) | | |
| Adequacy | <i>Jessica</i> <ul style="list-style-type: none"> Reviewed and discussed adequacy Got not met QIP Ultrafiltration Reporting measure – missed points for no clinical data submissions during the week of the Kt/V lab draw in CrownWeb <p><i>Refer to Adequacy Report in QAPI tool for more information</i></p> | <ul style="list-style-type: none"> Considering a process change to draw necessary labs while patients are hospitalized, meet with Amy to discuss; per CrownWeb process instructions and Network 18, patient hospitalizations greater than 30 days are to be discharged from CrownWeb and readmitted upon return to the clinic | <ul style="list-style-type: none"> Completed |
| Transfusions | <i>Jessica</i> <ul style="list-style-type: none"> No significant issues to report Met with Revenue Cycle team to discuss ways of reducing expenses and becoming more profitable | <ul style="list-style-type: none"> Michele and Dr. Haley to meet prior to next QAPI meeting | <ul style="list-style-type: none"> In process, more to come |

| Topic | Discussion | Action | Status |
|---------------------------------|--|---|--|
| | <p>Refer to Transfusion Report in QAPI tool for more information</p> | | |
| <p>Infection Control</p> | <p>Jessica</p> <ul style="list-style-type: none"> • Reviewed and discussed infections • Goal not met • Create a Dialysis Vascular Access Related Blood Culture Protocol • Tracking tool <p>Refer to Infection Control Report in QAPI tool for more information</p> | <ul style="list-style-type: none"> • Coleen will assist Melissa • Utilize root cause analysis tool (fishbone) to investigate (shift, who put patient on, organism, day, technique, staff, station, access related, etc.) | <ul style="list-style-type: none"> • Currently working on • In process |
| <p>Modality</p> | <p>Jessica</p> <ul style="list-style-type: none"> • No modality changes to PD to report for September <p>Refer to Modality Report in QAPI tool for more information</p> | | |
| <p>Readmissions</p> | <p>Jessica</p> <ul style="list-style-type: none"> • Reviewed and discussed readmissions • Tracking tool <p>Refer to Readmissions Report in QAPI tool for more information</p> | <ul style="list-style-type: none"> • Utilize root cause analysis tool (fishbone) to investigate dialysis related readmissions <ul style="list-style-type: none"> ○ Hyperkalemia, fluid overload, VA issues/infections, missed treatments, CHF exacerbation | <ul style="list-style-type: none"> • In process |
| <p>Hospitalizations</p> | <p>Jessica</p> <ul style="list-style-type: none"> • Reviewed and discussed hospitalizations • Tracking tool <p>Refer to Hospitalizations Report in QAPI tool for more information</p> | <ul style="list-style-type: none"> • Utilize root cause analysis tool (fishbone) to investigate <ul style="list-style-type: none"> ○ Dialysis related categories to look at are hyperkalemia, fluid overload, VA issues, missed treatments, CHF exacerbation | <ul style="list-style-type: none"> • In process |
| <p>Vaccinations</p> | <p>Jessica</p> <ul style="list-style-type: none"> • Reviewed and discussed vaccination data | | |

| Topic | Discussion | Action | Status |
|--------------------|--|---|--|
| | <ul style="list-style-type: none"> • Goal not met • No significant issues to report <p><i>Refer to Vaccinations Report in QAPI tool for more information</i></p> | <ul style="list-style-type: none"> • Will begin administering flu vaccines 10/1/20 | |
| Nutritional Status | <p>Nicole B/Stephanie</p> <ul style="list-style-type: none"> • Albumin – goal met <ul style="list-style-type: none"> ○ No significant issues to report <p><i>Refer to Nutritional Status Report in QAPI tool for more information</i></p> | | |
| Mineral Metabolism | <p>Nicole B/Stephanie</p> <ul style="list-style-type: none"> • Calcium – 1 of 2 goals met <ul style="list-style-type: none"> ○ No significant issues to report • Phosphorus – goals met <ul style="list-style-type: none"> ○ No significant issues to report <p><i>Refer to Mineral Metabolism Report in QAPI tool for more information</i></p> | <ul style="list-style-type: none"> • Patient adherence to medication <ul style="list-style-type: none"> ○ Calcium based binders ○ Higher calcium bath ○ Adjustments to Calcimimetics | <ul style="list-style-type: none"> • Ongoing |
| Anemia Management | <p>Coleen</p> <ul style="list-style-type: none"> • iPTH – 1 of 2 goals met <ul style="list-style-type: none"> ○ No significant issues to report • Hgb – 2 of 4 goals met <ul style="list-style-type: none"> ○ No significant issues to report • Saturation – goal met <ul style="list-style-type: none"> ○ No significant issues to report • Ferritin – 1 of 2 goals met <ul style="list-style-type: none"> ○ No significant issues to report <p><i>Refer to Anemia Management Report in QAPI tool for more information</i></p> | <ul style="list-style-type: none"> • Dr. Haley to meet with Coleen to discuss iPTH; keep both measures and adjust goal or add <175 • Dr. Haley will look at TSAT data in Clarity | <ul style="list-style-type: none"> • In process • In process |
| Vascular Access | <p>Kim</p> | | |

| Topic | Discussion | Action | Status |
|----------------------|---|---|--|
| | <ul style="list-style-type: none"> Reviewed and discussed vascular access information AVF rate – goal not met <ul style="list-style-type: none"> AVF's placed in September - 1 LTC rate – goal not met <ul style="list-style-type: none"> LTC's removed in September - 2 VA Patency – from use or placement (survival curve graph, life-table analysis) <p>Refer to Vascular Access Report in QAPI tool for more information</p> | <ul style="list-style-type: none"> Dr. Haley to look into | <ul style="list-style-type: none"> In process |
| Infection Prevention | <p>Michele</p> <ul style="list-style-type: none"> 5 of 9 goals met IP recommendation switching from purple top wipes to alcohol wipes and/or bleach Monthly audits new accountability tracking process starting 11/1/20 <p>Refer to Infection Prevention Report in QAPI tool for more information</p> | <ul style="list-style-type: none"> Will review the policy for revisions During monthly audits, charge RN's will record employee name being recorded, data will be summarized and sent to Michele and Amy; celebrate successes, formal follow up for any fallouts will include an email warning with the policy attached and progressive discipline as necessary | <ul style="list-style-type: none"> In approval in PolicyTech Ongoing |
| ICH CAHPS | <p>Michele</p> <ul style="list-style-type: none"> 2020 Spring (May 20 – Jul 20) Survey Results <ul style="list-style-type: none"> Met clinic goal in 0 out of 6 areas <p>Refer to ICH CAHPS Report in QAPI tool for more information</p> | <ul style="list-style-type: none"> Nicole R will email out survey questions Team to put a plan together to improve | <ul style="list-style-type: none"> In process In process |
| Care Coordination | <p>Michele</p> <ul style="list-style-type: none"> No significant issues to report <p>Refer to Care Coordination Report in QAPI tool for more information</p> | | |
| Mortalities | Michele | | |

| Topic | Discussion | Action | Status |
|---|---|--|--|
| | <ul style="list-style-type: none"> Reviewed and discussed mortalities 2 mortalities in September No mortalities were found to be directly related to dialysis <p><i>Refer to Mortalities Report in QAPI tool for more information</i></p> | | |
| Medical Errors & Occurrences | <p>Michele</p> <ul style="list-style-type: none"> Reviewed and discussed medical errors & occurrences 10 submitted for September <ul style="list-style-type: none"> 7 occurrences 3 transfers to higher level of care Tracking tool <p><i>Refer to Medical Errors & Occurrences Report in QAPI tool for more information</i></p> | <ul style="list-style-type: none"> Will work with Michele to revise tracking tool | <ul style="list-style-type: none"> In process |
| Ultrafiltration | <p>Michele</p> <ul style="list-style-type: none"> Goal not met <p><i>Refer to Ultrafiltration Report in QAPI tool for more information</i></p> | | |
| Employee Vaccinations | <p>Michele</p> <ul style="list-style-type: none"> No significant issues to report Medical staff office flu vaccinations <p><i>Refer to Employee Vaccinations Report in QAPI tool for more information</i></p> | <ul style="list-style-type: none"> Michele to request flu vaccination data for physicians from medical staff office | <ul style="list-style-type: none"> In process |
| Transplant Report | <p>Minnie/Rocio</p> <ul style="list-style-type: none"> Reviewed and discussed transplant report Goal met 1 patient declined transplant <p><i>Refer to Transplant Reports in QAPI tool for more information</i></p> | | |

| Topic | Discussion | Action | Status |
|--|---|--|--|
| KDQOL | <p>Minnie/Rocio</p> <ul style="list-style-type: none"> Reviewed and discussed KDQOL data Goal met <p>Refer to KDQOL Reports in QAPI tool for more information</p> | | |
| Grievances | <p>Minnie/Rocio</p> <ul style="list-style-type: none"> No grievances reported for September <p>Refer to Complaint/Grievance Log for more information</p> | | |
| HD Core Team Updates (operational matters, patient concerns, unstable, etc.) | <p>HD IDT</p> <ul style="list-style-type: none"> No significant issues to report | | |
| Peritoneal Dialysis Outcomes | | | |
| Census | CAPD/CCPD Visalia – 25 patients (September) | | |
| Adequacy | <p>Melissa/Naomi/Ron</p> <ul style="list-style-type: none"> Reviewed and discussed adequacy Monthly goal not met 4 month cumulative QIP goal not met <p>Refer to PD Reports in QAPI tool for more information</p> | | |
| Infection Control | <p>Melissa/Naomi/Ron</p> <ul style="list-style-type: none"> Reviewed and discussed infections 2 infections for September <ul style="list-style-type: none"> 2 peritonitis Medical Director recommendations <ul style="list-style-type: none"> Consider doing cell counts? Management and Prevention of Peritonitis Protocol and Policy <p>Refer to PD Reports in QAPI tool for more information</p> | <ul style="list-style-type: none"> Waiting for Fresenius peritonitis handouts to be translated into Spanish Management and Prevention of Peritonitis Policy and Protocol revisions pending, revision of Prophylactic Antibiotic Admin Protocol pending | <ul style="list-style-type: none"> In process In process |

| Topic | Discussion | Action | Status |
|----------------------|--|---|--|
| Infection Prevention | <p><i>Melissa/Naomi/Ron</i></p> <ul style="list-style-type: none"> No monthly audits performed in September <p><i>Refer to PD Reports in QAPI tool for more information</i></p> | <ul style="list-style-type: none"> Will restart audits 10/1/20 | |
| Readmissions | <p><i>Melissa/Naomi/Ron</i></p> <ul style="list-style-type: none"> Reviewed and discussed readmissions 0 readmissions in September <p><i>Refer to PD Reports in QAPI tool for more information</i></p> | | |
| Hospitalizations | <p><i>Melissa/Naomi/Ron</i></p> <ul style="list-style-type: none"> Reviewed and discussed hospitalizations 4 hospitalizations in September Hospitalizations were not found to be directly related to dialysis <p><i>Refer to PD Reports in QAPI tool for more information</i></p> | <ul style="list-style-type: none"> Implement a process for follow up regarding any access issues | <ul style="list-style-type: none"> In process |
| Mortalities | <p><i>Melissa/Naomi/Ron</i></p> <ul style="list-style-type: none"> 2 mortalities in September Mortalities were not found to be directly related to dialysis <p><i>Refer to PD Reports in QAPI tool for more information</i></p> | | |
| Transfusions | <p><i>Melissa/Naomi/Ron</i></p> <ul style="list-style-type: none"> Transfusions are not offered in the PD clinic | | |
| Vaccinations | <p><i>Melissa/Naomi/Ron</i></p> <ul style="list-style-type: none"> Reviewed and discussed vaccination data Received Flu vaccines, will begin administering October 1st No significant issues to report | | |

| Topic | Discussion | Action | Status |
|---------------------------|---|--|---|
| | <p><i>Refer to PD Reports in QAPI tool for more information</i></p> | | |
| Modality | <p>Melissa/Naomi/Ron</p> <ul style="list-style-type: none"> • 2 options in September <p><i>*In clinic options currently on hold due to COVID-19</i></p> <p><i>Refer to Home Dialysis Referral Report in QAPI tool for more information</i></p> | <ul style="list-style-type: none"> • Contacting patients over the phone and referring to the Fresenius website to watch videos online | <ul style="list-style-type: none"> • Ongoing |
| Care Coordination | <p>Melissa/Naomi/Ron</p> <ul style="list-style-type: none"> • No significant issues to report <p><i>Refer to Care Coordination Report in QAPI tool for more information</i></p> | | |
| Nutritional Status | <p>Nicole B/Stephanie</p> <ul style="list-style-type: none"> • Albumin – goal met <ul style="list-style-type: none"> ○ No significant issues to report <p><i>Refer to Nutritional Status Report in QAPI tool for more information</i></p> | | |
| Mineral Metabolism | <p>Nicole B/Stephanie</p> <ul style="list-style-type: none"> • Calcium – goals met <ul style="list-style-type: none"> ○ No significant issues to report • Phosphorus- goals met <ul style="list-style-type: none"> ○ No significant issues to report • iPTH – goals met <ul style="list-style-type: none"> ○ No significant issues to report <p><i>Refer to Mineral Metabolism Report in QAPI tool for more information</i></p> | | |
| Anemia Management | <p>Coleen</p> <ul style="list-style-type: none"> • Hgb – 1 of 4 goals met <ul style="list-style-type: none"> ○ No significant issues to report • Saturation – goal met <ul style="list-style-type: none"> ○ No significant issues to report | | |

| Topic | Discussion | Action | Status |
|---|---|--|--|
| | <ul style="list-style-type: none"> • Ferritin – goals met <ul style="list-style-type: none"> ○ No significant issues to report <p><i>Refer to Anemia Management Report in QAPI tool for more information</i></p> | | |
| Medical Errors & Occurrences | <p><i>Michele</i></p> <ul style="list-style-type: none"> • 0 medical errors or occurrences for September • Tracking tool <p><i>Refer to Medical Errors & Occurrences Report in QAPI tool for more information</i></p> | <ul style="list-style-type: none"> • Will work with Michele to revise tracking tool | <ul style="list-style-type: none"> • In process |
| Transplant Report | <p><i>Minnie/Rocio</i></p> <ul style="list-style-type: none"> • Reviewed and discussed transplant report • Goal met • 1 live donor transplant scheduled for November <p><i>Refer to Transplant Reports in QAPI tool for more information</i></p> | | |
| KDQOL | <p><i>Minnie/Rocio</i></p> <ul style="list-style-type: none"> • Reviewed and discussed KDQOL data • Goals met <p><i>Refer to KDQOL Reports in QAPI tool for more information</i></p> | | |
| Grievances | <p><i>Minnie/Rocio</i></p> <ul style="list-style-type: none"> • No grievances for September <p><i>Refer to Complaint/Grievance Log for more information</i></p> | | |
| PD Core Team Updates (operational matters, patient concerns, unstable, etc.) | <p><i>PD IDT</i></p> <ul style="list-style-type: none"> • No significant issues to report | | |

| Topic | Discussion | Action | Status |
|--------------------------------------|--|---|--|
| Additional Clinic Information | | | |
| COVID-19 Clinic Update | <p>All</p> <ul style="list-style-type: none"> • Hand sanitizer • Isolation shift has 0 patients <ul style="list-style-type: none"> ○ PUI – 0 ○ COVID19 + - 2 hospitalized • CDPH survey follow up week of 10/19/20 <ul style="list-style-type: none"> ○ No findings ○ Validated audits and processes <p>Refer to COVID-19 meeting notes binder for more information</p> | <ul style="list-style-type: none"> • When hand sanitizer is low, send an email to Amy and she will notify the appropriate department for refills • Flu positive patients may impact the isolation shift, will continue to monitor and develop a plan | <ul style="list-style-type: none"> • Ongoing • In process |
| Education | <p>Cathy/All</p> <ul style="list-style-type: none"> • Chlorhexidine swabs instead of the alcohol swabs | <ul style="list-style-type: none"> • Will need to update protocols and policies | <ul style="list-style-type: none"> • In process |
| Facility Maintenance | <p>Darren/David G</p> <ul style="list-style-type: none"> • Patient chairs • Replacement of dialysis machines • Replacement of treatment floor • Dialysis machines • Automatic door openers • Leak at acid gauge in water treatment room • Running out of space in the inventory room | <ul style="list-style-type: none"> • In process of fixing chairs needing repair • Summary put together • Received quote, added to capital budget, awaiting approval • Currently upgrading machines to Blue Star, bibag units are spread further, uncertain if machines with the critlines can be upgraded • Maintenance request submitted for automatic door openers (pushbutton) to be installed at north and south doors from weigh area into treatment area • Badge entry will be installed at door from lobby into weigh area • Temporary fix to prevent it from leaking • Waiting on parts ordered • Will need to replace on a Sunday | <ul style="list-style-type: none"> • In process • In process • In process • In process, two-thirds completed • In process • In process • In process • In process |

| Topic | Discussion | Action | Status |
|--|--|---|--|
| | | <ul style="list-style-type: none"> Michele to meet with Darren, David, and Eli to reconfigure the inventory and supply rooms to create more space | |
| Water Quality | <p>Darren/David G</p> <ul style="list-style-type: none"> Reviewed and discussed water quality Chronic Hemodialysis <ul style="list-style-type: none"> 2 RO samples tested for September – no additional action required 2 dialysis machine samples tested for September – no additional action required Acute Dialysis <ul style="list-style-type: none"> 15 RO samples tested for September – no additional action required 0 dialysis machine samples tested for September Drums of acid are temperature controlled, proposal to switch to dry acid (not temperature controlled) Granuflo policy | <ul style="list-style-type: none"> Policy currently being revised in PolicyTech Nicole R to look in to Granuflo policy | <ul style="list-style-type: none"> In process In process |
| Old Business | | | |
| <p>Ultrafiltration Rate</p> <p>KEEP ON AGENDA AS OLD BUSINESS WITH MONTHLY UPDATES</p> <p>NO UPDATE</p> | <p>Nicole B/Dr. Haley</p> <ul style="list-style-type: none"> 10mL/kg/hr is optimal Create a project team following data gathering RTC UFR mean value? UFR Policy 3 months of data run in August | <ul style="list-style-type: none"> 5 months of data collected Nicole R. to schedule a meeting to move forward with project Add section to RTC to show UFR for the last 5 treatments Dr. Haley to look at the data again Prepare policies and protocols in preparation for UFR becoming a clinical measure <ul style="list-style-type: none"> Include in policy: <ul style="list-style-type: none"> Identify patients and extend time | <ul style="list-style-type: none"> In process In process In process In process |

| Topic | Discussion | Action | Status |
|---|---|---|---|
| | <ul style="list-style-type: none"> ○ Clarity report is underestimating patients that need to be reviewed ○ Recommendation to change the parameter to 12 ○ 14-16 patients are outside of the range 25% of treatments ○ Have not identified a plan <ul style="list-style-type: none"> ▪ Time vs. fluid adherence ▪ Needs to be individualized ○ Review with Nephrologists during POC meetings | | |
| <p>Transition of Care (Readmission Prevention)</p> <p>KEEP ON AGENDA AS OLD BUSINESS WITH MONTHLY UPDATES</p> | <p><i>Dr. Haley/Coleen/Jessica/Michele/Nicole R./Charge RNs</i></p> <ul style="list-style-type: none"> ● Will re-categorize items on post hospitalization checklist to assign tasks ● Medication Reconciliation <ul style="list-style-type: none"> ○ Need easy access to the discharge medications in Cerner ● KD Readmission Prevention Process, opportunity to enhance program by combining efforts | <ul style="list-style-type: none"> ● Reviewed post hospitalization checklist, updating revisions and will move forward with it ● Working on process to make it easier ● Sandra Volchko, Director of Quality & Patient Safety, is heading up committee; more collaboration with ESRD patients | <ul style="list-style-type: none"> ● In process ● In process ● Ongoing |
| <p>Missing Labs</p> <p>KEEP ON AGENDA AS OLD BUSINESS WITH MONTHLY UPDATES</p> | <p><i>IDT</i></p> <ul style="list-style-type: none"> ● Current chairside computers' software cannot accommodate a Bridge icon, working on getting a quote to update the software. The Bridge icon can only be added to the COWs currently. ● Items being elevated through the Employee engagement survey <ul style="list-style-type: none"> ○ Software (Bridge/Cerner) issues with interfacing and updates ● Moving to Windows 10 in July | <ul style="list-style-type: none"> ● Clint currently on vacation, will contact David upon return to come over and do the update ● Clint currently on vacation, will contact David upon return to come over and do the update | <ul style="list-style-type: none"> ● In process ● In process |
| <p>Network 18 Putting Patients First 2020</p> | <p><i>Nicole R</i></p> <ul style="list-style-type: none"> ● Bloodstream Infections (BSI) Reduction <ul style="list-style-type: none"> ○ Reduce BSI Baseline by 20% | | |

| Topic | Discussion | Action | Status |
|---|---|--|--|
| <p>KEEP ON AGENDA AS OLD BUSINESS WITH MONTHLY UPDATES</p> <p>NO UPDATE</p> | <ul style="list-style-type: none"> ○ Bi-monthly webinar ● Long Term Catheters (LTC) Reduction <ul style="list-style-type: none"> ○ 0.25% LTC reduction in Network Service Area (NSA) ● Patient Engagement <ul style="list-style-type: none"> ○ 3 patient subject matter experts (SME) (3 – HD, 1 – PD) ○ Increase involvement in quality improvement initiatives and in patient care ● Transplant Waitlist <ul style="list-style-type: none"> ○ Increase rate of patients on the transplant wait list in NSA by 1.25% ○ Bi-monthly webinars ● Home Dialysis <ul style="list-style-type: none"> ○ Increase # of patients on home modality in NSA by 2.25% ○ Bi-monthly webinar | <ul style="list-style-type: none"> ● Review transplant list quarterly ● Meeting scheduled 3/5/2020 to review home modality patient education binder | <ul style="list-style-type: none"> ● Ongoing ● On hold due to COVID-19 |
| <p>Clarity Direct Access Database</p> <p>KEEP ON AGENDA AS OLD BUSINESS WITH MONTHLY UPDATES</p> | <p>Dr. Haley</p> <ul style="list-style-type: none"> ● Direct Access Database ● Have not received the technical specs for the VPN setup ● Will need SQL Server Management Studio | <ul style="list-style-type: none"> ● Still configuring, delays due to COVID19, reconnected with Visonex and moving forward ● Need to set up VPN with Scott Furrer | <ul style="list-style-type: none"> ● In process ● In process |
| <p>Icodextrin/Extraneal</p> <p>KEEP ON AGENDA AS OLD BUSINESS WITH MONTHLY UPDATES</p> <p>REMOVE FROM AGENDA</p> | <p>Melissa/Amy</p> <ul style="list-style-type: none"> ● Use in PD clinic ● Blood sugar meters ● PD to obtain cost on drug and list of compatible glucometers from Baxter rep | <ul style="list-style-type: none"> ● Melissa to obtain more information and find a physician to champion it ● Melissa to email Amy with blood sugar meter information ● Baxter rep, Todd Richardson, in contact with KD Materials Management Buyer, Diana Lozano. Price list submitted to KD. Will need to go through appropriate committees for approval and finalize contract | <ul style="list-style-type: none"> ● In process ● In process ● In process |

| Topic | Discussion | Action | Status |
|---|--|---|--|
| | <ul style="list-style-type: none"> New Baxter rep provided cost per bag, which is more (\$91/case, \$70/bag); low reimbursement from Medicare Ron emailed Olivia for a comparative for Dextrose | <ul style="list-style-type: none"> Working with Adam in Materials Distribution to get a quote from Baxter | <ul style="list-style-type: none"> Completed, will revisit in the future |
| Advance Directives KEEP ON AGENDA AS OLD BUSINESS WITH MONTHLY UPDATES | Michele/IDT <ul style="list-style-type: none"> Advance Directives and DNR Policy (new) Patient Rights and Responsibilities Form Terms of Hemodialysis/PD Treatment Form Resuscitation in the Event of a Cardiopulmonary Arrest Protocol (new) Pulmonary Arrest Policy (new) | <ul style="list-style-type: none"> Currently creating a workflow Rescheduled meeting to review and update | <ul style="list-style-type: none"> In process In process In process In process In process |
| Chronic Dialysis Integration with Cerner REMOVE FROM AGENDA | All <ul style="list-style-type: none"> Account Executive with Cerner is not interested in setting up an interface with CrownWeb Meeting with ISS Directors to develop our own software Revisit different EMR | <ul style="list-style-type: none"> Cerner lined up and giving KD a cost | <ul style="list-style-type: none"> Completed |
| New Business | | | |
| ISPD Guidelines for Peritonitis Reporting | Melissa <ul style="list-style-type: none"> Guidelines state that every PD center should monitor the incidence of peritonitis on a yearly basis. Additionally, peritonitis rates should be reported as number of episodes per patient year rather than as one episode per number of patient month of treatment | <ul style="list-style-type: none"> Will discuss more during the QAPI tool review meeting Melissa to email document to Dr. Haley and Amy | <ul style="list-style-type: none"> In process In process |
| Humana Denials | All <ul style="list-style-type: none"> Most denials are due to preferred drug Retacrit vs. Epogen | <ul style="list-style-type: none"> Dr. Haley to meet with Coleen to discuss Nicole R to email a copy of the denial letter to Dr. Haley and Amy | <ul style="list-style-type: none"> In process In process |
| Next QAPI Meeting | All <ul style="list-style-type: none"> Due to the Thanksgiving holiday, the November QAPI meeting has been moved | | |

| Topic | Discussion | Action | Status |
|--------------------|---|-----------------------------|--------|
| | to 12/15/20 and will cover October and November reporting periods | | |
| Adjournment | | Meeting adjourned at 1:35pm | |

**Next meeting:
December 15, 2020**

QAPI Indicators

| Month | | | | | | J | F | M | A | M | J | J | A | S | O | N | D | AVG | |
|--|---------------------------------|--|---|----------------------------|---------------|--------|--------|---------|---------|--------|--------|--------|--------|--------|----|----|----|--------|--|
| INDICATORS | QIP Benchmark (90th percentile) | QIP Performance Standard (50th percentile) | QIP Achievement Threshold (15th percentile) | US Threshold (Core Survey) | Facility Goal | HD | HD | HD | HD | HD | HD | HD | HD | HD | HD | HD | HD | HD | |
| Total Patient Census | N/A | N/A | N/A | N/A | N/A | 146 | 148 | 150 | 152 | 151 | 151 | 147 | 144 | 140 | | | | 148 | |
| > 90 days on ESRD, > 30 days in clinic (as indicated by QIP) | N/A | N/A | N/A | N/A | N/A | 131 | 135 | 137 | 140 | 142 | 136 | 136 | 138 | 140 | | | | 137 | |
| RENAL CARE COORDINATOR | | | | | | | | | | | | | | | | | | | |
| % KT/V ≥ 1.2 (QIP) | 99.15% | 97.04% | 93.10% | 97.9% | 98% | 99.20% | 98.40% | 100.00% | 100.00% | 99.80% | 98.40% | 99.20% | 98.40% | 96.10% | | | | 98.83% | |
| Standardized Transfusion Ratio (STR) Reporting Measure (QIP) | Yes | Yes | Yes | N/A | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | | | | | |
| NHSN BSI Ratio (SIR = # observed BSI / # of predicted BSI) (QIP) | 0 | 0.604 | 1.365 | N/A | 0 | 0.000 | 1.842 | 0.900 | 3.996 | 0.000 | 0.863 | 2.779 | 0.868 | 0.854 | | | | 1.345 | |
| Dialysis events/ required components reported in NHSN (QIP) | Yes | Yes | Yes | N/A | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | | | | | |
| Home dialysis referral (modality change) | N/A | N/A | N/A | N/A | N/A | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | |
| Standardized Readmission Ratio (SRR) (QIP & DFC) (2 months behind QAPI reporting) | 0.629 | 0.998 | 1.268 | N/A | | 2.214 | 1.384 | 3.045 | 0.554 | 1.661 | 0.553 | 0.830 | 0.830 | | | | | 1.384 | |
| Standardized Hospitalization Ratio (SHR) (QIP & DFC) | 0.670 | 0.967 | 1.248 | N/A | | 1.386 | 1.662 | 1.552 | 1.053 | 1.386 | 0.942 | 1.108 | 1.053 | 0.720 | | | | 1.207 | |
| % of Patients with Hepatitis B Complete Series (including currently receiving) | N/A | N/A | N/A | N/A | 90% | 93.1% | 93.2% | 91.9% | 92.1% | 94.0% | 93.0% | 92.5% | 93.7% | 94.3% | | | | 93.1% | |
| Hepatitis B - # Immune | N/A | N/A | N/A | N/A | N/A | 105 | 108 | 108 | 108 | 107 | 101 | 103 | 102 | 97 | | | | | |
| Hepatitis B - # Currently Receiving | N/A | N/A | N/A | N/A | N/A | 22 | 19 | 19 | 21 | 25 | 31 | 22 | 19 | 24 | | | | | |
| Hepatitis B - # Refusing | N/A | N/A | N/A | N/A | N/A | 8 | 9 | 9 | 9 | 9 | 9 | 8 | 9 | 8 | | | | | |
| Hepatitis B - # Nonresponders | N/A | N/A | N/A | N/A | N/A | 10 | 10 | 10 | 10 | 10 | 8 | 11 | 14 | 11 | | | | | |
| % of Patients with Influenza Vaccine (2019 - 2020 Season) | N/A | N/A | N/A | N/A | 95% | 85.5% | 86.0% | 85.0% | 86.0% | 87.4% | 82.6% | 84.4% | 81.2% | 80.0% | | | | | |
| % of Patients with Pneumococcal Vaccine | N/A | N/A | N/A | N/A | 95% | 96.6% | 96.7% | 95.0% | 96.0% | 95.0% | 96.0% | 96.6% | 97.2% | 97.1% | | | | | |
| DIETITIANS | | | | | | | | | | | | | | | | | | | |
| % Albumin < 3.5 g/dL (lower is better) | N/A | N/A | N/A | 67.7% | 67.7% | 21.92% | 20.41% | 24.84% | 15.03% | 19.35% | 24.36% | 18.00% | 23.97% | 18.75% | | | | 20.74% | |
| % Calcium uncorrected > 10.2 mg/dL (all patients) (lower is better) | N/A | N/A | N/A | 1.3% | 1.3% | 1.36% | 0.68% | 0.00% | 0.65% | 1.93% | 1.27% | 0.00% | 1.36% | 2.08% | | | | 1.04% | |
| % Hypercalcemia (Uncorrected serum calcium > 10.2 mg/dL) (QIP) (3 month rolling avg) (lower is better) | 0.00% | 0.58% | 1.77% | N/A | 1.3% | 0.00% | 0.72% | 0.71% | 1.41% | 0.69% | 0.00% | 0.00% | 0.00% | 0.00% | | | | 0.39% | |
| % Phosphorus > 7.0 mg/dL (lower is better) | N/A | N/A | N/A | 12.6% | 12.6% | 6.16% | 6.85% | 5.23% | 7.84% | 8.39% | 5.13% | 3.33% | 5.48% | 6.94% | | | | 6.15% | |
| % Phosphorus > 5.5 mg/dL (lower is better) | N/A | N/A | N/A | N/A | 36% | 36.30% | 40.41% | 32.03% | 29.41% | 36.13% | 37.82% | 28.00% | 30.14% | 31.25% | | | | 33.50% | |
| CLINIC PHARMACIST | | | | | | | | | | | | | | | | | | | |
| % Intact PTH 175 - 600 (3 month rolling avg) (All patients) (higher is better) | N/A | N/A | N/A | N/A | 75% | 71.60% | 74.00% | 75.70% | 75.30% | 70.70% | 70.50% | 70.30% | 72.00% | 67.40% | | | | 71.94% | |
| % Intact PTH > 600 (all patients) (lower is better) | N/A | N/A | N/A | N/A | 25% | 18.18% | 15.29% | 10.45% | 15.66% | 24.05% | 10.19% | 14.28% | 17.50% | 14.50% | | | | 15.57% | |
| % Hgb 10 - 12g/dL (higher is better) | N/A | N/A | N/A | N/A | 75% | 72.6% | 71.4% | 72.7% | 77.3% | 73.1% | 76.4% | 75.8% | 74.8% | 75.9% | | | | 74.4% | |
| % Hgb < 10g/dL (lower is better) | N/A | N/A | N/A | 16.8% | 16.8% | 19.2% | 20.4% | 17.5% | 12.3% | 16.0% | 12.1% | 15.0% | 15.0% | 17.2% | | | | 16.1% | |
| % Hgb < 10g/dL on EPO | N/A | N/A | N/A | N/A | 16.8% | 22.1% | 22.4% | 18.0% | 12.9% | 17.8% | 13.1% | 17.1% | 17.7% | 20.2% | | | | 17.9% | |
| % Hgb > 12 on EPO (lower is better) | N/A | N/A | N/A | N/A | 10% | 1.6% | 2.4% | 1.6% | 1.6% | 3.1% | 4.6% | 3.9% | 1.6% | 0.0% | | | | 2.3% | |
| % Saturation ≥ 20 (3 month rolling avg) (higher is better) | N/A | N/A | N/A | N/A | 65% | 61.6% | 65.6% | 57.8% | 63.5% | 61.0% | 64.7% | 63.2% | 67.3% | 78.3% | | | | 64.8% | |
| % Ferritin 200 - 800ng/ml (3 month rolling avg) (higher is better) | N/A | N/A | N/A | N/A | 65% | 68.0% | 69.1% | 65.3% | 64.8% | 62.1% | 65.4% | 65.2% | 64.7% | 63.6% | | | | 65.4% | |
| % Ferritin > 1200ng/ml (3 month rolling avg) (lower is better) | N/A | N/A | N/A | N/A | 25% | 7.4% | 8.2% | 10.1% | 9.5% | 9.2% | 6.6% | 9.0% | 10.9% | 14.0% | | | | 9.4% | |
| Monitor patients on ESAs | N/A | N/A | N/A | N/A | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | | | | | |
| CHRONIC RENAL ACCESS COORDINATOR (CRAC) | | | | | | | | | | | | | | | | | | | |

| Month | | | | | | J | F | M | A | M | J | J | A | S | O | N | D | AVG | |
|--|---------------------------------|--|---|----------------------------|---------------|--------|--------|--------|---------|---------|--------|---------|---------|--------|-----|--|----|--------|--|
| INDICATORS | QIP Benchmark (90th percentile) | QIP Performance Standard (50th percentile) | QIP Achievement Threshold (15th percentile) | US Threshold (Core Survey) | Facility Goal | HD | HD | HD | HD | HD | HD | HD | HD | HD | HD | HD | HD | HD | |
| Standardized Fistula Rate (SFR) (% AVF using 2 needles) (QIP & DFC) (higher is better) | 76.16% | 63.76% | 52.52% | N/A | 70% | 60.50% | 62.20% | 61.70% | 60.00% | 58.50% | 56.50% | 57.80% | 59.20% | 60.00% | | | | 59.60% | |
| % AVG | N/A | N/A | N/A | N/A | N/A | 9.5% | 9.5% | 9.7% | 10.3% | 10.1% | 10.4% | 10.4% | 10.9% | 11.0% | | | | 10.2% | |
| % AVF + AVG | N/A | N/A | N/A | N/A | N/A | 0.0% | 0.0% | 0.0% | 0.6% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | | | | 0.6% | |
| Long Term Catheter Rate (% Catheters > 90 days) (QIP & DFC) (lower is better) | 5.07% | 11.22% | 18.57% | 10.7% | 10.7% | 23.90% | 23.00% | 20.70% | 22.50% | 23.20% | 24.60% | 22.70% | 24.50% | 25.50% | | | | 23.40% | |
| Catheter Rate (All Patients) | N/A | N/A | N/A | N/A | N/A | 30.0% | 28.4% | 28.5% | 29.0% | 31.4% | 33.0% | 31.1% | 29.2% | 28.9% | | | | 29.94% | |
| % Catheter + AVF | N/A | N/A | N/A | N/A | N/A | 8.2% | 6.8% | 5.8% | 7.7% | 7.5% | 8.4% | 7.1% | 7.5% | 6.9% | | | | 7.3% | |
| % Catheter + AVG | N/A | N/A | N/A | N/A | N/A | 1.4% | 2.0% | 1.3% | 0.6% | 0.6% | 0.6% | 0.0% | 0.0% | 0.0% | | | | 0.7% | |
| % Catheter < 90 days | N/A | N/A | N/A | N/A | N/A | 6.1% | 5.4% | 7.8% | 6.5% | 8.2% | 8.4% | 8.4% | 5.4% | 3.4% | | | | 6.6% | |
| Thrombosis Events: AVF % < 2 | N/A | N/A | N/A | N/A | N/A | 0 | 1 | 0 | 1 | 1 | 1 | 0 | 1 | 0 | | | | 1 | |
| Thrombosis Events: AVG % < 1 | N/A | N/A | N/A | N/A | N/A | 1 | 2 | 1 | 1 | 0 | 0 | 0 | 0 | 2 | | | | 1 | |
| VA patency: % w/AVF > 3 years | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | | | | | |
| VA patency: % w/AVG > 2 years | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | | | | | |
| Infections per use-life of AVF < 1% | N/A | N/A | N/A | 1.0% | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | | | | 0 | |
| Infections per use-life of AVG < 10% | N/A | N/A | N/A | 10.0% | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | | | | 0 | |
| CLINIC MANAGER | | | | | | | | | | | | | | | | | | | |
| Hand Hygiene Observed by Staff | N/A | N/A | N/A | N/A | 100% | 95% | 95% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | | | | 98.9% | |
| Catheter Connection/Disconnection | N/A | N/A | N/A | N/A | 100% | 100% | 92% | 100% | NO DATA | NO DATA | 100% | 100% | NO DATA | 100% | | | | 98.7% | |
| CVC Exit Site Care | N/A | N/A | N/A | N/A | 100% | 100% | 100% | 100% | NO DATA | NO DATA | 100% | NO DATA | NO DATA | 100% | | | | 100.0% | |
| AVF/AVG Cannulation/Decannulation | N/A | N/A | N/A | N/A | 100% | 93% | 40% | 100% | NO DATA | NO DATA | 100% | 100% | NO DATA | 77% | | | | 85.0% | |
| Dialysis Station Disinfection | N/A | N/A | N/A | N/A | 100% | 70% | 87% | 79% | NO DATA | NO DATA | 100% | 100% | 100% | 60% | | | | 85.1% | |
| Injection Safety Preparation | N/A | N/A | N/A | N/A | 100% | 93% | 91% | 100% | NO DATA | NO DATA | 100% | NO DATA | NO DATA | 80% | | | | 92.8% | |
| Infection Safety Administration | N/A | N/A | N/A | N/A | 100% | 100% | 100% | 100% | NO DATA | NO DATA | 100% | 100% | 100% | 100% | | | | 100.0% | |
| Hand Hygiene Observed by Patients | N/A | N/A | N/A | N/A | 100% | 92% | 100% | 0% | NO DATA | NO DATA | 100% | NO DATA | NO DATA | 100% | | | | 78.4% | |
| Station Disinfection Observed by Patients | N/A | N/A | N/A | N/A | 100% | 50% | 67% | 0% | NO DATA | NO DATA | 100% | NO DATA | NO DATA | 64% | | | | 56.2% | |
| ICH CAHPS: Overall Rating of Dialysis Center Staff (QIP) | 77.49% | 63.04% | 49.12% | N/A | 90% | 96.3% | N/A | N/A | N/A | 62.9% | | | N/A | N/A | N/A | Fall Survey Period (Nov 2020 - Jan 2021) | | | |
| ICH CAHPS: Overall Rating of the Dialysis Facility (QIP) | 83.03% | 68.59% | 53.98% | N/A | 90% | 100.0% | N/A | N/A | N/A | 74.3% | | | N/A | N/A | N/A | | | | |
| ICH CAHPS: Nephrologists' Communication and Caring (QIP) | 78.52% | 67.89% | 58.12% | N/A | 80% | 73.2% | N/A | N/A | N/A | 67.1% | | | N/A | N/A | N/A | | | | |
| ICH CAHPS: Quality of Dialysis Center Care and Operations (QIP) | 72.11% | 62.47% | 54.16% | N/A | 75% | 72.9% | N/A | N/A | N/A | 58.0% | | | N/A | N/A | N/A | | | | |
| ICH CAHPS: Providing Information to Patients (QIP) | 87.14% | 80.48% | 74.09% | N/A | 90% | 86.5% | N/A | N/A | N/A | 75.2% | | | N/A | N/A | N/A | | | | |
| ICH CAHPS: Overall Rating of Nephrologists (QIP) | 76.57% | 62.22% | 49.33% | N/A | 85% | 74.1% | N/A | N/A | N/A | 55.6% | | | N/A | N/A | N/A | | | | |
| Total # missed treatments | N/A | N/A | N/A | N/A | N/A | 98 | 88 | 91 | 79 | 111 | 118 | 97 | 89 | 98 | | | | | |
| # pts with 1 missed treatment | N/A | N/A | N/A | N/A | N/A | 20 | 26 | 19 | 19 | 21 | 17 | 30 | 22 | 21 | | | | | |

| Month | | | | | | J | F | M | A | M | J | J | A | S | O | N | D | AVG | | |
|---|---------------------------------|--|---|----------------------------|---------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|----|----|----|-------|-------|--|
| INDICATORS | QIP Benchmark (90th percentile) | QIP Performance Standard (50th percentile) | QIP Achievement Threshold (15th percentile) | US Threshold (Core Survey) | Facility Goal | HD | HD | HD | HD | HD | | |
| # pts with 2 missed treatments | N/A | N/A | N/A | N/A | N/A | 10 | 14 | 15 | 10 | 7 | 10 | 9 | 7 | 9 | | | | | | |
| # pts with ≥ 3 missed treatments | N/A | N/A | N/A | N/A | N/A | 14 | 9 | 10 | 10 | 15 | 17 | 12 | 13 | 15 | | | | | | |
| # Restart | N/A | N/A | N/A | N/A | N/A | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | |
| # Recovered Function | N/A | N/A | N/A | N/A | N/A | 1 | 1 | 0 | 0 | 0 | 0 | 2 | 1 | 0 | | | | | | |
| # Involuntary Discharges | N/A | N/A | N/A | N/A | N/A | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | |
| # New Admissions | N/A | N/A | N/A | N/A | N/A | 5 | 2 | 3 | 5 | 4 | 3 | 3 | 0 | 0 | | | | | | |
| # Acute Kidney Injury | N/A | N/A | N/A | N/A | N/A | 0 | 1 | 2 | 2 | 2 | 4 | 2 | 1 | 1 | | | | | | |
| # Transients | N/A | N/A | N/A | N/A | N/A | 0 | 0 | 1 | 2 | 2 | 0 | 3 | 1 | 0 | | | | | | |
| # Transfer in | N/A | N/A | N/A | N/A | N/A | 0 | 1 | 2 | 1 | 0 | 0 | 0 | 1 | 2 | | | | | | |
| # Transfer out (chronic, acute, transients, transplant, discontinue) | N/A | N/A | N/A | N/A | N/A | 3 | 1 | 2 | 5 | 7 | 2 | 4 | 2 | 3 | | | | | | |
| # Transfer out due to hospital > 30 days | N/A | N/A | N/A | N/A | N/A | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | |
| Standardized Mortality Rate (SMR) (DFC) # of Mortalities | N/A | N/A | N/A | N/A | N/A | 0 | 1 | 5 | 0 | 3 | 4 | 2 | 2 | 2 | | | | | | |
| # Medical Errors and Occurrences | N/A | N/A | N/A | N/A | N/A | 20 | 9 | 13 | 11 | 18 | 8 | 6 | 10 | 10 | | | | | | |
| % Patients with Avg UFR < 13 ml/kg/hr | N/A | N/A | N/A | 90.6% | 90% | 93.1% | 87.7% | 90.1% | 88.9% | 90.3% | 92.2% | 91.3% | 91.7% | 88.1% | | | | 90.4% | | |
| Ultrafiltration Rate Reporting Measure (QIP) | Yes | Yes | Yes | N/A | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | | | | | | |
| NHSN: Influenza (healthcare workers) | N/A | N/A | N/A | N/A | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | | | | | | |
| Patient education and training: experience, treatment options, self-care, QOL, infection prevention, rehabilitation, etc. | N/A | N/A | N/A | N/A | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | | | | | | |
| Medication Reconciliation Reporting Measure (QIP) | Yes | Yes | Yes | N/A | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | | | | | | |
| SOCIAL WORKERS | | | | | | | | | | | | | | | | | | | | |
| % Prevalent Patients Waitlisted (PPPW) (QIP) | 33.90% | 16.73% | 8.12% | 20.1% | 20.1% | 20.2% | 20.7% | 22.1% | 21.0% | 23.0% | 23.0% | 24.0% | 24.0% | 24.0% | | | | | 22.4% | |
| % of KDQOL Assessments completed within 3 months of initial treatment | N/A | N/A | N/A | N/A | 90% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | | | | | 100% | |
| % of KDQOL Assessments completed annually | N/A | N/A | N/A | N/A | 90% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | | | | | 100% | |
| Grievances - Total # | N/A | N/A | N/A | N/A | N/A | 2 | 2 | 1 | 5 | 4 | 2 | 1 | 1 | 0 | | | | | | |
| Grievances - # Resolved | N/A | N/A | N/A | N/A | N/A | 2 | 2 | 1 | 5 | 4 | 1 | 1 | 1 | 0 | | | | | | |
| Grievances - # Escalated | N/A | N/A | N/A | N/A | N/A | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | | | | | | |
| Clinical depression screening and follow up Reporting Measure (QIP) | Yes | Yes | Yes | N/A | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | | | | | | |

QAPI Indicators

| Month | | | | | | J | F | M | A | M | J | J | A | S | O | N | D | AVG |
|--|---------------------------------|--|---|----------------------------|---------------|-------|--------|--------|---------|---------|---------|---------|---------|---------|----|----|----|--------|
| INDICATORS | QIP Benchmark (90th percentile) | QIP Performance Standard (50th percentile) | QIP Achievement Threshold (15th percentile) | US Threshold (Core Survey) | Facility Goal | PD | PD | PD | PD | PD | PD | PD | PD | PD | PD | PD | PD | PD |
| Patient Census | N/A | N/A | N/A | N/A | N/A | 34 | 33 | 32 | 35 | 34 | 34 | 28 | 28 | 25 | | | | 31 |
| > 90 days on ESRD, > 30 days in clinic (as indicated by QIP) | N/A | N/A | N/A | N/A | N/A | 31 | 28 | 28 | 28 | 31 | 26 | 25 | 27 | 24 | | | | 28 |
| PD NURSE | | | | | | | | | | | | | | | | | | |
| % KT/V ≥ 1.7 (Monthly) | N/A | N/A | N/A | N/A | 92.0% | 100% | 92% | 91% | 83% | 91% | 78% | 75% | 100% | 75% | | | | 87% |
| % KT/V ≥ 1.7 (4 Month Cumulative) (QIP) | 99.15% | 97.04% | 93.10% | 94.8% | 95.0% | 97% | 97% | 96% | 92% | 89% | 86% | 82% | 86% | 82% | | | | 90% |
| # of Peritonitis Infections | N/A | N/A | N/A | N/A | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 1 | 2 | 2 | | | | 1 |
| Peritonitis Infection Rate (# infections / # patients x 100 patient months) | N/A | N/A | N/A | N/A | 0 | 0.00 | 3.03 | 0.00 | 0.00 | 2.94 | 2.94 | 3.57 | 7.14 | 8.00 | | | | 3.07 |
| # of Exit Site Infections | N/A | N/A | N/A | N/A | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | | | | 0 |
| # of Tunnel Infections | N/A | N/A | N/A | N/A | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | 0 |
| # of Other Infections | N/A | N/A | N/A | N/A | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | | | | 0 |
| Hand Hygiene | N/A | N/A | N/A | N/A | 100% | N/A | 100.0% | 100.0% | NO DATA | NO DATA | NO DATA | NO DATA | NO DATA | NO DATA | | | | 100.0% |
| PD Station Disinfection | N/A | N/A | N/A | N/A | 100% | N/A | 100.0% | 100.0% | NO DATA | NO DATA | NO DATA | NO DATA | NO DATA | NO DATA | | | | 100.0% |
| Injection Safety Preparation | N/A | N/A | N/A | N/A | 100% | N/A | 100.0% | 100.0% | NO DATA | NO DATA | NO DATA | NO DATA | NO DATA | NO DATA | | | | 100.0% |
| Infection Safety Administration | N/A | N/A | N/A | N/A | 100% | N/A | 100.0% | 100.0% | NO DATA | NO DATA | NO DATA | NO DATA | NO DATA | NO DATA | | | | 100.0% |
| Standardized Readmission Ratio (SRR) (QIP & DFC) | 0.629 | 0.998 | 1.268 | N/A | | 0.000 | 0.000 | 0.553 | 0.000 | 0.000 | 0.000 | 0.276 | 0.553 | 0.000 | | | | 0.154 |
| Standardized Hospitalization Ratio (SHR) (QIP & DFC) | 0.670 | 0.967 | 1.248 | N/A | | 0.111 | 0.221 | 0.166 | 0.166 | 0.166 | 0.277 | 0.221 | 0.388 | 0.221 | | | | 0.215 |
| Standardized Mortality Rate (SMR) (DFC) # of Mortalities | N/A | N/A | N/A | N/A | N/A | 2 | 0 | 0 | 0 | 0 | 2 | 1 | 0 | 2 | | | | |
| Standardized Transfusion Ratio (STR) Reporting Measure (QIP) | Yes | Yes | Yes | N/A | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | | | | |
| % of Patients with Hepatitis B Complete Series (including currently receiving) | N/A | N/A | N/A | N/A | 70% | 76% | 65% | 63% | 89% | 88% | 97% | 96% | 96% | 92% | | | | 85% |
| Hepatitis B - # Immune | N/A | N/A | N/A | N/A | N/A | 19 | 22 | 22 | 30 | 21 | 22 | 20 | 20 | 22 | | | | |
| Hepatitis B - # Currently Receiving | N/A | N/A | N/A | N/A | N/A | 13 | 11 | 11 | 11 | 10 | 11 | 6 | 6 | 3 | | | | |
| Hepatitis B - # Refusing | N/A | N/A | N/A | N/A | N/A | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 1 | 1 | | | | |
| Hepatitis B - # Nonresponders | N/A | N/A | N/A | N/A | N/A | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | | | | |
| % of Patients with Influenza Vaccine (2019 - 2020 Season) | N/A | N/A | N/A | N/A | 90% | 97% | 94.0% | 94.0% | 91.0% | 91.0% | 91.0% | 92.8% | 92.8% | 100% | | | | |
| % of Patients with Pneumococcal Vaccine | N/A | N/A | N/A | N/A | 90% | 97% | 85.0% | 86.0% | 83.0% | 79.0% | 91.0% | 89.2% | 89% | 96% | | | | |
| Home dialysis referral - Options | N/A | N/A | N/A | N/A | N/A | 16 | 3 | 1 | 0 | 0 | 0 | 0 | 5 | 2 | | | | |
| Total # Missed Treatments | N/A | N/A | N/A | N/A | N/A | 10 | 17 | 12 | NO DATA | NO DATA | NO DATA | NO DATA | NO DATA | NO DATA |
| # Restart | N/A | N/A | N/A | N/A | N/A | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| # Recovered Function | N/A | N/A | N/A | N/A | N/A | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| # Involuntary Discharges | N/A | N/A | N/A | N/A | N/A | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |

| Month | | | | | | J | F | M | A | M | J | J | A | S | O | N | D | AVG |
|---|---------------------------------|--|---|----------------------------|---------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|----|----|----|--------|
| INDICATORS | QIP Benchmark (90th percentile) | QIP Performance Standard (50th percentile) | QIP Achievement Threshold (15th percentile) | US Threshold (Core Survey) | Facility Goal | PD | PD | PD | PD | PD | PD | PD | PD | PD | PD | PD | PD | PD |
| # New Admissions (Including modality change) | N/A | N/A | N/A | N/A | N/A | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| # Acute Kidney Injury | N/A | N/A | N/A | N/A | N/A | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| # Transients | N/A | N/A | N/A | N/A | N/A | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | | | | |
| # Transfer in | N/A | N/A | N/A | N/A | N/A | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| # Transfer out (chronic, acute, transients) | N/A | N/A | N/A | N/A | N/A | 0 | 0 | 1 | 0 | 0 | 3 | 0 | 1 | 0 | | | | |
| # Transfer out due to hospital > 30 days | N/A | N/A | N/A | N/A | N/A | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| Patient education and training: experience, treatment options, self-care, QOL, infection prevention, rehabilitation, etc. | N/A | N/A | N/A | N/A | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | | | | |
| Medication Reconciliation Reporting Measure (QIP) | Yes | Yes | Yes | N/A | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | | | | |
| DIETITIANS | | | | | | | | | | | | | | | | | | |
| % Albumin < 3.5 g/dL (lower is better) | N/A | N/A | N/A | 67.7% | 67.7% | 48.48% | 46.88% | 56.25% | 40.63% | 38.71% | 51.85% | 42.31% | 55.56% | 42.31% | | | | 47.00% |
| % Calcium uncorrected > 10.2 mg/dL (all patients) (lower is better) | N/A | N/A | N/A | 1.3% | 1.3% | 0.00% | 0.00% | 3.13% | 3.03% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | | | | 0.68% |
| % Hypercalcemia (Uncorrected serum calcium > 10.2 mg/dL) (QIP) (3 month rolling avg) (lower is better) | 0.00% | 0.58% | 1.77% | N/A | 1.3% | 0.00% | 0.00% | 3.57% | 3.44% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | | | | 0.78% |
| % Phosphorus > 7.0 mg/dL (lower is better) | N/A | N/A | N/A | 12.6% | 12.6% | 21.21% | 9.38% | 15.63% | 25.00% | 19.35% | 22.22% | 11.54% | 11.11% | 7.69% | | | | 15.90% |
| % Phosphorus > 5.5 mg/dL (lower is better) | N/A | N/A | N/A | N/A | 36% | 39.39% | 40.63% | 40.63% | 43.75% | 48.39% | 51.85% | 42.31% | 40.74% | 23.08% | | | | 41.20% |
| % Intact PTH 175 - 600 (3 month rolling avg) (All patients) (higher is better) | N/A | N/A | N/A | N/A | 75% | 69.3% | 66.1% | 65.0% | 65.5% | 70.7% | 70.0% | 71.4% | 71.7% | 84.6% | | | | 70% |
| % Intact PTH > 600 (all patients) (lower is better) | N/A | N/A | N/A | N/A | 25% | 33.33% | 38.5% | 15.6% | 31.3% | 23.5% | 11.1% | 25.0% | 28.6% | 7.69% | | | | 24% |
| CLINIC PHARMACIST | | | | | | | | | | | | | | | | | | |
| % Hgb 10 - 12g/dL (higher is better) | N/A | N/A | N/A | N/A | 75% | 57.6% | 62.5% | 51.6% | 50.0% | 64.5% | 51.9% | 50.0% | 55.6% | 53.8% | | | | 55.3% |
| % Hgb < 10g/dL (all patients) (lower is better) | N/A | N/A | N/A | 26.2% | 26.2% | 30.3% | 31.3% | 32.3% | 31.3% | 16.1% | 33.3% | 30.8% | 25.9% | 30.8% | | | | 29.1% |
| % Hgb < 10g/dL on EPO | N/A | N/A | N/A | N/A | 26.2% | 38.5% | 40.0% | 38.5% | 39.1% | 21.7% | 42.9% | 42.1% | 36.8% | 42.1% | | | | 38.0% |
| % Hgb > 12 on EPO (lower is better) | N/A | N/A | N/A | N/A | 10% | 7.7% | 0.0% | 7.7% | 8.7% | 4.3% | 9.5% | 0.0% | 5.3% | 0.0% | | | | 4.8% |
| % Saturation ≥ 20 (3 month rolling avg) (higher is better) | N/A | N/A | N/A | N/A | 65% | 78.7% | 71.7% | 69.5% | 73.6% | 71.0% | 74.2% | 73.2% | 75.0% | 78.0% | | | | 73.9% |
| % Ferritin 100 - 800ng/ml (3 month rolling avg) (higher is better) | N/A | N/A | N/A | N/A | 65% | 80.8% | 79.1% | 87.2% | 85.1% | 85.7% | 79.0% | 73.2% | 68.7% | 72.5% | | | | 79.0% |
| % Ferritin > 800ng/ml (3 month rolling avg) (lower is better) | N/A | N/A | N/A | N/A | 25% | 17.0% | 18.7% | 10.9% | 12.9% | 11.1% | 16.1% | 19.6% | 22.9% | 20.0% | | | | 17% |
| Monitor patients on ESAs | N/A | N/A | N/A | N/A | N/A | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| CLINIC MANAGER | | | | | | | | | | | | | | | | | | |
| # Medical Errors and Occurrences | N/A | N/A | N/A | N/A | N/A | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | | | | |
| SOCIAL WORKERS | | | | | | | | | | | | | | | | | | |
| % Prevalent Patients Waitlisted (PPPW) (QIP) | 33.90% | 16.73% | 8.12% | 20.1% | 20.1% | 26.0% | 22.0% | 26.0% | 29.0% | 35.0% | 30.0% | 32.0% | 36.0% | 33.0% | | | | 29.9% |
| % of KDQOL Assessments completed within 3 months of initial treatment | N/A | N/A | N/A | N/A | 90% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | | | | 100% |
| % of KDQOL Assessments completed annually | N/A | N/A | N/A | N/A | 90% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | | | | 100% |
| Grievances - Total # | N/A | N/A | N/A | N/A | N/A | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | | | | |
| Grievances - # Resolved | N/A | N/A | N/A | N/A | N/A | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | | | | |

| Month | | | | | | J | F | M | A | M | J | J | A | S | O | N | D | AVG | |
|---|---------------------------------|--|---|----------------------------|---------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|----|----|----|-----|-------|
| INDICATORS | QIP Benchmark (90th percentile) | QIP Performance Standard (50th percentile) | QIP Achievement Threshold (15th percentile) | US Threshold (Core Survey) | Facility Goal | PD | PD | PD | PD | PD | |
| Grievances - # Escalated | N/A | N/A | N/A | N/A | N/A | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | ----- |
| Clinical depression screening and follow up (QIP) | Yes | Yes | Yes | N/A | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | | | | | |



End-Stage Renal Disease Quality Incentive Program - Preview Performance Score Report

Payment Year: 2021

Facility: 053506, 050057



Report Run Date: 07/23/2020

Clinical Care Domain

Improvement Period: 01/01/2018-12/31/2018

Performance Period: 01/01/2019-12/31/2019

Table 1 - Clinical Care Domain Measures and Measure Topics (Clinical Measures)

| Clinical Care Measures/Measure Topics | Improvement Period Numerator | Improvement Period Denominator | Improvement Period Rate/Ratio | Performance Period Numerator | Performance Period Denominator | Performance Period Rate/Ratio | Achievement Threshold | Benchmark | Improvement Score | Achievement Score | Measure Score | Measure Weight (% of Domain) |
|---------------------------------------|------------------------------|--------------------------------|-------------------------------|------------------------------|--------------------------------|-------------------------------|-----------------------|-----------|-------------------|-------------------|----------------|------------------------------|
| Hypercalcemia | 13 | 1971 | 0.66% | 7 | 2118 | 0.33% | 1.86% | 0.00% | 5 | 8 | 8 | 7.50% |
| Kt/V Comprehensive | 1743 | 1807 | 96.46% | 1902 | 1957 | 97.19% | 92.98% | 99.14% | 2 | 7 | 7 | 22.50% |
| Standardized Transfusion Ratio | 5 | 22.117 | 0.226 | 10 | 22.526 | 0.444 | 1.684 | 0.200 | 0 | 8 | 8 | 25.00% |
| Vascular Access Type Topic | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 2 ^c | 30.00% |
| Standardized Fistula Rate | 3111270.04 | 5139653 | 60.53% | 3210276.82 | 5294756 | 60.63% | 51.79% | 75.22% | 0 | 4 | 4 | N/A |
| Long-term Catheter Rate | 475 | 1814 | 26.19% | 494 | 1818 | 27.17% | 19.20% | 5.47% | 0 | 0 | 0 | N/A |

Table 2 - Clinical Care Domain Measures (Reporting Measure)

| Clinical Care Measure | Number of Successfully Reported Months | Number of Eligible Months | Measure Score | Measure Weight (% of Domain) |
|-----------------------|--|---------------------------|---------------|------------------------------|
| Ultrafiltration Rate | 4 | 12 | 2 | 15.00% |

Eligible Clinical Care Measures/Measure Topics: 5 of 5

Weighted Clinical Care Domain Score: 50.750

^c The measure score was calculated by aggregating its component measure scores

Notes:

- "No Score" indicates that the facility was not eligible to receive a score on the measure during the measurement period.
- "N/A" indicates the value is not applicable to the measure/measure topic scoring calculation.



End-Stage Renal Disease Quality Incentive Program - Preview Performance Score Report

Payment Year: 2021

Facility: 053506, 050057



Report Run Date: 07/23/2020

Care Coordination Domain

Improvement Period: 01/01/2018-12/31/2018

Performance Period: 01/01/2019-12/31/2019

Table 3 - Care Coordination Domain Measures (Clinical Measures)

| Care Coordination Measures | Improvement Period Numerator | Improvement Period Denominator | Improvement Period Rate/Ratio | Performance Period Numerator | Performance Period Denominator | Performance Period Rate/Ratio | Achievement Threshold | Benchmark | Improvement Score | Achievement Score | Measure Score | Measure Weight (% of Domain) |
|------------------------------------|------------------------------|--------------------------------|-------------------------------|------------------------------|--------------------------------|-------------------------------|-----------------------|-----------|-------------------|-------------------|---------------|------------------------------|
| Standardized Hospitalization Ratio | 162 | 220.605 | 0.734 | 199 | 228.466 | 0.871 | 1.249 | 0.670 | 0 | 6 | 6 | 46.67% |
| Standardized Readmission Ratio | 38 | 44.207 | 0.860 | 44 | 49.137 | 0.895 | 1.268 | 0.629 | 0 | 6 | 6 | 46.67% |

Table 4 - Care Coordination Domain Measures (Reporting Measure)

| Care Coordination Measure | Number of Successfully Reported Patients | Number of Eligible Patients | Measure Score | Measure Weight (% of Domain) |
|---|--|-----------------------------|---------------|------------------------------|
| Clinical Depression Screening and Follow Up | 206 | 206 | 10 | 6.67% |

Eligible Care Coordination Domain Measures: 3 of 3

Weighted Care Coordination Domain Score: 62.667

Notes:

- "No Score" indicates that the facility was not eligible to receive a score on the measure during the measurement period.
- "N/A" indicates the value is not applicable to the measure/measure topic scoring calculation.



End-Stage Renal Disease Quality Incentive Program - Preview Performance Score Report

Payment Year: 2021

Facility: 053506, 050057



Report Run Date: 07/23/2020

Safety Domain

Improvement Period: 01/01/2018-12/31/2018

Performance Period: 01/01/2019-12/31/2019

Table 5 - Safety Domain Measures (Clinical Measure)

| Safety Measures | Improvement Period Numerator | Improvement Period Denominator | Improvement Period Rate/Ratio | Performance Period Numerator | Performance Period Denominator | Performance Period Rate/Ratio | Achievement Threshold | Benchmark | Improvement Score | Achievement Score | Measure Score | Measure Weight (% of Domain) |
|----------------------------|------------------------------|--------------------------------|-------------------------------|------------------------------|--------------------------------|-------------------------------|-----------------------|-----------|-------------------|-------------------|---------------|------------------------------|
| NHSN Bloodstream Infection | 30 | 16.852 | 1.780 | 33 | 17.058 | 1.935 | 1.479 | 0.000 | 0 | 0 | 0 | 60.00% |

Table 6 - Safety Domain Measures (Reporting Measure)

| Safety Measure | Number of Successfully Reported Months | Number of Eligible Months | Measure Score | Measure Weight (% of Domain) |
|-------------------------------|--|---------------------------|---------------|------------------------------|
| NHSN Dialysis Event Reporting | 12 | 12 | 10 | 40.00% |

Eligible Safety Measures: 2 of 2

Weighted Safety Domain Score: 40.000

Notes:

- "No Score" indicates that the facility was not eligible to receive a score on the measure during the measurement period.
- "N/A" indicates the value is not applicable to the measure/measure topic scoring calculation.



End-Stage Renal Disease Quality Incentive Program - Preview Performance Score Report
Payment Year: 2021
Facility: 053506, 050057



Report Run Date: 07/23/2020

Patient and Family Engagement Domain

Improvement Period: 01/01/2018-12/31/2018

Performance Period: 01/01/2019-12/31/2019

Table 7 - Patient and Family Engagement Domain Measures

| Patient and Family Engagement Measures | Improvement Period Numerator | Improvement Period Denominator | Improvement Period Rate/Ratio | Performance Period Numerator | Performance Period Denominator | Performance Period Rate/Ratio | Achievement Threshold | Benchmark | Improvement Score | Achievement Score | Measure Score | Measure Weight (% of Domain) |
|--|------------------------------|--------------------------------|-------------------------------|------------------------------|--------------------------------|-------------------------------|-----------------------|------------|-------------------|-------------------|----------------------|------------------------------|
| ICH CAHPS | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 9^c | 100.00% |
| Neph Comm and Caring | N/A | N/A | 77.24% | N/A | N/A | 73.02% | 58.09% | 78.52% | 0 | 7 | 7 | N/A |
| Quality of Dialysis Care and Ops | N/A | N/A | 67.06% | N/A | N/A | 71.96% | 54.16% | 72.03% | 9 | 9 | 9 | N/A |
| Providing Info to Patients | N/A | N/A | 80.21% | N/A | N/A | 83.77% | 73.90% | 87.07% | 5 | 7 | 7 | N/A |
| Overall Rating of Neph | N/A | N/A | 82.91% | N/A | N/A | 71.28% | 49.33% | 76.57% | 0 | 8 | 8 | N/A |
| Overall Rating of Dialysis Staff | N/A | N/A | 75.42% | N/A | N/A | 89.20% | 49.12% | 77.46% | No Score | 10 | 10 | N/A |
| Overall Rating of Dialysis Facility | N/A | N/A | 84.15% | N/A | N/A | 95.04% | 53.98% | 82.48% | No Score | 10 | 10 | N/A |

Eligible Patient and Family Engagement Measures: 1 of 1
 Weighted Patient and Family Engagement Domain Score: 90.000

^c The measure score was calculated by aggregating its component measure scores

Notes:

- “No Score” indicates that the facility was not eligible to receive a score on the measure during the measurement period.
- “N/A” indicates the value is not applicable to the measure/measure topic scoring calculation.



End-Stage Renal Disease Quality Incentive Program - Preview Performance Score Report

Payment Year: 2021

Facility: 053506, 050057



Report Run Date: 07/23/2020

Preview Performance Score

Table 8 - Preview Performance Score Details

| Category | Facility Score | State Average Score* | National Average Score* | Facility Measure Weights | Facility Weighted Score |
|--|----------------|----------------------|-------------------------|--------------------------|-------------------------|
| Total Performance Score Before Applicable Deductions+ | 59 | 58 | 59 | N/A | N/A |
| Clinical Care Measures Domain (40.00%) | 50.750 | 55.813 | 58.002 | N/A | 20.3000 |
| Hypercalcemia | 8 | 6 | 7 | 7.50% | 0.6000 |
| Kt/V Comprehensive | 7 | 6 | 7 | 22.50% | 1.5750 |
| Standardized Transfusion Ratio | 8 | 5 | 6 | 25.00% | 2.0000 |
| Ultrafiltration Rate | 2 | 4 | 5 | 15.00% | 0.3000 |
| Vascular Access Type Topic | 2 | 6 | 6 | 30.00% | 0.6000 |
| Care Coordination Measures Domain (30.00%) | 62.667 | 52.463 | 53.700 | N/A | 18.8000 |
| Clinical Depression Screening and Follow Up | 10 | 10 | 10 | 6.67% | 0.6670 |
| Standardized Hospitalization Ratio | 6 | 5 | 5 | 46.67% | 2.8002 |
| Standardized Readmission Ratio | 6 | 5 | 5 | 46.67% | 2.8002 |
| Safety Measure Domain (15.00%) | 40.000 | 76.328 | 75.307 | N/A | 6.0000 |
| NHSN Bloodstream Infection | 0 | 6 | 6 | 60.00% | 0.0000 |
| NHSN Dialysis Event Reporting | 10 | 10 | 10 | 40.00% | 4.0000 |
| Patient and Family Engagement Domain (15.00%) | 90.000 | 56.562 | 48.316 | N/A | 13.5000 |
| ICH CAHPS | 9 | 6 | 5 | 100.00% | 9.0000 |

* State and National Average Scores are unweighted

Note:

- "No Score" indicates that the facility was not eligible to receive a score on the measure during the measurement period.

Minimum Total Performance Score: 56 points

Extraordinary Circumstance Exception Approved: N/A

+Total Performance Score Before Applicable Deductions: 59 points

Reduction for Noncompliance with CMS CROWNWeb or NHSN Validation Studies: 0 points

Total Performance Score: 59 points

Total Payment Reduction: No Reduction

Please consult the CMS ESRD Measures Manual (<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/Downloads/ESRD-Manual-v40-.pdf>) and the CMS ESRD QIP Guide to the PSR (<https://qualitynet.org/esrd/esrdqip/reports>) for additional details on scoring calculations.

Unit/Department: Sub Acute, TCS, and SS Rehab Report Date: October 2020

Measure Objective/Goal:

1. Falls (internal data),
2. Pressure Injuries (internal data)
3. Psychoactive medication use (MDS/Casper)

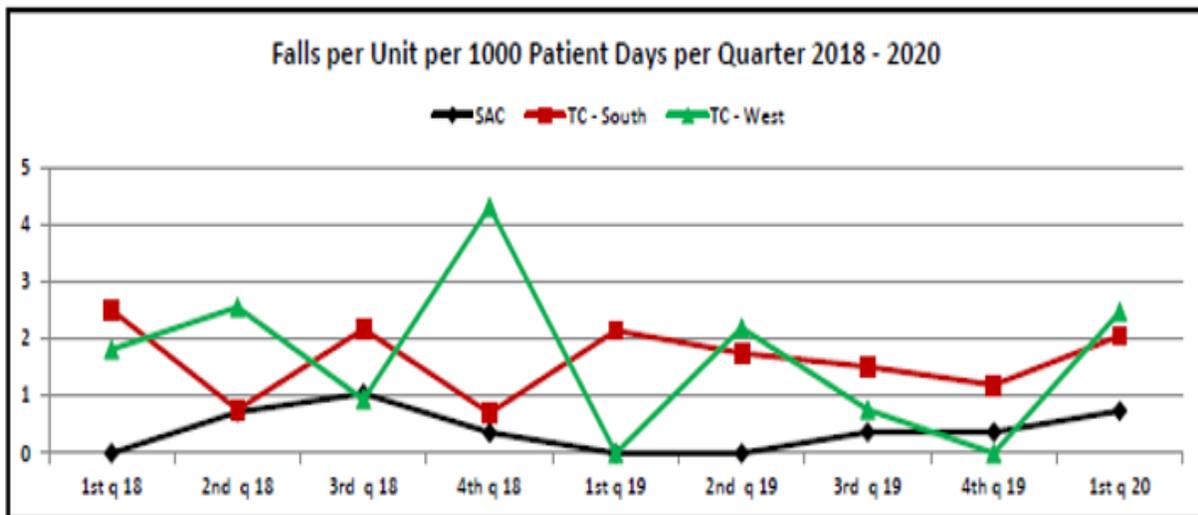
Date range of data evaluated:

All categories are from the Report Period: Comparison group: Casper Report from 04/01/2020 to 09/30/2020 and 1st quarter 2018 through 1st quarter 2020, internal data.

Nationally benchmarked quality data is collected through the MDS submissions process. CMS divides data between short-stay cases (<100 day length) and long-stay cases (>100 day length). The Skilled Nursing program client group is predominately in the short-stay category. Statistically this means that Long-Stay measures typically have a denominator of 33-34. Short-Stay measures typically have a denominator of 275+. Internal data is based on total units of service and does not differentiate based upon length of stay. There is no comparable national bench-marking of Short Stay cases for falls, and for HAPI prevalence overall. For these two indicators, we assess ourselves as relate to internal performance.

FALLS:

There were 8 falls across the three skilled nursing units in the 4th quarter of 2019. Falls per 1000/pt. days for 1st quarter 2020 was 1.48 , up from 1.23 in 2018 and 0.69 in 2019. While this demonstrates a slight uptrend, the change in value is not statistically significant. Typical fall incidence per quarter for the units has been maintained at 6-8 per quarter for the past two years. CASPER is the only available national benchmark for this measure. Facility observed percent for falls for long stay patients in the most current CASPER report is 3.2%, remaining well below national average of 46.1%, placing the units in the top 1 percentile nationally.

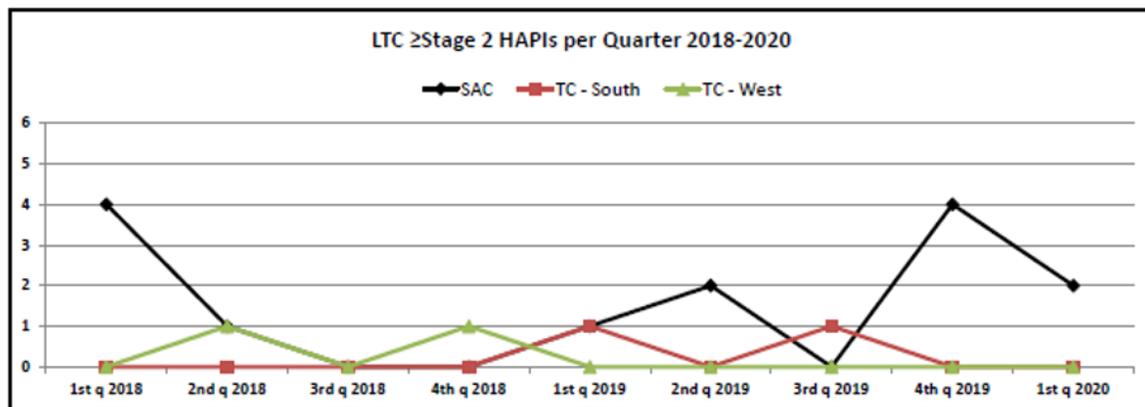


- Staff continue to participate in, and has a high rate of compliance with, district-wide initiatives for fall prevention. The skilled nursing units have many mobile patients and also a “no restraint” environment. While falls are infrequent, they do occur most commonly with our short-stay population, all of whom are involved with therapy programs to enhance functional mobility. We will continue full participation in the Kaweah Delta fall prevention protocols.

PRESSURE INJURIES:

There were 0 pressure injuries new or worsened (HAPI) reported for the 1st quarter of 2020 for the two departments typically housing our shorter stay clients (Transitional Care and Short Stay Rehab).

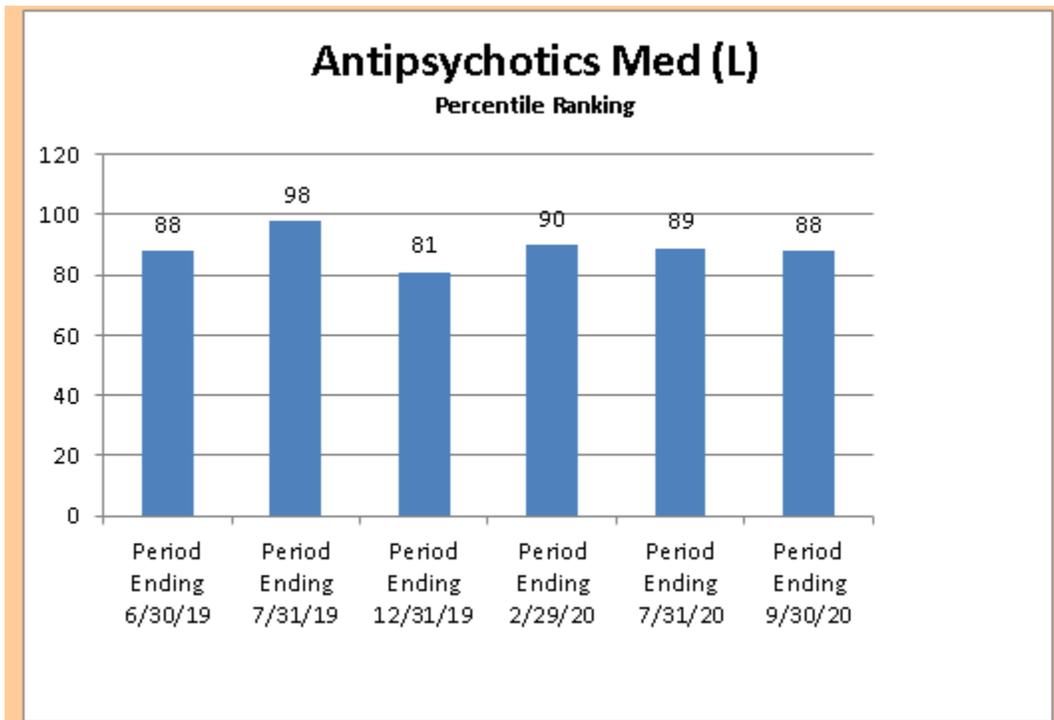
- A. Patients at High risk for Pressure Ulcers (Long Stay residents, defined as high risk, who have Stage II-IV pressure ulcers) showed a decrease from 11.8% to 10.3% the prior year. This puts us at the 65th percentile. The definition for this long-stay quality measure asks if a wound is present, not if it is acquired by the facility. The numerator is 3 and denominator is 29. This is particularly challenging in a program that preferentially admits cases with pressure ulcers for ongoing treatment. This quarter all 3 patients (denominator) have a history of documented non-compliance or skin failure.
- B. Internal Data through 1st quarter in 2020 shows year to date overall SNF rate per 1000/pt. days was 0.37. This is a decrease from 0.71 for 2019.



PSYCHOACTIVE MEDICATION USE:

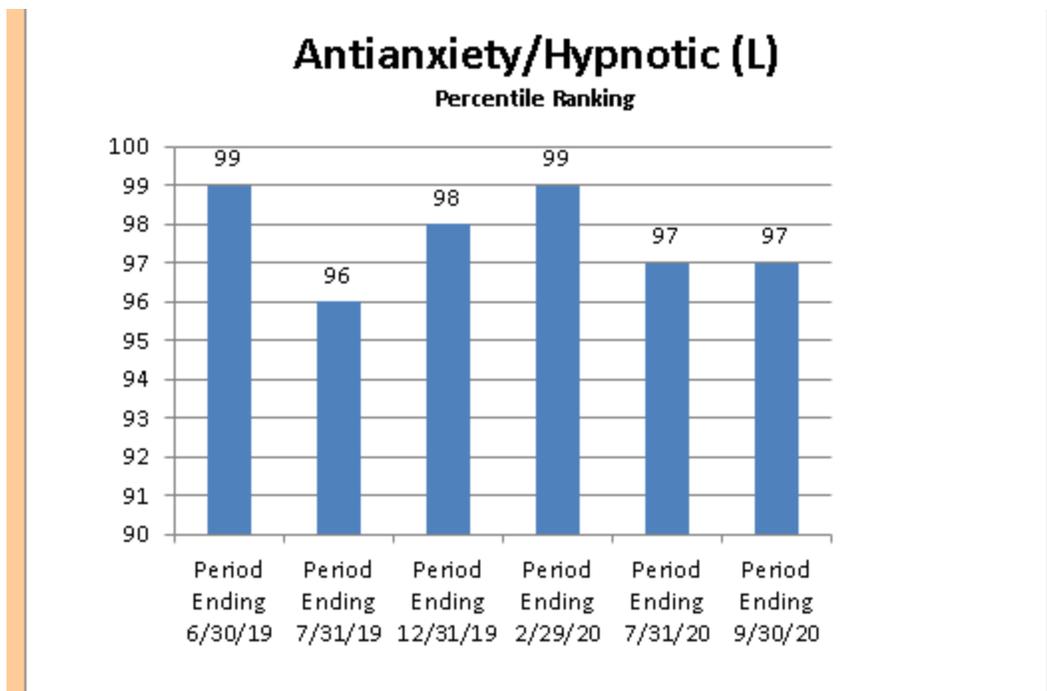
- **Short Stay residents (<100 days):** Antipsychotic medication use for short stay patients is below national average, which measures only cases with newly prescribed antipsychotics. The facility percent for short stay patients who begin a new anti-psychotic during their stay is 0.7%. The comparison national average is 2.0%.

- Long Stay residents:** The facility percent for antipsychotic use in long stay residents is 24.1%, a slight decrease from 24.6% prior quarter and a decrease from 90th percentile to the 88th. The national average is 14.3%. Unlike the short stay measure, which only includes newly prescribed antipsychotics, the long-stay measure includes all patients on the medication for any portion of the time (even if it was a home medication). Included in this measure are medications like quetiapine which may be used for depression or for ventilator management cases. This is another instance where our target client group for long-term care (our Sub Acute program) is the primary driver of our performance.



SNF leadership has been working closely with the medical team and our MDS nurses to ensure that appropriate psychiatric diagnoses are captured in the medical record whenever possible. A small number of these diagnoses are excluded from this quality measure.

- Long Stay residents:** Antianxiety/Hypnotic Medication use for long stay residents has remained the same at 97th percentile prior quarter, with 45.2% utilization, compared to 50% prior quarter and above the 19.7% national average. Our utilization rate is increased, but national rates are unchanged. There are no exclusions for medical diagnosis for this measure.



Improvement Opportunities

Psychotropic medications are under constant scrutiny by CMS. Concerns around these medications are primarily founded in two concepts: 1: inappropriate or excessive medications and 2: using psychotropic medications to control behaviors (as a chemical restraint) or for more “convenient” management of “difficult” patients. While the majority of our client group has clear and compelling indications for these agents, we continue to monitor the medications very closely. Our LTC pharmacist plays an important role in helping us ensure that we follow all of these medications closely during the transition process. Our primary focus is on unnecessary medications, (like prn hypnotics). But we also monitor for the potential for dose reductions when possible.

All residents receive a monthly medication regimen review and physician consultation by our LTC pharmacist. This close partnership has helped reduce psychoactive medication use generally, including reducing doses through gradual dose reduction practices. We have seen a reduction in the use of hypnotic medications in our short-term (under 100 days) patients, in particular.

It is important to note that we have made significant and sustained improvement in our overall quality ranking. A contribution to this is partly due to the elimination of Self-report of moderate to severe pain measure. In the past three years, the program has moved from 3-star quality rating overall to a 5 star overall quality rating and has remained at 5 star the last three quarters. In addition, with continued strong performance in both staffing and survey results, our quality ratings are now 4 and 5 stars in every category.

Submitted by Name: Elisa Venegas

Date Submitted: October 09, 2020

| Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2020 | | | | | | | |
|--|-----------------------|---------------|---------------|---------------|----|---------------|--|
| | | Q1 | Q2 | Q3 | Q4 | AVG. or TOTAL | SUMMARY / ACTION |
| I. Overall Surgical Site Infections (SSI) | IR/SIR | | | | | | SSIs calculated internally though standard incidence rate and externally through Standardized Infection Ratio (SIR) from National Health and Safety Network (NHSN). |
| A. #Total Procedure Count | | 1381 | 442 | 1428 | | | Annual running total: 3,251 |
| B. Total Infection Count <i>[note: SSI events can be identified up to 90 days from the last day of the month in each quarter and only DIP and Organ Spc SSI are reported in NSHN]</i> | | 6 | 6 | 10 | | | 1st QTR: 6 Predicted: not available 2nd QTR: 6 Predicted: not available 3rd QTR: 10 Predicted: not available |
| C. Incidence Rate (IR) [# of total SSI infections/# total procedures x 100] | Internal 0.70 Goal | 0.43 | 1.36 | 0.7 | | | 1st QTR: Total number of SSI events fell well below the threshold of 0.70 this is better than Statewide averages. 2nd QTR: Total number of SSI event exceeded the threshold of 0.70 this is worse than Statewide averages. However, the number of total surgeries performed dropped by 939 procedures. This occurred as a result of restrictions associated with the ongoing COVID-19 pandemic. 3rd QTR: Total number of SSI events matched the threshold of 0.70 this is no different than Statewide averages. |
| D. SIR Confidence Interval (CI-KDHCD predicted range, based on risks) | | not available | not available | not available | | | 1st QTR: not available 2nd QTR: not available 3rd QTR: not available |
| E. Standardized Infection Ratio (SIR) | NHSN | not available | not available | not available | | | 1st QTR: not available 2nd QTR: not available 3rd QTR: not available |
| F. Action Plan for Improvement | | | | | | | 1st QTR: Ongoing action plans to improve on administration timing of pre-op antibiotics; antibiotic selection; antibiotic dosing. Reduction of staff entering/exiting O.R. suite during surgery. 2nd QTR: A new SSI prevention gap analysis performed using newer literature from 2017 to current. Comparisons made between current practice (implemented based on 2015 action plan) to current SSI prevention literature. Two interventions identified and being considered for adoption to the surgical services line - irrigation/lavage with dilute Iodophor solution, intraoperative hyperoxygenation. 3rd QTR: Solidifying action plans to address trends in MRSA decolonization (5/10 SSI events were due to MRSA), Diabetes Management, and review of suture material for morbidly obese patients. |

| Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2020 | | | | | | | |
|--|--|---------------|---------------|---------------|----|---------------|--|
| | | Q1 | Q2 | Q3 | Q4 | AVG. or TOTAL | SUMMARY / ACTION |
| II. Specific Surgical Review | | SIR | | | | | |
| A. Colon Surgery (COLO) CMS/VBP | | | | | | | |
| 1. #Total Procedure Count | | 32 | 32 | 46 | | | Annual running total: 110 |
| 2. Total Infection Count | | 0 | 1 | 3 | | | 1st QTR: 0 Predicted: not available 2nd QTR: 1 Predicted: 0.77 3rd QTR: 3 Predicted: 1.99 |
| 3. SIR CI (KDHCD predicted range, based on risks) | | not available | not available | not available | | | 1st QTR: not available 2nd QTR: not available 3rd QTR: not available |
| 4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [] | | not available | 1.3 | 1.51 | | | 1st QTR: No COLO SSI events reported. Clean Closure is routinely being performed. 2nd QTR: 1 COLO SSI events reported. There was evidence of infection was present at the time of surgery (PATOS). 3rd QTR: 2 COLO SSI events were superficial - Povidone Iodine was used instead of Chlorprep for skin prep in one, another was a complicated case with erythema noted to incision site when patient went to Hanford Adventist. 1 COLO IAB involving an anastomosis leak. Considering replacing saline irrigation with Povidone Iodine. This patient was not redosed prophylactic antibiotic Cefotetan at 2 hours into surgery as recommended by Pharmacy. |
| B. Cesarean Section (CSEC) | | | | | | | |
| 1. #Total Procedure Count | | 368 | 357 | 375 | | | Annual running total: 725 |
| 2. Total Infection Count | | 1 | 0 | 0 | | | 1st QTR: 1 Predicted: not available 2nd QTR: 0 Predicted: not available 3rd QTR: 0 Predicted: not available |
| 3. SIR CI (KDHCD predicted range, based on risks) | | not available | not available | not available | | | 1st QTR: Although an SIR is not available the CSEC incident rate = 0.27 which is very low. 2nd QTR: No events. 3rd QTR: No events. |
| 4. SIR (Standardized Infection Ration) total | | not available | not available | not available | | | 1st QTR: Working on addressing "splash & dash" skin prep technique for emergency CSEC procedures. Also, recommending limiting number of staff in entering/exiting the O.R. suite during surgery. 2nd QTR: It appears some of the actions initiated to reduce CSEC SSI events at the end of 1st QTR 2020 have helped prevent new events in the 2nd QTR. 3rd QTR: Doing well with control of CSEC SSI events. |

| Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2020 | | | | | | | |
|--|--|---------------|---------------|---------------|----|---------------|---|
| | | Q1 | Q2 | Q3 | Q4 | AVG. or TOTAL | SUMMARY / ACTION |
| C. Spinal Fusion (FUSN) | | | | | | | |
| 1. #Total Procedure Count | | 39 | 49 | 65 | | | Annual running total: 153 |
| 2. Total Infection Count | | 1 | 2 | 2 | | | 1st QTR: 1 Predicted: not available 2nd QTR: 2 Predicted: not available 3rd QTR: 2 Predicted: not available |
| 3. SIR CI (KDHCD predicted range, based on risks) | | not available | not available | not available | | | 1st QTR: Although an SIR is not available the FUSN incident rate = 2.56 which is high for the volume of this type of procedure being performed. 2nd QTR: Although an SIR is not available the FUSN incident rate = 4 which continues to be high for the volume of this type of procedure being performed. 3rd QTR: Although an SIR is not available the FUSN incident rate = 3.07 which continue to be high for the volume of this type of procedure being performed. |
| 4. SIR (Standardized Infection Ration) total | | not available | not available | not available | | | 1st QTR: Action plan includes recommendations to provide nares and skin decolonization for MRSA/MSSA. Recommendation to clip, not shave the surgery site. Recommend providing ample instructions on what to do post-operatively if evidence of infection is apparent. 2nd QTR: First case caused by skin flora and likely pressure caused by the cages placed during surgery. Second case appears to be associated with incontinent bowel episode and exposure of stool to the spinal incision site. Education provided about both these findings. 3rd QTR: Both events related to MRSA infections causing spinal abscesses 15 days post-op. Patients were not screened for MRSA colonization and glucose monitoring post-operatively on one diabetic patient not performed/documented. Wound dehiscence occurred 15 days post-op on second patient who went AMA to stay at a friends house on day 4 post-op. |
| D. Hysterectomy (HYST) CMS/VBP | | | | | | | |
| 1. #Total Procedure Count | | 48 | 13 | 35 | | | Annual running total: 96 |
| 2. Total Infection Count | | 0 | 0 | 1 | | | 1st QTR: 0 Predicted: not available 2nd QTR: 0 Predicted: not available 3rd QTR: 1 Predicted: 0.24 |
| 3. SIR CI (KDHCD predicted range, based on risks) | | not available | not available | not available | | | 1st QTR: not available 2nd QTR: not available 3rd QTR: not available |
| 4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [] | | not available | not available | 4.16 | | | 1st QTR: No HYST events reported. Clean Closure is routinely being performed. 2nd QTR: No HYST events reported. 3rd QTR: 1 HYST event involving a deep pelvic tissue infection. Patient developed symptoms on day 8 post-op and event criteria met on day 11 post-op. Extensive manipulation of the uterus around the bladder required due to very large fibroids. No cultures collected for this event. Criteria met via presence of a pelvic abscess and symptoms. |

| Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2020 | | | | | | | |
|---|--------------------|---------------|---------------|---------------|----|---------------|--|
| | | Q1 | Q2 | Q3 | Q4 | AVG. or TOTAL | SUMMARY / ACTION |
| II. Ventilator Associated Events (VAE) | | SIR | | | | | |
| A. Ventilator Device Use SUR (standardized utilization ratio) | | not available | not available | not available | | | 1st QTR: 891 vd Predicted: not available 2nd QTR: not available Predicted: not available 3rd QTR: not available Predicted: not available |
| B. Total VAEs ICU (NHSN Reportable) | Includes IVAC Plus | 2 | 6 | 7 | | | 1st QTR: 2 Predicted: not available 2nd QTR: 6 Predicted: not available 3rd QTR: 10 Predicted: not available |
| 1. SIR Total VAE CI (KDHCD predicted range, based on risks) | | not available | not available | not available | | | This is an internal quality driven metric. A State or National benchmark has not been made available. |
| 2. Total VAEs SIR | | not available | not available | not available | | | 1st QTR: not available 2nd QTR: not available 3rd QTR: not available |
| C. Total IVAC Plus -ICU | | 0 | 4 | 2 | | | 1st QTR: 0 Predicted: not available 2nd QTR: 4 Predicted: not available 3rd QTR: 2 Predicted: not available |
| 1. Total IVAC Plus CI (KDHCD predicted range, based on risks) | | not available | not available | not available | | | This is an internal quality driven metric. A State or National benchmark has not been made available. |
| 2. Total IVAC Plus ICU SIR | | 0 | not available | not available | | | 1st QTR: No IVAC or PVAPs reported. 2nd QTR: No SIR available. 3rd QTR: No SIR available. |
| D. CVICU/KDHCD Total VAEs (not NHSN/Internal) | | 0 | 0 | 0 | | | 1st QTR: CVICU had no VAEs. 2nd QTR: CVICU had no VAEs. 3rd QTR: CVICU had no VAEs. |
| E. Total VAEs-Both Units | | 2 | 6 | 7 | | | 1st QTR: There were 2 VAC events both in ICU. 2nd QTR: There were 3 VAC, 3 IVAC, 1 PVAP events identified in ICU. This quarter has been exceptionally difficult due to the COVID-19 pandemic. COVID-19 patients have extensive lengths-of-stay and remain on the ventilator several weeks at a time. Secondary pneumonia is quite common in COVID-19 patients. 3rd QTR: 7 VAEs, 2 IVAC events, 5 VAC events, 0 PVAP events. Continued challenges with COVID positive patients that intubated and placed on a ventilator. We are getting better at addressing these challenges as identified by the absence of PVAP. Advance Practice Nursing is implementing the Pneumonia Prevention Bundle, this is in addition to the already used Ventilator Associated Pneumonia Prevention Bundle. Emphasis is placed on oral care and mobility. Of note, we do often see PPI administered for vented patients, this goes against bundle compliance and will be addressed. |

| Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2020 | | | | | | | |
|---|----------|--------------|---------------|---------------|----|---------------|--|
| | | Q1 | Q2 | Q3 | Q4 | AVG. or TOTAL | SUMMARY / ACTION |
| III. Central Line Associated Blood Stream Infections (CLABSI) CMS/VBP | NHSN SIR | | | | | | |
| A. Total number of Central Line Days (CLD) | | 3917 | 3410 | 4085 | | | Annual running total: 7,495 |
| B. Central Line Device Use SUR (standardized utilization ratio) | | 0.74 | not available | not available | | | 1st QTR: 3917 Predicted: 5261.50 2nd QTR: 3283 Predicted: unavailable 3rd QTR: 4085 Predicted: unavailable |
| C. Total Infection Count Value Based Purchasing (VBP) # events = [] | | 2 | 6 | 5 | | | 1st QTR: 2 Predicted: 3.86 2nd QTR: 6 Predicted: 3.264 3rd QTR: 5 Predicted: 3.892 |
| D. SIR Confidence Interval | | 0.087, 1.713 | not available | not available | | | 1st QTR: No different than National benchmark. 2nd QTR: No confidence-interval provided. 3rd QTR: No confidence-interval provided. |
| E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [] | | 0.519 | 1.84 | 1.28 | | | 1st QTR: Implementation of action plans approved through the CLABSI Kaizen Project. Performing daily nursing unit "Gemba" rounds. Emphasizing methods to reduce the "culture-of-culturing" and "just-in-case" culture of peripheral and CVC line utilization. 2nd QTR: Daily Gemba rounds, provider education related to CLABSI distributed in physician lounges. Letters submitted to providers for a line they inserted identified as in a CLABSI event. Blood culture electronic alert reduced approximately 50% of unnecessary serial blood culture orders. Elimination of the IV Safety Team. COVID-19 Pandemic heavily impacting operations at the hospital. With approval of ECE offered by CMS, HAI data for 4th QTR 2019 through 2nd QTR 2020 not reported via NHSN, as result predicted values and SIR have been calculated manually. 3rd QTR: Enormous amount of work being performed to reduce CLABSI. Taskforce assigned to the following: CHG bathing; TPN utilization/Candidemia scoring; Culture-of-Culturing; Midlines as an Alternative; Vascular Access Team; Gemba rounds AM/PM with Resident follow-up. Candidemia cases have taken precedence with CLABSI events this year and are often related to TPN and Colorectal anastomosis. |

| Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2020 | | | | | | | |
|---|-----------------|--------------|---------------|---------------|----|---------------|---|
| | | Q1 | Q2 | Q3 | Q4 | AVG. or TOTAL | SUMMARY / ACTION |
| IV. Catheter Associated Urinary Tract Infections (CAUTI) CMS/VBP | NHSN SIR | | | | | | |
| A. Total number of Catheter Device Days (CDD) | | 3549 | 2865 | 3955 | | | Annual running total: 10,369 |
| B. Catheter Device Days SUR (Standardized Utilization Ratio) | | 0.767 | 0.14 | not available | | | 1st QTR: 3549 Predicted: 4624.70 2nd QTR: 2884 Predicted: unavailable 3rd QTR: 3955 Predicted: unavailable |
| C. Total Infection Count Value Based Purchasing (VBP) # of events = [] | | 3 | 5 | 4 | | | 1st QTR: 3 Predicted: 4.553 2nd QTR: 5 Predicted: 3.67 3rd QTR: 4 Predicted: 5.124 |
| D. SIR Confidence Interval | | 0.168, 1.793 | not available | not available | | | 1st QTR: No different than National benchmark. 2nd QTR: No confidence-interval provided. 3rd QTR: No confidence-interval provided. |
| E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [] | | 0.66 | 1.49 | 0.781 | | | 1st QTR: Implementation of action plans approved through the CAUTI Kaizen Project. Performing daily nursing unit "Gemba" rounds. Emphasizing methods to reduce the "culture-of-culturing" and "just-in-case" culture of inserting indwelling urinary catheters when not indicated. Emphasizing alternatives to an indwelling urinary catheter and straight catheterization. Guiding providers away from ordering cultures based on urine color/sediment. 2nd QTR: Work underway to establish a physician PowerPlan built in Cerner to guide the provider to appropriately order urine cultures based on urine culture algorithm (developed from review of evidence-based literature). Gemba rounds have reduced indwelling urinary catheter days by 684 days. Peri care improving. Still have culture-of-culture issues. Also, need to address urinary retention/neurogenic bladder as an indication for an indwelling urinary catheter (diagnosis may be being overly used). With approval of ECE offered by CMS, HAI data for 4th QTR 2019 through 2nd QTR 2020 not reported via NHSN, as result predicted values and SIR have been calculated manually. 3rd QTR: Just exceeded the CMS benchmark of 0.727. The CAUTI events for this quarter occurred as a result of not using/complying with the bladder management policy, not collecting urine specimens from a new fresh IUC, and culture-of-culturing practices. There are several interventions in the works to address these fallouts. |
| V. Clostridium difficile Infection (CDI) CMS/VBP | SIR | | | | | | |
| A. Total Infection Count | All units | 3 | 10 | 0 | | | 1st QTR: 3 Predicted: 15.297 2nd QTR: 10 Predicted: 12.55 3rd QTR: 0 Predicted: 15.99 |
| B. SIR CI (KDHC predicted range, based on risks) | | 0.050, 0.534 | not available | not available | | | 1st QTR: No different than national benchmark. 2nd QTR: unavailable 3rd QTR: unavailable |
| C. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [] | | 0.196 | 0.80 | 0 | | | 1st QTR: Closely monitoring C. difficile rates. Occasionally reminding providers and nurses to look for alternative reasons for diarrhea (i.e. stool regimen) in advance of testing for C. difficile. 2nd QTR: Exceeded new national benchmark for CDI. Benchmark = 0.646. Antimicrobial Stewardship rounds and Infection Preventionist interventions still ongoing in the moment daily to prevent healthcare onset CDI events. The increase HO CDI events is likely due to very ill COVID positive patient treated with antibiotics and having very lengthy stays in critical care developing CDI. 3rd QTR: There were no healthcare onset C. difficile cases. |
| | | | 84/111 | | | | |

| Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2020 | | | | | | | |
|--|------------|------|------|------|----|---------------|---|
| | | Q1 | Q2 | Q3 | Q4 | AVG. or TOTAL | SUMMARY / ACTION |
| VI. Hand Hygiene | 95% | | | | | | |
| A. All units Percentage of correct Hand Hygiene observations/opportunities (30 observations/month/unit) | | 88% | 87% | 88% | | | <p>1st QTR: ICU and 4N Renal Unit are trialing Biovigil electronic hand hygiene surveillance system. Hand hygiene compliance rates remain above 97% with thousands of observations occurring weekly. The remaining nursing units perform unit based hand hygiene observations and the IP Liaison and Infection Prevention perform hand hygiene audits in these locations. The 88% HH compliance rate is composite of these observations. The Do You Disinfect Everytime (D.U.D.E.) Campaign continues with videos posted on KDCentral.</p> <p>2nd QTR: 87% compliance for all units/departments (excluding 4N and ICU) a total of 2,663 observations with 2,317 compliant. Biovigil trial still ongoing. Very high hand hygiene compliance rates in 4N a little less so in ICU (4N 99.1% & ICU 96.4%). New Leapfrog hand hygiene criteria achieved (increased hand hygiene observation volume per month/education/validation testing/marketing, etc.)</p> <p>3rd QTR: 88% compliance for all units/departments during the months of July and August. During September there was a transition to use of Biovigil electronic hand hygiene surveillance for all units/departments at the downtown campus with the exception of the ED, ASC/PACU, MH, CVCU units that were manually acquired and rolled into the 88% hand hygiene compliance. Total 4,916 observations/589 non-compliant. The September Biovigil hand hygiene compliance rate is depicted in the brackets above in 3rd column.</p> |
| VII. VRE (HA) Blood-Hospital Onset (HO) | BM | | | | | | |
| A. Total Infection Count | | 0 | 1 | 0 | | | <p>1st QTR: 0 Predicted: 2nd QTR: 1 Predicted: not available</p> |
| B. Prevalence Rate (x100) | | 0 | 1.45 | 0 | | | <p>1st QTR: No VRE BSI events reported. 2nd QTR: This is the first event of VRE BSI reported in a very long time at KDCHD. 3rd QTR: No VRE BSI events reported.</p> |
| C. Number Admissions | | 6591 | 6881 | 5600 | | | 19,072 |

| Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2020 | | | | | | | |
|---|--|--------------|---------------|---------------|----|---------------|--|
| | | Q1 | Q2 | Q3 | Q4 | AVG. or TOTAL | SUMMARY / ACTION |
| VIII. MRSA (HAI) Blood CMS/VBP | | SIR | | | | | |
| A. Total Infection Count (IP Facility-wide) | | 2 | 0 | 5 | | | 1st QTR: 2 Predicted: 2.51 2nd QTR: 0 Predicted: 1.83 3rd QTR: 5 Predicted: 2.15 |
| B. SIR CI (KDHCD predicted range, based on risks) | | 0.212, 4.180 | not available | not available | | | 1st QTR: No different than National benchmark. 2nd QTR: not available 3rd QTR: not available |
| C. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [] | | 1.265 | 0.00 | 2.15 | | | 1st QTR: Both cases involved patients who had blood cultures later than 3 days into their admission. Both patients demonstrated elevation in WBCs which initiated blood culture orders. However, findings for one patient demonstrated evidence of pneumonia, this patient never had respiratory secretion cultures performed. The second patient had a liver abscess that was drained, but blood cultures were performed a day in advance of the drainage procedure and MRSA was found. 2nd QTR: MRSA BSI infection identified was a joint MRSA BSI and CLABSI event. The blood culture was collected on day 4 which results in the event being healthcare onset related instead of present-on-admission. 3rd QTR: There were a significant amount of MRSA BSI events during this quarter. Underlying trends for these identified events include: pan culture practices, late culture (POA), Serial blood cultures, and in three cases didn't identify pneumonia as the actual source of infection, instead pursued blood cultures. |
| IX. Influenza Rates (Year 2019-2020) | | NHSN | | | | | |
| A. All Healthcare Workers | | 97.8% | | | | | Season 2020-2021: 3,947 out of 4,034 healthcare personnel received influenza vaccination during the influenza season. This is down by 0.2% from the 2019-2020 Influenza Season vaccination rate. A total of 84 healthcare personnel declined influenza vaccine and 3 healthcare personnel had a medical contraindication to receiving influenza vaccination. Action: Early preparation for a potentially challenging year with a combined influenza season and COVID-19 pandemic. |
| Approved IPC: Approved IPC: Approved IPC: Approved IPC: Prepared by Shawn Elkin, MPA, BSN, RN, PHN, CIC Infection Prevention Manager | | | | | | | |



Hospital-Acquired Pressure Injury Quality Focus Team HAPI QFT Quality Council Report

Mary Laufer DNP RN NE-BC
Director of Nursing Practice
December 2020

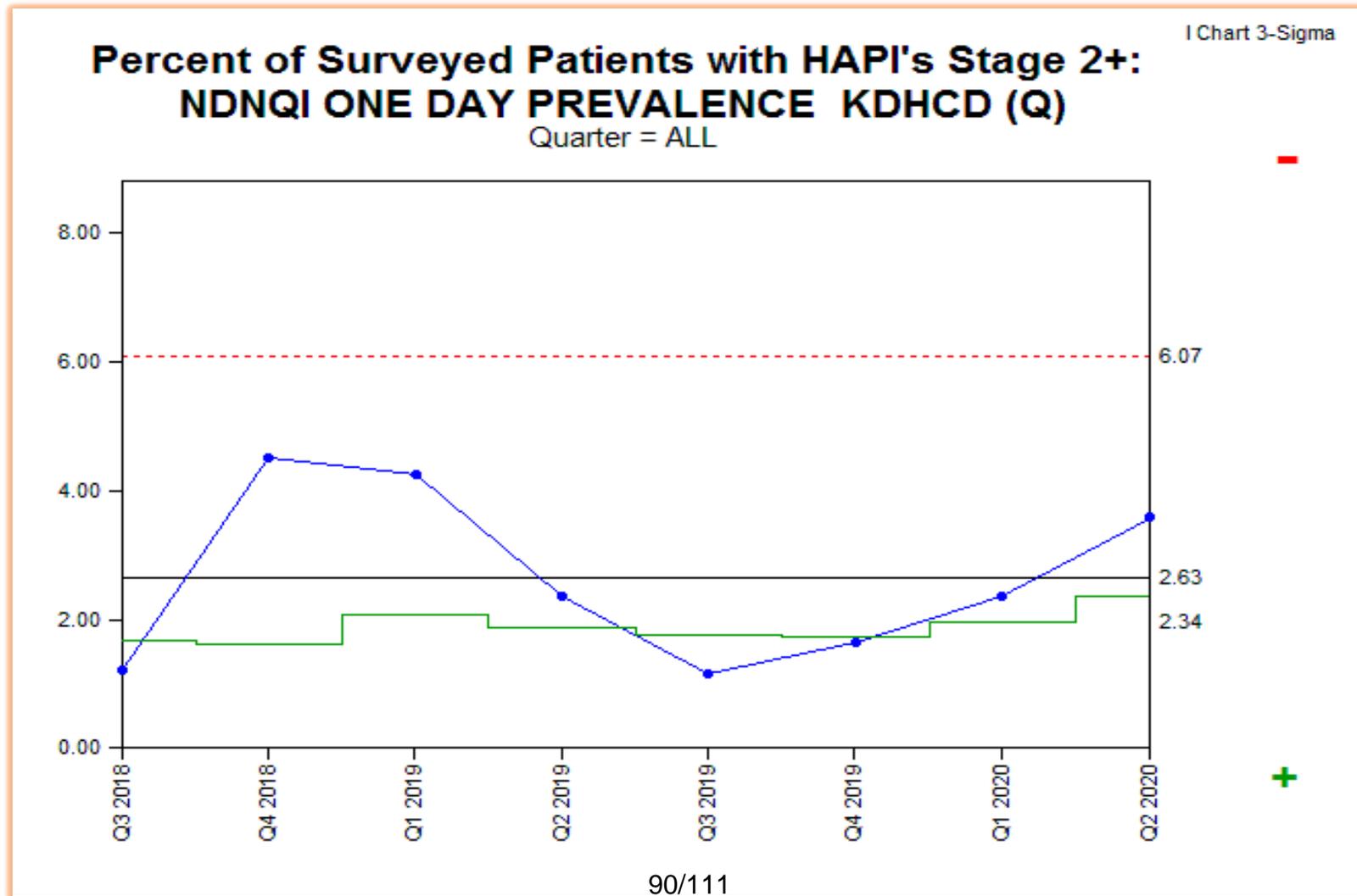
Hospital-Acquired Pressure Injury

- HAPI – formerly known as “pressure ulcer” or “bed sore”
- Localized injury to skin and/or underlying tissue that occurs during an inpatient hospital stay
- Resulting from pressure and/or shear forces that damage tissue
- Usually over a bony prominence or related to a medical device
- Injury may present as intact skin or an open ulcer, and may be painful

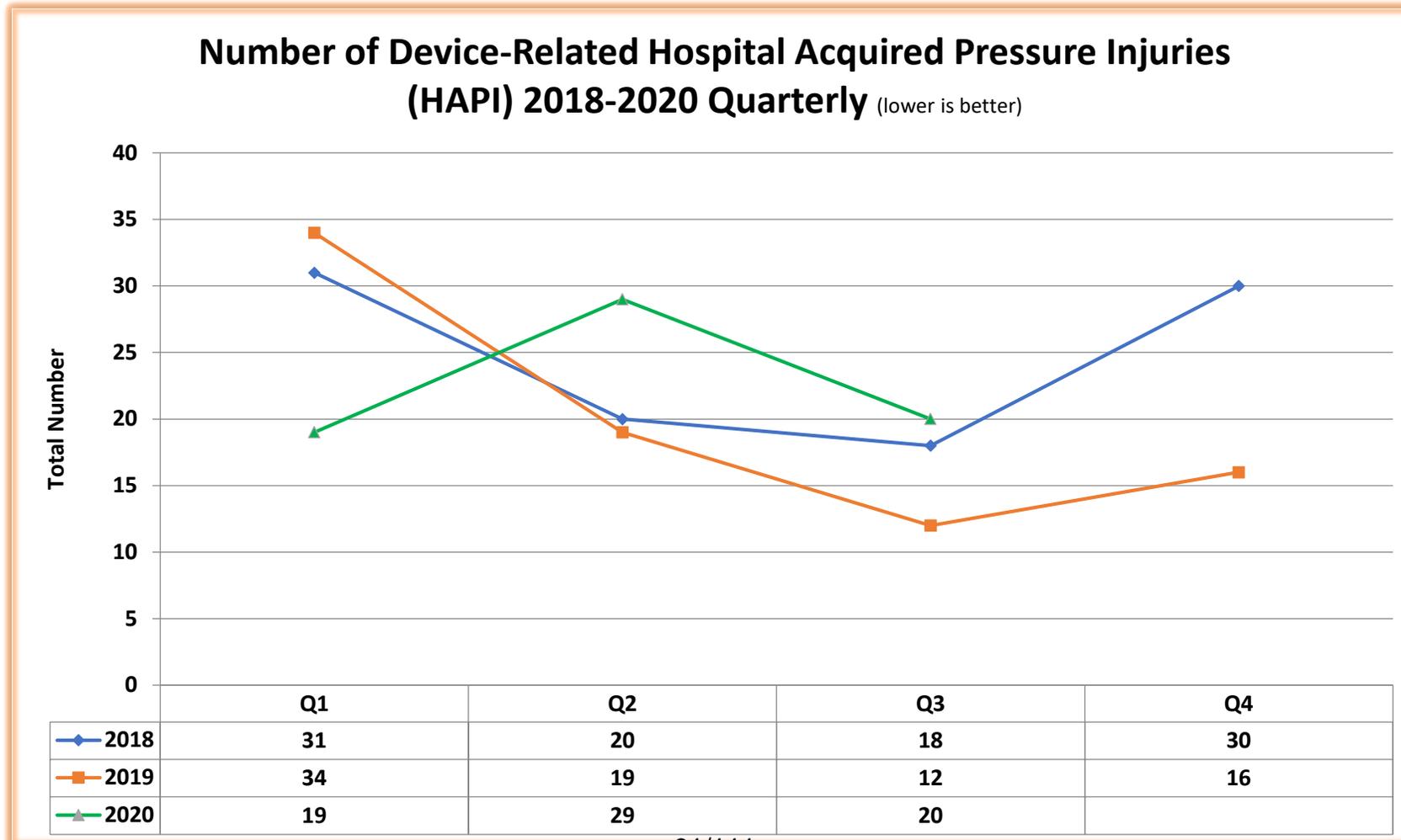
National Database of Nursing Quality Indicators[®] (NDNQI) Prevalence Study

- NDNQI computes HAPI rates based on skin inspection of each patient, performed on one (1) day each quarter
- Pressure injuries are classified as hospital-acquired or community-acquired (present on admission)
- Pressure injuries are categorized according to standardized guidelines as Stage 1-4, unstageable, suspected deep tissue pressure injury (DTPI), or indeterminable

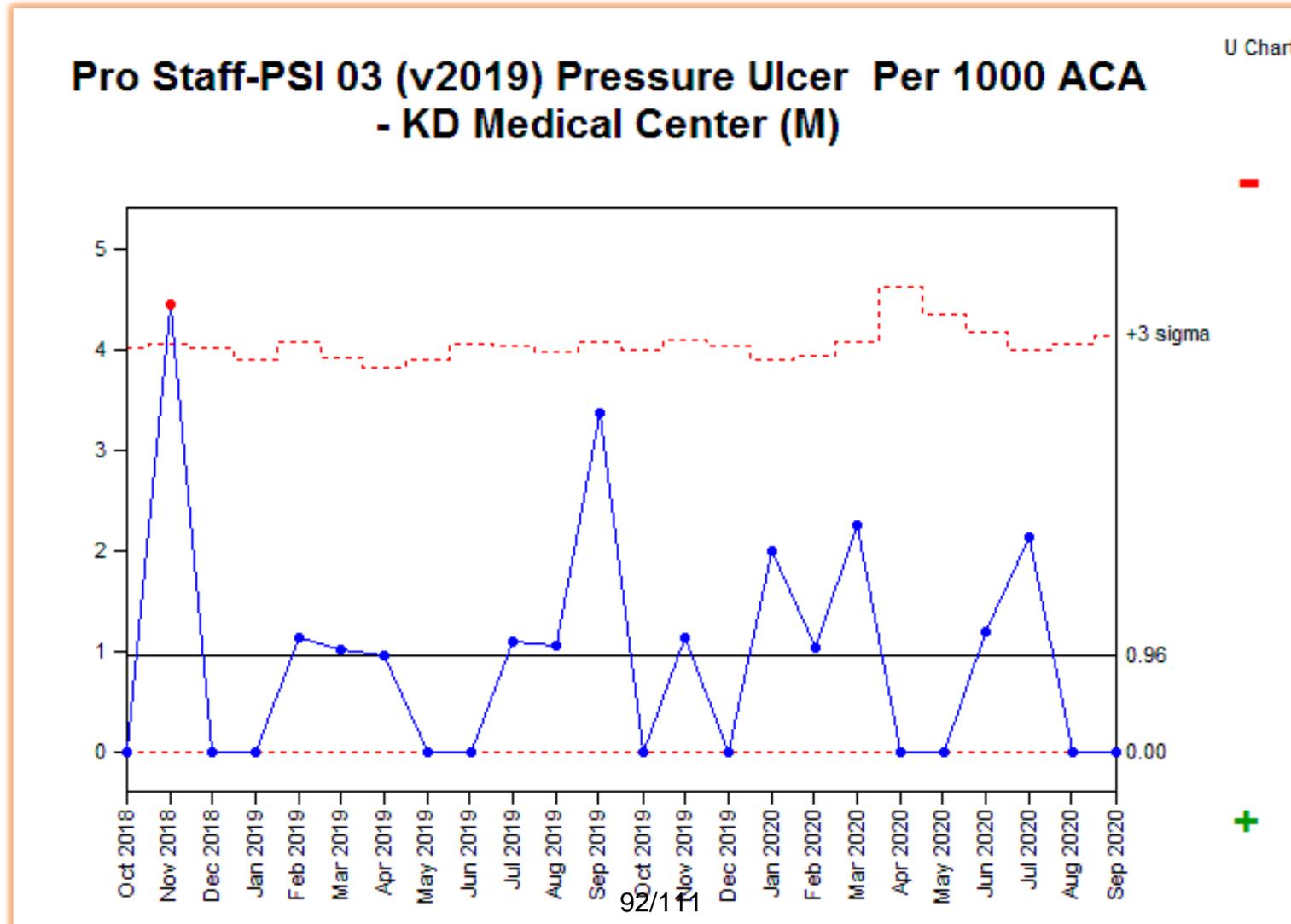
Goal-1 Outperform the national HAPI prevalence target statistic two consecutive reporting intervals



Goal-2 Reduce number of device-related HAPIs by 10% by end of next reporting interval



Goal-3 Pressure ulcer rate for adult medical or surgical patients < 1.0 three consecutive months



Action:
 Develop user-
 friendly HAPI
 Dashboard to
 include unit-
 level incidence
 rates

HAPI QFT Dashboard

| Measure Description | Benchmark/ Target | 2019 | | | | | | | | |
|--|---|----------|--------|--------|--------|--------|--------|--------|--------|----------|
| | | Baseline | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | YTD 2020 |
| Outcome Measures | | | | | | | | | | |
| HAPI Stage 2+ per 1,000 pt days (all HAPIs) | 1.31 (-20% from 2019) | 1.64 | 0.60 | 3.08 | 1.26 | 2.35 | 1.73 | 2.13 | 1.38 | 1.76 |
| Device Associated HAPI per 1,000 pt days | 0.59 (-20% from 2019) | 0.74 | 0.00 | 1.16 | 0.42 | 1.51 | 1.15 | 0.93 | 0.76 | 0.81 |
| NDNQI % Surveyed Patients Stage 2+ (1 day prevalence per quarter) | 1.96 (1Q 2020) 2.34 (2Q 2020) | 2.62 | | | 2.35 | | | 3.57 | | 2.92 |
| PSI 3 - Claims-based HAPI Stage 3, 4, DTPI, and Unstageable per 1,000 discharges | 0.6 - Hospital Compare (Q3 2017-Q2 2019) 0.35 - Midas 50th Percentile (2019) | 0.79 | 1.98 | 1.03 | 2.25 | 0 | 0 | 1.35 | 2.16 | 1.33 |
| Process Measures | | | | | | | | | | |
| EXAMPLE 02 Device associated HAPI per 1,000 pt days | | | | | | | | | | |
| TBD | | | | | | | | | | |
| Unit Level (-15% from 2019) | | | | | | | | | | |
| 4N - HAPI 2+ per 1,000 pt days | 1.14 | 1.34 | 1.15 | 11.03 | 1.24 | 1.69 | 0.00 | 1.29 | 0.00 | 2.42 |
| 3W - HAPI 2+ per 1,000 pt days | 1.92 | 2.26 | 0.00 | 2.58 | 1.30 | 1.70 | 3.96 | 13.13 | 1.77 | 3.08 |
| ICU - HAPI 2+ per 1,000 pt days | 6.04 | 7.1 | 1.97 | 12.58 | 4.26 | 9.43 | 12.74 | 10.18 | 1.92 | 7.44 |
| CVICU - HAPI 2+ per 1,000 pt days | 4.42 | 5.2 | 4.38 | 8.79 | 9.05 | 8.15 | 1.77 | 4.63 | 18.52 | 6.99 |
| 2N - HAPI 2+ per 1,000 pt days | YTD ≤ 2019 | 0.1 | 0.00 | 0.00 | 1.41 | 0.00 | 0.00 | 0.00 | 0.00 | 0.19 |
| 2S - HAPI 2+ per 1,000 pt days | YTD ≤ 2019 | 0.7 | 0.00 | 0.00 | 0.00 | 8.81 | 5.85 | 0.00 | 4.21 | 2.84 |
| 3N - HAPI 2+ per 1,000 pt days | YTD ≤ 2019 | 0.86 | 0.00 | 2.07 | 0.00 | 1.28 | 0.00 | 1.17 | 0.00 | 0.63 |
| 3S - HAPI 2+ per 1,000 pt days | YTD ≤ 2019 | 0.46 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 1.18 | 0.00 | 0.18 |
| 4S - HAPI 2+ per 1,000 pt days | YTD ≤ 2019 | 1.37 | 1.01 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.16 |
| 4T - HAPI 2+ per 1,000 pt days | YTD ≤ 2019 | 1.23 | 0.00 | 1.72 | 0.00 | 0.00 | 0.00 | 0.00 | 3.62 | 0.79 |
| BP - HAPI 2+ per 1,000 pt days | YTD ≤ 2019 | 0 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Rehab - HAPI 2+ per 1,000 pt days | YTD ≤ 2019 | 0.75 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| 5T - HAPI 2+ per 1,000 pt days | n/a | | | | | | | 0.00 | 0.00 | 0.00 |
| Other Units | | | | | | | | | | |
| ED | n/a | 4 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 2 |
| Sub-acute | n/a | 5 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 2 |
| Surgery | n/a | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Cath Lab | n/a | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| MA | n/a | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TCS | n/a | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Green | Better than Target | | | | | | | | | |
| Yellow | Within 10% of Target | | | | | | | | | |
| Red | Does not meet Target | | | | | | | | | |

Work in Progress

- Generate wound consult for pressure injury documented present on admission
- Expand wound nurse weekday rounds (GEMBA) participation to include intensive care unit (ICU)
- Restart wound class for new hire nurses and existing staff
- Review and incorporate action priorities resulting from HAPI 6-Sigma Style rapid improvement event into standard work of existing HAPI Quality Focus Team

What's Next...

- Report to Board of Directors on key outcome measures and actions from HAPI 6-Sigma Style rapid improvement event (RIE)
- Develop HAPI QFT infrastructure to support continued work on current goals and HAPI RIE deliverables



Thank You...



Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Unit/Department: HAPI QFT & Inpatient Wound Prevention **Report Date:** December 2020

Measure Objectives / Goals:

Goal 1 *Outperform the national HAPI prevalence target statistic two consecutive reporting intervals*

The National Database of Nursing Quality Indicators® (NDNQI) Prevalence Study

Founded by the American Nurses Association (ANA) in 1998 and having been managed by The University of Kansas School of Nursing since 2001, NDNQI was purchased by PressGaney, a long-standing leader in performance measurement, in 2014. NDNQI promotes nursing excellence through the most robust source of comparative norms in the industry. Nurse sensitive quality measures and indicators reflect the impact of nursing actions on patient outcomes.

The NDNQI computes hospital acquired pressure injury (HAPI) rates based on surveys carried out by each participating hospital unit on *one (1) day each quarter*. A trained survey team carries out a skin inspection of each patient on the unit, classifies each pressure injury as hospital- or community-acquired (i.e., present on admission), and categorizes each pressure injury according to standardized guidelines as Stage 1-4, unstageable, suspected deep tissue pressure injury, or indeterminable. Hospitals report to the NDNQI the number of patients on the units who were assessed for pressure injuries and the count and category of pressure injuries observed. The NDNQI uses these data to compute pressure injury rates and, based on these rates, the percentile ranking among units/hospitals of same type.

Goal 2 *Reduce number of device-related HAPIs by 10% by end of next reporting interval*

Hospital Acquired Pressure Injuries (HAPI), Total and Device-Related

Incidence data are compiled from staff/unit-level self-report, with and without prompting from wound nurse consultant. Includes Stage 1-4, unstageable, suspected deep tissue pressure injury (DTPI).

Goal 3 *PSI 03 Rate < 1.0 for three consecutive months*

PSI 03: Pressure Ulcer Rate

Pressure ulcers have been associated with an extended length of hospitalization, sepsis, and mortality. The Agency for Healthcare Research and Quality (AHRQ) developed measures that health providers use to identify potential in-hospital patient safety problems for targeted institution-level quality improvement efforts. Patient Safety Indicator (PSI) 03 includes stage 3 or 4 pressure ulcers or unstageable (secondary diagnosis) per 1000 discharges among surgical or medical patients ages 18 years and older. *Exclusions: stays less than 3 days; cases with principal stage 3 or 4 (or unstageable) pressure ulcer diagnosis; cases with a secondary diagnosis of stage 3 or 4 pressure ulcer (or unstageable) that is present on admission; obstetric cases; severe burns; exfoliative skin disorders.*

Date Range of Data Evaluated:

1. NDNQI Prevalence Study: Q2 2020
2. HAPIs, Total and Device-Related: Q2 2020
3. PSI 03 Pressure Ulcer Rate: Jul – Sep 2020

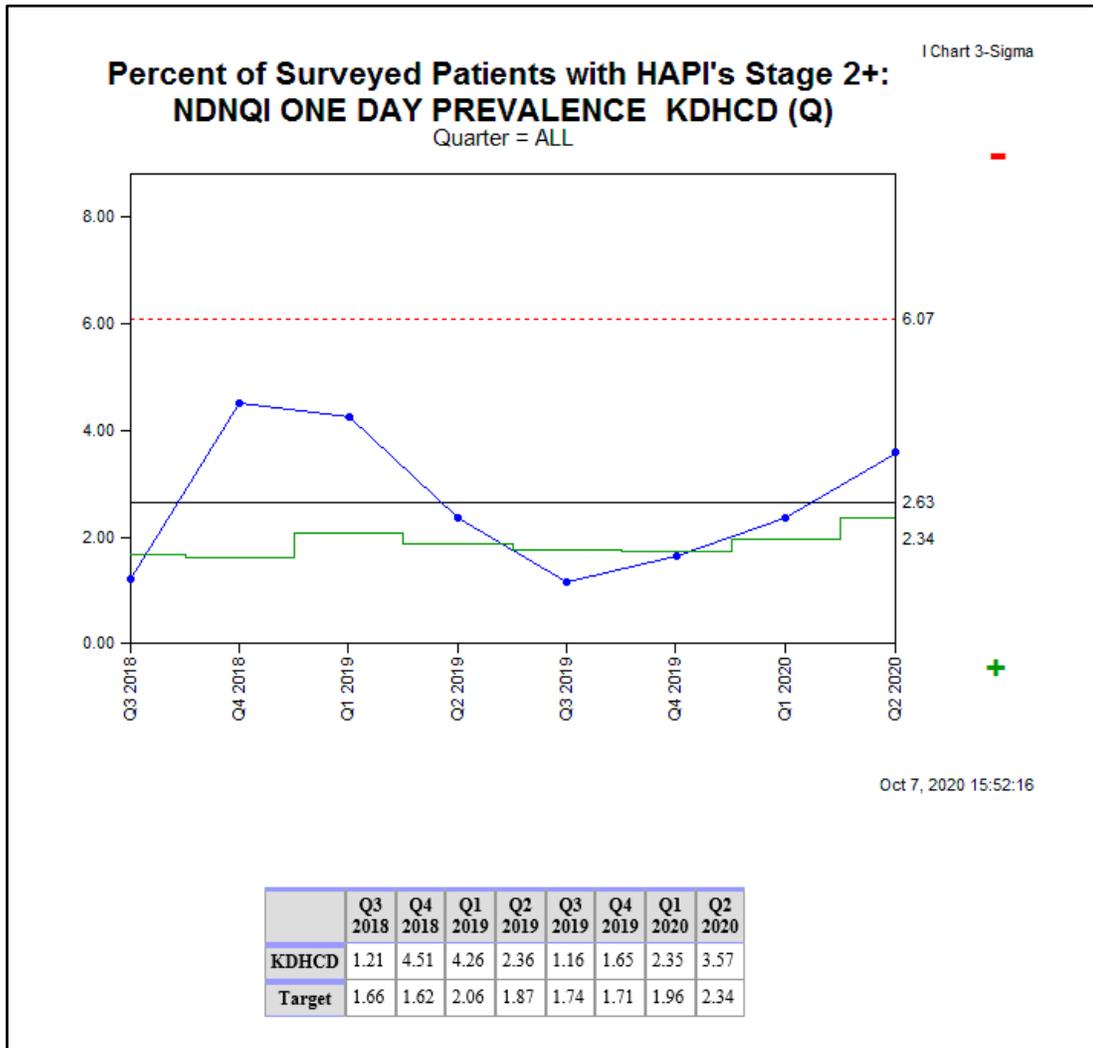
Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Analysis of Measures / Data: (include key findings, improvements, opportunities)

1. NDNQI Prevalence Study

Ø Goal 1 Not Met: Underperformed national target statistic Q2 2020



2. Hospital Acquired Pressure Injuries (HAPI), Device Related

The total number of HAPIs reported in 1Q *increased* from 46 to 54 reported in 2Q 2020 (+17.4%)

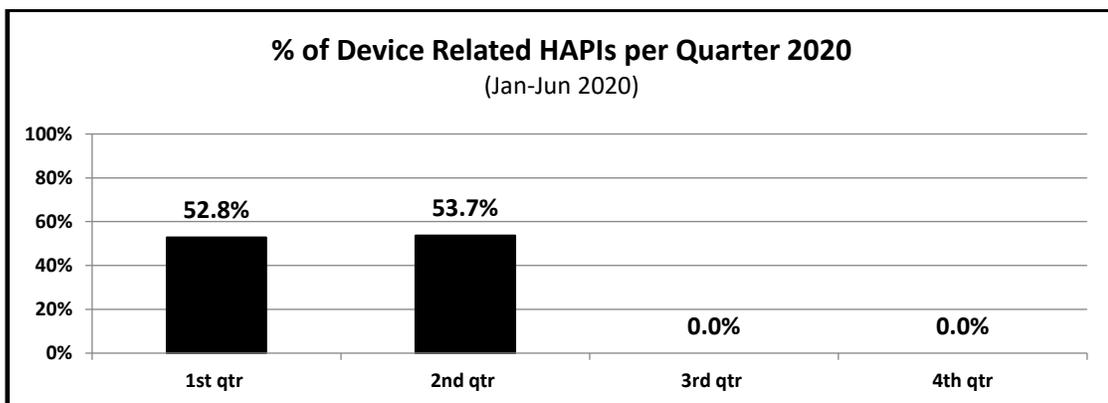
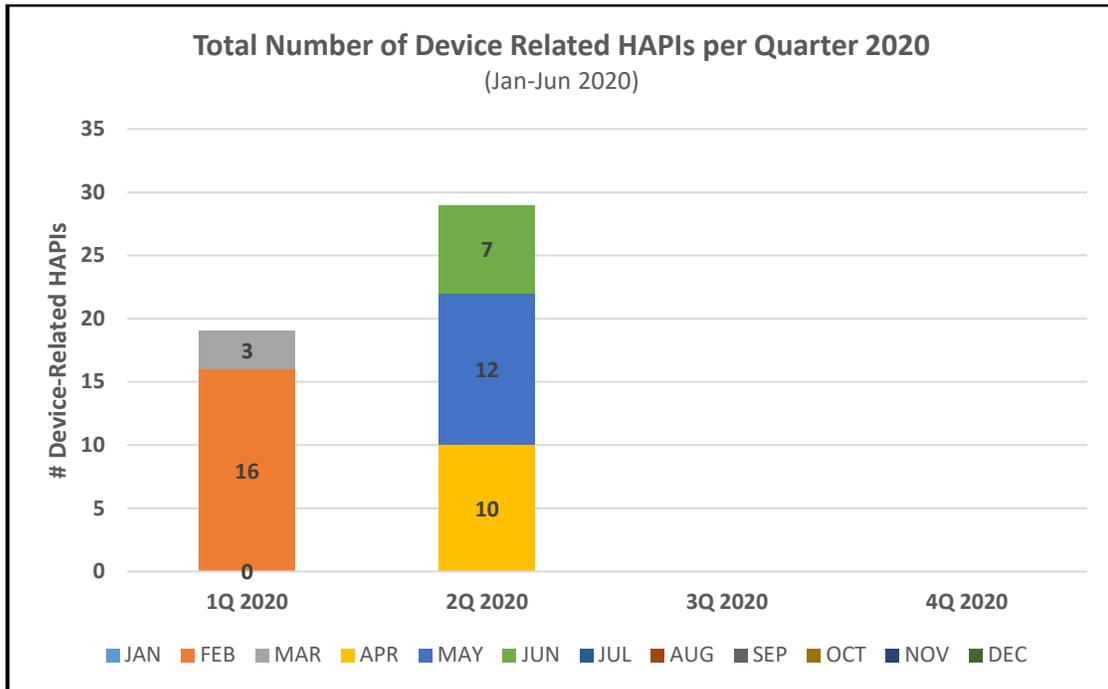
- 1Q: 29 patients accounted for 46 HAPIs
 - 8 patients (28%) with ≥ 2 HAPIS (two patients with 5 HAPIs)
- 2Q 35 patients accounted for 54 HAPIs
 - 13 patients (37%) with ≥ 2 HAPIS (two patients with 4 HAPIs)

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Ø Goal 2 Not Met:

- Number of HAPIs related to devices *increased* from 19 in 1Q to 29 in 2Q 2020 (+52.6%)
- Percent of total HAPIs related to devices *increased* by 1.8% from 1Q to 2Q 2020

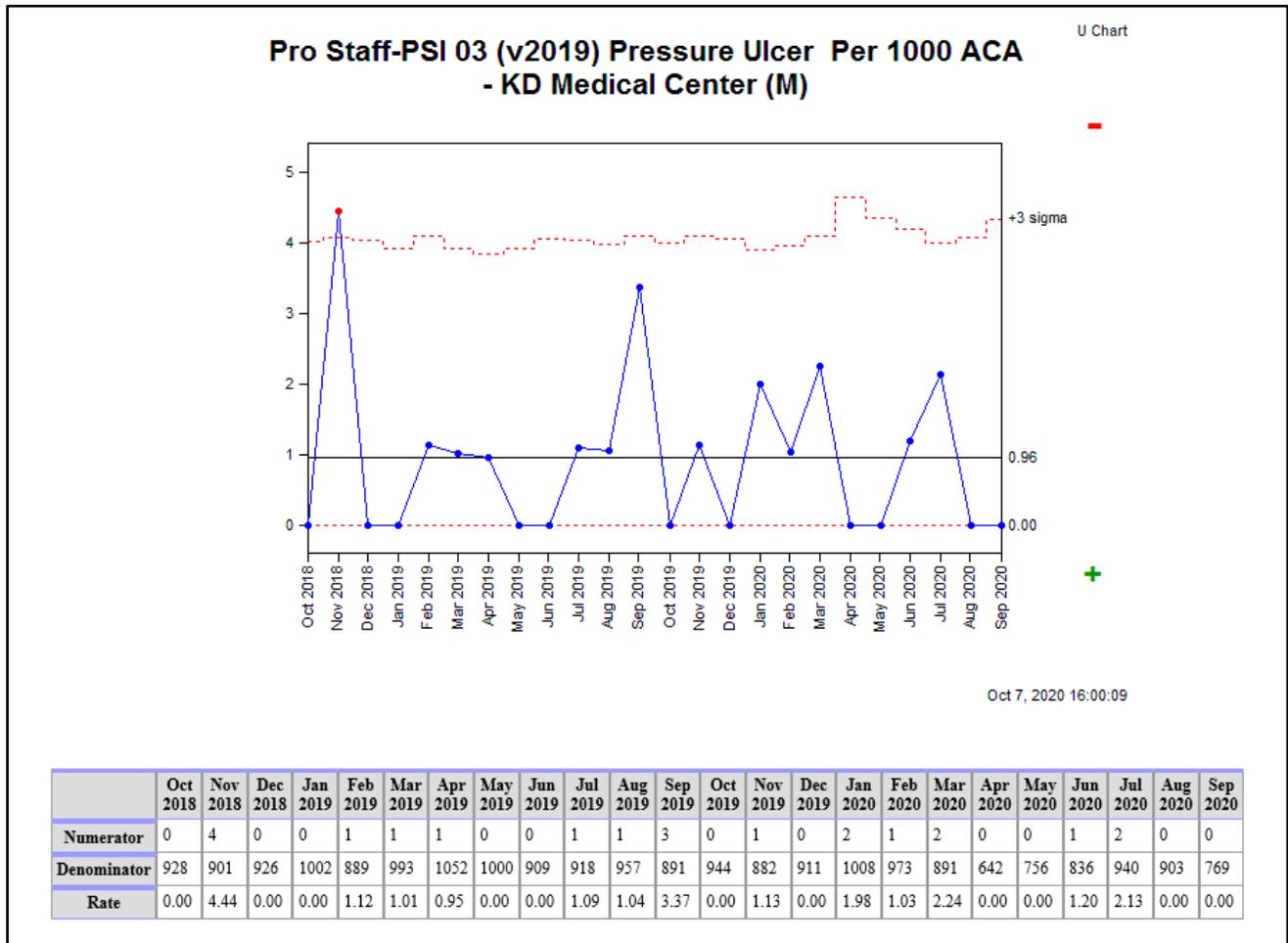


Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

3. PSI 03 Pressure Ulcer Rate

Ø Goal 3 Not Met: Rate for July > 1.0 (2.13); rates for August, September < 1.0 (0.0)



Improvement Opportunities Identified, Action Plan and Expected Resolution Date / Next Steps, Recommendations, Outcomes:

1. Develop user-friendly HAPI Dashboard to include NDNQI and PSI benchmarks, trend unit-level HAPI incidence rates (per 1,000 patient days).
 - a. Draft developed in partnership with Quality & Patient Safety leaders/analysts [Jul-Sep 2020].
 - b. Review and approval of content/format by HAPI QFT membership, Chief Nursing Officer, Patient Care Leadership (PCL) and Patient Care Managers (PCM) [Oct-Nov 2020].
2. In collaboration with VP Chief Quality Officer and Clinical Informatics team, a new wound RN consult is generated based on documentation of pressure ulcer/injury present on admission.
 - a. Wound RN assessment validates (or refutes) presence pressure injury on admission
 - b. Increases opportunity to capture potential PSI-03 while patient is hospitalized rather than retrospectively [go-live October 1, 2020].

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

3. Expand weekday GEMBA participation by Wound RNs to intensive care unit (ICU) [Oct 12, 2020] to mitigate development/progression of skin issues.
4. Restart comprehensive Wound Class for new hire nursing staff; retro-fit staff hired post-pandemic [Nov 2020].
5. In partnership with Quality & Patient Safety Team, utilize Lean Six Sigma tools to explore HAPI data and develop process metrics to include in new dashboard [Nov-Dec 2020].
6. Continue to explore risk stratification tools and documentation improvement opportunities, in partnership with VP Chief Quality Officer.
7. Promote involvement of direct care staff in efforts to prevent HAPI events by developing a structure to review HAPI events with unit leaders and staff (mirror current Falls University) by end of FY21.

Submitted by:

Mary Laufer, DNP, RN, NE-BC
Director of Nursing Practice

Date Submitted: October 13, 2020

Handoff Quality Focus Team

**Kassie Waters, Director of Cardiac Critical Care Services
& Brad Danby, Director of Emergency Services**

Team Mission

Implement standardize structure for nurse to nurse handoff when admitting a patient from the Emergency Department to in-patient departments.

Standardize structure will:

- Include critical content to eliminate communication errors.**
- Provide accurate and complete information to the receiver.**
- Meet the needs of the sender and receiver to handoff and receive care.**
- Accomplish a timely handoff (transfer) of the patient to the admitting department by removing barriers.**



Team Deliverables & Goals

Deliverables

1. Establish standard process
2. Standardize critical content elements
3. Build standard handoff tool utilizing EMR
4. Standardize training & education

Goals

Quality of Handoff Measurement

1. ED nurse "sender" provided accurate and complete information with 80% of handoffs (Current state is 15%)

Timeliness Measurement

2. Handoff completed and bed occupied with in 30 minutes of the bed being ready. (Current state is 1hour 18 minutes)

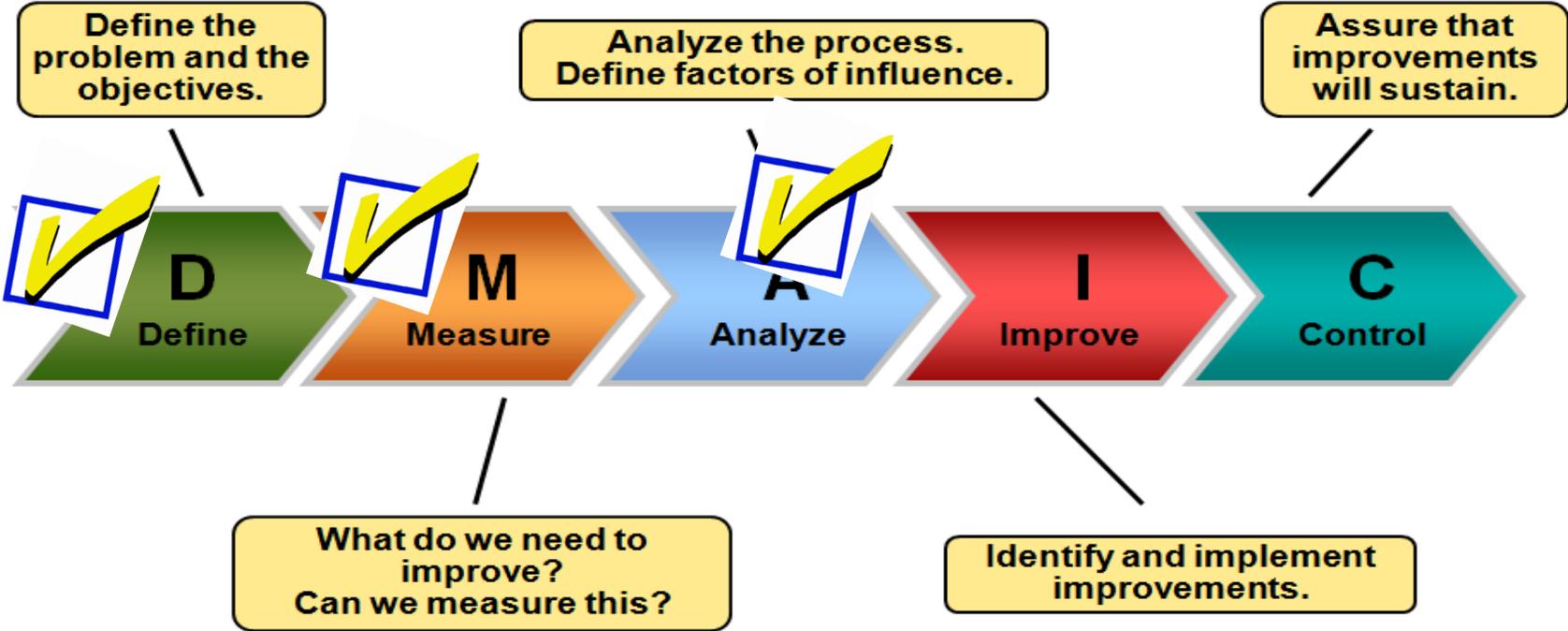
Safety Measurement

3. Reduce the number of handoff safety events from the ED to In-patient departments by 20%.



DMAIC

DMAIC Roadmap



Analyze

- Maternal Child Health – Share current EMR handoff process (best practice identified by ISS)
- Review Cleveland Clinic process & EMR tools
- Review UC Davis Health System process & EMR tools
- List critical content to be included in the handoff
- Reviewed handoff tool in EMR



Established 10 Absolutes Handoff Tool

Joint Commission Handoff List

Make sure the receiver gets the following minimum information:

- Sender contact information
- Illness assessment, including severity
- Patient summary, including events leading up to illness or admission, hospital course, ongoing assessment, and plan of care
- To-do action list
- Contingency plans
- Allergy list
- Code status
- Medication list
- Dated laboratory tests
- Dated vital signs



05

10 Absolutes Handoff Tool

HANDOFF TOOL

Please try to follow this as close as possible so that report becomes more streamline.

If you don't know something, then just say, "I don't know," so that the next RN can follow up

| 10 ABSOLUTES (in this order) | Example |
|--|---|
| Situation | |
| 1. Patient, age, allergies, code status, admitting provider (If not sure, say "I don't know") language spoken if not English | I am calling report on Ms. Betty. She is an 86-year-old female. Full code. |
| 2. Diagnosis: (why is patient being kept here?) | Pt came in with SOB, being admitted for LLL pneumonia. |
| Background | |
| 3. Pertinent History (items that will affect care for this visit) | Pt has history of HTN, DM, AKI, CVA 2012 |
| 4. MEDS and tx received location of IV and when placed, if the IV is started by EMS state "Field Start" devices – Chest tubes, cardiac pacer, NGT | We gave her an hour long neb and started azithromycin Pt has a 20g to RAC placed today |
| 5. Pertinent Labs & Results | Pt's x-ray showed LLL pneumonia, WBC was 21. |
| Assessment | |
| 6. ASSESSMENT: Neurological Status | She is alert and oriented x4, She has no neuro deficits, and equal strength bilaterally. |

| | |
|--|---|
| Cardiac | Her cardiac is NSR on the monitor in the 90s. |
| Respiratory | Respiratory: Left side sounds diminished with crackles, right side clear. Does not give respiratory effort. |
| GI/GU | GI/GU: No difficulties or pain at this time |
| Skin INTEGUMENTARY | Skin: is intact, with some scattered bruising to BUE. Backside is intact with no skin breakdown. Pt is on a waffle mattress for comfort Pt's ROM is good, no limitations. Pt is able to stand and move to chair with assistance. |
| Muskoskeletal | |
| MOBILITY (If pt has not got up yet, then state that) Is the patient a fall risk? | |
| 7. Current 10 SOV (Vital signs and pain score) that have been taken within the last hour | Afebrile, 144/88, 20 RR, 92 HR, NC 1L saturating at 96%, Denies any chest pain |
| 8. Current Blood Sugar (taken within last 30 minutes if diabetic or here for a glycemic issue) AND diet if known | Last blood glucose check was 124, and unsure of diet, but pt currently not hungry. |
| Recommendations & Questions | |
| 9. Patients NEXT STEPS or Action List: any new orders/tests Transfusion of blood products Next Antibiotic Timing of anticoagulants | EKG and blood work in AM |
| 10. Any last questions the receiving RN has | Answer then say, THANK YOU |

Improvement Action Plan

1. 10 Absolute Handoff Tool

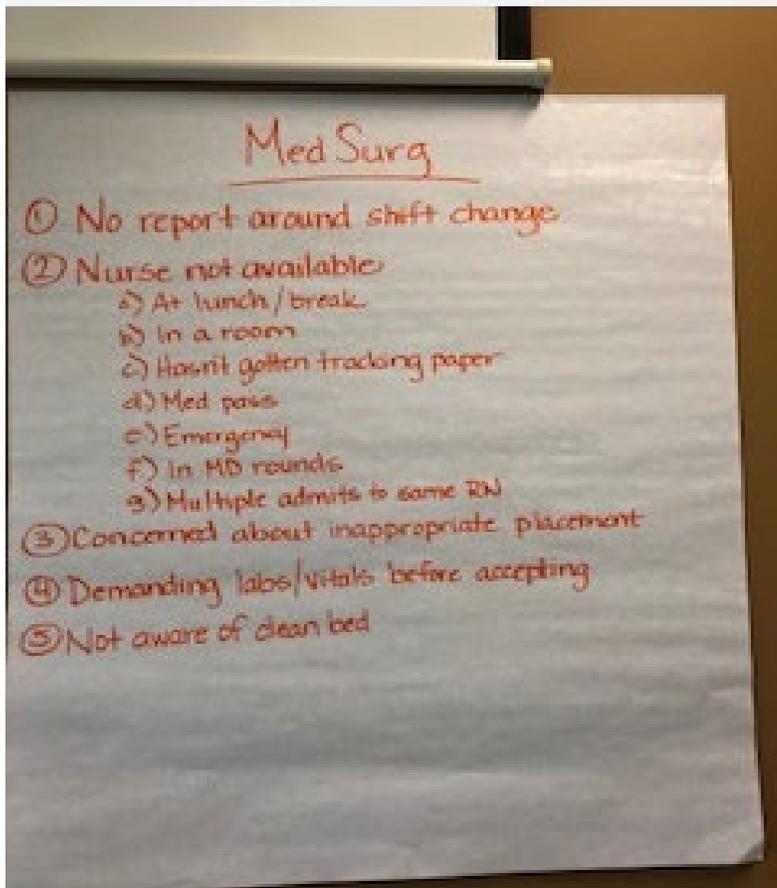
- Incorporated into Kaweah Nursing Orientation for all Nurses – Done

2. Pilot Handoff Test (ED & 4T) – October 2020 - Done

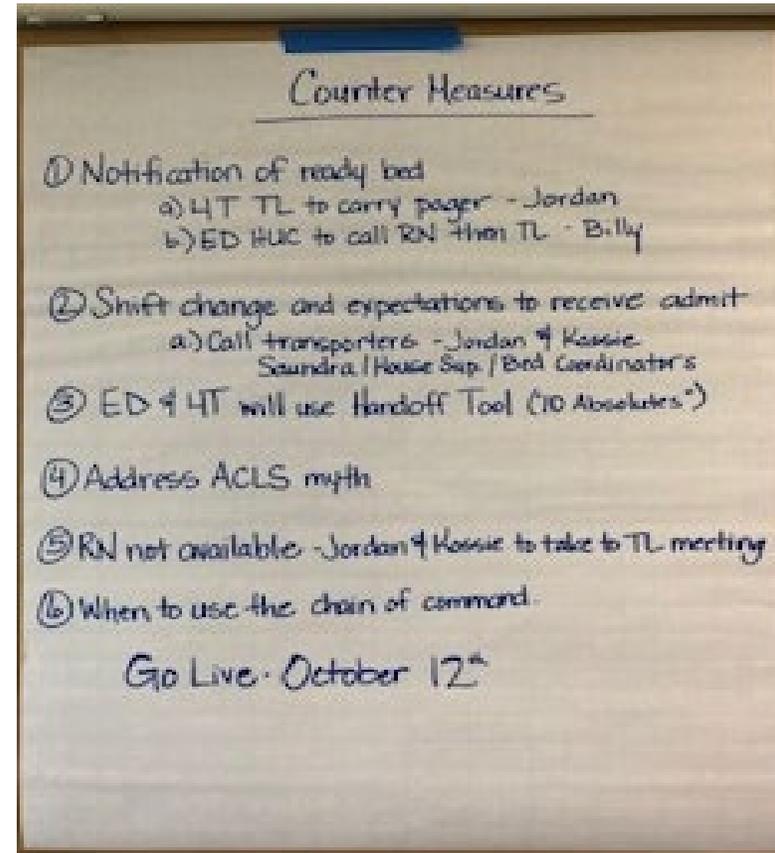
- Data – Pending
- Feedback
 - 4T staff members state the information provided at handoff is more complete and has improved greatly.
 - Timing of Handoff barriers improved but do continue.

Barriers and Counter

Identified Barriers



Counter Measures Completed



Next Steps

1. Align Handoff EMR with the 10 Absolute Handoff Tool. In-Process
2. Assigned ED nurse to oversee all patients that need to be admitted.
In-Process
 - A. Standardizes care and improves throughput. In-Process
3. Expand pilot to all patient care areas. To Be Completed
4. Continue to work on barriers to receive handoff and transport barriers.

Questi ons