Nephrology - Clinical Quality Overview

Division Clinical Units and Leads	Quality Committees and Roles
Division Chief: Sub Pennathur Quality Council Representative: Mike Heung Division Administrator: Giselle Ciorciari Associate Chief for Clinical Operations: Mike Heung Pod C Taubman ACU Medical Director: Patrick Gipson Interventional Nephrology Unit (INU) medical director: Alex Yevzlin 7D Dialysis M-PLAN Medical Director: Lenar Yessayan Outpatient Dialysis Medical Director: Lenar Yessayan Kidney Transplant: Vahakn Shahnian	• Nephrology Division QA group (meets quarterly, Jonathan Segal leads) • Note: Dialysis and Transplant are part of Nephrology as a whole but their QI activities are separate from the rest of the division. Their infrastructure and oversight have developed in response to strong CMS involvement and are considered separate for the purposes of this summary.
Highest Volume Conditions	**Division Specific Specialty Conditions**
1. Chronic kidney disease 2. Hypertension with underlying kidney disease (hypertension is a comorbidity)	1. Glomerulonephritis 2. Kidney stone clinic 3. Kidney transplant (high users of health care system, many comorbidities) 4. Kidney failure on dialysis (small volume but large impact on utilization of health resources)
Choosing Wisely – Selected Measures	**Quality Improvement Priorities**
1. Don't perform routine cancer screening for dialysis patients with limited life expectancies without signs or symptoms. *[Have an anemia management program but could do some work here]* 2. Don't administer erythropoiesis-stimulating agents (ESAs) to chronic kidney disease (CKD) patients with hemoglobin levels greater than or equal to 10 g/dL without symptoms of anemia. *[Already do this]* 3. Avoid nonsteroidal anti-inflammatory drugs (NSAIDS) in individuals with hypertension or heart failure or CKD of all causes, including diabetes. 4. Don't place peripherally inserted central catheters (PICC) in stage III–V CKD patients without consulting nephrology. *: [CKD IV, V, part of III]* 5. Don't initiate chronic dialysis without ensuring a shared decision-making process between patients, their families, and their physicians. *[Informal program; could be an area for improvement with inpatient discussions]*	• Understanding how to capture/prevent all adverse events in real-time (e.g., complications after kidney biopsy) • Maximizing opportunities to improve patient care and meet payer incentives with hypertension and CKD registries

Measurement – Peer Review Metrics	Measurement – Registries and Other Data
Rate-Based Indicators • Complications for renal biopsy (only applies to a few providers) • Difficult to develop indicators for non-procedural physicians Case-Based Indicators • Procedure complications (e.g. dialysis catheter, kidney biopsy, dialysis procedure) • Timeliness of service: (e.g. response to hyperkalemia)	*Registries* • CKD • Hypertension *Regularly Reviewed Data* Quality Analytics • Renal biopsy complications • Hypertension CKD registry Dashboards • UMMG performance measures – HTN, CKD Other data • Dialysis – CMS indicators