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Joint Network Council Meeting

ESRD Network 2023-2024 Kick Off

May 18, 2023

Presented by ESRD Networks 10 and 12

Meeting Reminders

- This meeting will be recorded, and slides will be available on Network website
- Participant engagement is appreciated – share with us via chat & answer polling questions
- Please mute your line when not speaking
- We will take all questions at the end of the presentation
- Turn your cameras on, we would love to see you!

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Agenda

- Introduction of Qsource ESRD Team
- Qsource ESRD Demographics
- Role and Expectations of Network Council
- CMS 2023 – 2024 Priorities
- Quality Improvement Department
- Patient Services Department
- Information Management Department

Polling Question

Who do we have on the call today?

- Nephrologist
- Facility Manager/Administrator
- Lead Nurse/Home Nurse
- Technician
- Social Worker
- Dietician
- Community Partner
- Patient Representative

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ESRD Staff

Executive Directors

Audrey Broaddus

Stephanie Smith

Information Services

Jeff Arnall

Sandy Cannon

Patient Services

Erica Anderson

Keisha Wilson

Eleanor Nelson

Quality Improvement

Roma Heater

Mandy Vires

Debbie Ulm

Ashley Dixon

Meghan VanSlyke

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Qsource's Values and Mission

Mission: To improve healthcare quality through patient-centered, provider-focused solutions that enhance the patient's quality of life.

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ESRD Network 10 Demographics

Qsource holds two End-Stage Renal Disease Network Contracts

ESRD Network 10
Illinois

31,865
ESRD/Transplant Patients

346 Dialysis Clinics

9 Transplant Centers

Modality
In-Center patients: 15,644
Home patients: 3,127

Race
White: 58%
African American: 32%
Asian: 4%
Unknown 5%

Ethnicity
18% Hispanic
77% Non-Hispanic
5% Unknown

Facility Location
96% urban
4% rural

Gender
Male 59%
Female 41%

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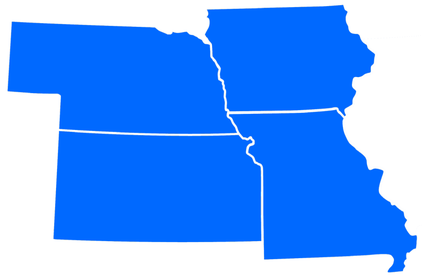
ESRD Network 12 Demographics



ESRD Network 12

Iowa, Missouri, Nebraska, Kansas

28,864
ESRD/Transplant Patients

318
Dialysis Clinics

12
Transplant Centers

Modality
In-Center patients: 13,165
Home patients: 3,290

Race
White: 71%
African American: 24%
Asian: 2%
Pacific Islander 1%
Native American 1%
Unknown 2%

Ethnicity
6% Hispanic
92% Non-Hispanic
2% Unknown

Facility location
80% urban
20% rural

Gender
Male 59%
Female 41%

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Role of Network Council

Collaborate with the ESRD Network to achieve goals set by the Centers for Medicare & Medicaid Services (CMS) and our leadership boards

Members:

- Dialysis Facilities
- Transplant Centers
- Community Partners
- ESRD/Transplant Patients
- Network Governance – Medical Review Board and Patient Advisory Council

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Expectation of Network Council

- Participate in Quality Improvement Activities
- Collaboration with Network on CMS Goals and Priorities
- Ensure Accuracy of Facility Information in EQRS
- Lead transformation in quality patient care
- Be a change agent for patient engagement
- Support Patient Experience of Care

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2023 CMS ESRD Priorities

The CMS ESRD Network contract has specific initiatives designed to achieve results in improvement for the care of ESRD patients.

- Quality Improvement Initiatives
- Oversight of Medical Review Board
- Emergency Preparedness
- Patient Experience of Care
- EQRS Data Management
- Health Equity
- Patient and Family Engagement
- Community Partner Collaboration
- Facility Specific Technical Assistance

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The Importance of Partners| Dialysis Facilities

V755 and V772 – Relationship with the ESRD network

The governing body receives and acts upon recommendations from the ESRD network. The dialysis facility must cooperate with the ESRD network designated for its geographic area, in fulfilling the terms of the Network's current statement of work. Each facility must participate in ESRD network activities and pursue network goals.

Polling Question

When are you most likely to contact your ESRD Network?

1. Help with EQRS issue
2. Help with a Patient Grievance
3. Assistance with CMS goals
4. For Patient Activity idea
5. Emergency Notification (i.e. flood, closure etc.)
6. Present at facility/community event
7. Invite us to your next Party!

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The Importance of Partners| Kidney Community Stakeholders

Change Agents

Outreach and Education

Data Collection and Validation

Bidirectional Information Exchange

Routine Communication

Identify Performers

- State Healthcare-Associated Infection and Antimicrobial Resistance Programs
- State Agencies & Accrediting Organizations
- Missouri Kidney Program
- Transplant Centers
- Making Dialysis Safer for Patients Coalition
- National Kidney Foundation
- Hospital Associations
- QIN/QIOs – Quality Improvement Orgs
- Age Options – Voc Rehab Partner
- Long-Term Care Associations

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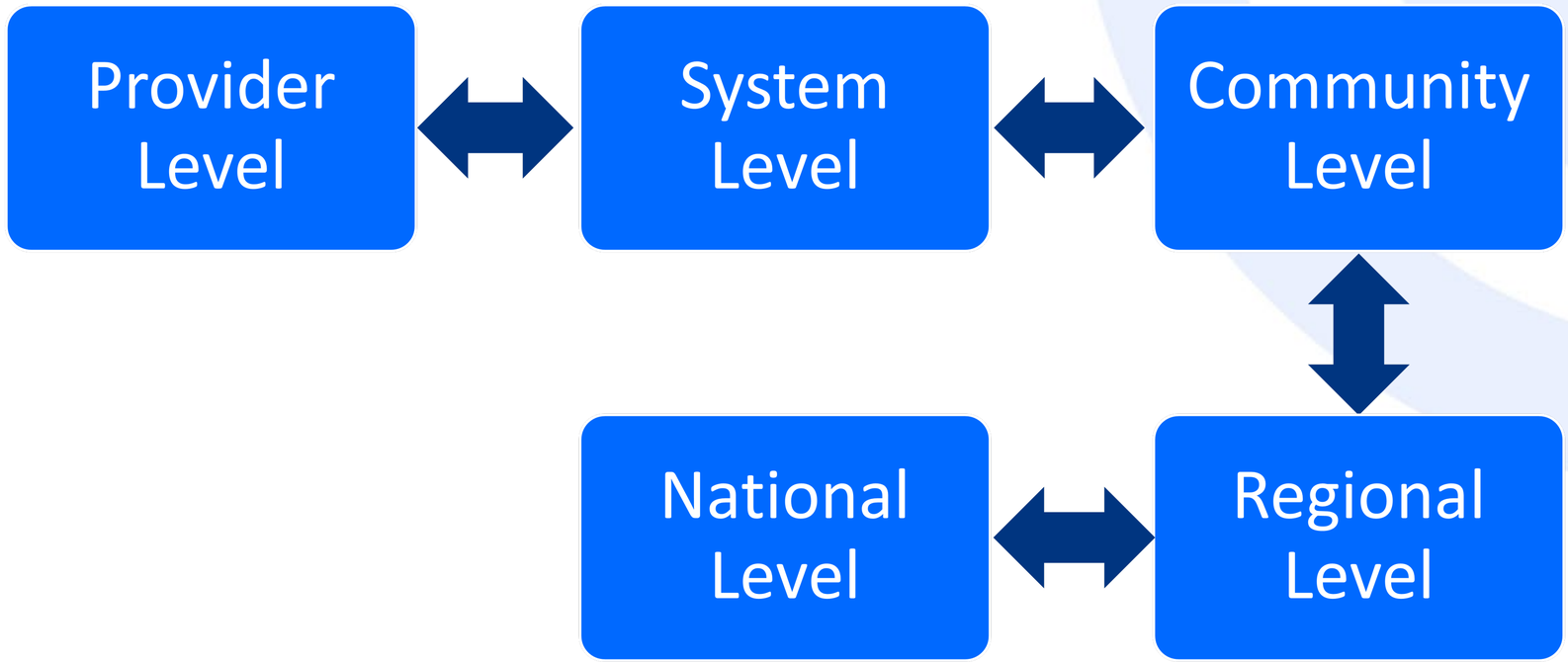
Impacting Change on Multiple Levels

The Network is tasked with focused & measurable improvement goals to improve the outcome of ESRD patients, address health equity, provide education, and support improvement at each level.



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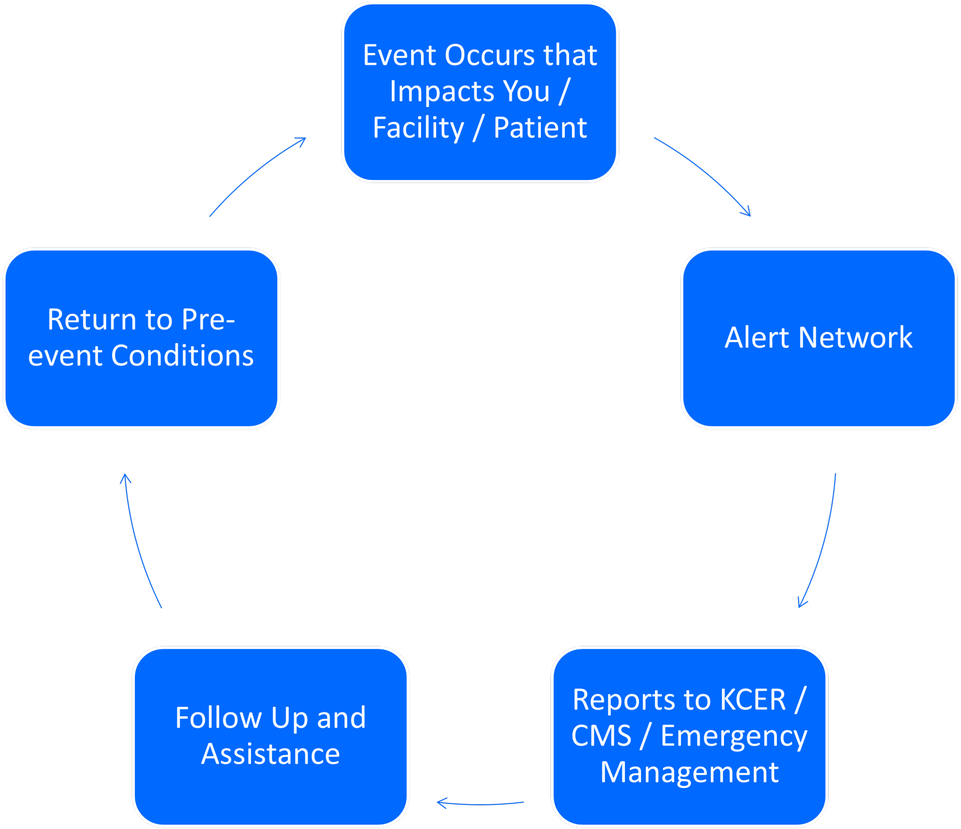
Emergency Preparedness and Response



- Preparation and planning is expected at the facility level (per Conditions for Coverage)
- Communication to the Network can occur prior to an expected event or after: https://www.surveymonkey.com/r/fac_status
- The Network monitors for events, and provides information and support
- Network takes active role in pandemic surveillance and support

Contact Us!

Nw10-emergency@qsource.org
Nw12-emergency@qsource.org

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Success Highlights from Last Year

- Partnered with our largest Nursing Home Provider to improve infection control practices, vascular access management care, and anemia management.
- Partnership with Network 11 and other subject matter experts to prov Health Equity Webinar series
- Provided a quarterly quality improvement newsletter to spread highly rated resources to all clinics
- Bulletin Board kits on mental health stigma and benefits of home dialysis

Network 10 Goals Met

Patients added to waitlist, transplanted, COVID Admissions, ESRD Admissions, Unplanned Readmissions, Telemedicine, NH Blood transfusions, NH Peritonitis

Network 12 Goals Met

PPSV23 Booster Vaccination, COVID Admissions, ED Visits, ESRD Admissions, Unplanned Readmissions, Telemedicine, NH Peritonitis, NW Catheter Infection

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Quality Improvement Department

CMS Focus Areas and Quality Improvement Activities

Improvements Over a Five-Year Period (2021 to 2026)

- QAPI ↑
- Life Plan ↑
- Peer Mentoring ↑
- Health Equity

National Long-Term Goals

Behavioral Health

- ↑ Treatment for Depression
- ↑ Technical Assistance for cognitive decline

Nursing Homes

- ↓ catheter infections
- ↓ peritonitis
- ↓ blood transfusions

Hospitalizations

- ↓ rate of obesity
- ↓ hospital admissions, 30-day unplanned readmissions, and outpatient ED visits

Vaccinations

- ↑ flu vax for patients and staff
- ↑ Pneumococcal vax for patients
- ↑ COVID vax for staff and patients

Home Dialysis

- ↑ incident home dialysis
- ↑ moving to home dialysis
- ↑ rural using telemedicine

Transplant

- ↑ transplant waiting list
- ↑ kidney transplants

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Quality Improvement Strategies for Excellence

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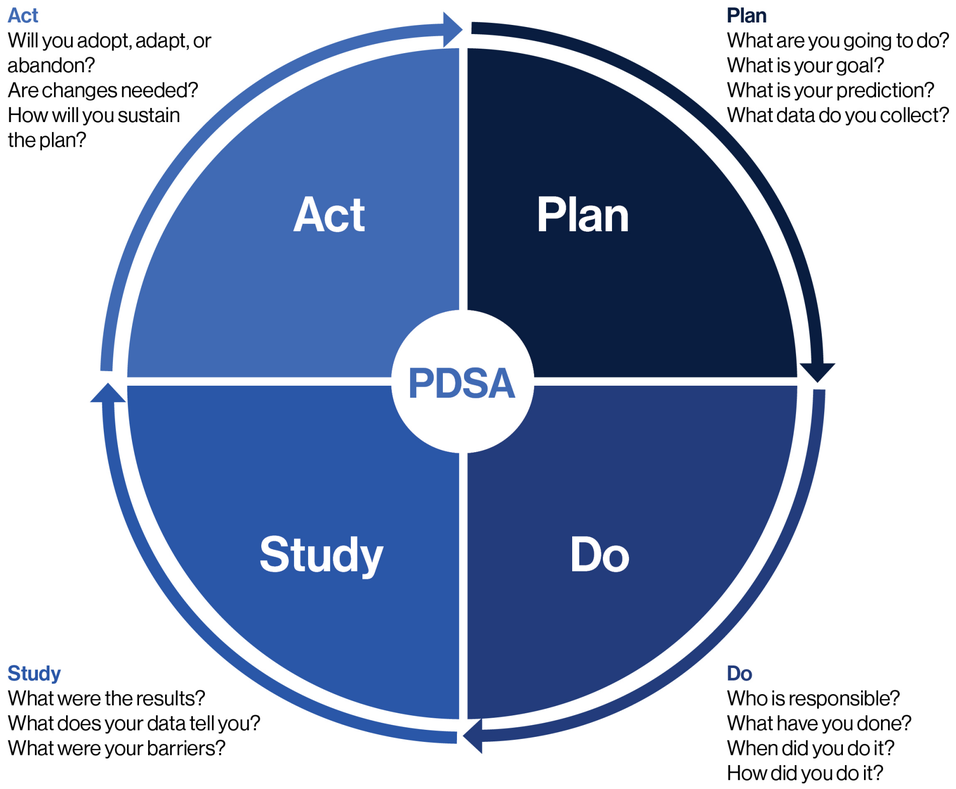
Quality Improvement Process

- Low performers Identified through data analytics
- Facilities complete RCA to determine barriers
- 4 -month PDSA cycle introduced
- Network provides support throughout the process
- Sustainability Planning completed at conclusion



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Quality Improvement | Participation Cycle

Patient Peers

- Champion activities at facility and on Network level
- Assist facilities in facility activities (lobby days, games, peer mentoring, bulletin boards)
- Share education materials to other patients & caregivers
- Share feedback with Network on ways to improve patient experience

The Network

- Analyze data (EQRS, NHSN, self-collected) to build facility focus groups
- Assist facilities in PDSA process for local level change
- Provide monthly facility interventions, resources & support
- Share facility benchmarks to reach to CMS goals
- Perform targeted 1:1 technical assistance to improve quality of care
- Assist facilities in sustaining improvement

Community Stakeholders/Coalitions

- Recruit Community Members
- Identify promising practices and low performing facilities
- Identify local and regional challenges
- Assist in resource development and intervention deployment
- Support PDSA cycle and provide recommendations

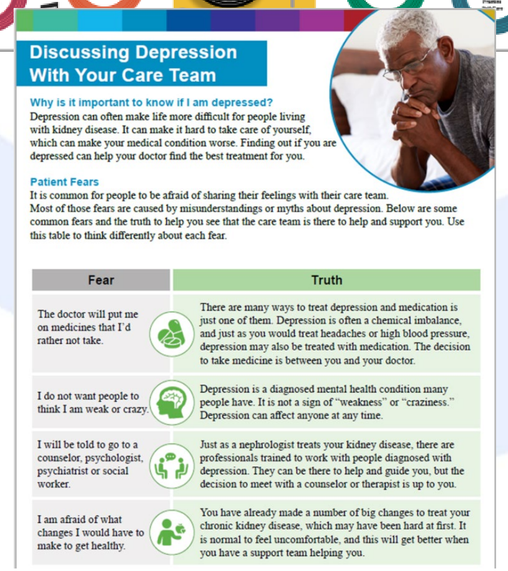
Dialysis Clinics

- Participate in Quality Improvement Activities
- Perform Plan-Do-Study-Act Cycles
- Attend webinars, complete required surveys
- Engage patient peers in facility goals
- Aim to achieve CMS goals

Improve Behavioral Health Outcomes

Goal

- Achieve a 10% increase from baseline (calendar year 2022) in the percentage of patients receiving, or having received, treatment by a mental health professional after having been screened positively for depression, as identified in the QIP attestation.
- Top Interventions 2022/23: Stigma Bulletin Board Kit; use of MSW students in the clinic to support Social Workers and patient who screen positive for depression; Discussing Depression with your Care Team patient handout
- 2023/24 focus on increasing patients seeking treatment; expand the use of MSW students in the clinic; care pathways for dialysis patients to be seen by the MHP in a timely manner



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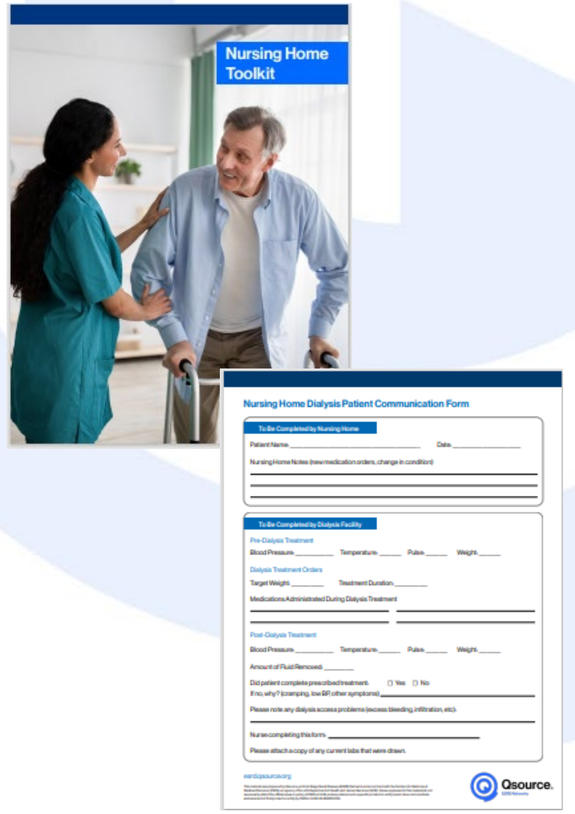
Nursing Home Focus: Improve Safety and Reduce Harm

Goals

- Achieve a 3% decrease in the rate of blood transfusions, among patients receiving dialysis in nursing homes, from the baseline to the end of Option Period 2.

- Achieve a 6% decrease in the hemodialysis catheter infection rate, among dialysis patients receiving home dialysis within nursing homes, from the baseline to the end of Option Period 2.

- Achieve a 3% decrease in the peritonitis infection rate, among dialysis patients receiving home dialysis within nursing homes, from the baseline to the end of Option Period 2.



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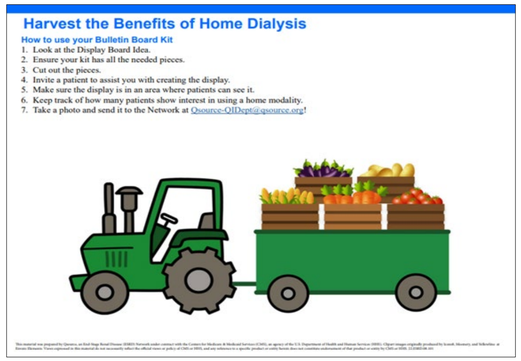
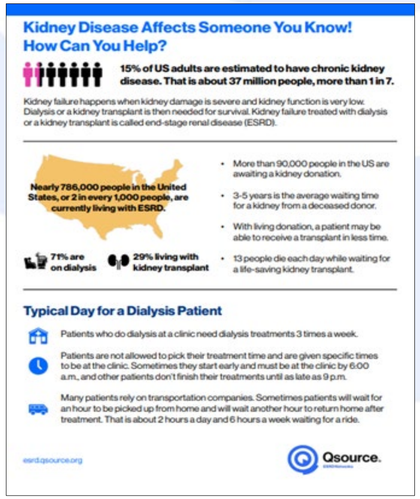
Empower Patient Choice in Home Modality

Goals:

- Achieve a 30% total increase from baseline in the number of incident ESRD patients starting dialysis using a home modality by the end of Option Period 2.
- Achieve a 12% increase from baseline in the number of prevalent ESRD patients moving to a home modality by the end of Option Period 2.
- Achieve a 3% increase in the number of rural ESRD patients using telemedicine to access a home modality from the baseline the end of Option Period 2.





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Empower Patient Choice of Transplant

Goals:

- Achieve a 9% total increase from the baseline to the end of Option Period 2 in the number of patients added to a kidney transplant waiting list.

- Achieve a 12% total increase from baseline to the end of Option Period 2 in the number of patients receiving a kidney transplant.

Kidney Transplant

Living Donation

Living donation is when a living person donates an organ, or part of an organ, to another person. It is a way to receive a kidney transplant sooner! Living donors don't need to be related. They can be family members, friends, or strangers. Kidney transplants from living donors may have advantages over deceased donors. Use the following resources to learn more.

Living Donors

The National Kidney Foundation has created resources that can give you ideas on how to talk to loved ones about living donation.

https://www.kidney.org/transplantation/livingdonors

Donate Life Kidney Donation

Donate Life is a website that provides valuable information about living donation and the need for living donors. Learn more about how loved ones and friends can become a kidney donor.

https://www.donatelife.net/types-of-donation/kidney-donation/

National Living Donor Assistance Center (NLDAC)

The NLDAC exists to provide access to transplantatio want to donate but face financial barriers to doing so.

https://www.livingdonorassistance.org/

Kidney Disease Affects Someone You Know!
How Can You Help?

15% of US adults are estimated to have chronic kidney disease. That is about 37 million people, more than 1 in 7.

Kidney failure happens when kidney damage is severe and kidney function is very low. Dialysis or a kidney transplant is then needed for survival. Kidney failure treated with dialysis or a kidney transplant is called end-stage renal disease (ESRD).

Nearly 786,000 people in the United States, or 2 in every 1,000 people, are currently living with ESRD.

- More than 90,000 people in the US are awaiting a kidney donation.
- 3-5 years is the average waiting time for a kidney from a deceased donor.
- With living donation, a patient may be able to receive a transplant in less time.
- 13 people die each day while waiting for a life-saving kidney transplant.

71% are on dialysis

29% living with kidney transplant

Typical Day for a Dialysis Patient

Patients who do dialysis at a clinic need dialysis treatments 3 times a week.

Patients are not allowed to pick their treatment time and are given specific times to be at the clinic. Sometimes they start early and must be at the clinic by 6:00 a.m., and other patients don't finish their treatments until as late as 9 p.m.

Many patients rely on transportation companies. Sometimes patients will wait for an hour to be picked up from home and will wait another hour to return home after treatment. That is about 2 hours a day and 6 hours a week waiting for a ride.

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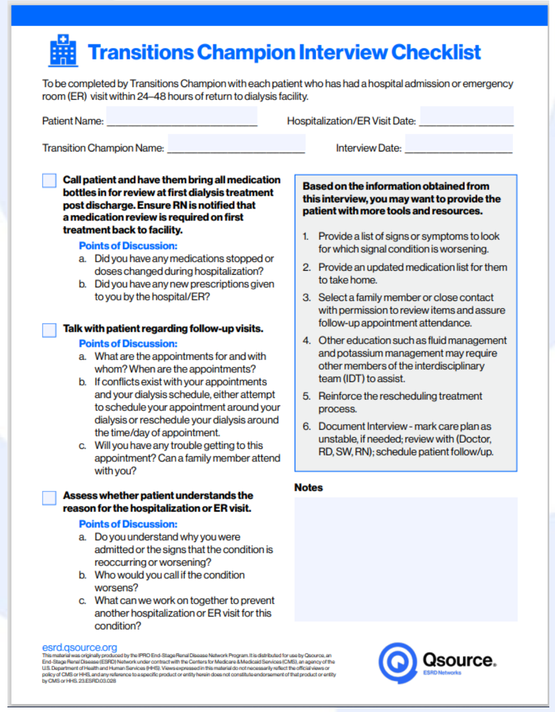
Decreasing Hospitalizations

- Achieve a 4% decrease from the baseline in hospital admissions for a diagnosis on the List of Primary Diagnosis Categories
- Achieve a 4% decrease from the baseline in Hospital thirty (30)-day unplanned readmissions for a diagnosis on the List of Primary Diagnosis Categories following an admission
- Achieve a 4% decrease from baseline in rate of Outpatient Emergency Department Visits for a diagnosis on the List of Primary Diagnosis Categories
- Achieve a 1% decrease, from the baseline, in average body weight, among prevalent ESRD patients identified as obese



Transitions Champion Interview Checklist

To be completed by Transitions Champion with each patient who has had a hospital admission or emergency room (ER) visit within 24–48 hours of return to dialysis facility.

Patient Name: _____ Hospitalization/ER Visit Date: _____

Transition Champion Name: _____ Interview Date: _____

☐ **Call patient and have them bring all medication bottles in for review at first dialysis treatment post discharge. Ensure RN is notified that a medication review is required on first treatment back to facility.**

Points of Discussion:

a. Did you have any medications stopped or doses changed during hospitalization?
b. Did you have any new prescriptions given to you by the hospital/ER?

☐ **Talk with patient regarding follow-up visits.**

Points of Discussion:

a. What are the appointments for and with whom? When are the appointments?
b. If conflicts exist with your appointments and your dialysis schedule, either attempt to schedule your appointment around your dialysis or reschedule your dialysis around the time/day of appointment.
c. Will you have any trouble getting to this appointment? Can a family member attend with you?

☐ **Assess whether patient understands the reason for the hospitalization or ER visit.**

Points of Discussion:

a. Do you understand why you were admitted or the signs that the condition is reoccurring or worsening?
b. Who would you call if the condition worsens?
c. What can we work on together to prevent another hospitalization or ER visit for this condition?

Based on the information obtained from this interview, you may want to provide the patient with more tools and resources.

1. Provide a list of signs or symptoms to look for which signal condition is worsening.
2. Provide an updated medication list for them to take home.
3. Select a family member or close contact with permission to review items and assure follow-up appointment attendance.
4. Other education such as fluid management and potassium management may require other members of the interdisciplinary team (IDT) to assist.
5. Reinforce the rescheduling treatment process.
6. Document Interview - mark care plan as unstable, if needed; review with (Doctor, RD, SW, RN); schedule patient follow/up.

Notes

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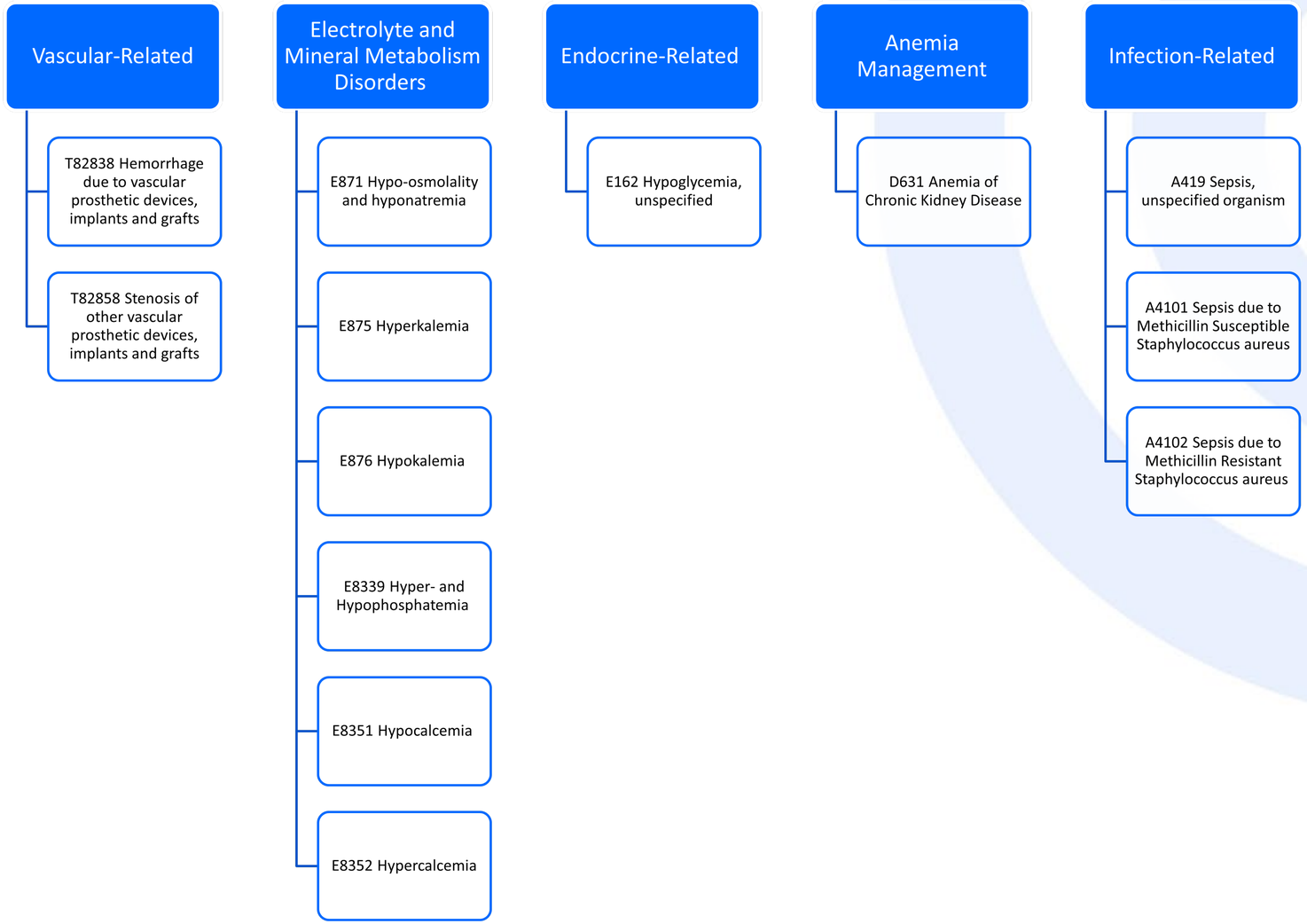
List of Priority Diagnosis Categories



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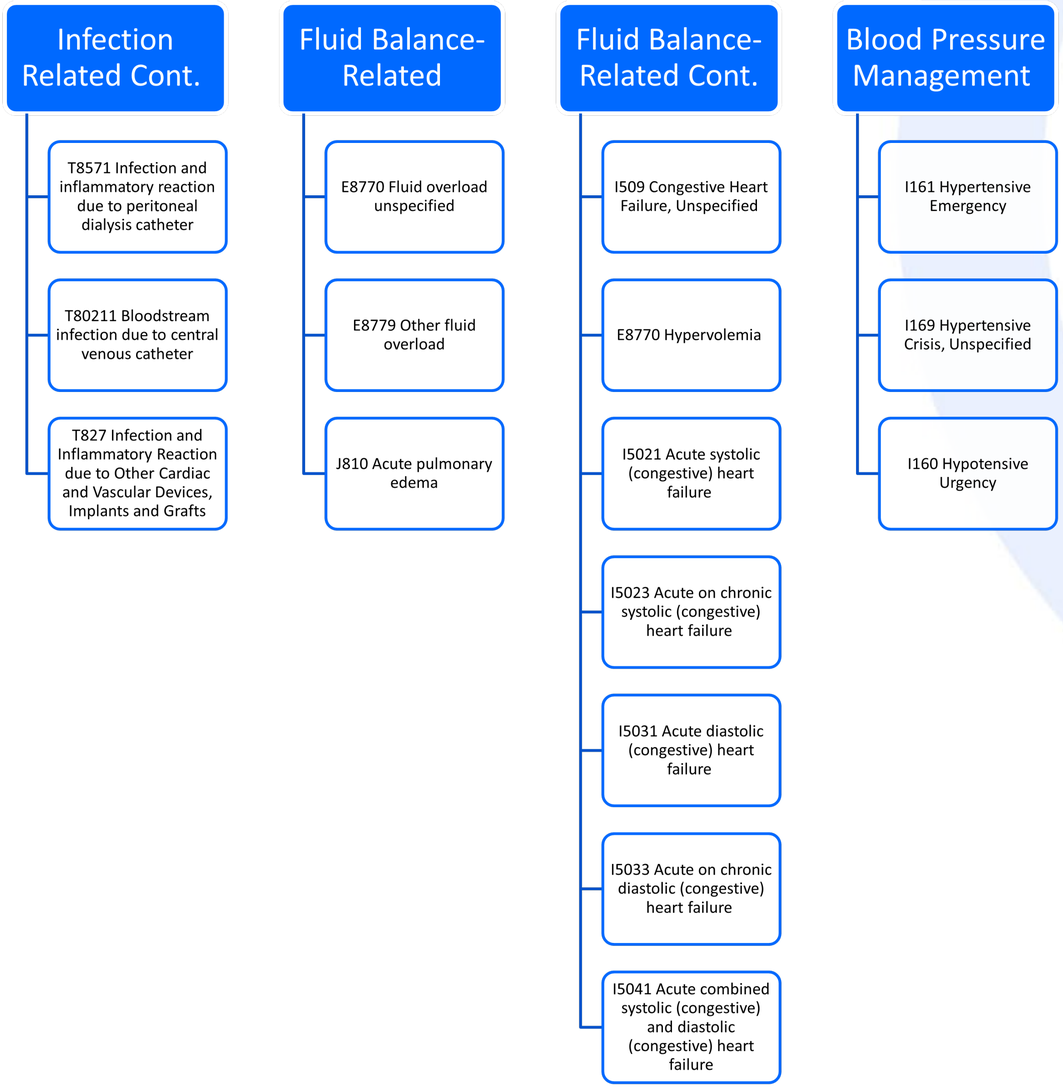
List of Priority Diagnosis Categories (cont.)



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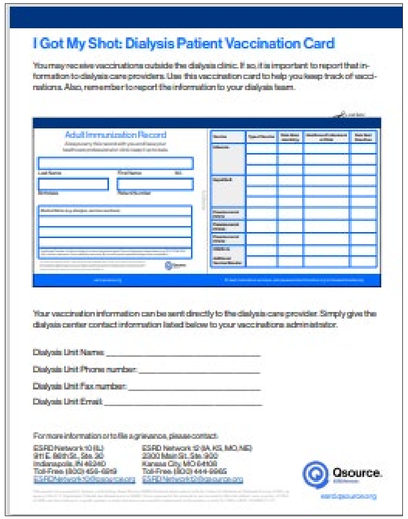
Increasing Vaccinations

COVID-19 Vaccination

- Minimum of 80% of dialysis patients are fully vaccinated for COVID-19, including boosters, as determined by the CDC and/or CMS.
- Minimum of 95% of dialysis facility staff are fully vaccinated for COVID-19, including boosters, as determined by the CDC and/or CMS

**Based on NHSN Data*


I Got My Shot: Dialysis Patient Vaccination Card

You may receive vaccinations outside the dialysis clinic. If so, it is important to report that information to dialysis care providers. Use this vaccination card to help you keep track of vaccinations. Also, remember to report the information to your dialysis team.

Adult Immunization Record

Your vaccination information can be sent directly to the dialysis care provider. Simply give the dialysis center contact information listed below to your vaccinations administrator.

Dialysis Unit Name: _____

Dialysis Unit Phone number: _____

Dialysis Unit Fax number: _____

Dialysis Unit Email: _____

For more information or to file a grievance, please contact:

ESRD Network 10 (IL)
911 E. 86th St., Ste. 30
Indianapolis, IN 46240
Toll-Free (800) 456-6913
ESRD Network 10@qsource.org

ESRD Network 12 (IA, KS, MO, NE)
2300 Main St. Ste. 900
Kansas City, MO 64108
Toll-Free (800) 444-9965
ESRD Network 12@qsource.org

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Influenza Vaccination

- Minimum of 90% of dialysis patients receive an influenza vaccination
- Minimum of 90% of dialysis facility staff receive an influenza vaccination

Pneumococcal Pneumonia

- 7% increase in fully vaccinated for pneumococcal
  - *Multiple avenues to achieve this metric*

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Patient and Family Engagement

- Achieve a total of 30% increase in the number of facilities that integrate patients and families into QAPI
- Achieve a total of 30% increase in the number of facilities that successfully assist patient to develop a life plan from which the dialysis facility develops the dialysis plan of care
- Achieve a total of 15% increase in the number of facilities that develop and support a Patient-to-Patient Support Program
- Maintain a National Patient/Family Engagement (NPFE) LAN attendance rate of at least 60% for each task order period

Facility Level Patient Engagement | Peer Representative

Goal: For every dialysis facility to have a Peer Representative to increase patient activities and collaboration

Peer Representative
- Patient
- Family Member

+

Dialysis Clinic
- Staff Coordinator
- Clinic Team

+

Qsource ESRD Networks 10 & 12 Resources

=

Improved Patient Experience

Qsource ESRD Networks

Onsite Quality Improvement Assistance

The Network team will provide targeted support to individual facilities to achieve CMS goals and/or facility specific goals

1. Work with facilities to identify barriers to improvement
2. Lead facility through a Plan-Do-Study-Act process to test change
3. Share data, resources & educational tools to overcome barriers
4. Assist in achievement of CMS goals through local onsite mitigation & support
5. Support health equity priorities
6. Provide ongoing support to facilities throughout the year

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Onsite Quality Improvement Assistance

How are facilities selected for onsite TA?

- CMS provided a Priority List of facilities for each ESRD Network based on Health Equity needs
- Facilities were then selected based on facility performance data *(EQRS and NHSN from May 2022-March 2023)*

What will a site visit consist of?

- 2–4-hour site visit with IDT team
- Completion of pre-visit facility specific survey
- Review facility progress toward CMS metrics
- Implement PDSA cycle and provide needed support materials for goal achievement
- Meet with patients & caregivers to spearhead PFE goals
- Facility Follow-up after visit at 1 week, 30 days, and 90 days

When will my facility know if I was selected?

- Facility managers will be notified to schedule site visit at least 30-days prior to visit
- Request will include time for SW, RD, Nephrologists and other staff, as deserved, to participate

Culturally and Linguistically Available Services

CLAS Implementation Action Plan Development

- HHS CLAS Checklist
- National CLAS Standards
- Agency for Healthcare Research and Quality Guide

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Information Management

Data Quality Improvement Goals

- Achieve a 1% decrease in Initial 2728 Forms (Saved or Missing) that are over one year old (this is a New Measure).
- Achieve a 4% increase in the rate of Initial 2728 forms that are submitted within 45 days of the first chronic treatment.
- Achieve a 9% increase in the rate of 2746 forms submitted within 14 calendar days of the date of death.

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Late is Too late!

- Once an admission or form is late, it cannot become “un-late”. For that reason, it is critical to maintain data timeliness.
- CMS is measuring timeliness on a rolling twelve months, so improved scores are slow to appear as you improve your timeliness.
- Your EQRS dashboard will help you to stay on track. Monitor it weekly for aging forms that are due.
- Each quarter we will review facility performance and select low performers for specific interventions.

Critical Communications

- We use EQRS personnel as our sole source of contact information with your staff on important email communications.
- Missing out on these communications could adversely affect your facility as we start the new contract year this month.
- Please see our website for instructions on how to maintain current contact information in EQRS. https://esrd.qsource.org/data-services/personnel-updates/

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EQRS and Transplant Centers

We've just transitioned all transplant centers to EQRS. One of the primary benefits to them is that Transplant Coordinators can now access all chronic ESRD patients in the country to streamline the waitlist process.

They can view current facilities for patients as well as their CMS-2728 forms.

Also coming soon to your EQRS Facility Dashboard....

A waitlist screen that shows UNOS data on all your clinic patients who are on a waitlist at one or more transplant centers, along with their current waitlist status.

Patient Services Department

How We Will Support You

- Patient Experience of Care
  - Evaluate and resolve grievances
  - Assist with facility concerns and provide guidance
  - Address at-risk and involuntary discharges and transfers
- Support the development of patient education resources and outreach

Grievances

How does CMS define Grievance?

"A written or oral communication from an ESRD patient or patient representative…, alleging that an ESRD service received from a Medicare-certified provider **did not meet the grievant's expectations** with respect to safety, civility, patient rights, and/or clinical standards of care."

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Grievances

- Facility Policy and Procedures must describe all available grievance procedures to the patient.
  - Internal Process
  - ESRD Network
  - State Survey Agency

- The procedure is clear that the patient has a right to directly file a grievance with the Network (or State Survey Agency) without first using the facility's grievance process.

Source: ESRD Conditions for Coverage (V465, V466, V467, V765)

Involuntary Discharges and Transfers

V766 and V767: The governing body must ensure that all staff follow the facility's patient discharge and transfer policies and procedures.

Involuntary discharge or transfer should be rare and preceded by a demonstrated effort on the part of the interdisciplinary team to address the problem in a mutually beneficial way.

- Specifically note: For behavioral issues, the facility has reassessed the patient and determined that the behavior is disruptive and abusive to the extent that the delivery of care to the patient or the ability of the facility to operate effectively is seriously impaired.

Involuntary Discharges & Transfers

- Document the reassessments, ongoing problems(s), and efforts made to resolve the problem(s) and enter this documentation into the patient's medical record.
- In the event facility staff members believe the patient may have to be involuntarily discharged, the interdisciplinary team must reassess the patient with an intent to identify any potential action or plan that could prevent the need to discharge or transfer the patient involuntarily.

  - The reassessment must focus on identifying the root causes of the disruptive or abusive behavior and result in a plan of care aimed at addressing those causes and resolving unacceptable behavior.

Grievances and Access to Care | Year In Review

Patient Services Department processed 396 Cases from May 2022 to March 2023

Access to Care

- NW10: 149 Cases
- NW12: 61 Cases
- Ongoing Behavioral Issues
- Verbal Abuse
- Threat of Physical Harm

Grievances

- NW10: 37 Cases
- NW12: 27 Cases
- Staff Related Issues
- Professionalism
- Mis-communication/Communication

Facility Concerns

- NW10: 69 Events
- NW12: 53 Events
- Nonadherence
- No Show/Missed Treatment

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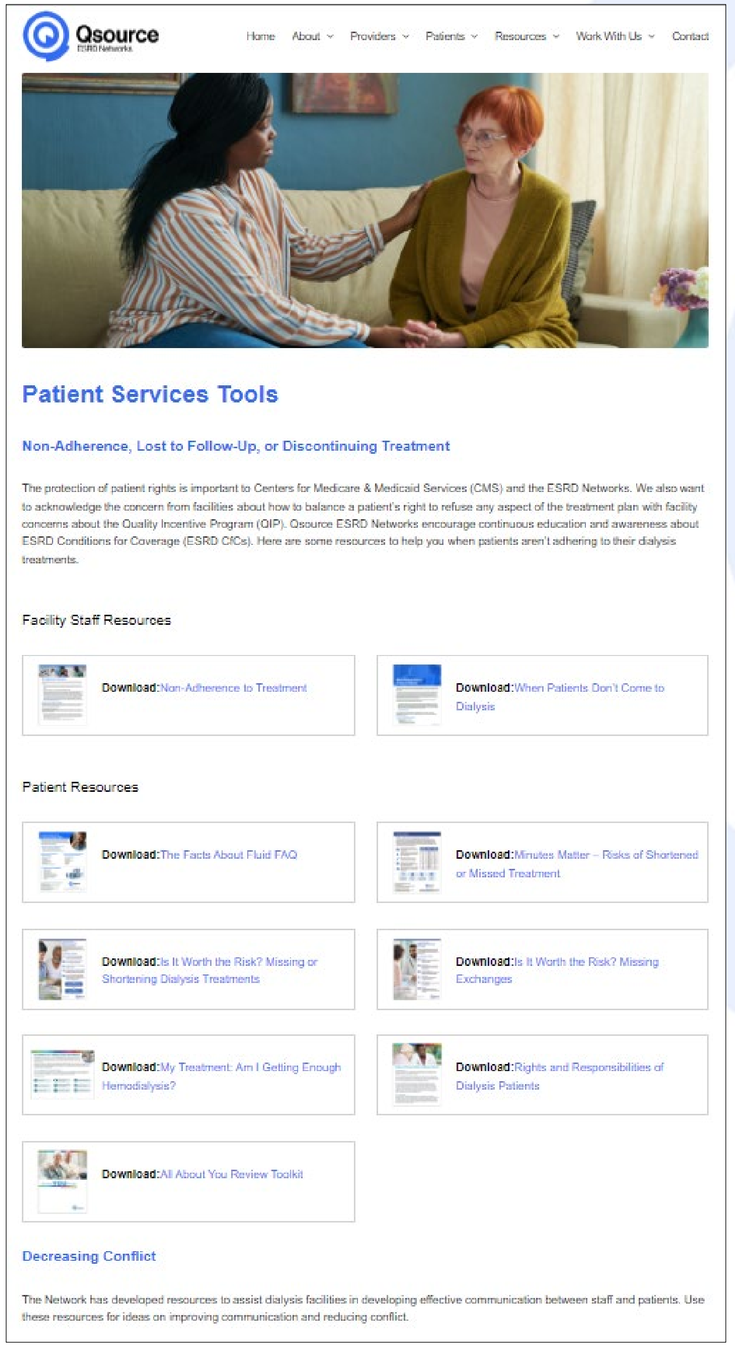
Patient Services Webpage

Patient and Provider Resources For:

- Non-adherence, Lost to Follow-Up, or Discontinuing Treatment
- Decreasing Conflict
- Behavioral Health and Coping With Dialysis



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Contacting the Patient Services Department

Notify us…

- When a patient is at-risk of losing their access to care
    - IVD/IVT concerns
    - Ongoing behavioral issues
    - Non-adherence
- Have Ready:
    - Your facility’s Medicare Certification Number (CCN). Please note the CCN # is six-digits
    - The patient’s first name, last name and date of birth

Wrap Up

Network Website

The Network website has valuable tools and resources.
Visit us at esrd.qsource.org.

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Next Steps

- Submit a facility Commitment Attestation
- Recruit Facility Peers In Action
- Update EQRS Facility Personnel for Accuracy
- Contact any members of our team should you have questions or concerns
- Ways to Stay Involved
  - Invite Network staff to your regional meetings to discuss collaboration
  - Attend National Coordinating Center (NCC) Learning and Action Calls
  - Represent the Network through presentation at the National Level
  - Inform us of kidney events in the community
  - Become a member of a Community Coalition

Contact Us By Department

Quality Improvement Department: qsource-qidept@qsource.org

PEERS program: qsource-peers@qsource.org

Data Department: esrddatadept@qsource.org

Emergency Preparedness:

- Nw12-emergency@qsource.org
- Nw10-emergency@qsource.org

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Thank You

Questions?

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