ALLIANT
ESRD NETWORK 8

2023
ANNUAL REPORT

This report will cover quality improvement efforts led by ESRD Network 8
Task Order Number 75FCMC21F0003 from May 1, 2023- April 30, 2024.

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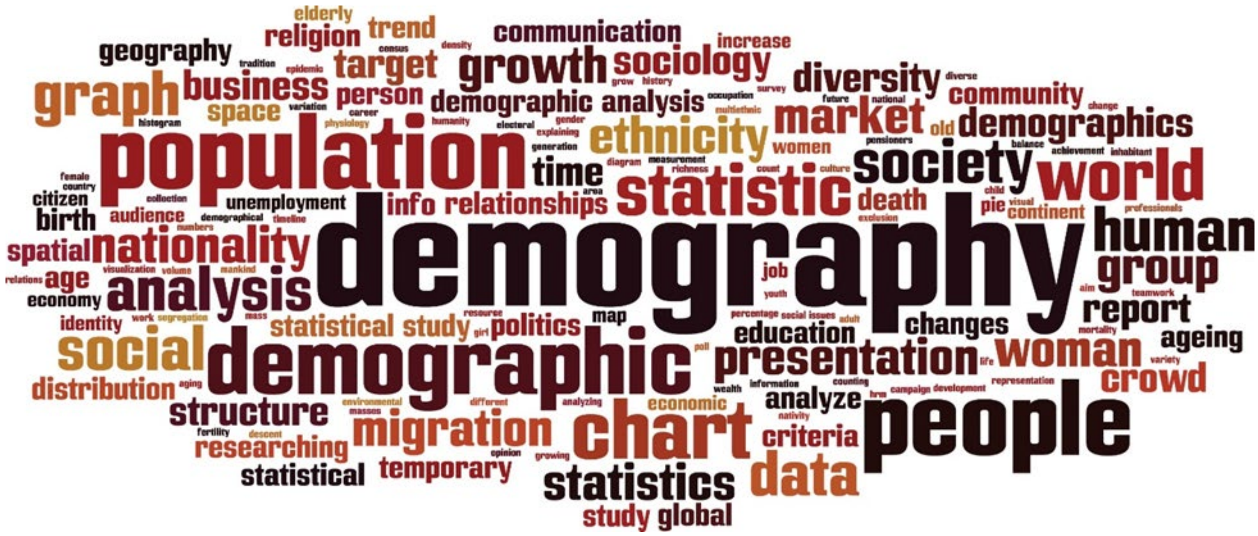
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ESRD Demographic Data

The End-Stage Renal Disease (ESRD) Network 8 contract is held by Alliant Health Solutions (AHS), as is the ESRD Network 14 contract. AHS is a Network of Quality Improvement and Innovation Contractor (NQIIC) under contract with the Center for Medicare & Medicaid Services (CMS) for quality improvement services. AHS provides federal and state government entities with the services, expertise, and information systems necessary to increase the effectiveness, accessibility, and value of health care. AHS is also the division that manages Quality Innovation Network-Quality Improvement Organization (QIN-QIO) and Hospital Quality Improvement Contractor (HQIC) work. As a leading provider of innovative health solutions, AHS' services include utilization management, program integrity, and quality improvement while being clinically led, technology-driven, and customer-focused. 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.

ESRD Network 8 serves dialysis and transplant patients and providers in Alabama, Mississippi, and Tennessee, with the administrative office in Ridgeland, Mississippi. Administrative guidance is received from the Alliant Board of Directors, program oversight from the Medical Review Board (MRB), and project development advice and consultation from a diverse group of patient subject matter experts (SMEs) who form the Patient Advisory Council (PAC) and ESRD professionals who serve on the Network Council.

Geography and General Population

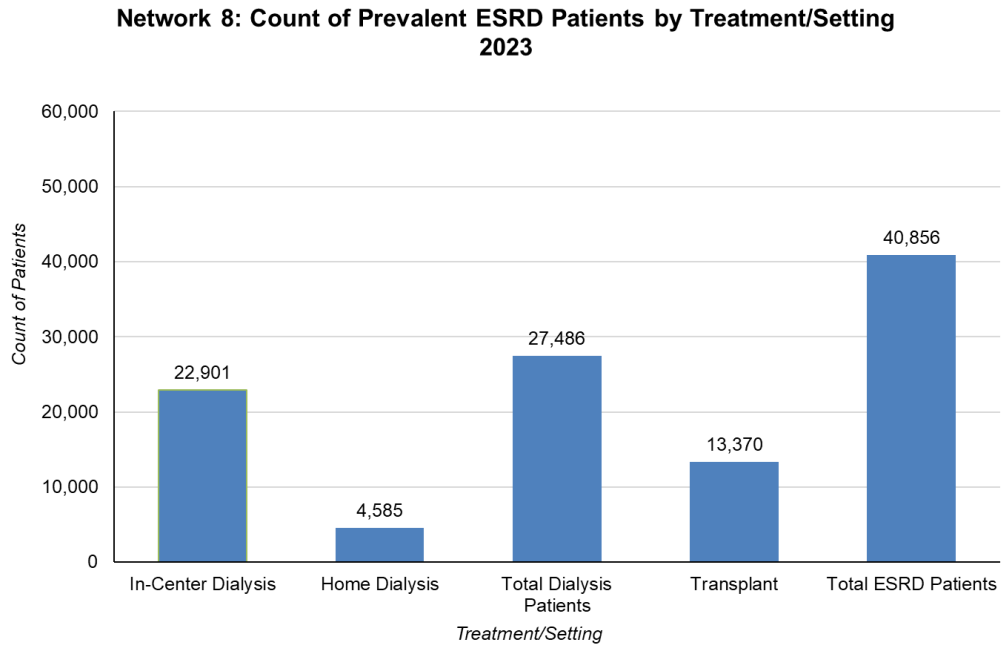
The Network service area has a general population of approximately 15.1 million. Alabama and Mississippi share geographic, climate, population, and cultural similarities, while their neighbor to the north, Tennessee, has more topographic and demographic diversity and shares boundaries with eight states. Mississippi is the most rural of the three states, followed by Alabama and Tennessee.

ESRD Population

In 2023, 4 new Medicare-certified dialysis facilities opened in the Network service area, and 9 Medicare-certified dialysis facilities closed, bringing the total number of facilities to 482 (Chart 3). Approximately 93% of the dialysis facilities in Network 8 are managed by large dialysis organizations (LDO), while small dialysis organizations or independent organizations manage the remaining 7%.

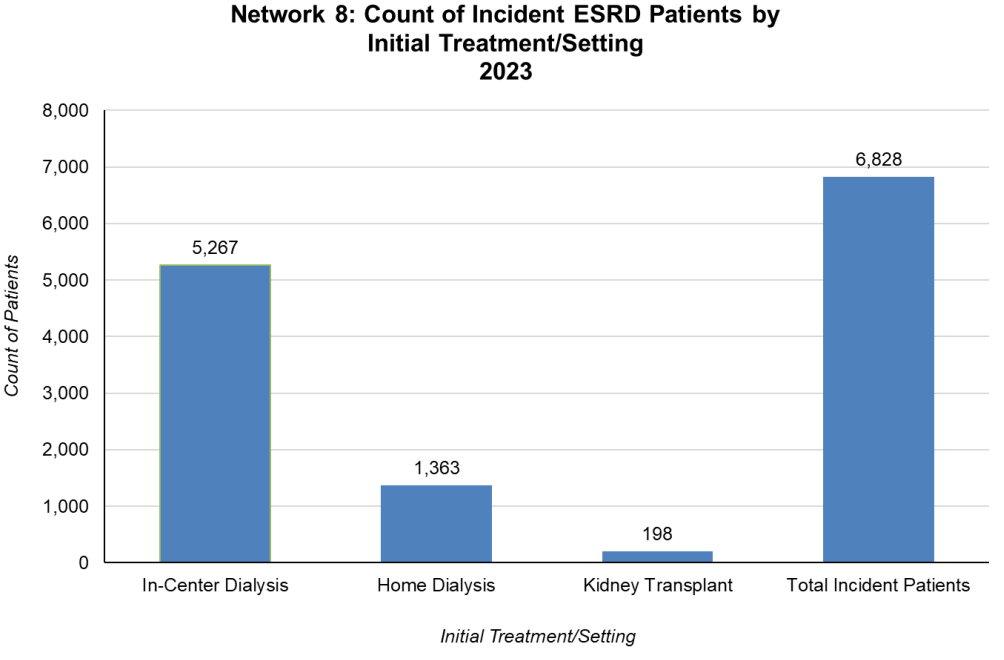
As of December 31, 2023, data shows that Network 8 served 22,901 in-center patients and 4,585 home patients who received renal replacement therapy from one of the 482 dialysis units (Chart 1). An additional 13,370 kidney transplant patients received care at one of 10 transplant units, bringing the total Network 8 ESRD population to 40,856. By modality type, 56% of ESRD patients received in-center dialysis, 11.2% dialyzed at home, and 32.7% had a kidney transplant. As of December 31, 2023, 34% of Network 8 patients received dialysis services in Alabama, 27% in Mississippi, and 39% in Tennessee.

Chart 1: Count of Prevalent ESRD Patients by Treatment/Setting 2023



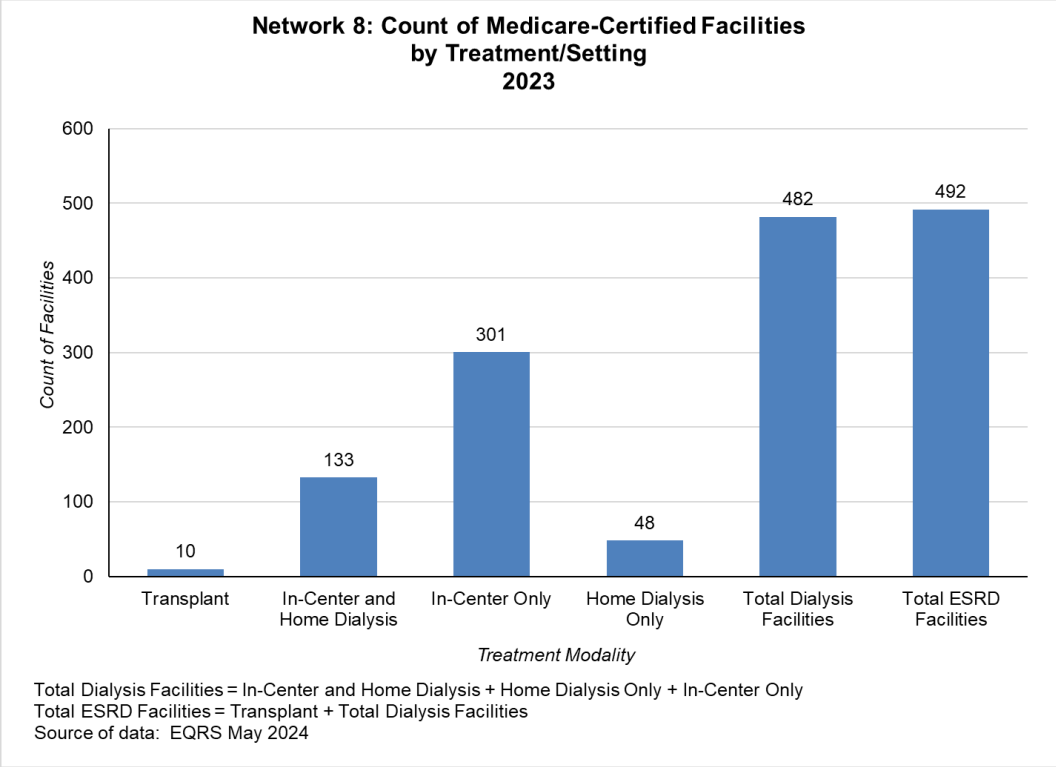
Total Dialysis Patients = In-Center Dialysis + Home Dialysis
Total ESRD Patients = Transplant + Total Dialysis
SNF dialysis patients are not shown due to small numbers
Source of data: EQRS May 2024

Chart 2: Count of Incident ESRD Patients by Treatment/Setting 2023



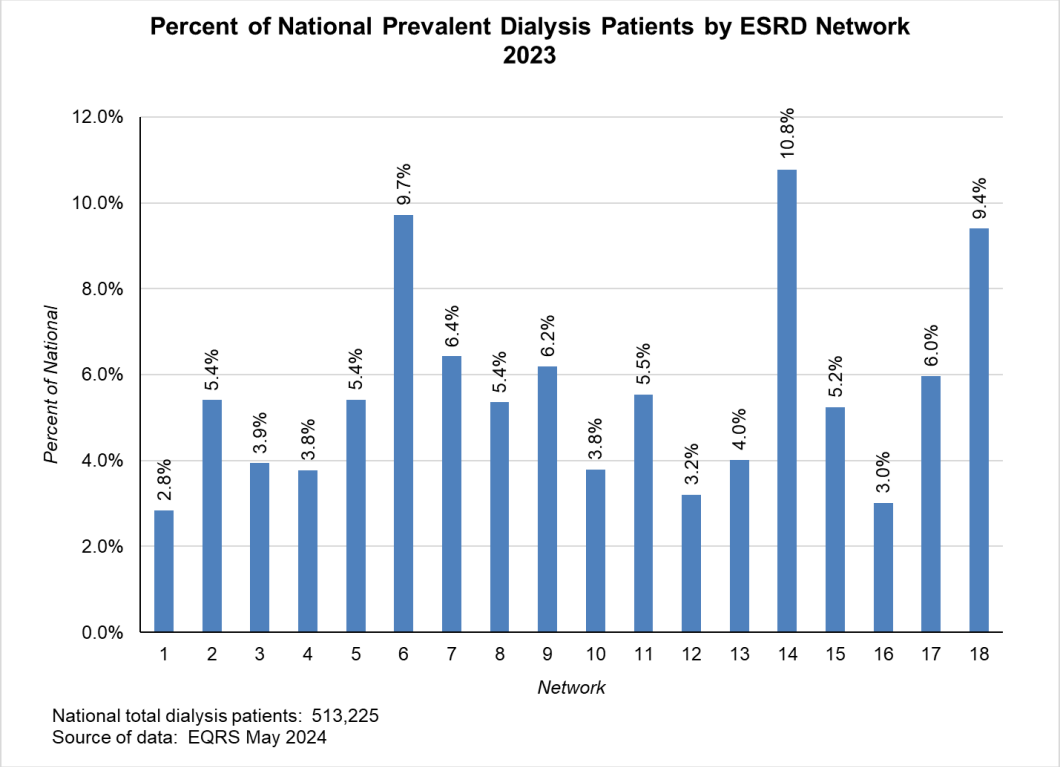
Total Incident Patients = In-Center + Home + Kidney Transplant
Source of data: EQRS May 2024

Chart 3: Count of Medicare-Certified Facilities by Treatment/Setting 2023



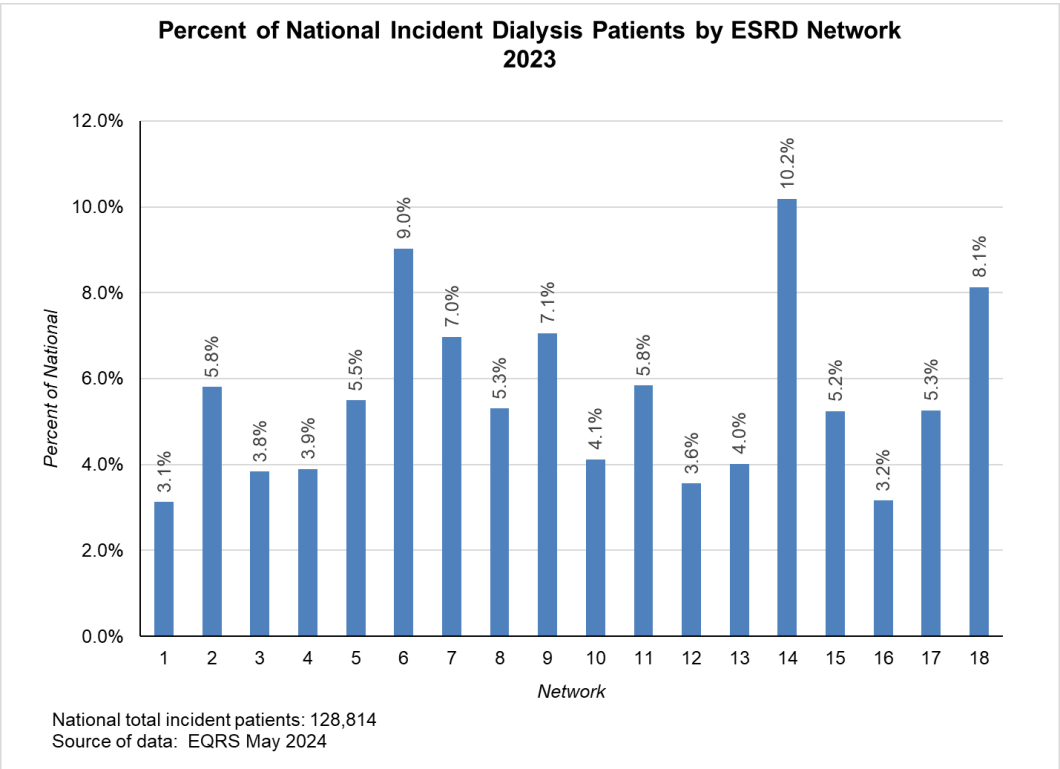
Total Dialysis Facilities = In-Center and Home Dialysis + Home Dialysis Only + In-Center Only
Total ESRD Facilities = Transplant + Total Dialysis Facilities
Source of data: EQRS May 2024

Chart 4: Percent of National Prevalent Dialysis Patients by ESRD Network 2023



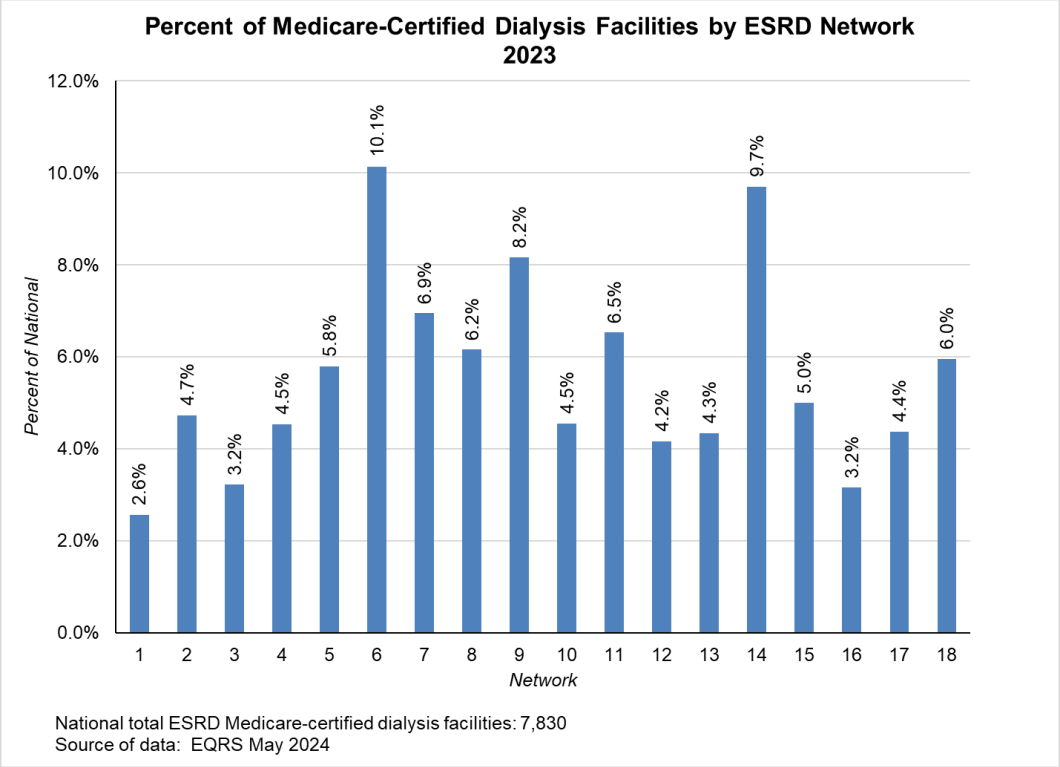
National total dialysis patients: 513,225
Source of data: EQRS May 2024

Chart 5: Percent of National Incident Dialysis Patients by ESRD Network 2023



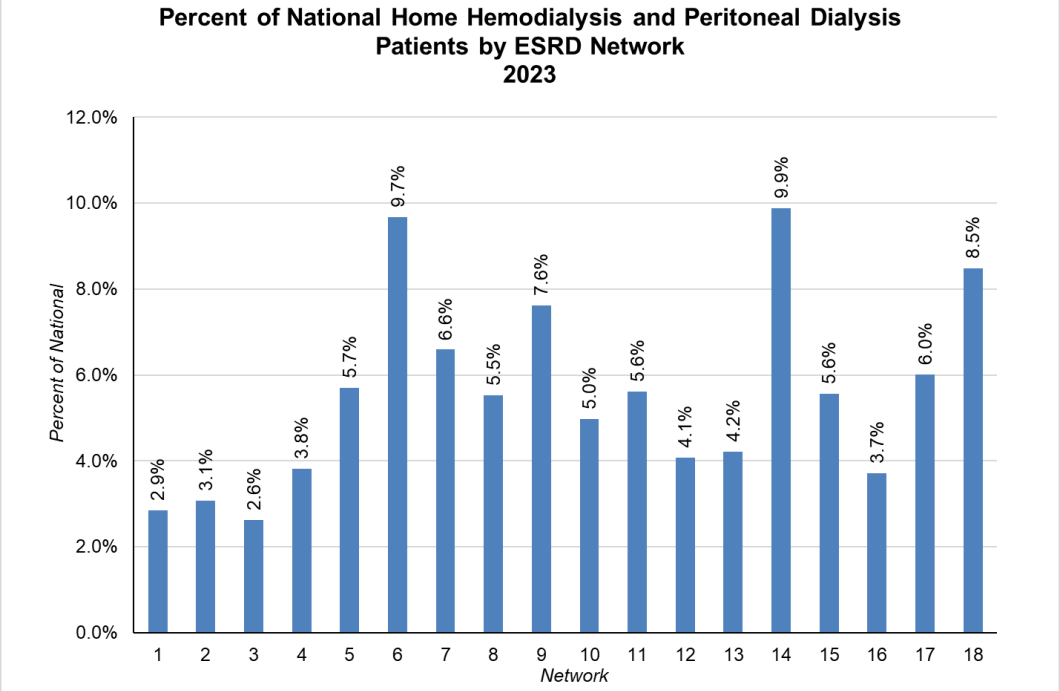
National total incident patients: 128,814
Source of data: EQRS May 2024

Chart 6: Percent of Medicare-Certified Dialysis Facilities by ESRD Network 2023



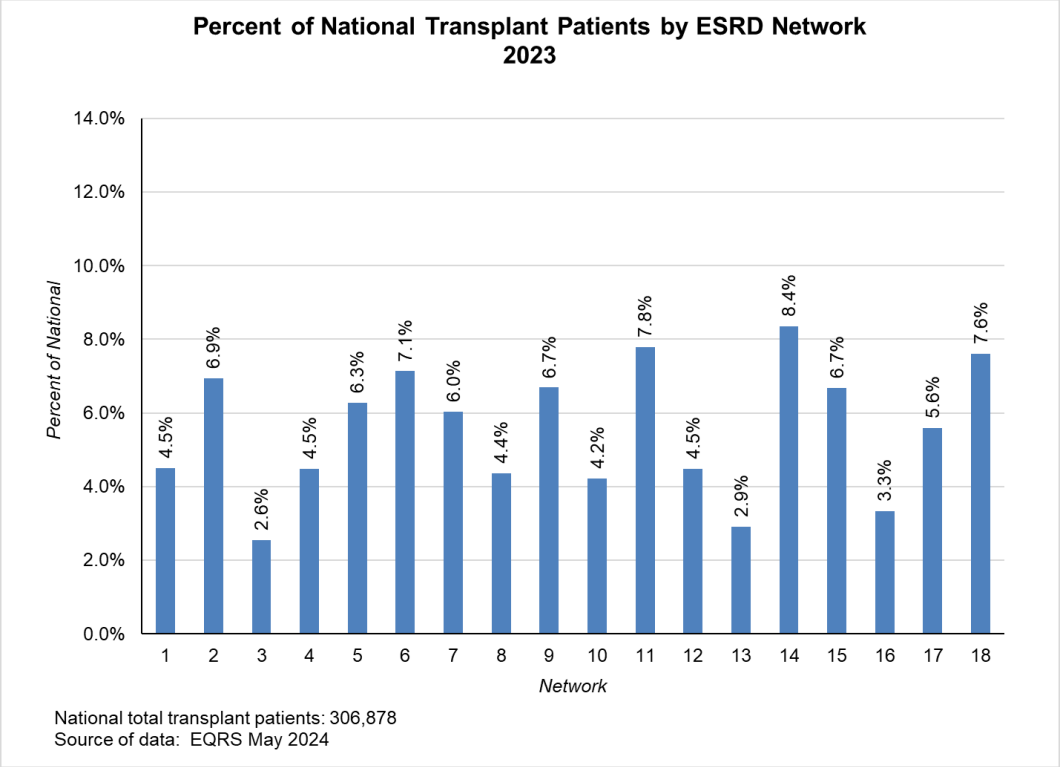
National total ESRD Medicare-certified dialysis facilities: 7,830
Source of data: EQRS May 2024

Chart 7: Percent of National Home Hemodialysis and Peritoneal Dialysis Patients by ESRD Network 2023



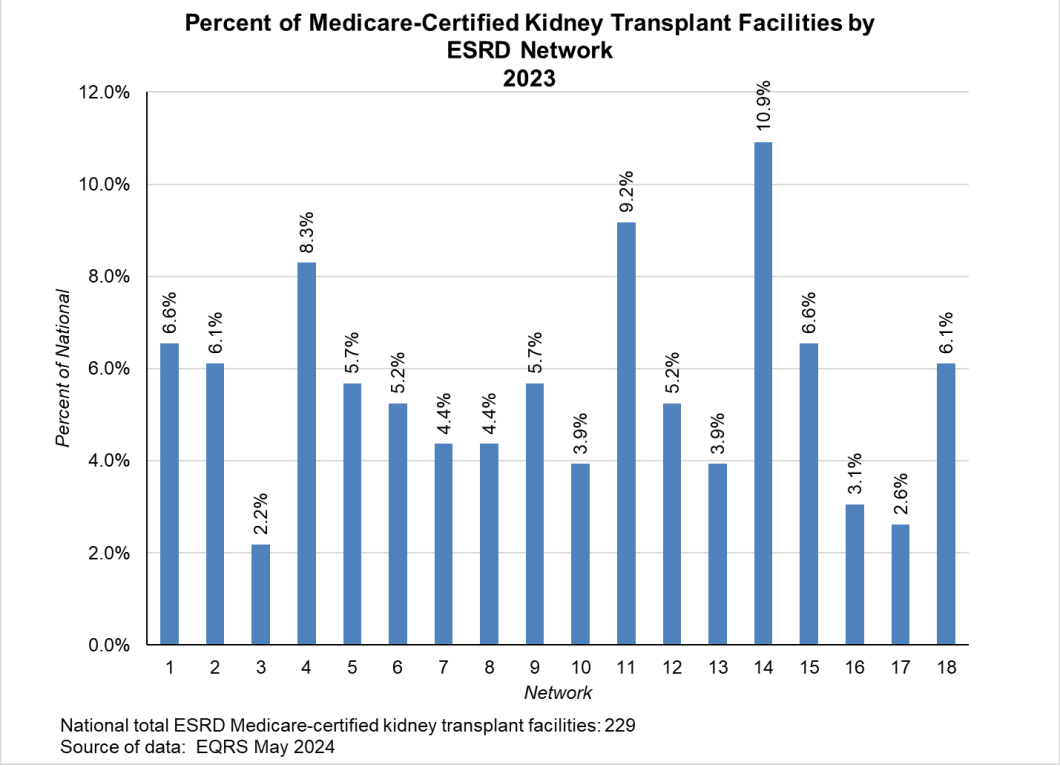
National total home hemodialysis and peritoneal dialysis patients: 82,964
Source of data: EQRS May 2024

Chart 8: Percent of National Transplant Patients by ESRD Network 2023



National total transplant patients: 306,878
Source of data: EQRS May 2024

Chart 9: Percent of Medicare-Certified Kidney Transplant Facilities by ESRD Network 2023



National total ESRD Medicare-certified kidney transplant facilities: 229
Source of data: EQRS May 2024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settle
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mutual
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give up
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discuss
dispute
risk
cooperation
arrangement
success

Transplant Waitlist & Transplanted Quality Improvement Activity May 2023-April 2024

The Network worked to empower patient choice of transplant by implementing interventions and coaching facility staff on process improvements to increase the number of patients added to the transplant waitlist and receiving a kidney transplant. The Network was charged with achieving a 9% increase in the number of patients added to the kidney transplant waitlist and a 12% increase in the number of prevalent patients receiving a kidney transplant.

The Network-led transplant community coalition, consisting of Subject Matter Experts (SMEs) from transplant centers, Organ Procurement Organizations (OPOs), and dialysis facilities, identified common barriers and brainstormed possible solutions which were then utilized during one-on-one technical assistance with facilities to improve waitlisting and transplantation rates. Monthly technical assistance included an initial root cause analysis, sharing of promising practices and provision of resources as indicated with follow-up three months after initial coaching session. Coaching calls focused on various aspects of the transplant process, transplant education, transplant waitlisting management, and promoted specific primary drivers from the ESRD National Coordinating Center (NCC) Transplant Change Package.

Commonly identified barriers:

- Patient lack of follow-up, such as missing appointments without rescheduling or being unresponsive to transplant center phone calls.
- Lack of communication between transplant centers, dialysis facilities, and patients
- Patient lack of understanding of the transplant process
- Lack of motivation or interest
- Lack of reliable personal transportation for transplant appointments
- Existing co-morbid conditions for which transplant is contraindicated
- Lack of financial resources needed for travel, medication, and insurance costs

Interventions and processes improvements:

- Establishing a Transplant Improvement Team to include a transplant champion for a team-based approach.
- Identifying a small group of eligible patients to concentrate on moving toward the waitlist or transplantation.
- Promoting consistent and continuous chairside education with the implementation of the teach-back method by members of the facility improvement team. Additional educational resources were easily accessible to facilities via the Transplant Improvement Dashboard.
- Promoting continuous monthly follow-up by the facility's improvement team for patient's transplant progress or status.
- Utilization and promotion of the Kidney Transplant Checklist.
- Utilization and promotion of the Transplant Road Map
- Identifying and utilization of transplant trailblazers to share their transplant experience and journey with their peers.

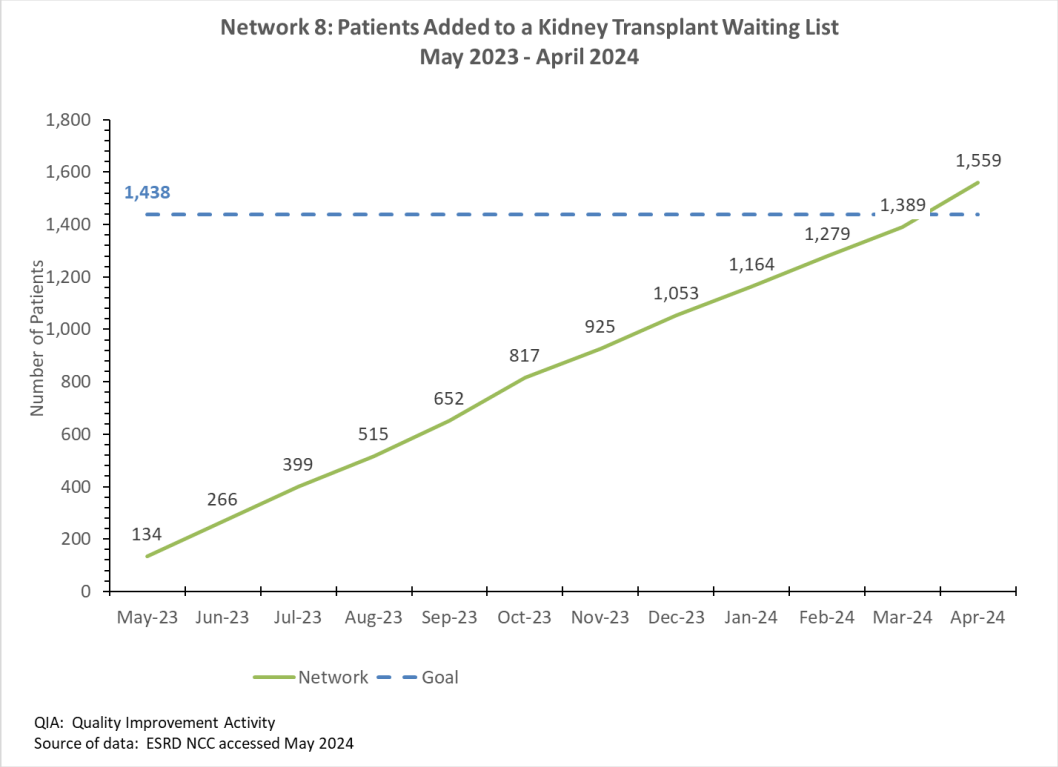
- Promotion of transplant lobby days within dialysis facilities.
- Utilization of transplant bulletin boards in dialysis facilities to promote transplantation and patient engagement.
- Utilization of the Transplant Change Package

Promising practices:

- The "Kidney Transplant Checklist", developed by Network 14 and utilized within Network 8 region, was recognized by the National Forum of ESRD Networks as a Highly Effective Practice.
- The "Kidney Transplant Road Map", developed collaboratively with Networks 14 and 16, streamlined the process for patients who do not understand the transplant process, helping visual learners see their progress on paper.
- The Network functioned as a liaison to bridge the gap of communication between dialysis centers and transplant centers.
- "How to Avoid Transplant Waitlisting Delays" was developed by the transplant community coalition to further assist patients with understanding the importance of timely completion of required health maintenance exams.
- Utilization of a transplant trailblazer increased patients' interest in a kidney transplant and increased the facility's transplant referrals.

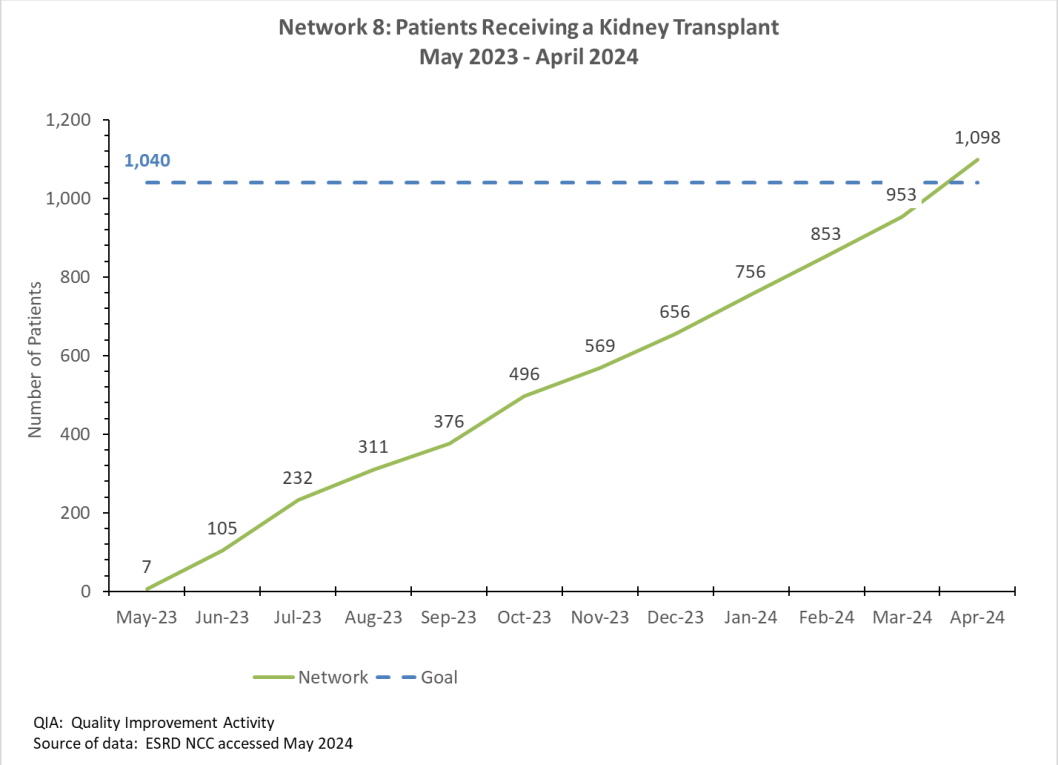
In summary, the Network successfully surpassed both the waitlist and the transplant goals. A total of 1,559 patients dialyzing in a Network 8 facility (prevalent patients) were added to the kidney transplant waitlist and 1,098 patients received a kidney transplant during the performance period. In addition to the 1,098 prevalent transplants performed, 190 patients received a preemptive kidney transplant from a transplant facility within the Network 8 region, according to the National Coordinating Center (NCC) Network Patient Reports, Period Prevalence table from April 2024.

Chart 10: Patients Added to a Kidney Transplant Waiting List May 2023 – April 2024



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2024

Chart 11: Patients Receiving a Kidney Transplant May 2023 – April 2024



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2024

Home Therapy (Incident & Transition to Home) Quality Improvement Activity May 2023-April 2024

The 2023-2024 goal for incident patients beginning ESRD treatment on a home modality was 30%; Network 8 achieved a 22.7% increase, adding 1,487 incident patients to a home modality. The Network also worked to achieve a 12% increase in the rate of prevalent patients transitioning to a home modality and achieved a 3.94% increase, adding 1,508 prevalent patients to a home modality.

A home community coalition, consisting of high-performing providers and patient subject matter experts, was established by the Network to identify barriers and potential solutions to assist low-performing facilities improve home dialysis rates. The Network utilized coalition feedback to provide targeted technical assistance and share best practices to drive process improvements for three groups of intervention facilities.

Monthly technical assistance included an initial root cause analysis, sharing of promising practices and provision of resources as indicated with follow-up three months after initial coaching session. Coaching calls focused on various aspects of home modality education and promoted specific primary drivers from the ESRD National Coordinating Center (NCC) Home Dialysis Change Package.

Commonly identified barriers:

- Difficulties reaching and collaborating with CKD providers and patients
- Lack of physician knowledge and comfort with solo-home hemodialysis, urgent-start peritoneal dialysis, and transitional care units
- Patient choice of in-center setting for socialization and a sense of security associated with the provision of treatment by dialysis professionals
- Patient lack of care partner, family support, or adequate housing

Interventions and processes improvements implemented:

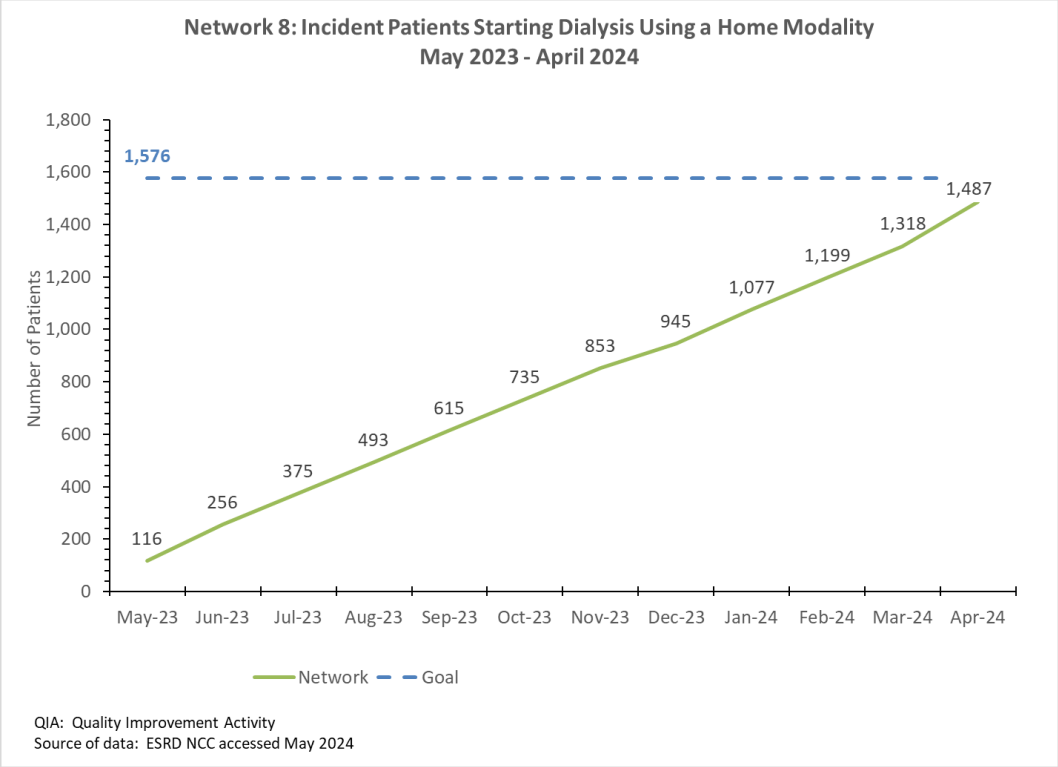
- Individualized, facility-specific coaching based on identified barriers and needs
- Provision of resources to highlight advantages of solo home hemodialysis (HHD), promoting this as an option for patients without a care partner and for whom peritoneal dialysis (PD) was not possible
- Sharing LDO-specific program successes with other facilities owned by same corporation
- Sharing information regarding Urgent Start Peritoneal Dialysis and Transitional Care Units (TCUs) with providers
- Promoting self-care for in-center patients to master basic skills and build self-confidence before initiation of home training
- Conducting roster reviews and routine data checks to ensure correct reporting of patient modality in EQRS

Promising practices:

- Establishing a home improvement team for a team-based education approach
- Selecting a small group of eligible patients for 1:1 coaching; identifying patient-specific life plan goals and exploring the benefits of home dialysis in this context
- Utilizing Kidney Care Advocate, Kidney Smart educator, or Home Hero to provide early home modality education
- Employing home modality videos, lobby days, and chairside education to educate patients on the socialization aspects of home dialysis as well as the 24-hour availability of dialysis staff if needed.

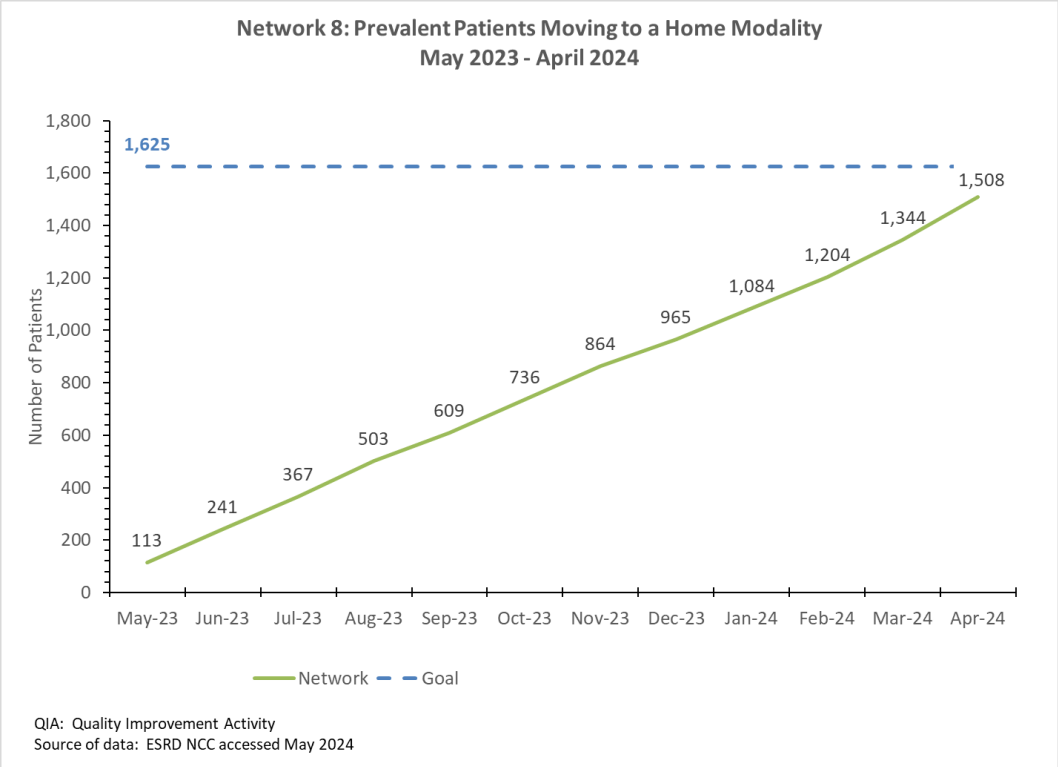
By partnering with high-performing facilities to learn best practices while providing targeted technical assistance and spreading best practices, a total of 2,995 patients started or moved to a home modality. Also of note, the percentage of dialysis patients initially starting on a home modality increased from 17.05% in 2021 to 19.96% in 2024.

Chart 12: Incident Patients Starting Dialysis Using a Home Modality May 2023-April 2024



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2024

Chart 13: Prevalent Patients Moving to a Home Modality May 2023-April 2024



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2024

Influenza Vaccinations (Patient and Staff) May 2023-April 2024

ESRD Networks were tasked to meet the following influenza vaccination goals by the end of the contract period:

- 90% of dialysis patients receive an influenza vaccination.
- 90% of dialysis staff received an influenza vaccination.

Monthly technical assistance included an initial root cause analysis, sharing of promising practices and provision of resources as indicated with follow-up three months after initial coaching session.

Commonly identified barriers:

- Vaccination fatigue
- Allergies
- Refusal of all vaccines
- Distrust /fear
- Political / religious beliefs
- Failure to report staff flu data in NHSN
- Inaccurate data reported to EQRS/National Healthcare Safety Network (NHSN)
- Discrepancies between internal records and EQRS

Interventions and process improvements:

- Individualized coaching calls to review patient-specific data and discrepancies in data reporting
- Provision of training on the new EQRS Vaccination Module
- Incorporation of patient engagement activities to provide fun, interactive vaccination education.
- Utilization of the Vaccination Change Package
- Utilization of the Immunization Data Collection Tool from the National Forum of ESRD Networks' Vaccination Toolkit
- Provision of monthly education to address vaccination hesitancy and common vaccination misconceptions.
- Assistance with obtaining EQRS access.
- Assistance with obtaining access to NHSN's Healthcare Personnel Safety component.
- Provision of training on how to enter staff vaccination data into NHSN.
- Assistance with identifying and troubleshooting batch submission errors to the new EQRS Vaccination Module
- Monthly sharing of influenza vaccination rates to provide awareness and trend progress.

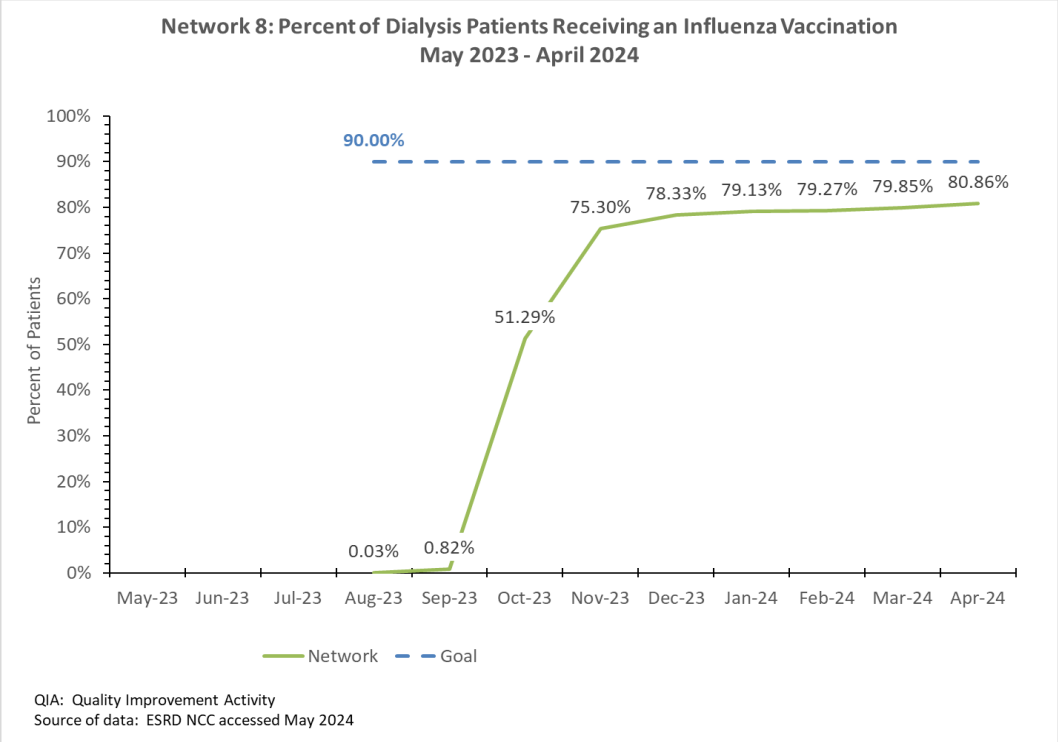
Promising practices:

- Utilization of State Immunization Registries to identify vaccines received by non-dialysis providers
- Appointment of facility vaccination manager to track/trend vaccines
- Development of a vaccination binder to assist with tracking
- Involvement of the entire interdisciplinary team
- Development of an immunization bulletin board
- Incorporation of visual aids to assist with patient education
- Outreach to other healthcare providers to determine vaccination status

In addition to the facility-specific interventions above, the Network partnered with the following coalitions: National COVID-19 Resiliency Network (NCRN) Regional Community Coalition, Texas Medical Foundation (TMF) Health Quality Institute Partnership for Community Health, TMF Mississippi Partnerships for Community Health, and Tennessee Statewide Partnerships for Community Health. Coalition resources were utilized to enhance technical assistance efforts to address vaccine hesitancy.

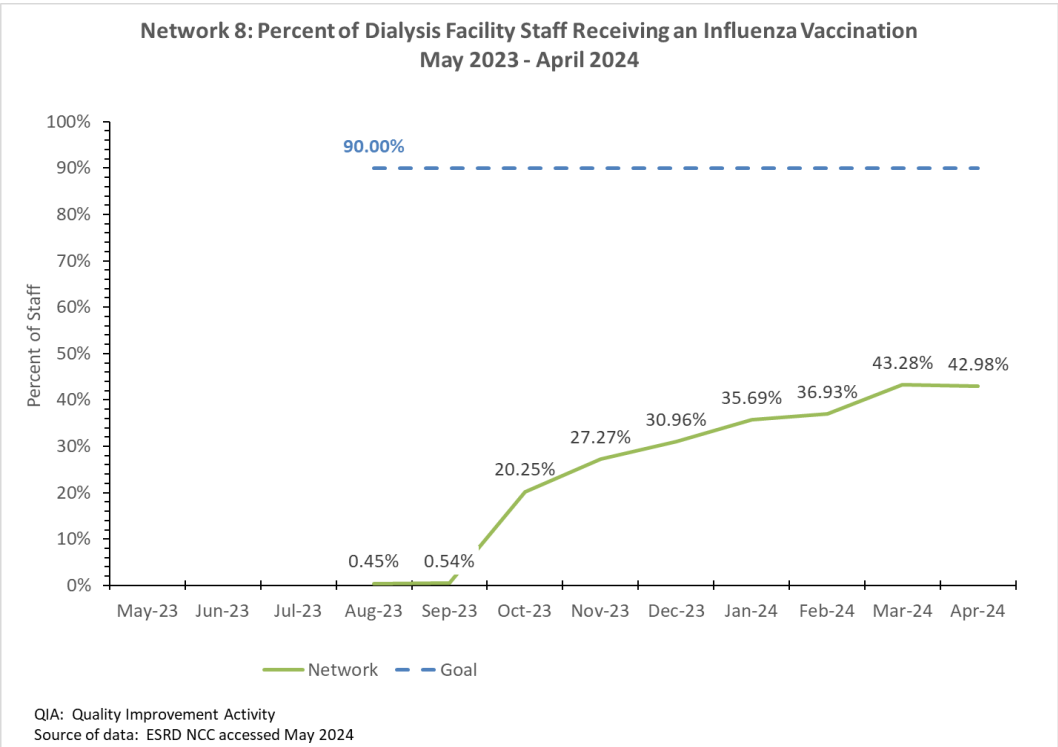
Despite the above interventions and ongoing efforts to increase influenza vaccinations, Network 8 did not meet the patient or staff influenza vaccination goals during the contract period. The Network achieved a rate of 80.86% in dialysis patient influenza vaccinations as recorded in EQRS and 42.98% in dialysis staff influenza vaccinations as recorded in NHSN.

Chart 14: Percent of Dialysis Patients Receiving an Influenza Vaccination May 2023-April 2024



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2024

Chart 15: Percent of Dialysis Facility Staff Receiving an Influenza Vaccination May 2023-April 2024



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2024

COVID-19 Vaccinations (Patients and Staff) May 2023-April 2024

ESRD Networks were tasked to meet the following COVID-19 vaccination goals by the end of the contract period:

- 80% of dialysis patients fully vaccinated for COVID-19, including boosters, as determined by the CDC and/or CMS
- 95% of dialysis facility staff fully vaccinated for COVID-19, including boosters, as determined by the CDC and/or CMS

Monthly technical assistance included an initial root cause analysis, sharing of promising practices and provision of resources as indicated with follow-up three months after initial coaching session.

Commonly identified barriers:

- Vaccination fatigue
- Allergies
- Refusal of all vaccines
- Lack of trust
- Fear of side effects
- Inaccurate facts/myths
- Knowledge deficit
- Political/religious beliefs
- Lack of reporting in NHSN
- Inaccurate data in NHSN
- Lack of awareness of vaccination rates recorded in NHSN

Interventions and process improvements:

- Individualized coaching calls to review and identify discrepancies in data reporting.
- Incorporation of patient engagement activities to provide fun, interactive vaccination education.
- Utilization of the Vaccination Change Package
- Utilization of the Immunization Data Collection Tool from the ESRD Forum's Vaccination Toolkit
- Provision of monthly education to address vaccination hesitancy and common vaccination misconceptions.
- Assistance in obtaining access to NHSN's Healthcare Personnel Safety component.
- Provision of training on how to enter vaccination data into NHSN.
- Assistance in identifying and troubleshooting batch submission errors to NHSN.
- Monthly sharing of COVID-19 vaccination rates to provide awareness and trend progress.

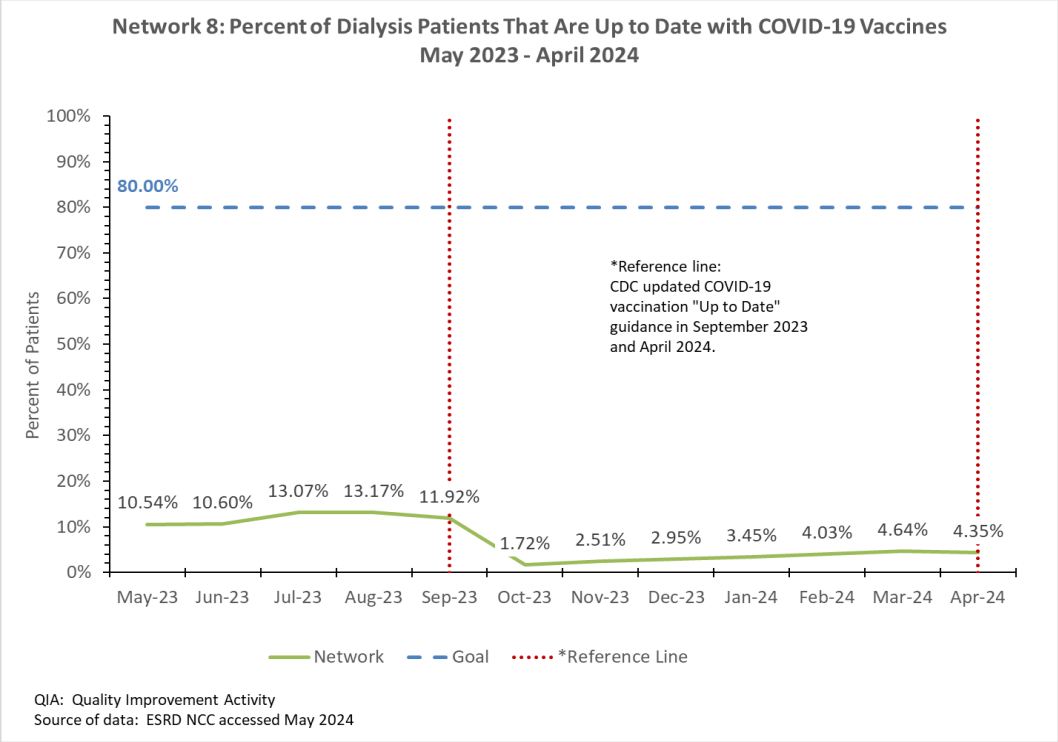
Promising practices:

- Utilization of State Immunization Registries to identify vaccines received by non-dialysis providers
- Assigning vaccine manager to track/trend vaccines
- Incorporation of vaccination education with new patients within 30 days of admissions
- Involvement of the entire interdisciplinary team
- Improved communication with other healthcare providers to determine vaccination statuses
- Utilization of competitions and prizes to encourage patients to receive vaccinations
- Identification and collaboration with community partners for COVID-19 vaccination

In addition to the facility-specific interventions above, the Network partnered with the following coalitions: National COVID-19 Resiliency Network (NCRN) Regional Community Coalition, Texas Medical Foundation (TMF) Health Quality Institute Partnership for Community Health, TMF Mississippi Partnerships for Community Health, and Tennessee Statewide Partnerships for Community Health. Coalition resources were utilized to enhance technical assistance efforts to address vaccine hesitancy.

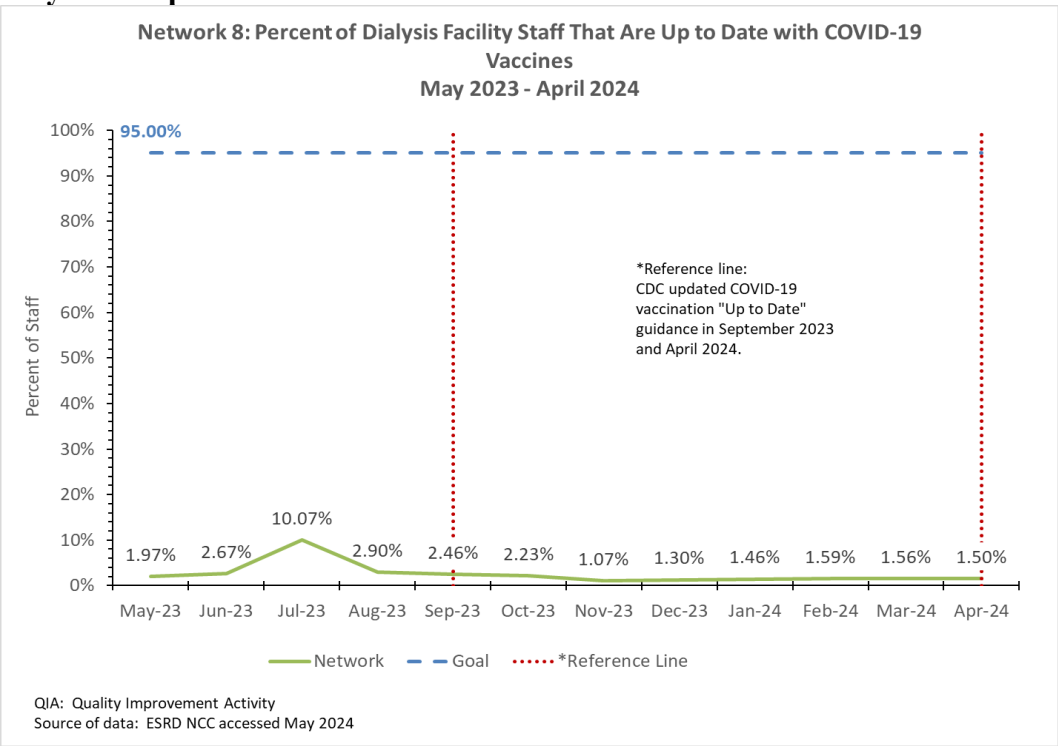
With two changes to the definition of "fully vaccinated" by the CDC, once in September 2023 and again in April 2024, effectively resetting vaccination rates to zero, Network 8 did not meet the patient or staff COVID-19 vaccination goals. As of April 30, 4.35% of patients were fully vaccinated for COVID-19 and 1.50% of dialysis staff were fully vaccinated for COVID-19 as recorded in the National Healthcare Safety Network (NHSN) database.

Chart 16: Percent of Dialysis Patients That Are Up to Date with COVID-19 Vaccines May 2023-April 2024



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2024

Chart 17: Percent of Dialysis Facility Staff That Are Up to Date with COVID-19 Vaccines May 2023-April 2024



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2024

Pneumococcal Vaccinations May 2023-April 2024

Network 8 was tasked with ensuring that 58.12% of patients were fully vaccinated for pneumococcal pneumonia, a 7% increase from the baseline of 54.32%.

Monthly technical assistance included an initial root cause analysis, sharing of promising practices and provision of resources as indicated with follow-up three months after initial coaching session.

Commonly identified barriers:

- Vaccination fatigue
- Knowledge deficit
- Refusal of all vaccines
- Lack of trust
- Fear
- Religious beliefs
- Inaccurate data in EQRS
- Unaware of vaccination rates in EQRS

Based on identified root causes and facility-specific feedback, the Network provided targeted technical assistance to facilities.

Interventions and process improvements:

- Individualized coaching calls to review patient-specific data and data reporting
- Provision of training on the new EQRS Vaccination Module
- Incorporation of patient engagement activities to provide fun, interactive vaccination education.
- Utilization of the Vaccination Change Package
- Utilization of the Immunization Data Collection Tool from the ESRD Forum's Vaccination Toolkit
- Provision of monthly education to address vaccination hesitancy and common vaccination misconceptions.
- Assistance in obtaining EQRS access.
- Assistance in identifying and troubleshooting batch submission errors to the new EQRS Vaccination Module
- Provision of education regarding new pneumococcal vaccinations (PCV 15 and PCV 20)
- Monthly sharing of pneumococcal vaccination rates to provide awareness and trend progress.

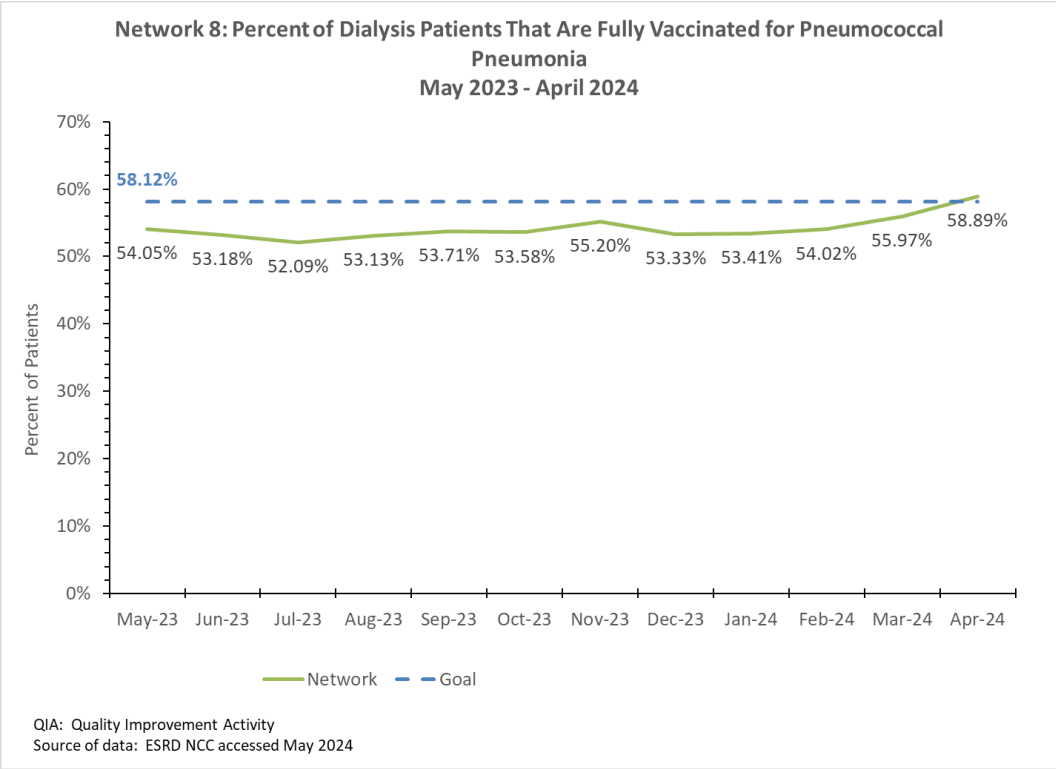
Promising practices:

- Utilization of State Immunization Registries
- Implementation of Vaccination Manager to track/trend vaccines.
- Implementation of a new pneumococcal algorithm
- Involvement of the entire interdisciplinary team
- Improved communication with other healthcare providers to determine vaccination statuses.
- Increased focus on vaccination tracking
- Provision of pneumococcal vaccinations in the dialysis facility

In addition to the facility-specific interventions above, the Network partnered with the following coalitions: National COVID-19 Resiliency Network (NCRN) Regional Community Coalition, Texas Medical Foundation (TMF) Health Quality Institute Partnership for Community Health, TMF Mississippi Partnerships for Community Health, and Tennessee Statewide Partnerships for Community Health. Coalition resources were utilized to enhance technical assistance efforts to address vaccine hesitancy.

Utilizing above interventions and ongoing technical assistance efforts to increase pneumococcal vaccinations, Network 8 met the pneumococcal vaccination goal during the contract period, with 58.89% of patients fully vaccinated by April 30.

Chart 18: Percent of Dialysis Patients That Are Fully Vaccinated for Pneumococcal Pneumonia May 2023-April 2024



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2024

Data Quality (2728 Forms Over 1 Year, CMS Form 2728, CMS Form 2746) May 2023-April 2024

Network 8 focused on improving data quality for the annual performance period from May 1, 2023, through April 30, 2024. During the performance period, the Network engaged facilities and corporations in dialogue and communication surrounding the topic of data quality.

Key areas of focus for data quality:

- Achieve 1% increase, from the baseline, in the number of incomplete initial CMS-2728 forms that are over one (1) year old, that are completed and submitted.
- Achieve 4% increase, from the baseline, in the rate of initial CMS-2728 forms that are submitted from dialysis facilities within forty-five (45) days
- Achieve 9% increase, from the baseline, in the rate of CMS-2746 forms submitted from dialysis facilities within fourteen (14) days of the date of death

Commonly identified barriers:

- Lack of designated staff member to manage EQRS forms completion/submission
- Lack of knowledge of timeframes for EQRS form submission
- Key facility staff without EQRS account
- Frequent staffing changes
- Missing creatinine lab value within 45 days prior to chronic dialysis initiation
- Inability to obtain accurate cause of death within timeframe specified for 2746 form submission
- Inability to obtain physician signature on within timeframe specified for 2728 form submission

Interventions and processes improvements:

- Network collaboration with LDO leadership to address barriers and issues to improve admission data submission rate within 5 days
- Notification of First Not New ESRD patient admissions
- Provision of educational articles regarding EQRS tips, tools, and trainings via ESRD Network professional newsletter
- Sharing Data Quality Improvement scores to facilities and associated corporations
- Weekly notifications of CMS 2728 forms due within 10 days with daily notifications of outstanding forms
- Utilization of online ticketing system to provide customer support for admission issues including automating response and providing resources to facilities to collect data needed to resolve admission issues.
- Reporting of data quality metrics to facilities and corporations
- Assisting transplant facilities to obtain access to EQRS
- Review of EQRS forms timeliness during routine monthly facility report card reviews by quality improvement staff with coaching and resources as needed

Promising practices:

- Sharing of staff with EQRS knowledge and expertise across sister facilities to ensure forms are completed accurately and timely
- Posting of ESRD NCC EQRS Data Submission Stopwatch for key personnel review
- Ensuring that key personnel obtain EQRS account and attend EQRS new user training in a timely manner
- Utilizing hospital portals to obtain necessary information for form completion
- Setting internal facility goals for forms completion prior to CMS deadline

Utilizing above interventions, process improvement techniques and ongoing technical assistance efforts, Network 8 met all three Data Quality Measures as indicated in (Chart 19, 20, & 21) by April 30.

Chart 19: Number of Incomplete Initial CMS-2728 Forms that are Over One (1) Year Old that are Completed and Submitted May 2023-April 2024

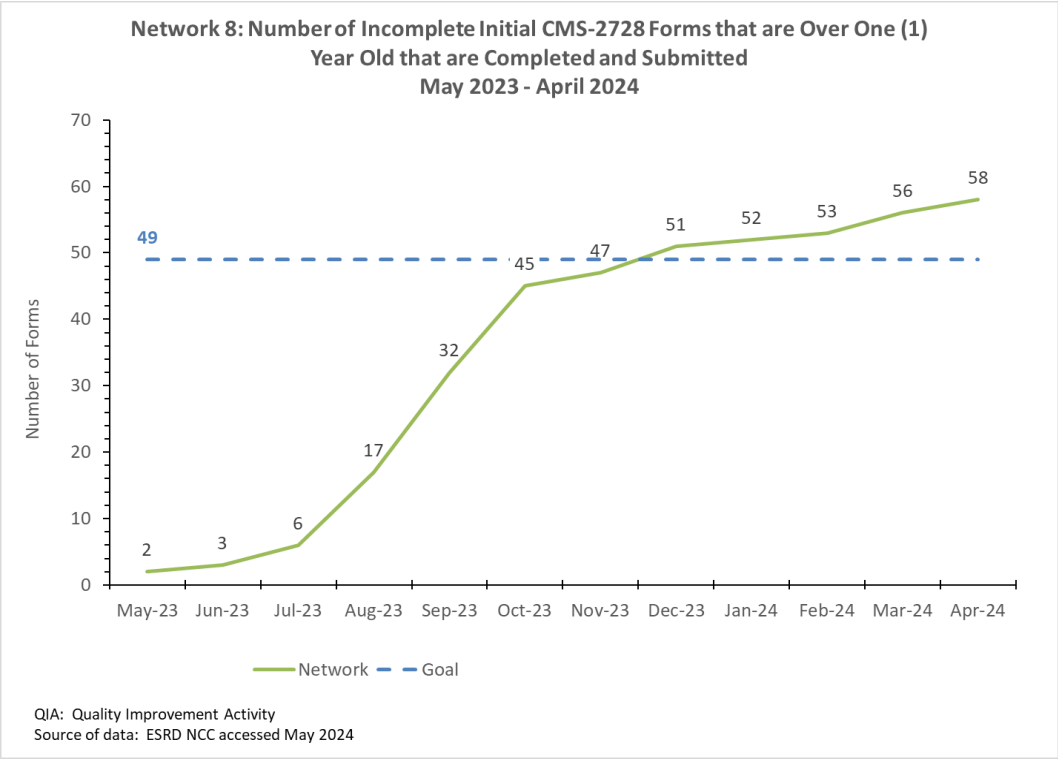


Chart 20: Percent or Initial CMS-2728 Forms Submitted Within Forty-five (45) Days May 2023-April 2024

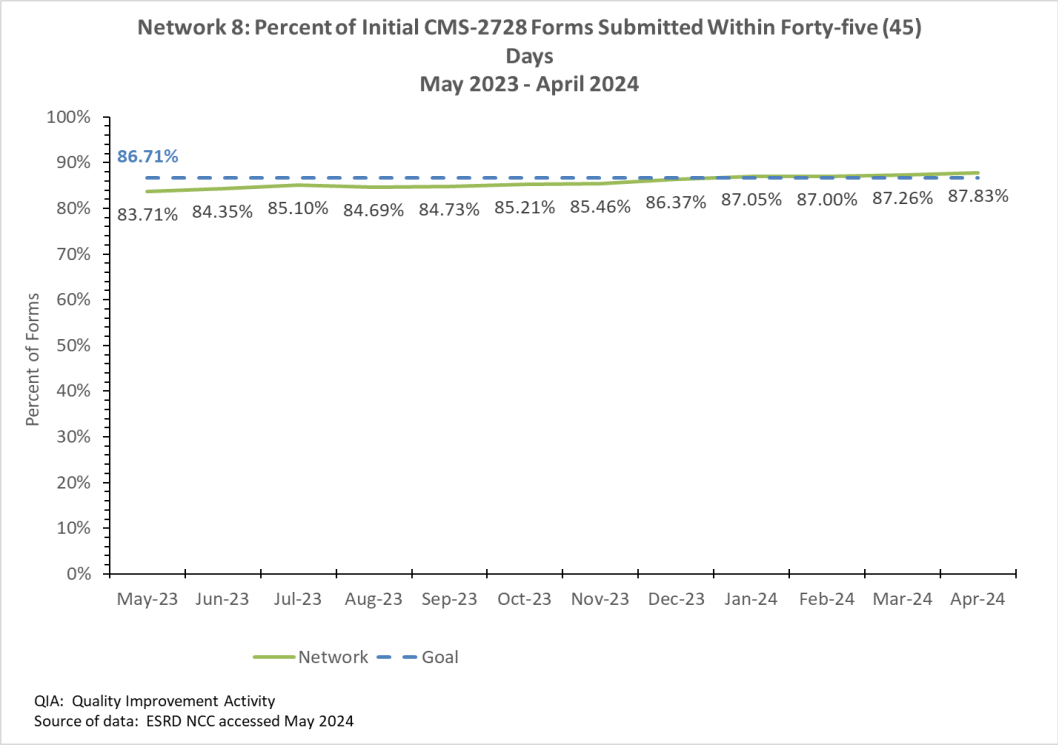
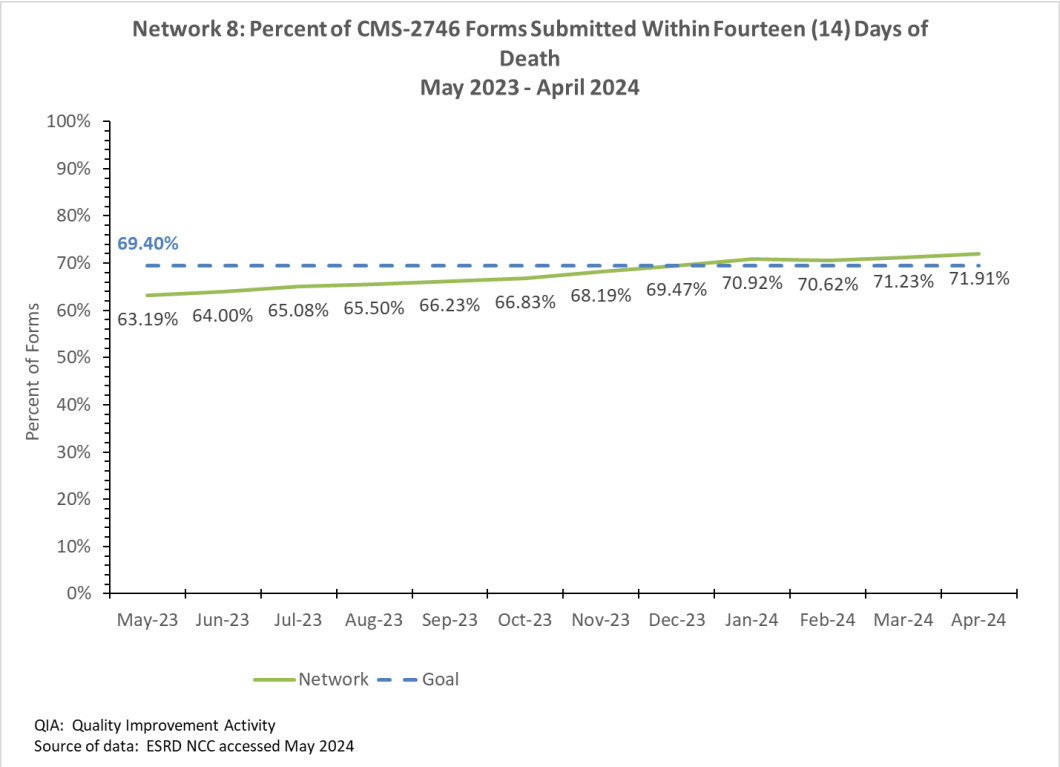


Chart 21: Percent or CMS-2746 Forms Submitted Within Fourteen (14) Days of Death May 2023-April 2024



Hospitalization (Inpatient Admissions, ED Visits, Readmissions) May 2023-April 2024

During the contract period, Network 8 sought to achieve a 4% decrease in hospital admissions, 30-day unplanned readmissions, and outpatient emergency department visits. Monthly technical assistance included an initial root cause analysis, improvement plan development, sharing of promising practices and provision of resources as indicated with follow-up three months after initial coaching session.

Commonly identified barriers:

- Missed treatments associated with transportation challenges and/or lack of adherence to scheduled outpatient dialysis sessions leading to ER visit / admission
- Failure to recognize early complications that could have been addressed more quickly at the facility level to avoid unplanned hospitalizations
- Inability to access timely vascular access intervention, leading to access malfunction requiring ER visit for prolonged bleeding or hospital admission for access revision
- Early hospital discharge prior to stabilization/resolution of admission diagnosis, leading to readmission
- Inappropriate use of emergency department due to lack of primary care physician
- Patient/family inability to manage multiple co-morbid conditions such as blood sugar, diabetic wounds, gastroparesis, hypertension, congestive heart failure and additional cardiac conditions

Interventions and processes improvements:

- Sharing and promoting the use of the Forum of ESRD Networks Transitions of Care Toolkit
- Sharing and promoting the use of the ESRD NCC Change Package to Reduce Hospitalizations
- Providing patients with educational resources addressing missed treatments, tips to manage thirst, dangers of fluid overload, infection prevention, medication adherence, and the importance of following a renal diet.
- Ensuring patients have the correct nephrologist and facility contact information and know when to reach out.
- Utilization of vaccination and zone tools
- Promotion of 5 Diamond Patient Safety Program Care Coordination and Missed Treatment Modules for staff education.

Promising practices:

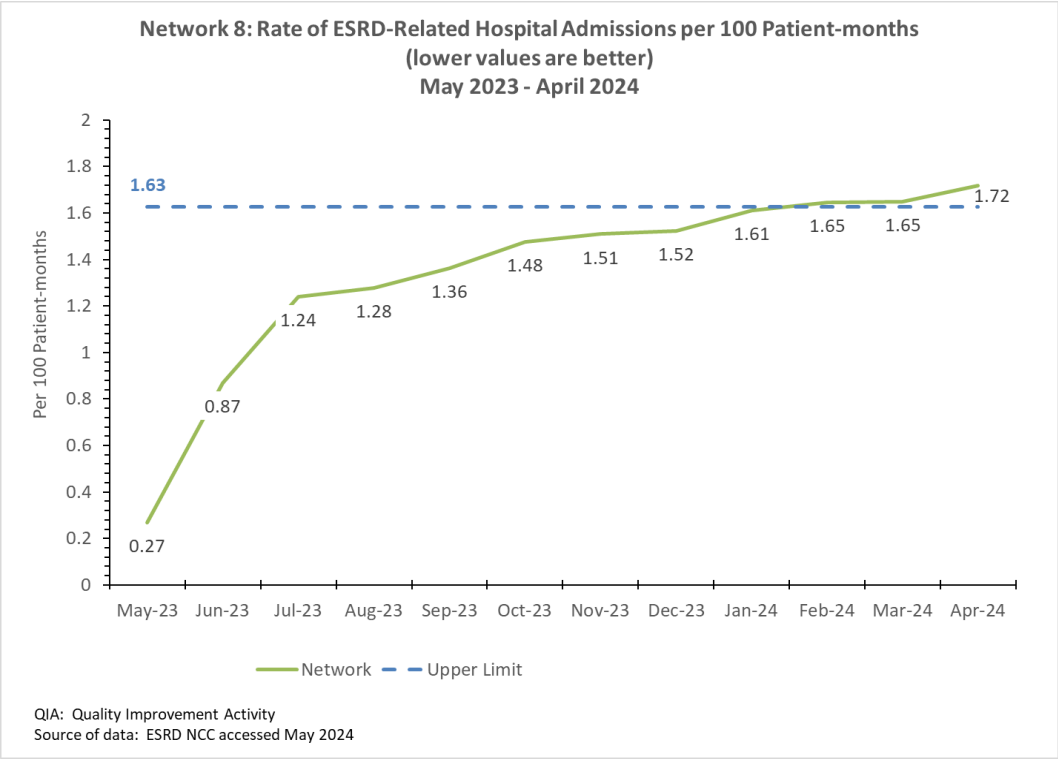
- Use of post-hospitalization tracking tool to track facility trends and to identify patients at risk for repeat hospitalization allowing for early intervention
- Use of designated hospitalization outcomes manager to review hospital discharge records and review discharge instructions with patients, identifying opportunities for education and utilizing teach-back to ensure information was clearly understood
- Use of small incentives to encourage patients to attend all treatments as scheduled

- Encouraging patients to re-schedule missed treatments, even a partial treatment, in an attempt to prevent fluid overload/hyperkalemia.
- Keeping an open treatment chair for patients who need additional fluid removal on non-dialysis day
- Obtaining and reviewing hospital discharge records within a short window of time to ensure timely follow-up for appointments and medication changes.

In addition to the facility-level interventions above, the Network continued to partner with Alliant Health Solutions, the QIN/QIO for Alabama and Tennessee, and TMF, the QIN/QIO for Mississippi to share information and resources. Additionally, the Network worked with individual State Departments of Health within the Network 8 region to monitor COVID-19 cases and distribute information to dialysis facilities as needed.

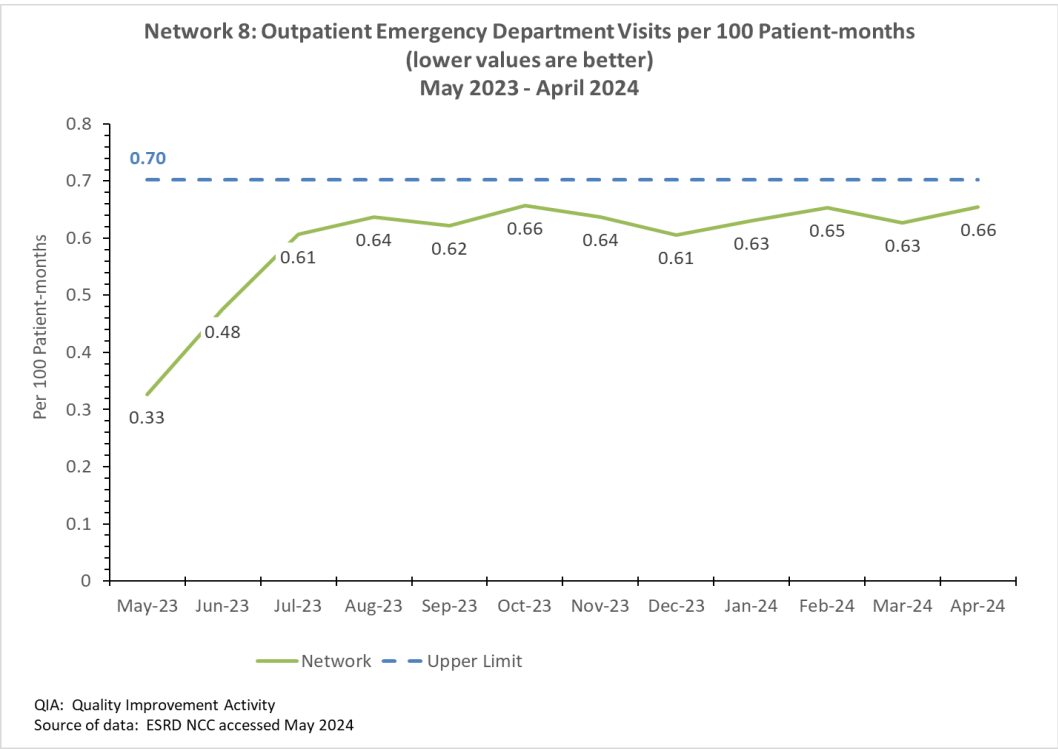
In summary, based on data provided by the ESRD NCC as of April 2024, the Network successfully maintained rates below the upper limit threshold established by CMS for emergency department visits; the ceiling for inpatient admissions was exceeded by 0.09 percentage points and the ceiling for unplanned readmissions was exceeded by1.63 percentage points.

Chart 22: Rate of ESRD-Related Hospital Admissions per 100 Patient-months (lower values are better) May 2023-April 2024



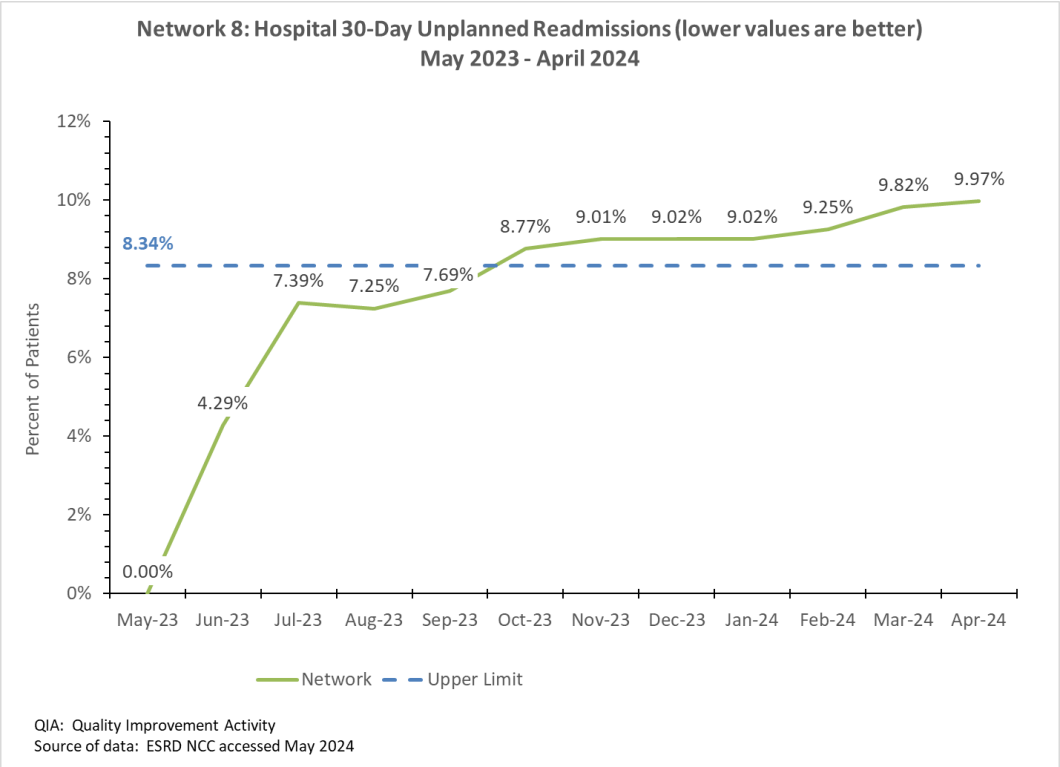
QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2024

Chart 23: Outpatient Emergency Department Visits per 100 Patient-months (lower values are better) May 2023-April 2024



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2024

Chart 24: Hospital 30-Day Unplanned Readmissions (lower values are better) May 2023-April 2024



Nursing Home (Blood Transfusion, Catheter Infection, and Peritonitis) May 2023-April 2024

Network 8 endeavored to achieve a 6% decrease in the hemodialysis catheter infection rate in dialysis patients receiving home dialysis in nursing homes, a 3% decrease in peritonitis events, and a 3% decrease in the rate of dialysis patients receiving dialysis at nursing homes who also received a blood transfusion by April 30, 2024. During the contract period, there were five providers offering dialysis as of April 30, 2023. No dialysis programs in Alabama or Mississippi currently offer SNF/LTC home dialysis.

Commonly identified barriers:

- Lack of clear, effective communication between SNF/LTC staff and dialysis staff
- Co-morbid conditions leading to blood loss
- Improper management of CVC such as missing or wet CVC dressings and improper dressing change procedure
- Improper peritoneal dialysis (PD) catheter management such as exit site assessment/care

Interventions and processes improvements:

- Development of a coalition of stakeholders to assist with identifying local issues and potential interventions
- Individualized coaching calls to conduct needs assessments and brainstorm solutions to identified barriers
- 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
- Monthly collaborative meeting with the Tennessee Department of Health covering topics such as LTC facility data trends, Project Frontline educational offerings, COVID-19 outbreaks, and additional available support services such as infection control assessment and response surveys
- Monthly data review and reconciliation with facility contact to maintain data integrity

Promising practices:

- Use of standardized, bi-directional communication tools to ensure that nursing facility staff and dialysis staff are knowledgeable of pre and post dialysis data, including vital signs, medication administration, fluid volume status and relevant lab values.

Through implementation of the above interventions and ongoing efforts to improve the quality of SNF/LTC admission records within EQRS, Network 8 successfully met all three measures for the contract period.

Chart 25: Rate of Blood Transfusions in ESRD Patients Receiving Dialysis in Nursing Home (lower values are better) May 2023-April 2024

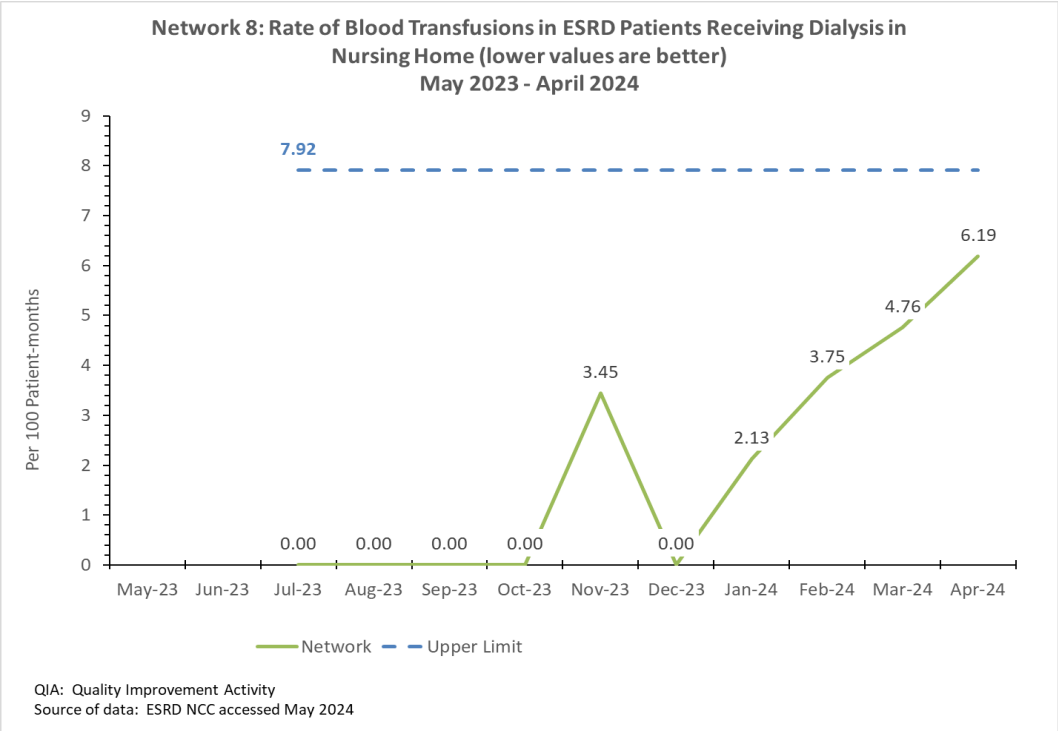


Chart 26: Hemodialysis Catheter Infections in Home Dialysis Patients Within Nursing Home (lower values are better) May 2023-April 2024

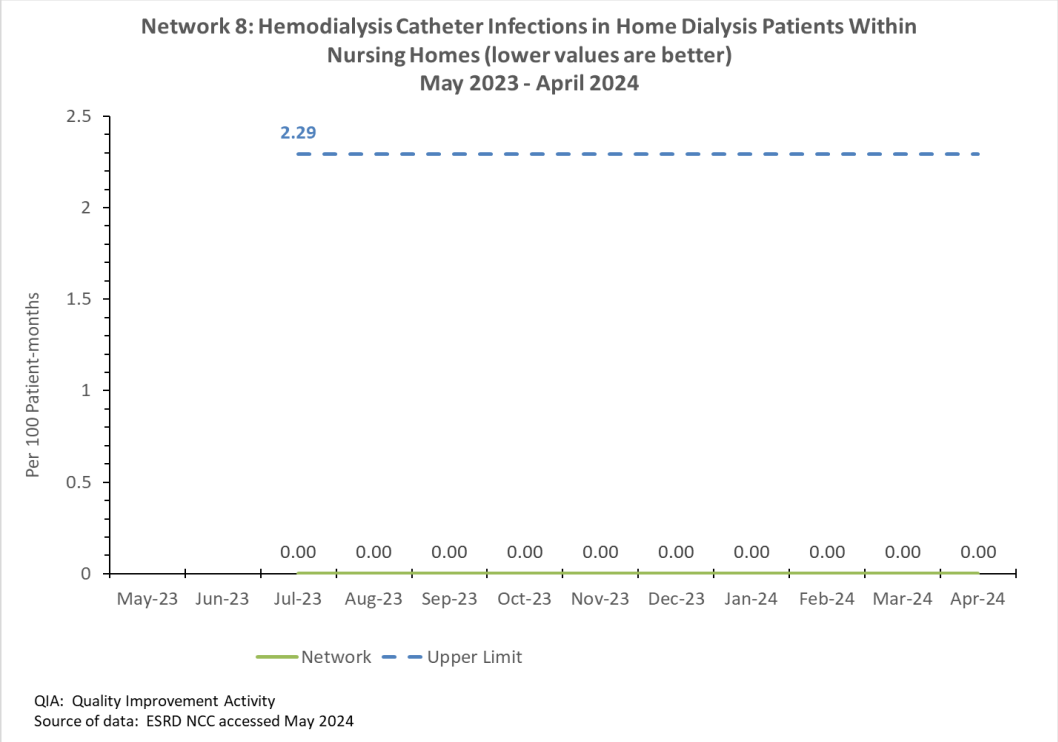
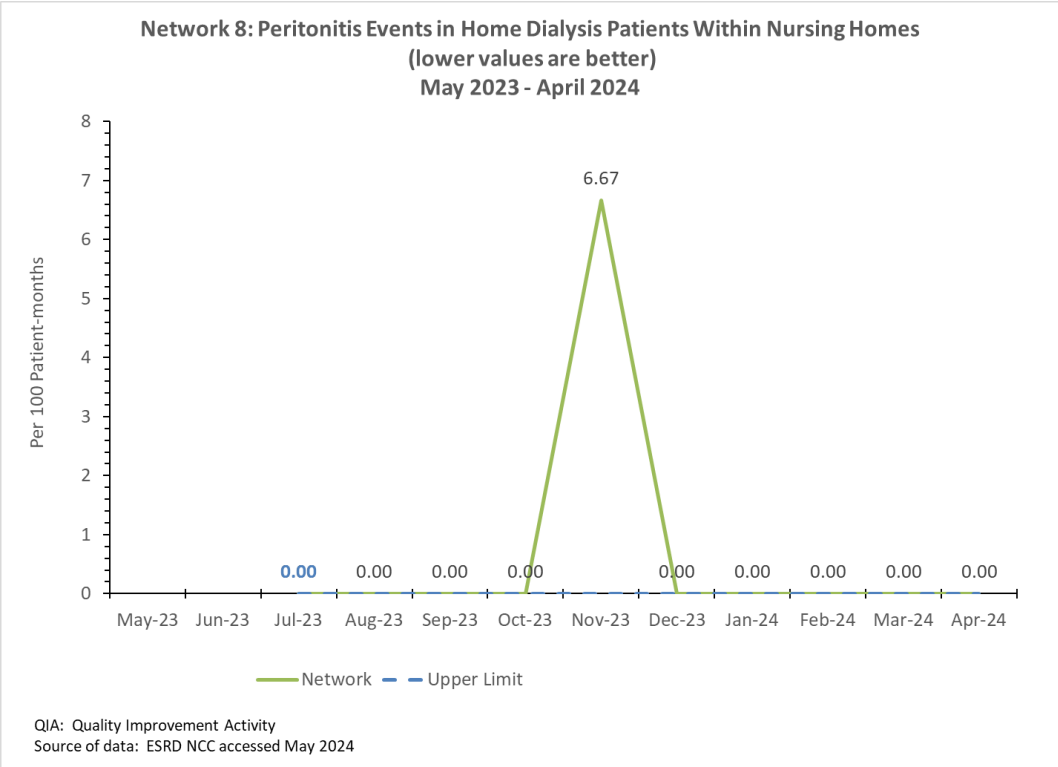


Chart 27: Peritonitis Events in Home Dialysis Patients Within Nursing Home (lower values are better) May 2023-April 2024



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2024

Telemedicine May 2023-April 2024

The Network was tasked with achieving a 3% relative increase in the number of rural ESRD patients using telemedicine while dialyzing in a home setting. As part of our home dialysis QI activity, the Network conducted an RCA to determine the greatest barriers and challenges for facilities and patients in utilizing telemedicine services.

Commonly identified barriers:

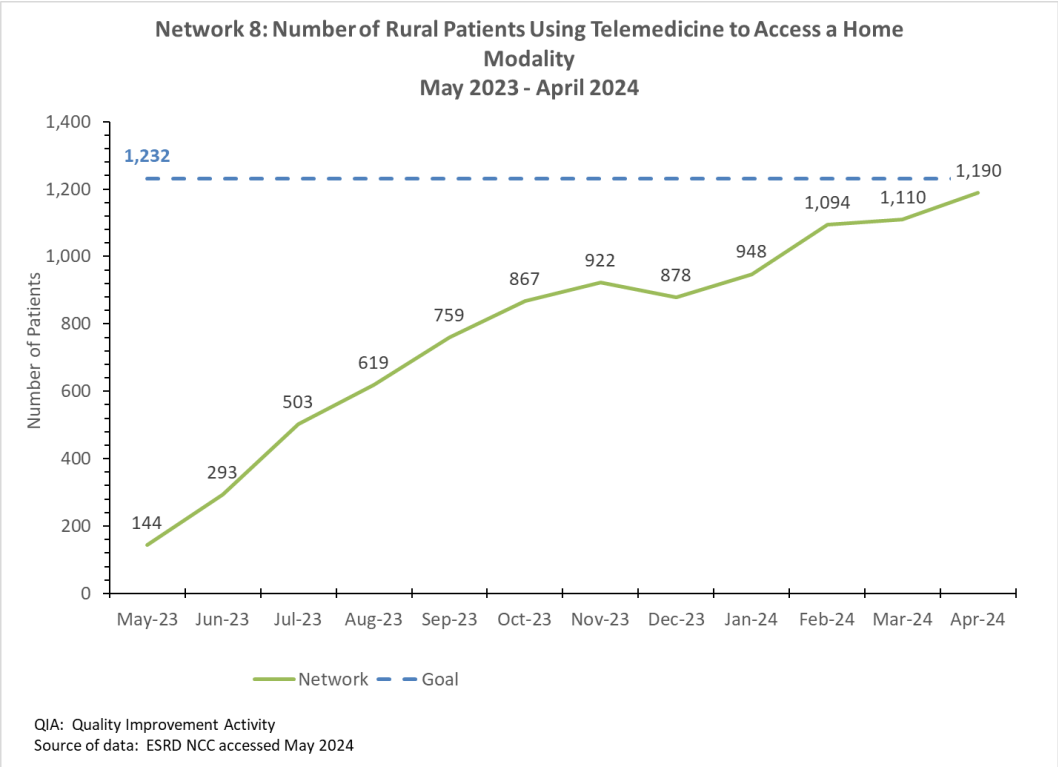
- Technology limitations
- Limited smart phone data plans due to financial constraints
- Preference for face-to-face visit with provider
- Vision and/or hearing impairments, impacting the benefit of telehealth

Interventions and processes improvements:

- Provision of one-on-one technical assistance, interventions, and resources such as videos and literacy level written information to promote the usage and benefits of 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

While some providers continue to offer telehealth as an option for rural patients, the federal public health emergency for COVID-19, declared under Section 319 of the Public Health Service Act, expired on May 11, 2023, impacting payment for these services. Network 8 met 96.6% of the contract period goal, with 1,190 rural home dialysis patients using telemedicine services.

Chart 28: Number of Rural Patients Using Telemedicine to Access a Home Modality May 2023-April 2024



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2024

Depression Treatment May 2023-April 2024

130 clinics were selected for focused intervention based on lack of documented follow up to positive screening for depression and low rate of Part B claims for treatment of depression.

The following resources and assessment tools were shared with focus facilities and regional MSW team leads who actively participated in this improvement activity. After resources were shared, the Network offered 1:1 coaching calls or Open Office Hours calls to discuss how to use the tools and best practice opportunities to leverage better outcomes.

Interventions and processes improvements:

- "Depression in Older African American Men and Self-Assessment Tool"
- "How Do You Know When You Need Help"
- "5 Diamond Safety Program Metal and Behavioral Health Toolkit"
- Substance Abuse Cage Aide
- Anxiety -GAD 7 Questionnaire
- Epworth Sleepiness Scale
- AHD Delirium, Dementia, and Depression Comparison and Assessment Tool
- Geriatric Depression Screening Tool
- National COVID-19 Resiliency Network (NCRN) Distress Thermometer
- National Coordinating Center (NCC) Depression Screening: Specifications and Data Dictionary

Network-developed resources:

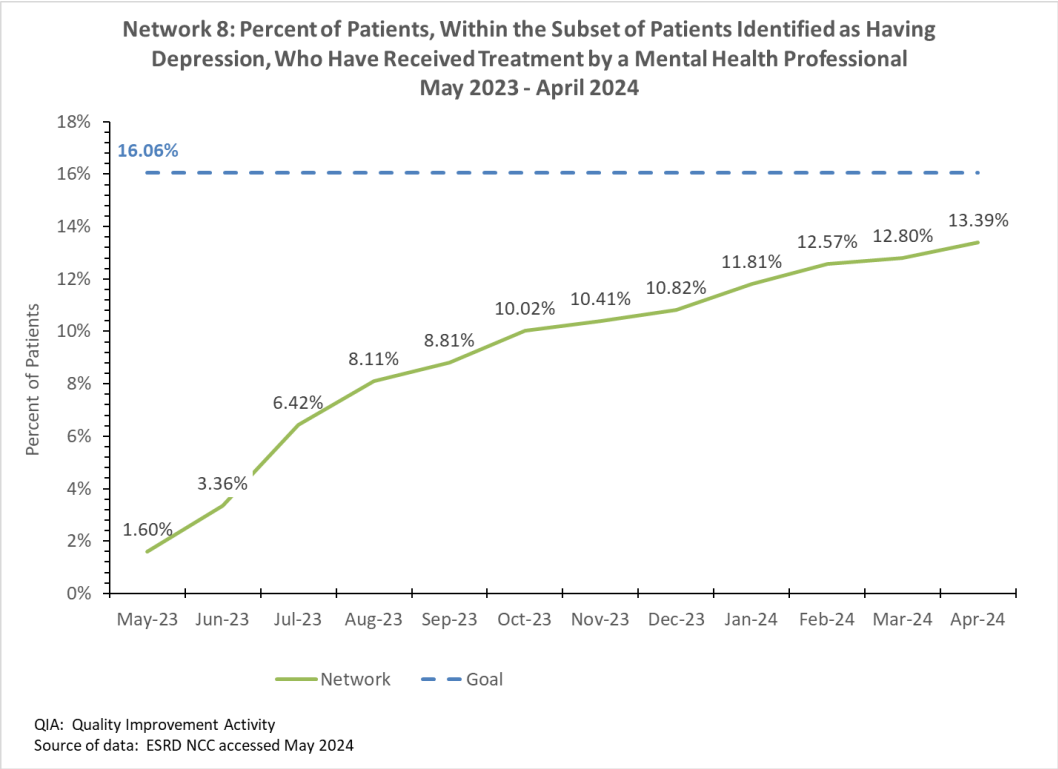
- Alliant Health Solutions-PHQ9 Best Practice Workflow-designed to encourage more accurate Depression Screenings
- Alliant Health Solutions-ESRD "Out of Balance Flyer" to educate patients on Depression while addressing the stigma of mental health.

The Network 8 community coalition was reformed for the option period two contract period, with meetings held in August, October, December, February, and April. Members shared the importance of standardized follow-up to positive screenings. An adaptable tool kit was shared with low performers to be adapted to local mental health resources. Members were also able to share some successful tips on how to access mental health services for patients who face health inequalities in each state covered by Network 8.

Successes:

- Large dialysis organizations implemented the use of PHQ2 at chairside by nursing staff.
- Standardized follow-up plan for positive screenings was implemented by one large dialysis organization.
- MRB feedback recommending that MSWs reach out to Nephrologists for antidepressant prescriptions and/or referrals to primary care physicians when indicated was shared widely.

Chart 29: Percent of Patients, Within the Subset of Patients Identified as Having Depression, Who Have Received Treatment by a Mental Health Professional May 2023-April 2024



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2024


compromise
negotiation
settlement
agreement
negotiate
communication
understanding
business
compromised
compromising
mutual
agree
concessions
acceptance
negotiating
contract
successful
partnership
argument
mediation
tolerance
meeting
demand
balance
deal
give up
dispute
cooperation
success
arrangement
benefit
give
argue
handshake
beneficial
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relationship
strategy
conflict
solution
adjustment
debate
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discussion
discuss
problem
settle
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pact

ESRD Network Grievance and Access to Care Data

The Network responds to grievances filed by or on behalf of ESRD patients in its service area. For each grievance filed, the Network conducted outreach to patients and providers to promote education about the Network's role in addressing patient grievances. Opportunities to educate clinics and to advocate for patients with Health Equity issues were presented in each case. The following is a summary of case counts by type as of April 30, 2024:

- Immediate Advocacy: 6
- General: 13
- Clinical Quality of Care: 4
- Facility Concerns: 55
- Patient Concerns: 20

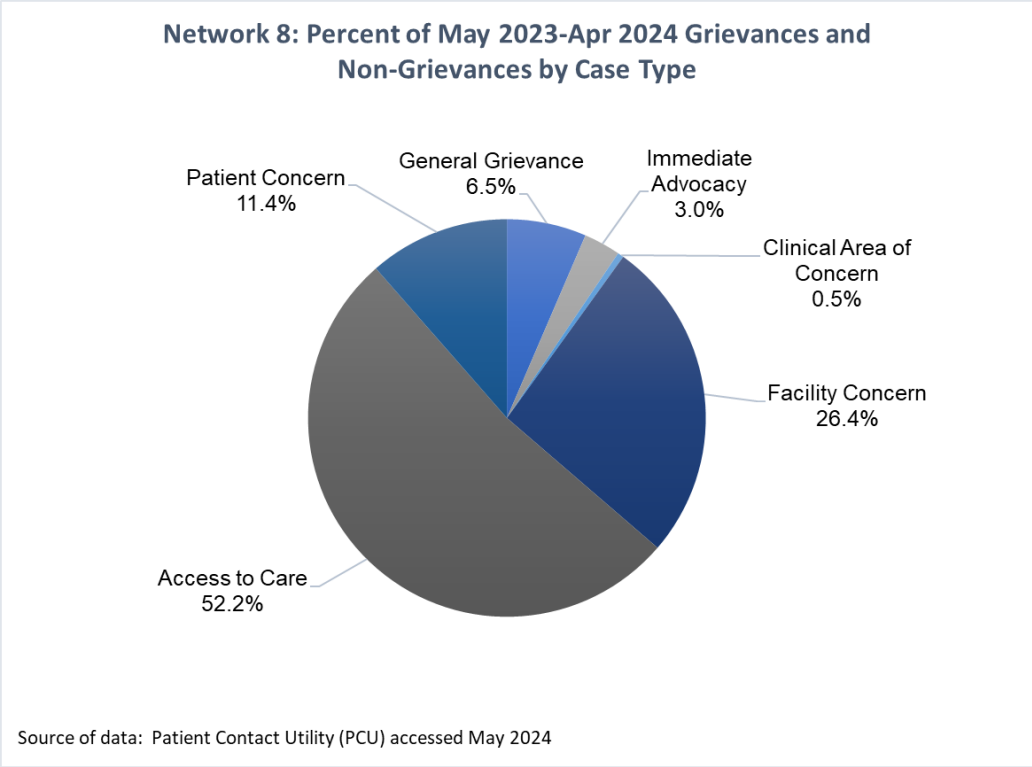
Patient Services staff assessed for issues related to health literacy, discrimination, and resource barriers with each patient call, and promoted self-advocacy through improved communication. When permitted, Network staff mediated concerns with the patient and clinic. Network staff also provided suggestions for resources, communication tips for health literacy issues, and coaching to facility staff on issues related to effective communication with patients. As grievances are often directly linked to health inequities experienced by patients, leading to a sense of discrimination, clinic staff were educated on those contributing factors when warranted.

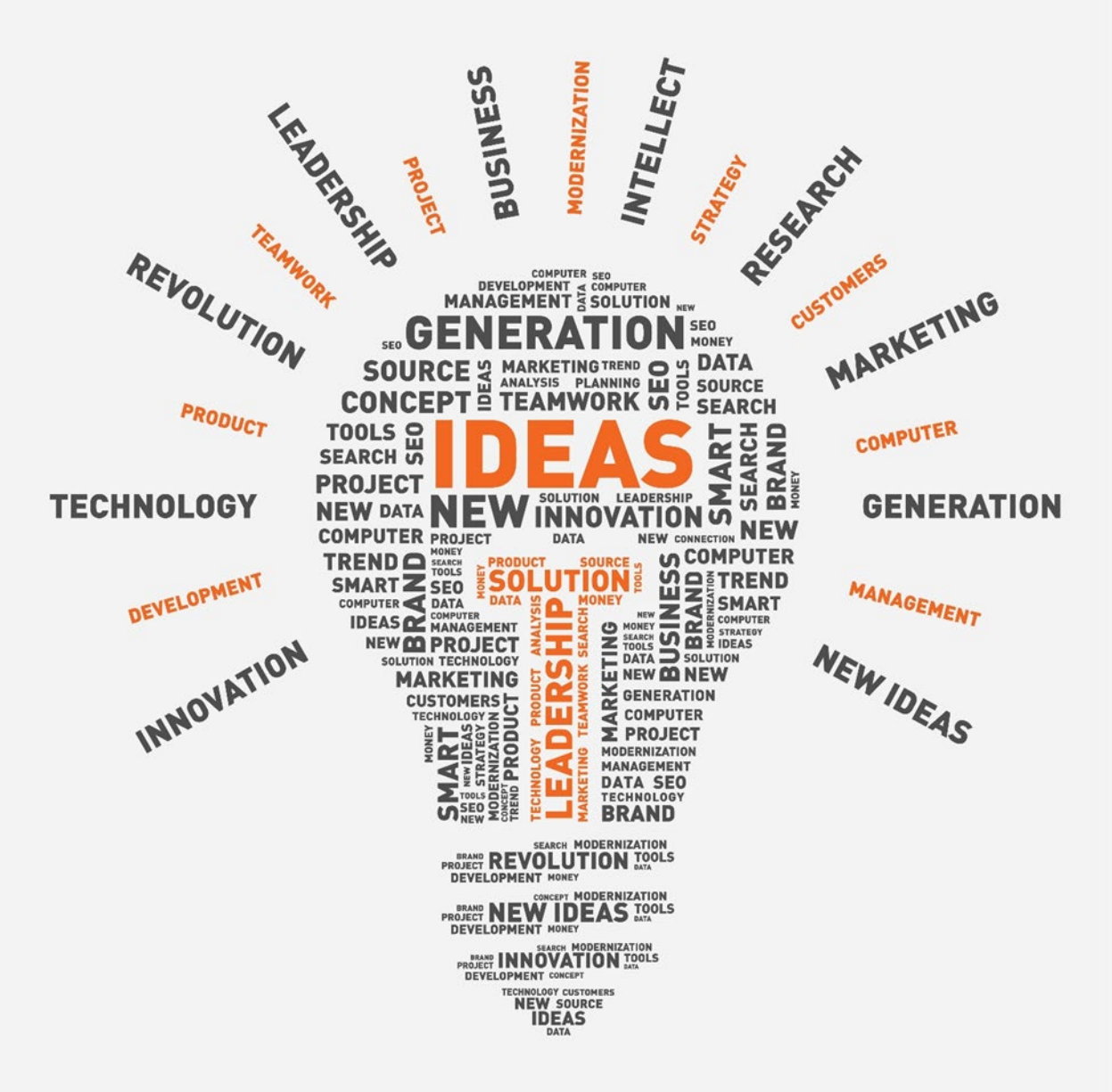
Access to Care

All dialysis facilities in Network 8's service area have been advised to notify the Network prior to providing the patient with a 30-day notice of Involuntary Discharge (IVD), and efforts are made to avert discharge during an initial phone call with facility staff. The initial phone call consists of a review of facility interventions to improve the behavior and develop a detailed action plan. To ensure that Patient Services staff assesses potential health disparities when working with clinics, a facility call screening tool was implemented to assess for health disparities that the patient could be facing. From May 2023 through April 2024, there were 109 reported Access to Care cases, 100 of which were at risk for IVD. Of these, 65 cases were successfully averted IVDs, and 35 resulted in involuntary discharge. One IVD was successfully placed in another dialysis facility.

The Network promoted the use of the "Safety First" patient education flyer to address common statements and threats made that could lead to IVD. These statements were addressed on a cross-cultural basis for universal understanding of what threats mean. The Network also promoted the use of the DPC Addendum in Conflict Resolution. Training was conducted by Webinar, train the trainer Webinars to regional leadership, and trainings held with individual facility managers based on the train the trainer model.

Chart 30: Percent of May 2023-Apr 2024 Grievances and Non-Grievances by Case Type




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

ESRD Network Recommendations

Providers in the Network 8 region are monitored throughout the year for their participation and performance in improvement activities specified in the Network's CMS contract for various quality metrics. The Network provides resources, coaching, and assists with action plan development for measures that are not meeting CMS goal. Networks may recommend that sanctions or alternative sanctions be imposed on facilities that do not cooperate with Network improvement activities. In 2023, there were no providers who consistently failed to cooperate with Network goals.

CMS Expanded Services:

1. Based on feedback from patients and providers, Network 8 would recommend that CMS provide enhanced benefits for beneficiaries related to transportation services, which would decrease missed treatments and unplanned hospitalizations. Transportation services would also assist patients with access to transplant centers for assessments and follow-up appointments. Patients especially in need of this are those who are ineligible for Medicaid transportation yet cannot afford private transportation.
2. To increase the utilization of Home Dialysis, CMS may consider reimbursement for In-Home Staff Assist Dialysis which would allow those that do not have a care partner, transportation, low health literacy, or motor functions to benefit from Home Dialysis.
3. CMS promotion of in-center Self-Care to Dialysis providers would increase patients' awareness and comfort with transitioning to home dialysis.


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
medical
urgent
danger
disaster
supplies
emergency room
service
help
protection
kit
evacuation
stretcher
paramedic
business
alarm
medic
safe
jeopardy
resilience
emergency
incident
equipment
disease
urgency
threat
natural disaster
natural
information
property
recovery
nurse
crisis
doctor
government
health
environmental
situation
risk management
public
response
rescue
hospital
security
room
intervention
operations
life
accident
risk
medicine
education
loss
system

ESRD Network COVID-19 Emergency Preparedness Intervention

While the federal Public Health Emergency for COVID-19 expired on May 11, 2023, Network 8 continued to support facilities in their efforts to vaccinate patients and manage cases of COVID-19. Patients who were COVID-positive were treated at their home facilities. Network 8 continued to work closely with Alliant Health Solutions and TMF the two QIN/QIO organizations for our states as well as other state emergency management organizations to address COVID-19 cases. One of the main barriers for facilities and patients was vaccine fatigue.

Tools presented to facilities to overcome barriers were vetted and discussed by Network 8 MRB, and other stakeholders. Network 8 also distributed COVID-19 professional and patient educational material through email blasts, social media postings, and website postings throughout the year.

Despite the waning of the pandemic, dialysis and transplant facilities continued to experience staffing shortages, often causing dialysis organizations to consolidate shifts and close smaller facilities. Network staff worked closely with providers, offering support and resources to help address frustrations, fears, and stressors caused by these changes and faced by staff and patients alike.

ESRD Network Significant Emergency Preparedness Intervention

The Network 8 service area experienced various weather conditions that impacted numerous facility operational statuses in 2023. During and after each emergency disaster event, Network 8 staff provided, if applicable, the required CMS after-action reports and attended Kidney Community Emergency Response (KCER) hot wash meetings.

In the Network 8 service area, severe thunderstorms, winter weather events, flooding, tornadoes, and a water crisis occurred during June, July, August, September, November, and December. These events had a minor impact on the dialysis community.

Severe weather impacted the Lower Mississippi Valley and Southeast overnight on June 14, 2023. An update regarding any impacts to facility operations and/or patient access to care concerns due to the severe weather was provided to KCER. The Network reached out to all facilities in the affected area. There were no significant impacts to facilities. One facility reported power loss on June 15th and 16th. Patients were on a modified schedule and were offered alternative locations. A generator was provided until the power was restored.

Staff attended annual Mississippi State Dept. of Health Emergency Support Function (ESF)-8 meeting June 27, 2023. ESF-8 is the Public Health and Medical Services component of the Statewide Emergency Plan. The meeting attended by various organizations including Board of Nursing, Board of Pharmacy, Board of Medical Licensure, MSDH Survey and Certification, MSDH Medical Support Unit (special needs shelter), Office of Emergency Preparedness and Response—HazMat and Unmanned Aerial Vehicle program, and Mississippi Mortuary Response Team.

On July 20, 2023, Germantown, TN issued an emergency water alert after a diesel spill. Two facilities in the Germantown area were affected by this water emergency. Those clinics re-routed patients to other facilities in the Memphis area for treatment. Most patients were successfully placed at other facilities, while some refused and were educated on the risk of missing treatments. Network completed an KCER Emergency Situational Status Report (ESSR), due to the facilities being closed for more than three days. Both facilities were able to successfully reopen. All patients were accounted for and returned to regularly scheduled treatment. Network 8 staff were on hand to assist with patient and facility needs.

On February 22, 2023, the Network conducted an annual Emergency Disaster Tabletop drill with Networks 7, 13, and 14. KCER facilitated the drill with 214 stakeholders which included one patient. Participants included CMS representatives, LDO leadership, State Agencies, ESRD Emergency Coalition, and the Network staff. Additionally, Network 8 provides ongoing resources and educational outreach to dialysis facilities in preparation for events. Network capacity is enhanced through ongoing collaborations with emergency management agencies. The Network maintains an updated comprehensive emergency management plan and has a reciprocal relationship with a partner Network as well as sister Network 14 that can provide services to this region in case a catastrophic event occurs at Network 8's work site.

Acronym List Appendix

This appendix contains an acronym list created by the KPAC (Kidney Patient Advisory Council) of the National Forum of ESRD Networks. We are grateful to the KPAC for creating this list of acronyms to assist patients and stakeholders in the readability of this annual report. We appreciate the collaboration of the National Forum of ESRD Networks especially the KPAC.

This material was prepared by Alliant Health Solutions, an End Stage Renal Disease (ESRD) Network under contract with the Centers or Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute an endorsement of that product or entity by CMS or HHS. Produced under contract numbers NW 8: 75FCMC19D0005-75FCMC21F0001