ALLIANT QUALITY

KIDNEY COLLABORATIVE

ESRD NETWORK 14

2020 ANNUAL REPORT

June 28, 2021
Deliverable #8b

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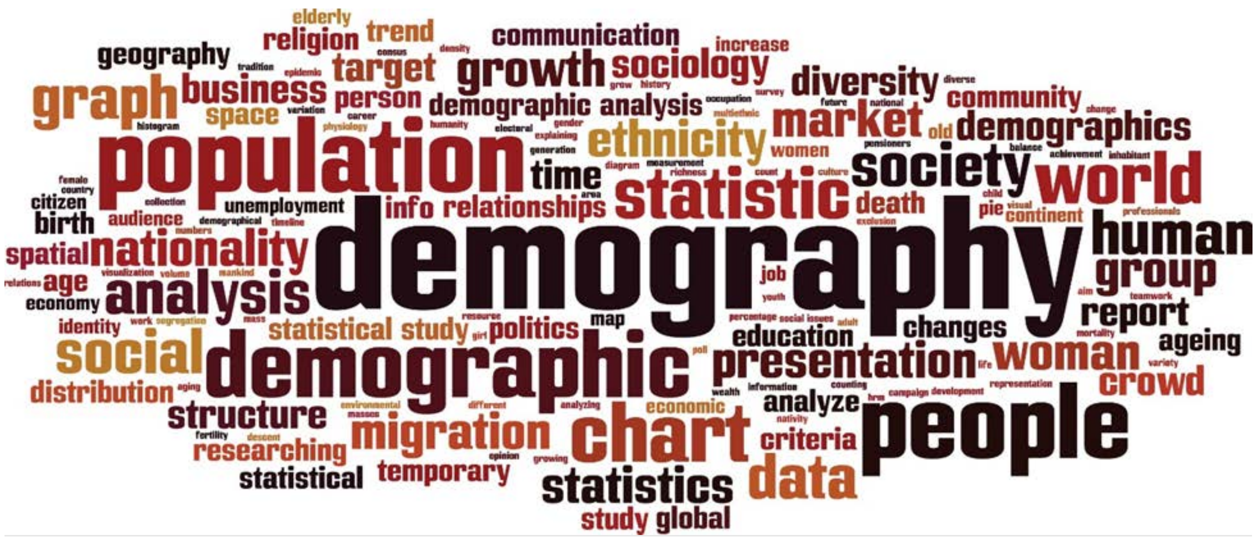
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ESRD DEMOGRAPHIC DATA

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 (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 29.4 million. Houston is the most populous city in Texas and the fourth largest in the US[1], while San Antonio is the second most populous in the state and seventh largest in the US[2].

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. End-Stage Renal Disease Quality Reporting System (EQRS) data indicated that, in 2020, ESRD Network 14 had the largest percentage of prevalent ESRD patients by Network with 63.1% of patients receiving in-center dialysis, 9.6% choosing a home modality, and the remaining 27.3% 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 second largest Network with 9.2% of the national total home hemodialysis and peritoneal dialysis patients (Chart 7), and 8.0% of the national total transplant patients by ESRD Network (Chart 8).

Patient and Family Engagement

The ESRD Network PAC is a diverse group of 30 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

[1] https://worldpopulationreview.com/us-cities/
[2] https://worldpopulationreview.com/us-cities/

interventions to address these activities are developed in collaboration with the PAC during these meetings to increase patient engagement at the dialysis facilities. PAC members are also encouraged to create patient educational resources on topics outside the QIA projects. 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 Chronic Kidney Disease (CKD) Taskforce, and function as facility patient representatives (FPRs). They also provide a patient voice on the ESRD Network 14 CGB and MRB. Additionally, PAC members provide individual experiences and lessons learned as guest speakers throughout the year to different organizations.

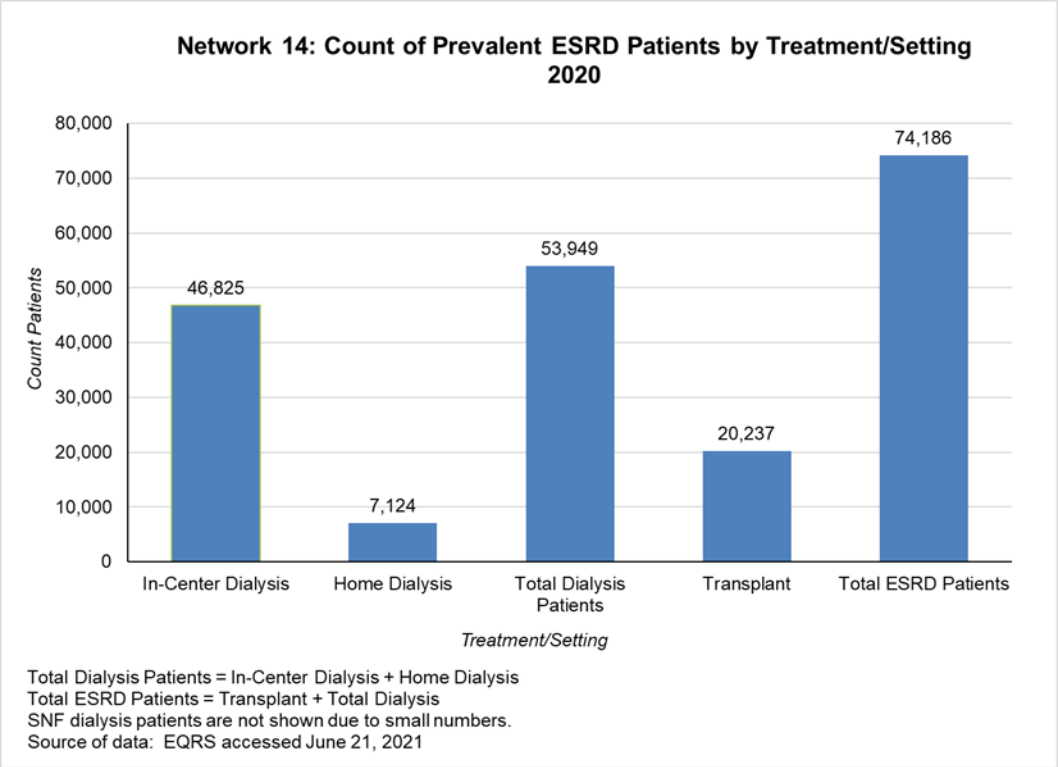
Examples of PAC involvement in the ESRD Network include:

- Representation as speakers and attendees during the National Coordinating Council (NCC) COVID-19 patient webinars
- Participated in the NCC, Kidney Coalition Emergency Response (KCER), Kidney Patient Advisory Committee (KPAC), and Patient and Family Engagement Learning and Action Network (PFE LANs)
- Provided patient Subject Matter Expert (SME) voice on weekly TEEC calls concerning COVID-19, tropical storms, hurricanes, and additional emergency disaster events.
- Provided patient SME voice during monthly CMS Contract Officer Representative (COR) meetings.
- Attended the American Society of Nephrology Conference in Washington, DC
- Caregiver created a You-Tube video on the life a caregiver.
- Participated in social media campaigns supporting national kidney events.
- Participated in the NCC Peer Mentoring pilot project.
- Participated in COVID-19 surveys and provided SME feedback to other organizations as well as the FORUM of ESRD Networks, CMS, Centers for Disease Control and Prevention (CDC), and KCER.
- Participated in the CMS Quality Conference as participants and speakers.

In July 2020, Network 14 launched a Patient Portal for patients, caregivers, and professionals to obtain the latest tools to support patient education. The portal's extensive resources range from Coronavirus (COVID-19), home modality and transplantation, to emergency preparedness. In July there were 687 viewers where data shows COVID-19 information is the top resource viewed by our audience to present time.

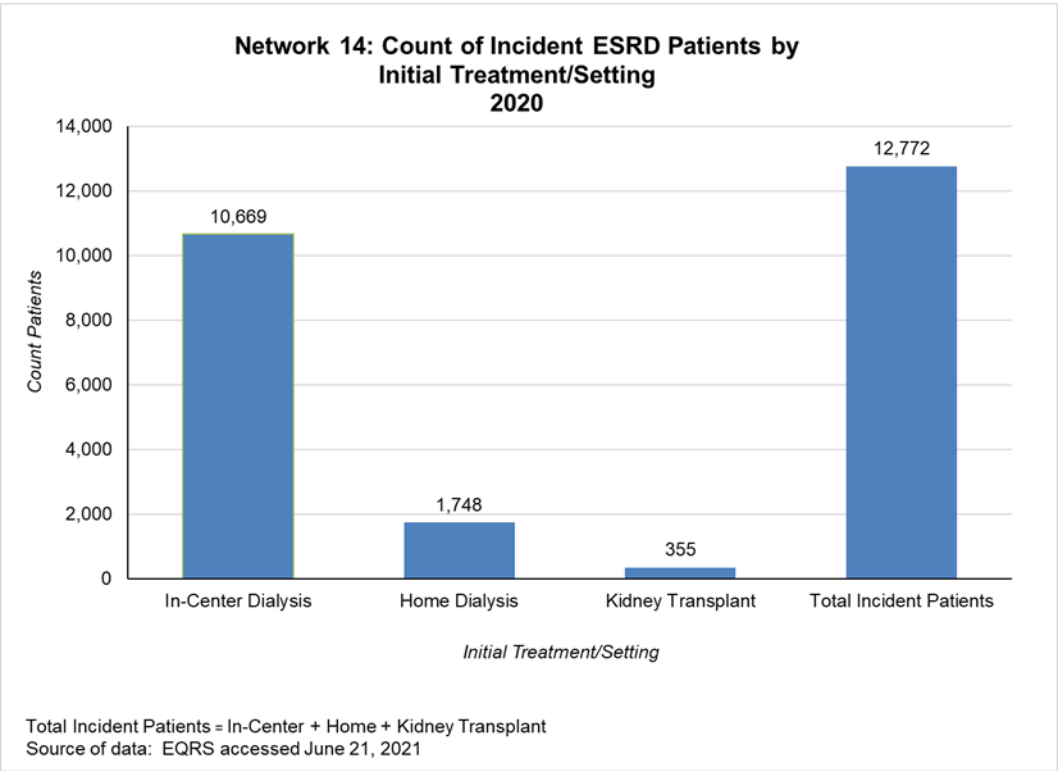
Patient educational materials created by Network staff and PAC members are translated into Spanish as per the ESRD Network's contract with CMS and the Statement of Work (SOW) requirements to assist the high number of Spanish-speaking patients in the Texas ESRD Network geographic area. Educational resources 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



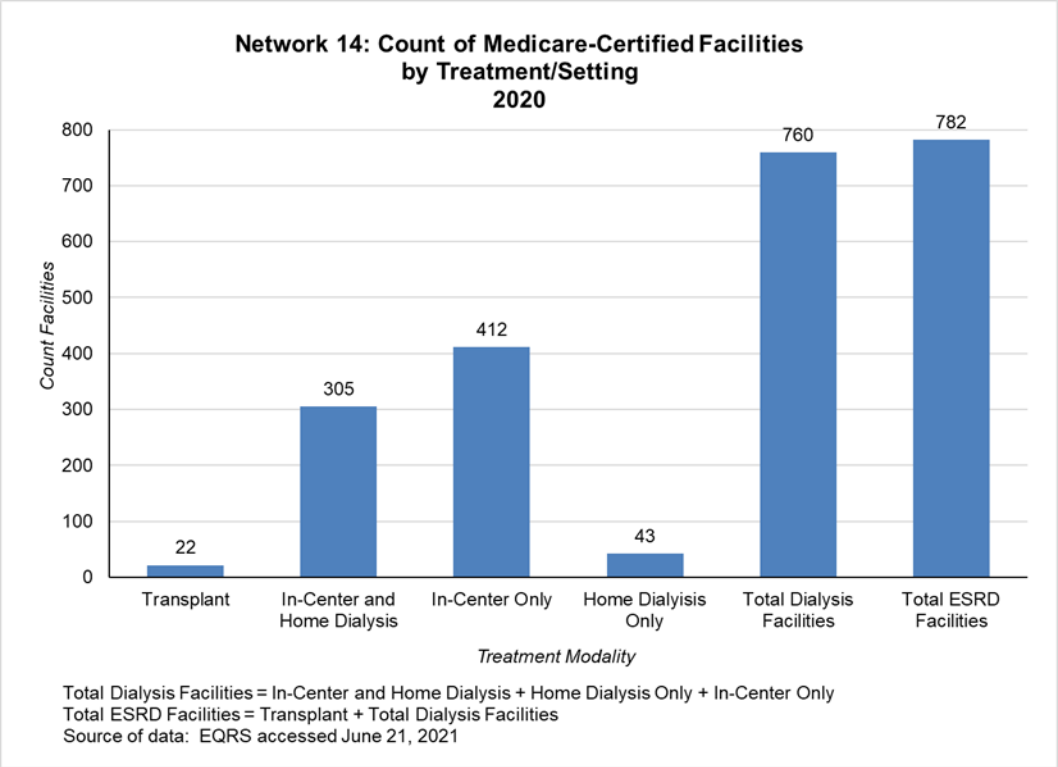
Total Dialysis Patients = In-Center Dialysis + Home Dialysis
Total ESRD Patients = Transplant + Total Dialysis
SNF dialysis patients are not shown due to small numbers.
Source of data: EQRS accessed June 21, 2021

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



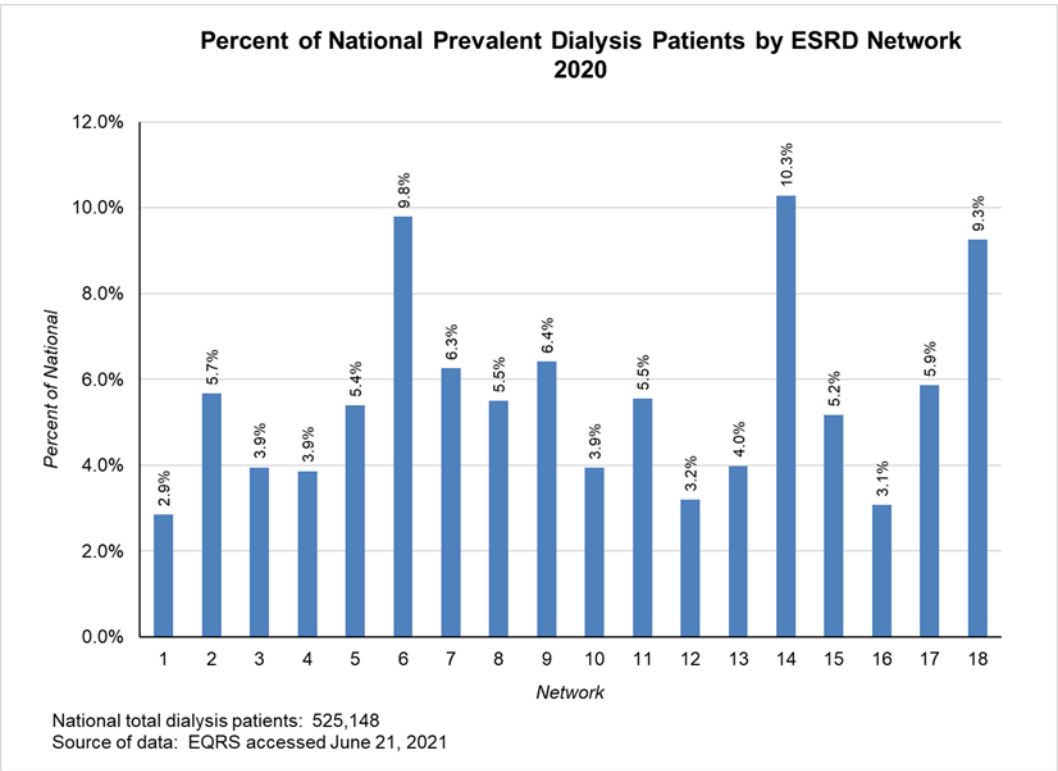
Total Incident Patients = In-Center + Home + Kidney Transplant
Source of data: EQRS accessed June 21, 2021

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



Total Dialysis Facilities = In-Center and Home Dialysis + Home Dialysis Only + In-Center Only
Total ESRD Facilities = Transplant + Total Dialysis Facilities
Source of data: EQRS accessed June 21, 2021

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



National total dialysis patients: 525,148
Source of data: EQRS accessed June 21, 2021

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

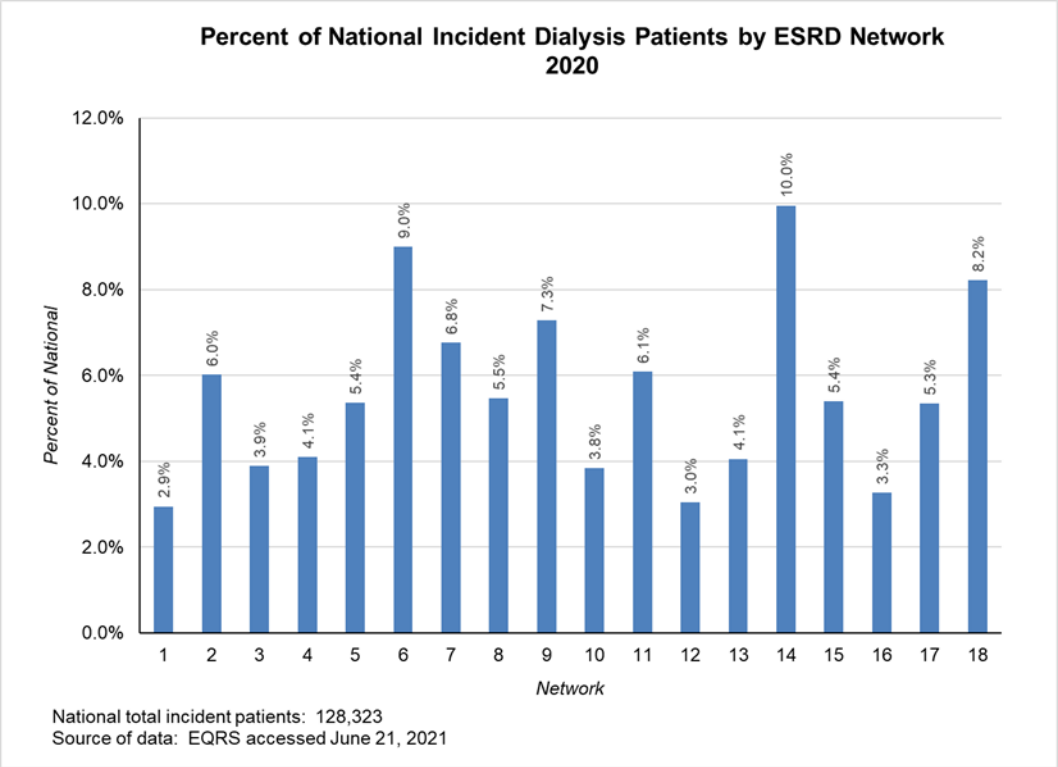


Chart 6: Percent of Medicare-Certified Dialysis Facilities by ESRD Network

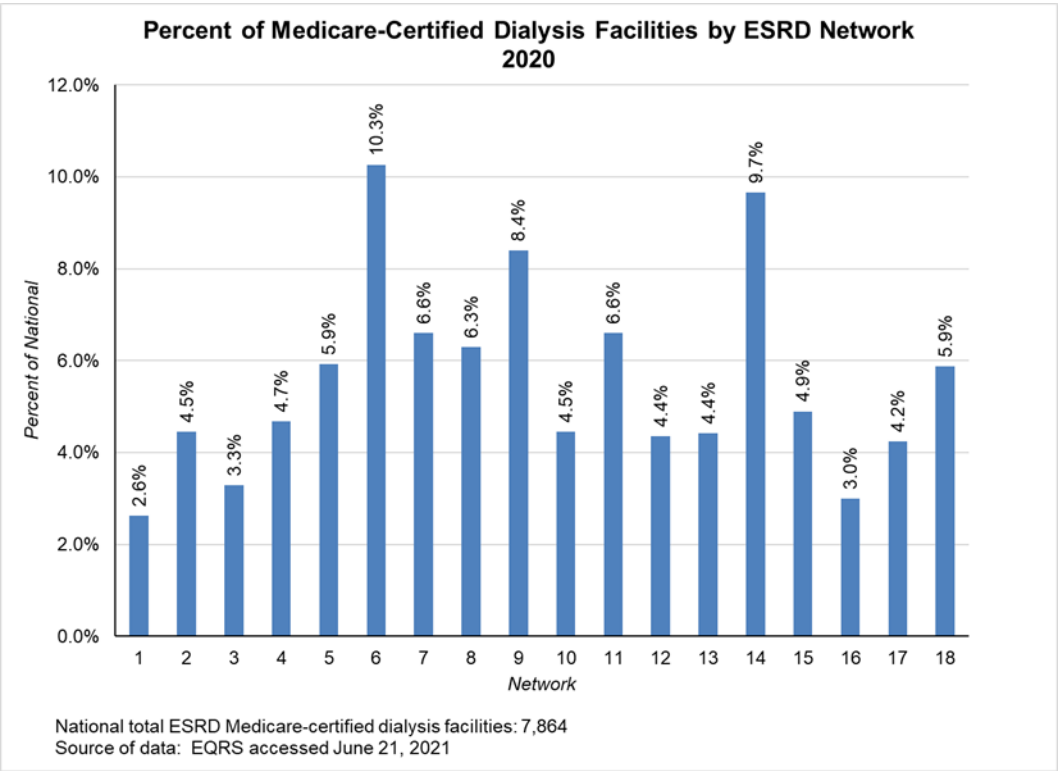


Chart 7: Percent of National Home Hemodialysis and Peritoneal Dialysis

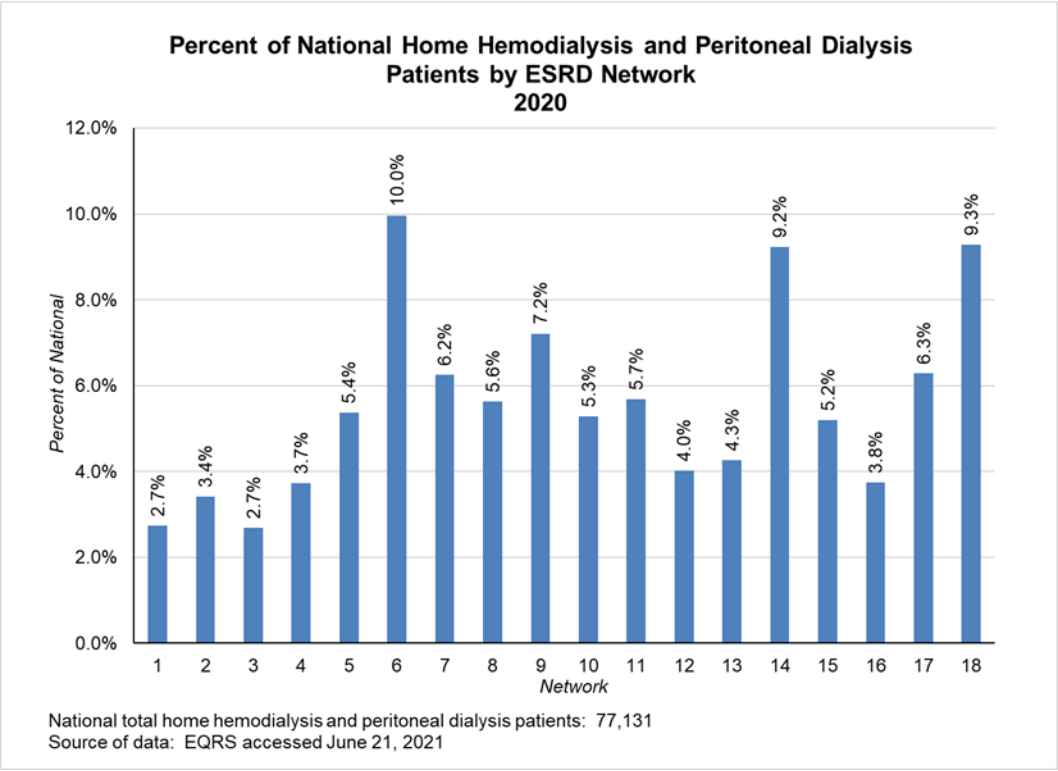


Chart 8: Percent of National Transplant Patients by ESRD Network

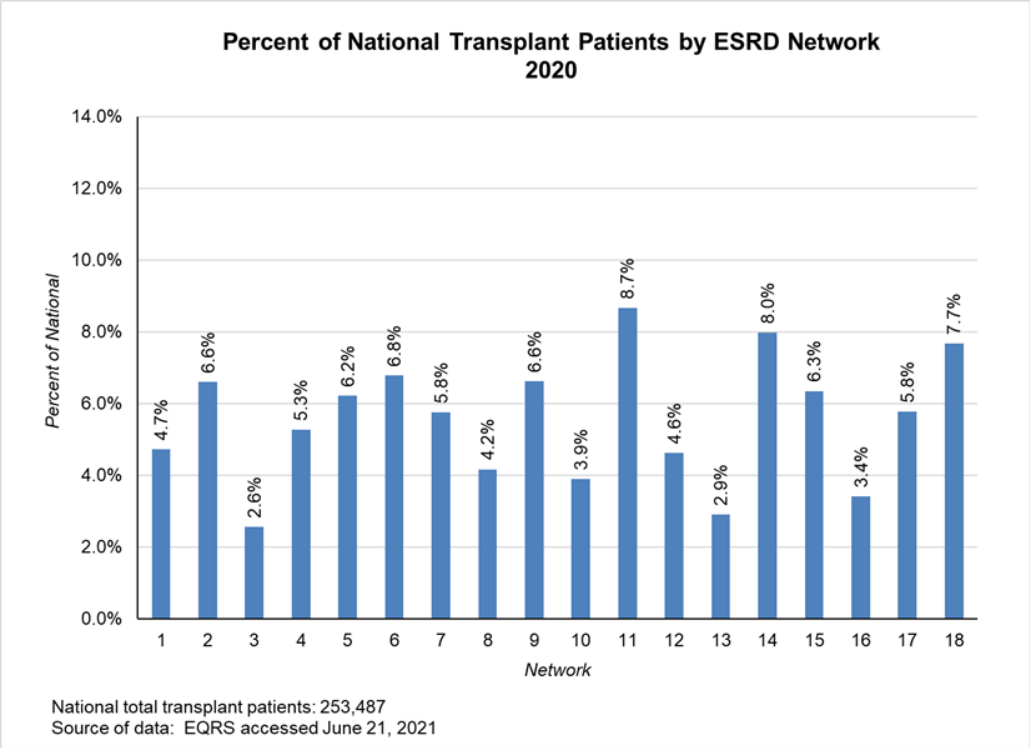
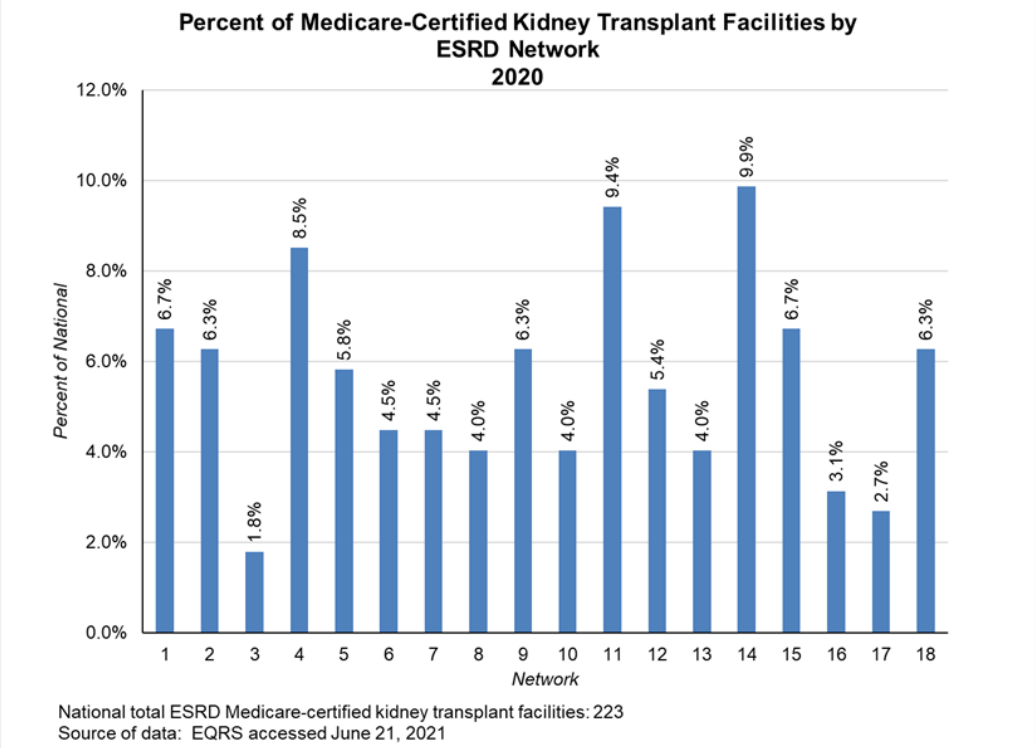


Chart 9: Percent of Medicare-Certified Kidney Transplant Facilities by ESRD Networks

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ESRD NETWORK GRIEVANCE AND ACCESS TO CARE DATA

During calendar year 2020, ESRD Network 14 continued implementation of processes to fulfill CMS requirements, standards established by the ESRD contract. The Network also developed, implemented, and distributed new processes and tools 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; developing and distributing resources to both patients and providers; incorporating patients and caregivers in the development of processes and interventions designed to improve the patient experience of care; case management and documentation; and establishing and maintaining partnerships with stakeholders and community resource agencies.

Improving the ESRD Network 14's Grievance Satisfaction Scores

Each year, CMS directs the Network to improve the grievance satisfaction scores and identify satisfactory scores. In 2020, the Network implemented strategic plans and procedures designed to improve grievance satisfaction scores and ultimately enhance the patient experience of care.

The Network continued its 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, as well as completing follow-ups 30 days after Grievance Summary letters have been sent to complete the process related to the grievance. These procedures allowed the Network to gain post-grievance feedback related to grievance outcomes, address any additional concerns, and continue advocacy efforts.

In efforts to resolve grievances, the Network utilized an interdisciplinary approach and regularly included organizational leadership in grievance resolution efforts and participated with patient care conferences. This practice strengthened partnerships with facilities and patients.

In addition to advocacy and partnership initiatives, the Network completed internal practices to aide in improving the patient experience of care. The Network utilized monthly grievance satisfaction scorecards to target and identify focus areas to develop interventions related to Grievance Satisfaction Scores. The Patient Services Department completed weekly meetings to review all open cases and assess grievances. Network Staff completed weekly discussions related to reviewing grievance resolution interventions to ultimately improve Grievance Satisfaction Scores. These practices offered opportunities to evaluate interventions to ensure they would offer optimal outcomes for both patients and providers.

Technical Assistance

In 2020, 72% of the cases handled by the Network's Patient Services Department were Facility Concerns 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 order to both support providers and promote optimal patient outcomes, the Network implemented changes to technical assistance practices. The Network partnered with dialysis facilities and other providers to provide education and technical assistance related to dealing with challenging patients and resolving patient and provider conflict. Utilizing the feedback from patients and providers, the Network identified common areas of concerns and developed resources to address these

identified issues. The Network's increased efforts to effectively resolve Facility Concern cases resulted in a decrease in the number of Access to Care concerns and improved the patient-provider relationship.

Access to Care

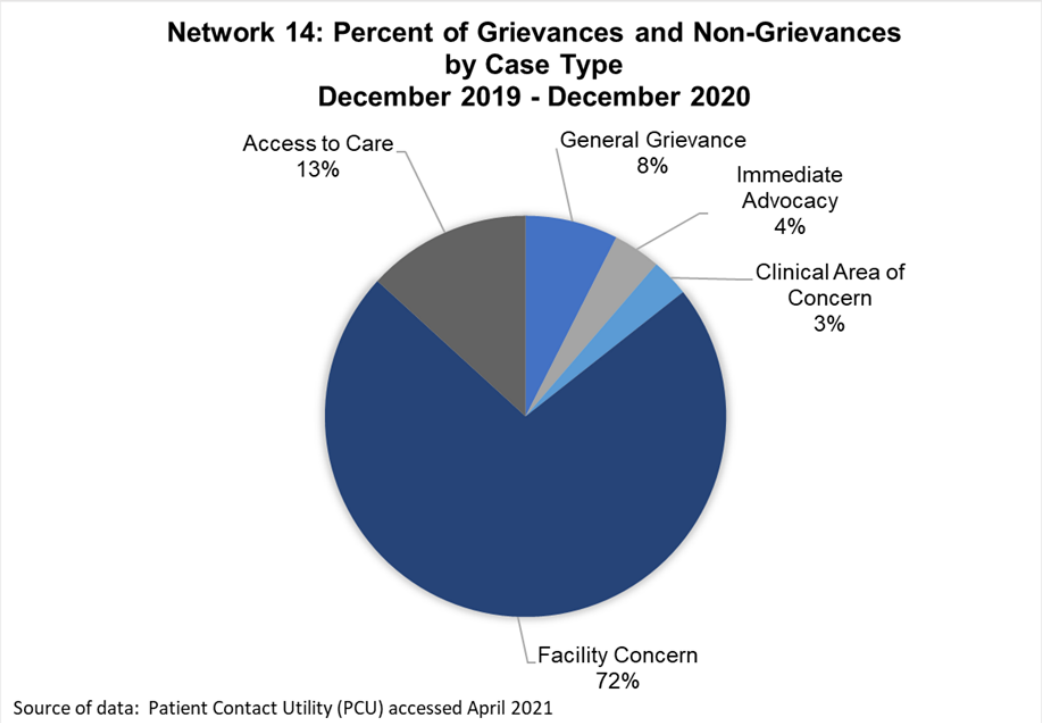
Utilizing reports and feedback from patients and providers, the Network developed processes to reduce Access to Care concerns. The Network assisted insurance representatives, hospitals and other providers serving ESRD patients with access to care concerns. The Network provided ongoing education related to the ESRD Conditions for Coverage and the involuntary discharge (IVD) process to facilities and providers. In reviewing access to care concerns, the Network aided providers with identifying alternative interventions. The Network also educated facility staff members on the importance of understanding de-escalation 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. Increasing education and technical assistance resulted in a decrease in actual involuntary discharges, which meant that more patients were able to maintain access to care.

The Network assisted 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. In efforts to advocate for patients and families and ensure that facilities can operate safely, with minimized patient disruption, Network 14 continued to utilize the Second Chance Program for Access to Care Patients. The Second Chance program has fostered patient and family engagement; increased partnership with providers; and reduced burdens to patients, caregivers, providers, and hospitals. The Network's Second Chance Program has maintained a 100% success rate and has been highlighted by CMS as a best practice. Network 14 partnered with Network 8 to complete a presentation on the program at the 2019 CMS Quality Conference and completed two presentations during the NCC Patient Experience of Care Community of Practice Call.

Summary

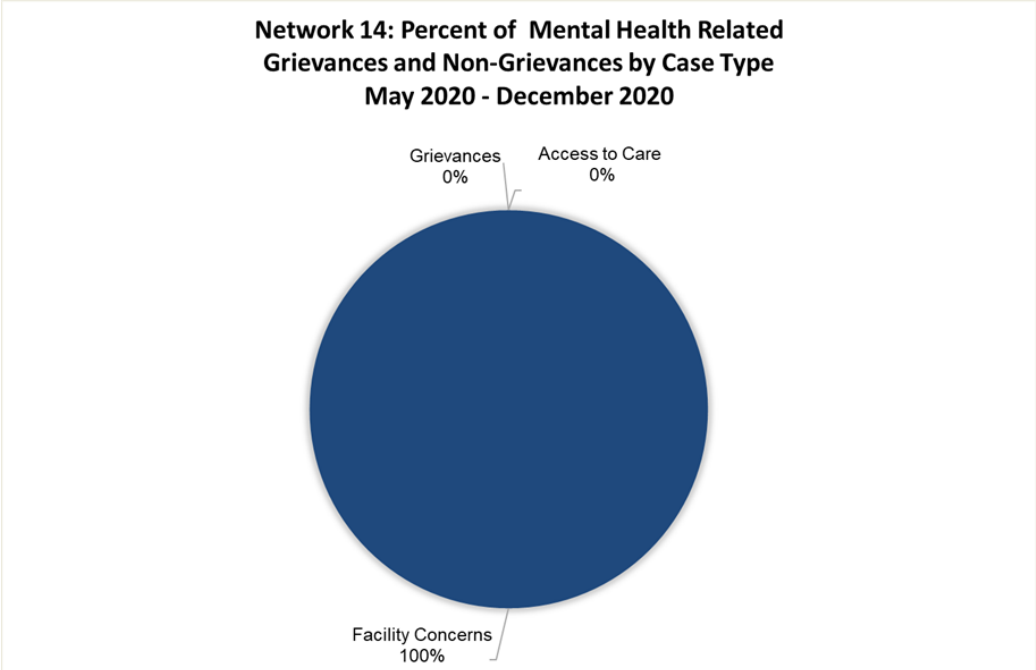
The Network's interventions to improve grievance and access to care outcomes resulted in the development of highly effective practices, strengthened partnerships with organizational leadership personnel, and increased collaborations with the State Agency. Utilizing best practices allowed the Network to develop sustainability models to help facilities maintain patient and family engagement and effectively manage concerns, and ultimately enrich the patient experience of care.

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



Source of data: Patient Contact Utility (PCU) accessed April 2021

Chart 11: Percent of Mental Health Related Grievances and Non-Grievances by Case Type



Grievances include Immediate Advocacy, General Grievance, and Clinical Quality of Care
Source of data: Patient Contact Utility (PCU) accessed April 2021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ESRD NETWORK QUALITY IMPROVEMENT ACTIVITY DATA

Long Term Catheter Quality Improvement Activity

Due to the COVID-19 pandemic limiting provider staffing and procedures, along with contract goal adjustments, the Network worked toward the goals of this quality improvement activity but was not evaluated on results. In 2020, the Network's goal for vascular access was to improve long-term catheter (LTC) rates by at least a 0.25 percentage point decrease from baseline (October 2019) in incident and prevalent dialysis patients. The ESRD Network of Texas's LTC QIA enrolled 53 facilities (adult patients with all access types regardless of dialysis modality) with an average LTC rate of 19.26% at baseline. The aggregate baseline LTC rate for the whole Network was 11.4% with a requirement of achieving at least a 0.25-point reduction to a target Network LTC rate of 11.35% based on ABC methodology established by CMS using available vascular access final data provided by the NCC (Chart 12).

Interventions were developed with guidance and input from subject matter experts including Network staff, the Network's MRB, and the Network's PAC. This feedback was gathered through face-to-face meetings, phone and 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 9, 2020. Project kick-off occurred with an introductory webinar on January 22, 2020, which included an overview of the project goals, facility selection, baseline review, interventions, tools, resources, and requirements.

Summary of barriers and root cause analysis (RCA)

Network 14 guided facilities in performing an RCA via Smartsheet to identify the causes leading to high LTC rates in their clinics. The RCA results helped facilities identify barriers that were key in the adoption and execution of appropriate interventions. The main barriers for high LTC utilization selected by facilities by category included:

- Patient-related barriers: patient refuses to get an arteriovenous fistula (AVF) or an arteriovenous graft (AVG); lack of knowledge about access options; access sites exhausted or not suitable; comorbidities; cancelation/no-show for vascular access appointments; and financial/insurance issues.
- Nephrologist-related barriers: vascular access referral issues (not done in a timely manner); failure to initiate or activate patient's vascular access plan; lack of communication between nephrologist and surgeon for preference to have AVF or AVG placed instead of catheter; nephrologist does not effectively educate patients about risks of catheters and permanent vascular access options; and no long-term access plan.
- Surgeon-related barriers: payment/reimbursement issues (lack of or underpayment as compared to other procedures); poor surgical placement and outcomes; lack of available vascular access surgeons in the area; and lack of surgical training/experience in placement of permanent vascular access.

- Facility-related barriers: fistula maturation/healing graft and catheter monitoring system in place but not being followed or used as intended (example: inconsistently used, not documented, incomplete); no vascular access protocol in place or not being followed adequately; lack of/poor staff cannulation skills; and high staff turnover.
- Other factors: hospital discharge of patient with no access plan in place; no vein mapping prior to hospital discharge; and admission of new patients with catheters.

Interventions

Network staff helped and support to the focus facilities including: electronic monthly reports via Smartsheet; collaboration with large dialysis organizations (LDOs) regional vascular access coordinators; rapid cycle improvement (RCI) and action plans; utilization of the Medical Advisory Council (MAC) Catheter Reduction Toolkit from the Forum of ESRD Networks, CDC Core Interventions, and Healthcare-Associated Infection (HAI) LANs. The ESRD Network continues a simplified approach by selecting interventions in alignment with CMS' "patients over paperwork" goal.

Main interventions included: root cause analysis; electronic LTC Monthly Report via Smartsheet for detection of untoward (non-decreasing) LTC rates and review during the Quality Assurance Performance Improvement (QAPI) facility monthly meeting; activation of an engaged facility-level vascular access manager, completion of monthly infection control observations including the CDC's Catheter Connection and Disconnection audits; attending the NCC HAI LAN bi-monthly calls; infection control videos by the CDC, and creation of an infection reduction portal that's updated monthly and is accessible through the Network's website.

Results

The LTC goal was suspended due to COVID-19. Based on available final data in September 2020 (for the month of July), Network 14 did not meet the initial intended goal for LTC by obtaining a rate of 13.7% in long-term catheters among prevalent and incident adult dialysis patients during the CMS QIA evaluation period. There was a nationwide increase in catheter rates among all ESRD Networks. However, Network 14 successfully remained below the national average of 14.1% at the end of the project (Chart 12).

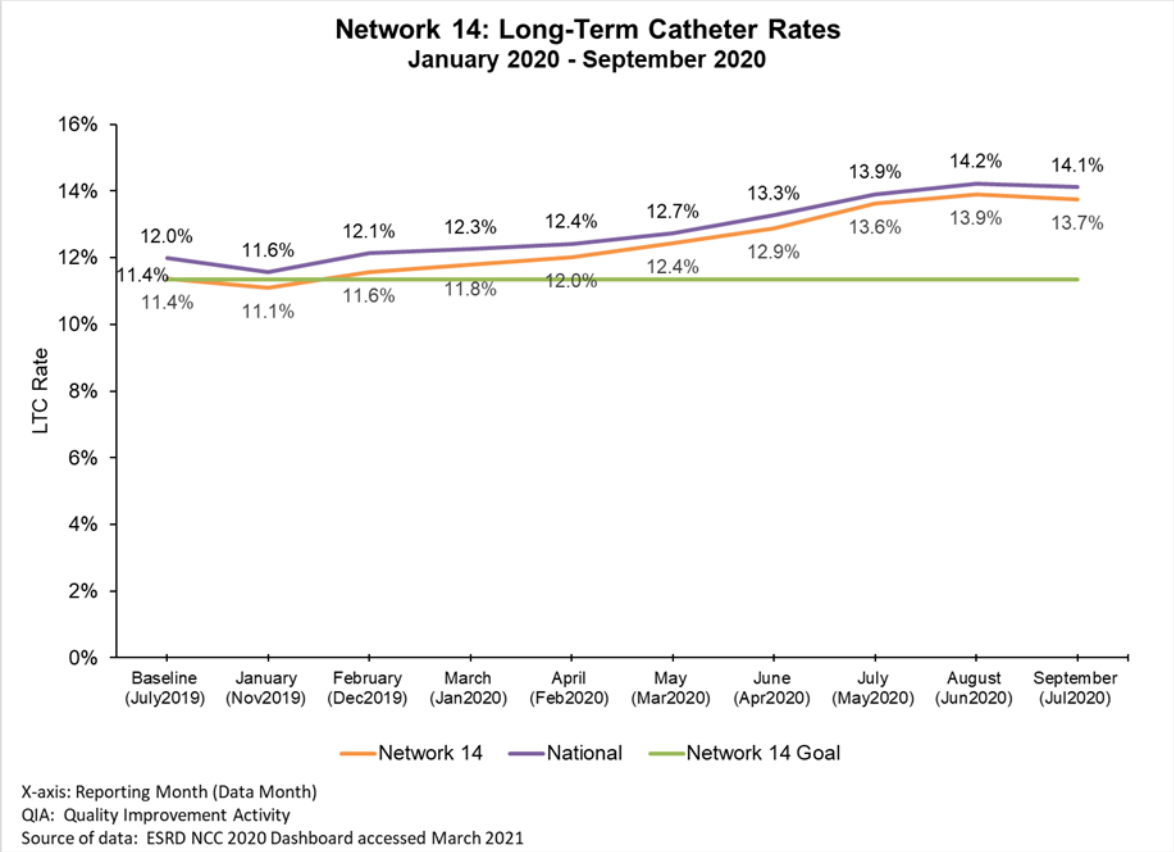
Best Practices and Sustainability

Best practices identified during the project included: collection of facilities' self-reported data through the Network-developed LTC Monthly Report for tracking purposes via Smartsheet; 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 targeted interventions; having an engaged Medical Director and attending physicians; monthly outcomes review with the interdisciplinary team (IDT) during QAPI/QA; and development of an infection prevention portal that continues to be available on the Network's website beyond the completion of the project.

In Summary

Although Network 14 did not meet the initial goal for 2020, the Network has successfully sustained catheter rates below the national average. In addition, best practices were identified and adopted by providers to further decrease LTC utilization and associated vascular access infection rates for dialysis patients in the state of Texas.

Chart 12: Long-Term Catheter Rates



X-axis: Reporting Month (Data Month)
QIA: Quality Improvement Activity
Source of data: ESRD NCC 2020 Dashboard accessed March 2021

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. In support of the national initiative to reduce the BSIs amongst the ESRD population, in 2020 the ESRD Network provided interventions to Medicare certified facilities within the Network's service area with the highest BSI rates (150 facilities). These facilities received increased interventions with a specialized emphasis on BSI reduction using the CDC's Nine Core Interventions. The cohort group's goal was to achieve at least a 20% relative reduction in its semi-annual BSI rate for the first and second quarter of 2020, as compared to their 2019 semi-annual BSI rate.

Facility selection began with an analysis of the BSI Excess Infection report from the National Healthcare Safety Network (NHSN) database for the first and second quarters of 2019. Facilities were first ranked by their BSI rates from highest to lowest, and the final selection included the top 20% of these facilities (n=150) with the highest BSI rates. The 150 facilities represented a total of 13,144 patients at baseline. During the baseline period of January to June of 2019, the focus facilities reported a total of 573 bloodstream infections at a pooled mean rate (PMR) of 0.88, with 57% of the reported BSIs in the Network service area coming from the 150-focus facility group. The overall Network's BSI PMR for the baseline period was 0.39.

Root Cause Analysis

An initial RCA was conducted prior to the start of the project to determine the facilities' understanding of BSIs 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 identified among the QIA facilities for the infections occurring in that period included: patient non-compliance; staff and patient's lack of knowledge; and staff non-compliance. Considering these findings, the QIA's specific interventions were designed to best impact the patient engagement level and improve staff and patient knowledge and compliance. A variety of educational materials focused on the CDC's Nine Core Interventions, data reporting to NHSN, and the importance of patient engagement in infection prevention were distributed to promote a culture of safety at 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 involvement for staff and patients in their facilities. Facilities additionally participated in a monthly patient engagement activity and were encouraged to create an "Infection Prevention Station". These activities were centered around the CDC's "Days Since Last BSI" poster to educate and engage patients in the different CDC's Nine Core Intervention topics and to promote 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 also share their 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 helped sustain patient infection prevention practices.

Facilities were instructed to complete the annual NHSN Dialysis Event training (Chart 14) and to maintain at least two staff members with access to NHSN. Staff were directed to complete monthly infection control observations using four of the CDC's audit tools (Hand Hygiene; Catheter Connection and Disconnection; AV Fistula Cannulation and Decannulation; and Dialysis Station Disinfection). Focus facilities achieved the most significant improvement in the number of Dialysis Station Disinfection and Hand Hygiene audits completed towards the end of the project. Facilities indicated that they intend to continue the use of the CDC's infection prevention audit tools and found them to be "very helpful" in identifying areas of improvement. Facilities were additionally encouraged to join a Health Information Exchange (HIE) (Chart 15) and ensure their organization had policies and procedures for obtaining patient information during transitions of care.

In addition to the infection prevention education, additional focus was provided to facilities regarding COVID-19 mitigation. Facilities received information regarding the new mandates for updated infection control precautions as provided by the CDC. Facilities were provided with information for staff and patients including: the CDC's new video series for frontline staff; the CDC's Dialysis Preparedness Checklist; the 5-Diamond Safety Program's COVID-19 module; environmental and transportation disinfection guidance; masking guidance and encouragement; reminders on proper hand hygiene and hand sanitizer use; and other resources to help patients identify if they could have been exposed or infected with COVID-19. Facilities were also provided with the NCC's new Hand Sanitizer Audit tool, to help assess facility staff and patient's adherence to proper hand sanitizing steps. Facilities found this increased focus on COVID-19 education to be "extremely helpful" and reported an overall decrease in their infection rates due to the increased COVID-19 infection control efforts. Additionally, facilities reported that patient compliance and patient's willingness to learn about infection control measures has significantly increased during COVID-19.

In Summary

The 20% cohort surpassed the goal and achieved a 61% reduction in the BSI rate compared to the previous year. A total of 573 BSIs were reported at baseline and a reduction of at least 114 BSIs was needed by re-measurement to achieve the project goal. The 20% cohort exceeded the goal with a reduction of 355 BSIs (Chart 13) resulting in a reporting of only 218 BSIs at re-measurement. Of the 150 facilities, 86% (129 facilities) achieved a 20% or greater reduction in their pooled mean BSI rate at re-measurement. Facilities attributed their improvements to the increased awareness of patient and staff infection control and hand hygiene, completion of the CDC's infection control audits, and improving overall education regarding COVID-19 and infection prevention measures.

Chart 13: Reduction in Bloodstream Infections (BSI) in QIA Facilities

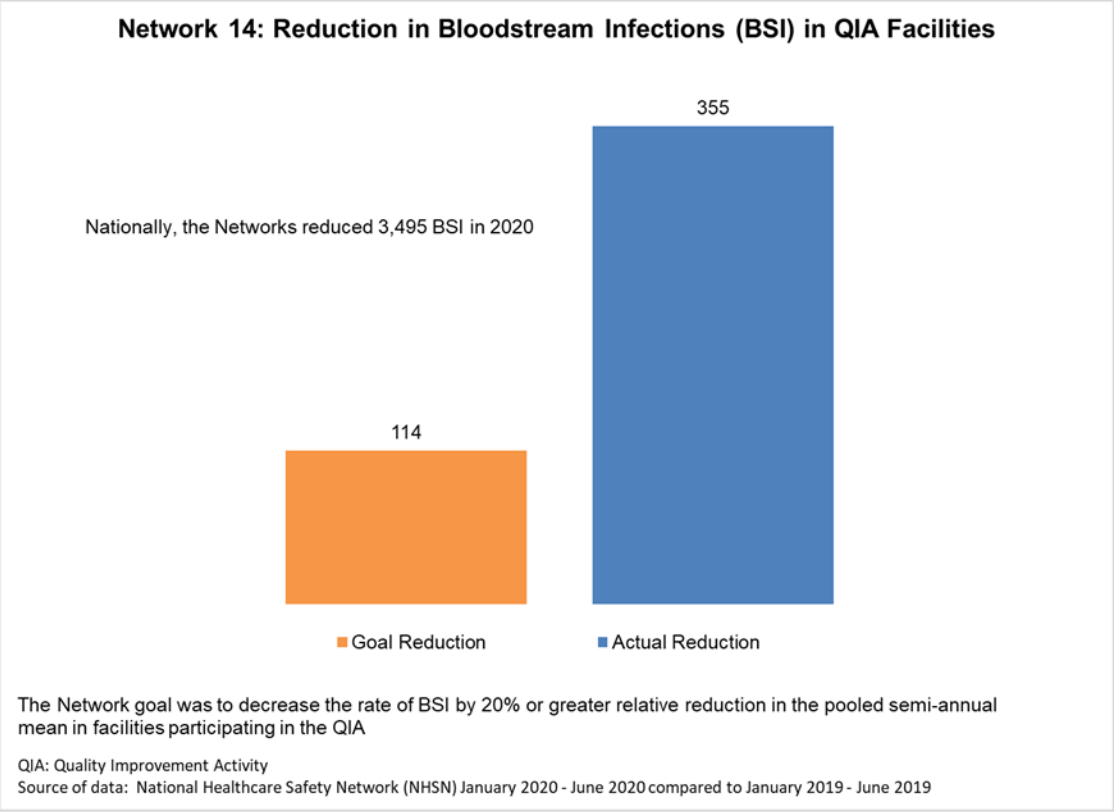
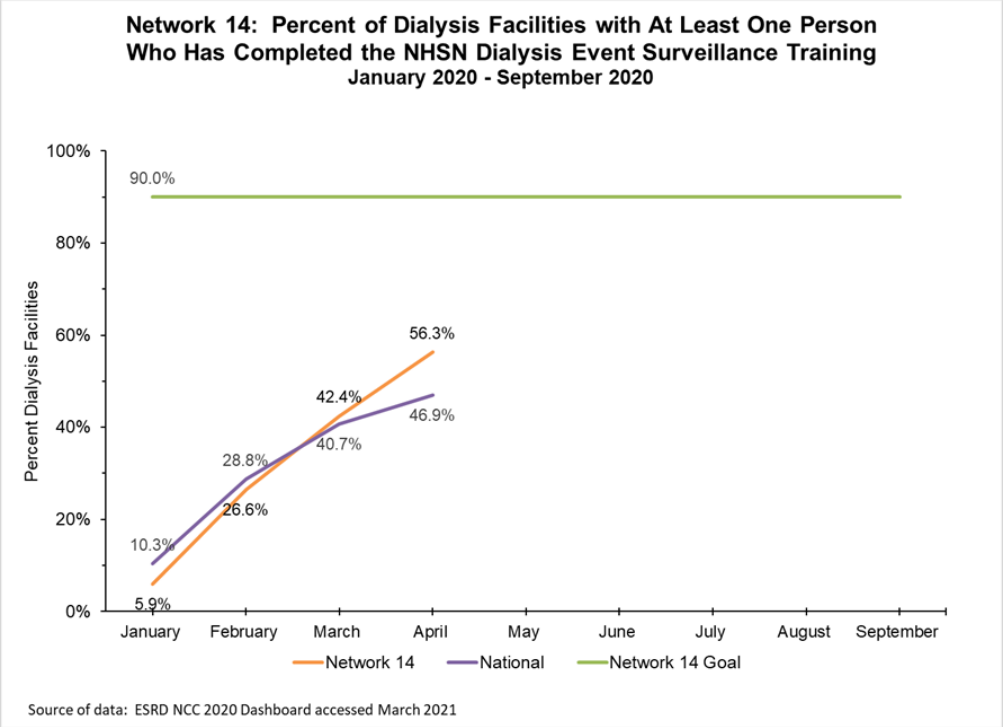
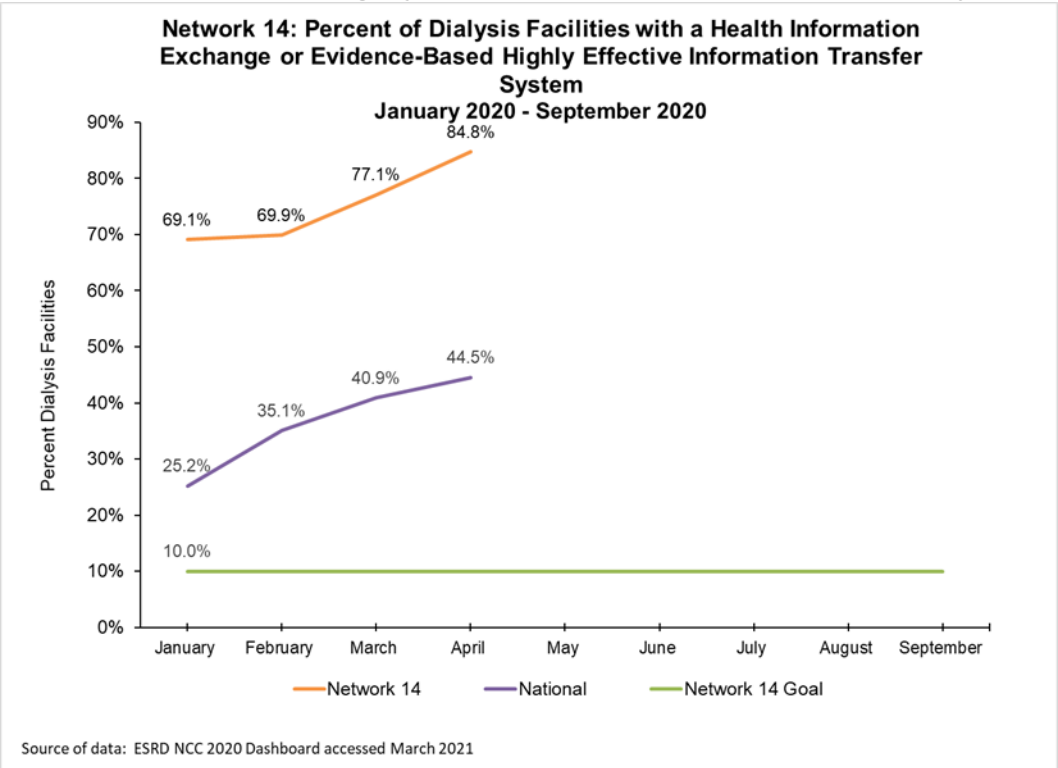


Chart 14: Percent of Dialysis Facilities with At Least One Person Who Has Completed the NHSN Dialysis Event Surveillance Training



Source of data: ESRD NCC 2020 Dashboard accessed March 2021

Chart 15: Percent of BSI QIA Facilities with a Health Information Exchange or Evidence-Based Highly Effective Information Transfer System



Source of data: ESRD NCC 2020 Dashboard accessed March 2021

Transplant Waitlist Quality Improvement Activity

In 2020, the Network's goal was to increase the percentage of ESRD patients on a kidney transplant waiting list in the Network service area by at least 1.25% from baseline (October 2019), based on rates reported on remeasurement data in October 2020 for prevalent ESRD patients. The Network's Transplant Waitlist QIA enrolled 155 low performing focus facilities with an average transplant rate of 2.48% at baseline (based on NCC September 2019 data file), which was below the total Network baseline of 3.83% (based on NCC September 2019 data file). To meet goal, the Network was initially required to reach a kidney transplant waitlist target rate of 3.91% in the Network service area, based on the ABC methodology established by CMS (Chart 16).

Project interventions were developed with guidance and input from subject matter experts including Network staff, the Network's MRB, and the Network's 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 electronic project notification letter. Project kick-off occurred with an introductory webinar on December 18, 2019, which included an overview of the project goals, baseline review, interventions, timeline, resources, project requirements, and an attestation for attendance.

Summary of barriers and root cause analysis

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 related 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 candidacy 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/organ donors; selection criteria vary significantly among different transplant centers; distance: transplant centers can be far or there are none available in some particular areas; lack of communication between transplant center and dialysis facilities.

Interventions

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

- One-on-one coaching and technical support as rapid cycle improvement
- Pre-project Survey and electronic RCA
- Monthly 7 and 5 Steps for Home and Transplant Tracking Tool
- Review of QIA progress during quality assurance interdisciplinary meetings
- Promote patient attendance and participation in transplant QIA activities.
- Recruitment of FPRs and Star patient care technicians (SPCTs)
- Recruitment and participation of Transplant Trailblazers
- Participation of staff and patients in the NCC Transplant LAN calls
- Monthly staff and patient modality education calendar
- Network's Modalities and Patient Portal (online)
- Facility site visits were planned but not conducted due to COVID-19 restrictions.

Results

The Network activities were impacted by the COVID-19 pandemic and quantitative goals were suspended for 2020. However, based on available final data for September 2020, the Network achieved 87.40% of the transplant waitlist target goal, which represented a cumulative of 1,911 patients added to the UNOS kidney transplant waitlist, with an improvement from 0.4% to 3.0% (Chart 16).

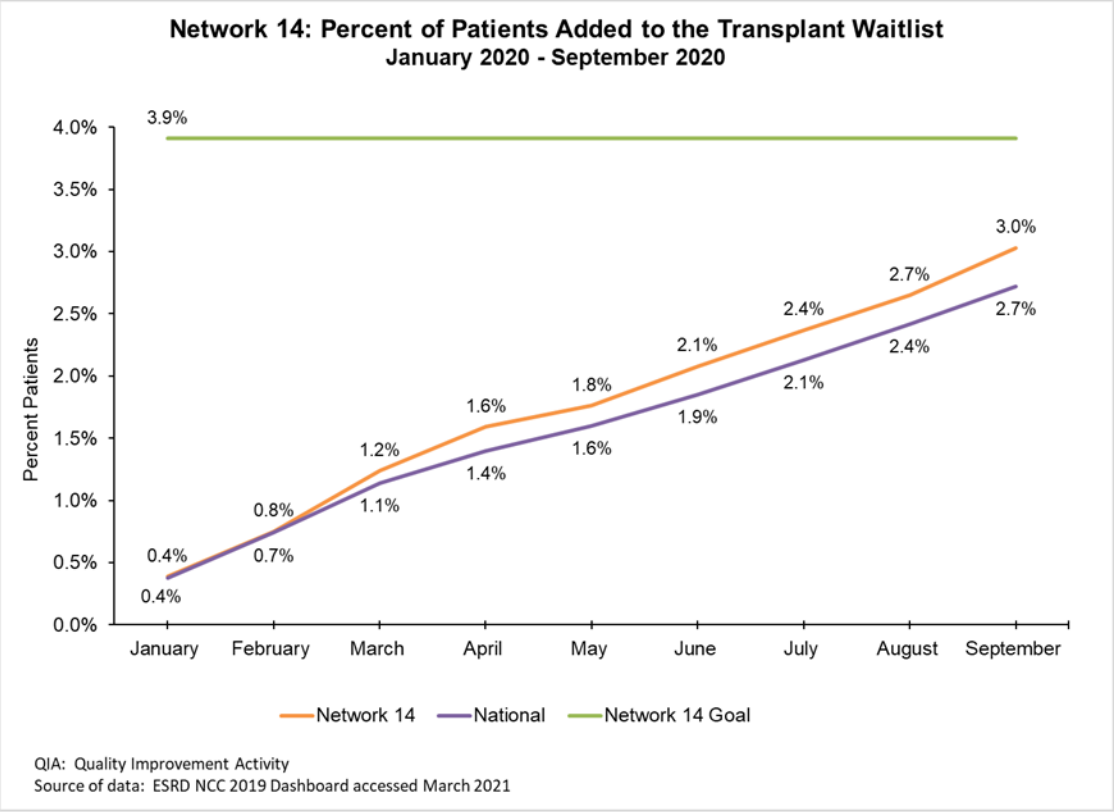
Best Practices, Solutions to Common Barriers, and Sustainability

Despite numerous challenges encountered during the COVID-19 pandemic, best practices were identified, including the following: engaged staff and patients at the facility level; utilization of virtual platforms to continue referrals; utilization of Network-developed and recommended tools such as the modalities and patient portals; utilization of transplant Trailblazers as liaisons; and improved communication and collaboration between dialysis providers and transplant centers.
Possible solutions to common barriers: Continue to provide education to all disciplines so that all staff members are more knowledgeable and comfortable discussing transplant; selection of a "Star PCT" to be a conversation starter and a point of referral to initiate further steps; and continue to promote transplant Trailblazers who can act as liaisons and provide peer support during the listing and transplant process.
Sustainability: The Network created a transplant coalition including transplant programs, organ procurement organizations, providers, and other stakeholders. This group sustains monthly meetings to discuss barriers, brainstorm potential solutions, and share best practices to close the gap on the different layers that form the transplant process. The goal is that over time, the transplant waitlist process will become more standardized, and best practices will be shared and sustained long term.

In Summary

Although Network 14 did not achieve 100% of CMS' initial goal on the transplant waitlist project, overall communication between dialysis providers and transplant centers improved. Additionally, the percentage of patients added to the transplant waitlist among focus facilities increased above Texas and national averages (Chart 16).

Chart 16: Percent of Patients Added to the Transplant Waitlist



QIA: Quality Improvement Activity
Source of data: ESRD NCC 2019 Dashboard accessed March 2021

Home Therapy Quality Improvement Activity

In 2020, the Network's goal was to increase the percentage of ESRD patients transitioning to a home modality in the Network 14 service area by at least 2.5% from baseline (October 2019), based on rates reported on remeasurement data in October 2020 for prevalent ESRD patients. The Network's Home QIA enrolled 155 low performing focus facilities with an average home dialysis rate of 2.57% at baseline (based on NCC September 2019 data file), which was below the total Network 14 baseline of 4.49% (based on NCC September 2019 data file). To meet goal, the Network was initially required to obtain a home modality target rate of 4.80% in Network 14 service area, based on the ABC methodology established by CMS.

Project interventions were developed with guidance and input from subject matter experts including Network 14 staff, the Network's MRB, and the Network's 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 electronic project notification letter. Project kick-off occurred with an introductory webinar on December 18, 2019, which included an overview of the project goals, baseline review, interventions, timeline, resources, project requirements, and an attestation for attendance.

Summary of barriers and root cause analysis

Network 14 guided facilities in performing an electronic RCA via Survey Monkey to identify the root causes leading to low home dialysis 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 related to low home dialysis rates included:

- Patient-related factors: Patient's lack of stable home environment or resources; obesity or other comorbidity (cancer, morbid obesity, etc.); Lack of family support or involvement (burdensome, patient feels alone in the process); financial status; and lack of follow-up with appointments (i.e., missing and not rescheduling).
- Dialysis facility-related factors: Perception that "patient is not a good candidate" instead of fully assessing for presence of absolute home dialysis contraindications; different eligibility criteria among nephrologists (differs from one physician to another); staff time constrains and shortage to be able to effectively provide home education; lack of/no follow-up by physician or provider.
- Organizational-related factors: lack of communication between in-center and home programs; ineffective teaching practices regarding home modalities.
- Other-related factors: distance: some home facilities can be far or there are none in some areas; and demographics: cultural differences, beliefs, and religion.

Interventions

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

- One-on-one coaching and technical support as rapid cycle improvement
- Pre-project Survey and electronic RCA
- Monthly 7 and 5 Steps for Home and Transplant Tracking Tool

- Review of QIA progress during quality assurance interdisciplinary meetings
- Promote patient attendance and participation in Home QIA activities
- Recruitment of FPRs and SPCTs
- Recruitment and participation of Home Heroes
- Participation of staff and patients in the NCC Home LAN calls
- Monthly staff and patient modality education calendar
- Modalities and Patient Portals (online)
- Support site visits were planned but not conducted due to COVID-19 restrictions.

Results

Network 14 activities were impacted by the COVID-19 pandemic and quantitative goals were suspended for 2020. However, based on available final data for September 2020, Network 14 achieved 103.75% of the home QIA initial target goal, which represented a cumulative of 2,950 patients transitioned to a home modality, with an improvement from 0.5% to 5.0% (Chart 17)

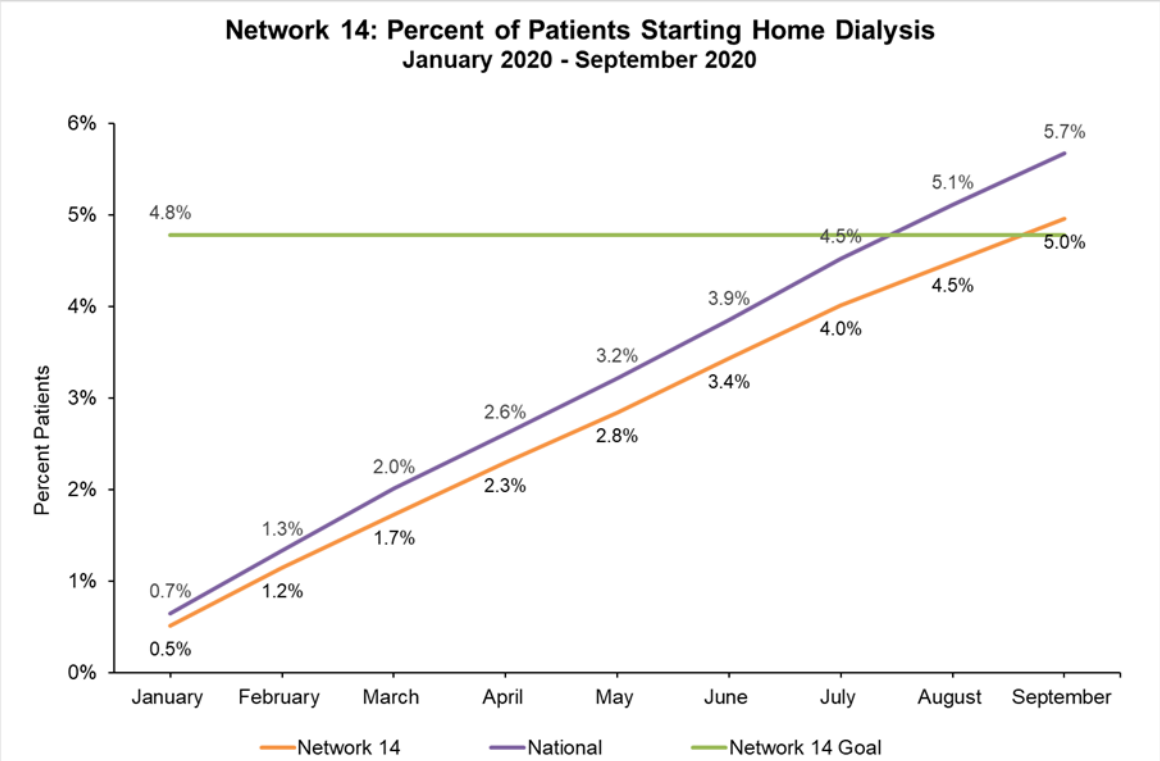
Best Practices, Solutions to Common Barriers, and Sustainability

Despite numerous challenges encountered during the COVID-19 pandemic, best practices identified include the following: engaged staff and patients at the facility level; utilization of virtual platforms to continue home referrals; utilization of Network-developed and recommended tools such as the modalities and patient portals; utilization of Home Heroes as liaisons; and improved communication and collaboration between in-center and home dialysis programs.
Possible solutions to common barriers: Continue to provide education to all disciplines so that all staff members are more knowledgeable and comfortable discussing home modalities; continue selection of a “Star PCT” to be a conversation starter and a point of referral to initiate further steps; and continue to promote Home Heroes who can act as liaisons and provide peer support during the transition process to a home dialysis modality.
Sustainability: Network 14 created a home dialysis coalition including the Network’s MRB, PAC members, dialysis providers, and other stakeholders. This group sustains monthly meetings to discuss barriers, brainstorm potential solutions, and share best practices to help mitigate hurdles in the home dialysis process. The goal is that over time, the process for patients to transition to a home modality will become more standardized and best practices will be shared and sustained long term.

In Summary

Network 14 surpassed CMS’ initial goal for the home modalities project. Overall communication between in-center hemodialysis and home dialysis programs improved, and the percentage of patients transitioned to a home modality among focus facilities increased above Texas and national averages (Chart 17).

Chart 17: Percent of Patients Starting Home Dialysis



QIA: Quality Improvement Activity
Source of data: ESRD NCC 2020 Dashboard accessed March 2021

Population Health Focus Pilot Project Quality Improvement Activity

Due to the COVID-19 pandemic and contract goal adjustments, Network 14 worked toward the goals of this QIA, but was not evaluated on results as these goals were suspended by CMS. This project was designed to assist facilities to improve dialysis care coordination with a focus on reducing unplanned hospitalizations for ESRD patients. The Network aimed to: (1) achieve a one-percentage point decrease in the rate of ESRD related hospitalizations from baseline (January – September 2019) and (2) successfully incorporating the six attributes into the QIA. Fifteen focus facilities were selected to participate in the project, which included a rural facility and nine home dialysis programs. Additionally, the focus group had an average LTC rate of 12.48%, and a prevalent patient count of 1,943 dialysis patients at baseline.

Interventions were developed with guidance from subject matter experts including the MRB and the PAC. Focus facilities were contacted and notified of project selection via a standardized project notification email. Project kick-off occurred with an introductory webinar on February 28, 2020, 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

Network 14 staff guided facilities in performing an electronic RCA via Smartsheet to identify the top root causes leading to increased hospitalization rates in their clinics. This activity assisted facilities in identifying barriers that were essential to the development and implementation of appropriate interventions. The main root causes were identified based on three categories: facility-specific barriers, patient-specific factors, and organizational-specific factors.

- Facility-specific barriers: Lack of follow-up by Doctor (indicated by 62% of the facilities); Perception that "patient is non-compliant" instead of assessing for health barriers (50%); Lack of designated staff to discuss/follow-up on hospitalizations (50%).
- Patient-specific factors: Lack of follow up with appointments (i.e., missing and not rescheduling) (indicated by 62% of the facilities); Socioeconomic: Home environment, unstable housing, etc. (54%); and Eligibility: Documented severe non-compliance, cognitive impairment, illegal immigrants, and lack of family support or involvement (46%).
- Organizational-specific factors: No protocol or process in place regarding frequency of follow up and/or revisiting hospitalized patients (indicated by 46% of the facilities); Ineffective teaching practices: no teach-back, no peer-to-peer, no assessment of teaching effectiveness (35%); and no protocol for data sharing between the hospital and dialysis facility (31%)

Interventions

Based on results from the RCA, the surveyed facilities identified specific proposed interventions to suit the needs of their patient population. The top five interventions selected are listed according to the highest percentage indicated by facilities as their main choices.

1. Utilize CMS/Network provided root cause analysis (selected by 81% of the facilities)
2. Monthly tracking and reporting of hospitalizations to the Network (65%)
3. Kick-off meeting with facilities and hospitals (62%)
4. Health Information Exchange: Facilities to gain access to hospitals' records system (54%)
5. NCC LAN presentations and resources (42%)

In addition, all focus facilities were provided with a comprehensive list of proposed interventions that are available on Network 14 webpage portal. These interventions were originally approved by the MRB and were included in the project checklist approved by CMS.

Attributes

Innovation – 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 do to provide better care for dialysis patients.
Boundarilessness – Network 14 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 – Analyzed ICD10/diagnosis codes data and focused facility's monthly interventions on the top five admission reasons identified each month. Facilities were provided with a Plan-Do-Study-Act (PDSA) Cycle template to be utilized and adopted as part of their QAOI procedures, including the "Optional Reference" provided to the Networks by CMS.
Customer Focus – The Network designed and developed a portal with resources and materials that are readily and easily accessible by providers and patients through Network 14 webpage.
Unconditional Teamwork – Utilized numerous tools and resources developed by Alliant Health Solutions (AHS), TMF, the Forum of ESRD Networks, and other stakeholders to assist facilities in reducing hospitalizations. A coalition including various community partners such SNFs, hospitalists, transportation, pharmacies, and emergency providers (such as MedStar), was formed in 2019 and sustained through 2020.
Sustainability – Facilities were encouraged to develop and adopt communication channels with nursing homes, identify a point of contact for all patients that reside in SNFs, and report out each month during their QAPI meetings.

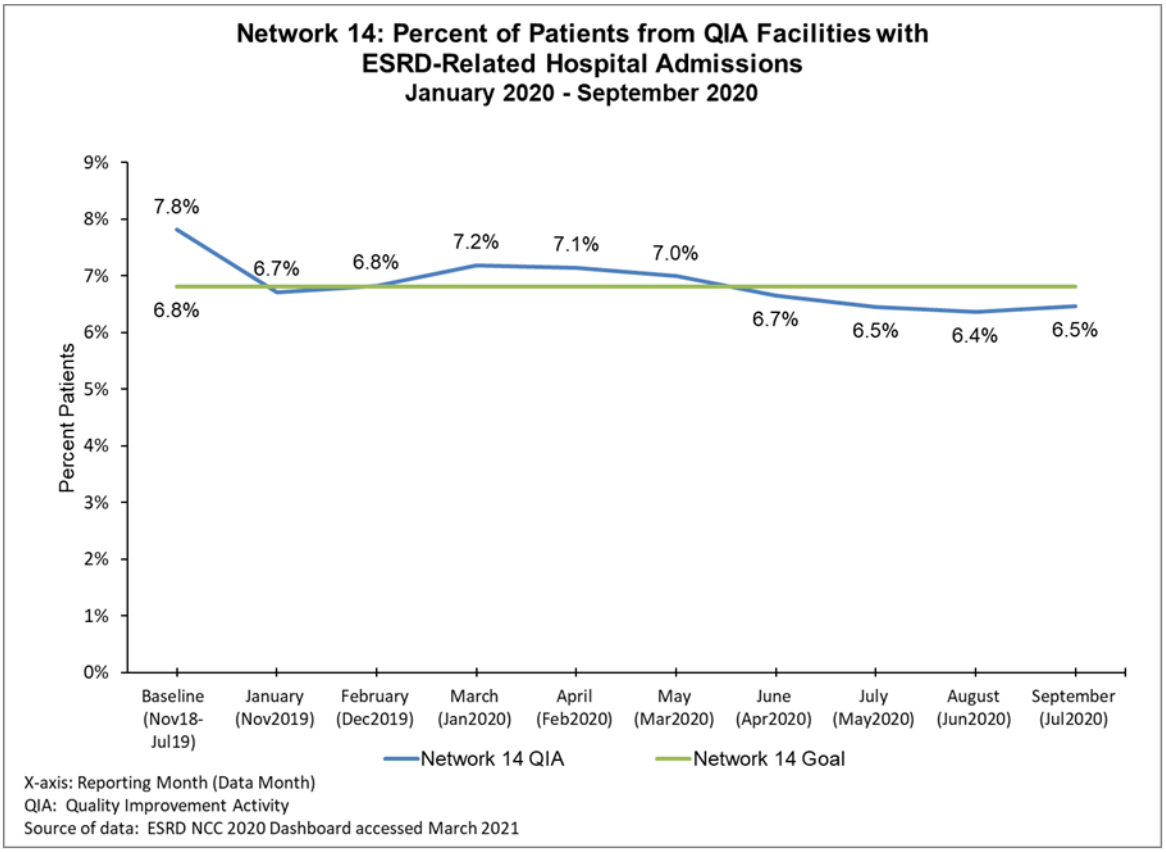
Best Practices

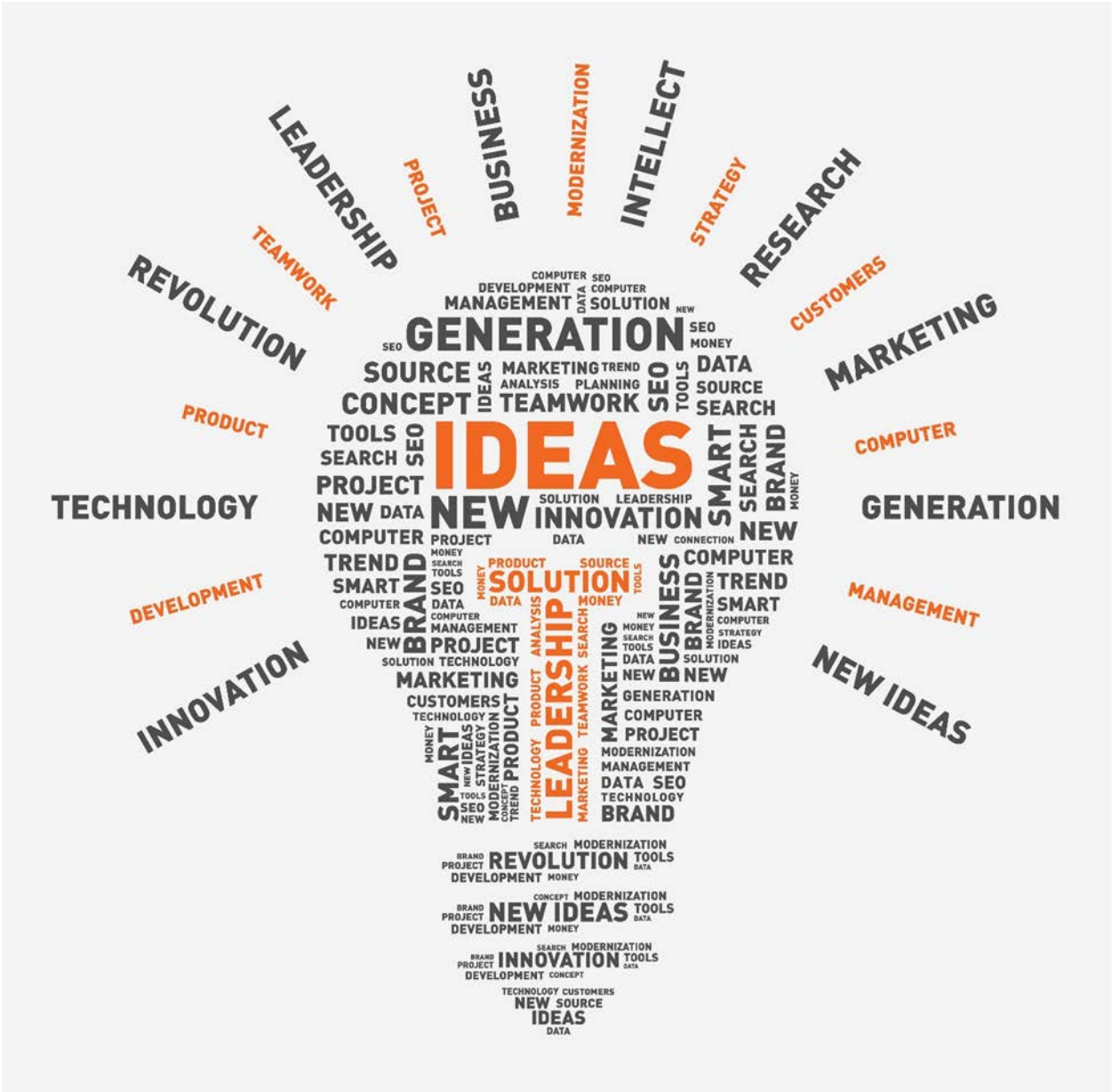
Network 14 continued partnership with TMF and established a Texas Renal Coalition to address hospitalizations and re-admissions in the ESRD community. The coalition enabled Network 14 to brainstorm with representatives impacted by hospital admissions and find solutions to common barriers. Network 14 planned to conduct webinars and live sessions to address issues with patients residing in nursing homes, SNFs, transitions of care, as well as addressing renal patient medication management. All interventions developed from the MRB and PAC, based on the RCA results and top diagnosis codes for admission, were distributed to the focus facilities and are available on the Network's webpage. The Network's MRB and PAC SMEs were pivotal in the development of tools, resources, interventions to address hospitalizations, and manage fluid overload, which was one of the top reasons leading to unplanned hospitalizations.

In Summary

Network 14 met the stated goal of 6.8% or below required for the project. Facilities showed 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 18). The ESRD-Related Hospital Admissions from baseline (7.8%) to September (July 2020) at a rate of 6.5%, demonstrate a total decrease of 1.3 percentage points, which surpasses the goal initially established by CMS for this project.

Chart 18: Percent of Patients from QIA Facilities with ESRD-Related Hospital Admissions




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

ESRD NETWORK RECOMMENDATIONS

Providers in the Network 14 are monitored throughout the year for their participation in activities specified in the Network's CMS contract and for their performance on several quality metrics. Facilities that fail to comply with Network requests have the potential to be placed on the Network 14 Watch List, the first in a sequence of steps that may lead to a recommendation for sanctions by CMS. Network 14 monitors these facilities and develops an action plan for improvement. Facilities are provided a timeline for completing activities to be removed from the Watch List. Networks may recommend that sanctions or alternative sanctions be imposed on facilities that do not cooperate in meeting Network goals or ESRD Conditions for Coverage. In 2020, there were no providers who consistently failed to cooperate with Network goals.

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. In 2020, Network 14's service area experienced 20 new openings and four facility closures. The facility closures were a result of dialysis organizations consolidating smaller patient census facilities for operational efficiency and proportionate staffing.


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

ESRD NETWORK COVID-19 EMERGENCY PREPAREDNESS INTERVENTION

In 2020, Texas as all states across the nation experienced the Coronavirus (COVID-19) pandemic. Dialysis facilities opened cohort facilities to provide treatment for all patient COVID-19 positive and Person Under Investigation (PUI). Network 14 expanded its partnership to include TMF Health Quality Institute and other State Emergency Management Organizations to address the COVID-19 pandemic. Due to the severity of the nationwide pandemic, the TEEC hosted 31 meetings in 2020 to address barriers, strengthen resources amongst dialysis facilities, and collaborate with State organizations for vaccination procurement. 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 presented an opportunity for Network 14 to have the Texas State Operations team assist with COVID-19 vaccine enrollment and status updates.

The ESRD Network 14 COVID-19 Weekly Newsletter contains instructions to visit the CDC website for COVID-19 information and resources as well as highlighting the ESRD Telemedicine Toolkit for COVID-19. Information from the CDC, American Society of Nephrology (ASN), KCER, NCC, CMS and other health care organization concerning webinars, meetings, and resources, were distributed in the ESRD Network of Texas COVID-19 newsletter.

Network 14 submitted 49 Emergency Situational Status Reports (ESSRs) to KCER and CMS addressing independent dialysis facilities with staff and patient COVID-19 positive and PUI cases. In addressing technical assistance, the Network identified trending facilities encountering ongoing barriers. Weekly facility follow-up calls are completed to pinpoint root causes and address facility-specific barriers. All tools presented to facilities to overcome barriers are vetted ideas discussed by Network 14, TEEC, the Network's MRB, and other State Representatives to determine what resources are available and what best practices are used by other facilities that have decreased the number of cases. Network 14 also distributed COVID-19 professional and patient educational material through fax blasts, email blasts, and website postings through the year.

The Network hosted TEEC bi-weekly meetings discussing COVID-19 hotspots. In December 2020, the Network began having a more robust dialogue about COVID vaccine enrollment status and current vaccine processes for hospitals that have begun providing vaccines to staff and frontline workers. The Network collaborated with Southwest Texas Regional Advisory Council (STRAC), Southeast Texas Regional Advisory Council (SETRAC) and Capital Area Trauma Regional Advisory Council (CATRAC) for emergency dialysis placement of patients that had been hospitalized. The collaboration helped ease the influx of patients with COVID-19 going to the emergency room for dialysis treatment. Reports from STRAC have identified Kerrville and Fredericksburg as major rural area hotspot locations for emergency assistance.

The Network identified facilities in COVID-19 “Hotspot” areas using the NCC’s dashboard, and through extensive data analysis of facilities overall COVID-19 reporting rates compared to other facilities in the same zip code and county. Facilities that were found to be adding COVID-19 cases at a higher rate than others were contacted directly by Network staff to identify the root cause of the cases and provide technical support. These efforts initiated in July 2020 and continued through December 2020. During this period, the Network contacted a total of 248 facilities as an initial call and to follow-up on an ongoing problem. Of these facilities, the Network provided targeted technical assistance and ongoing support to 188 facilities.

Network staff focused on assisting facility staff to pinpoint the source of their patients’ COVID-19 infection, and to ensure that facilities were implementing the proper policies and procedures in place to mitigate any COVID-19 infection spread within the facility. Initially, the main cause of spread amongst the dialysis patients was nursing home related and patients living in multi-generational housing. Therefore, the Network provided resources such as the nursing home communication tool and guidance regarding multi-generational housing.

In providing technical assistance calls, the Network identified facilities inaccurately reporting COVID-19 infections. The Network validated the data with these facilities and provided technical assistance to verify and correct positive infections. As technical assistance and access to resources progressed, the Network saw a decrease in nursing home related infections. However, the number of infections due to patients living in a multigenerational housing continued to be a barrier. Facilities also reported an increase in patient’s non-compliance regarding COVID-19 policies, including masking, and not allowing visitors in the lobby. The Network Patient Services Department has continually provided new resources to help facilities address patient’s impatience and fear, as well as addressing the mental health strain patients and staff have faced due to the pandemic.

The Network’s technical assistance efforts have focused on specific interventions including: Reiterating and sharing new COVID-19 policies and recommendations; ensuring facilities have access to updated COVID-19 information; sharing of best practices as identified from other facilities; creating and disseminating tools to improve communication among providers and settings (i.e., nursing homes, SNFs, hospitals, state agencies, transportation providers, utility companies, and dialysis organizations); providing guidance on proper COVID-19 reporting requirements and data validation/correction; mitigating staffing and PPE shortages; assisting with placement of patients; and identifying new and emerging community barriers to create and provide resources as necessary.

ESRD NETWORK SIGNIFICANT EMERGENCY PREPAREDNESS INTERVENTION

In 2020, Texas experienced numerous emergencies expanding from a statewide Coronavirus (COVID-19) pandemic to four major storms (Tropical Storm Beta and Hurricanes Hanna, Laura, and Delta) within the ESRD Network geographic area. Texas prepared for the potential impact of 28 disastrous weather conditions and tropical depressions, of which 27 became tropical storms and 10 became hurricanes between the Louisiana and Texas coastal regions. There were reports of other isolated facility incidents including fire, water issues, hail damage, and power outages resulting in seven ESSRs submitted to KCER and CMS.

August 25 thru September 2, 2020 the Network staff fielded over 50 calls from patients and caregivers for assistance in finding dialysis treatment due to being displaced from Hurricane Laura. Due to the COVID-19 pandemic the State took quick action and arranged for evacuated patients to be sheltered in hotels where they had Red Cross stations to assist. Based on the recommendation of our TEEC members the Network quickly developed our online Texas ESRD Emergency Portal and distributed a flyer with weblink and QR code to dialysis facilities, State Operations and emergency providers. The portal is updated with current information and resources related to impending storms and emergencies.

During local and nationwide emergencies, TEEC conducted 29 conference calls to ensure the safety of all dialysis patients and assess for facilities' immediate needs for patients and staff. Network 14 and KCER continue to share important safety strategies with dialysis facilities, patients, family members, and caregivers. The Texas State Operations Center (SOC) and TEEC have played a key role to ensure the Network is aware of areas impacted by significant weather events, 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 real time emergency system identified as a best practice), and ongoing interactive 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.