ESRD NETWORK 2022 ANNUAL REPORT

ESRD Network 10

Illinois

This report will cover quality improvement efforts led by ESRD Network 10 Task Order Number 75FCMC21F0003 from May 1, 2022 - April 30, 2023.

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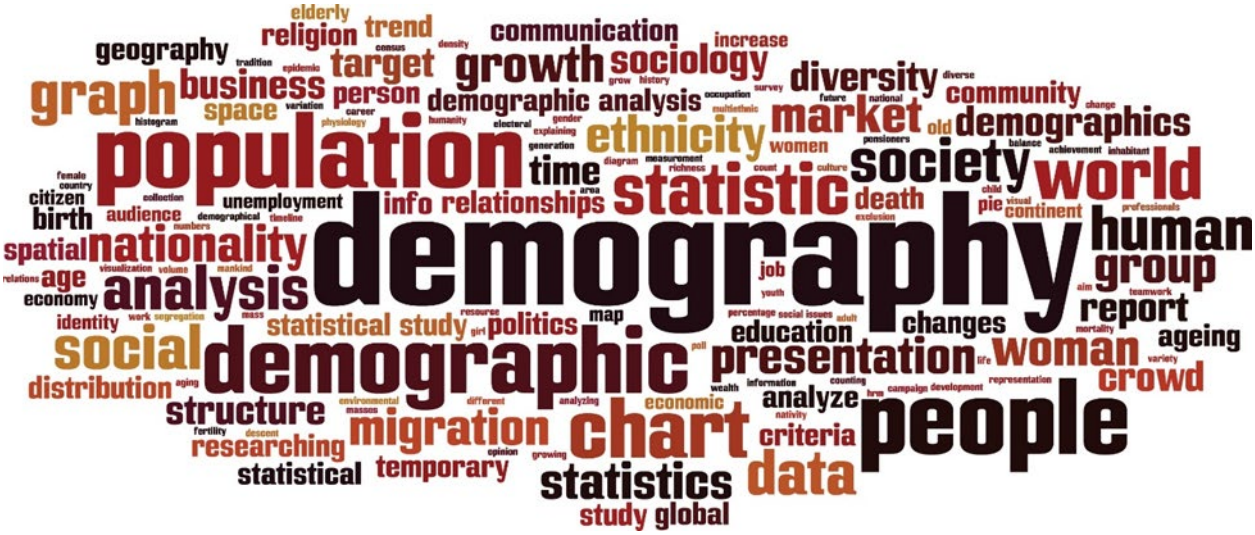
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ESRD Demographic Data

During the performance period of May 2022 to April 2023, Qsource ESRD Network 10 collaborated with its many stakeholders to improve the quality of care for 31,439 dialysis and transplant patients, receiving treatment in 362 dialysis facilities and nine transplant centers throughout the State of Illinois. Qsource ESRD Network 10 is a 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 12,812, 508. Springfield is the capital city of the state. The top six cities by population are:

- Chicago (2.706 million)
- Aurora (199, 602)
- Schaumburg (157, 781)
- Naperville (148, 304)
- Joliet (148,009)
- Rockford (147, 651)

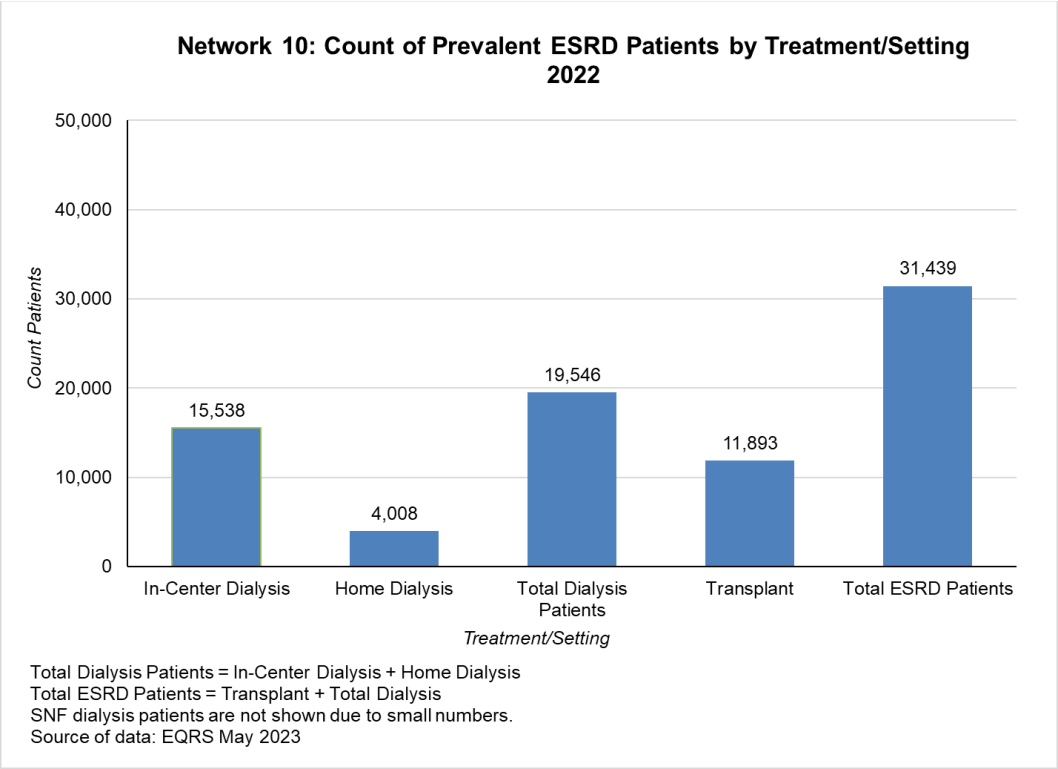
About one-half of the population of Illinois lives in the metropolitan Chicago area. In total, 88 percent of the population lives in urban areas and 12 percent of the population lives in rural areas. Population characteristics are illustrated in the table below.

Figure 1 – 2020 Census General Population – Illinois
Race, Age, Ethnicity & Gender Information*

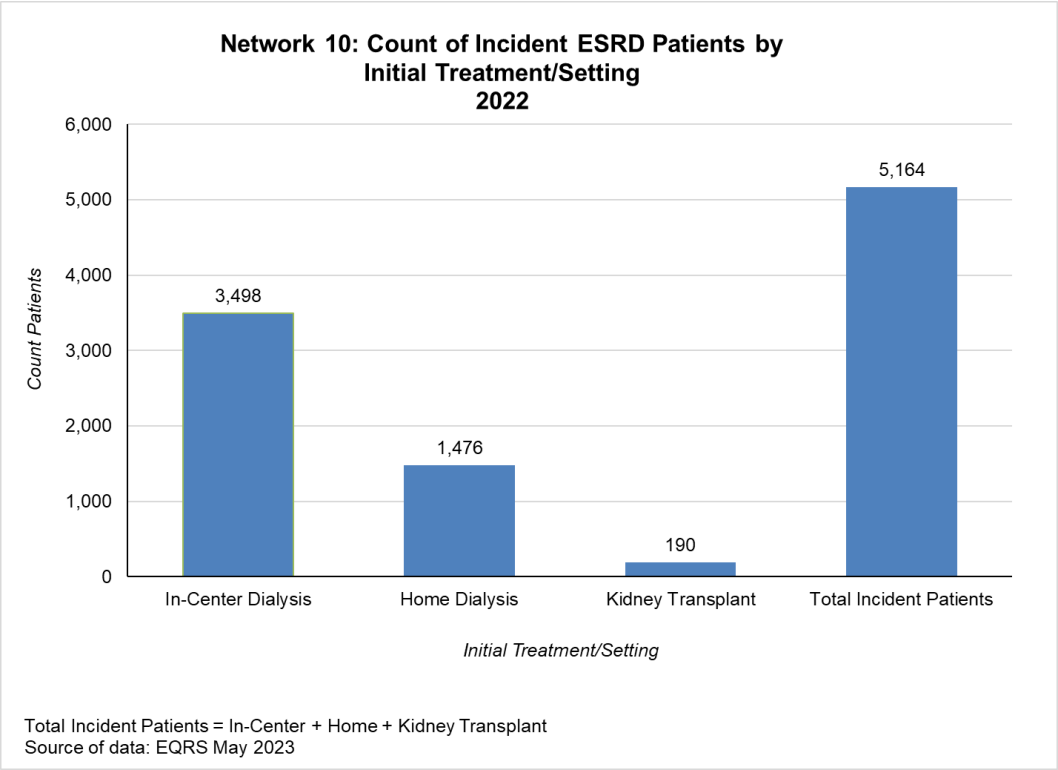
State	Illinois
Population	12,812,508
State Rank	5th
White	70%
Black	14%
Asian	6%
Other	6%
Hispanic (All Races)	15.8%
Under 19	24%
19 – 64	62%
65 & Over	14%
Male	49%
Female	51%

*U.S. Census Bureau
https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF

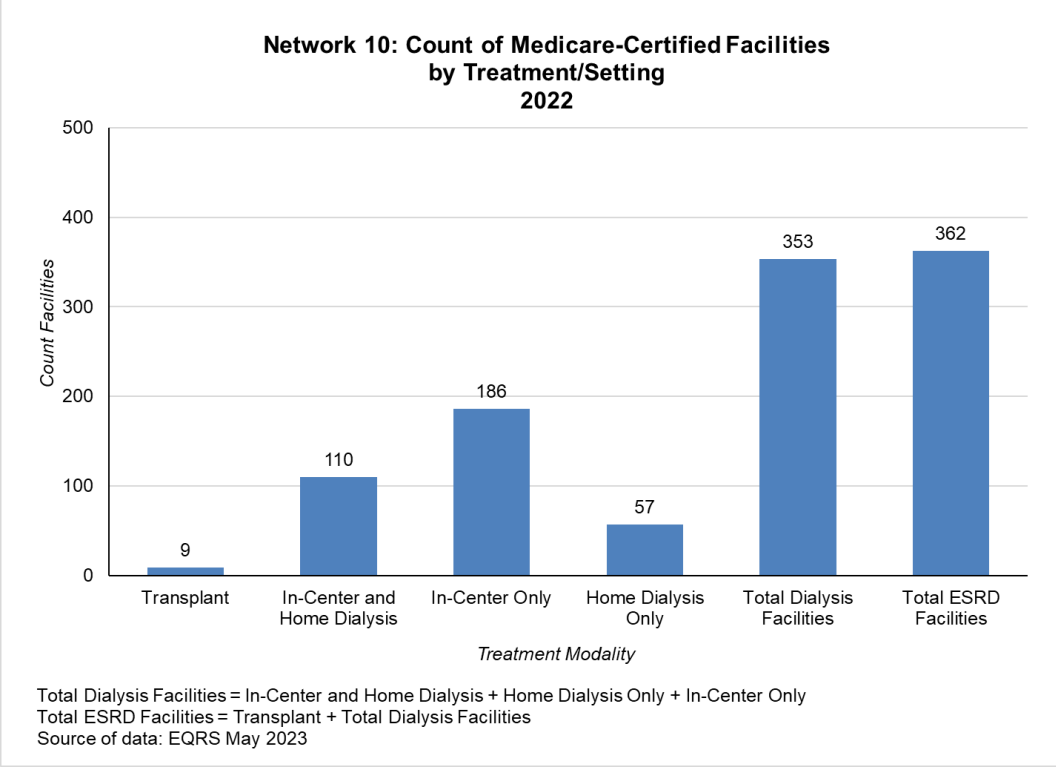
At year-end 2022, ESRD Network 10 was comprised of 362 total ESRD facilities (Graph 3), serving 31,439 dialysis patients (Graph 1). Additionally, Illinois had nine transplant centers (Graph 3) and a total of 11,893 transplant patients (Graph 1).



Graph 1: Count of network prevalent ESRD patients by treatment/setting for 2022

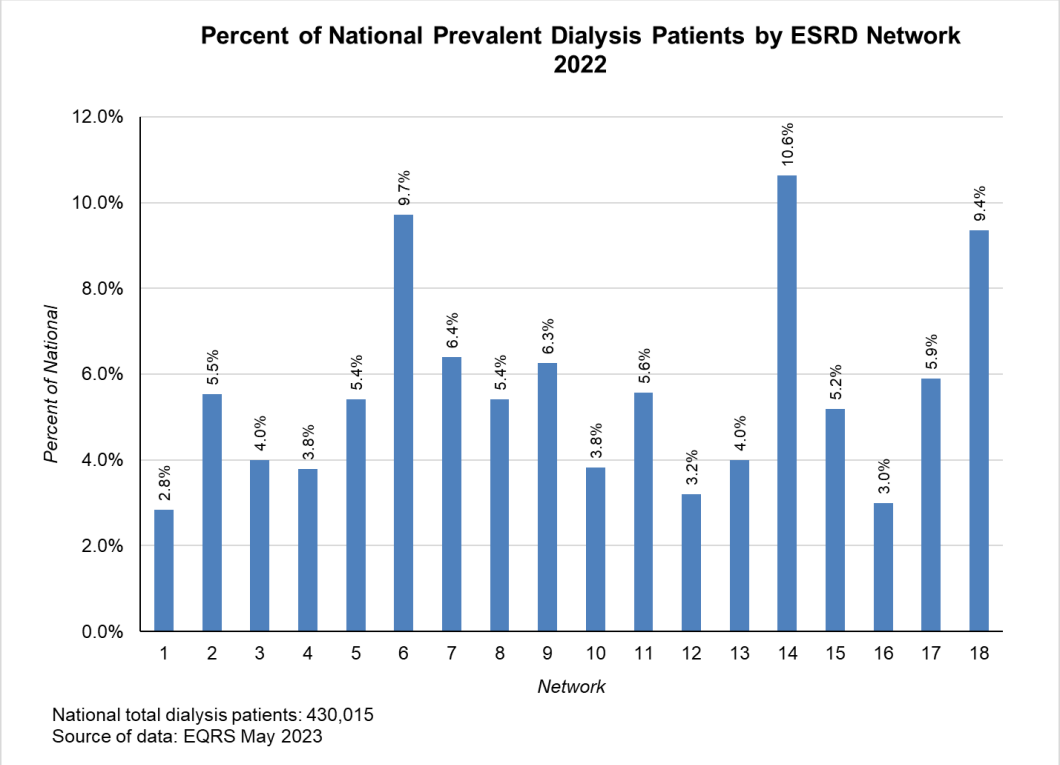


Graph 2: Count of network incident ESRD patients by initial treatment/setting for 2022

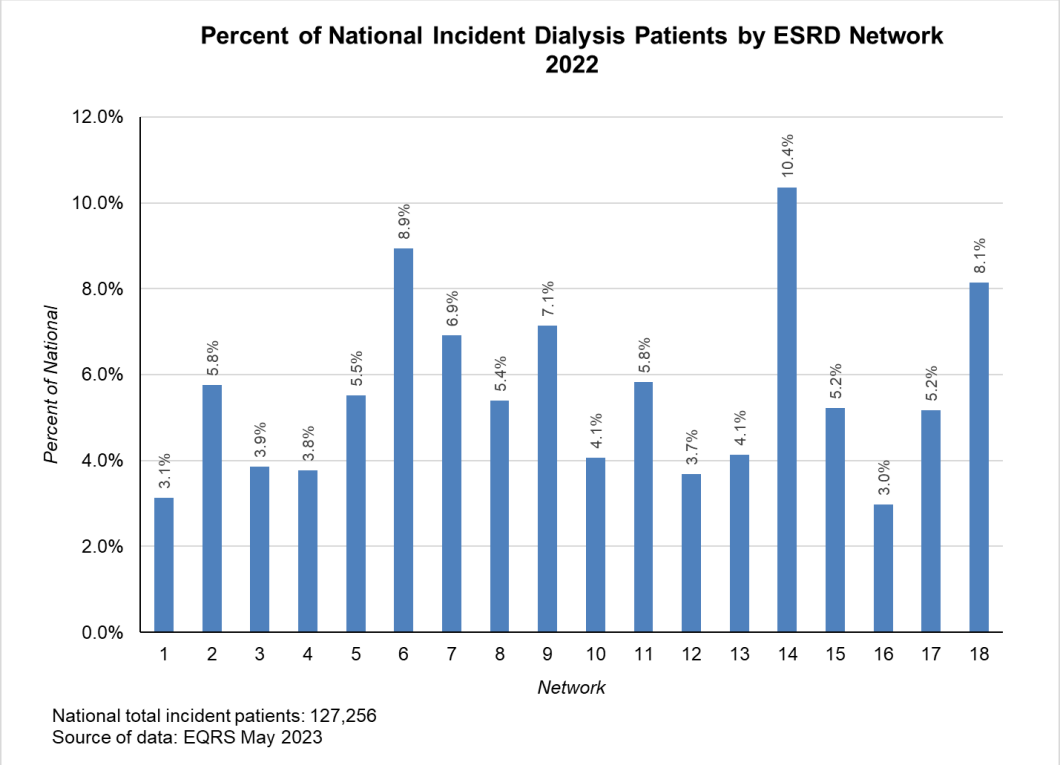


Graph 3: Count of network Medicare-certified facilities by treatment/setting for 2022

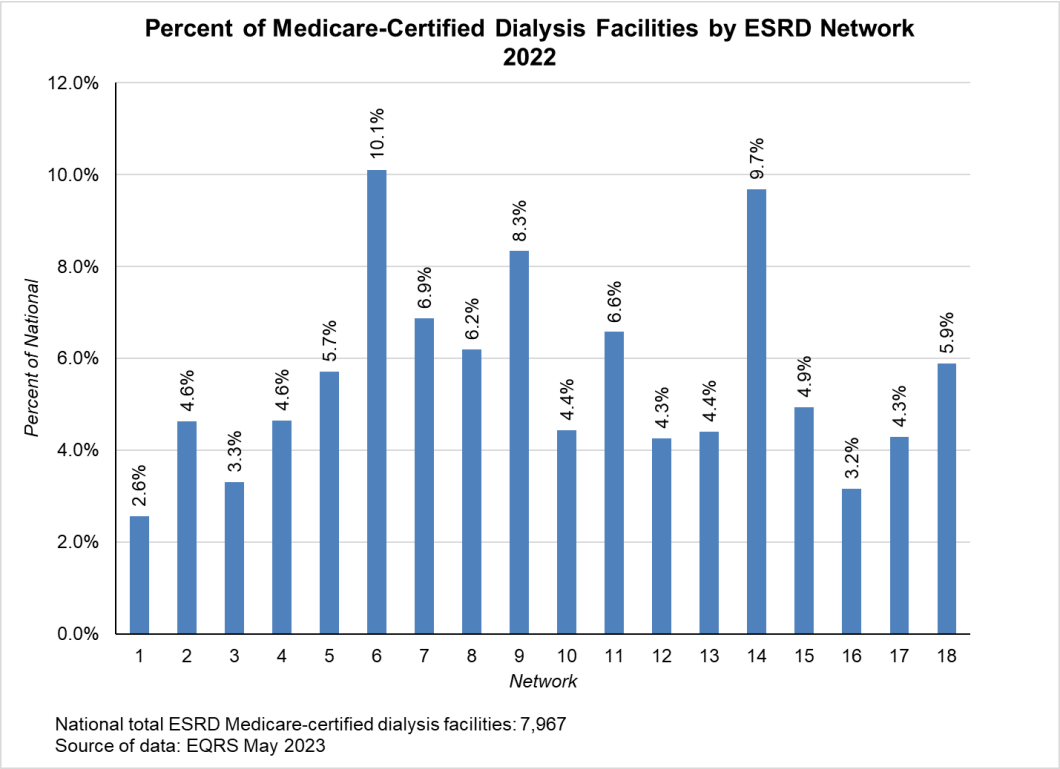
The graphs found on the following pages provide a comparison of the number of ESRD patients (prevalence and incidence) by renal replacement therapy in the Network 10 region, the number of dialysis facilities and transplant centers in the Network 10 region, the rates of patients (prevalence and incidence) across the nation by ESRD Network region, and the rates of facilities by type (dialysis and transplant) in the nation by ESRD Network region, the rates of Home Dialysis Therapies (i.e., Home Hemodialysis and Peritoneal Dialysis) across the nation by ESRD Network region, and the rates of Transplants Patients across the nation by ESRD Network region.



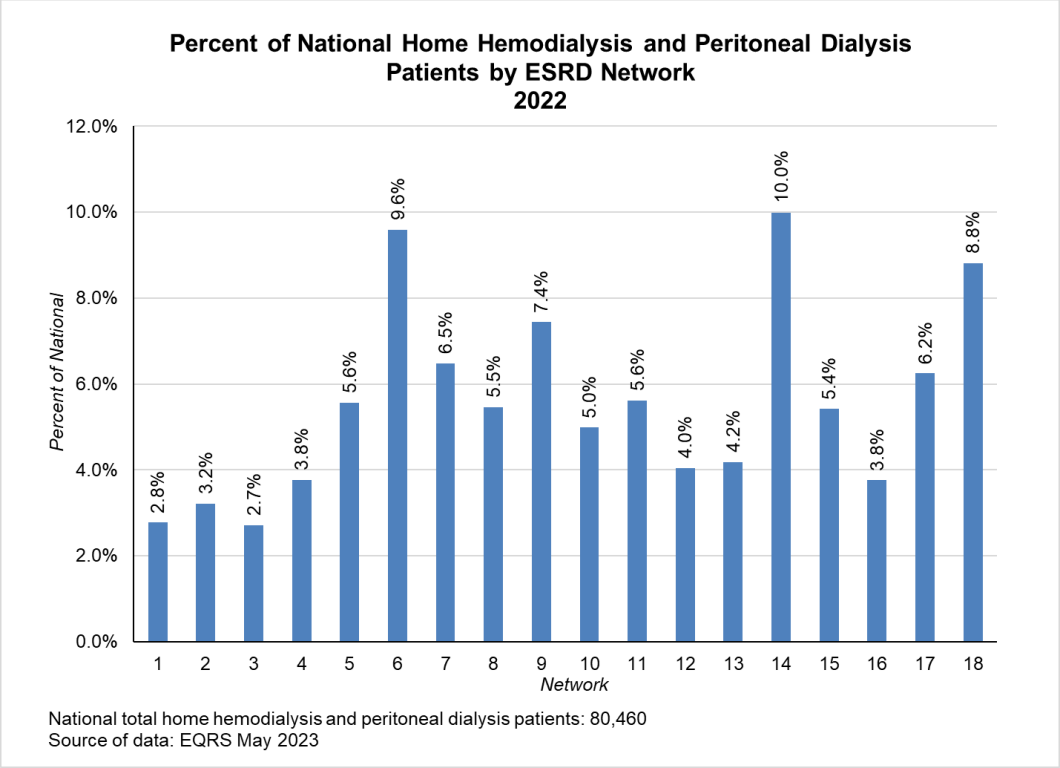
Graph 4: Percent of national prevalent dialysis patients by ESRD network for 2022



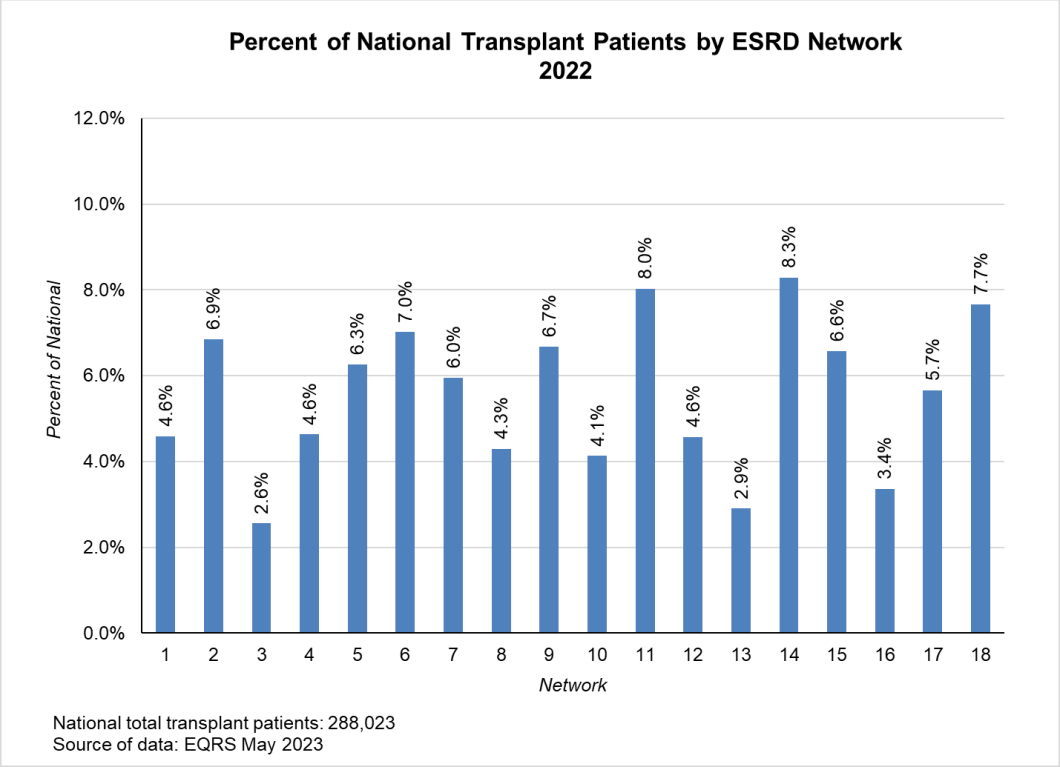
Graph 5: Percent of national incident dialysis patients by ESRD network for 2022



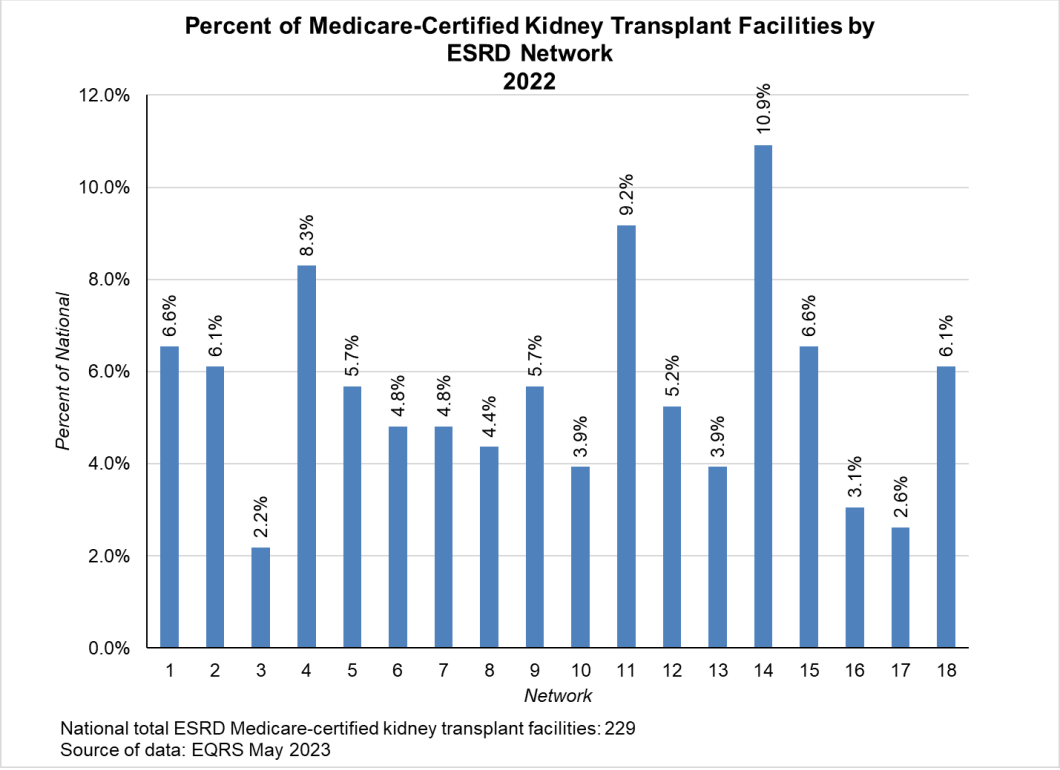
Graph 6: Percent of Medicare-certified dialysis facilities by ESRD network for 2022



Graph 7: Percent of national home hemodialysis and peritoneal dialysis patients by ESRD network for 2022



Graph 8: Percent of national transplant patients by ESRD network for 2022



Graph 9: Percent of Medicare-certified kidney transplant facilities by ESRD network for 2022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ESRD Network Grievance and Access to Care Data

ESRD Network 10 responds to calls for assistance from stakeholders, including dialysis patients, caregivers, family members, dialysis clinic staff members, and physicians. During 2022, the majority of contacts were received in the following CMS-defined categories:

Access to Care (55%): These contacts deal specifically with concerns for patients who are in danger of being involuntarily discharged (IVD) from their dialysis clinics and regarding 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.

Facility Concern (23%): Facility concerns are brought to the Network's attention by staff members or physicians of Network 10 dialysis clinics. Facility concerns are often made to ask for assistance with an issue before it grows to be a 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.

General Grievance (5%): 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.

Immediate Advocacy (2%): 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.

Clinical Quality of Care (5%): 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.

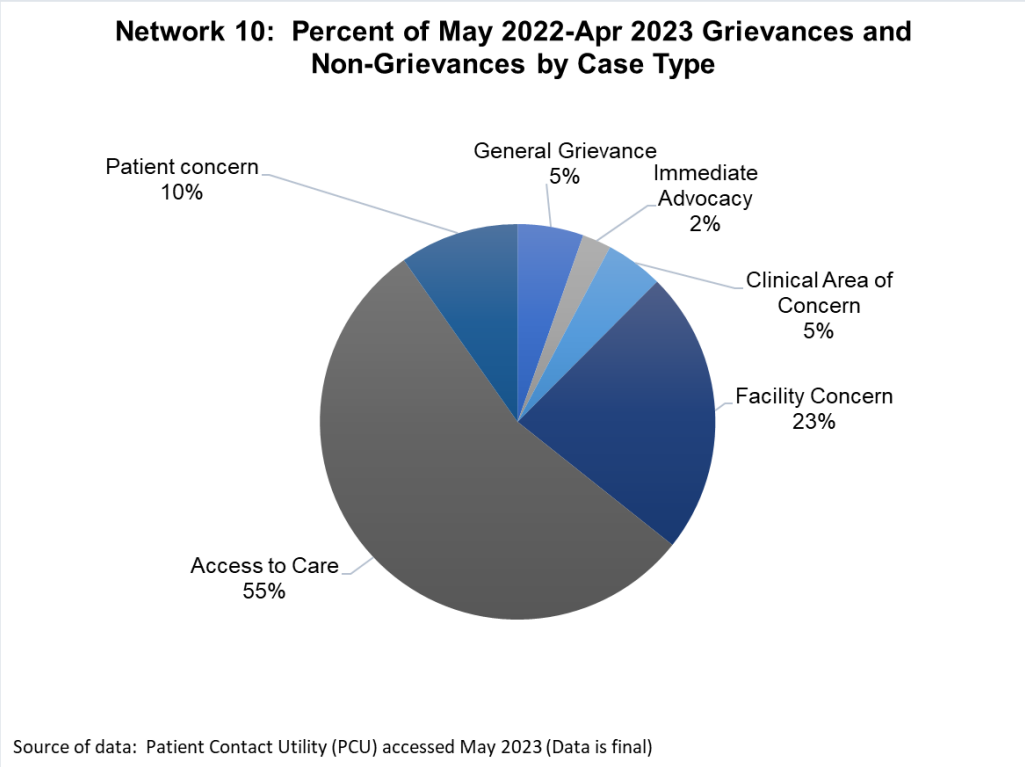
The Network used trending information from grievances to find existing resources or develop new resources for patients and staff to assist in solving conflicts and in improving communications for all parties. A sample of resources provided is listed below:

Network Interventions for Providers: referenced *Decreasing Dialysis Patient-Provider Conflict (DPC) Toolkit* (including recently updated modules); 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) and information on life planning; 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, which are available on the network website.

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 as *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.



Graph 10: Percent of May 2022-Apr 2023 Grievances and Non-Grievances by Case Type

Qsource ESRD Network 10 completed the quality improvement activities (QIA) as outlined in the ESRD Network Statement of Work, including all applicable contract directed change orders that may have occurred during the performance period. 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)
- Working with Community Coalitions and stakeholders in the kidney community to identify barriers and share emerging solutions and best practices to these common barriers
- Provision of resources to dialysis clinics based on needs identified by the QIA participants and Community Coalitions, with the goal for the Network to achieve customer focus
- Overall focus on Shared Decision Making, Relationship Centered Care, and Motivational Interviewing to help patients and staff understand the importance of patient involvement in their care and modality choice
- Patient engagement through encouragement of facilities recruiting and supporting a patient or patients to act as mentors to other patients and provide the patient perspective in quality improvement processes at the facility level
- Rapid Cycle Improvement through consistent reassessment of resources and interventions, based on the feedback from the participating dialysis clinics and patients
- Sustainable impacts through early introduction of the concept and re-enforcement of the importance of integration into the culture of the clinic

Details for each of the QIAs follow here.

Transplant Waitlist & Transplanted May 2022-April 2023

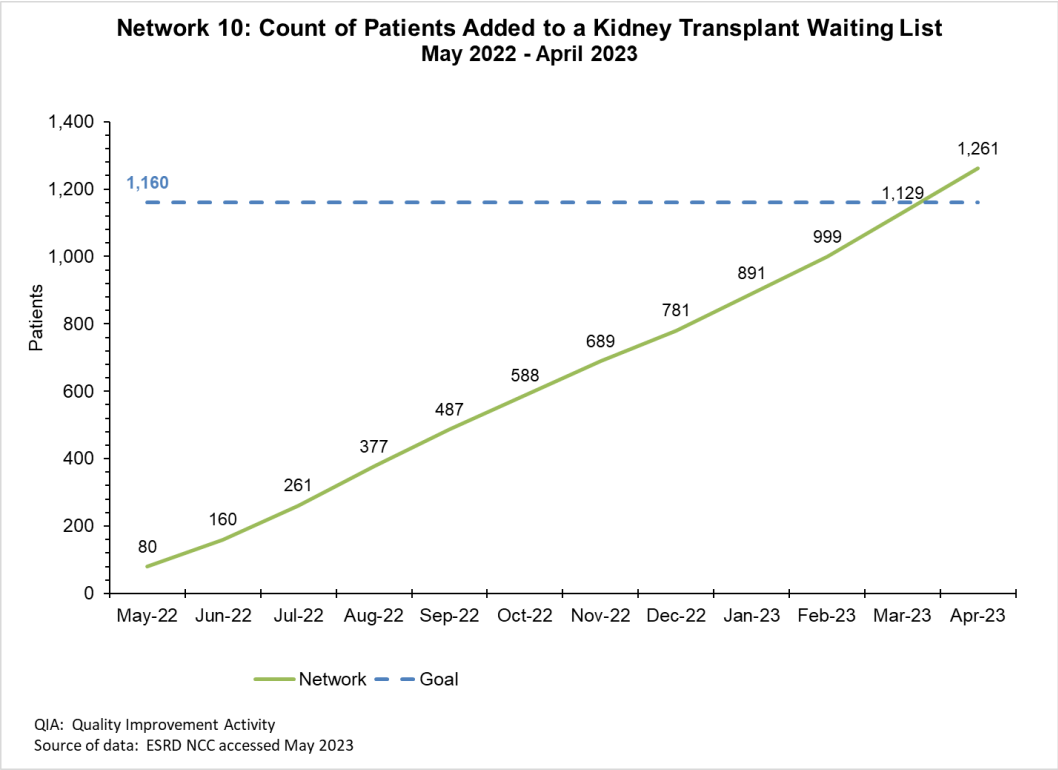
The goal for this activity was to achieve a total of 5% increase in the number of patients added to a kidney transplant waiting list and a total of 6% increase in the number of patients receiving a kidney transplant from the baseline to the end of the option period.

Facilities with room for improvement were chosen as focus groups for small tests of change, working in collaboration with the Network's Transplant Community Coalition in 4-month PDSA cycles. The coalition included subject matter experts able to assess local issues pertinent to transplant and waitlisting for ESRD patients, such as transplant programs representatives, high performing dialysis providers and clinicians, Nephrologists, Network Medical Review Board members, local hospitals, Quality Improvement Organizations, patient subject matter experts, and other kidney community stakeholders and beneficiaries, among others.

Technical assistance was provided based on facility-level data provided by the ESRD NCC and emerging best practices were spread to the entire network service area for increased opportunities for improvement and sustainability.

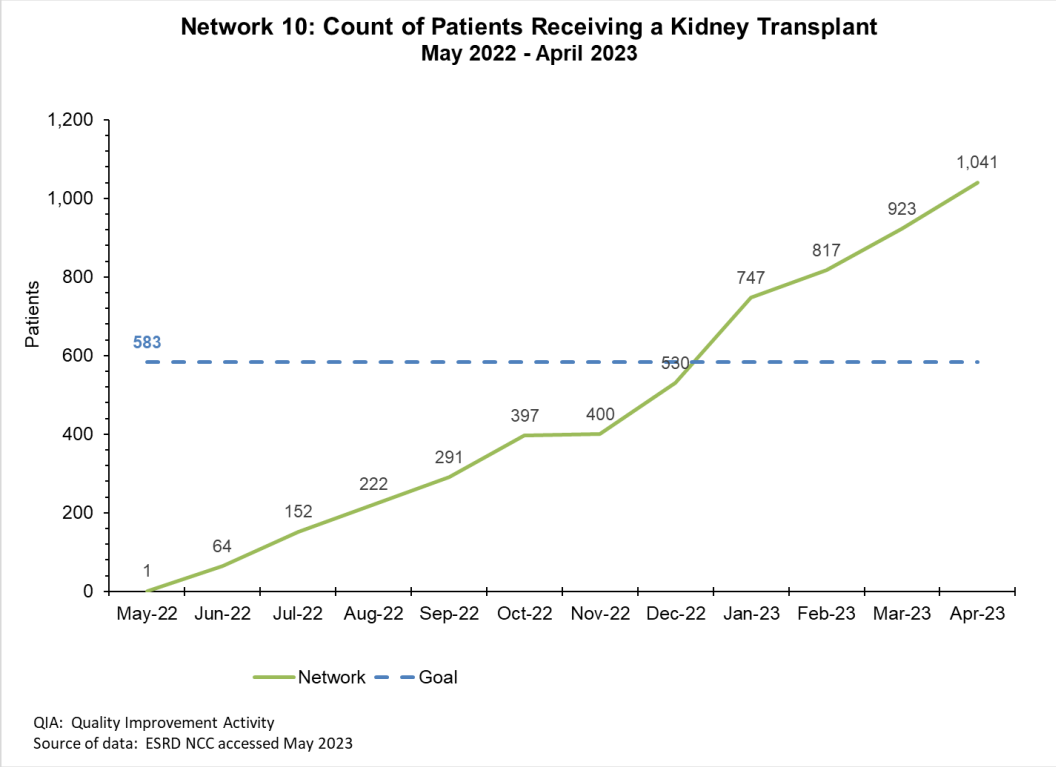
The Network held quarterly meetings with the 9 transplant centers in Illinois and surrounding transplant centers in nearby St. Louis, across the Illinois/Missouri border where many Illinois patients are listed. Faculty from the transplant programs discussed changes that could impact facility partnership, including lingering process changes due to the COVID-19 public health emergency. Best practices were shared across transplant programs, including successes with virtual lobby days for patient education.

By the period ending April 2023, the Network had surpassed the goal for waitlisted, achieving 1,261 patients added to the kidney transplant waiting list (Graph 11).



Graph 11- Count of Patients Added to Transplant Waitlist May '22 - Apr '23

By the end of April 2023, through a dedicated and collaborative effort with dialysis providers and the transplant programs of Illinois, Network 10 had surpassed the goal for kidney transplants for the second year in a row (Graph 12), achieving 1,041 patients having been transplanted during the period. One strategy that proved successful to assist the Network in achieving this metric was ongoing technical assistance provided to transplant centers related to entering forms into the ESRD Quality Reporting System (EQRS) and a routine comparison of UNOS data to EQRS data to identify and mitigate discrepancies in the number of transplanted patients and ensure that data was captured and entered correctly.



Graph 12- Count of Patients Receiving Kidney Transplant May '22 - Apr '23

Home Therapy May 2022-April 2023

The goal for this activity was to achieve a total 20% increase in the number of incident patients starting dialysis using a home modality and achieve a total 6% increase in the number of prevalent patients moving to a home modality based on EQRS data from baseline to the end of the option period.

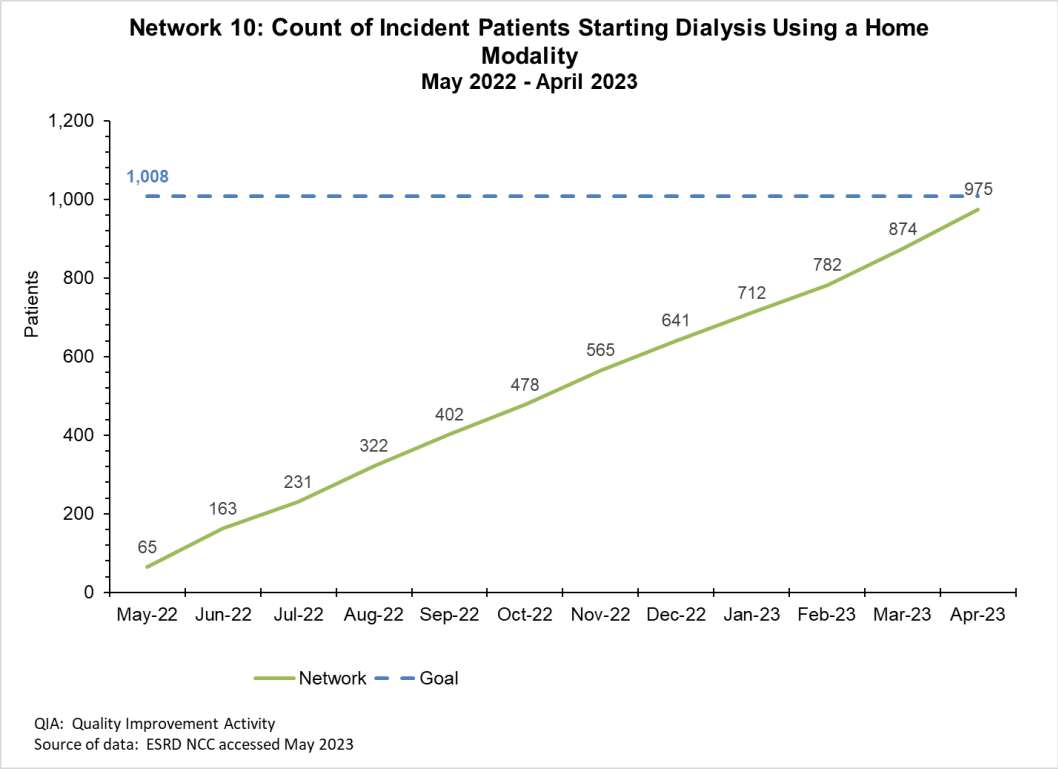
Using NCC data, Network 10 chose facilities based on their room for growth and ability to achieve, with mid-to-low-level performers being chosen as cohort facilities. Low performers received technical assistance throughout the year based on data. Barriers were identified through Network-wide environmental scans and primary and secondary drivers were chosen by the Network 10 Home Modality Community Coalition. The coalition included subject matter experts able to assess local issues pertinent to home modality education and training, such as modality educators and program managers, high performing dialysis providers and clinicians, Nephrologists, Network Medical Review Board members, local hospitals, Quality Improvement Organizations, patient subject matter experts, and other kidney community stakeholders and beneficiaries, among others.

The coalition reviewed the environmental scans and assessments of focus facilities alongside the ESRD NCC Home Change Package and identified Key Driver: *Educate and support patients and caregivers throughout the continuum of care* as the first goal for the focus group. Major barriers were identified as lack of support or assistance at home, lack of available home programs and/or nephrologists in rural areas, and patient preference for in-center due to socialization.

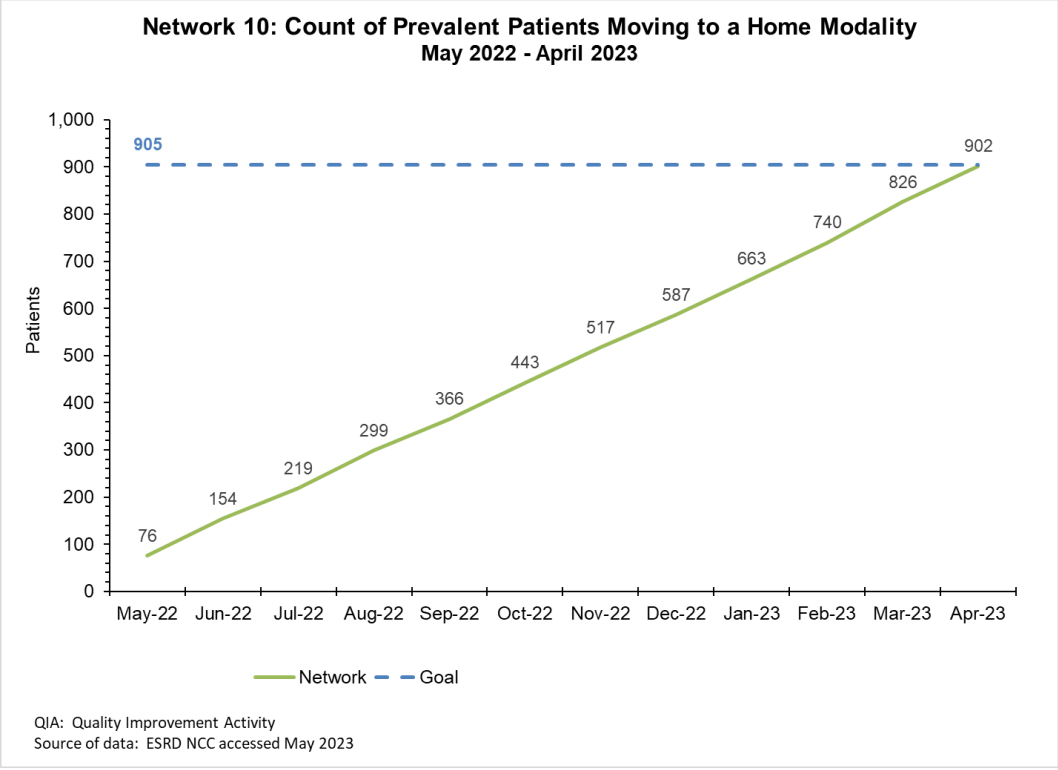
The Network began intervention support toward key strategies including Shared Decision Making, Life Planning with patients including a discussion about modality choice, sharing best practices from transitional care units and those using “Experience the Difference,” Options educators, early education upon incident start, Urgent Start PD, increased use of lobby days as the public health emergency began to wind down, and other interventions that built upon the Network’s prior year strategy of a Home First Approach.

At the end of the performance period, Network 10 saw strides toward incident patients starting dialysis using a home modality, falling short of the goal by fewer than 100 patients. Nearly 900 patients in the Network 10 region were able to begin home as their first choice during the performance period (Graph 13).

For the metric to move prevalent patients to a home modality, the network saw great advances with steady movement month over month, ending with an achievement of 902 prevalent patients moving to a home modality, missing the metric goal by a mere 3 patients (Graph 14).



Graph13- Incident Patients Starting Dialysis Using a Home Modality May '22 to Apr '23

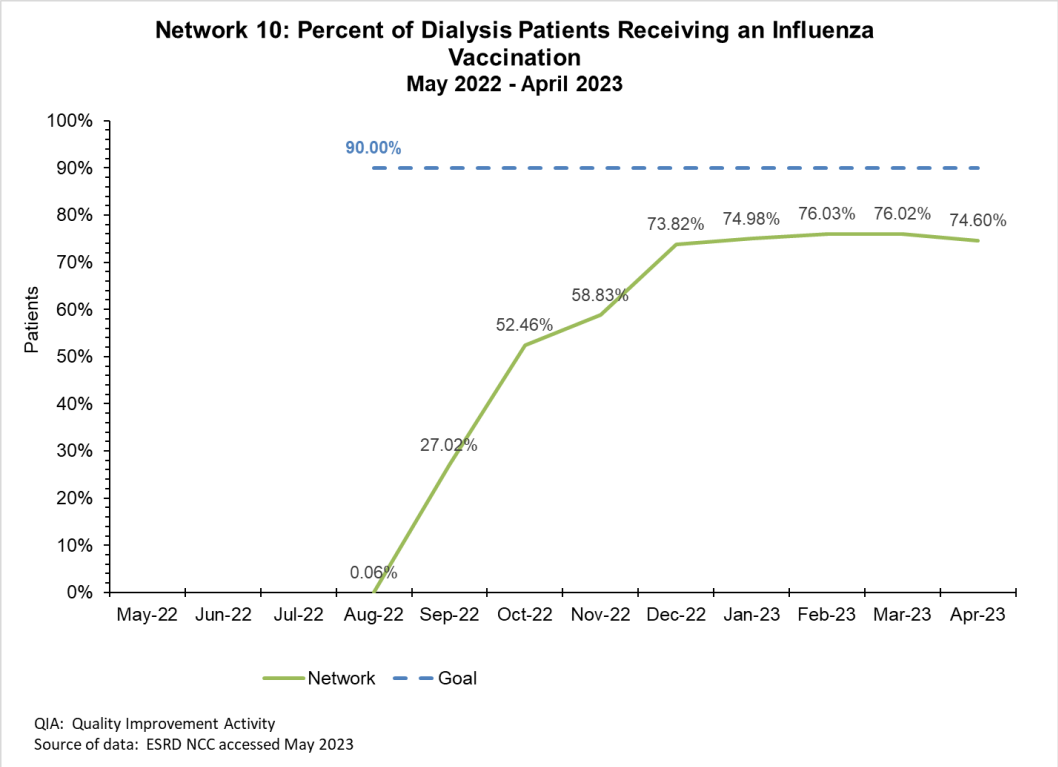


Graph14- Prevalent Patients Moving to a Home Modality May '22 to Apr '23

Influenza Vaccinations (Patient and Staff) May 2022-April 2023

ESRD Network programs were tasked with achieving 90% of dialysis patients receiving an influenza vaccination based on EQRS data by the end of the option period.

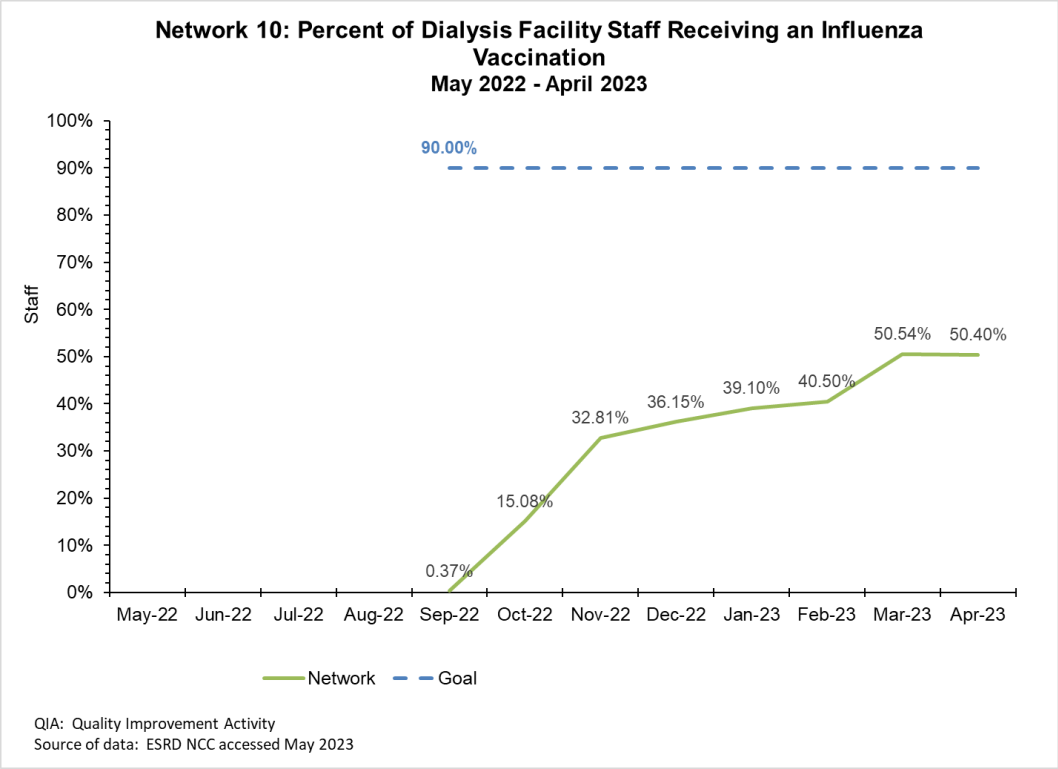
A rigorous Flu Campaign was run from the months of August 2022 through April 2023 to encourage both patients and dialysis staff to receive the vaccination. Monthly newsletters including resources about the importance of the influenza vaccine, vaccine burnout, tips for talking to patients, CDC guidelines, and reasons for patients and their family members to choose to be vaccinated. Resources were offered in both English and Spanish as about 13% of Illinois' population are primarily Spanish speaking according to the 2020 U.S. Census. Technical support and assistance was provided ongoing for clinics to ensure proper entry of vaccination. Individualized support was needed to ensure valid data entry particularly in cases where patients both reside in a nursing home and receive dialysis treatment in the nursing home setting, when the dialysis provider does not administer the vaccine, but the nursing home does. Process improvement plans developed through identification during technical assistance were rolled out to facilities with a barrier related to data entry of vaccinations given in another setting. Despite great efforts, the Network was unable to achieve the goal set forth for influenza vaccination in the base period (Graph 15).



Graph15- Percent of Patients Receiving an Influenza Vaccination May '22 to Apr '23

The ESRD Network Statement of Work required networks to ensure a minimum of 90% of dialysis facility staff receive an influenza vaccination annually, measured using National Healthcare Safety Network (NSHN) data for the entire task order period of performance.

Rates for dialysis staff fell even lower with a rate of only about 50% of staff vaccinations being captured in NSHN (Graph 16). Ongoing technical assistance was provided to facilities with high rates of healthcare personnel without documented influenza vaccines. Large Dialysis organizations batch submit much of their data and facility level staff are sometimes unable to make changes in the systems or override the batched data. No network in the program was able to achieve this metric in this performance period.



Graph16- Percent of Dialysis Staff Receiving an Influenza Vaccination May '22 to Apr '23

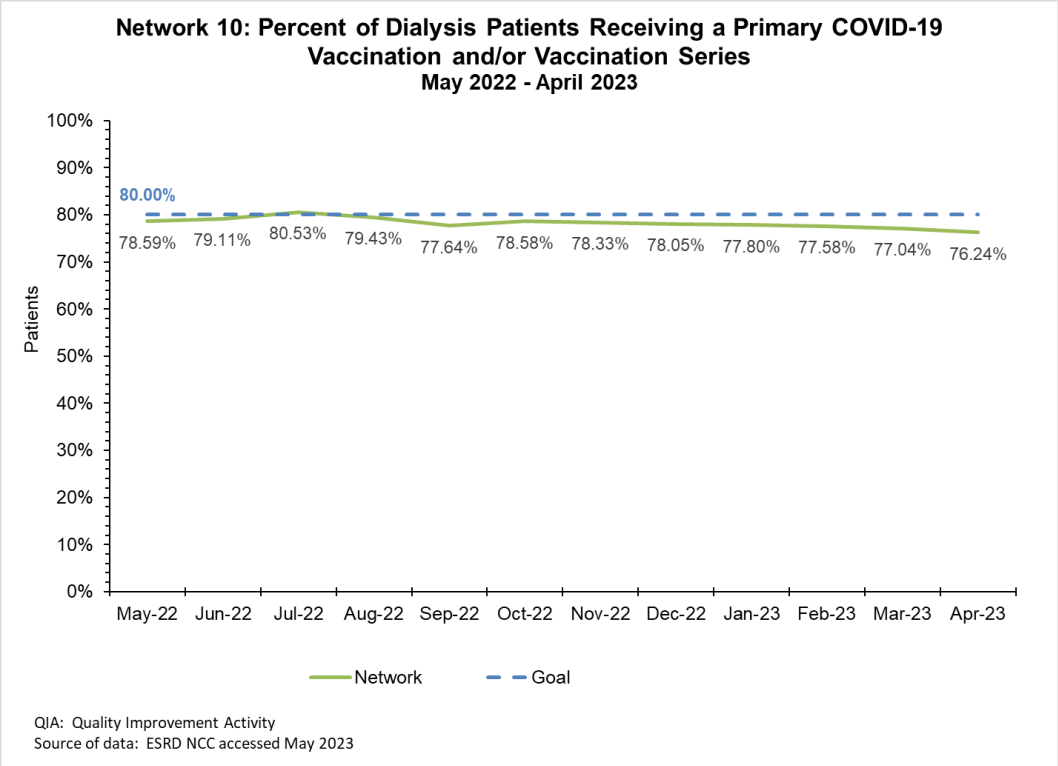
COVID-19 Vaccinations (Patients and Staff) May 2022-April 2023

ESRD Networks were expected to achieve 80% COVID-19 Vaccination Rate for dialysis patients for primary vaccination and/or series and 100% of dialysis staff to be vaccinated against COVID-19 in the option period. Many methods of intervention and education were completed toward this effort, including but not limited to, monthly broad education to the Network including both patient and staff educational resources, flyers, short videos, webinars, printed materials mailed to facilities, printable posters and handouts, continued updates via weekly email from the CDC and local health departments, targeted technical assistance using county level information on COVID rates, and motivational interviewing instruction in order to increase vaccine uptake.

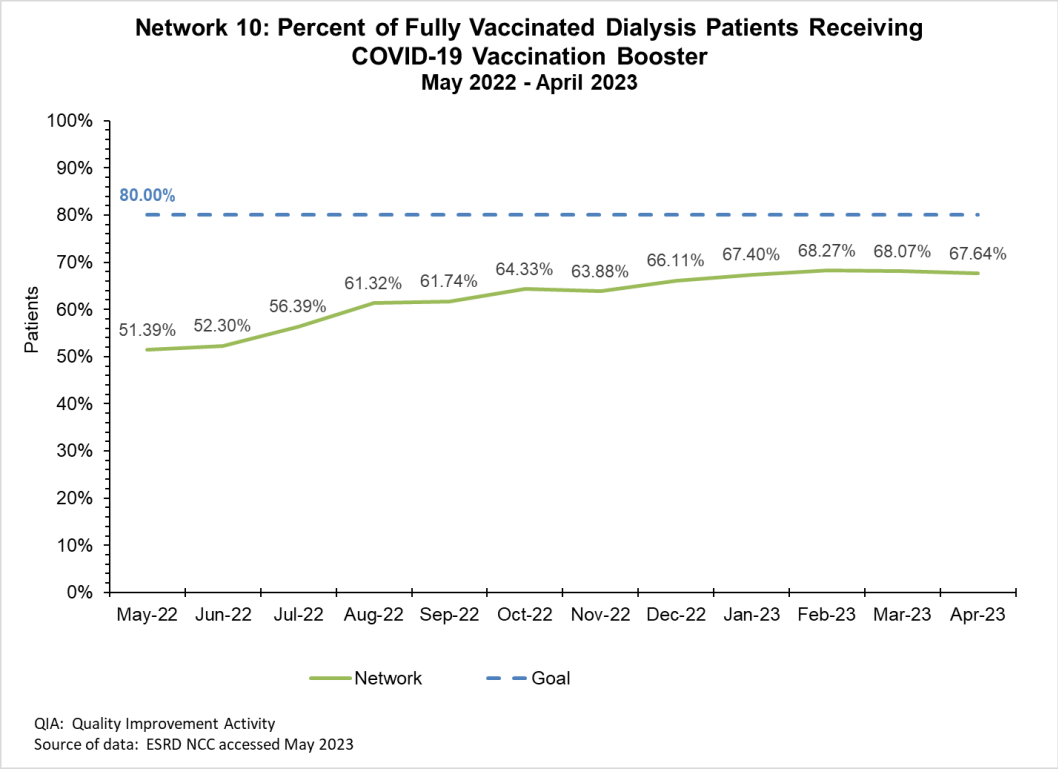
Ongoing technical assistance was provided based on data from the ESRD NCC and from NHSN. Barriers identified included misinformation regarding reporting requirements, high percentages in some facilities of patient receipt of vaccine or booster charted as unknown, initial series complete but no interest in additional boosters, patient and staff fear of death decreased due to better treatments and the availability of new drugs, and overall vaccine burnout.

Graphs 17-20 illustrate the results of this quality improvement activity, showing that Network 10 did not meet these metrics. Primary vaccination series for patients was near goal at 76.24% (Graph 17) with boosters dropping to 67% (Graph 18).

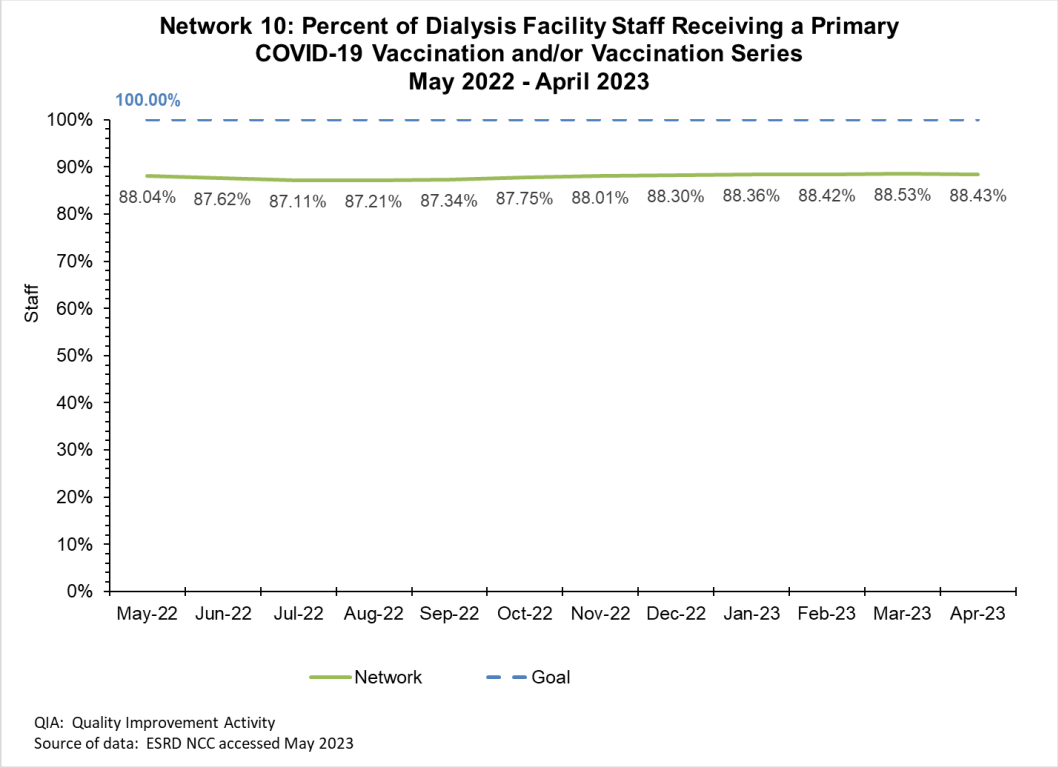
Over 88% of dialysis staff were charted as having a primary vaccine series which fell short of the 100% goal (Graph 19). Boosters for staff were entered into NHSN at a low rate of only 35.68% (Graph 20). At a national level, the Network program worked to mitigate these issues with the Large Dialysis Organizations to improve submission rates to no avail.



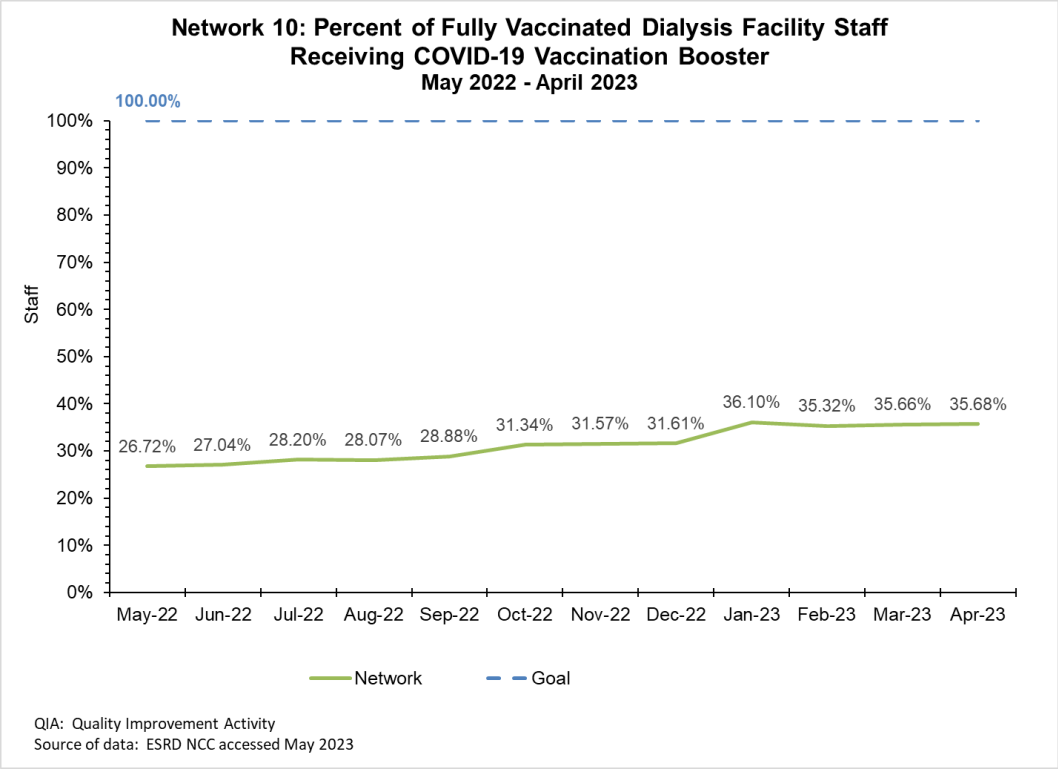
Graph 17- COVID Vaccination Rate for Dialysis Patients May '22 – Apr '23



Graph 18- COVID Vaccination Booster for Dialysis Patients May '22 – Apr '23



Graph 19- COVID Vaccination Rate for Dialysis Staff May '22 – Apr '23



Graph 20- COVID Vaccination Booster Rate for Dialysis Staff May '22 – Apr '23

Data Quality (Admissions, CMS Form 2728, CMS Form 2746) May 2022-April 2023

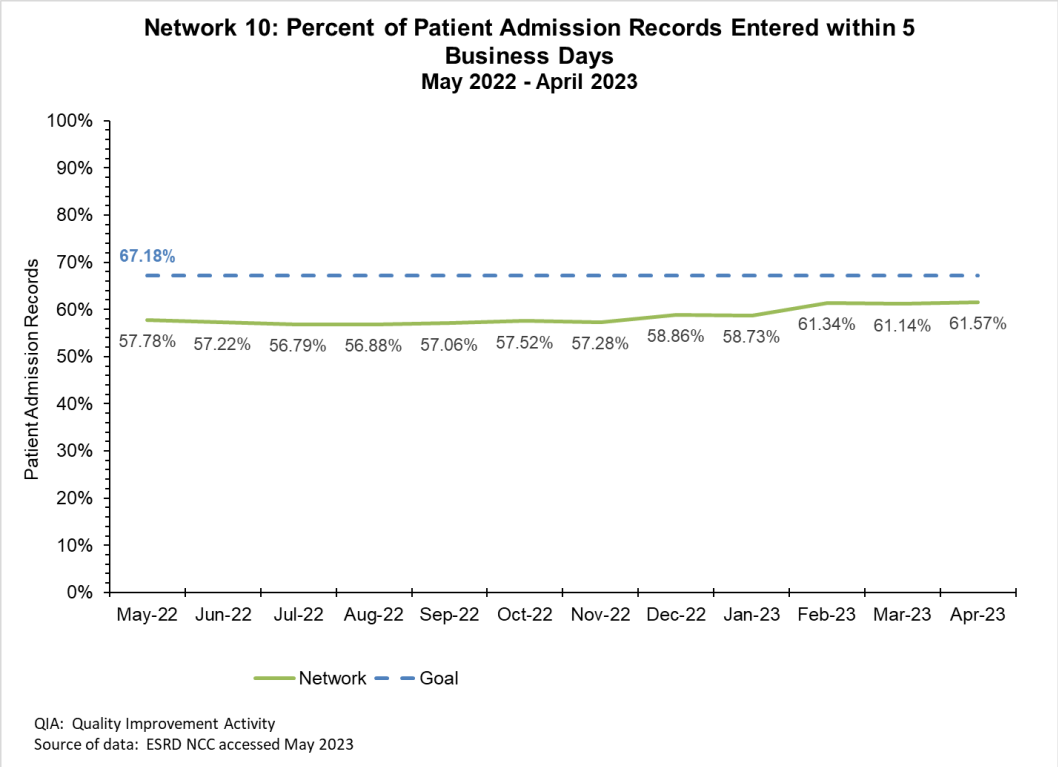
ESRD Network goals for data quality in the option period include the following:

- Achieve a total 5% increase in the rate of patient admission records from dialysis facilities entered within 5 business days from the baseline to the end of the option period
- Achieve a total 4% increase in the rate of initial CMS-2728 forms submitted from dialysis facilities within 45 days from the baseline to the end of the option period
- Achieve a total 5% increase in the rate of CMS-2746 forms submitted from dialysis facilities within 14 days of the date of death from the baseline to the end of the option period.

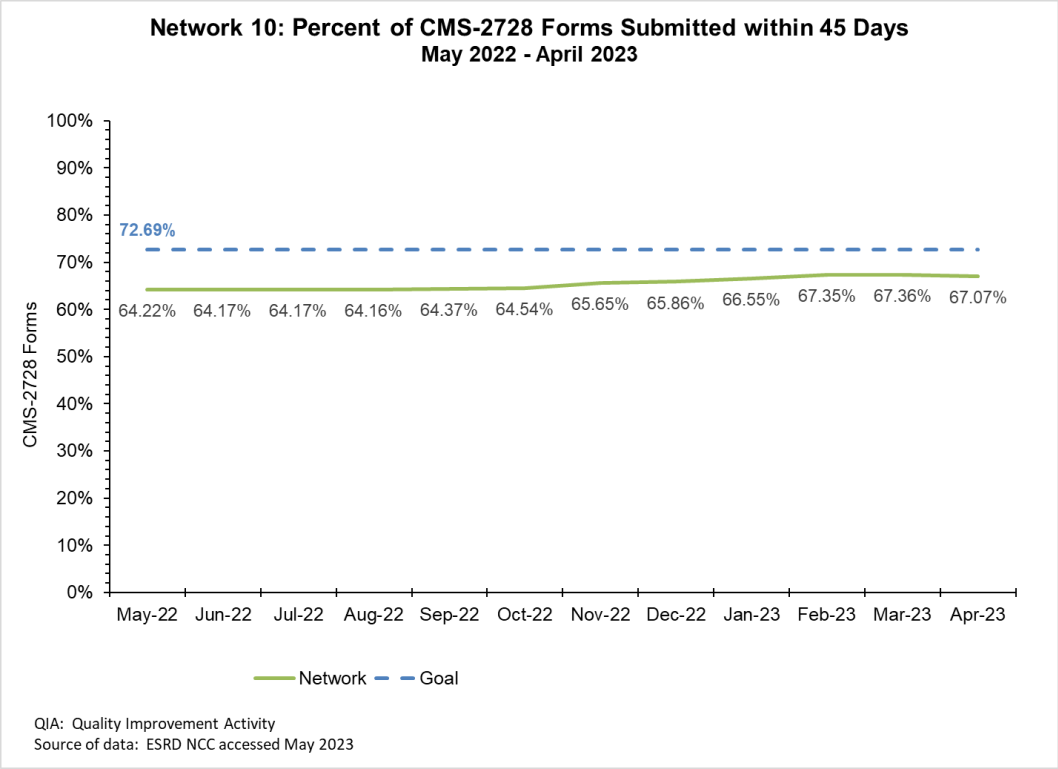
The Network used reports provided by the ESRD NCC to ensure accuracy of data in EQRS to provide technical assistance to individual facilities to validate and correct patient information. The Network worked with both individual clinics and batch submitting organization in these concentrated efforts. The Network participated with CMS in calls and workgroups to discuss maintenance of the registry and barriers, challenges, and solutions to the data quality metrics. The Network audited 20% of the dialysis facilities in the network service area including patient medical records to ensure the accuracy of the information on CMS-2728 forms and CMS-2746 forms in EQRS and performed routing and acute termination reports for the Social Security Administration.

Graphs 21, 22, and 23 display the available data toward these efforts at the end of the option period.

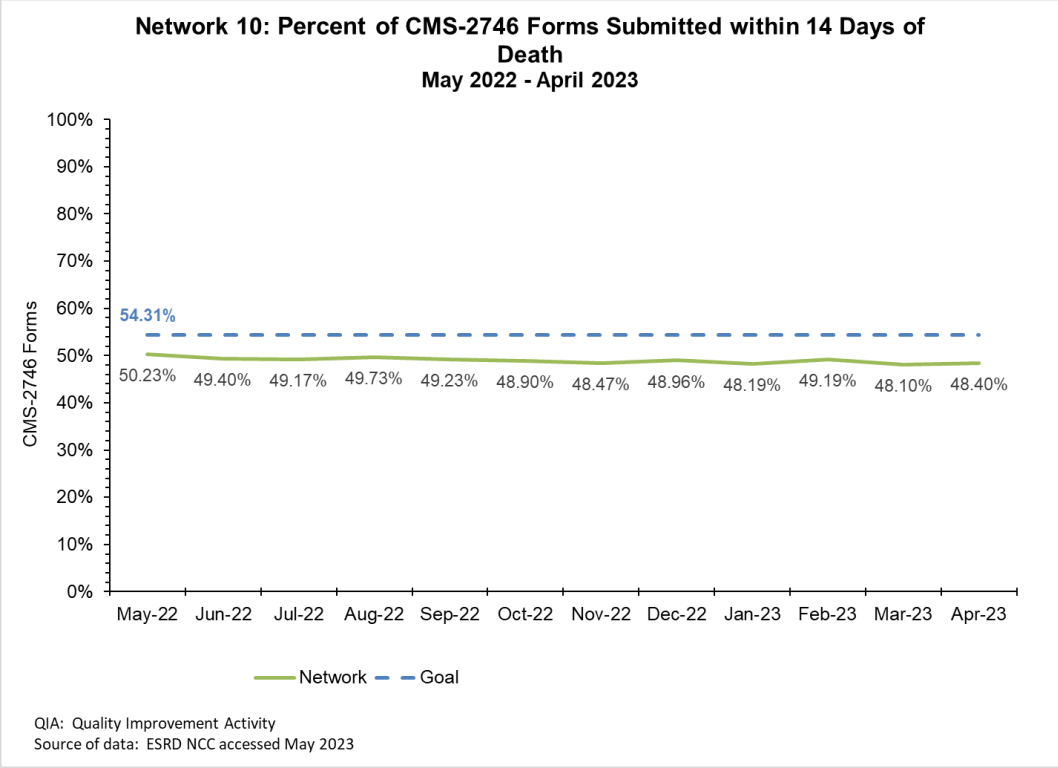
It is noted that the goals for patient admission records entered within 5 business days and the increase in rate of initial 2728 forms submitted within 45 days were omitted from the option period 1 evaluation via contracting officer notification dated March 29, 2023.



Graph 21- Admission Data Entered within 5 Days



Graph 22- CMS-2728 Forms Submitted within 45 Days



Graph 23- CMS 2746 Forms Submitted within 14 Days of Death

Hospitalization (Inpatient Admissions, ED Visits, Readmissions and COVID-19 Admissions) May 2022-April 2023

ESRD Networks were assigned four metrics related to reduction of hospitalization for ESRD patients which included the following:

- Achieve a total 5% decrease in hospital admissions for the Primary Diagnosis Categories identified by CMS from the baseline to the end of the option period.
- Achieve a total 5% decrease in hospital 30-day unplanned readmissions for a diagnosis from the Primary Diagnosis Categories identified by CMS following an admission for a diagnosis from the Primary Diagnosis Categories from the baseline to the end of the option period.
- Achieve a total 5% decrease in outpatient emergency department visits for a diagnosis on the Primary Diagnosis Categories identified by CMS from the baseline to the end of the option period.
- Achieve a 25% decrease in the number of COVID-19 hospitalizations in the ESRD patient population with Medicare FFS as a payer source based on Medicare Claims data.

The Hospitalization Community Coalition continued forward from the base period and new members were added as high performing experts in the subject matter to assess local issue pertinent to hospitalizations and readmissions and to assist in creation of interventions to drive a 4-month PDSA cycle for focus groups who need targeted assistance in these areas.

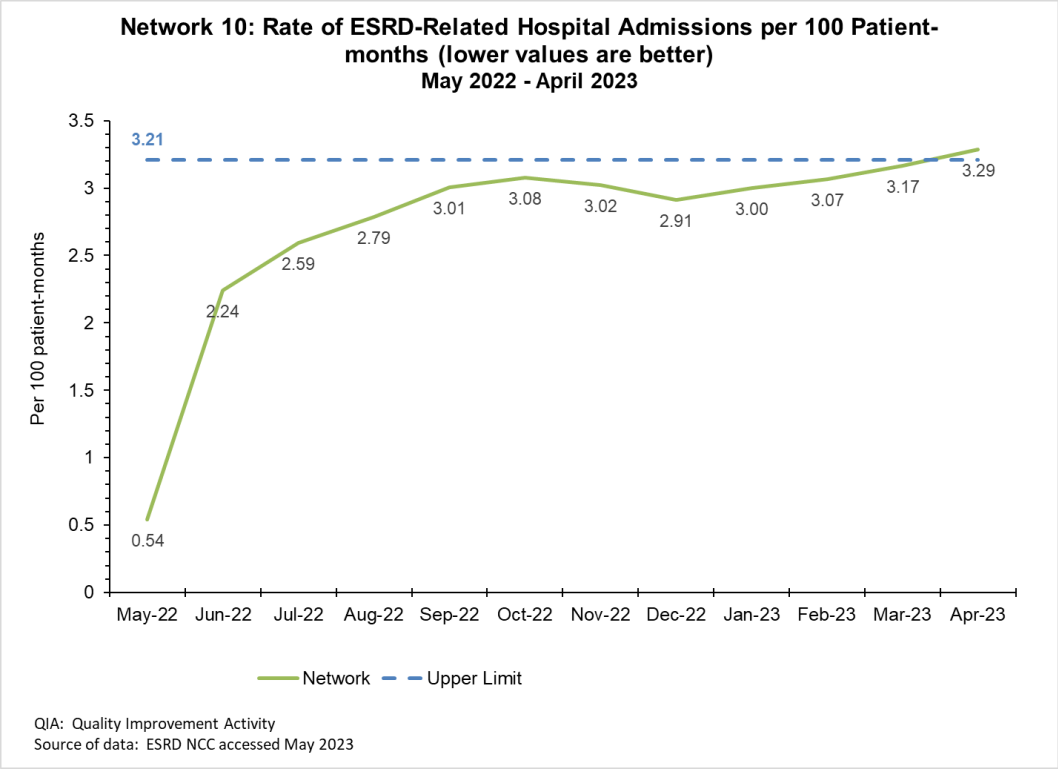
Throughout the course of the option period, low performers were provided with technical assistance using data from the ESRD NCC to assess need. Best practices identified through the coalition and focus groups were spread throughout the entire network service area for greater uptake of successful interventions.

COVID Hospitalization continued to be a major concern during this period and the Network facilitated interventions using real-time feedback from Nephrologists and hospitalists in the region, updates from the Illinois Department of Public Health, Cook County Health Department, local emergency management groups, and the Kidney Community Emergency Response team. Barriers were identified and interventions were deployed with quick turn-around for maximum efficacy.

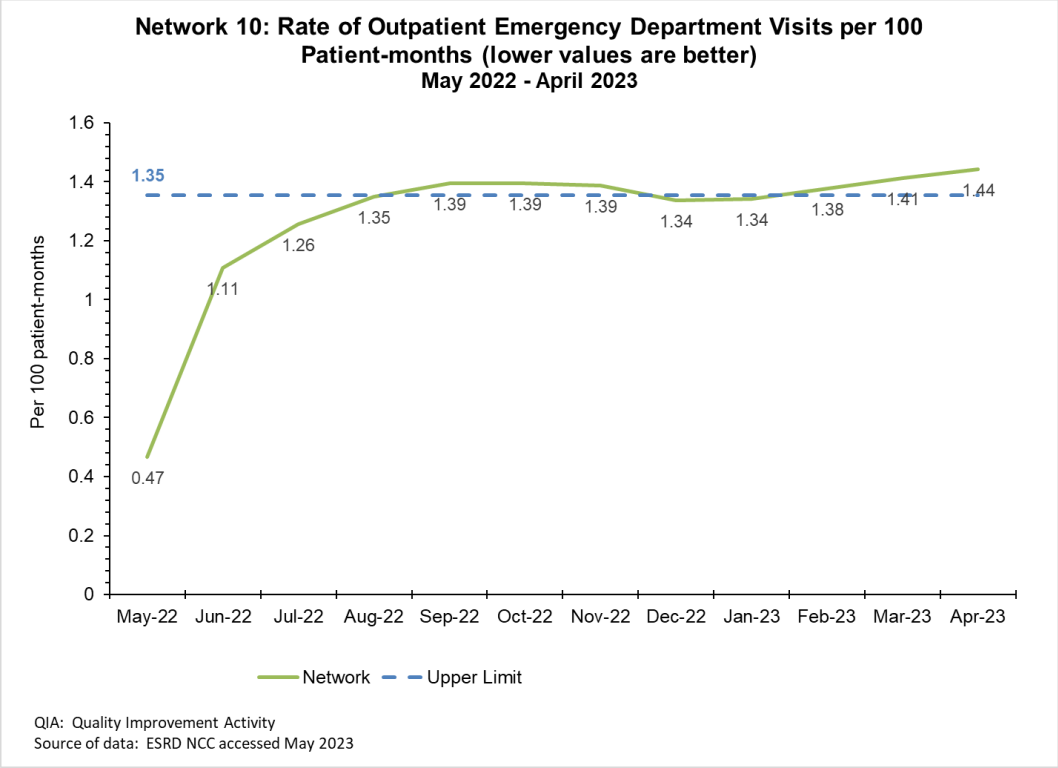
The Network created several supporting resources in the base period with input from the community coalition, medical review board, and patient advisory council including hospital transfer summary sheet, pocket ID cards for dialysis patients, patient guide for how to choose between the doctor's office, urgent care, or the emergency room, a hospitalizations workbook for patients, and numerous COVID-19 resources for control, management, and vaccination. These resources were edited and rebranded during the current option period and some were re-reviewed by the patient advisory council and medical review boards. Adaptations were made to improve meaningful use. These supporting resources are available on the ESRD Network 10 website.

As illustrated in the following graphs 24- 27 (lower rates are better), Network 10 was able to maintain two of these four metrics below the upper allowable limit throughout the option period, seeing upward trends near the close of the period beginning in February 2023 for hospital admissions and emergency department visits.

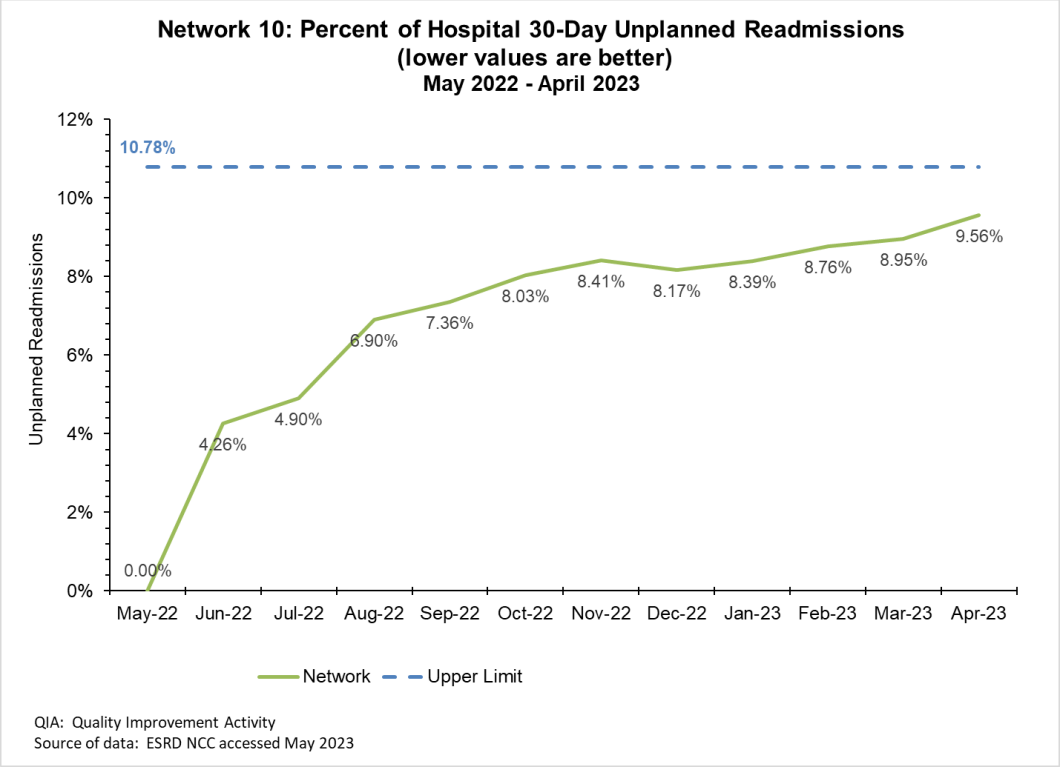
It is noted that the goal to achieve a total of 5% decrease from baseline to the end of the option period in hospital admissions from the primary diagnosis categories and the 25% decrease in COVID hospitalizations were omitted from the Option Period 1 evaluation without fault via contracting officer notification dated June 1, 2023.



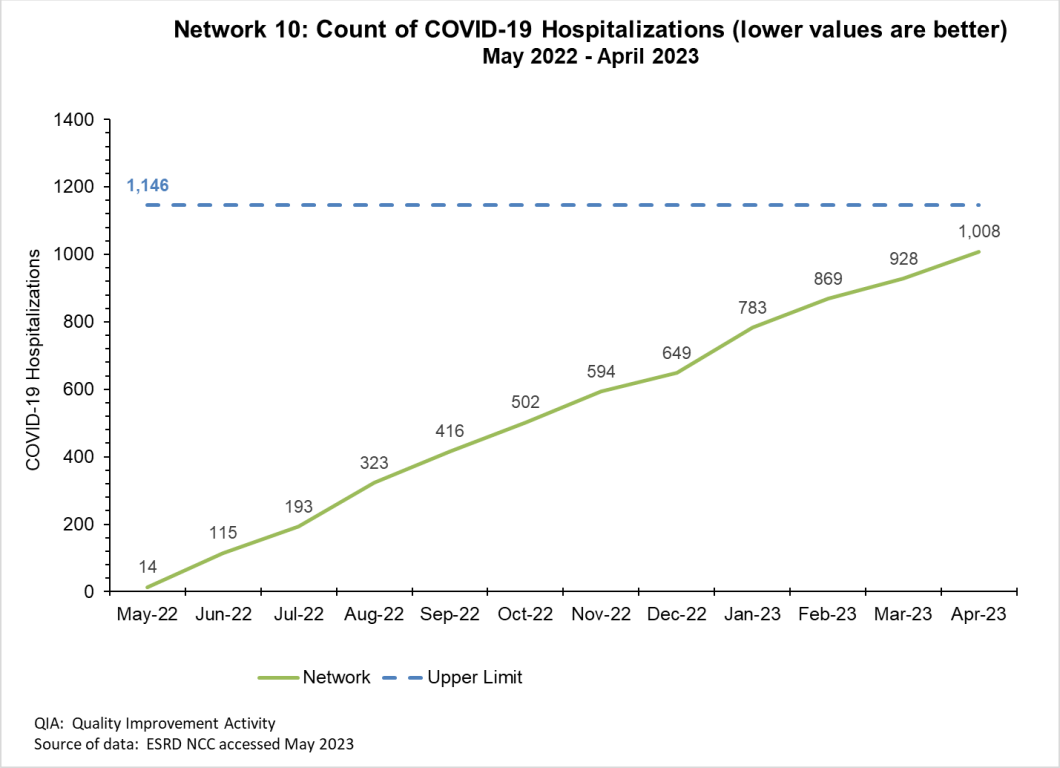
Graph 24- Rate of ESRD-Related Hospital Admissions per 100 Patient-months



Graph 25- Outpatient Emergency Department Visits per 100 Patient-months



Graph 26-Hospital 30-Day Unplanned Readmissions



Graph 27- COVID-19 Hospitalizations May '22 to Apr '23

Depression Treatment September 2022-April 2023

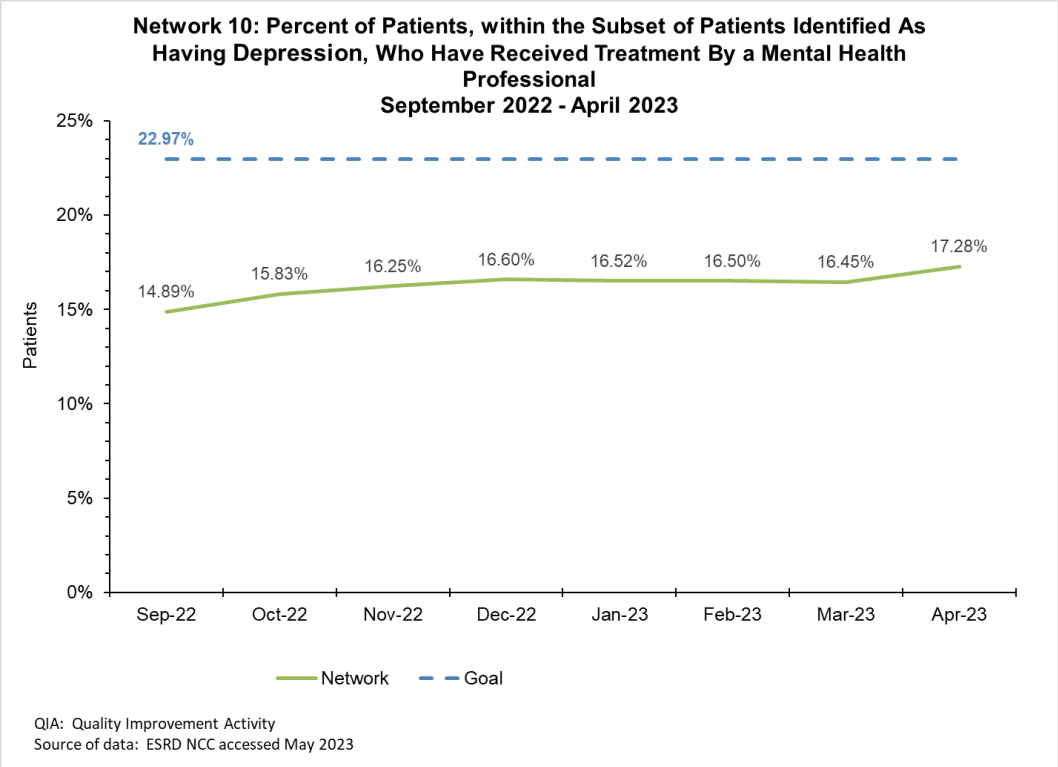
CMS set a goal for the ESRD Networks to achieve a total 20% increase in the percentage of patients, within the subset of patients identified as having depression, who have received treatment by a mental health professional from the established baseline to the end of this option period.

The ESRD Network 10 quality improvement team began working toward this goal by first identifying the following barriers:

- Social workers in dialysis facilities are burdened with high caseloads due to staffing shortages, causing delays in referral or follow up post-depression screening
- Batch submission data does not always match what was entered in facility EMR system for depression screening and options in EQRS
- Treatment availability is an issue with long wait times and lack of access in some communities
- Some patients may be receiving treatment that is unable to be identified by the data source for Medicare Part B claims, i.e. community resources, faith-based counseling, etc.

Mitigation efforts for these barriers were identified by the Network 10 Behavioral Health Community Coalition and included more focused work with smaller group of social workers who could test change and then spread best practices to already time constrained colleagues, one-on-one technical assistance with facilities to review accurate screening data from EMR to EQRS, encouraging facility staff to identify other options for patient support when wait times for mental health providers are too long, and working with the coalition to identify resources for Medicare and Mental Health Benefits providers. Resources created with the community coalition, patient advisory council, and behavioral health experts for improvement in this area of focus can be found on the Network 10 website.

It is noted that data was not available for the full option period and this metric was omitted from the evaluation for the option period at no fault per a contracting officer notification dated June 1, 2023.



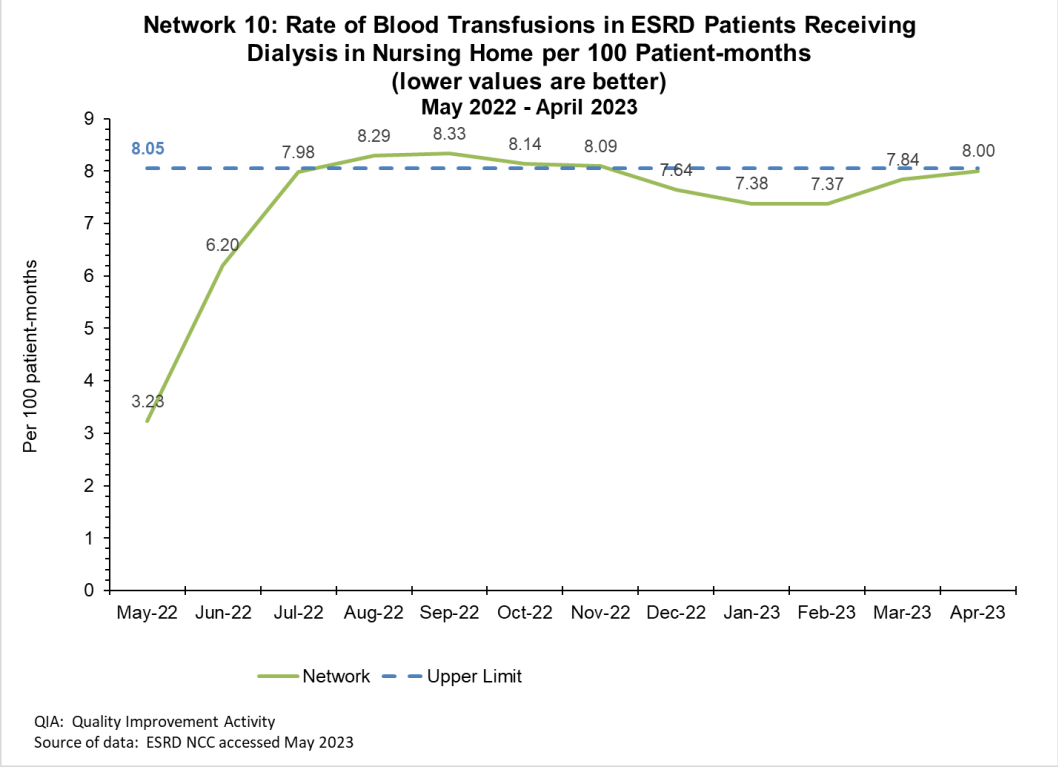
Graph 28- Percent of Depression Positive Patients Receiving Treatment Sept '22 – Apr '23

Nursing Home (Blood Transfusion, Catheter Infection, and Peritonitis) May 2022-April 2023

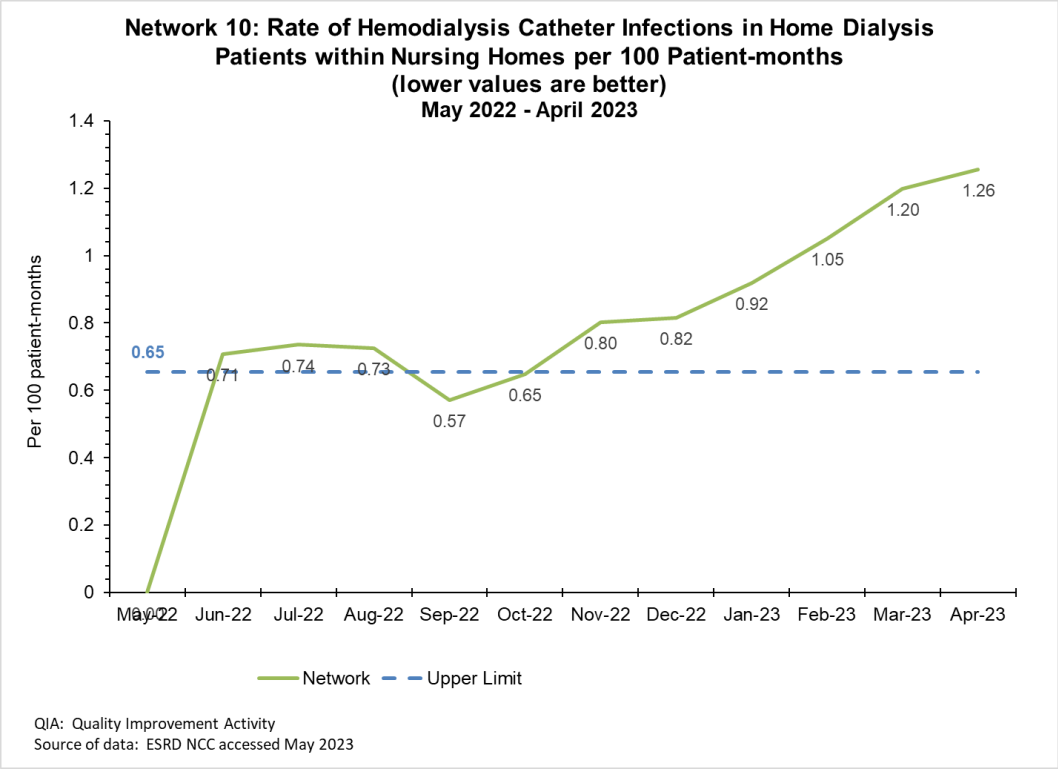
Goals for this metric included a 10% total decrease over baseline in the hemodialysis catheter infection rate in dialysis patients receiving home dialysis in a nursing home, a 5% total decrease in the incidence of peritonitis in dialysis patients receiving home dialysis in a nursing home, and a 5% total decrease in the rate of dialysis patients receiving dialysis at nursing homes that receive a blood transfusion from baseline to the end of the base period.

Network 10 worked through the Care in Nursing Homes Community Coalition to identify barriers that impact the targeted population. Barriers were ranked from most to least urgent, and interventions were developed with the community coalition through the PDSA cycle, with the top-rated issues being addressed in the first cycle, and so forth. Applicable providers, those providing dialysis care to residents in the NH setting, were given time to utilize resources, implement suggested interventions, and provide feedback to measure progress and perform rapid cycle improvement. That data was brought back to the community coalitions and either adopted, adapted or abandoned. Technical assistance was provided using a Network-developed *TA Checklist,* assessing needs related to access infections, both central venous catheter and peritoneal catheter, and anemia management. The Network provided individualized strategy plans and supporting resources to aid in success with these metrics. Quarterly, the Network shared a QI Connect e-Newsletter containing resources and interventions from all Objectives and Key Results including the most highly rated and beneficial resources as reported by facility staff.

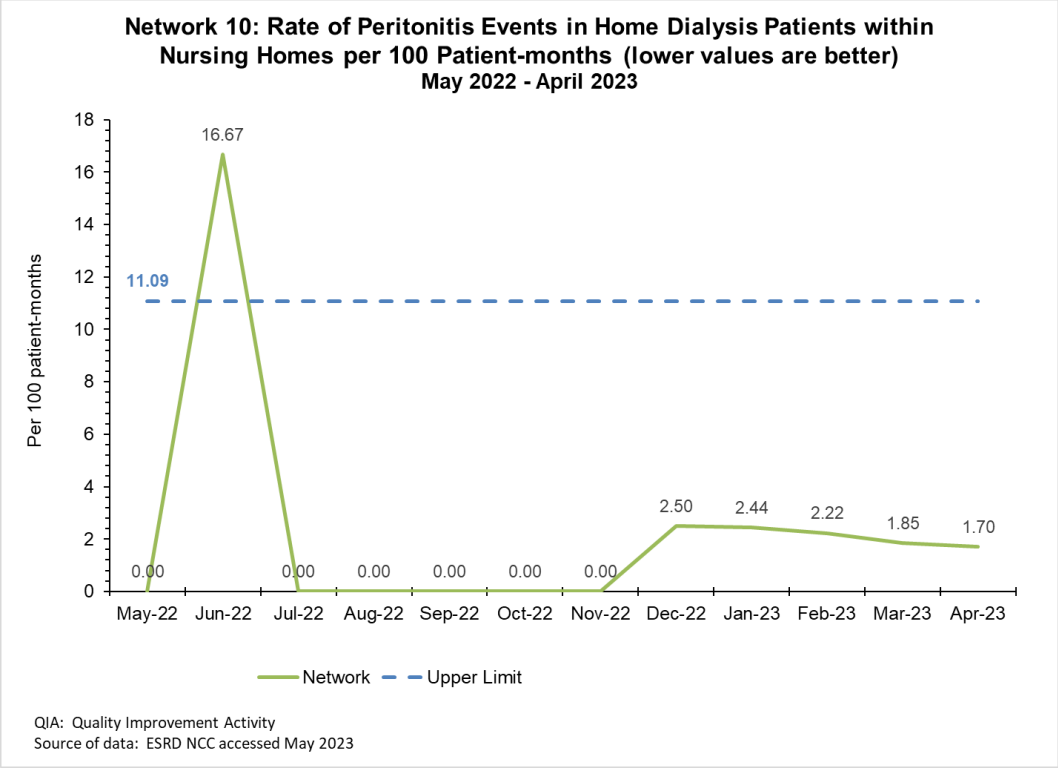
The following graphs depict the final data for the period, with achievement in blood transfusion and peritonitis (Graph 29 and 31, respectively). Catheter infection goals were not achieved (Graph 30) despite close monitoring of large nursing home dialysis provider and monthly one-on-one review of patient data and a robust process improvement plan in place. The Network hopes to see the fruition of those efforts in the forthcoming option period.



Graph 29- Rate of Blood Transfusion in ESRD Patients Receiving Dialysis in Nursing Home May '22 to Apr '23



Graph 30- Hemodialysis Catheter Infections in Home Dialysis Patients within Nursing Homes May '22 to Apr '23

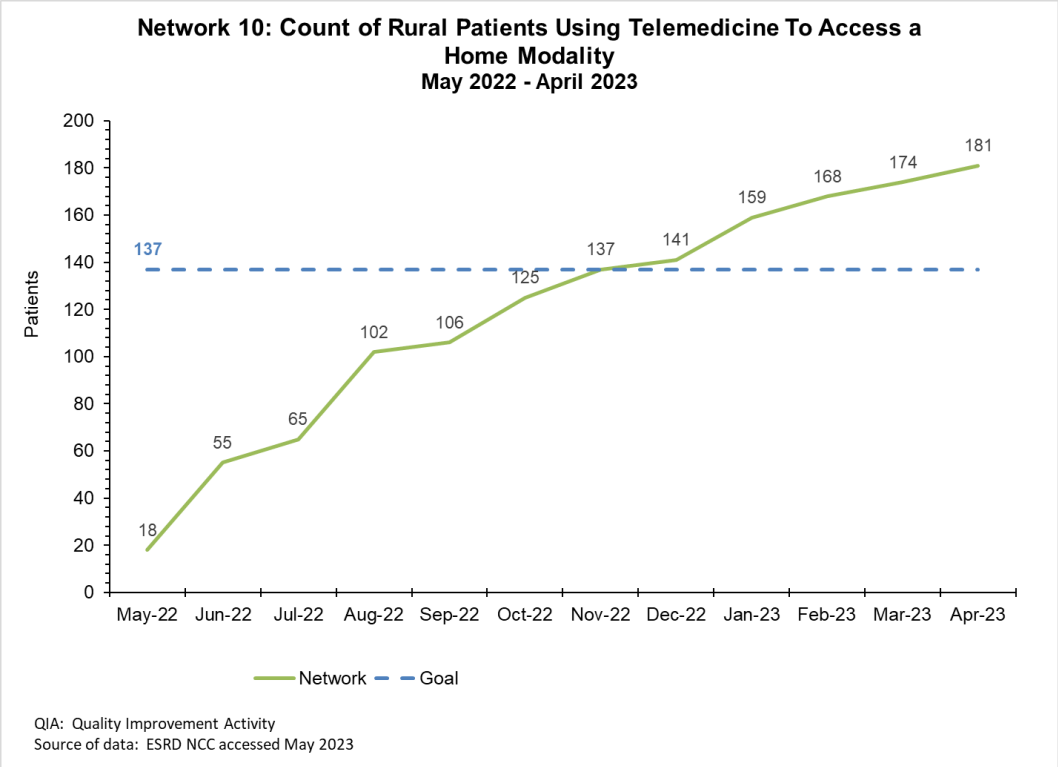


Graph 31- Peritonitis Events in Home Dialysis Patients within Nursing Homes May '22 to Apr '23

Telemedicine May 2022-April 2023

ESRD Networks worked toward a goal of 5% total increase in the number of rural ESRD patients using telemedicine to access a home modality based on EQRS from baseline to the end of the option period. The Network employed strategies including use of the Home Modality Community Coalition, Home Modality Change Packages from the ESRD National Coordinating Center, Qsource ESRD Networks' Telehealth Passport developed by our quality improvement team, continued support for patients through our Patient Advisory Council and Peers in Action groups, and monthly resources to focus facilities. Identified best practices were shared network-wide and technical assistance was provided to facilities in need.

Graph 32 illustrates that Network 10 exceeded the goal for telemedicine usage.



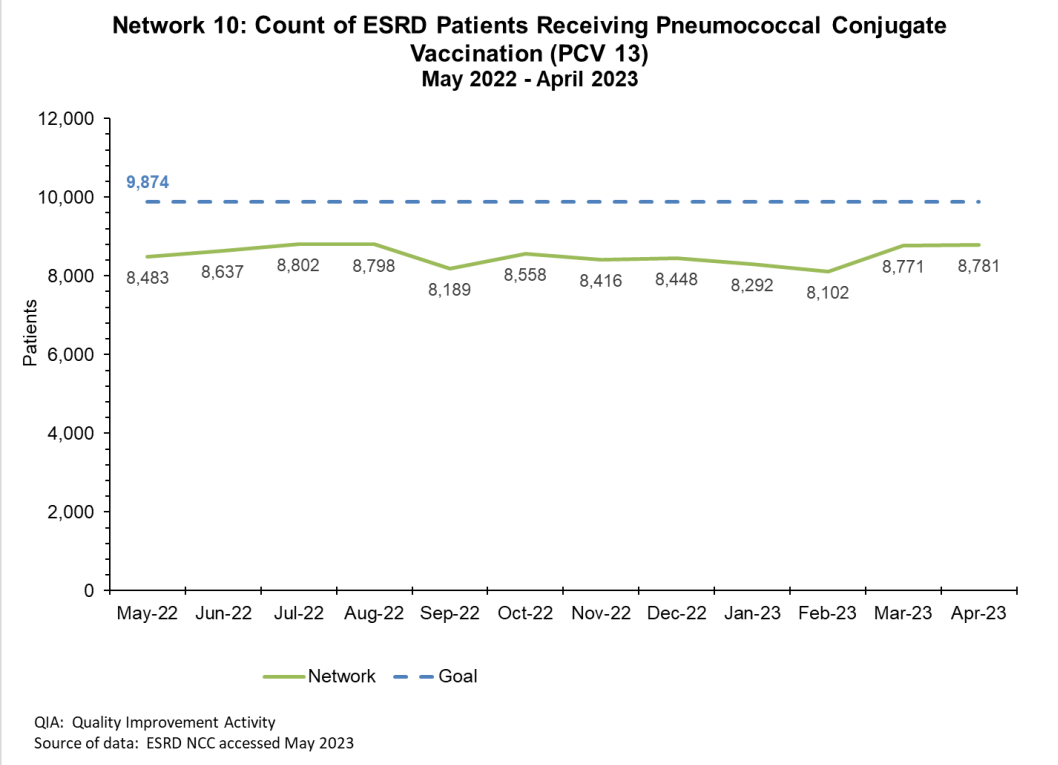
Graph 32- Number of Rural ESRD Patients Using Telemedicine May '22 to Apr '23

Pneumococcal Vaccinations (PCV13 & PPSV23) May 2022-April 2023

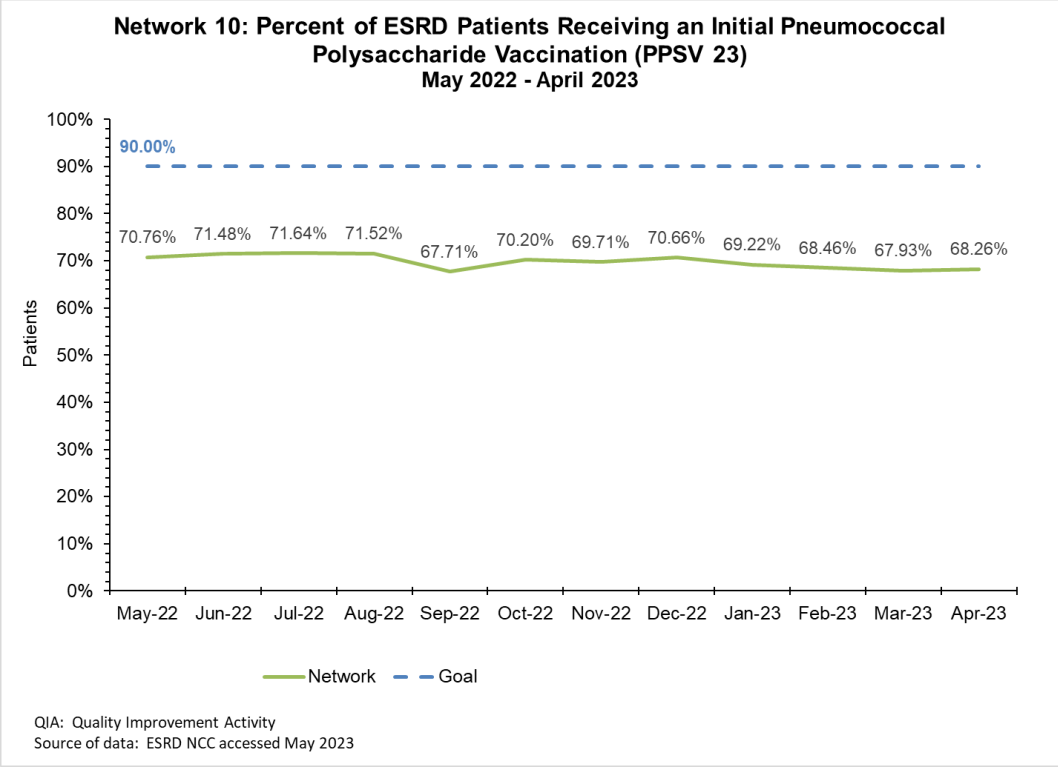
ESRD Networks were tasked with increasing by an additional 10% from base year the number of dialysis patients receiving a pneumococcal conjugate vaccination (PCV 13) based on EQRS data over the option period. In addition to the PCV 13, Networks were expected to ensure dialysis patients receive the full series of PPSV 23 as age appropriate, with a minimum of 90% of dialysis patients receiving by the close of the option period. An additional 10% increase in the number of patients receiving a booster for PPSV23 from the base year and 85% of dialysis patients over the age of 65 receiving a PPSV 23 vaccination were also part of this metric.

The Network worked through the Network 10 Vaccination Coalition on pneumococcal in a similar fashion as the vaccination metrics for influenza and COVID-19. Technical assistance was provided based on data from the ESRD NCC and best practices were shared network-wide.

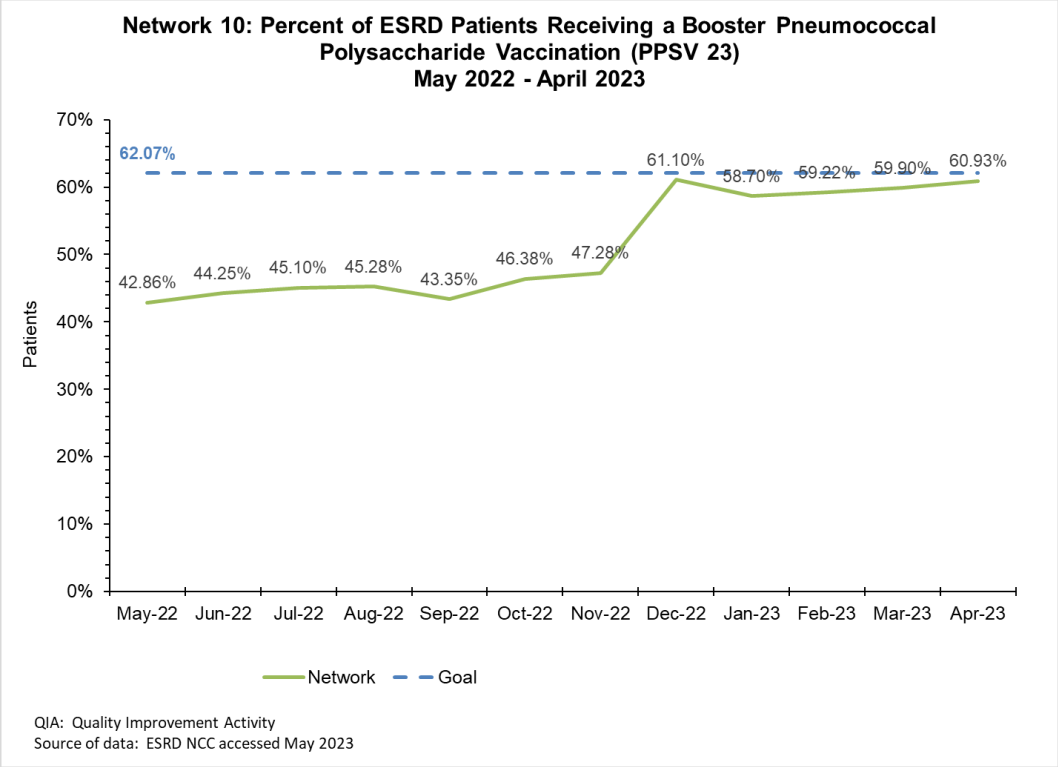
It is noted that these metrics were omitted from the annual evaluation by way of contracting officer notification dated March 29, 2023 without fault of the contractor.



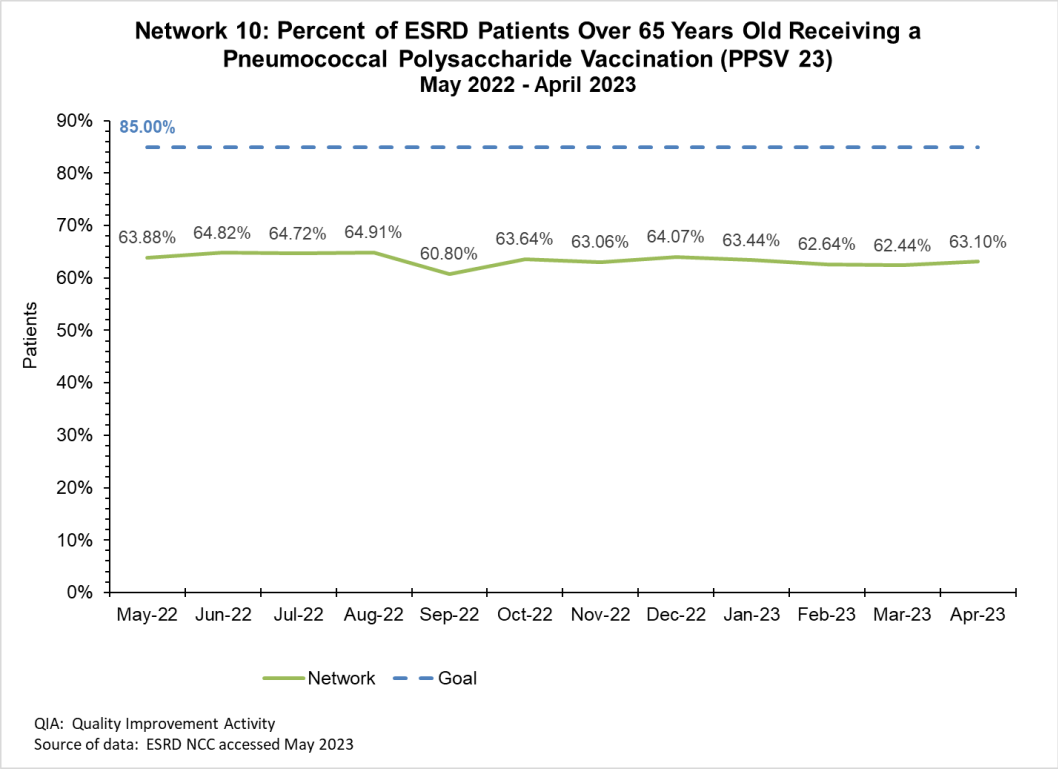
Graph 33- ESRD Patients Receiving Pneumococcal Conjugate Vaccination May '22–Apr '23



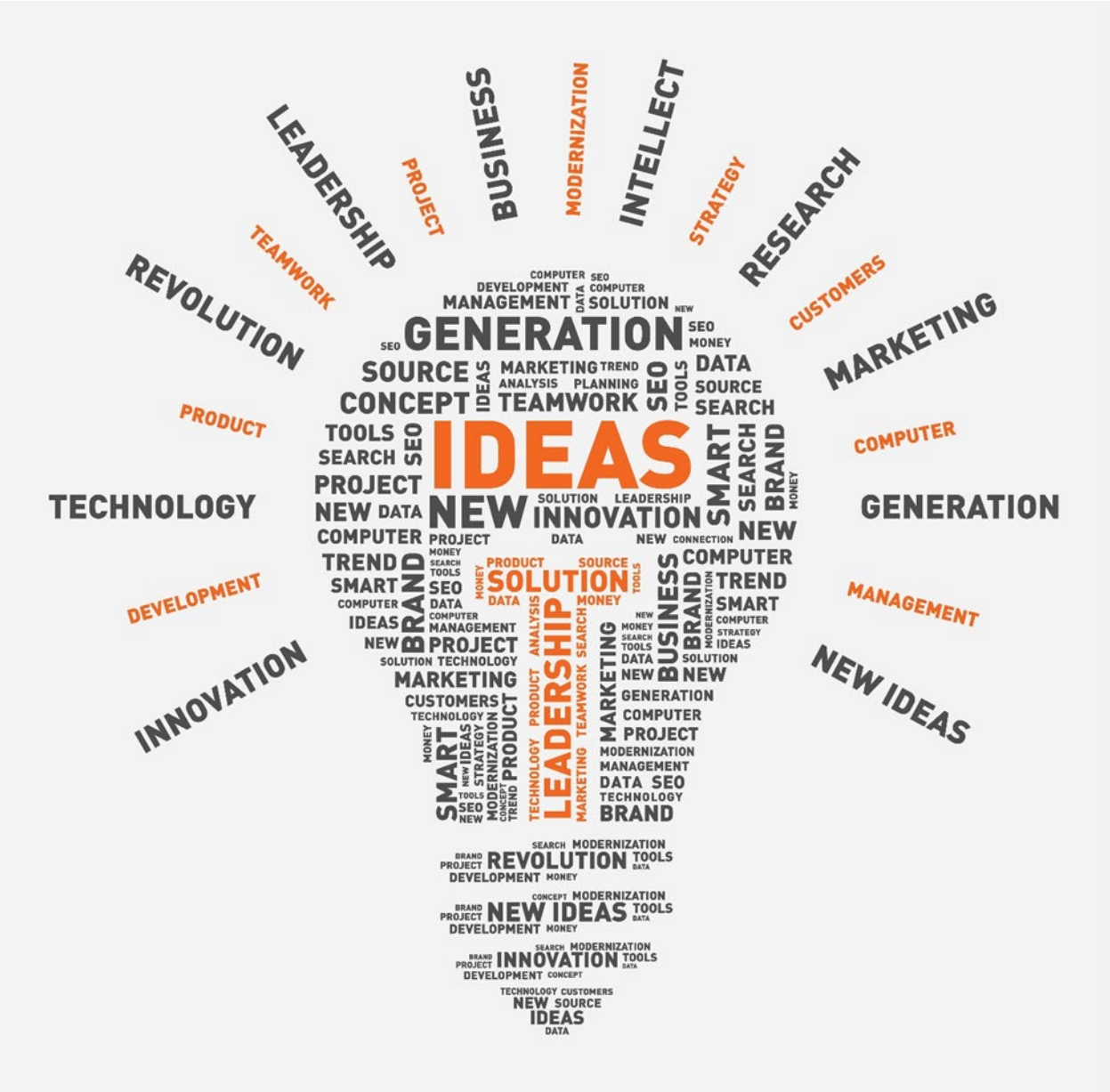
Graph 34- Percent of ESRD Patients Receiving Initial Pneumococcal Polysaccharide Vaccination May '22–Apr '23



Graph 35- Percent of ESRD Patients Receiving Booster Pneumococcal Polysaccharide Vaccination May '22–Apr '23



Graph 36- Percent of ESRD Patients over 65 Receiving Pneumococcal Polysaccharide Vaccination May '22–Apr '23


LEADERSHIP
PROJECT
BUSINESS
MODERNIZATION
INTELLECT
STRATEGY
RESEARCH
TEAMWORK
REVOLUTION
CUSTOMERS
MARKETING
PRODUCT
COMPUTER
TECHNOLOGY
GENERATION
DEVELOPMENT
MANAGEMENT
INNOVATION
NEW IDEAS
IDEAS
NEW
SOLUTION
LEADERSHIP
GENERATION
REVOLUTION
NEW IDEAS
INNOVATION

ESRD Network Recommendations

ESRD Network 10 made no recommendations for sanctions during this period.

ESRD Network 10 made no recommendations for new services during this period.


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

ESRD Network COVID-19 Emergency Preparedness Intervention

Facilities that are impacted by emergencies, unexpected closings or schedule changes complete an online survey to explain the situation, how many patients and staff were impacted, current statues and any other valuable information. Network staff is alerted and follow up, as necessary.

During the Annual Network Council meeting, information is shared with attendees about their role in an emergency and the Network's role. The Network also has a specific emergency email address and the Network main email address for reporting. Technical assistance is provided to dialysis facilities upon request to develop comprehensive and feasible emergency disaster plans.

The Network meets quarterly with LDO leadership and emergency preparation, and reporting is a standing agenda item. The Network communicates routinely with local/state health departments. Network staff reaches out to emergency contacts at minimum bi-annually, and as needed, for emergencies. Contact information is routinely updated in the Emergency Disaster Plan and shared with the Kidney Community Emergency Response team upon request and/or per the statement of work.

The annual KCER drill was held on February 22, 2022. Stakeholders included regional leadership from DaVita and Fresenius, regional emergency management SME, state survey agencies, and CMS representatives. An After-Action Report was submitted to CMS.

ESRD Network Significant Emergency Preparedness Intervention

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.

Should an emergency arise, the Network COR is immediately notified of any emergency. KCER and CMS KCER SME are notified of emergency situations as needed and updates are provided until the situation is resolved.

There were no significant events that occurred in Network 10 that initiated an ESSR during this option period. Outreach is completed to any facility in an area where severe weather or another event that could initiate an ESSR has occurred.

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 especially the KPAC.

2728 ESRD Medical Evidence Report
2744 Annual Facility Survey Form
2746 Death Notification Form

A
AAKP American Association of Kidney Patients
AAMI Association for the Advancement of Medical Instrumentation
ACO Accountable Care Organizations
AHCPR Agency of Health Care Policy and Research
AHRQ Agency for Healthcare Research and Quality
AHQA American Health Quality Association (QIOs)
AJKD American Journal of Kidney Disease
AKF American Kidney Fund
AKI Acute Kidney Injury / Acute Renal Failure
AMA American Medical Association
ANNA American Nephrology Nurses' Association
ARF Acute Renal Failure
ASN American Society of Nephrology
AV Arteriovenous
AVF Arteriovenous Fistulae
AVG Arteriovenous Graft

B
BAC Beneficiary Advisory Council (Forum) BFR Blood Flow Rate
BIC Beneficiary Identification Code
BIPA Benefits Improvement and Protection Act
BUN Blood Urea Nitrogen
BOD Board of Directors
BSA Body Surface Area
BSN Bachelor of Science in Nursing
BSW Bachelor of Social Work
BUN Blood Urea Nitrogen
BV Blood Volume

C
CAD Cadaveric Donor
CAHPS Consumer Assessment of Healthcare Providers and Systems
CAN Chronic Allograft Nephrology
CAPD Continuous Ambulatory Peritoneal Dialysis
CCHT Certified Clinical Hemodialysis Technician
CCl Creatinine Clearance
CCPD Continuous Cycling Peritoneal Dialysis
CCSQ Centers for Clinical Standards & Quality (CMS)
CCT Controlled Clinical Trial
CDC Centers for Disease Control and Prevention
CDE Certified Diabetes Educator
CDN Certified Dialysis Nurse
CDS Core Data Set

CEU Continuing Education Unit
CfC Conditions for Coverage
CHT Certified Hemodialysis Technician
CKD Chronic Kidney Disease
CME Continuing Medical Education
CMHCB Care Management for High Cost Beneficiaries
CMMI Center for Medicare and Medicaid Innovation (CMS)
CMO Chief Medical Officer
CMS Centers for Medicare & Medicaid Services CMSDC CMS Data Center
CMSW Certified Master of Social Work
CNN Certified Nephrology Nurse
CNSW Council of Nephrology Social Workers
CO Central Office (CMS)
COB Coordination of Benefits
COI Conflict of Interest
COPs Conditions of Participation
CPHQ Certified Professional in Healthcare Quality
CPM Clinical Performance Measures
CQI Continuous Quality Improvement
CQISCO Consortium for Quality Improvement & S & C Operations (CMS, Regional Offices)
CRI Chronic Renal Insufficiency
CROWN Consolidated Renal Operations in a Web-enabled Network
CRRT Continuous Renal Replacement Therapy
CSC Computer Sciences Corporation
CV Curriculum Vitae

D
DEPCH Division of ESRD, Population and Community Health (CMS)
DFC Dialysis Facility Compare
DHHS Department of Health and Human Services
DHIT Division of Health Information Technology (CMS)
DHR Department of Human Resources
DM Data Manager
DOPPS Dialysis Outcomes Practice Patterns Study
DON Director of Nursing
DOQI Dialysis Outcomes Quality Initiative
DPC Decreasing Dialysis Patient/Provider Conflict
DPMCE Division of Program, Management, Communication and Evaluation (CMS)
DQIIMT Division of Quality Improvement Innovations Model Testing (CMS)
DQM Division of Quality Measurement (CMS)
DRG Diagnosis Related Group
DTCP Division of Transforming Clinical Practices (CMS)
DVA Department of Veteran's Affairs
DVIQR Division of Value, Incentives & Quality Reporting (CMS)
DW Dry Weight

E
EC Executive Committee of the Network
ED Executive Director
EDAC Executive Director Advisory Council (Forum)
EDEES ESRD Data Entry and Editing System
eGFR Estimated Glomerular Filtration
EGHP Employer Group Health Plan
EHR Electronic Health Record

ELAB Electronic collection of lab data
eKt/V Equilibrated Kt/V (See Kt/V)
EOB Explanation of Benefits
EPO Epogen or Erythropoietin
EQRS ESRD Quality Reporting System
ESCO ESRD Seamless Care Organizations
ESRD End Stage Renal Disease
eSOURCE ESRD Software for our Users in Renal Care Environments

F
FDA Food & Drug Administration
FF Fistula First
FFBI Fistula First Breakthrough Initiative
FFS Fee For Service
FI Fiscal Intermediary
FMQAI Florida Medical Quality Assurance, Inc (QIO)
FNP Family Nurse Practitioner
FORUM Forum of ESRD Networks
FPR Final Project Report
FY Fiscal Year

G
GAO General Accounting Office
GFR Glomerular Filtration Rate
GTL Government Task Leader (CMS)

H
HAI Healthcare-Associated Infections
HbsAb Hepatitis B surface antibody
HbsAg Hepatitis B surface antigen
HBV Hepatitis B Virus
HCFA Health Care Financing Administration (Now CMS)
HCQIP Health Care Quality Improvement Program
HCT Hematocrit
HD Hemodialysis
HENs Hospital Engagement Networks
HGB Hemoglobin
HHA Home Health Agency
HHD Home Hemodialysis
HHS Department of Health and Human Services
HIC Health Insurance Claim
HIE Health Information Exchange
HIPAA Health Information Portability and Accountability Act
HIT Health Information Technology
HMO Health Maintenance Organization
Hx History

I
ICD-9-CM International Classification of Disease, 9th Revision, Clinical Modification
ICH CAHPS In-Center Hemodialysis
CAHPS IHI Institute for Healthcare Improvement
IM Information Management
IOM Institute of Medicine
IPD Intermittent Peritoneal Dialysis

IPRO Island Peer Review Organization (QIO)
IPP Innovation Pilot Project
ISHD International Society of Hemodialysis
IT Information Technology
IV Intravenous
IVD Involuntary Discharge
IVT Involuntary Transfer

J
JAMA Journal of the American Medical Association
JASN Journal of the American Society of Nephrology
JCAHO Joint Commission on Accreditation of Healthcare Organizations

K
Kt/V A method to measure adequacy of dialysis. K = the dialyzer clearance, t = time on dialysis, and V =volume of water in the patient's body.
KCER Kidney Community Emergency Response
KCP Kidney Care Partners
KCQA Kidney Care Quality Alliance (part of KCP)
KDIGO Kidney Disease: Inspiring Global Outcomes
KDOQI Kidney Disease Outcomes Quality Initiative
KEEP Kidney Early Evaluation Program
KPAC Kidney Patient Advisory Council (KPAC)

L
LAN Learning & Action Network LCSW Licensed Clinical Social Worker
LDO Large Dialysis Organization
LISW Licensed Independent Social Worker
LMSW Licensed Master of Social Work
LORAC Life Options Rehabilitation Advisory Council
LPN Licensed Practical Nurse
LRD Living Related Donor
LRD Licensed Registered Dietician
LTFU Lost to Follow-Up
LURD Living Unrelated Donor

M
M+C Medicare + Choice
MAC Medical Advisory Council (Forum)
MCO Managed Care Organization
MD Medical Doctor
MDH Medicare Dependent Hospital
MDO Medium Dialysis Unit
MedPAC Medicare Payment Advisory Commission
MEI Medical Education Institute
MPH Master of Public Health
MRB Medical Review Board
MSN Master of Science in Nursing
MSW Master of Social Work
MU Meaningful Use

N
NANT National Association of Nephrology Technicians/Technologists
NC Network Council

NCC Network Coordinating Council
NCQA National Committee for Quality Assurance
NEJM New England Journal of Medicine
NEPOP New ESRD Patient Orientation Packet
NHHD Nocturnal Home Hemodialysis
NHSN National Healthcare Safety Network
NIDDK National Institute for Diabetes and Digestive and Kidney Diseases
NIH National Institutes of Health
NIP National Improvement Plan
NIPD Nocturnal Intermittent Peritoneal Dialysis
NKDEP National Kidney Disease Education Program
NKF National Kidney Foundation
NKR National Kidney Registry
NN&I Nephrology News & Issues
NPP Narrative Project Plan
NPSF National Patient Safety Foundation
nPCR Normalized Protein Catabolic Rate
NQF National Quality Forum
NQS National Quality Strategies (CMS)
NRAA National Renal Administrators Association
NVAII National Vascular Access Improvement Initiative

O
OAGM Office of Acquisition & Grants Management (CMS)
OCSQ Office of Clinical Standards and Quality
ODIE Online Data Input and Edit
OGC Office of General Council (CMS)
OHRP Office of Human Research Protection
OIC Opportunity to Improve Care
OIG Office of Inspector General (CMS)
ONC Office of the National Coordinator for Health Information Technology
OPO Organ Procurement Organization
OPTN Organ Procurement and Transplant Network
ORD Office of Research and Demonstrations
ORS Office of Regulatory Services
OSCAR Online Survey Certification Reporting
OSHA Occupational Safety and Health Administration
OY Option Year

P
PA Physician's Assistant
PAR Patient Activity Report
PCP Primary Care Physician
PCT Patient Care Technician
PCU Patient Contact Utility
PD Peritoneal Dialysis
PFCC Patient & Family Centered Care
PfP Pay for Performance
PfP Private for Profit
PFP Priority Focus Process
PhD Philosophy Doctorate
PHIPP Population Health Innovation Pilot Project
PID Project Idea Document
PIP Performance Improvement Plan

PKCI Peer Kidney Care Initiative
PKD Polycystic Kidney Disease
PMMIS Program Management and Medical Information System
PO Project Officer (CMS)
PPS Prospective Payment System
PRO Peer Review Organization (Now called QIO)
PSC Patient Services Coordinator
PSD Patient Services Director

Q
QA Quality Assurance
QAPI Quality Assurance and Performance Improvement
QCPC Quality Conference Planning Committee (Forum)
QI Quality Improvement
QIA Quality Improvement Activity
QID Quality Improvement Director
QIG Quality Improvement Group (CMS)
QIIG Quality Improvement and Innovation Group (CMS)
QIO Quality Improvement Organization (Formerly PRO)
QIP Quality Improvement Project
QIS Quality Improvement Specialist
QMHAG Quality Measurement & Health Assessment Group (CMS)
QMVIG Quality Measurement & Value-Based Incentive Group (CMS)
QNET Quality Net (Exchange vs. Conference)

R
RD Registered Dietician
REBUS Renal Beneficiary Utilization System
REMIS Renal Management Information System
RHIT Registered Health Information Technician
RN Registered Nurse
RO Regional Office (CMS)
ROPO Regional Office Project Officer
RPA Renal Physicians' Association
RSN Renal Support Network

S
SA State Agency/ State Survey Agency
SC Subcutaneous
SIMS Standard Information Management System
SKF Skilled Nursing Facility
SLE Systemic Lupus Erythematosus
SME Subject Matter Expert
SOD Statement of Deliverables
SOW Statement of Work
SSA Social Security Administration
SSN Social Security Number

T
TCPI Transforming Clinical Practice Initiative (CMS)
TCV Total Cell Volume
TEP Technical Expert Panel
TQE Total Quality Environment
Tsat Transferring Saturation

TX Transplant

U
UKM Urea Kinetic Modeling
UNOS United Network of Organ Sharing
UPI Unique Patient Identifier
UPIN Unique Physician Identification Number
URR Urea Reduction Ratio
USRDS United States Renal Data System
USAT Unit Self-Assessment Tool

V
VA Veteran's Administration or Veteran's Affairs
VHA Veteran's Health Administration
VISION Vital Information System to Improve Outcomes in Nephrology
VR Vocational Rehabilitation

W X Y Z
WHO World Health Organization

ADDITIONAL ACRONYM AND GLOSSARY RESOURCES

Baxter Renal Glossary of Terms Associated with Kidney Disease
http://www.renalinfo.com/us/resources/glossary/index.html NKF

Glossary of Terms http://www.nkfi.org/education/glossary-of-terms#.VXByf2fbKUk

FMC Glossary
http://www.ultracare-dialysis.com/Footer/Glossary.aspx

National Center for Biotechnology Information Acronyms and Abbreviations
http://www.ncbi.nlm.nih.gov/books/NBK84563/

Renal Support Network
http://www.rsnhope.org/programs/kidneytimes-library/article-index/renal-acronym