ESRD NETWORK 10 2018 ANNUAL REPORT

The Renal Network

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HHSM 2016-00010C

ESRD Network 10

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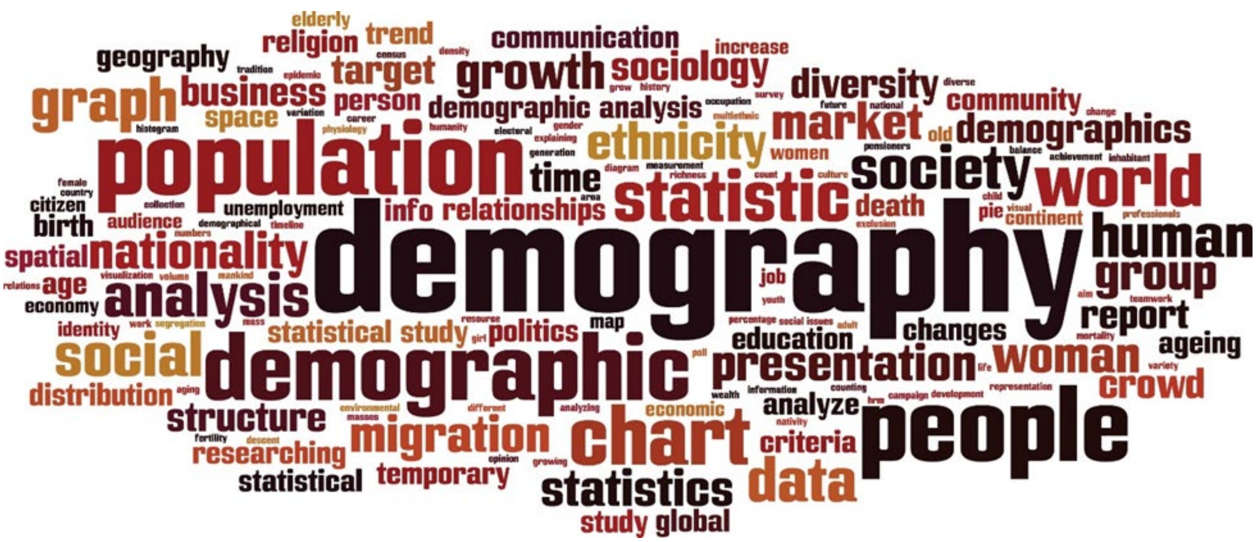
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ESRD DEMOGRAPHIC DATA

During 2018, The Renal Network collaborated with its many stakeholders to improve the quality of care for 30,356 dialysis and transplant patients, receiving treatment in 330 providers of dialysis therapy and nine transplant centers in the State of Illinois. The Renal Network (TRN) is a member of the ESRD Networks Strategies Division of Qsource, a nonprofit, healthcare quality improvement and information technology consultancy headquartered in Memphis, Tennessee.

The total population of Illinois, the single-state area of Network 10, is 12,830,632. Springfield is the capital city of the state. The top six cities by population are:

- Chicago (2,695,598)
- Aurora (197, 899)
- Rockford (152,871
- Joliet (147,433)
- Naperville (141,853)
- Springfield (116,250)

About one-half of the population of Illinois lives in the metropolitan Chicago area. In total, 83 percent of the population lives in urban areas and 17 percent of the population lives in rural areas. Population characteristics are illustrated in the table below.

Figure 1 – 2010 Census General Population – Illinois
Race, Age, Ethnicity & Gender Information*

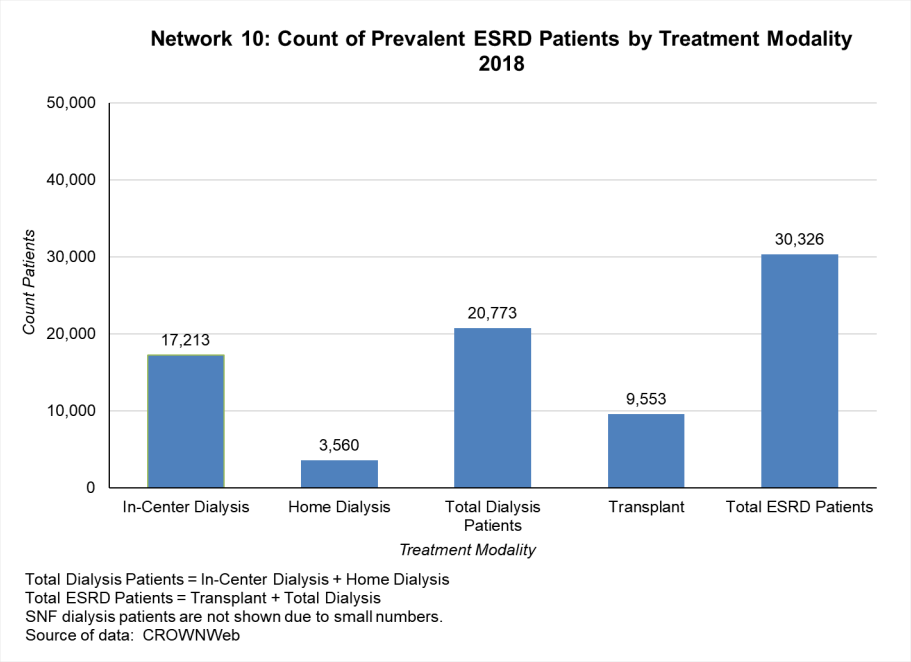
State	Illinois
Population	12,830,632
State Rank	5th
White	72%
Black	15%
Asian	5%
Other	8%
Hispanic (All Races)	15.8%
Under 19	24%
19 – 64	62%
65 & Over	14%
Male	49%
Female	51%

*U.S. Census Bureau

https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF

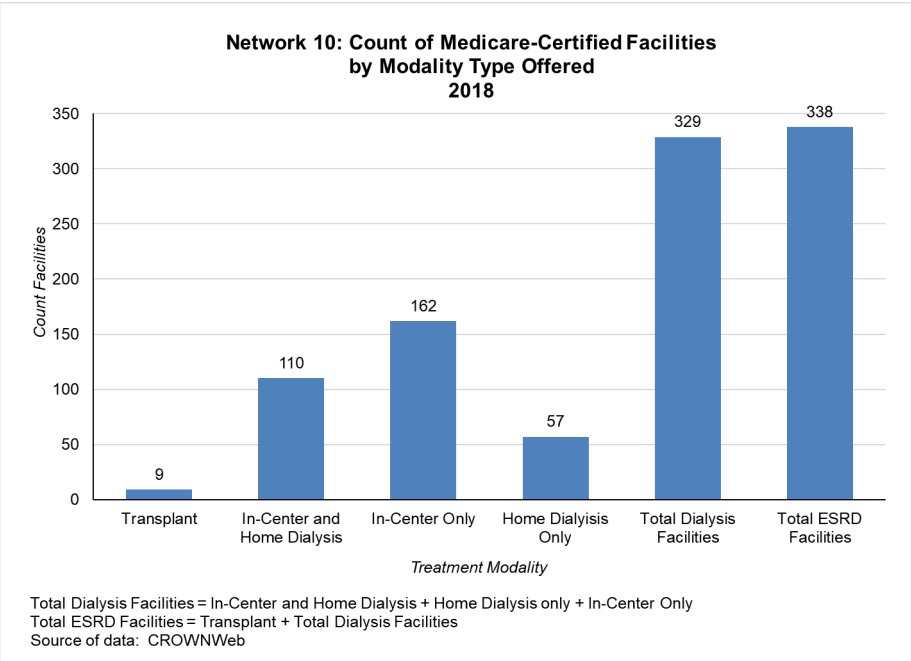
At year-end 2018, ESRD Network 10 was comprised of 339 total ESRD facilities (Graph 2), serving 20,801 dialysis patients (Graph 1). Additionally, Illinois had nine transplant centers (Graph 2) and a total of 9,555 transplant patients (Graph 1).

GRAPH 1



Total Dialysis Patients = In-Center Dialysis + Home Dialysis
Total ESRD Patients = Transplant + Total Dialysis
SNF dialysis patients are not shown due to small numbers.
Source of data: CROWNWeb

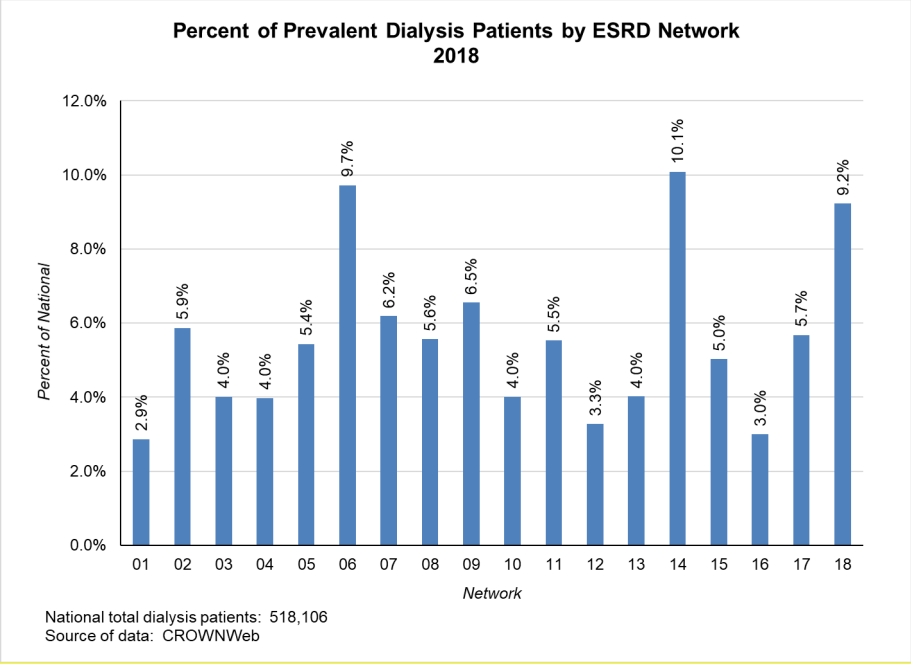
GRAPH 2



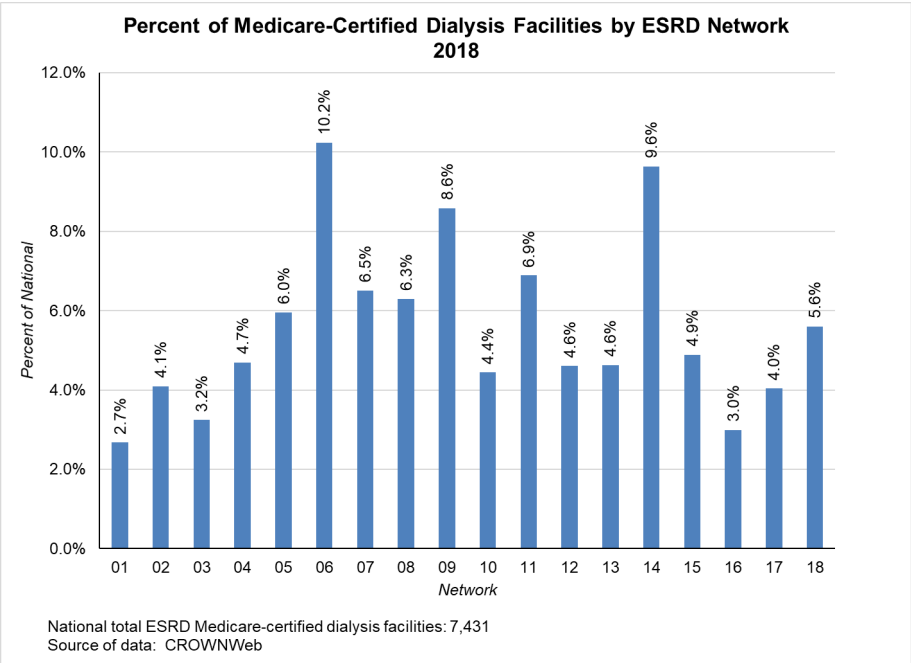
Total Dialysis Facilities = In-Center and Home Dialysis + Home Dialysis only + In-Center Only
Total ESRD Facilities = Transplant + Total Dialysis Facilities
Source of data: CROWNWeb

Graphs 3, 4, and 5 show national comparisons of all ESRD Networks for dialysis patients by modality.

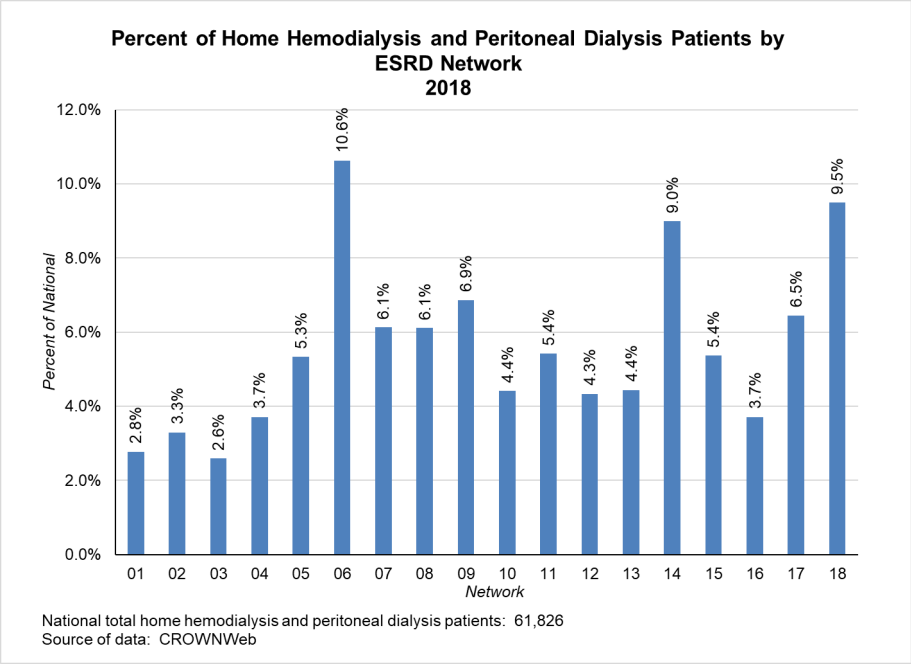
GRAPH 3



GRAPH 4

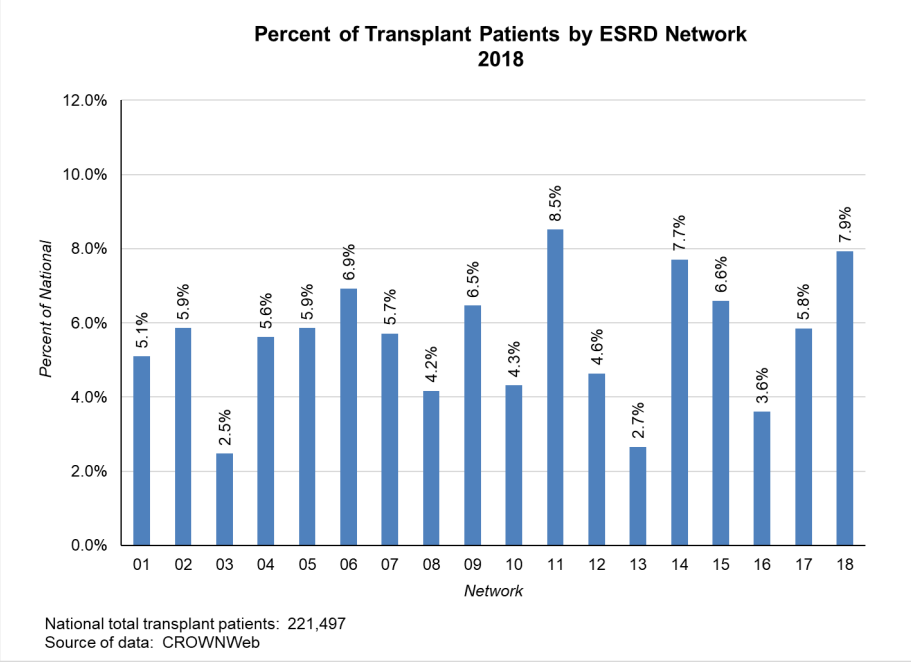


GRAPH 5

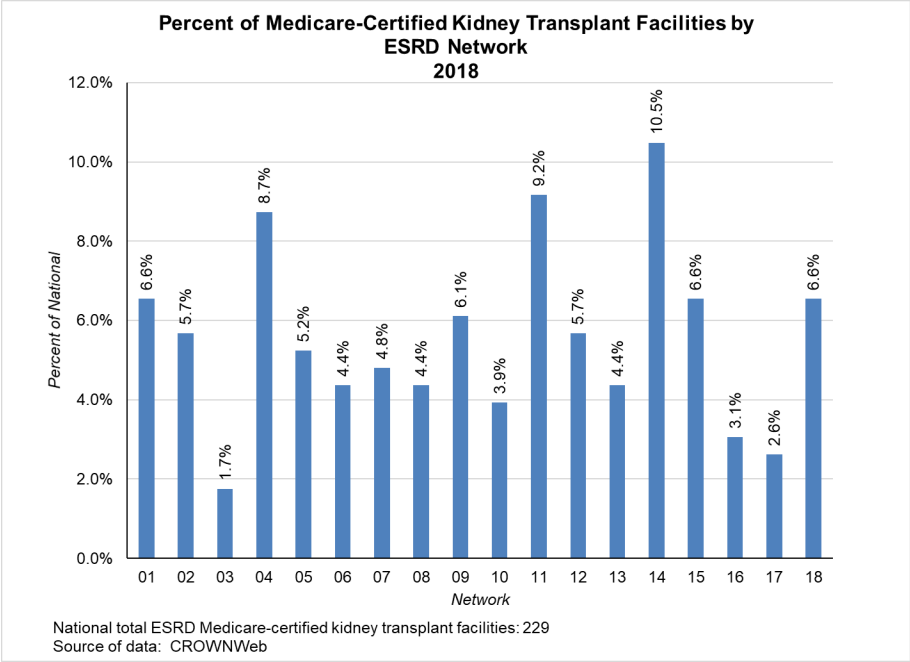


Graphs 6 and 7 show national comparisons for transplant recipients and transplant centers.

GRAPH 6



GRAPH 7


Percent of Medicare-Certified Kidney Transplant Facilities by ESRD Network
2018
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
Percent of National
6.6%
5.7%
1.7%
8.7%
5.2%
4.4%
4.8%
4.4%
6.1%
3.9%
9.2%
5.7%
4.4%
10.5%
6.6%
3.1%
2.6%
6.6%
01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18
Network
National total ESRD Medicare-certified kidney transplant facilities: 229
Source of data: CROWNWeb


compromise
negotiate
negotiation
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agreement
business
communication
understanding
compromised
compromising
mutual
agree
concessions
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successful
partnership
negotiating
mediation
argument
deal
tolerance
meeting
demand
balance
dispute
give up
benefit
cooperation
success
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debate
truce
discuss
give
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handshake
beneficial
share
relationship
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conflict
solution
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settle
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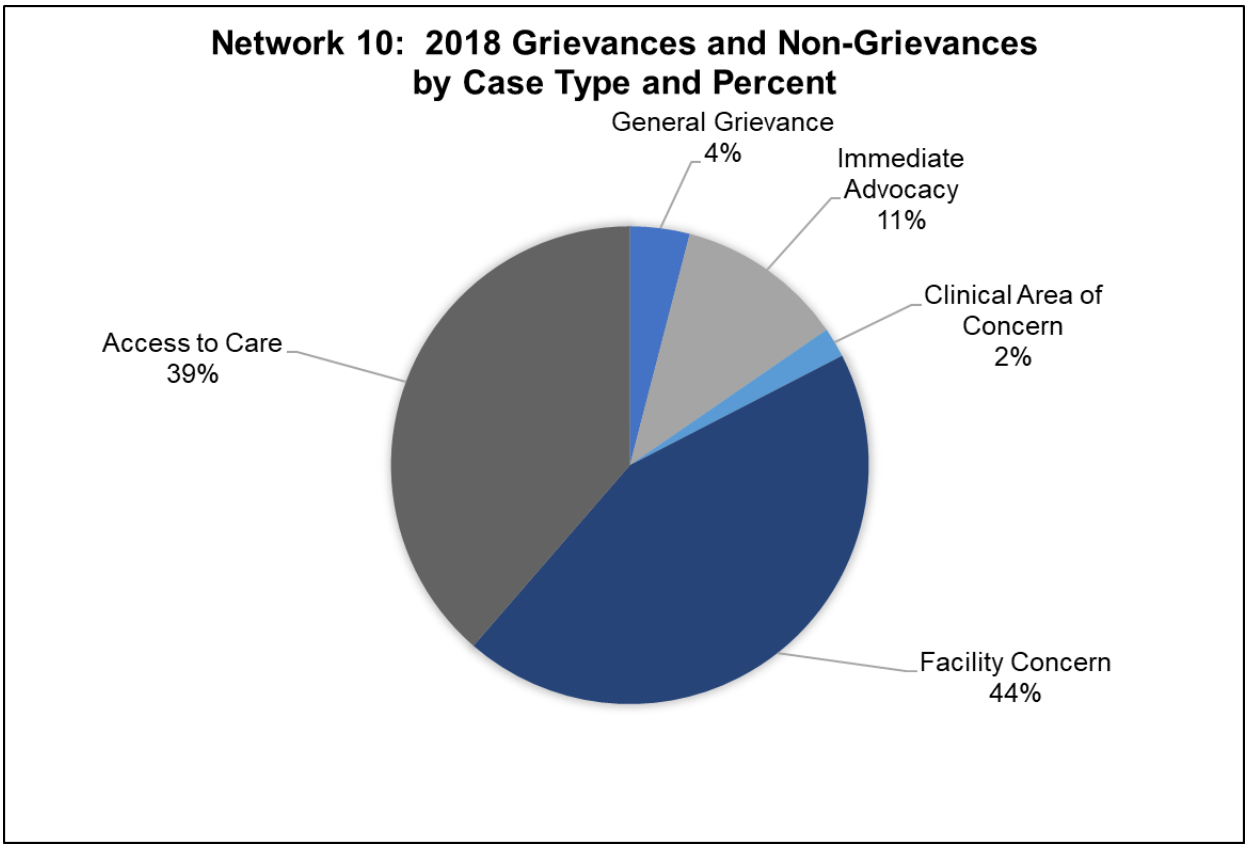
risk

ESRD NETWORK GRIEVANCE AND ACCESS TO CARE DATA

GRAPH 8



Source of data: Patient Contact Utility (PCU)

ESRD Network 10 responds to calls for assistance from stakeholders, including dialysis patients, caregivers, family members, dialysis clinic staff members, and physicians. During 2018, the majority of contacts were received in the following CMS-defined categories:

Facility Concern (44%): Facility concerns are brought to the Network's attention by staff members or physicians of Network 10 dialysis clinics. Facility concerns are often made in an effort to ask for assistance with an issue before it grows to be larger concern. Facility staff members frequently call to discuss situations involving patients with behavioral issues and seek guidance to diffuse tense situations within the dialysis setting.

Access to Care (39%): These contacts deal specifically with concerns for patients who are in danger of being involuntarily discharged (IVD) from their dialysis clinics and also in regard to patients who have been involuntarily discharged without a placement at another unit. In many instances, ESRD Network 10 works with individual facilities to identify and address difficulties in placing or maintaining patients in treatment. These access to care cases may come to the Network's attention in the form of a grievance,

or they may be initiated by facility staff. An IVD is a discharge initiated by the treating dialysis facility without the patient's agreement. An involuntary transfer (IVT) occurs when the transferring facility temporarily or permanently closes due to a merger, or due to an emergency or disaster situation, or due to other circumstances, and the patient is dissatisfied with the transfer to another facility. A failure to place is defined as a situation in which no outpatient dialysis facility can be located that will accept an ESRD patient for routine dialysis treatment.

Immediate Advocacy (11%): Patients often reach out to the Network for assistance in solving issues they are experiencing in their dialysis clinics. In the case of Immediate Advocacy, the concerns are ones that can be settled within seven calendar days and do not involve clinical issues. For issues which take more time, the case will be escalated to a general grievance to allow more time for investigation. The case may be escalated to a clinical quality of care grievance if clinical issues are identified during the course of the initiation investigation.

General Grievance (4%): These are cases of a more complex nature that do not involve clinical quality of care issues, and that need more than seven calendar days for resolution. General grievances often involve communications problems between staff and patients, disagreements over treatment times/assignments, and the patient perception of lack of professionalism by dialysis facility staff members.

Clinical Quality of Care (2%): These are circumstances in which the grievant alleges that an ESRD service received from a Medicare-certified provider did not meet professionally recognized standards of clinical care. Clinical QoC cases may be either 1) a patient-specific Clinical QoC case, in which the care impacted a specific patient, or 2) a general Clinical QoC case, in which two or more patients at a facility were impacted. All Clinical QoC grievances include review by a Network Registered Nurse (RN) for the clinical aspects of the case.

The Network uses the trending information from grievances to find existing resources or develop new resources for patients and staff to assist in solving conflicts and in improving communications for all parties. A sample of resources provided is listed below:

Network Interventions for Providers: referenced *Decreasing Dialysis Patient-Provider Conflict (DPC) Toolkit*; Network staff participated in care or grievance conferences; advocated for patient rights; education about *The ESRD Network Forum - Dialysis Patient Grievance Toolkit*; discussed staff professionalism, mental health evaluation and follow up needs; highlighted websites for patient and caregiver education resources; discussion of behavioral agreement or agreements for change; identifying other treatment modalities; staff education about end-of-life, palliative care, and hospice services; review of plan of care (POC); informing clinic staff about related regulations and ESRD Conditions for Coverage (CfCs) guidelines; educating about involuntary discharge (IVD) or transfer (IVT) processes; and increasing awareness about Network-specific resources, such as *Kidney Patient Views - Real Life Stories from Real Patients* podcasts.

Network Interventions for Patients: educating patient on rights and responsibilities; initiating or participating in discussions about substance use/withdrawal, mental health evaluation and follow up, or other modalities; identifying providers for patients and caregivers; offered Network mediation; referred patient, family or caregiver to ESRD website and resources, such *The ESRD Network Forum - Dialysis Patient Grievance Toolkit;* assisting patient and representatives with self-advocacy by encouraging

participation in care planning; discussing depression and coping skills; coaching on communication techniques; and identifying other agencies for possible referral(s) when appropriate.

At-Risk, IVD or IVT Interventions:
Provider specific: Network contacts clinic staff, physician or physician groups, as well as Medical Directors to discuss case issues and develop solutions; educating staff about coping strategies and anger management; recommending or assisting with implementation of a behavior contract or care plan agreement, coaching clinic staff about professionalism and communication techniques, advocating for patient rights and maintaining access to care by assisting with placement if/when and IVD or IVT event occurs. Patient specific: coaching patient/family/caregivers about communication technique and self-advocacy by routinely encouraging use of *The National Forum of ESRD Networks – The Dialysis Patient Grievance Toolkit;* educating patients about anger management, coping skills and/or mental health evaluation follow up, specifically, how lack of these skills or left untreated can lead to IVD or IVT events.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best practice
target
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industry best
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survey

ESRD NETWORK QUALITY IMPROVEMENT ACTIVITY DATA

The Renal Network/ESRD Network 10 completed the four quality improvement activities (QIA) as outlined in the 2018 CMS Scope of Work. Additionally, a subset of the dialysis clinics in the BSI QIA participated in an activity to reduce prevalence of long term catheters (LTC). Although the topics of the QIAs varied, each of the project plans employed the basic elements of quality improvement:

- Conducting an environmental scan/needs assessment with participating dialysis clinics.
- Training dialysis clinic staff to use quality improvement tools of root cause analysis (RCA) and plan-do-study-act cycles (PDSA).
- Provision of resources to dialysis clinics based on needs identified by the QIA participants, with the goal for the Network to achieve customer focus.
- Patient engagement was achieved when facilities recruited a patient or patients to help teach other patients about the QIA interventions.
- Rapid Cycle Improvement was maintained through consistent reassessment of resources and interventions, based on the feedback from the participating dialysis clinics.
- The element of sustainability was introduced and re-enforced throughout each of the projects, to encourage facilities to sustain the improvements that they had made during the course of the QIAs. A Sustainable Change Kit was developed and can be found online at: http://therenalnetwork.org/quality-improvement/sustainable-change-kit/

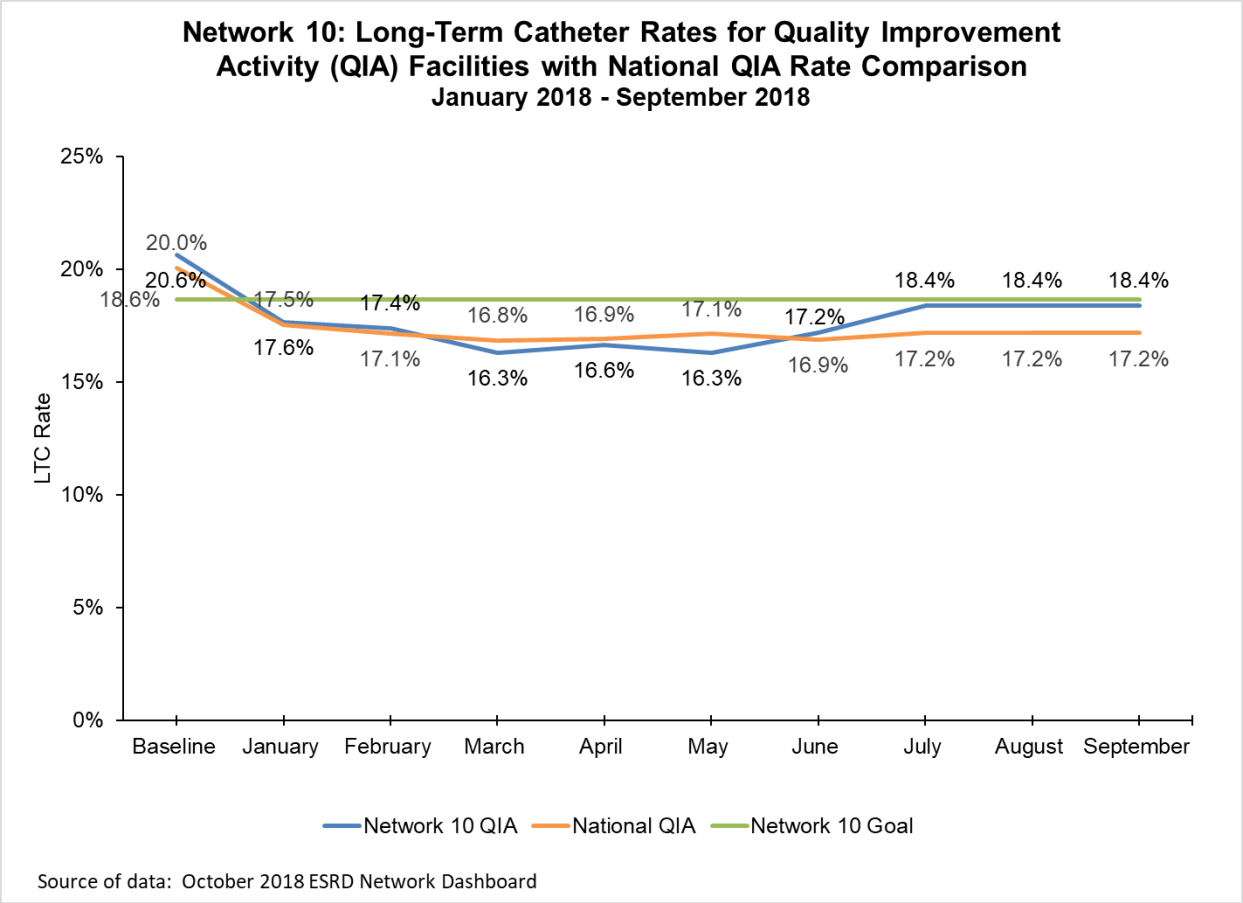
At the conclusion of each of the QIA, evaluations were given to the participating facilities to provide feedback to the Network on positives and negatives of the project. This feedback was used to develop the QIAs for the 2019 project cycle.

Details for each of the QIAs follow here.

Long Term Catheter Quality Improvement Activity

Within the project cohort of 41 dialysis clinics, rates of prevalent LTC dropped from 20% to 18.4%, exceeding the goal of reducing to 18.6%, as shown in Graph 9. Over the course of the project, 317 long-term catheters were removed.

GRAPH 9



Source of data: October 2018 ESRD Network Dashboard

The project began with facilities completing an environmental scan to determine barriers to reducing prevalent LTC. Facilities were next trained in conducting RCA in PDSA methodologies to help them improve processes and to carry out changes which would be sustainable. Each dialysis clinic submitted individual PDSA plans. These were reviewed by Network staff and technical assistance was offered to the participating clinics throughout the project to help in goal attainment.

A Monthly Highlighted Resource was provided to each dialysis clinic with education and technical assistance for reducing LTC. Resources were found for dialysis clinic staff and also for direct patient use. The Network encouraged the facilities to choose a patient volunteer to help distributing the information and in collecting assessment data after the patients had a chance to review it. Resources were translated into Spanish at the request of QIA participants.

Clinics were encouraged to establish a Vascular Access Manager (VAM) in an effort to improve continuity of patient vascular access care. To assist, the Network provided Vascular Access Manager resources, including a VAM Toolkit. Additionally, Dr. Jonathan Levine presented a webinar on permanent

access and included a question and answer section for participants. Dr. Levine is an Interventional Radiologist in Chicago and also a member of the Medical Review Board of Network 10. At the conclusion of the project, 29 clinics had identified a VAM.

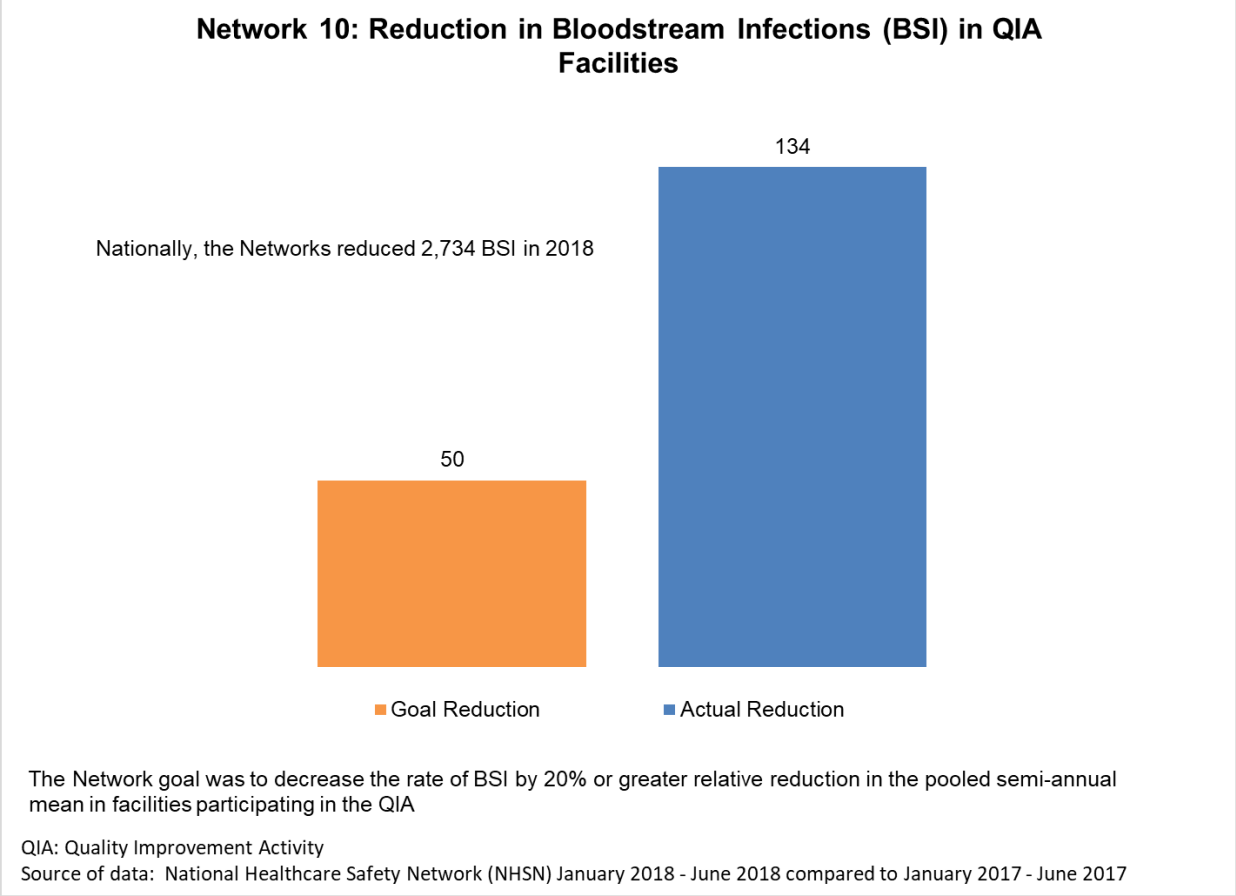
The Network sent monthly Progress Reports to each dialysis clinic an effort to show clinics real time progress or identify the need for added intervention.

At the conclusion of the QIA, facilities reported adoption of the following changes: prompt referral to see Vascular Access Surgeon within two weeks of admission as long as patient is stable without insurance issues; Vascular Access Manager follows up with patient closely and assist with appointments to keep the process going; continuous patient education; scheduling access manager about four hours away from direct patient care to work on catheter reduction, access appointments and education; having newly admitted patients arrive early to discuss plan and timeline for permanent access placement, and constant monitoring with patients appointments with vascular surgeon and continued education on the importance of fistula/graft placement.

Blood-Stream Infection Quality Improvement Activity

The goal of this QIA was to decrease the rate of BSI for 50% of the facilities in the Network 10 service area (149 clinics), with special focus on the 20% (59 clinics) with the highest semi-annual pooled mean bloodstream infection rates from baseline period of January to June of 2017. Within the special focus project cohort of 59 dialysis clinics, rates of bloodstream dropped by nearly half, from 1.072% down to 0.572%. This result exceeded the project goal, which was to decrease to 0.800%. Network 10 followed the national trend where all Networks reduced the rates of BSI, as shown in Graph 10.

GRAPH 10



The project began with facilities completing an environmental scan to determine barriers to reducing bloodstream infection. Facilities were next trained in conducting RCA and PDSA methodologies to help them improve processes and to carry out changes which can be sustainable. A specific BSI Root Cause Analysis tool was provided to the clinics to help in their RCA efforts. Each dialysis clinic submitted individual PDSA plans. These were reviewed by Network staff and technical assistance was offered to the participating clinics throughout the project to help in goal attainment.

Each month, a Highlighted Resource was provided with specific resources for staff members and others developed for patients. Hand hygiene audits, using the CDC Core Intervention Audits tools, were a part of the monthly requirements. In addition to staff completing the audits, the Network encouraged the

facilities to instruct patients on how to perform the audits. At the conclusion of the project, 2,706 hand hygiene audits were completed by patients.

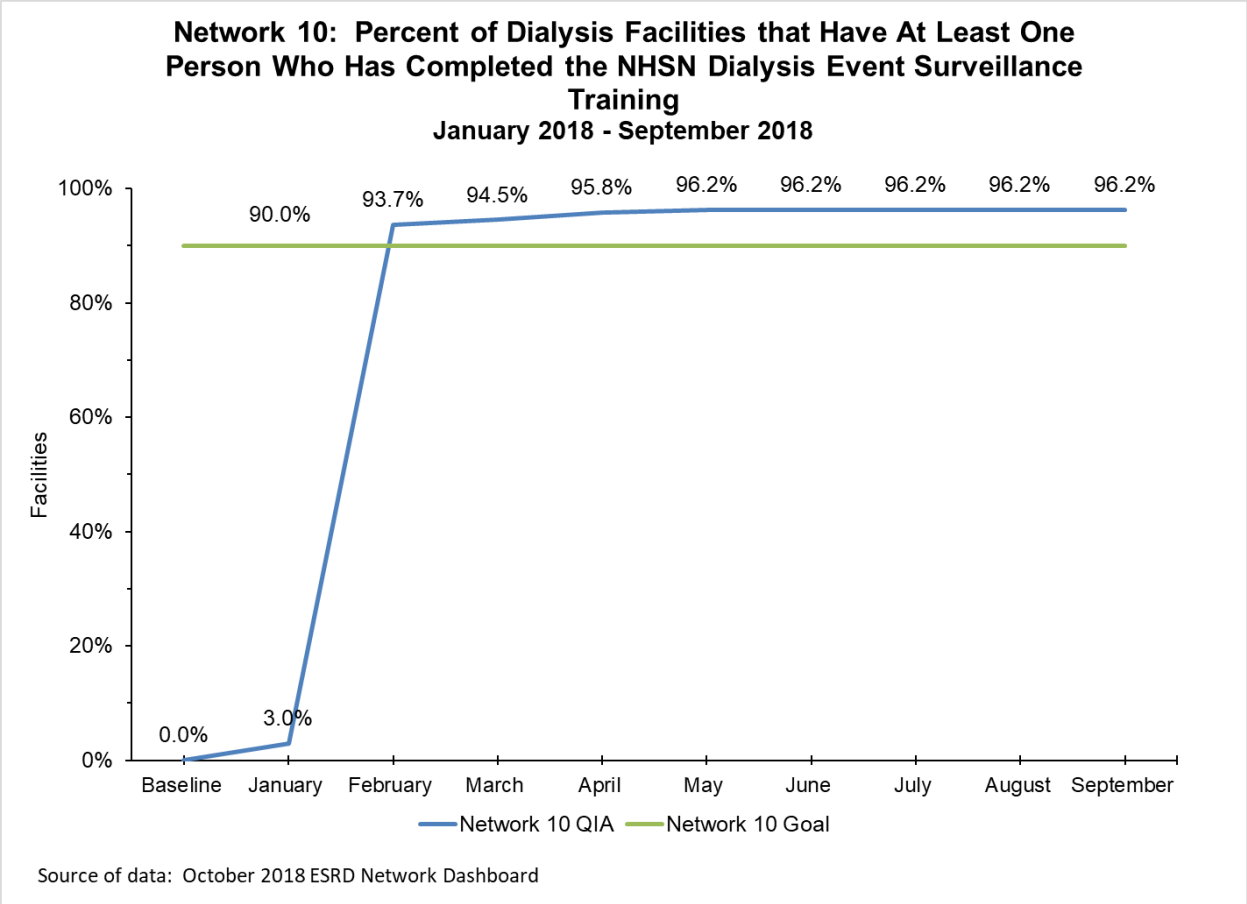
Clinics were encouraged to establish an Infection Control Manager (ICM) or team in an effort to quickly determine the root cause(s) of patient infections and perform the appropriate steps to accurately document the event into NHSN. At the conclusion of the project, 68 clinics had identified an ICM.

The clinics were required to attend CMS-sponsored learning and action network webinars. Elements from each of these LAN meetings were stressed during follow-up with the participating clinics.

At the conclusion of the QIA, facilities reported adoption of the following changes: using chlorhexidine infused caps for catheters; appointing a patient representative to act as “the Watch” for clinical cleanliness, infection control breaks, and patient adherence to hand hygiene; educating all staff on the importance of hand hygiene; monthly audit checklists to identify infection control breaches; hand washing reminders posted at the scale and near the sinks; using games and puzzles to engage patients in infection control, and many clinics reported that they would continue to have patients conduct hand hygiene audits after the QIA concluded.

NHSN Event Surveillance Training. This QIA had an additional goal for facilities to complete NHSN Dialysis Event Surveillance Training. The Network promoted NHSN Event Surveillance Training for all dialysis clinics in Network 10. Follow up contacts were done throughout the remainder of the project cycle to encourage completion. Network 10 surpassed the goal of 90% facilities completing by achieving 93.7% training (illustrated in Graph 11).

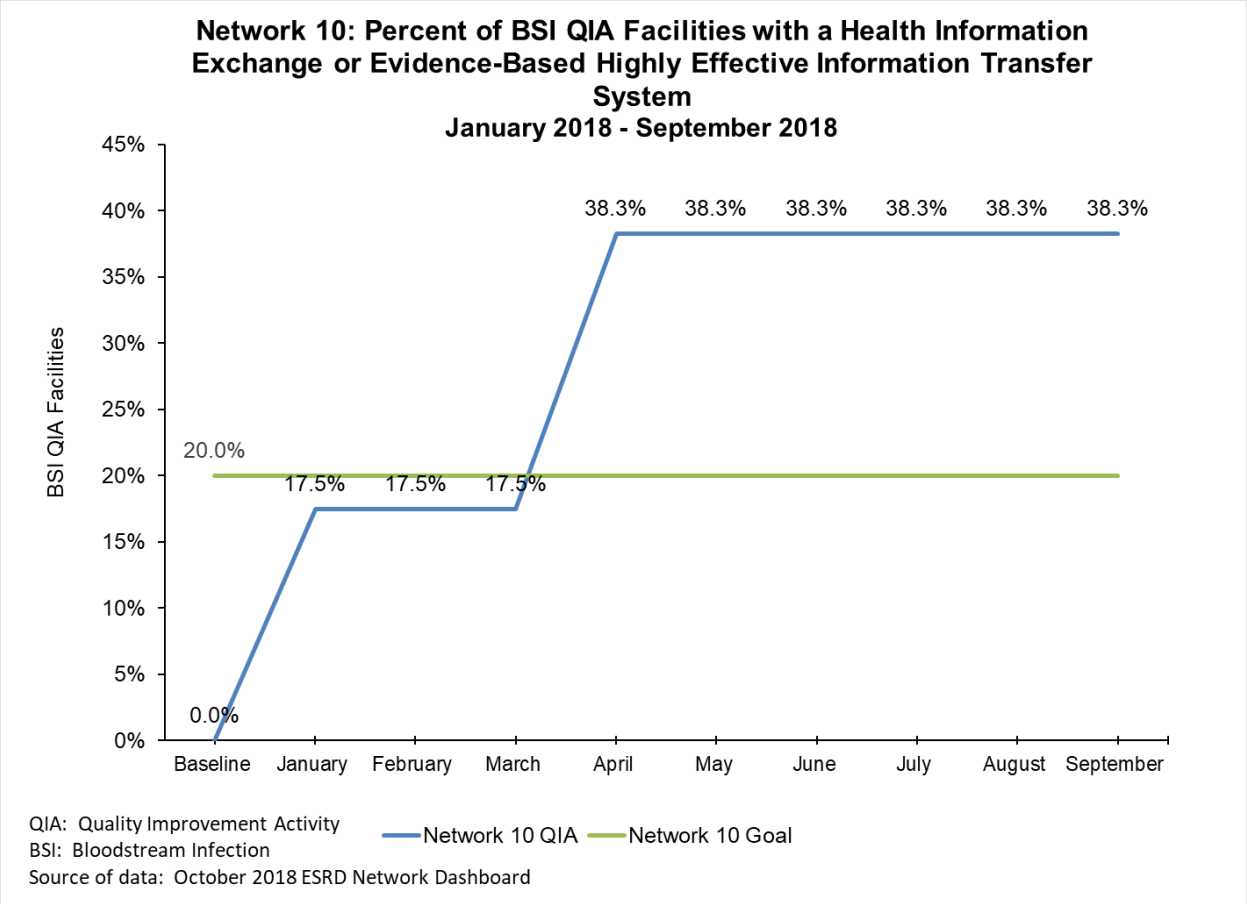
GRAPH 11



Source of data: October 2018 ESRD Network Dashboard

Health Information Exchange. The BSI QIA also included a goal for 20% of the facilities within the cohort to participate in a Health Information Exchange (HIE) or evidence-based highly effective information transfer system to track bloodstream infections occurring during hospitalizations. The Network brought stakeholders together in an ongoing manner to discuss the importance of communication between hospitals and dialysis providers. Network 10 achieved 38.3 percent of facilities participation, exceeding the project goal of 20%, as shown in Graph 12.

GRAPH 12

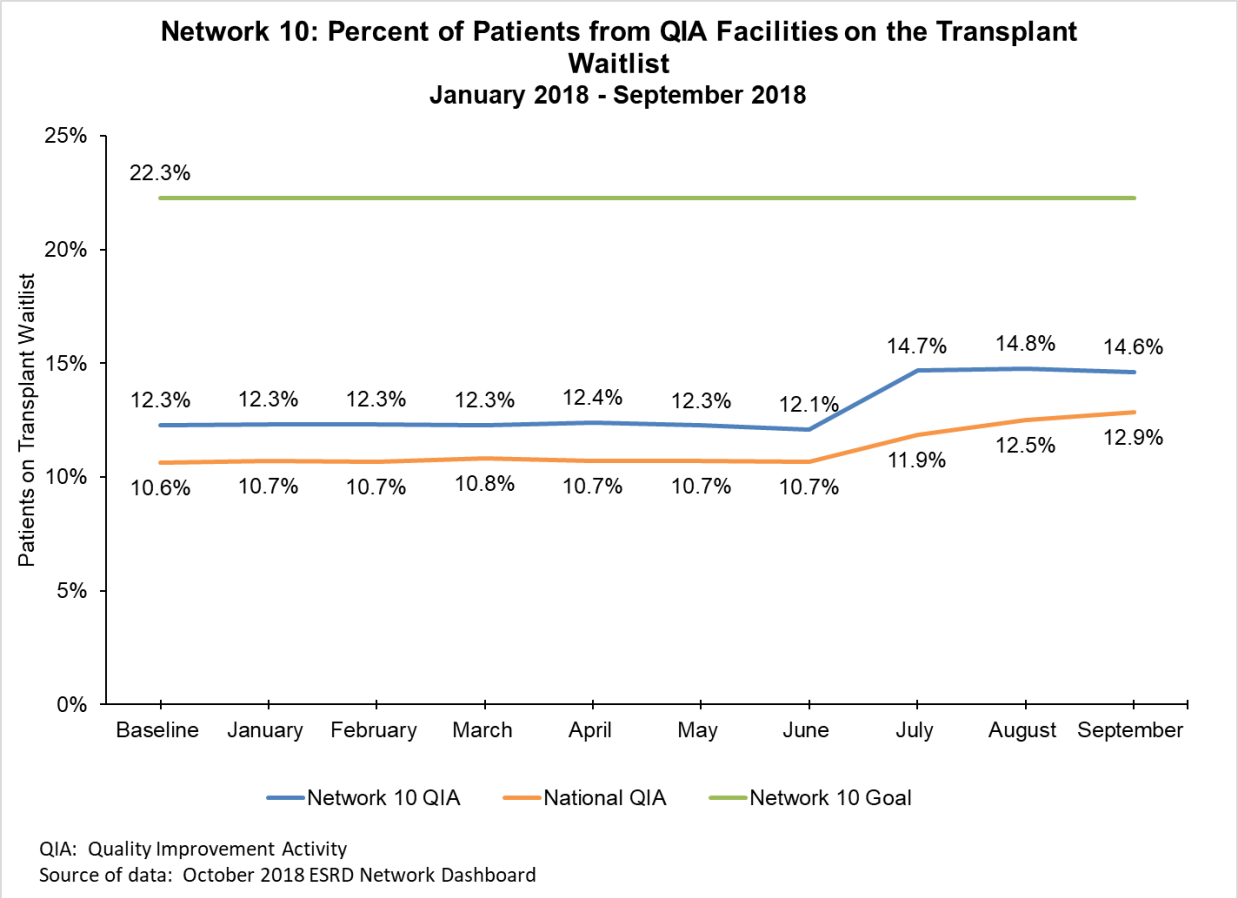


QIA: Quality Improvement Activity
BSI: Bloodstream Infection
Source of data: October 2018 ESRD Network Dashboard

Transplant Waitlist Quality Improvement Activity

The goal for this project was to increase the number of patients on the transplant wait list by 10 percentage points in 30% of the dialysis clinics. Nationally, no Networks achieved this goal in 2018; Network 10 achieved a four percentage point increase (Graph 13). Although this goal was not achieved, within the project cohort of 93 dialysis clinics, 260 patients were added to the transplant waitlist and 63 patients were transplanted.

GRAPH13



QIA: Quality Improvement Activity
Source of data: October 2018 ESRD Network Dashboard

The project began with facilities completing an environmental scan to determine barriers referring patients to transplant. Barriers identified included: advanced age, lack of insurance, transportation problems to and from the transplant center, lack of social support, comorbidities, poor communication with the transplant center, patient BMI too high, lack of living donor, keeping track of appointments for work-up, patients not interested, patient non-compliance, undocumented patients, lack of understanding of KDPI ranking for cadaver kidneys, and fear of transplant surgery.

These findings from the environmental scan were shared with the transplant centers and Gift of Hope, the organ procurement organization, to help them understand barriers faced by the dialysis clinics. To help the dialysis clinics address the barriers, these topics were used by the Network to develop resources and suggested interventions.

Facilities were trained in conducting RCA and in PDSA methodology to help them improve processes and to carry out changes which can be sustainable. Each dialysis clinic submitted individual PDSA plans. These were reviewed by Network staff and technical assistance was offered to the participating clinics throughout the project to help in goal attainment.

A Monthly Highlighted Resource was provided with education and technical assistance for staff members and also resources to be shared with patients. The dialysis clinics were required to attend CMS-sponsored learning and action network webinars. Elements from each of these LAN meetings were stressed during follow-up with the participating clinics.

The Network partnered with other transplant professionals and organizations to provide information of value to the dialysis clinics.

Christina Goalby of Health Literacy Media/Explore Transplant presented a series of webinars to a.) promote health literacy for patients; b.) teach professionals on methods to teach patients the basis about kidney donation and transplant; and c.) apply best practices to improve discussion on transplant and living donations.

Dr. Ed Hollinger, transplant surgeon from Rush University in Chicago, presented a webinar on the steps of the transplant work-up process. This webinar was intended to clarify questions that staff have about the work-up process so that they can better assist patients through the steps to transplant.

Kevin Cmunt, CEO for The Gift of Hope, presented a webinar on Transplant Referral and the Illinois Transplant Fund. Additionally, GOH partnered with the Network by bringing the transplant centers together with Network staff members for an in person meeting at the beginning of the project cycle. Follow-up visits to each of the transplant centers were made by Network staff members to discuss what each felt were barriers to patient referral.

The Network combined the barriers expressed by the transplant centers into a “Wish List” of factors that the transplant centers felt would be beneficial to increase transplant referral, including: designating a point person at dialysis clinic, dialysis clinic remind patients or give resources for scheduling work-up, focus more heavily on options education, including transplant, discuss living donation, especially for older patients, use Explore Transplant if possible as it has comprehensive education for patients, encourage follow-up by staff members after a transplant center has done a lobby day, tell patients to check out other centers if they get rejected from one, make sure to approach young patients early, encourage lobby days, but spread out between different transplant centers, i.e. don’t have two or three in same month.

The Network used the “Wish List” to decide what monthly interventions and education to use for the transplant QIA participants in an effort to improve the relationship between the dialysis clinics and the transplant programs.

The Network tracked the number of patient educated on transplant each month per facility, as well as the number of patients referred and transplanted.

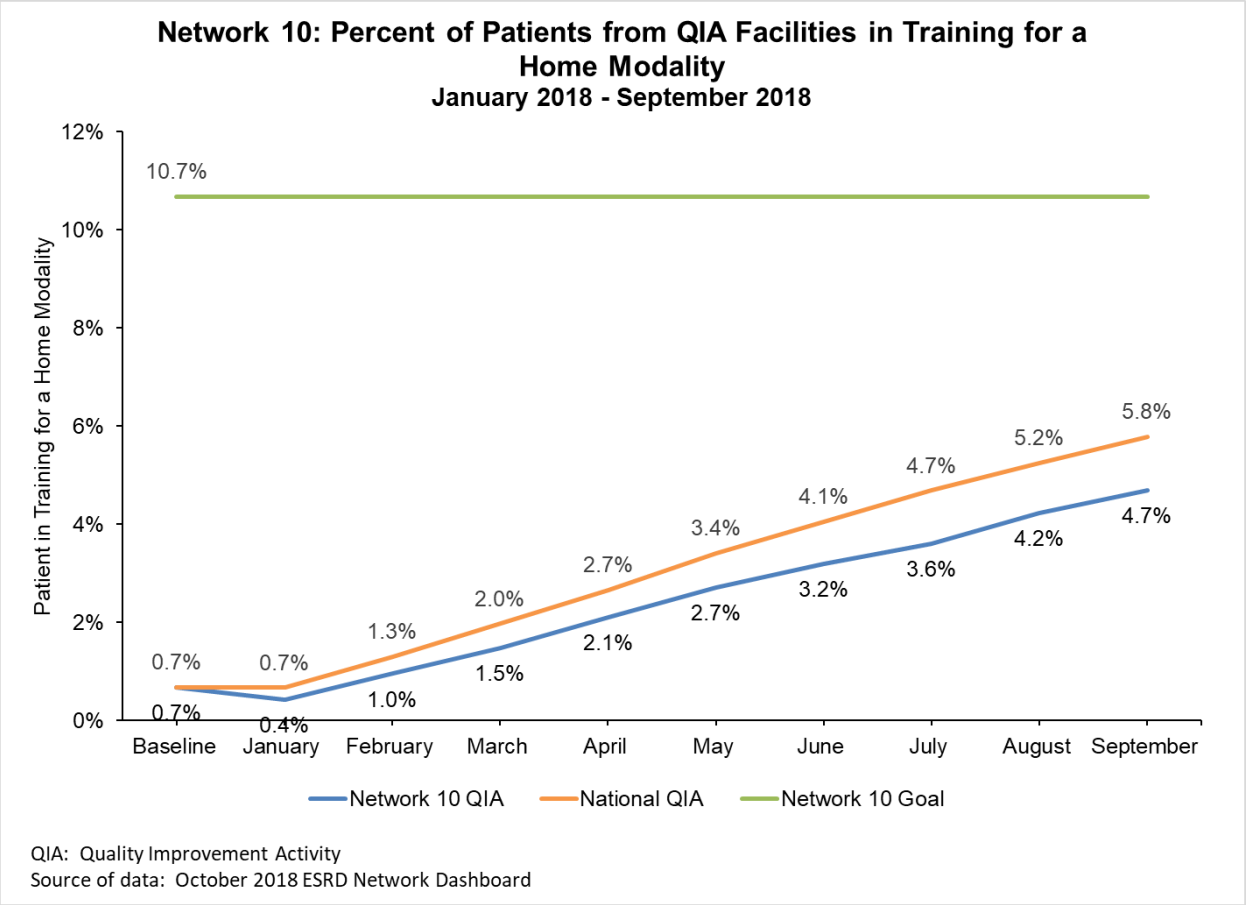
At the conclusion of the QIA, facilities reported adoption of the following changes: more frequent patient education; different methods for education, i.e. bulletin boards, flyers, posters, hearing info

from different staff members, apps, and web-based materials; more collaboration with Nephrologists and encouraging them to speak to patients more frequently about transplantation; inviting transplant centers into the dialysis clinic for lobby days; training administrative assistants to use their first contact with patients to ask if patient is aware of transplant options and report to appropriate team member for further education when needed; assigning a Transplant Champion in the clinic; developing transplant binders for resources; discussing transplant candidates in QAPI, including specific barriers; staff training forms to track that all staff are learning about transplant along with patients; and using the "teach back" method to track at least 20 patients per month for focused education.

Home Therapy Quality Improvement Activity

The goal for this project was to increase the number of patients referred for home dialysis by 10 percentage points in 30% of the dialysis clinics. Nationally, no Networks achieved this goal in 2018; Network 10 achieved a four percentage point increase (Graph 14). Although this goal was not achieved, within the project cohort of 92 dialysis clinics in Network 10, 612 patients initiated home dialysis.

GRAPH 14



QIA: Quality Improvement Activity
Source of data: October 2018 ESRD Network Dashboard

The project began with an environmental scan for the facilities to complete to show barriers to referring patients to home dialysis training. Barriers identified included: patients not interested; Hispanic patients not interested because in their country HD home dialysis is “second-rate”; patients do not understand their options; patients are afraid to take care of themselves; comorbidities; no partner; elderly patients; home space is not big enough; fear of infection based on stories from other patients who failed peritoneal dialysis; patients not given modality education prior to start of HD and don’t want to switch; patients comfortable with in-center hemodialysis; staff not understanding home options and giving poor information that they heard from other patients, and lack of support from the nephrologist. The results of the scan were provided to the participating clinics to help in their improvement efforts. The results were also used by the Network to find, or develop, resources to help dialysis clinics overcome these barriers.

Facilities were next trained in conducting RCA and in PDSA methodologies to help them improve processes and to carry out changes which can be sustainable. Each dialysis clinic submitted individual PDSA plans. These were reviewed by Network staff and technical assistance was offered to the participating clinics throughout the project to help in goal attainment.

A Monthly Highlighted Resource was provided with education and technical assistance for staff members and also resources to be shared with patients. The dialysis clinics were required to attend CMS-sponsored learning and action network webinars. Elements from each of these LAN meetings were stressed during follow-up with the participating clinics.

The Network partnered with other home dialysis professionals and organizations to provide information of value to the dialysis clinics.

The Network worked with educators from KidneySmart (DaVita) and Kidney Care Advocates (Fresenius Kidney Care) to promote their internal educational programs for the home therapy options. This assisted clinics to gain a better understanding of their own resources; it was discovered in the 2017 ICH CAHPS QIA about PD education, that not all clinics are utilizing their options educators as much as they could.

Denise Eilers from Home Dialyzors United presented a webinar on “The Pros and Cons of Going Home” where she discussed different aspects of home dialysis. Ms. Eilers also visited eight of the facility clinics to provide lobby days on home therapy options, in conjunction with the QIA.

In collaboration with Network 11 Midwest Kidney Network, The Renal Network worked with NxStage to present a webinar on home hemodialysis options.

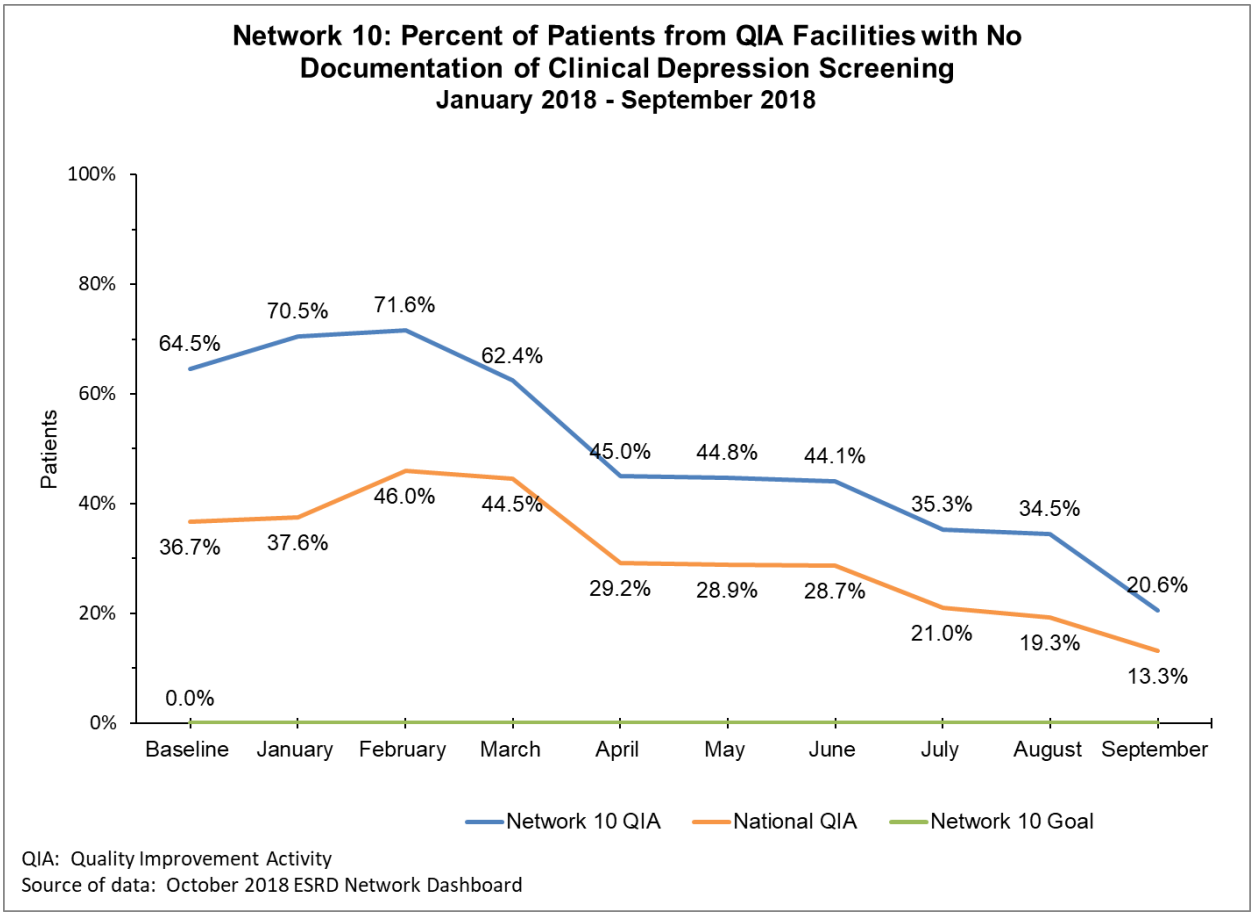
At the conclusion of the QIA, facilities reported adoption of the following changes: sponsoring a “Feel the Difference” lobby day with a focus on NxStage; home dialysis nurse visiting the clinic and speaking to the patients at chairside; one clinic is beginning a transitional care at their clinic to start patients on HD, but use HD as a temporary treatment for one month as the patients prepare to begin PD or start training for HHD; many clinics reported using the MATCH-D tool from the Medical Education Institute as a screening tool for all of their patients. The MATCH-D tool was provided by the Network as one of the monthly Highlighted Resources.

Population Health Focus Pilot Project Quality Improvement Activity

Positively Impact the Quality of Life of the ESRD Patient with a Focus on Mental Health
This project had three-part goal:

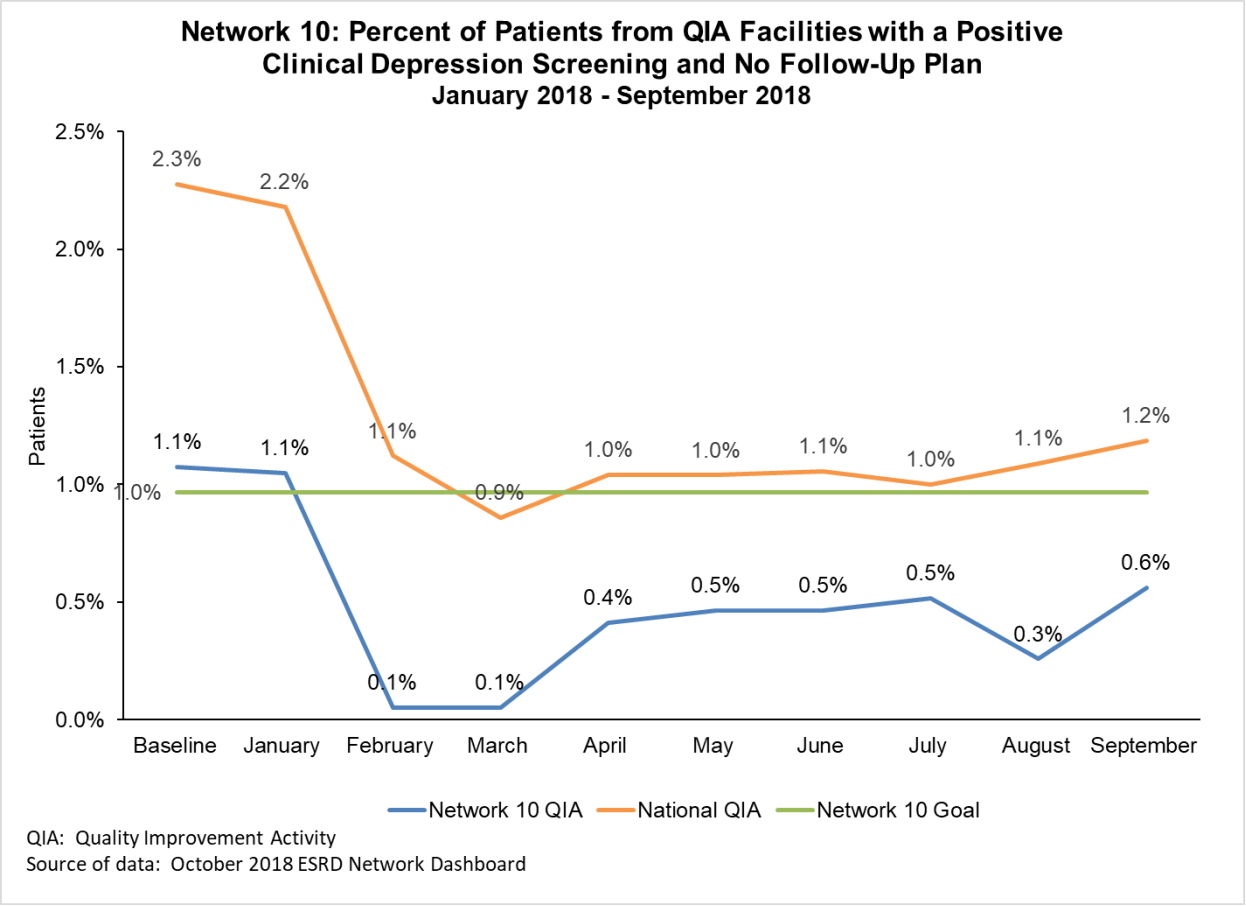
1. Attain a goal of zero responses to option number 6 in the CROWNWeb Depression Screening: Clinical depression screening not documented, and no reason is given (Graph 15). This goal was not achieved due to unforeseen circumstances with dialysis clinic internal care planning calendars; i.e. screening is done annually and may not have been due before the close of the project so patients remained listed in a suboptimal category. No network was able to attain the goal of zero responses to option 6 in CROWNWeb Depression Screening.
2. Achieve a 10% decrease over baseline in responses to option number 3 in CROWNWeb Depression Screening: Screening for clinical depression documented as positive, the facility possesses no documentation of a follow-up plan, and no reason is given (Graph 16). Network 10 surpassed this goal for decreasing positive screens with no follow-up, starting from 1.1% at baseline and dropping to 0.6% at the end of the QIA, 0.4% under goal.
3. Improve the disparity in elderly patients who receive depression screenings as documented in CROWNWeb (Graph 17). The disparity component was reversed, achieving the goal.

GRAPH 15



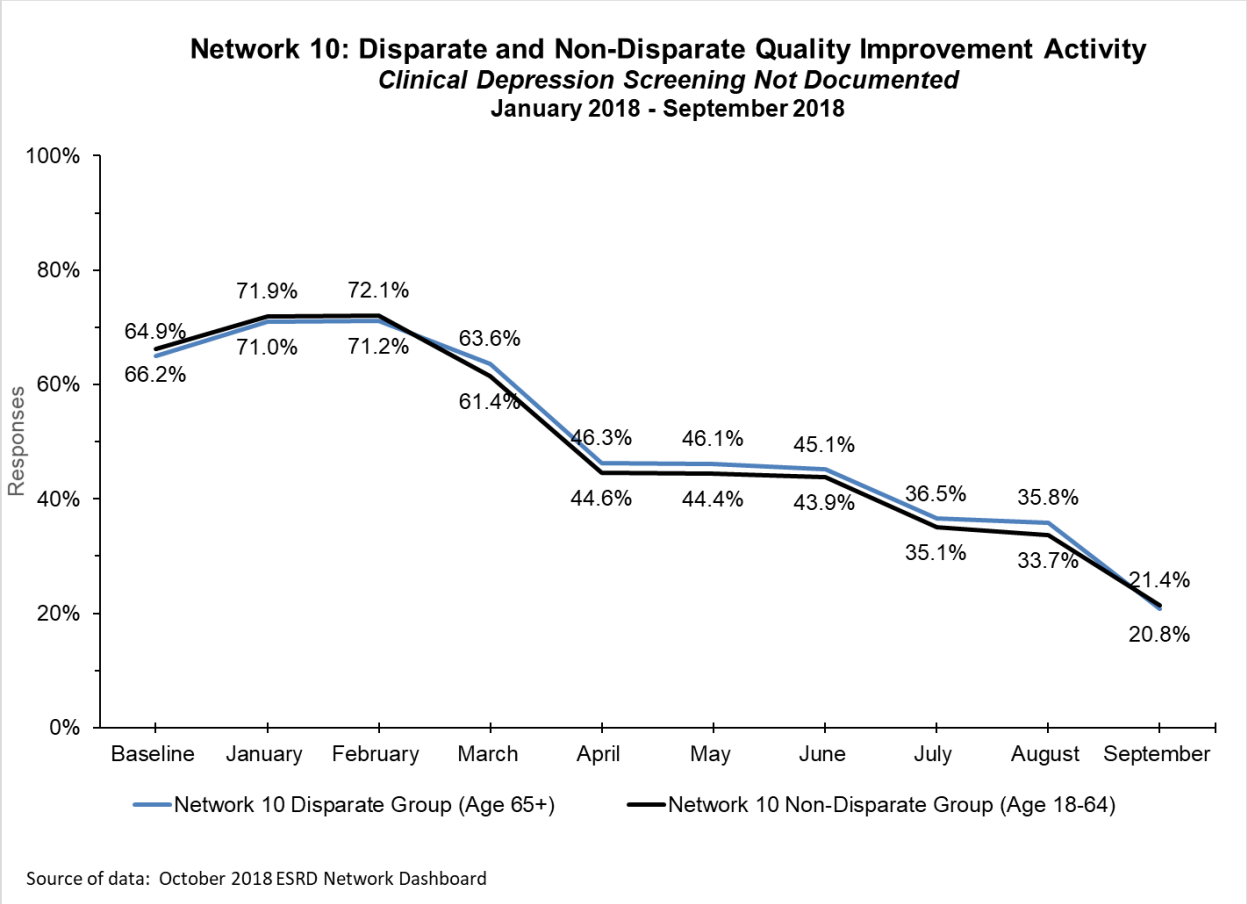
QIA: Quality Improvement Activity
Source of data: October 2018 ESRD Network Dashboard

GRAPH 16



QIA: Quality Improvement Activity
Source of data: October 2018 ESRD Network Dashboard

GRAPH 17



Source of data: October 2018 ESRD Network Dashboard

Additional goals included assisting clinics in development of a process to ensure completion, documentation, and appropriate follow-up of depression screening for qualifying patients and benefitting facilities and patients through mental health interventions that can be done in the dialysis clinic.

Selection criteria for the project included 10% of facilities in the Network 10 coverage area with the highest reporting rates of the two responses to option 3 and option 6 in the CROWNWeb Depression Screening as described above; 33 clinics participated in the activity.

Root Cause Analyses were completed by each of the 33 participating clinics and the top three barriers were found to be:

RCA Issue 1. 22 dialysis clinics listed the following barrier: Patients' misconception about depression and mental health, including a stigma with identification of the need for help, refusal to complete screenings, and refusal of treatment (both at chairside and in an outside setting with medication or other treatment). To deal with this issue, the Network developed the webinar "Assessment and Intervention of Depressive Symptoms Among ESRD Patients," for staff to address depression symptoms in dialysis patients and possible chairside interventions that can be done in the dialysis clinic. The Network, with input from the Patient Advisory Committee (PAC) created a poster, Feeling Blue?, geared

toward patients to help them recognize possible symptoms of depression and let them know how to ask for help. The poster was offered in both English and Spanish and is available on The Renal Network website.

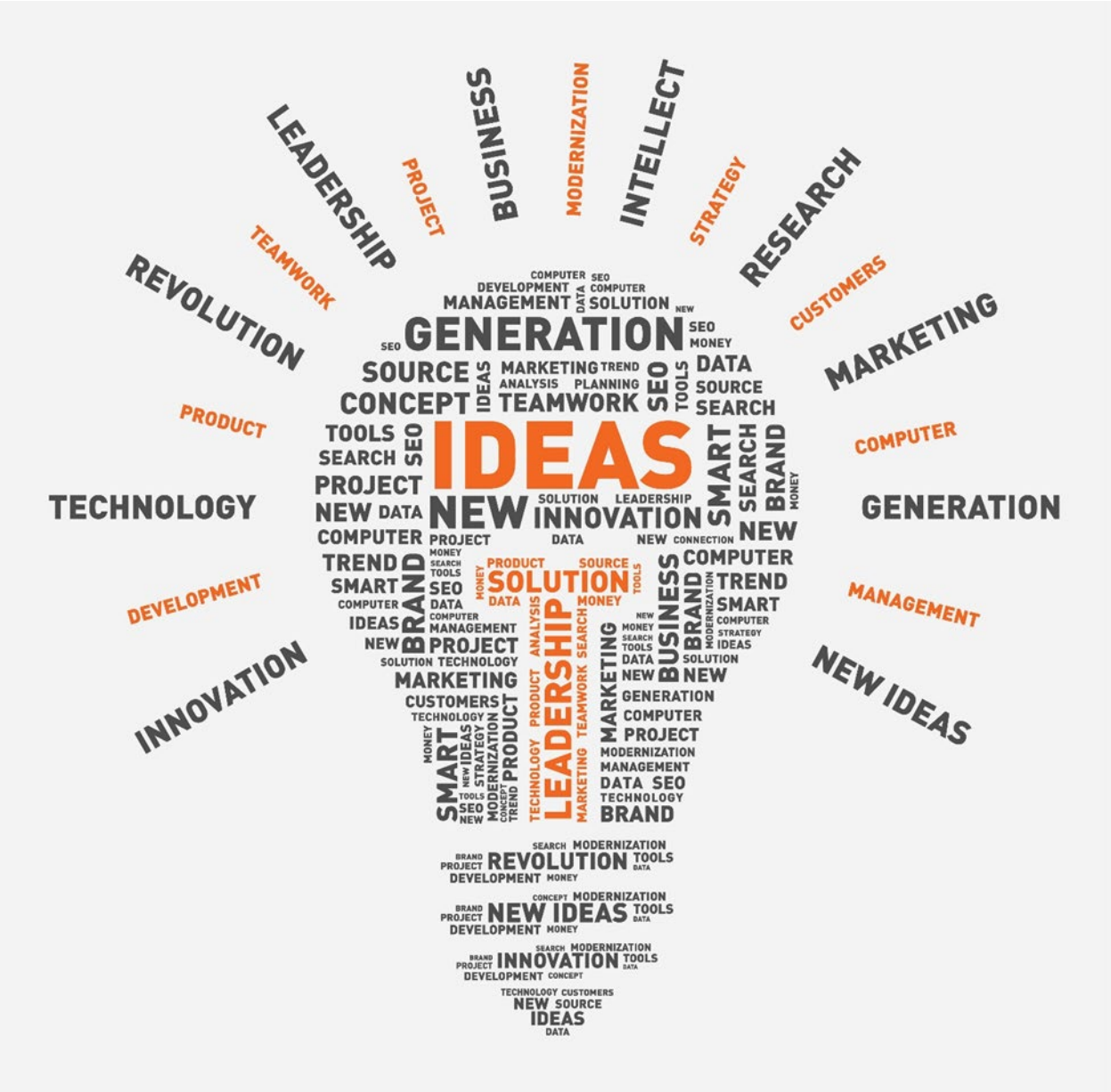
RCA Issue 2. 18 facilities listed the following barrier: CROWNWeb Batch errors that clinics were unaware of, including lack of individual clinic data validation. The Network data team developed a CROWNWeb Tutorial for technical assistance in documentation of CROWNWeb Depression Screenings. Along with the tutorial, the team developed a Depression Screening Status report that allowed clinics to see specific patients who were missing a screening or who had been screened as positive and no follow-up was documented. The report included action items for any missing documentation to bring the clinics into compliance with the project requirements.

RCA Issue 3. 16 facilities listed this barrier: Staff lack of understanding of Depression Screening policies, including unclear timeline for completion and follow up process. To address this barrier, a Train the Trainer Manual for Depression in ESRD was developed. The manual included resources for identification of depression and possible interventions that can be done chairside, plus non-pharmacologic interventions such as art therapy, exercise, mindfulness, goal planning, motivational interviewing techniques, and laughter therapy.

A Mental Health Task Force was created that included representatives from three dialysis organizations, members from The Renal Network Medical Review Board and Patient Advisory Committee, and members from Qsource Quality Improvement Organization. The purpose of this task force was to identify interventions that would be helpful for dialysis patients suffering from depression and for staff who care for these patients to be able to identify and mitigate mental health problems to assist patients with getting needed treatment.

The Network also collaborated with the Behavioral Health staff at Qsource atom Alliance to develop a Train the Trainer Manual for ESRD patients which included PHQ-2, PHQ-9, CES-10, and the Geriatric Depression Screening tool, among others, with a grading scale and what steps to take if a patient is screened as positive. It also included recommendations for referring patients to a mental health provider if chairside interventions were not appropriate for the patient. Further collaboration with the Behavioral Health team included a webinar presentation aimed at dialysis providers and primary care physicians who treat dialysis patients and focused on the effects of transition of care on dialysis patients, specifically the journey from CKD to ESRD, and the overlap in symptoms of uremia and depression. Finally, both Network 10 and Network 12 worked on a blog campaign in October for Depression Awareness month sharing resources to the entire network coverage area regarding mental health symptoms and treatments.

At the conclusion of the project, 92.5% of clinics reported adoption of Network interventions. Clinics were required to complete Sustainability Plans to help ensure that their process changes would become part of their daily, weekly, or monthly routines and that progress would be maintained for the betterment of patient care. In order for the Network to assess areas for improvement and to encourage patient engagement, patients in the cohort clinics were asked for their opinions on the most beneficial resources. Final Evaluations for staff project leads were also completed at the wrap-up of the project in order to provide suggestions for improvement for future projects.


LEADERSHIP
PROJECT
BUSINESS
MODERNIZATION
INTELLECT
STRATEGY
RESEARCH
TEAMWORK
REVOLUTION
CUSTOMERS
MARKETING
PRODUCT
COMPUTER
TECHNOLOGY
GENERATION
DEVELOPMENT
MANAGEMENT
INNOVATION
NEW IDEAS
IDEAS
GENERATION
SOURCE
CONCEPT
TEAMWORK
MARKETING
DATA
SEARCH
SMART
BRAND
NEW
SOLUTION
LEADERSHIP
INNOVATION
PROJECT
TREND
COMPUTER
BUSINESS
MANAGEMENT
REVOLUTION
NEW IDEAS
INNOVATION

ESRD NETWORK RECOMMENDATIONS FOR SANCTIONS< SERVICES, and/or FACILITES

ESRD Network 10 made no recommendations for sanctions during 2018.

ESRD Network 10 made no recommendations for new services during 2018.


first
infrastructure
contingency
environment
aid
continuity
public safety
ambulance
training
communications
earthquake
damage
critical
management
patient
mitigation
injury
planning
preparedness
healthcare
plan
safety
fire
agency
warning
survival
team
medical
service
help
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danger
disaster
supplies
protection
emergency room
kit
evacuation
stretcher
paramedic
business
alarm
medic
safe
jeopardy
resilience
emergency
incident
equipment
disease
urgency
threat
natural disaster
natural
information
property
recovery
nurse
crisis
doctor
government
situation
health
environmental
risk management
public
response
rescue
hospital
security
room
intervention
operations
life
accident
risk
medicine
education
loss
system

ESRD NETWORK SIGNIFICANT EMERGENCY PREPAREDNESS INTERVENTION

The Network is a resource for its providers during disasters. The Network routinely contacts dialysis units within areas where disasters have been reported, such as floods, tornadoes, snowstorms, water issues, and power outages. Network 10 has an emergency back-up agreement in place with ESRD Network 6 in the event the Network office would close.

During 2018, the Network responded to six individual facility-specific or regional emergencies, including:

- Snow Storm
- Sewer Back-Up
- Power Outage
- Water Equipment Failure
- Water Main Break (two separate occurrences)

During disaster events in 2018 in ESRD Network 10, facilities were contacted by Network staff to monitor their open and closed status and to offer Network assistance. The open and closed status of affected facilities was provided to the CMS Regional Office.

The Network staff worked throughout the year to remind facilities of their role in the event of an emergency or disaster. The Network routinely sends emergency preparedness information to all facility administrators prior to impending storms. The information provides disaster preparedness resources for patients and staff. Reminders to update facility disaster plans are included with the information sent.

On November 7, 2018, Network staff participated in an emergency preparedness drill led by the KCER Coalition. The drill simulated an outbreak of a novel influenza pandemic. The goal of the exercise was to test Network level emergency response plans, policies and procedures as they would pertain to an influenza pandemic. The Network staff held meetings to assess the situation and made decisions on how to remain functional despite the challenges presented by the hypothetical pandemic.

ACRONYM LIST APPENDIX

This appendix contains an acronym list created by the KPAC (Kidney Patient Advisory Council) of the National Forum of ESRD Networks. We are grateful to the KPAC for creating this list of acronyms to assist patients and stakeholders in the readability of this annual report. We appreciate the collaboration of the National Forum of ESRD Networks, and especially to the members of the KPAC.