ESRD NETWORK 2018 ANNUAL REPORT

END STAGE RENAL DISEASE
NETWORK 8, INC.

ESRD Network 08
Contract Number:
HHSM-500-2016-0008C
Deliverable #11
June 30, 2019

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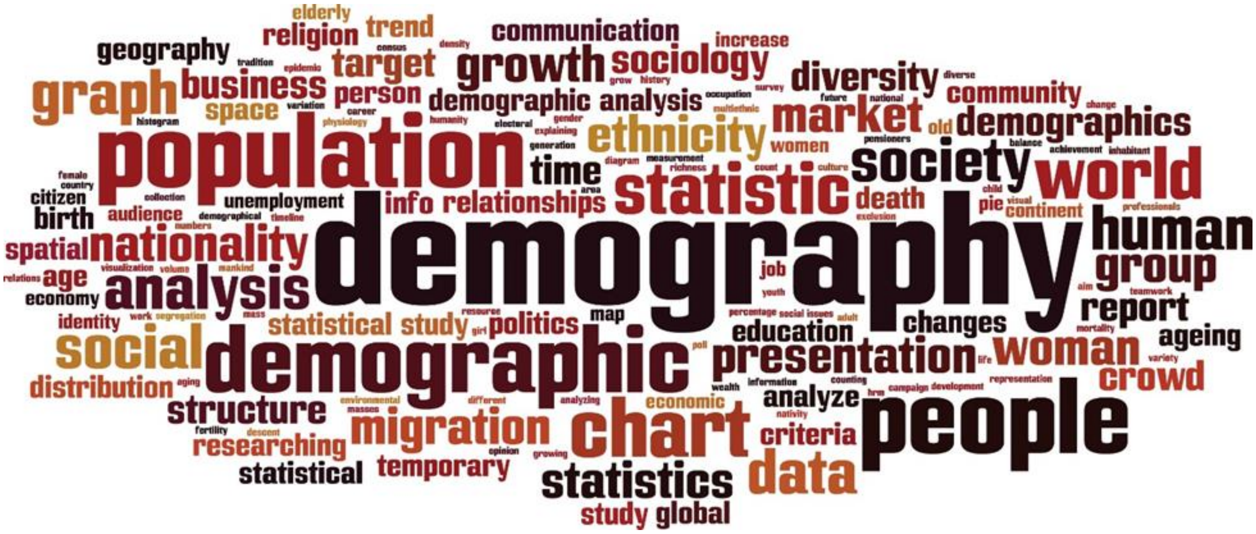
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ESRD DEMOGRAPHIC DATA

Network 8, Inc. is a subsidiary of Alliant Health Solutions, a corporation that also holds the ESRD Network 14 contract. The two ESRD Networks comprise the Alliant Quality Kidney Collaborative (AQKC) and rely on the corporate partnership for daily administrative, human resources, and information technology services. The AQKC partnership facilitates rich collaboration and increased efficiencies for both Networks' quality improvement and patient engagement activities.

Network 8 serves the ESRD community in the states of Alabama, Mississippi, and Tennessee, with the administrative office located in Ridgeland, Mississippi. Administrative guidance is received from the Board of Directors, program oversight from the Medical Review Board, and program development advice and consultation from patient subject matter experts who form the Patient Advisory Council (PAC) and ESRD professionals who serve on the Network Council.

The PAC is a diverse group of subject matter experts who represent the demographic characteristics of ESRD patients in the Network's service area. The PAC is instrumental in identifying the needs of patients and opportunities for provider education. Requirements for each Quality Improvement Activity (QIA) are reviewed with the PAC during quarterly meetings and workgroup calls. Patient-centered interventions to address these activities are developed in collaboration with the PAC during these meetings in an effort to cultivate patient engagement at the dialysis facility level. PAC members have served as peer mentors, participated on national Learning and Action Network (LAN) calls, shared experiences in the development of support groups, and functioned as facility patient representatives.

The Network area has a population of approximately 14.5 million. Alabama and Mississippi share more geographic, climate, population, and cultural similarities with each other than with their neighbor to the north, Tennessee, which has more topographic and demographic diversity, and shares boundaries with eight states. Mississippi is the most rural of the three states, followed by Alabama and Tennessee.

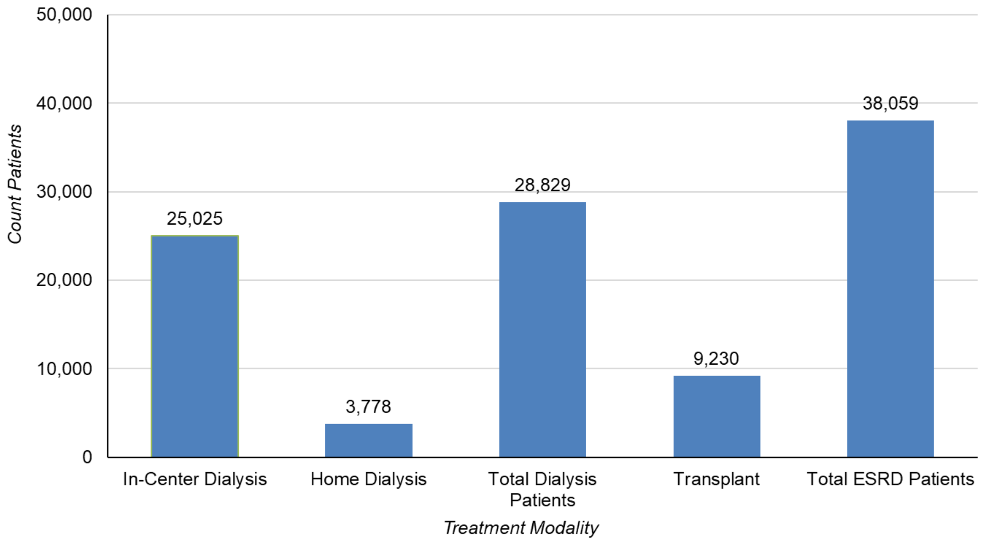
Alabama lies at the southern end of the Appalachian Mountains and extends southward from the Tennessee border to the Gulf of Mexico and the Florida panhandle. Urban areas include Birmingham (the largest city), Montgomery (the capital), Mobile, and Huntsville.

Mississippi borders Tennessee to the north, the Gulf of Mexico to the south, and Alabama to the east, and shares its western border with Arkansas and Louisiana.

Tennessee's geography and topography differ substantially from those of the other two states. Its regions are so different from each other that three distinct divisions are canonized in state law: West Tennessee, Middle Tennessee, and East Tennessee. Population centers include Memphis in West Tennessee, Nashville (state capital) in Middle Tennessee, and Knoxville and Chattanooga in mountainous East Tennessee.

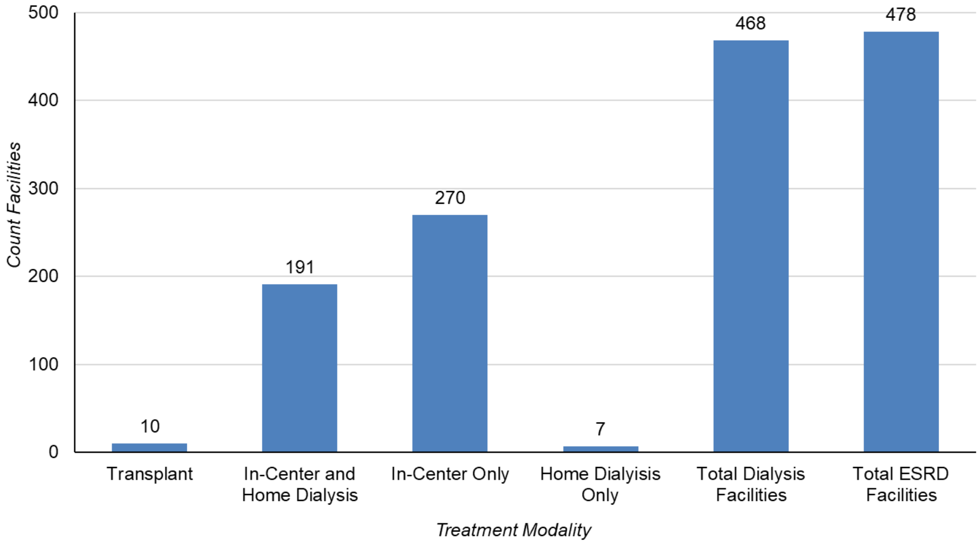
ESRD National Coordinating Center (NCC) data indicated that as of December 31, 2018, Network 8 served 25,025 in-center patients and 3,778 home patients who received renal replacement therapy from one of 468 dialysis units. There were an additional 9,230 kidney transplant patients who received care at one of 10 transplant units, bringing the total Network 8 ESRD population to 38,059. By modality type, 66% of total ESRD patients received in-center dialysis, 10% dialyzed at home, and 24% had a kidney transplant.

As of December 31, 2018, a total of 11,468 patients were receiving dialysis services in Tennessee, 9,747 in Alabama and 7,499 in Mississippi.



Network 08: Count of Prevalent ESRD Patients by Treatment Modality 2018

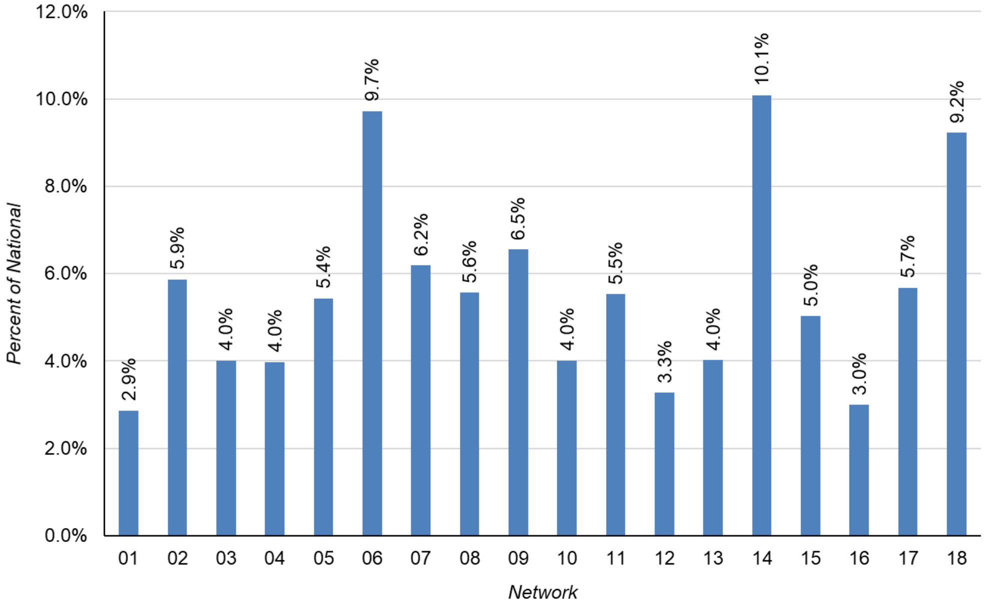
Total Dialysis Patients = In-Center Dialysis + Home Dialysis
Total ESRD Patients = Transplant + Total Dialysis
SNF dialysis patients are not shown due to small numbers.
Source of data: CROWNWeb



Network 08: Count of Medicare-Certified Facilities by Modality Type Offered 2018

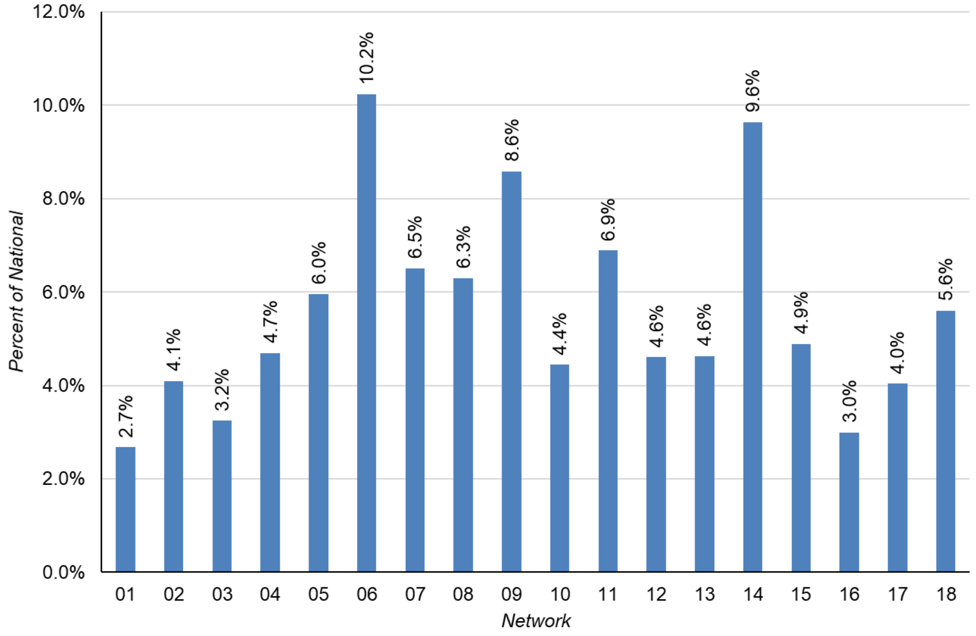
Total Dialysis Facilities = In-Center and Home Dialysis + Home Dialysis only + In-Center Only
Total ESRD Facilities = Transplant + Total Dialysis Facilities
Source of data: CROWNWeb

Percent of Prevalent Dialysis Patients by ESRD Network
2018



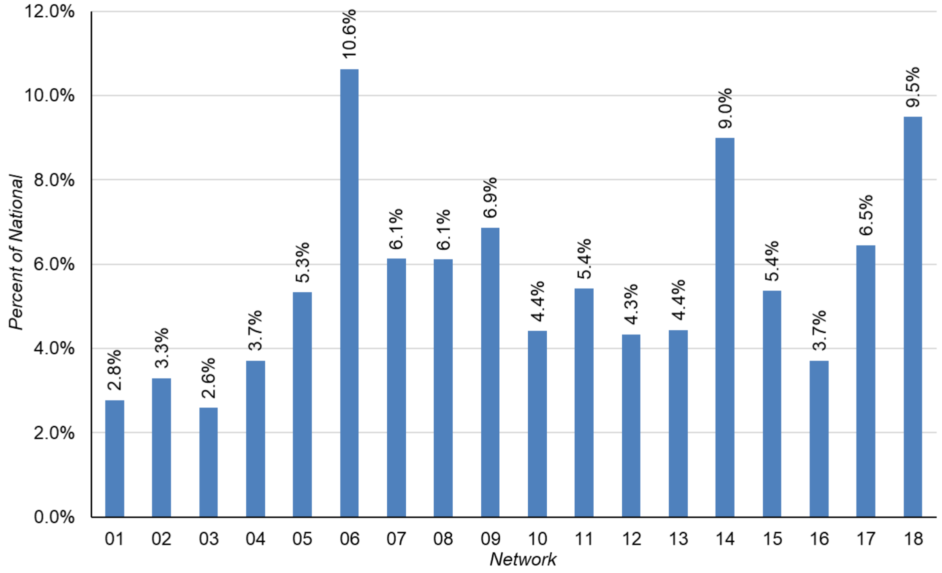
National total dialysis patients: 518,106
Source of data: CROWNWeb

Percent of Medicare-Certified Dialysis Facilities by ESRD Network
2018



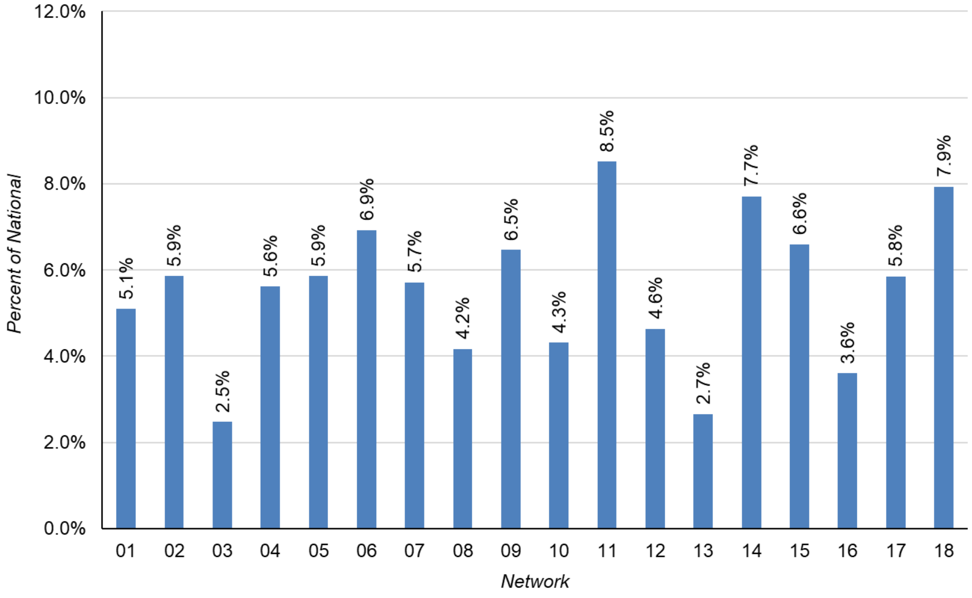
National total ESRD Medicare-certified dialysis facilities: 7,431
Source of data: CROWNWeb

Percent of Home Hemodialysis and Peritoneal Dialysis Patients by ESRD Network 2018

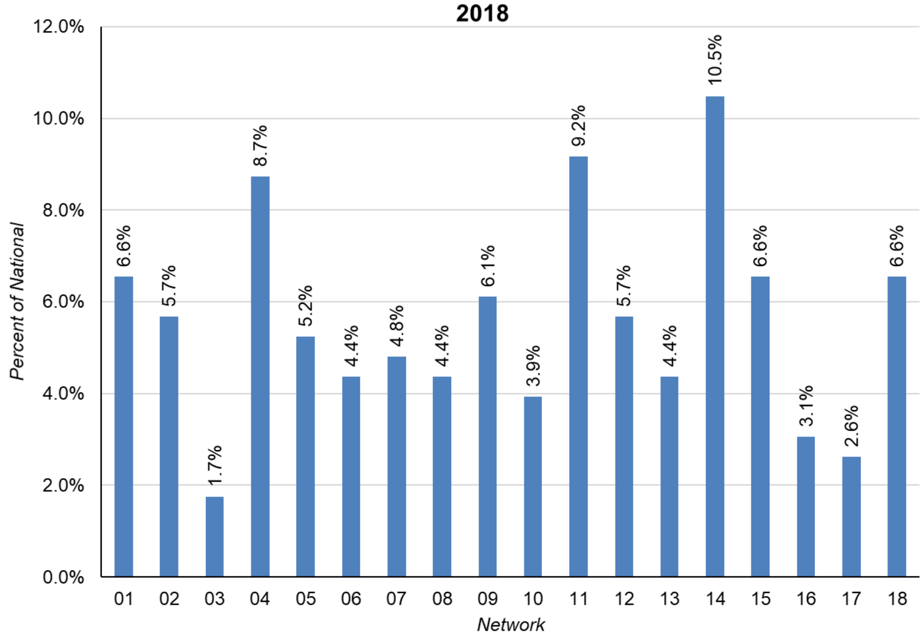


National total home hemodialysis and peritoneal dialysis patients: 61,826
Source of data: CROWNWeb

Percent of Transplant Patients by ESRD Network 2018



National total transplant patients: 221,497
Source of data: CROWNWeb



Percent of Medicare-Certified Kidney Transplant Facilities by ESRD Network 2018

National total ESRD Medicare-certified kidney transplant facilities: 229
Source of data: CROWNWeb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negotiation
negotiate
settlement
agreement
communication
understanding
business
balance
deal
contract
agree
mutual
concessions
negotiating
compromising
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acceptance
argument
tolerance
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ESRD NETWORK GRIEVANCE AND ACCESS TO CARE DATA

Grievances

The Network responds to grievances filed by or on behalf of ESRD patients in its service area. In 2018, the Network received and investigated 45 grievances. All grievances are classified into one of three categories: Immediate Advocacy, General, or Clinical Quality of Care. Upon resolution of a grievance, patients and patient representatives filing a grievance with the Network are contacted by a third party to complete a grievance satisfaction survey detailing their experience with the Network during the grievance process. The CMS goal is for Networks to achieve and maintain a grievance satisfaction score of 80% or greater. Network 8 exceeded the goal with a satisfaction score of 93.10%. In November, the Network's best practices for addressing grievances were presented on a CMS Patient Experience of Care call, the routine monthly call held between CMS and ESRD Networks to promote patient-centered care.

Of the 45 patient grievances, a majority were addressed using Immediate Advocacy (n=28). Immediate advocacy cases are simple, generally non–quality of care cases that can be completed in seven calendar days or less. Network 8 investigated eight General Grievances. A general grievance does not entail clinical quality of care issues, but is more complex than an immediate advocacy grievance. The timeframe for a General Grievance is 60 calendar days. Nine grievances were classified as Clinical Quality of Care Grievances. These grievances allege that a facility did not meet professionally recognized standards of clinical care and are generally resolved within 60 calendar days.

Access to Care

Network 8 collaborates with individual patients and facility staff to identify and address barriers to obtaining or maintaining patient dialysis treatment. Access to care cases may be presented to the Network in the form of a grievance or an at-risk access to care case initiated by facility staff, an ESRD patient, and/or an individual representing an ESRD patient. These situations occur when the patient is at risk for involuntary discharge or after the patient has been discharged from a facility. An involuntary discharge is a discharge initiated by the treating dialysis facility or nephrologist without the patient's consent.

All dialysis facilities in Network 8's service area have been advised to notify the Network prior to providing the patient with a 30-day notice of discharge, and efforts are made to avert the discharge during an initial phone call with facility staff. The initial phone call consists of a review of facility interventions to improve the behavior and development of a detailed action plan. The Patient Services Director (PSD) reviews the Medicare regulations with the facility staff and ensures that guidelines are being followed.

There were a total of 240 documented phone calls in 2018. Of these calls, 81 were initiated by facility staff requesting assistance addressing patient specific issues. These cases were most commonly at-risk access to care cases in which a patient was deemed at risk for being involuntarily discharged (*n*=72). The primary areas of concern for access to care calls were categorized as follows: 20 disruptive patient behaviors, 31 nonadherence to treatments, 11 immediate/severe threats, and 7 due to nonpayment for treatment.

In 2018, there were 70 potential involuntary discharges reported to the Network. Of those, 36 (51%) were averted. The 34 involuntary discharges that occurred were categorized as immediate severe threats (n=16), physician discharges (n=16), and nonpayment discharges (n=2).

The last area of phone calls were classified as facility concerns (n=102). This occurs when facility staff request guidance in areas such as mental health resources, nonadherence, patients lost to follow up, and other general inquiries.

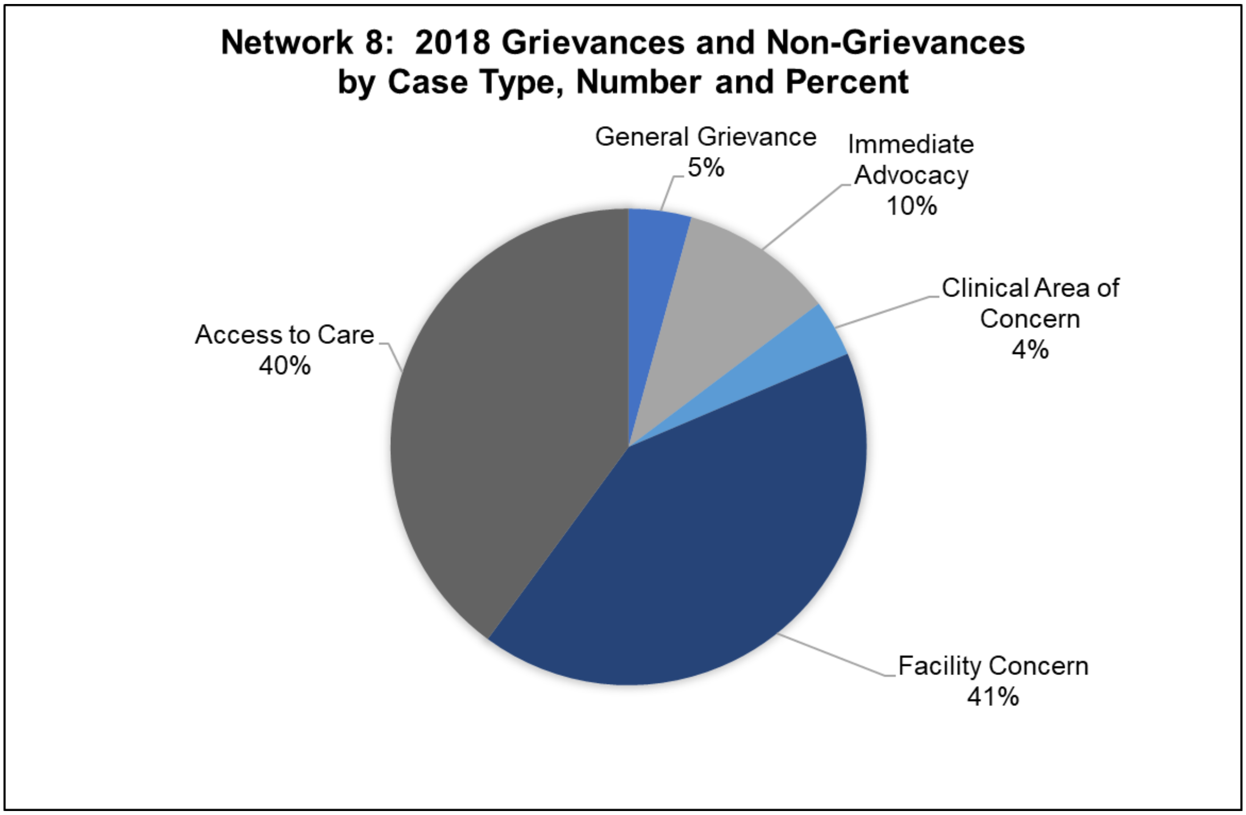
Interventions

1. Focused audit of grievances--Based on a review of grievances, the categories most prevalent were professionalism, policy/procedure, and access-related concerns. In an effort to address these areas, all Network facilities received educational resources.
2. Focused audit of involuntary discharges--Based on a review of all Network involuntary discharges, the most prevalent areas for involuntary discharges were immediate threats and physician- initiated discharges for behavior and nonadherence. Strategies and other tools, such as the Forum of ESRD Networks Grievance Toolkit, were provided to all facilities to reduce the number of involuntary discharges in these areas.
3. The *Involuntary Discharge Expectations* handout--This handout was created to provide guidance to facility staff when an involuntary discharge is being considered.
4. Medical Review Board’s Position Statement--The position statement is distributed to facilities as appropriate and opposes discharge for nonadherence to treatment, i.e., missing/shortening treatments.

Best Practice

In collaboration with the MRB, BOD, and PAC, Network 8 developed an innovative approach to decrease the number of involuntary discharged and failure to place patients dialyzing in the emergency room. **The Second Chance Program-90-day Trial Basis Policy** was a pilot program in 2017 with full implementation in 2018. The process provides a consistent protocol to address access to care issues and lessen the use of urgent dialysis via emergency room visits for involuntarily discharged patients. Facilities collaborate with the Network to admit difficult to place patients and have ongoing support from the Network for 90 days. At a minimum, Network interventions include: monthly contact with the patient and facility, notification to the State Survey Agency, and collaboration to develop an acceptable Expectations of Treatment agreement. If there are no behavioral issues, the patient is admitted as a permanent patient at the end of the 90 days.

To date, the Network has successfully utilized the Second Chance program to place five patients who would otherwise receive dialysis in the emergency department. The Network was invited to share this practice during a CMS Patient Experience of Care call and at the CMS Annual Quality Conference.



Source of data: Patient Contact Utility (PCU)


metrics
product
target
best practice
industry best
indicator
procedure
quality
process
standard
continuous
strategic
professional
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experience
identify
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measurement
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best firm
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improvement
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solution
financial
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ESRD NETWORK QUALITY IMPROVEMENT ACTIVITY DATA

Long Term Catheter Quality Improvement Activity

Goal: The long-term catheter (LTC) Quality Improvement Activity (QIA) was implemented with the selection of 37 facilities enrolled in the Blood Stream Infection (BSI) reduction project, as further discussed below, and reporting a LTC rate above 15%, i.e., total number of patients in the selected facility dialyzing via LTC only / total number of hemodialysis patients in the facility for July 2017. The baseline LTC rate was 18.8% (490 LTC patients / 2610 total hemodialysis patients) with a goal to decrease the LTC rate by at least two percentage points by July 31 (final data reported September 30; see following chart).

Project Outcome: A total of 68 catheters were removed in project facilities during the course of this QIA, thereby meeting project goal of 16.8% hemodialysis patients dialyzing via LTC only.

Barriers: A Root Cause Analysis (RCA) was performed with all LTC QIA facilities prior to interventions. The analysis revealed a large number of patients refusing access referral, non-compliance with access physician appointments, and extended wait times for surgeon appointments.

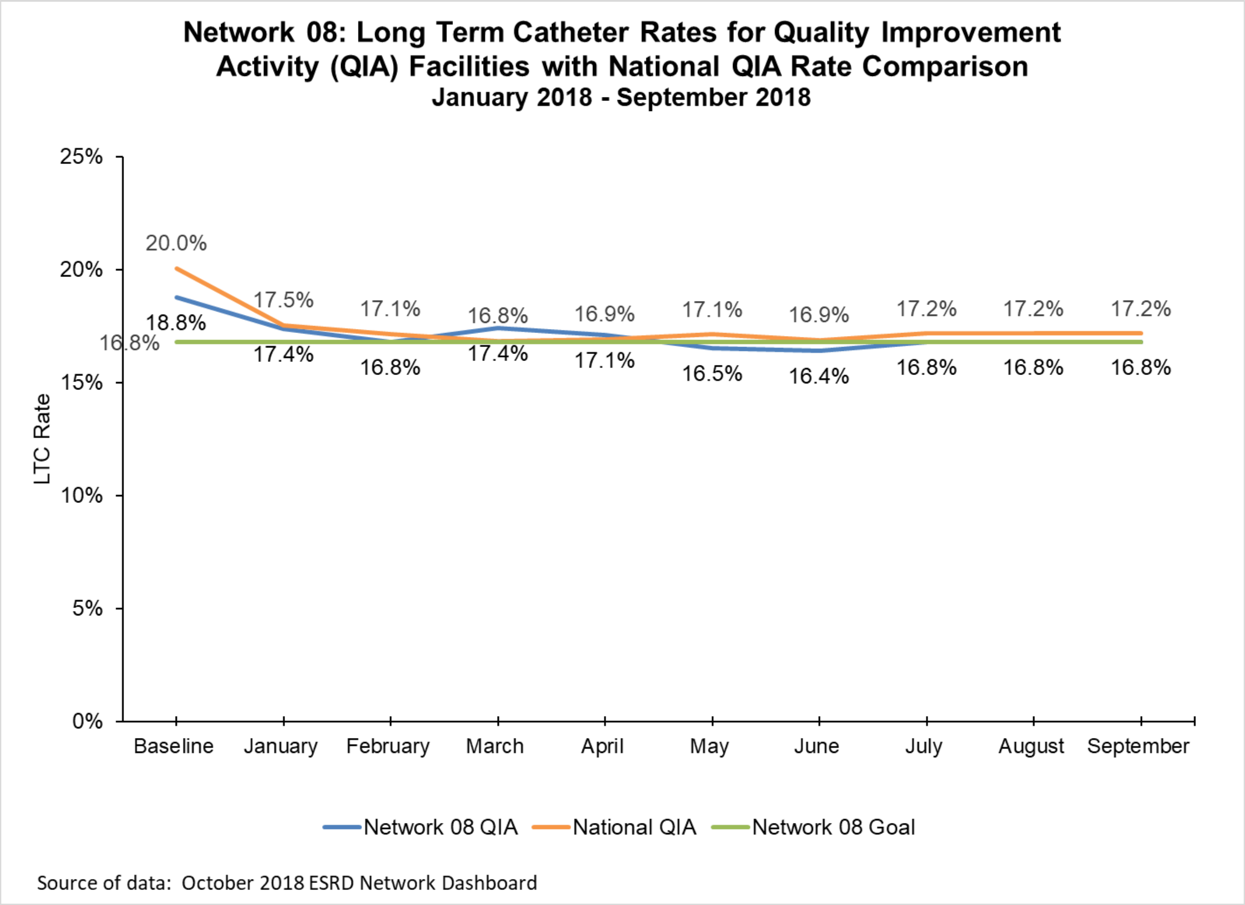
Interventions: Monthly, CROWNWeb LTC data was reviewed by Network staff, and coaching calls were conducted in order to identify barriers and provide technical assistance with improvement activities as well as to learn successful strategies implemented in facilities with improved outcomes. Facilities that reported an increase in LTC rates for three consecutive months were asked to perform a second RCA and develop an action plan addressing specific challenges identified.

Facilities implemented a number of interventions to decrease LTC rates and ensure these improvements are sustained. Interventions included:

- Scheduling of new patient admissions for vein mapping and surgery consult on the first day of admission
- Discussions with patients on the risk of infection with catheters, and that the CVC is a temporary access
- Nephrologist involvement with scheduling patients for access evaluation prior to discharge from the hospital for newly diagnosed ESRD patients who initiated dialysis in the hospital.
- Nephrologist and vascular surgeon collaboration on patient access planning
- Identification of a Vascular Access Manager who is committed to getting patients referred for access evaluation, placement, and follow up
- Dedicated staff to work as a team with common goal of reducing LTCs

Best Practices: Facilities that achieved the greatest reduction of LTCs identified the following best practices:

- Scheduled referral of new patients for vein mapping and vascular access planning within a minimum of two weeks of admission
- Collaborated with Nephrologist to refer patients for vein mapping and vascular access evaluation prior to discharge from the hospital
- Collaborated with vascular access surgeon and/or staff on routine basis
- Provided adequate time for dedicated staff to evaluate, educate, and follow up with patients and their vascular access plan
- Provided timely patient education on treatment options
- Ensured that patient care staff monitored newly created accesses for appropriate maturation and patency at each dialysis treatment



Network 08: Long Term Catheter Rates for Quality Improvement Activity (QIA) Facilities with National QIA Rate Comparison
January 2018 - September 2018

Source of data: October 2018 ESRD Network Dashboard

Blood Stream Infection Quality Improvement Activity

Goal: The BSI project was implemented with the selection of 50% of National Healthcare Safety Network (NHSN) eligible facilities (*n*=202), with special focus placed on selected facilities (*n*= 85) with the highest BSI rates. The purpose was to reduce BSI rates within the focus facilities. The baseline pooled mean BSI rate was 1.37% with a goal to achieve a 20% or greater reduction (1.10%).

Project Outcome: Target facilities exceeded the goal with a pooled mean BSI rate of 0.67% by the end of second quarter 2018. Of the 85 facilities in the project, 67 facilities (80%) surpassed the project goal of a 20% or greater reduction in their BSI rate at re-measurement. An independent sample t-test was conducted to compare BSI rates for focus facilities and non-focus facilities. The results revealed that focus facilities had a significant decrease in BSI rates. BSI rates decreased in focused facilities on average by 0.70 percentage point, while rates increased in non-focus facilities on average by 0.10 from baseline to re-measurement ($p<.0001$). Overall, the focus group achieved a 51% reduction, while the non-focus group increased BSI rate by 32%. The QIA achieved a reduction in Any CVC (Tunneled and Nontunneled Central Line) BSIs from 248 in 2017 to 120 in 2018, preventing an estimated 128 central line associated bloodstream infections (CLABSIs).

Barriers: Root cause analyses were performed by project facilities prior to implementation of monthly interventions. The most commonly identified barriers were non-access related infections, catheter-related infections, access-related infections, and poor patient hygiene.

Interventions: Monthly, BSI data was reviewed by Network staff in order to assess trends. Target facilities that reported an increase of BSIs for three consecutive months were required to perform an RCA and develop an action plan addressing specific challenges identified. Facilities implemented a number of interventions in order to decrease BSI rate. Improvements in facility processes will contribute to sustained improvements in BSI rate.

Interventions included:

- NCC BSI Learning and Action Network calls--All project facilities were invited to attend these calls to gain best practices and identify successful interventions to reduce BSIs. Following the calls, the Network monitored facility level interventions utilizing concepts from the LAN.
- Lifeline for a Lifetime--Facilities were provided this tool to assist staff with developing access plans for catheter patients. The tool also helped patients choose the most appropriate access and understand proper care for their access.
- Conversation Starter to Prevent Infections in Dialysis Patients--Facilities incorporated this tool to assist with guiding conversations with patients about preventing infections and engagement in care.
- Sepsis materials--This included facility utilization of various resources including CDC resources on prevention of sepsis and rapid identification of sepsis as well as pictures of catheter infections from the Atlas of Vascular Access.

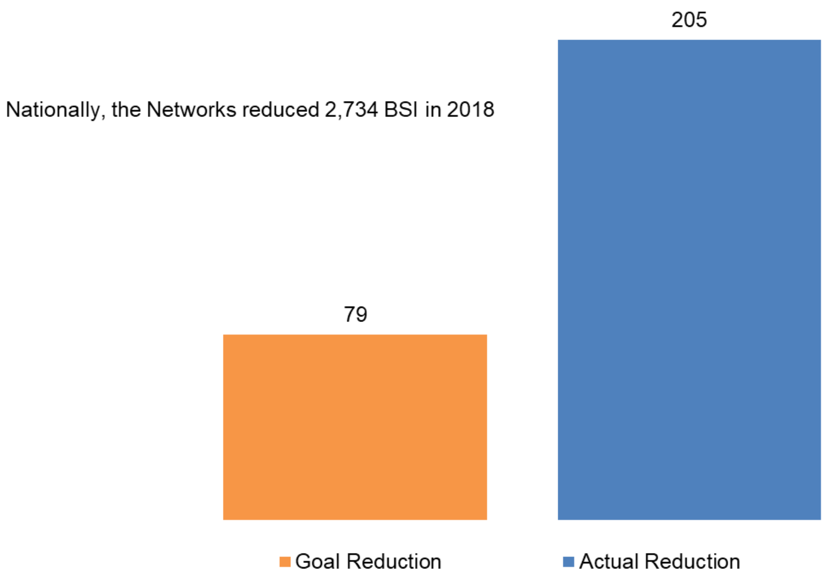
- WHOs 5 Steps to Hand Hygiene--Project facilities educated patients on the steps of hand hygiene. Upon completion of the education, the patients assisted with monitoring staff and other patients and provided recognition when hand hygiene was performed correctly.
- Monthly infection control audits, BSI prevention materials, Core Interventions for Dialysis BSI Prevention, Protocols, checklists, audit tools, "Preventing BSIs in Outpatient Hemodialysis Patients: Best Practices for Dialysis Staff" video, Infection Prevention in Dialysis Settings continuing education course, Clean Hands Count materials, and 5 Diamond materials.

Best Practices: Throughout the duration of the project, the Network collaborated with facilities to identify best practices and barriers. Improvement strategies were developed and shared among the QIA facilities. RCA follow-up identified the following best practices:

- Utilization of sterile kits for dressing changes
- Monthly hand hygiene audits
- Implementation of CDC's Scrub-the-Hub Protocol
- Utilization of a Sepsis Risk Tool
- Proper disinfection of dialysis station after the patient has left the station.

National Healthcare Safety Network (NHSN): All in-center hemodialysis units are eligible for and required to enroll in NHSN, the CDC's healthcare-associated infection tracking system. Home dialysis programs are not eligible for NSHN enrollment. NHSN-eligible facilities in the Network's service area (416) were supported in the completion of the online annual NHSN Dialysis Events Surveillance Training. The baseline was 0.0%, with a goal to achieve 90% or more of facilities completing the training. Facilities exceeded the goal with a rate of 98.3% by the end of second quarter 2018.

Health Information Exchange (HIE): Assistance was provided to all BSI QIA facilities (*n*=202) to join a HIE or another evidence-based highly effective information transfer system (i.e., hospital portal access). The baseline was 0.0%, with a goal to achieve 20% or more facilities obtaining hospital portal access. Facilities exceeded the goal with a rate of 46.5% by the end of second quarter 2018. Interventions included fostering relationships with hospitals and dialysis facilities and providing detailed instructions on obtaining hospital portal access.

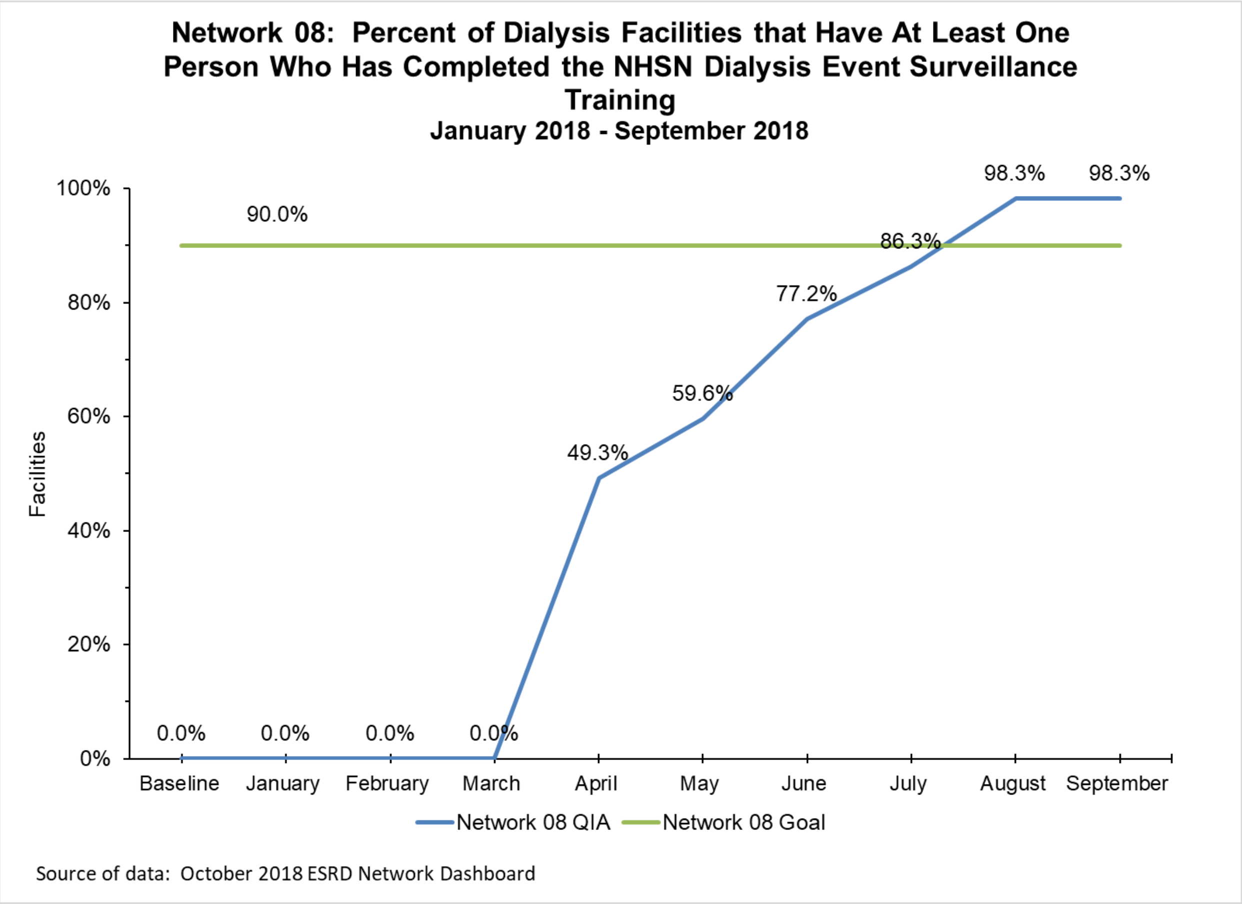


Network 08: Reduction in Bloodstream Infections (BSI) in QIA Facilities

Nationally, the Networks reduced 2,734 BSI in 2018

The Network goal was to decrease the rate of BSI by 20% or greater relative reduction in the pooled semi-annual mean in facilities participating in the QIA

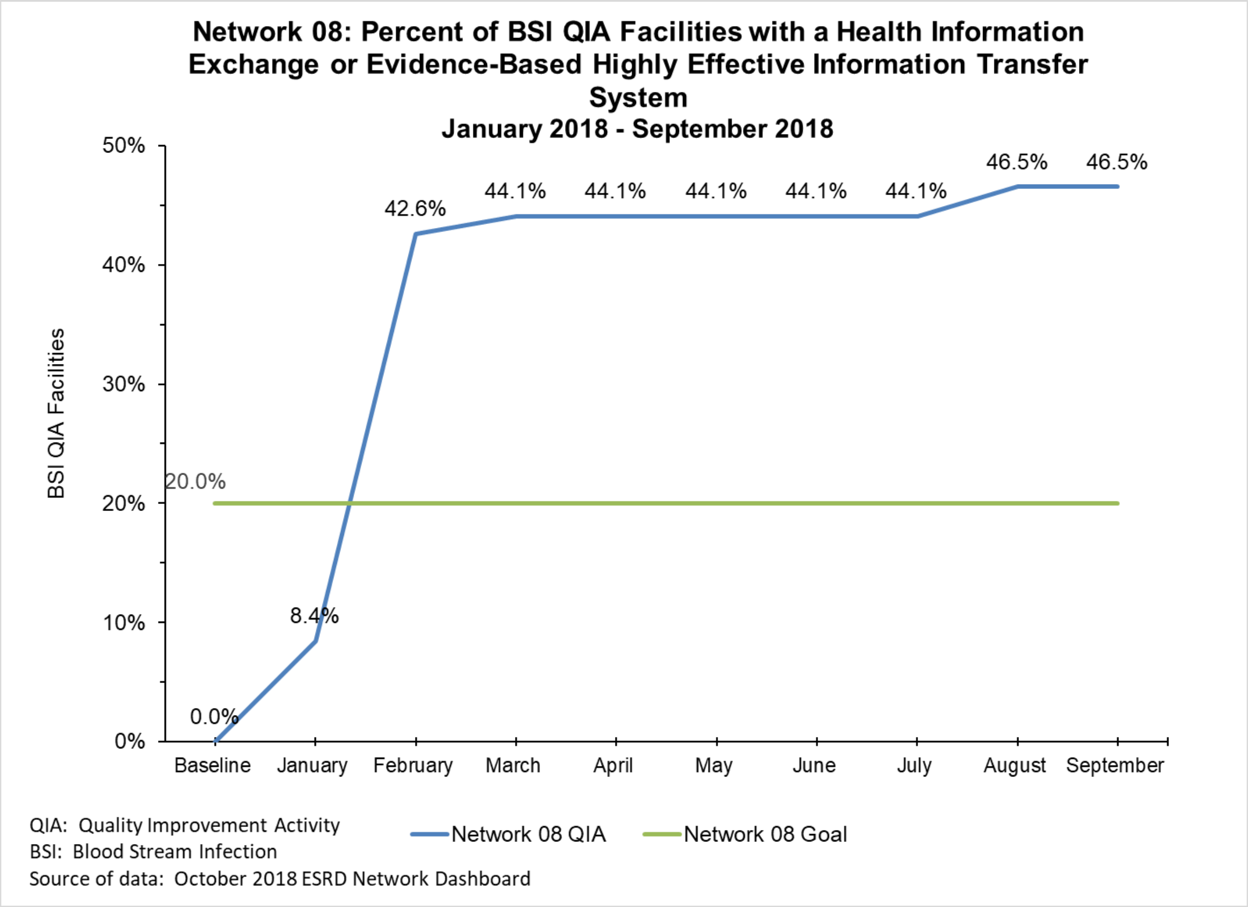
QIA: Quality Improvement Activity
Source of data: National Healthcare Safety Network (NHSN) January 2018 - June 2018 compared to January 2017 - June 2017



Network 08: Percent of Dialysis Facilities that Have At Least One Person Who Has Completed the NHSN Dialysis Event Surveillance Training

January 2018 - September 2018

Source of data: October 2018 ESRD Network Dashboard



Network 08: Percent of BSI QIA Facilities with a Health Information Exchange or Evidence-Based Highly Effective Information Transfer System
January 2018 - September 2018

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

Transplant Waitlist Quality Improvement Activity

Goal: In 2018, the Network was tasked with increasing the number of patients added to kidney transplant waitlists. The baseline for the Quality Improvement Activity (QIA) was 13.5% of all ESRD patients with a treatment modality other than transplant with a goal of a 10 percentage point increase to 23.5%. The Network selected 30% or 137 out of 435 facilities from the service area to participate in the Transplant Coordination QIA. A combination of facilities with varying rates were solicited for the QIA in order to help facilities increase low waitlist rates and share best practices from facilities with above average rates.

Project Outcome: The National Coordinating Center (NCC) provided baseline and monthly data to the Network. The Network demonstrated 2.33 percentage points improvement with 311 patients added to a waitlist by September 30, 2018.

Barriers: Root cause analyses were performed by project facilities prior to implementation of monthly interventions. The most commonly identified patient barriers were multiple medical comorbidities, nonadherence to dialysis treatment, and transportation. Staff barriers included poor communication with transplant facilities and limited knowledge about transplant referral and processes.

Interventions: Monthly, transplant waitlist data were reviewed to monitor improvement. Target facilities received monthly coaching calls to discuss barriers, interventions, and potential transplant candidates. Interventions included:

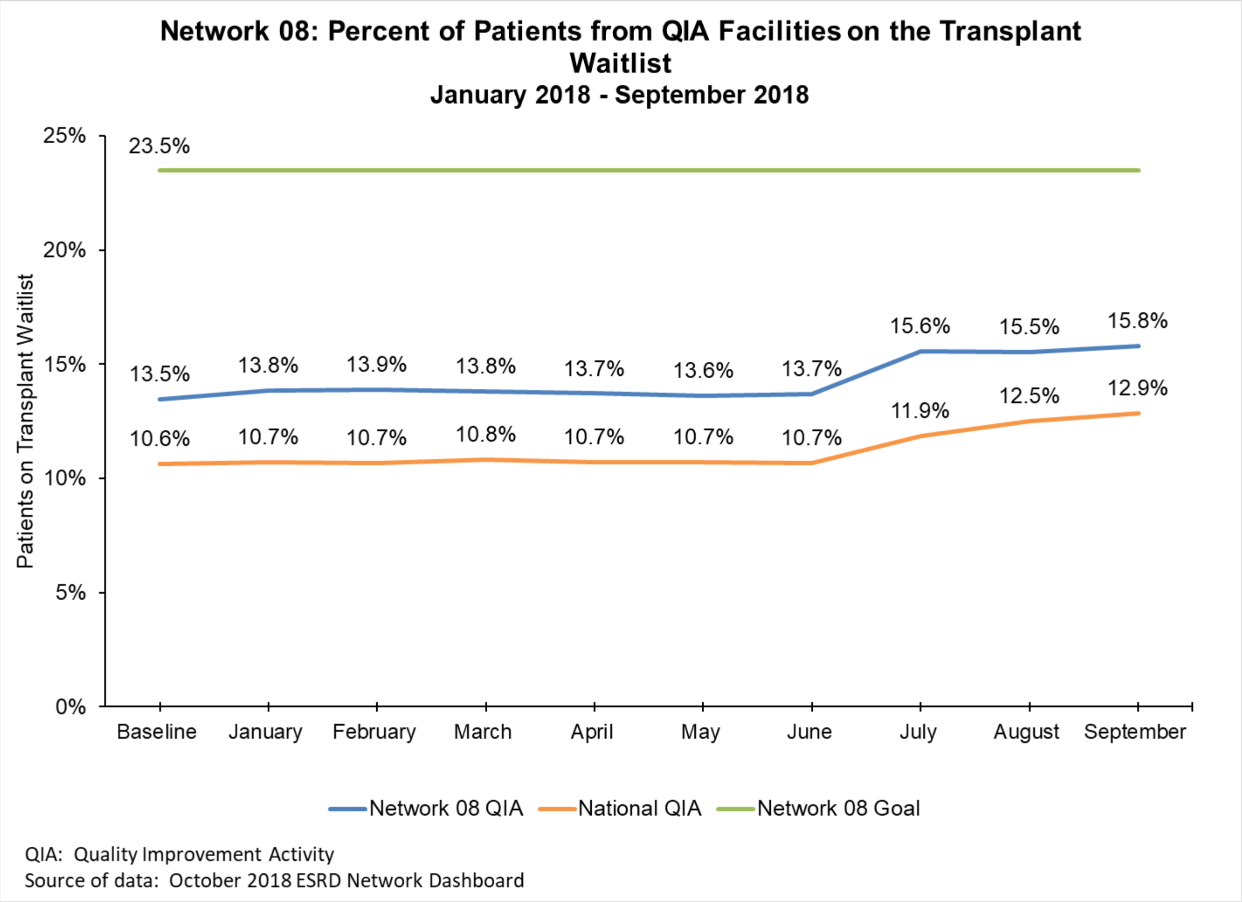
- **Peer-to-Peer Education -** Facilities identified a patient who successfully completed the transplant referral process to serve as a mentor and educator to peers. The peer shared personal experiences about the transplant referral process in an effort to empower candidates. Staff also utilized this individual to mentor patients who may not currently be a candidate for transplant due to contraindications such as nonadherence. Approximately 77% of facilities incorporated peer-to-peer education into facility activities.
- **Facility Level Lobby Days -** These events provided an avenue for transplant facilities and transplant recipients to speak with potential candidates about the transplant process. Lobby days helped provide education to patients and staff as well as address barriers. Implementing lobby days assisted with improving communication between dialysis and transplant facilities and also between dialysis facility staff and dialysis patients.
- **Transplant Champion Handbook - Transplant Coordination: What You Need to Know -** This was a comprehensive resource to prepare staff to educate patients about transplantation. The content included information about the kidney allocation system, multiple listing, organ procurement agencies, and the individual transplant facility criteria for the facilities in the Network 8 service area. The handbook served as a tool to increase staff knowledge about transplantation. All project facilities received a handbook, with 54.3% actively implementing the use of the handbook to educate patients.
- **NCC Transplant Learning and Action Network (LAN) calls -** All project facilities were invited to attend these calls to gain best practices and increase awareness of ways to

support patients through the transplant waitlist process. Following the calls, the Network monitored facility level interventions utilizing concepts from the LAN. On the June LAN call, a Network 8 facility and patient presented a best practice of utilizing a kidney transplant interest form to assess interest in transplantation upon admission and providing consistent follow-up. This practice was spread to all project facilities.

- **Kidney Transplants in Older Adults -** This handbook offered patient stories of those successfully transplanted. The handout was provided to all facilities, with 45.7% identifying the resource as successful in their facility. Project facility patients evaluated the tool and 100% of respondents stated the transplant experiences in the handout were relatable for patients.
- **Your Life, Your Choice:** This resource, a collection of patient stories about their transplant journeys, offered transplant patient experiences that facilities could share with candidates. According to feedback from the Subject Matter Experts (SMEs), patients relate and learn better from other patients. Project facilities shared the patient-specific stories with patients in the facility. An evaluation of the tool concluded that 43.3% of respondents rated the tool as helpful to patients.

Best Practices: Throughout the duration of the project, the Network collaborated with facilities to identify best practices and barriers. At the conclusion of the project, best practices were shared with all facilities. The following best practices were identified:

- Educate patients early; if possible, begin education during early stages of Chronic Kidney Disease (CKD), prior to initiation of dialysis
- Identify a transplant navigator/champion for the facility to incorporate a peer into the education process
- Assess patients' interest in transplant and, use the transplant interest form shared on the Transplant LAN call, or develop a similar form
- Educate patients and their support systems frequently, to include information about living and deceased kidney donation
- Identify barriers initially, and implement a plan to address those barriers
- Establish a contact person with the transplant facilities you frequently refer to, and determine the best form of communication (fax, email, phone calls, etc.)
- Follow up with patients and transplant facilities, and provide patients with appointment reminders.



Network 08: Percent of Patients from QIA Facilities on the Transplant Waitlist
January 2018 - September 2018

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

Home Therapy Quality Improvement Activity

Goal: The Network was tasked with increasing the number of patients utilizing home dialysis. The Network selected 30% or 123 out of 410 in-center facilities from the service area to participate in the Home Dialysis Quality Improvement Activity (QIA). The baseline for the QIA was 0.7% (all patients not dialyzing with a home modality) with a goal of a 10 percentage point increase to 10.7%.

Project Outcome: The National Coordinating Center (NCC) provided baseline and monthly data to the Network. The Network demonstrated a 4.3% improvement with an additional 379 patients initiating home dialysis training by September 30, 2018.

Barriers: Root cause analyses were performed by project facilities prior to implementation of monthly interventions. The most commonly identified patient barriers were lack of family support, socioeconomic barriers, and in-center dialysis preference due to social reasons. Staff barriers included poor in-center staff knowledge about home modalities, lack of engagement with home dialysis therapies staff, and the perception that certain patients are not home candidates based on myths.

Interventions: Monthly, home dialysis training start date data were reviewed to monitor improvement. Target facilities received monthly coaching calls to discuss barriers, interventions, and potential home candidates. Interventions included:

- **Peer-to-Peer Education** – Based on comments from our PAC that patients generally learn best from other patients with similar experiences, facilities invited home dialysis patients to speak with in-center patients. This afforded in-center patients an opportunity to ask questions and listen to personal experiences from someone who has experienced a home modality.

- **Lobby Days** – Facilities incorporated lobby days as an intervention in an effort to address the identified number one most problematic issue to initiating home dialysis training: lack of patient interest in home dialysis.

- **Make Yourself at Home Talking Points** –This tool was provided to guide in-center staff with conversation starters to learn what matters to their patients. Based on the information learned, staff can encourage patients to choose a treatment modality based on their desired lifestyle.

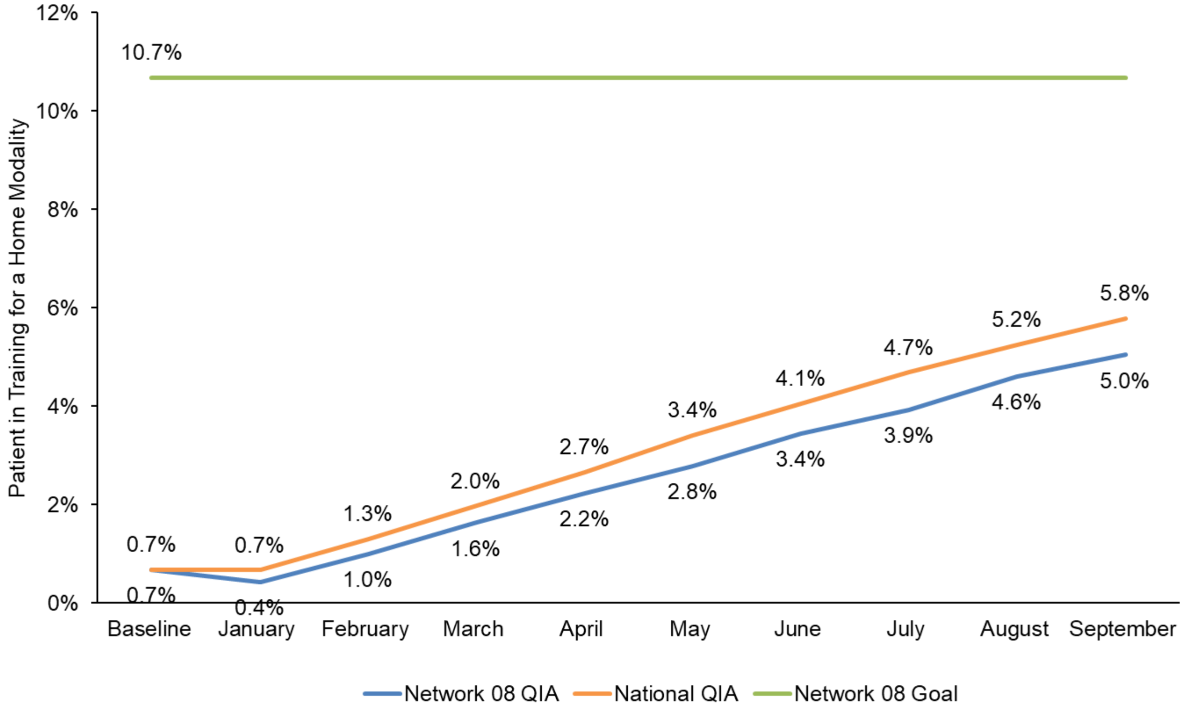
- **NCC Home Learning and Action Network calls** – All project facilities were invited to attend these calls to gain best practices and increase communication between in-center and home dialysis facilities. Following the calls, the Network monitored facility level interventions utilizing concepts from the LAN.

- **Method to Assess Treatment Choices for Home Dialysis (MATCH-D) Tool** – This tool was selected to assist nephrologists and dialysis staff with identifying and assessing candidates for home modalities in addition to sensitizing clinicians to key issues about who can use home dialysis.

- **My Life, My Choice Online Decision Aid** – This resource was incorporated to guide patients in choosing the modality that best fits their lifestyle by answering a series of questions and selecting what matters most to them. The results of the survey then indicate which modality is the best fit for the patient's desired lifestyle.
- **Home Modality Fact Sheets** – Fact sheets were implemented to provide an overview of each of the home modalities and address many of the barriers identified in the initial root cause analysis. For example, some of those barriers included lack of family support or involvement (the resource explained that peritoneal dialysis does not require a care partner), fear of medical emergency while on home dialysis (the fact sheets explain that a nurse will always be on call), and lack of patient interest.

Best Practices: Throughout the duration of the project, the Network collaborated with facilities to identify best practices and barriers. At the conclusion of the project, best practices were shared with all facilities. The following best practices were identified:

- Identify a home dialysis champion for your facility. Use a patient and a staff member to jointly speak to patients.
- Educate patients and support systems about home modalities early and frequently. If possible, during early stages of Chronic Kidney Disease (CKD), prior to initiation of dialysis.
- Use the MATCH-D tool to help identify and assess patients for home dialysis candidacy.
- Assess patients' interest in home dialysis by utilizing the My Life, My Dialysis Choice Online Decision Aid.
- Educate all in-center dialysis staff on home modalities, and familiarize them with the "Make Yourself at Home" Talking Points to serve as discussion starters to learn what really matters to patients.
- Identify barriers early in the process, and implement a plan to address those barriers.
- Establish a contact person with the home dialysis centers to whom you frequently refer patients.
- Schedule a lobby day to allow patients to speak to home dialysis patients or home dialysis staff.
- Remind patients that they can return to in-center dialysis if they try a home modality and decide that it is not right for them.



Network 08: Percent of Patients from QIA Facilities in Training for a Home Modality
January 2018 - September 2018

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

Population Health Focus Pilot Project Quality Improvement Activity: Support Gainful Employment of ESRD Patients

Goal: The intent was to assist ESRD patients with seeking gainful employment and/or returning to work. Specifically, we aimed to: (1) increase referrals made for vocational rehabilitation (VR) services by five percentage points, and (2) increase numbers of patients receiving services by two percentage points. We selected 45 Network 8 facilities to participate in the project: 18 from Alabama, 9 from Mississippi, and 18 from Tennessee, equalling10% of the total number of dialysis facilities in each state.

Project Outcome: Baseline CROWNWeb data supplied by the ESRD NCC suggested that vocational rehabilitation services were woefully underutilized throughout the Network 8 region; however, we were uncertain if these services were underutilized, underreported in CROWNWeb, or both underutilized *and* underreported. The Network exceeded project goals with an overall improvement of 12.7 percentage points for referrals and 4.2 percentage points for patients receiving services by September 30, 2018.

Barriers: Root cause analyses were performed by project facilities prior to implementation of monthly interventions. The most commonly identified patient barriers were fear of losing Medicare and/or disability benefits, a belief that the process takes too much time, and lack of personal motivation and willingness to participate in VR.

Interventions: Monthly, patient VR referrals and patient's receiving VR services data were reviewed to monitor improvement. Target facilities then received monthly coaching calls to discuss barriers, interventions, and potential VR candidates. Conducting a root cause analysis was the first step to learn more about patient-level reporting processes in order to develop actionable, sustainable improvement plans for each participating facility.

Facility-level interventions included:

- Reviewing individual facility practices for reporting vocational rehabilitation status to ensure routine and timely update of information;
- Reviewing individual facility practices to ensure a work-friendly environment;
- Educating staff on early referrals to VR services;
- Educating staff on the Social Security Administration's Ticket to Work Program and patient implementation;
- Working with state VR programs to understand the referral process and then providing this information to facility social workers;
- Educating staff on Social Security income eligibility guidelines;
- Educating staff on appropriate CROWNWeb documentation of VR referrals and utilization, and;
- Encouraging facilities to participate in NCC-led VR Learning and Action Network calls.

Patient-level interventions included:

- Conducting a focus group interview with selected members of the Network 8 Patient Advisory Council to identify patient-level barriers to working or going to school;

- Educating patients by dispelling common myths about working while on dialysis;
- Educating patients about available VR benefits; and
- Promoting peer-to-peer support utilizing employed patients or those who have benefited from VR services to share experiences and provide support.

Attributes: The project required the implementation of the following six attributes in project activities. Following are examples of the incorporation throughout the project.

Innovation – Developed and distributed BRIEFS (Building Rehabilitation Infrastructure Essential for Success) to all project facilities. This resource contained concise (brief) tools for patient and staff education such as a checklist of best practices, blank VR appointment cards, and Ticket to Work tools.

Boundarilessness – Held conference calls with state VR agencies to gain insight into the referral process and enhance VR counselors' knowledge of dialysis patients. These calls led to the development of state-specific VR Frequently Asked Questions tool.

Rapid Cycle Improvement – Conducted monthly data review and coaching calls with project facilities to identify and correct data errors and identify patients who could benefit with VR as well as assisting facilities with resources to overcome facility-specific barriers to VR.

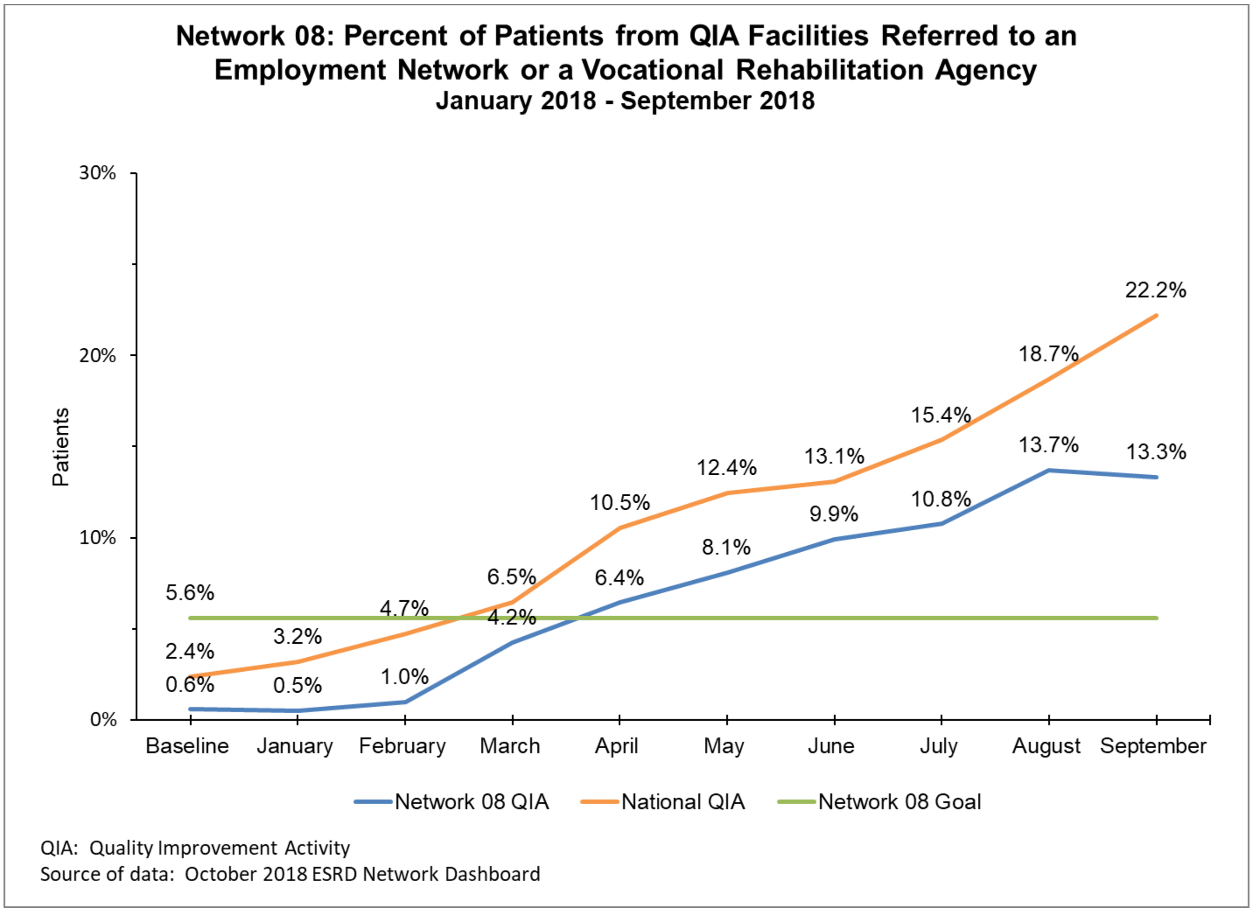
Customer Focus – Incorporated ideas from the Patient Advisory Council and VR patient workgroup into the QIA. The workgroup assisted with the development of a patient engagement survey for project facilities to identify efforts to engage patients throughout the project.

Unconditional Teamwork – Collaborated with other Networks to conduct a VR innovation challenge that allowed project facilities from each of the Networks to submit best practices for educating patients about VR services. These practices were shared with all project facilities.

Sustainability – Collaborated with each facility to develop a routine process for discussing VR candidates during monthly QAPI meetings. Developed a best practices tool on actions to sustain progress and continue promoting VR services.

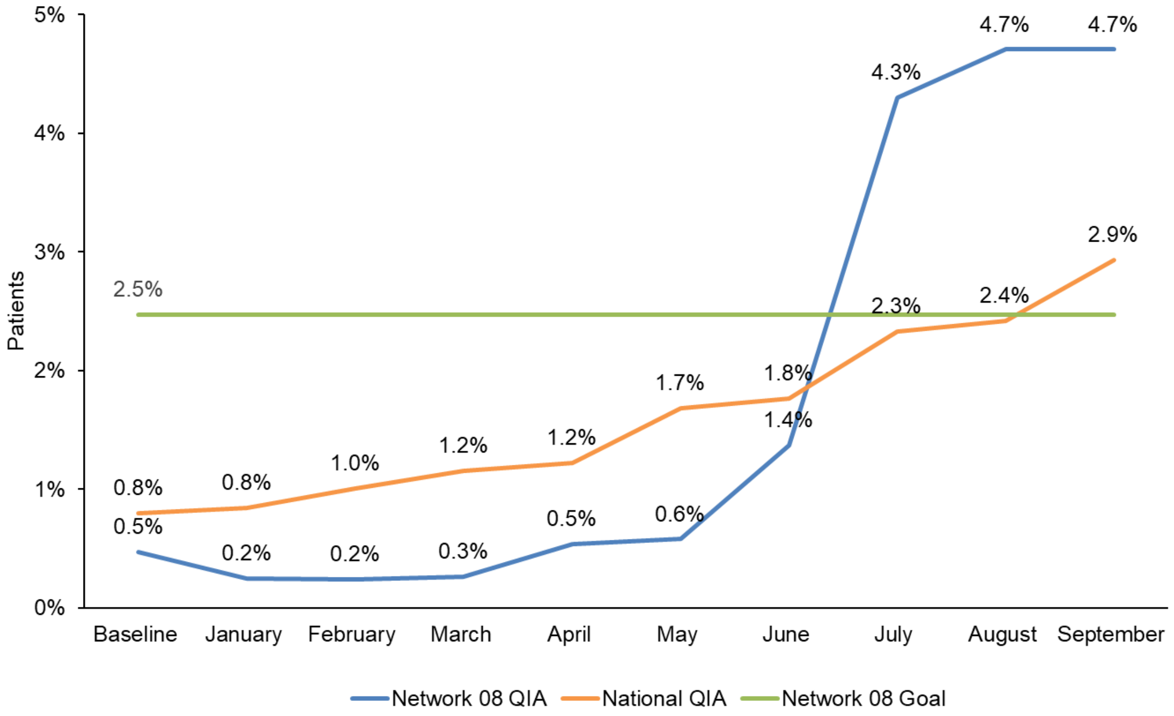
Best Practices: Throughout the duration of the project, the Network collaborated with facilities to identify best practices and barriers. At the conclusion of the project, best practices were shared with all facilities. The following best practices were identified:

- Develop a process for reviewing VR status for eligible patients at least quarterly and update status in CROWNWeb
- Invite local VR agency to come to unit for periodic Lobby Days focusing on VR
- Include rehabilitation in assessment and care plan forms
- Keep brochures and other materials on rehabilitation in public areas
- Collaborate with rehabilitation and vocational personnel in the community to educate them on the vocational needs of dialysis patients



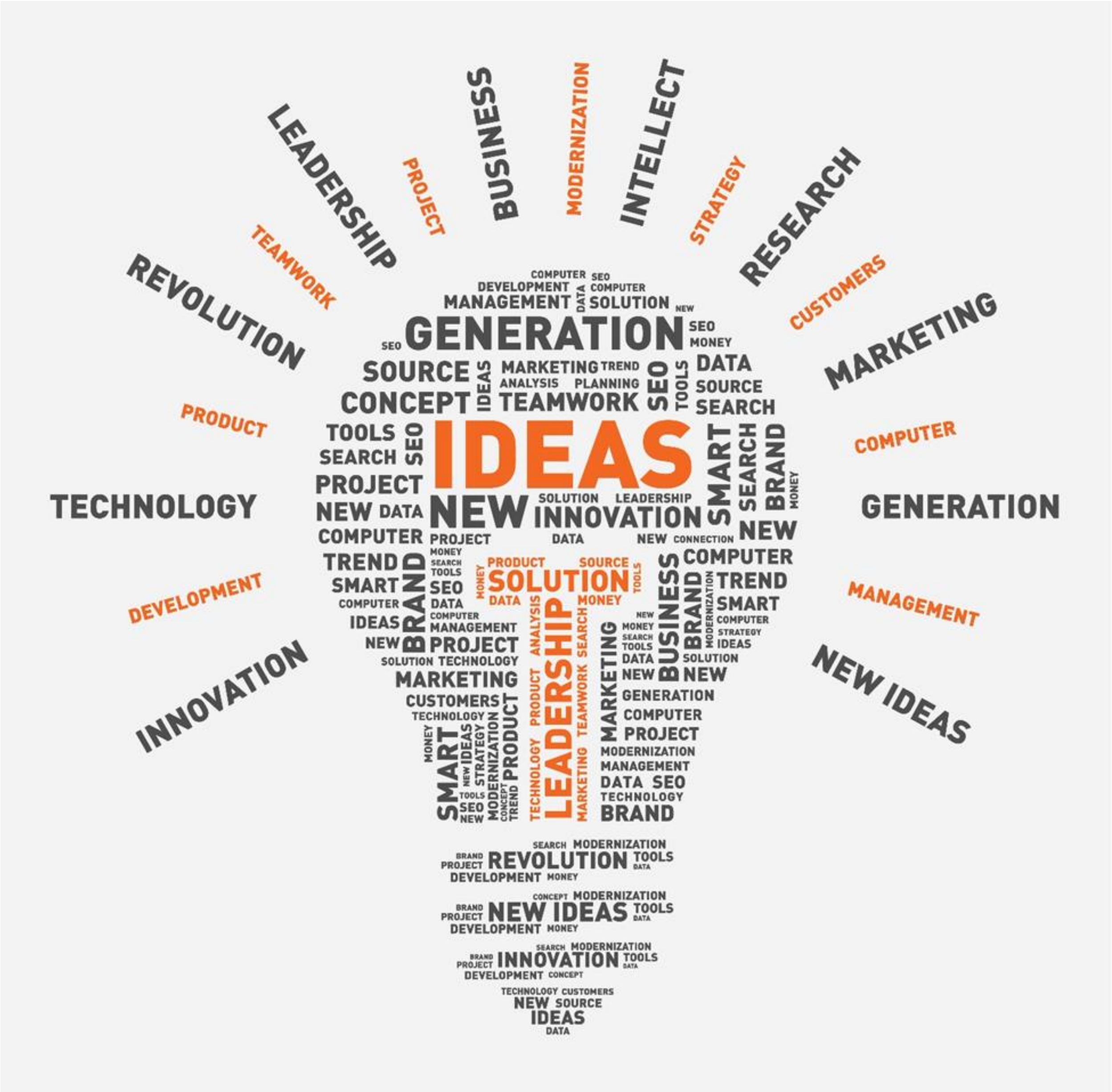
QIA: Quality Improvement Activity

Source of data: October 2018 ESRD Network Dashboard



Network 08: Percent of Patients from QIA Facilities Receiving Services from the Employment Network or Vocational Rehabilitation Agency
January 2018 - September 2018

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


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

ESRD NETWORK RECOMMENDATIONS

Recommendation for Sanctions

Providers in the Network region are monitored throughout the year for their participation in activities specified in the Network's CMS contract and for their performance on a number of quality metrics. Facilities that fail to comply with Network requests have the potential to be placed on the Network Watch List, the first in a sequence of steps that may lead to a recommendation for sanction by CMS. The Network monitors these facilities and develops an action plan for improvement. Facilities are provided a timeline for completing activities in order to be removed from the Watch List. Networks may recommend that sanctions or alternative sanctions be imposed on facilities that do not cooperate in meeting Network goals or ESRD Conditions for Coverage. In 2018, there were no providers who consistently failed to cooperate with Network goals.

Additional or Alternative Services for Facilities in the Network

Network 8's service area experienced 19 new openings and 2 facility closures in 2018. The increase in facilities appears to be aligned with the patient population and the treatment modalities of patients. The Network has not identified a specific need for additional facilities in the service area.


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

ESRD NETWORK SIGNIFICANT EMERGENCY PREPAREDNESS INTERVENTION

In 2018, the Network 8 service area experienced various weather conditions that impacted numerous facility operational statuses. Network staff responded to 11 events including tornadoes, winter storms, and hurricanes. On October 8, in anticipation of Hurricane Michael, a state of emergency was declared in Alabama. Beginning Tuesday, October 9, through Friday, October 12, the storm impacted 21 facilities in Network 8's service area.

Throughout the event, Network staff remained in contact with affected facilities. Facilities implemented their emergency plans and made schedule adjustments in advance to accommodate dialysis needs. Network staff confirmed 17 facility closures and four altered schedule facilities as a result of Hurricane Michael. The Kidney Community Emergency Response (KCER) program, which serves as the leading authority on emergency preparedness and response for the kidney community, was on standby throughout the event and hosted daily status calls with the three impacted Networks (6, 7, and 8), dialysis corporate leadership, and CMS to monitor needs and local conditions.

The Network provides ongoing resources and educational outreach to dialysis facilities in preparation for events. Network capacity is enhanced through ongoing collaborations with emergency management agencies and through annual desktop exercises coordinated by KCER. The Network maintains an updated comprehensive emergency management plan and has a reciprocal relationship with a partner Network that can provide services to this region in case a catastrophic event occurs at Network 8's work site.

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.