

# ESRD NETWORK 2018 ANNUAL REPORT

ESRD Network 14



END STAGE RENAL DISEASE  
NETWORK OF TEXAS

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## ESRD DEMOGRAPHIC DATA

The End Stage Renal Disease Network of Texas (ESRD Network 14) is a subsidiary of Alliant Health Solutions, a Georgia corporation that also holds the ESRD Network 8 contract. The two ESRD Networks comprise the Alliant Quality Kidney Collaborative and rely on the corporate partnership for daily administrative and information technology services. This partnership allows for more efficient quality and patient and family engagement activities.

Network 14 serves the state of Texas with the administrative office located in Dallas, Texas. In 2018, the number of incident (new) patients increased by 12,266 bringing the total number of prevalent ESRD patients to 69,266 including all treatment modalities (Chart 1). This increase resulted in an additional 79 Medicare-certified dialysis facilities. The number of dialysis facilities in Texas totaled 716 for all modalities, for a total of 740 ESRD facilities (Chart 2). There were 24 transplant centers, of which 22 were currently active at the end of 2018, which represented 10.5% of the national total ESRD Medicare-certified kidney transplant facilities (Chart 7). Network 14 is the second largest Network based on the percentage of dialysis facilities with 9.6% of the national total ESRD Medicare-certified dialysis facilities (Chart 4).

Texas is the second largest state in the United States by both territory, with 267 thousand square miles, and population, estimated at 29 million. Houston is the most populous city in Texas and the fourth biggest in the US, while San Antonio is the second most populous in the state and seventh biggest in the US. Diabetes continues to be the leading cause of ESRD in prevalent patients in Texas at 55.2%, with hypertension ranking second at 27%.

A geographic area this large that is home to a large general population and a large population with kidney failure is a major factor in the large number of dialysis facilities and transplant centers operating in the state. CROWN Web data indicated that, in 2018, Network 14 had the largest percentage of prevalent dialysis patients by ESRD Network with 67% of patients receiving in-center dialysis, 8% choosing a home modality, and the remaining 25% living with transplant, representing 10.1% of the national total dialysis patient population (Chart 3). By treatment modality, Network 14 was the third largest Network with 9.0% of national total home hemodialysis and peritoneal dialysis patients (Chart 5), and 7.7% of the national total transplant patients by ESRD Network (Chart 6).

In 2018, the Network incorporated patient and caregiver voices into all Network projects. The Network and the Centers for Medicare & Medicaid Services (CMS) identify patient and family engagement (PFE) as a best practice for success in all initiatives related to health care. Patient and family feedback was obtained by the Network using information from patient and caregiver surveys completed through Survey Monkey, conference calls, site visits, Patient Advisory Committee (PAC) meetings, PAC Subcommittee meetings, and National Patient and Family Learning and Action Network (NPFLAN) meetings. Network 14's PFE involvement has been recognized by both CMS and the ESRD NCC as one of the most involved and active groups in the renal community.

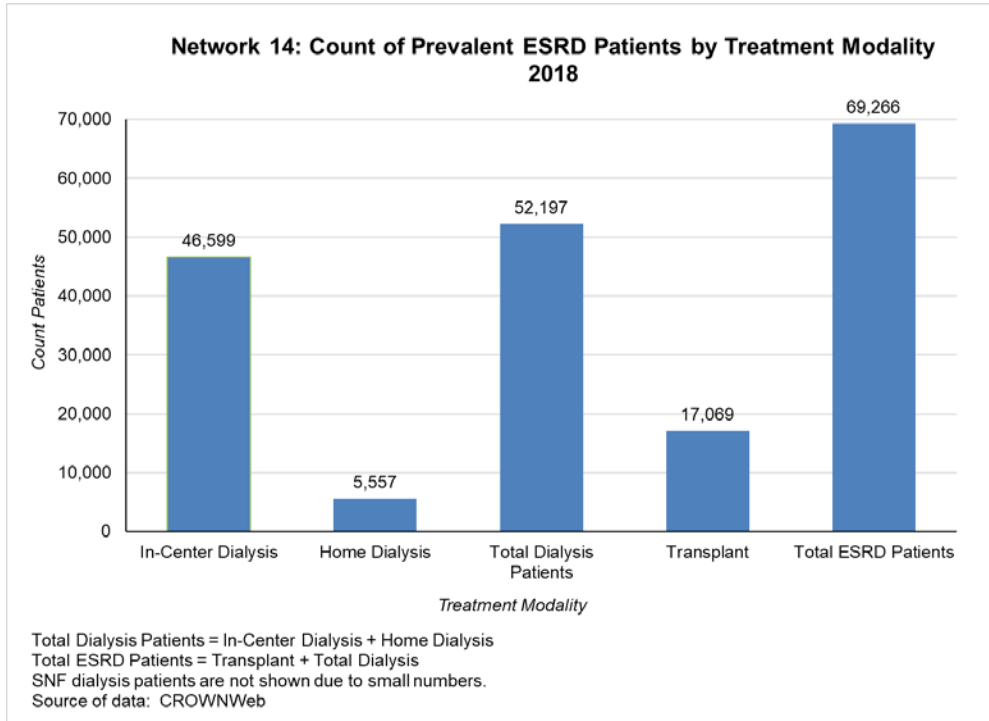
### **PFE involvement strategies and approaches included:**

- Patient Advisory Council (PAC) involvement during the creation, implementation, and progression of each Quality Improvement Activity (QIA).

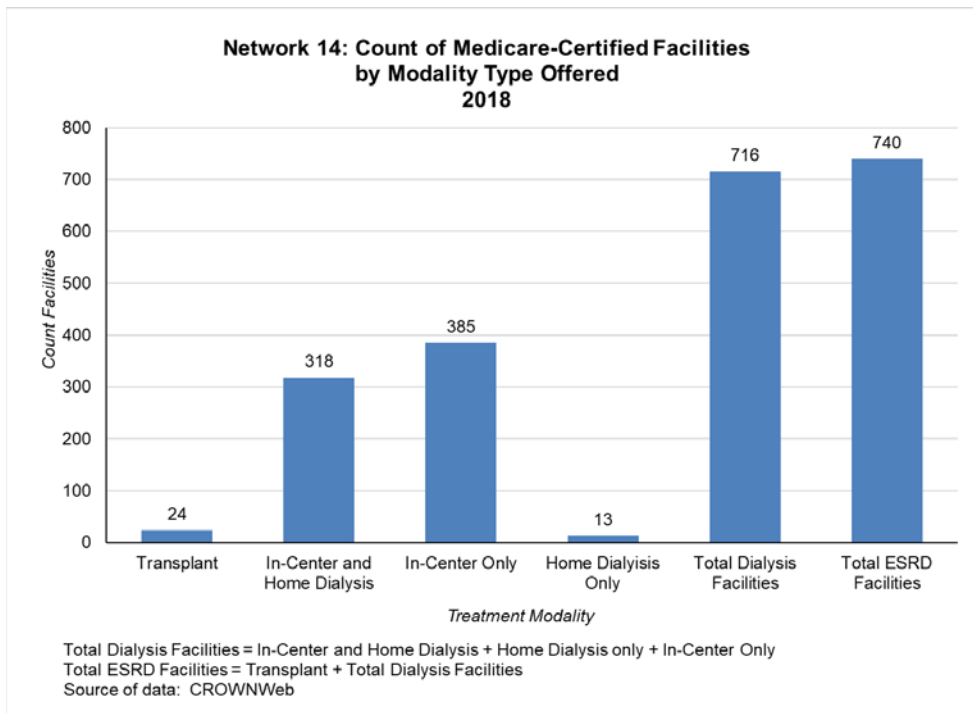
- PAC development of patient resources to address patient-selected topics and areas of concern.
- Utilizing feedback from patient subject matter experts (SMEs) and PAC members to update Network resources.
- PFE calendar and handouts created by the PAC were utilized in all QIA projects throughout the year.
- Facility Patient Representatives (FPRs) participated in QI projects and provided feedback on interventions, resources, and webinars. During site visits and presentations, Network staff provided coaching to facility staff and patients regarding patient engagement activities. PAC members actively participated in national PFE LAN events.
- PAC members shared the information provided during PFE LANs with other patients and facility staff members.
- PAC members assisted and lead facility-based patient engagement and education activities.

Patient educational materials created by Network staff and PAC members were translated into Spanish as per the ESRD Networks contract with CMS and the Statement of Work (SOW) requirements to assist the high number of Spanish-speaking patients in the Network's geographic area. Educational resources were distributed to Medicare-certified facilities via fax blast or email blast and made available on our website.

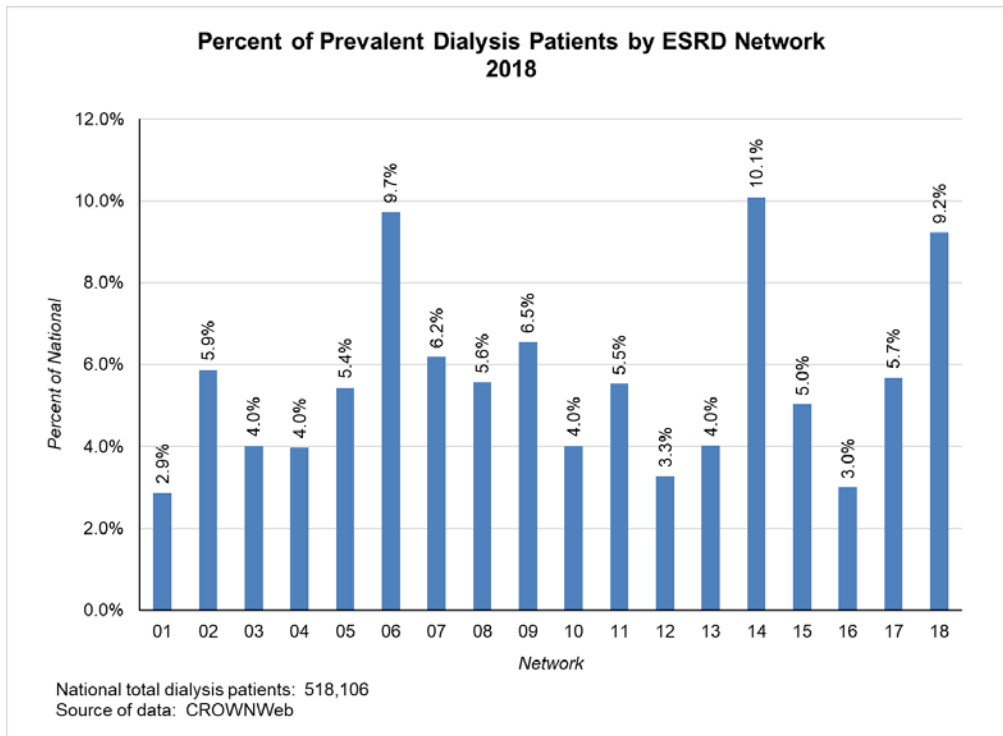
**Chart I. Count of Prevalent ESRD Patients by Treatment Modality 2018**



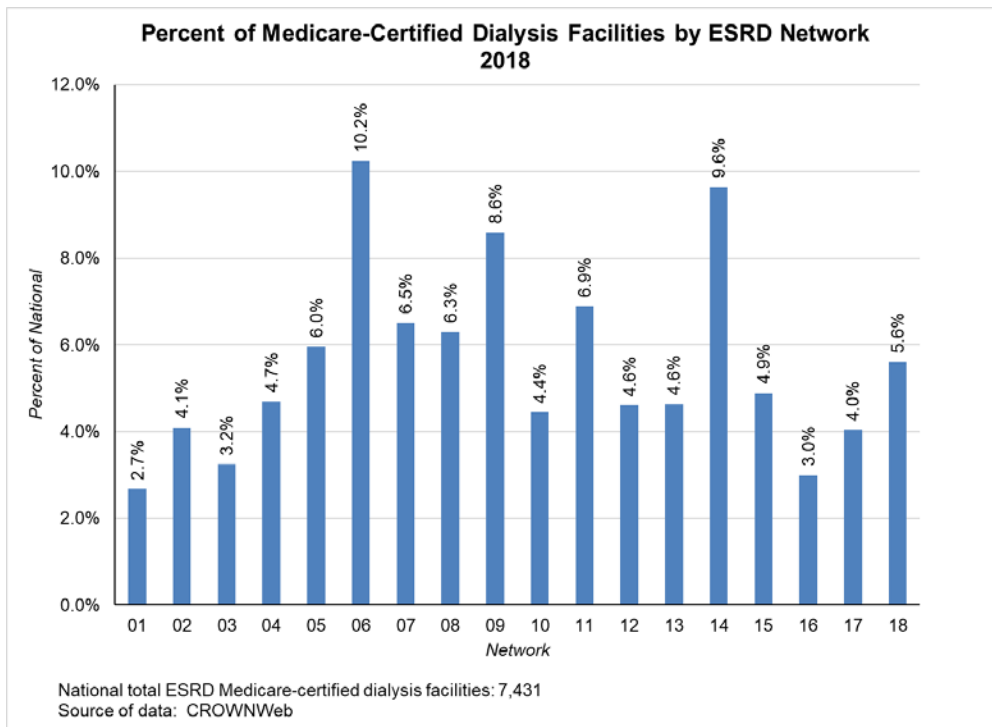
**Chart 2. Count of Medicare-Certified Facilities by Modality Type Offered 2018**



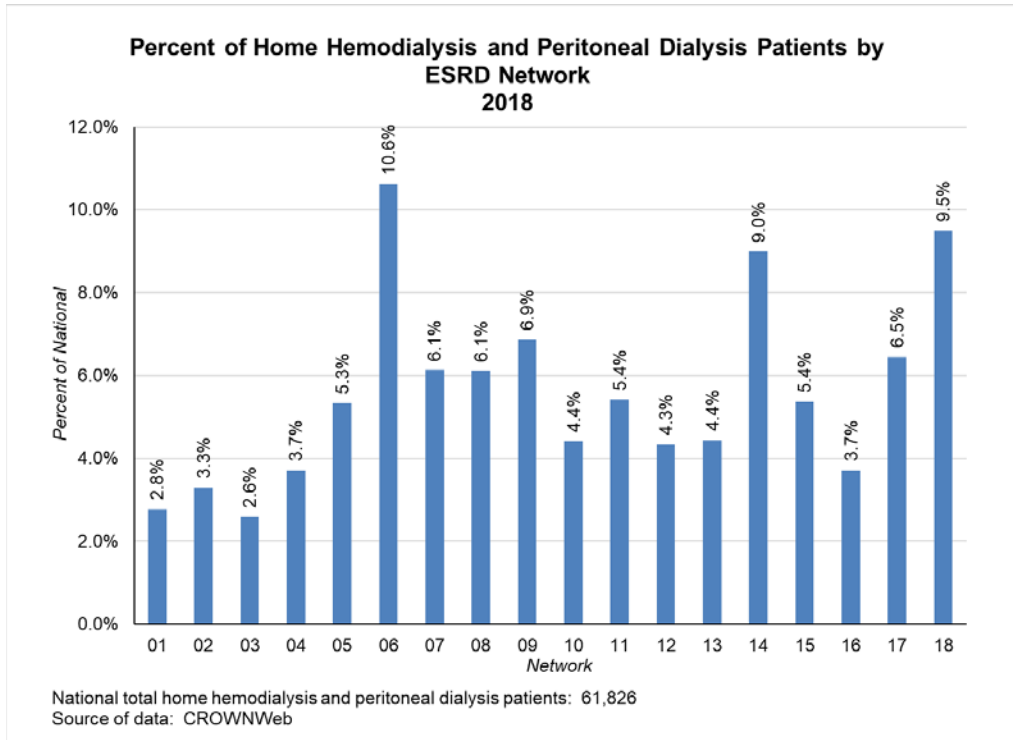
**Chart 3. Percent of Prevalent Dialysis Patients by ESRD Network 2018**



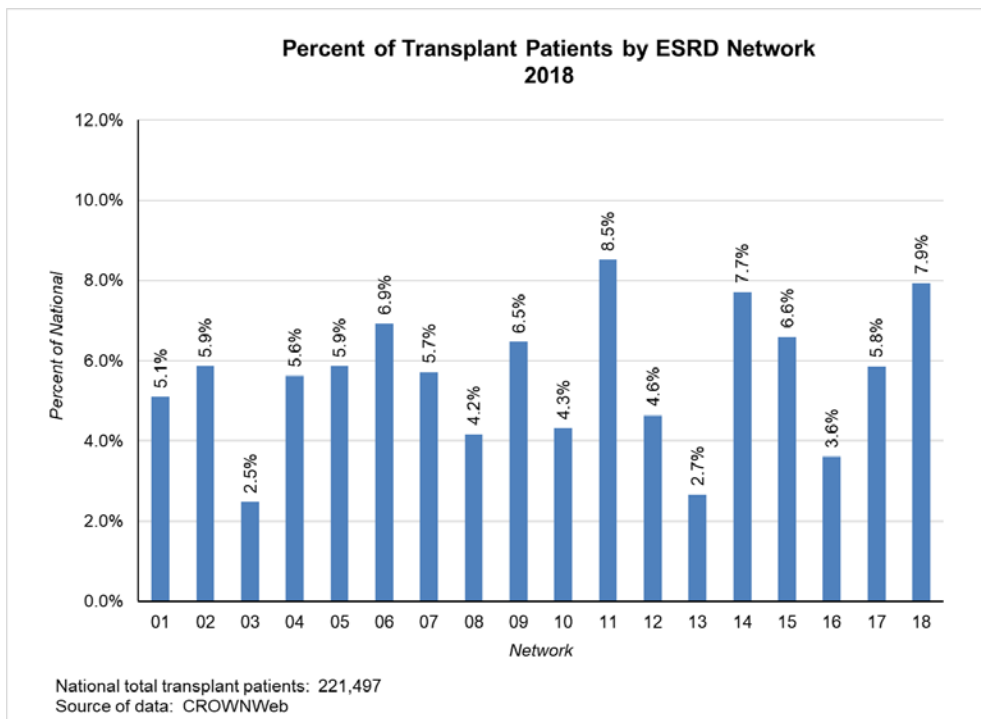
**Chart 4. Percent of Medicare-Certified Dialysis Facilities by ESRD Network 2018**



**Chart 5. Percent of Home Hemodialysis and Peritoneal Dialysis Patients by ESRD Networks 2018**

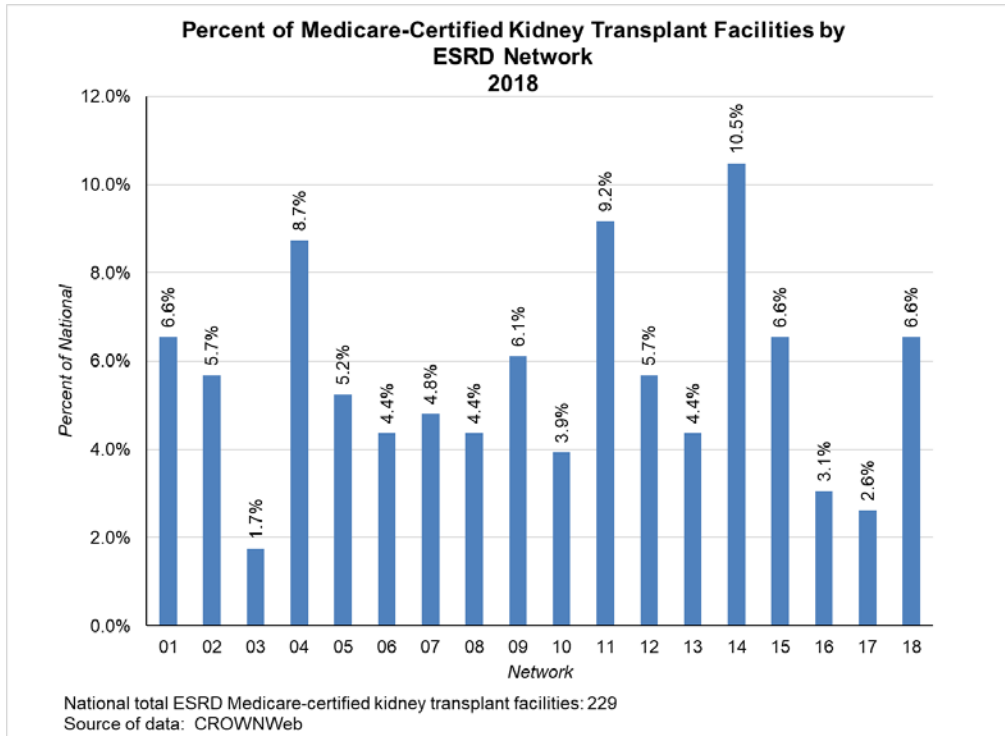


**Chart 6. Percent of Transplant Patients by ESRD Network 2018**





**Chart 7. Percent of Medicare-Certified Kidney Transplant Facilities by ESRD Network 2018**





## ESRD NETWORK GRIEVANCE AND ACCESS TO CARE DATA

*Don't Worry*



*Speak Up*

During calendar year 2018, Network 14 successfully implemented processes and procedures to fulfill CMS requirements and standards established by the ESRD contract and the J-8 attachment. The Network worked diligently to increase understanding and awareness of the Network's role among patients and facilities, and ensure that patients and facilities understood the Network's grievance investigation process. The Network focused on case documentation, improving the Network's Grievance Satisfaction Scores, and providing increased technical assistance related to grievances and access to care concerns to facilities and patients.

### **Case Documentation**

The Network identified ten target facilities and oversampled by two for a total of twelve focus facilities. For quality improvement purposes, the Network completed a rapid cycle improvement activity related to documentation and filing procedures. The Network then developed new methods to ensure that case documentation was complete and organized moving forward. These developments include the following:

- The Patient Services Department ensures the utilization of all applicable tabs in the Patient Contact Utility (PCU) program to accurately identify the area(s) of concern.
- The Network updated the Acknowledgement and Summary letters sent to patients and facilities as part of the grievance process. Acknowledgement and Summary letters are individualized templates utilized to address the specific concerns of each grievant. Prior to sending each letter, the Patient Services Department notifies the grievant that the letter will be sent via mail and reviews the content of the letter with the grievant to ensure that the content is understood.
- Medical records for each case are reviewed by the Patient Services Department. A summary of the review is entered in the PCU. For Clinical Quality of Care cases, all medical records are reviewed by the Network's Clinical Quality Manager (CQM) who is a certified dialysis nurse (RN-CDN). The CQM documents the medical records review, findings, recommendations, and contact with patient/grievant in the PCU.
- The Network utilizes 8-tab pressboard folders to file all Grievances and Access to Care Cases. The file folders outline content with cover sheets for each section.

As a result of these improved processes, the Network received positive feedback and recognition from our CMS Contracting Officer's Representative (COR) in regard to efficient case documentation.

### **Low Patient Satisfaction Scores**

Concerns related to the Network's low patient satisfaction scores were identified during the previous contract year. A review of Network grievance satisfaction scores indicated concerns related to customer service and low Network grievance numbers. The Network developed the following processes to address low grievance scores:

- The Network staff conducts weekly team discussions related to improving grievance satisfaction scores, reviews grievances, identifies challenging patients, and discusses resolution strategies.
- The Network reviews Patient Satisfaction report in the PCU to determine patients who may have received a Satisfaction Survey and negatively impacted the monthly report.
- The Network implemented a process of calling patients prior to sending Grievance Summary letters, which gives patients the opportunity to ask questions related to investigation findings and other information included in the Grievance Summary letters.
- The Network implemented a process of contacting patients 30 days after Grievance Summary letters have been sent to complete a follow-up related to the grievance.

- In efforts to resolve grievances, the Network participates in facility patient care conferences both in-person and via teleconference.
- The Network completed a rapid cycle improvement plan related to satisfaction scores and identified barriers to patient completion of Grievance Satisfaction Surveys.
- In efforts to increase visibility and understanding of the Network's role, the Network has advised all facilities to post a grievance poster where all patients and family members can clearly see it.

CMS established a goal for Networks to achieve 80% overall patient satisfaction scores for the contract year 2018. January 2018 through December 2018 Network 14 results indicate a mean score of 83.01% overall patient satisfaction, which represents a significant improvement as compared to the mean score in 2017 at 70.44 for the comparable time period. The Patient Services Department and Executive Director are continuing to review the Patient Satisfaction Query and discuss concerns that may negatively impact our grievance satisfaction scores.

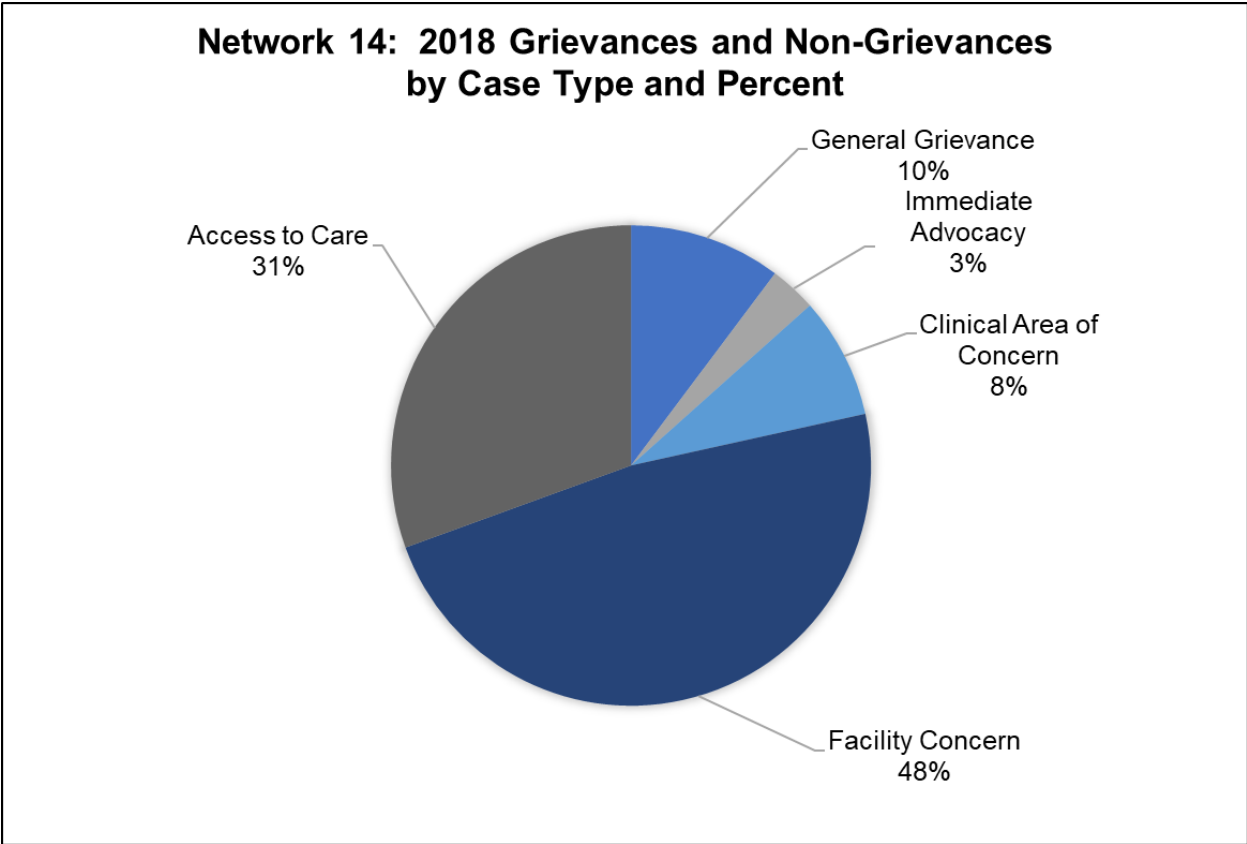
### **Technical Assistance**

The Network staff provided technical assistance to facilities related to grievance resolution, patient engagement, and alignment with treatment goals, behavior management, resource referrals, and Access to Care concerns. In efforts to support providers, effectively resolve grievance concerns, and provide guidance to facilities, the Network implemented the following processes:

- The Network provides education and technical assistance related to dealing with challenging patients.
- The Network provides detailed overviews of the ESRD Conditions for Coverage and the involuntary discharge (IVD) process to facilities and providers.
- The Network assists involuntarily discharged patients with placement. In assisting with placement, the Network encountered barriers related to multiple facilities denying patients due to concerns related to patient behaviors and non-compliance. The Network also encountered barriers related to being unable to contact patients to assist with placement.
- The Network implemented and utilized the Second Chance Program to assist patients who may have been involuntarily discharged in obtaining placement. As of the end of 2018 there had been no reported breakdowns in placements during the calendar year.

During contact with facilities, the Network provided technical assistance to facility staff members, encouraging meetings with both patients and family members to communicate treatment goals and discuss areas of concern. The Network's increased efforts to effectively resolve Facility Concern cases have resulted in a decrease in patients Access to Care concerns, which means that fewer patients are left without a dialysis facility.

**Chart 8. 2018 Grievances and Non-Grievances by Case Type and Percent**



Source of data: Patient Contact Utility (PCU)



## ESRD NETWORK QUALITY IMPROVEMENT ACTIVITY DATA

### Long Term Catheter Quality Improvement Activity

In 2018, Network 14 had the goal to improve long-term catheter (LTC) rates by at least a two (2) percentage point decrease from baseline (June 2017) in prevalent dialysis patients. The ESRD Network of Texas's Long-term Catheter Quality Improvement Activity (QIA) enrolled 54 facilities (adult patients regardless of dialysis modality) with a LTC rate of >15% at baseline. The aggregate baseline LTC rate for the overall group was 20.0% with a requirement of achieving at least a 2 point reduction to an aggregate LTC rate of 18.0% using available CROWNWeb vascular access final data provided by the NCC.



Baseline and known barriers were reviewed by Network staff and Subject Matter Experts (SMEs) such as members of the ESRD Network Medical Review Board (MRB) and the Network's PAC, and considered for choosing focus facilities and developing interventions. Facility interventions were developed with guidance and input from the subject matter experts. This feedback was gathered through face-to-face meetings, phone and email communication, and the Teamwork Project Management (TPM) platform. Focus facilities were contacted and notified of project selection via a standardized project notification letter developed by the Network. Project kick-off occurred with an introductory webinar on March 14, 2018, which included an overview of the project goals, interventions, tools, resources, and requirements. Network staff provided a range of assistance and support to these facilities including one-on-one coaching calls, data review through the LTC monthly reports, collaboration with large dialysis organizations (LDOs) regional vascular access coordinators, rapid cycle improvement (RCI) and action plans, root cause analysis (RCA), encouraging utilization of the Medical Advisory Council (MAC) Catheter Reduction Toolkit from the FORUM of ESRD Networks, using FPRs as liaisons, and the provision of educational materials.

### Summary of barriers and root cause analysis (RCA)

Network 14 conducted a webinar to guide facilities in performing a RCA via Survey Monkey to identify the causes leading to high long-term catheter rates in their clinics. This activity helped facilities identify barriers that were key in the development and execution of appropriate interventions. Major barriers and challenges to reducing LTC use included a myriad of factors. The top reasons for high long-term catheter utilization selected by facilities by category were:

- Patient-related factors: patient refuses to get an arteriovenous fistula (AVF) or an arteriovenous graft (AVG), comorbidities, cancel/no-show for appointments, access sites exhausted or not suitable, financial issues, transportation difficulties.
- Nephrologist-related factors: lack of communication between the nephrologist and the surgeons, referral issues, failure to initiate/activate vascular access plan, failure to work with patient on a long-term access plan, does not educate patient about risks of catheters.
- Surgeon-related factors: payment/reimbursement (lack/underpayment as compared to other procedures), lack of available surgeons in the area, surgeon not seeing new dialysis patients until 90 days after initiation of dialysis, other (poor surgical outcomes, cardiac clearances delays, Veterans Affairs patients/surgeons).
- Dialysis facility-related factors: fistula maturation/healing graft monitoring system in place but not being followed or used as intended (example: inconsistently used, not documented,

incomplete), staff turnover, catheter monitoring system in place but not being followed or used as intended (example: inconsistently used, not documented, incomplete), other (continuous admission of new patients with catheters, high acuity patients, rural area).

- External-related factors: hospital discharge of patient with no access plan in place, other (undocumented patients, acute kidney injury admissions, no vein mapping prior to hospital discharge).

### **Interventions**

In 2018, the ESRD Network utilized a simplified method by selecting interventions that reflected a “patient over paperwork” approach. This strategy was adopted based on feedback obtained from the Network’s one-on-one coaching calls performed in 2017 and in alignment with CMS’s goals. Selected interventions included: facility notification by the Network, root cause analysis requirement, facilities monitored via the LTC Monthly Report for detection of untoward trends with their LTC rate (should this occur, the facility was required to update/develop an action/improvement plan and have the Medical Director sign off on it and review during the Quality Assurance Performance Improvement (QAPI) monthly meeting), Network staff to attend monthly regional/vascular access meetings, site visits as needed, patient engagement (FPR/Patient Champion involvement and Network’s Patient Engagement Calendar), participation in the national ESRD NCC Healthcare-Associated Infection (HAI) Learning and Action Network (LAN) calls, and sustainability plans.

### **Results**

Based on available final data, the Network achieved a 3.1 percentage point reduction in the LTC rate from baseline (20.0%) to the last set of data released in October 2018 which represents July 2018 at 16.9% (Chart 9). Overall, the 54 focus facilities achieved a total decrease of 119 long-term catheters from baseline, thus reducing the risk of infections for their patients.

### **Best Practices and Sustainability**

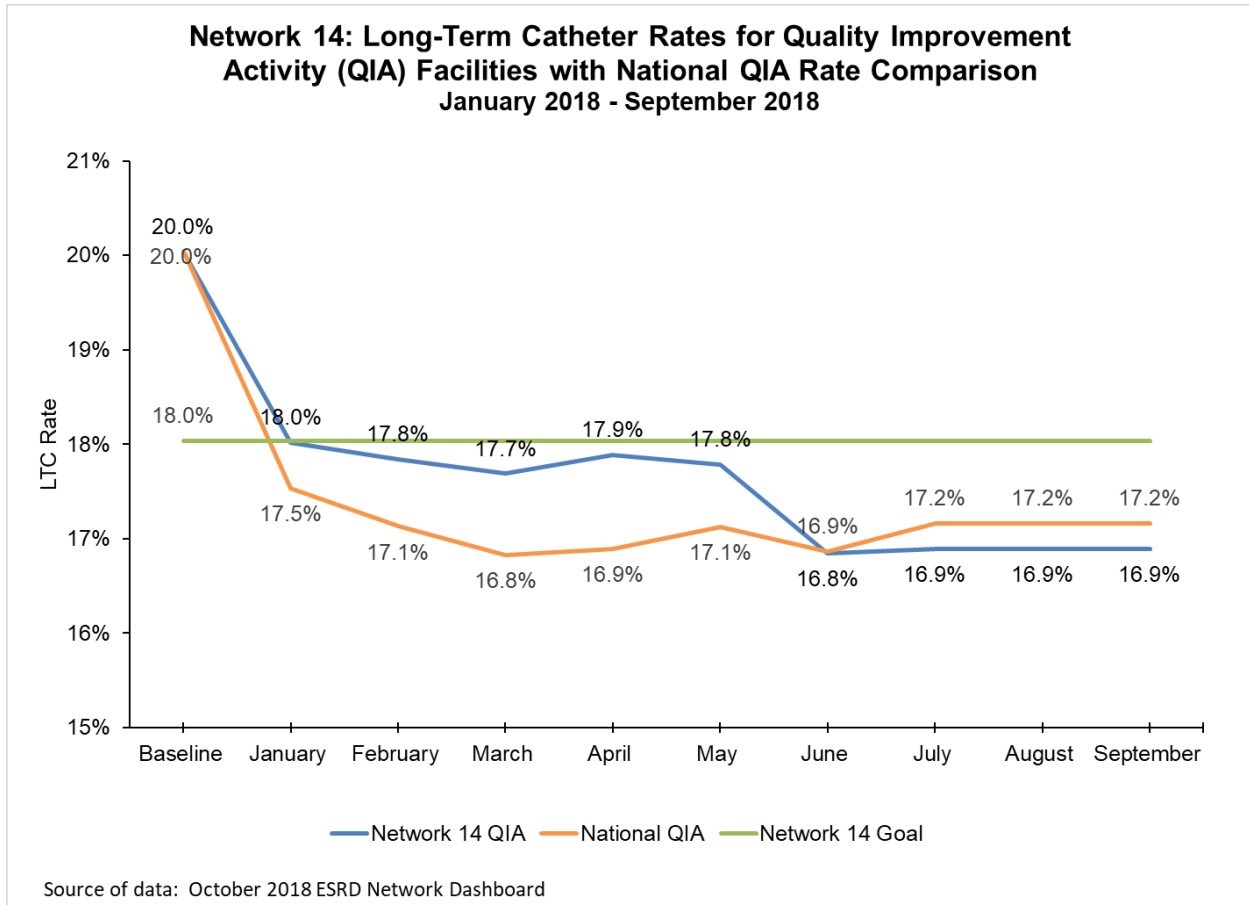
Best practices were identified during the project, including: having a regional Vascular Access Coordinator, an engaged vascular access manager at the facility level, an engaged Medical Director, weekly meetings with the facility’s vascular access team, attending HAI LAN calls and utilizing resources provided, utilization of Network-developed as well as Network-recommended tools, utilizing FPRs as patient liaisons, monthly outcomes review with the interdisciplinary team IDT, Clinical Specialist, and Director of Operations, weekly LTC Champion calls with the clinic’s vascular access team, collection of facilities’ self-reported data through the Network-developed LTC Monthly Report for tracking purposes as data is reported by facilities via Survey Monkey, periodic internal QIA team meetings for Network team feedback, brainstorming sessions conducted by Network staff during regional management meetings, and standardization of an early overarching sustainability plan to be used with outgoing and incoming focus facilities to sustain gains after completion of the project.

### **In Summary**

Network 14 achieved and surpassed the goal for LTC by obtaining a 3.1 percentage point reduction in the rate of long-term catheters among prevalent adult dialysis patients (regardless of modality) based on final data for July 2018. With this achievement, the Network is eager to continue its collaboration with patients and stakeholders to further decrease LTC utilization and associated infection rates for dialysis patients in the state of Texas.



**Chart 9. Long-Term Catheter Rates for Quality Improvement Activity (QIA) Facilities with National QIA Rate Comparison**



## Bloodstream Infection Quality Improvement Activity

The Bloodstream Infection (BSI) Quality Improvement Activity (QIA) included a selection of 50% of the Medicare-certified facilities in the Network service area with the highest BSI rates (264 facilities), and provided specialized focus and increased interventions for the facilities with BSI rates in the highest 20% of the focus facilities (106 facilities). The focus facility selection impacted a population of approximately 20,000 patients. Selection began with an analysis of BSI data from the National Healthcare Safety Network (NHSN) database for the first and second quarters of 2017, ranked by BSI rate from highest to lowest. Of the 264 facilities with the highest BSI rates, 106 facilities in the highest 20% were selected to receive specialized focus. The goal of each facility in the 20% cohort group was to achieve a 20% or greater relative reduction in its semi-annual pooled mean rate at re-measurement compared to its 2017 BSI rate, with the remainder of the facilities (30% cohort) participating in the QIA to reinforce and encourage infection prevention best practices.



### Root cause analysis (RCA)

An initial root cause analysis (RCA) was conducted prior to the start of the QIA to determine the facilities' understanding of bloodstream infections and the cause for their high rates. Staff members were instructed to gather their facility's data for bloodstream infections and reported dialysis events from January 1, 2017 - June 30, 2017 and determine which factors most directly contributed to the infections that occurred. The top two reasons given among the QIA facilities for the infections occurring in that period were: patient non-compliance, and staff and patient's lack of knowledge, research, and education. These two factors alone accounted for 80% of the total responses from the selected QIA facilities. Considering these findings, the QIA's specific interventions were designed to best impact the patient adherence level and improve staff and patient education. A variety of educational materials centered on the Centers for Disease Control and Prevention (CDC) 9 Core Interventions, data reporting to the NHSN, and the importance of patient engagement were used to promote engagement at all levels of the clinic.

### Interventions

A high focus was placed on educating patients and staff on the best infection prevention practices according to research and the CDC's recommendations. A variety of educational materials were utilized to increase the QIA's reach including educational videos from organizations such as the CDC, World Health Organization (WHO), Agency for Healthcare Research and Quality (AHRQ), and other Networks were utilized to promote awareness for staff and patients. Facilities were invited to join the NCC HAI LAN bi-monthly calls, which were staff directed, and encouraged to share best practices they learned. Additionally, other stakeholders' webinars and evidence based materials were offered each month to further promote engagement at all levels of the clinic. Facilities were encouraged to join a Health Information Exchange (HIE) or ensure they had hospital portal access, and education was provided on the five regionally located HIEs within Texas and the national HIE Exchange (eHealth Exchange). Facilities were invited to educational webinars for HIEs in their service area and given the opportunity to ask questions to the HIE's representative.

Facility staff members were instructed to implement the CDC's nine best practices (the CDC Core Interventions for Dialysis Bloodstream Infection [BSI] Prevention). At the start of the QIA, focus facilities identified their current level of implementation of each of the nine CDC Core Interventions, and

continued to identify their current level of implementation of each core intervention through the monthly feedback survey. Monthly education was reinforced by focusing on one core intervention each month from February through October 2018. Scheduling the nine core concepts to align with each month of the project built a routine and familiarity with the concepts on a continual basis. In addition, training was provided for all facilities on the benefits of performing CDC-recommended audits each month and how adherence to the CDC's practices have been shown to prevent infections in dialysis settings. Facilities were then instructed to confirm they had at least two staff members with access to NHSN, and at least one staff member to complete the annual NHSN Dialysis Event training. Facilities were instructed to perform four of the CDC audit tools (Hand Hygiene, Catheter Connection and Disconnection, Catheter Exit Site Care, and AV Fistula and Graft Cannulation) and to submit the monthly Prevention Process Measures (PPMs) in NHSN.

Facilities participated in a monthly patient engagement activity, which included three options to engage their patients: National Infection Prevention Awareness Events, the Network Patient Engagement Calendar, or their facility's own plan. The Network promoted National Awareness Events (including World Kidney Day, Patient Safety Awareness Week, World Hand Hygiene Day, Sepsis Awareness Month, Global Handwashing Day, International Infection Prevention Week, and US Antibiotic Awareness Week) and encouraged facilities to share the respective organization's educational materials with their patients and staff to discuss the impact of infections on their health.

### **Best Practices and Sustainability**

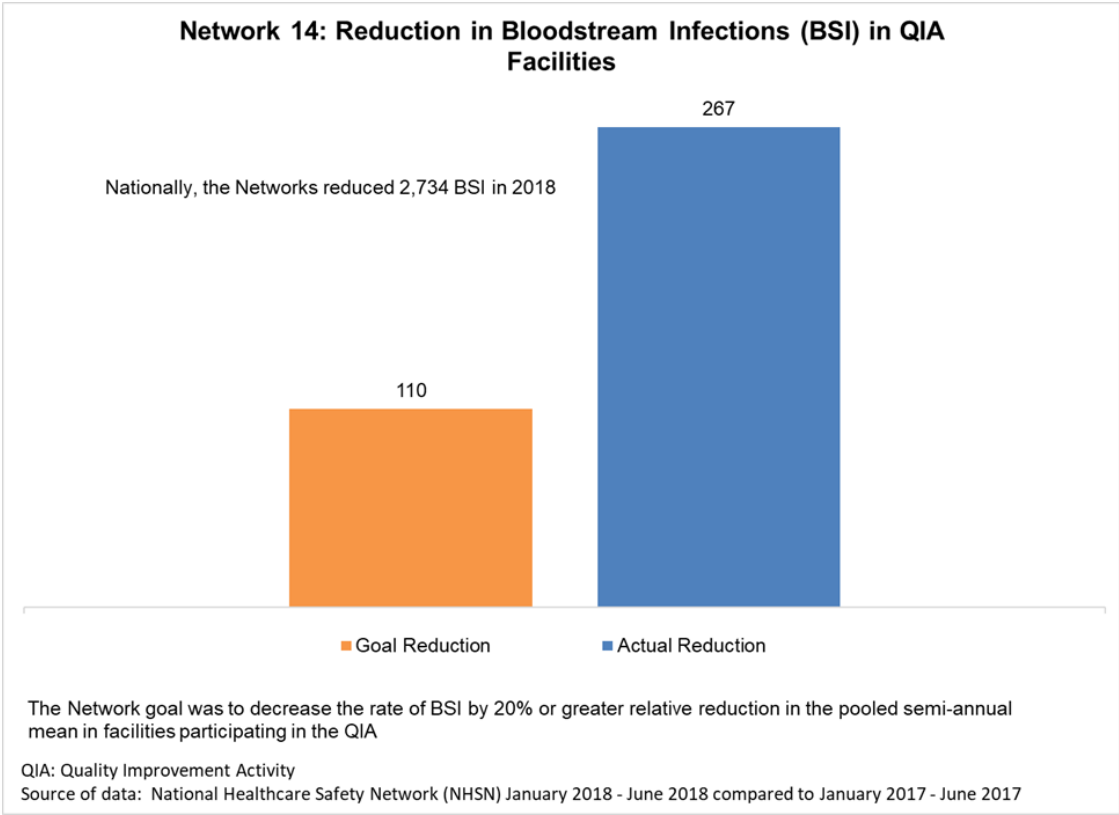
Facility and patient feedback indicated scheduling the nine core concepts to align with each month of the project built a routine and familiarity with the concepts on a continual basis, and many indicated continued use going forward. The inclusion of the various patient engagement activities helped to increase awareness of BSIs and infection prevention practices into the project and to sustain patient practices even after a facility is released from the project. Facility feedback indicated intent to continue using the CDC's infection prevention audits, as well as the education videos as a best practice even after release from the QIA.

Due to substantial staff turnover in the short nine months of the project, the Network continues to recommend all focus facilities have two NHSN-trained associates who are able to access and submit Dialysis Event and prevention process measures (PPMs) data into NHSN. After analyzing missing NHSN data submissions by facilities on a monthly basis, it was determined that facilities require a more hands-on approach when monitoring their NHSN data entry and completion of project requirements. As a result, monthly project notices, which included resources, were distributed to facilities to help staff stay on track.

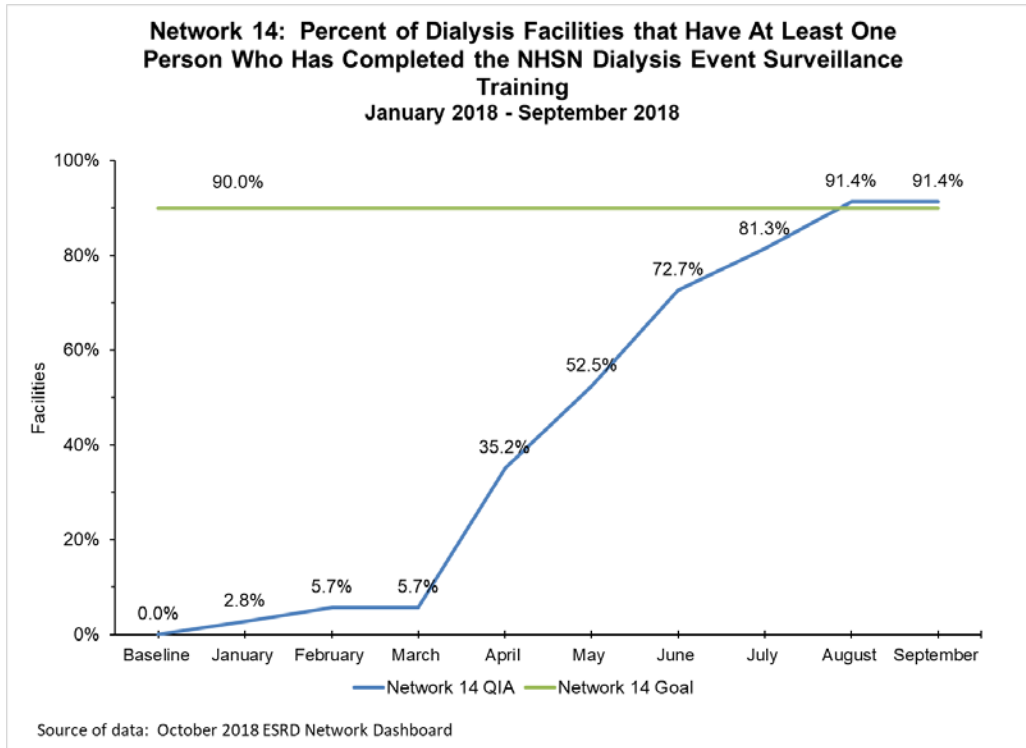
### **In Summary**

The 20% cohort reported a total of 555 BSIs at baseline, and needed a reduction of at least 110 BSIs by re-measurement to achieve the project goal. The 20% cohort exceeded the goal with a reduction of 267 BSIs (Chart 10) resulting in a reporting of only 288 BSIs at re-measurement, and out of the 106 facilities in the 20% cohort 80% (85 facilities) achieved a 20% or greater reduction in their pooled mean BSI rate at re-measurement. The 20% goal for 2018 was a steep increase from the previous year's 5% improvement goal and was challenging for some of the facilities to obtain. Facilities attribute their improvements to the increased implementation of the CDC Core interventions as well as the increased patient engagement focus.

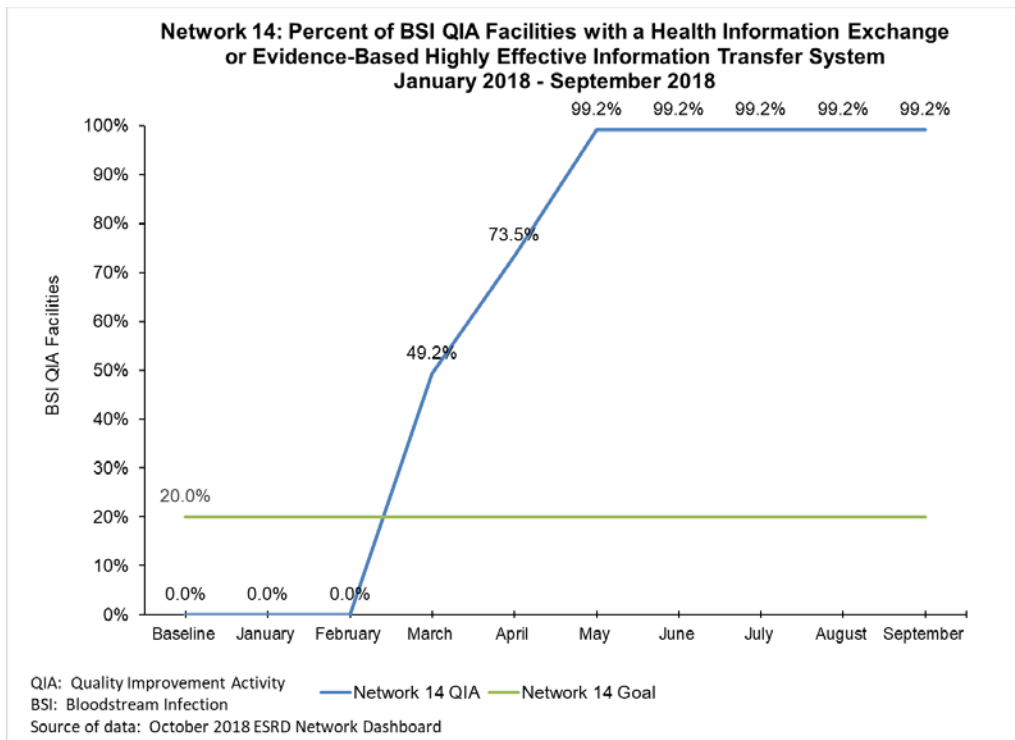
**Chart 10. Reduction in Bloodstream Infections (BSI) in QIA Facilities**



**Chart 11. Percent of Dialysis Facilities that Have at Least One Person Who Has Completed the NHSN Dialysis Event Surveillance Training**



**Chart 12. Percent of BSI QIA Facilities with a Health Information Exchange or Evidence-Based Highly Effective Information Transfer System**



## Transplant Waitlist Quality Improvement Activity



In 2018, Network 14's goal was to increase the transplant waitlist rate by at least 10 percentage points from baseline (October 2016 to June 2017) to remeasurement (based on data available in October 2019) in prevalent ESRD patients, excluding pediatric and prison facilities. The Network's Transplant Waitlist QIA enrolled 185 facilities with initial United Network of Organ Sharing (UNOS) data waitlist rates of <9% at baseline. The aggregate final data baseline transplant waitlist rate for the overall focus group was 12.4%, with a requirement of achieving at least an aggregate 22.4% transplant waitlist rate according to available final UNOS data provided by the NCC.

After selection of participants, facility interventions were developed with guidance and input from the MRB and patient subject matter experts (SMEs). The Network worked closely with the MRB as well as with patient SME workgroups such as the PAC during face-to-face meetings, workgroup phone calls, and communications via email. Feedback from these activities was also gathered through the TPM platform, which is the main forum where PAC members communicate, download and revise documents, and exchange ideas related to Network projects. Focus facilities were contacted and notified of project selection via a standardized project notification letter developed by the Network. Project kick-off occurred with an introductory webinar on February 15, 2018, to provide an overview of the project goals, interventions, tools, resources, and requirements. Network staff provided a range of assistance and support to these facilities including: one-on-one calls, data review through a 7-Steps Navigation Tool, collaboration with large dialysis organization (LDO) regional leadership, RCI and action plans, RCA, encouraging ongoing communication between facilities and local transplant centers, using FPR and transplant champions as liaisons, and the provision of educational materials and resources.

### Summary of barriers and root cause analysis (RCA)

Network 14 provided a webinar to guide facilities in performing an RCA via Survey Monkey to identify the root causes leading to high long-term catheter rates in their clinics. This activity helped facilities identify barriers that were essential to the development and execution of appropriate interventions. Major barriers and challenges to increasing transplant waitlist rates included a myriad of factors. The top reasons selected by facilities for each category in regard to low transplant waitlist rates were:

- Patient-related factors: non-compliance with dialysis treatment, lack of education and/or understanding, cultural/religious beliefs, limited resources, documented absolute contraindications, lack of follow-up with appointments, and health status changes.
- Transplant facility-related factors: lack of communication by transplant centers with the dialysis facility staff, unclear processes and/or dissemination of information, no central point of contact for questions and answers, different criteria among different transplant programs, and staff turnover.
- Dialysis facility-related factors: lack of organization of work flow and staff assignments related to transplant, staff lack of education or understanding of transplant, failure to follow policies and procedures, and staff turnover.
- Administration-related factors: upper management covering multiple facilities and not always available to assist with transplant questions when staff is absorbed with work, incongruent processes within different organizations, lack of accountability in the transplant referral process.

## **Interventions**

Based on feedback gathered from the Network MRB and PAC, and taking into consideration time constraints to make progress toward achieving the goal, the following interventions were selected as the major components for the transplant waitlist QIA:

- Root Cause Analysis
- 7-Steps Transplant Navigation Tool
  - Improve communication between facilities and transplant centers
  - Completion of monthly reports by facilities via Survey Monkey (self-reported data)
- Review of QIA progress during QAPI
  - Promote patient/family attendance and participation in transplant QIA activities
- Patient engagement component
  - Utilization of National Recognized Events such as the National Donate Life Month (April)
  - Network-developed Patient Engagement Calendar with its respective monthly tools
  - Facility's own patient engagement plan (must be approved)
- Promoting the recruitment of FPRs to be part of the project (utilizing Network FPR Toolkit)
- Attendance and participation of staff and patients in the NCC Transplant LAN calls
- Disparities
  - Identify, address, and provide resources
  - Disparity webinar recording and slides from August 23, 2018, available on our website

## **Results**

Based on available final data, the Network achieved a 1.0 percentage point increase in the transplant waitlist rate from baseline (12.4%) to the last set of data released in October 2018, which represents September 2018 at 13.4%.

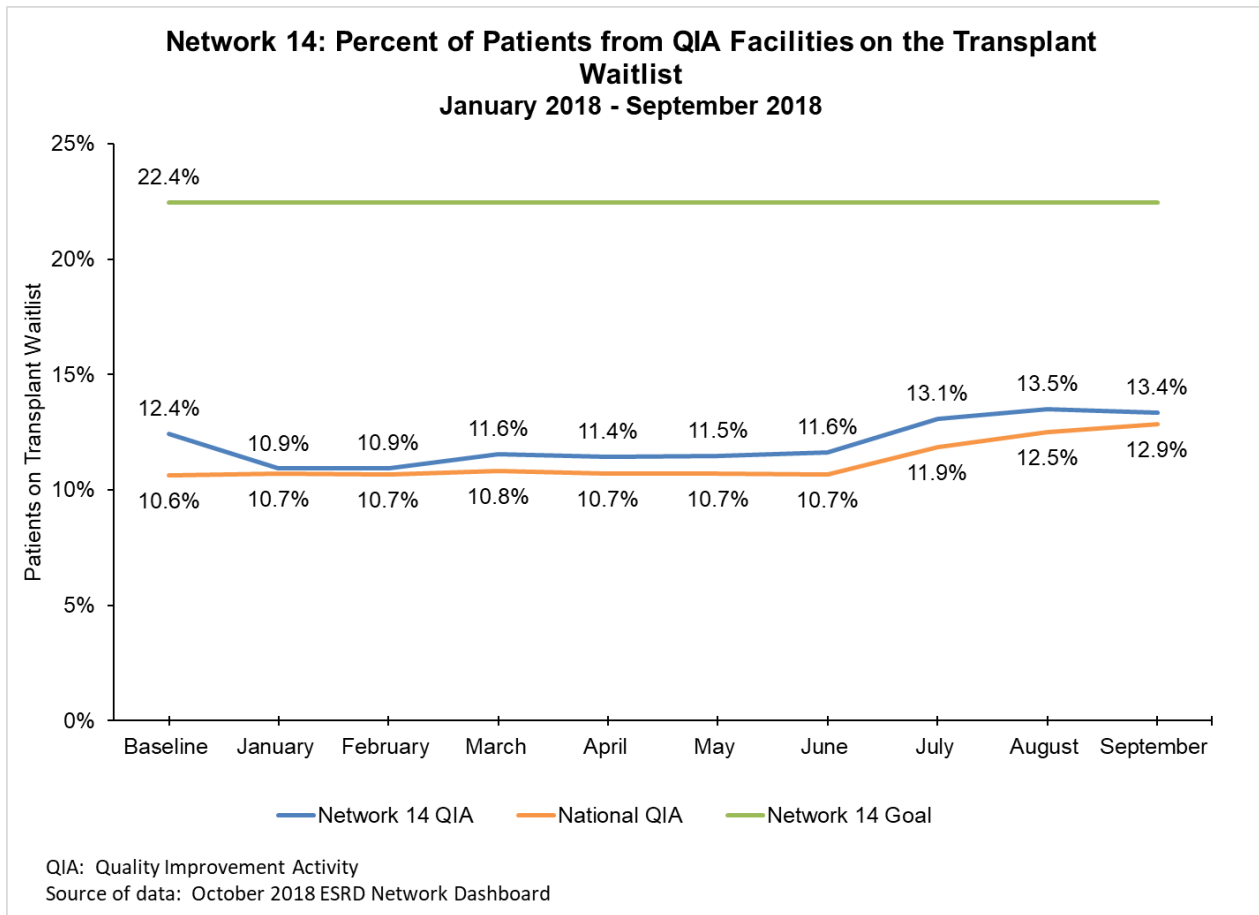
## **Best Practices and Sustainability**

Best practices were identified during the project including: meetings with regional leadership, engaged staff at the facility level, engaged Medical Directors, attending Transplant LAN calls and utilizing resources provided, utilization of Network-developed as well as Network-recommended tools, utilizing FPRs and transplant champions as patient liaisons, monthly outcomes review with IDT during QAPI/QA, facility self-reported data tracking by the Network, periodic internal QIA team meetings for Network team feedback, brainstorming sessions conducted by Network staff during regional management meetings, and standardization of an early overarching sustainability plan to be used with outgoing and incoming focus facilities to sustain gains after completion of the project.

## **In Summary**

Although Network 14 did not achieve the 10 percentage point increase goal on the transplant waitlist project, data barriers and discrepancies were identified. Communication between facilities and transplant centers improved due to the required monthly reporting, with an overall total of 461 patients added to the UNOS transplant waitlist. With these improvements, the Network is eager to continue its collaboration with patients and stakeholders to increasing transplant waitlist rates for ESRD patients in the state of Texas.

**Chart 13. Percent of Patients from QIA Facilities on the Transplant Waitlist**





## Home Therapy Quality Improvement Activity



In 2018, Network 14's goal was to increase home dialysis training rates by at least 10 percentage points from baseline 0.6% (October 2016 to June 2017) in prevalent ESRD patients. Network 14 partnered with facilities based on their home training rates provided by the NCC via CROWNWeb patient data, and included facilities in Texas with the greatest opportunity for improvement according to location (access to a home training program) and low home training rates. Based on analysis of these factors, 181 facilities met the criteria and were enrolled in the home project. This group of focused facilities accounted for at least 30% of the eligible total Network-area facilities as required in the CMS contract. The Network also included eight home-only facilities to participate in the Home QIA project as a resource for best demonstrated practices as well as a referral source for in-center facilities that lacked a home program. The current national rate of dialysis patients who dialyze at home is 12%, and CMS' goal for the nation is to reach at least a 16% home dialysis rate by 2023.

### Interventions

The focus facilities were notified in January of all required interventions for this quality improvement activity (QIA). Network staff worked with the MRB and the PAC through face-to-face meetings, workgroup phone calls, and email communication to review facility selection and appropriate interventions. Based on feedback gathered from these activities, the following interventions were selected as the major components for the Home Training QIA:

- Root Cause Analysis - Project facilities completed a root cause analysis to identify the most common patient, facility, and organizational factors contributing to a lack of patients being trained for home modalities.
- Project Webinars - Project webinars are designed to educate facilities on the next steps in the project as well as give them the opportunity to discuss barriers or success with other project facilities.
- 7-Steps Home Navigation Tool – Tool which was created by the Network for facilities to utilize and submit 7 steps progress data to the Network.
- Patient Engagement component – Project facilities were required to engage patients by utilizing an FPR and the Network-developed Patient Engagement Calendar with its respective monthly tools.
- Advanced Renal Education Program (AREP) - The Network partnered with the Advanced Renal Education Program (AREP) on a series of home webinars that included CEU opportunities for attendees.
- Attendance and participation in NCC Home QIA Learning and Action Network (LAN) calls - The Network invited all project facilities to each Home QIA LAN call via multiple email notices and reminders. Following the LAN calls, the Network asked facilities to identify any resources or best practices identified from the LAN webinar via a post LAN survey. LAN resources were shared with all project facilities.
- Disparities - Project facilities were provided a disparities survey in which they identified location and access to care as barriers leading to disparities for patients in rural areas. In response, the Network partnered with Dr. Julie St. John at Texas Tech University Health Sciences Center, who presented the webinar "[Addressing Health Disparities in Rural Communities](#)" to project facilities. Facilities were also given the [IHI Disparity/Equity Tool](#) and the [CMS Health Disparities Action](#) Guide as resources to address disparities.
- Sustainability - The Network developed a sustainability model to help facilities sustain the improvements made during the project after the project has ended.

**Results**

Based on available final data, the Network achieved a 4.9 percentage point overall increase in the home dialysis training rate from baseline (0.6%) to the last set of data released in October 2018, which represents September 2018 at 5.5%.

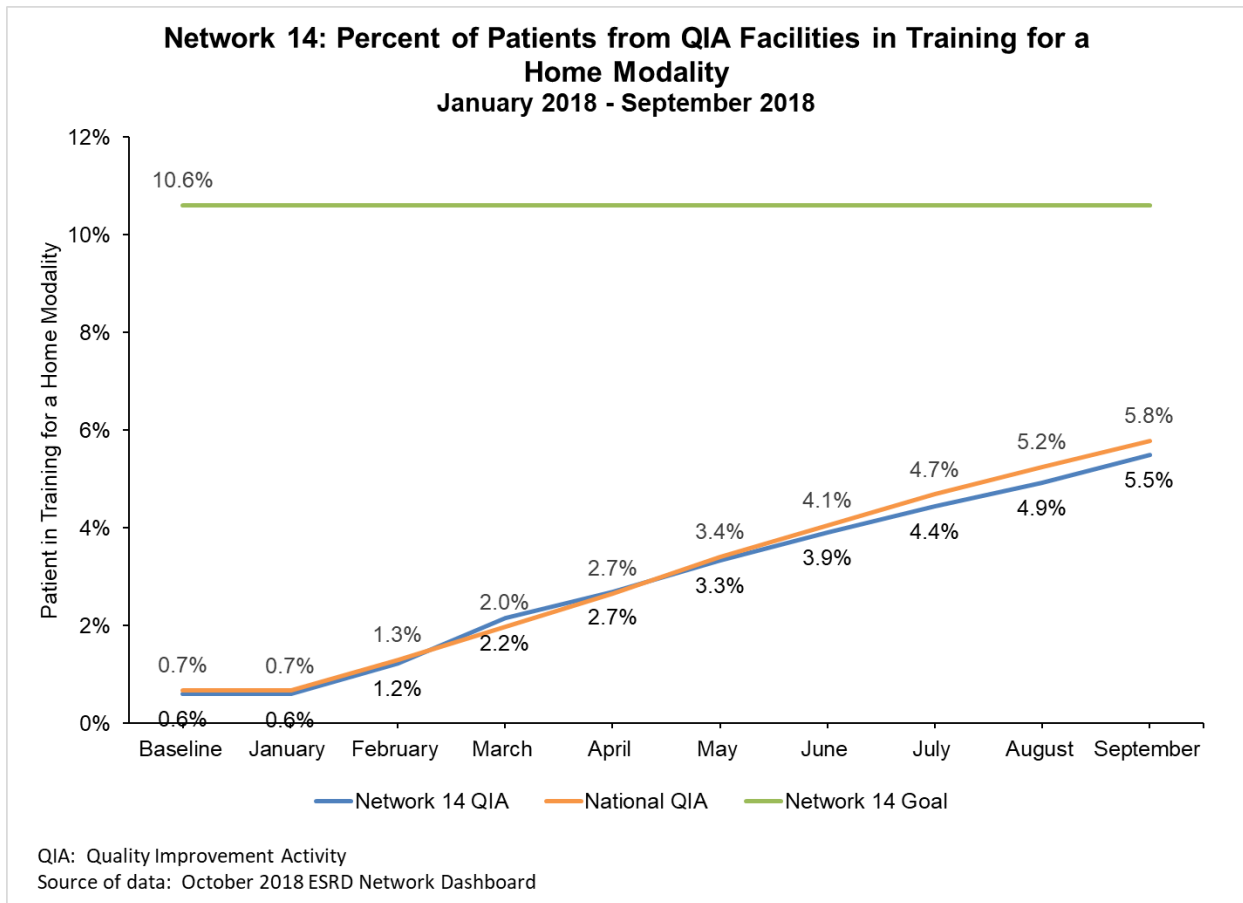
**Best practices**

Best practices were identified during the project including: facility staff educating and referring patients on all modalities within the first three months of initiation of treatment, Home QIA LAN calls and utilizing resources provided, utilization of Network-developed as well as Network recommended tools, utilizing FPRs and home champions as patient liaisons, monthly review of all conversations with patients, regional contest to determine which facility transitions the most patients to home, periodic internal QIA team meetings for Network team feedback, brainstorming sessions conducted by Network staff during large dialysis organization regional management meetings, and standardization of an early overarching sustainability plan to be used with outgoing and incoming focus facilities to sustain gains after completion of the project.

**Closing remarks**

Although Network 14 did not achieve the goal of the 10 percentage point increase in the home dialysis training rate, patient-specific barriers were identified, a variety of home modality misconceptions were clarified, and overall a total of 862 patients initiated training for a home dialysis modality. The Network will continue its collaboration with patients and stakeholders to increase home modality rates for ESRD patients in the Network service area.

**Chart 14. Percent of Patients from QIA Facilities in Training for a Home Modality**



## Population Health Focus Pilot Project Quality Improvement Activity



The intent of the Population Health Focus Pilot Project (PHFPQ) project B was to improve the screening and treatment of depression for ESRD patients. In 2018, Network 14's goal was to decrease responses to CROWNWeb depression screening data (Option 3), "Screening for clinical depression documented as positive, the facility possesses no documentation of a follow-up plan, and no reason is given," by 10%. An additional goal was to decrease the response to Option 6, "Clinical depression screening not documented, and no reason is given," to zero (0). The Network team analyzed facilities in Texas and identified facilities with the greatest opportunity for improvement based on the facilities with the highest rate for Option 6. Our baseline was obtained from October 2016 through June 2017 data and included 10% of the Network service area Medicare-certified facilities. The Network worked with 69 facilities based on CROWNWeb patient data for depression screenings.

### Interventions

The PHFPQ project incorporated all six CMS attributes (Commitment to Boundarilessness and Unconditional Teamwork; Customer Focus and Value of the QIAs to Patients, Participants, and CMS; Value Placed on Innovation; Patient and Family Engagement; Rapid Cycle Improvement in QIAs and Outputs; and Ability to Prepare the Field to Sustain the Improvement) throughout the contract year via six phases of interventions. The facility interventions began in January 2018 and continued through September 2018. The six phases of the project included: introduction RCA and FPR recruitment, patient engagement activities, data submission and accuracy, developing follow-up plans, a disparity webinar, and sustainability plans. For each phase of the project, facilities were required to attend the respective webinar for that phase and complete an attendance attestation and polling via Survey Monkey. All focus facilities were required to attend the NCC LAN meetings for depression screening and provide feedback to the Network on at least one intervention they used from the NCC LAN meetings within their facilities.

### RCA

The top three underlying issues that facility staff from the 69 facilities in the project identified as potential causes for poor performance on the identified measure(s) targeted for this PHFP QIA:

- staffing – 34/69 or 48.8%
- patient interest – 17/69 or 24.4%
- resources/training – 18/69 or 26.6%

The specific barriers surrounding staffing were high facility staff turnover and low staffing. The barriers related to patient interest encompassed the patient's unwillingness to be open and honest during the screenings, but also the patient's ability to stay before or after treatment for follow up discussions and planning. Regarding facility resources, the barriers include lack of CROWNWeb training for facility staff members and the absence of a tracking mechanism for staff to follow up with patient screenings.

### Tracking and monitoring

The Network implemented a monthly collection and reporting of depression screenings by facilities. Focus facilities completed electronic monthly data collection tools and quarterly contact sheets. The data collection tools helped the Network accurately track patients' screenings and encourage documentation into CROWNWeb, and the tools also served as a data validation tool. The quarterly contact forms provided the Network valuable and timely information regarding staff turnover such as project lead changes at the facility level. In contrast, the monthly data collection tools identified data discrepancies in CROWNWeb and prompted facilities to validate and correct data.

## **Results**

Based on available final data, the Network achieved a 1.8 percentage point decrease in the responses to Option 3 from baseline of 3.9% to the last set of data released in October 2018, which represents September 2018 at 2.1%. The Network also achieved a 9.2 percentage point decrease in responses to Option 6 from baseline (20.5%) to the last set of final data at 11.3%. Last, the responses to Option 6 for the disparate group (Rural location) improved from baseline at 29.0% to a response rate of 90.6% based on final data from the October 2018 ESRD Network Dashboard.

## **Best practices**

Best practices were identified from focus facility feedback during the project including: follow up with the patients who scored positive on the Patient Health Questionnaire (PHQ-2), not only as a follow up to the PHQ-2, but on a regular basis to assess them for any small changes that can lead to a patient feeling depressed develop a plan that encourages a new system of reporting in QAPI to be sustainable and assigning an individual to be responsible all staff to monitor patients for any signs of depression and report it to the social worker have a clear process and for communicating to other facility staff so that in the absence of the social worker it is clear what has been done and what needs to be done; ensuring that the data reported in CROWNWeb is accurate.

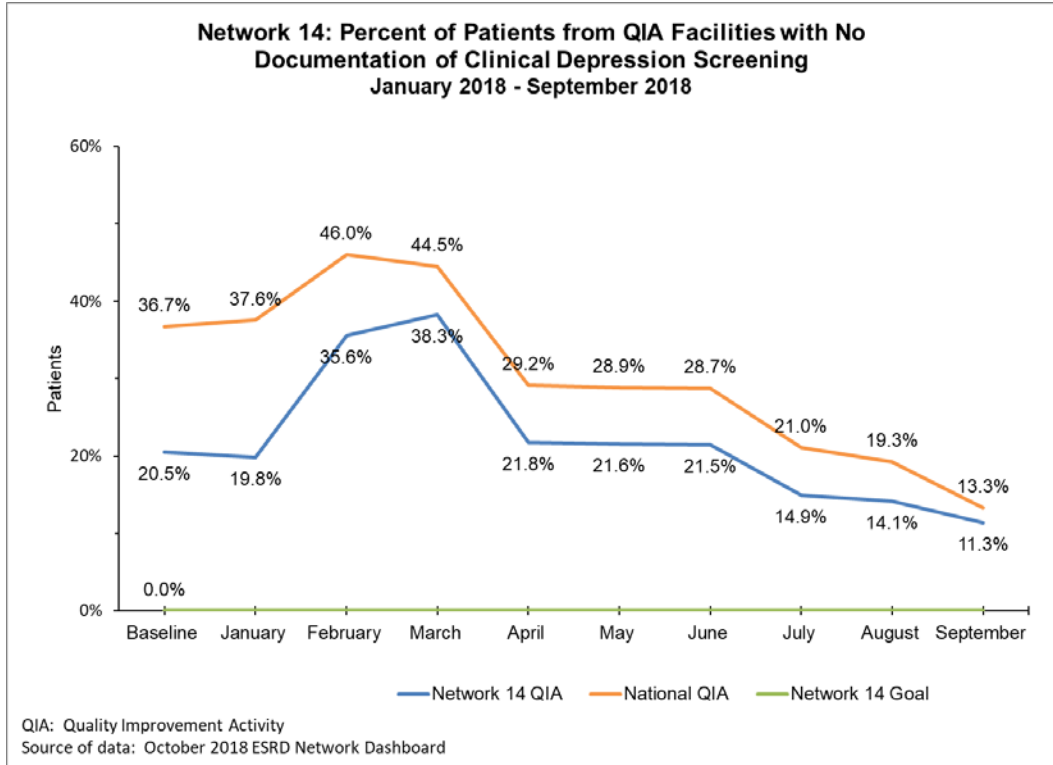
## **Disparity Intervention**

The Network found that 21.7% of the PHFPQ focus facilities indicated that they served patients from a vulnerable population, and that 69% of these vulnerable patients included those living in a rural area. The Network provided a disparities survey to all focus facilities to identify location and access to care as barriers leading to disparities for patients in these rural areas, so that these facilities could develop interventions specific to their patient population. In addition, the Network partnered with Dr. Julie St. John at Texas Tech University Health Sciences Center to host a one hour webinar called "[Addressing Health Disparities in Rural Communities.](#)" The purpose of this webinar was to inform facilities about health disparities that affect Texas rural communities, present risk factors for rural health, and share solutions, strategies, resources, and best practices. The webinar ended with an interactive question and answer session in which Network QIA leads and Dr. St. John had an open discussion with webinar attendees. Facilities were also assigned the [IHI Disparity/Equity Tool](#) and the [CMS Health Disparities Action](#) guide as an intervention to close the gap between the disparate and non-disparate groups.

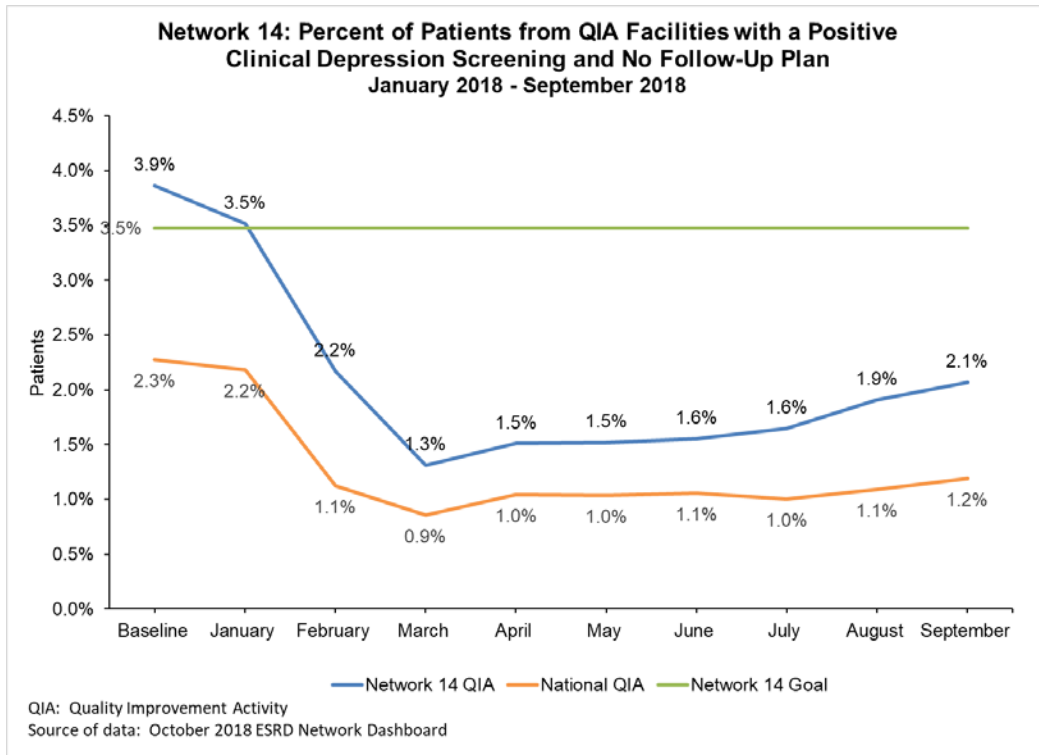
## **Closing remarks**

Although Network 14 did not achieve the goal to decrease responses to Option 3 by 10 percentage points and Option 6 to zero (0), several barriers were identified and addressed, including validation and correction of recorded responses in the patient's medical record. Additionally, the disparity in depression screenings for responses in rural facilities improved by 61.6 percentage points from 29% to 90.6%, closing the gap in inequality and improving equity among depression screening for patients from different demographic areas.

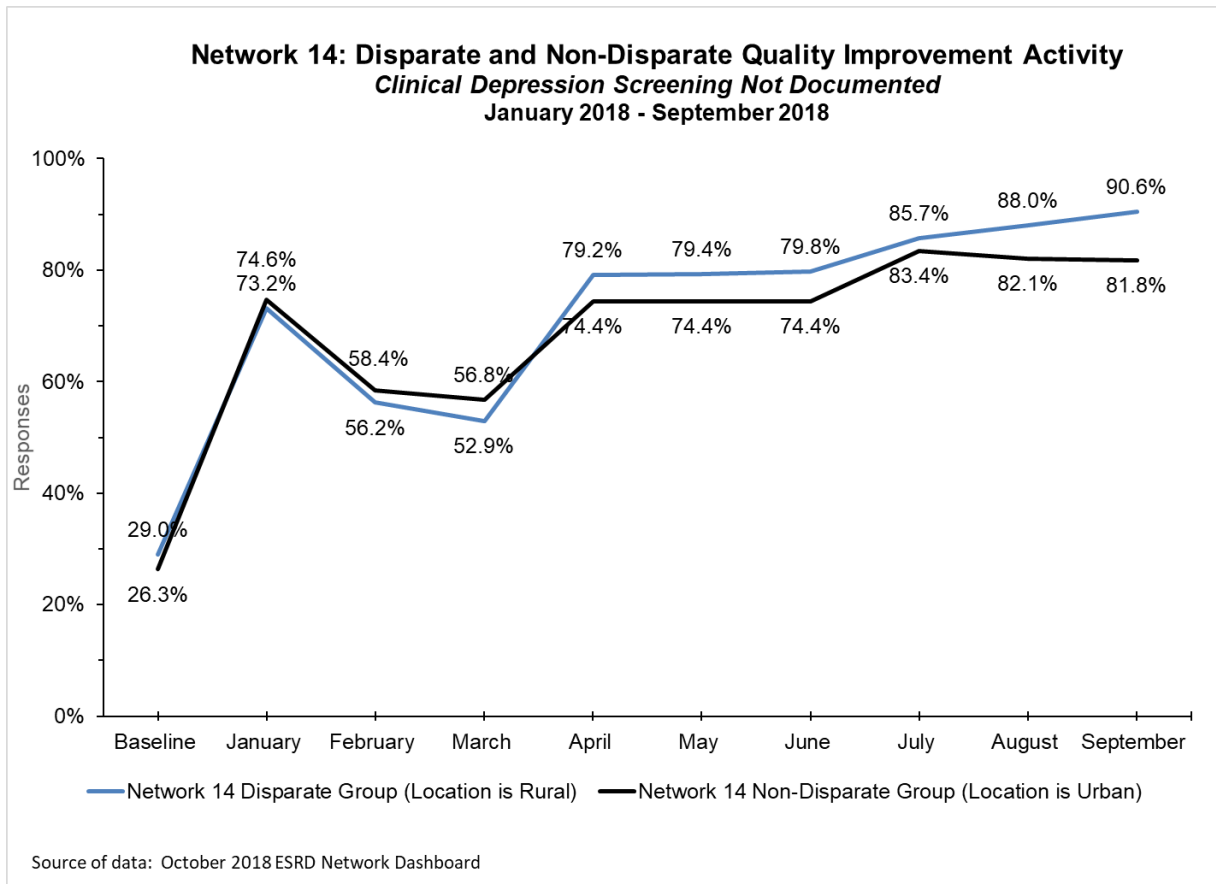
**Chart 15. Percent of Patients from QIA Facilities with No Documentation of Clinical Depression Screening**

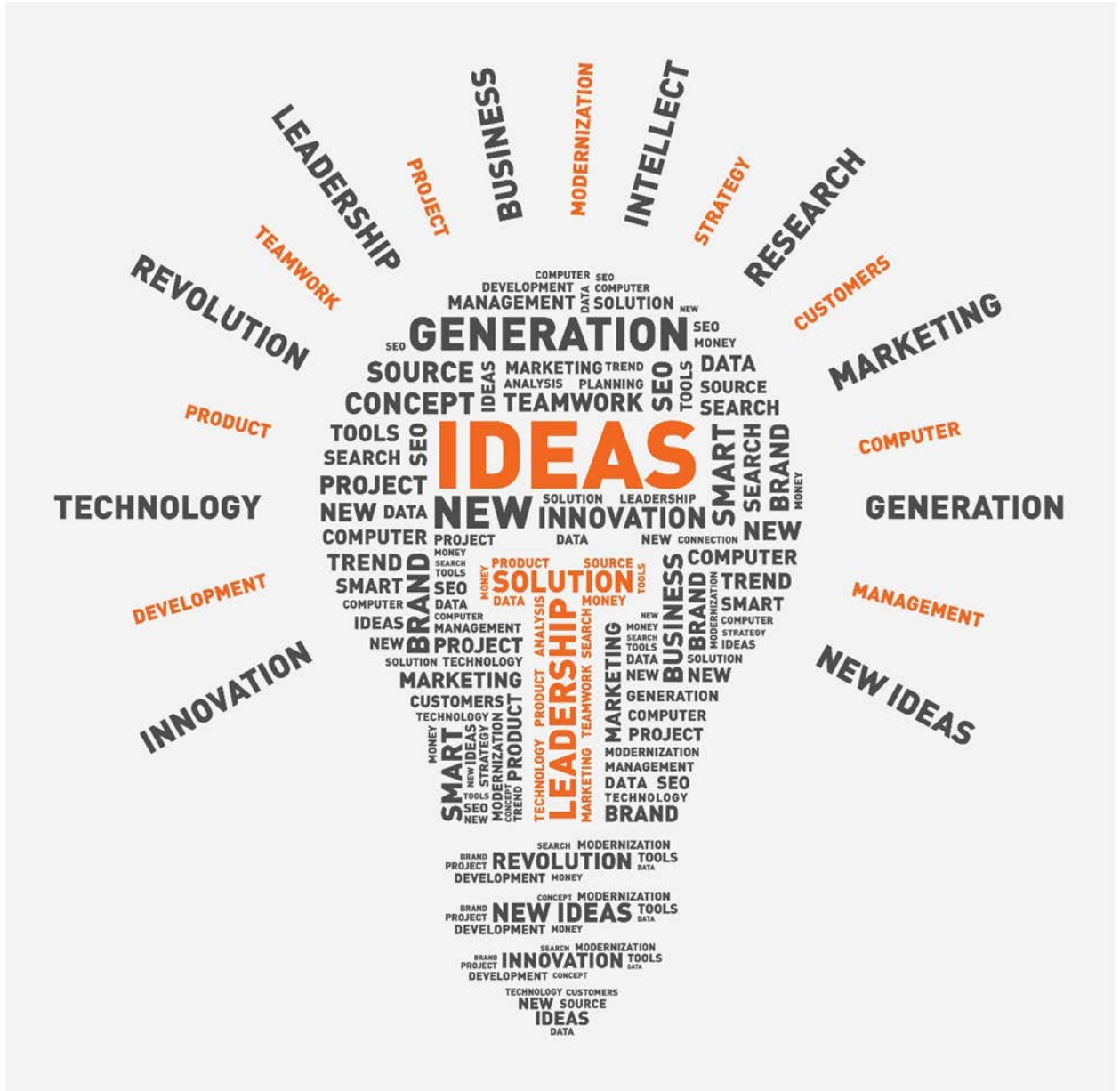


**Chart 16. Percent of Patients from QIA Facilities with a Positive Clinical Depression Screening and No Follow-Up Plan**



**Chart 17. Disparate and Non-Disparate Quality Improvement Activity**







## ESRD NETWORK RECOMMENDATIONS

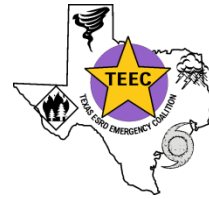
Provider participation in the Network service area is monitored throughout the year for compliance with QIA activities specified in the Network's CMS contract and for performance on quality measures. Facilities that fail to comply with Network requests have the potential to be placed on the Network Watch List, and subsequently may be referred for sanctions by CMS. Networks may recommend that sanctions or alternative sanctions be imposed on facilities that do not cooperate in meeting Network goals or the ESRD Conditions for Coverage.

In 2018, no facilities were referred to CMS for sanctions. However, there were facilities that struggled to maintain expected levels of participation in ESRD Network 14 project QIA activities. The implementation of the Network Watch List warning was successful in reducing the number of facilities placed on the Network Watch List. This process entailed sending the facility leadership notification that detailed the reason the facility was being placed on the Network Watch List, the actions required to be removed from the Watch List, and consequences if those actions were not completed. The notification was sent to the facility's Administrator and a corporate leader (if applicable) as well as notification to the CMS Contracting Officer's Representative for ESRD Network 14.

ESRD Network 14 strongly believes in fostering partnerships with the dialysis facilities in Texas to meet and exceed the Network goals established by CMS to support the Department of Health and Human Services (HHS) and CMS national improvement goals and priorities. While ESRD Network 14 has always valued a collaborative, collegial approach, in 2016 we initiated the Network Watch List to address ongoing failure of facilities to fully participate, complete projects, and achieve project goals, despite outreach to corporate levels.



## ESRD NETWORK SIGNIFICANT EMERGENCY PREPAREDNESS INTERVENTION



In 2018, Texas experienced various weather conditions that impacted numerous facility operational statuses. In January 2018, in preparation for severe weather, Network 14 staff met with the State Medical Operations Coalition (SMOC) in Austin, Texas, to discuss methods of improving emergency plans and partnerships with ESRD providers and patients. Through this collaboration, a partnership was developed that resulted in State Representatives joining the Texas ESRD Emergency Coalition (TEEC). For the betterment of our healthcare systems, the Network addresses how to educate other organizations on the importance of helping ESRD patients. To streamline communication processes during emergencies, each TEEC representative has access to a private group communication portal and a phone tree.

Network 14 presented an ESRD Tabletop Emergency Drill Webinar on April 19 for facilities that had not met their CMS Emergency Preparedness requirements. The Network held the drill on May 3, 2018, at the Dallas Command Center, where over 354 facilities participated and completed their full scale exercise. Through collaboration between the Network and DaVita, Network staff participated in eleven divisional community based meetings throughout the state of Texas to conduct emergency preparedness drills. In 2018, the Network submitted five Emergency Situational Status Reports (ESSRs) to Kidney Community Emergency Response (KCER) due to flooding, fire, tornado, and an isolated facility incident. No casualties were caused by any of the events, and facilities were able to gain full operational status within 24-48 hours.

The Network has continued to support the efforts of all organizations by providing resources on the Network's website. The Network strives to continue its educational processes with ESRD facilities and the state of Texas Emergency Coalitions on the importance of disaster planning for ESRD patients. These efforts are generated through outreach to county officials, statewide speaking engagements, presentations with a Large Dialysis Organization as well as to the Texas Kidney Foundation. After assessment of resources available to aid patients, the Texas Department of State Health Service granted Network 14 a \$100,000 grant for the purchasing of 90,000 bags to disburse to all ESRD patients for emergency use. Through this endowment, patients will have a backpack "Go Bag" for them to store their medications, medical documents, and personal items in the event of an emergency. Network 14 will continue to work diligently in building partnerships with Texas State Department Emergency Coalitions and implement best practices for the safety of all Texas residents. As in previous years, EMResource has been noted as a best practice during emergency disaster events. EMResource allows dialysis facilities and other emergency organizations to view real time data when transferring patients to other dialysis facilities and hospitals during a disaster.

## **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.