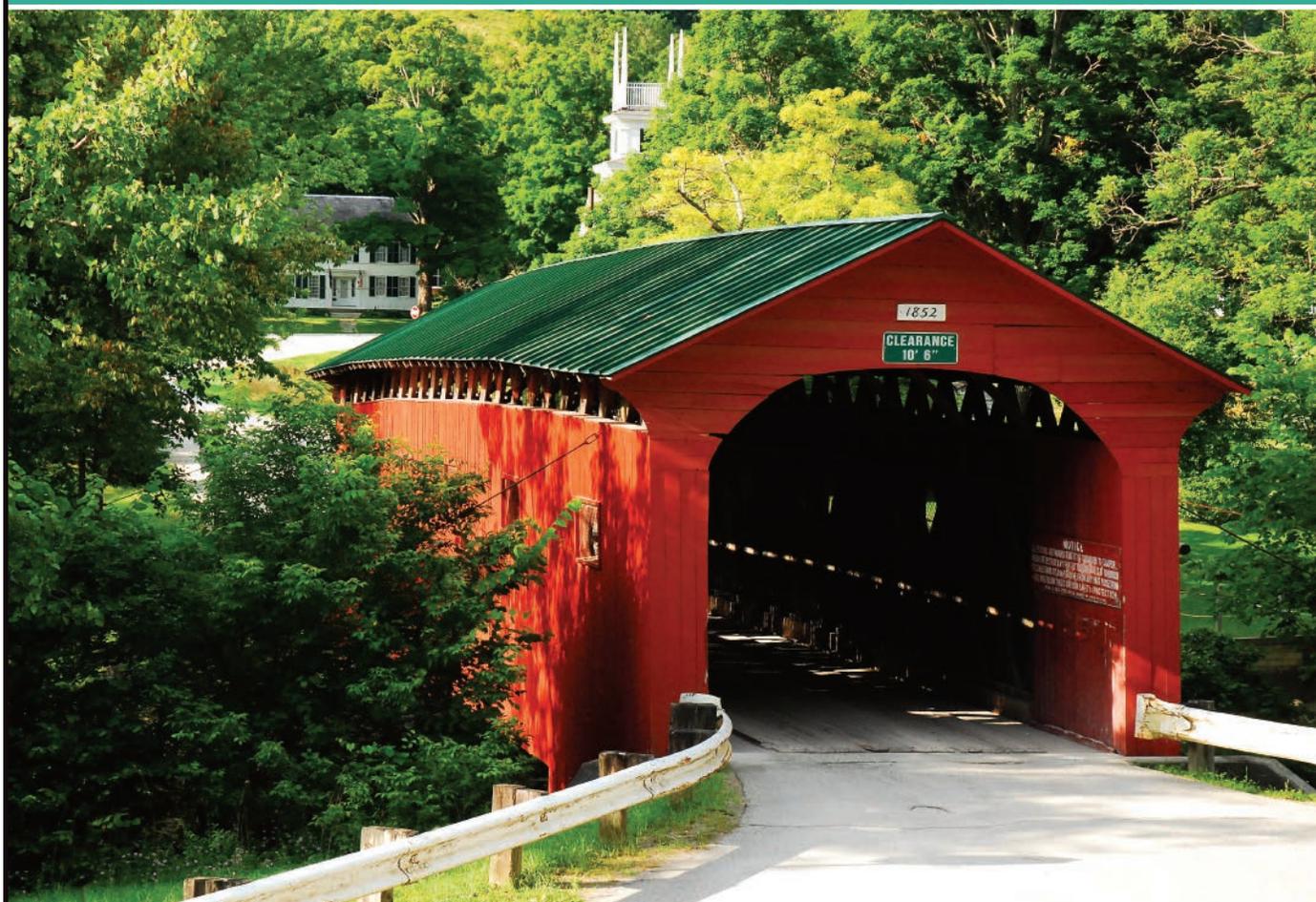




End-Stage Renal Disease
Network of New England

2018 Annual Report



Covered Bridge in Allington, VT

June 2019
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IPRO ESRD Network of New England
<http://network1.esrd.ipro.org>

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ESRD DEMOGRAPHIC DATA

I PRO ESRD Network of New England (Network 1) is one of four ESRD Networks managed by I PRO, a non-profit organization that works with government agencies, providers, and consumers to implement innovative programs that improve healthcare. I PRO supports nearly 100 state and federal programs, and is contracted by CMS as the Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for New York State, South Carolina, and the District of Columbia. I PRO also manages the ESRD Network of New York, ESRD Network of the Ohio River Valley, and ESRD Network of the South Atlantic. I PRO is fully committed to the goals and vision of the ESRD Network Program and supports the renal community in ensuring safe, effective, patient-centered care for the more than 130,411 renal patients in the four Network areas it manages.

Network 1 serves ESRD patients, dialysis providers, and transplant centers in Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. The role of the I PRO ESRD Network of New England is to improve the quality of care for people who require dialysis, transplantation, and/or related life-sustaining treatment for ESRD. The Network aligns its mission and activities with the National Quality Strategy's three broad aims and the Centers for Medicare & Medicaid Services' (CMS) priorities for the ESRD Network Program. Our goals, our methodology for attaining them, and our achievements are described throughout this report.

New England's 14.8 million residents are distributed over approximately 72,000 square miles. Its six states differ widely in terms of geography, population density, and socio-economic factors, all of which influence the availability of services, treatment choices, and quality of care for ESRD patients. For example, Maine is the largest New England state but it has the lowest population density, which presents a challenge for ESRD patients who may have to travel long distances to reach the nearest dialysis facility.

Of the total population of New England in 2018, 78% resided in the three southernmost states (Connecticut, Massachusetts and Rhode Island), which also had the greatest number of metropolitan areas. The remaining 22% resided in the three northernmost states (Maine, New Hampshire and Vermont), which are primarily urban and rural and had the fewest dialysis facilities.

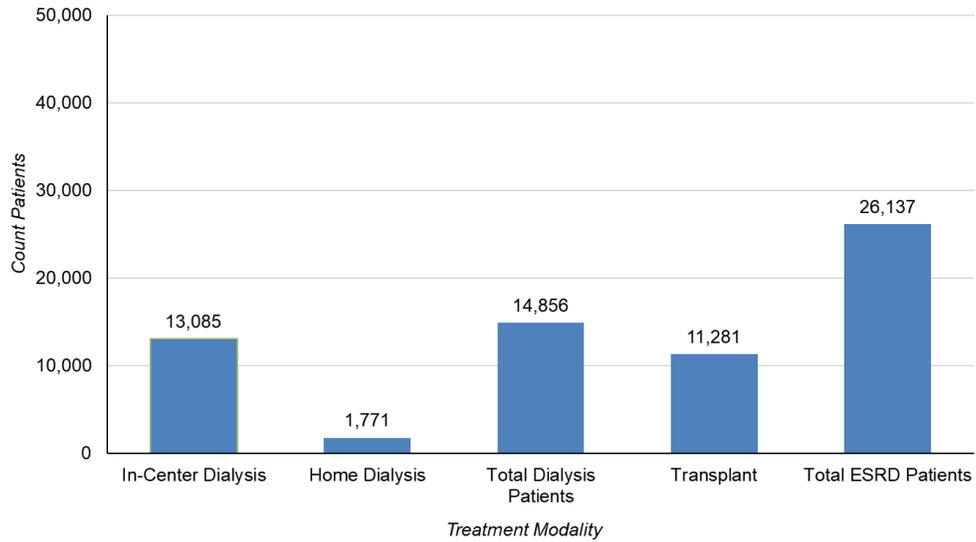
According to the U.S. Census Bureau estimates for 2018, New England's population was 84.15% white, 7.88% African American, 5.06% Asian, and 0.53% American Indian and Alaska Native. A little over 11% of the population was Latino. With the exception of African American and white ESRD prevalent patients in 2018, at 17.81% and 76.73% respectively, data for the remaining U.S. Census Bureau populations closely aligned with the distribution of ESRD patients in New England (see Table 2 in Appendix).

The ESRD population in Network 1's service area was the second smallest in the country as of December 31, 2018, according to ESRD National Coordinating Center (NCC) end-of-year data. As of December 2018, more than 14,967 ESRD patients were reported as receiving dialysis treatment from facilities in the Network service area. These patients were served by 202 Medicare-certified dialysis facilities, which included four Veterans Affairs (VA) hospitals and 15 transplant centers. The number of operating Medicare-certified dialysis facilities in the New England region increased by 5.33%, from 206 in December 2017, to accommodate the growing patient population. Fifty seven (26.3%) dialysis facilities in the Network's service area provided evening services in 2018. Access to care after normal business hours can greatly improve quality of life for ESRD patients who are able to work full-time while receiving treatment.

In 2018, the Network worked in collaboration with its Network Council, Medical Review Board, Patient Advisory Committee, Grievance Committee, and Network activity-specific committees to develop quality improvement projects aligned with the goals identified by CMS for the ESRD Network program. The Network works closely with ESRD patients, patients' family members and care partners, nephrologists, dialysis facilities and other healthcare organizations, ESRD advocacy organizations, and other ESRD stakeholders to improve the care for ESRD patients throughout New England.

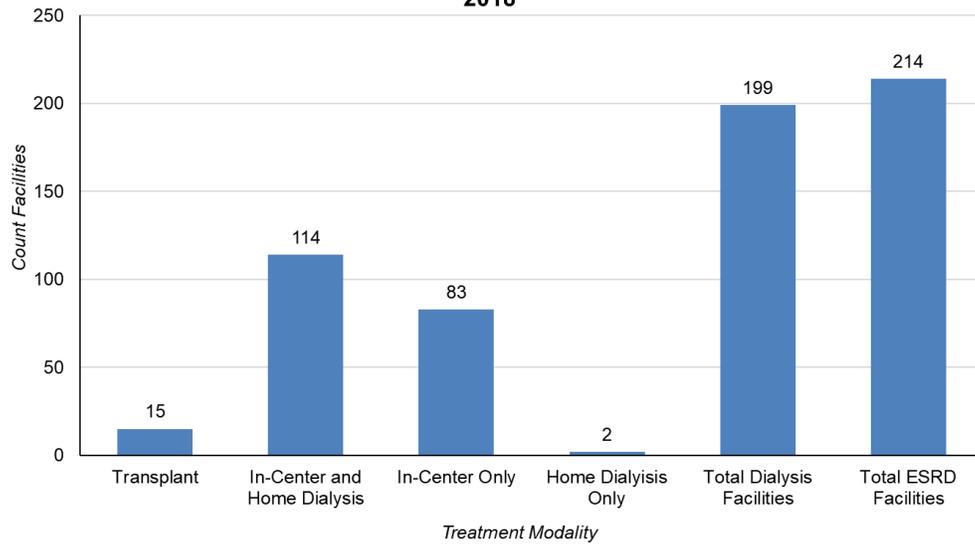
The Network deployed interventions that targeted patients, dialysis and transplant providers, and other stakeholders. These interventions, which focused on engaging patients, reducing disparities, and improving quality of care for ESRD patients are detailed in this report.

Network 01: Count of Prevalent ESRD Patients by Treatment Modality 2018



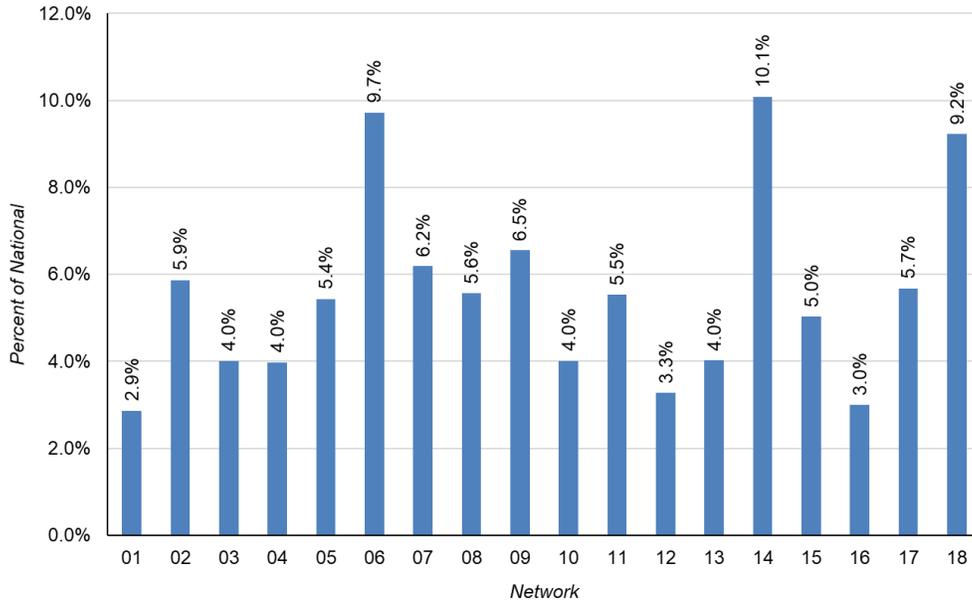
Total Dialysis Patients = In-Center Dialysis + Home Dialysis
 Total ESRD Patients = Transplant + Total Dialysis
 SNF dialysis patients are not shown due to small numbers.
 Source of data: CROWNWeb

Network 01: Count of Medicare-Certified Facilities by Modality Type Offered 2018



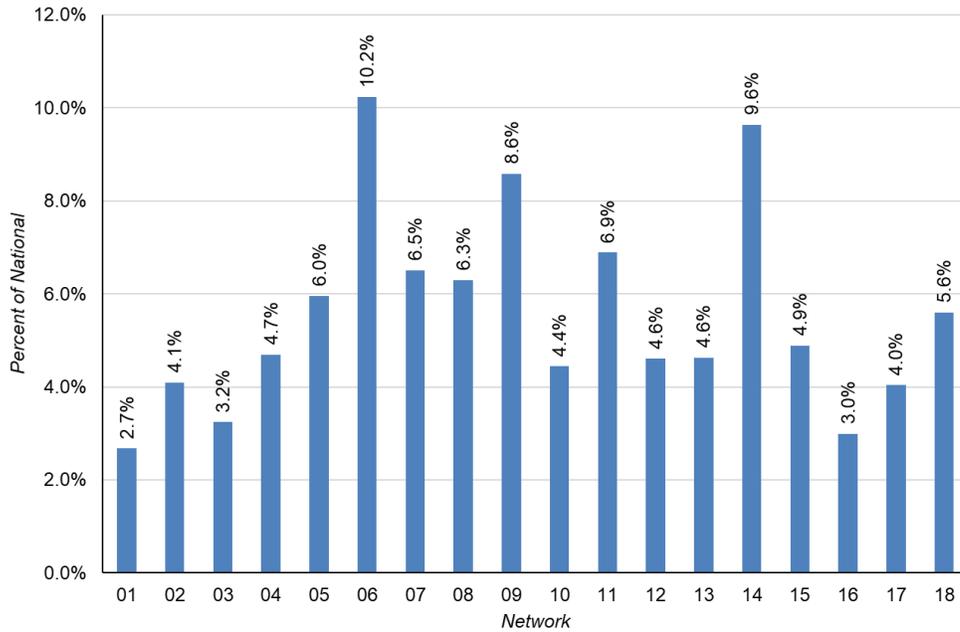
Total Dialysis Facilities = In-Center and Home Dialysis + Home Dialysis only + In-Center Only
 Total ESRD Facilities = Transplant + Total Dialysis Facilities
 Source of data: CROWNWeb

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



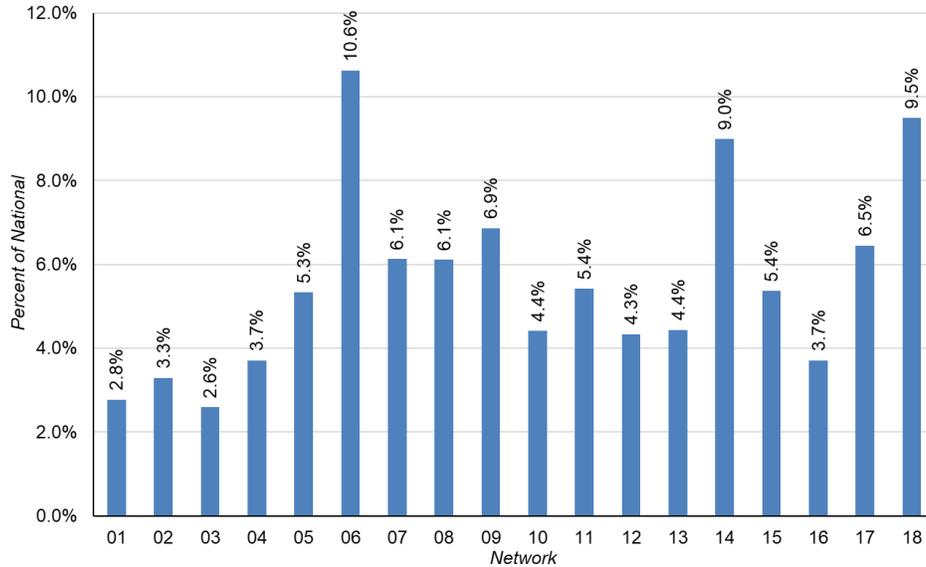
National total dialysis patients: 518,106
Source of data: CROWNWeb

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



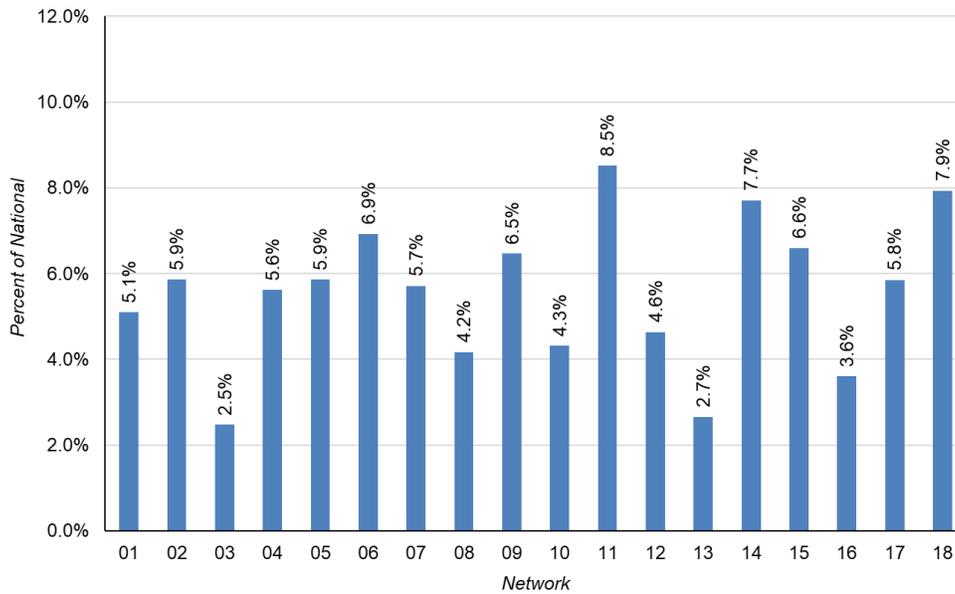
National total ESRD Medicare-certified dialysis facilities: 7,431
Source of data: CROWNWeb

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



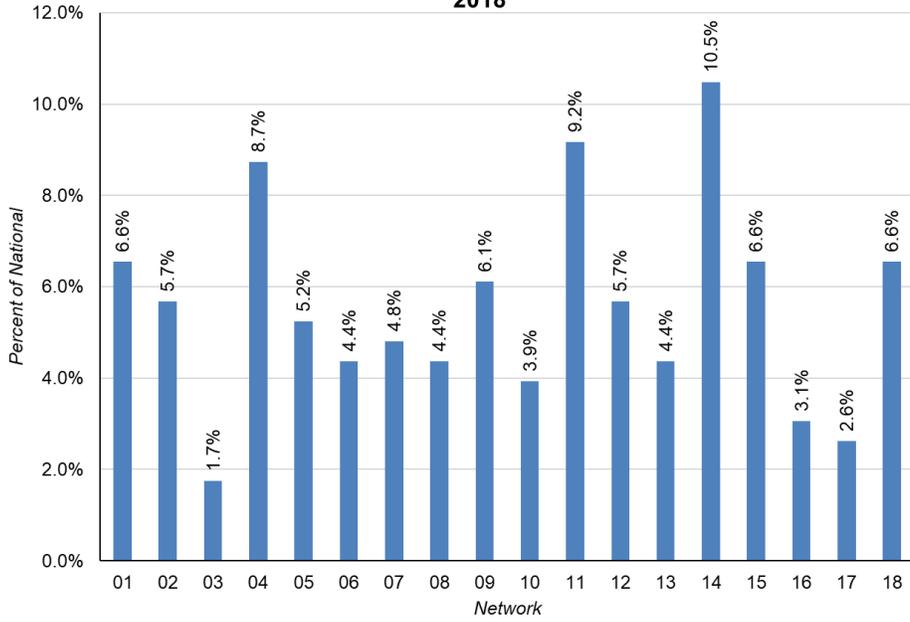
National total home hemodialysis and peritoneal dialysis patients: 61,826
Source of data: CROWNWeb

Percent of Transplant Patients by ESRD Network 2018



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

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



National total ESRD Medicare-certified kidney transplant facilities: 229
Source of data: CROWNWeb

ESRD NETWORK GRIEVANCE AND ACCESS TO CARE DATA

IPRO ESRD Network of New England responds to grievances filed by or on behalf of ESRD patients in Connecticut, Massachusetts, Maine, New Hampshire, Rhode Island and Vermont.

According to the Centers for Medicare & Medicaid Services, a grievance is defined as follows:

“A written or oral communication from an ESRD patient, and/or an individual representing an ESRD patient, and/or another party, alleging that an ESRD service received from a Medicare-certified provider did not meet the grievant’s expectations with respect to safety, civility, patient rights, and/or clinical standards of care.” Case review activities fall into three categories: 1) Facility Concerns, 2) Grievances, which have three) subcategories, and 3) Access to Care, which has two sub-categories.

A facility concern is initiated by a contact from a facility staff member who wishes to discuss either a specific or general circumstance(s) about a patient or the facility, for which there is insufficient information to meet the criteria for a grievance or access to care case. An “immediate advocacy” is a case of a simple, generally non-quality of care nature that can be completed in seven calendar days or less. A general grievance is a case of a more complex nature than an immediate advocacy that does not involve clinical quality of care issues and that cannot be resolved within seven calendar days. A clinical quality of care (QoC) grievance involve situations in which the grievant alleges that an ESRD service received from a Medicare-certified provider did not meet professionally recognized standards of clinical care.

The Network works with individual facilities to identify and address difficulties in placing or maintaining patients in treatment. These “access to care” cases may come to the Network’s attention in the form of a grievance filed by or on behalf of the patient.

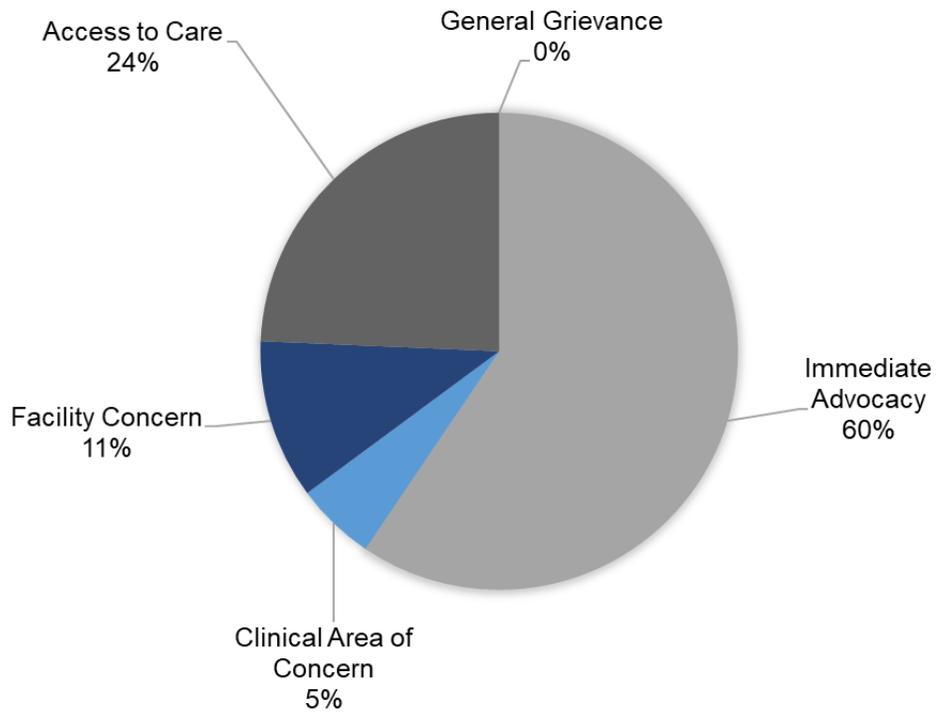
There are three types of access to care cases: involuntary transfers, involuntary discharges, and failures to place. Involuntary transfer occurs when a facility closes, either temporarily or permanently, requiring the patient to be transferred to another facility. Involuntary transfers may also occur when a patient is transferred to another facility due to safety concerns such as threatening or abusive behavior. An involuntary discharge is initiated by the treating dialysis facility without the patient’s agreement. Failure to place is when all local outpatient dialysis facilities have denied the patient acceptance for routine dialysis treatment.

The Network responded to two Quality of Care grievances filed by or on behalf of patients in 2018. These two cases involved allegations that the services received from the facility did not meet professionally recognized standards of care. The Network carefully examined patient concerns and conducted a thorough review of the relevant medical records and facility policies and procedures pertaining to the grievances raised to determine appropriate interventions.

There were 21 Immediate Advocacy cases involving environmental, operational, or interpersonal issues that were resolved to the patients’ satisfaction within seven days.

Facilities reported ten Non-Grievance Access to Care cases to the Network in 2018. Eight of the ten cases resulted in patients being involuntarily discharged based on ongoing disruptive behavior. The Network assisted with averting two discharges. The Network responded to four facility concerns about disruptive patient behavior, and provided interventions to assist facilities with de-escalating techniques. The Network also provided facilities with education about grievances and patient rights.

Network 1: 2018 Grievances and Non-Grievances by Case Type and Percent



Source of data: Patient Contact Utility (PCU)

ESRD NETWORK QUALITY IMPROVEMENT ACTIVITY DATA

Long-Term Catheter Quality Improvement Activity

Project Overview

In 2018, the Network worked with 50% of the facilities in its service area with the highest rate of bloodstream infections to reduce long-term catheter (LTC) usage by 2 percentage points in facilities that had a greater than 15% usage rate. Network staff worked with target facilities to identify knowledge gaps, increase accurate reporting of central venous catheters (CVC), and improve communication with vascular surgeons throughout the region.

Through the use of the Centers for Disease Control and Prevention's (CDC) core interventions, and Network-developed patient level tracking tool for facilities to monitor patient use of LTCs. The Network was able to achieve and surpass the Center for Medicare and Medicaid Services (CMS) goal and achieved a 3.04% reduction in LTC use.

Interventions

Network strategies included:

- Grouping long-term catheter patients into four categories
 - Patients with no options for internal vascular access placement
 - Patients who are choosing to keep a CVC even after adequate education
 - Patients who are being evaluated for internal vascular access
 - Patients who are not taken steps to have CVC removed

The Network focused improvement efforts on the group of patients who were choosing to keep their catheters and the patients who have not started the process.

- Facilities hosted lobby days during which patients promoted educational information about vascular access options to other patients. Peer mentors provided information about the benefits of an internal vascular access vs a CVC

Barriers to achieving goals

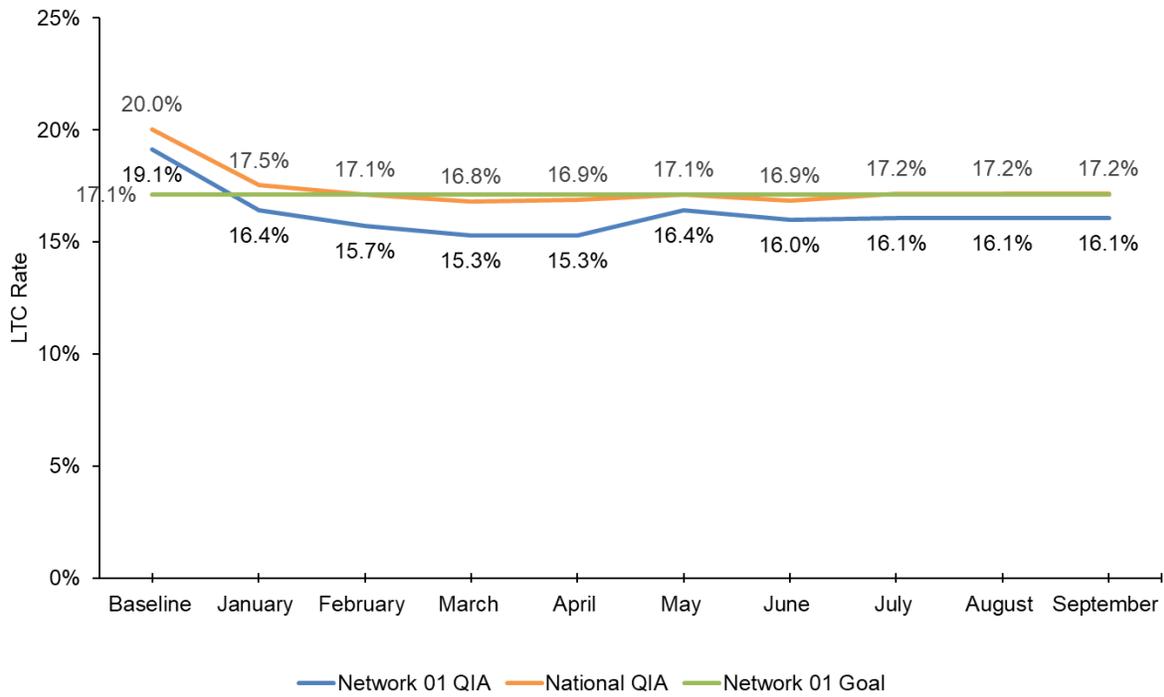
- Patients are often discharged from a hospital with a LTC and no follow up appointment with a vascular surgeon.
- Patients do not understand of the importance of having their catheters removed as quickly as possible
- Patients have difficulty making additional doctor appointments in a timely manner
- There is often a delay time in patients getting appointments with interventional radiologists and surgeons
- There is often a lack of patient follow up after a referral is made to vascular surgeon

Best practices spread to achieve goals

Target facilities identified the following strategies as best practices:

- Facilities have one person identified in a primary role as the vascular access coordinator
- Patients are scheduled to meet with a vascular surgeon before being discharged from the hospital
- Facilities establishing regular meetings with vascular access groups to discuss all patients with CVCs in the facility and any recurring issues identified with grafts or fistulas.
- Facilities following up with the vascular surgeon group shortly after the patient's initial appointment

**Network 01: Long-Term Catheter Rates for Quality Improvement
Activity (QIA) Facilities with National QIA Rate Comparison
January 2018 - September 2018**



Source of data: October 2018 ESRD Network Dashboard

Bloodstream Infection Quality Improvement Activity

Project Overview

IPRO End-Stage Renal Disease (ESRD) Network of New England supports the national initiative to reduce the rate of bloodstream infection (BSI) by 50% over the next five years. To aid in achieving this goal the Network worked with facilities reporting the highest BSI rates (those facilities with reported BSI rates in the top 50% within the Network's service area) based on the National Health Safety Network (NHSN) semi-annual pooled mean at baseline (Quarters 1 and 2, 2017). Within that group of facilities, the Network worked with a 20% cohort that had the highest rates of infection. The outcome goal was to achieve a 20% reduction in the semi-annual pooled mean BSI rate from baseline.

Data for this activity came from the Center for Disease Control and Prevention (CDC) National Healthcare Safety Network system. Baseline for this project was the semi-annual quarterly pooled mean BSI rate from January to June 2017, with the premeasure period being the semi-annual quarterly pooled mean BSI rate for January to June 2018. The baseline rate for the 20% cohort was 1.34% with a 20% reduction goal of 1.07%. The Network was able to reach 0.65% semi-annual quarterly pool mean rate, and achieved a 51% reduction in the BSI rate for the 20% cohort.

Interventions

Network strategies included:

- Topic-specific monthly newsletters highlighting the CDC's "Pieces of the Puzzle" tools to promote and spread best practices and provide additional resources to educate staff and patients
- Facility staff and patients working together to host facility lobby days focused on infection prevention
- 99.5% of the NHSN users in the service area completed annual NHSN training to ensure accurate reporting
- Monthly CDC audits
 - Including patients performing hand hygiene audit
- RCAs for every identified BSI during the project period with findings discussed during Quality Assessment Performance Improvement (QAPI) meetings
- Tracking and monitoring of patients to trend catheter removal
- Implementation of quarterly meetings with local vascular surgeon groups
- Assisted 24.5% of the BSI QIA facilities to enroll in a Health Information Exchange (HIE) or set-up an evidence-based highly effective information transfer system.

Barriers to achieving goals

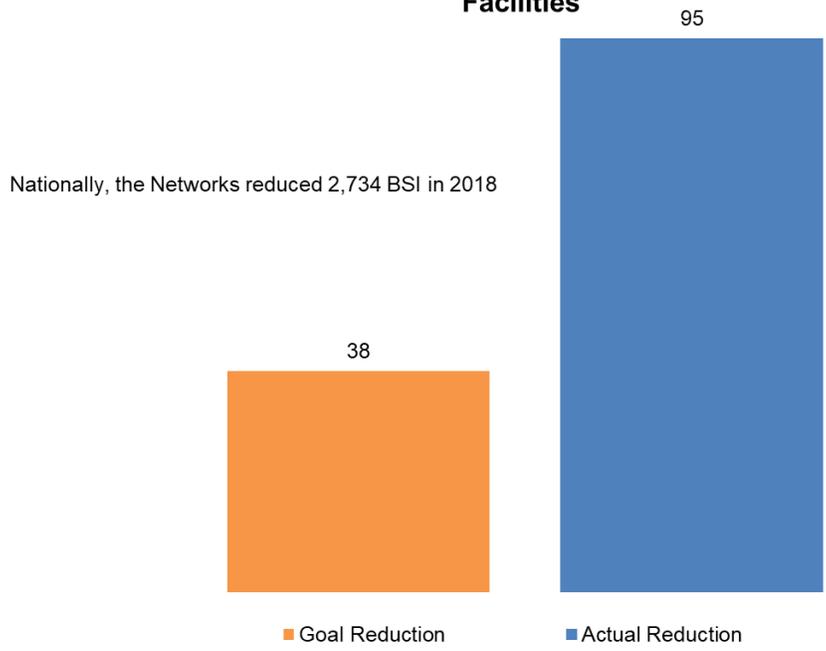
- Staff missing hand hygiene opportunities to discuss/demonstrate hand hygiene techniques with patients
- Patients not performing hand hygiene when entering and exiting the unit
- Staff feeling rushed during turn over
- Lack of compliance with environmental disinfection practices
- Lack of communication between staff at skilled nursing facilities and dialysis facilities regarding shared patients

Best practices spread to achieve goals

Target facilities identified the following strategies as best practices:

- Facilities appointing a primary infection control coordinator
- Having a staff member on site with NHSN access
- Completing NHSN audit tools
- Running monthly NHSN infection rate data and reviewing them in QAPI

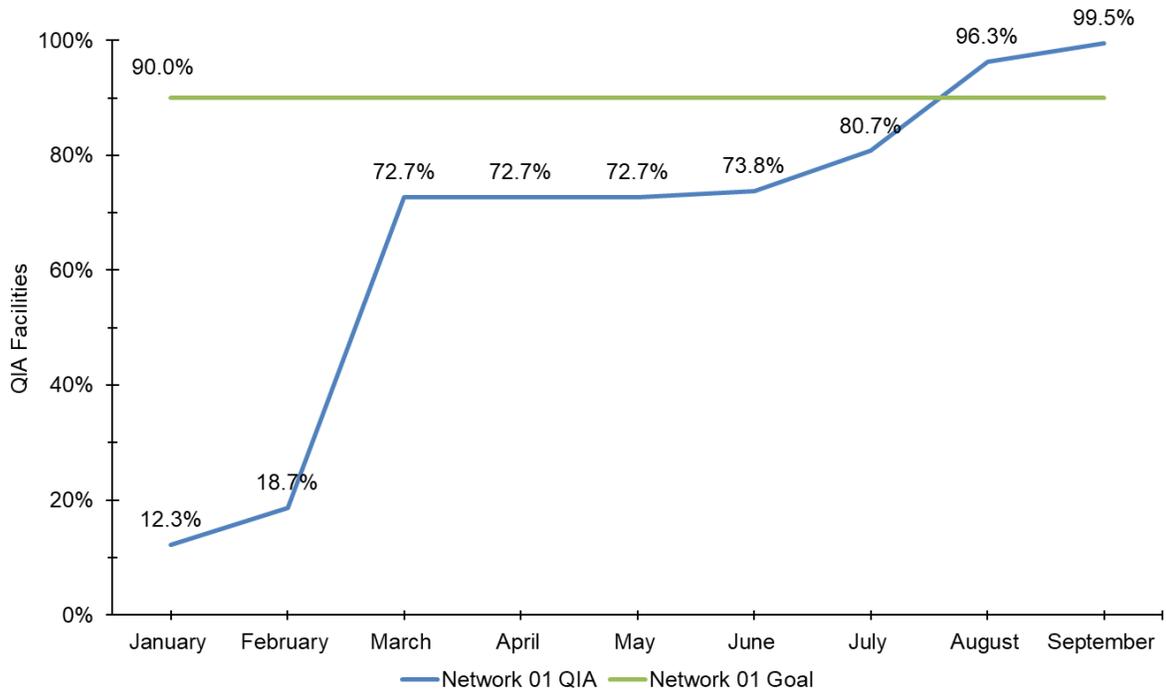
Network 01: Reduction in Bloodstream Infections (BSI) in QIA Facilities



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

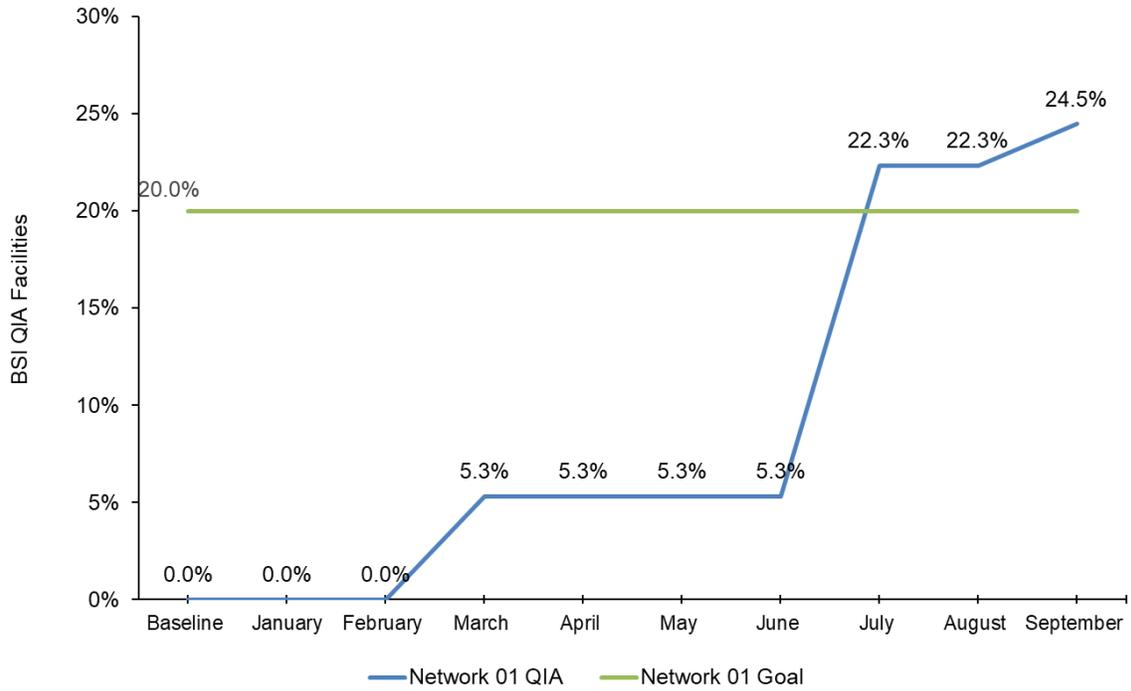
QIA: Quality Improvement Activity
Source of data: National Healthcare Safety Network (NHSN) January 2018 - June 2018 compared to January 2017 - June 2017

**Network 01: Percent of Dialysis Facilities that Have At Least One Person Who Has Completed the NHSN Dialysis Event Surveillance Training
January 2018 - September 2018**



Source of data: October 2018 ESRD Network Dashboard

**Network 01: Percent of BSI QIA Facilities with a Health Information Exchange
or Evidence-Based Highly Effective Information Transfer System
January 2018 - September 2018**



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

Transplant Waitlist Quality Improvement Activity

Project Overview

Despite transplantation options and transplant referrals being required by the Conditions for Coverage for dialysis facilities, there continue to be barriers to the transplant referral of interested patients. In 2018, Network staff designed a quality improvement activity to improve individual dialysis facility transplant referral rates, to overcome barriers in any identified disparate groups to and tailor interventions to ensure that all interested and suitable patients are given the opportunity for transplant as a treatment option. The Network worked with 30% (60) of the dialysis facilities in the service area, with a goal to increase the number of patients on the United Network of Organ Sharing (UNOS) waitlist by 10 percentage points. Baseline for this project was from October 2016- June 2017, with a baseline rate of 10.57%. The goal was to increase the rate to 20.57% by re-measure in October of 2018. Data was provided by UNOS to the Network via the ESRD National Coordinating Center (NCC).

The Network utilized a “7 Step” methodology to monitor patient progression through the transplant evaluation process: 1) Patient suitability for transplant (defined as absence of absolute contraindication identified in the medical record), 2) Patient interest in transplant, 3) Referral call to transplant center, 4) First visit to transplant center, 5) Transplant center work-up, 6) Successful transplant candidate, and 7) On waiting list or evaluate potential living donor. These steps were designed to track the patients through their journey from their initial interest in transplant to placement on the waitlist.

Although, the Network did not achieve the full 10 percentage point increase at re-measure, it did achieve an 8.36 percentage point increase for an overall rate of 18.9%. Network performance exceeded the national QIA trend by 6 percentage points.

Interventions

Network strategies included:

- Working with facilities to identify eligible transplant candidates in each facility
- Supporting each facility in conducting root cause analysis to identify barriers that keep patients from completing the transplant evaluation process
- Identifying a transplant coordinator in each facility
- Providing facility staff education on the “7 Step” process, including information on how to track patients through the process
- Addressing identified communication barriers between dialysis facilities and transplant centers
- Identifying patient navigators to help guide transplant candidates through the evaluation process.
- Supporting patients to host Lobby Days and creating Education Stations promoting the benefits of a kidney transplant

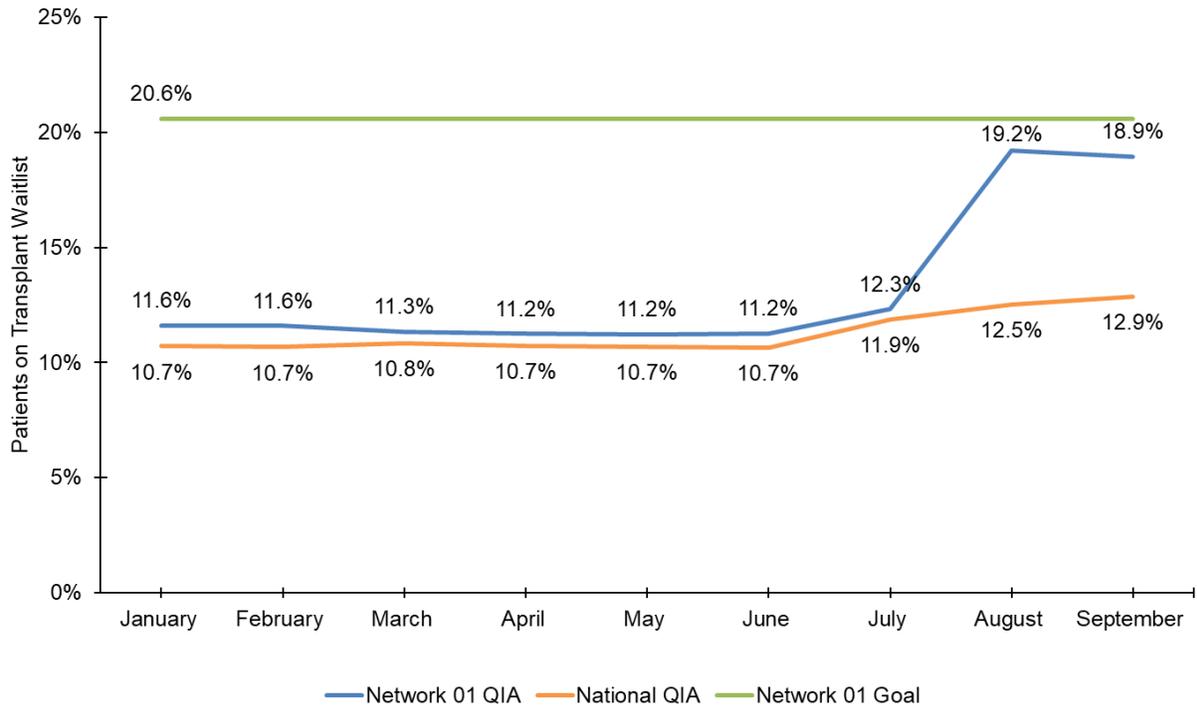
Barriers to achieving goals

- Patients’ lack of interest in kidney transplantation
- Lack of communication between the dialysis facilities and the transplant centers
- The number of appointments required to complete the transplant evaluation process
- Inadequate patient transportation to and from multiple medical appointments
- Patients and dialysis facilities losing track of where patients are in the work up process

Best practices spread to achieve goals Target facilities identified the following strategies as best practices:

- Identifying a dedicated transplant coordinator in each dialysis facility
- Identifying and obtaining contact information for patient transplant coordinators
- Fostering regular communications between the dialysis facility and the transplant center
- Having the transplant center host a lobby day at the dialysis facility
- Frequent and ongoing patient education
- Dialysis facilities must refer every patient that is interested in transplant to a transplant center for evaluation

Network 01: Percent of Patients from QIA Facilities on the Transplant Waitlist
January 2018 - September 2018



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

Home Therapy Quality Improvement Activity

Project Overview

The Network worked with 30% (60) facilities in the Network service area to increase the number of patients receiving home dialysis therapy by 10 percentage points from 0.81% at baseline (October 2016 – June 2017) to 10.81% at re-measurement (October 2018). The primary data source for this quality improvement activity was CROWNWeb.

Network staff used a “7 Step” methodology to monitor patient progression from initial interest in modality change through the start of the new modality training: 1) Patient interest in home dialysis, 2) Educational session to determine the patient’s preference of home modality, 3) Patient suitability for home modality determined by a nephrologist with expertise in home dialysis therapy, 4) Assessment for appropriate access placement, 4) Placement of appropriate access, 5) Patient accepted for home modality training, and 7) Patient begins home modality training. The seven steps were designed to help facilities identify barriers with progression of the modality change.

Although, the Network did not achieve the full 10 percentage point increase at re-measure, it did achieve a 5.27 percentage point increase for an overall rate of 6.1%. Network performance exceeded the national QIA trend by 0.3 percentage points.

Interventions

Network strategies included:

- Encouraging facilities to participate in the ESRD National Coordinating Center (NCC) Learning and Action Network (LAN) home modality events
- Supporting facilities in appointing a home dialysis champion to help educate patients about the benefits of home dialysis
- Encouraging facilities to host Lobby Days and create Education Stations promoting home dialysis
- Providing information to facilities on the utilization of the “7 Steps” to track patients’ progress toward utilizing a home modality.
- Working with facility leadership to increase communication between the hemodialysis staff and home dialysis units

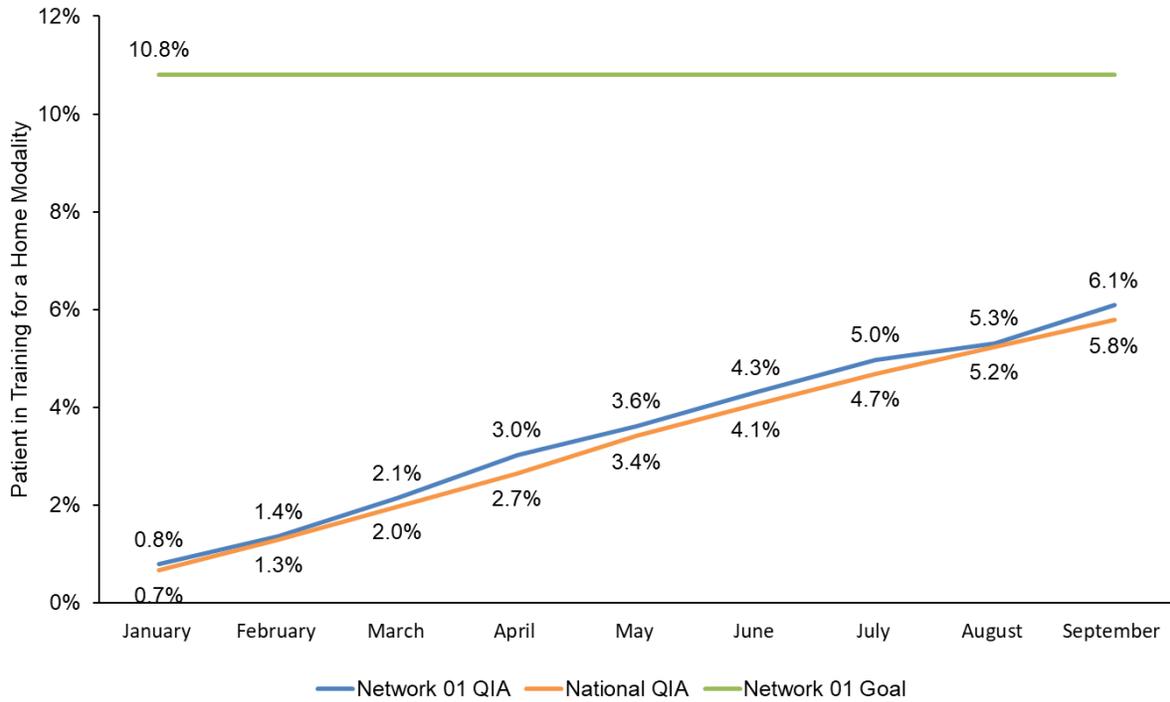
Barriers to achieving goals

- Patients choosing to stay in-center
- Physicians lack of comfortable with managing home dialysis patients
- Facilities closing, resulting in consolidation of home programs
- Shortage of home dialysis nurses

Best practices spread to achieve goals

- Early education for patients, even before starting dialysis
- Peer-to-peer education on the benefits of home dialysis
- Frequent staff education
- Promotion of home dialysis by in- center staff
- Including a care partner in the decision and education of home dialysis

Network 01: Percent of Patients from QIA Facilities in Training for a Home Modality
January 2018 - September 2018



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

Population Health Focus Pilot Project Quality Improvement Activity

Project Overview

Network 1 selected the project: *Support Gainful Employment of ESRD Patients* for its 2018 Population Health Focused Pilot (PHFPQ) QIA. The Network worked with participating facilities to engage and educate patients on the benefits of working with a vocational rehabilitation/employment network agency (VR/EN). The goal of the project was to improve referrals by 5% and overall usage by 2% and to reduce the identified disparity by one percent in the targeted facilities from the baseline period (October 2016-June 2017) to the final re-measure period (September 2018). The referral rates and utilization at the beginning of this project were 0% of 333 patients. By re-measure referral rates had increased to 20.4% and utilization rates increased to 4.0% of 274.

The QIA targeted prevalent patients, ages 18-55, who were receiving dialysis at 65 selected facilities in the Network's service area. Data on the progress of the project was supplied to the Network by the ESRD NCC on a monthly basis.

Facilities were selected based on the following criteria: 1) Facilities with less than 27% working patient population, 2) Facilities with a census of 20 or more patients between the ages of 18 to 55, and 3) Facilities with low percentages of patients currently receiving vocational rehabilitation services.

Interventions

The Network staff conducted a root cause analysis as the first step in identifying where barriers to the referral of patients and their usage of VR/EN existed. Following the RCA, the Network used a plan-do-study act model (PDSA) to test the success of strategies implemented to overcome those barriers. To elicit patient driven goals for vocational rehabilitation the Network used the General Interventionist Model (GIM), and followed patients through the process to referral with the "7 Step" approach (Kirst-Ashman & Hull, 2013).

Target facilities worked with patients to set goals that were incorporated into their care plans, monitor their progress, address barriers, and follow-up with patients on both clinical and self-management goals. The GIM's "7 Steps" include: (1) **Engagement** (Motivational interviewing and active listening), (2) **Assessment** (Articulation of a clear statement of the need, problem, or situation) (3) **Planning** (Prioritizing needs, establishing goals, setting action steps) (4) **Implementation** (Following plan and revising when necessary) (5) **Evaluation** (Monitoring progress) (6) **Termination** (Evaluating achievement of objectives/maintaining and continuing progress) (7) **Follow-up** (Discussing problems and addressing barriers).

The Network also launched a vocational rehabilitation campaign with a goal to encourage dialogue about vocational rehabilitation in targeted facilities. The campaign featured distribution of

- Educational materials about EN/VR
- Network-developed resources addressing the identified disparity in the vocational rehabilitation setting as a way to encourage this segment of the patient population to take advantage of the available services and to help facility staff to promote these services to all segments of the patient population.
- Additional campaign resources including a list of ENs local to the facility, information about the state adult career and continuing education services and the Social Security Administration's Ticket to Work program.

The Network collaborated with selected employment networks /vocational rehabilitation (EN/VR) agencies to promote their support of the unique challenges faced by the ESRD patient population;

including time accommodations due to the three day a week dialysis schedule. The Network worked with the EN/VR to assist more patients in utilizing these services.

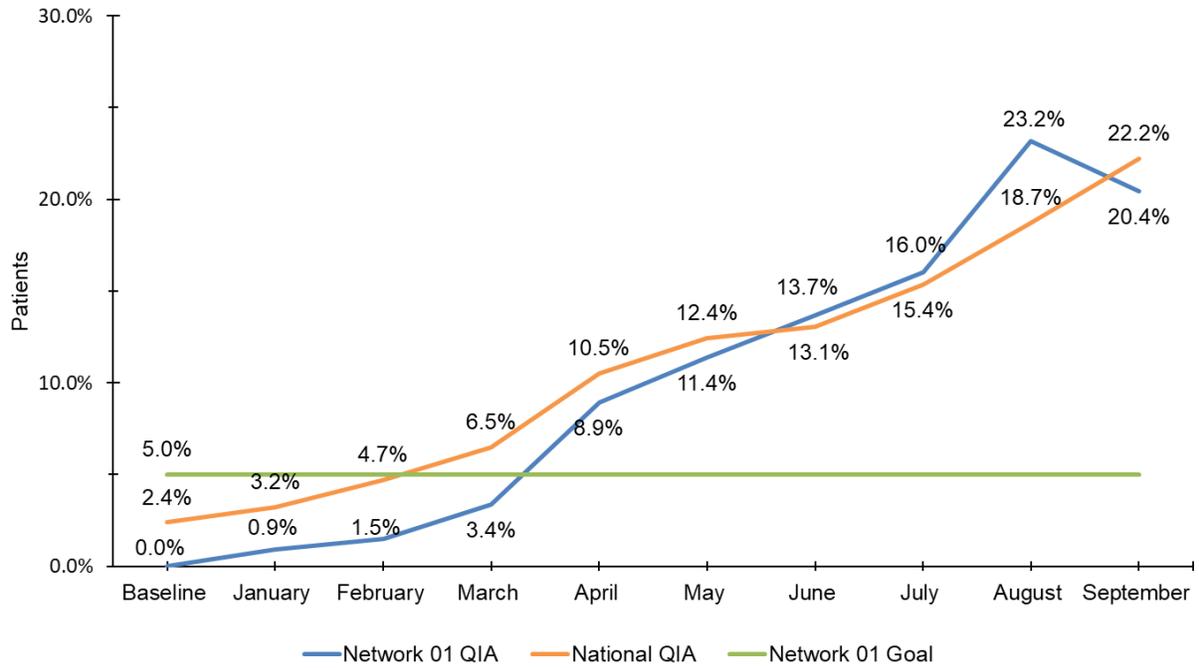
Barriers to achieving goals

During the implementation of this project, the Network identified a community-wide lack of knowledge about the Ticket to Work program (TTW). The Network focused on providing education to the community about the various services offered by the TTW program. The Network conducted a RCA with participating facilities, which identified that patients' lack of interest in VR/EN services was the number one barrier associated with low patient enrollment; patients feeling too ill/sick as the number two barrier, and lack of transportation as the number three barrier.

Best practices spread to achieve goals

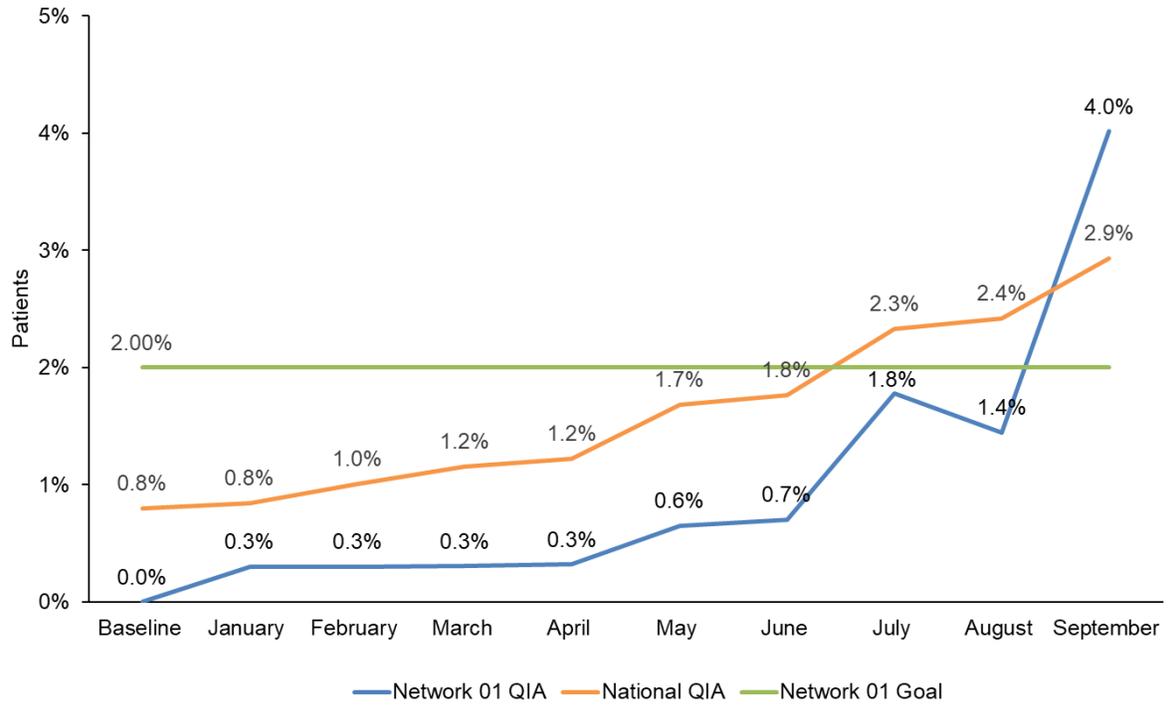
- Increased review and evaluation of identified barriers
- Provision of increased education to patients regarding the VR program and other services that could improve their quality of life
- Staff training about the appropriate VR/RN resources
- Inclusion of a conversation regarding VR during care plan meetings
- Educating new staff about the need for the process for documentation of VR referrals in CROWNWeb
- Routine follow-up with patients to monitor employment and/or vocational rehabilitation interest/involvement and offering support to patients throughout the process.

**Network 01: Percent of Patients from QIA Facilities Referred to an
Employment Network or a Vocational Rehabilitation Agency
January 2018 - September 2018**

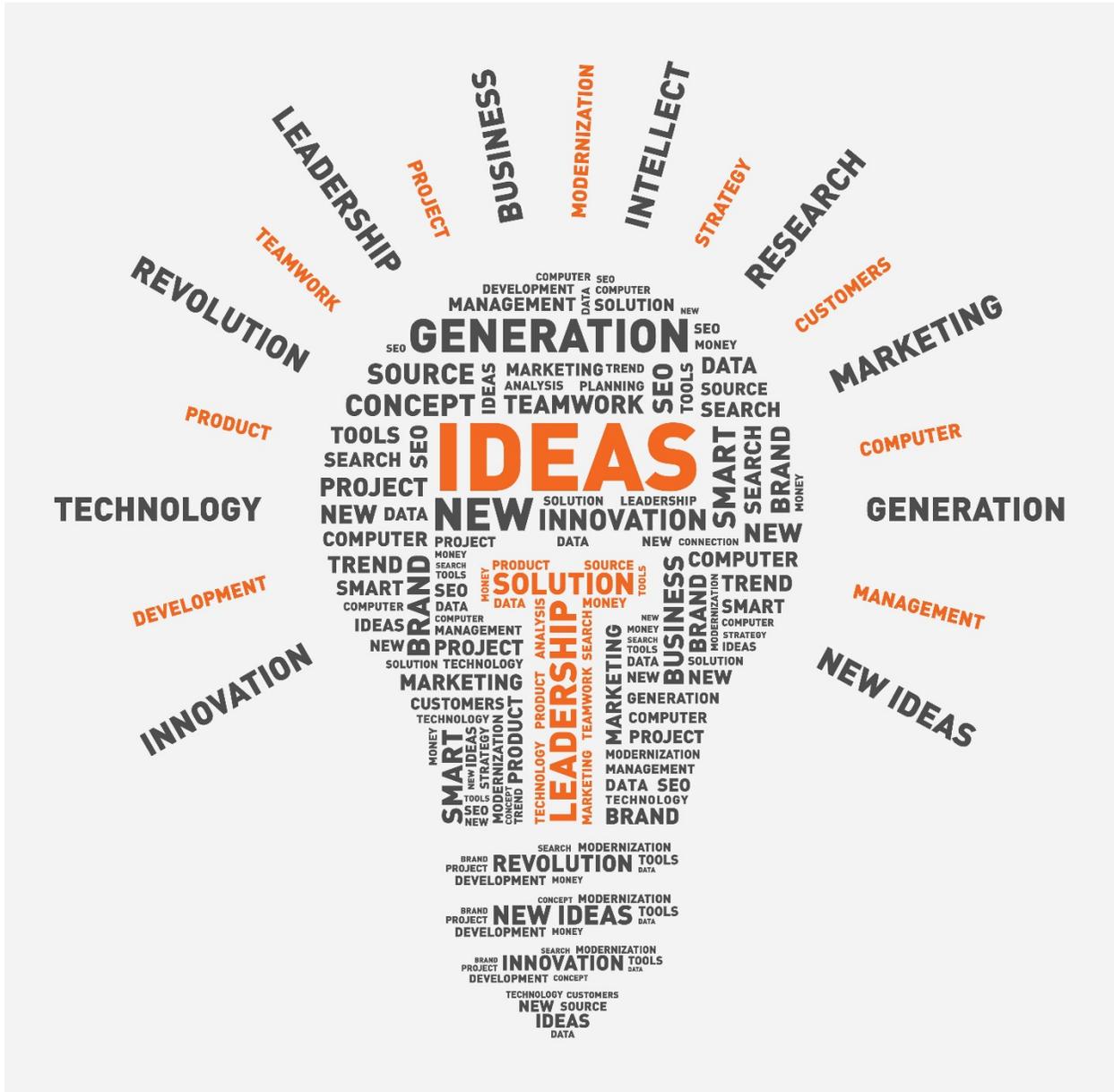


QIA: Quality Improvement Activity
Source of data: October 2018 ESRD Network Dashboard

**Network 01: Percent of Patients from QIA Facilities Receiving Services from the Employment Network or Vocational Rehabilitation Agency
January 2018 - September 2018**



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



ESRD NETWORK RECOMMENDATIONS

Facilities that Consistently Failed to Cooperate with Network Goals

The Network did not identify any facilities in its service area that failed to cooperate with Network goals in 2018.

Recommendations for Sanctions

No recommendations were made to CMS for additional services or facilities in the Network service area during 2018.

Recommendations to CMS for Additional Services or Facilities

In 2018, the Network made no recommendations to CMS for additional services or facilities.

ESRD NETWORK SIGNIFICANT EMERGENCY PREPAREDNESS INTERVENTION

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 health departments, offices of emergency management, and large dialysis organization emergency management teams to ensure safety and continuity of care for ESRD patients in New England.

For all emergencies reported in 2018, Network staff offered comprehensive support to ESRD patients and linked dialysis providers with appropriate emergency response resources, including the Kidney Community Emergency Response (KCER) program, state Offices of Emergency Management, and other stakeholders. The Network worked with facility staff to ensure that all information about “closed” or “altered” status was available to the Network for assisting with access to care coordination, as needed.

The Network successfully assessed, responded to, and tracked 12 emergency events in 2018. In dealing with emergency events, the Network staff members were trained to:

- Evaluate the affected area to assess impact;
- Release email or fax blasts notifying dialysis facilities and response agencies in the affected area of the occurrence;
- Provide dialysis facilities, patients, and family members, and/or care partners with information on appropriate local resources;
- Connect facilities and individual patients, families, and/or care partners with appropriate local resources;
- Participate in emergency meetings with local offices of emergency management and state health departments; and
- Measure and quantify the impact of the occurrence.

Events

Winter Storm

In January and March 2018, the Network informed facilities of severe weather and provided education to facilities on hurricane and tropical storm preparedness by providing resources on hurricane safety, flood zone information, and preparedness guidelines for patients.

Water Main Break

On April 24, 2018, the Network was notified of water main break in Danbury, CT, which led to two days of altered treatment schedules for affected patients.

Strike

On July, 24 2018, the Network was notified that nurses at two Rhode Island hospitals went on strike after negotiators couldn't agree on contract terms during a meeting requested by a federal mediator. Dialysis patients were not impacted.

Non-Emergency Medical Transportation

On December 12, 2017, the Network notified facilities about the Department of Social Services (DSS) contract with Veyo, a Total Transit Company. The contract with the state became effective January 1, 2018 through December 31, 2020. The NEMT program has been restructured to provide the contractor with greater flexibility and capacity to engage a range of transportation through the state in order to best serve Medicaid members. The contract changes required ESRD facilities to complete new Medically Appropriate Mode Forms in order to have the transportation option best suited for patients. Dialysis facilities and patients reported transportation barriers from January – February.

Gas Line Explosion

On September 14, 2018, the Network was notified of a gas line explosion in Boston, Massachusetts. No dialysis facilities were impacted by the explosion.

ACRONYM LIST APPENDIX

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