

ESRD NETWORK 2023 ANNUAL REPORT

This report will cover quality improvement efforts led by End Stage Renal Disease (ESRD)
Network 15 Task Order Number 75FCMC21F0003 from May 1, 2023–April 30, 2024.

ESRD Network 15

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ESRD DEMOGRAPHIC DATA

ESRD Network 15

As a member of the Health Services Advisory Group (HSAG) team of dialysis networks, ESRD Network 15 works with patients, dialysis facilities, and transplant centers in Arizona, Colorado, Nevada, New Mexico, Utah, and Wyoming to improve the quality of care and quality of life for patients with ESRD. HSAG has held the Network 15 contract since 2016.

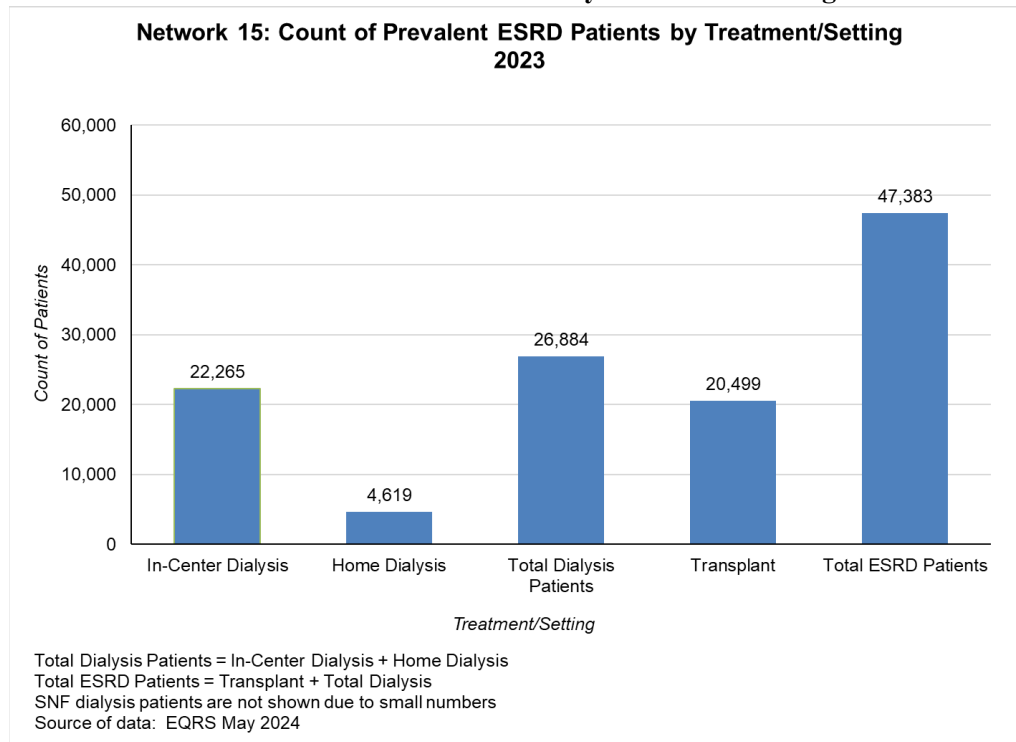
Geography and General Population

Geographically, Network 15 encompasses 21% of the landmass of the contiguous United States and includes mountains, plains, and desert. Urban population centers contain most residents. However, there are vast rural and wilderness areas in each state, which impact availability of care for ESRD patients due to length of travel for treatments. According to the most recently available information from the U.S. Census Bureau, Network 15's population was estimated at 22,619,292 as of July 1, 2023.¹

ESRD Population

As of December 31, 2023, there were 26,884 dialysis patients and 20,499 transplant patients, for a total of 47,383 patients with ESRD in the Network 15 service area. (See Chart A) The Network had a total of 6,759 individuals newly diagnosed with ESRD in 2023. (See Chart B) Of these patients, 17.9% (1,213) were home patients and 5.6% (380) received a transplant. As of December 31, 2023, Network 15 comprised 5.2% of the total national prevalent dialysis patient population and 5.2% of the national incident patient population. (See Charts C and D)

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



EQRS = ESRD Quality Reporting System

¹United States Census Bureau. Quick Facts. Available at <https://www.census.gov/quickfacts/fact/table/WY,UT,NM,NV,CO,AZ/PST045222>. Accessed on June 25, 2024.

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

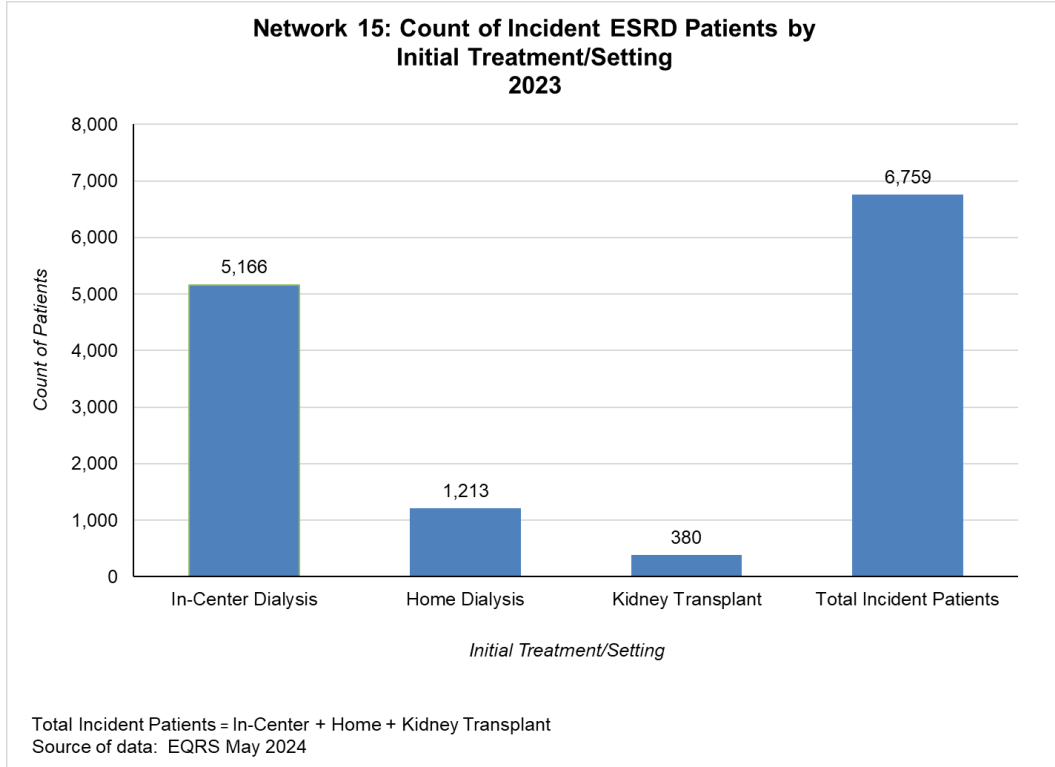


Chart C: Percent of National Prevalent Dialysis Patients by ESRD Network 2023

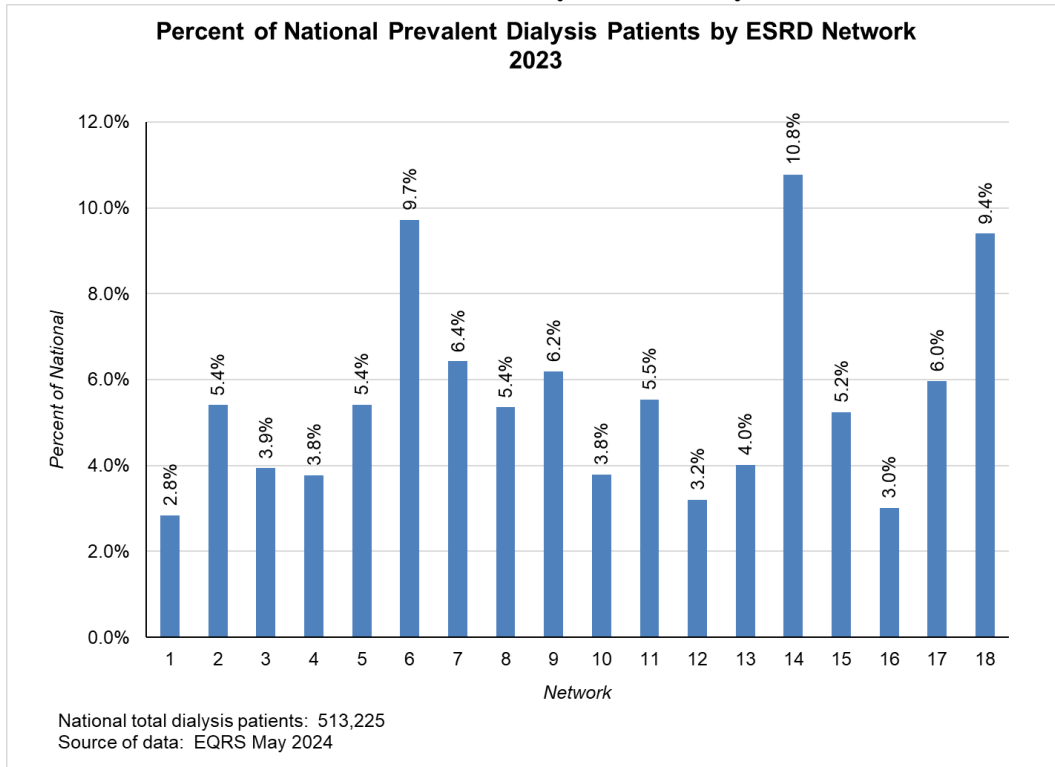
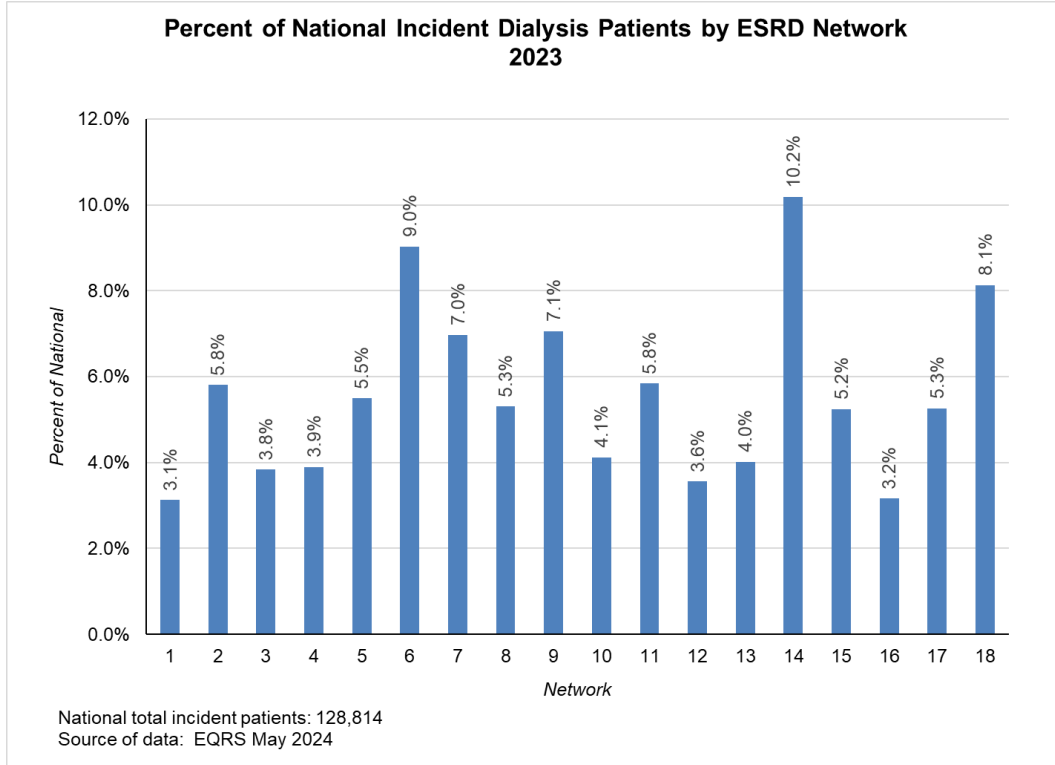


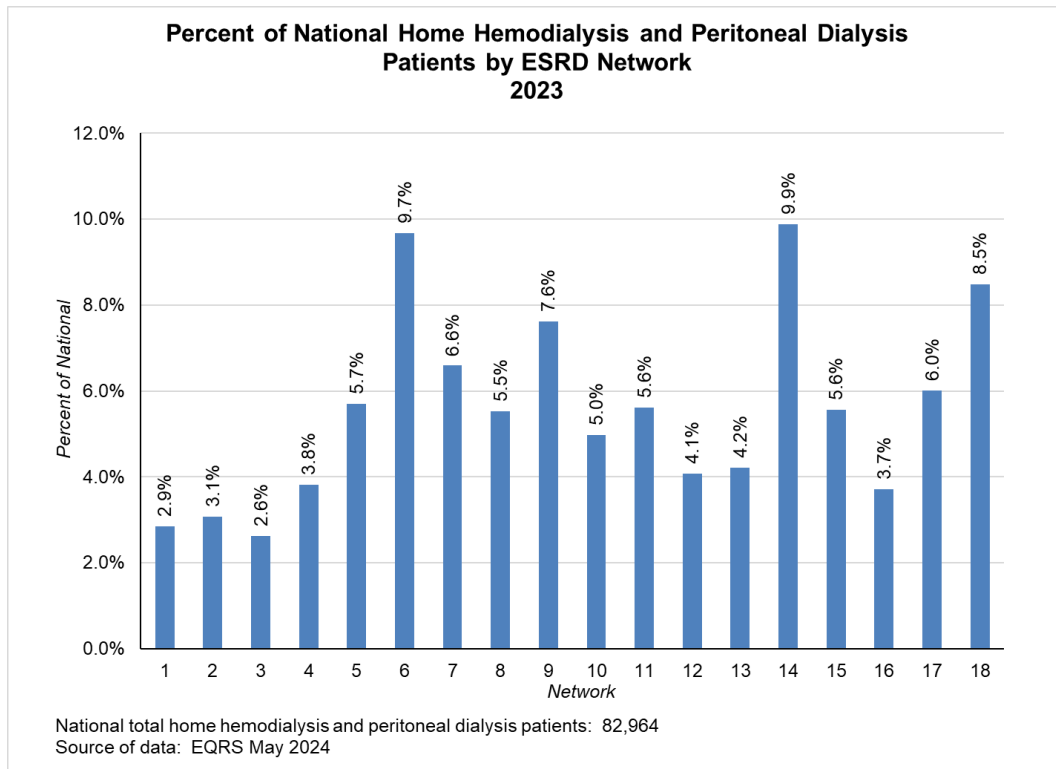
Chart D: Percent of National Incident Dialysis Patients by ESRD Network 2023



Dialysis Treatment Options

As of December 31, 2023, 82.8% of Network 15’s dialysis patients were receiving in-center hemodialysis (ICHD) treatments and 17.2% were using a home dialysis modality, including continuous-cycling peritoneal dialysis (CCPD), continuous-ambulatory peritoneal dialysis (CAPD), or home hemodialysis (HHD). (See Chart A) Nationally, the Network comprised 5.6% of all HHD, CCPD, and CAPD patients. (See Chart E)

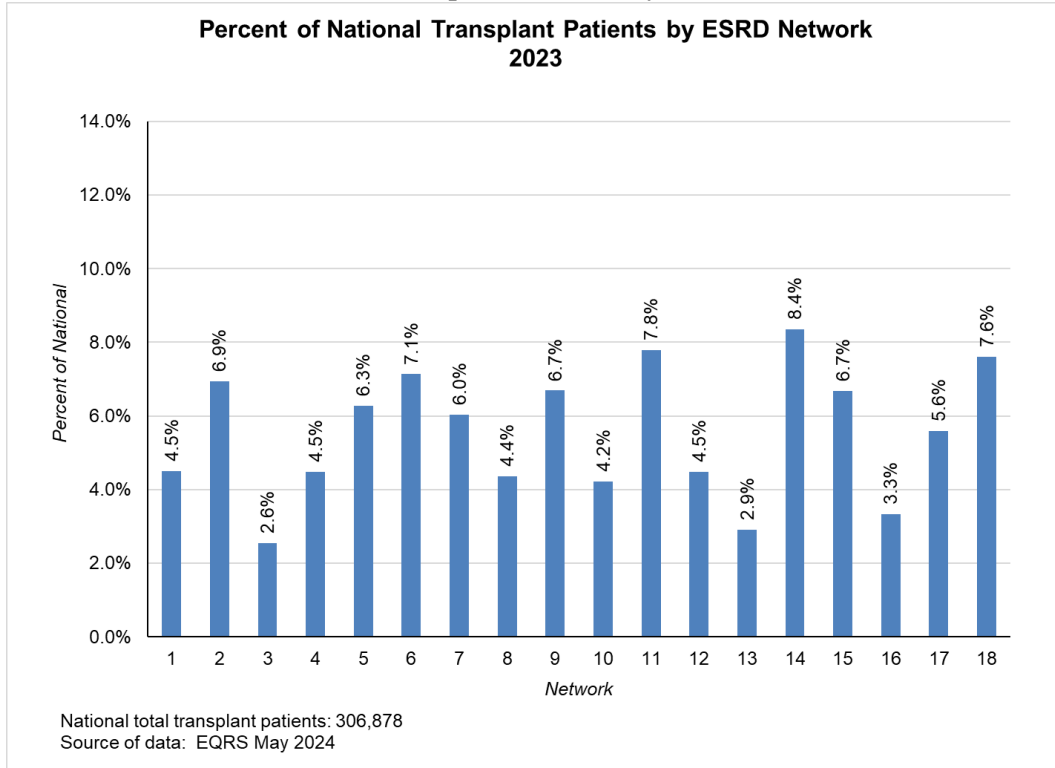
Chart E: Percent of National Home Hemodialysis and Peritoneal Dialysis Patients by ESRD Network 2023



Transplant

During 2023, transplants were completed by 15 transplant centers in the Network 15 service area. As of December 31, 2023, there were 306,878 transplant patients nationally, of which 6.7% were in Network 15. (See Chart F)

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



ESRD Facilities

As of December 2023, Network 15's service area included 391 dialysis facilities and 15 transplant facilities for a total of 406 ESRD facilities. (See Chart G) Nationally, Network 15 comprised 5.0% of all dialysis facilities and 6.6% of all transplant facilities. (See Charts H and I)

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

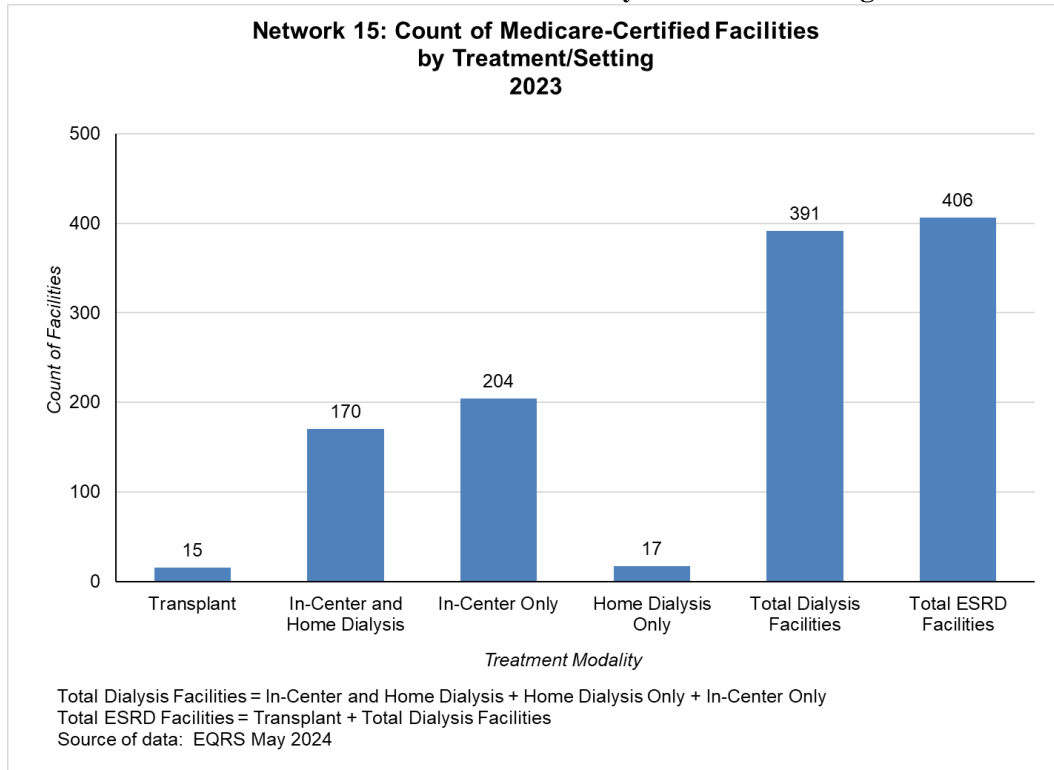


Chart H: Percent of Medicare-Certified Dialysis Facilities by ESRD Network 2023

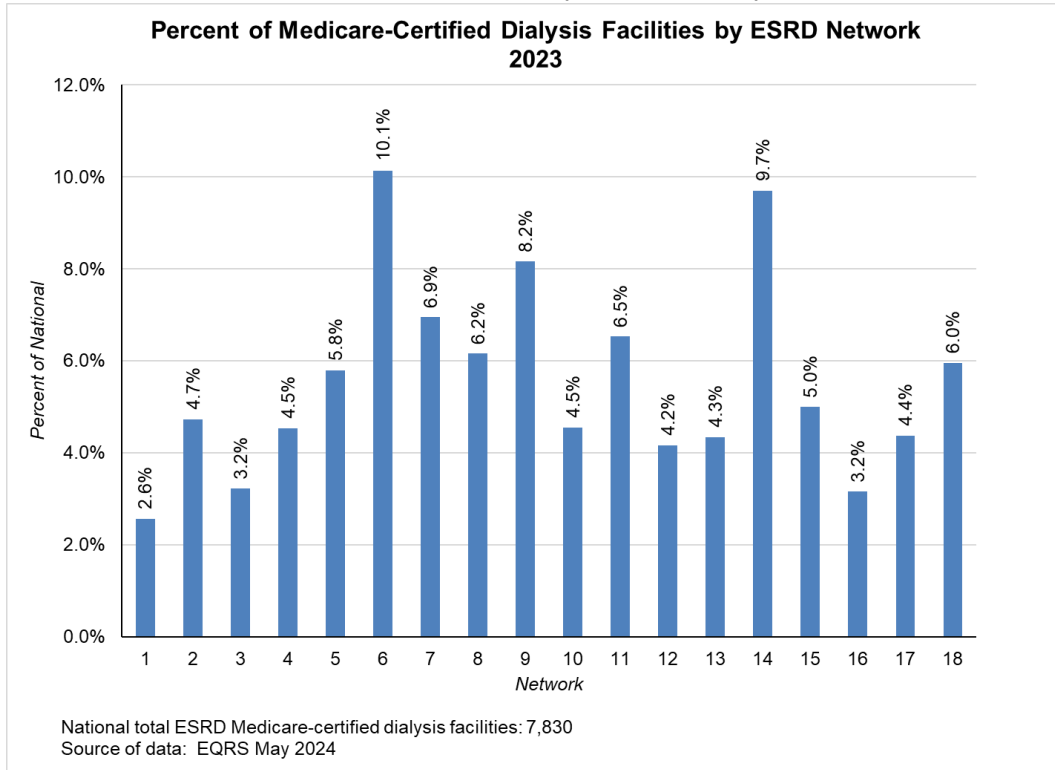
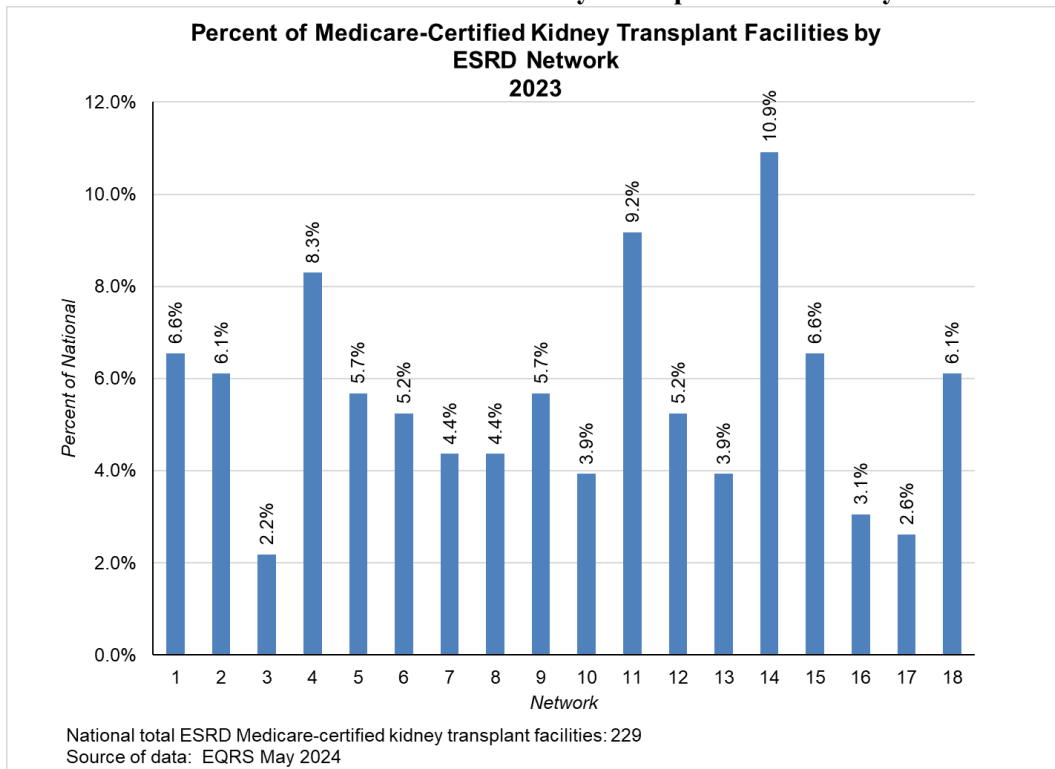


Chart I: Percent of Medicare-Certified Kidney Transplant Facilities by ESRD Network 2023



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 area of concern, general grievance, and immediate advocacy. The Network addressed immediate advocacy grievances by contacting the facility to resolve an issue within seven business 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 and, as with all grievances, the grievant receives an outcome letter. According to Chart J below, from May 2023–April 2024, 18.3% of contacts to the Network were for grievances, including 11.5% for immediate advocacy, 3.4% for general grievance, and 3.4% for clinical area of concern.

Facility Concerns

In addition to grievances, the Network also responded to facility concerns, which accounted for 40.2% of all contacts to the Network for May 2023–April 2024. (See Chart J) Facility concerns included contacts received from ESRD facilities and providers related to managing difficult patient situations, requests for technical assistance, and other concerns.

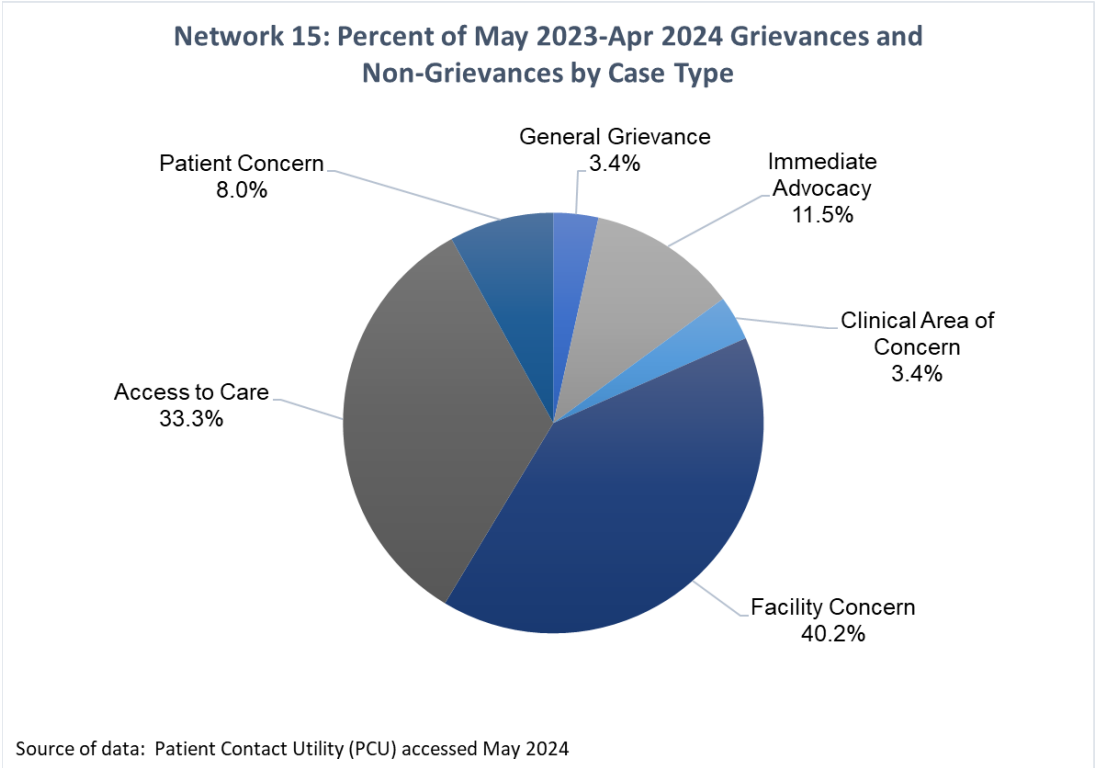
Patient Concerns

Patient concerns are general concerns or questions that patients contact the Network to discuss but are not formal complaints they want the Network to address with a facility. Patient concerns accounted for 8.0% of contacts to the Network from May 2023–April 2024. (See Chart J)

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. Access-to-care issues accounted for 33.3% of contacts to the Network from May 2023–April 2024. (See Chart J)

Chart J: Percent of Grievances and Non-Grievances by Case Type May 2023–April 2024





ESRD NETWORK QUALITY IMPROVEMENT ACTIVITY (QIA) DATA

Transplant Waitlist & Transplanted QIA May 2023–April 2024

Goal and Outcomes

The Transplant QIA implemented May 2023–April 2024 included two goals:

- Achieve a 9% increase in the number of patients added to a kidney transplant waiting list by April 2024, using calendar year 2020 as a baseline.
- Achieve a 14% increase in the number of patients receiving a kidney transplant by April 2024, using calendar year 2020 as a baseline.

By April 2024, the number of patients added to a transplant waitlist was 1,611, which exceeded the QIA goal of 1,052. (See Chart K) The number of patients receiving a transplant was 1,317, which also exceeded the QIA goal of 1,206. (See Chart L)

Barriers

Barriers to meeting the QIA goals included:

- Lack of a structured communication process between the dialysis facilities and transplant centers to readily track and expedite the flow of information.
- Patients' inability to meet the criteria for transplant referral or to complete the evaluation process.
- Patient-level psychosocial issues, including caregiver support, insurance coverage and financial barriers.
- Lack of consistent follow-up with transplant centers and collaborative case management.
- Frequent changes and additional information required by transplant centers to complete the referral process.

Interventions

Interventions implemented included:

- Providing dialysis facilities with technical assistance to review available data, conduct a facility specific root cause analysis (RCA), and recommend resources and interventions to include in the facility's action plan.
- Identifying each transplant center's criteria and requirements for waitlisting, the best process for communication (i.e., online portal, faxing, email, phone) between the facility and the transplant centers for referrals, appointments, and updates, and contact information for transplant staff at each center to improve collaboration and address specific patient barriers.
- Tracking and documenting each patient's referral, evaluation, and progress through the process being added to the transplant waitlist.
- Providing the following resources to facilities to use for on-going education of staff and patients related to transplant:
 - Instructions for using the ESRD National Coordinating Center's (NCC's) [Transplant Change Package](#).
 - Education on receiving a kidney with a higher Kidney Donor Profile Index (KDPI) (e.g., *Better Than Dialysis Kidneys* and *Understanding the Journey from Referral to Transplant Waitlisting*) to encourage increased involvement by the interdisciplinary team (IDT) in promoting transplant.
 - Information regarding the ESRD Quality Reporting System (EQRS) Transplant Dashboard and how facilities can access and use it to ensure patients are aware of their transplant status.

- Engaging patients with the [Kidney Transplant Hub](#) resources.

Best Practices

Best practices identified from the QIA included:

- Developing relationships with transplant coordinators to effectively communicate patient status updates consistently and to collaboratively provide the patient with support to increase a waitlisting opportunity.
- Involving the entire team in educating and supporting patients throughout their transplant journey to manage issues and provide encouragement during the long process of waitlisting and staying transplant ready.
- Providing staff education/in-services on the importance of transplant and motivational interviewing to encourage patients to consider transplant and complete the evaluation.
- Using the *Transplant Change Package* as a resource to overcome barriers using proven successful interventions.

Chart K: Patients Added to the Transplant Waiting List May 2023–April 2024

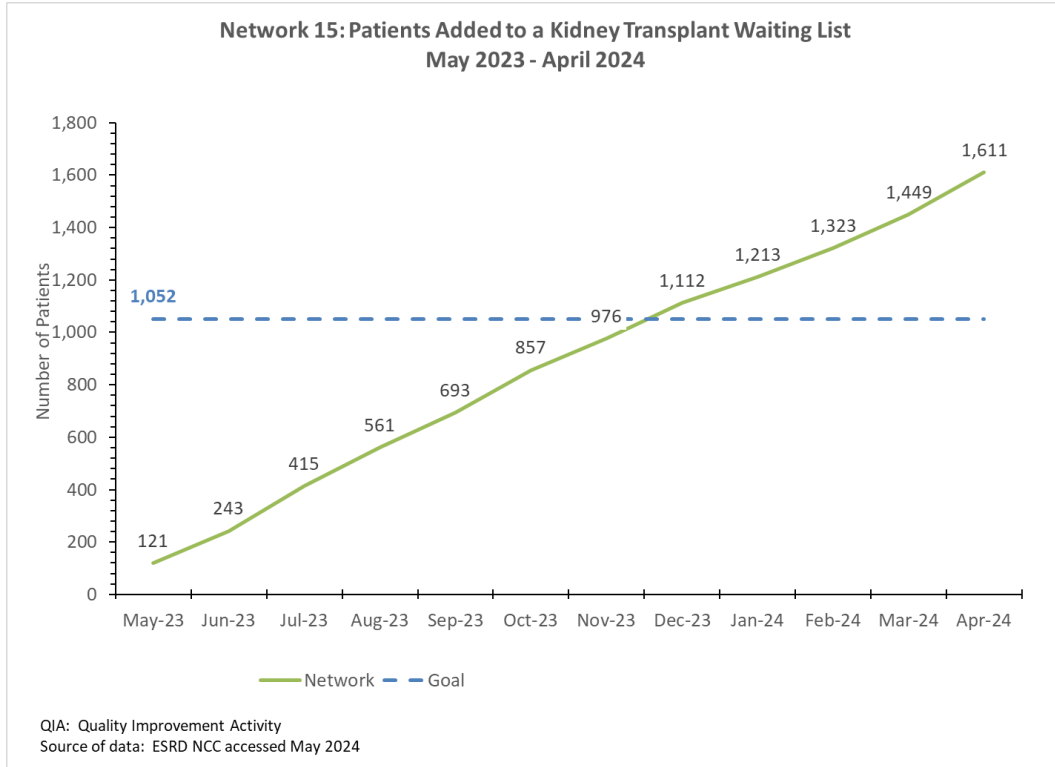
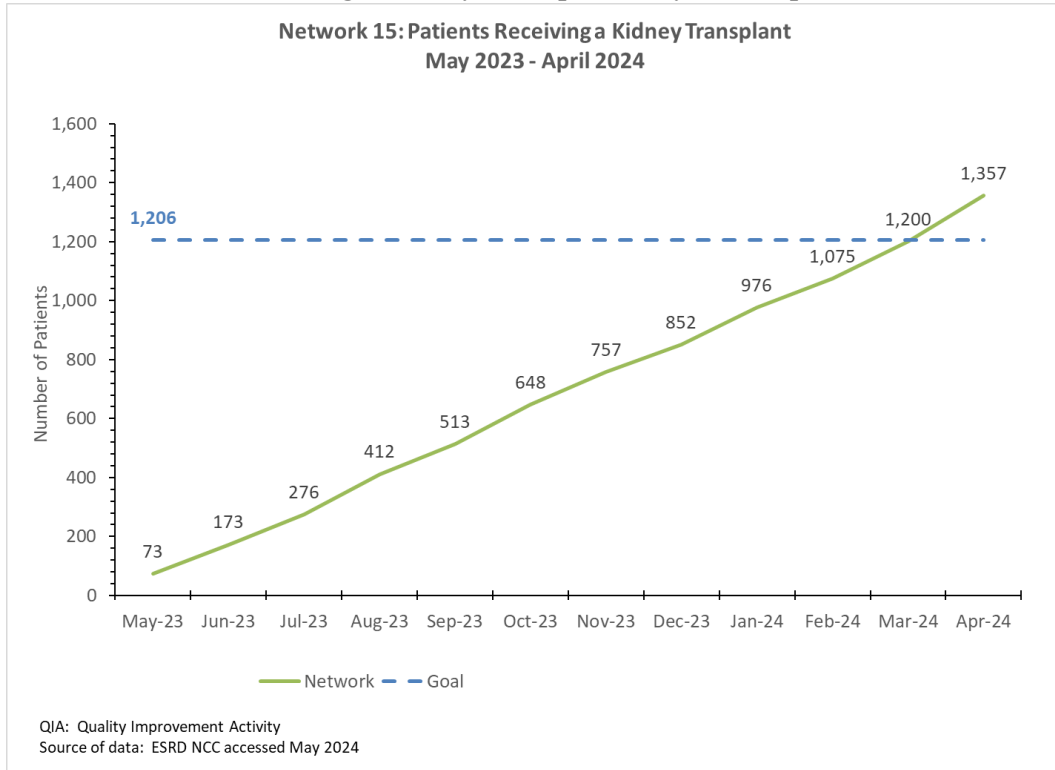


Chart L: Patients Receiving a Kidney Transplant May 2023–April 2024



Home Therapy QIA May 2023–April 2024

Goals and Outcomes

The Home Therapy QIA implemented May 2023–April 2024 included two goals:

- Achieve a 30% increase in the number of incident ESRD patients who start dialysis using a home modality by April 2024, using calendar year 2020 as a baseline.
- Achieve a 12% increase in the number of prevalent ESRD patients who move to a home modality by April 2024, using calendar year 2020 as a baseline.

By April 2024, the Network had 1,291 incident patients start on a home modality and 1,595 prevalent patients transition to home dialysis. This is 98.2% of the incident goal and 103.3% of the transition goal. (See Charts M and N).

Barriers

Barriers to meeting QIA goals included:

- Lack of staff time to focus on home modality education.
- Patient resistance to changing modalities due to comfort on in-center dialysis.
- Lack of physicians advocating for home dialysis, providing early education to patients, and offering patients the option to start dialysis on a home modality.
- Lack of education provided to in-center dialysis staff about home dialysis to develop a “home dialysis” culture at the facility.
- Home training nurse staffing shortages.

Interventions

The following interventions were implemented over the course of the QIA:

- Using the *Home Change Package* as a resource to overcome barriers and create new action plans.
- Providing targeted technical assistance and resources to facilities based on their RCA and choice of *Home Change Package* drivers.
- Promoting communication between physicians and in-center and home dialysis program staff to establish early education of patients regarding home modalities.
- Providing patient educational resources for use by physicians in their offices, hospitals, and acute dialysis programs.
- Collaborating with a home dialysis program to provide in-person or telehealth education to patients and families regarding home dialysis.
- Connecting interested patients with peer mentors or virtual patient support groups.
- Tracking facility progress to achieve the QIA goals and reviewing it with the IDT and medical director during the facility’s monthly Quality Assessment and Performance Improvement (QAPI) meeting, using the Network’s *QAPI QIA Monitoring Form*.

Best Practices

Best practices identified through the QIA include:

- Using the *Home Change Package* interventions to mitigate facility barriers to home dialysis.
- Implementing an “all team” approach by creating a process to educate staff so they can talk with patients and discuss progress during the monthly QAPI meetings.
- Ensuring collaboration between the in-center dialysis facilities and home programs for continuity of patient education and care.

- Collaborating between home program staff and nephrologists to assist with providing early education to office patients.
- Connecting with hospital dialysis staff in their area to promote home modalities and share resources.
- Utilizing group home modality training to mitigate home training nurse shortages.

Chart M: Incident Patients Starting Dialysis Using a Home Modality May 2023–April 2024

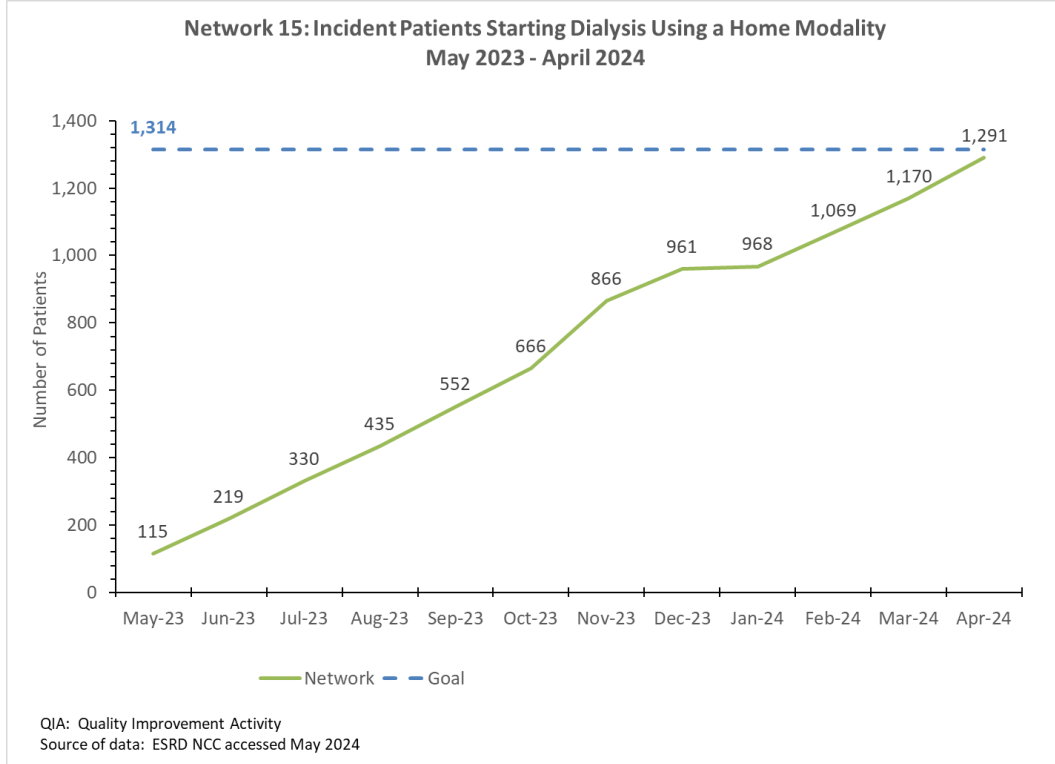
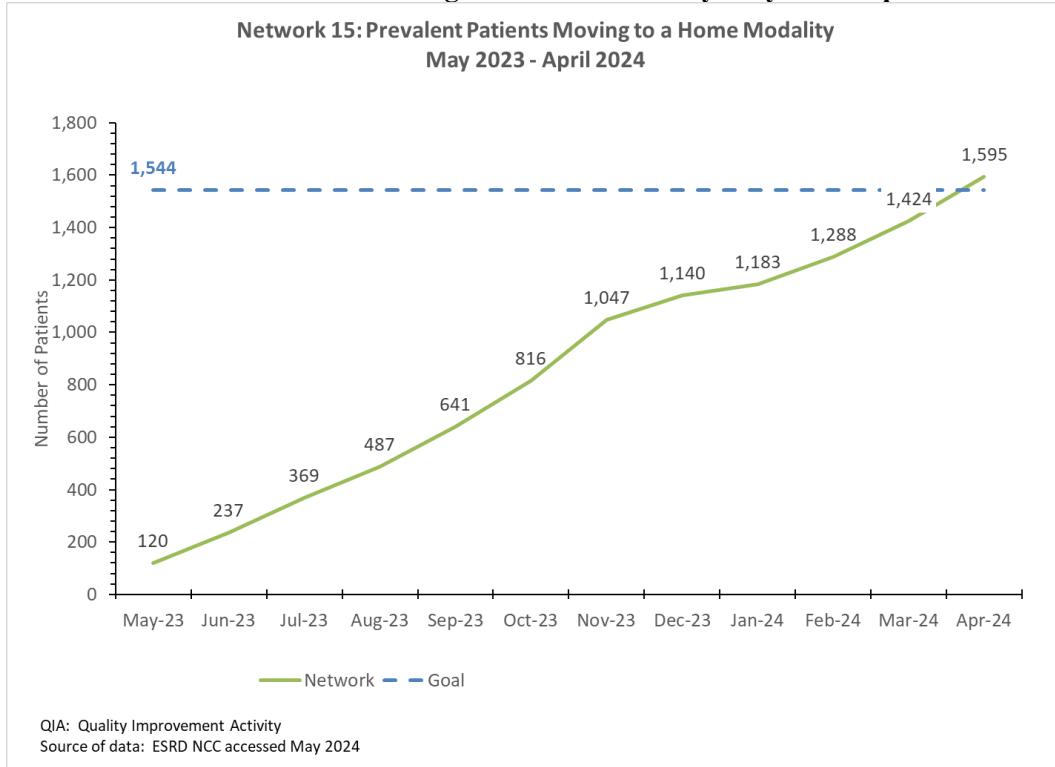


Chart N: Prevalent Patients Moving to a Home Modality May 2023–April 2024



Telemedicine QIA May 2023–April 2024

Goals and Outcomes

The goal of the Telemedicine QIA was to increase the number of rural home patients using telemedicine to engage in home dialysis by 3% by April 2024. The Network exceeded the goal count of 323 patients, with 336 home patients having documented telemedicine visits in EQRS by April 2023. (See Chart O)

Barriers

Barriers for the QIA included:

- Staff misconceptions about the use of telemedicine in the home program.
- Lack of a facility tracking process for monthly telemedicine visits with patients.
- Lack of reporting of patient telemedicine visits by facilities in EQRS.

Interventions

The following interventions were implemented over the course of the QIA:

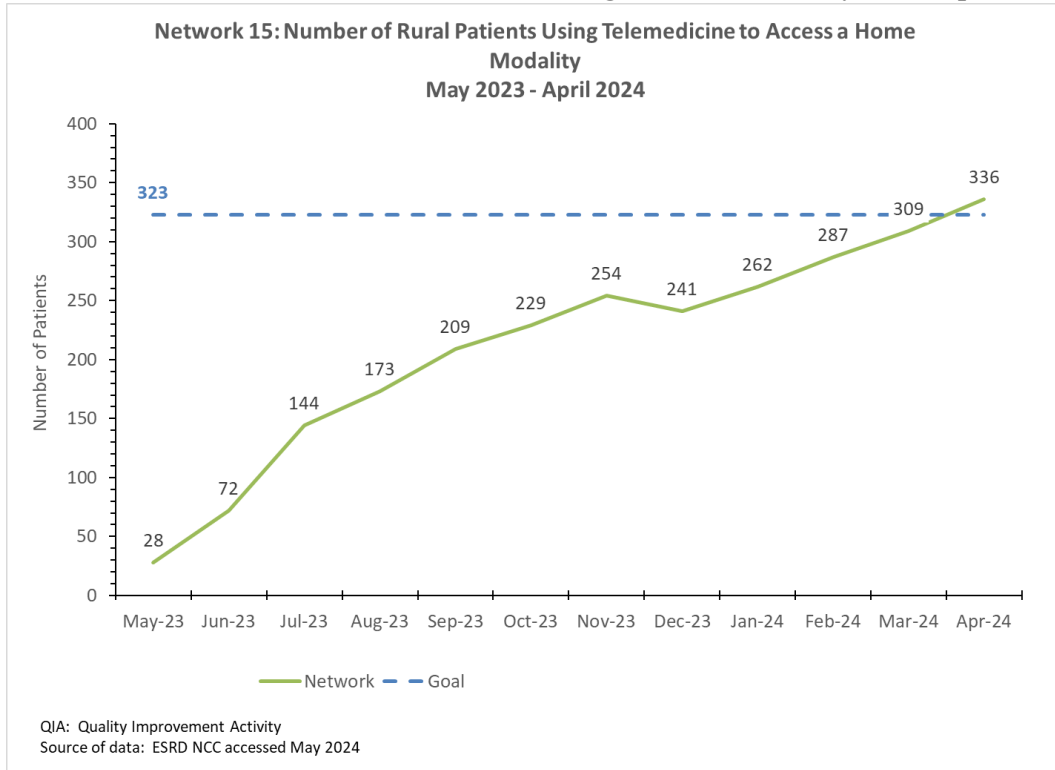
- Providing facilities with educational resources and technical assistance to implement telemedicine in the home dialysis program.
- Distributing information including a step-by-step guide to reporting telemedicine visits in EQRS to facilities that were under 100% telemedicine usage.
- Reminding staff about the definition of telehealth as it relates to the QIA and tracking monthly activities.

Best Practices

Best practices identified through the QIA include:

- Educating all patients regarding the option to use telemedicine.
- Exploring and addressing barriers to using telemedicine with patients (i.e., no access to broadband, language barriers).
- Using the Telehealth Tip Sheet created by the Network with FAQ's for documenting monthly visits.

Chart O: Number of Rural ESRD Patients Using Telemedicine May 2023–April 2024



Improving Transitions of Care QIA May 2023–April 2024

Goals and Outcomes

The Network's Transitions of Care QIA focused on reducing the following by 4% by April 2024:

- ESRD-related Inpatient Admissions
- ESRD-related 30-Day Unplanned Readmissions
- ESRD-related Emergency Department (ED) Visits

Although the Network did not remain under the upper limit for Inpatient Admissions and 30-Day Unplanned Readmissions, it did remain under the upper limit rate for ED visits. (See Charts P, Q, and R)

Barriers

Barriers to achieving the QIA goals included:

- Patient belief that going to the hospital is the most effective way to get treatment for conditions that could be addressed as an outpatient.
- Patient and staff educational needs regarding:
 - The benefits of patients remaining out of the hospital.
 - The importance of preventing, identifying and fully treating any signs, symptoms, or active diagnosis of possible sepsis.
 - Comorbid condition follow-up.
 - Patients who use the ED for routine dialysis care and do not communicate with dialysis facility staff about care goals.
 - Utilizing outpatient providers when available and appropriate.
- Patient knowledge deficit of the need and benefit of communicating health-related concerns and care sought outside of dialysis for both ESRD and comorbid health conditions. This behavior prevents the dialysis staff from supporting and responding to issues prior to escalation or repeated hospital use.
- Patient treatment nonadherence with patient refusal to speak about a plan of care to adjust or alter the dialysis plan.
- Facility staff not fully engaging patients about hospital visits that are not directly related to dialysis which creates potential for readmissions.
- Difficulties with obtaining hospital records promptly so staff can review and assist with follow-up.

Interventions

Interventions for the QIA included:

- Providing facilities with targeted technical assistance to conduct a facility-specific RCA, identify opportunities for change and to develop an action plan to address unplanned hospital use.
- Using the Hospitalizations Change Package to identify and implement change ideas to address the facility's primary barriers to keeping patients out of the hospital.
- Reviewing available data to identify facility hospitalization trends and opportunities for improvement related to the reasons for hospitalizations.
- Discussing the QIA, RCA, action plan, interventions, and outcomes with the IDT during monthly QAPI meetings.
- Educating patients and staff on areas of improvement based on the RCA and action plan.

- Addressing nonadherent patients with open communication and motivational interviewing.
- Tracking and monitoring interventions, outcomes, and identified metrics to flag increases in unplanned hospital use and prevent future use.
- Working with patients and caregivers to better understand unplanned hospital use events to provide education and resources to avoid future hospital visits.

Best Practices

Best practices identified throughout the QIA by facilities include:

- Using a team approach to patient education, tracking of events, and implementing interventions.
- Focusing on interventions that address the top identified diagnoses, including sepsis, that cause hospital admissions and readmissions.
- Completing a post-hospitalization checklist for each patient returning to the facility with a focus on lessons learned to avoid a future hospital stay and implementing the discharge instructions.
- Communicating with hospital discharge planners before and after discharge to address barriers to successfully transitioning the patient back home and to recommend services and complete medical appointment scheduling.
- Engaging Skilled Nursing Facility staff to communicate about patient care needs and conditions and create a plan so that unplanned hospital use is avoided.
- Focusing on patient dry weight management, including performing regular dry weight reviews, scheduling patients for additional treatments, providing enhanced patient education and training staff on proper weighing of patients.
- Addressing patients in need of a primary care provider.
- Providing case management to patients who are high utilizers of hospital services.

Chart P: Rate of ESRD-Related Hospital Admissions per 100 patient-months May 2023–April 2024

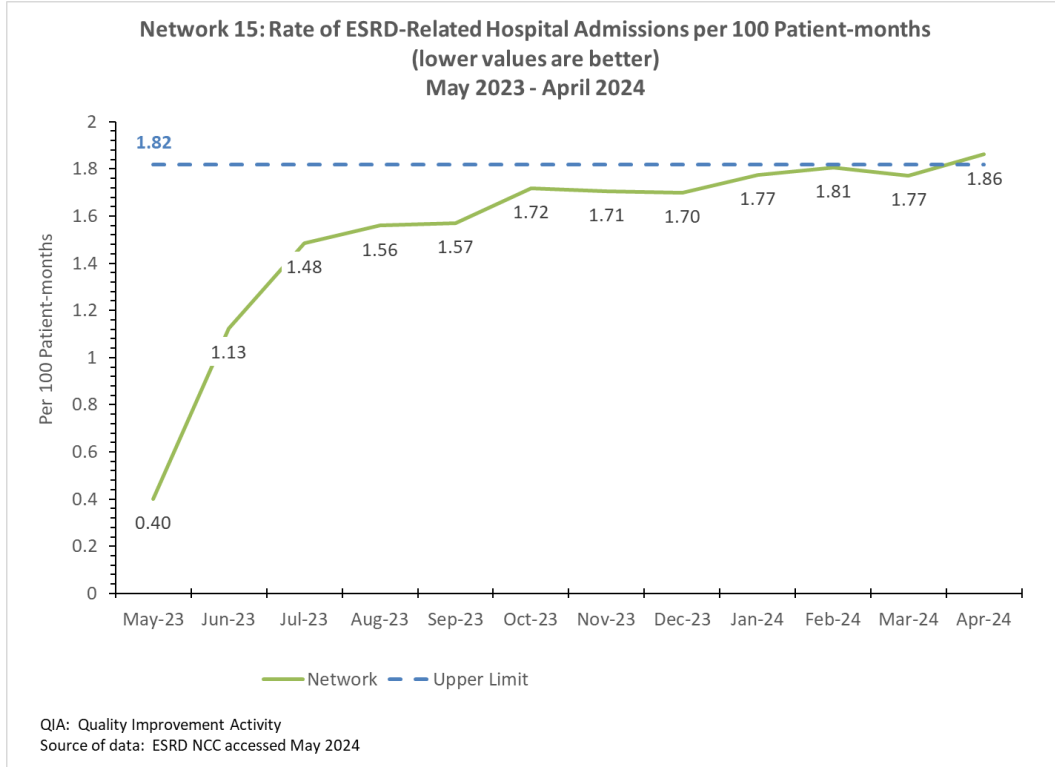


Chart Q: Hospital 30-Day Unplanned Readmissions May 2023–April 2024

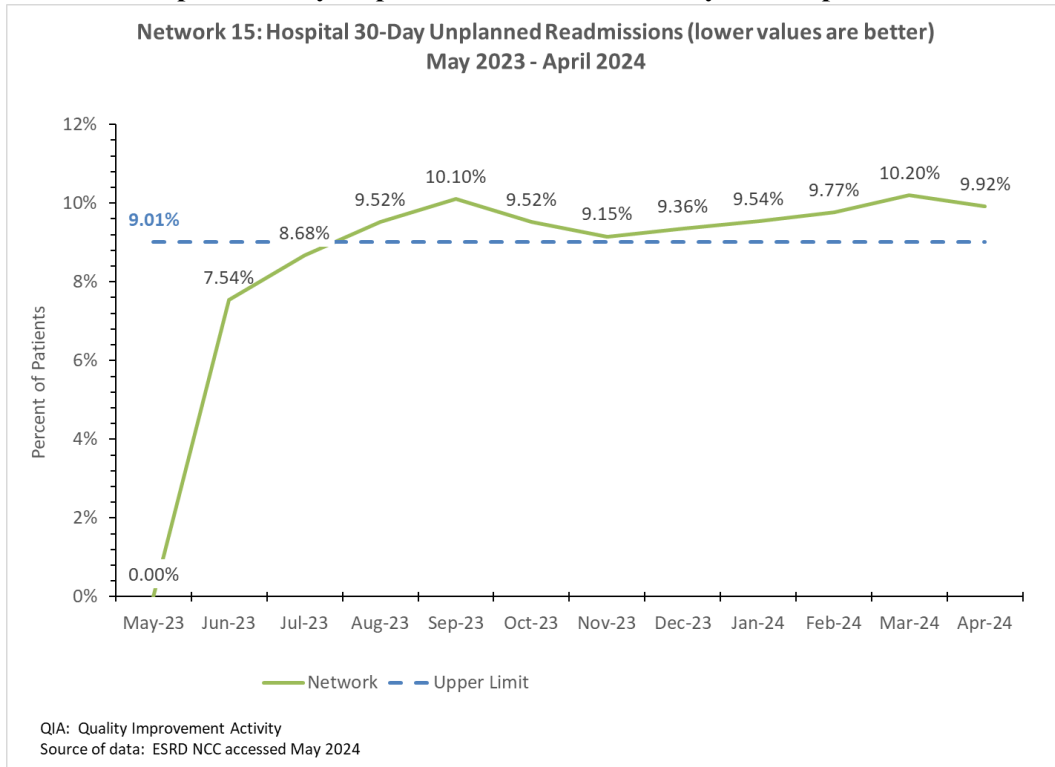
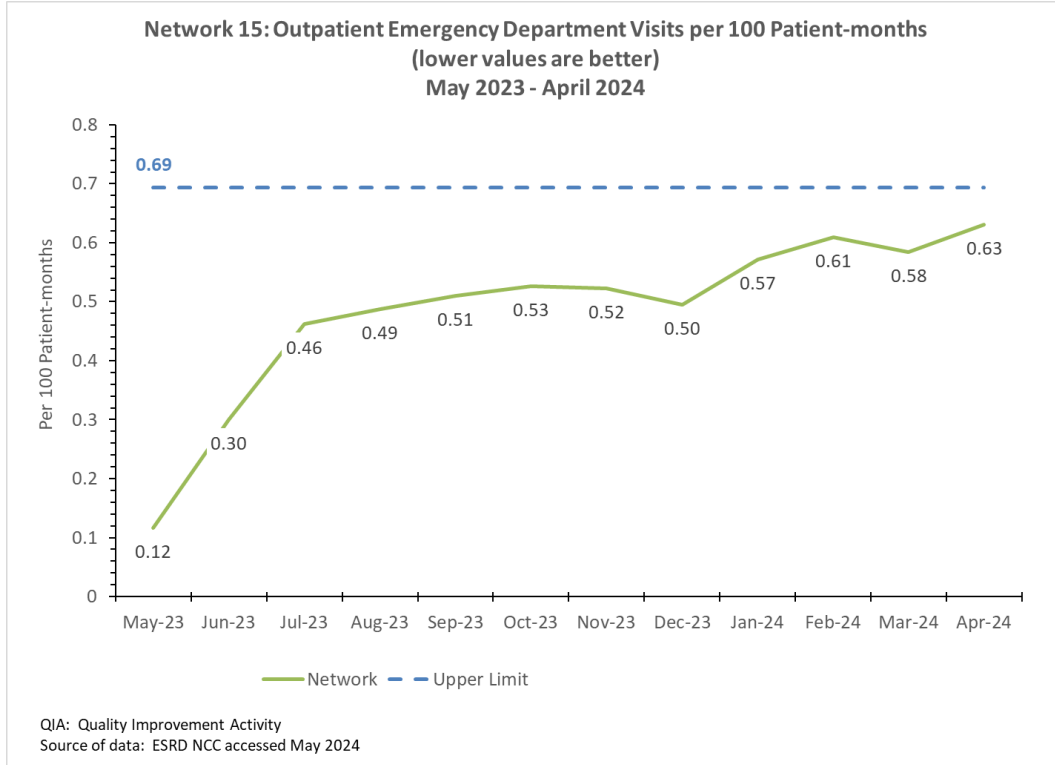


Chart R: Outpatient Emergency Department Visits per 100 patient-months May 2023–April 2024



COVID-19 Vaccinations for Patients and Staff QIA May 2023–April 2024

Goals and Outcomes

The QIA focused on the following goals:

- Ensure 80% of dialysis patients are up to date for COVID-19 vaccination, by April 2024.
- Ensure 95% of dialysis staff are up to date for COVID-19 vaccination, by April 2024.

Barriers

Barriers to achieving the QIA goals include:

- Tracking vaccinations received by patients and staff outside the facility.
- Facilities having stopped providing the vaccination or decreased the frequency that vaccinations were offered.
- Patient and staff hesitancy and refusal based on religious and/or personal beliefs.
- Transportation barriers for patients or staff who needed to travel to receive vaccines.
- Trust barriers caused by the everchanging scientific-based information provided to the public for the different COVID-19 vaccines.
- Facility staff do not have access to National Healthcare Safety Network (NHSN), or vaccination counts are not consistently reported.

Interventions

Interventions for the QIA include:

- Providing facilities with targeted technical assistance to complete an RCA and action plan related to improving COVID-19 vaccinations.
- Implementing the *Vaccination Change Package* and its primary and secondary drivers.
- Sharing educational resources from reputable sources that facilities could use to educate patients and staff during vaccination conversations.
- Assisting facilities with obtaining access to the National Healthcare Safety Network (NHSN) and reporting of vaccinations.
- Distributing information regarding vaccine availability outside of the facility.
- Disseminating community coalition resources, such as motivational interviewing techniques and best practices.

Best Practices

Best practices identified from the QIA include:

- Completing an RCA and action plan to identify barriers and implementing change ideas from the *Change Package to Increase Vaccinations* to create processes for change.
- Providing follow up education and offering COVID-19 vaccines to patients and staff who previously refused or were initially hesitant.
- Using Network-provided resources, such as *What Kidney Patients Need to Know About the COVID-10 Vaccine* and *Guidance to Increase COVID-19 Vaccine Confidence* to educate staff and patients.
- Identifying vaccinations provided outside the facility from state registries or other sources so they can be tracked and reported in NHSN.

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

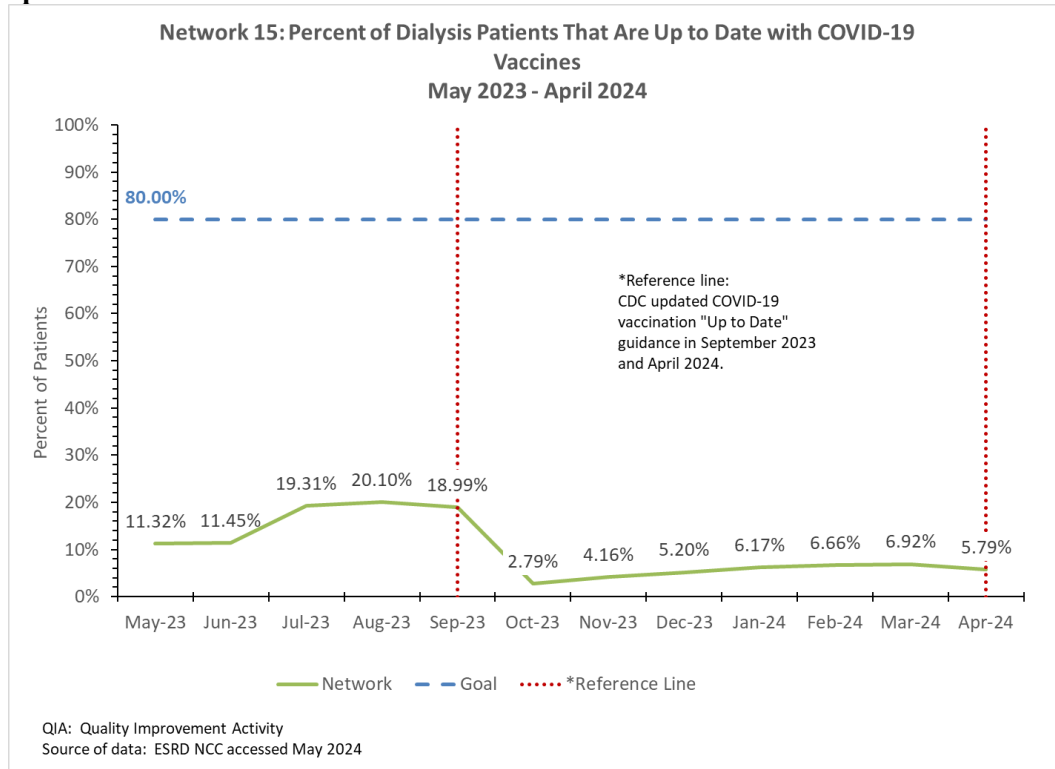
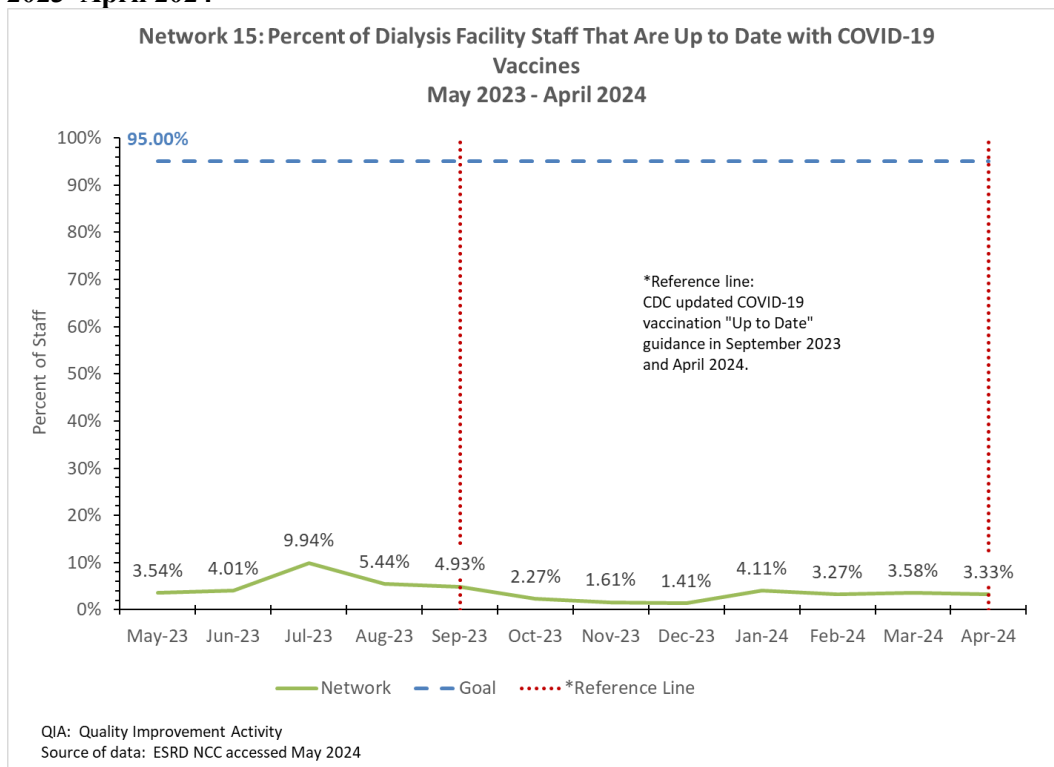


Chart T: Percent of Dialysis Facility Staff That Are Up to Date with COVID-19 Vaccines May 2023–April 2024



Influenza Vaccination QIA May 2023–April 2024

Goals and Outcomes

The two goals of the QIA were to:

- Achieve a patient influenza vaccination rate of 90% by April 2024.
- Achieve a facility staff influenza vaccination rate of 90% by April 2024.

By April 2023, 71.0% of patients received an influenza vaccination. Reporting of staff vaccinations was limited reflecting 37.0% of staff vaccinated for influenza by April 2024. (See Charts U and V)

Barriers

Barriers to achieving the QIA goals included:

- Tracking patients and staff who received the influenza vaccine outside of the dialysis facility.
- Patient and staff hesitancy and refusal due to personal, religious, or political beliefs.
- Data reporting challenges including facility and EQRS batching delays, facilities not reporting, or facilities not having appropriate staff to report consistently.

Interventions

Interventions for the QIA included:

- Providing targeted technical assistance to facilities to complete an RCA and use the *Change Package to Increase Vaccinations* and its primary and secondary drivers (e.g., Achieve a High-Performing Culture and Implement Quality Improvement Strategies).
- Sharing Influenza Vaccination Campaign materials and other resources from reputable sources that facilities could use to educate patients and staff during vaccination conversations.
- Assisting facilities with manual reporting and collaborating with corporate dialysis leadership to improve batch reporting of vaccinations in EQRS.

Best Practices

Best practices identified from the QIA include:

- Completing an RCA and action plan to identify barriers and implementing change ideas from the *Change Package to Increase Vaccinations*.
- Providing follow up education and offering vaccinations to patients and staff who previously refused or were initially hesitant.
- Comparing internal tracking of patient and staff vaccinations to those entered in EQRS to improve reporting.
- Using Network-provided resources and tools for educating patients and staff.
- Engaging facilities via technical assistance to enter vaccinations in EQRS.

Chart U: Percent of Dialysis Patients Receiving an Influenza Vaccination May 2023–April 2024

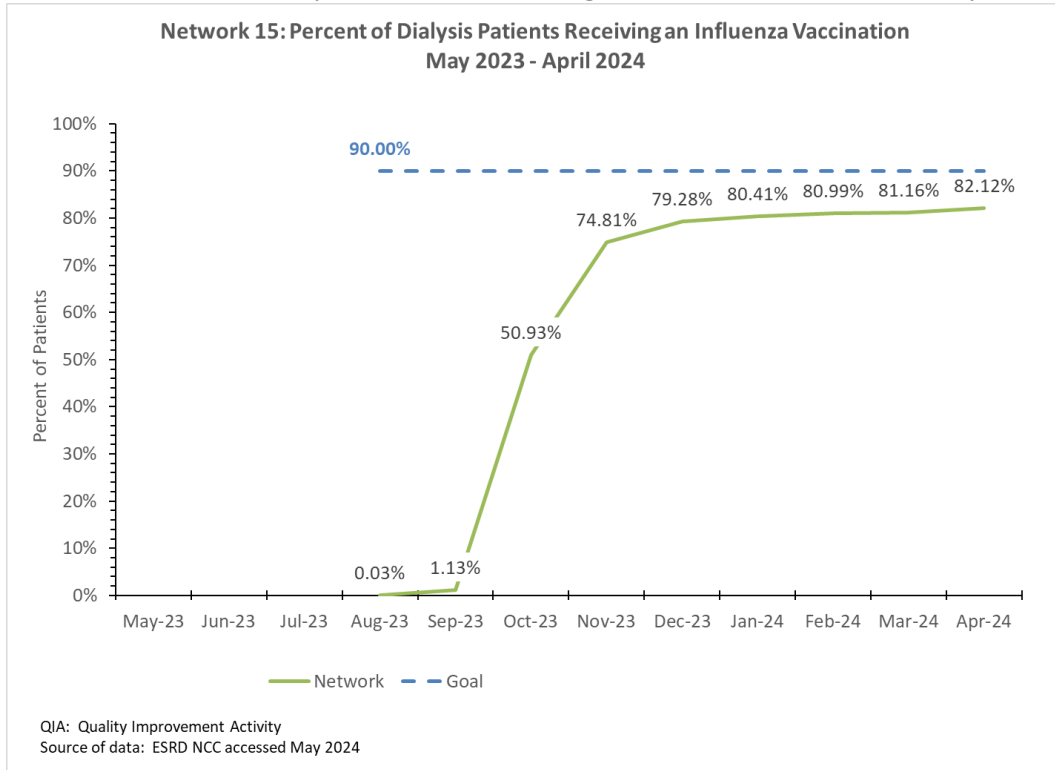
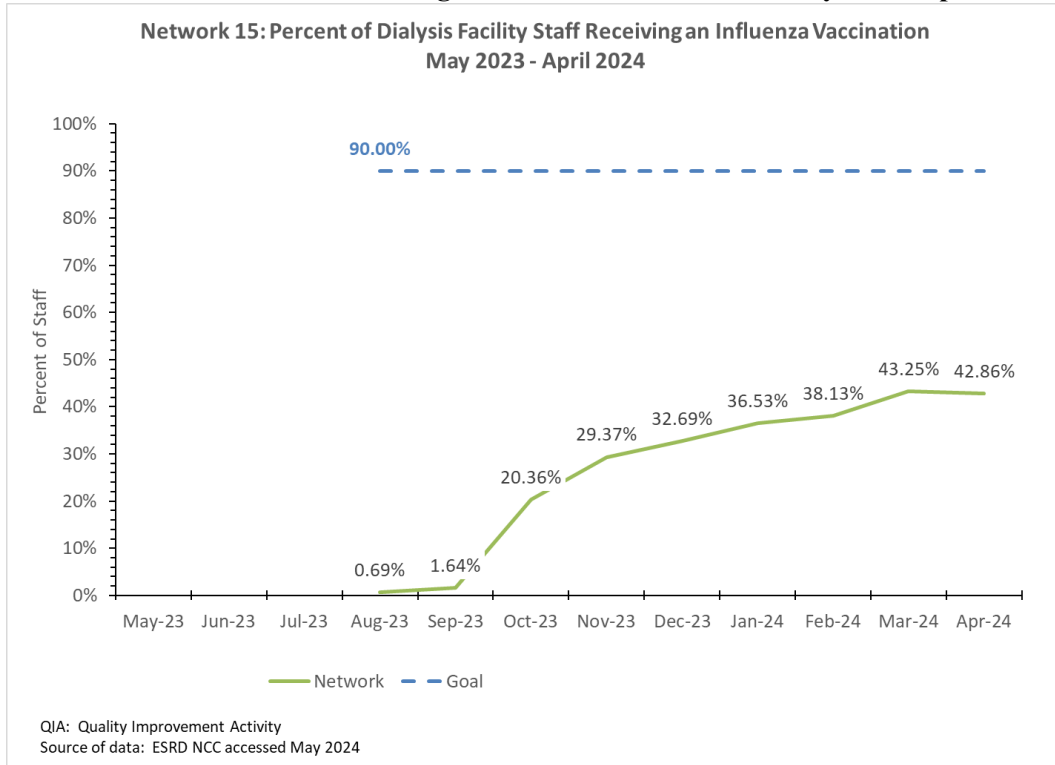


Chart V: Percent of Staff Receiving an Influenza Vaccination May 2023–April 2024



Pneumococcal Vaccination QIA May 2023–April 2024

Goals and Outcomes

The goal of the QIA was to increase the percentage of patients who are fully vaccinated for pneumococcal pneumonia by 7% over baseline by April 2024.

By April 2024, the Network achieved a rate of 41.8%, which was 96.2% of the goal, and included 13,258 patients being fully vaccinated. (See Chart W)

Barriers

Barriers to achieving the QIA goals included:

- Patient hesitancy and refusal due to personal beliefs.
- Lack of consistent tracking and reporting of patient vaccinations in EQRS.
- Lack of facility knowledge regarding the Centers for Disease Control and Prevention (CDC) recommendations or facility policies regarding which vaccinations to provide and when.

Interventions

Interventions for the QIA included:

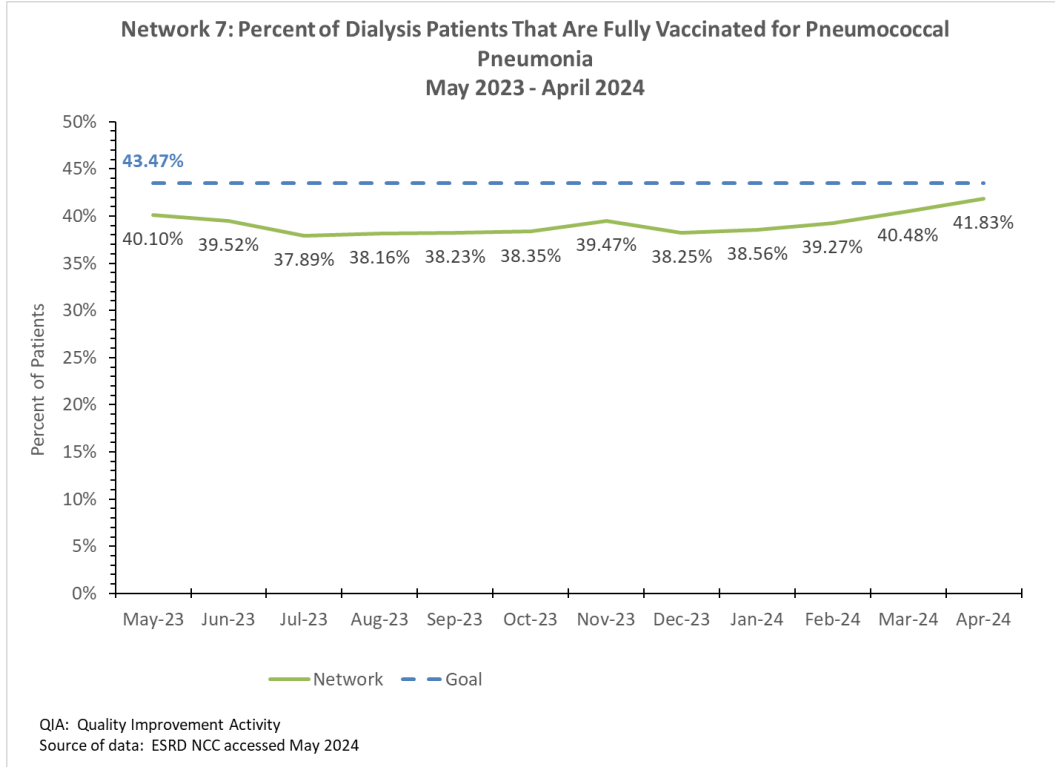
- Providing technical assistance to individual facilities to complete RCAs and action plans using the *Change Package to Increase Vaccinations*.
- Engaging facilities to complete an RCA and action plan related to increasing pneumococcal vaccinations.
- Sharing community-coalition-recommended educational resources from reputable sources that facilities could use to educate patients during vaccination conversations.
- Assisting facilities with obtaining access to EQRS and providing instructions for reporting vaccinations.

Best Practices

Best practices identified throughout the QIA by facilities include:

- Completing an RCA and action plan to identify barriers and implement resources and processes for change.
- Providing follow-up education and offering vaccinations to patients and staff who previously refused or were initially hesitant.
- Having the facility medical director talk directly with patients about vaccinations.

**Chart W: Percent of Dialysis Patients That Are Fully Vaccinated for Pneumococcal Pneumonia
May 2023–April 2024**



Improving Nursing Home Care QIA May 2023–April 2024

Goals and Outcomes

The Improving Nursing Home Care QIA goals included the following for patients receiving dialysis in a Nursing Home (NH):

- Achieving a 6% relative decrease in the rate of catheter infections by April 2024.
- Achieving a 3% relative decrease in the rate of peritoneal catheter infections by April 2024.
- Achieving a 3% relative decrease in the rate of blood transfusions by April 2024.

The Network's upper limit for the QIA goal for catheter infections was set at 0.0% but the Network was unable to meet the goal due to new NH dialysis programs opening during the QIA and reached a rate of .48% in April 2024. (See Chart X) The Network's upper limit for the QIA goal for blood transfusions was set at 8.31% and the Network met the goal with a final rate of 8.11%. (See Chart Y) The upper limit for the QIA goal for peritoneal catheter infections was set as 6.06% and the Network met the goal with a final rate of 0.00%. (See Chart Z)

Barriers

Barriers to achieving the QIA goals included:

- Complex comorbidities of NH patients who require extensive medical care.
- NH staff availability and education.
- Communication barriers between dialysis and NH staff.
- Challenges for NH dialysis programs in obtaining timely patient hospitalization records.

Interventions

Interventions for the QIA included:

- Providing low performers with technical assistance to conduct a facility-level RCA and develop an action plan with streamlined processes for change.
- Discussing the QIA, RCA, action plan, interventions, and outcomes with the IDT during monthly QAPI meetings.
- Educating patients and staff on areas of improvement based on the RCA and action plan.
- Tracking and monitoring interventions, outcomes, and identified metrics.
- Engaging in community coalitions to learn and share best practices.
- Obtaining direct access to hospital portals to obtain electronic medical record for patients when needed.
- Creating internal organizational systems that record and monitor admissions/discharges and blood transfusions and reviewing this at monthly QAPI meetings.
- Implementing the *Looking at Quality Improvement Through a Health Equity Lens* worksheet with one patient to identify and work on one health-related social need.

Best Practices

Best practices identified throughout the QIA by facilities include:

- Using a team approach to patient education, tracking of events, and implementing interventions.
- Conducting regular care planning and QAPI meetings with NH staff.
- Reviewing the QIA and goals with NH staff and dialysis NH medical directors.

- Reviewing a patient’s medical records prior to admission to the NH and dialysis program.
- Setting admission hemoglobin goals and making the goals are part of the NH dialysis program’s policy.
- Adopting new internal processes and policies for obtaining patient medicals records promptly with education to staff.
- Using the *Looking at Quality Improvement Through a Health Equity Lens* worksheet, by choosing one patient and working on one health-related social need.

Chart X: Hemodialysis Catheter Infections in Home Dialysis Patients Within NHs May 2023–April 2024

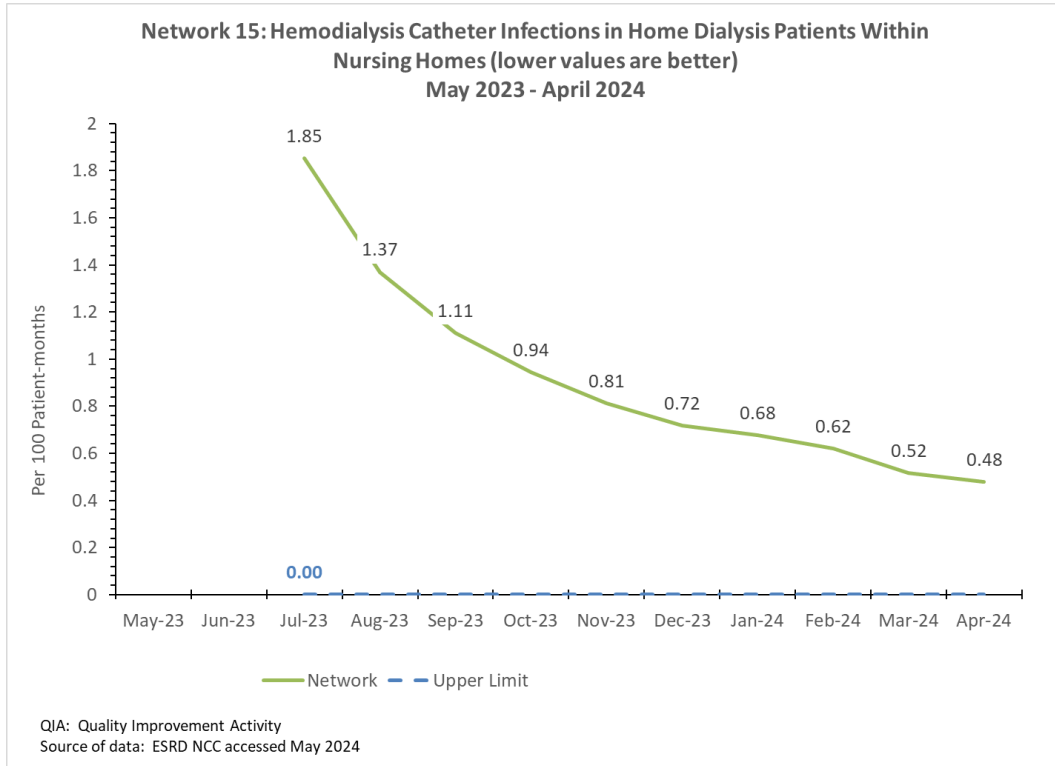


Chart Y: Rate of Blood Transfusions in ESRD Patients Receiving Dialysis in a NH May 2023–April 2024

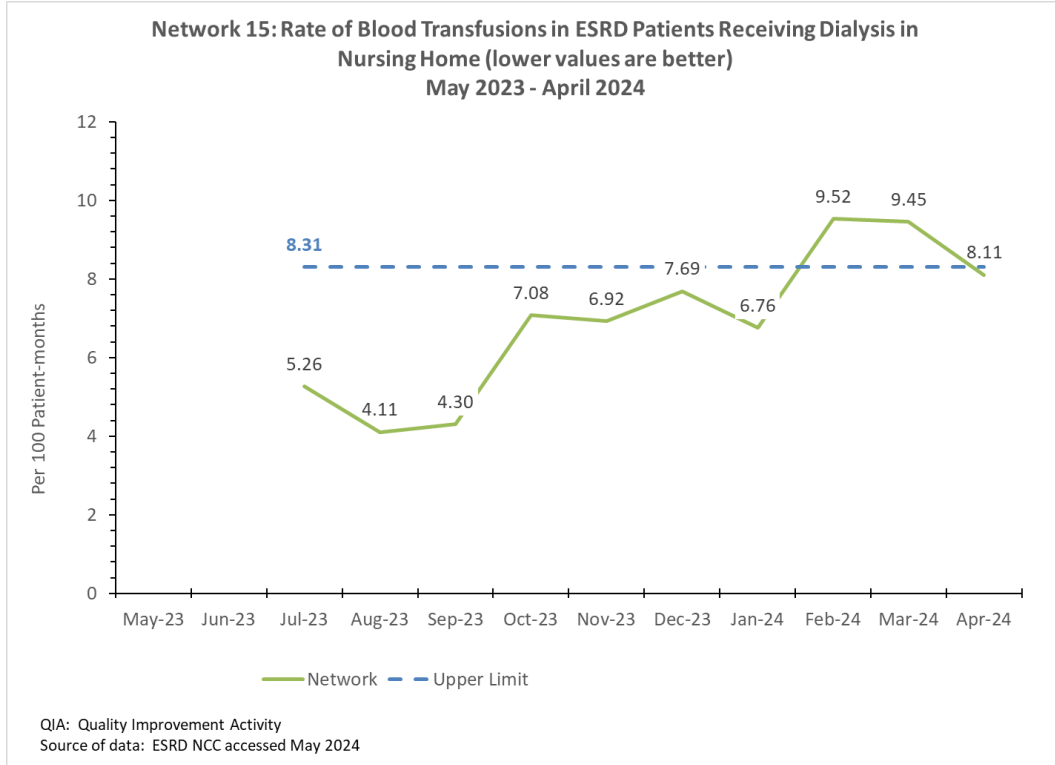
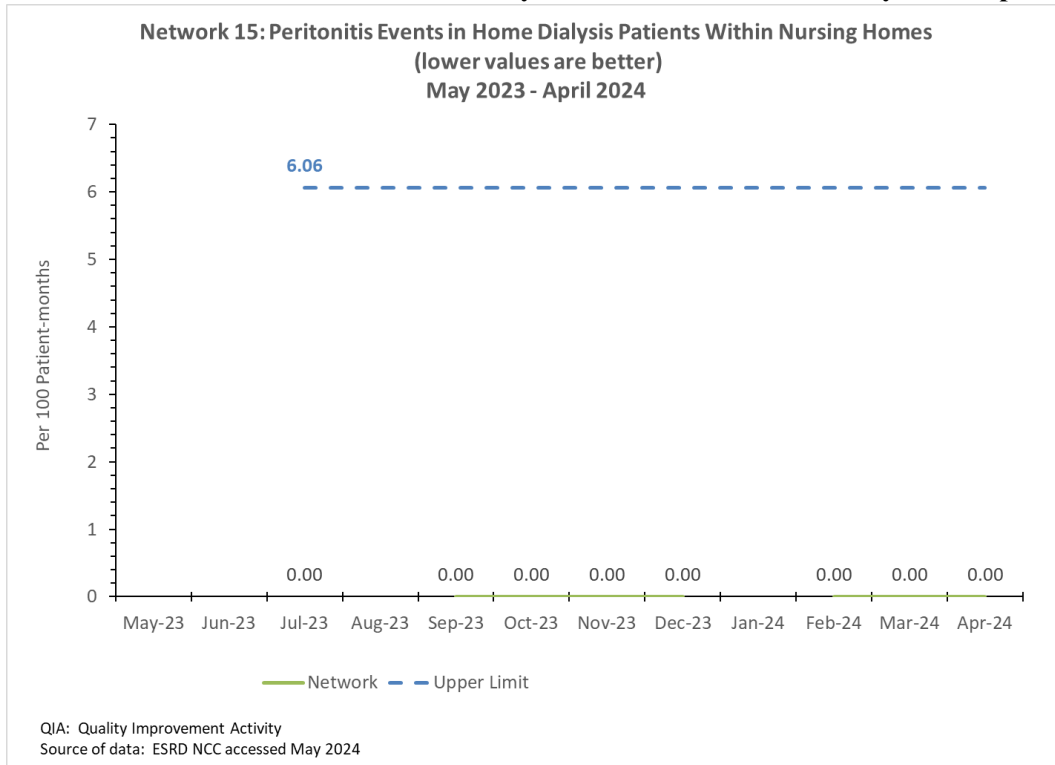


Chart Z: Peritonitis Events in Home Dialysis Patients Within NHs May 2023–April 2024



Data Quality QIA May 2023–April 2024

Goals and Outcomes

The QIA goals included:

- Achieving a 1% increase in the number of incomplete initial CMS-2728 forms, that are over 1-year old, that are completed and submitted.
- Achieving a 4% increase in CMS-2728 forms submitted within 45 business days.
- Achieving a 5% increase in CMS-2746 forms submitted within 14 days of the date of death.

By April 2024, the Network achieved 111.1% of the goal for 2728 forms, over 1-year old, that were completed and submitted. The Network also achieved 100.4% of the goal for 2728 forms, and 87.7% of the goal for 2746 forms, submitted in EQRS timely. (See Charts AA, BB, CC)

Barriers

Barriers to achieving the QIA goals include:

- Lack of dialysis facility staff time to follow up on information needed or to enter the forms in EQRS on time.
- Difficulty obtaining needed medical records and/or patient and physician signatures to complete forms.
- Lack of dialysis facility staff knowledge of submission time requirements and/or consistent facility processes to submit forms on time.

Interventions

Interventions for the QIA include:

- Discussing timeliness of admissions and forms when facilities contacted the Network for technical assistance with other issues.
- Providing facilities with technical assistance to conduct an RCA and create an action plan and to recommend resources for improvement (i.e., Tips for Completing CMS 2728 and CMS 2746 Forms Timely).
- Reminding facilities via email and phone to complete specific forms coming due in 7–14 days.
- Distributing facility-specific data reports for review, comparison, and benchmarking with internal data during QAPI meetings.
- Recommending facilities focus on interventions to improve timeliness with one form (e.g., physician signatures for 2728) at a time.

Best Practices

Best practices identified throughout the QIA by facilities include:

- Using a team approach to addressing areas of improvement and ensuring multiple facility staff have access to EQRS.
- Having a tracking system in place for all forms.
- Faxing 2728 forms to physician offices for signatures.
- Communicating with hospital discharge planners to obtain information needed for forms.

Chart AA: Number of Incomplete Initial CMS-2728 Forms That Are Over 1 Year Old That Are Completed and Submitted May 2023–April 2024

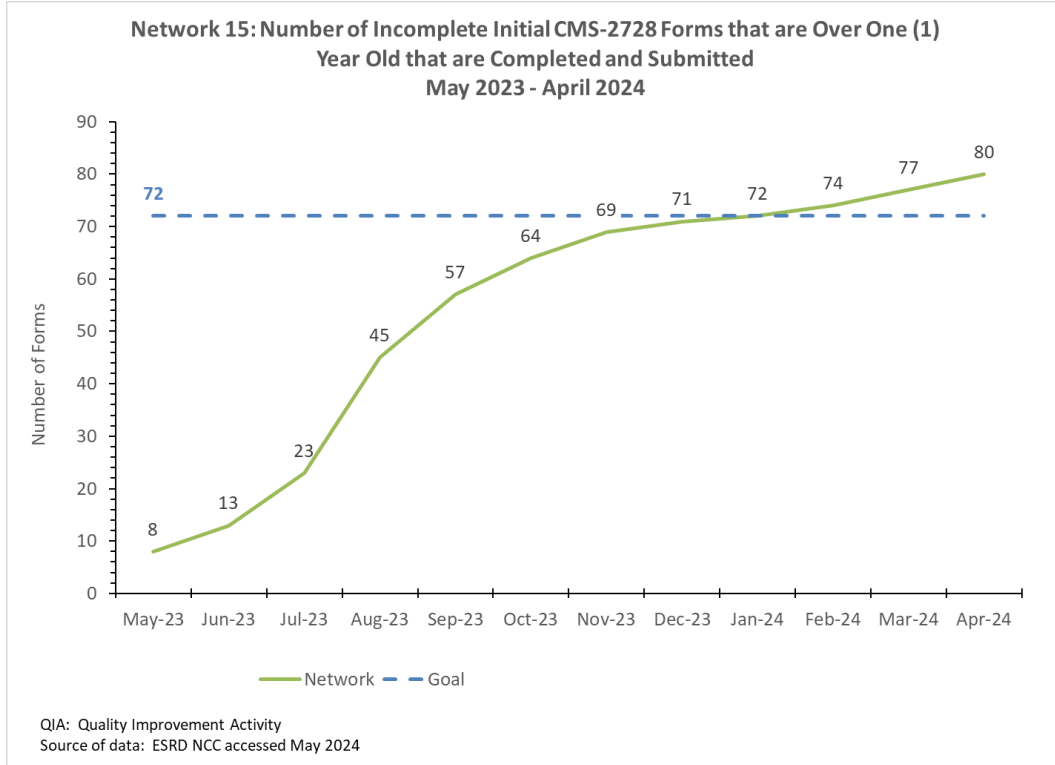


Chart BB: Percent of Initial CMS-2728 Forms Submitted Within 45 Days May 2023–April 2024

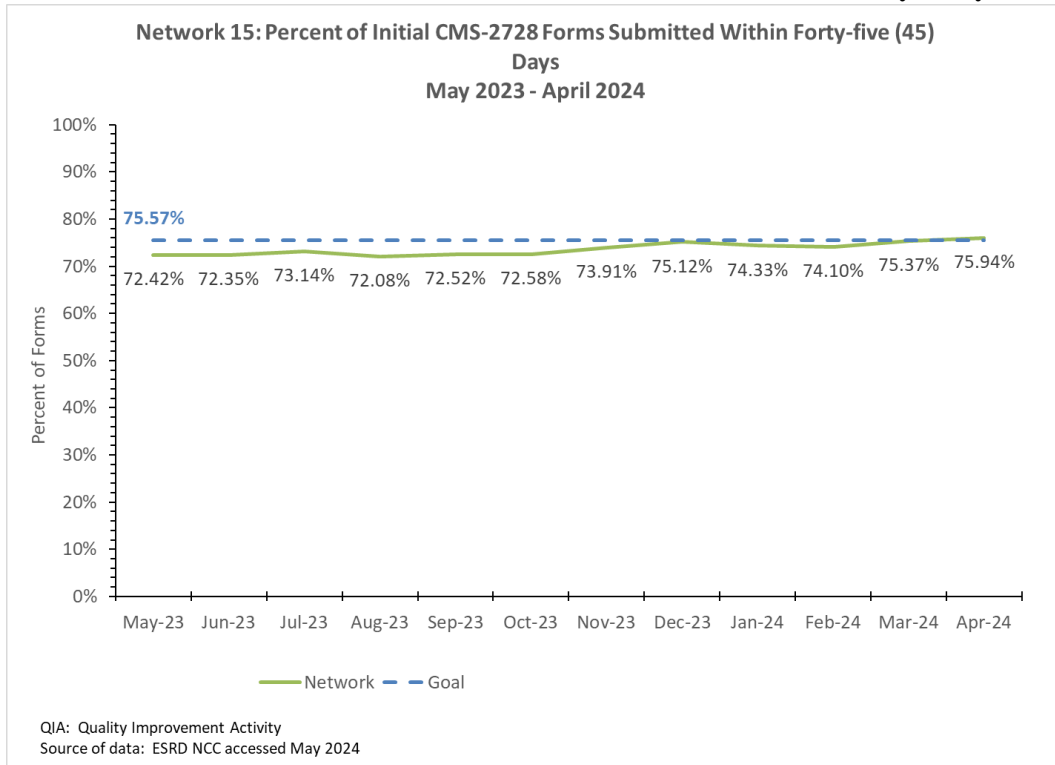
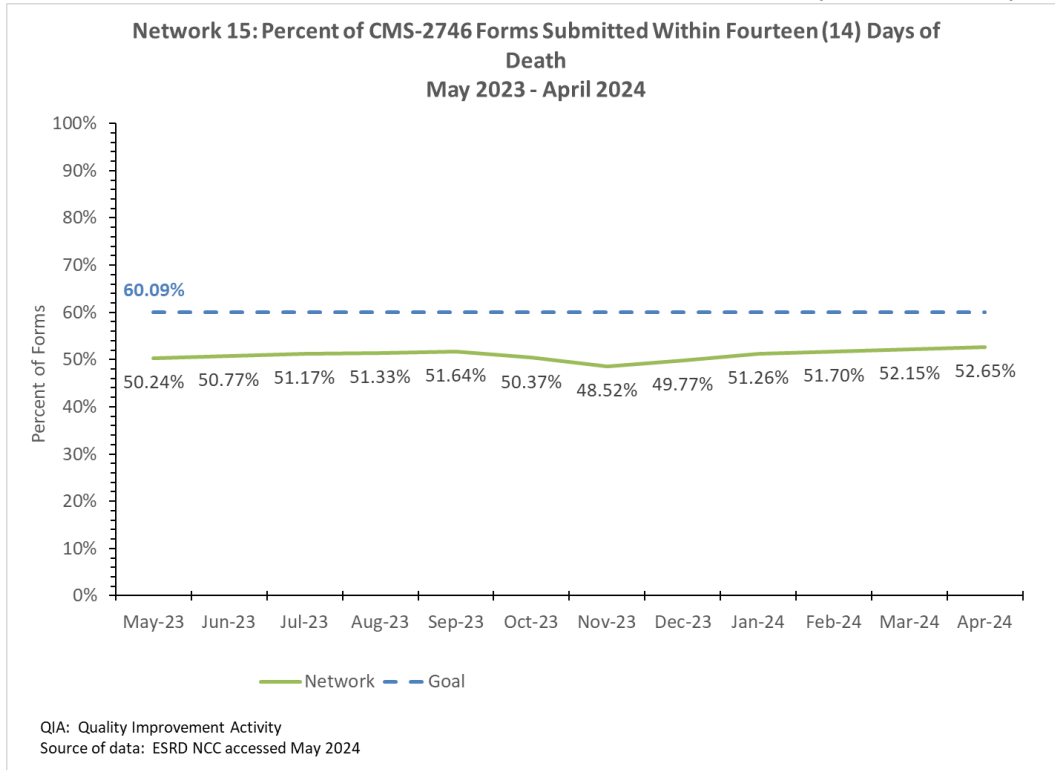


Chart CC: Percent of CMS-2746 Forms Submitted Within 14 Days of Death May 2023–April 2024



Depression QIA May 2023–April 2024

Goals and Outcomes

The QIA goal was to achieve a 10% increase over baseline in the percentage of patients who were identified as having depression and received treatment by a mental health professional.

The Network achieved a QIA rate of 12.90%, which was 80.5% of the goal of 16.02%. (See Chart DD)

Barriers

Barriers to achieving the QIA goal include:

- Patients' level of comfort with pursuing assistance for mental health-related issues based on stigma or hope that the condition will improve or resolve without treatment.
- Patients' reluctance to share mental health issues with facility staff or others.
- Lack of access to mental health providers due to:
 - Limited providers in certain locations.
 - Insurance coverage limitations regarding which providers can be used.
 - Transportation barriers
 - Limited access to or trust for the Internet or limited technological proficiency to use telehealth options.
- Lack of patient motivation to pursue mental health treatment, due to the demands of dialysis treatments and having other medical appointments.

Interventions

Interventions for the QIA include:

- Providing technical assistance to dialysis facilities to review available data, conduct an RCA, and identify opportunities and solutions to improve the rates of patients receiving treatment for depression.
- Disseminating educational materials to dialysis facilities via email and during technical assistance calls that could be used when conducting screenings and talking with patients. Examples include:
 - [*Talking to Patients about Depression Treatment*](#)
 - NCC Depression [*Expert Teams Calls*](#)
 - [*Discussing Depression with Your Care Team*](#)
- Developing and disseminating the *Doctor Fax Template* to assist facilities in communicating with outside providers to request screenings and referrals.

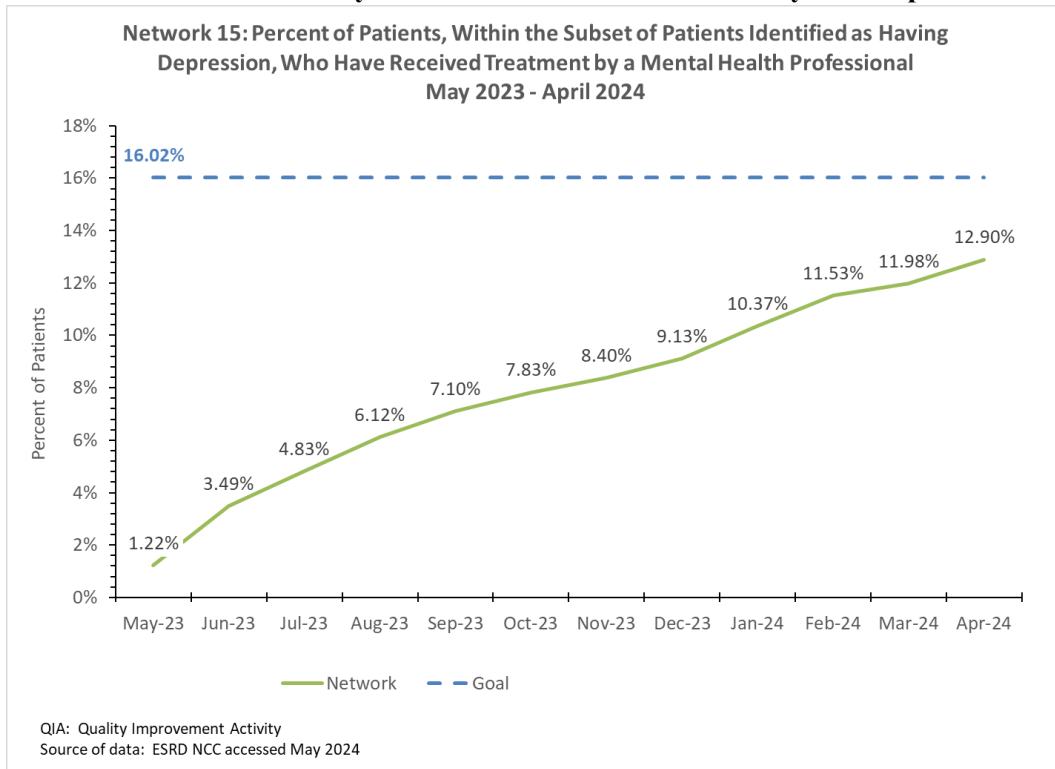
Best Practices

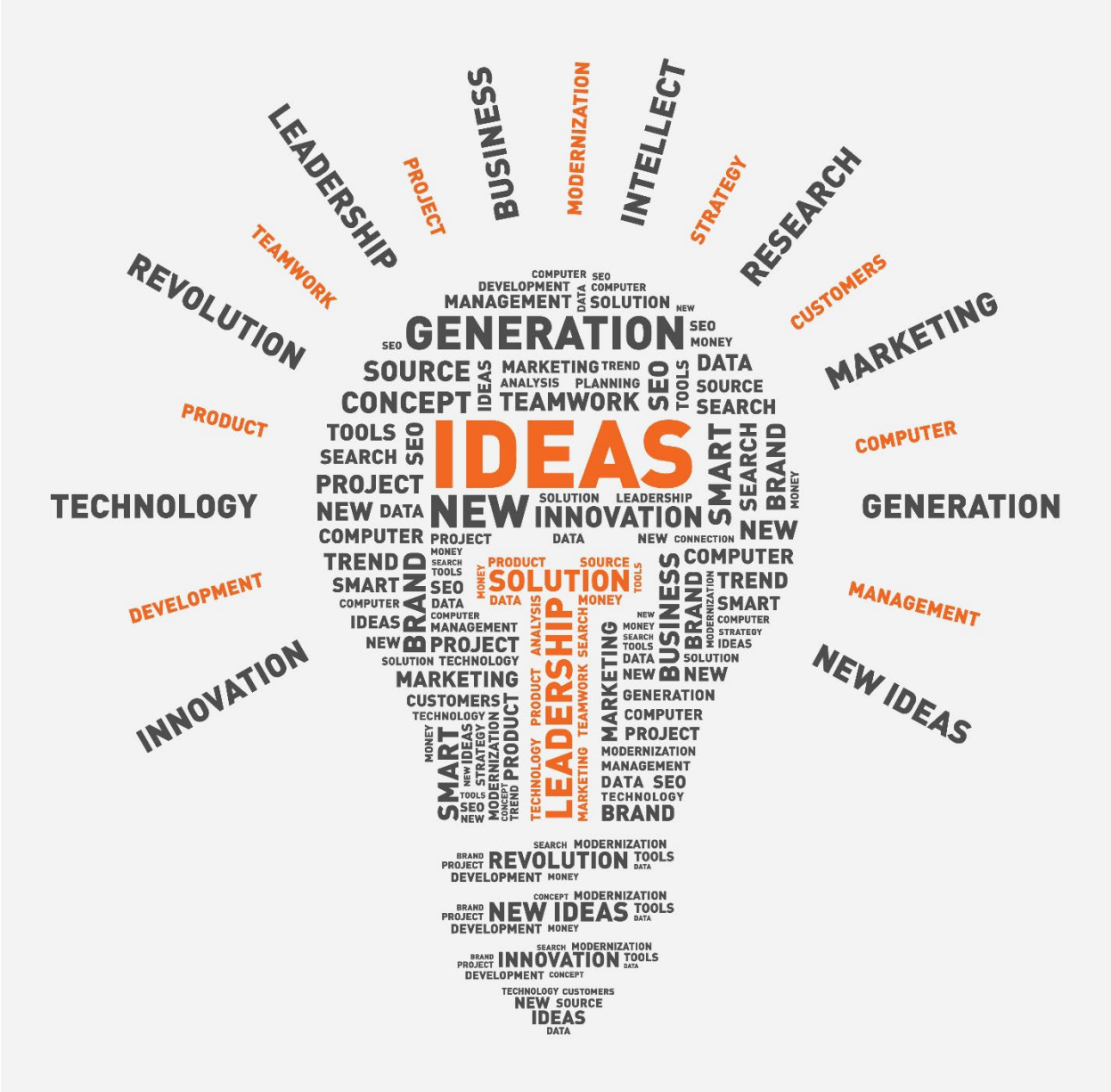
Best practices identified through the QIA include:

- Patient engagement:
 - Providing consistent education, that is easy to understand, that helps link emotions and non-traditional symptoms (i.e., difficulty making decisions) to the concept of mental health.
 - Normalizing the seeking of mental health support for patients by using positive mental health language, and related resources is a strategy to increase patient comfort with discussing mental health issues.
 - Involving family members to support patient with getting help.

- Provider-related interventions:
 - Exploring the use of evolving telehealth technology to provide mental health services.
 - Expanding the concept of “mental health provider” because many patients seek mental health support or treatment outside of the traditional office setting, such as through their faith community or from a community elder.
 - Involving the primary care physician for additional assessment, treatment, and referrals.

Chart DD: 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





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 maintained a cooperative and collaborative partnership with ESRD providers in all activities in 2023. The Network regularly interacted with facilities regarding QIAs and projects, patient grievances, data reporting, and the provision of technical assistance and education.

In 2023, the Network did not identify any facilities that warranted a recommendation for sanctions.

Recommendations to CMS for Additional Services or Facilities

The Network did not make any recommendations to CMS for additional facilities in its service area in 2023.

ESRD NETWORK COVID-19 EMERGENCY PREPAREDNESS INTERVENTION

During early 2023, the Network continued to use its emergency preparedness experience to adjust to the needs of patients and facilities during the COVID-19 pandemic. The Network's pandemic response included an all-team approach and routine assessment of needs and distribution of current information, resources, and data-targeted technical assistance.

Technical Assistance

The Network reviewed COVID-19 vaccination data and identified and contacted facilities for data-driven technical assistance. Technical assistance included vaccination education for patients and reporting guidance. Infection prevention education was also provided, including CDC guidance, patient and staff educational materials on hand washing and use of hand sanitizer, and guidance on facility isolation procedures.

Collaboration Activities

The Network maintained communication with various partners during the pandemic. The Network connected dialysis facilities with department of health (DOH) offices, healthcare coalitions (HCC) and county emergency operations centers (EOCs) for training and personal protective equipment (PPE) needs. State- and county-level information obtained through collaboration with the state and county DOH offices and HCCs was shared with dialysis facilities.

Data Collection and Reporting Activities

The Network continued to support all facilities with reporting to NHSN and disseminated NHSN enrollment instructions and information regarding the NHSN COVID-19 dialysis reporting module to all facilities in the Network service area. The Network identified facilities currently not enrolled in NHSN and provided step-by-step instructions for NHSN enrollment and individualized technical assistance via phone and email to ensure all facilities were able to enter data. Facility-level reports available from NHSN were submitted to Kidney Community Emergency Response (KCER) as requested.

ESRD NETWORK SIGNIFICANT EMERGENCY PREPAREDNESS INTERVENTION

ESRD Network 15 is tasked with providing support to dialysis facilities related to emergency preparedness, planning, and response. To ensure this support is provided, the Network:

- Conducts a risk assessment and submits an emergency plan to CMS.
- Provides education and technical assistance to dialysis facilities and patients related to emergency preparedness, including hurricane readiness.
- Monitors for weather events or other emergencies that can impact dialysis facilities and transplant centers located in the Network region.
- Collects and tracks the open and closed status of facilities and the location of patients during the response to an emergency event.
- Works closely with KCER and other stakeholders to ensure patients have access to dialysis before and after an emergency event.

During 2023, the Network monitored the weather and possible impacts to facilities, distributed educational materials and provided technical assistance to facilities related to emergency preparedness.

ACRONYM LIST APPENDIX

This appendix contains an [acronym list](#) created by the Kidney Patient Advisory Council (KPAC) 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.