

# 2020 Quality Improvement Activities (QIAs) Overview

QIA/Goal	Inclusion Criteria and Description
<p><b>Reduce Bloodstream Infections (BSIs) by 20%</b> (of Pooled Mean Rate of Targeted Facilities)</p> <p><b>Reduce Use of Long-Term Catheters (LTCs) by 0.25% using the Achievable Benchmark of Care (ABC™) Model</b></p>	<p>This includes a focus on 77 facilities based upon the National Healthcare Safety Network (NHSN) report with highest excess infection rates. LTC includes a reduction throughout the entire Network with a focus on 50 facilities with an LTC rate of 15% and greater.</p> <ul style="list-style-type: none"> <li>• Directs facilities and stakeholders to improve BSI rates and reporting by engaging in the following activities:               <ul style="list-style-type: none"> <li>– Conducting Centers for Disease Control and Prevention (CDC) audits for staff members and patients.</li> <li>– Adhering to the nine CDC Core Interventions for BSI Prevention and using CDC tools.</li> <li>– Analyzing monthly infections and creating an action plan for improvement.</li> <li>– Reporting BSIs to the NHSN, per CDC guidelines.</li> <li>– Participating in the National BSI Learning and Action Network (LAN).</li> </ul> </li> <li>• The Network will work to increase the number of facilities in the service area to join a Health Information Exchange (HIE) or an alternative evidence-based effective information transfer system by 10%.</li> </ul>
<p><b>Increase Rates of Patients on a Transplant Waitlist by 1.25% Using the ABC™ Model</b></p>	<p>This includes the entire Network area with 28 facilities in a focus cohort.</p> <ul style="list-style-type: none"> <li>• Directs facilities and stakeholders to increase patients on a transplant waiting list by engaging in the following activities:               <ul style="list-style-type: none"> <li>– Increasing collaboration between transplant centers and dialysis facilities.</li> <li>– Involving patient subject matter experts (PSMEs) at the facility level to provide support and education.</li> <li>– Tracking transplant barriers and implementing interventions to overcome barriers.</li> <li>– Encouraging transplant recipients and centers to develop educational materials to overcome barriers.</li> <li>– Educating patients, families, caregivers, and dialysis staff members on the benefits of transplant, as well as the kidney allocation system.</li> <li>– Encouraging wait listing at more than one transplant center.</li> <li>– Incorporating the 5-Steps process leading to receiving a transplant:                   <ol style="list-style-type: none"> <li>1. Patient interest in transplant</li> <li>2. Referral call to transplant center</li> <li>3. First visit to transplant center</li> <li>4. Transplant center work-up</li> <li>5. On waiting list or evaluate potential living donor</li> </ol> </li> <li>– Participating in the National Transplant LAN.</li> </ul> </li> </ul>

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<p><b>Increase Rates of Patients Dialyzing at Home by 2.5% Using the ABC™ Model</b></p>	<p>This includes the entire Network area with 55 facilities in a focused cohort.</p> <ul style="list-style-type: none"> <li>• Directs facilities and stakeholders to increase patients on home dialysis by engaging in the following activities: <ul style="list-style-type: none"> <li>– Increasing collaboration between in-center hemodialysis (ICHD) facilities and home dialysis facilities.</li> <li>– Involving PSMEs at the facility level to provide support and education.</li> <li>– Tracking home dialysis barriers and implementing interventions to overcome barriers.</li> <li>– Encouraging ICHD facilities and home facilities to provide better support and education to patients.</li> <li>– Incorporating the 7-Steps process leading to home dialysis utilization: <ol style="list-style-type: none"> <li>1. Patient interest in home dialysis (after assisting the patient to determine modality options that fit the patient’s lifestyle)</li> <li>2. Educational session about home modality</li> <li>3. Patient suitability for home modality determined by a nephrologist with expertise in home dialysis therapy</li> <li>4. Assessment for appropriate access placement</li> <li>5. Placement of appropriate access</li> <li>6. Patient accepted for home modality training</li> <li>7. Patient begins home modality training</li> </ol> </li> <li>– Participating in the National Home Dialysis LAN.</li> </ul> </li> </ul>
<p><b>Population Health Pilot: Support Gainful Employment of End Stage Renal Disease (ESRD) Patients</b></p>	<p>This includes 45 dialysis facilities in the Network area.</p> <ul style="list-style-type: none"> <li>• Directs facilities and stakeholders to screen patients for interest in vocational rehabilitation services, with results documented in CROWNWeb. The facilities will work to engage in the following activities: <ul style="list-style-type: none"> <li>– Screening and documenting vocational rehabilitation results on all eligible prevalent patients.</li> <li>– Referring eligible patients to employment networks or vocational rehabilitation agencies.</li> <li>– Encouraging referred eligible patients to engage in services.</li> </ul> </li> </ul>
<p><b>Patient and Family Engagement (PFE)</b></p>	<p>This includes all dialysis facilities in the Network area.</p> <ul style="list-style-type: none"> <li>• Directs facilities and stakeholders in the Network area to implement interventions to foster PFE in the areas of promoting better health. The Network will provide technical assistance on: <ul style="list-style-type: none"> <li>– Establishing and increasing the accessibility of patient council support groups, new patient adjustment groups, or patient councils.</li> <li>– Promoting patient, family member, or caregiver inclusion into the monthly Quality Assurance Performance Improvement (QAPI) and governing body meetings.</li> <li>– Promoting patient, family member, or caregiver participation in the patient’s plan of care (POC).</li> </ul> </li> </ul>