



END STAGE RENAL DISEASE  
NETWORK OF TEXAS

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# 2019 ANNUAL REPORT

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Deliverable #11**

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## **Table of Contents**

<b>ESRD DEMOGRAPHIC DATA .....</b>	<b>3</b>
<b>ESRD NETWORK GRIEVANCE AND ACCESS TO CARE DATA.....</b>	<b>11</b>
<b>ESRD NETWORK QUALITY IMPROVEMENT ACTIVITY DATA .....</b>	<b>15</b>
<b>Long Term Catheter Quality Improvement Activity .....</b>	<b>16</b>
<b>Blood-Stream Infection Quality Improvement Activity .....</b>	<b>19</b>
<b>Home Therapy Quality Improvement Activity .....</b>	<b>26</b>
<b>Population Health Focus Pilot Project Quality Improvement Activity: .....</b>	<b>29</b>
<b>Improve Dialysis Care Coordination with a Focus on Reducing Hospital Utilization .....</b>	<b>29</b>
<b>ESRD NETWORK RECOMMENDATIONS.....</b>	<b>33</b>
<b>ESRD NETWORK 14 SIGNIFICANT EMERGENCY PREPAREDNESS INTERVENTION.....</b>	<b>35</b>
<b>ACRONYM LIST APPENDIX.....</b>	<b>36</b>



## 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 (AKQC) and rely on the corporate partnership for daily administrative and information technology services. The AKQC partnership facilitates rich collaboration and increased efficiencies for both Networks' quality improvement and patient engagement activities.

Network 14 serves the ESRD community in the state of Texas, with the administrative office located in Dallas, Texas. Administrative guidance is received from the Corporate Governing Board (CGB); program oversight from the Medical Review Board (MRB); program development advice and consultation from patient subject matter experts who form the Patient Advisory Council (PAC); ESRD professionals who serve on the Texas ESRD Emergency Coalition (TEEC); and the Network Council (NC).

### Geography and General Population

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 largest in the US<sup>1</sup>, while San Antonio is the second most populous in the state and seventh largest in the US<sup>2</sup>.

### ESRD Population

A geographic area of this size that is home to a large general populace and a substantial population with kidney failure is a major factor in having a significant number of dialysis facilities and transplant centers operating in the state. CROWNWeb data indicated that, in 2019, ESRD Network 14 had the largest percentage of prevalent dialysis patients by ESRD Network with 66.5% of patients receiving in-center dialysis, 9% choosing a home modality, and the remaining 24.4% living with transplant (Chart 1), representing 10.3% of the national total ESRD patient population (Chart 4). By treatment modality, ESRD Network 14 was the third largest Network with 9.1% of national total home hemodialysis and peritoneal dialysis patients (Chart 7), and 7.5% of the national total transplant patients by ESRD Network (Chart 8).

### Patient and Family Engagement

The ESRD Network PAC is a diverse group of 15-25 subject matter experts who represent the demographic characteristics of ESRD patients in the Network's service area. Members are comprised of patients as well as caregivers. The PAC is actively involved in identifying the needs of patients and opportunities for provider education.

Requirements for each Quality Improvement Activity (QIA) are reviewed with the PAC during the annual and monthly meetings, as well as frequent subcommittee calls. Patient-focused interventions to address these activities are developed in collaboration with the PAC during these

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<sup>1</sup> <https://worldpopulationreview.com/us-cities/>

<sup>2</sup> <https://worldpopulationreview.com/us-cities/>

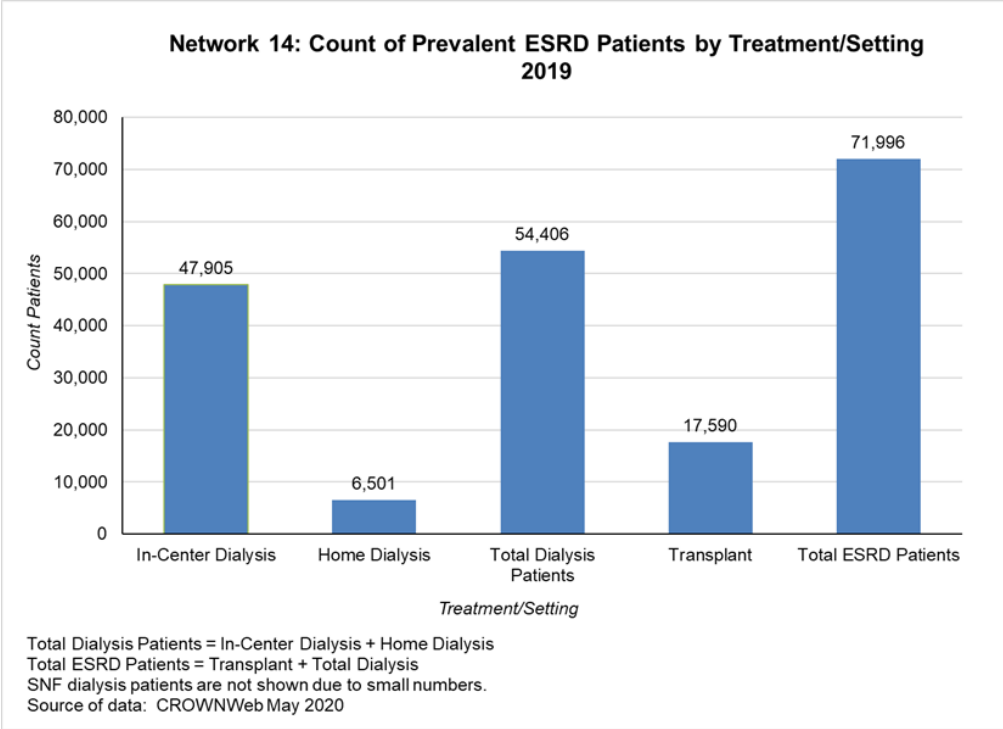
meetings in an effort to increase patient engagement at the dialysis facilities. PAC members are also encouraged to create patient educational resources on topics outside the QIA projects. These materials are reviewed, translated into Spanish, and distributed to the ESRD Network 14 patient population. PAC members serve as peer mentors in their communities, attend national Learning and Action Network (LAN) calls, attend Centers of Medicare & Medicaid Services (CMS) national meeting(s), provide membership on the Texas Governor's CKD Taskforce, and function as facility patient representatives (FPRs). They also provide a patient voice on the ESRD Network 14 Corporate Governing Board and Medical Review Board. PAC members are able to provide individual experiences and lessons learned as guest speakers throughout the year to different organizations.

Examples of PAC involvement in the ESRD Network include:

- Involvement in the creation of resources and interventions designed to progress each QIA.
- PAC development of patient resources to address patient-selected topics and areas of concern and share the resources with their fellow patients.
- Provide patient feedback and suggestions concerning treatment related topics to ESRD Network 14 Boards and committees as well as other renal organizations
- Utilizing a multifaceted approach to provide tools and resources at the facility level that support increased patient satisfaction and optimal clinical outcomes.
- Utilizing feedback from patient subject matter experts (SMEs) and PAC members to create and update ESRD Network 14 resources, guide trainings and technical assistance, and complete root cause analyses.
- Incorporating patient and family engagement in each of the QIA(s).
- Providing education and guidance related to patient engagement activities to facility staff members and patients during site visits, trainings, resource distribution and individual contacts.
- Participation with national PFE LAN events and sharing information with other patients and facility staff members.
- Creation and review of resources developed to promote patient and family engagement, address common concerns; and achieve QIA goals.
- Assist facilities with conducting lobby days to provide patients with current and new information.

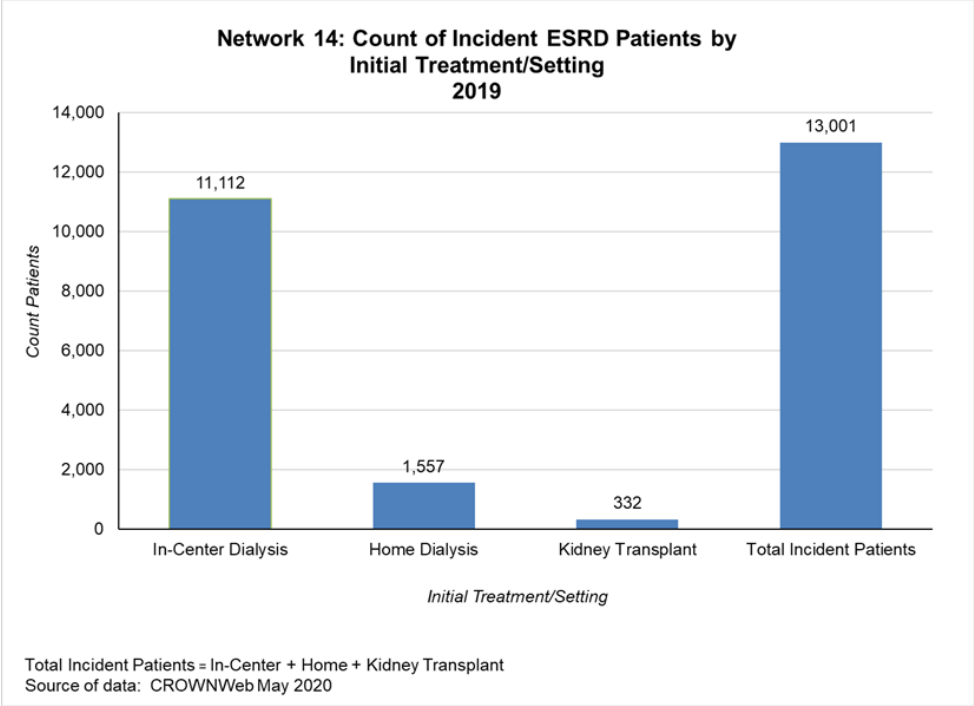
Patient educational materials created by Network staff and PAC members are translated into Spanish as per the ESRD Network's contract with CMS and the Statement of Work (SOW) requirements to assist the high number of Spanish-speaking patients in the ESRD Network geographic area. Educational resources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

**Chart 1: Count of Prevalent ESRD Patients by Treatment Setting**



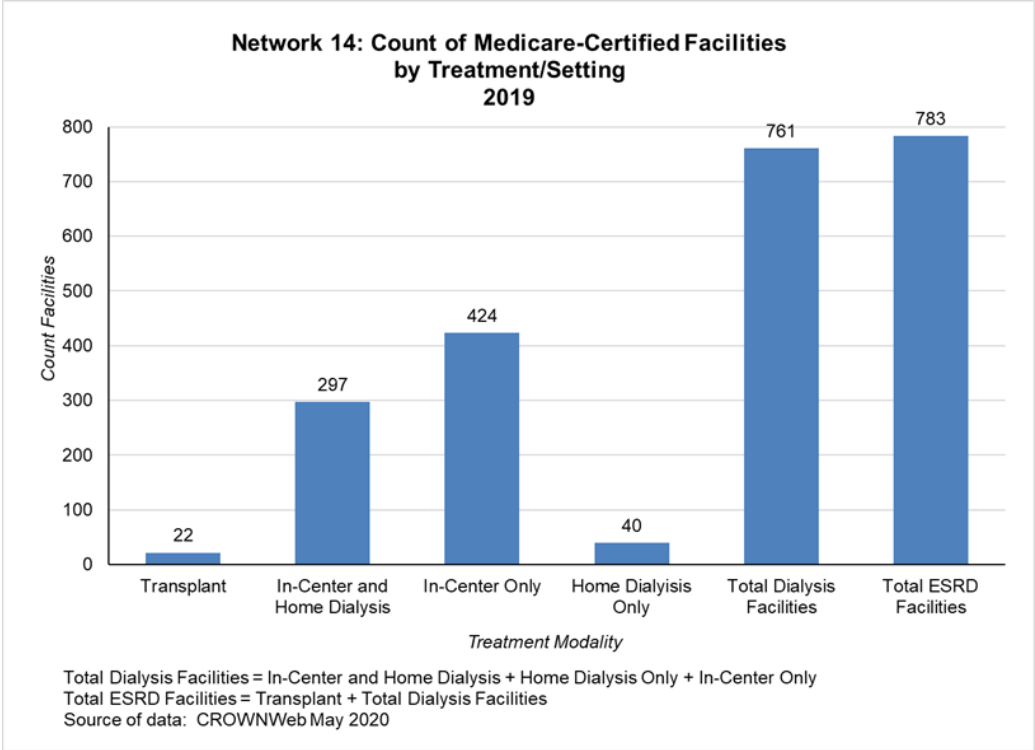
Source of data: CROWNWeb

**Chart 2: Count of Incident ESRD Patients by Initial Treatment/Setting**



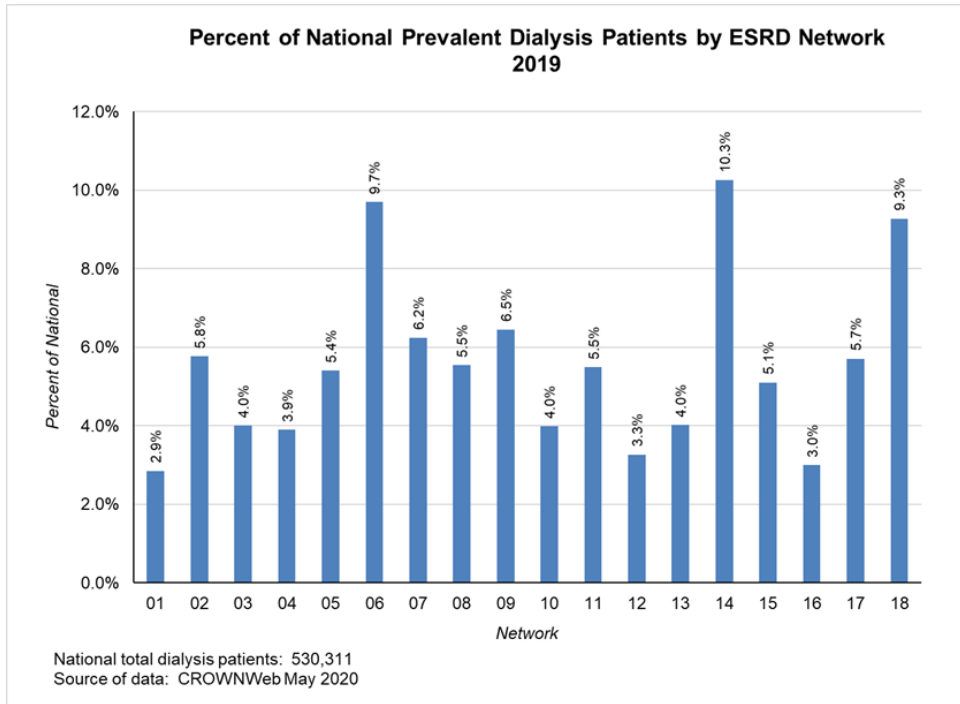
Source of data: CROWNWeb

**Chart 3: Count of Medicare-Certified Facilities by Treatment/Setting**



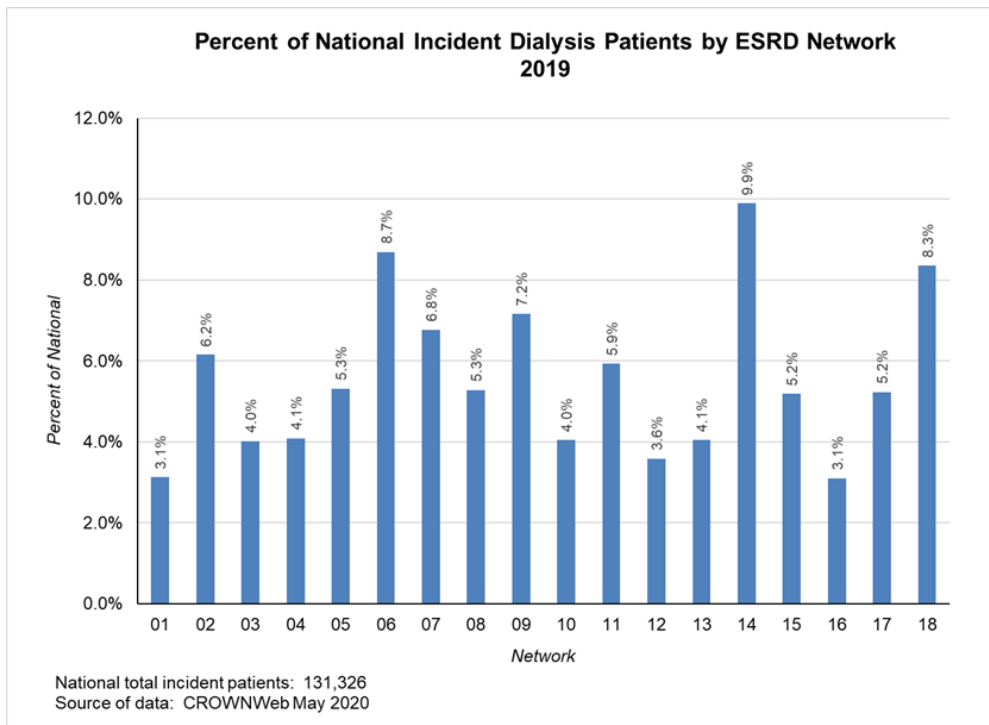
Source of data: CROWNWeb

**Chart 4: Percent of Prevalent Dialysis Patients by ESRD Network**



Source of data: CROWNWeb

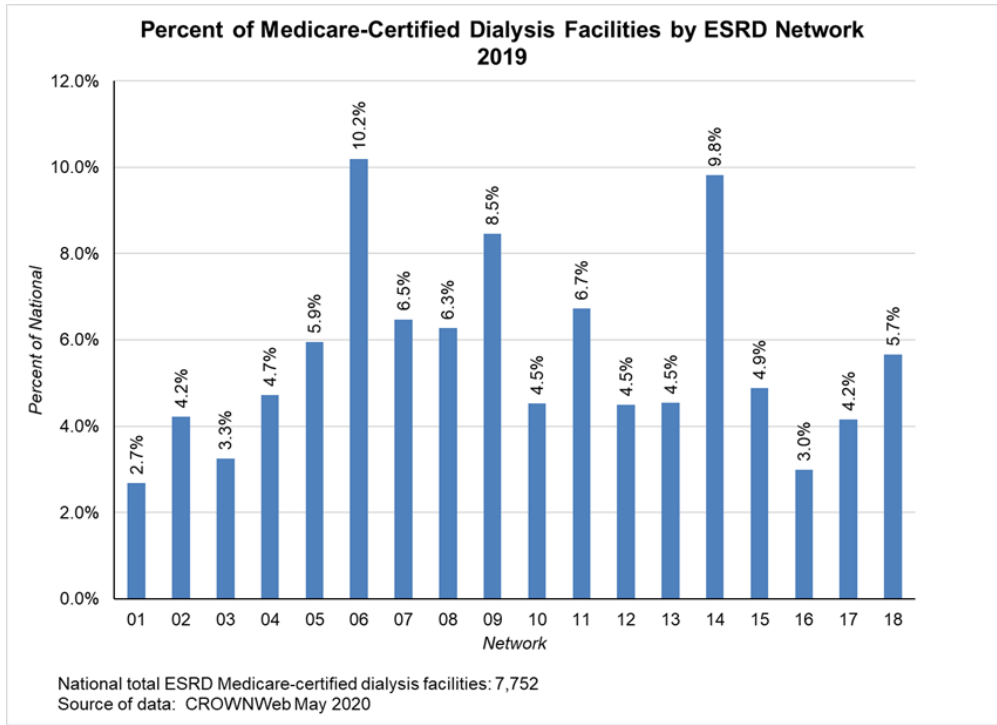
**Chart 5: Percent of Incident Dialysis Patients by ESRD Network**



Source of data: CROWNWeb

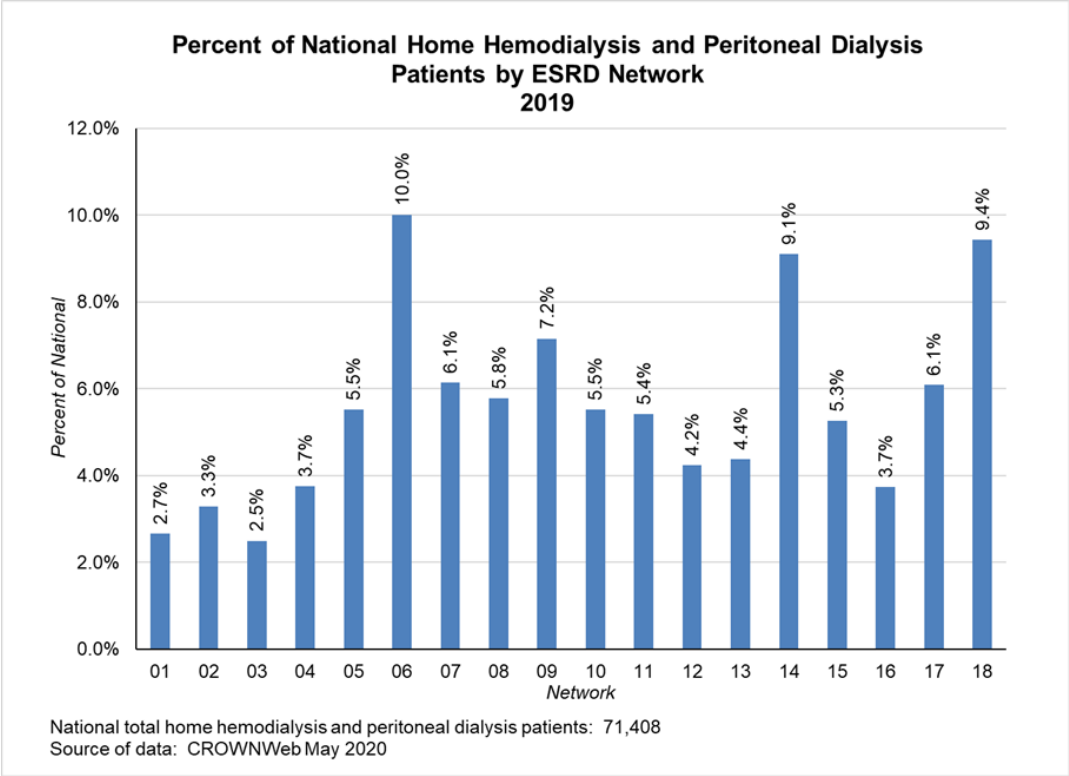


**Chart 6: Percent of Medicare-Certified Dialysis Facilities by ESRD Network**



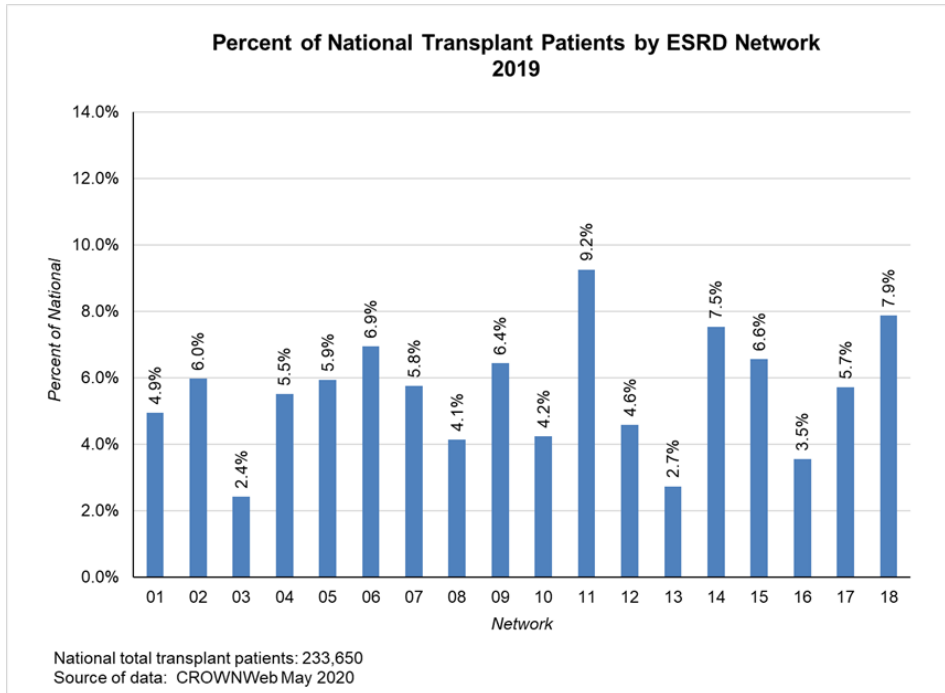
Source of data: CROWNWeb

**Chart 7: Percent of Home and Peritoneal Dialysis Patients by ESRD Network**



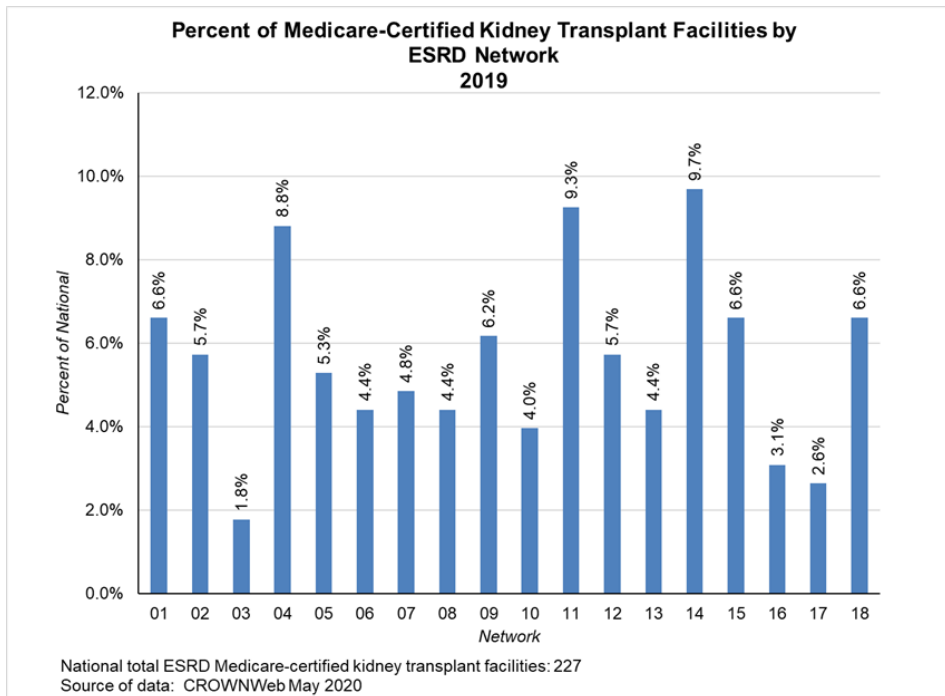
Source of data: CROWNWeb

**Chart 8: Percent of Transplant Patients by ESRD Network**



Source of data: CROWNWeb

**Chart 9: Percent of Medicare-Certified Kidney Transplant Facilities by ESRD Network**



Source of data: CROWNWeb



## **ESRD NETWORK GRIEVANCE AND ACCESS TO CARE DATA**

During calendar year 2019, ESRD Network 14 continued implementation of processes to fulfill CMS' requirements, standards established by the ESRD contract and J-8 attachment. The ESRD Network also developed, implemented, and distributed new processes and resources to increase visibility, understanding, and awareness of the Network's role in grievance resolution. The Network focused on: improving the Network's Grievance Satisfaction Scores; providing technical assistance related to grievances, access to care concerns, and facility concerns; and developing and distributing resources to both patients and providers.

### **Improving the ESRD Network 14's Grievance Satisfaction Scores**

For 2019, the Network was to improve the grievance satisfaction score, provided by the National Coordinating Center (NCC) for the month of December (2018), by at least 10% relative improvement by the end of the contract option year. The ESRD Network's December 2018 score was 75.19, which required a Grievance Satisfaction Score of at least 80.66 by annual evaluation. The ESRD Network developed the following processes to improve Grievance Satisfaction Scores:

- The Patient Services Department conducted weekly staff meetings to review all open cases and assess grievances. ESRD Network staff completed weekly discussions related to reviewing grievance resolution interventions which ultimately lead to improving Grievance Satisfaction Scores.
- The ESRD Network continued the process of calling patients prior to sending Grievance Summary letters, which gave patients the opportunity to ask questions and voice additional concerns. During these calls, Network staff provided a review of investigation findings and a detailed outline of information included in the Grievance Summary letters.
- The ESRD Network utilized monthly Grievance Satisfaction Scorecards to target and identify focus areas to develop interventions related to Grievance Satisfaction Scores.
- The ESRD Network developed templates to aid the Network's Patient Services Staff with ensuring that patients understand their grievance rights, ensure that patients understand the ESRD Network 14's role in grievance resolution, and to assess patient satisfaction with grievance resolution.
- The ESRD Network utilized an interdisciplinary approach to resolve grievances and regularly included dialysis organizational leadership in grievance resolution efforts. This practice strengthened partnerships with facilities and patients.
- The ESRD Network continued a process of contacting patients 30 days after Grievance Summary letters had been sent, to complete a follow-up related to the grievance.

Utilizing insight from the Executive Director, Quality Improvement Director, QIA Leads, and PAC, the ESRD Network 14's Patient Services Department aided in successfully resolving grievances, facility concerns, and access to care cases; which in turn lead to optimal patient outcomes. The ESRD Network successfully met the CMS directive related to grievance satisfaction scores by achieving a score of 81.74.

### **Technical Assistance**

In 2019, the Network processed 384 facility concern cases (Chart 10). In handling these cases, Network staff provided technical assistance to facilities related to grievance resolution, patient engagement, alignment with treatment goals, behavior management, resource referrals, and

access to care concerns. In an effort to support providers and promote optimal patient outcomes, the Network implemented the following to provide technical assistance:

- Partnered with dialysis facilities and providers to provide education and technical assistance related to dealing with challenging patient circumstances and resolving patient-provider conflict.
- Provided ongoing education related to the ESRD Conditions for Coverage (CfCs) and the involuntary discharge (IVD) process to facilities and providers. In reviewing access to care concerns, the Network aided providers with identifying alternative patient-centered interventions.
- Educated facility staff members on the importance of understanding the de-escalation process and proper de-escalation interventions; supporting patients when they have questions or concerns related to their care; and providing ongoing education to patients and caregivers.
- Assisted involuntarily discharged patients with placement in a dialysis facility. In assisting with placement, the Network encountered barriers related to facilities denying patients due to patient behaviors and non-compliance. The Network also assisted hospitals and other providers serving ESRD patients with access to care concerns.
- Continued the Second Chance Program to assist patients, who may have been involuntarily discharged, in obtaining placement. At the end of 2019, there were 12 placements through this program with no reported breakdown in placement during the calendar year.

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 to provide for their treatment regimen.

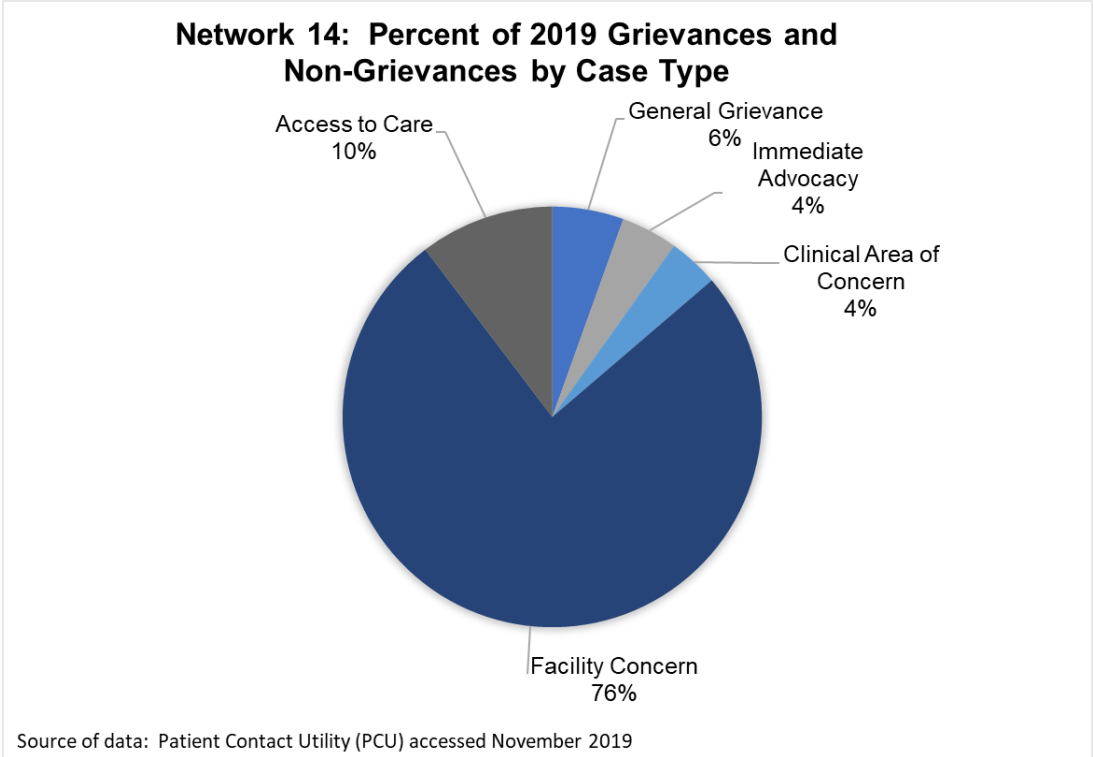
### **Resource Development and Distribution**

Utilizing feedback from patients and providers, the ESRD Network identified common areas of concern and developed resources to address identified issues. The Network used the following methods to develop and distribute resources:

- The Network completed focused audits using information from the Patient Contact Utility (PCU) to identify primary areas of concern.
- The Network developed a number of one-page resources for both patients and providers.
- The Network included the PAC members in resource development. This process offered a patient-centered approach to resource development.
- The Network also incorporated feedback from patients and providers to make resource development recommendations.
- The Network completed educational presentations during regional trainings held by Large Dialysis Organizations (LDO).

The ESRD Network completed mass distribution of resources to providers and posted these resources on the Network's website. The distribution of these resources resulted in increased communication and meaningful partnerships with patients and providers.

**Chart 10: Percent of Grievances and Non-Grievances by Case Type**







## Long Term Catheter Quality Improvement Activity



In 2019, the ESRD Network's goal for vascular access was to improve long-term catheter (LTC) rates by at least two percentage points decrease from baseline (July 2018) in prevalent dialysis patients. The Network's LTC Quality Improvement Activity (QIA) enrolled 38 facilities (adult patients with all access types regardless of dialysis modality), with a LTC rate of greater than 15% at baseline from the 50% of facilities in the Network's service area reporting the highest bloodstream infection (BSI) rates. The aggregate baseline LTC rate for the overall group was 21% with a requirement of achieving at least a two percentage point reduction to an aggregate LTC rate of 19% or below using available CROWNWeb vascular access final data provided by the NCC.

Facility interventions were developed with guidance and input from subject matter experts including Network 14 staff, MRB, and PAC members. This feedback was gathered through face-to-face meetings, phone, email communication, and the PAC's Teamwork Project Management (TPM) platform. Focus facilities were contacted and notified of project selection via a standardized project notification letter on January 4, 2019. Project kick-off occurred with an introductory webinar on January 19, 2019, which included an overview of the project goals, baseline review, interventions, tools, resources, and project requirements. ESRD Network 14 staff provided assistance and support to the focus facilities including one-on-one calls, data validation, electronic LTC monthly reports via Survey Monkey®, collaboration with LDOs' regional vascular access coordinators, rapid cycle improvement (RCI), action plans, root cause analysis (RCA), utilization of the Medical Advisory Council (MAC) Catheter Reduction Toolkit from the FORUM of ESRD Networks, Centers for Disease Control (CDC) Core Interventions, healthcare-acquired infections Learning and Action Networks (HAI LANs), and using FPRs as liaisons.

### Summary of Barriers and Root Cause Analysis (RCA)

ESRD Network 14 guided facilities in performing a RCA via Survey Monkey® to identify the causes leading to high long-term catheter rates in their clinics. The RCA results helped facilities identify barriers that were key in the adoption and execution of appropriate interventions. The major barriers for high long-term catheter utilization selected by facilities by category included:

- **Patient-related factors:** patient refuses to get an arteriovenous fistula (AVF) or an arteriovenous graft (AVG); cancel/no-show for diagnostic or surgical appointments; access sites exhausted or not suitable; financial issues; transportation difficulties; and fear of needles.
- **Nephrologist-related factors:** failure to initiate/activate vascular access plan; lack of communication between the nephrologist and the surgeons on preferred access type (AVF/AVG instead of catheter); does not educate patient about risks of catheters and permanent vascular access options; and referral issues.
- **Surgeon-related factors:** payment/reimbursement (lack of or underpayment as compared to other procedures); poor surgical placement and outcomes; lack of available surgeons in the area; and surgeon not seeing new dialysis patients until 90 days after initiation of dialysis.

- **Dialysis facility-related factors:** fistula maturation/healing graft and catheter monitoring system in place but not being followed or used as intended (example: inconsistently used, not documented, incomplete); and high staff turnover.
- **External and other related factors:** hospital discharge of patient with no access plan in place; no vein mapping prior to hospital discharge; and admission of patients with catheters.

### Interventions

The Network utilized a simplified approach by selecting interventions in alignment with CMS' "Patients over Paperwork" goal. Main interventions included: root cause analysis; electronic LTC Monthly Report for detection of untoward (non-decreasing) LTC rates; update and develop action/improvement plans and have Medical Director sign off 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 ESRD Network 14's Patient Engagement Calendar); participation in the national ESRD NCC HAI LAN calls; and completion of sustainability plans.

### Results

Based on final data, ESRD Network 14 achieved and surpassed the goal for LTC by obtaining a 6.3 percentage point reduction in the rate of long-term catheters among prevalent adult dialysis patients (regardless of modality) during the CMS QIA evaluation period performed on final data for July 2019. Post evaluation, the Network continued to surpass the goal for the remaining three months included for this measure (Chart 11).

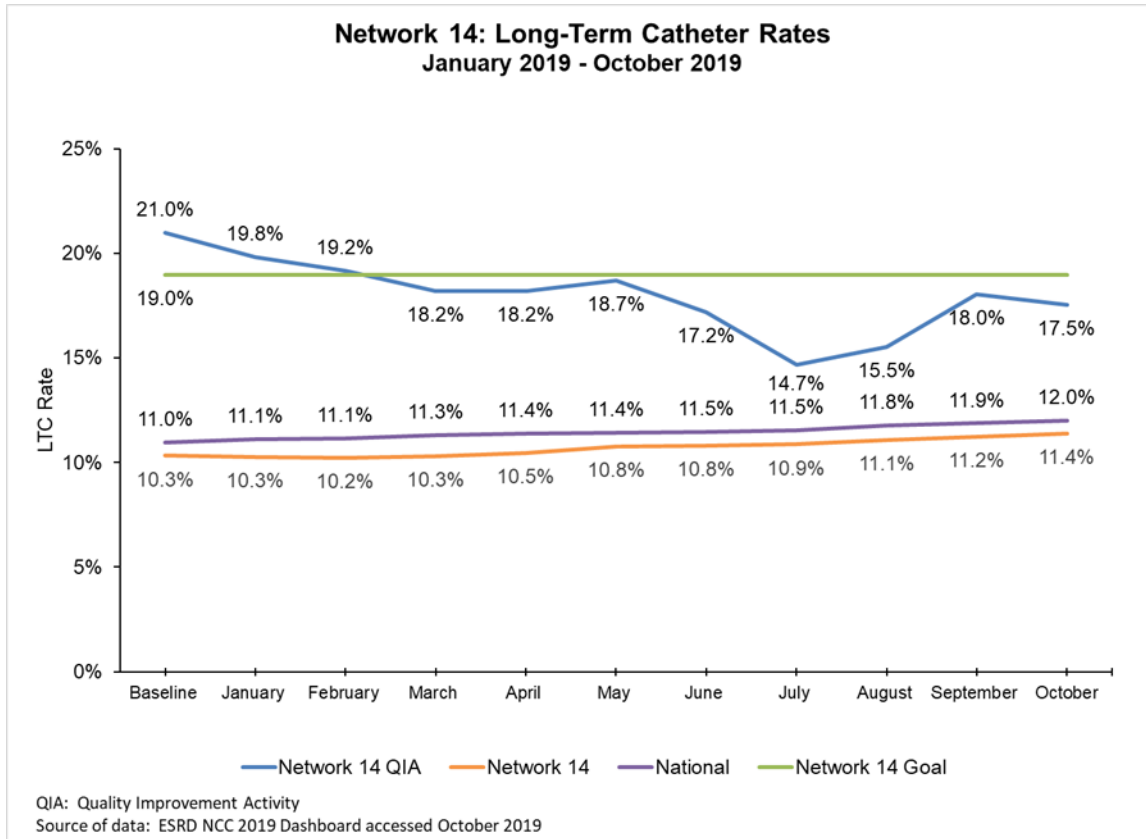
### Best Practices and Sustainability

Best practices identified during the project included: simplification of communication and requirements aligned with CMS' Patients Over Paperwork; collection of facilities' self-reported data through the Network-developed LTC Monthly Report for tracking purposes via Survey Monkey®; having a designated and engaged vascular access manager at the facility level; performing an electronic one-time RCA at the beginning of the project to use as a roadmap to identify barriers and apply interventions; having an engaged Medical Director and attending physicians; monthly outcomes review with the interdisciplinary team (IDT) during QAPI/QA; collaboration with Medical City Dallas to provide a free Cannulation Camp with CEs for nurses and technicians; 5 Whys for Patients activity for BSI and LTC which obtained a total of 525 responses from patients; data validation activities with 2,966 access records reviewed and 107 errors found for a total error rate of 3.61% vascular access discrepancies between internal electronic medical records (EMRs) and CROWNWeb; and standardization of an early overarching sustainability plan to be approved by corporate/regional management to sustain gains after completion of the project.

### In Summary

The ESRD Network met and surpassed the LTC goal for 2019. The Network is looking forward to continuing its collaboration with patients and stakeholders to further decrease LTC utilization and associated infection rates for dialysis patients in the state of Texas.

**Chart 11: Long-Term Catheter Rates**



## Blood-Stream Infection Quality Improvement Activity



Bloodstream infections (BSIs) are the second leading cause of death for patients with ESRD, and can be preventable employing the correct precautions<sup>3</sup>. In support of the national initiative to reduce the BSIs amongst the ESRD population, the ESRD Network provided interventions to Medicare certified facilities within the Network's service area with BSI rates in the highest 50% (286 facilities). A focus cohort with BSI rates in the highest 20% (115 facilities) was selected to receive increased interventions with a specialized emphasis on BSI reduction using the CDC's Nine Core Interventions. The 20% cohort group's goal was to achieve a 20% or greater relative reduction in its semi-annual BSI rate for the first and second quarter of 2019 as compared to their 2018 semi-annual BSI rate. The remaining 30% cohort participated in all the QIA's activities to reinforce infection prevention best practices.

Facility selection began with an analysis of BSI Excess Infection report from the National Healthcare Safety Network (NHSN) database for the first and second quarters of 2018. Facilities were first ranked by their BSI rate from highest to lowest, and selection included the top 50% of the facilities (286) with the highest (worst) BSI rates. As a group, these facilities reported a baseline pooled mean rate (PMR) of 0.68. The cohort of 20% (115) with the highest BSI rates possessed a PMR of 1.03, while the remaining 30% cohort started with a baseline PMR of 0.46, which is consistent with the ESRD Network 14's average BSI rate.

### Root Cause Analysis

An initial RCA was conducted prior to the start of the QIA to determine the facilities' understanding of BSI's and the cause for their high rates. Staff members were instructed to gather their facility's data for bloodstream infections and determine which factors most directly contributed to the infections that occurred. The top reasons given among the QIA facilities for the infections occurring in that period included: patient non-compliance, staff and patient's lack of knowledge; and inadequate education. These factors accounted for approximately 80% of the total responses. Considering these findings, the QIA's specific interventions were designed to best impact the patient engagement 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 NHSN, and the importance of patient engagement were distributed to promote a culture of safety in all levels of care.

### Successful Interventions

An elevated focus was placed on engaging and educating patients and staff on infection prevention practices according to the current CDC's research and 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 ESRD Networks. Facilities were invited to join the NCC HAI LAN bi-monthly calls and encouraged to share best practices learned. Additional stakeholders' webinars and evidence-based materials were offered each month to further promote engagement at all levels of engagement for staff and patients in the clinic.

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<sup>3</sup> <https://www.cdc.gov/nhsn/dialysis/index.html>

Facilities participated in a monthly patient engagement activity and were encouraged to create an “Infection Prevention Station” centered around the CDC’s “Days Since Last BSI” poster to educate and engage patients in the different CDC Core Intervention topics. Facilities were also given the option to engage their patients by using the ESRD Network Patient Engagement Calendar and promoting national infection prevention awareness events. The Network promoted national awareness events (i.e., World Kidney Day, Patient Safety Awareness Week, World Hand Hygiene Day, Sepsis Awareness Month, and Global Handwashing Day) and encouraged facilities to share the respective organization’s educational materials with their patients and staff. The inclusion and adoption of various patient engagement activities helped increase awareness of HAIs and will help sustain patient infection prevention practices.

Facilities were instructed to complete the annual NHSN Dialysis Event training (Chart 13) and encouraged to maintain at least two staff members with access to NHSN. Staff was encouraged to use four of the CDC audit tools (Hand Hygiene, Catheter Connection and Disconnection, Catheter Exit Site Care, and Dialysis Station Disinfection) and to submit their audits in NHSN monthly. Facilities in the 20% cohort achieved a 10% improvement in their Dialysis Station Disinfection and Hand Hygiene audits by the end of the project. Facilities indicated that they intend to continue the use of the CDC’s infection prevention audits tools and found them to be very helpful in identifying areas of improvement. Facilities were encouraged to join a Health Information Exchange (HIE) (Chart 14) and ensure their organization’s policies and procedures for obtaining patient information during transitions of care were employed. Education was provided to independent facilities, smaller organizations, and facilities in rural areas on the five regionally located HIEs within Texas and the national HIE Exchange (eHealth Exchange).

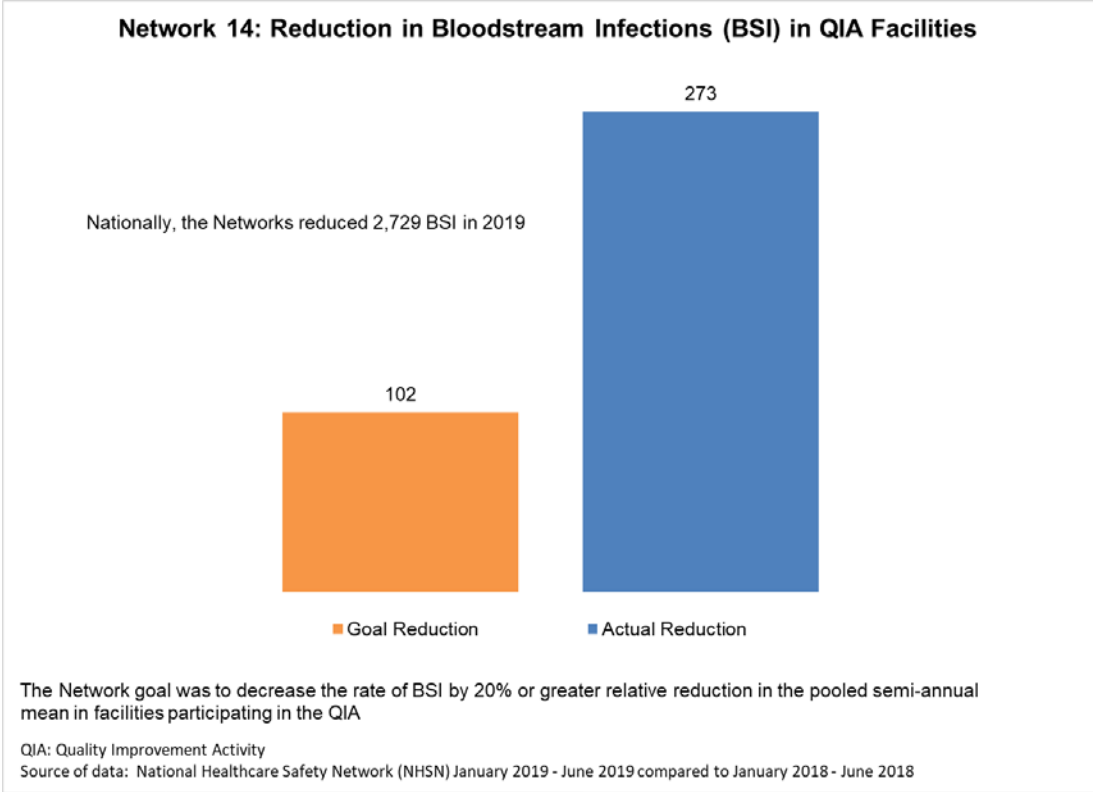
### **Barriers and Challenges**

Facilities continually implemented the CDC Core Interventions into their practice with the exception of the ninth Core Intervention (application of antimicrobial ointment). Facilities only use antimicrobial ointment at the discretion of their Medical Director and physician’s orders. Due to substantial staff turnover in the short nine months of the project, the ESRD Network continues to recommend all focus facilities to have at minimum two NHSN-trained associates who are able to access and submit dialysis event and prevention process measures (PPMs) data into NHSN.

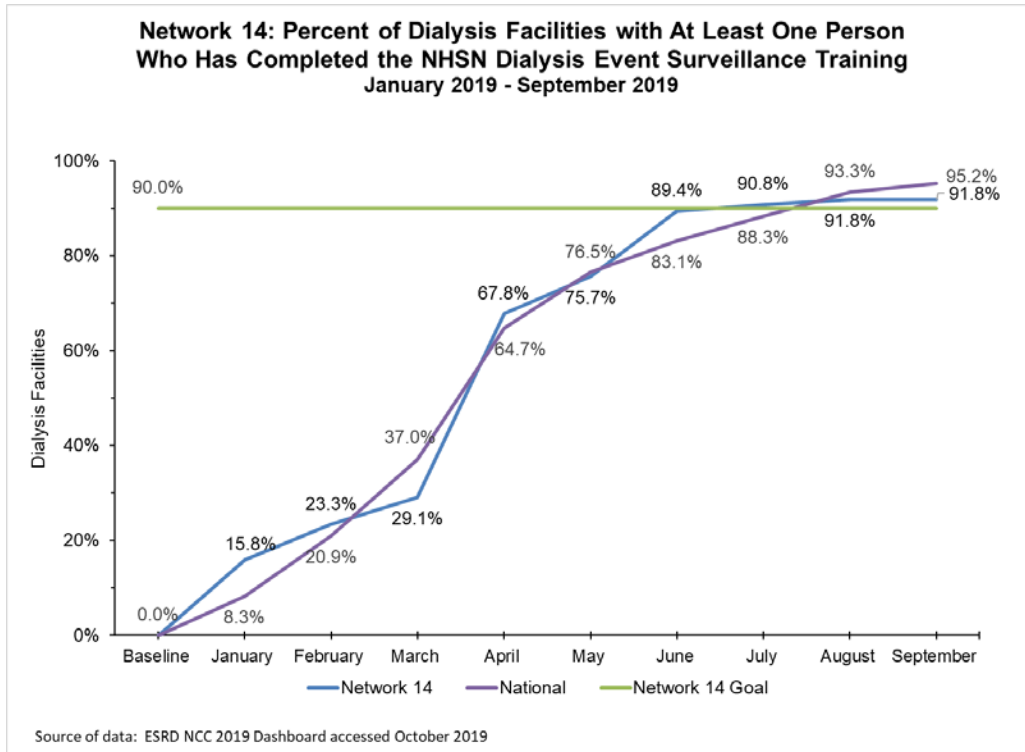
### **In Summary**

The 20% cohort surpassed the goal and achieved a 54% reduction in the BSI rate compared to the previous year. A total of 512 BSIs were reported at baseline and a reduction of at least 102 BSIs was needed by re-measurement to achieve the project goal. The 20% cohort exceeded the goal with a reduction of 273 BSIs (Chart 12) resulting in a reporting of only 239 BSIs at re-measurement. Of the 115 facilities in the 20% cohort, 85% (98 facilities) achieved a 20% or greater reduction in their pooled mean BSI rate at re-measurement. Facilities attributed their improvements to the increased patient and staff engagement, completion of the CDC’s infection control audits, and education of the n CDC Core interventions.

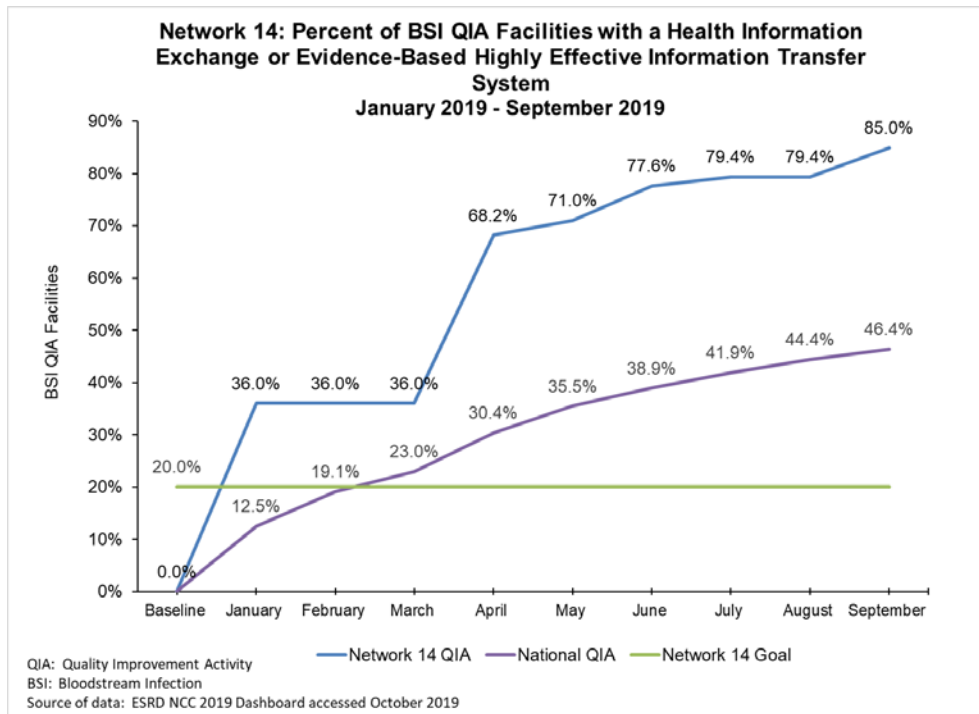
# Chart 12: Reduction in Bloodstream Infections in QIA Facilities



**Chart 13: Percent of Dialysis Facilities Who Completed NHSN Training**



**Chart 14: Percent of BSI QIA Facilities with a Health Information Exchange**



## Transplant Waitlist Quality Improvement Activity



In 2019, the Network's goal was to demonstrate a two percentage point improvement in the natural trend of patients on the transplant waitlist in 30% of facilities in the Network service area from baseline (October 2013 – September 2018) to re-measurement (based on data available during the 2019 evaluation) in prevalent ESRD patients. The ESRD Network's Transplant Waitlist QIA enrolled 207 facilities with an initial United Network of Organ Sharing (UNOS) 60-month trend for waitlist rates of 1.97% or below at baseline. The aggregate final data baseline transplant waitlist rate for the overall focus group was 0.70%. To meet goal, the Network was required to add at least 907 patients to the kidney transplant waitlist.

Facility interventions were developed with guidance and input from subject matter experts including Network staff, MRB, and PAC. This feedback was gathered through face-to-face meetings, phone, email communication, and the PAC's TPM platform. Focus facilities were contacted and notified of project selection via a standardized project notification letter on January 8, 2019. Project kick-off occurred with an introductory webinar on January 24, 2019 which included an overview of the project goals, baseline review, project interventions, timeline, tools, resources, project requirements, and an attestation for webinar attendance.

### Summary of Barriers and Root Cause Analysis (RCA)

ESRD Network 14 guided facilities in performing an electronic RCA via Survey Monkey® to identify the root causes leading to low transplant waitlist rates in their clinics. This activity helped facilities identify barriers that were essential to the development and execution of appropriate interventions. The top reasons selected by facilities for each category in regard to low transplant waitlist rates included:

- **Patient-related factors:** lack of follow-up with appointments (i.e., missing and not rescheduling); morbid obesity; lack of motivation due to different factors (fear, grief, anger, guilt, body image changes); eligibility issues (i.e., documented severe non-compliance, cognitive impairment); and lack of family support.
- **Dialysis facility-related factors:** Perception that “patient is not a good candidate” instead of fully assessing for presence of absolute contraindications; lack of staff training on how to educate patients about transplant options; staff time constrains to be able to effectively provide transplant advice; and kidney doctor's transplant criteria differing from one physician to another.
- **Organizational-related factors:** lack of communication by transplant centers with the dialysis facility staff; ineffective teaching practices among different settings; and not involving patients in the design, development, and implementation of the organization's transplant initiatives.
- **Other-related factors:** National shortage of organs available and organ donors; selection criteria vary significantly among different transplant centers; distance: transplant centers can be far or there are none in particular areas; lack of communication between transplant centers and dialysis facilities.



## Interventions

Based on feedback gathered from the Network’s MRB and PAC, as well as RCA results, the following interventions were provided as the major components for the transplant waitlist QIA:

- One-on-one coaching and technical support
- Electronic RCA via Survey Monkey®
- 6-Steps Transplant Navigation Tool developed by the ESRD Network
  - Improve communication between facilities and transplant centers
  - Completion of monthly self-reported data by facilities via Survey Monkey®
- Review of QIA progress during QAPI/QA interdisciplinary meetings
  - Promote patient/family attendance and participation in transplant QIA activities
- Patient engagement component
  - Utilization of national recognized events (i.e., National Donate Life Month in April)
  - Network-developed Patient Engagement Calendar with monthly tools
  - Facility’s own patient engagement activities approved by the Network
- Recruitment and participation of FPRs and patient champions (utilizing the ESRD Network FPR Toolkit)
- Participation of staff and patients in the NCC Transplant LAN calls
- Disparities
  - Identify, address, and provide resources
  - Disparity webinar on August 31, 2019 (presentation available on our website)

## Results

Based on available final data in September 2019, the ESRD Network achieved 87.10% of the transplant waitlist target goal, which represents a total of 790 patients added to the UNOS waitlist, with an improvement from 0.6% to 4.5% (Chart 15)

## Best Practices, Possible Solutions to Common Barriers, and Sustainability

Best practices identified included: engaged staff and physicians at the facility level; utilization of Transplant LAN resources; utilization of Network-developed and recommended tools; utilization of FPRs and transplant champions as liaisons; and improved communication and collaboration between facilities, the Network, and transplant centers.

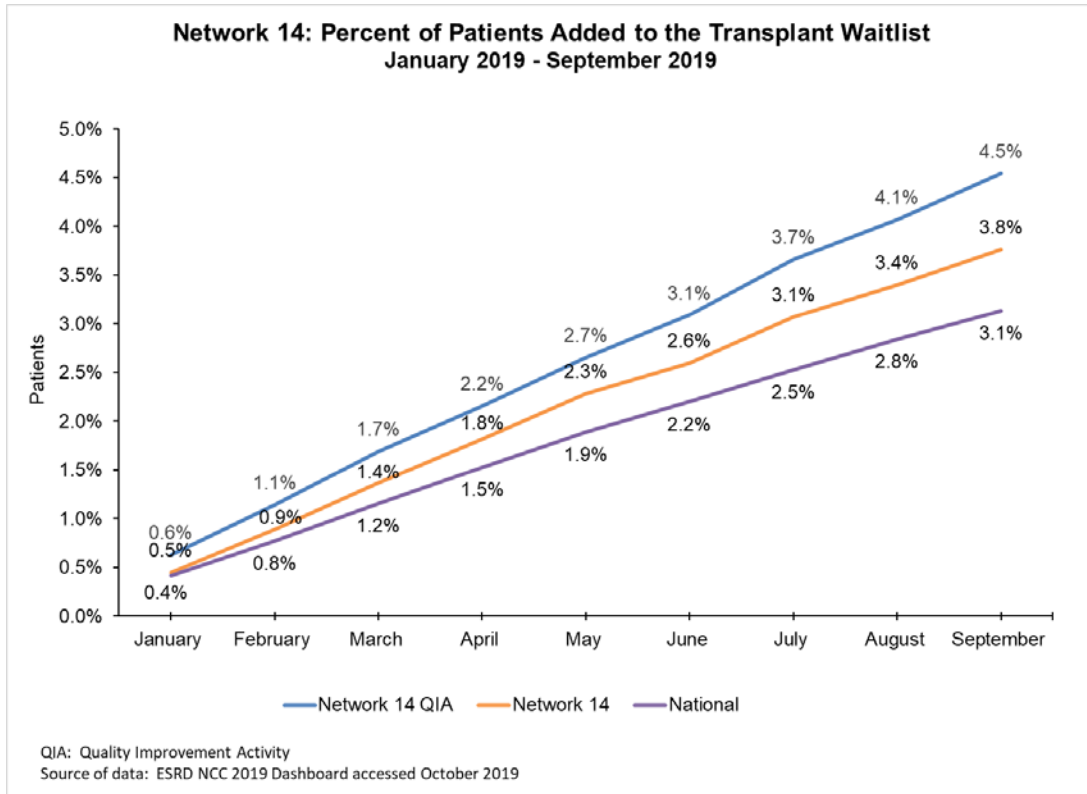
Possible solutions to common barriers: providing education to all disciplines to ensure all staff is comfortable discussing benefits of transplant; selection of a “Star PCT” to be a conversation starter; utilize “Star PCT” to refer potential candidates to Social Worker for further steps; and allow FPR and Star PCT to attend and discuss transplant during QAPI/QA meetings.

Sustainability: standardization of an early overarching sustainability plan to be approved by corporate or regional management to sustain gains after completion of the project.

## In Summary

Although ESRD Network 14 did not achieve 100% of CMS’ goal on the transplant waitlist project, overall communication between facilities and transplant centers was reportedly improved, and the percentage of patients added to the transplant waitlist among focus facilities increased above the Texas and national averages (Chart 15).

**Chart 15: Percent of Patients Added to the Transplant Waitlist**



## Home Therapy Quality Improvement Activity



Home modality is a safe dialysis treatment option available to many patients. Home dialysis modalities are underutilized in the U.S. with only 8% of the dialysis patients undergoing renal replacement therapy at home versus 92% being treated with in-center hemodialysis.<sup>4</sup> In 2019, the ESRD Network goal was to demonstrate a two-percentage point improvement in the natural trend of prevalent ESRD patients using a home modality in 30% of facilities in the Network service area from baseline (October 2013 – September 2018) to re-measurement (based on data available during the 2019 evaluation). ESRD Network 14 staff analyzed the sixty-month trend home referrals baseline data based on the 30% inclusion criteria and selected 206 facilities within this parameter. To meet goal, the Network was required to assist facilities in adding at least 907 patients to a home modality. Self-reported data for all dialysis facilities selected within this project was delivered to the NCC through their corporate office to alleviate burden on facility staff, therefore the seven steps data collection tool was not required by the ESRD Network 14. However, all QIA facilities were instructed to utilize the seven steps data collection tool for internal tracking purposes and to facilitate review of monthly progress during QAPI meetings.

### Interventions

Facility interventions were developed with guidance and input from the MRB and Patient Subject Matter Experts (PSMEs). The ESRD 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. Additional feedback from these activities was gathered through TPM, where PAC members can download, revise documents, and exchange ideas related to the ESRD Network projects. Discussion topics applied to determine effective interventions for the QIA included:

- Patient and Family Engagement (PFE), Support Groups, LAN call participation
- Collaboration with the Advanced Renal Education Program (AREP)
- Collaboration with other stakeholders (i.e., Dallas Nephrology Associates)
- Home Modality Webinars
- Discussion Groups
- Educational Campaigns (i.e., Home Conversation Starter, Home Patient Engagement Calendar)
- Sustainability Plan
- Monthly contact and communication between facilities and ESRD Network 14
- Data collection tool, monthly NCC Dashboard, Network Surveys
- Addressing disparities

The Network administered a patient engagement survey to obtain direct feedback from patients. Facilities were given the option to request patients to complete this task via computer using Survey Monkey® or utilizing a hard paper copy. Facility staff members facilitated computers in the lobby, an iPad/tablet for patients who elected to complete the survey via computer, and patients were also given the link if they chose to complete the survey at their own convenience. The ESRD Network obtained a total of 920 patient responses from the ten-question survey.

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<sup>4</sup> [https://pubmed.ncbi.nlm.nih.gov/25949508/?from\\_term=Neitzer+A%5BAuthor%5D&from\\_pos=4](https://pubmed.ncbi.nlm.nih.gov/25949508/?from_term=Neitzer+A%5BAuthor%5D&from_pos=4)

Results indicated 66% of patients have a fistula and 65% are not interested in a home modality. Survey data identified 55% of patients reported that their facility invited them to attend a home modality educational presentation. The survey continued to reflect a common factor of patients being fearful in transitioning to home therapy. Top reasons for not transitioning to a home modality included fear of doing their treatment incorrectly and patients not having support at home. The ESRD Network facilitated six webinars with the Advanced Renal Education Program (AREP) to provide education on home therapies to dialysis staff, patients, and family members as follows:

1. A Center Experience: The Impact of Transitional Start Unit
2. A Patient's Perspective on Dialysis Education
3. PD Catheters and Placement
4. The PD Prescription
5. Home Hemodialysis: Adequacy, Prescriptions, and Outcomes
6. Transitioning from PD to HHD

Each presentation was hosted by Network 14 and directed by a nephrologist offering a wealth of knowledge-based material. Facilities were asked to apply the information at their clinics to further increase and strengthen patient engagement for home dialysis.

### **Barriers and Successes**

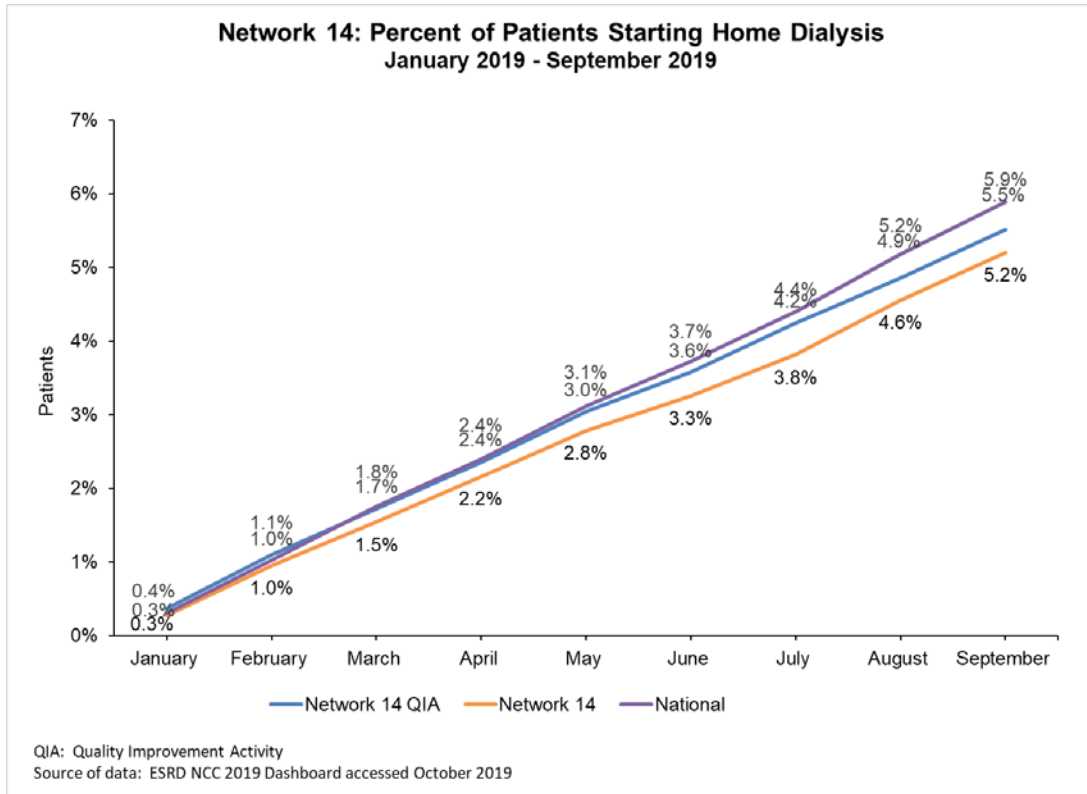
Patient-specific barriers (i.e., home modality misconceptions) were identified and addressed. The most common barrier included patients' belief that they did not have the required space for dialysis supplies and machine. Patients also expressed they did not have readily available support if an emergency occurred. Additional concerns involved patients who have small children and pets who feared home dialysis would create a disruption in their home environment.

Successes included: Facilities employing a home champion to education in-center patients, family members, and caregivers on home modality options; and facilities included transplantation education with home modality for patients who are candidates for both treatment options. As a result, facilities saw an increase of patients actively asking about home modalities. ESRD Network 14 saw an upturn of nephrologist proactively referring patients to a home modality. The AREP Transitional Start webinar assisted facilities to initiate transitional care units in their centers to further strengthen patient's access to home dialysis. All successful interventions will continue to be embedded into the sustainability plan for facilities maintain the momentum of increasing their home modality rates.

### **In Summary**

ESRD Network 14 met and exceeded the two-percentage point improvement goal in the natural trend of patients using a home modality. The 206 facilities participating in the Home QIA achieved a 5.5% overall rate of patients starting a home modality by project evaluation (Chart 16). As a result of strategically implementing all interventions, ESRD Network 14 achieved 104% of the QIA goal established by CMS with facilities adding a combined total of 1013 patients to a home dialysis modality from January 2019 through September 2019.

**Chart 16: Percent of Patients Starting Home Dialysis**



## Population Health Focus Pilot Project Quality Improvement Activity: Improve Dialysis Care Coordination with a Focus on Reducing Hospital Utilization

The Population Health Focus Pilot Project was designed to assist facilities in Network 14 to identify and implement appropriate facility-level interventions with the goal to improve the coordination of care for ESRD patients and their family members between care settings. Specifically, we aimed to: (1) achieve a two-percentage point decrease in the average rate of overall hospitalizations from the baseline period (October – June of the previous contract year), and (2) achieve a 10% decrease in ESRD related hospitalizations. The Network selected 72 focus facilities to participate in the project, equaling 10% of the dialysis facilities within the ESRD Network’s geographic territory.



Facility interventions were developed with guidance and input from subject matter experts including the MRB and the PAC. This feedback was gathered through face-to-face meetings, phone and email communication, and the PAC TPM platform. Focus facilities were contacted and notified of project selection via a standardized project notification email on January 25, 2019. Project kick-off occurred with an introductory webinar on February 1, 2019, which included an overview of the project goals, baseline review, interventions, timeline, tools, resources, project requirements, and an attestation to verify attendance.

### Summary of Barriers and Root Cause Analysis

ESRD Network 14 staff guided facilities in performing an electronic RCA via Survey Monkey® to identify the top root causes leading to current hospitalization rates in their clinics. This activity assisted facilities in identifying barriers that were essential to the development and implementation of appropriate interventions. The top reasons identified by facilities for each category regarding high hospitalization rates included:

- **Patient-related factors:** lack of follow up with appointments (i.e., missing and not rescheduling); lack of family support or involvement; and socioeconomic (home environment, unstable housing)
- **Dialysis facility-related factors:** perception about patients: "patient is noncompliant" instead of assessing for other barriers to patients’ missed treatments”; lack of designated staff to discuss/follow-up on hospitalizations; and time constraints to provide education
- **Organizational-related factors:** no specific protocol for data sharing for hospitalized patients between settings; no protocol or process in place regarding frequency of follow-up with patients; ineffective teaching practices (no teach-back method, and no peer to peer teaching)

### Interventions

- Forum of ESRD Networks’ “Transitions of Care Toolkit” which includes the “Transfer Summary” from “Dialysis Unit to Hospital” and “Hospital to Dialysis Unit”
- The American Kidney Fund “Barriers to Treatment Adherence for Dialysis Patients”
- Quality Improvement (HHQI) best practices toolkit on transitions of care
- The KEPRO Patient Navigation tool
- Monthly data collection tracking tool

All focus facilities were required to attend the National Coordinating Center Learning and Action Network (NCC LAN) meetings and provide feedback to the ESRD Network on at least one intervention they have used from the LAN within their facility.

### Attributes

**Innovation** – The Network provided facilities and nursing homes with a perspective from the dialysis provider and the Skilled Nursing Facility/Long Term Acute Care (SNF/LTAC). This collaborative event presented what a “Day on Dialysis” looks like as well as what SNF/LTAC staff can provide better for dialysis patients.

**Boundarilessness** – Network staff collaborated with the Texas Medical Foundation (TMF) and developed a presentation in collaboration with a SNF physician. The presentation discussed ESRD patients in the SNF/LTAC setting and increasing coordination of care for ESRD patients.

**Rapid Cycle Improvement** – The Network analyzed ICD10/diagnosis codes data and focused facility’s monthly interventions on the top five admission reasons identified each month.

**Customer Focus** – The Network designed and produced “Orange Zipper Envelopes” that were created to help address barriers with communication between care settings and to ensure proper hand-off of documentation. Five pilot facilities received a supply of these envelopes for their patients residing in a nursing home. Positive feedback was received from all five facilities.

**Unconditional Teamwork** – The Network utilized numerous tools and resources developed by Alliant Health Solutions (AHS), TMF, the Forum of ESRD Networks, and Network’s 16 and 18 to assist facilities in reducing hospitalizations.

**Sustainability** – Facilities were encouraged to develop and adopt communication channels with nursing homes, identify a point of contact for all patients that reside in nursing homes, and report out each month during QAPI. Facilities were required to complete sustainability plans approved by their leadership and submitted to the Network.

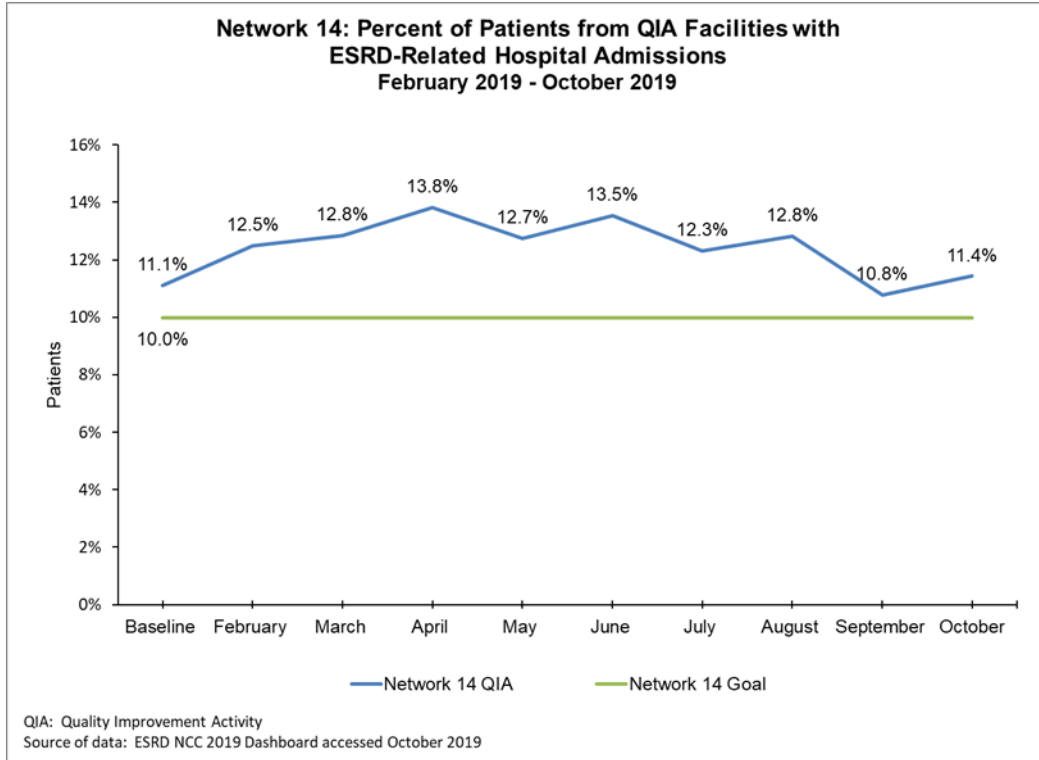
### Best Practices and Sustainability

Best practices identified included: Network 14 partnered with TMF and successfully established a Texas Renal Coalition to address hospitalizations and re-admissions in the ESRD community, which included representatives from hospitals, skilled nursing, transportation, pharmacy, patients, and dialysis providers. The coalition enabled the ESRD Network to brainstorm with representatives impacted by ESRD hospital admissions and find solutions to common barriers. In conjunction with TMF, the Network conducted webinars to address issues with patients residing in nursing homes, SNFs, as well as addressing renal patient medication management. Focused interventions based on top diagnosis codes for admission each month were distributed to facilities. PAC SMEs were engaged and developed additional tools, resources, and interventions to address how to avoid hospitalizations and manage fluid overload during the summer months.

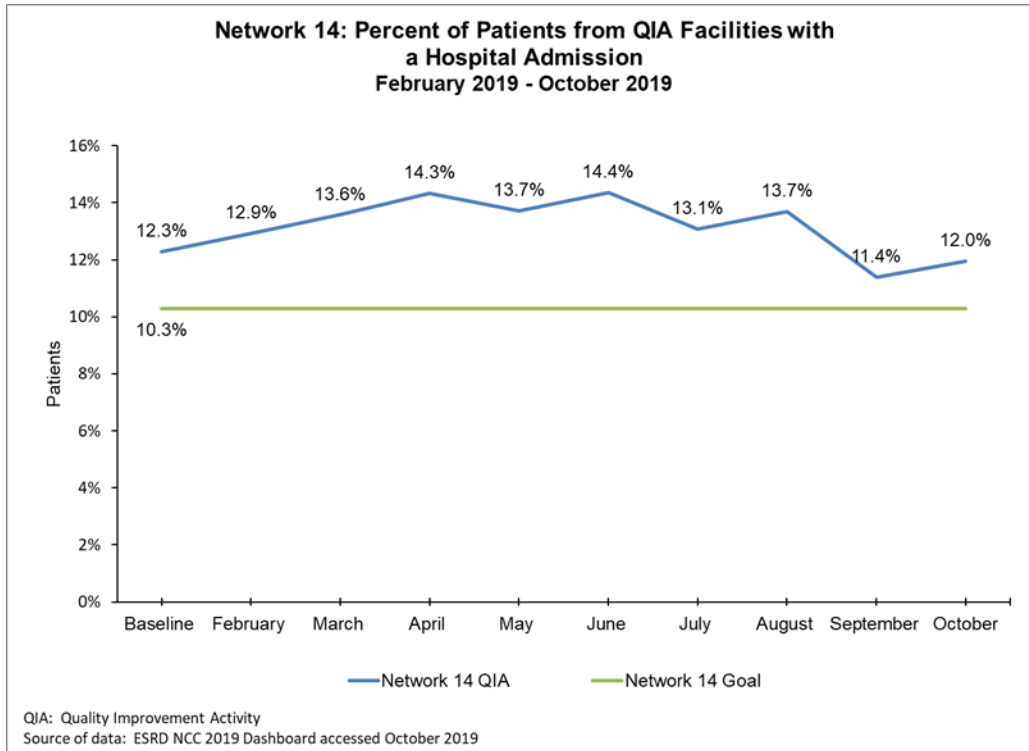
### In Summary

Although the ESRD Network did not meet the stated goals required for the project, facilities did show significant improvement from the time of the project kick-off date in February which is indicted in April due to the data for this project having a two-month lag time (Chart 17 & 18). The ESRD-Related Hospitalizations (Chart 17) from April to October demonstrates a decrease of 2.4 percentage points, with overall hospital admissions (Chart 18) indicating a 2.3 percentage point decrease within the same time frame.

**Chart 17: Percent of Patients from QIA Facilities with ESRD-Related Hospital Admissions**



**Chart 18: Percent of Patients from QIA Facilities with Hospital Admissions**







## ESRD NETWORK RECOMMENDATIONS

Providers in ESRD Network 14 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 ESRD Network 14 requests face the potential to be placed on the ESRD Network 14 Watch List, the first in a sequence of steps that may lead to a recommendation for sanctions by CMS. The Network monitors these facilities and provides them with technical assistance to develop an action plan for improvement. Facilities are provided a timeline for completing activities to be removed from the Watch List. ESRD Network 14 may recommend specific or alternative sanctions to be imposed on facilities that do not cooperate in meeting Network goals or ESRD Conditions for Coverage.

In 2019, no facilities were referred to CMS for sanctions. However, there were facilities that struggled to maintain expected levels of participation in ESRD Network 14 QIA activities. The implementation of the ESRD Network 14 Watch List warning has proven to be successful in reducing the number of facilities placed on the ESRD Network 14 Watch List. This process entailed sending the facility leadership notification that detailed the reason the facility was being placed on the ESRD Network 14 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 (COR) for ESRD Network 14.

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



## ESRD NETWORK 14 SIGNIFICANT EMERGENCY PREPAREDNESS INTERVENTION

In 2019, Texas experienced nineteen various weather conditions and one internal facility closure that impacted facility operational statuses within the ESRD Network geographic area, which included the following:



- 13 tornados
- 4 flood events
- 2 severe storms
- 1 facility closure (isolated flooding)

During local and nationwide emergencies, Texas ESRD Emergency Coalition (TEEC) conduct weekly conference calls to ensure the safety of all dialysis patients and assess if facilities have immediate needs for their patients and staff. Network 14 has continued its partnership with the Department of Health and Human Services Emergency Preparedness Management team in Austin, Texas, to discuss methods of improving emergency plans for dialysis facilities and utilization of Texas emergency community resources. This partnership has afforded Network 14 the ability to have the Texas State Operations Team join a statewide dialysis emergency tabletop drill conducted on May 22, 2019 for facilities that had not met their CMS Emergency Preparedness requirements. Through collaboration between Network 14 and one of the large dialysis organizations, Network 14 staff participated in nine divisional community-based meetings throughout the state of Texas to conduct emergency preparedness drills.

ESRD Network 14 and the Kidney Community Emergency Response (KCER) continue to share important safety strategies with dialysis facilities, patients, family members, and caregivers. The Texas State Operations Center (SOC) and TEEC both have played a substantial role to ensure the Network is aware of areas impacted by significant weather events. This partnership has allowed Network 14 to assist facilities and patients with emergency preparations, transportation, and access to care. These efforts are generated through daily correspondence sent by the SOC, alerts sent through EMResource (a tool identified as a best practice), and ongoing telephone meetings with TEEC representatives.

## **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.