

# 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!



# 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



# ESRD Staff

## Executive Directors



**Audrey  
Broaddus**



**Stephanie  
Smith**



**Jeff  
Arnall**



**Sandy  
Cannon**



**Erica  
Anderson**



**Keisha  
Wilson**



**Eleanor  
Nelson**

## Information Services

## Patient Services

## Quality Improvement



**Roma  
Heater**



**Mandy  
Vires**



**Debbie  
Ulm**



**Ashley  
Dixon**



**Meghan  
VanSlyke**



# Qsource's Values and Mission

<b>Diversity/Equity/Inclusion</b>   Celebrate differences, promote awareness, eliminate inequities, and embrace all.	<b>Respect for People</b>   Demonstrate kindness, compassion, and consideration to everyone in every interaction.	<b>Continuous Improvement</b>   Seek opportunities to excel and deliver service better today than you did yesterday.	<b>Integrity</b>   Demonstrate high moral standards, be honest, and do what you say you're going to do.
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**Mission: To improve healthcare quality through patient-centered, provider-focused solutions that enhance the patient's quality of life.**



# ESRD Network 10 Demographics

Qsource holds two End-Stage Renal Disease Network Contracts



ESRD Network 10  
Illinois

31,865  
ESRD/Transplant  
Patients

### Modality

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

### Race

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

346 Dialysis  
Clinics

### Ethnicity

18% Hispanic  
77% Non-Hispanic  
5% Unknown

### Facility Location

96% urban  
4% rural

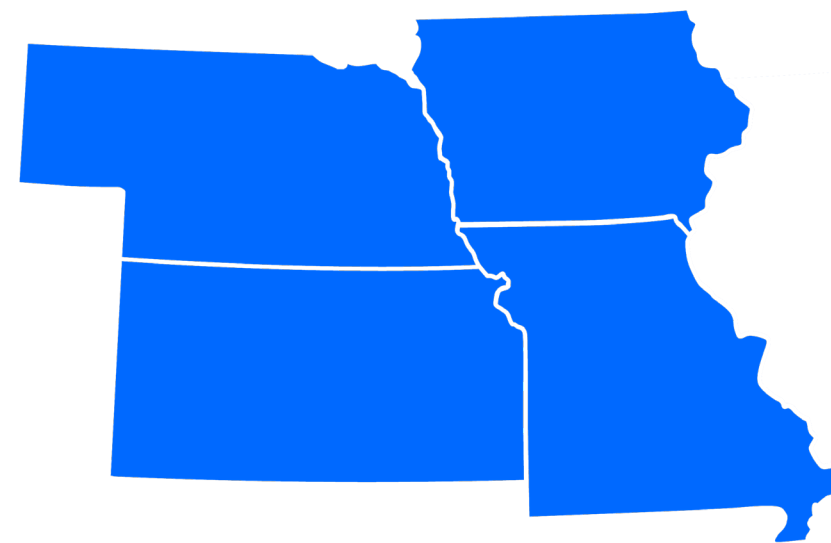
9 Transplant  
Centers

### Gender

Male 59%  
Female 41%



# ESRD Network 12 Demographics



ESRD Network 12

Iowa, Missouri, Nebraska, Kansas

28,864  
ESRD/Transplant  
Patients

### 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%

318  
Dialysis Clinics

### Ethnicity

6% Hispanic  
92% Non-Hispanic  
2% Unknown

### Facility location

80% urban  
20% rural

12  
Transplant  
Centers

### Gender

Male 59%  
Female 41%

# 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





# 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

# 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



# 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!

# The Importance of Partners | Kidney Community Stakeholders



**Change Agents**



**Outreach and Education**



**Data Collection and Validation**



**Bidirectional Information Exchange**



**Routine Communication**



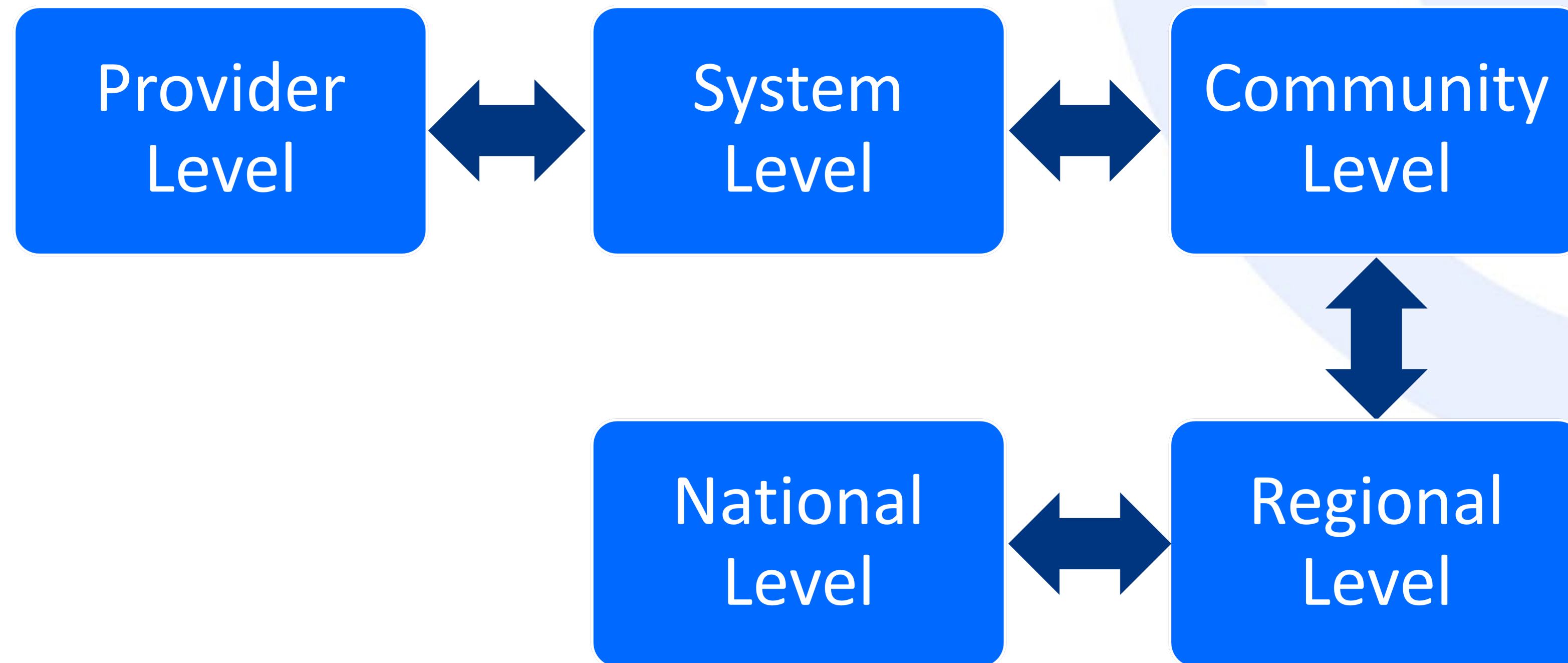
**Identify Performers**

- 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

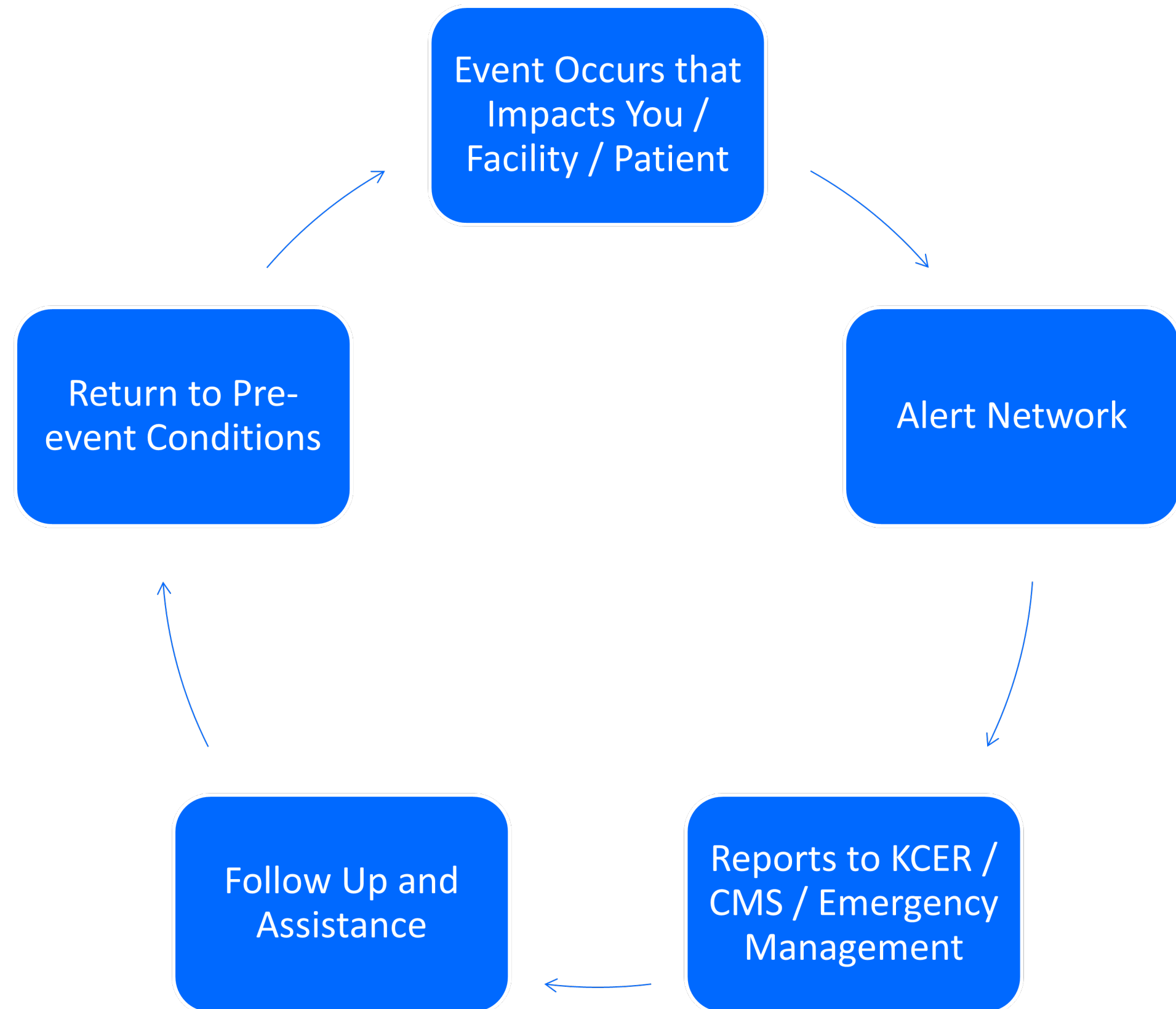


# Impacting Change on Multiple Levels

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.



# 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](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

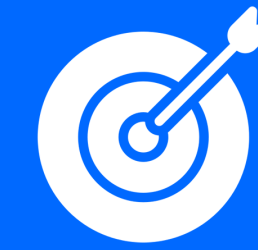
## Contact Us!

[Nw10-emergency@qsource.org](mailto:Nw10-emergency@qsource.org)

[Nw12-emergency@qsource.org](mailto:Nw12-emergency@qsource.org)

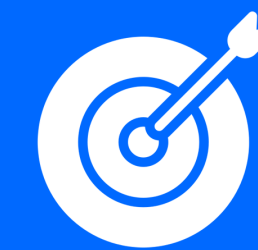
# Success Highlights from Last Year

- 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 provide 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



A blue-tinted photograph of a doctor and an elderly patient. The doctor, on the left, is wearing a white lab coat and has a stethoscope around their neck. They are smiling and looking towards the patient. The patient, on the right, is an elderly woman with short, curly hair, wearing a light-colored sweater. She is also smiling and looking back at the doctor. The background is slightly blurred, suggesting an indoor setting like a clinic or hospital.

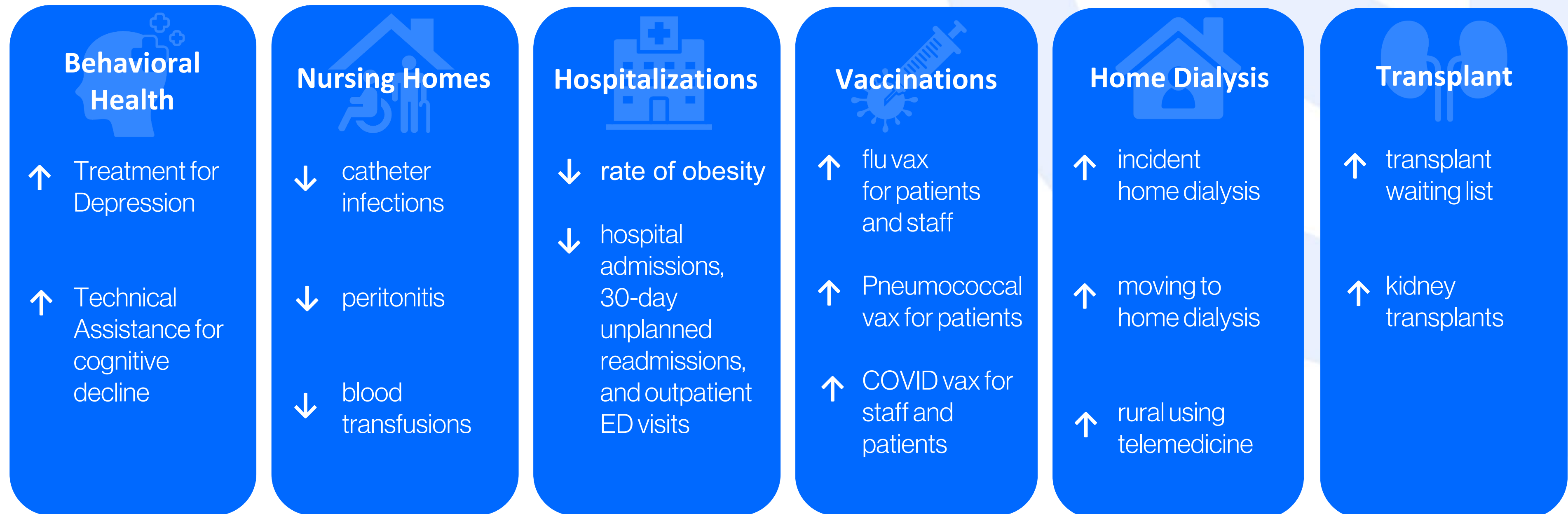
# Quality Improvement Department

# CMS Focus Areas and Quality Improvement Activities

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



### National Long-Term Goals





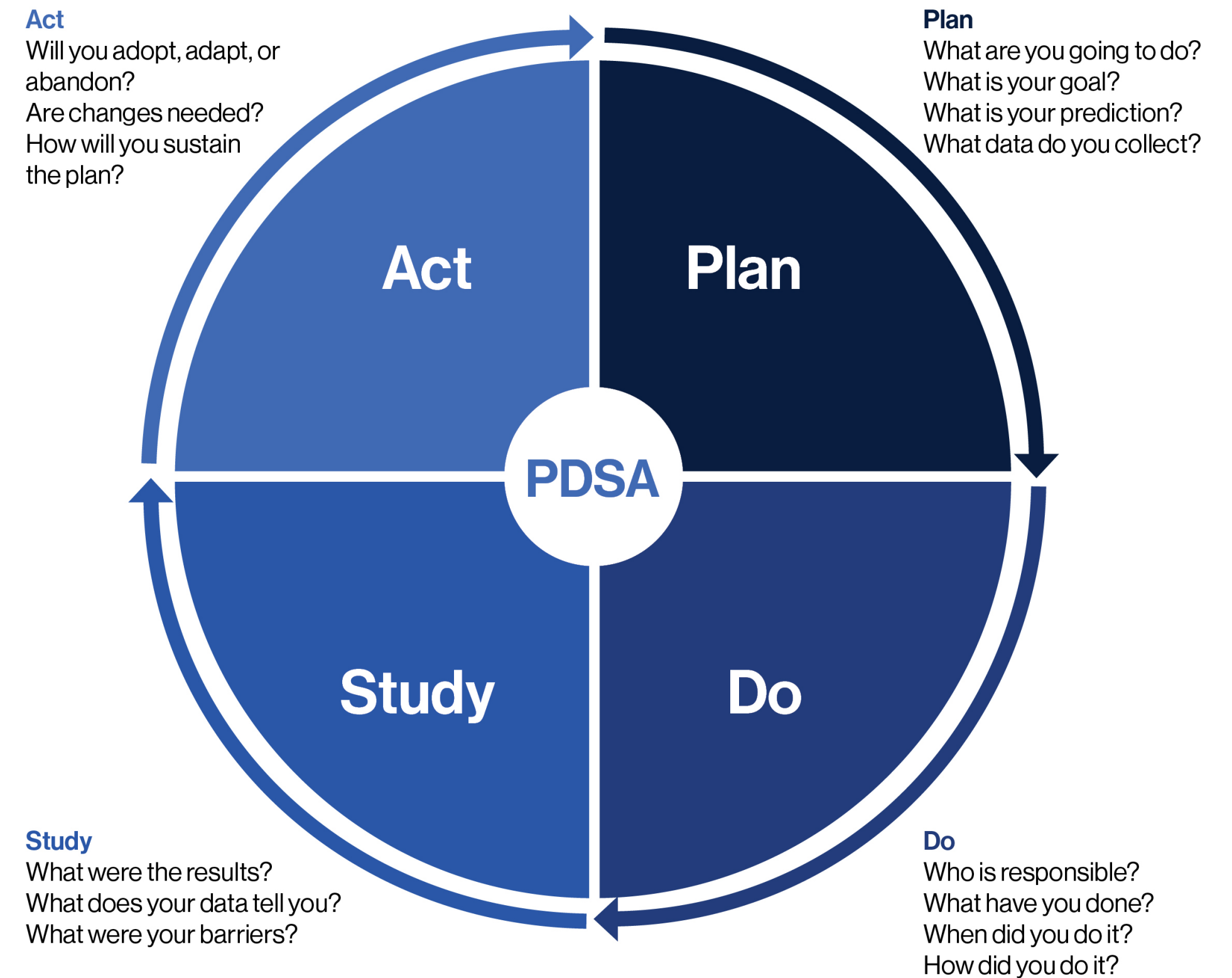
# Quality Improvement Strategies for Excellence






# 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




# 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



Let's Talk About Mental Health  
**Break the Silence. Break the Stigma.**

Mental Health Is Not	Mental Health Is
A Sign of Weakness	Important
Shameful	Linked to Physical Health
"All In Your Head"	Real
Something You Can "Snap Out Of"	Worth Making Time For
	Something We Need to Take Care Of

Ways to Improve Mental Health

### Discussing Depression With Your Care Team

**Why is it important to know if I am depressed?**  
 Depression can often make life more difficult for people living with kidney disease. It can make it hard to take care of yourself, which can make your medical condition worse. Finding out if you are depressed can help your doctor find the best treatment for you.

#### Patient Fears

It is common for people to be afraid of sharing their feelings with their care team. Most of those fears are caused by misunderstandings or myths about depression. Below are some common fears and the truth to help you see that the care team is there to help and support you. Use this table to think differently about each fear.

Fear	Truth
The doctor will put me on medicines that I'd rather not take.	There are many ways to treat depression and medication is just one of them. Depression is often a chemical imbalance, and just as you would treat headaches or high blood pressure, depression may also be treated with medication. The decision to take medicine is between you and your doctor.
I do not want people to think I am weak or crazy.	Depression is a diagnosed mental health condition many people have. It is not a sign of "weakness" or "craziness." Depression can affect anyone at any time.
I will be told to go to a counselor, psychologist, psychiatrist or social worker.	Just as a nephrologist treats your kidney disease, there are professionals trained to work with people diagnosed with depression. They can be there to help and guide you, but the decision to meet with a counselor or therapist is up to you.
I am afraid of what changes I would have to make to get healthy.	You have already made a number of big changes to treat your chronic kidney disease, which may have been hard at first. It is normal to feel uncomfortable, and this will get better when you have a support team helping you.



# 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.

A screenshot of a "Nursing Home Dialysis Patient Communication Form". The form is divided into two main sections: "To Be Completed by Nursing Home" and "To Be Completed by Dialysis Facility".  
**To Be Completed by Nursing Home:**  
- Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
- Nursing Home Notes (new medication orders, change in condition): \_\_\_\_\_  
**To Be Completed by Dialysis Facility:**  
- Pre-Dialysis Treatment: Blood Pressure \_\_\_\_\_ Temperature \_\_\_\_\_ Pulse \_\_\_\_\_ Weight \_\_\_\_\_  
- Dialysis Treatment Orders: Target Weight \_\_\_\_\_ Treatment Duration \_\_\_\_\_  
- Medications Administered During Dialysis Treatment: \_\_\_\_\_  
- Post-Dialysis Treatment: Blood Pressure \_\_\_\_\_ Temperature \_\_\_\_\_ Pulse \_\_\_\_\_ Weight \_\_\_\_\_  
- Amount of Fluid Removes: \_\_\_\_\_  
- Did patient complete prescribed treatment?  Yes  No  
- If no, why? (cramping, low BP, other symptoms): \_\_\_\_\_  
- Please note any dialysis access problems (excess bleeding, infiltration, etc.): \_\_\_\_\_  
- Nurse completing this form: \_\_\_\_\_  
- Please attach a copy of any current labs that were drawn: \_\_\_\_\_  
The form includes the Qsource logo and website (www.qsource.org) at the bottom.

# 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.

**Harvest the Benefits of Home Dialysis**

How to use your Bulletin Board Kit

1. Look at the Display Board Idea.
2. Ensure your kit has all the needed pieces.
3. Cut out the pieces.
4. Invite a patient to assist you with creating the display.
5. Make sure the display is in an area where patients can see it.
6. Keep track of how many patients show interest in using a home modality.
7. Take a photo and send it to the Network at [Qsource-QIDept@qsource.org](mailto:Qsource-QIDept@qsource.org)

**Tis the Season to Learn About Home Dialysis**

How to use your Bulletin Board Kit

1. Look at the Display Board Idea.
2. Ensure your kit has all the needed pieces.
3. Cut out the pieces.
4. Invite a patient to assist you with creating the display.
5. Use cotton balls for snow or have patients make their own snowflakes to add to the board.
6. Make sure the display is in an area where patients can see it.
7. Keep track of how many patients show interest in using a home modality.
8. Take a photo and send it to the Network at [Qsource-QIDept@qsource.org](mailto:Qsource-QIDept@qsource.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.

**77% are on dialysis**    **29% living with kidney transplant**    **13 people die each day while waiting for a life-saving 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.


[www.qsource.org](http://www.qsource.org)



# 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.com/transplantation/livingdonors>

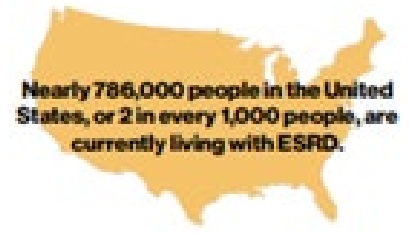
**Donate Life Kidney Donation**  
Donate Life is a website that provides valuable information about living donation and the need for living donors. Learn more about how loved ones and friends can become a kidney donor.  
<https://www.donatelife.net/types-of-donation/kidney-donation/>

**National Living Donor Assistance Center (NLDAC)**  
The NLDAC exists to provide access to transplantation 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).




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- More than 90,000 people in the US are awaiting a kidney donation.
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**71% are on dialysis**   **29% living with kidney transplant**

### Typical Day for a Dialysis Patient

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- 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.

esrdsource.org   



# 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:**

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

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

**Points of Discussion:**

- What are the appointments for and with whom? When are the appointments?
- 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.
- 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:**

- Do you understand why you were admitted or the signs that the condition is reoccurring or worsening?
- Who would you call if the condition worsens?
- 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.**

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

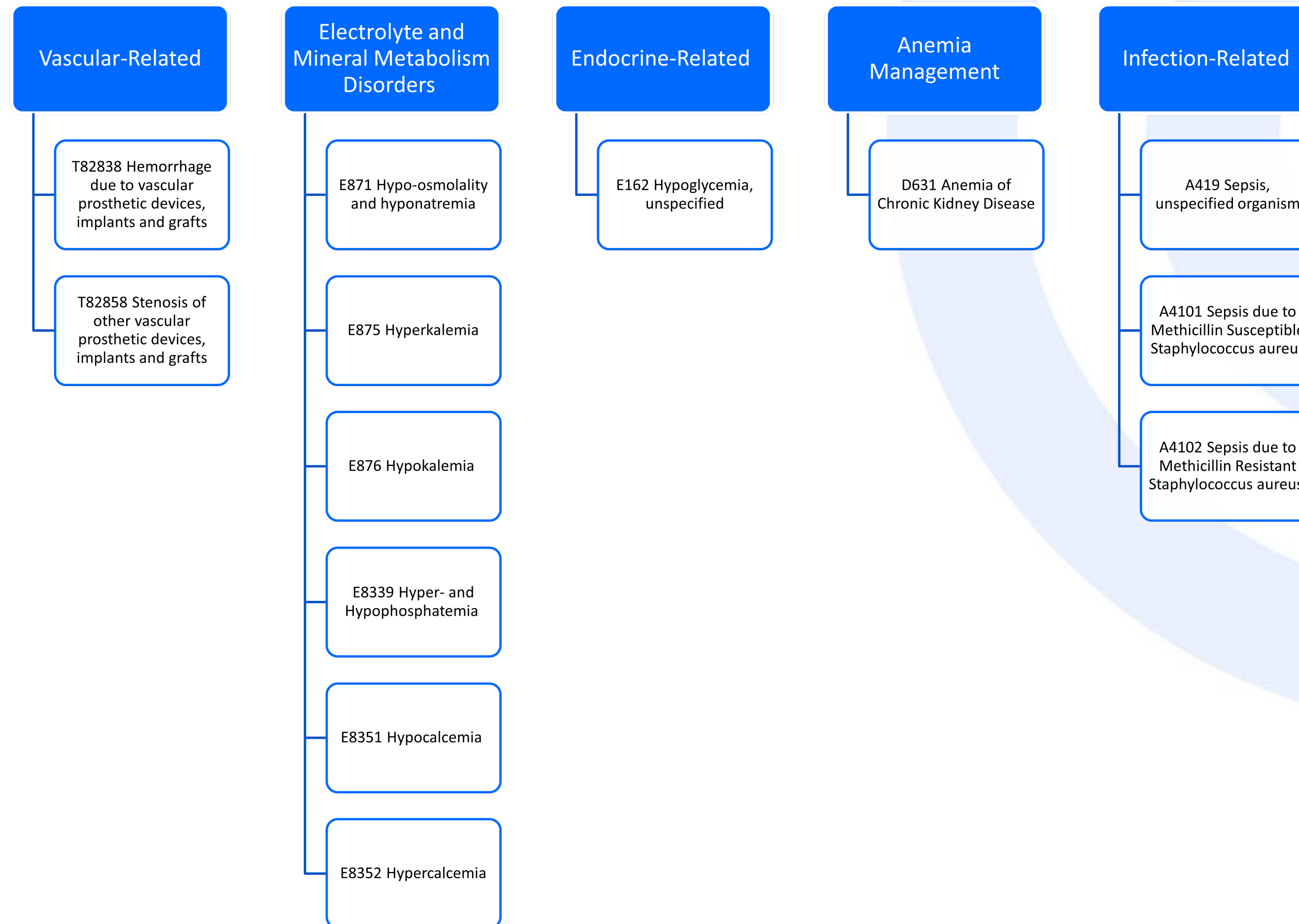
**Notes**

\_\_\_\_\_

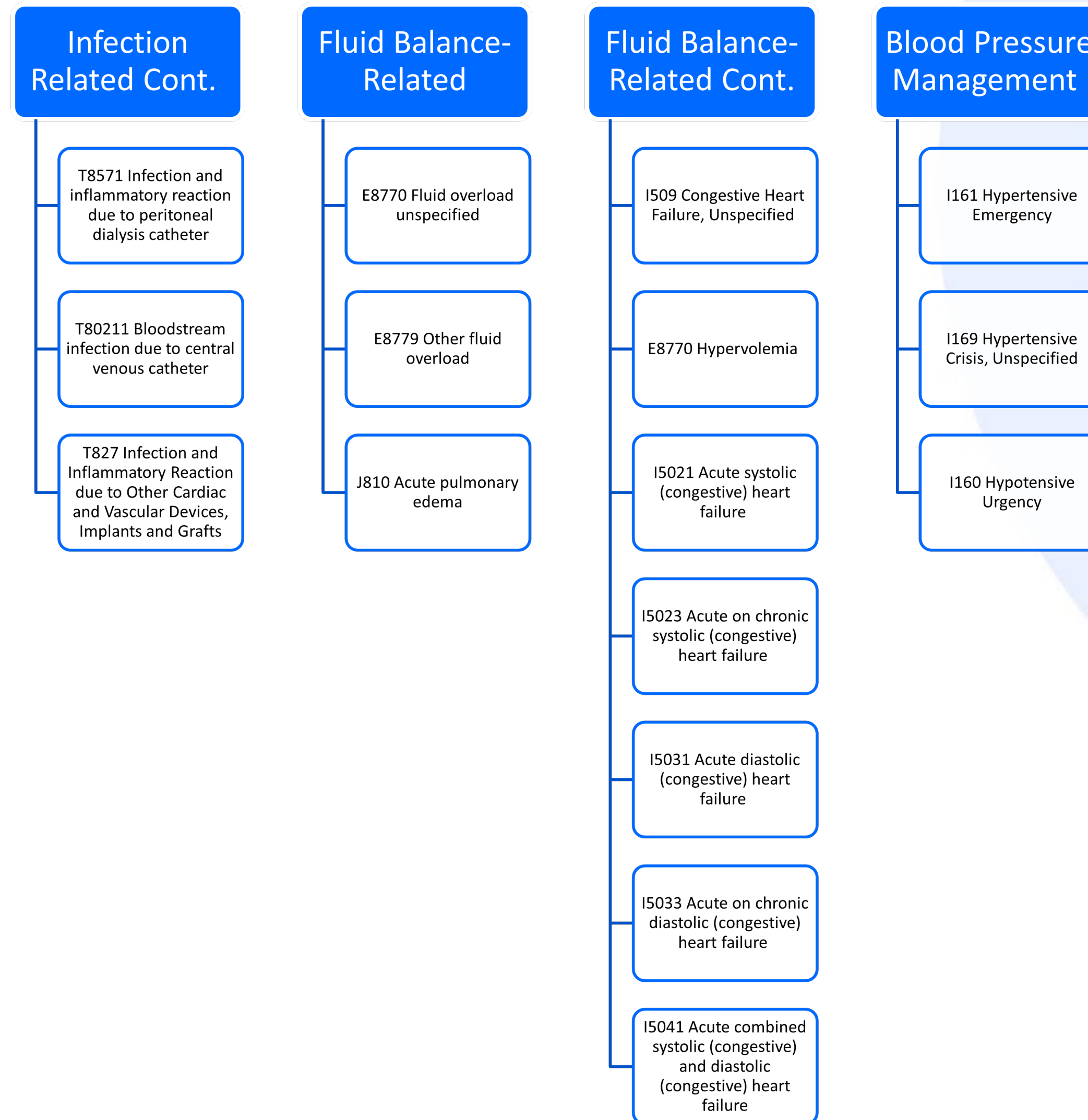
esrd.qsource.org  
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 **Qsource**  
ESRD Networks

# List of Priority Diagnosis Categories



# List of Priority Diagnosis Categories (cont.)





# 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. 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.

Vaccine	Date Administered	Lot Number	Site

Adult Immunization Record  
Please print or type your name and date of birth in the spaces provided.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Sex: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Your vaccination information can be sent directly to the dialysis care provider. Simply give the dialysis center contact information listed below to your vaccination 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) ESRD Network 12 (IA, KS, MO, NE)  
911 E. 81st St., Ste. 20 2300 Main St., Ste. 900  
Indianapolis, IN 46240 Kansas City, MO 64108  
Toll-Free (800) 456-1689 Toll-Free (800) 444-2666  
[www.esrdnetworks.com](http://www.esrdnetworks.com) [www.esrdnetworks.com](http://www.esrdnetworks.com)

**Qsource**  
ESRD Networks  
[www.qsource.org](http://www.qsource.org)

## 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*



# Patient and Family Engagement

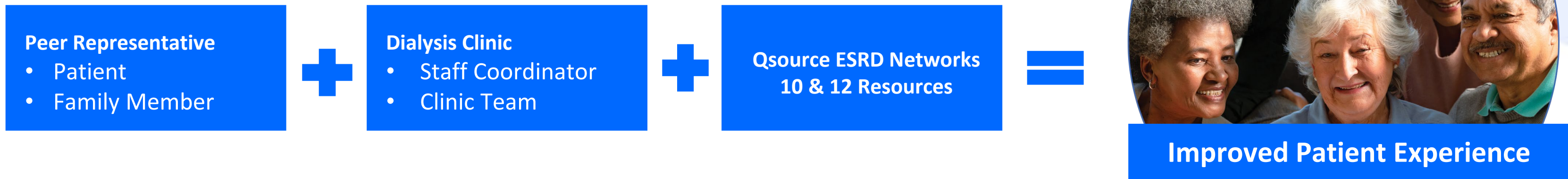
- Achieve a total of 30% increase in the number of facilities that integrate patients and families into QAPI
- Achieve a total of 30% increase in the number of facilities that successfully assist patient to develop a life plan from which the dialysis facility develops the dialysis plan of care
- Achieve 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





# 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



# 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



A blue-tinted photograph of a person's hands working at a desk. The person is wearing a dark blue long-sleeved shirt. Their hands are positioned over a laptop keyboard and a document. The desk is cluttered with various items: a laptop, a white coffee cup on a saucer, a glass of water, a pencil holder with several pencils, and several sheets of paper. One of the papers in the foreground has a bar chart and some text, including the words "Local Competition" and "Quality Score". The overall scene suggests a professional or academic setting focused on data analysis or information management.





# 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.



# 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/>



# 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.”

# 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

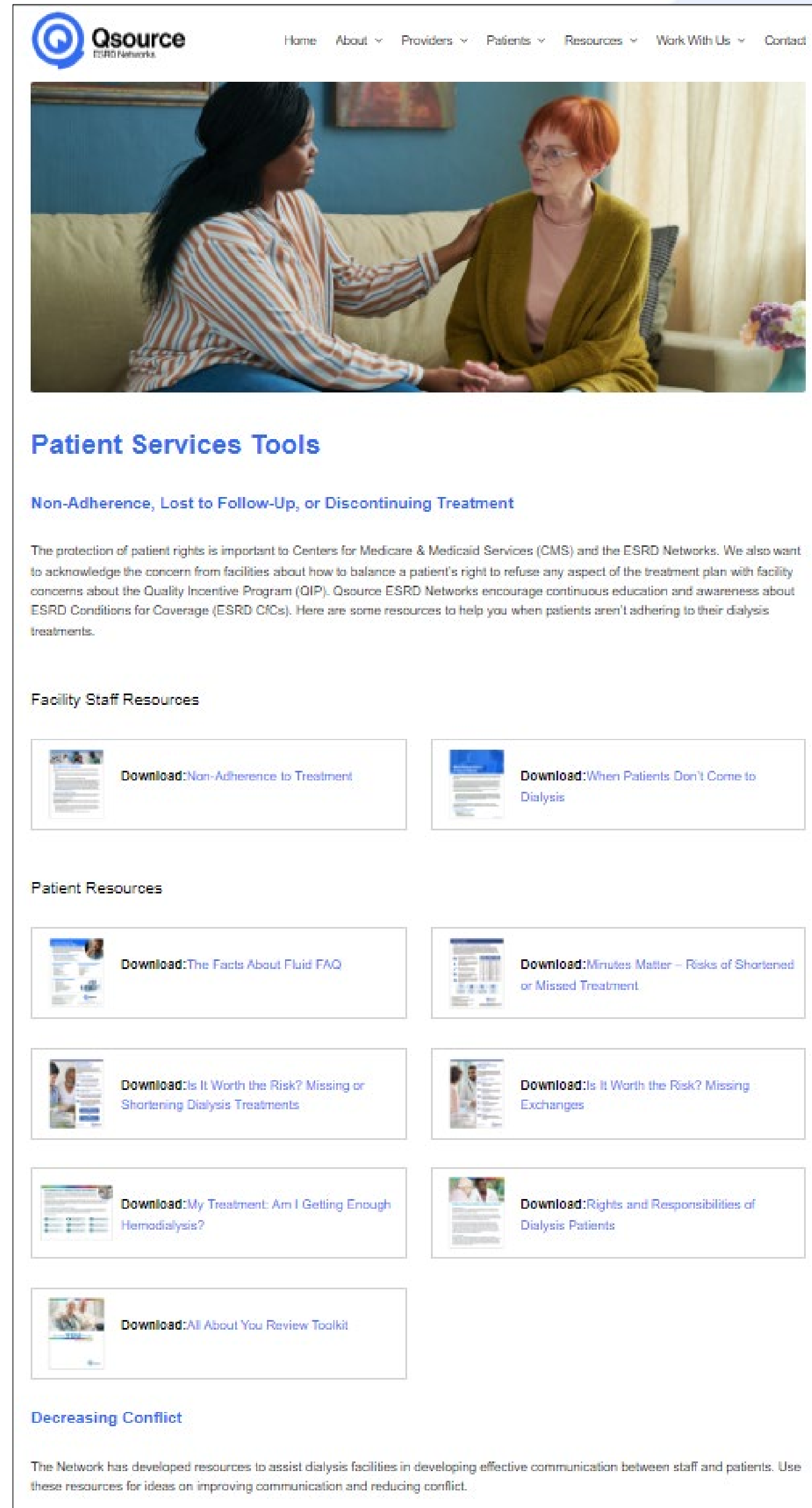
No Show/Missed Treatment



# 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



**Qsource**  
ESRD Networks

Home About Providers Patients Resources Work With Us Contact



## Patient Services Tools

### Non-Adherence, Lost to Follow-Up, or Discontinuing Treatment

The protection of patient rights is important to Centers for Medicare & Medicaid Services (CMS) and the ESRD Networks. We also want to acknowledge the concern from facilities about how to balance a patient's right to refuse any aspect of the treatment plan with facility concerns about the Quality Incentive Program (QIP). Qsource ESRD Networks encourage continuous education and awareness about ESRD Conditions for Coverage (ESRD C/Cs). Here are some resources to help you when patients aren't adhering to their dialysis treatments.

#### Facility Staff Resources

- [Download: Non-Adherence to Treatment](#)
- [Download: When Patients Don't Come to Dialysis](#)

#### Patient Resources

- [Download: The Facts About Fluid FAQ](#)
- [Download: Minutes Matter – Risks of Shortened or Missed Treatment](#)
- [Download: Is It Worth the Risk? Missing or Shortening Dialysis Treatments](#)
- [Download: Is It Worth the Risk? Missing Exchanges](#)
- [Download: My Treatment: Am I Getting Enough Hemodialysis?](#)
- [Download: Rights and Responsibilities of Dialysis Patients](#)
- [Download: All About You Review Toolkit](#)

### Decreasing Conflict

The Network has developed resources to assist dialysis facilities in developing effective communication between staff and patients. Use these resources for ideas on improving communication and reducing conflict.

# 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





A photograph of a female doctor in a white lab coat with a stethoscope around her neck, smiling and talking to an elderly female patient. The entire image is overlaid with a semi-transparent blue filter. The text 'Wrap Up' is centered in white.

# Wrap Up



# Network Website

The Network website has valuable tools and resources.  
Visit us at [esrd.qsource.org](https://esrd.qsource.org).



The screenshot shows the Qsource ESRD Networks website homepage. At the top left is the Qsource logo with the tagline "ESRD Networks". To the right is a navigation menu with links for Home, About, Providers, Patients, Resources, Work With Us, and Contact. Below the navigation is a large circular graphic containing a photo of a man in a white lab coat. To the right of this graphic is the heading "Qsource ESRD Networks" followed by a paragraph: "Qsource ESRD Networks work within Illinois, Iowa, Kansas, Missouri and Nebraska to assist both dialysis patients and dialysis facilities to achieve better outcomes in the treatment of kidney disease and improve quality of life for Medicare beneficiaries with end-stage renal disease." Below this are two columns. The left column features a blue outline of Illinois, the text "Network 10 Patient Toll-Free Number", and the phone number "(800) 456-6919". The right column features a blue outline of Missouri, Iowa, Kansas, and Nebraska, the text "Network 12 Patient Toll-Free Number", and the phone number "(800) 444-9965". At the bottom left is a photo of four healthcare professionals (three men and one woman) in a meeting around a table with a laptop. To the right of this photo is the heading "Support for Providers" followed by a paragraph: "Qsource ESRD Networks act in partnership with nearly 700 Medicare-certified dialysis facilities or services and more than 20 transplant centers. Through collaboration with this stakeholder community, we strive to assist dialysis providers in their efforts to improve quality of care and quality of life for nearly 60,000 ESRD patients." Below this paragraph is the text "We provide support for:" followed by a bulleted list: "Data Quality and Reporting", "Quality Improvement", and "Patient Engagement".

# 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](mailto:qsource-qidept@qsource.org)



PEERS program: [qsource-peers@qsource.org](mailto:qsource-peers@qsource.org)



Data Department: [esrddatadept@qsource.org](mailto:esrddatadept@qsource.org)



Emergency Preparedness:

- [Nw12-emergency@qsource.org](mailto:Nw12-emergency@qsource.org)
- [Nw10-emergency@qsource.org](mailto:Nw10-emergency@qsource.org)



[esrd.qsource.org](http://esrd.qsource.org)



[facebook.com/QsourceESRDNetworks](https://facebook.com/QsourceESRDNetworks)



# Thank You

## Questions?

