The QIP: 2012 and Beyond

Oct. 23, 2012

Presented by

Nephrology News & Issues
NephrologyNews.com
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Objectives

Following this presentation, the participant will:

- Review the measurement process by which QIP will be applied to dialysis clinics for 2013 and 2014
- Describe CMS's philosophy concerning value-based purchasing
- Explain how QIP measures link to the National Quality Strategy
- List the proposed changes for QIP 2015
Our Agenda Today

The QIP for 2013-2014: What score is the most important…and how do you get there?
Steven Fishbane, MD

Future Directions for the QIP
Jay Wish, MD

Correlating QIP measures with improved outcomes
Glenda Payne, RN, MSN, CNN

The proposed rule for 2015
Andy Howard, MD
NN&I resources on the QIP

Links to these NN&I issues and CMS websites are on your console
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Hemodialysis Review Course

Course Content:

- Kidney Anatomy, Physiology and Pathophysiology
- Principles of Dialysis
- Patient Evaluation and Monitoring
- Hemodialysis Vascular Access
- Dialysis Treatment – Equipment Monitoring
- Water Treatment and Dialyzer Reuse
- Patient Education
- Patient Safety, Documentation, Infection Control, Emergency Preparedness

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The mechanics of the QIP for 2013-2014

What score is the most important…and how do we get there?

Steven Fishbane, MD
North-LIJ Health System
Purpose

• Mandated by Social Security Act Amendment
• Objective: to incentive provision of high quality care to patients with ESRD
Performance Year 2012

• Affects payments in 2014
• Up to 2% payment reduction
• Quality performance
  – 3 clinical indicators
  – 3 reporting measures
Three Clinical Indicators

- **90%** of Total Quality Score
- Percentage of patients with Hgb > 12 g/dL
- Percentage of patients with URR ≥ 65%
- Dialysis Access type
Anemia Clinical Measure

• Percentage of patients with Hgb > 12 g/dL
  – Purpose to avoid treatment to potentially unsafe Hgb levels
  – Combined with previous FDA and CMS changes
  – probably makes the Hgb target range 9-11 g/dL or
  – 10-11 g/dL for most patients
Mean monthly hemoglobin and mean EPO dose per week

USRDS 2011 ADR
Impact on Anemia Treatment

- Reduce or hold ESA treatment when Hgb > 11 g/dL, but avoid low Hgb
  - Worse symptoms
  - Risk for transfusions
  - Lack of “buffer” if bleeding episode
Acute bleeding episode when baseline Hgb is allowed to remain low
Anemia Treatment (cont.)

- Avoid Hgb > 12 and < 9-10 by:
  - Less variability in treatment
  - Attention to Hgb trends
  - Investigate other causes contributing to anemia
Dialysis Adequacy Indicator

• Percentage of patients with URR ≥ 65%
  – Monitor to identify patients with URR too close to 65%, and at risk to fall below
  – Ensure long enough treatment time for catheter patients
  – Educate patients to maintain compliance with prescribed treatment time
Access Type Indicator

• Percent of hemodialysis patients using an AVF (with 2 needles) during the last treatment of the month AND

• Percent of hemodialysis patients with an intravenous catheter used for the last treatment of the month and for 90 days prior to the last dialysis session (without a fistula or graft in place)

• Average of the 2 scores
Vascular access at first outpatient dialysis

Percent of patients

- AV fistula
- Catheter w/ maturing fistula
- AV graft
- Catheter w/ maturing graft

USRDS ADR 2011
Interventions

• Educate on risk of catheters
• Treat depression and anxiety
• If AVF doesn’t develop well within a month of placement- evaluate
• Perseverance
Reporting Measures

• 10% of the total quality score

• 1) Reporting of dialysis safety events (currently dialysis related infections) to the National Healthcare Safety Network (NHSN), a program administered by the Centers for Disease Control and Prevention (CDC)

• 2) Attestation of administering a patient satisfaction survey; the In-Center Hemodialysis (ICH) Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS)

• 3) Attestation that calcium and phosphorus have been tested on at least a monthly basis
Total Performance Score

• 90% - 3 clinical indicators
• 10% - 3 reporting measures
Clinical Indicator Scoring

• Higher of an Achievement Score (0-10) or an Improvement Score (0-9)
• Performance period- calendar year, 2012
• Baseline Period- July 1, 2010 to June 30, 2011
Clinical Indicator Achievement Score

• Achievement Threshold
  – Minimal acceptable performance
  – Score is zero if below
  – Set at 15\textsuperscript{th} percentile of national performance in the baseline period

• Benchmark
  – Maximum achievement score = 10
  – Set at 90\textsuperscript{th} percentile of national performance
Achievement Score Example

- Percentage of patients with URR ≥ 65%
- Achievement threshold 91%
- Benchmark 100%
- Facility – 96% - Achievement Score - 6
Clinical Indicator Improvement Score

- Measures improvement from baseline to performance period
- Improvement Score Formula: $10 \times \left( \frac{\text{facility rate in performance period} - \text{facility rate in baseline period}}{\text{benchmark-facility rate in baseline period}} \right) - 0.5$
- Facility improved from 82% to 96%
- Improvement score - 7
Clinical Indicator Score

Improvement score of 7 is higher than achievement score of 6, URR performance score is 7
Reporting Measures Scoring

• 1-Reporting of safety events (infections) to the CDC’s National Healthcare Safety Network results in
  – 5 points for simply enrolling and training in the program
  – 10 points for 3 months of reporting.

• 2-Attestation that patient satisfaction is being measured with the ICH CAHPS tool earns 10 points.

• 3- Attestation that calcium and phosphorus are tested at least monthly earns 10 points.
Total Performance Score

- Determines payment reduction
- TPS 0-100 scale
  - 0-90 points from clinical indicators
    - Each 0-10 then multiply by 3
  - 0-10 points from reporting indicators
    - Each 0-10, divide by 3
Minimal TPS determines payment reduction – 53

<table>
<thead>
<tr>
<th>Total Performance Score (TPS)</th>
<th>Percentage Payment Reduction</th>
</tr>
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<tbody>
<tr>
<td>Above Minimum TPS</td>
<td>No Reduction</td>
</tr>
<tr>
<td>1-10 points below minimum</td>
<td>0.5%</td>
</tr>
<tr>
<td>11-20 points below minimum</td>
<td>1.0%</td>
</tr>
<tr>
<td>21-30 points below minimum</td>
<td>1.5%</td>
</tr>
<tr>
<td>&gt;30 points below minimum</td>
<td>2.0%</td>
</tr>
</tbody>
</table>
Will the Program Work?

• 2% maximal penalty may be too low to truly drive quality
• When quality indicators are better supported by science then could increase the maximal penalty
Conclusion

• Payment year 2014 / performance period 2012 ESRD QIP has significant changes
• Requires ongoing monitoring of performance
• Future QIP will likely have a greater number of clinical indicators
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Future Directions for the QIP (Beyond PY 2015)

Can anyone read CMS’s mind?

Jay Wish, MD
University Hospitals of Cleveland
Case Medical Center
What Do We Know?

• CMS held a “Quality Measurement Listening Session” on May 4, 2011 to solicit stakeholder input on future QIP topics. Those measures not already proposed for PY 2014 or 2015:
  – Nutritional status (serum albumin)
  – Serum phosphorus
  – Hospitalization rate
  – Patient education
What Do We Know?

• CMS convened two technical expert panels (TEPs) in May 2012 to examine the development of QIP measures for
  – Hospitalization/Readmissions
    • Recommended an SMR methodology to include case-mix adjustment from claims as well as from 2728
    • Recommended a readmission measure that uses patients at risk rather than hospitalizations as the denominator with adjustment for readmission rate by hospital
  – Anemia (see next slide)
Anemia

- Anemia TEP recommended
  - A transfusion measure
  - Restoring the Hgb floor of 10 g/dL as a measure
- The fact that CMS has included reporting Hct/Hgb levels and ESA doses in the PY 2015 QIP proposed rule suggests that additional anemia measures are being considered
What Is required of a measure?

1. Have a solid evidence basis
2. Measure clinical performance (not cost or utilization)
3. Be actionable by a provider or professional
4. Cover the domains of interest
5. Specify methodologic considerations
6. Be biometrically tested for validity, sensitivity, specificity, reliability and reproducibility
Furthermore, AHRQ recommends that public disclosure of provider profiles be postponed until:

1. methodology regarding case mix adjustment is validated (providers accepting higher-risk patients should not be penalized for adverse outcomes), and
2. appropriate safeguards to avoid "cherry picking" (providers refusing to accept high-risk patients in order not to blemish their aggregate outcomes) must be specified.
CMS measurement development and approval process

• Identify domain of interest
• Convene TEP and contract with support organization (e.g. Arbor) do to literature review and methodologic analysis
• If measures approved by TEP, submit to NQF for approval
• CMS policy requires that measures used for payment and/or public reporting be endorsed by community consensus (NQF or other body)
CMS measurement development and approval process (cont’d)

• QIP measures are specified in a proposed rule for public comment
• CMS must address every comment in final rule
• Comments have been shown to change CMS’s mind
  – Elimination of SHR from QIP for PY 2014
  – Stay tuned for final rule for PY 2015 to be released next month
ESRD Measures approved by NQF (not already in QIP)

- SMR
- SHR
- Influenza immunization
Additional domains addressed by TEPs in 2010

- Fluid weight management
- Iron stores
- Mineral metabolism
- Vascular access infections
- Pediatric adequacy
- Pediatric anemia management
Will reporting measures evolve into process or outcome measures?

- NHSN reporting of infections
- Reporting administration of ICH-CAHPS
- Reporting monthly serum Ca and phos testing
- Reporting monthly Hct/Hgb level and ESA dose
Summary and conclusions

- Predicting what CMS will do can be difficult
- CMS must follow its own rules regarding measure development and vetting
- Anemia clearly on radar screen based on TEP activity and reporting measure for PY 2015
- Other reporting measures likely to evolve into clinical (outcomes) measures
- CMS does seem to listen to comments
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QIP: Measures that matter

Glenda M. Payne, RN, MS, CNN
President, 2012-13
American Nephrology Nurses’ Association
Will the QIP affect outcomes?

• Expectation vs. reality
• Current examples:
  • Vascular access type (+)
  • Hemoglobin < 10 (-)
Will the QIP affect outcomes?

• Current measures with future potential:
  – Increase patient centeredness: ICH CAHPS\textsuperscript{1} scores
  – Reduce VA infection: NHSN\textsuperscript{2} scores

• Problem: multiple data systems in use to collect data takes caregiver time and energy away from patients

\textsuperscript{1}In Center Hemodialysis Consumer Assessment Healthcare Professionals Survey
\textsuperscript{2}National Healthcare Safety Network
Measures that matter

- Having data and an NQF\(^1\) approved measure should $\neq$ a QIP performance measure
- Each measure chosen for the QIP should affect patient survival and quality of life

\(^1\)National Quality Forum
What’s missing from the QIP?

Fluid management:

– #1 reason for dialysis patient deaths: cardiovascular
– Not measured by Kt/V or URR
– Could possibly be measured by hospitalizations for CHF or volume overload
What would ANNA like to see in future QIP measures?

Nursing sensitive outcomes

• Under development; could include:
  – Shortened or missed treatments
  – Falls
  – Failure to rescue: failure to take prompt action to avert complications

Challenges:

1. Research required to establish evidence base
2. Who has this data?
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The proposed rule for the Quality Incentive Program (QIP) PY 2015 –

What’s new?

Andrew D. Howard, MD, FACP
Forum of ESRD Networks
ESRD Quality Incentive Program
Economic Impact for 2015

• Total payment reductions - $8.5 million
• Total costs (collection of information requirements for selected measures) - $12.4 million
  • The estimated payment reduction will continue to incentivize facilities to provide higher quality care to beneficiaries. The reporting measures that result in costs associated with the collection of information are critical to better understanding the quality of care beneficiaries receive, particularly a patient’s experience of care, and will be used to incentivize improvements in the quality of care provided
ESRD QIP – PY 2015
Value-Based Purchasing (VBP)

• Transition: Quantity of services provided to beneficiaries to quality of those services delivered

• Advancing the National Quality Strategy and 3-part aim

• 6 domains of measurement (National Priorities of the NQS)
  • Care coordination, Population health, Cost reduction, Safety, Patient (Caregiver) centered care, Clinical care

• “We seek to adopt measures for the ESRD QIP that promote better, safer, and more efficient care.”
ESRD Quality Incentive Program
Summary of Changes for 2015

• Continue most previous measures, remove 1 clinical measure, add 2 new clinical measures, expand the scope of several existing reporting measures, add 1 new reporting measure.

• Anemia
  • Hgb > 12 g/dL (clinical measure)
    • Anemia management (new reporting measure)

• Adequacy
  • Remove URR clinical measure
  • Kt/V for adult HD/PD, pediatric HD (new clinical measure)
ESRD Quality Incentive Program
Summary of Changes for 2015

• Vascular Access Type (clinical measure)
• Bone & Mineral Metabolism
  • Mineral metabolism (reporting measure)
    • Monthly reporting actual calcium and phosphorus values
  • Hypercalcemia (new clinical measure)

• Safety
  • NHSN Dialysis Event (reporting measure)
    • Expand reporting to 12 months of DE data
    • Will become a clinical measure in the future
ESRD QIP Proposed Rule PY 2015
Dialysis Adequacy – New Clinical Measure

• Proposed rule PY 2014 (never finalized)
  • “Retire” the URR measure and begin reporting spKt/V values on claims for in-center and home HD, using the UKM or Daugirdas II formulas (> 1.2)
    • Patients age > 18, on dialysis > 90 days, 3X/week dialysis ≥ 2X claim month, spKt/V 0.5-2.5, no AKI
    • Patients Age < 18, NOT on home HD, on dialysis ≥ 90 days, 3-4X/week dialysis ≥ 2X claim month, spKt/V 0.5-2.5, no AKI
    • No residual renal function reported
    • Last measurement of the month
    • For PD, use a weekly Kt/V (dialytic + residual) of ≥ 1.7
      • Patients age ≥ 18, on dialysis ≥ 90 days, Kt/V 0.5-5.0, no AKI

• Proposed rule PY 2015
  • As proposed in PY2014
  • Combination of 3 measures into a single performance score as the average of the submeasure scores
ESRD QIP Proposed Rule PY 2015

Hypercalcemia – New Clinical Measure

• “Numerous studies have associated disorders of mineral metabolism with morbidity, including fractures, cardiovascular disease, and mortality. Therefore, we believe it is necessary to adopt a clinical measure that encourages proper bone mineral metabolism management.”

• Number of patients with uncorrected serum calcium > 10.2 mg/dL for a 3-month rolling average.
  • “Uncorrected” means not corrected for serum albumin concentration.

• Performance is expressed as a proportion of patient-months for which the 3-month rolling average exceeds the threshold
  • Beginning PY 2016 use 3-month rolling average for January
ESRD QIP Proposed Rule PY 2015

Expansion of reporting measures

• NHSN Dialysis Event Reporting Measure
  • Expand the reporting to **12 months** of DE data
  • Final month of data reported by 1/31/14
  • Only applies to in-center HD patients
  • NQF #1460 assesses number of HD patients with positive blood cultures over specified time period
    • NHSN DE reporting measure only assesses enrollment and reporting of data
    • Propose to adopt NQF #1460 as a clinical measure in the future
ESRD QIP Proposed Rule PY 2015

Expansion of reporting measures

• Mineral metabolism reporting measure
  • Require *monthly reporting* of an *actual serum phosphorus and calcium value* for each qualifying patient (98%)
    • Alive end of the month, treated IC ≥ 2 times/month, home dialysis with claim submitted
  • Data entered into CROWNWeb with a grace period of 1 month with the final month of data reported by 1/31/14
  • May use laboratory values from other accredited providers/facilities
ESRD QIP Proposed Rule PY 2015

Anemia Management – New Reporting Measure

• Average monthly blood transfusion rate increased from 2.7 percent in 2010 to 3.2 percent in 2011
  • Plan to continue to monitor the rate of transfusions and may consider the adoption of relevant quality measures through future rulemaking if necessary
• Our current policy of paying claims that include a default Hgb/Hct value of 99.99 could lead to the under-reporting of patients’ Hgb/Hct values and ESA dosage by facilities
• Report a Hgb or Hct value and, as applicable, an ESA dosage for all Medicare patients at least once per month via claims (98%)
  • May use laboratory values from other accredited providers/facilities
## ESRD QIP
Comparisons – Performance Standards

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<tr>
<th>Measure</th>
<th>PY 2012</th>
<th>PY 2013</th>
<th>PY 2014</th>
<th>PY 2015</th>
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<td>26%</td>
<td>14%</td>
<td>4%</td>
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<td>Dialysis Adequacy (URR)</td>
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<td>97%</td>
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<td>Dialysis Adequacy (Kt/V)</td>
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<tr>
<td>Adult HD</td>
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<tr>
<td>% Fistula</td>
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<td>58%</td>
<td>59%</td>
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<td>% Catheter</td>
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<td>13%</td>
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<tr>
<td>Hypercalcemia</td>
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<td>3%</td>
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## ESRD QIP
Comparisons Achievement Thresholds/Benchmarks

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<tr>
<th>Measure</th>
<th>PY 2014 Threshold (15th %-tile)</th>
<th>PY2014 Benchmark (90th %-tile)</th>
<th>PY 2015 Threshold (15th %-tile)</th>
<th>PY 2015 Benchmark (90th %-tile)</th>
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<td>7%</td>
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<td>Dialysis Adequacy (URR)</td>
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<td>100%</td>
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<td>NA</td>
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<td>Dialysis Adequacy (Kt/V)</td>
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<td>Adult HD</td>
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<td>Adult PD</td>
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<td>5%</td>
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<td>Hypercalcemia</td>
<td></td>
<td></td>
<td>6%</td>
<td>0%</td>
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</table>
ESRD QIP Proposed Rule PY 2015

Performance Standards
Dialysis Adequacy and Hypercalcemia

• For 2 of the PY 2015 measure topics, Kt/V Dialysis Adequacy and Hypercalcemia, we do not possess data for the entirety of CY 2011, the year on which we propose to base the performance standards.

• We propose to calculate performance standards for the Hypercalcemia measure using the data that we collected via CROWNWeb Pilots collected during CY 2011.

• We propose to calculate the performance standards for the three proposed Kt/V measures using CY 2011 claims data.
  • Stakeholders may be concerned about the nuances of the data and we invite public comment on this proposal.
  • If, after consideration of the comments, we decide to not adopt the adult, hemodialysis Kt/V measure for PY 2015, we propose to continue to use URR as a measure of hemodialysis adequacy for this population.

•
ESRD QIP Proposed Rule PY 2015
Performance Period

• All CY 2013 data vs 1/1/11 - 12/31/11 national data
  • Ensure enough time to calculate & assign numerical values to the proposed performance standards for PY 2015 - proposing to set the performance standards based on CY 2011
  • Data on which we base the performance standards would only capture 6 months of more recent data when compared to PY 2014 and would also overlap with 6 months of the data used to calculate the PY 2014 performance standards
  • We would not be addressing stakeholder requests that we take steps to minimize the length of “data lag”
  • Request comment concerning whether we should instead use data closer in time to the PY and set the performance standards using 7/1/11 – 6/30/12 national data
  • If the final numerical values for the PY 2015 performance standards are worse than PY 2014 for a measure, we propose to substitute the PY 2014 performance standard
  • We believe that the ESRD QIP should not have lower standards than previous years
# ESRD QIP

## Comparisons Payment Reduction Scale

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<th>SCORE</th>
<th>REDUCTION</th>
<th>SCORE</th>
<th>REDUCTION</th>
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<tr>
<td>100 - 53</td>
<td>0%</td>
<td>100 - 52</td>
<td>0%</td>
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<tr>
<td>52 - 43</td>
<td>0.5%</td>
<td>51 - 42</td>
<td>0.5%</td>
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<td>41 - 32</td>
<td>1.0%</td>
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<td>32 - 24</td>
<td>1.5%</td>
<td>31 - 22</td>
<td>1.5%</td>
</tr>
<tr>
<td>23 or below</td>
<td>2.0%</td>
<td>21 or below</td>
<td>2.0%</td>
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</table>
ESRD QIP Proposed Rule PY 2015
Total Performance Score (TPS)

• Scoring methodology identical to the PY 2014 QIP
• Propose to equally weight the clinical measures for which a facility receives a score equal to 80 percent of the TPS
• Propose to equally weight the reporting measures for which a facility receives a score as 20 percent of the TPS
• Propose to require a facility to have at least one clinical and one reporting measure to receive a TPS
• propose to set a proposed case minimum threshold of 11 cases
  • If the facility reports between 11 and 25 cases during the 12-month performance period, it would be scored based on its raw performance rate plus a favorable reliability adjustment to account for a possible unfavorable skew in the measure rate due to small sample size
  • No adjustment for > 26 cases
ESRD QIP Proposed Rule PY 2015

Total Performance Score (TPS)

Data Validation - Proposed

- Procured the services of a data validation contractor who will be tasked with validating a national sample of facilities’ records as they report data under the ESRD QIP
- Because data validation for the ESRD QIP is new to both facilities as well as CMS, we believe that the first year of validation should result in no payment reductions to facilities
- beginning in CY 2013, we would randomly sample the records of approximately 750 facilities. We anticipate that a CMS-designated contractor would request approximately 10 records from each of these facilities. We propose that the facility must comply with this request for records within 60-days of receiving notice
- Contemplating increasing a facility’s payment reduction by one tier (from 0.5 % to 1.0 %) if its data is incorrect beyond a threshold
The QIP: 2012 and what lies ahead

Questions for our panelists
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