

ESRD NETWORK 2019 ANNUAL REPORT

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

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This material was prepared by HSAG: ESRD Network 15, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication Number CO-ESRD-15G094-06082020-01

ESRD DEMOGRAPHIC DATA

ESRD Network 15

As a member of the Health Services Advisory Group (HSAG) team, 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 ESRD patients. HSAG has held the Network 15 contract since 2016.

Geography and General Population

Geographically, Network 15 encompasses 21.0% 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. Network 15 works closely with the Kidney Community Emergency Response (KCER) Program to monitor weather patterns, natural disasters, and other emergency situations to ensure patient safety in both rural and urban areas.

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 27,070 individuals with ESRD in 2019. During the reporting period of December 31, 2018 to December 31, 2019, the Network's ESRD patient census increased by 879 patients (3.2%) for a total of 27,076 prevalent patients in the Network's service area, as compared to the national total of 530,094 as of December 31, 2019. The number of incident dialysis patients in the Network service area increased to 6,814 (25.1%) individuals newly diagnosed with ESRD in 2019, compared to 6,689 (25.5%) in 2018. The Network's prevalent patient population comprises 5.1% of the national prevalent dialysis patient population and its incident patient population comprises 5.2% of the national prevalent dialysis patient population. (See Charts A and B)

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

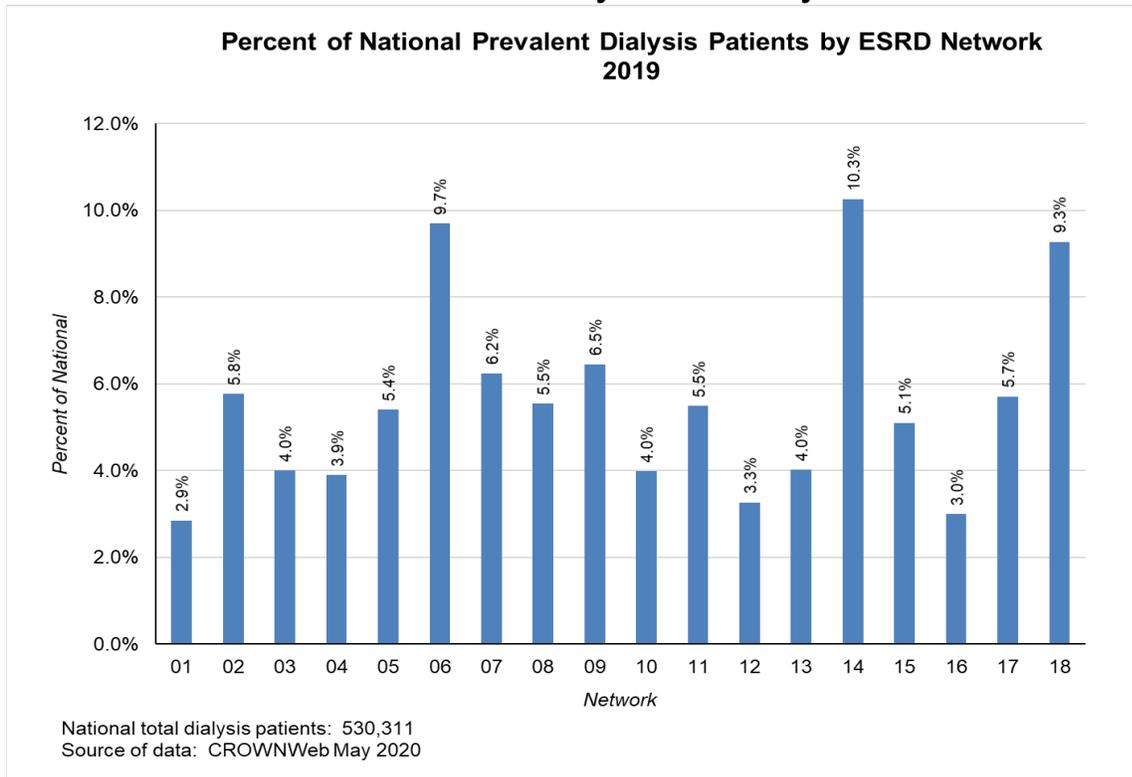
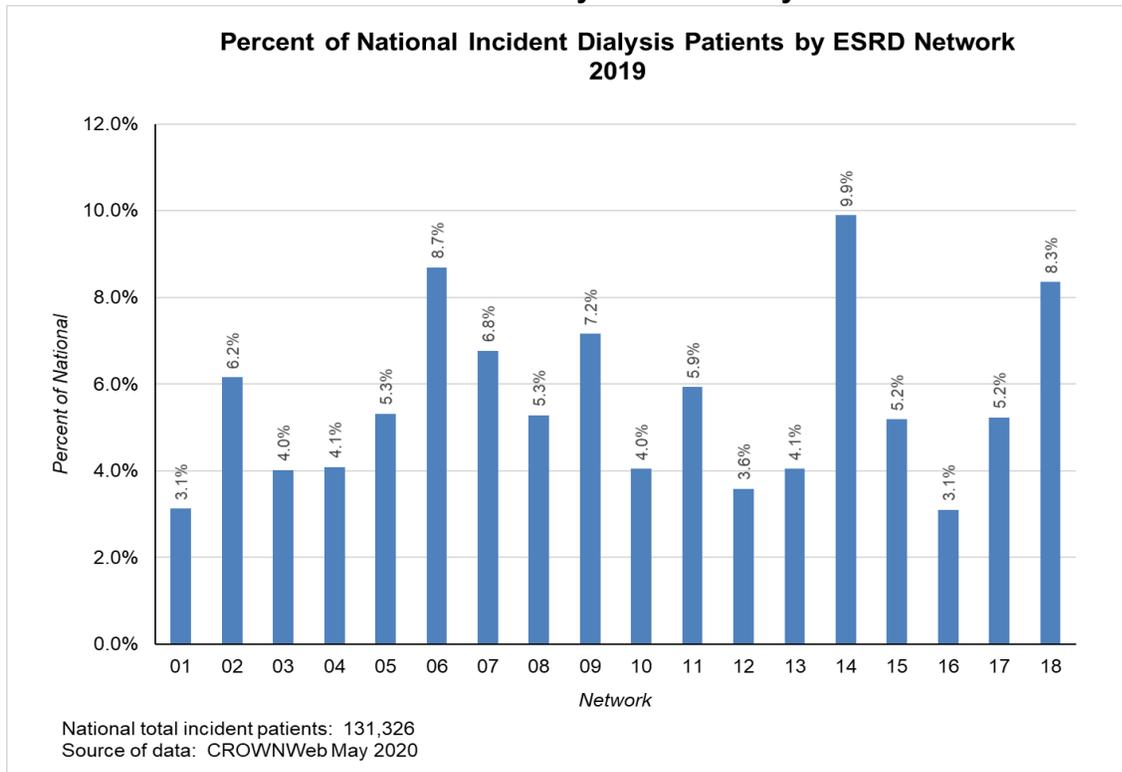


Chart B: Percent of National Incident Dialysis Patients by ESRD Network



Race and Ethnicity¹

As of December 31, 2019, 72.5% of prevalent patients in the Network 15 service area were characterized as White and 10.7% as American Indian/Alaska Native. The third largest racial group reported by patients was African American at 10.2%. As of December 31, 2019, 71.3% of prevalent patients in the Network 15 service area, were characterized ethnically as Not Hispanic or Not Latino.

Gender and Age

As of December 31, 2019, 58.5% of prevalent ESRD patients in the Network 15 service area were male, 41.5% were female, and 68.0% 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-Morbidities¹

Network data reflected that in 2019, 72.0% of ESRD patients in the service area had a primary cause of ESRD that fell into one of two co-morbid categories: 52.5% showed diabetes and 19.5% showed hypertension as primary causes of ESRD, respectively.

Dialysis Treatment Options

As of December 31, 2019, 86.1% of prevalent patients in the Network 15 service area were receiving in-center hemodialysis (ICHD). The remaining patients were using the following home modalities (See Chart C):

- Continuous-cycling peritoneal dialysis (CCPD): 11.2%
- Continuous-ambulatory peritoneal dialysis (CAPD): 1.2%
- Home hemodialysis (HHD): 1.5%

Additionally, 83.2 % of incident patients were receiving ICHD and 12.8% were using home modalities at the end of 2019. (See Chart D). Overall, Network 15 accounted for 5.3% of all HHD and peritoneal dialysis patients in 2019. (See Chart E)

¹ Data on “ethnicity” and “race” should be interpreted with caution because of the inherent instability of race/ethnicity data.

Chart C: Network 15: Count of Prevalent ESRD Patients by Treatment/Setting

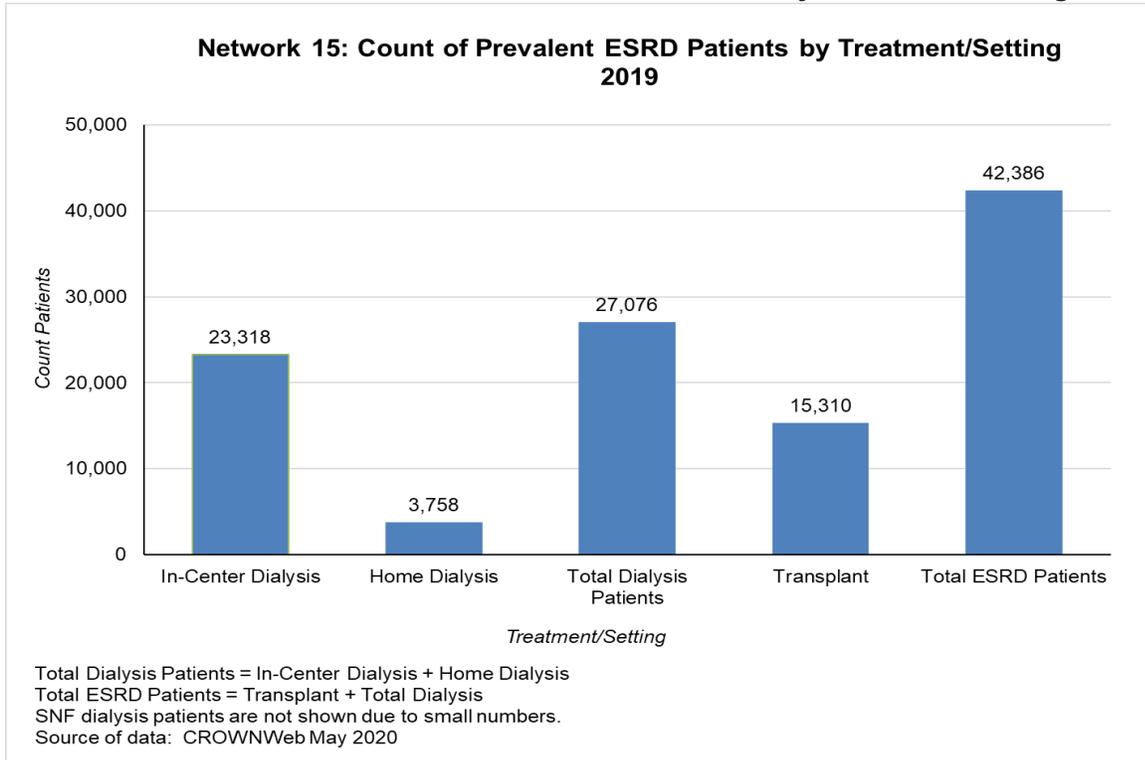


Chart D: Count of Incident ESRD Patients by Initial Treatment/Setting

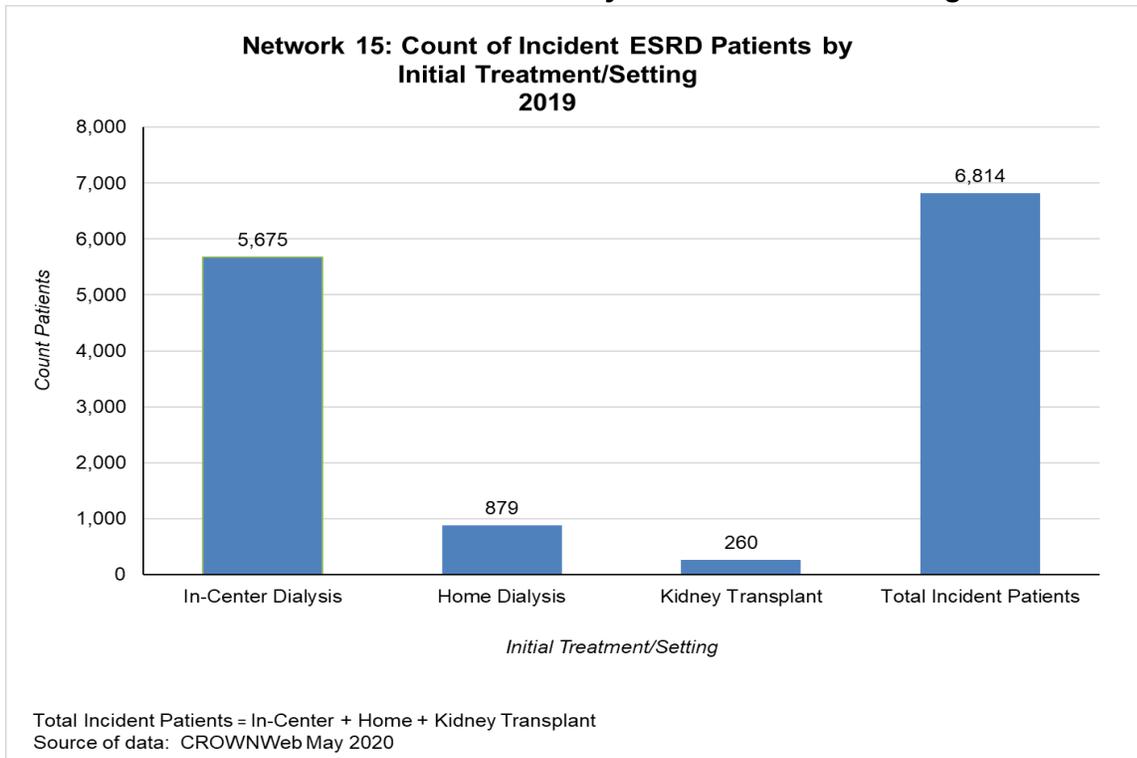
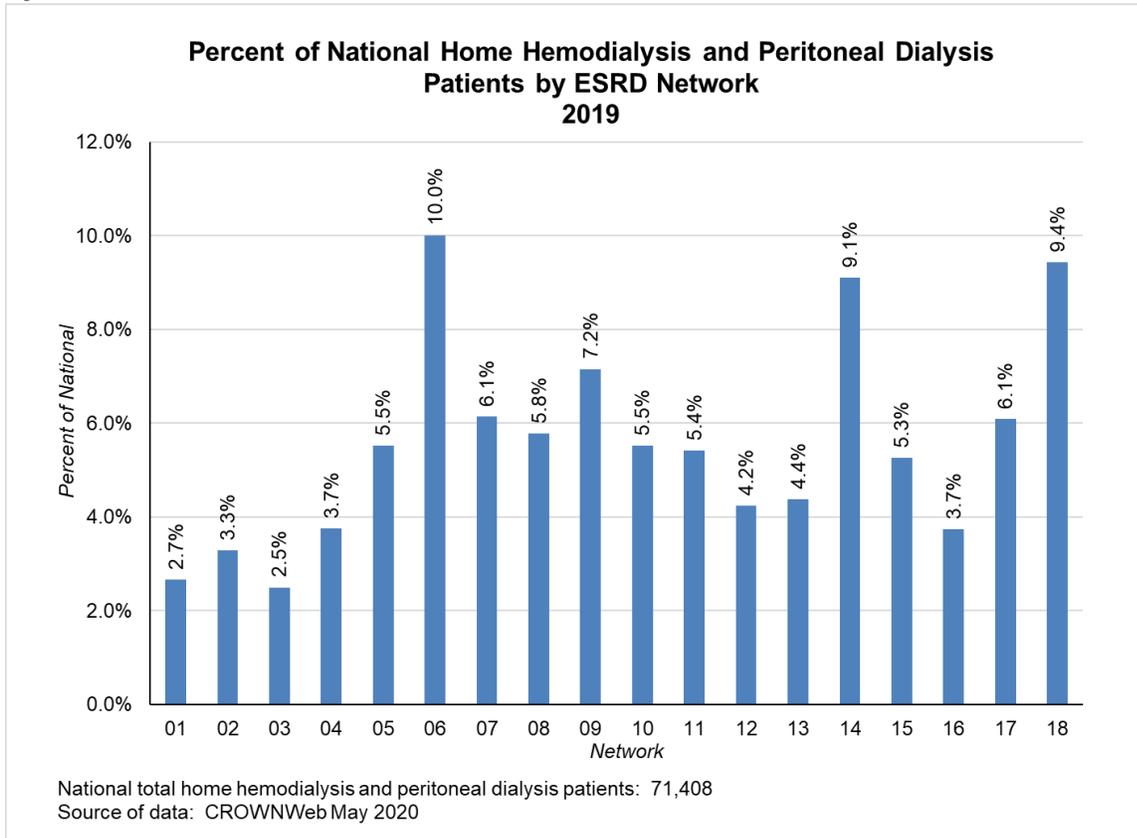


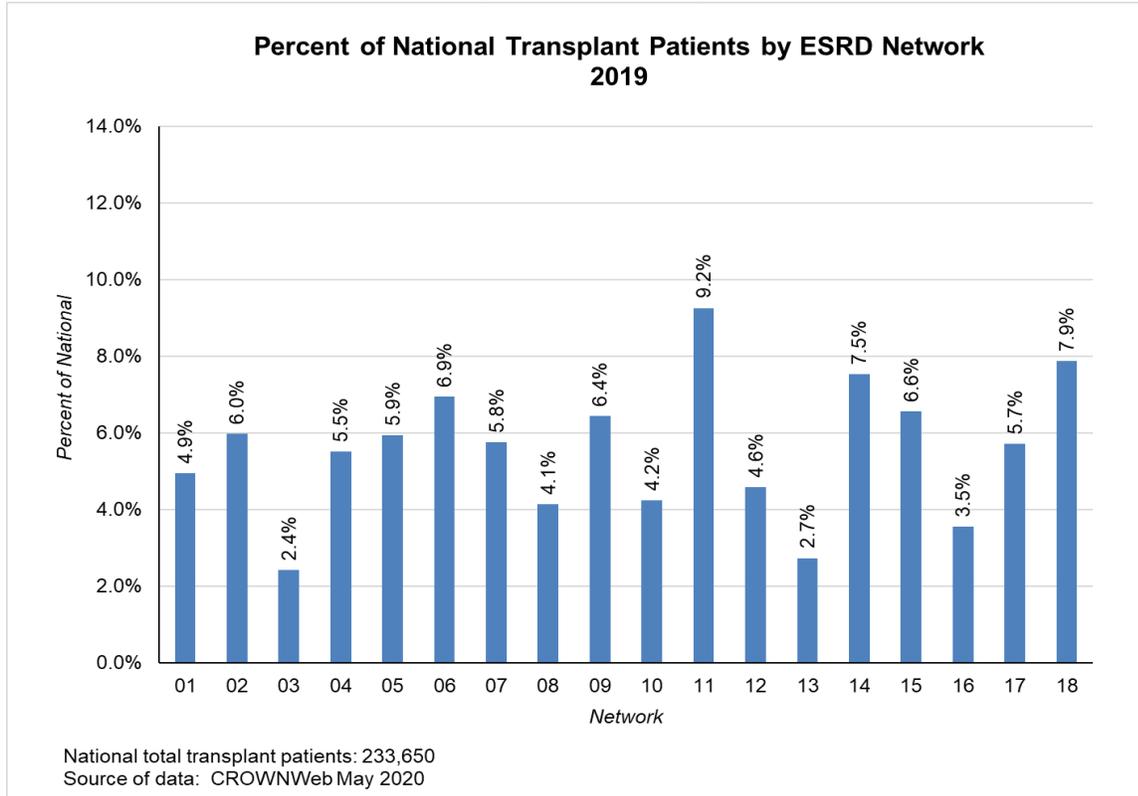
Chart E: Percent of National Home Hemodialysis and Peritoneal Dialysis Patients by ESRD Network



Transplant

During 2019, 1,532 kidney transplants were completed by 15 transplant centers in the Network 15 service area. As of December 31, 2019, there were 230,931 transplant patients nationally, of which 6.6% were in Network 15. (See Chart F)

Chart F: Percent of National Transplant Patients by ESRD Network



Providers

As of December 2019, 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 (see Chart G). Forty percent of the dialysis facilities offered home dialysis services. Of the 378 dialysis facilities in Network 15's service area, 21.6 % offered dialysis shifts starting after 5 p.m. Mountain Time (MT). Network 15 accounted for 6.6% of all Medicare-certified kidney transplant facilities and 4.9% of all medicare-certified dialysis facilities nationally. (See Charts H and I)

Chart G: Count of Medicare-Certified Facilities by Modality Type

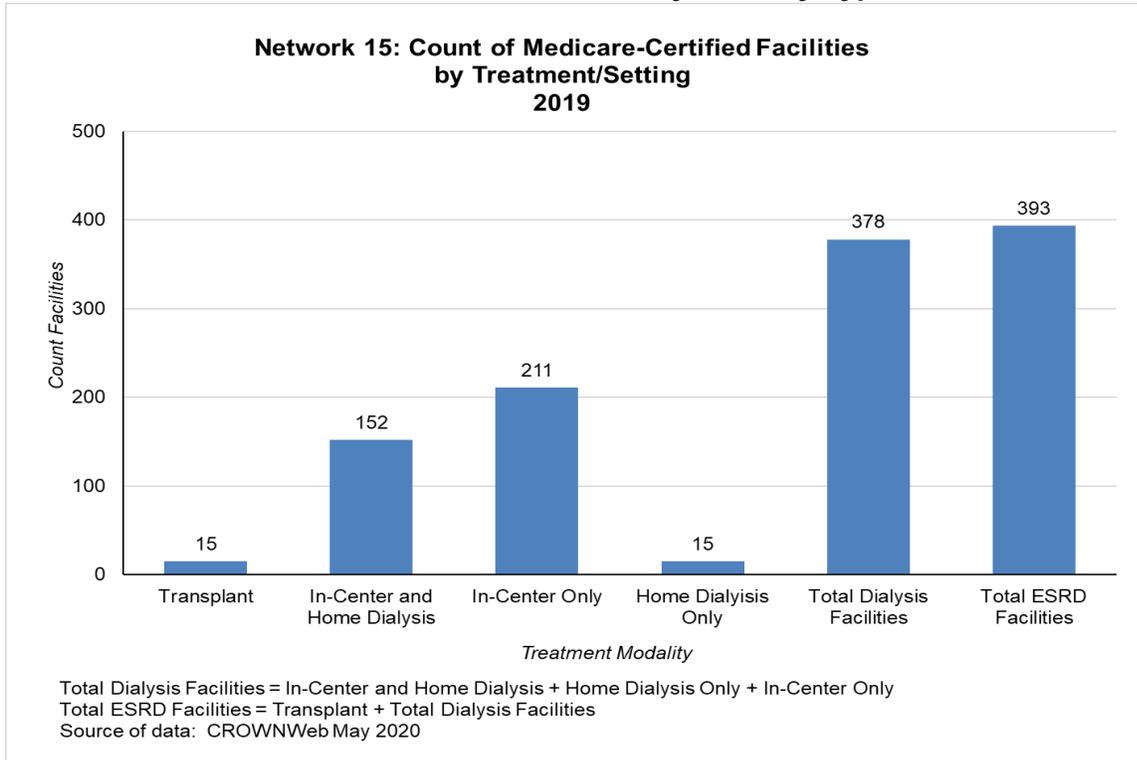


Chart H: 2019 Percent of Medicare-Certified Kidney Transplant Facilities by ESRD Network

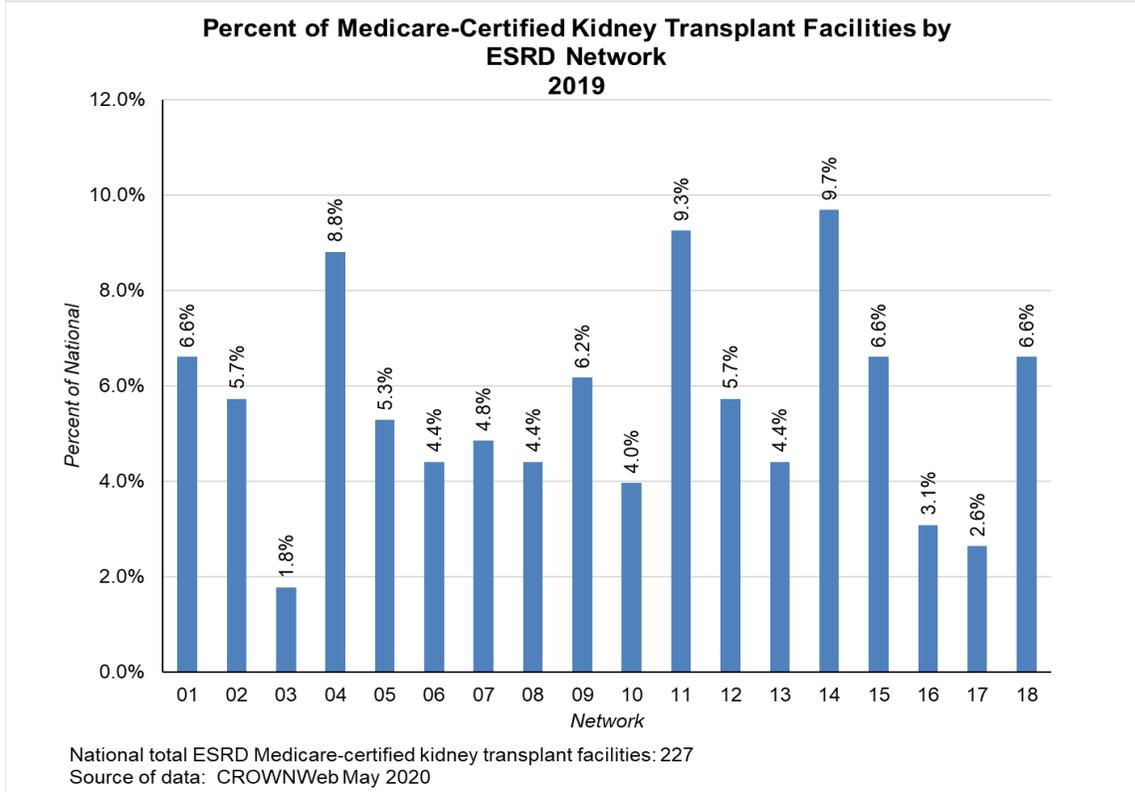
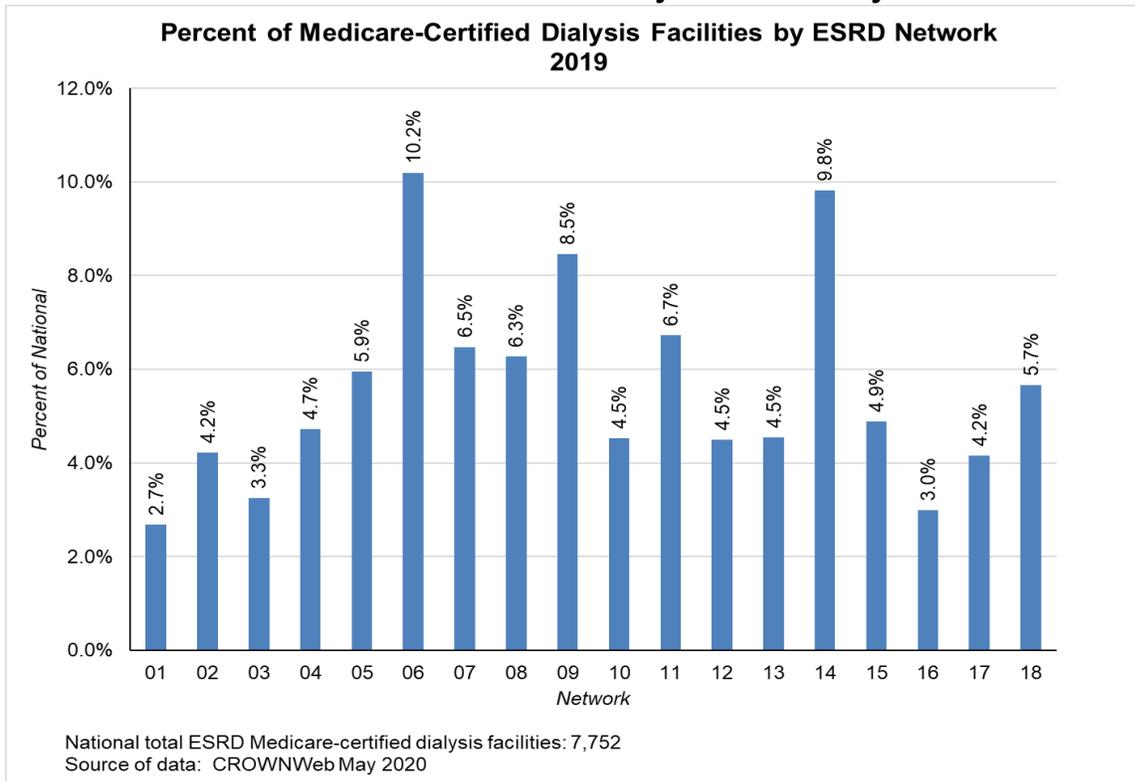


Chart I: 2019 Percent of Medicare-Certified Dialysis Facilities by ESRD Network



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. 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. Cases are investigated using a thorough record review of any documentation pertaining to the grievance. Quality-of-care grievances are addressed through records reviews overseen by the Network's nephrology nurse. Grievants receive an outcome letter following the close of any grievance. According to Chart J below, during 2019, 33.0% of contacts to the Network were for grievances, including 15.0% for immediate advocacy, 12.0% for general grievances, and 6.0% for clinical areas of concern.

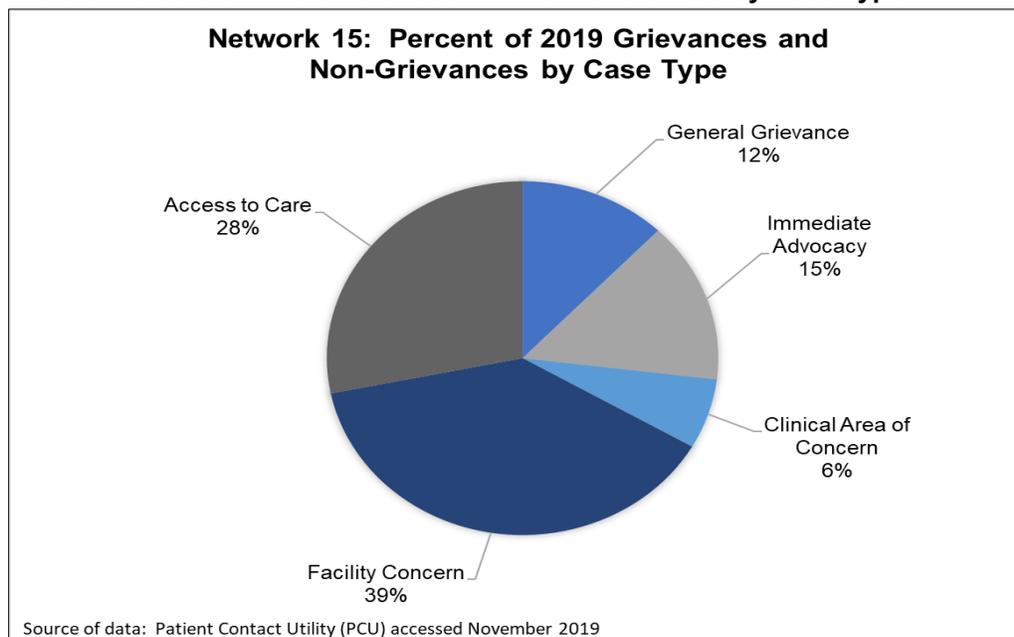
Facility Concerns

In addition to grievances, the Network also responded to facility concerns, which accounted for 39.0% of all contacts to the Network in 2019. Facility concerns included contacts received from dialysis facilities 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 2019, access-to-care issues accounted for 28.0% of contacts to the Network.

Chart J: Percent of 2019 Grievances and Non-Grievances by Case Type



ESRD NETWORK QUALITY IMPROVEMENT ACTIVITY DATA

Long-Term Catheter (LTC) Quality Improvement Activity (QIA)

During 2019, the Network conducted a QIA to reduce LTC (catheter in use for 90 days or longer) use in a cohort of 68 facilities with both higher than expected excess infection rates and a high rate of LTCs. This cohort of 68 facilities impacted approximately 5,166 patients. The Network also implemented more intensive interventions for a subset of 25 facilities, impacting approximately 1,590 patients within the 5,166 total of patients previously cited. The subset facilities were selected based on having a greater than 15.0% LTC rate.

Goals and Outcomes

The baseline LTC rate for the cohort of 68 facilities, based on July 2018 CROWNWeb data, was 18.7%. By the end of the measurement period in October 2019, the cohort facilities reduced their aggregate LTC rate to 16.8%, which was a decrease of 1.9 percentage points. Although this did not meet the QIA goal to demonstrate at least a two-percentage point reduction, the LTC subset facilities did exceed the goal rate for five consecutive months of the QIA with the lowest rate being 15.8% in June 2019. (See Chart K).

Barriers

Facility-reported barriers to achieving QIA goals included:

- Initiation of treatment in an urgent manner that prevented an opportunity to cannulate a permanent vascular access (VA) within 90 days.
 - Unpredictable influx of catheter patients admitted and transferred into dialysis facilities (who often were not under the care of a nephrologist prior to the initiation of dialysis) contributed to the lack of a permanent access plan.
 - Adjustment to an ESRD diagnosis did not allow new patients to receive proper orientation, education, and VA planning in time to have a permanent access in use within 90 days.
- Insufficient relationships with VA centers and surgeons to facilitate fully functional permanent VA within a 90-day period.
- Lack of designated staff to monitor patients as they move through the process of getting a permanent VA from the initial planning appointment through cannulation.
 - This deficit caused delays in using maturing accesses, establishing procedure appointments, detecting surgical issues requiring intervention, and removing existing catheters in a timely manner.

Interventions

A combination of Centers for Medicare & Medicaid Services (CMS)-directed activities incorporated with patient subject matter experts' (PSMEs') perspective led to the following Network interventions:

- Requiring the subset facilities to conduct root cause analyses (RCAs).
 - Results from the RCA 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.

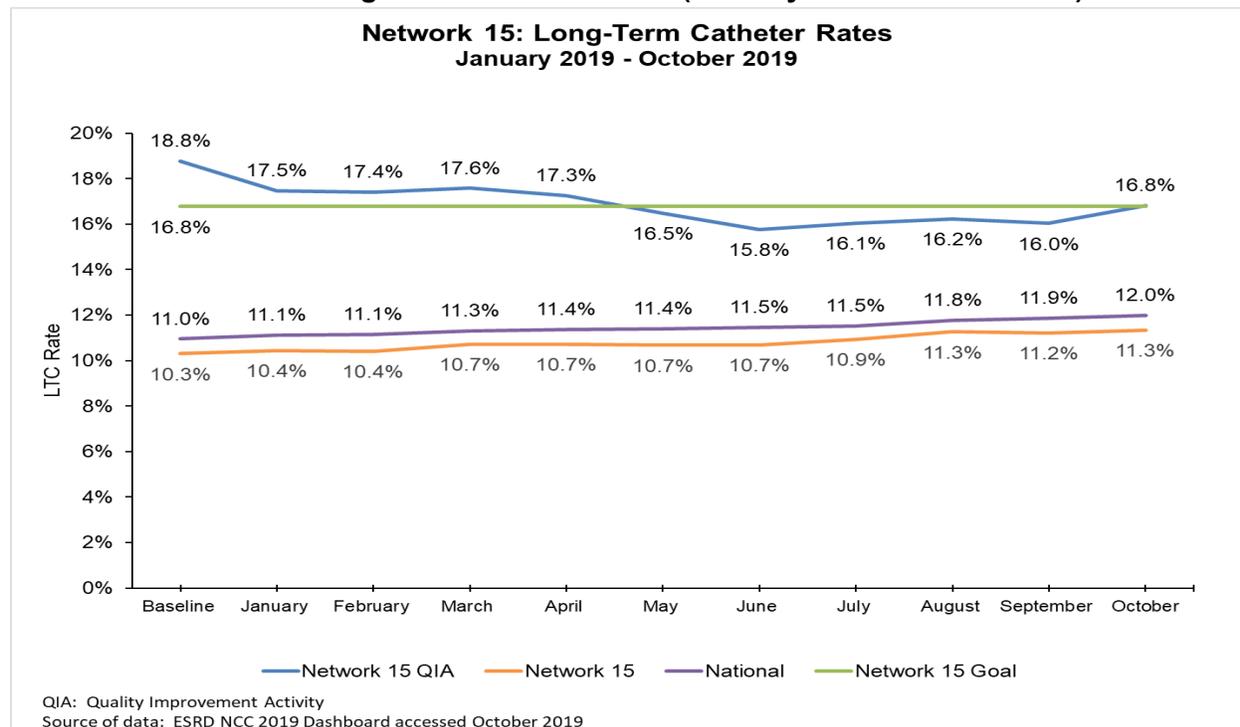
- Distributing and reviewing facility specific feedback reports that compared self-reported data to official CROWNWeb data with the QIA facilities.
- Reviewing the current status and next steps in permanent access plans for each patient with a catheter.
- Providing training and technical support to ensure accurate progression and use of VA reporting in CROWNWeb.
- Reinforcing patient-focused interventions by asking PSMEs to participate on QIA calls and provide their perspective on challenges and possible solutions to permanent VA placement.

Best Practices

Best practices identified by the QIA facilities included:

- Working with hospital interventionalists and surgeons to schedule and place permanent internal accesses for chronic kidney disease (CKD) patients prior to beginning dialysis.
- Encouraging VA surgeons to round at the outpatient dialysis facility, allowing them to establish VA plans and address any financial, transportation, or psychosocial barriers with staff in the outpatient setting.
- Setting the expectation of establishing a permanent VA upon admission, before a patient becomes complacent with a central venous catheter (CVC).
- Providing frequent patient education on infection prevention to facilitate heightened staff and patient awareness of the risks associated with having an LTC.

Chart K: Network 15: Long-Term Catheter Rates (January 2019–October 2019)



Blood-Stream Infection (BSI) Quality Improvement Activity

During 2019, 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 20% of service area facilities with the highest excess infection rates as reported in the National Healthcare Safety Network (NHSN). Sixty-eight facilities, impacting approximately 5,166 patients, were included.

Goals and Outcomes

The goal of the QIA was to achieve at least a 20% relative reduction in the pooled mean BSI rate for the 20% of facilities with the highest excess infection rates, from January–June 2019. This would include preventing at least 56 BSIs during the nine-month measurement period. By the conclusion of the QIA, the aggregate BSI rate in the 68 facilities decreased from 1.836% to 0.510%, and at least 131 BSIs were prevented, exceeding the 2019 QIA goal (see Chart L). Additionally, the Network engaged dialysis facilities and had 100% complete the NHSN Dialysis Event Surveillance Training and 66.9% establish a Health Information Exchange (HIE) or Evidence-Based Highly Effective Information Transfer System between January – September 2019 (see Charts M and N).

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 and infection-free for a duration of time.
- Discomfort of staff with patient participation in hand hygiene audits: a persistent apprehension that the audits might lead to scrutiny of staff or potential mistrust of the patient/caregiver relationship when steps are perceived as “missed.”

Patient-identified barriers included:

- Lack of staff enthusiasm or commitment to improving infection control, giving the perception that fixing broken processes was not important.
- Acute Kidney Failure (AKF) patients with catheters perceiving that their need for dialysis was not permanent and therefore they did not need to adhere to infection prevention guidelines. They felt that their situation and need for involvement was not as great as patients with ESRD.

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.
 - These tools have been tested and proven to be successful.
 - The tools provided by the CDC are the industry standard for infection prevention.
- Incorporating actions steps developed from ESRD NCC BSI Learning and Action Network (LAN) calls to assist facilities in implementing the CDC-recommended interventions.

- Providing patient education on the importance of washing hands, vascular accesses, and knowing the signs and symptoms of infection.
- Increasing patient education regarding catheters, including specific resources directed towards improving the patients' knowledge of how to care for their CVC outside of the dialysis facility.
- Attending an educational webinar, developed with the Colorado Department of Health and Environment (CDHE), on CDC approaches to preventing BSIs in the dialysis facility and reporting accurately 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).
- Promoting use of HIE to facilities and the completion of attestations for facilities participating in HIEs.
- Conducting monthly hand hygiene audits with patients completing the observations on dialysis staff.

Best Practices

QIA facilities tested interventions to address barriers to remaining infection-free and best practices were shared with all facilities in the Network service area. Best practices identified during the QIA included:

- Engaging patients in infection control by including them as auditors for hand hygiene practices and documenting observations on the CDC *Hand Hygiene Audit Tool*.
- Using patient centered resources to guide discussion with patients about infection control, such as the CDC handout, *Conversation Starter*.
- Conducting ongoing hand hygiene audits to heighten staff awareness of hand washing practices.
- Reviewing and discussing CDC Core Interventions and monthly Network provided interventions during monthly quality assessment and performance review meetings, in addition to reviewing of infection rates, with the medical directors of facilities.

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

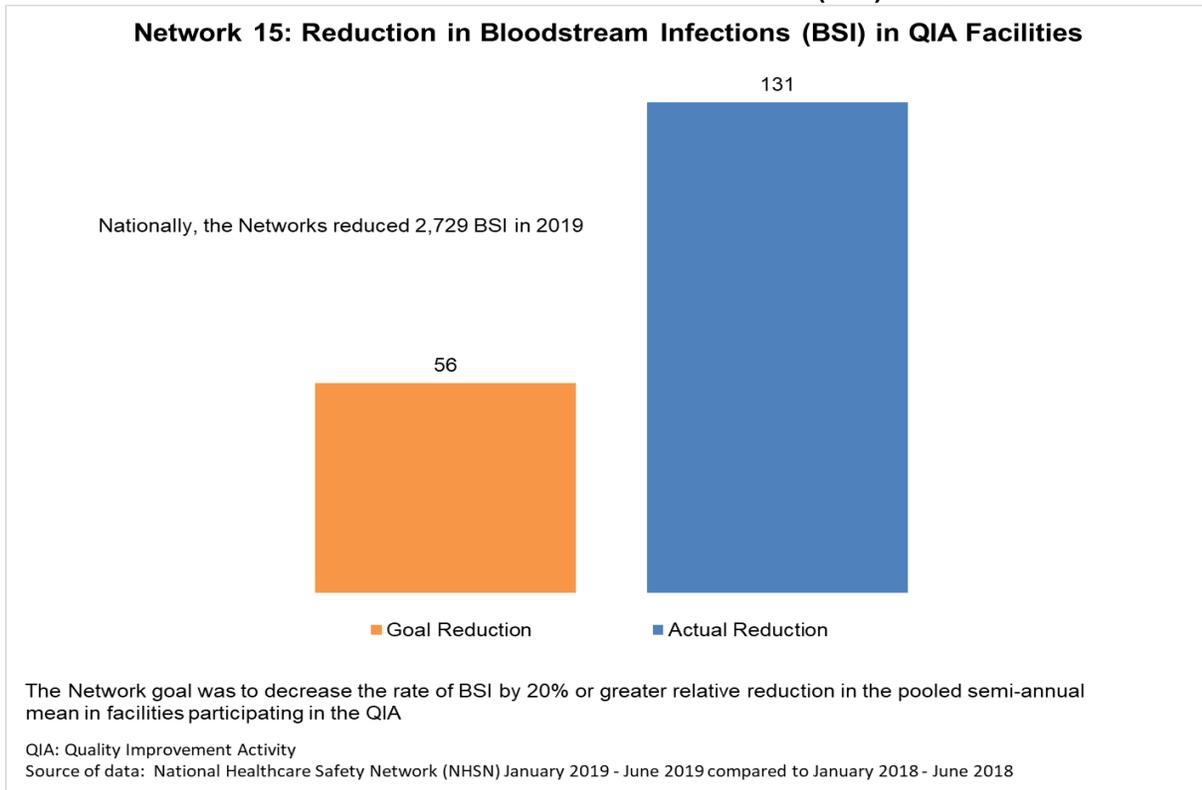


Chart M: Network 15: Percent of Dialysis Facilities With At Least One Person Who Has Completed the NHSN Dialysis Event Surveillance Training (January–September 2019)

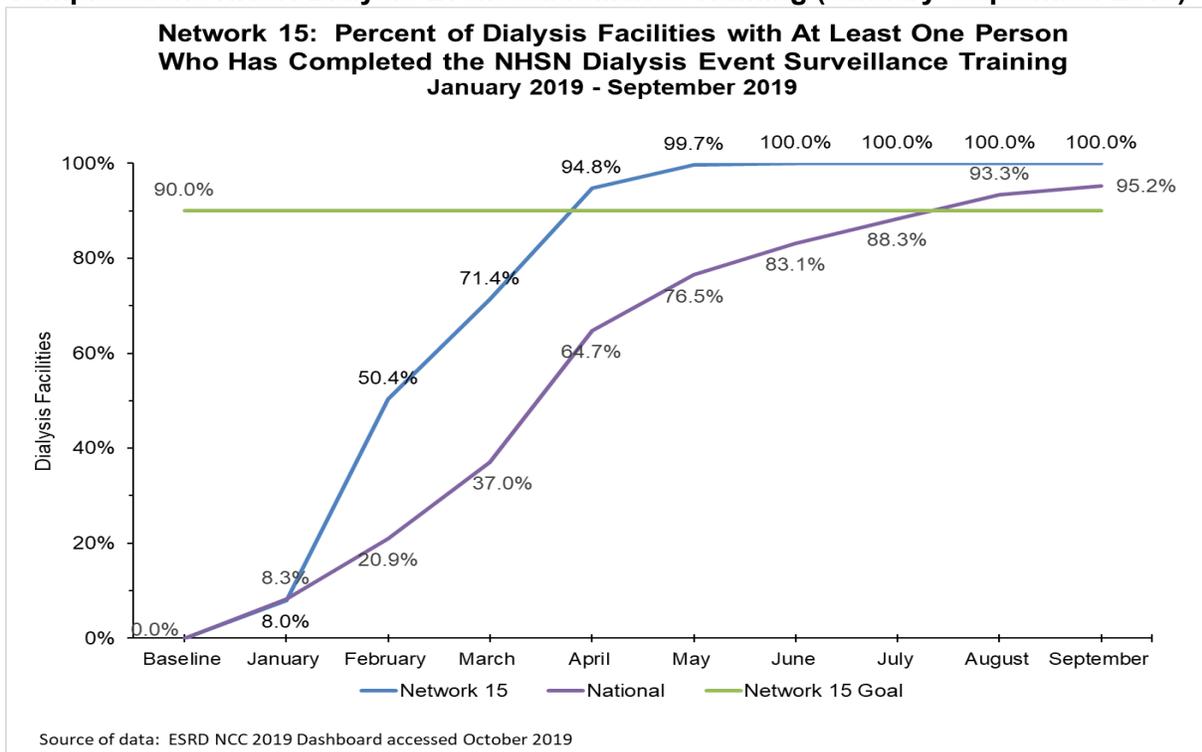
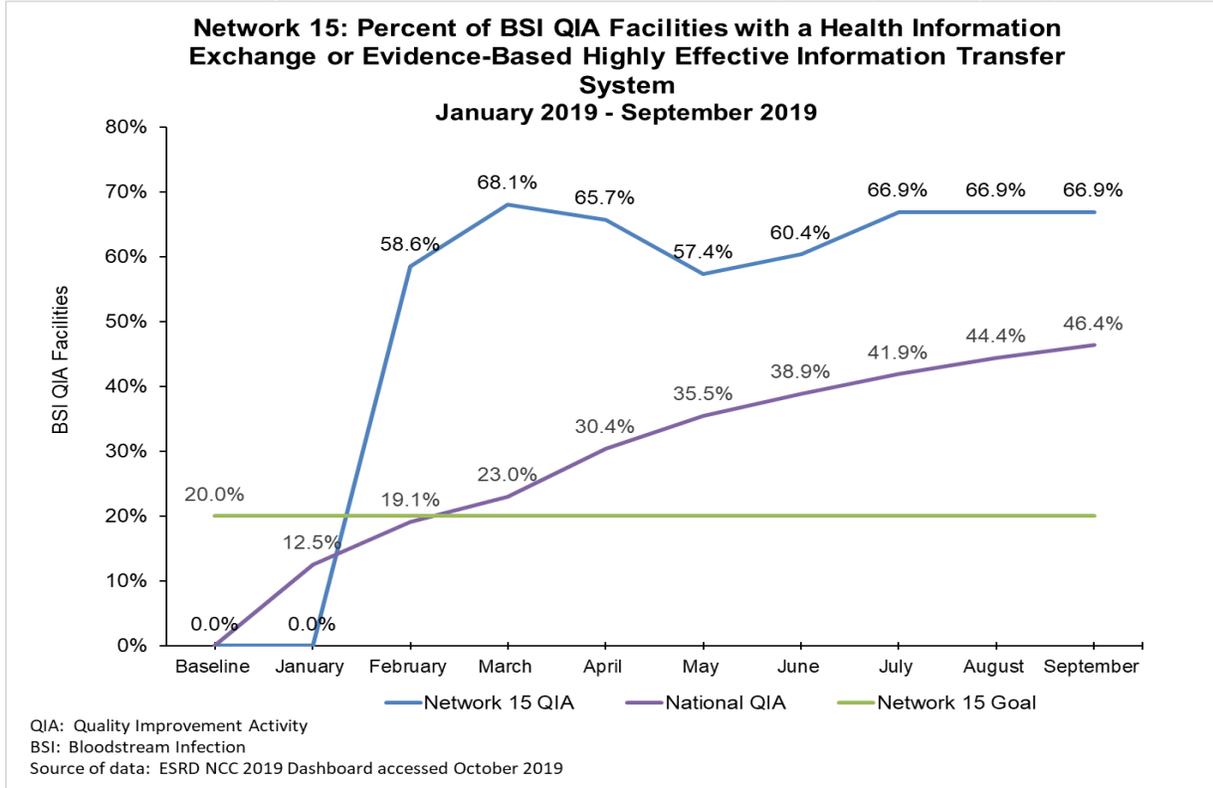


Chart N: Network 15: Percent of BSI QIA Facilities with a Health Information Exchange or Evidence-Based Highly Effective Information Transfer System (January–September 2019)



Transplant Waitlist Quality Improvement Activity

The 2019 Transplant Waitlist QIA was intended to increase the number of ESRD patients added to a transplant waitlist. The Network identified 110 dialysis facilities with historically low rates of adding patients to a transplant list for inclusion in the QIA, impacting approximately 9,960 hemodialysis patients.

Goals and Outcomes

The QIA sought to meet the goal of a 2.0% improvement over the natural trend or the addition of 311 patients to a transplant waitlist. The QIA used educational interventions, early referral to transplant centers, and staff-provided patient support through the waitlist process to reach this goal. At the end of the QIA in September 2019, the final rate was 2.0%, indicating the addition of 195 patients to a transplant waitlist. (See Chart O) This was a 62.7% achievement toward the total goal.

Barriers

Barriers to achieving the QIA goals included:

- Lack of education and clarity on the referral and transplant criteria for transplant centers for both patients and facility staff.
- Lack of facility involvement assisting patients through the transplant referral-to-waitlist process.
 - Assessments revealed patients did not receive adequate encouragement and support in navigating the transplant process. This barrier was found in the evaluation-through-active-listing phases, as well as for ongoing actively listed patients.
- Poor communication between the transplant centers and dialysis facilities impacted patients throughout the transplant process.
 - Often, patients did not receive proper support and follow-up relating to appointments and evaluation needs from either the dialysis facilities or transplant center.
- Waitlists for kidney transplants are often lengthy.
 - A waiting process with an undetermined end-date was reported as discouraging to both patients and staff.
 - Long wait times were also found to contribute to communication barriers between transplant and facility staff when a process for simple, shared communication was not in place.
- Patients' lack of interest in transplant.
 - Personal lifestyle choices and complacency with the current plan of care were often reported.
 - Fear of the outcome of more medical testing, more surgery, complications, medication side-effects, and the possibility of needing to return to dialysis at some point in the future were also reported as barriers.
- Financial, transportation, and caregiver requirements.
 - Even when physical candidacy had been established, these stressors were reported.

Interventions

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

- Providing structured suggestions for individualized patient assistance from both transplant and dialysis facility staff.
- Initiating individual facility RCAs and providing technical assistance during tests of change using the PDSA cycle.
- Creating an *Absolute Exclusion* transplant guide in collaboration with staff from the transplant centers for future dissemination.
- Creating and providing education for patients and staff through handouts, Lobby Days, site visits, and webinars featuring speakers from various transplant centers on pertinent topics, such as:
 - Why transplant?
 - Preparing for transplant evaluation.
 - Living donor facts.
 - Health maintenance items necessary to complete prior to transplant evaluation.
 - Tips from the transplant centers.
 - State-specific transplant center information.
- Engaging transplanted peer mentors and transplant center coordinators to speak to transplant candidates and share experiences informally and during Lobby Days.
- Assisting facilities to adopt LAN transplant interventions, including the use of:
 - Transplant binders for tracking patient's progress.
 - Education for patients at their level of readiness and re-educating existing patients that may have developed interest.
 - Family and caregiver involvement to understand benefits, barriers, and the process of kidney transplant.
 - A communication process for dialysis facility staff and transplant centers.
 - A transplant focal point in the facility, such as a bulletin board, display, or a resource table.
 - Activities that make the transplant process engaging for patients.
 - Education for the entire facility team about transplant benefits, processes, requirements, and outcomes.
 - An identified transplant champion at the dialysis facility for continued patient assistance.
- Sharing information on expanded donor criteria, living donation, and how to ask someone for a living donation.

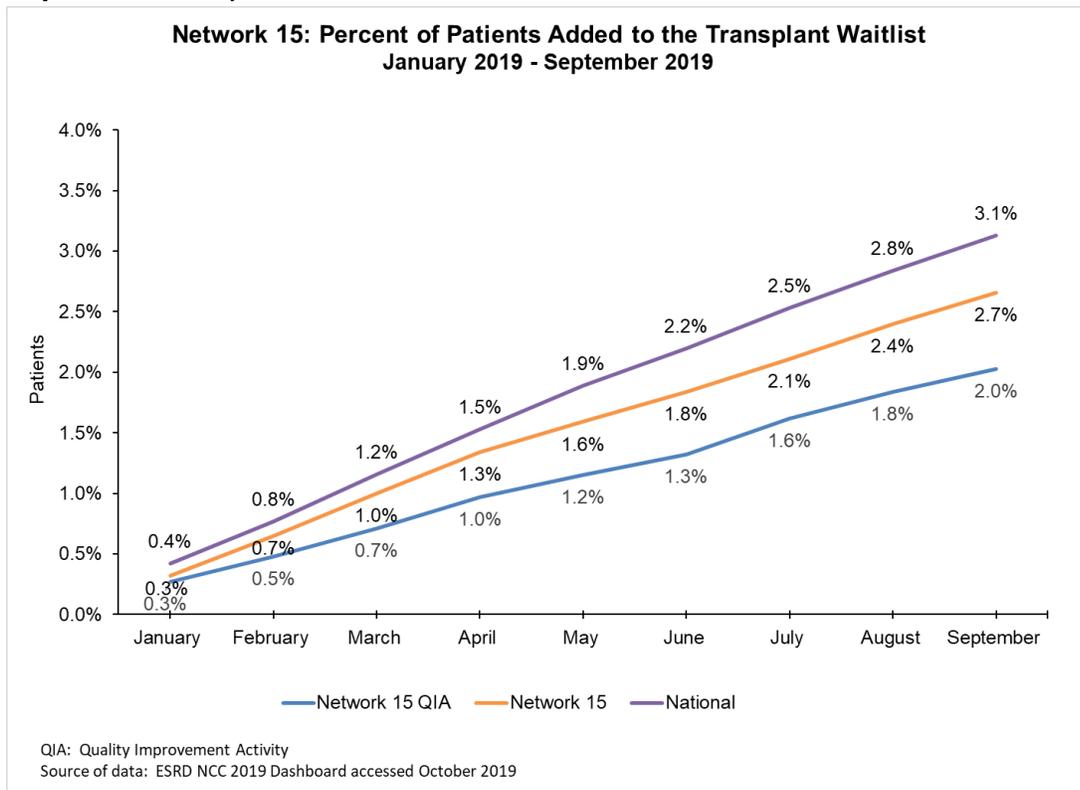
- Including patients, family members, and/or caregivers in Quality Assessment and Performance Improvement (QAPI) meetings to review methods for enhanced transplant engagement.

Best Practices

Best practices identified during the QIA include:

- Holding bi-monthly meetings with the transplant centers.
- Hosting monthly collaborative meetings with Large Dialysis Organizations (LDOs).
- Engaging in staff educational opportunities at local transplant centers.
- Involving all the facility staff to encourage and educate all patients on transplant.
- Sharing best practices by top performing QIA facilities.
- Hosting educational conferences for facility staff by transplant centers in Utah and New Mexico.

Chart O: Network 15: Percent of Patients Added to the Transplant Waitlist (January–September 2019)



Home Therapy Quality Improvement Activity

In 2019, the Network conducted a QIA to support the CMS goal of increasing the number of ESRD patients on home therapies. The Network sought to accomplish this by identifying barriers to the referral process, education, and interventions to assist practitioners in transitioning eligible patients to a home modality. The Network identified 110 dialysis facilities for inclusion in the QIA, which constitute 30.0% of all facilities in its coverage area. These facilities had historically low rates of patients transitioning to a home modality. The QIA impacted approximately 4,154 patients.

Goals and Outcomes

The QIA goal was to improve the rates of patients transitioning to home dialysis in the target facilities by 2.0% over the natural trend of home dialysis patients in the service area. The goal included moving 387 patients to a home dialysis modality. The baseline rate, identified using UNOS and CROWNWeb data, was 0.3%. At the end of the QIA in September 2019, the final rate was 8.5%, and included the movement of 446 patients or achievement of 115.3% of the goal (see Chart P).

Barriers

Barriers to achieving the QIA goals included:

- Lack of education and clarity about home modalities and eligibility. This was an issue with patients and facility staff.
 - Poor staff understanding about dialysis modalities resulted in poor communication with patients about home therapies. This left patients uneducated or unaware of their choices.
- Lack of facility involvement in assisting patients with selecting and revisiting possible modality options.
 - Assessments revealed patients do not receive adequate encouragement, education, and support in choosing a modality that suits their lifestyle and preferences. The staff often state that patients are more comfortable doing something familiar. This response reflects a common staff opinion that comfort in one treatment modality is the only way the patient will feel comfortable treating. This staff mindset then becomes a barrier to patients being educated about additional benefits of home therapy.
 - Similarly, there is a reported general lack of patient interest in home therapies. Many patients report being satisfied with in-center dialysis and consider the facility staff and patients to be their support and social interaction.
- Frequent poor communication between the home dialysis centers and dialysis facilities that impacts the patients. Dialysis facilities lack engagement and specific involvement in the eligibility, referral, and assistance of moving patients through the home modality process.
 - Patients do not receive proper support and follow-up relating to assessing for interest in home therapies, answering questions, and discussing modality options.

Interventions

PSMEs provided the patient perspective for development of all QIA educational materials and interventions. PSMEs gave input on the practicality and usefulness of all Network interventions as the project took shape. Network interventions included:

- Encouraging individualized patient education and individualized support in decision making for modality choice.
- Implementing structured tracking of patients at all steps in the home dialysis process.
- Initiating individual facility RCAs and providing technical assistance during tests of change using the PDSA cycle.
- Providing individualized technical assistance to overcome identified RCA issues as well as ongoing identified barriers.
- Training dialysis staff on how to approach patients about home modalities.
- Educating staff and patients on the barriers and myths around home therapy through:
 - Lobby Days.
 - Handouts.
 - Use of videos showing patient-to-patient interaction and discussion.
 - Site visits.
 - Webinars with expert speakers.
 - Involving home hemodialysis (HHD) patients in monthly quality meetings at the facilities.
- Engaging patient advocates and HHD partners to actively engage in-center patients and families through giving input into the home program and sharing experiences during Lobby Days.
- Assisting facilities to adopt LAN interventions to promote home dialysis, including:
 - Opening transitional care units.
 - Distributing the *My Dialysis, My Choice* decision aid.
 - Engaging home dialysis peer mentors and home dialysis facility staff to speak to interested home candidates and by sharing experiences informally during Lobby Days.
 - Encouraging open communication between home dialysis program managers and in-center programs by providing guidance and tools.

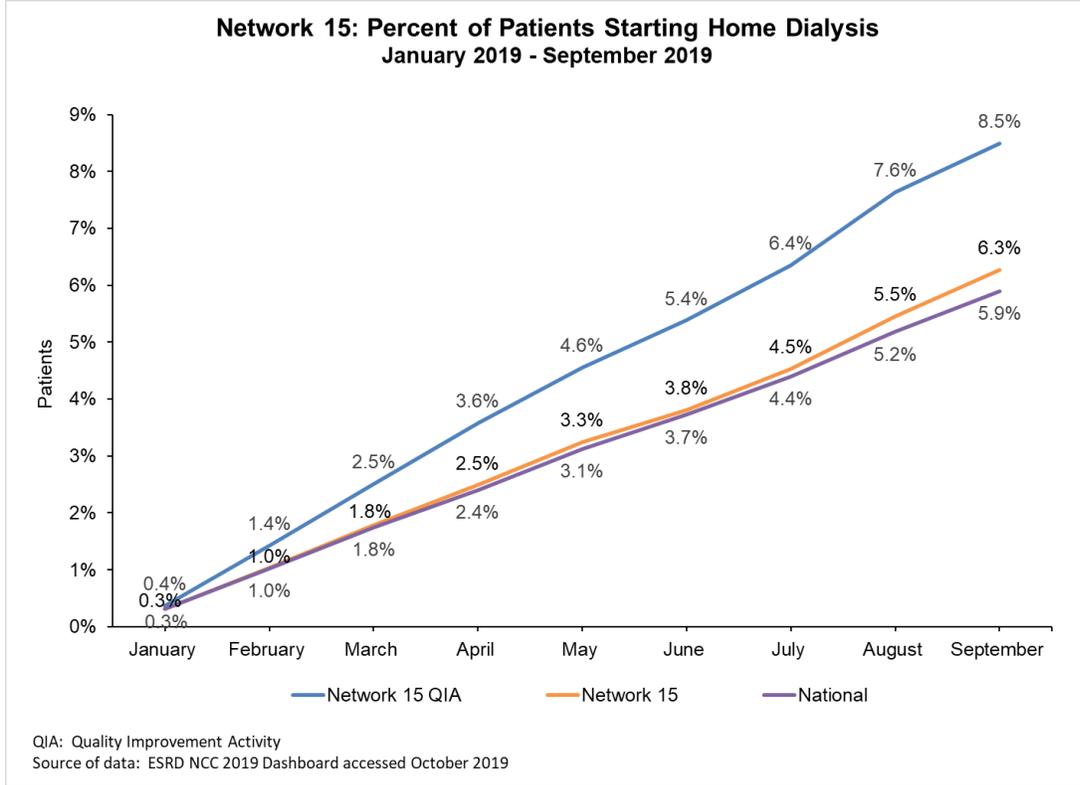
Best Practices

Best practices identified by the QIA facilities include:

- Increasing communication on home modality to create interest and improve participation by medical directors and nephrologists.
- Monthly collaborative meetings with LDOs.
- Using monthly trackers to follow patients from interest to access to training and reviewing this tracker at quality meetings.
- Engaging the entire facility staff to encourage and educate all patients about home dialysis options.

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

Chart P: Network 15: Percent of Patients Starting Home Dialysis (January–September 2019)



Population Health Focus Pilot Project Quality Improvement Activity

In 2019, Network 15 conducted a QIA on improving the quality of life for ESRD patients by assisting them with seeking gainful employment and/or returning to work. Network 15 assisted facilities with developing processes to assess patient interest and eligibility for returning to work. The Network used federal, state, and local resources, such as those from Vocational Rehabilitation (VR) programs, Ticket to Work, and employment networks (EN) for the project. The Network also supported facilities with education, technical assistance, and support to develop processes for tracking and documenting all patient status in the attribute section in CROWNWeb. The Network identified 35 dialysis facilities constituting at least 10.0% of dialysis facilities in the service area where $\leq 25.0\%$ of the eligible target population (patients 18–55 years old) had not met the desired outcome.

Goals and Outcomes

The primary goal of the QIA was to ensure that 100% of patients were screened for interest in returning to work or school with their response documented in CROWNWeb. The Network then worked to achieve a 10.0% improvement in the referrals of eligible patients to EN/VR programs in the Network service area. The Network also had a goal of demonstrating a 5.0% increase in referred patients receiving EN/VR services by September 2019. The baseline rate for the 35 identified facilities reporting patients were screened, referred, and receiving services at an EN/VR program was 0.6% based on October 2017–June 2018 CROWNWeb data. By QIA completion, the screening rate for interest met the 100.0% completion goal. By the QIA completion, data related to the referral rate of patients who reported an interest in an EN/VR program reflected a 28.2% increase in the baseline rate. Data also showed patients receiving services from an EN/VR program increased to 8.6%, which exceeded the 5.0% increase goal (See Charts Q and R).

Barriers

Barriers to achieving the QIA goals included:

- Inaccurate data caused by omission or lack of updating reported information in the CROWNWeb system due to:
 - Lack of staff education about the importance of the field in CROWNWeb.
 - Failure to update patients' interest, referral, and receiving data in CROWNWeb due to facility staff's incorrect understanding of CROWNWeb data update processes.
- Patients are nervous/afraid to lose health insurance and financial benefits.
 - Many patients receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) often misunderstand and/or are not educated on benefit planning or work options.
 - Facilities reported that many patients erroneously believe returning to work or school will disqualify them for benefits and income through the federal system.
 - Lack of education of staff and patients in QIA facilities about the availability of EN/VR services and how they can be used to maximize patient income and benefits for people interested in returning to work or school.

Interventions

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

- Querying participating facilities about their current processes to educate staff and assess patients for interest in EN/VR services and their processes for entering the patient response into CROWNWeb.
- Providing individualized education and technical assistance related to use of EN/VR services, screening tools, tracking tools, and CROWNWeb data entry as patients' status evolved.
- Initiating RCA and conducting tests of change using the PDSA cycle.
- Providing education to facility staff regarding how to screen and assist patients with the EN/VR programs and how to discuss this area of focus during QAPI meetings.
- Providing academic peer reviewed articles on the psychosocial and emotional benefits of returning to work.
- Assisting facilities that reported having patients that were interested in working by tailoring interventions for referring patients to EN/VR programs using culturally-based approaches and vocations.

Best Practices

Best practices identified by the QIA facilities include:

- Providing tools to the facility to screen and track interest of, referral to, and need for support with patients eligible for EN/VR programs.
- Educating and providing technical assistance to facilities about the importance of helping patients with referrals to EN/VR programs and their ability to maximize benefits.
- Educating patients about how their modality choice can support their preferred schedule, lifestyle, and ability to participate in EN/VR services or returning to work.
- Engaging the Network's Medical Review Board (MRB) by eliciting expertise from direct care providers to review and critique project materials.
 - Many members of the board expressed a desire to assist with keeping patients employed by knowing more about the system, benefits, and possibilities for patients starting ESRD therapy.
- Linking dialysis facilities to local, regional, and federal resources that assist patients in understanding the individual and financial benefits of EN/VR programs.
 - This approach took some of the onus off facility staff from predicting potential negative outcomes.

Chart Q: Network 15: Percent of Eligible Patients Referred to an Employment Network or a Vocational Rehabilitation Agency (February–September 2019)

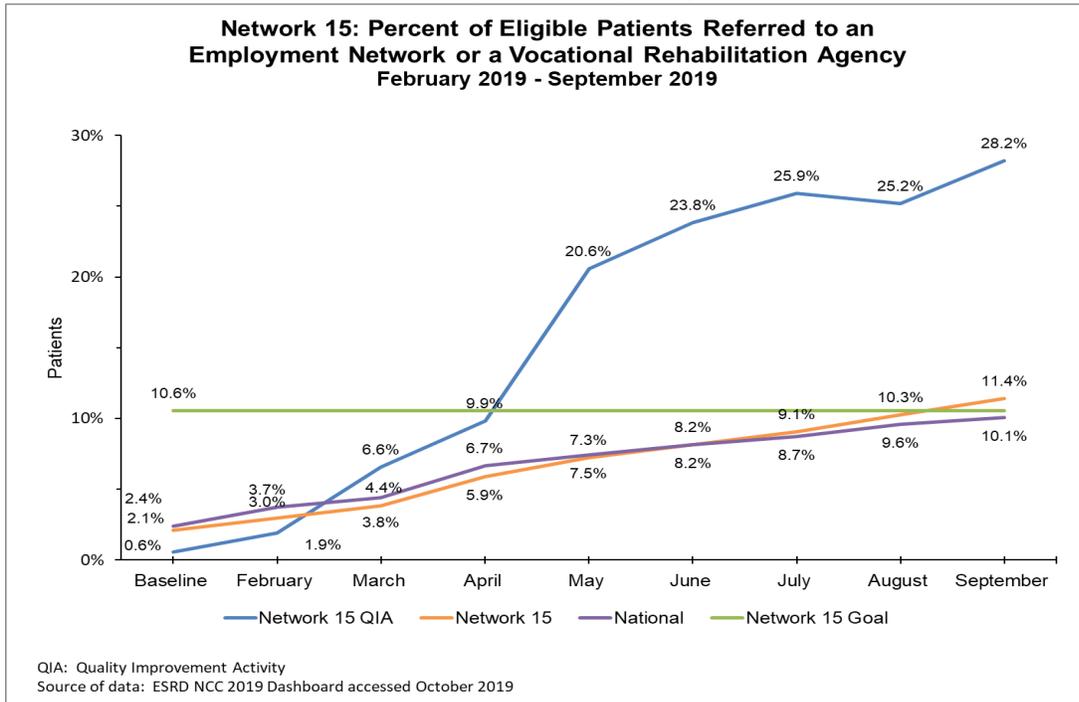
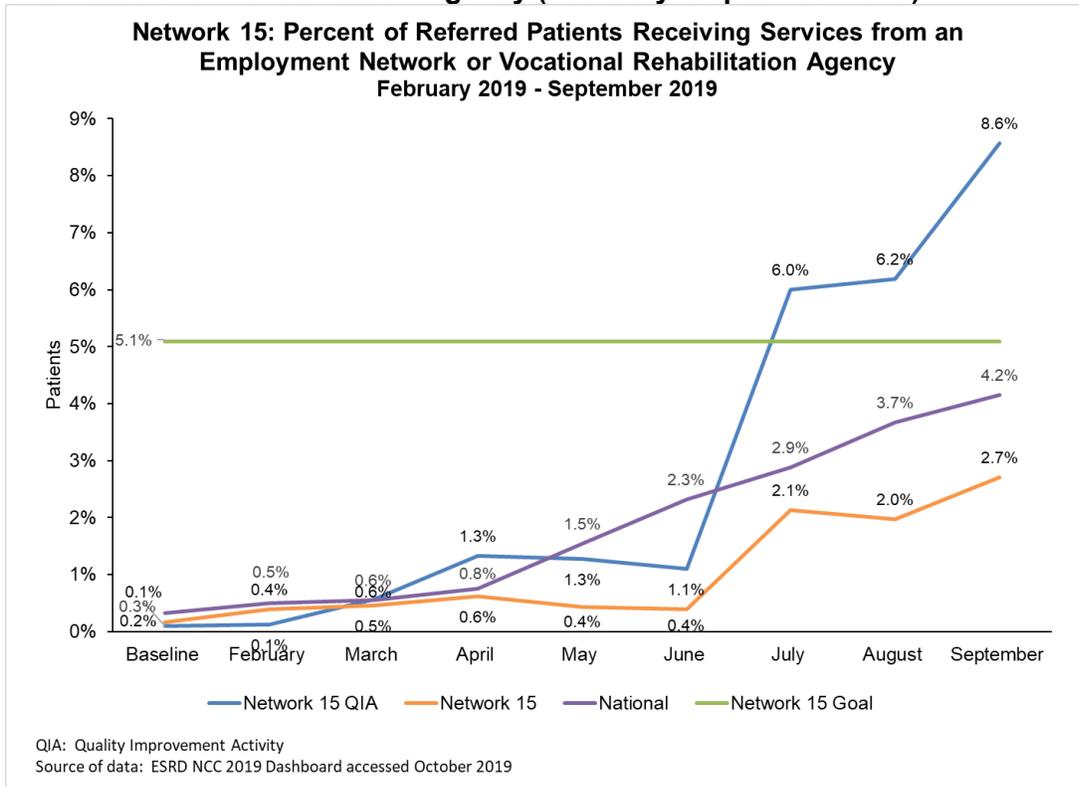
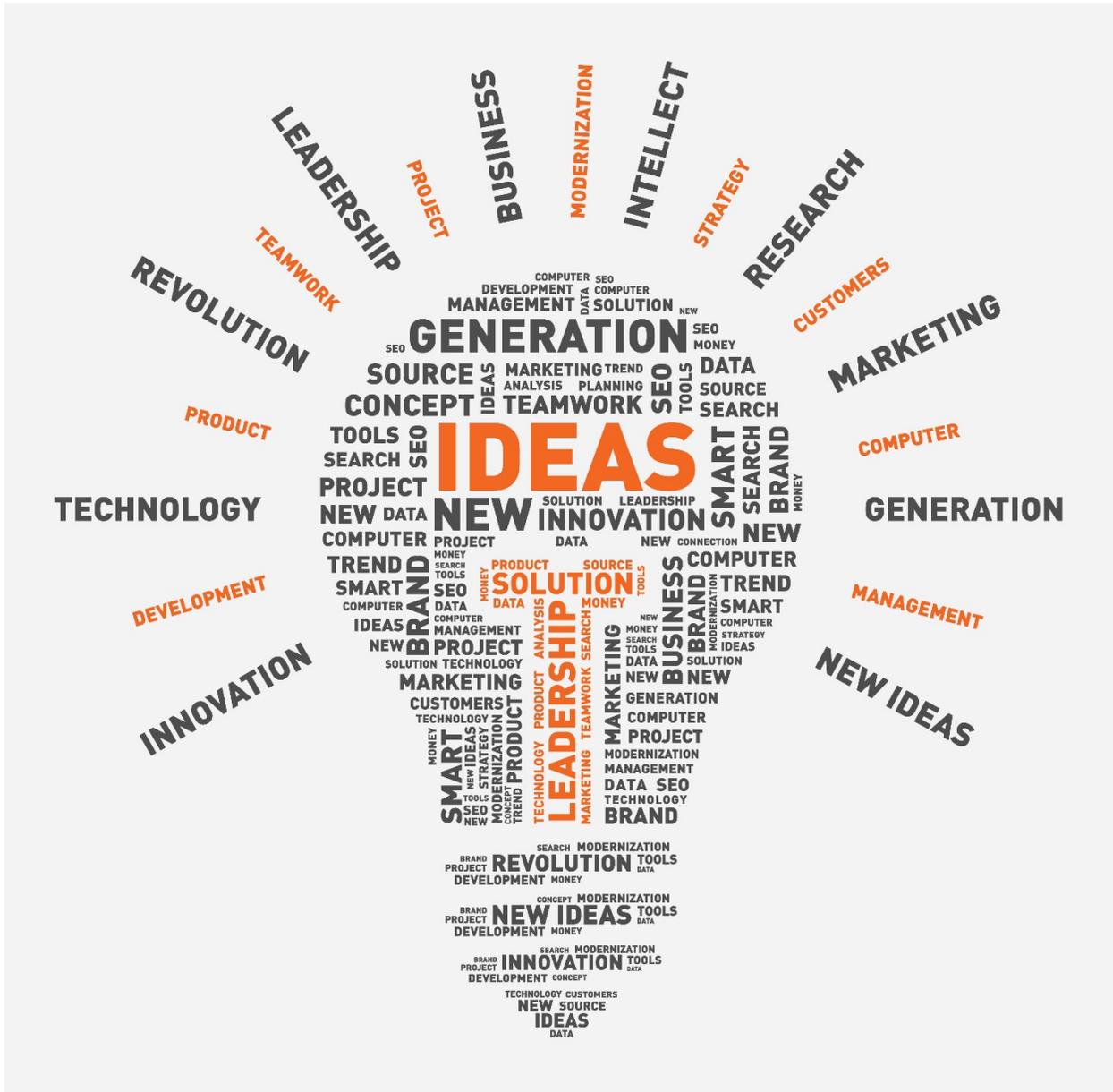


Chart R: Percent of Referred Patients Receiving Services from an Employment Network or a Vocational Rehabilitation Agency (February–September 2019)





ESRD NETWORK RECOMMENDATIONS

Recommendations for Sanction

The ESRD Network can recommend to CMS to impose a sanction when an ESRD provider is not cooperating in achieving Network goals, per Section 1881(c) of the Social Security Act. 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 throughout 2019. 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.

As such, 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 any recommendations to CMS for additional facilities in its service area in 2019.

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 was provided, the Network:

- Conducted a risk assessment and submitted an emergency plan annually to CMS.
- Monitored and tracked the open and closed status of facilities and the location of patients during the response to an emergency event.
- Worked closely with the KCER Program and other stakeholders to ensure patients have access to dialysis before and after an emergency event.
- Hosted a webinar for facilities titled, *Don't Make It an Emergency When You Have an Emergency*. The webinar was presented by an Arizona state surveyor who reviewed and explained the Conditions for Coverage related to emergency preparedness. A recording of the webinar was placed on the Network website and the link was provided to all facilities in the Network service area.
- Provided all facilities in its service area with emergency preparedness resources and information throughout the year, including:
 - The KCER Watch newsletter and links to the KCER website for resources including:
 - *3-Day Emergency Kidney Diet* in English and in Spanish
 - *Preparing for Emergencies: A Guide for People on Dialysis*
 - *Emergency Preparedness Checklist*, created by patients for patients
 - Patient identification card
 - Contact information for local healthcare coalitions
 - U.S. Food and Drug Administration (FDA) Med Watch announcements
 - PDFs of Network 15 emergency preparedness posters in English and Spanish
 - Reminders to update CROWNWeb information including:
 - Facility disaster contacts
 - Patient contact information
 - Back-up facility information
 - Links to resources in English and Spanish on wildfire safety on the CDC and Red Cross websites
 - Links to flooding resources at Ready.gov and the Red Cross websites
 - Tips and reminders for facility emergency preparedness plans to:

- Update the facility emergency preparedness plan annually and update all staff emergency contact information within the plan.
 - Contact local emergency preparedness agencies at least annually to confirm the agency is aware of the dialysis facility’s needs in the event of an emergency.
 - Create facility-based emergency plans that are based on community risk assessment, using an all-hazards approach.
 - Ensure the facility has a written policy and that staff receive training for emergencies, including knowing what to say to patients, familiarity with emergency plan, and knowing where to find a written copy of the emergency plan.
 - Educate patients on emergency evacuation procedures including locations of emergency exits, designated meeting location, advise staff if a patient chooses to leave and not wait at the meeting location, and the plan for patients with mobility issues.
 - Provide patients with a refresher on how to disconnect themselves from their machines in an emergency and to keep track of those who would need assistance.
 - Ensure the facility has a system for tracking the location of on-duty staff and sheltered patients during and after an emergency.
 - Remind facilities to conduct emergency preparedness exercises.
- Recommendations that facilities host an Emergency Preparedness Lobby Day for National Preparedness Month.

February 2019: Winter Storm

A winter snowstorm affected areas of Northern Arizona, Southern Utah, Western Colorado, and Northern New Mexico. Network staff reached out to facilities in the impacted areas to determine if facility operational status or patients’ ability to receive dialysis was affected. Two facilities reported closing for one day related to weather issues. Numerous patients rescheduled their treatments due to the weather, so the Network placed follow-up calls to ensure patients were able to obtain treatment.

March 2019: Winter Blizzard

A winter blizzard “bomb cyclone” caused heavy snow and hurricane-force wind gusts in Colorado and Wyoming. This caused numerous businesses to close early due to the weather and hazardous driving conditions. Network staff contacted facilities in the impacted areas to determine operational status and patients’ ability to receive dialysis. Multiple patients refused to attend treatment and many facilities closed early that afternoon due to the blizzard conditions. Facilities were able to reopen the next day and patients were able to return to treatment. The high winds also knocked out electricity in Roswell, New Mexico and its surrounding area, but the Roswell dialysis facility was not affected.

April 2019: Spring Snowstorm

A spring snowstorm affected Colorado, Wyoming, and Utah. Network staff contacted all Network facilities in the impacted areas to determine their operational status and the patients' ability to receive dialysis. A few patients refused to attend treatment due to weather but only one facility reported closing early in anticipation of the storm, which turned out not to be as severe as forecasted.

April 2019 through September 2019: Wildfires

During the six-month period of April–September 2019, Network staff monitored wildfire activity in the Network service area to determine any adverse impact to patients and facilities. Network staff:

- Researched fire locations daily.
- Maintained constant contact with facilities in the affected areas via email.
- Requested regular updates on the facilities' operational status.
- Contacted facilities near fire locations to determine:
 - Any adverse impact on the 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.

ACRONYM LIST APPENDIX

This appendix contains an acronym list created by the KPAC (Kidney Patient Advisory Council) of the National Forum of ESRD Networks. You can access the acronym list on the [National Forum of ESRD Networks website](#). 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.

| Acronym | Definition |
|--------------|---|
| BSI | Blood Stream Infection |
| CDC | Centers for Disease Control and Prevention |
| CDHE | Colorado Department of Health and Environment |
| CMS | Centers for Medicare & Medicaid Services |
| ESRD | End Stage Renal Disease |
| FDA | Food and Drug Administration |
| HAIs | Healthcare Associated Infections |
| HHS | Health and Human Services |
| HSAG | Health Services Advisory Group |
| HIE | Health Information Exchange |
| KCER | Kidney Community Emergency Response |
| LAN | Learning and Action Network |
| LTC | Long-Term Catheter |
| LDOs | Large Dialysis Organizations |
| PDSA | Plan Do Study Act: A cycle of improvement |
| PHFPQ | Population Health-Focused Pilot |
| PSME | Patient Subject Matter Expert |
| QAPI | Quality Assurance and Performance Improvement |
| QIA | Quality Improvement Activity |
| RCA | Root Cause Analysis |
| SME | Subject Matter Expert |
| UNOS | United Network for Organ Sharing |