# ESRD NETWORK 2018 ANNUAL REPORT

Health Services Advisory Group (HSAG): End Stage Renal Disease (ESRD) Network 15

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# ESRD DEMOGRAPHIC DATA

## ESRD Network 15

As part of the HSAG team, ESRD Network 15 works with patients and providers in Arizona, Colorado, Nevada, New Mexico, Utah, and Wyoming to improve the quality of care and quality of life for ESRD patients. HSAG has held the Network 15 contract since 2016.

## Geography and General Population

Geographically, Network 15 encompasses 21% of the landmass of the contiguous United States and includes mountains, plains, and desert. Urban population centers contain the majority of residents. There are, however vast rural and wilderness areas in each state, which impact availability of care for ESRD patients due to length of travel for treatments. Network 15 works closely with the Kidney Community Emergency Response (KCER) Coalition to monitor weather patterns, natural disasters, and other emergency situations to ensure patient safety in both rural and urban areas. Following are characteristics unique to the individual Network 15 service area states:

- **Arizona:**
  - Is the sixth largest state in the nation with an area of 113,635 square miles.
  - Has one of the largest Native American populations.
    - More than 14 tribes represented on 20 reservations.
  - Is ranked 14th in the U.S. for total population.
  - Has a 389-mile international border with Mexico.
  - Is the largest landlocked U.S. state by population.

- **Colorado:**
  - Is the eighth largest state in the country, extending 387 miles east to west and 276 miles north to south, with an area of 103,718 square miles.
  - Is geographically characterized by the Continental Divide, which extends northeast to southwest and roughly bisects the state into the eastern and western slopes.
  - Is ranked 21st in population in the U.S.
    - The majority of the population lives in metropolitan areas, nearly all in an 11-county urban corridor along the eastern edge of the Continental Divide, which includes the cities of Boulder, Denver, Colorado Springs, and Pueblo.
  - Is primarily rural.
  - Depends on agriculture, tourism, and mining as its major economic producers.
  - Has topography that varies from semi-arid plains to high-mountain ranges.
  - Has its major healthcare referral center located in Metropolitan Denver.
    - Denver also serves as the major healthcare referral center neighboring states.

- **Nevada:**
  - Is the driest state in the nation, with an average annual rainfall of only about 7 inches.
    - Much of Nevada is uninhabited, sagebrush-covered desert.
  - Is the seventh largest state in the U.S., with an area of 109,826 square miles that covers the Mojave Desert in the south to the Great Basin in the north.
  - Is 86 percent owned by the federal government.
  - Has Boundary Peak, at 13,147 feet as its highest point and the land along the Colorado River as its lowest point at 479 feet.

- **New Mexico:**
  - Is the fifth largest state in the country, with an area of 121,356 square miles.

- o Ranks 37th in the U.S. in population.
- o Is 42% federally owned.
- o Has the third-highest percentage of Native Americans in the country, after Arizona and Oklahoma.

- **Utah:**
  - o Has 82,114 square miles within its borders, ranking 13th in total area and 31st in population.
  - o Has three-quarters of its population living along the western slope of the Wasatch Mountains.
    - ▪ Called the Wasatch Front Metropolitan area.
  - o Is comprised of mountains and desert.
  - o Is 57.5% federally owned.
  - o Has 79% of its population living in metropolitan areas.

- **Wyoming:**
  - o Is the tenth largest state in the U.S., with an area of 97,100 square miles.
  - o Is the least populated state in the country.
  - o Is characterized by sparsely populated rural and wilderness areas with a few urbanized population concentrations.
    - ▪ Only 30% of the population lives in urban areas.
  - o Has topography that varies from semi-arid grasslands to high mountain ranges.
    - ▪ Climate and topography combine to make travel times and accessibility difficult and sometimes impossible.
  - o Is a leading coal-/petroleum-/natural gas-producing state.

## ESRD Population

Network 15 worked in collaboration with the renal community and other key stakeholders to improve the quality of life and quality of care for 26,191 individuals with ESRD in 2018. During the reporting period of December 31, 2017 to December 31, 2018, the Network's ESRD patient census increased by 1,198 patients (4.8%) for a total of 26,191 prevalent patients in the Network's service area, as compared to the national total of 518,106 as of December 31, 2018. The number of incident dialysis patients in the Network service area increased by 6,689 (25.5%) individuals newly diagnosed with ESRD in 2018, compared to 6,265 (26.8%) in 2017. (See Chart A)

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

**Percent of Prevalent Dialysis Patients by ESRD Network**
**2018**



National total dialysis patients: 518,106
Source of data: CROWNWeb
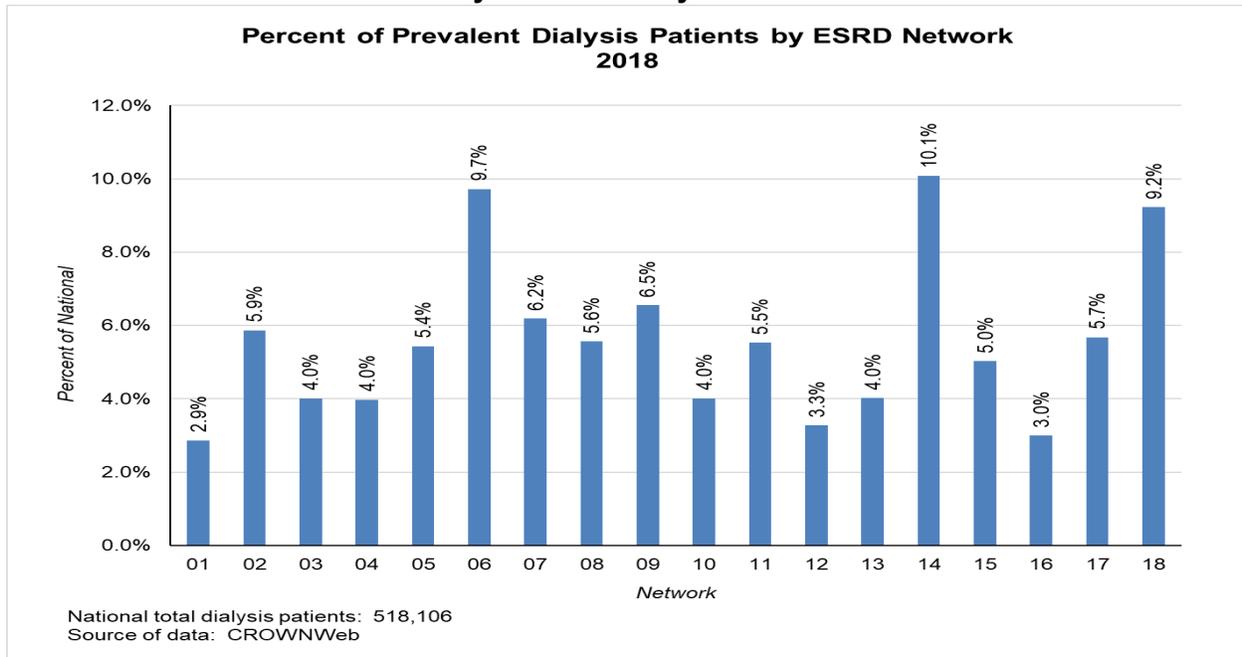
## Race and Ethnicity[1]

As of December 31, 2018, 72.7% of prevalent patients in the Network 15 service area were characterized as White and 10.8% as American Indian/Alaska Native. The third largest racial group reported by patients was African American at 10.8%. As of December 31, 2018, the majority of prevalent patients in the Network 15 service area, 71.7%, were characterized ethnically as Not Hispanic or Latino.

## Gender and Age

As of December 31, 2018, 58.5% of prevalent ESRD patients in the Network 15 service area were male, 41.5% were female, and 67.9% were between the ages of 45 and 74. No significant regional differences were noted with respect to the gender or age of prevalent ESRD patients in the Network's service area.

## Primary Cause of ESRD/Co-Morbidities[1]

Network data reflected that in 2018, 73% of ESRD patients in the service area had a primary cause of ESRD that fell into one of two co-morbid categories: 53.2% showed diabetes and 19.8% showed hypertension as primary causes of ESRD.

## Dialysis Treatment Options

As of December 31, 2018, 26,191 dialysis patients in the Network 15 service area were using four main modalities of dialysis treatment:

- In-center hemodialysis (ICHD):                           87.0%

- Continuous-cycling peritoneal dialysis (CCPD):          10.5%

- Continuous-ambulatory peritoneal dialysis (CAPD):        1.2%

- Home hemodialysis (HHD):                                 1.3%

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[1] Data on "ethnicity" and "race" should be interpreted with caution because of the inherent instability of race/ethnicity data.

**Chart B: Count of Prevalent ESRD Patients by Treatment Modality in Network 15**

**Network 15: Count of Prevalent ESRD Patients by Treatment Modality 2018**



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: CROWNWeb
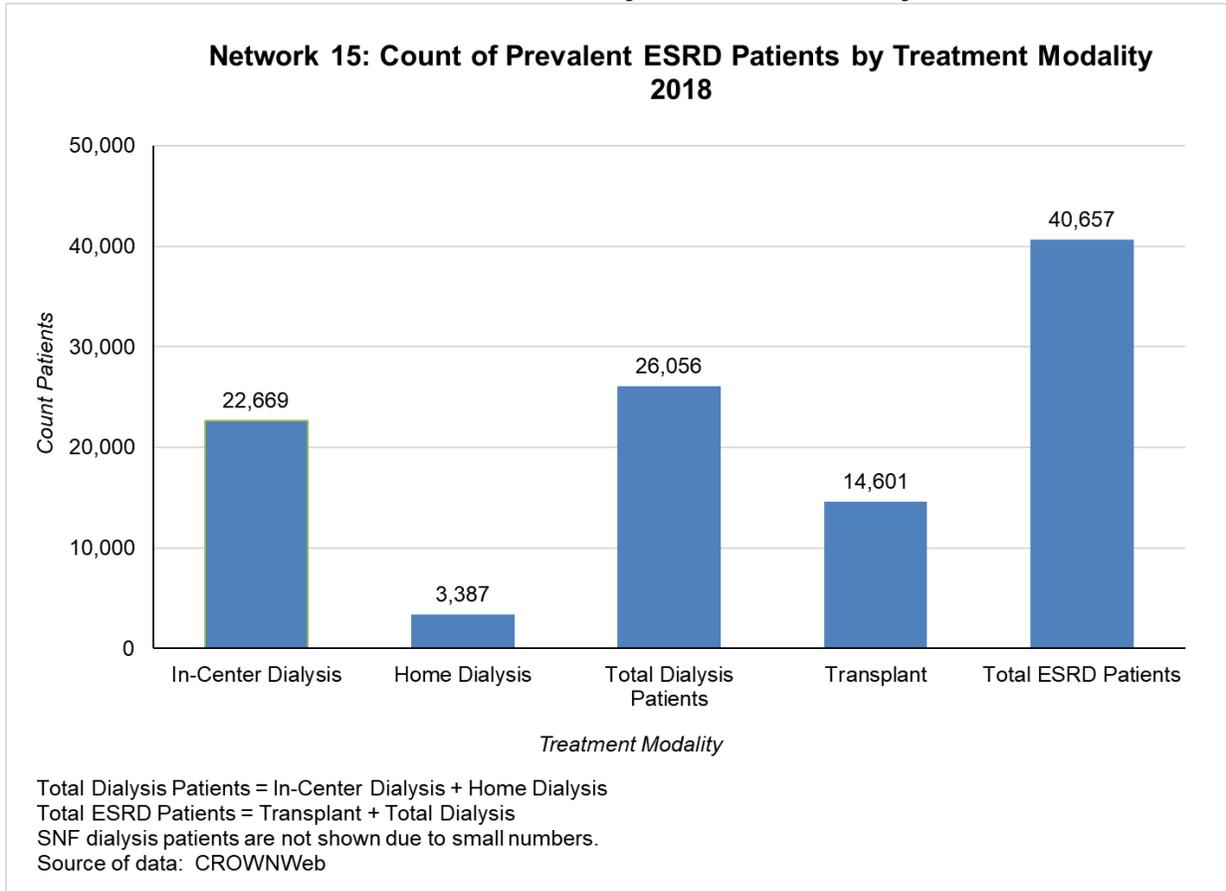
**Chart C: 2018 Percent of Home Dialysis Patients by ESRD Network**

**Percent of Home Hemodialysis and Peritoneal Dialysis Patients by ESRD Network 2018**



National total home hemodialysis and peritoneal dialysis patients: 61,826
Source of data: CROWNWeb
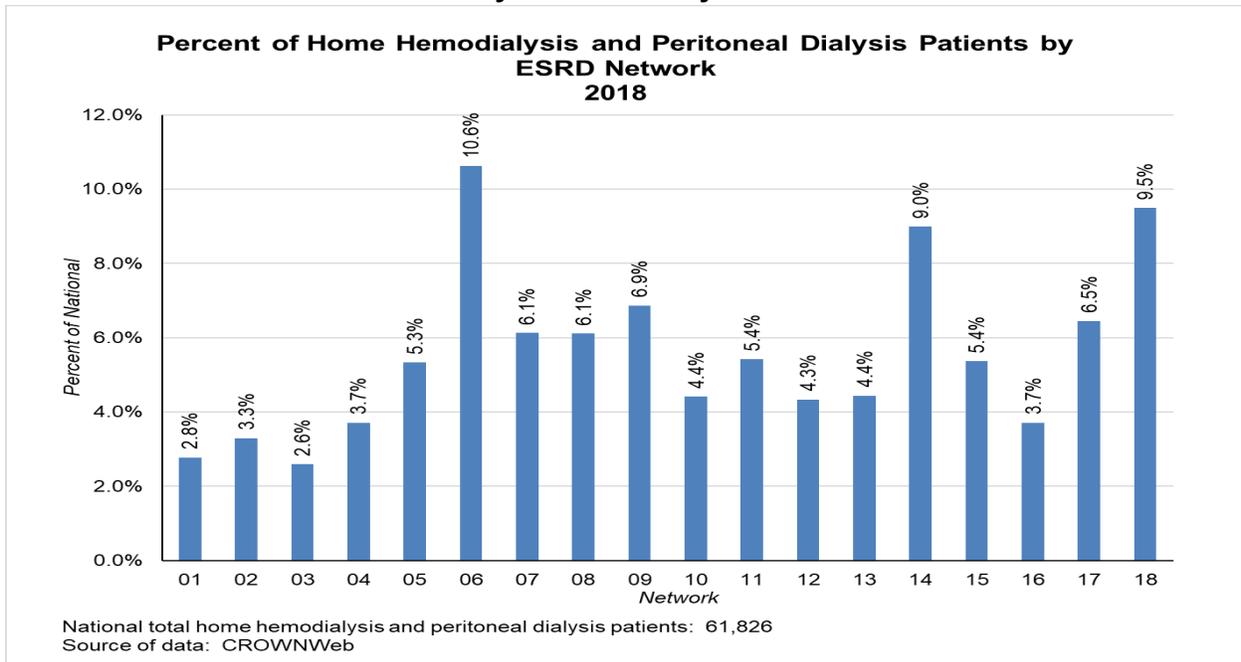
## Transplant

During 2018, 14,619 kidney transplants were completed by 15 transplant centers in the Network 15 service area. As of December 31, 2018, there were 221,497 transplant patients nationally, of which 6.6% were in Network 15. (See Chart D)

**Chart D: 2018 Percent of Transplant Patients by ESRD Network**



Percent of Transplant Patients by ESRD Network
2018

National total transplant patients: 221,497
Source of data: CROWNWeb
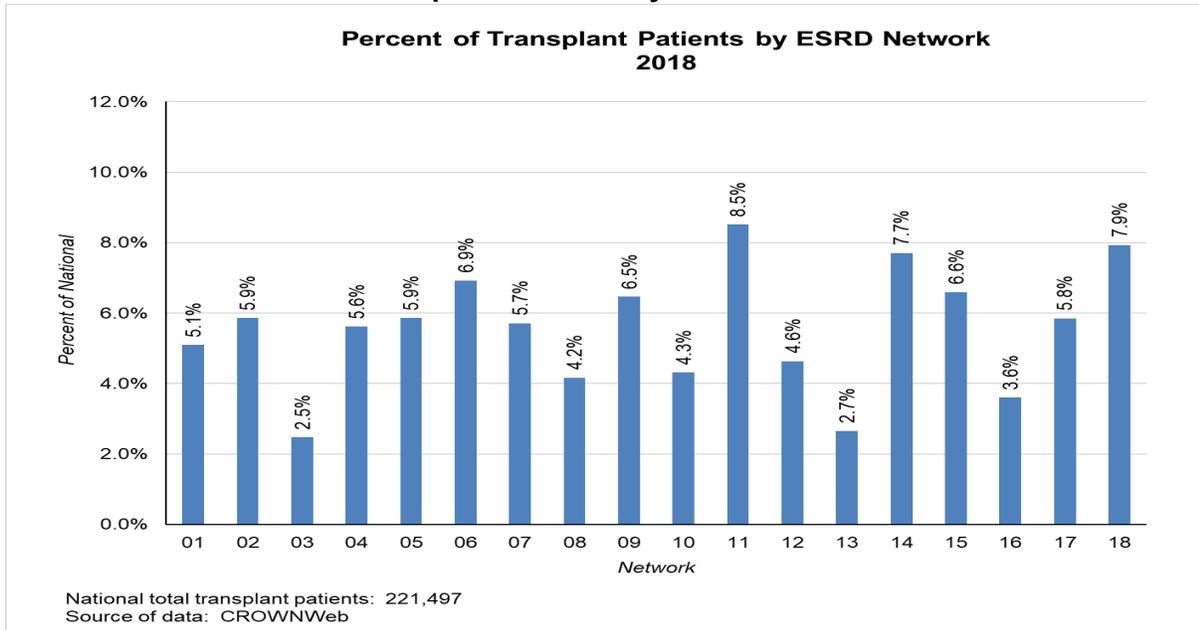
## Providers

As of December 2018, Network 15's service area included a total of 378 dialysis providers, including providers pending Medicare certification and federal/prison facilities, and 15 transplant centers, one of which has temporarily suspended its transplant program with tentative reopening in Fall 2019. Of the 378 dialysis facilities in Network 15's service area, 24.3 % offered dialysis shifts starting after 5 p.m. MT.

**Chart E: 2018 Percent of Medicare-Certified Kidney Transplant Facilities by ESRD Network**



Percent of Medicare-Certified Kidney Transplant Facilities by
ESRD Network
2018

National total ESRD Medicare-certified kidney transplant facilities: 229
Source of data: CROWNWeb
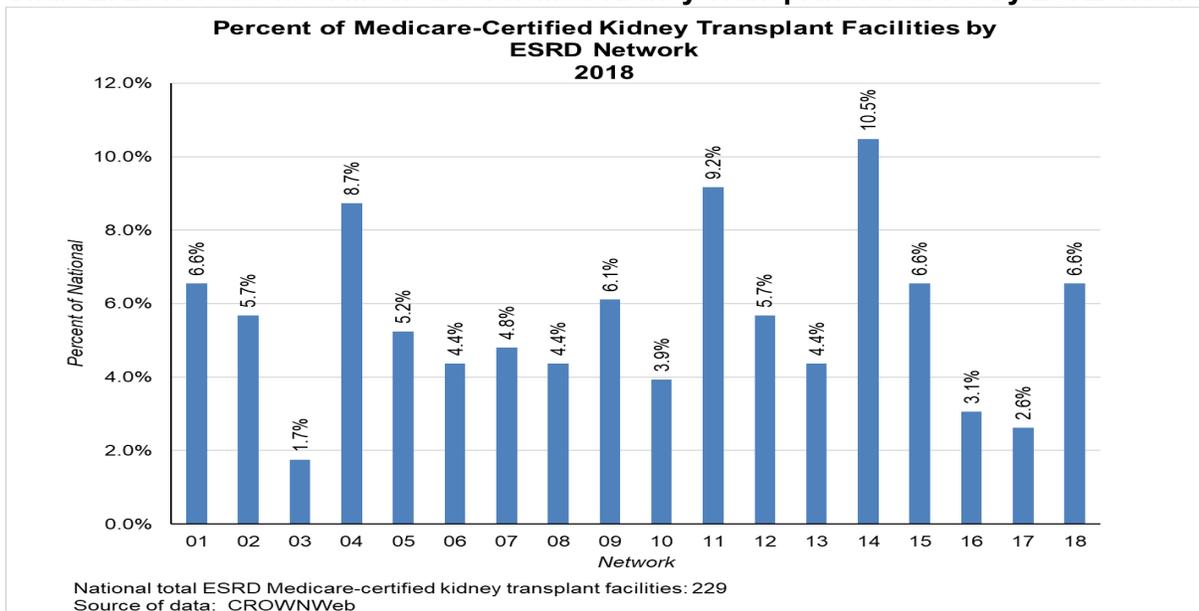
**Chart F: 2018 Count of Medicare-Certified Facilities by Modality Type**

**Network 15: Count of Medicare-Certified Facilities by Modality Type Offered 2018**

| Treatment Modality | Count Facilities |
|---|---|
| Transplant | 15 |
| In-Center and Home Dialysis | 148 |
| In-Center Only | 202 |
| Home Dialyisis Only | 13 |
| Total Dialysis Facilities | 363 |
| Total ESRD Facilities | 378 |

Total Dialysis Facilities = In-Center and Home Dialysis + Home Dialysis only + In-Center Only
Total ESRD Facilities = Transplant + Total Dialysis Facilities
Source of data: CROWNWeb

**Chart G: 2018 Percent of Medicare-Certified Dialysis Facilities by ESRD Network**

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

| Network | Percent of National |
|---|---|
| 01 | 2.7% |
| 02 | 4.1% |
| 03 | 3.2% |
| 04 | 4.7% |
| 05 | 6.0% |
| 06 | 10.2% |
| 07 | 6.5% |
| 08 | 6.3% |
| 09 | 8.6% |
| 10 | 4.4% |
| 11 | 6.9% |
| 12 | 4.6% |
| 13 | 4.6% |
| 14 | 9.6% |
| 15 | 4.9% |
| 16 | 3.0% |
| 17 | 4.0% |
| 18 | 5.6% |

National total ESRD Medicare-certified dialysis facilities: 7,431
Source of data: CROWNWeb
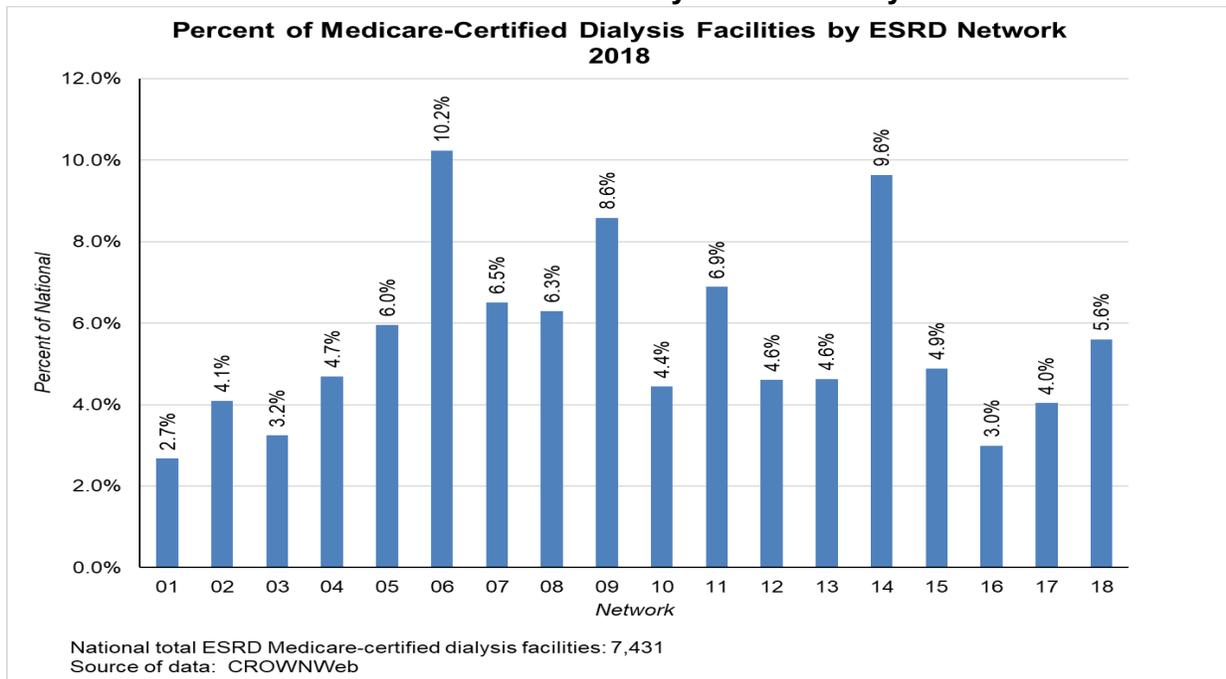
# ESRD NETWORK GRIEVANCE AND ACCESS TO CARE DATA

## Grievances

The Network responds to grievances filed by or on behalf of ESRD patients in its service area. Grievances may focus on staff issues, quality of care issues, and/or environmental issues and fall under several categories, including Clinical Quality of Care, General Grievance, and Immediate Advocacy. (see Table 3) Immediate Advocacy grievances are addressed by the Network contacting the facility to resolve an issue within seven calendar days. General Grievances, in which the Network addresses more complex non-quality of care issues, are addressed over a 60-day period. Quality of Care grievances are addressed through records review. Grievants receive a final outcome letter. During 2018, 65% of contacts to the Network were for grievances, including 21% for Immediate Advocacy, 7% for Clinical Quality of Care, and 8% for General Grievances. (see Chart H)

## Facility Concerns

In addition to grievances, the Network also responded to facility concerns, which accounted for 35% of all contacts to the Network in 2018. Facility Concerns included contacts received from providers related to managing difficult patient situations, requests for technical assistance, and other concerns

## Access to Care Issues

The Network works with facilities and advocates for patients to avert potential Access to Care issues whenever possible. Access to Care concerns include patients at-risk for Involuntary Discharge (IVD) or Involuntary Transfer (IVT), and patients who have not been able to permanently establish themselves with an outpatient dialysis facility. During 2018, Access to Care issues accounted for 29% of contacts to the Network.

**Chart H: 2018 Network Grievances and Non-Grievances**
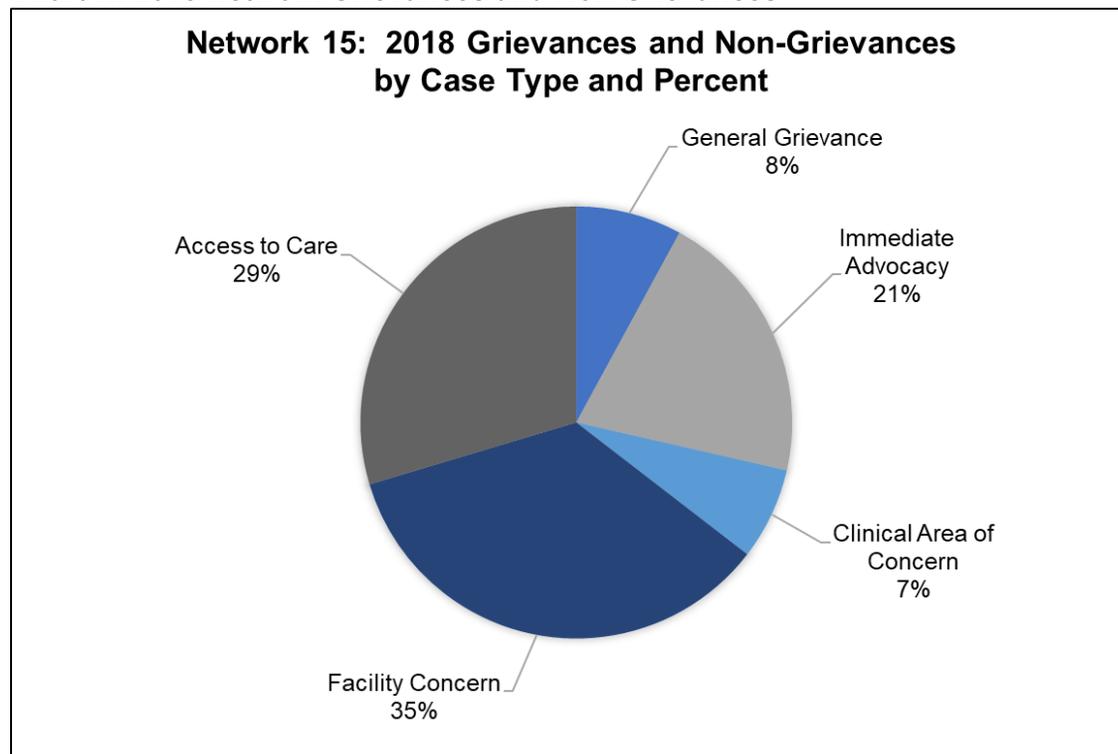


Source of data: Patient Contact Utility (PCU)

# ESRD NETWORK QUALITY IMPROVEMENT ACTIVITY DATA

## Network Goals

CMS establishes priorities for the ESRD Network contractors annually in the Statement of Work section of each Network's contract with the agency. These priorities support CMS and Department of Health and Human Services (HHS) national quality improvement goals and priorities.

In 2017, the ESRD Network contractors were tasked with meeting the following goals:

- Improving care for ESRD patients in the Network's service area by:
  - Promoting patient- and-family-centered care.
  - Responding to grievances about ESRD-related services filed by, or on behalf of ESRD patients.
  - Supporting improvement in patients' experience of care.
  - Working with dialysis facilities to ensure that all dialysis patients have access to appropriate care.
  - Promoting best practices in vascular access (VA) management.
  - Helping dialysis facilities reduce the incidence of healthcare-associated infections (HAIs).

- Improving the health of the ESRD patient population in the Network's service area through activities designed to reduce disparities in ESRD care.

## Improving Staff Communication Quality Improvement Activity (QIA)

In 2018, The Network engaged in a QIA with clinics in its service area to improve the patient experience of care (PEOC) by improving communication between patients, facility staff, and the Network. Four clinics were initially selected to work on this initiative, starting in May of 2018, with an initial combined census of approximately 330 patients. By August, the project was opened to all clinics in The Network. This allowed additional clinics to join calls discussing the interventions. The Network also pushed out reviews of the interventions throughout its coverage area via Network-wide emails, the Network website, social media, and during technical assistance interactions.

### Goals and Outcomes

The goal of the QIA was to provide tools and best practices to positively impact communication at the facility level. Using the means outlined above, the Network did achieve thorough saturation of the interventions throughout its clinics. However, as detailed below under "Barriers," the framework of the QIA made it difficult to concretely quantify the effectiveness of the interventions presented. It can be asserted that by the end of the reporting year (September 30, 2018), 95.7% of clinics participating nationally (including the clinics from Network 15's coverage area) stated they felt better prepared to communicate with patients as a result of participating in the QIA.

### Barriers

Three inter-related barriers to achieving goals were noted during the course of the QIA:

- Frequent staff turnover
  - Facilities reported that high turnover impacted the ability to share the QIA interventions and maintain stable staff representation for the projects.

- Difficulty with communication and staff professionalism
  - Identified nationally over the past several years.

- The ability to gather and measure improvement and sustainability from interventions
  - Involvement from included and voluntarily participating facilities has hampered measurement efforts.

## Interventions

Interventions included, but were not limited to:

- Educating multiple staff members on QIAs, creating sustainability despite staff turnover.

- Including all facilities in the PEOC QIA, allowing for increased education dissemination and participation across the Network service area.

- Educating clinics on how to use the *ESRD Networks Grievance Toolkit*.

- Reviewing the fundamentals of relationship-centered care (RCC) with clinics and how to incorporate it in communications with patients.

- Introducing the concept of "Net Forward Energy" and how to apply it in tools and communications with patients.

## Best Practices

One key best practice introduced in the course of the QIA was to incorporate an understanding of a dialysis patient's psychological challenges into providers' communication expectations by reviewing patients' general psychological needs. Of the QIA participants surveyed, 97.5% stated they learned a new skill or strategy for communicating with their patients, and 99.0% stated that they felt better prepared to help patients by incorporating this concept in their service communications.

# Long-Term Catheter (LTC)

During 2018, the Network conducted a QIA to reduce LTC use (catheter in use for 90 days or longer) in a cohort of 65 facilities with rates greater than 15.0%, impacting 4,932 patients. The Network implemented more intensive interventions for a subset of 25 facilities, impacting approximately 1,935 patients. The subset facilities were selected based on having low arteriovenous fistula (AVF) rates in addition to high LTC rates.

## Goals and Outcomes

The baseline LTC rate for the cohort of 65 facilities, which was based on August 2017 CROWNWeb data, was 18.067%. By September 2018, the cohort facilities reduced their aggregate LTC rate to 13.13%, which was a decrease of 4.937 percentage points. This exceeded the QIA goal and was also lower than the final measurement at the national QIA level, which was 17.2%. (See Chart I)

## Barriers

Facility-reported barriers to achieving QIA goals included:

- Initiation of treatment in an urgent manner.
  - Did not allow time for patients to receive proper orientation, education, and VA planning.

- Not having a designated staff member to monitor VA planning and maturing accesses.
  - Caused delays in using maturing accesses, detecting surgical issues requiring intervention, establishing procedure appointments, and removing existing catheters in a timely manner.

## Interventions

Patient SMEs provided the patient perspective for development of all QIA educational materials and interventions, which included the Network:

- Requiring the subset facilities to conduct root cause analyses (RCAs).
  - Results were used to develop small tests of change using the Plan-Do-Study-Act (PDSA) cycle.
  - The Network was able to provide individualized technical assistance to facilities based on RCA and PDSA results, such as developing/updating processes or providing relevant tools/resources.

- Distributing Fistula First Catheter Last reports from data collected by the National Coordinating Center (NCC) and providing feedback to QIA facilities about the data and next steps.

- Providing training and technical support to ensure accurate vascular access reporting in CROWNWeb.

- Reinforcing a patient focus by asking patient SMEs to participate on QIA calls and provide their perspective on challenges to permanent access placement and how challenges can best be addressed.

## Best Practices

Best practices identified by the QIA facilities included:

- Encouraging VA surgeons to round at the facility, allowing them to establish VA plans and address any financial or transportation barriers in an outpatient setting.

- Setting the expectation of establishing a permanent access upon admission, before a patient becomes comfortable with a central venous catheter (CVC).

- Providing frequent patient education on infection prevention to create a heightened awareness of the risks associated with having an LTC.

## Chart I: QIA Facility Aggregate LTC Rates



**Network 15: Long-Term Catheter Rates for Quality Improvement Activity (QIA) Facilities with National QIA Rate Comparison**
**January 2018 - September 2018**

Source of data: October 2018 ESRD Network Dashboard
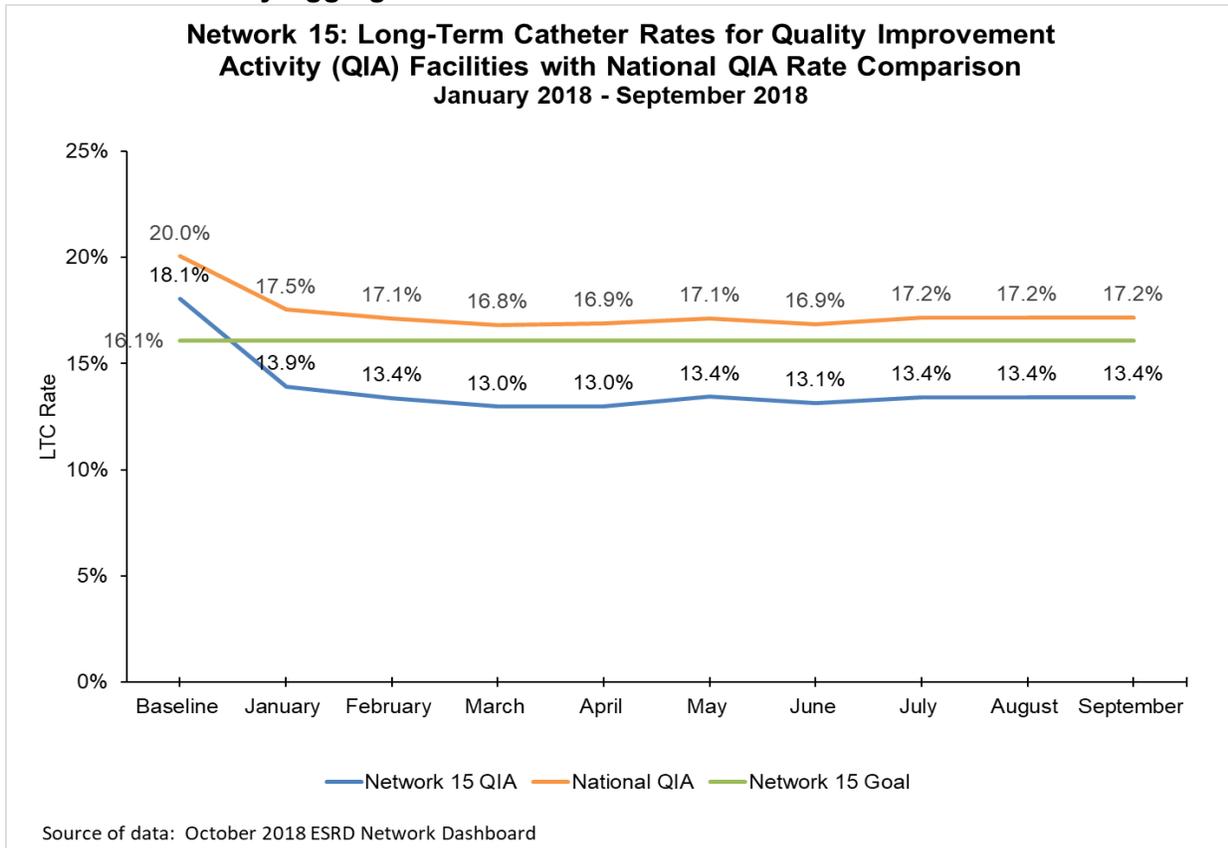
# Bloodstream Infection (BSI) QIA

During 2018, the Network conducted a QIA to reduce dialysis event rates, specifically BSIs, by improving infection control practices. The QIA was designed to support the National Action Plan to Prevent Healthcare-Associated Infections (HAIs) and the Centers for Disease Control and Prevention (CDC) Core Interventions for Dialysis BSI Prevention Program. The QIA included 65 facilities, impacting approximately 4,932 patients.

## Goals and Outcomes

The Network used the National Healthcare Safety Network (NHSN) BSI pooled mean rate per 100 patient-months to target facilities for the QIA. The goal was to achieve at least a 20% relative reduction in the pooled mean rate of BSIs from January–June 2018 and to prevent at least 60 BSIs. By the conclusion of the QIA, the aggregate BSI rate decreased from 1.0 to 0.0, and 112 BSIs were prevented, exceeding the QIA goal. (See Chart J)

## Barriers

Facilities reported the following barriers to further reducing BSIs at their facilities:

- Lack of patient interest in receiving education about infection prevention, especially after becoming established in the dialysis setting.

- Staff being uncomfortable with patient participation in hand hygiene audits, fearing the audits might lead to scrutiny of staff when steps are perceived as "missed."

Patient-identified barriers included:

- Lack of staff enthusiasm or commitment to improving infection control, giving the perception that it was not important.

## Interventions

Interventions implemented during the QIA included:

- Using the CDC BSI prevention audit tools and 9 Core Interventions for preventing BSIs.
  - This was the primary intervention for the QIA.

- Providing patient education on the importance of washing hands and vascular accesses and knowing the signs and symptoms of infection.

- Attending an educational webinar, developed with the Colorado Department of Health and Environment (CDHE), that focused on CDC approaches to preventing BSIs in the dialysis facility and reporting in NHSN.

- Encouraging patients to sign a pledge to engage as partners in infection prevention efforts.

- Tracking and analyzing facility processes, prevention measures, and BSIs to support rapid cycle improvement (RCI).

- HIE promotion to facilities and discussion about attestations for facilities participating in HIEs.

- Conducting monthly hand hygiene audits with patients.

## Best Practices

Interventions to address barriers were tested by QIA facilities and best practices were shared with all facilities in the Network service area. (See Charts K and L) Best practices identified during the QIA included:

- Engaging patients in infection control by including them in audits for hand hygiene, as well as documenting observations on the CDC hand hygiene audit tool.

- Using resources to guide discussion with patients about infection control, such as the CDC handout, *Conversation Starter*.

- Conducting hand hygiene audits to heighten staff awareness of hand washing practices.

**Chart J: BSI QIA Reduction**

**Network 15: Reduction in Bloodstream Infections (BSI) in QIA Facilities**

Nationally, the Networks reduced 2,734 BSI in 2018

| | Goal Reduction | Actual Reduction |
|---|---|---|
| Value | 59 | 150 |

The Network goal was to decrease the rate of BSI by 20% or greater relative reduction in the pooled semi-annual mean in facilities participating in the QIA

QIA: Quality Improvement Activity
Source of data:  National Healthcare Safety Network (NHSN) January 2018 - June 2018 compared to January 2017 - June 2017

## Chart K: Network Facilities Completing NHSN Surveillance Training

**Network 15: Percent of Dialysis Facilities that Have At Least One Person Who Has Completed the NHSN Dialysis Event Surveillance Training**
**January 2018 - September 2018**



Source of data: October 2018 ESRD Network Dashboard
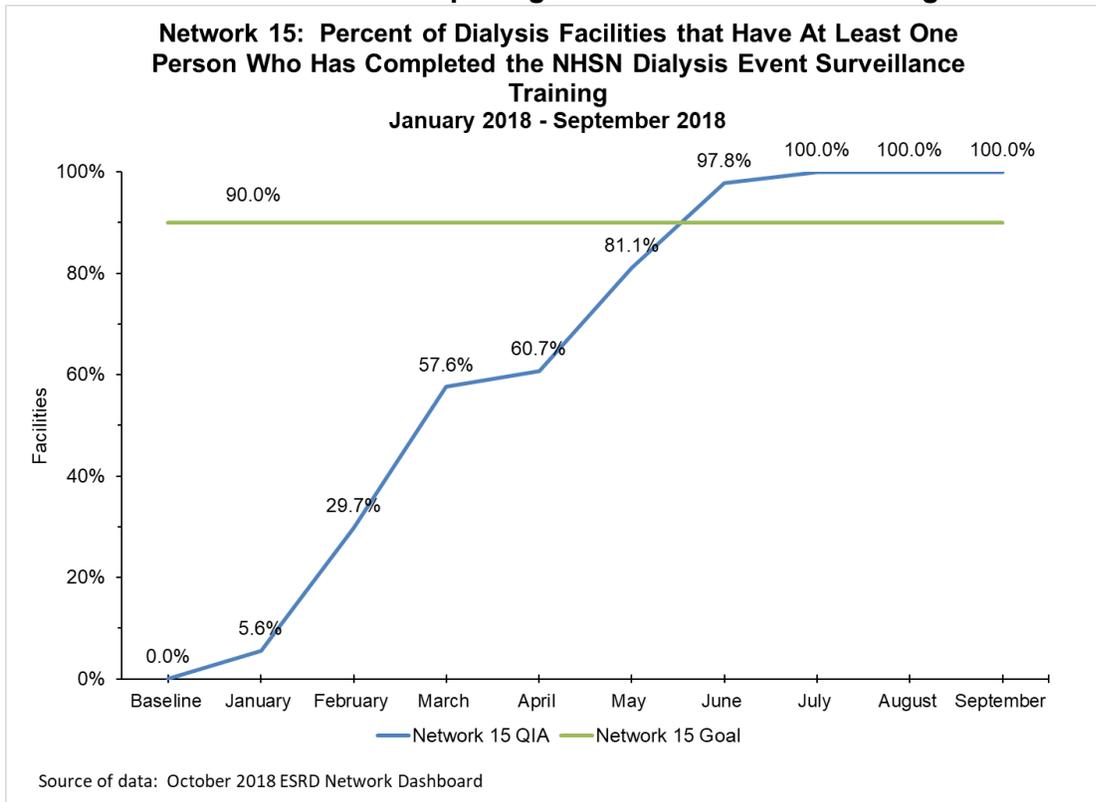
## Chart L: QIA Facilities Using an HIE

**Network 15: Percent of BSI QIA Facilities with a Health Information Exchange or Evidence-Based Highly Effective Information Transfer System**
**January 2018 - September 2018**



QIA: Quality Improvement Activity
BSI: Bloodstream Infection
Source of data: October 2018 ESRD Network Dashboard
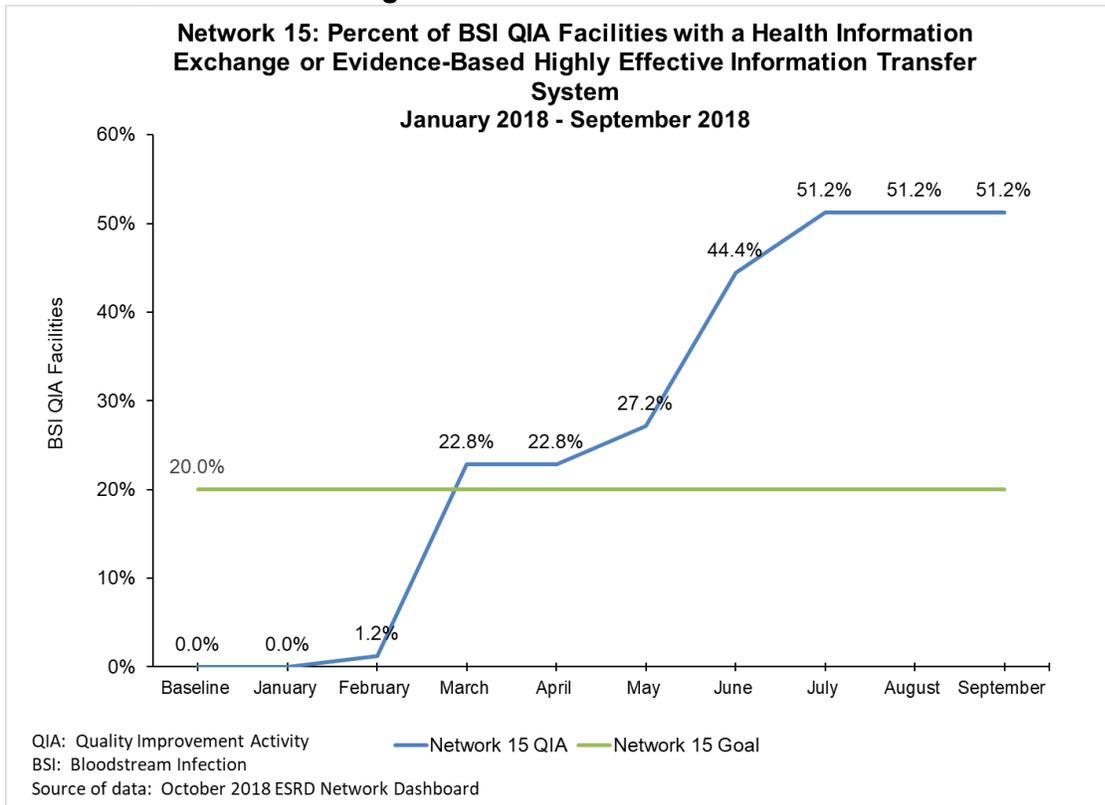
# Transplant Waitlist QIA

The 2018 Transplant Waitlist QIA aimed to increase the number of ESRD patients on transplant waitlists. The Network identified 104 dialysis facilities with low transplant referrals for inclusion in the QIA, impacting approximately 8,471 hemodialysis patients.

## Goals and Outcomes

The QIA goal was to improve the transplant waitlist rates by ten percentage points over baseline for a targeted group of dialysis facilities through education, early referral and patient support through the waitlist process. The baseline rate, identified using UNOS and CROWNWeb data, was 6.87%. As of the end of the QIA in September 2018, the final rate was 13.34%, an increase of 6.47 percentage points. (See Chart M)

## Barriers

Barriers to achieving the QIA goals included:

- Inaccurate information about transplant criteria.
  - An issue for both patients and facility staff.

- Lack of facility control over the waitlist process.
  - Transplant centers have control over the wait listing/eligibility requirements and testing, leaving facilities little control past the patient referral.

- Poor communication between the transplant centers and dialysis facilities that impacts the patients.
  - Patients do not receive proper direction regarding how to complete the required eligibility testing and/or health pre-requisites.

- Waitlists for kidneys are often years long.
  - Discourages both patients and staff.
  - Contributes to communication barriers between transplant and facility staff.

- Patient lack of interest in transplant.
  - Many patients are satisfied with dialysis and consider the facility staff and patients to be their support and social interaction.

- Financial and care giver requirements.
  - Even when eligibility has been established, these barriers can prevent wait listing.

## Interventions

Patient subject matter experts (PSMEs) provided the patient perspective for development of all QIA educational materials and interventions. Network interventions included:

- Providing individualized technical assistance.

- Initiating RCAs and conducting tests of change using the PDSA cycle.

- Posting transplant criteria from each of the 10 transplant centers in the Network area.

- Providing education on the barriers and myths around transplant for patients and staff through:
  - Handouts.
  - Lobby Days.
  - Site visits.
  - Webinars with speakers from transplant centers.

- Engaging transplanted peer mentors and transplant center coordinators to speak to transplant candidates and share experiences during Lobby Days.

- Developing and sharing financial resources for transplant requirements.

- Assisting facilities to adopt LAN transplant interventions, including the use of:
  - Transplant binders for tracking patient 7-steps.
  - Peer mentors.
  - A transplant interest form.

- Sharing expanded donor criteria, living donation materials, and how to ask for a living donation.

- Including social workers in Quality Assessment and Performance Improvement (QAPI) meetings to review transplant candidate progression to waitlist.

## Best Practices

Best practices identified by the QIA facilities included:

- Collecting and posting transplant-specific criteria to the Network website for dialysis facility staff to use during transplant discussion and education with ESRD patients.

- Conducting personal meetings with transplant centers and Network staff to establish relationships and inform centers of Network transplant activities and goals.

- Reviewing the Transplant 7-Step Tracker during quality meetings.

**Chart M: Percent of Patients from QIA facilities on the Transplant Waitlist**



**Network 15: Percent of Patients from QIA Facilities on the Transplant Waitlist**
**January 2018 - September 2018**

QIA: Quality Improvement Activity
Source of data: October 2018 ESRD Network Dashboard
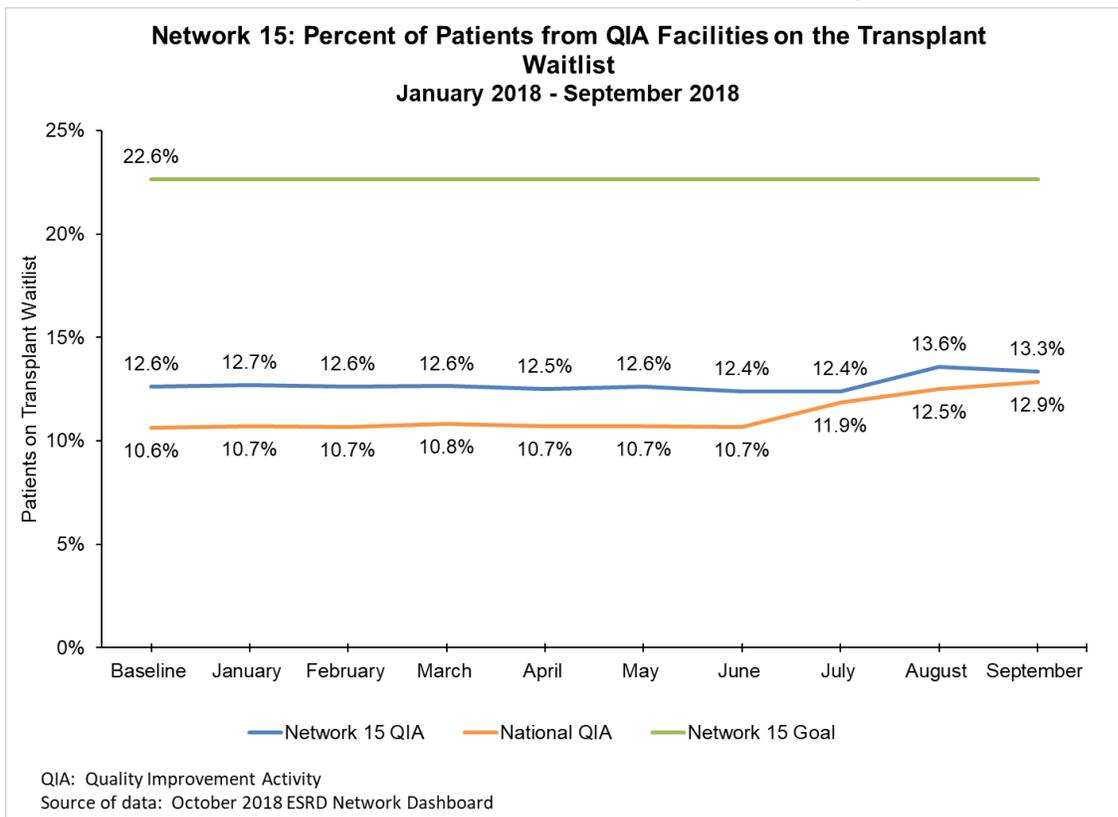
# Home Therapy QIA

In 2018, the Network conducted a QIA to support the CMS goal of increasing the number of ESRD patients on home therapies through identification of barriers to the referral process, education, and interventions to assist practitioners in moving eligible patients toward home therapy. The Network identified 99 dialysis facilities with low home therapy referrals for inclusion in the QIA, impacting approximately 7,326 hemodialysis patients.

## Goals and Outcomes

The QIA goal was to improve home therapy rates in the QIA facilities by ten percentage points over baseline. The baseline rate, identified using CROWNWeb data, was 0.778%. As of the end of the QIA in September 2018, the rate was 5.38%, an increase of 4.6 percentage points. (See Chart N)

## Barriers

Barriers to achieving the QIA goals included:

- Language and culture.
    - Network 15's large Hispanic population required bilingual patient advocates and/or phone translation.
    - The Network was proactive in addressing diversity by providing materials in Spanish, as well as sharing information about disparities in hemodialysis and how to overcome language and cultural barriers with dialysis staff.

- Inaccurate information about home modalities and eligibility.
    - This was an issue with both patients and facility staff.

- Poor staff understanding about dialysis modalities.
    - Resulted in poor communication with patients about home therapies, leaving patients uneducated or unaware of their choices.

- Patient lack of interest in home therapies.
    - Many patients are satisfied with in-center dialysis and consider the facility staff and patients to be their support and social interaction.

- Caregiver requirements.
    - Even when interest and eligibility have been established, this can be a barrier.

## Interventions

PSMEs provided the patient perspective for development of all QIA educational materials and interventions. Network interventions included:

- Providing individualized technical assistance.

- Initiating RCAs and conducting tests of change using the PDSA cycle.

- Providing home therapy-specific CROWNWeb training.

- Training dialysis staff on how to approach patients about home modalities.

- Educating staff and patients on the barriers and myths around home therapy through:
    - Handouts.
    - Lobby Days.
    - Site visits.
    - Webinars with expert speakers.

- Engaging patient advocates and home hemodialysis (HHD) partners to give input to the home program, actively engage in-center patients and families, and share experiences during Lobby Days.

- Developing and sharing sustainability resources,

- Involving HHD patients in QAPI.

- Encouraging open communication between home managers and in-center programs by.
  - Providing guidance and tools.
  - Supporting engagement through activities and interventions requiring collaboration.

- Assisting facilities to adopt LAN HHD interventions, including:
  - Opening transitional care units.
  - Distributing the *My Dialysis My Choice* decision aid.
  - Implementing a home admission process allowing nephrologists to admit to home as easily as in-center.

- Implementing RCI with facilities to ensure sustainability of effective interventions and discontinuation of ineffective interventions.

- Including social workers in QAPI meetings to review transplant candidate progression to waitlist.

## Best Practices

Best practices identified by the QIA facilities include:

- Increasing communication about and focus on home modality to create interest and improve participation by medical directors and nephrologists.

- Posting home modality tools and resources on the Network website, creating easy access for facility staff, patients, and nephrologists.

- Using monthly trackers to follow patients from interest to access to training, review at quality meetings, for use by the network, and to identify barriers to patients moving to home dialysis.

## Chart N: Percent of Patients from QIA facilities in Training for a Home Modality



Network 15: Percent of Patients from QIA Facilities in Training for a Home Modality
January 2018 - September 2018

QIA: Quality Improvement Activity
Source of data: October 2018 ESRD Network Dashboard
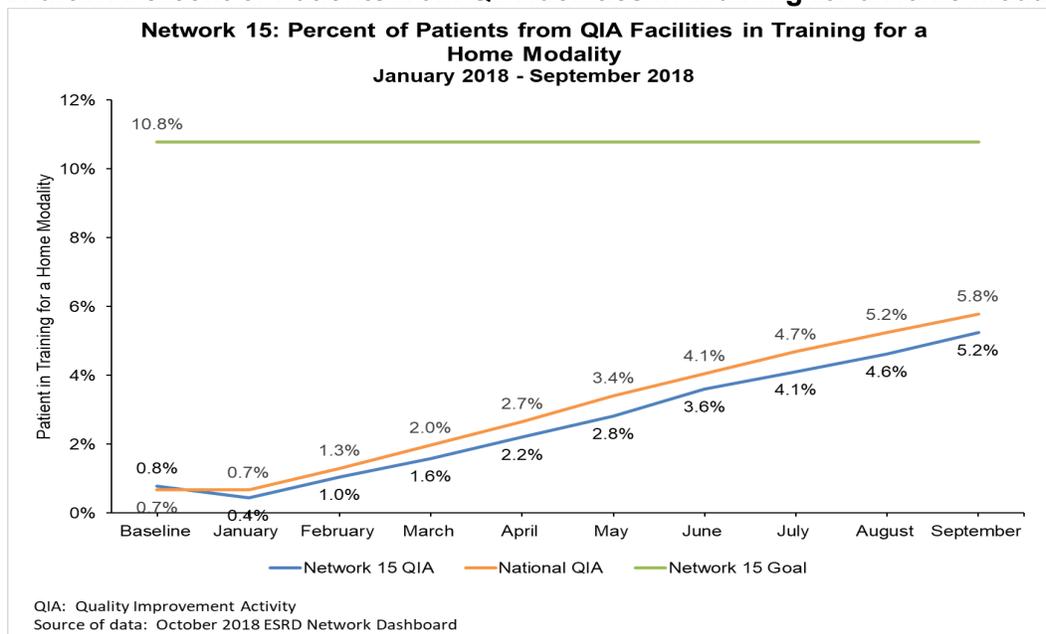
## Population Health Focus Pilot Project QIA (PHFPQ)

In 2018, Network 15 conducted a QIA focused on improving the quality of life for ESRD patients through the use of pain assessments and appropriate follow-up for those patients who report positive for pain. Network 15 assisted facilities with developing processes to ensure the completion, documentation, and appropriate follow-up of the twice-annual pain assessment for all qualifying patients in CROWNWeb. The Network identified 35 dialysis facilities with "no documentation of pain assessment, no reason given," or "positive pain assessment with no follow-up plan documented and no reason given."

## Goals and Outcomes

The primary goal of the QIA was to achieve a 10% improvement in the completion of pain assessments in the Network service area, including the number of patients screened for pain with screenings documented and the percentage of documented follow-up plans and a 100% zero rate of "no pain assessment completed, and no reason given" as reported in CROWNWeb by the end of September 2019. The baseline rate for the 35 identified facilities for "no documentation of pain assessment and no reason given" was 66.95% based on October 2016–June 2017 CROWNWeb data. By QIA completion, the pain assessment rate for "no documentation of pain assessment and no reason given," decreased to 0.70, representing a reduction of 66.25% percentage points. Data also reflected a 66.25% decrease in the rate of facilities reporting, "Pain assessment documented as positive using a standardized tool, a follow up plan is not documented, and no reason given." While the goals of 0% and decrease of 10% were not reached, data indicate significant progress was made and attention to pain management increased. A total of 1,510 new pain assessments and pain plans resulted for patients in this QIA.

A secondary goal of the QIA was to eliminate the disparity between the Hispanic and non-Hispanic populations when measuring pain assessments documented as "no pain assessment completed, and no reason given." The 35 QIA facilities represented approximately 2,234 hemodialysis patients, of which 56.28% identified as Hispanic. The baseline disparity rate among the 35 facilities was 5.20% based on October 2016–June 2017 CROWNWeb data. By the closure of the QIA, the Network reduced the disparate rate from 5.20% to 0.57%, representing a 4.63% reduction. (See Charts O, P, and Q)

## Barriers

Barriers to achieving the QIA goals included:

- Inaccurate data reported in the CROWNWeb system due to:
  - Staff entry and use errors.
  - Data batching errors (for large dialysis organizations [LDOs]).

- Staff turnover.
  - The Network emphasizes that the QIAs belong to the facility and not to an individual staff member or facility leader.
  - Network support and check-in help to mitigate this barrier.

## Interventions

PSMEs provided the patient perspective for development of all QIA educational materials and interventions. Network interventions included:

- Providing individualized technical assistance.

- Initiating RCA and conducting tests of change using the PDSA cycle.

- Querying the QIA facilities about existing processes for conducting pain assessments, subsequent documentation of a plan for patients who reported positive for pain, how patients are assessed,

tools used, training and competency of staff, CROWNWeb documentation, and pain project review in QAPI.

  o The Network provided baseline reporting data of which clinic staff were not always aware.

- Providing education to facility staff nurses on using the pain assessment tool, conducting pain assessments, non-pharmaceutical pain management practices, and local and state resources available to patients who are in need of pain management.

- Sharing best practices and providing education to medical directors and facility staff on community resources, including healthcare providers who have expertise in pain management.

- Providing CROWNWeb reporting and reporting requirements to at least two facility-level staff members per facility to ensure the timeliness and accuracy of reporting.

- Reviewing pain assessments and pain plans in QAPI meetings to track QIA progress and support sustainability.

- Providing scholarly and academic, peer reviewed articles on pain assessment and management for diverse patients, as well as the cultural values of Latino patients and families.

- Assisting clinics with Hispanic patients by addressing issues with reporting pain and using culturally-based pain management approaches.

- Sharing innovative approaches for obtaining feedback on pain from all patients, including those who refuse or postpone assessment.

## Best Practices

Best practices identified by the QIA facilities include:

- Adding a pain assessment section in the Plan of Care for documentation of patients with a positive pain assessment and plan to address.

- Identifying the patient as the primary focus of this QIA and reinforcing accurate knowledge and understanding of patient reporting of pain and how it impacts health.

- Using Patient Advisory Council (PAC) members and PSMEs to provide ongoing input and feedback on all aspects of the QIA, including development of education and interventions and discussion of barriers.

- Engaging the Medical Review Board (MRB) to review interventions to elicit expertise from direct care providers.

- Linking dialysis facilities with resources for pain management outside of the dialysis facility.

**Chart O: Percent of Patients with no Documentation of a Pain Assessment**

**Network 15: Percent of Patients from QIA Facilities with No Documentation of Pain Assessment**
**January 2018 - September 2018**



QIA: Quality Improvement Activity
Source of data: October 2018 ESRD Network Dashboard
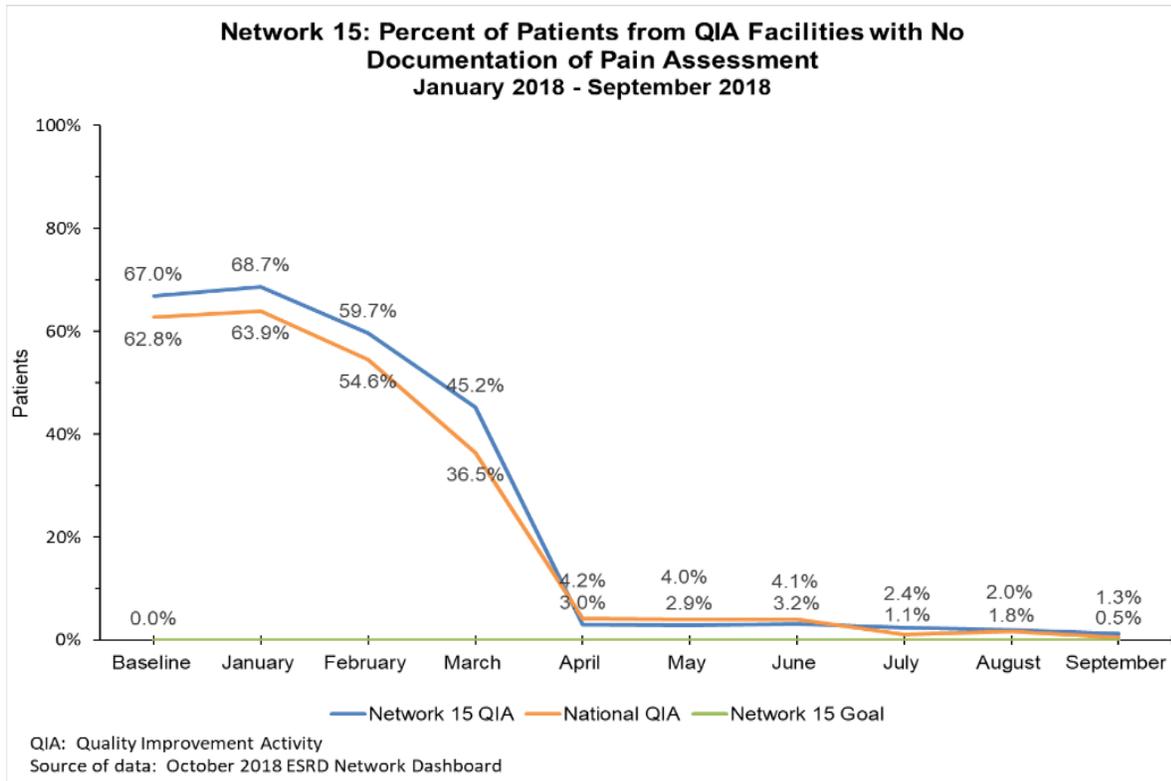
**Chart P: Percent of Patients with a Positive Pain Assessment and No Follow-Up Plan**

**Network 15: Percent of Patients from QIA facilities with a Positive Pain Assessment and No Follow-Up Plan**
**January 2018 - September 2018**



QIA: Quality Improvement Activity
Source of data: October 2018 ESRD Network Dashboard
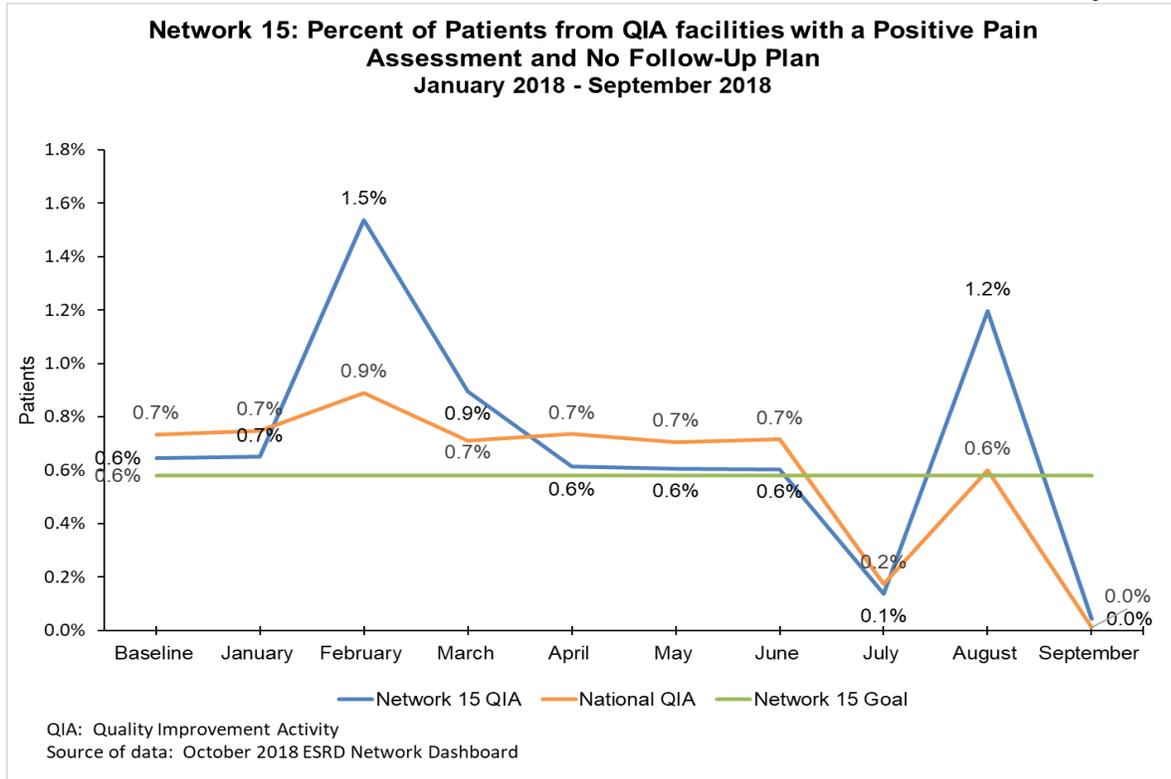
**Chart Q: Reduction in the Disparate Group for No Documentation of Pain Assessment**

**Network 15: Disparate and Non-Disparate Quality Improvement Activity**
*No Documentation of Pain Assessment*
**January 2018 - September 2018**



Responses

| | Baseline | January | February | March | April | May | June | July | August | September |

68.6%
70.9%
60.8%
46.5%

63.4%
63.7%
57.1%
42.5%

3.3%
2.3%
3.2%
2.2%
3.4%
2.7%
2.7%
1.8%
2.2%
1.6%
1.6%
0.5%

— Network 15 Disparate Group (Ethnicity is Hispanic)
— Network 15 Non-Disparate Group (Ethnicity is Non-Hispanic)

Source of data: October 2018 ESRD Network Dashboard

# ESRD NETWORK RECOMMENDATIONS

## Recommendations for Sanction

Section 1881(c) of the Social Security Act states that the ESRD Network can recommend to CMS the imposition of a sanction when an ESRD provider is not cooperating in achieving Network goals. The Federal Regulations that implement this statute are found in 42 CFR §405.2181.

The Network strived to maintain a cooperative and collaborative partnership with ESRD providers in all activities in 2018. The Network regularly interacted with facilities related to quality improvement activities and projects, patient grievances, data reporting, and the provision of technical assistance and education.

In 2018, the Network did not identify any facilities in its service area that consistently failed to cooperate with Network goals.

## Recommendations to CMS for Additional Services or Facilities

The Network did not make recommendations to CMS for additional facilities in its service area in 2018.

# ESRD NETWORK SIGNIFICANT EMERGENCY PREPAREDNESS INTERVENTION

## Wildfires

During the six-month period of April through September 2018, Network facilities were impacted by wildfires. During that time, Network staff:

- Maintained constant contact with facilities via email.

- Requested regular updates on facilities' operational status.

- Researched fire locations daily.

- Contacted facilities near fire locations to determine:
    - Any adverse impact on facilities.
    - Facilities' ability to provide treatment.
    - Patients' ability to access the facilities.

No facilities required assistance in providing services or placing patients due to the wildfires.

## Snow

During the month of December, Network staff worked with the New Mexico Department of Health to determine whether any New Mexico facilities required assistance due to a snow storm. Network staff phoned all New Mexico facilities to check their operational status. No facilities required assistance in providing services or placing patients.

## General

The Network provided all facilities in its service area with emergency preparedness information throughout the year, including:

- The KCER Watch newsletter and links to the KCER website.

- Food and Drug Administration (FDA) Med Watch announcements.

- PDFs of Network 15 emergency preparedness posters in English and Spanish.

- Links to Red Cross resources, including:
    - The Wildfire Safety Checklist in English and Spanish.
    - Information about wildfires.
    - Information about winter storm preparedness.

- Links to Arizona Department of Health Information on:
    - Heat safety.
    - Wildfire safety.
    - Flood safety.

- Registration links to a CMS National Emergency Preparedness webinar for providers.

- Emergency preparedness information for patients in the patient newsletter.

- Emergency Preparedness Checklist and Poster designed by patients for patients.

- Link to a Forum story on Mass Casualty Drill at dialysis unit.

- Links to the CDC *Epic Exchange* on emergency response activities and preparedness.

- National Weather Service warnings and links to tips on flood safety.

The Network reminded all facilities to update patient contact information (address and phone) in CROWNWeb and to be sure to list facility disaster contacts in CROWNWeb with cell numbers and email addresses.

Network 15 staff periodically reached out to all facilities reminding them to notify the Network of any operational issues or issues with patients not being able to receive treatment.

# 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.