



2021 ANNUAL REPORT

This report will cover quality improvement efforts led by ESRD Network 14 from January 1, 2021 – May 31, 2021 and the Base Year of Task Order Number 75FCMC21F0002, June 1, 2021 – April 30, 2022.

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ESRD DEMOGRAPHIC DATA

Alliant Health Solutions End-Stage Renal Disease (ESRD) Network 14 is a corporation that also holds seven Quality Innovation Network-Quality Improvement Organization (QIN-QIO) contracts, as well as the ESRD Network 8 contract. The two ESRD Networks rely on the corporate partnership for daily administrative, human resources, and data and information technology services. This partnership facilitates rich collaboration and increased efficiencies for the Networks' quality improvement, patient engagement, and emergency management activities.

Network 14 serves the ESRD community in Texas, with the administrative office located in Dallas, Texas. Administrative guidance is received from the Alliant Board of Directors; program oversight from the Medical Review Board (MRB); program development advice and consultation from patient subject matter experts (SMEs) 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 territory (268 thousand square miles) and population (estimated at 30.1 million). Houston is the most populous city in Texas and the fourth-largest in the United States¹, San Antonio is the second most populous in the state and seventh-largest in the United States, while Dallas is the third most populous in the state and ninth-largest in the United States².

ESRD Population

In 2021, 21 new Medicare-certified dialysis facilities opened in the Network service area, and 15 Medicare-certified dialysis facilities closed, bringing the total number of facilities to 783 (Chart 3). Approximately 72% of the dialysis facilities in Network 14 are managed by a Large Dialysis Organization (LDO), while the remaining 28% are managed by a small dialysis organization or an independent organization.

As of December 31, 2021, preliminary data shows that Network 14 served 46,186 in-center patients and 7,453 home patients who received renal replacement therapy from one of 783 dialysis units (Chart 1). There were an additional 22,099 kidney transplant patients who received care at one of 24 transplant units, bringing the total Network 14 ESRD population to 75,738. By modality type, 60% of ESRD patients received in-center dialysis, 11% dialyzed at home, and 29% had a kidney transplant.

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 2021, ESRD Network 14 had the largest percentage of prevalent ESRD patients by Network, with 61% of patients receiving in-center

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

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

dialysis, 10% choosing a home modality, and the remaining 29% living with transplant (Chart 1), representing 10.4% of the national total ESRD patient population (Chart 4). By treatment modality, ESRD Network 14 was the second largest Network, with 9.4% of the national total home hemodialysis and peritoneal dialysis patients (Chart 7) and 8.2% of the national total transplant patients by ESRD Network (Chart 8).

Chart 1: Count of Prevalent ESRD Patients by Treatment Setting

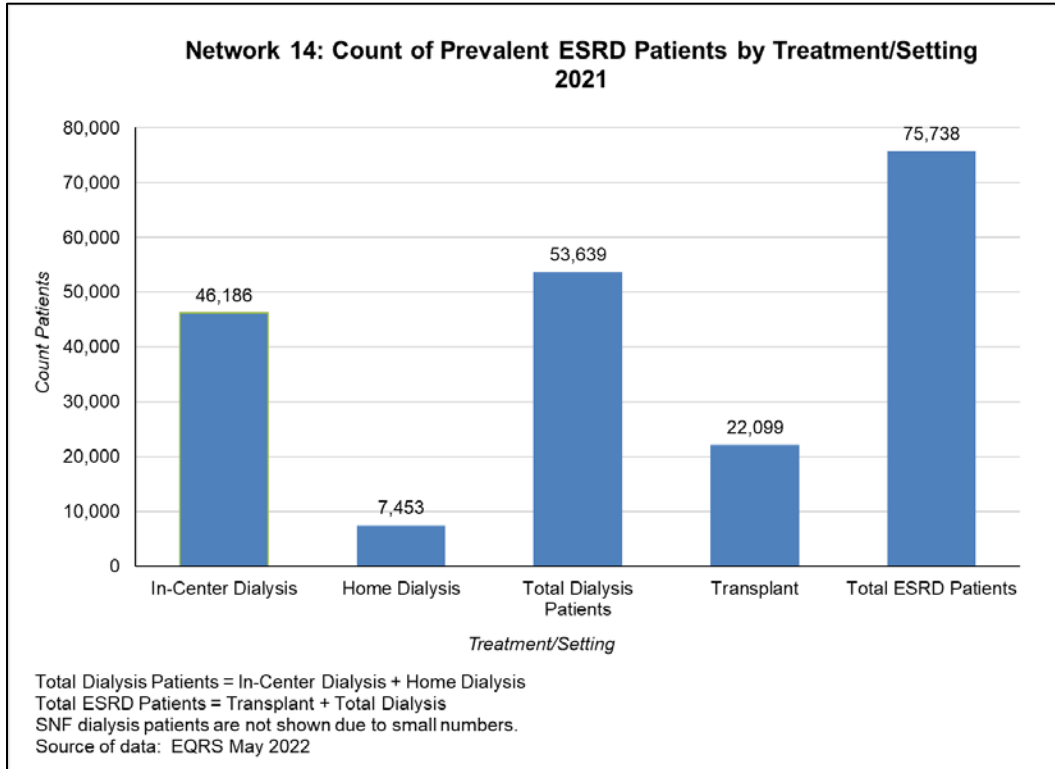


Chart 2: Count of Incident ESRD Patients by Initial Treatment

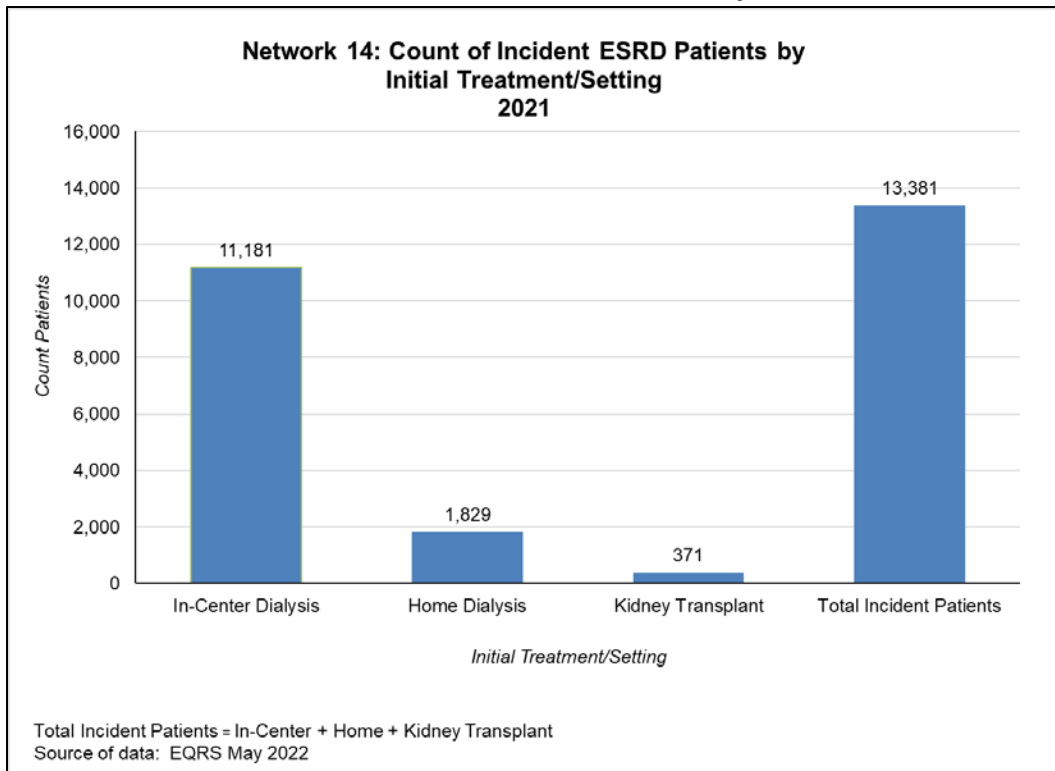


Chart 3: Count of Medicare-Certified Facilities by Treatment Setting

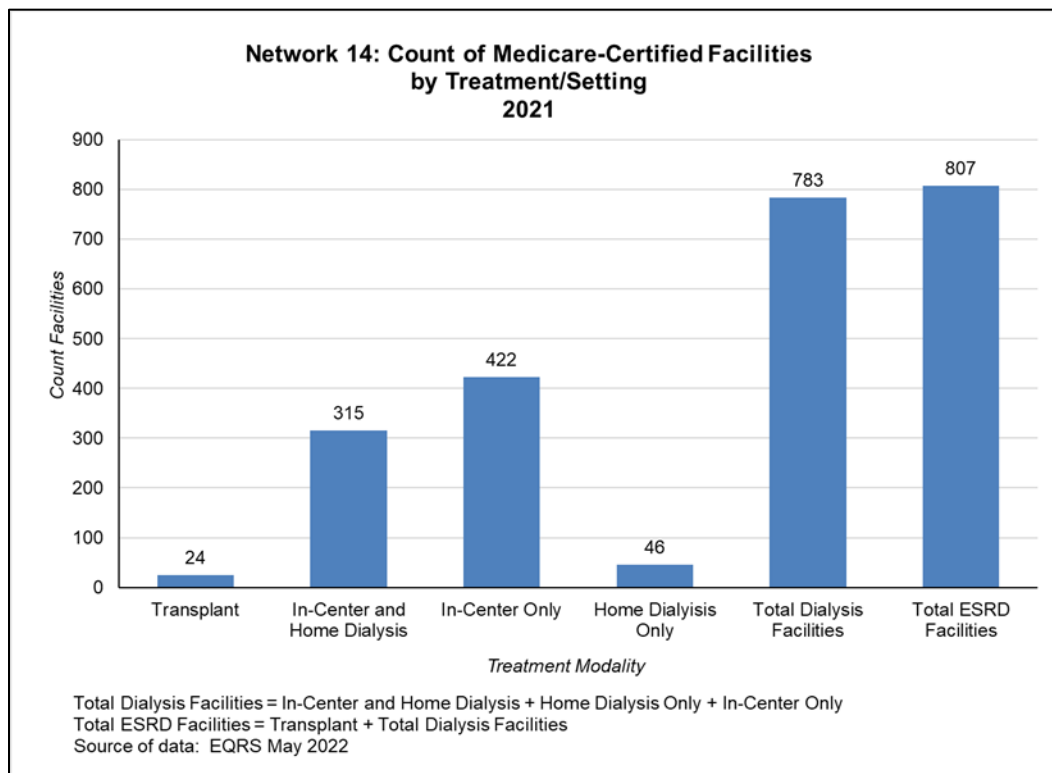


Chart 4: Percent of National Prevalent Dialysis Patients by ESRD Network

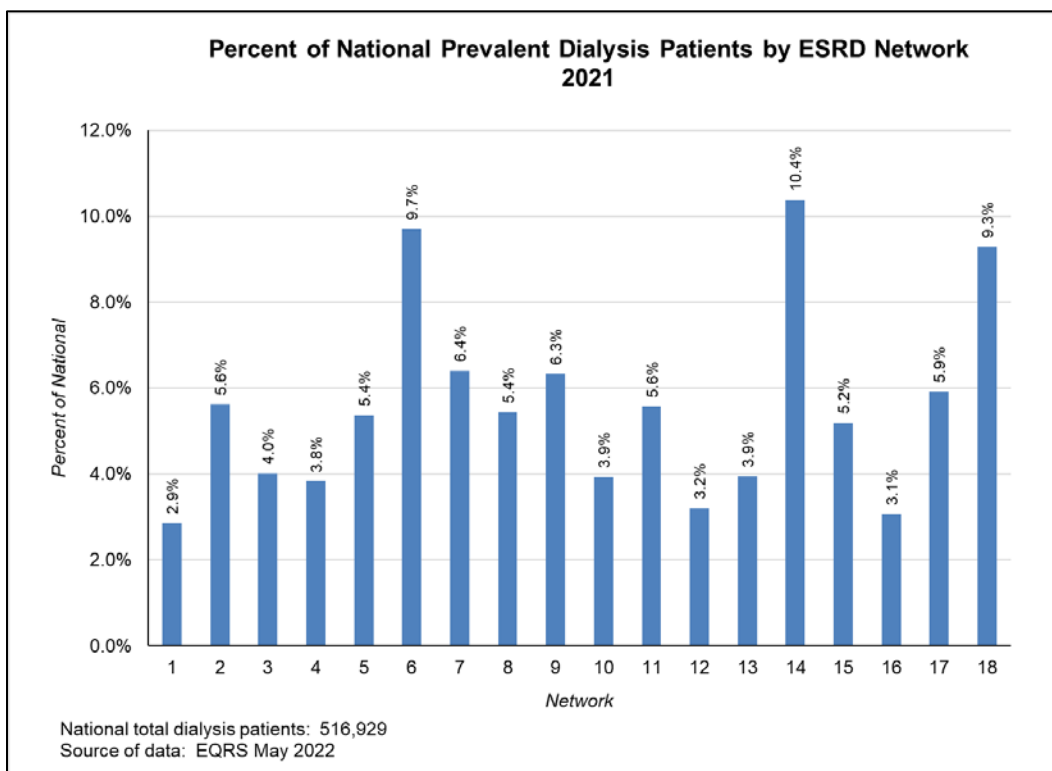


Chart 5: Percent of National Incident Dialysis Patients by ESRD Network

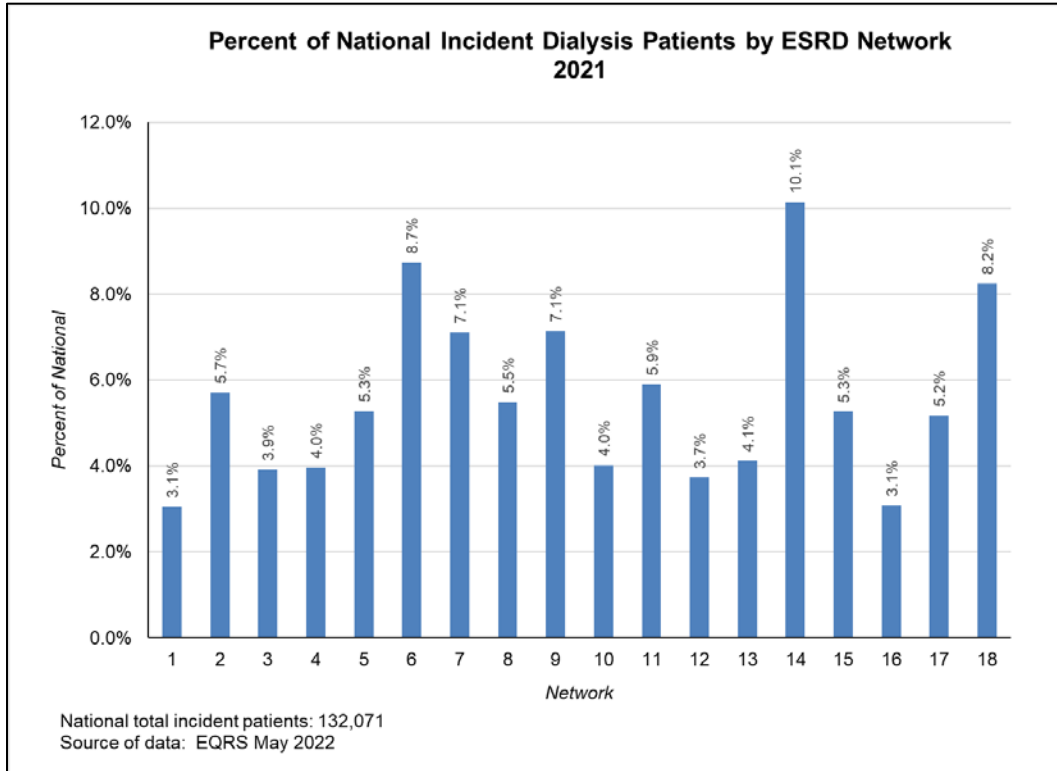


Chart 6: Percent of Medicare-Certified Dialysis Facilities by ESRD Network

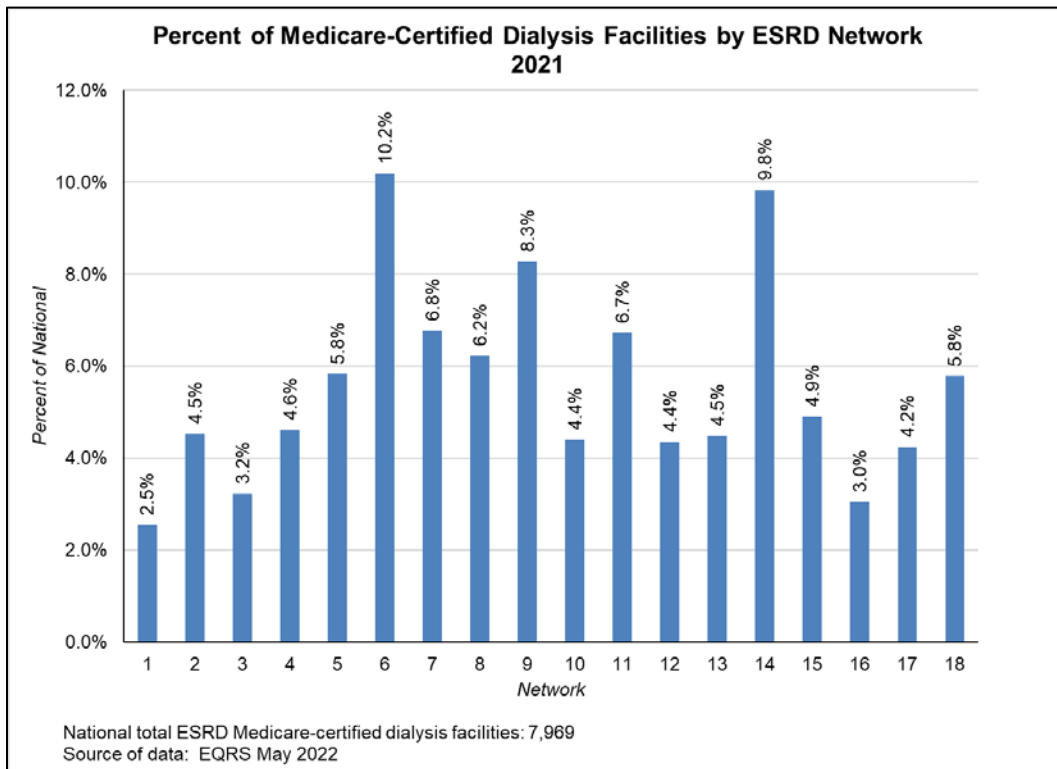


Chart 7: Percent of National Home Hemodialysis and Peritoneal Dialysis

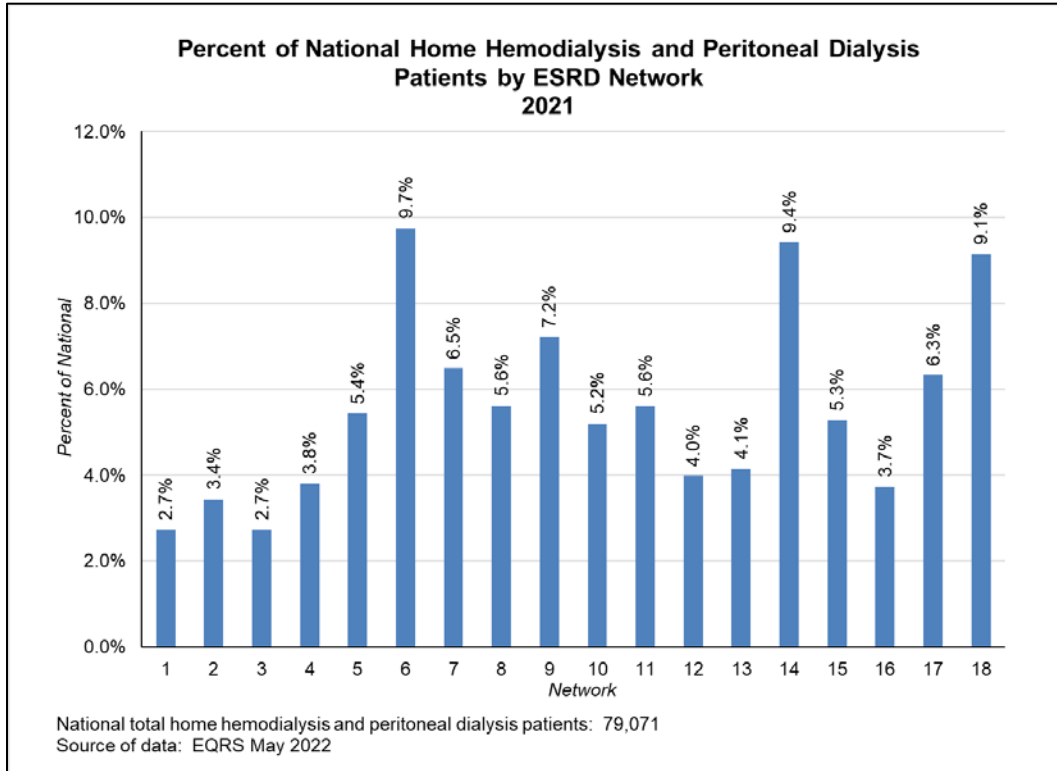


Chart 8: Percent of National Transplant Patients by ESRD Network

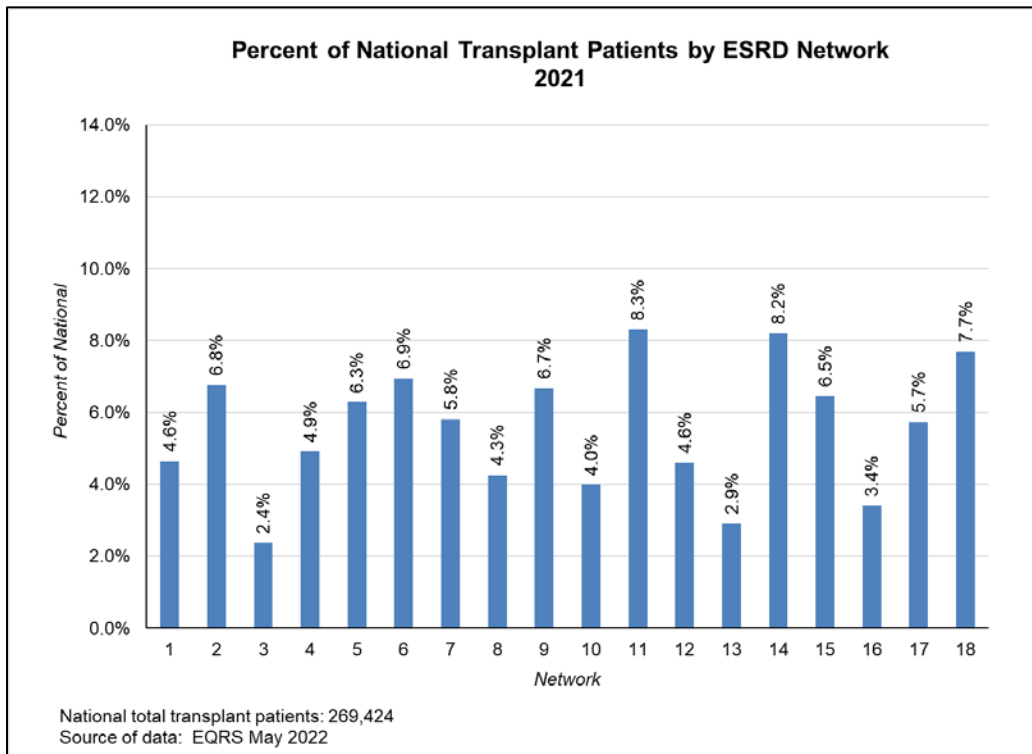
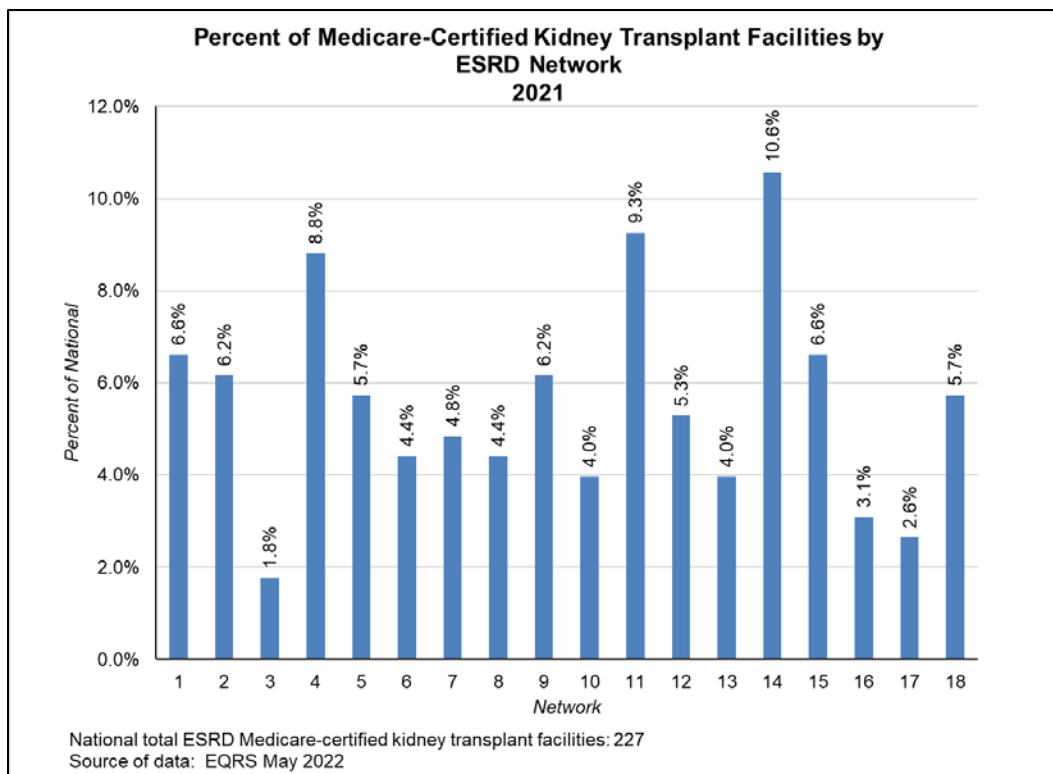


Chart 9: Percent of Medicare-Certified Kidney Transplant Facilities by ESRD Networks





ESRD NETWORK GRIEVANCE AND ACCESS TO CARE DATA

During calendar year 2021 through April 2022, ESRD Network 14 continued the implementation of processes to fulfill Centers for Medicare & Medicaid Services (CMS) requirements and standards established by the ESRD contract and J-8 attachment. The 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:

- Providing technical assistance related to grievances, access to care concerns, and facility concerns
- Developing and distributing resources to both patients and providers
- Incorporating patients and care partners in the development of processes and interventions designed to improve the patient experience of care
- Effective case management and documentation
- Establishing and maintaining partnerships with stakeholders and community resource agencies to aid in meeting the needs of patients, caregivers, and providers

Network Best Practices: Highly Effective Interventions Designed to Enhance the Patient Experience of Care

- The Patient Services Department completed weekly staffing to review all open cases and assess grievances.
- The Network utilized an interdisciplinary approach to resolve grievances and regularly included organizational leadership in grievance resolution efforts. This practice strengthened partnerships with facilities and patients.
- The Network began scheduling one-on-one coaching calls to aid in transition, onboarding and managing patient concerns. The Network discussed these concerns internally and with organizational leadership. The Network provided practical interventions related to patient experience of care, to aid with changes to staff and facility operations.
- The Network assisted with organizing patient plan of care meetings designed to aid with grievance resolution.
- The Network incorporated interventions related to mental wellness, increased depression screenings, patients' life plans and plan of care review into grievance resolution processes.
- The Network developed and updated grievance sustainability plans.

Next Steps for Patient Experience of Care

In efforts to improve and enrich the patient experience of care, the Network will implement processes that promote:

- Inclusion of hospital care management and facility staff members in efforts to educate and engage new ESRD patients
- Communication between patients, caregivers and providers without increasing staff burden (for example, contact posters for social workers and facility administrators who have more than one facility, promoting email communication through secure modes, etc.)
- Increased patient follow-up after grievance cases have been closed (i.e., sending thank you cards, educational brochures, marketing postcard, magnet).

Access to Care and Placements

From January-May 2021, 26% of the cases handled by the Network were classified as Access to Care cases, while 59% of cases handled by the Network were classified as Facility Concern cases. From June 2021-April 2022, 23% of the cases handled by the Network were classified as Access to Care cases, while 27% of cases handled by the Network were classified as Facility Concern cases. Feedback gathered during the assessment of both Access to Care and Facility Concern cases indicated the use of involuntary discharge as a behavioral management intervention. The Network increased technical assistance in efforts to address this trend. The Network also identified a trend that suggested that increased technical assistance resulted in decreased Access to Care/ involuntary discharges. In efforts to both support providers and promote optimal patient outcomes, the Network implemented the following changes to technical assistance:

- 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 conflicts.
- The Network provided ongoing education about the ESRD Conditions for Coverage and the involuntary discharge process to facilities.
- 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 about their care, and providing ongoing education to patients and care partners.
- The Network assisted LDOs with quarterly trainings, social worker onboarding and patient care conferences.

To advocate for patients and families and ensure that facilities can operate safely with minimized patient disruption, Network 14 has continued to promote the Second Chance Program for Access to Care Patients, a 90-day trial program based on Network 8's existing 90-Day Trial.

The Network's work with placement cases has:

- Increased partnership with providers
- Achieved buy-in from the LDO and State Survey Agency
- Fostered patient and family engagement and improved relationships and communication between the Network, patients, care partners, and providers
- Offered optimal clinical outcomes.
- Reduced burdens to patients, caregivers, providers and hospitals
- Facilitated partnerships with managed care providers
- Aided in addressing concerns related to health equity

Next Steps for Access to Care and Placements

In evaluating the Second Chance Placements, the Network identified key focus areas related to continued program implementation. These focus areas include:

- Determining the need for additional education
- Disseminating information about the program to ESRD providers and hospital staff
- Developing designated Second Chance facilities in each of the state's primary regions to increase patient placement opportunities

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

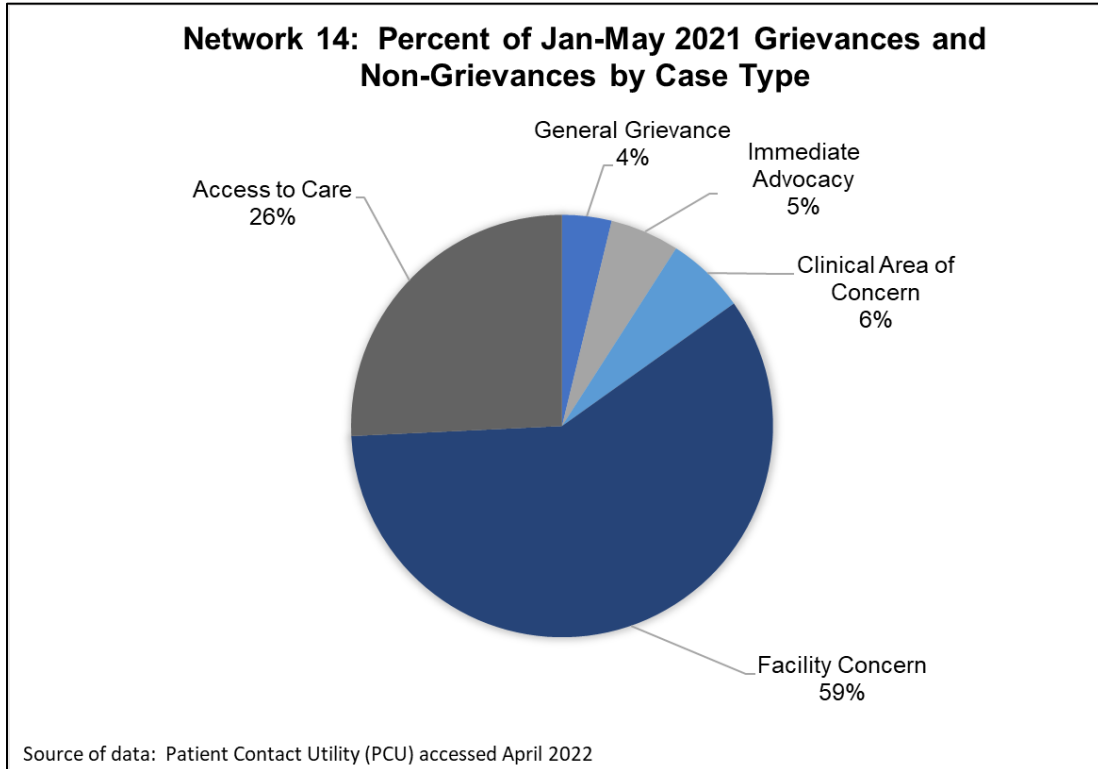
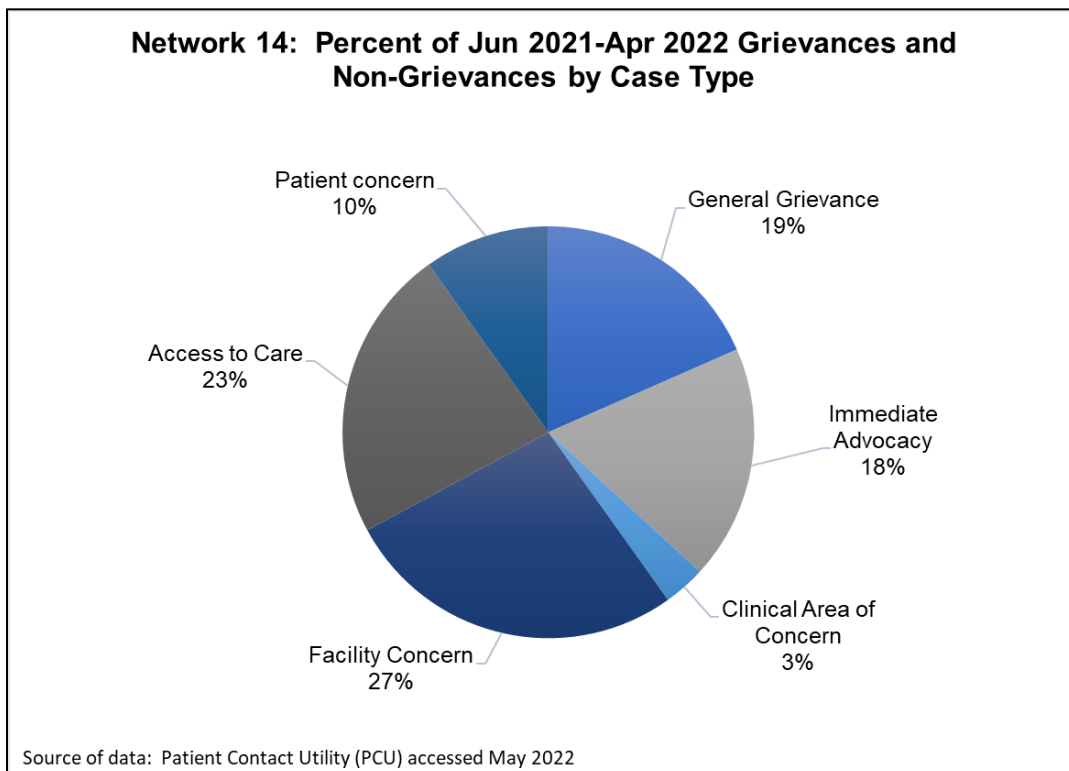


Chart 11: Percent of Grievance and Non-Grievances by Case Type





Transplant Waitlist Quality Improvement Activity through May 2021

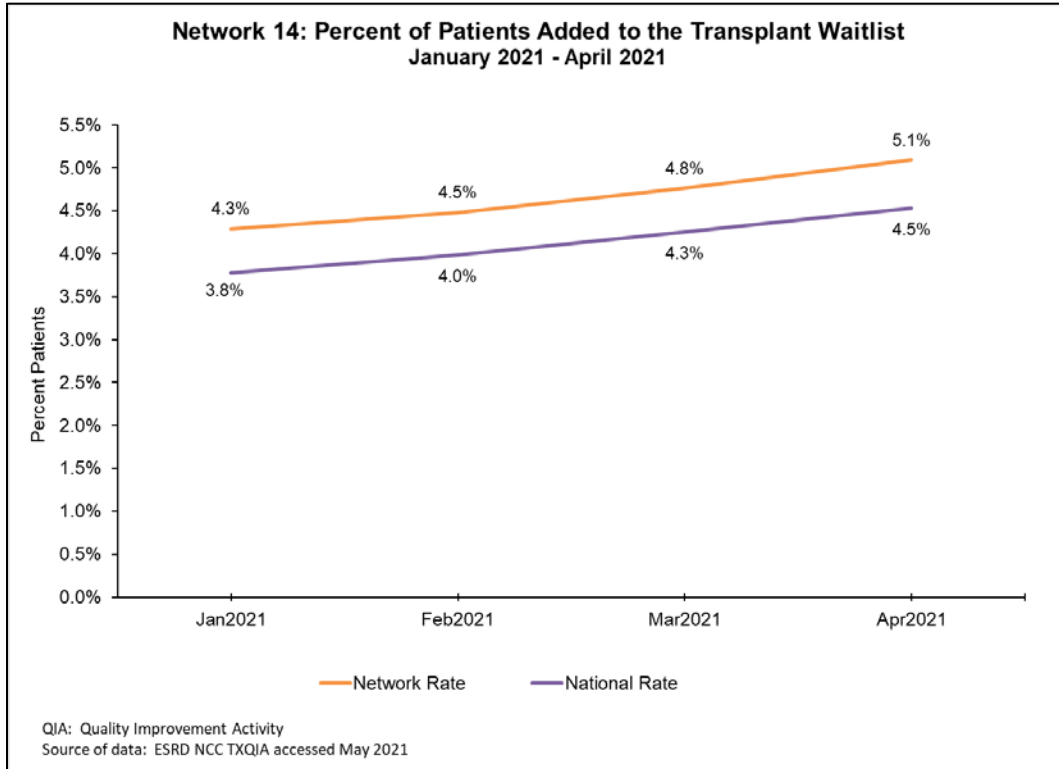
Due to the COVID-19 pandemic limiting provider staffing and procedures, along with contract goal adjustments, the Network worked toward the goals of this quality improvement activity but was not evaluated on results through May 2021. During the new contract, between June 2021-April 2022, the Network focused on Quality Improvement (QI) goals.

Network 14 continued to work to promote referrals to transplant and increase the number of patients on the transplant waitlist through May 2021.

Specific interventions and collaborations include:

- Collaborations with transplant centers and Organ Procurement Organizations (OPOs) during monthly Transplant Coalition meetings to identify barriers and possible solutions
- Monthly Transplant Trailblazer events in collaboration with the Network Patient Advisory Committee Members to share their transplant experience and discuss kidney transplantation for providers and patients
- Collaboration with the Kidney Transplant Connectors to host a webinar led by a donor and transplant recipient to share their transplant experience, provide education on high kidney donor profile index (KDPI) and underutilize kidneys
- Collaboration with Sanofi Transplantation Educational Initiative to host a webinar led by a physician on “Increasing Access to Kidney Transplantation” for facilities
- Provision and promotion of the Transplant Change Package to facilities to implement specific change ideas
- Creation of a Change Package Portal to highlight the different interventions of the Transplant Change Package to help guide facilities with the implementation of primary drivers
- Recruitment and participation of Transplant Trailblazers to assist facilities with peer-to-peer support
- Distribution of “Understanding High KDPI and Increase Risk Kidneys” video for patient education on the use of high KDPI kidneys
- Dissemination of specific transplant center trainings, webinars, provider updates on allocation, wait listing referrals and living donation to facilities for providers and patients

Chart 12: Percent of Patients Added to the Transplant Waitlist



Transplant Waitlist and Transplanted Quality Improvement Activity June 2021-April 2022

Network 14 was tasked with improving education and access to empower patient choice of transplant by increasing the number of patients added to a transplant waitlist and ultimately receiving a kidney transplant.

The Network goals were to achieve a 2% increase in the number of patients added to a kidney transplant waitlist and a 2% increase in the number of prevalent patients receiving a kidney transplant by April 30, 2022.

Transplant wait listing goals were successfully achieved, with 2,822 Network 14 ESRD patients added to a kidney transplant waitlist between June 2021 through April 2022. Transplant goals were not achieved; however, 1,799 Network 14 ESRD patients received a kidney transplant during the base performance period. In addition to the 1,799 prevalent patient transplants listed in (Chart 14), 351 preemptive Network 14 ESRD patient transplants were performed in 2021, based on the National Coordinating Center (NCC) Network Working Report, Period Prevalence table from May 25, 2022.

A root cause analysis (RCA) was conducted with facilities to identify barriers causing facilities to have low transplant waitlists and transplant rates. Common barriers reported include:

- Lack of follow-through by patients (i.e., missing appointments and not rescheduling)
- Lack of motivation or interest by patients
- Lack of understanding of the transplant evaluation process
- Obesity
- Transportation
- Lack of family support
- Financial cost
- Lack of communication by transplant centers with dialysis facility staff
- No living donor or hesitant to ask family members
- Lack of patient education and understanding

Weekly technical assistance was provided based on feedback from the transplant centers and the results from the RCA. The following interventions and collaborations were utilized for the transplant project:

- Development of an RCA Feedback Form to identify specific patient and facility barriers
- Individualized coaching calls with facility managers and social workers to discuss rates, barriers, possible solutions, and best practices
- Provision of monthly patient and provider educational resources to aid with barriers
- Provision of monthly updated waitlisted and transplanted rates with facilities for progress review

- Implementation of the Transplant Change Package and specific primary drivers for facilities
- Development of the Kidney Transplant Checklist in collaboration with the Transplant Coalition
- Recruitment and participation of Transplant Trailblazers and Transplant Champion
- Provision of specific transplant center workshops, provider updates, and webinars for providers and patients
- Conduction of quarterly Transplant Coalition meetings to identify barriers, potential interventions, and share best practices
- Collaboration with the Kidney Transplant Connectors to host Spanish webinars led by a transplant recipient and donor for patients and providers
- Development of a Provider Portal for transplant centers to easily submit Transplant Activity Reports electronically
- Utilization of the NCC's Network Working Reports and United Network for Organ Sharing reports to ensure all transplants performed were accounted for and entered in EQRS

Chart 13: Percent of Patients Added to the Transplant Waitlist

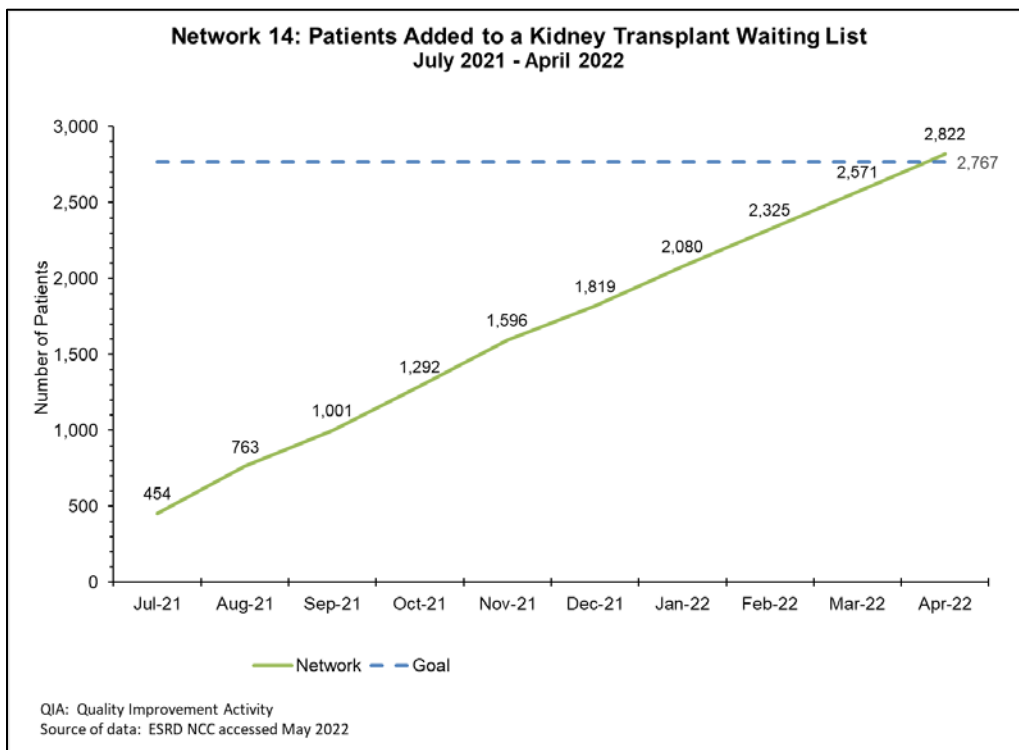
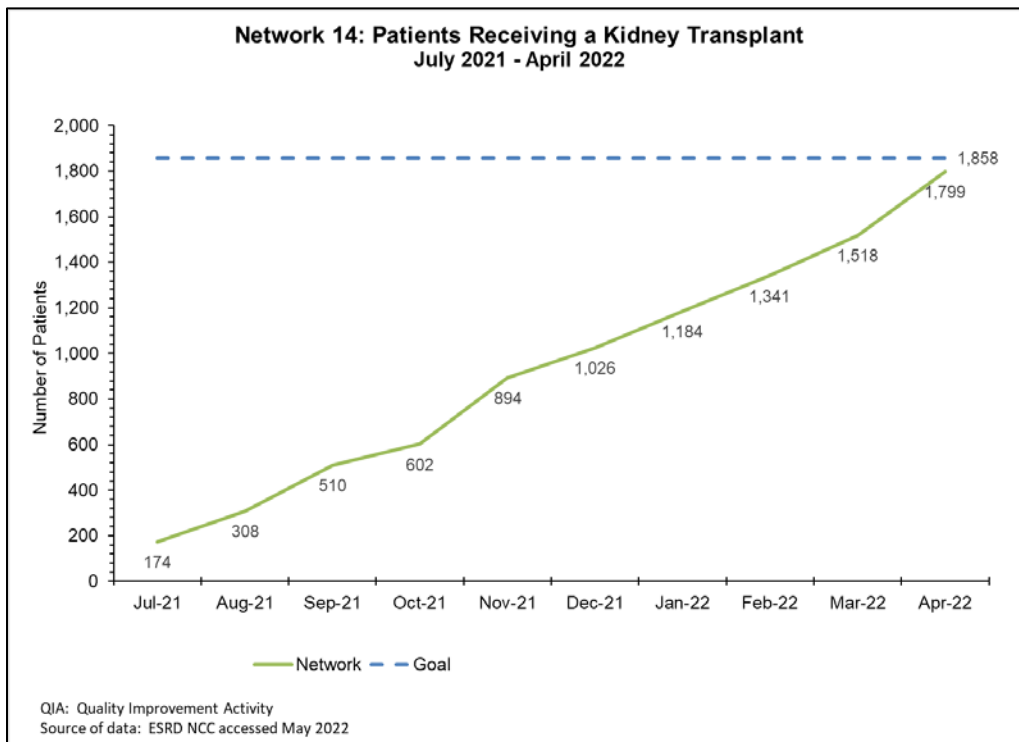


Chart 14: Count of Patients Receiving a Kidney Transplant



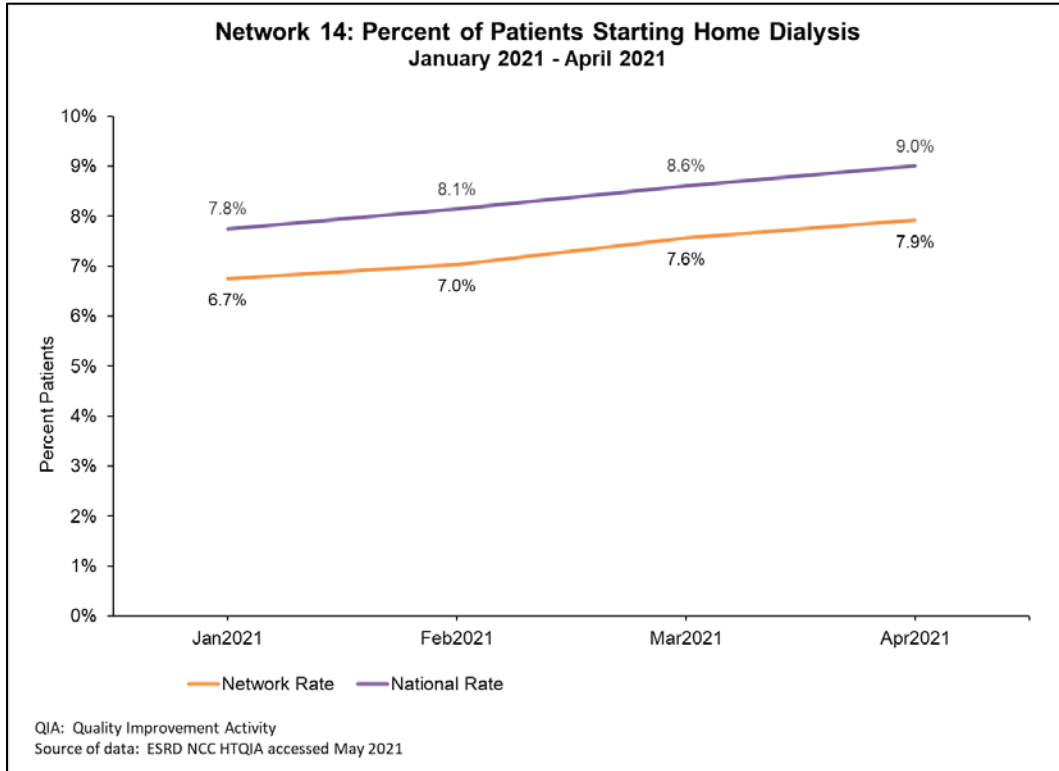
Home Therapy Quality Improvement Activity through May 2021

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 through May 2021. During the new contract, between June 2021-April 2022, the Networks focused on QI goals.

Network 14 worked to promote home dialysis through May 2021, utilizing the NCC's Home Change package and interventions listed below.

- Creating a home dialysis coalition and enlisting highly successful facilities, nephrologists, nurses, social workers, and other facility staff to share and discuss barriers and best practices.
- Promoting our patient SMEs as Home Heroes and hosting webinars for other patients to hear their stories and ask questions.
- Hosting webinars from our successful surgeons to discuss and educate more on home access options.
- Partnering with Advanced Renal Education Program (AREP) to host information webinars for professionals regarding urgent start peritoneal dialysis and transitional care units.
- Promoting the NCC's Home Change Package drivers.
- Creating the Network's Change Package Portal helped to display the different primary drivers, interventions and resources of the change package to make it easier for facilities to find ideas on implementing best practices in their facility.
- Promoting the NCC Universal Staff Education 3 course module and encouraging Patient Care Technicians to complete the course.
- Promotion of Network 8 nephrologist podcast, discussing benefits of home dialysis and addressing common barriers, successful home dialysis for unconventional candidates, and patients' reluctance to try home dialysis due to fear.
- Distribution of ESRD NCC Resource "My Home Dialysis Checklist" to assist patients with transition to home dialysis.

Chart 15: Percent of Patients Starting Home Dialysis



Home Therapy Quality Improvement Activity June 2021-April 2022

The Network's goals were to improve the rate of prevalent patients using a home modality and the rate of incident patients using a home modality.

Specifically, the Network was required to achieve a 10% increase in the rate of incident patients using a home modality. The Network achieved a 7.6% increase in the baseline and added 1,495 incident patients to a home modality.

The Network also was required to achieve a 2% increase in the rate of prevalent patients transitioning to a home modality. The Network achieved a 1.7% increase in the baseline and added 2,013 prevalent patients to a home modality.

To assess the needs of the facilities, the Network conducted an RCA to investigate the biggest barriers and challenges they were encountering. Barriers reported included:

- Short staffing in-center
- Lack of home nurses for home training
- Staff turnover
- Lack of time to educate patients
- Lengthy resources and overused resources
- Patients are not interested in home dialysis and prefer in-center
- Lack of family support
- Lack of economic resources

The Network completed monthly data analysis to select facilities with room for improvement within their region and utilized a Plan, Do, Act, Study methodology to provide interventions, technical assistance and follow-up with facilities. A variety of interventions that focused on alleviating staff burden and improving patient home education were utilized and promoted to the focus facilities. Interventions utilized included:

- Provided short, to-the-point resources based on facility-specific barriers to address home modality education needs
- Promoted the NCC's Universal Staff Education to educate newer staff and patient care technicians on proper ways to address patients' fears and misconceptions about home modalities
- Suggested specific Home Change Package drivers per the facility's reported barriers and provided resources that are adapted to the specific barrier reported by the facility
- Shared best practices from high performing facilities
- Focused on addressing the greatest barrier rather than multiple barriers
- Promoted the Network 14 Patient Portal and continually added new videos and resources
- Provided facilities with home rates to keep them aware and to ensure accurate data in EQRS
- Provided patient resources to highlight the benefits of home dialysis

- Promoted use of a Home Hero or Kidney Care Advocate to talk about their home experience to free up staff time
- Promoted education about self-care within the in-center so patients are ready to go home, reduce training time, and improve home retention rates.
- Engaged coalition to promote ways to encourage more nurses to go towards home dialysis
- Collaborated with AREP meaningful webinars for staff to stay educated
- Promoted the use of Transitional Care Unit
- Shared best practices from high performers, successful facilities and MRB
- Shared patient-focused webinars and stories about home dialysis
- Shared the Network's Home Hero webinars to promote self-care and a care partner's perspective.
- Conducted outreach to home-only facilities to offer support to improve communication from in-center
- Share the "My life, my dialysis choice" questionnaire and the Match-D tool to assist patients with the decision

By conducting an RCA to assess the facility-specific barriers and using one-on-one technical assistance and resources specific to these barriers, the Network added 3,831 incident and prevalent patients towards home modality.

Chart 16: Count of Incident Patients Starting Dialysis Using a Home Modality

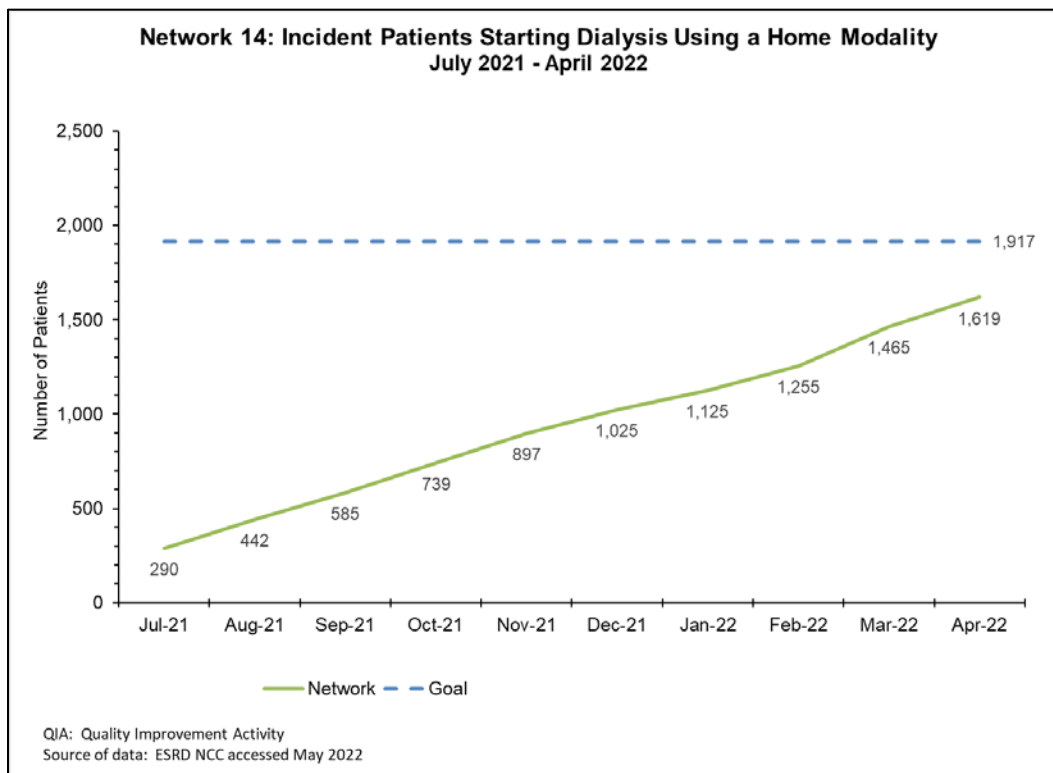
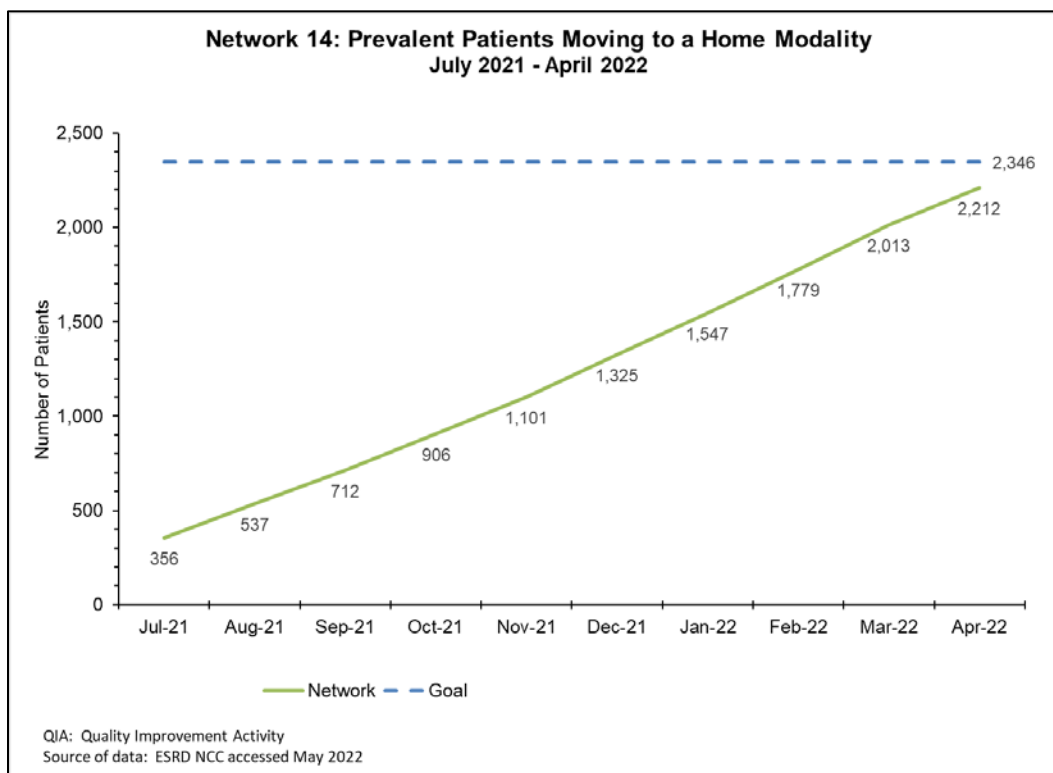


Chart 17: Count of Prevalent Patients Moving to a Home Modality



Influenza June 2021-April 2022

Networks were tasked to ensure that 85% of dialysis patients received an influenza vaccination by April 30, 2022.

Network facilities achieved an overall influenza vaccination rate of 81.05%.

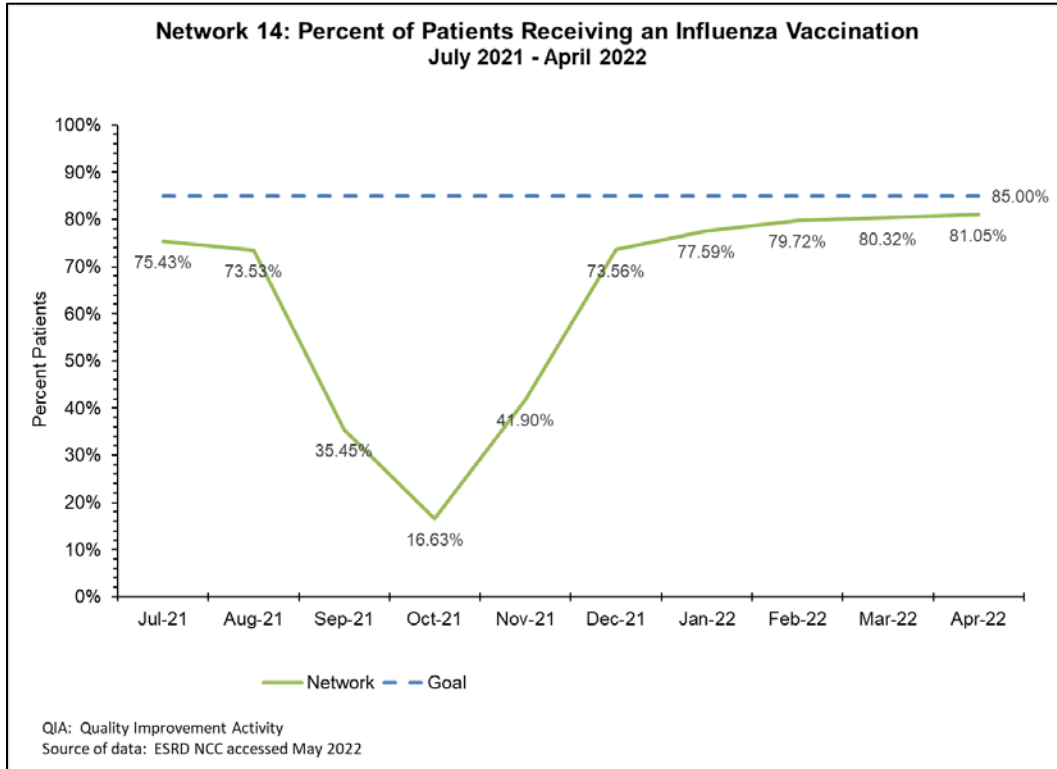
An RCA was conducted to determine facility-specific barriers to low influenza vaccination rates. Commonly identified barriers included:

- Lack of knowledge
- Needle phobia
- Allergies
- Lack of vaccination records
- Refusal of all vaccines
- Fear of side effects
- Inaccurate data in EQRS

Influenza data were reviewed monthly by Network staff, and weekly technical assistance was provided. Interventions included:

- Development of a coalition of stakeholders to assist with the identification of barriers and potential interventions
- Facility-specific coaching calls to discuss rates, barriers and gaps in influenza data
- Development of focus group to provide EQRS data entry instructions to non-batch submitting facilities
- Provision of monthly educational resources to combat barriers
- Monthly collaboration with regional management to assist facilities with timely data validation and entry
- Provision of patient-specific influenza data to inform staff of specific updates needed

Chart 18: Percent of Patients Receiving an Influenza Vaccination



COVID-19 Vaccinations Patients and Staff June 2021-April 2022

Networks were tasked to achieve the following COVID-19 vaccination rates by April 30, 2022:

- 80% of dialysis patients to receive an initial COVID-19 vaccination
- 80% of fully vaccinated dialysis patients to receive any additional recommended COVID-19 vaccinations
- 100% of dialysis facility staff to receive an initial COVID-19 vaccination
- 100% of fully vaccinated dialysis staff to receive any additional recommended COVID-19 vaccinations

Network facilities achieved the following COVID-19 vaccination rates:

- 73.7% of dialysis patients received an initial COVID-19 vaccination
- 53.9% of dialysis patients received an additional recommended COVID-19 vaccination
- 76.4% of dialysis facility staff received an initial COVID-19 vaccination
- 23.7% of fully vaccinated dialysis staff received an additional recommended COVID-19 vaccination

An RCA was conducted to determine facility-specific barriers to low COVID-19 vaccination rates in patients and staff. Commonly identified barriers included:

Patients

- Lack of trust
- Political beliefs
- Refusal of all vaccines
- Fear of long-term side effects
- Needle phobia
- Inability to provide COVID-19 vaccination cards
- Religious beliefs
- Inaccurate data in National Healthcare Safety Network (NHSN)

Staff

- Political beliefs
- Religious beliefs
- Fear of side effects
- Required to always wear mask
- Inaccurate data in NHSN

COVID-19 data were reviewed monthly by Network staff, and weekly technical assistance was provided. Interventions included:

- Development of a coalition of stakeholders to assist with the identification of barriers and potential interventions
- Facility-specific coaching calls to discuss rates, barriers and gaps in COVID-19 data
- Development of focus group to provide NHSN data entry instructions to non-batch submitting facilities
- Provision of monthly educational resources to combat barriers
- Monthly collaboration with regional management to assist facilities with timely data validation and entry
- Development of a focus group to reduce the high number of unknown COVID-19 vaccinations
- Provision of information regarding the Texas Immunization Registry to assist with unknown vaccination statuses
- Provision of monthly COVID-19 vaccination metrics

Chart 19: COVID Vaccination Rate (Dialysis Patients)

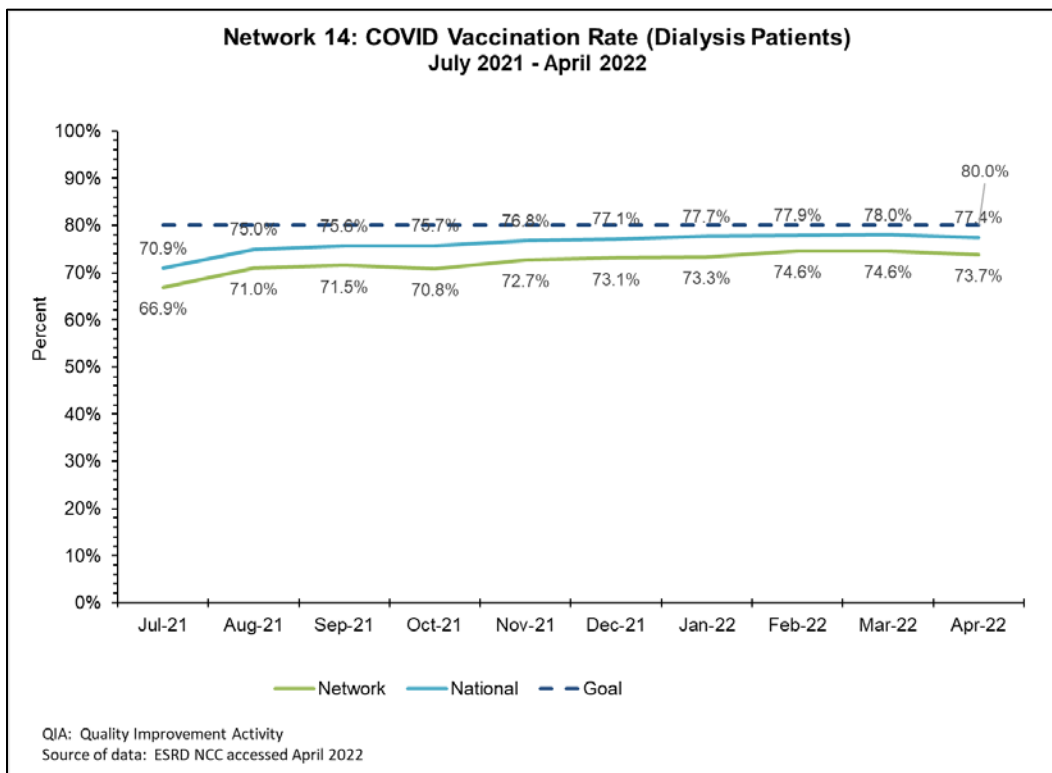


Chart 20: Percent of Fully Vaccinated Dialysis Patients (COVID Booster)

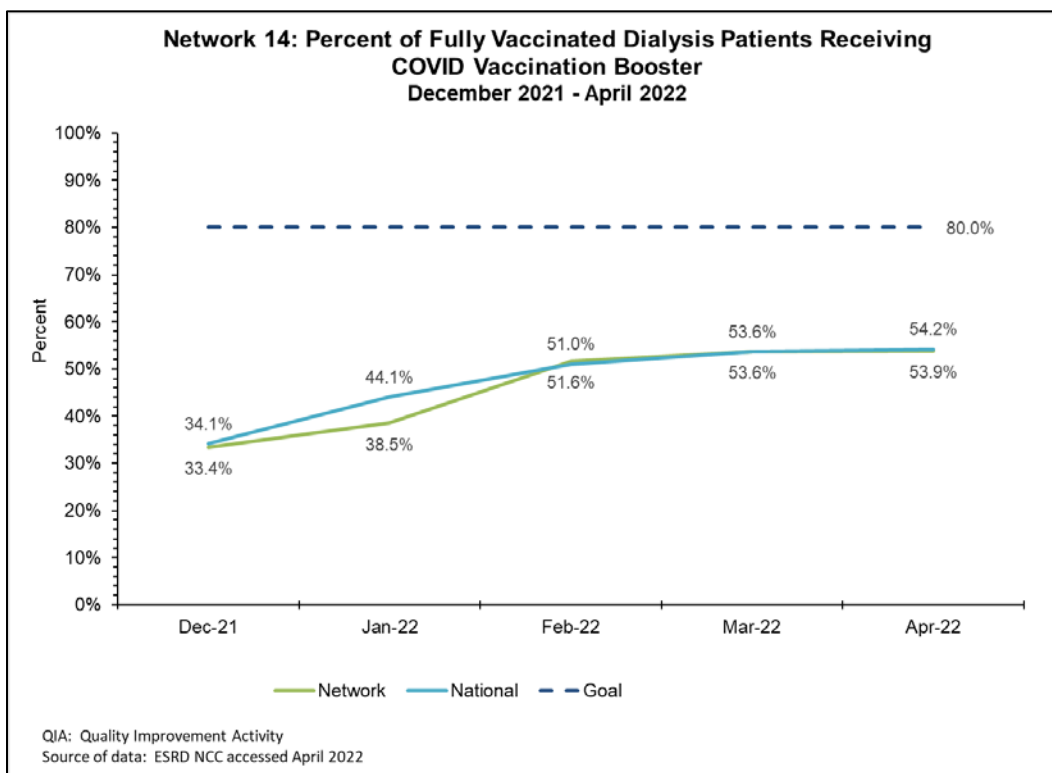


Chart 21: COVID Vaccination Rate (Dialysis Facility Staff)

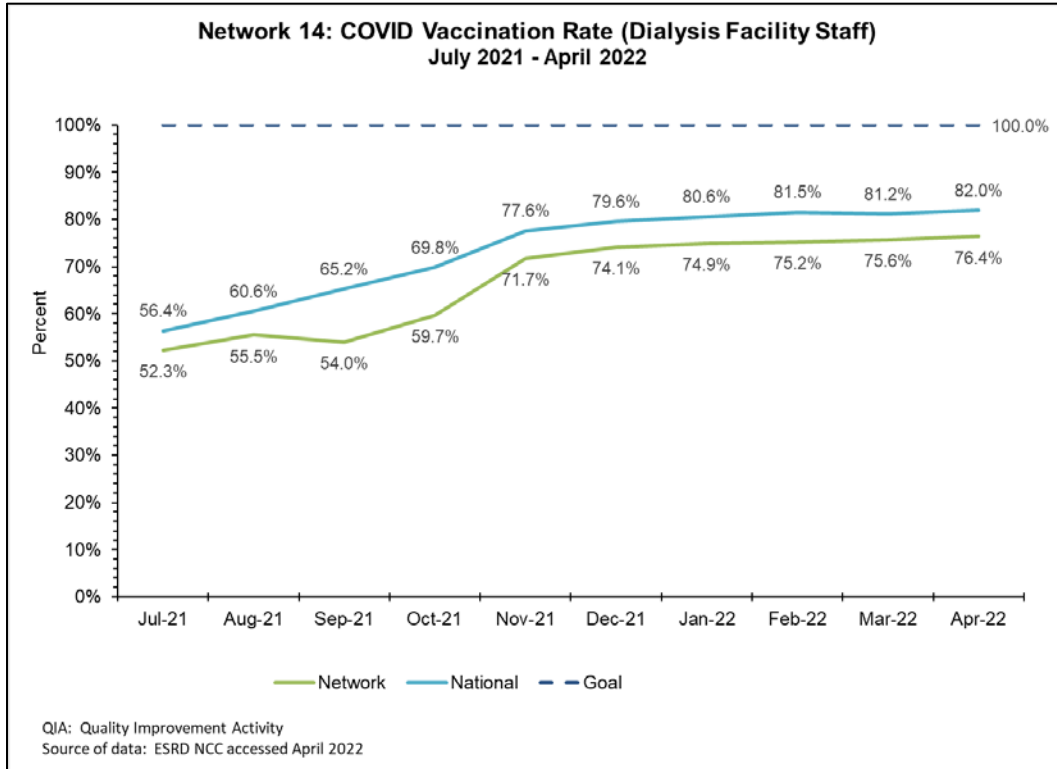
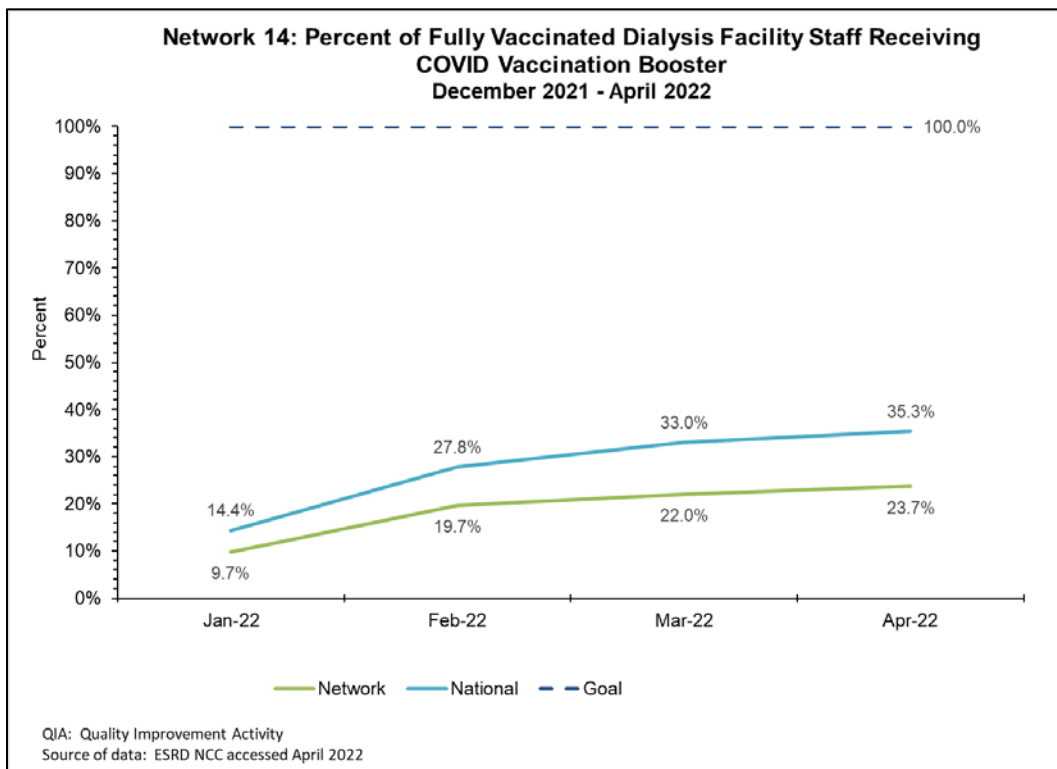


Chart 22: Percent of Fully Vaccinated Dialysis Staff (COVID Booster)



Data Quality (Admissions, CMS Form 2728, CMS Form 2746) June 2021-April 2022

Network 14 focused on improving data quality for the annual performance period from May 1, 2021, through March 30, 2022.

During the performance period, the Network engaged facilities and corporations in dialogue and communication surrounding the topic of data quality.

These efforts included:

- Automating the distribution of emails to facilities to alert them to forms due within 10 days
- Automatic tracking of these emails in a customer relationship management tool (Salesforce) used by all Network staff at Alliant Health Solutions
- Multiple meetings with large dialysis organization corporate IT staff regarding data quality efforts
- Development of a customer support portal to streamline the data quality audit process for non-LDO facilities
- Reporting of data quality metrics to facilities and corporations
- Updating of Transplant Activity Report (TAR) templates
- Development and implementation of customer service support portal to streamline submission and entry of transplant data
- Communication with corporate staff detailed for EQRS/data quality support initiatives
- Cross-training of non-information management (IM) staff on EQRS issues, customer support, and data entry

Network 14 conducted a roster validation and forms review on 20% of its dialysis facilities during the performance period.

One hundred fifty-five facilities were selected for roster validation. Data for comparison was provided by the NCC, EQRS reports, and the corporate information technology (IT) areas of the facilities reviewed.

Form validation was performed on 20% of dialysis facilities in the Network service area. Forms validation was performed on 20% of dialysis facilities in the Network service area. This data was also provided by the NCC, EQRS reports and the respective corporate IT areas.

Data Quality CMS Form 2728, CMS Form 2746 Form Validation	
Number of 2728 forms reviewed	Number of 2746 forms reviewed
1424	94

Chart 23: Admission Data Entered within 5 Days

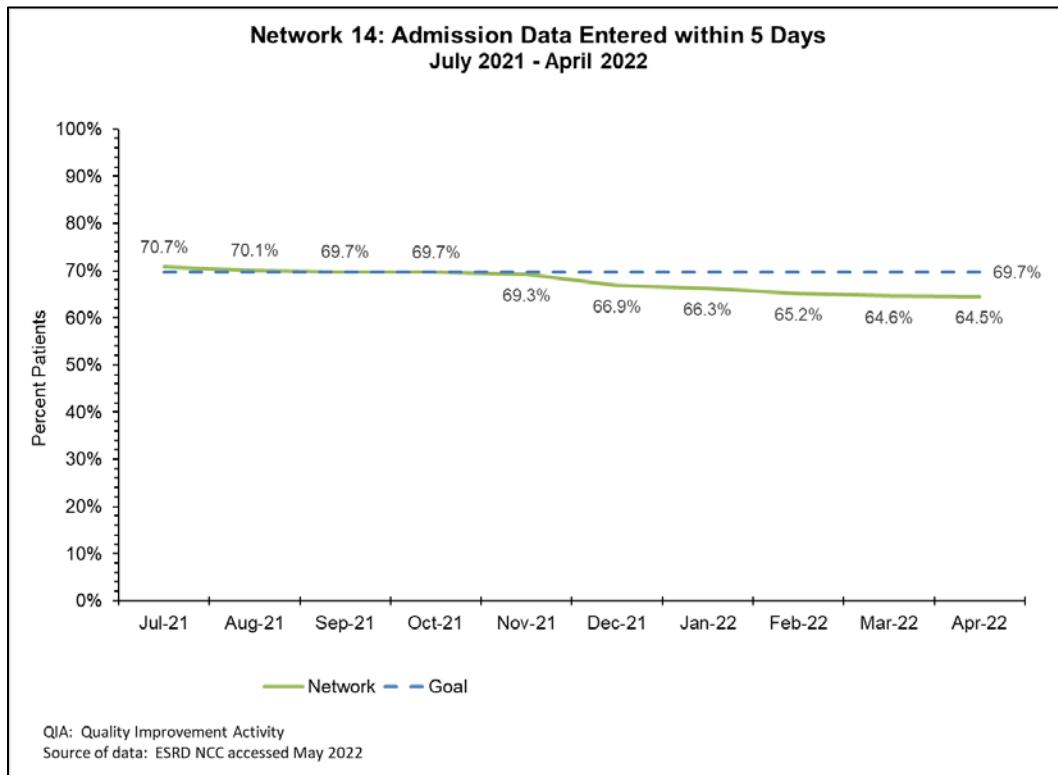


Chart 24: CMS-2728 Forms Submitted within 45 Days

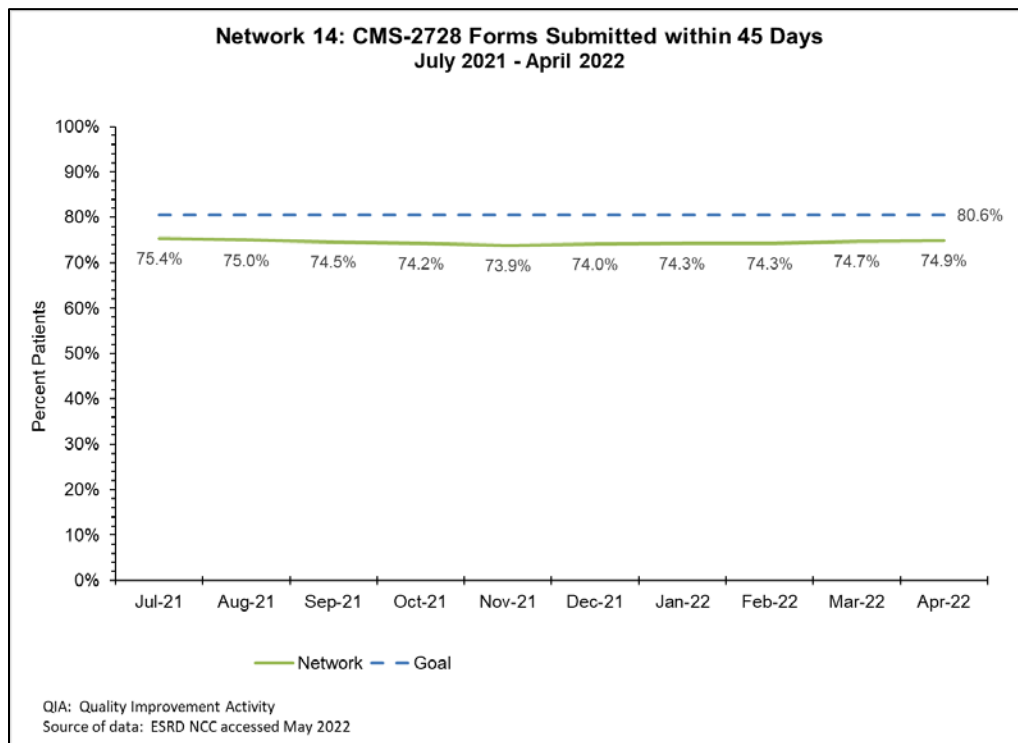
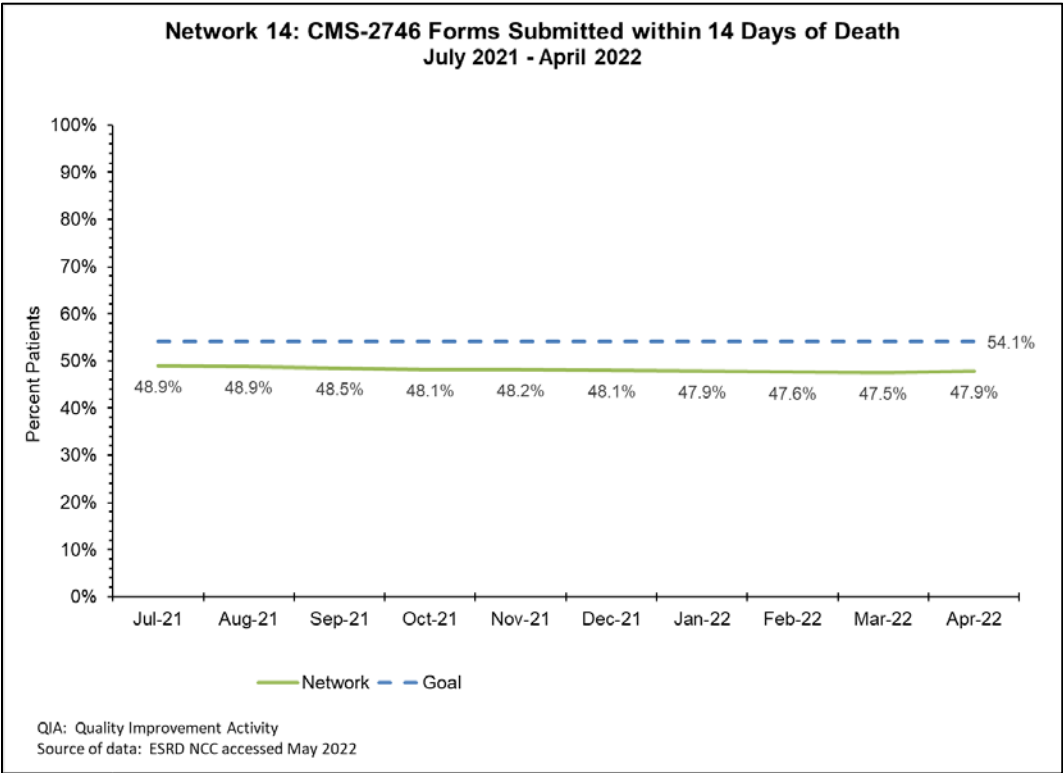


Chart 25: CMS-2746 Forms Submitted within 14 Days of Death



Hospitalization (Inpatient Admissions, ED Visits, Readmissions and COVID-19 Admissions) June 2021-April 2022

The COVID-19 pandemic limited ESRD providers' operations. Despite the impact of the pandemic, the Network worked toward improving the goals of this quality improvement activity with all facilities in the Network service area. The Network was not evaluated for the contract period from January 1, 2021, to May 31, 2021. During the contract period from June 2021-April 2022, the Network continued to provide technical assistance to facilities while staying focused on quality improvement goals to reduce emergency department visits and unplanned hospitalizations (including COVID-19). The Network aimed to achieve a 2% decrease in hospital admissions, a 2% decrease in hospital 30-day unplanned readmissions, a 2% decrease in outpatient emergency department visits, and a 25% decrease in the number of COVID-19 hospitalizations in the ESRD patient population.

In June 2021, the Network assembled a community coalition of subject matter experts and completed an RCA to identify the main barriers leading to unplanned hospitalizations.

The top three root causes identified included:

- Missed treatments associated with transportation challenges and not following treatment orders
- Repeat admissions to the hospital for dialysis treatments rather than directing the patient to an outpatient clinic to avoid an unnecessary admission
- Patients and staff failed to recognize early complications that could have been addressed more quickly at the facility level to avoid unplanned hospitalizations

Other important barriers included:

- Immunization fears and misconceptions
- Staff fatigue leading to reduced or ineffective patient education and follow-up
- Staffing and supplies shortages

Based on findings from the community coalition and feedback obtained from one-on-one interactions with providers, the Network identified and provided targeted interventions to dialysis facilities.

Interventions implemented included:

- Identifying patient champions who would volunteer to share their stories with other peers (promoting self-care, following plan of care and treatment orders, receiving recommended immunizations)
- Identifying and assigning a designated facility's hospitalizations manager
- Providing patient and professional newsletters
- Utilizing the Forum of ESRD Networks Transitions of Care Toolkit

- Promotion and provision of tools such as Post-Hospitalization Checklist, Dialysis to Hospital Transfer Summary, Hospital to Dialysis Unit Transfer Summary, and 7-Day Readmission Checklist Audit Tool
- Promoting access to health Information Exchange programs (HIEs) and telehealth
- Utilization of vaccination and zone tools

Best practices identified during this project included:

- Continued partnership with the TMF Health Quality Institute QIN-QIO
- Community coalition meetings and brainstorming sessions
- Utilization of tools that enhance communication between providers
- Availability of tools and resources via the Network's website

Additionally, the feedback obtained from the one-on-one technical assistance provided to facilities allowed the Network to identify pressing needs and offer specific targeted interventions for each facility.

In summary, based on data provided by the ESRD NCC as of April 2022, the Network successfully maintained rates below the upper limit threshold established by the CMS (as shown in the graphs below for all four measures). The Network will continue to partner with providers, patients, community experts, and other stakeholders to improve unplanned hospitalization while providing interventions to mitigate primary chronic comorbidities in the ESRD population.

Chart 26: Rate of ESRD-Related Hospital Admission per 100 Patient Months

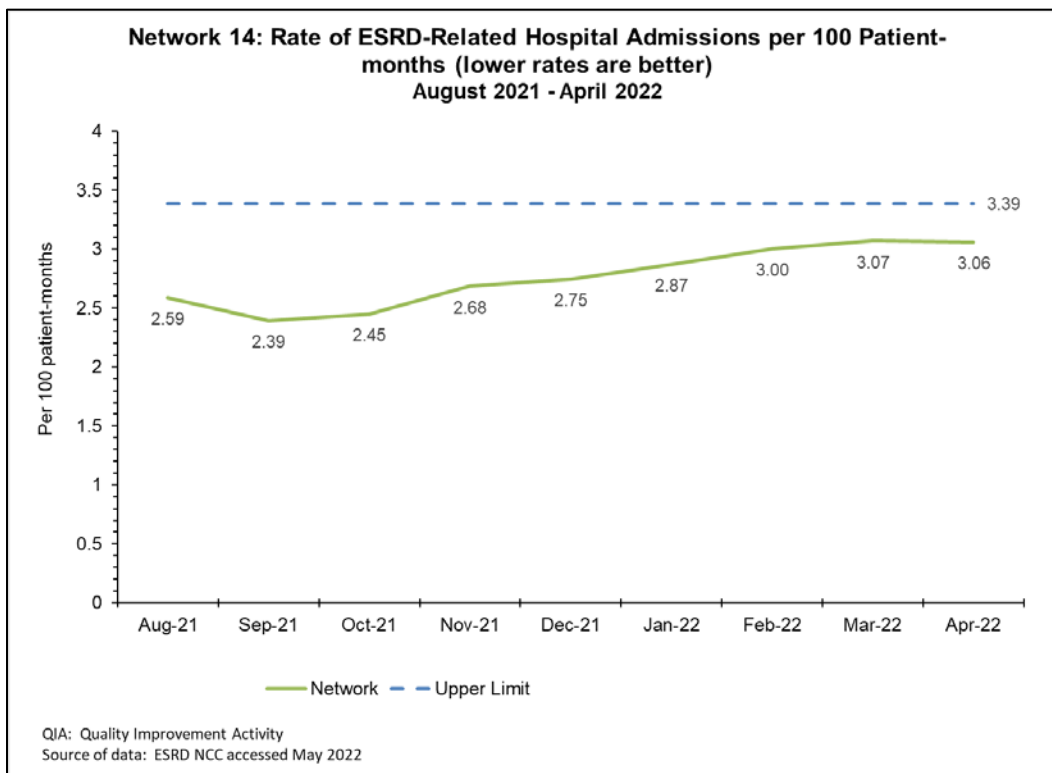


Chart 27: Outpatient Emergency Department Visits per 100 Patient Months

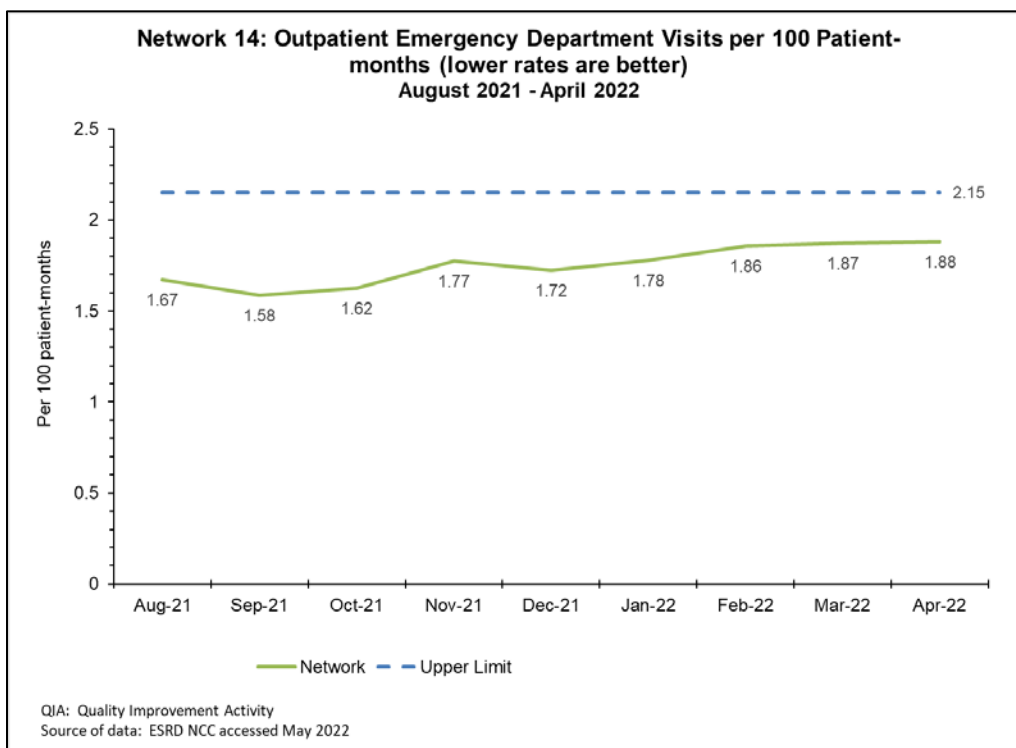


Chart 28: Hospital 30-Day Unplanned Readmissions

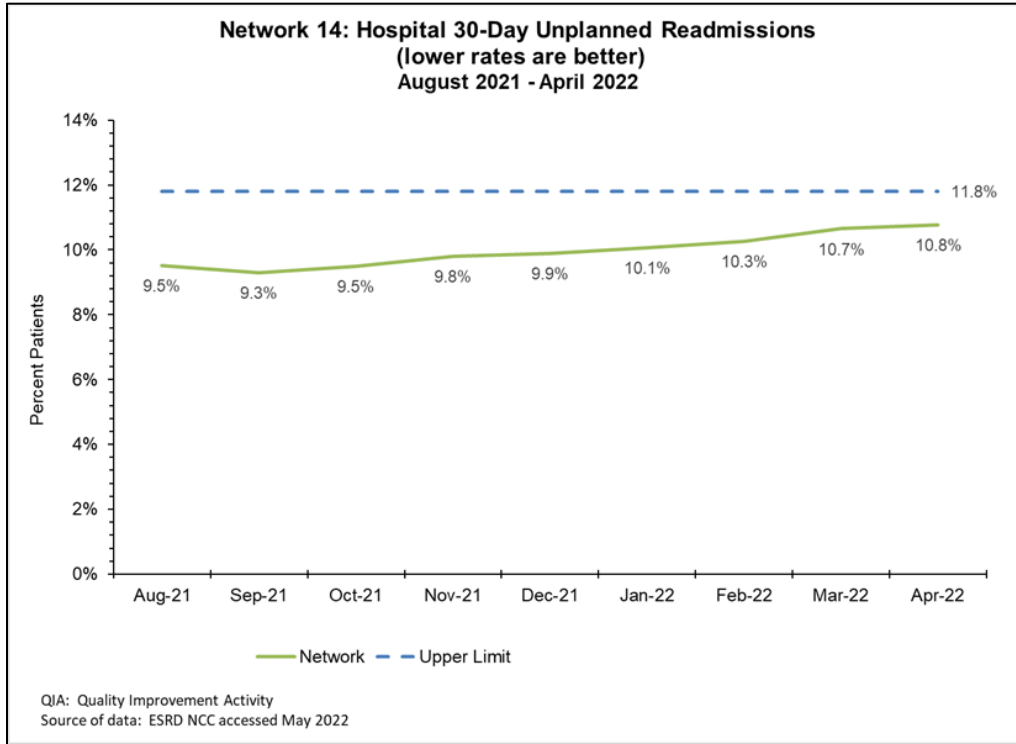
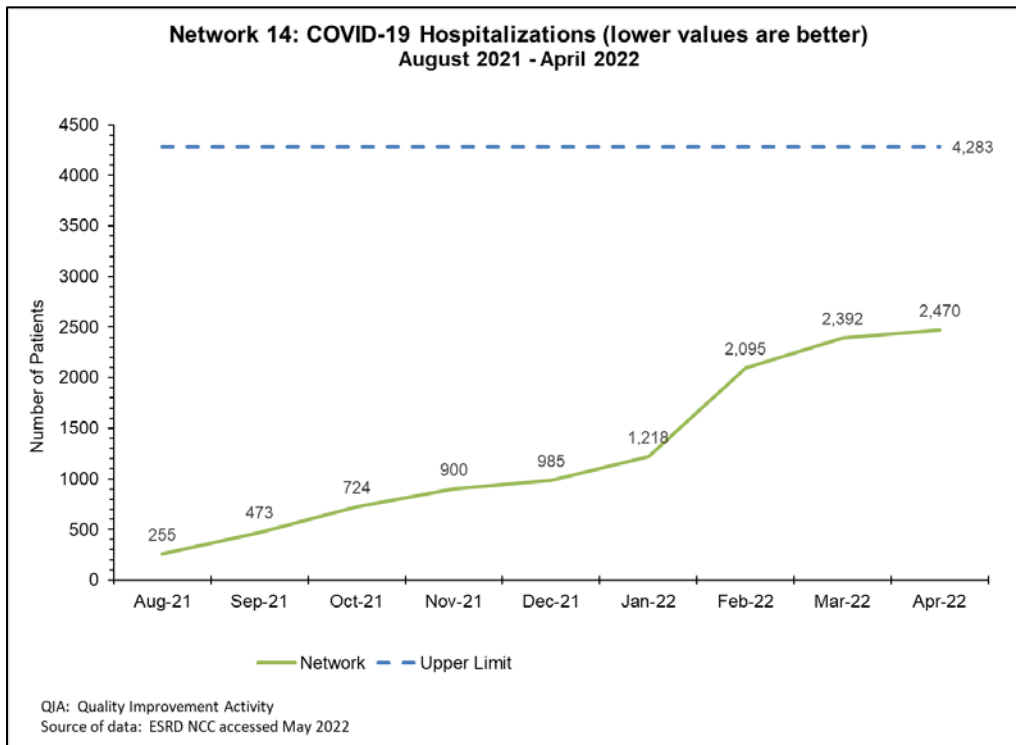


Chart 29: COVID-19 Hospitalizations



Depression June 2021-April 2022

Due to contract goal adjustments, the Network worked toward the goals of this quality improvement activity but was not evaluated on results. In the absence of data, the Network utilized feedback from community coalition representatives, organizational leadership, facility representatives, community partners and stakeholders to guide technical assistance, outreach and resource development to ensure that patients are properly screened and treated for depression and cognitive decline. During the time frame above, Network 14 completed the following action items related to this goal:

- Completed miniseries project that included targeted outreach with facilities
- Identified key barriers
- Assisted with mitigating identified barriers
- Utilized the feedback from project participants to develop resources and guide technical assistance with all facilities
- Assisted with onboarding processes and participated in facility training
- Completed one-on-one coaching calls to aid in behavior management
- Located State and Federal Resources
- Distributed relevant resource information on a routine basis
- Provided direct assistance to facility staff members in the form of patient outreach, resource acquisition and staff training
- Partnered with Long-Term Care Ombudsman Programs, Managed Care Organizations and Area Agency on Aging to address patient concerns related to managing behavioral health and cognitive decline
- Partnered with National COVID-19 Resiliency Network (NCRN) to develop a behavioral health screening workflow for providers
- Partnered with NCRN to address behavioral health concerns related to Health Equity

Next Steps for Behavioral Health

Based on information gathered during contract year 2021, the Network has identified strategic plans to guide behavioral health improvement efforts. These plans include:

- Outlining and explaining behavioral health goals to all providers in our service area
- Utilizing data to develop formal project/quality improvement interventions and guide technical assistance and outreach
- Decreasing the burden to facility staff members by utilizing data to track trends and identify areas of concern
- Continually assessing the burden to facility staff members when developing and implementing interventions
- Providing increased support to independent facilities

Nursing Home June 2021-April 2022

Network 14 was tasked with improving the quality of care for dialysis patients receiving renal replacement therapy within the skilled nursing facility (SNF) / long-term care (LTC) facility by reducing hemodialysis central line infections and peritonitis events, and by decreasing the number of blood transfusions in this vulnerable population. At the outset of this QI activity, there were 105 patients spread among four facilities in Texas. No additional programs were added through April 2022.

Specifically, Networks were required to achieve a 4% decrease in the hemodialysis catheter infection rate in dialysis patients receiving home dialysis within nursing homes, a 2% decrease in peritonitis events, and a 2% decrease in the rate of dialysis patients receiving dialysis at nursing homes that receive a blood transfusion by April 30, 2022. Project goals for hemodialysis catheter infections and transfusions were successfully achieved. There were no peritoneal dialysis programs in the SNF/LTC setting as of April 30, 2022.

While data to support quality improvement efforts was not available until January 2022, the following interventions were utilized to address these metrics.

- Development of a coalition of stakeholders to assist with identifying local issues and potential interventions to address
- Individualized coaching calls with the program lead to conduct a needs assessment and explain the purpose and goals of QI activity
- Identification of program EQRS data contact with monthly patient census review and assistance with patient admissions, discharges, and forms 2728 and 2746 completion as needed, as well as educating staff on new EQRS fields related to SNF/LTC setting
- Facility-specific coaching calls to review FY 2022 Dialysis Facility Report, focusing on infection and transfusion metrics
- Provision of monthly education for infection prevention and anemia management.
- Provision of monthly data updates for each metric and patient-specific case review as warranted
- Quarterly collaborative meeting with the Texas Department of State Health Services to identify areas of need and brainstorm potential solutions
- Ad hoc meetings with TMF Health Quality Institute, the QIN-QIO for Texas, to discuss needs in various areas of the state while routine coalition meetings are on hold

Chart 30: Rate of Blood Transfusions in ESRD Patients Receiving Dialysis in Nursing Homes

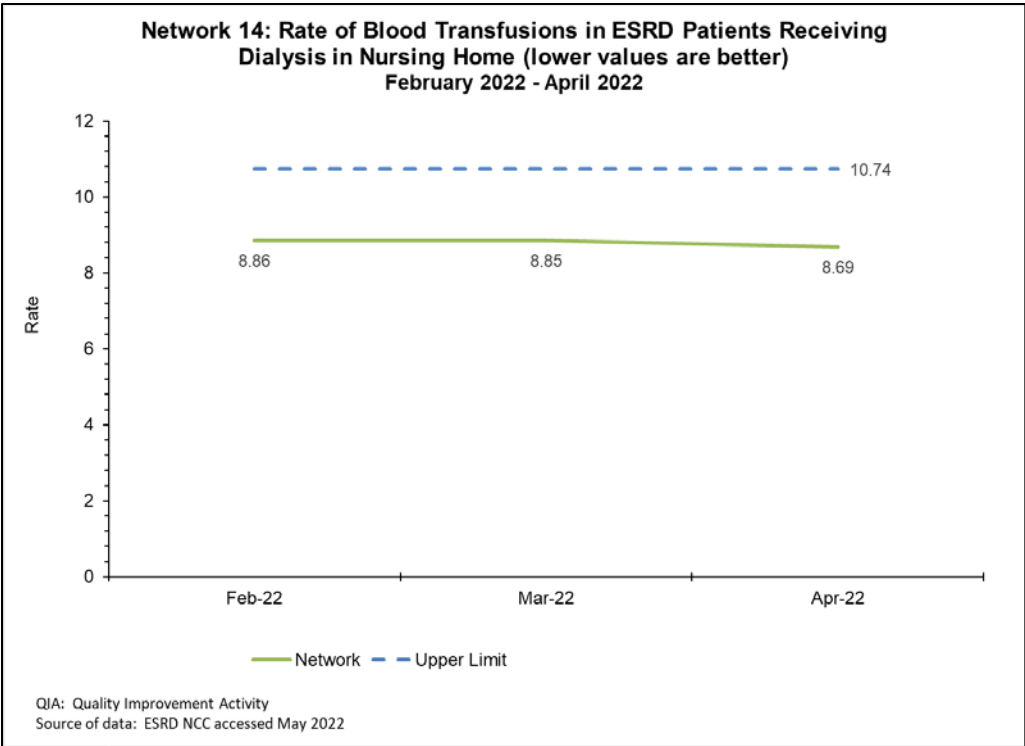


Chart 31: Hemodialysis Catheter Infections in Home Dialysis Patients within Nursing Homes

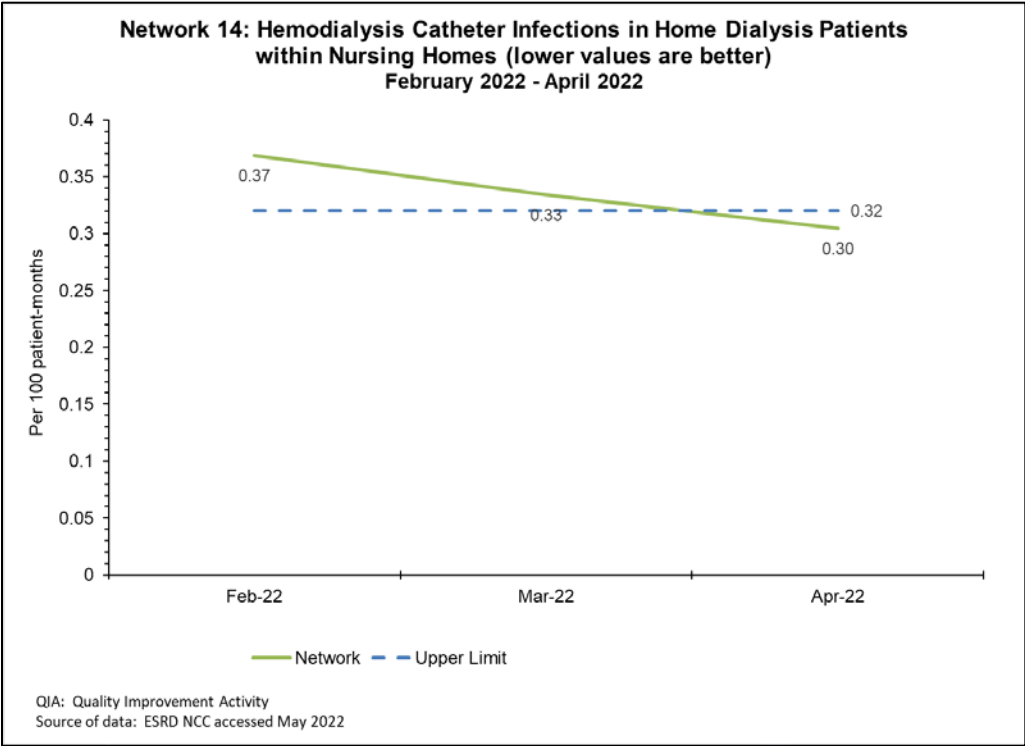
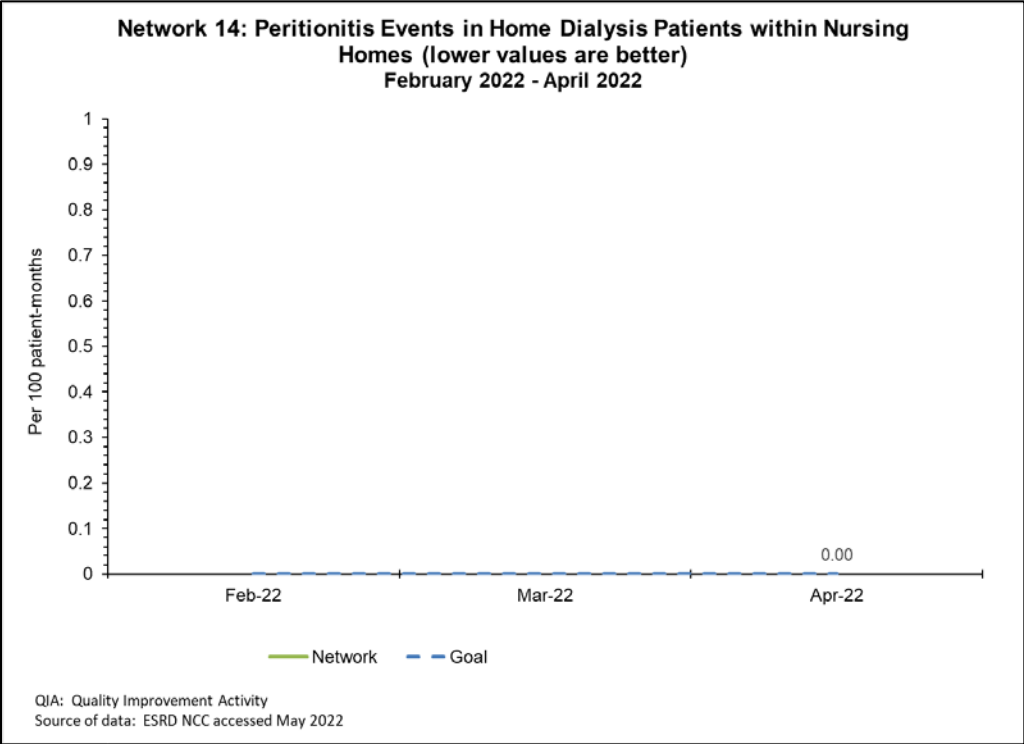


Chart 32: Peritonitis Events in Home Dialysis Patients within Nursing Homes



Telemedicine June 2021-April 2022

The Network was tasked with achieving a 2% increase in the number of rural patients using telemedicine as a home modality. The Network was able to add 352 patients to using telemedicine for a home modality.

The Network conducted an RCA to determine the greatest barriers and challenges for facilities using telemedicine. Results of the RCA showed that facilities are providing and encouraging the use of telemedicine; however, patients continue to have some barriers and lack of comfort with telemedicine. The patient barriers include:

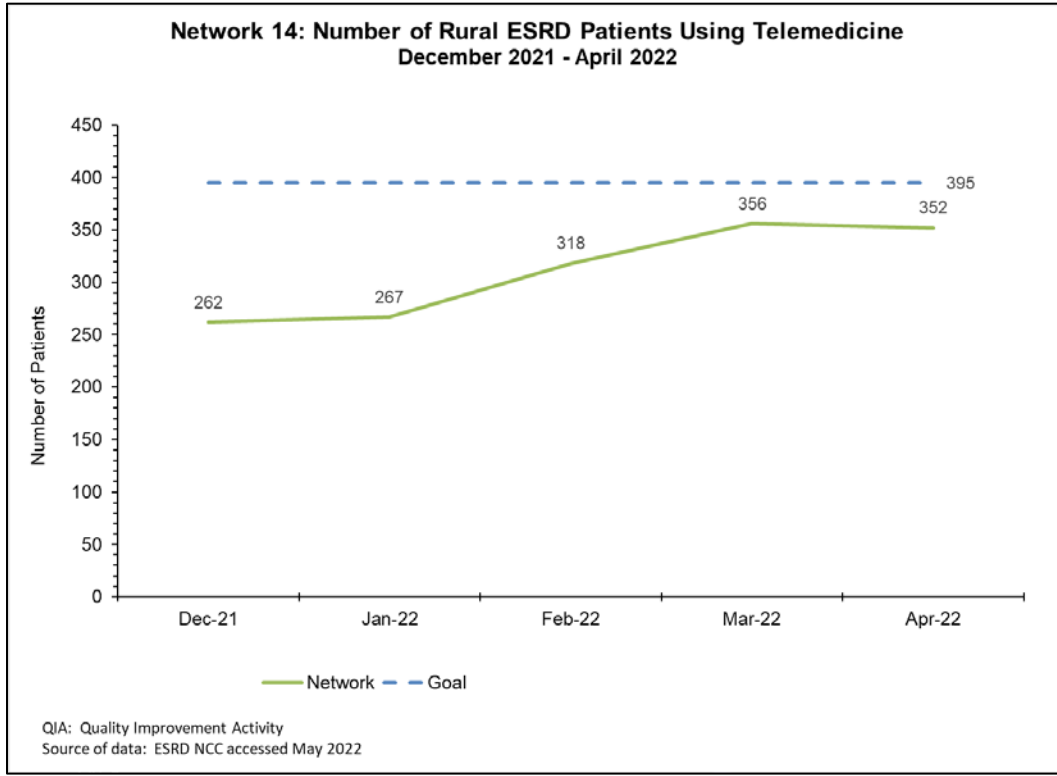
- Patients lack education on technology
- Patients lack the technology to use telemedicine
- Patients prefer to see a doctor face to face
- Older population's difficulties with technology

The Network provided one-on-one technical assistance, interventions, and resources to address these specific barriers. Some of the interventions and resources include:

- Data quality checks to ensure proper reporting of telemedicine in EQRS
- The Network14 Patient Portal Telehealth page, with recent videos, flyers and resourceful information regarding telehealth
- The Doctor will see you now: Telemedicine Makes It Easy
- Kidney Patient Care: Your Guide to Telemedicine
- Five Things to Know about Telehealth During the COVID-19 Pandemic video
- COVID-19: Using Telehealth to Visit Your Doctor video
- IPRO Network's Stay Healthy Stay Home Telehealth Toolkit

By providing more consistent education, and one-on-one training with telemedicine to each patient at the facility, staff can help patients become accustomed to using telemedicine. Dialysis patients, especially those in the older population, needed more one-on-one support and coaching on how to pull up the applications and use the devices. After this was provided, facilities found that patients had much more ease in using telemedicine as an option.

Chart 33: Number of Rural ESRD Patients Using Telemedicine



Vaccinations Pneumococcal 13 and 23 and Staff Influenza June 2021-April 2022

Networks were tasked to achieve the following pneumococcal conjugate (PCV13) and staff influenza vaccination rates by April 30, 2022:

- 10% increase in the number of patients receiving a PCV13 vaccination
- 90% of dialysis facility staff receive an influenza vaccination

Network facilities achieved the following PCV13 and staff influenza vaccination rates:

- A total of 24,134 patients received a PCV13 vaccination (8.85% increase)
- 47.4% of dialysis facility staff received an influenza vaccination

An RCA was conducted to determine facility-specific barriers related to low PCV13 and staff influenza vaccination rates. Common identified barriers included:

PCV13

- Vaccination hesitancy
- Lack of knowledge/understanding
- Vaccine fatigue
- Political beliefs
- Allergies
- Fear
- Refusal of all vaccines
- Outdated vaccination records
- Needle phobia
- Lack of vaccination tracking system
- Religious beliefs
- Inaccurate data in EQRS

Staff Influenza

- Vaccination hesitancy
- Fear
- Religious beliefs
- Allergies
- Political beliefs
- Required to always wear mask
- Inaccurate data in NHSN

The data were reviewed monthly by Network staff, and weekly technical assistance was provided. Interventions included:

- Development of a coalition of stakeholders to assist with the identification of barriers and potential interventions
- Facility-specific coaching calls to discuss rates, barriers and gaps in data.
- Development of focus group to provide EQRS and NHSN data entry instructions to non-batch submitting facilities
- Provision of monthly educational resources to combat barriers
- Monthly collaboration with regional management to assist facilities with timely data validation and entry
- Assistance with the development and implementation of new processes to avoid future reporting gaps

Chart 34: ESRD Patients Receiving Pneumococcal Conjugate Vaccination (PCV13)

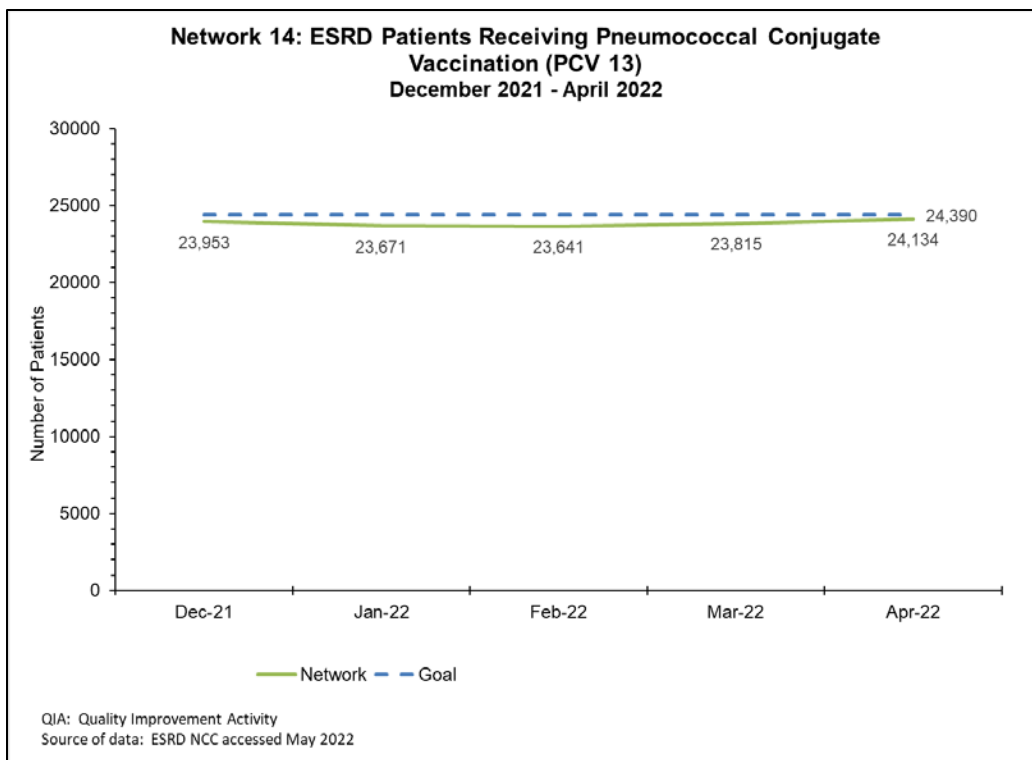
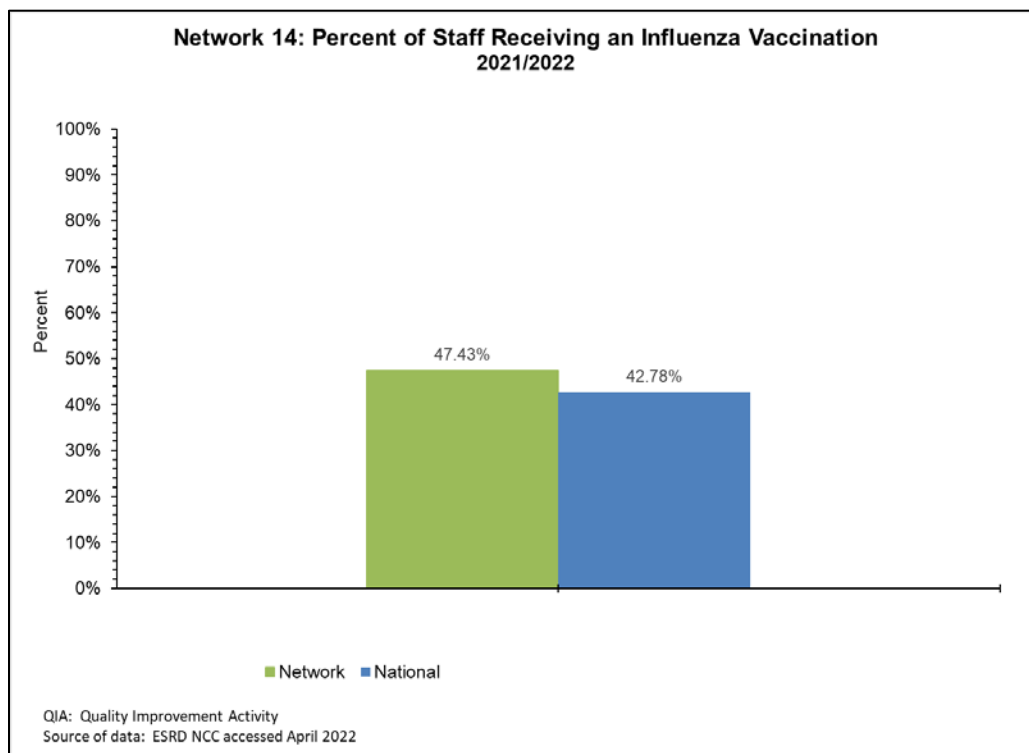


Chart 35: Percent of Staff Receiving in Influenza Vaccination



ESRD NETWORK RECOMMENDATIONS

Providers in Network 14 are monitored throughout the year for their participation in activities specified in the Network's CMS contract and their performance on several quality metrics. Network 14 monitors facilities that are struggling to meet quality measures and develops an action plan for improvement. Facilities are provided a timeline for completing activities. 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 2021, 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 2021, Network 14's service area experienced 13 new openings and 11 facility closures. Newly opened facilities consisted of 62% in urban areas and, of the 13 new openings, 69% were associated with an LDO. Of the 11 closures, 64% of the facilities were in an urban area, with 82% affiliated with a large dialysis organization. The facility closures resulted from dialysis organizations consolidating smaller patient census facilities for proportionate staffing.



ESRD NETWORK COVID-19 EMERGENCY PREPAREDNESS INTERVENTION

In 2021, Texas, like all states across the nation, continued to face the COVID-19 pandemic and its variants. Dialysis cohort facilities remained open to provide treatment for all patients COVID-19 positive and persons under investigation (PUI). Network 14 continued to work closely with the TMF Health Quality Institute and other state emergency management organizations to address the COVID-19 pandemic. The Texas ESRD Emergency Coalition (TEEC) hosted 14 meetings in 2021 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 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. One of the main barriers for facilities and patients was obtaining the vaccine.

The Network's Patient and Advisory Committee created two podcasts to assist patients who were hesitant to receive the COVID-19 vaccination. The podcasts featured in-center patients and transplant patients, who provided their experiences with the vaccine and fears. The podcasts were distributed using the Alliant Health Solutions Network social media platforms and email blasts to the renal community. The Network shared other resources created by patients on their experiences with the COVID-19 vaccination to help patients to make the best decision for them, along with the assistance of their healthcare team.

Network 14 submitted weekly emergency situational status reports (ESSRs) to the Kidney Community Emergency Response (KCER) and CMS to address 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 and discussed by Network 14, TEEC, the Network's MRB, and other State Representatives to determine which 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 throughout the year.

Network staff focused on assisting facility staff in pinpointing the source of their patients' COVID-19 infection and ensuring that facilities were implementing the proper policies and procedures to mitigate any COVID-19 infection spread within the facility. The main cause of spread among dialysis patients was patients living in multi-generational housing. Therefore, the Network provided guidance regarding multi-generational housing in English and Spanish.

The Network patient services department has continually provided resources to help facilities address patients' impatience and fear, as well as address the mental health strain patients and staff have faced due to the pandemic.

By December 2021, dialysis and transplant facilities were experiencing staffing and supply shortages. Dialysis organizations were closing shifts and facilities due to the lack of staff. Dialysis facilities made policy changes to patients' treatments due to dialysate supply shortages. One large dialysis organization opened hub centers throughout Texas and brought supplies to the hub centers for area dialysis facilities to pick up due to truck driver shortages.

ESRD NETWORK SIGNIFICANT EMERGENCY PREPAREDNESS INTERVENTION



In 2021, Texas battled the COVID-19 pandemic and three major storms (Winter Storm Uri, Tropical Cyclone Three, Hurricane Ida and Hurricane Nicholas) within the ESRD Network geographic area. Texas prepared for the potential impact of disastrous weather conditions and tropical depressions. One became a tropical storm, and two became hurricanes between the Louisiana and Texas coastal regions. There were additional reports of other isolated facility incidents, including fire, water issues, hail damage, and power outages, which resulted in the submission of the required ESSRs to KCER and CMS.

From February 12 through February 22, the Network staff fielded over 60 calls from patients, caregivers, hospitals and other agencies for assistance in finding dialysis treatment due to Winter Storm Uri. Storm Uri caused snow, ice, rolling blackout outages and over five days of sub-freezing temperatures throughout the state. The Network hosted daily TEEC meetings to discuss facility and patient needs and continued to promote the [Texas ESRD Emergency Portal](#). The portal is updated with current information and resources related to impending storms and emergencies. The Network provided information to facilities and patients to help with transportation issues, information concerning financial assistance through various organizations, and information concerning regulation waivers and supply assistance.

From August 25 through September 9, Network 14 participated in KCER calls concerning Hurricane Ida and assisted Network 13 with six patient placements.

During local and nationwide emergencies, TEEC conducted emergency conference calls to ensure the safety of all dialysis patients and assisted facilities' immediate needs for patients and staff. Network 14 and KCER 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 in ensuring 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.

In 2021, Network 14 staff continued to provide training opportunities to the dialysis and transplant facilities through one-on-one sessions or by attending and presenting during dialysis organization's emergency disaster drills/training sessions.

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.

FORUM OF ESRD NETWORKS
KIDNEY PATIENT ADVISORY COUNCIL (KPAC)
FREQUENTLY USED ACRONYMS



2728 ESRD Medical Evidence Report
 2744 Annual Facility Survey Form
 2746 Death Notification Form

A

AAKP American Association of Kidney Patients
 AAMI Association for the Advancement of Medical Instrumentation
 ACO Accountable Care Organizations
 AHCPR Agency of Health Care Policy and Research
 AHRQ Agency for Healthcare Research and Quality
 AHQA American Health Quality Association (QIOs)
 AJKD American Journal of Kidney Disease
 AKF American Kidney Fund
 AKI Acute Kidney Injury / Acute Renal Failure
 AMA American Medical Association
 ANNA American Nephrology Nurses' Association
 ARF Acute Renal Failure
 ASN American Society of Nephrology
 AV Arteriovenous
 AVF Arteriovenous Fistulae
 AVG Arteriovenous Graft

B

BAC Beneficiary Advisory Council (Forum)
 BFR Blood Flow Rate
 BIC Beneficiary Identification Code
 BIPA Benefits Improvement and Protection Act
 BUN Blood Urea Nitrogen
 BOD Board of Directors
 BSA Body Surface Area
 BSN Bachelor of Science in Nursing
 BSW Bachelor of Social Work
 BUN Blood Urea Nitrogen
 BV Blood Volume

C

CAD Cadaveric Donor
 CAHPS Consumer Assessment of Healthcare Providers and Systems
 CAN Chronic Allograft Nephrology
 CAPD Continuous Ambulatory Peritoneal Dialysis
 CCHT Certified Clinical Hemodialysis Technician
 CCI Creatinine Clearance
 CCPD Continuous Cycling Peritoneal Dialysis

CCSQ	Centers for Clinical Standards & Quality (CMS)
CCT	Controlled Clinical Trial
CDC	Centers for Disease Control and Prevention
CDE	Certified Diabetes Educator
CDN	Certified Dialysis Nurse
CDS	Core Data Set
CEU	Continuing Education Unit
CfC	Conditions for Coverage
CHT	Certified Hemodialysis Technician
CKD	Chronic Kidney Disease
CME	Continuing Medical Education
CMHCB	Care Management for High Cost Beneficiaries
CMMI	Center for Medicare and Medicaid Innovation (CMS)
CMO	Chief Medical Officer
CMS	Centers for Medicare & Medicaid Services
CMSDC	CMS Data Center
CMSW	Certified Master of Social Work
CNN	Certified Nephrology Nurse
CNSW	Council of Nephrology Social Workers
CO	Central Office (CMS)
COB	Coordination of Benefits
COI	Conflict of Interest
COPs	Conditions of Participation
CPHQ	Certified Professional in Healthcare Quality
CPM	Clinical Performance Measures
CQI	Continuous Quality Improvement
CQISCO	Consortium for Quality Improvement & S & C Operations (CMS, Regional Offices)
CRI	Chronic Renal Insufficiency
CROWN	Consolidated Renal Operations in a Web-enabled Network
CRRT	Continuous Renal Replacement Therapy
CSC	Computer Sciences Corporation
CV	Curriculum Vitae

D

DEPCH	Division of ESRD, Population and Community Health (CMS)
DFC	Dialysis Facility Compare
DHHS	Department of Health and Human Services
DHIT	Division of Health Information Technology (CMS)
DHR	Department of Human Resources
DM	Data Manager
DOPPS	Dialysis Outcomes Practice Patterns Study
DON	Director of Nursing
DOQI	Dialysis Outcomes Quality Initiative
DPC	Decreasing Dialysis Patient/Provider Conflict
DPMCE	Division of Program, Management, Communication and Evaluation (CMS)
DQIIMT	Division of Quality Improvement Innovations Model Testing (CMS)
DQM	Division of Quality Measurement (CMS)

DRG	Diagnosis Related Group
DTCP	Division of Transforming Clinical Practices (CMS)
DVA	Department of Veteran's Affairs
DVIQR	Division of Value, Incentives & Quality Reporting (CMS)
DW	Dry Weight

E

EC	Executive Committee of the Network
ED	Executive Director
EDAC	Executive Director Advisory Council (Forum)
EDEES	ESRD Data Entry and Editing System
eGFR	Estimated Glomerular Filtration
EGHP	Employer Group Health Plan
EHR	Electronic Health Record
ELAB	Electronic collection of lab data
eKt/V	Equilibrated Kt/V (See Kt/V)
EOB	Explanation of Benefits
EPO	Epogen or Erythropoietin
ESCO	ESRD Seamless Care Organizations
ESRD	End Stage Renal Disease
eSOURCE	ESRD Software for our Users in Renal Care Environments

F

FDA	Food & Drug Administration
FF	Fistula First
FFBI	Fistula First Breakthrough Initiative
FFS	Fee For Service
FI	Fiscal Intermediary
FMQAI	Florida Medical Quality Assurance, Inc (QIO)
FNP	Family Nurse Practitioner
FORUM	Forum of ESRD Networks
FPR	Final Project Report
FY	Fiscal Year

G

GAO	General Accounting Office
GFR	Glomerular Filtration Rate
GTL	Government Task Leader (CMS)

H

HAI	Healthcare-Associated Infections
HbsAb	Hepatitis B surface antibody
HbsAg	Hepatitis B surface antigen
HBV	Hepatitis B Virus
HCFA	Health Care Financing Administration (Now CMS)
HCQIP	Health Care Quality Improvement Program
HCT	Hematocrit
HD	Hemodialysis
HENs	Hospital Engagement Networks

HGB	Hemoglobin
HHA	Home Health Agency
HHD	Home Hemodialysis
HHS	Department of Health and Human Services
HIC	Health Insurance Claim
HIE	Health Information Exchange
HIPAA	Health Information Portability and Accountability Act
HIT	Health Information Technology
HMO	Health Maintenance Organization
Hx	History

I

ICD-9-CM	International Classification of Disease, 9 th Revision, Clinical Modification
ICH CAHPS	In-Center Hemodialysis CAHPS
IHI	Institute for Healthcare Improvement
IM	Information Management
IOM	Institute of Medicine
IPD	Intermittent Peritoneal Dialysis
IPRO	Island Peer Review Organization (QIO)
IPP	Innovation Pilot Project
ISHD	International Society of Hemodialysis
IT	Information Technology
IV	Intravenous
IVD	Involuntary Discharge
IVT	Involuntary Transfer

J

JAMA	Journal of the American Medical Association
JASN	Journal of the American Society of Nephrology
JCAHO	Joint Commission on Accreditation of Healthcare Organizations

K

Kt/V	A method to measure adequacy of dialysis. K = the dialyzer clearance, t = time on dialysis, and V = volume of water in the patient's body.
KCER	Kidney Community Emergency Response
KCP	Kidney Care Partners
KCQA	Kidney Care Quality Alliance (part of KCP)
KDIGO	Kidney Disease: Inspiring Global Outcomes
KDOQI	Kidney Disease Outcomes Quality Initiative
KEEP	Kidney Early Evaluation Program
KPAC	Kidney Patient Advisory Council (KPAC)

L

LAN	Learning & Action Network
LCSW	Licensed Clinical Social Worker
LDO	Large Dialysis Organization
LISW	Licensed Independent Social Worker
LMSW	Licensed Master of Social Work
LORAC	Life Options Rehabilitation Advisory Council

LPN	Licensed Practical Nurse
LRD	Living Related Donor
LRD	Licensed Registered Dietician
LTFU	Lost to Follow-Up
LURD	Living Unrelated Donor

M

M+C	Medicare + Choice
MAC	Medical Advisory Council (Forum)
MCO	Managed Care Organization
MD	Medical Doctor'
MDH	Medicare Dependent Hospital
MDO	Medium Dialysis Unit
MedPAC	Medicare Payment Advisory Commission
MEI	Medical Education Institute
MPH	Master of Public Health
MRB	Medical Review Board
MSN	Master of Science in Nursing
MSW	Master of Social Work
MU	Meaningful Use

N

NANT	National Association of Nephrology Technicians/Technologists
NC	Network Council
NCC	Network Coordinating Council
NCQA	National Committee for Quality Assurance
NEJM	New England Journal of Medicine
NEPOP	New ESRD Patient Orientation Packet
NHHD	Nocturnal Home Hemodialysis
NHSN	National Healthcare Safety Network
NIDDK	National Institute for Diabetes and Digestive and Kidney Diseases
NIH	National Institutes of Health
NIP	National Improvement Plan
NIPD	Nocturnal Intermittent Peritoneal Dialysis
NKDEP	National Kidney Disease Education Program
NKF	National Kidney Foundation
NKR	National Kidney Registry
NN&I	Nephrology News & Issues
NPP	Narrative Project Plan
NPSF	National Patient Safety Foundation
nPCR	Normalized Protein Catabolic Rate
NQF	National Quality Forum
NQS	National Quality Strategies (CMS)
NRAA	National Renal Administrators Association
NVAII	National Vascular Access Improvement Initiative

O

OAGM	Office of Acquisition & Grants Management (CMS)
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OCSQ	Office of Clinical Standards and Quality
ODIE	Online Data Input and Edit
OGC	Office of General Council (CMS)
OHRP	Office of Human Research Protection
OIC	Opportunity to Improve Care
OIG	Office of Inspector General (CMS)
ONC	Office of the National Coordinator for Health Information Technology
OPO	Organ Procurement Organization
OPTN	Organ Procurement and Transplant Network
ORD	Office of Research and Demonstrations
ORS	Office of Regulatory Services
OSCAR	Online Survey Certification Reporting
OSHA	Occupational Safety and Health Administration
OY	Option Year

P

PA	Physician's Assistant
PAR	Patient Activity Report
PCP	Primary Care Physician
PCT	Patient Care Technician
PCU	Patient Contact Utility
PD	Peritoneal Dialysis
PFCC	Patient & Family Centered Care
PfP	Pay for Performance
PfP	Private for Profit
PFP	Priority Focus Process
PhD	Philosophy Doctorate
PHIPP	Population Health Innovation Pilot Project
PID	Project Idea Document
PIP	Performance Improvement Plan
PKCI	Peer Kidney Care Initiative
PKD	Polycystic Kidney Disease
PMMIS	Program Management and Medical Information System
PO	Project Officer (CMS)
PPS	Prospective Payment System
PRO	Peer Review Organization (Now called QIO)
PSC	Patient Services Coordinator
PSD	Patient Services Director

Q

QA	Quality Assurance
QAPI	Quality Assurance and Performance Improvement
QCPC	Quality Conference Planning Committee (Forum)
QI	Quality Improvement
QID	Quality Improvement Director
QIG	Quality Improvement Group (CMS)
QIIG	Quality Improvement and Innovation Group (CMS)

QIO	Quality Improvement Organization (Formerly PRO)
QIP	Quality Improvement Project
QIS	Quality Improvement Specialist
QMHAG	Quality Measurement & Health Assessment Group (CMS)
QMVIG	Quality Measurement & Value-Based Incentive Group (CMS)
QNET	Quality Net (Exchange vs. Conference)

R

RD	Registered Dietician
REBUS	Renal Beneficiary Utilization System
REMIS	Renal Management Information System
RHIT	Registered Health Information Technician
RN	Registered Nurse
RO	Regional Office (CMS)
ROPO	Regional Office Project Officer
RPA	Renal Physicians' Association
RSN	Renal Support Network

S

SA	State Agency/ State Survey Agency
SC	Subcutaneous
SIMS	Standard Information Management System
SKF	Skilled Nursing Facility
SLE	Systemic Lupus Erythematosus
SME	Subject Matter Expert
SOD	Statement of Deliverables
SOW	Statement of Work
SSA	Social Security Administration
SSN	Social Security Number

T

TCPI	Transforming Clinical Practice Initiative (CMS)
TCV	Total Cell Volume
TEP	Technical Expert Panel
TQE	Total Quality Environment
Tsat	Transferring Saturation
TX	Transplant

U

UKM	Urea Kinetic Modeling
UNOS	United Network of Organ Sharing
UPI	Unique Patient Identifier
UPIN	Unique Physician Identification Number
URR	Urea Reduction Ratio
USRDS	United States Renal Data System
USAT	Unit Self-Assessment Tool

V

VA	Veteran's Administration or Veteran's Affairs
VHA	Veteran's Health Administration

VISION Vital Information System to Improve Outcomes in Nephrology
VR Vocational Rehabilitation

W X Y Z

WHO World Health Organization

ADDITIONAL ACRONYM AND GLOSSARY RESOURCES

NKF Glossary of Terms

<https://www.kidney.org/atoz/content/simple-kidney-vocabulary-list>

FMC Glossary

<https://www.freseniuskidneycare.com/glossary>

National Center for Biotechnology Information Acronyms and Abbreviations

<https://www.ncbi.nlm.nih.gov/books/NBK84563/>

Renal Support Network

<http://www.rsnhope.org/programs/kidneytimes-library/article-index/renal-acronyms/>

Kidney Care Partners

<https://kidneycarepartners.com/glossary-of-terms/>