DOPPS Practice Monitor (DPM): Emerging Trends

Arbor Research Collaborative for Health
September 4, 2014

www.dopps.org/DPM
CNE Credits for this Web Conference

- An evaluation form will be available at www.nephrologynews.com/ce at the end of this program.

- Special thanks to Nephrology Clinical Solutions (www.nephrologyclinicalsolutions.com) for providing continuing education credits. Provider approved by the California Board of Registered Nursing, Provider No. 14961 for 1 contact hour.
In Memoriam
Sally Burrows-Hudson, RN, MSN, CNN
July 28, 2014
Learning Objectives

- Explain the US DOPPS Practice Monitor (DPM) as a tool to understand current trends in US hemodialysis care.
- Describe recent trends in US hemodialysis practice through April 2014 using DPM and CMS data.
- Discuss long-term trends in international IV iron treatment practices and related intermediate outcomes.
- Provide an update of ongoing payment, regulatory, clinical guidelines, and research that may affect US dialysis care.
Topics and Speakers Today

• Welcome/Introduction • Mark Neumann

• DOPPS Practice Monitor, data through April 2014
  – Overview of DPM Design and Methods • Francesca Tentori
  – Current DPM trends • Doug Fuller
  – Featured topic: IV Iron • Ron Pisoni
  – CMS Claims-based Monitoring Project Data and DPM Summary • Francesca Tentori

• Legislative/Regulatory Update • Mark Neumann
Throughout today’s presentation, we will offer several poll questions about treatment practices in your unit. Please be assured that individual responses will remain confidential.

When the poll is opened and pops up on your screen, please answer the question and don’t forget to hit the ‘Submit’ button.
Poll Results

CMS is getting ready to implement the five-star rating system for dialysis clinics. Please respond to the following questions:

1. Are you familiar with this plan and understand what the rating system is based on?

2. Have you compared your rating from CMS (provided to all clinics last month at www.dialysisreports.org) with your QIP rating from this past year?

3. Do you think the rating system is a fair way to help patients evaluate the quality of care at a dialysis clinic?

There has been a well-publicized shortage of PD solution for dialysis clinics in the US.

1. Has this shortage forced you to cut back on adding new patients on PD?

2. Do you feel quantities on hand and what is being delivered are sufficient to maintain your current PD population?
Submitting Questions

We welcome your questions throughout the session and will pause to answer them at the end of each section.

Please submit your questions using the “Q&A” feature to “All Panelists”, accessed from the main menu, located at the top of the presentation screen.
DOPPS Practice Monitor (DPM): Emerging Trends

Francesca Tentori, MD MS
Ron Pisoni, PhD MS
Doug Fuller, MS

Arbor Research Collaborative for Health
September 4, 2014

www.dopps.org/DPM
DOPPS Practice Monitor (DPM): Background and Brief Methods

Francesca Tentori, MD MS

www.dopps.org/DPM
DOPPS: Principal Funders

- The DOPPS Program would not be possible without these organizations’ generous support for independent scientific research to improve patient care:

- Principal Study Support:
  - **Amgen** (founding supporter, since 1996)
  - **Kyowa Hakko Kirin** (since 1999, in Japan)
  - **AbbVie** (since 2009)
  - **Sanofi Renal** (since 2009)
  - **Baxter Healthcare** (since 2011)
  - **Vifor Fresenius Medical Care Renal Pharma** (since 2012)

- Support for the DOPPS Program is provided without restrictions on publications.
Special thanks to Mark Neumann at *NN&I* for moderating this event and presenting perspectives and information regarding recent health policy, reimbursement, & regulatory changes pertinent to US dialysis patients

To stay current on news events in the renal care field, visit the NN&I website at [www.nephrologynews.com](http://www.nephrologynews.com) where you can subscribe to their thrice-weekly eNewsletters.
The Changing Landscape (US Dialysis)

Bundled payment System (PPS)
ESA Label + QIP Change (June 2011)
KDIGO Anemia (Aug 2012)
Oral meds in bundle: DELAYED to 2016-2024

Jan 2011
Jan 2012 QIP Year 1 Jan 2013 QIP Year 2 Jan 2014 QIP Year 3 Jan 2015

Current DPM Data

Omontys recall

ESCOs*
QIP updates Bundle rebasing etc?

*ESCO: ESRD Seamless Care Organization
http://innovation.cms.gov/initiatives/comprehensive-ESRD-care/
DOPPS Practice Monitor

- Stratified random sample of ~120 US facilities, 5000+ patients
  - Oversampling of non-LDO & hospital-based HD facilities

- US data are weighted to be nationally representative
  - Facility subgroups: Rural vs. non-rural; dialysis chain size
  - Patient subgroups: Black vs. non-black

- Agrees well with national data sources (Robinson, et al., AJKD 57:822-831, 2011)

- Monthly clinical data available from August 2010 (+ annual medical director survey data)
DPM Highlights:
August 2014
Doug Fuller, MS
Dialysis Dose, Treatment Time, and Vascular Access
Single-pool Kt/V
– National Sample –

Among patients with >365 days on dialysis. Source: DOPPS Practice Monitor, August 2014
Dialysis Session Length
– National Sample –

Source: DOPPS Practice Monitor, August 2014
Vascular Access
– National Sample –

National sample

Percent

AV-Fistula | AV-Graft | Catheter

N Pts: AUG10 3599  DEC10 4061  APR11 4162  AUG11 4310  DEC11 3952  APR12 1353  AUG12 2487  DEC12 2982  APR13 3659  AUG13 3084  DEC13 2719  APR14 3436

Source: DOPPS Practice Monitor, August 2014
Anemia
Has the frequency of epoetin administration changed in your facility in the last year?

a. No
b. Yes – more often administering 2x/week
c. Yes – more often administering 1x/week
d. Both b and c
e. Unsure

If you have additional details or questions you would like to share with us, please submit via the Q&A mechanism; responses to polling questions will be confidential.
## Prescription of Anemia Therapies (% patients)

### – Prior 3 Months –

<table>
<thead>
<tr>
<th>Percent</th>
<th>ESA</th>
<th>IV Iron</th>
<th>SQ ESA (non-LDO)</th>
<th>SQ ESA (LDO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>95</td>
<td>95</td>
<td>95</td>
<td>93</td>
<td>93</td>
</tr>
<tr>
<td>93</td>
<td>92</td>
<td>93</td>
<td>92</td>
<td>93</td>
</tr>
<tr>
<td>92</td>
<td>91</td>
<td>90</td>
<td>90</td>
<td>90</td>
</tr>
<tr>
<td>90</td>
<td>89</td>
<td>89</td>
<td>89</td>
<td>89</td>
</tr>
<tr>
<td>89</td>
<td>89</td>
<td>89</td>
<td>89</td>
<td>89</td>
</tr>
</tbody>
</table>

Values for each month reflect any use during the prior three months.

Source: DOPPS Practice Monitor, August 2014
Prescribed Weekly IV Epoetin Dose – by Dialysis Organization (DO) Size –

<table>
<thead>
<tr>
<th>Large/medium DO (10+ units)</th>
<th>Small DO (&lt;10 units) and independents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LDO/MDO: Aug 10–Apr 14</strong></td>
<td><strong>SDO/Indep: Aug 10–Apr 14</strong></td>
</tr>
<tr>
<td>50th declined 41%, 90th declined 44%</td>
<td>50th declined 31%, 90th declined 28%</td>
</tr>
<tr>
<td>Mean declined by 39% (12.7 ku/wk, Apr 14)</td>
<td>Mean declined by 29% (10.0 ku/wk, Apr 14)</td>
</tr>
</tbody>
</table>

Vertical lines extend from 10th to 25th (lower) and 75th to 90th (upper) percentiles; circle represents median.

Source: DOPPS Practice Monitor, August 2014
Hemoglobin Trends
– National Sample, 10th - 90th percentiles –

Aug 10–Jul 11: median declined 0.09 g/dL (mean 0.10 g/dL)
Jul 11–Oct 11: median declined 0.45 g/dL (mean 0.38 g/dL)
Oct 11–Apr 14: median declined 0.11 g/dL/year (mean 0.09 g/dL/year)

Most recent (single) monthly value; vertical lines extend from 10th to 25th (lower) and 75th to 90th (upper) percentiles; circle represents median.
Source: DOPPS Practice Monitor, August 2014
Delayed response to QIP and ESA label change in non-LDO facilities.
Hemoglobin

National Sample

<table>
<thead>
<tr>
<th>National sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>N Pts:</td>
</tr>
<tr>
<td>AUG10: 3208</td>
</tr>
<tr>
<td>DEC10: 3548</td>
</tr>
<tr>
<td>APR11: 3595</td>
</tr>
<tr>
<td>AUG11: 3842</td>
</tr>
<tr>
<td>DEC11: 3596</td>
</tr>
<tr>
<td>APR12: 1784</td>
</tr>
<tr>
<td>AUG12: 2600</td>
</tr>
<tr>
<td>DEC12: 2813</td>
</tr>
<tr>
<td>APR13: 2630</td>
</tr>
<tr>
<td>AUG13: 2915</td>
</tr>
<tr>
<td>DEC13: 3042</td>
</tr>
<tr>
<td>APR14: 2794</td>
</tr>
</tbody>
</table>

Most recent (single) monthly value.
Source: DOPPS Practice Monitor, August 2014
Hemoglobin Upper Target
– DOPPS Medical Director Surveys, 2010 to 2013 –

% of Facilities

<table>
<thead>
<tr>
<th>Year</th>
<th>≤11</th>
<th>11.1-11.9</th>
<th>≥12</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>94</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>2011</td>
<td>64</td>
<td>45</td>
<td>9</td>
</tr>
<tr>
<td>2012</td>
<td>44</td>
<td>50</td>
<td>9</td>
</tr>
<tr>
<td>2013</td>
<td>71</td>
<td>61</td>
<td>17</td>
</tr>
<tr>
<td>2014</td>
<td>46</td>
<td>61</td>
<td>20</td>
</tr>
</tbody>
</table>
Has the frequency of epoetin administration changed in your facility?

a. No
b. Yes – more often administering 2x/week
c. Yes – more often administering 1x/week
d. Both b and c
e. Unsure

If you have additional details or questions you would like to share with us, please submit via the Q&A mechanism; **responses to polling questions will be confidential**
Mineral and Bone Disorder
### Prescription of MBD Therapies (% of Patients)

**– National Sample –**

<table>
<thead>
<tr>
<th>Month</th>
<th>N Pts.</th>
<th>P Binders</th>
<th>IV Vitamin D</th>
<th>Cinacalcet</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUG10</td>
<td>3300</td>
<td>87</td>
<td>73</td>
<td>25</td>
</tr>
<tr>
<td>DEC10</td>
<td>3657</td>
<td>86</td>
<td>72</td>
<td>25</td>
</tr>
<tr>
<td>APR11</td>
<td>3823</td>
<td>86</td>
<td>72</td>
<td>24</td>
</tr>
<tr>
<td>AUG11</td>
<td>3976</td>
<td>86</td>
<td>73</td>
<td>26</td>
</tr>
<tr>
<td>DEC11</td>
<td>3850</td>
<td>87</td>
<td>75</td>
<td>26</td>
</tr>
<tr>
<td>APR12</td>
<td>1390</td>
<td>88</td>
<td>74</td>
<td>26</td>
</tr>
<tr>
<td>AUG12</td>
<td>2895</td>
<td>87</td>
<td>77</td>
<td>27</td>
</tr>
<tr>
<td>DEC12</td>
<td>3078</td>
<td>87</td>
<td>78</td>
<td>28</td>
</tr>
<tr>
<td>APR13</td>
<td>1390</td>
<td>86</td>
<td>77</td>
<td>27</td>
</tr>
<tr>
<td>AUG13</td>
<td>3223</td>
<td>85</td>
<td>76</td>
<td>26</td>
</tr>
<tr>
<td>DEC13</td>
<td>3354</td>
<td>84</td>
<td>75</td>
<td>25</td>
</tr>
<tr>
<td>APR14</td>
<td>3114</td>
<td>85</td>
<td>75</td>
<td>26</td>
</tr>
</tbody>
</table>

Values for each month reflect active or analog prescription at end of study month (2010, 2011) or anytime during study month (2012+). Source: DOPPS Practice Monitor, August 2014
IV Vitamin D Product
– by Dialysis Organization (DO) Size –

Values at each month are based on the most recent measurement obtained within the prior 3 months.
Source: DOPPS Practice Monitor, August 2014
Parathyroid Hormone (PTH) – National Sample –

Aug 10–Apr 11
Median increased 32% (mean 29%)
90th percentile increased 32%

≥600 pg/ml (Apr 14)
30% in black patients
15% in non-black patients

Values at each month are based on the most recent measurement obtained within the prior 3 months; vertical lines extend from 10th to 25th (lower) and 75th to 90th (upper) percentiles; circle represents median.

Source: DOPPS Practice Monitor, August 2014
PTH Upper Target
– DOPPS Medical Director Surveys, 2010-2014 –

% of Facilities

- ≤300*
- 400, 500
- ≥600

<table>
<thead>
<tr>
<th>Year</th>
<th>≤300*</th>
<th>400, 500</th>
<th>≥600</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>83</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>2011</td>
<td>40</td>
<td>24</td>
<td>37</td>
</tr>
<tr>
<td>2012</td>
<td>41</td>
<td>25</td>
<td>34</td>
</tr>
<tr>
<td>2013</td>
<td>37</td>
<td>21</td>
<td>42</td>
</tr>
<tr>
<td>2014</td>
<td>22</td>
<td>16</td>
<td>62</td>
</tr>
</tbody>
</table>

Fac N = 95 63 44 71 45
Serum Calcium and Phosphorus Levels
– National Sample –

Most recent (single) monthly value.
Source: DOPPS Practice Monitor, August 2014
Number of MBD markers out of range
– National Sample –

Values indicate number of MBD parameters outside target ranges: PTH 150-600 pg/ml, total Ca 8.4-10.2 mg/dl, P 3.5-5.5 mg/dl. Source: DOPPS Practice Monitor, August 2014
Summary of Highlights – 1
(Through April 2014)

• Modest increases in Kt/V and treatment time coincide with proposed 2011 QIP measure for dialysis adequacy

• Impact of 2011 regulatory and guideline changes on anemia treatments
  – Decline of ~40% in prescribed and delivered IV EPO doses since late 2010
  – Greatest decline seen among highest LDO/MDO doses; dose caps of 30K u/wk
  – IV iron use increase in early 2011 sustained through early 2014

• Impact of 2011 regulatory and guideline changes on Hgb
  – Rapid decline of ~0.4 g/dl in mid-late 2011
  – Pre-PPS decline of ~0.1 g/dl/year is resumed in 2012 through early 2014
  – Delayed reaction among SDO/independent facilities
Summary of Highlights – 2
(Through April 2014)

• 30% higher PTH in early 2011 coincides with increase in PTH upper targets from 2010 to 2011
  – PTH remained relatively stable from mid-2011 through early 2014

• IV vitamin D use up slightly in 2011 through early 2014
  – LDO/MDOs appear to use primarily doxercalciferol in majority of their patients in early 2014

• No substantial changes seen in calcium, phosphorus, or in MBD treatments

• New data showing combinations of MBD markers out of range
Discussion:

Please submit your questions through the Q&A feature, accessed from the main menu, located at the top of the presentation screen.

www.dopps.org/DPM
www.arborresearch.org
Featured Topic: IV Iron

Ron Pisoni, PhD MS

Arbor Research Collaborative for Health
September 4th, 2014
# Poll Questions

<table>
<thead>
<tr>
<th>What is the upper limit of your ferritin target?</th>
<th>How often do you continue to prescribe IV iron to patients at target Hgb, TSAT, and ferritin?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. No upper limit</td>
<td>a. Never continue</td>
</tr>
<tr>
<td>b. 500 ng/mL</td>
<td>b. Seldom continue</td>
</tr>
<tr>
<td>c. 600 ng/mL</td>
<td>c. Continue about half the time</td>
</tr>
<tr>
<td>d. 700 ng/mL</td>
<td>d. Usually continue</td>
</tr>
<tr>
<td>e. 800 ng/mL</td>
<td>e. Always continue</td>
</tr>
<tr>
<td>f. 1000 ng/mL</td>
<td></td>
</tr>
<tr>
<td>g. 1200 ng/mL</td>
<td></td>
</tr>
<tr>
<td>h. &gt;1200 ng/mL</td>
<td></td>
</tr>
</tbody>
</table>

If you have additional details or questions you would like to share with us, please submit via the Q&A mechanism; responses to polling questions will be confidential.
Values for each month reflect any IV iron prescription at end of study month (2010, 2011) or anytime during study month (2012+). Source: DOPPS Practice Monitor, August 2014
Monthly IV Iron Dose (Prescribed)
– National Sample, 10th - 90th percentiles –

Values for each month reflect monthly dose prescribed over prior month among patients receiving IV iron (<=1,000 mg in each month); vertical lines extend from 10th to 25th (lower) and 75th to 90th (upper) percentiles; circle represents median.

Source: DOPPS Practice Monitor, August 2014
Transferrin Saturation (TSAT) – National Sample –

Aug 10–Apr 14
No change in median (mean)
No change in 90th percentile

Values at each month are based on the most recent measurement obtained within the prior 3 months; vertical lines extend from 10th to 25th (lower) and 75th to 90th (upper) percentiles; circle represents median.

Source: DOPPS Practice Monitor, August 2014
Serum Ferritin
– National Sample –

Aug 10–Apr 14
Median increased 24% (mean 22%)
90th percentile increased 18%

Values at each month are based on the most recent measurement obtained within the prior 3 months; vertical lines extend from 10th to 25th (lower) and 75th to 90th (upper) percentiles; circle represents median.
Source: DOPPS Practice Monitor, August 2014
ASN - November 14, 2014: DOPPS Oral Presentation

Karaboyas et al, “Understanding the Recent Increase in Ferritin Levels in US Dialysis Patients”
Why do you think ferritin levels have increased in the United States?

a. Patients are getting more IV iron  
b. Patients are more inflamed  
c. IV iron needs (to support ESA therapy) are lower now than before  
d. Other  
e. Unsure

If you have additional details or questions you would like to share with us, please submit via the Q&A mechanism; responses to polling questions will be confidential.
High IV Iron Doses and Mortality: Recent DOPPS Analysis

G. Bailie et al, Kidney Int (2014)
[advance on-line publication: July 30, 2014]
Cox regressions were adjusted for age, vintage, gender, black race, baseline catheter use and 13 comorbidities, ESA weekly dose, hgb, spKt/V, s.albumin, and creatinine, BMI, white blood cells, s. ferritin and TSAT; stratified by phase and country, accounting for facility clustering effects. N=32,435, DOPPS 2,3,4.

Bailie et al, KI (2014)
IV iron dose is total 4-month dose, expressed as average mg/month. Adjustments and effect estimates (95% CI) are same as prior slide.

Average Monthly IV Iron Dose (mg/mo)

CV related mortality (CVM)  △ Infection related mortality (IM)
Non-CV and Non-Infection related mortality

% of observations

0 32%
1-99 10%
100-199 19%
200-299 17%
300+ 21%

Hazard Ratio (95% CI)

Bailie et al, KI (2014)
Strengths & Limitations

Strengths:

a) large sample size
b) extensive case-mix adjustment
c) relationship of IV iron dose level with mortality:
   - consistent in North America and Europe
   - consistent via instrumental variable analysis, based on facility IV iron–dosing practices, which is expected to further reduce possible patient-level confounding

Limitations:

a) observational study - -can not infer causality; results could be due to residual confounding not accounted for
b) does not address the impact of cumulative doses of IV iron over many years
IV Iron Summary

• In the US:
  – 65-69% patients prescribed IV iron in Jan – Apr 2014 which is similar to that seen in Apr – Jul 2011
  – Median ferritin levels rose >25% to 796 ng/mL from Aug 2010 to Sep 2012 but have since declined to 736 ng/mL
  – However: since Aug 2010 relatively small changes seen in the distribution of monthly prescribed IV iron doses

• High IV iron doses (>300mg/month over 4 months) were associated with elevated mortality, as well as CV mortality and hospitalizations
Why do you think ferritin levels have increased in the United States?

a. Patients are getting more IV iron
b. Patients are more inflamed
c. IV iron needs (to support ESA therapy) are lower now than before
d. Other
e. Unsure

If you have additional details or questions you would like to share with us, please submit via the Q&A mechanism; responses to polling questions will be confidential
Discussion:

Please submit your questions through the Q&A feature, accessed from the main menu, located at the top of the presentation screen.
CMS ESRD Monitoring Program: Trends in Mortality, Hospitalization, Home Dialysis Therapy

Francesca Tentori, MD MS
CMS Claims-Based Clinical Trends
January 2010 to December 2013

• Mortality
  – Jan 10–Dec 13: Declining 0.05% per year
  – Dec 13: 19.02 per 100 pts (annualized)

• Hospitalization
  – Jan 10–Dec 13: Declining 0.3% to 0.7% per year
  – Dec 13: 1.49 per pt (annualized)

• Home dialysis
  – Increased ~6%/year from 2010 to 2012
  – Above 10% level for the first time in Feb 2013

• Transfusions
  – Sustained increase from 2.8% pts/month in 2010 to 3.5% pts/month in 2012

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Spotlight.html
US Practice Trends: Conclusions

• Major changes observed in anemia management:
  – Lower Hgb levels with dramatic reductions in ESA
  – Dramatic rise in ferritin levels
  – Modest increase in blood transfusions

• Unclear whether lower Hgb has had an impact on patient well-being

• Important to continue to monitor trends in anemia related practices
DPM Website

Data Refresh every 2 months
Next in October 2014
(data through April 2013)

Major Updates every 4 months
Next in December 2014
(data through August 2014)
Discussion:

Please submit your questions through the Q&A feature, accessed from the main menu, located at the top of the presentation screen.

www.dopps.org/DPM
www.arborresearch.org
Legislative/Regulatory Update
Mark Neumann

• Rebasing of the Bundle
  • Comments were due Sept. 2; final rule out in November
• Coordinated ESRD Care Initiative
  – Applications for small providers due Sept. 15; LDOs = 17 (approx.)
  – QIP for 2014/2016
    – Comments due Sept. 2; big changes for PY 2016
• Physician pay, ICD-10, paying for oral meds in the bundle
• SGR (sustainable growth rate) reform: where did it go?; ICD-10 implementation given a one-year reprieve; oral drugs placed in the bundle delayed until 2024
Renal ACO demonstration

10-15 applications wanted by CMS

New rules reduce risk, eliminated rebasing, ease up on restrictions for physician participation, allow smaller providers to band together on one application

Risk, dialysis economics still a concern

“The economics are not great, the quality targets are not known and they haven't told us what interventions are going to be dictated by the waivers.”

— Robert Sepucha, vice president of corporate affairs for Fresenius Medical Care, Aug. 25 interview with Modern Healthcare

Why not include CKD?
Recap on Important Issues

• “Protecting Access to Medicare Act” provided Medicare physician pay relief, extended deadline for ICD-10 implementation, extended oral drug placement in the bundle by 8 years, reduced impact of 12% bundled payment cut

• “The Chronic Kidney Disease Improvement in Research and Treatment Act” (H.R. 4814)
  • Identify the gaps in critical research and improve the coordination of federal research efforts.
Recap on Important Issues

“The Chronic Kidney Disease Improvement in Research and Treatment Act” (H.R. 4814)

• require the GAO to submit a report on ways to improve care management, including progression of kidney disease and treatment of kidney failure in minority populations.

• Improve access to pre-dialysis kidney disease education programs; nephrologists and other health professionals would also be incentivized to work in underserved rural and urban areas. Patients with acute kidney failure would also be allowed to receive treatments through dialysis providers.
Recap on Important Issues

“The Chronic Kidney Disease Improvement in Research and Treatment Act” (H.R. 4814)

• Expand the options for patients by allowing individuals diagnosed with kidney failure to enroll in the Medicare Advantage program. It would also reauthorize on a permanent basis the Special Needs Plan for patients with kidney failure, as well as extend the length of time beneficiaries may choose to maintain their existing insurance coverage.
Recap on Important Issues

- **Quality Incentive Program 2014/2016**: expansion to PD, pediatric patients. Discussion continues on tying in hospitalization, morbidity and mortality data. Hemoglobin range would be retired.
  - 9.5% of clinics took a penalty hit from 2012 performance

**Performance Year 2016**: would include measures dealing with pain management, depression

**New Developments**
- Kidney Care Partners releases "A Strategic Blueprint for Advancing Kidney Care Quality"
  - Identify key areas for advancing improvement in kidney care.
    - Four patient-centric goals
      - Improve patient survival
      - Reduce hospitalizations
      - Improve health-related quality of life
      - Improve patient experiences with care

**Fluid Management a top priority for a CPM**
What did make it in for 2014...

**Clinical Measures – 75% of Total Performance Score (TPS)**
1. Anemia Management – Hgb > 12 g/dL
2. Kt/V Dialysis Adequacy Measure Topic – Adult Hemodialysis
3. Kt/V Dialysis Adequacy Measure Topic – Adult Peritoneal Dialysis
4. Kt/V Dialysis Adequacy Measure Topic – Pediatric Hemodialysis
5. Vascular Access Type Measure Topic – Arteriovenous Fistula (AVF)
6. Vascular Access Type Measure Topic – Catheter ≥ 90 days
8. Hypercalcemia

**Reporting Measures – 25% of TPS**
1. In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Patient Satisfaction Survey (expanded)
2. Mineral Metabolism – Serum Phosphorus
3. Anemia Management

New measure for PY 2016
Additional Potential QIP Measures

• Measures approved by NQF not already in QIP
  – SMR
  – SHR
  – Influenza immunization

• Domains addressed by TEPs
  – Fluid weight management
  – Iron stores
  – Vascular access infections
  – Pediatric adequacy
Recap on Important Issues

• Bundled Payment: legislation provided stability, but no major increases from market basket through 2018. Might see relief from "burdensome" case mix adjusters with re-examination by GAO.
  - Oral drug delay helps CMS save $$$
  - DaVita: We may need to close up to 20 low-performing facilities in 2014

• Still waiting for: lifetime immunosuppressive drug coverage for transplant patients
NN&I Resources

• Thrice-weekly eNews
Subscribe at www.nephrologynews.com, click on “eNews” tab

Special Topics
QIP: www.nephrologynews.com/qip
ACO/ESRD demonstration:
www.nephrologynews.com/aco
Bundled payment: www.nephrologynews.com/esrd-bundle
Discussion:
Please submit your questions through the Q&A feature, accessed from the main menu, located at the top of the presentation screen.

www.dopps.org/DPM
www.arborresearch.org
CNE Credits for this Web Conference

- Thank you very much for your participation!

- An evaluation form will be sent to you at the end of the program.

- Special thanks to Nephrology Clinical Solutions (www.nephrologyclinicalsolutions.com) for providing continuing education credits. Provider approved by the California Board of Registered Nursing, Provider No. 14961 for 1 contact hour.
If you want to re-listen to this WebEx to complete your CNEs, or download the slides, go to: http://www.dopps.org/DPM/EmergingTrends.aspx