

ESRD NETWORK 2017 ANNUAL REPORT

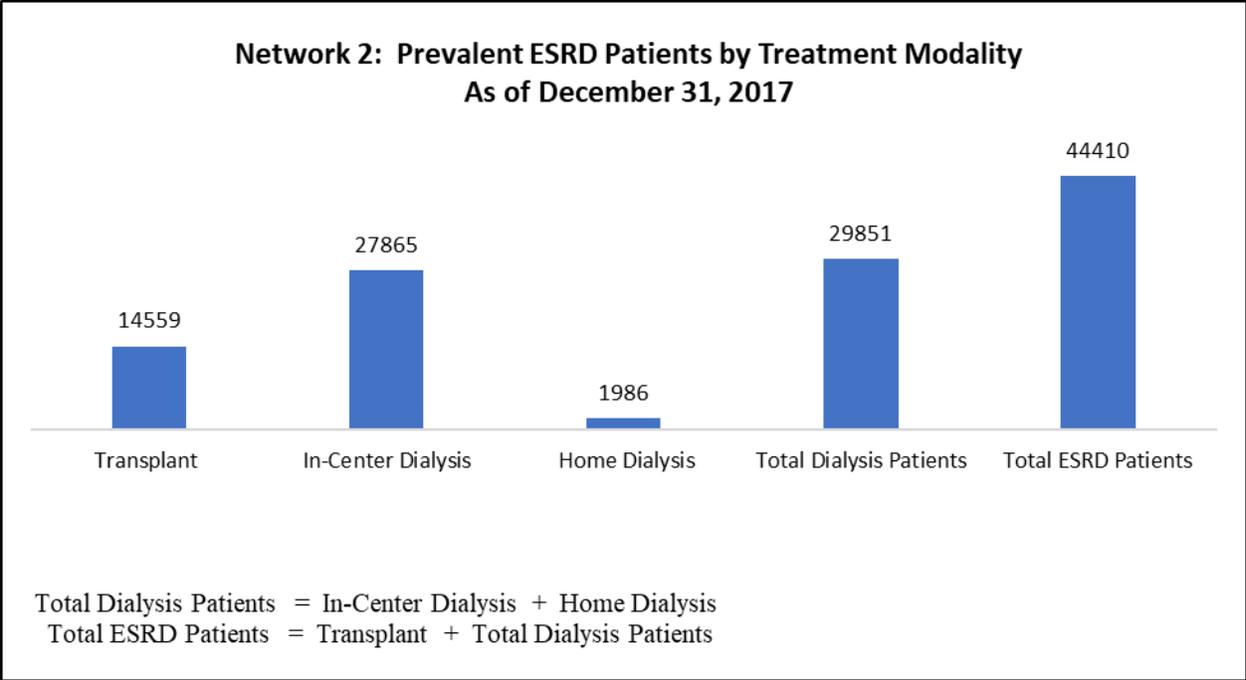
Description of the patient and facility population in the ESRD (End Stage Renal Disease) Network program and the outcomes of the quality improvement activities performed by this Network compared to the Network program performance

ESRD Network 2

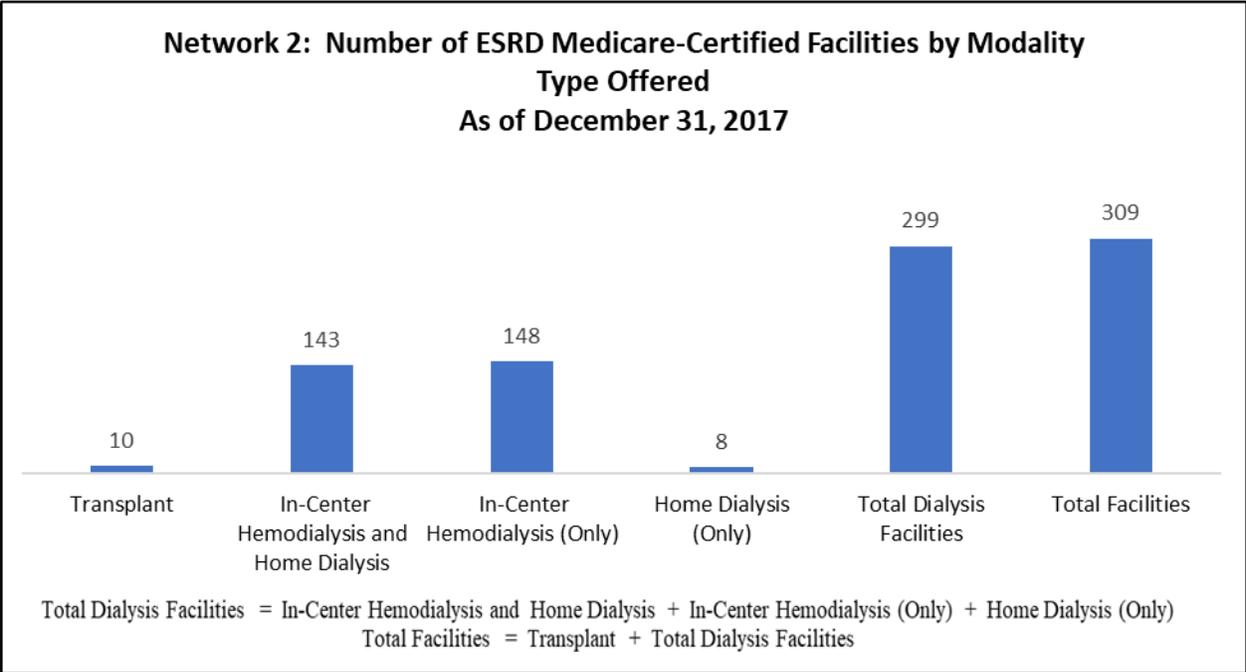
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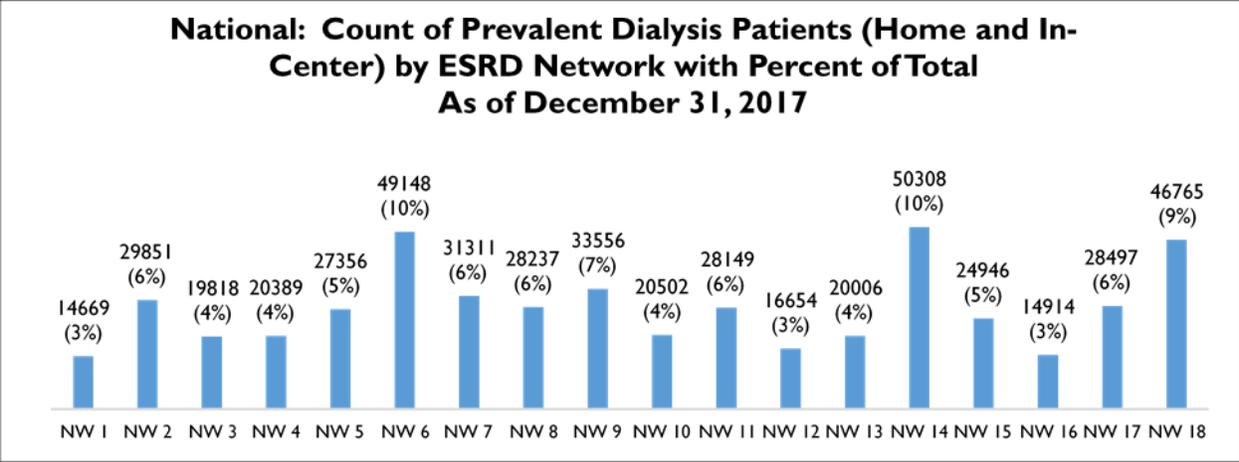
ESRD DEMOGRAPHIC DATA



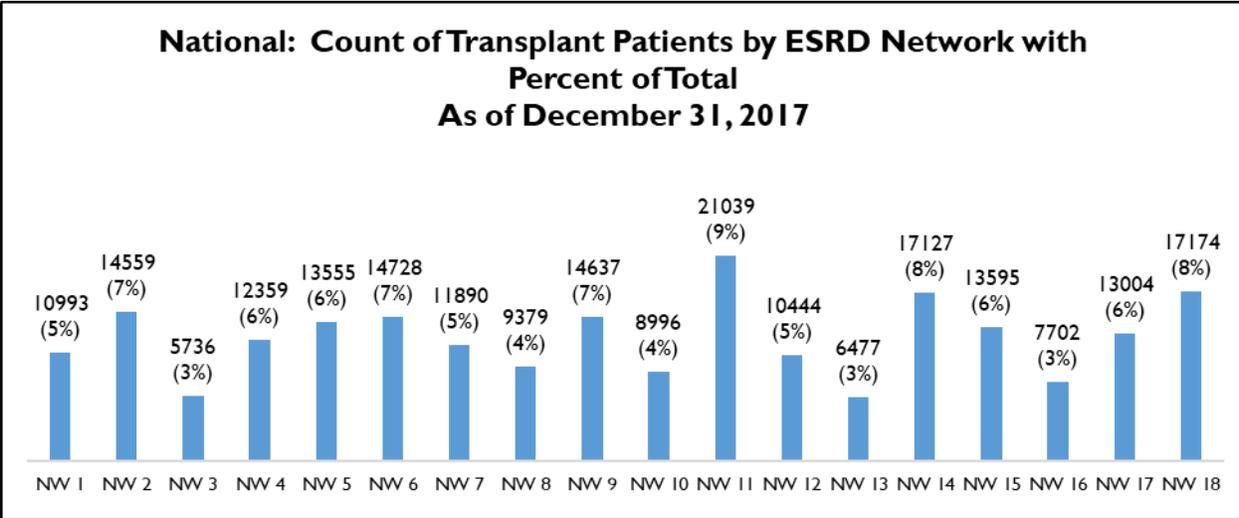
Source of data: CROWNWeb



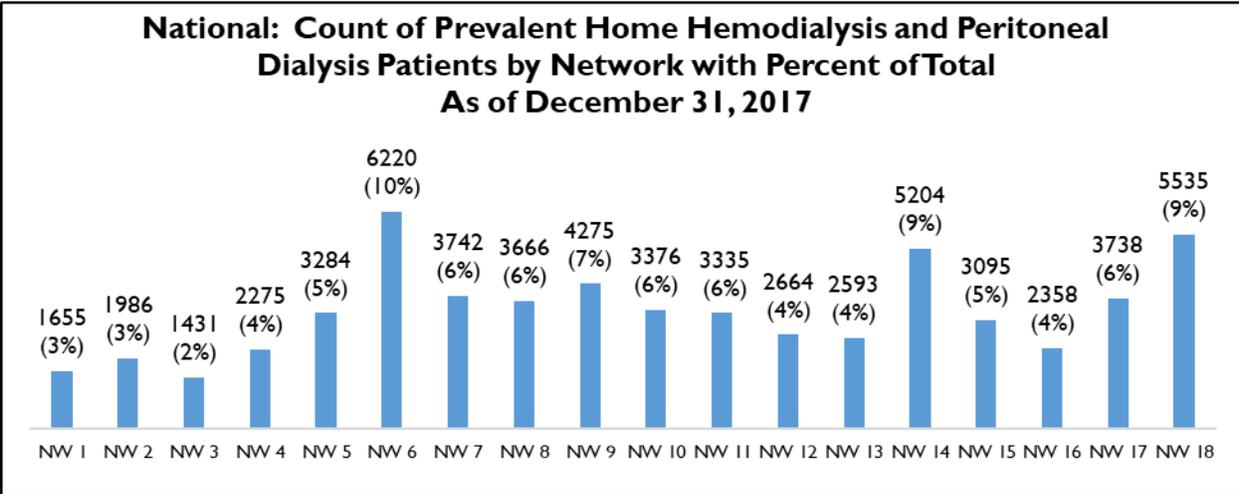
Source of data: CROWNWeb



Source of data: CROWNWeb

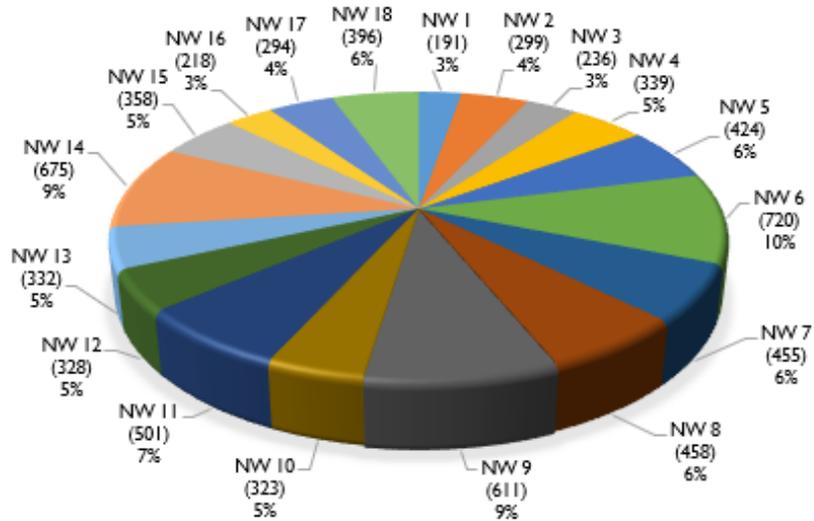


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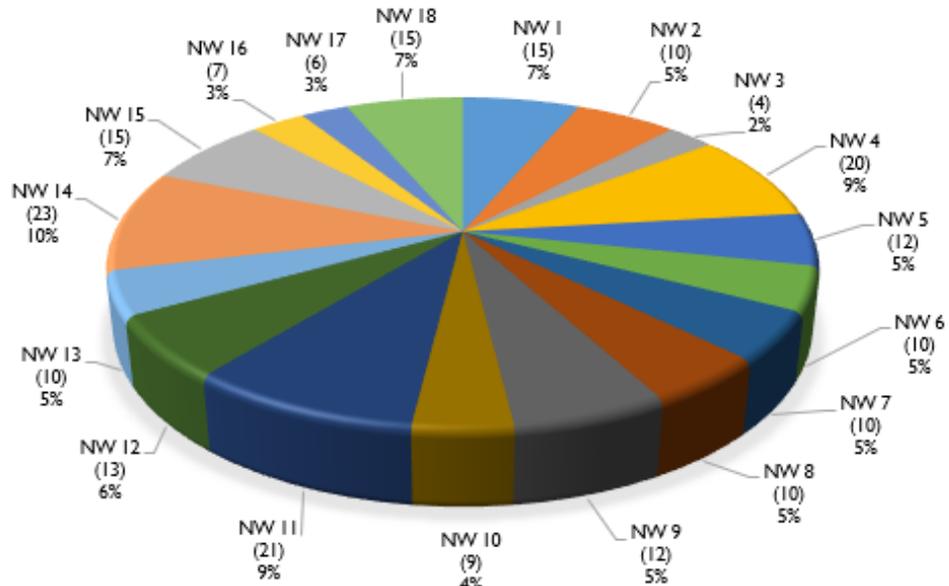
Source of data: CROWNWeb

National: Count of ESRD Medicare-Certified Dialysis Facilities by ESRD Network with Percent of Total As of December 31, 2017



Source of data: CROWNWeb

National: Count of ESRD Medicare-Certified Kidney Transplant Facilities by ESRD Network with Percent of Total As of December 31, 2017



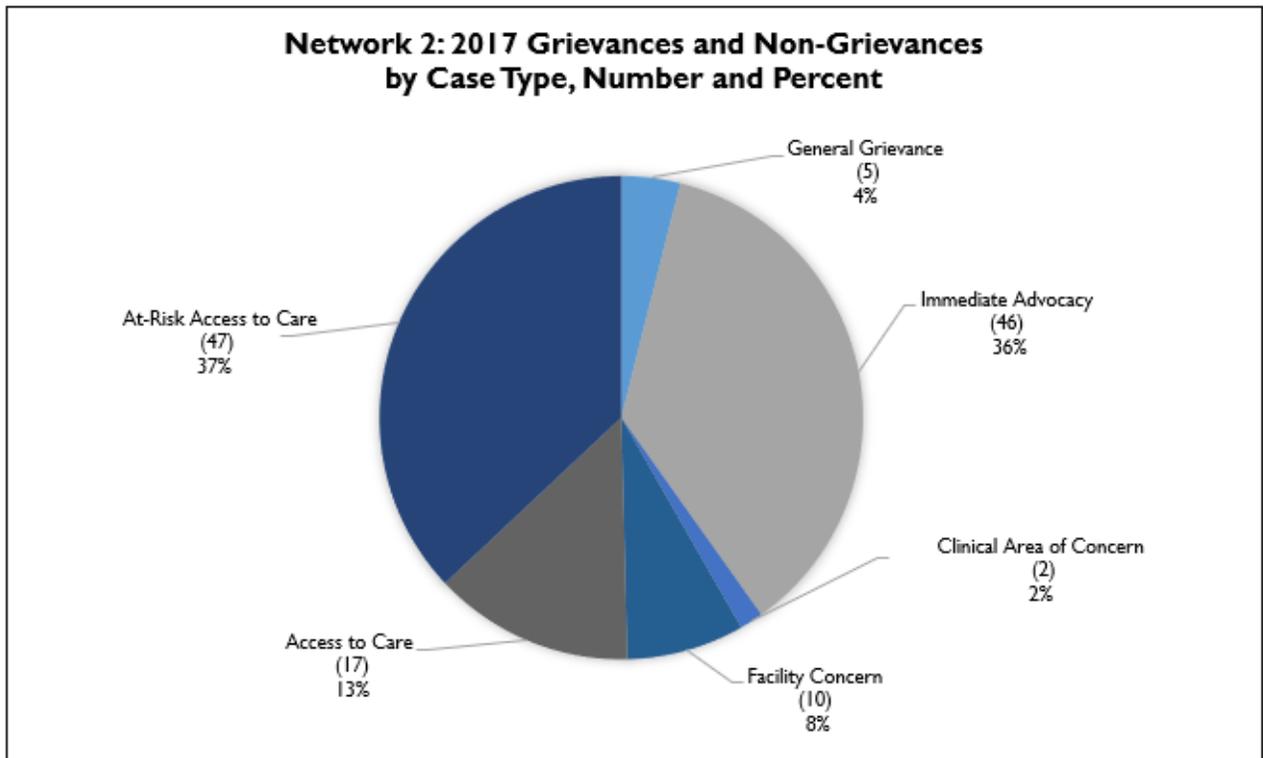
Source of data: CROWNWeb

ESRD NETWORK
GRIEVANCE AND ACCESS
TO CARE DATA

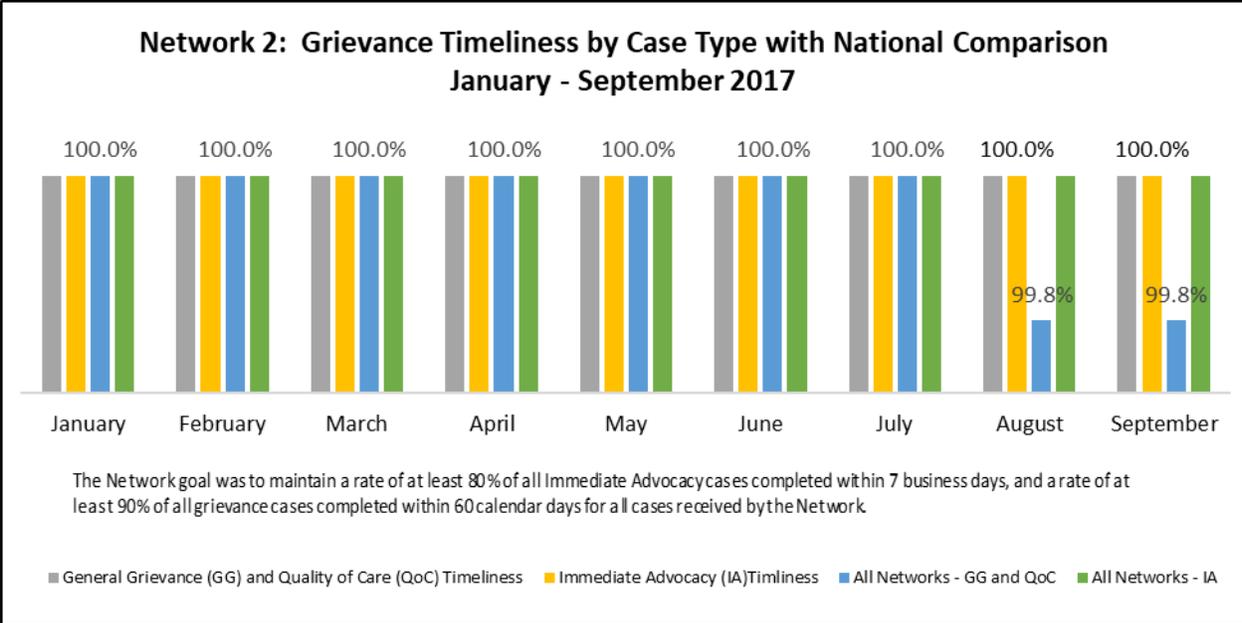
Network 2: Grievance Data for Calendar Year 2017

Category	Cases
Grievance Cases	53
General Grievance	5
Immediate Advocacy	46
Clinical Area of Concern	2
Non-Grievance Cases	74
Facility Concern	10
Access to Care: Confirmed Involuntary Transfer/Discharge (IVT/IVD)	17
At-Risk Access to Care	47
Additional Case Information	
Averted IVT/IVD	0
Failure to Place	0
Total Cases 2017	127

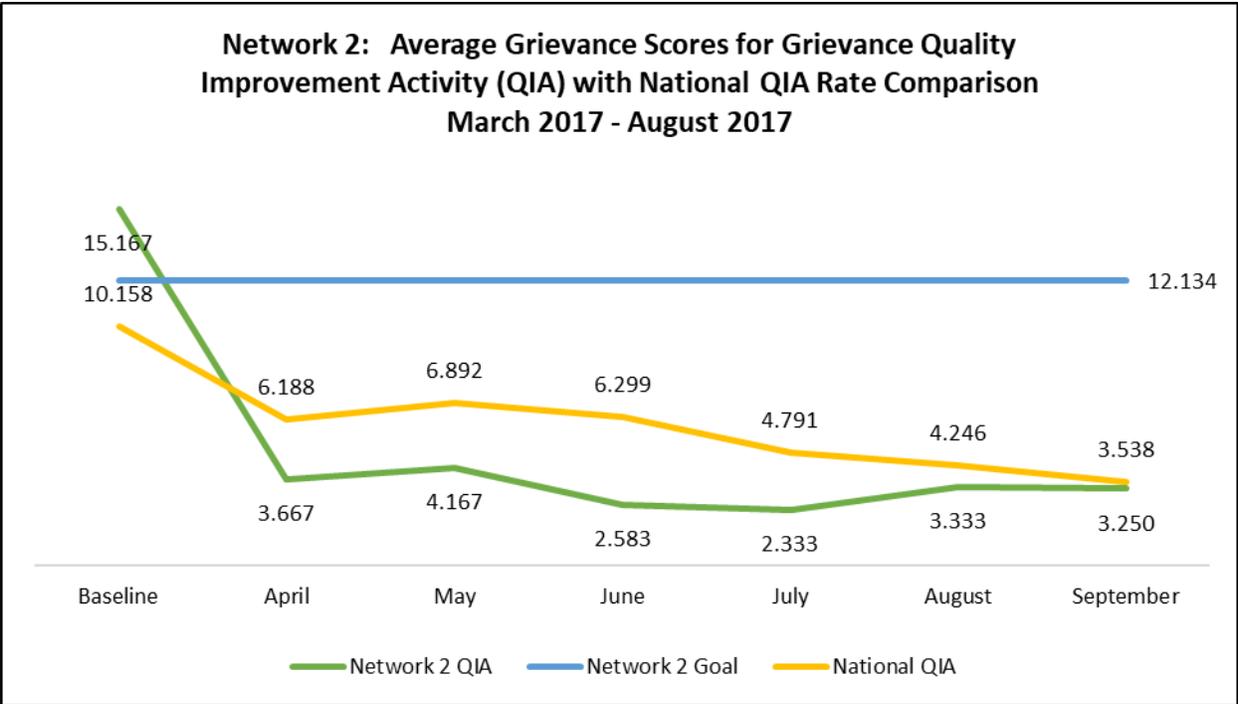
Source of data: Patient Contact Utility (PCU)



Source of data: Patient Contact Utility (PCU)



Source of data: October 2017 ESRD Network Dashboard



Source of data: October 2017 ESRD Network Dashboard

Evaluating and Resolving Grievances

Background

A comprehensive analysis of grievances and access to care issues occurring in the Network's service area from January through October 2016 revealed that the most prevalent grievance issues were staff related and dealt with communication and professionalism. Based on these findings, the Network's quality improvement activity (QIA) included interventions focused on improving communications and enhancing staff-patient interactions.

Targeted Facilities

The Network worked with 12 facilities that had the highest grievance scores and access to care issues based on March 2017 data provided by the facilities. Each of the facilities participating in the QIA had two or more grievances (immediate advocacy, general, or quality of care) and one or more access to care issues reported to the Network.

Goals and Outcomes

The goal was to achieve a 20% relative reduction (6.07) in participating facilities' average grievance scores from baseline 15.17% (March 2017) to re-measurement (September 2017), based on weighted scoring. Improvement was defined by a decrease from baseline to re-measurement in the level of grievances, using the Centers for Medicare & Medicaid Services (CMS) defined five-point scale.

As such, the emphasis of this QIA was to educate participating facility staff members to be more proactive in supporting patients in resolving lower-weighted grievances (those that involve interpersonal or environmental issues) and helping empower patients in effectively addressing their concerns about these issues. The Network worked to foster enhanced patient/staff relationships to improve patient self-efficacy in handling concerns related to the facility. The Network was successful in reducing the grievances by 70%, resulting in a final grievance score of 2.17.

Interventions

Key to the success of the project was the creation of an ACT 2 Resolve team, which included representation by staff members and patients to support strengthening of relationships and increased communication among patients and staff members. Teams participated in bimonthly virtual learning sessions and promoted educational tools and resources.

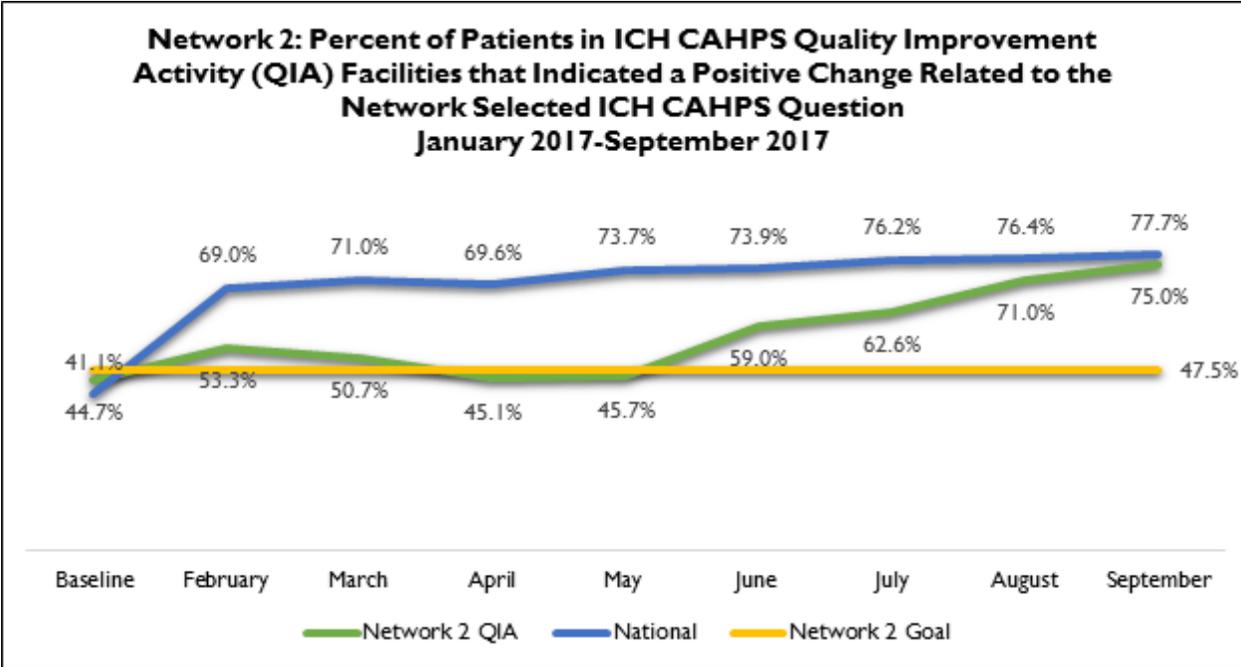
ACT 2 Resolve Educational materials targeting patients:

- Dialysis Patient Grievance Toolkit created by the Kidney Patient Advisory Council of the Forum of ESRD Networks included resources to support patients' understanding of how and when to escalate issues to a grievance; Grievance preparation worksheets; and a poster to create awareness of the resources available with a focus on improving communication early in the grievance process.

ACT 2 Resolve educational materials targeting staff members:

- An educational poster promoting successful communication techniques; a white board poster; and a grievance template and score log.

ESRD NETWORK QUALITY
IMPROVEMENT ACTIVITY
DATA



Source of data: October 2017 ESRD Network Dashboard. Option 1 to use for Networks 2, 3, 5, 6, 7, 8, 10, 11, 12, 13, 14, 15, 16, 17, and 18.

*In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS)

Improving Patients' Scores on the In-Center Hemodialysis Survey – Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS®)

Background

The results of the 2016 ICH CAHPS survey of patients served by facilities in the Network service area indicate that scores on question #18, which falls within the composite measure of “Dialysis Center Staff,” were the second highest in the region. Question #18 asks patients whether, in the last three months, any staff member at the facility asked about how the patient’s kidney disease affected other parts of their life.

Targeted Facilities

Target facilities included those that performed poorest on question #18 and those facilities with a combined patient census of 5% of the total ESRD patient population in the Network’s service area. Based on question #18 scores, 20 facilities with a total patient census of 4,146 were selected to participate in the QIA; 876 individuals responded to question #18, with 482 negative responses.

Goals and Outcomes

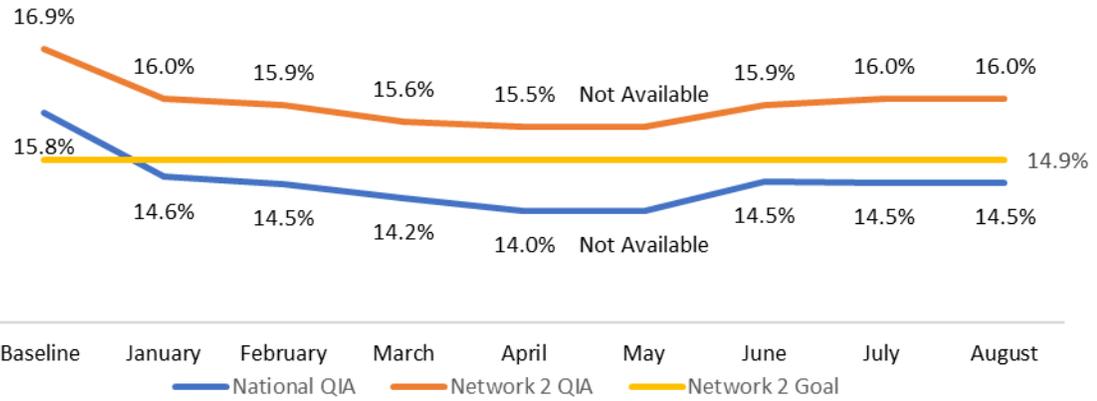
The goal was to achieve a 5% relative improvement in the positive responses of patients treated by targeted facilities to question #18 from baseline (44.7% Spring 2016) to re-measurement (75% September 2017); and to promote positive interactions, learning processes and best practices related to the ICH CAHPS survey and serve as the foundation for changing staff interactions with patients to be in line with a patient-centered approach. The Network succeeded in achieving the goal of the QIA, resulting in a 30.3% improvement.

Interventions

Interventions included educational training sessions on how to effectively communicate with patients who have a chronic illness. Four interdisciplinary staff training sessions were structured to provide education to 50% of target facility staff, using the train the trainer model. Staff members who received training then provided training to other staff members. In addition, the Network distributed pocket reference cards that included a list of frequently-asked-questions, with recommendations, tips, and example responses that staff members could use to prompt a patient-centered discussion. Facility staff members were encouraged to ask patients questions related to their health.

Patient-focused interventions featured a campaign to encourage patients to discuss with staff how dialysis has affected their lives and information about resources they might find useful. This was driven by the recommendations of a committee of patient subject matter experts. The interventions chosen for the project includes “playing cards” that feature open ended questions for staff members to choose in order to help create rapport between staff and patients. Additionally, patient and provider posters were created to support the project goals. The poster intervention for the staff and patients revealed common patient concerns among all the facilities in the project including concerns with a patient’s time, travel needs, diet restrictions and sexual health concerns. The poster proved it was a valuable tool to help patients learn more about each other and could help decrease feelings of isolation. For facility staff it served as a way to help them empathize with their patients by eliciting their own guidance they would give to their family.

**Network 2: Long-Term Catheter (LTC) Rates for Quality Improvement Activity (QIA) Facilities with National QIA Rate Comparison
January 2017 - August 2017**



Source of data: CROWNWeb

Vascular Access: Reducing Long-Term Catheter (LTC) Use

Background

Research shows that patient morbidity and mortality rates are related to the type of vascular access used for dialysis with a higher infection rate associated with use of LTC compared with fistula use among eligible adult (≥ 18 years of age) in-center hemodialysis patients. Patients with long-term catheters are defined as those with catheters in use (for dialysis treatments) for 90 days or longer.

Targeted Facilities

The Network worked with 138 facilities and 13,055 patients in its service area; targeted facilities had a LTC rate greater than 10% as reported in the September 2016 Fistula First Catheter Last (FFCL) data provided by the ESRD NCC. Targeted facilities were further categorized into two tiers. Tier 1 facilities had LTC rates greater than or equal to 15%; Tier 2 facilities had LTC rates greater than 10%, but less than 15%.

Goals and Outcomes

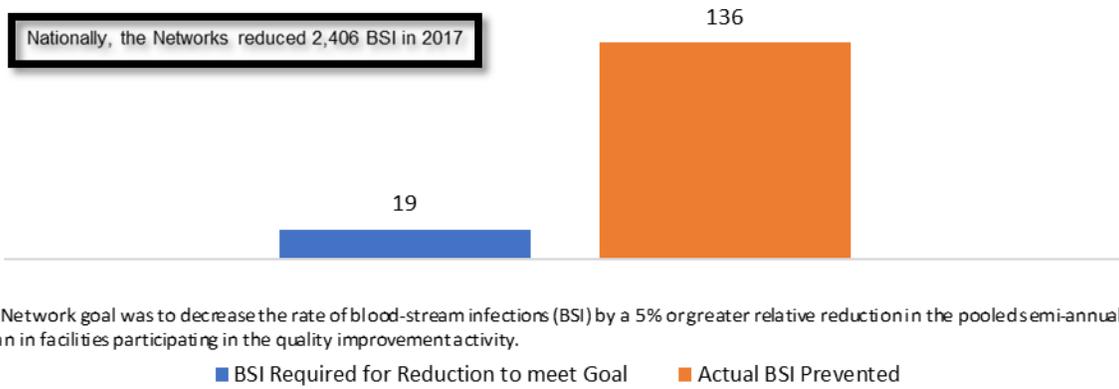
The goal of this project was to achieve a two percentage point decrease of LTC rates in the identified dialysis facilities from baseline, September 2016 (16.94%), through re-measure, September 2017 (16%). The Network attained a 0.94 percentage point reduction in LTC use, but did not meet the goal of the QIA.

Interventions

Staff members were provided education on using the root cause analysis (RCA) tool to identify the root cause(s) of the facility's high LTC rate and to determine an appropriate corrective action plan (CAP). The Network encouraged each facility to identify a vascular access planning team, to include representation by different interdisciplinary team members. The Network implemented use of a monthly "Vascular Access Placement: Patient Tracking Tool" to track progress of patients' vascular access planning and to review any barriers that may be preventing patients from moving to the next step. The Network hosted a Technician Training Program, offering CEUs on topics that included vascular access planning. Information and materials were shared to promote communication between patients and technicians, using common terminology and strategies to develop a vascular access plan. Quarterly educational webinars promoted sharing and spread of best practices employed by facilities that successfully overcame a barrier and/or had a significant decrease in their LTC rates. A patient educational poster was designed in collaboration with Patient SMEs to emphasize the importance of patients developing an access plan with their care teams.

By establishing patient educators who served as *Access Ambassadors* within the target facilities, the Network effectively utilized its peer mentorship training program to support patient and staff education on the importance of permanent access placement and the benefits of achieving catheter freedom. Through one-to-one facility coaching sessions with poor performers the following barriers were identified as contributors to the Network not achieving its goal for this QIA: 1) A large number of patients with LTCs are admitted to dialysis facilities with catheters due to acute emergent dialysis treatment; this prevented the care team from planning for permanent access placement. 2) In certain geographic areas within the Network's service area there are few or no vascular surgeons specialized in dialysis access placement – creating a barrier to access surgery coordination. 3) Patient fears and apprehensions about catheter removal, vascular access surgery, body image, and needle fear cannot be overlooked as ongoing barriers.

Network 2: Bloodstream Infections (BSI) and Quality Improvement Activity (QIA) by ESRD Network



Source of data: June 2017 NHSN (National Healthcare Safety Network)

Reduce Rates of Dialysis Events: Healthcare Associated Infections; Bloodstream Infections/Sepsis

Background

Published reports have estimated that bloodstream infections are responsible for more than \$28 billion in yearly national healthcare expenditures. According to the Dialysis Facility Report for Fiscal Year (FY) 2017, 12.7% of dialysis patients in New York were hospitalized due to BSIs compared with the national average of 10.9%. In the same report the mortality rates due to infections was 15.9% in New York, compared with the national average of 11.7%.

Target Facilities

The Network worked with 20% of facilities in its service area that had high BSI rates reported in National Health Safety Network (NHSN). After comprehensive analysis of NHSN BSI data from the first and second quarters of 2016, the Network selected 56 facilities with infection rates ranging from 0.70 to 12.69 per 100 patient months and with between four and 17 BSIs in the first and second quarters of 2016.

Goals and Outcomes

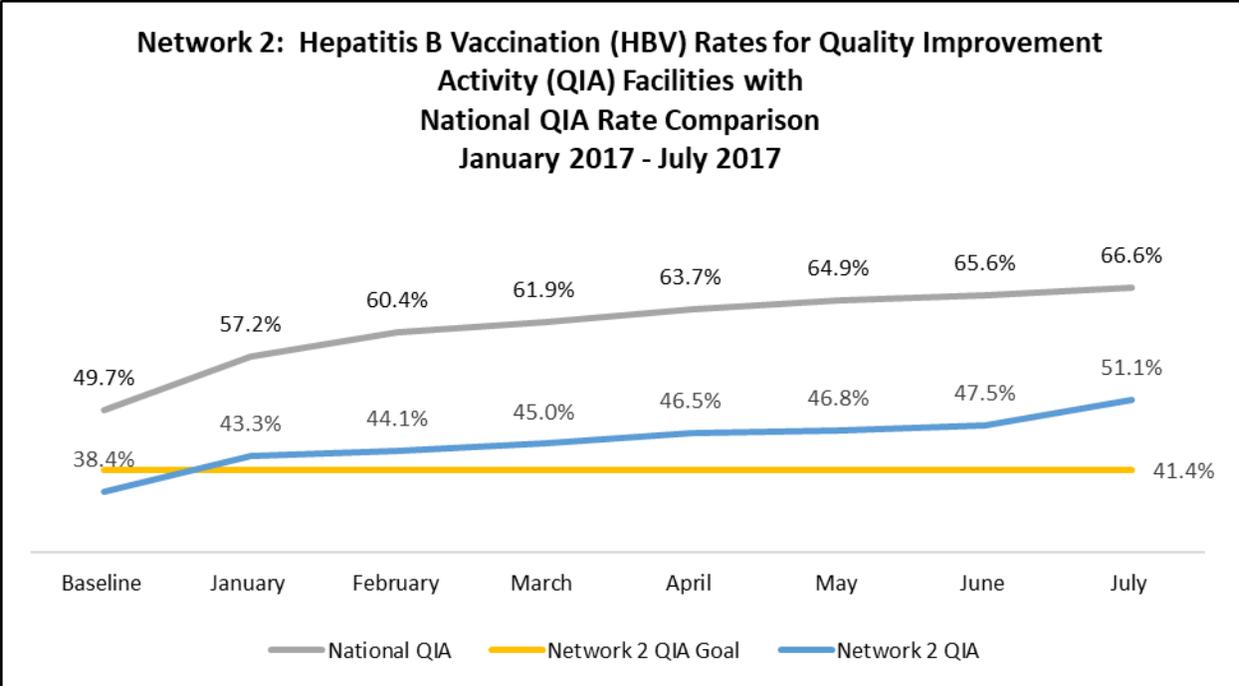
The goal of this QIA was to decrease BSI rates during a six-month intervention period (January-June 2017) and to achieve a five percent relative reduction in the pooled mean BSI rate (calculated by adding the mean, multiplied by the sample size for each sample, and dividing the number by the sum of the sample sizes) for the targeted facilities'. The Network succeeded in decreasing the pooled mean BSI rate (from 1.049% at baseline to 0.691% at re-measurement); yielding a 32% relative reduction.

Interventions

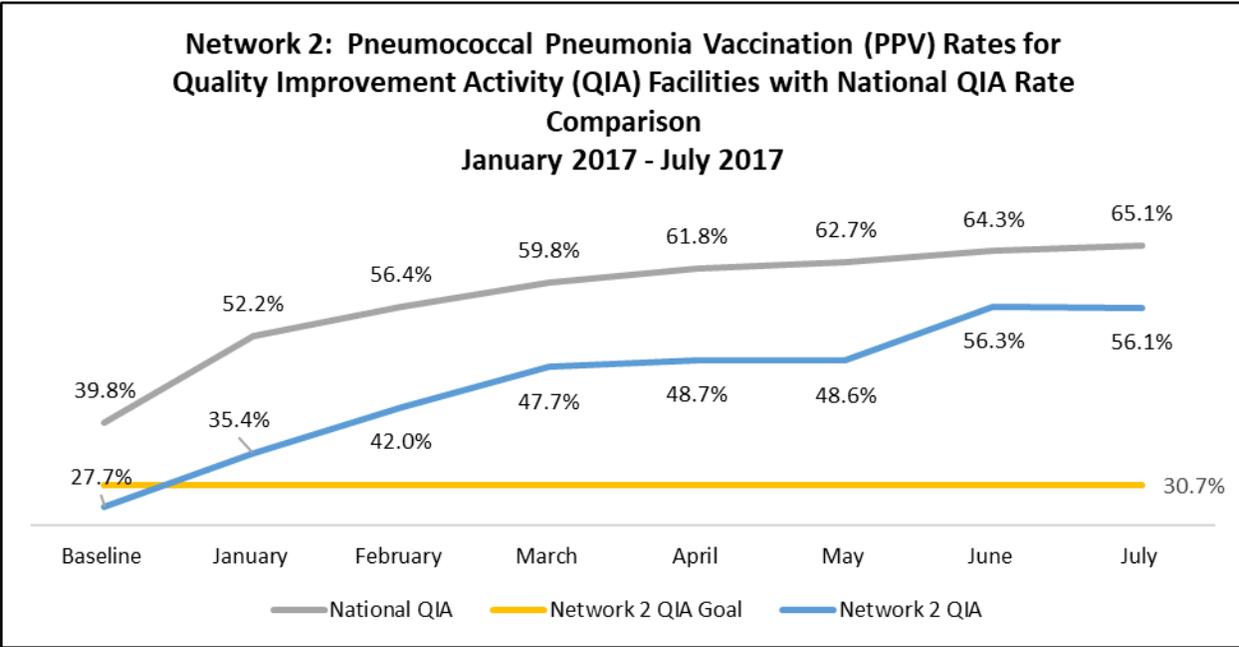
The Network worked with targeted facilities to complete a root cause analysis (RCA) "autopsy" (using the 5-Whys Tool) for each infection identified during the baseline period. The 5-Whys approach allowed users to identify the root cause-and-affect relationships. Network interventions promoted implementation of the CDC recommended audit tools; involved patient subject matter experts in directing the interventions; and included provision of data trending reports of each facility's performance and one-to-one coaching to poor performing facilities.

The Network distributed educational materials and resources from the CDC website, and requested feedback in the form of quizzes and or audits to ensure that facilities were using the materials and resources provided. Additionally, the Network facilitated quarterly HAI Learning and Action Network (LAN) meetings that met quarterly to discuss community challenges and barriers, share best practices, and provide feedback on a Network compiled resource toolkit, featuring presentations by experts on BSI reduction and facility best practices.

To support achieving BSI reduction goals, the Network promoted use of CDC core intervention resources, which included an educational poster and accompanying resources focused on nine components to preventing infections in a dialysis setting. This educational campaign included promotion of patient success stories. In working with QIA facilities through one-to-one coaching calls with poor performers, the Network uncovered the root cause barriers to high infection rates that included: 1.) A large number of patients were admitted to dialysis facilities from hospitals with a catheter, causing a higher risk of BSI. 2) The inability to control and monitor patient hygiene outside of the dialysis facility sometimes resulted in the spread of infection.



Source of data: CROWNWeb



Source of data: CROWNWeb

Increase Hepatitis B and Pneumococcal Pneumonia Vaccination Rates

Background

Dialysis patients are at greater risk for complications related to pneumococcal pneumonia and hepatitis B; however, despite the high risk to this population, a low percentage of patients are receiving them. Data from the ESRD NCC reveal that the rates for the pneumococcal and hepatitis B vaccines in the Network's service area for September 2016 were 27.7% and 38.4% respectively. In 2017 the Network worked with facilities in its service area that had low rates of hepatitis B (HBV) and pneumococcal pneumonia vaccinations.

Targeted Facilities

Facilities participating in the QIA were those in the lowest quintile for both vaccines. (10% of underperforming facilities to a maximum of 25 facilities)

Goals and Outcomes

The QIA had a facility-specific goal (to increase both pneumococcal pneumonia and hepatitis B vaccination rates at the facility level to greater than 60%) and a Network goal (to improve rates for both vaccines by three percentage points from baseline (September 2016) to re-measurement (February through September 2017)). The Network's interventions succeeded in increasing hepatitis B vaccination rates in target facilities from 38.4% at baseline to 51.1% at re-measurement; resulting in a 33 percentage point improvement. Network interventions succeeded in increasing PPV vaccination rates in target facilities from 27.7% at baseline to 56.1% at re-measurement; a 102 percentage point improvement.

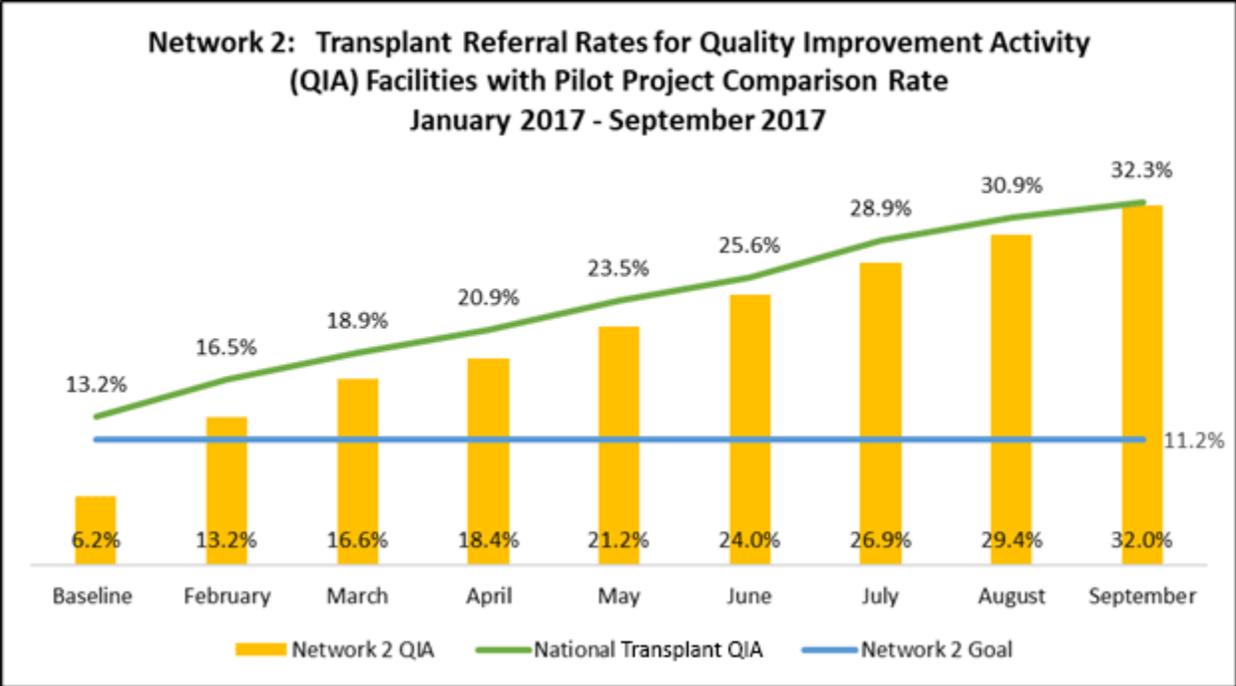
Interventions

In a majority of the target facilities staff members were not entering HBV antigen data correctly in CROWNWeb. Network staff reviewed available resources, consulted with the ESRD NCC and developed a CROWNWeb "Cheat Sheet" for staff to accurately enter HBV antigen data. This resulted in a baseline data cleanup early in the QIA and allowed for other practice-changing interventions to be launched to address patient immunization barriers. One of the main categories of barriers to patients receiving the needed vaccinations was patient refusal/lack of understanding/cultural mistrust. To address these issues, the Network developed educational materials to address patients' reasons for refusal.

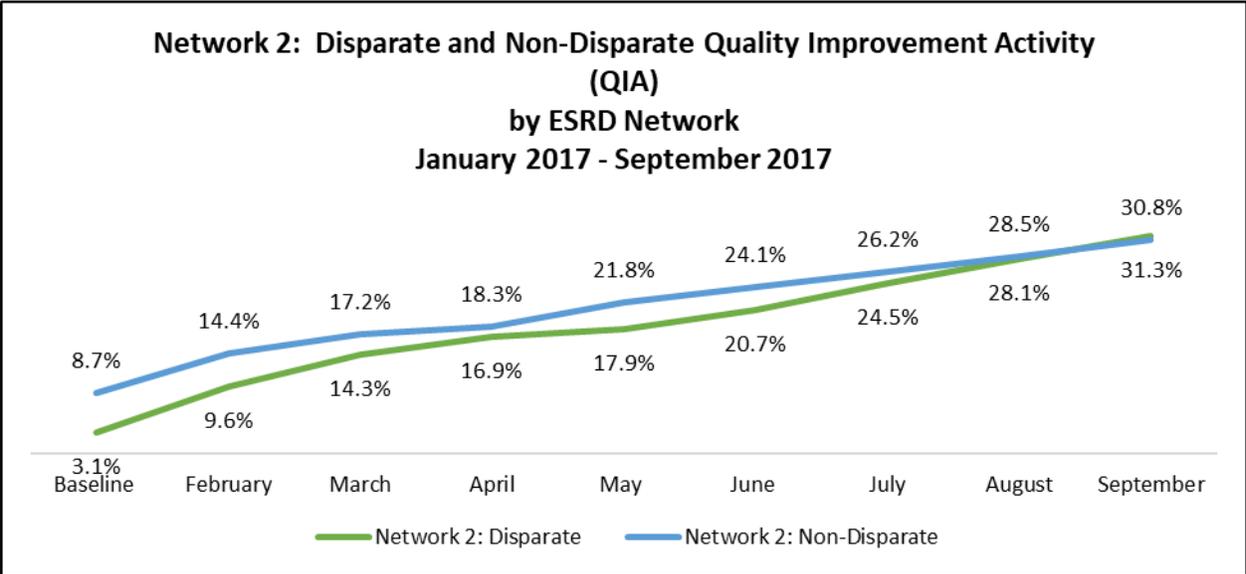
The Network identified the staff and patient educational resources available from the CDC's "Assessment, Feedback, Incentives, Exchange (AFIX) program to reduce missed opportunities to vaccinate and improve immunization delivery practices at the provider level.

- **A:** Assessment of the CROWNWeb data and baseline vaccination rates and distribution of this information to facility staff helped to increase awareness of the need to improve target facilities' vaccination rates.
- **F:** Feedback about baseline rates was provided to the facility upon notification of inclusion in the project in an effort to help clarify and emphasize the need to take action.
- **I:** Incentives throughout the project encouraged action toward improvement. The Network periodically provided staff members with goals, benchmarks and reminders to complete interventions. Network staff met with facility staff bi-monthly to review patient level data and ensure that as facilities progressed toward the graduation goal,
- **X:** Exchange of information allowed access to more experience and motivated improvement. Throughout the project the Network hosted webinars to encourage facilities to share information including best practices and strategies to overcome barriers.

By the end of the QIA, 40% (10/25) facilities exceeded the (60% of patient population) vaccination rate goals for both HBV and PPV.



Source of data: October 2017 ESRD Network Dashboard



Source of data: October 2017 ESRD Network Dashboard

*Disparate population is African American and non-disparate population White.

Population Health Focused Pilot Project (PHFPP): Improve Transplant Coordination

Background

Network 2 identified transplant coordination as the focus of its PHFPP after conducting a disparity assessment for race, ethnicity, location, gender, and age; using the ESRD Dialysis Prevalence Report from Consolidated Renal Operations in a Web-Enabled Network (CROWNWeb) for the period from April – September 2016 and the UNOS kidney transplant waiting list data. Eligibility for transplant varies depending on the transplant center, patient health status, physician perception of a patient's eligibility for transplant, and the patient's financial status. Although these factors influence all patients, a noticeably lower number of African Americans are being referred for transplant in NY, indicating a disparity area.

Targeted Facilities

Based on an analysis of 2016 data, three facilities with confirmed disparity gaps of >5% and transplant referral rates of <25% continued to participate in the project, which began in 2016. New facilities were selected for participation, based on the criteria listed above to replace the nine (9) facilities that were “graduated out” of the project, having attained the goal of reducing the disparity gap to less than 5%. A total of 12 facilities participated in the QIA.

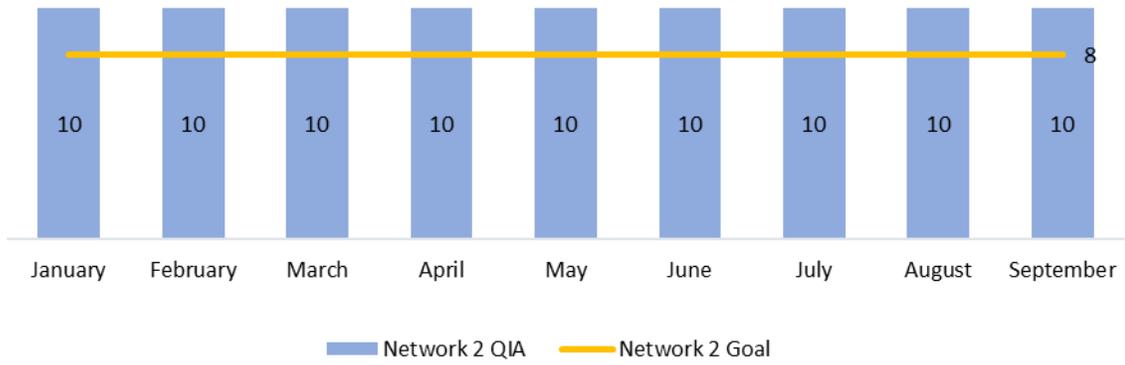
Goals and Outcomes

Increase the rate of patient referrals by five percentage points in the targeted facilities from the baseline period (April to September 2016) to the re-measurement period (January to September 2017). The transplant referral rate for the baseline period was 6.2%. The transplant referral rate for the re-measurement period was 32%; representing a 25.8 percentage point increase, significantly surpassing the goal. The racial disparity gap for the baseline period in the targeted facilities was 5.6%. The Network's interventions resulted in a 6 percentage point reduction, ending the project with a -0.4% disparity gap.

Interventions

The Network structured interventions to ensure that providers were aware of efficient techniques for talking to patients about transplant as an option with the use of patient mentor educators, serving as *Transplant Navigators*. As a long-term strategy to sustain the success of the project, the Network implemented a train-the-trainer approach, whereby Network-trained PAC Chair mentors worked with facility staff to provide education to interested patients. A Network-developed electronic root cause analysis survey tool, using the *5-Whys* iterative technique to explore the cause-and-effect relationships. Identification of a transplant lead coordinator for patient education and to track transplant referrals. Support to facilities in developing a dedicated transplant resource, the *Transplant Education Station*, with pertinent information about the transplant referral process. To support facilities in this endeavor, the Network distributed a tip-sheet highlighting best practices and successful strategies. Creation of a Transplant Advisory Committee to address barriers in data collection, inconsistent reporting, and communication breakdowns between dialysis facilities and transplant centers, and quarterly educational webinars to facilitate sharing of best practice models, educational articles and resources, and recommendations for intervention improvement among participating facilities. Additionally, the Network spearheaded an initiative with other Networks conducting a transplant QIA to create a Sustainability Guide including best practices, lessons learned, and examples of success from seven participating Networks. This Sustainability Guide was shared with all 18 Networks as part of the Network's support of unconditional teamwork and boundarilessness.

**Network 2: Count of Quality Incentive Program (QIP) Quality Improvement Activity (QIA) Facilities That Successfully Completed Plan-Do-Study-Act (PDSA) Cycles and Met the Improvement Target for Three Consecutive Months
April 2016 - September 2017**



Source of data: October 2017 ESRD Network Dashboard

ESRD Quality Incentive Program (QIP) Quality Improvement Activity (QIA): Kt/V Dialysis Adequacy

Background

Adequacy of dialysis is one of the most successful markers for determining patient survival and reducing hospitalizations and mortality. The ESRD QIP includes the Kt/V measure as one of its quality indicators. Clinics performing below standard are presenting risk to their patients and will lose QIP points, which could place them at risk for payment penalties. Most outpatient dialysis facilities have been working on this measure successfully since 2000, when the Kidney Disease Outcomes Quality Initiative (KDOQI) adopted the same measurement to serve as the marker for achieving maximum quality of life for the in-center dialysis patient.

Targeted Facilities

Facilities participating in this QIA were those in the Network's service area that lost points on the Kt/V measure for the QIP performance year 2015 (payment year 2017). The Network identified 80 eligible facilities (32.65% of the total facilities in its service area) that lost five (5) or more points or more for Kt/V under the ESRD QIP.

Goals and Outcomes

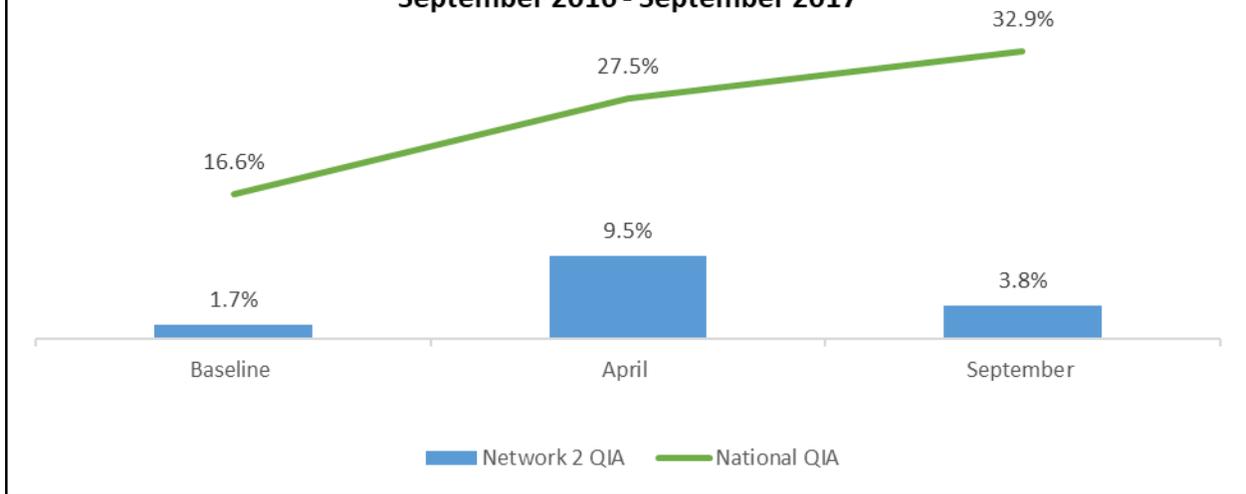
The QIA was based on a baseline period of twelve months (November 2014-October 2015) and an intervention period that concluded in October 2017. Project goals included a 25% relative improvement in rates of Kt/V, from baseline (November 2014 – October 2015), or the QIP threshold being exceeded for three (3) consecutive months or more, and a minimum of eight (8) facilities completing the PDSA cycle by October 2017. Ten of the participating facilities successfully met the requirements of the QIA by October 2017, thereby “graduating.” By May 2017, 40% of facilities in the project were meeting goal and were able to “graduate” from the QIA.

Interventions

Network staff members were aware that factors contributing to underperformance might have included prescriptive measures, blood drawing techniques and human factors- both patient and caregiver. Network interventions assisted facilities in conducting root cause analyses and PDSA cycles to identify opportunities for improvement. Tools and resources, including dialysis adequacy management tools, were provided to help facilities implement rapid cycle improvement and new interventions to overcome barriers. Staff education was provided via site visits, one-to-one technical assistance with target facility staff, and sharing PAC developed education materials. (*PAC Speaks*: “Why I do not skip dialysis treatments”) Identified barriers included: patient non-compliance to prescribed treatment; limitations at the facility level that inhibit the ability of facility staff to change protocols set by corporations (Large dialysis organizations [LDOs]); staff members were not following proper procedure for drawing post BUN. The Network implemented strategies to mitigate identified barriers that included:

- Providing patients with education about following prescribed treatment and the impact of non-compliance on their health.
- Discussions with corporations regarding any facilities that may have needed exception criteria or assistance with protocol development;
- Provision of technical assistance for independent facilities to establish a clear protocol for dialysis adequacy to ensure progress toward goal.

**Network 2: Bloodstream Infection Reporting Rates for National Healthcare Safety Network (NHSN) Data Quality Improvement Activity
Facilities with National QIA Rate Comparison
September 2016 - September 2017**



Source of data: September 2017 NHSN (National Healthcare Safety Network)

Improving NHSN Data Quality

Background

Staff members at dialysis facilities are frequently unaware of patients' BSIs, because the infections are diagnosed after patients are admitted to the hospital. One of the most significant challenges for many dialysis units has been identified as insufficient information transfer from hospitals to outpatient dialysis facilities. This results in underreporting of BSI and negatively impacts patient care. Underreporting also affects facility Quality Incentive Program (QIP) scores, and is a common cause of payment reductions for many dialysis facilities.

Targeted Facilities

The Network identified 20 facilities in its service area for Cohort I of this QIA based on identification of facilities that had a low number of reported positive blood cultures from the hospital setting and lacked access to hospital electronic medical records or were known to have challenges retrieving hospital medical records information for their patients. The Network also worked with six hospitals to which three or more of the identified dialysis facilities referred patients.

Goals and Outcomes

The goal of this QIA was to improve communication between hospitals and facilities, using RCA and the PDSA cycle; to demonstrate that each QIA facility adopted a strategy to capture positive blood cultures identified in hospitals; and to improve dialysis facility reporting rates of BSIs that are identified in the hospital and to document the BSIs in the NHSN database. Success was measured by an increase from the baseline period to the re-measurement period in the number of bloodstream infections reported in NHSN on the day of a dialysis patient's hospital- or emergency department admission, or the day after admission. The baseline period was January through June 2016, and the re-measurement period was January through June 2017. The Network was successful in increasing the number of BSIs reported from baseline (1.7%) to re-measurement (3.8%), representing a 2.1 percentage point increase.

Interventions

Identified barriers included lack of access by dialysis facilities to hospital EMR data systems; in cases where facilities have access to Health Information Exchange information (HIE), that information is often limited; in some instances nephrologists and medical directors may have access to the hospital EMR or HIE but not to NHSN; large dialysis organizations (LDO) submit data from a central location, and LDO data systems may not include a field to capture the BSIs identified in hospitals, and when dialysis facility staff members contact hospitals for BSI data, it is not unusual for hospital staff to refuse to provide the information, claiming that HIPAA regulations prevent them from doing so.

The Network collaborated with the Healthcare Association of New York State, the State Survey Agency, and the Atlantic Quality Innovation Network to bring interventions to the hospitals, as well as the dialysis facilities, involved in the project. The Network met with hospital infection preventionists to share the goals, strategies and interventions of the QIA, and to identify the information they would need from dialysis facilities to improve communications. The Network brokered discussions among the hospitals and the dialysis facilities referring patients to them; ensured that contact information was exchanged; and provided hospital staff with CDC educational materials.

Facilities that were identified to have successfully received the BSI data from hospital admissions had a working relationship with the hospital infection preventionists. The main barrier of this project was the change of staff in the dialysis unit, often causing no one to be aware of NHSN reporting requirements and not having access to NHSN. This would also cause a breakdown in communication between the hospital infection preventionists and the dialysis facility staff.

ESRD NETWORK RECOMMENDATIONS

Recommendations to CMS for Additional Services or Facilities

In the course of our work in 2017, Network staff identified a community need for Nursing Homes/Skilled Nursing Facilities that also provide dialysis services. Based on community feedback, this would help with transitions of care for patients who are hospitalized to step down to Skilled Nursing Facilities. In 2018, the Network plans to conduct community needs and capacity assessments to survey providers on best practices and perform asset mapping of Nursing Homes/Skilled Nursing Facilities to develop a comprehensive listing of existing services to support patient and provider communities.

Additionally, as a result of work in the Vascular Access QIA, the Network identified that in certain rural geographic areas within the Network's service area, there are few or no vascular surgeons specialized in dialysis access placement – creating a barrier to access surgery coordination. In 2018, the Network plans to survey dialysis providers on Vascular Surgeons frequently referred to in their area, to support the Network in developing an electronic Vascular Surgeon Directory to assist patients and providers in locating services to support permanent access placement.

ESRD NETWORK

SIGNIFICANT EMERGENCY

PREPAREDNESS

INTERVENTION

Emergency Preparedness and Response

For individuals who have been diagnosed with ESRD, missed dialysis treatments can have serious adverse health effects. This makes the ESRD patient population especially vulnerable during emergencies and disasters. The Network relies on longstanding partnerships with state and city health departments, offices of emergency management, and emergency preparedness coalitions to ensure safety and continuity of care for ESRD patients throughout New York State.

For all emergencies reported in 2017, Network staff offered comprehensive support to patients and linked healthcare practitioners to appropriate resources, including the KCER program, local and New York State Offices of Emergency Management, and other stakeholders, as appropriate.

The Network worked with facilities to ensure that all information about “closed” or “altered” status was reported to the Network. The Network also ensured that facilities reported to the New York State Department of Health (via the New York Patient Occurrence and Tracking System [NYPORTS], the state's adverse event reporting system) any event that caused delayed or cancelled treatments.

The Network successfully managed 26 emergency events that required intervention, response, and/or tracking during 2017. These events accounted for 223 total calendar days of facility closures and 83 schedule alterations.