



End-Stage Renal Disease
Network of New York

2019 Annual Report



Brooklyn Bridge, New York, NY

Submitted June 2020
Prepared by:
IPRO End-Stage Renal Disease Network of New York
<http://network2.esrd.ipro.org>

Submitted to:
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
for Contract Number HHSM-500-2016-00020C

TABLE OF CONTENTS

ESRD NETWORK DEMOGRAPHIC DATA	3
ESRD NETWORK GRIEVANCE AND ACCESS TO CARE DATA	12
ESRD NETWORK QUALITY IMPROVEMENT ACTIVITY DATA.....	16
Long Term Catheter Quality Improvement Activity (LTC QIA)	16
Bloodstream Infection Quality Improvement Activity	19
Transplant Waitlist Quality Improvement Activity	23
Home Therapy Quality Improvement Activity	26
Population Health Focus Pilot Project Quality Improvement Activity.....	29
ESRD NETWORK RECOMMENDATIONS.....	33
Facilities that Consistently Failed to Cooperate with Network Goals	33
Recommendations for Sanctions.....	33
Recommendations to CMS for Additional Services or Facilities	33
ACRONYM LIST APPENDIX.....	36

ESRD NETWORK DEMOGRAPHIC DATA

IPRO End-Stage Renal Disease (ESRD) Network of New York (Network 2) is one of four ESRD Networks managed by IPRO, a non-profit organization that works with government agencies, providers, and consumers to implement innovative programs that improve the healthcare system. In addition to serving as the ESRD Network for New York, IPRO manages the ESRD Network of New England, ESRD Network of the Ohio River Valley, and ESRD Network of the South Atlantic. IPRO 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 more than 132,000 renal patients in 13 states.

IPRO supports nearly 100 state and federal programs. IPRO is also contracted by the Centers for Medicare & Medicaid Services (CMS) as the Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for the New England States, New York, New Jersey, Ohio, Maryland, Delaware and the District of Columbia. In this role, IPRO works to bring Medicare beneficiaries, providers, and communities together in data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality.

Network 2 serves ESRD patients, dialysis providers, and transplant centers throughout New York State. The role of the Network is to improve the quality of care for people who require life-sustaining treatment for ESRD, such as hemodialysis or kidney transplantation. The Network aligns its mission and activities with the National Quality Strategy's three broad aims and CMS' priorities. Our goals, our methodology for attaining them, and our achievements are described throughout this report.

New York is the fourth most populous state in the country, with almost 20 million residents in 2019 and has the highest population density of any major city in the United States, with over 27,000 people per square mile. An estimated 43% of the population resides in NYC, with over 70% of the state's population concentrated within the city and its surrounding counties on Long Island and in the Hudson Valley. The dramatic variance in population density between upstate and downstate New York impacts the availability of and patient access to healthcare services.

In the downstate region (Hudson Valley, New York City, and Long Island), healthcare services are plentiful and relatively easily accessible by public and private transportation. In upstate New York, where the population density is much lower, transportation options are limited and there are fewer treatment facilities. This means that ESRD patients in rural areas typically travel farther and longer to reach dialysis clinics, vascular surgeons, hospitals, and other healthcare providers and clinicians; factors that may affect treatment options, patient experience of and satisfaction with care, and quality of care. The ESRD prevalent patient population in New York State was the sixth largest in the country as of December 31, 2019, according to ESRD National Coordinating Center (NCC) end-of-year data.

The population of the five boroughs of NYC—Bronx, New York, Richmond, Kings, and Queens Counties—grew to 8.5 million in 2019, according to U.S. Census Bureau estimates. Demographic and health-related changes in New York State's population parallel changes taking place nationwide. For example, New York's large baby boomer population is aging and, according to the Centers for Disease Control and Prevention (CDC), the risk for developing chronic kidney disease increases after age 50 and the disease is most common among adults age 70 and older. The state's population of almost 20 million is rich in ethnic, racial, religious/spiritual, cultural, and lifestyle diversity.

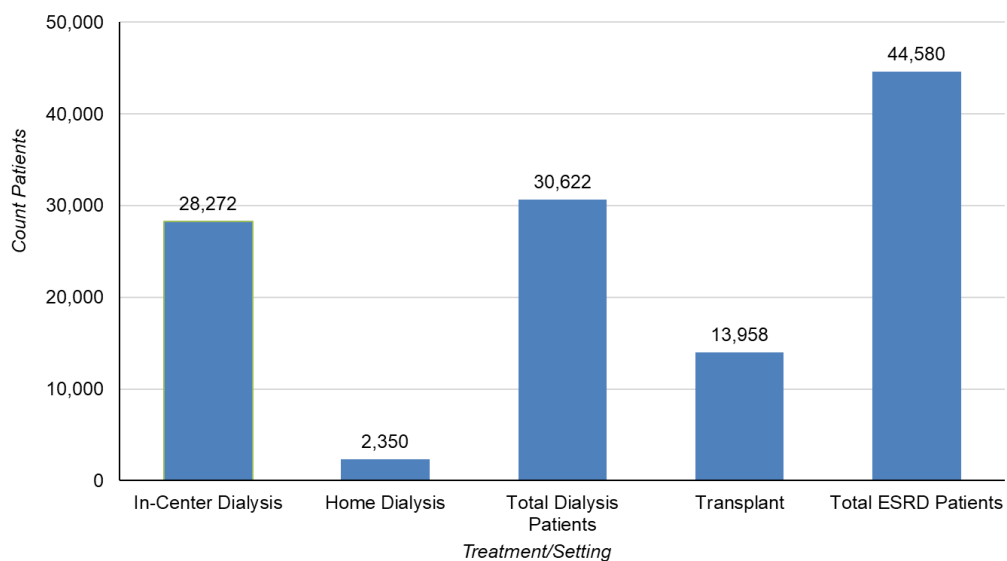
According to US Census Bureau estimates for 2019 New York State's population was 69.6% White, 17.7% African American, 9.1% Asian, 1.0% American Indian and Alaska Native, and 0.1% Native Hawaiian; 2.5% of the population identified with two or more races. The Hispanic or Latino population of the state was approximately 29.1% in 2019, according to the same source.

The Network's activities supported the more than 30,000 hemodialysis patients reported as receiving dialysis treatment for ESRD in the Network area as of December 2019. Almost 14,000 patients in the Network's service area received kidney transplantation in 2019. In New York State, renal patients were served by 325 Medicare certified dialysis facilities, 13 transplant centers, and six Veterans Affairs (VA) hospitals.

In 2019, the Network worked in collaboration with its Network Council, Medical Review Board, Patient Advisory Committee, Grievance Committee, Education 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 friends, nephrologists, dialysis facilities, patient advocacy organizations, and other ESRD stakeholders to improve the quality of care provided to ESRD patients in New York State.

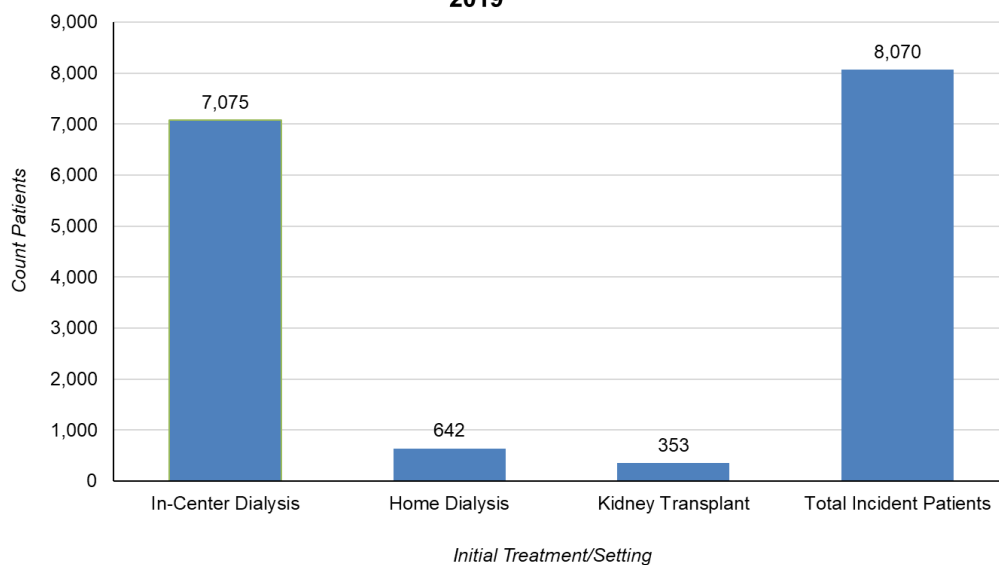
The Network deployed focused interventions that targeted patients, dialysis staff, transplant programs, and other renal community stakeholders. These interventions, which focused on engaging patients, reducing disparities, and improving quality of life for ESRD patients are detailed in this report.

**Network 02: Count of Prevalent ESRD Patients by Treatment/Setting
2019**



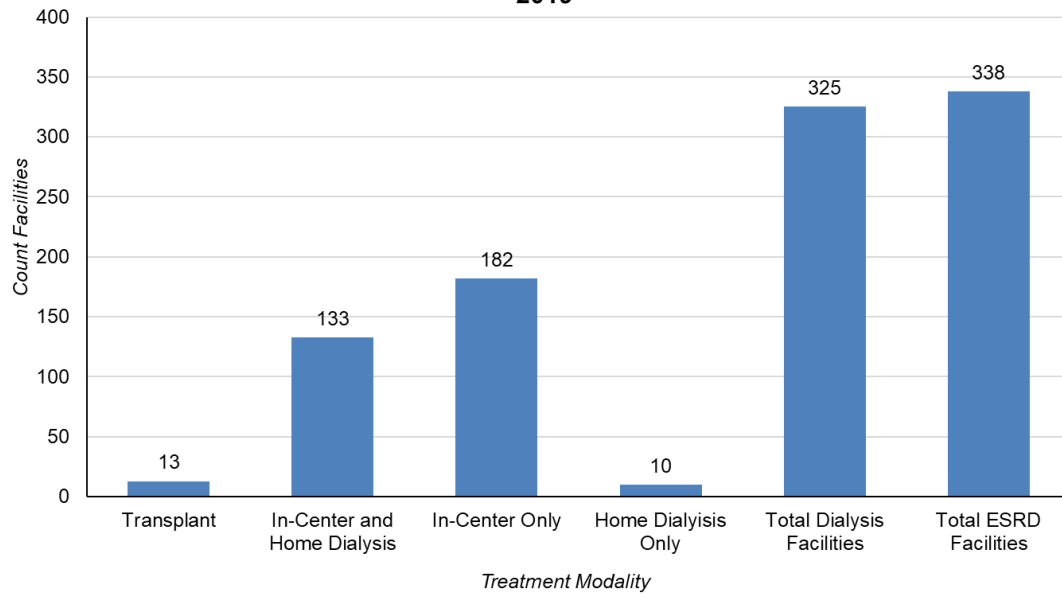
Total Dialysis Patients = In-Center Dialysis + Home Dialysis
 Total ESRD Patients = Transplant + Total Dialysis
 SNF dialysis patients are not shown due to small numbers.
 Source of data: CROWNWeb May 2020

**Network 02: Count of Incident ESRD Patients by
Initial Treatment/Setting
2019**



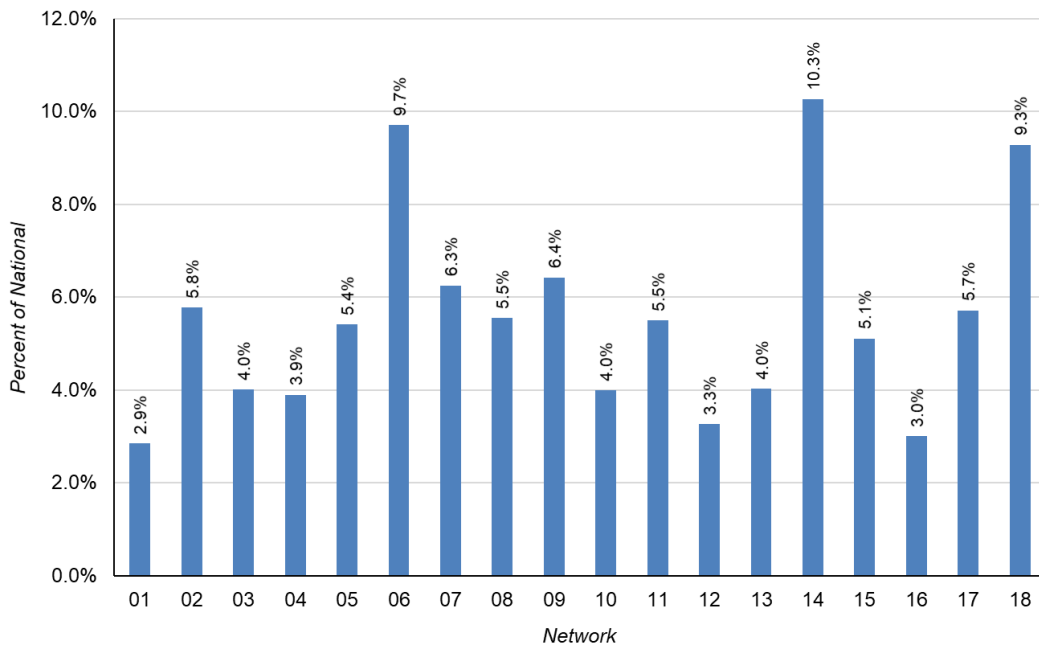
Total Incident Patients = In-Center + Home + Kidney Transplant
 Source of data: CROWNWeb May 2020

**Network 02: Count of Medicare-Certified Facilities
by Treatment/Setting
2019**



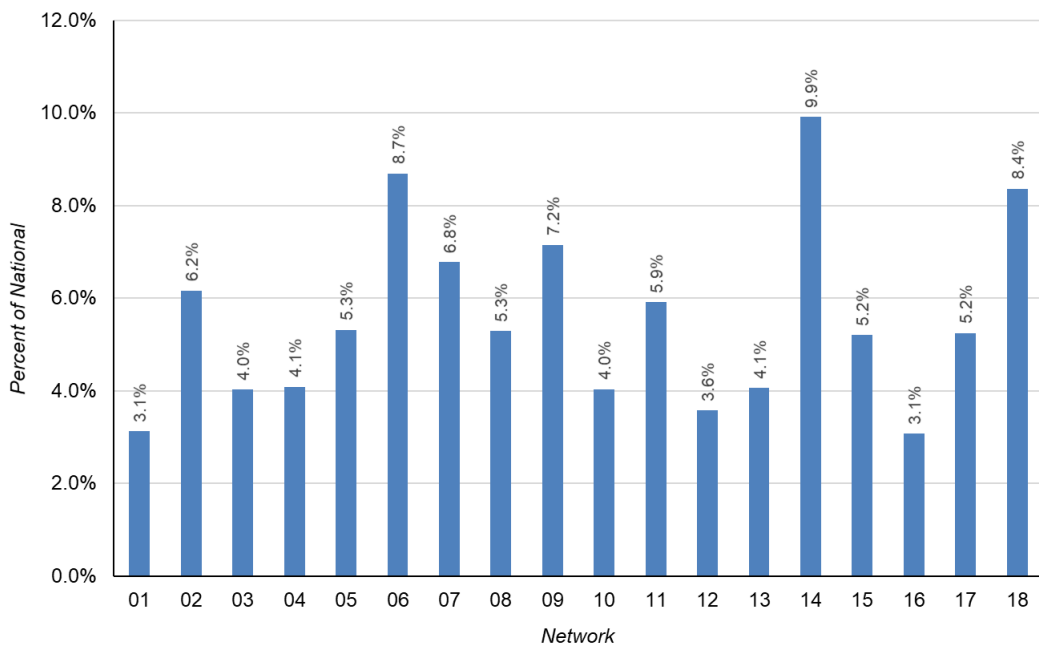
Total Dialysis Facilities = In-Center and Home Dialysis + Home Dialysis only + In-Center Only
 Total ESRD Facilities = Transplant + Total Dialysis Facilities
 Source of data: CROWNWeb May 2020

**Percent of National Prevalent Dialysis Patients by ESRD Network
2019**

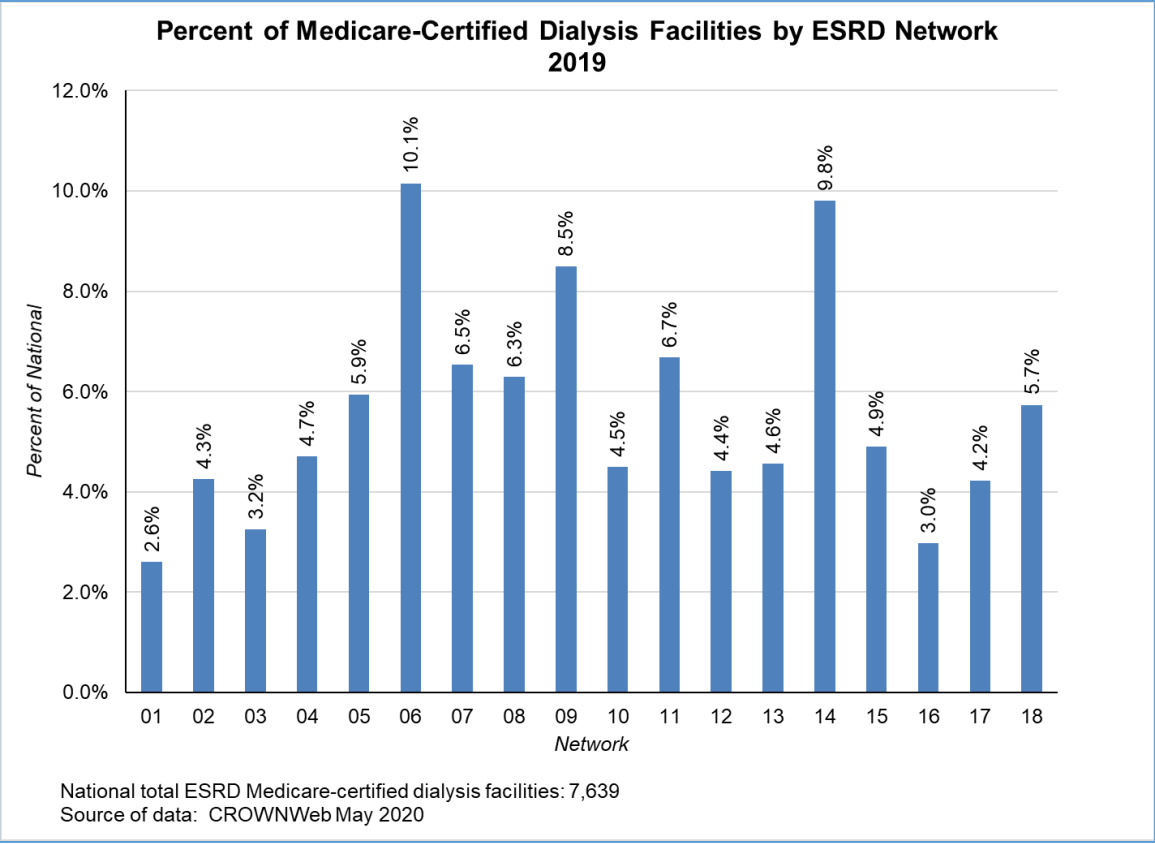


National total dialysis patients: 530,094
Source of data: CROWNWeb May 2020

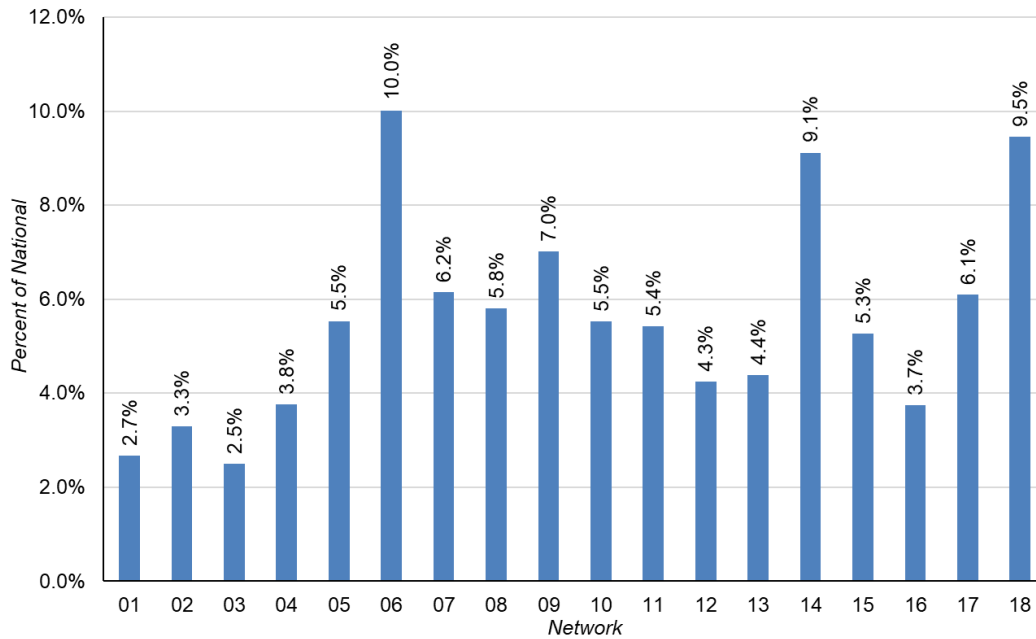
**Percent of National Incident Dialysis Patients by ESRD Network
2019**



National total incident patients: 130,916
Source of data: CROWNWeb May 2020

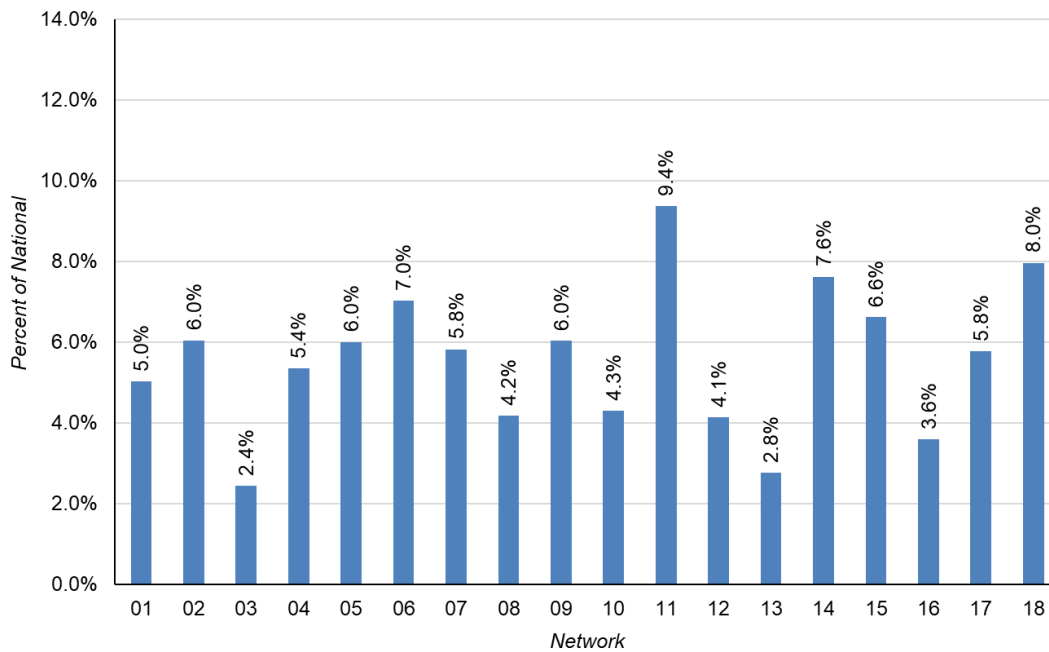


Percent of National Home Hemodialysis and Peritoneal Dialysis Patients by ESRD Network 2019



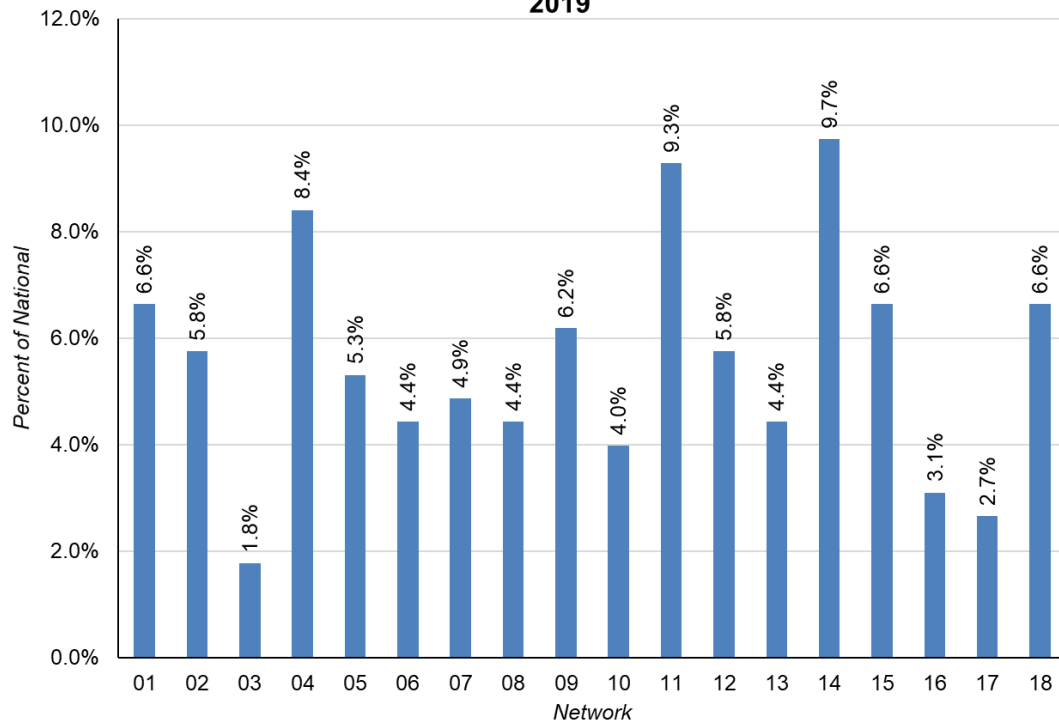
National total home hemodialysis and peritoneal dialysis patients: 71,291
Source of data: CROWNWeb May 2020

Percent of National Transplant Patients by ESRD Network 2019



National total transplant patients: 230,931
Source of data: CROWNWeb May 2020

**Percent of Medicare-Certified Kidney Transplant Facilities by
ESRD Network
2019**



National total ESRD Medicare-certified kidney transplant facilities: 226
Source of data: CROWNWeb May 2020



ESRD NETWORK GRIEVANCE AND ACCESS TO CARE DATA

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.

Grievances

In 2019 the Network addressed 32 reported patient grievance cases (26 Immediate Advocacy, five Quality of Care Grievance, and one General Grievance). A review of the grievance cases from this time period reveals that treatment-related concerns regarding the delivery of care (15), and staff-related concerns (11) were the most common reasons for grievances, with the remaining concerns related to physical environment (six).

With each of these cases, the Network advocated for the patient, promoting the patient’s right to participate in his or her healthcare, to have a voice in the services provided by the facility. The Network mediated cases regarding patients’ concerns with the facility Interventions were developed and implemented to provide facility staff with guidance on communication techniques that would better their patients’ care. In many cases, the Network discussed with facility staff

- The importance of establishing professional boundaries with patients.
- The value of patient centered care, reminding staff that what matters to the patient is important to understand how to best assist in his or her care.
- The importance of identifying patients’ barriers that might limit their ability to care for themselves. (e.g., mental health unmet needs, lack of housing, immigration, lack of health insurance). This assists staff in establishing goals that will be meaningful and helpful for each patient.

In addition, the Network provided the following resources to facilities:

- The *Dialysis Patient Grievance Toolkit* created by the Kidney Patient Advisory Council (KPAC) of the Forum of ESRD Networks includes 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.
- A poster and flyers that outline clearly defined parameters of the support that the Network could provide, as well a clear understanding of the types of support that the Network could not provide.

Access to Care

The Network responds to grievances filed by or on behalf of ESRD patients throughout New York State. This often involves working with individual facilities to identify and address difficulties in placing or maintaining patients in treatment. Access to care cases include those involving involuntary discharges, involuntary transfers, and failures to place. An involuntary discharge is initiated by the treating dialysis facility without the patient’s agreement. An involuntary transfer occurs when the facility temporarily or permanently closes (i.e. due to a merger, an emergency, a disaster situation, or other circumstance) and the patient is dissatisfied with the transfer to another facility. A failure to place occurs when no outpatient dialysis facility can be located that will accept an ESRD patient for routine dialysis treatment. In these cases, the Network assists facility staff and patients through advocacy and education and by promoting patient-centered care.

The Network averted 58 (28 in 2018) involuntary discharges through monthly check-ins with the facility. These check-ins promoted best practices, including:

- Provider education about the rights of patients and the role of the facility.
- Inclusion of family members in all meetings with the patient.
- Clear communication to the patient related to the facility's concerns and risk of involuntary discharge.
- Formation of a treatment plan to support the patient's identified barriers. (e.g. mental health unmet needs, lack of housing, immigration, lack of health insurance)
- Education of patients on the concept of boundaries, to assist in reducing conflict.
- Information about the availability of mobile crisis resources: interdisciplinary psychiatric teams that support patients in the community who have high-risk mental health needs, along with encouraging facility staff to partner with other organizations that could assist facility staff in supporting patients with mental healthcare needs.

Access to Care: Involuntary Discharges

The Network received 27 cases of involuntary discharges. In most of the reported cases the discharge was immediate due to a severe threat (18) followed by ongoing disruptive behavior (six), facility cannot meet the medical needs of the patient (two), and non-payment (one). The Network worked closely with each facility to ensure that staff provided the required care after discharge.

Access to Care: At Risk for Involuntary Discharges

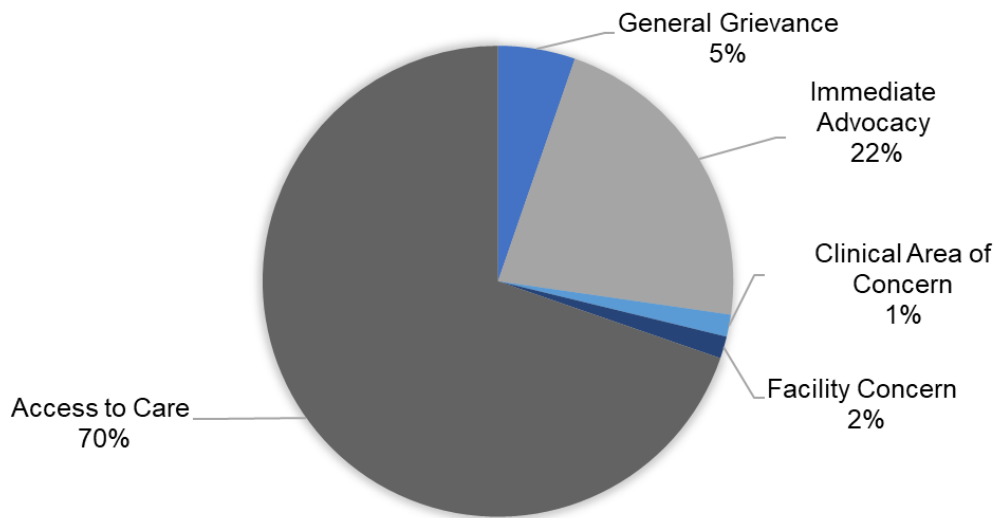
Behavioral concerns (43) was the most common reason for a patient to become at risk for involuntary discharged, followed by non-payment of services (six), Facility unable to meet the medical needs of the patient (five), and Immediate Severe Threat (four). The Network also encouraged facility staff members to continue supporting the patient even after discharge, by aiding in the referral to new facilities and by assisting hospitals that were working to identify a new placement for the patient.

The Network provided education to hospital discharge planners to help them support patients who were involuntarily discharged. This included information on possible solutions to finding placement, dialysis facility resources, and information of the 30-day Trial Program. This program allows facilities to treat a patient for 30 days with the permission of the NYS Department of Health. At the end of the 30-day period, the facility will either accept the patient on a permanent basis or request an additional 30 days. The maximum amount of time that can be given is 90 days, at which time the facility will need to decide if they will accept the patient permanently.

The Network guided facilities in reviewing practices they currently follow to support patients and, when appropriate, recommended new approaches. Network recommendations focused on involving patients and their families in their care from the moment of admission. The Network advised facilities to pay particular attention to patients who isolate themselves and to those who do not have significant support in their lives, with a goal to find ways to provide these patients with additional support.

An analysis of the cases from December 2018 to November 2019 indicated that of the total 117 cases reviewed by the Network (Grievance and Access to Care) 85 occurred in the state's downstate area (NYC and Long Island), while the remaining 32 cases occurred in the upstate regions. The areas with the most cases were the Bronx (19 cases), Brooklyn (18 cases) and Manhattan (16 cases).

Network 02: Percent of 2019 Grievances and Non-Grievances by Case Type



Source of data: Patient Contact Utility (PCU) accessed November 2019



ESRD NETWORK QUALITY IMPROVEMENT ACTIVITY DATA

Long Term Catheter Quality Improvement Activity (LTC QIA)

Project Overview

A major focus of the Network's work in 2019 was reducing the use of long term catheters in ESRD patients. Network staff worked with target facilities to identify knowledge gaps, increase accurate reporting of central venous catheters (CVC), and improve communication with vascular surgeons across the state.

Individuals who continuously utilize central venous catheters to undergo hemodialysis are at increased risk of developing infections due to the repeated need to access their blood, and the positioning of the catheter close to their heart. The Network continues to emphasize to both patients and professionals that catheters for ESRD patients should be a temporary solution. An approach to the reduction of the infection risks created by long-term use of central venous catheters, is exploration of placement of permanent accesses through the removal of long-term catheters (>90days).

Targeted Facilities

The Network identified 42 facilities to participate in the LTC reduction QIA. Each of these facilities had an LTC rate greater than 15%, as reported by the ESRD NCC for the period January – June 2019. Identified facilities were selected from the top 50% of facilities in the Network's service area with the highest rates of bloodstream infections. LTC rates in identified facilities ranged from 15.00% to 35.59%.

Goals and Outcomes

The Network focused on reducing use of LTCs, with a goal to achieve a two percentage point decrease in the LTC rates in the targeted dialysis facilities from 20% in June 2018 to re-measurement in June 2019. The Network did not meet the 18% goal target, but efforts resulted in the reduction of the LTC rate in targeted facilities to 18.3%.

Interventions

The Network developed an intervention plan based on facility-identified barriers revealed through a formal root cause analysis (RCA). Common barriers identified as root causes included: patient comorbidities, patient missed appointments/lack of follow-up, patient refusal to consider arteriovenous fistula (AVF) or arteriovenous graft (AVG) placement, delayed surgical appointments, and lack of adequate access to vascular surgeons. The findings from the RCA guided the following Network interventions.

- The Network worked with targeted facilities to develop individualized corrective action plans (CAP) to support facilities in implementing action steps that would address their barriers.
- The Network conducted 1:1 facility performance coaching calls to focus on progress, facility performance, barriers and solutions, and to offer support throughout the QIA.
- The Network created and introduced to facilities the *Vascular Access Incident Report*, which provides the nephrologist and facility a review of patients' accesses at the start of outpatient dialysis and which patients received pre-ESRD care.
- Facilities implemented a Network-developed monthly *Vascular Access Placement: Patient Tracking Tool* to follow the progress of patients' vascular access planning and to review any barriers that may be causing delays in appointments. The tracking tool also assisted in guiding catheter reduction activities and status in QAPI discussions.
- Facilities received monthly performance metric reports that included national and regional AVF goals and the facility's progress toward the QIA LTC goal. These Network-

developed data feedback reports allowed the facility to monitor outcomes, trends and, if necessary, to identify barriers that impeded progress toward the project end-goal.

- Facilities received resources and guidance to support them in establishing a peer mentorship program specific to vascular access. The peer mentorship program is designed to facilitate the sharing of information among patients about the benefits of a permanent access vs an LTC. The toolkit included a poster outlining the pros and cons of the different types of vascular access, a *Questions and Concerns about Permanent Accesses* booklet, and the *Lifeline for a Lifetime – Planning for Your Vascular Access* guide.
- The Network distributed the *Vascular Access Planning for Professionals* guide to facilities as a way to assist patients with navigating the “8 Steps to Catheter Freedom,” including supporting patients with scheduling appointments and preparing for surgery.
- Facilities hosted lobby days during which patients promoted educational information about vascular access options to other patients. Peer mentors provided information and success stories about the benefits of an internal vascular access.
- The Network encouraged patient engagement and participation in facility QAPI meetings, lobby days, and peer education.

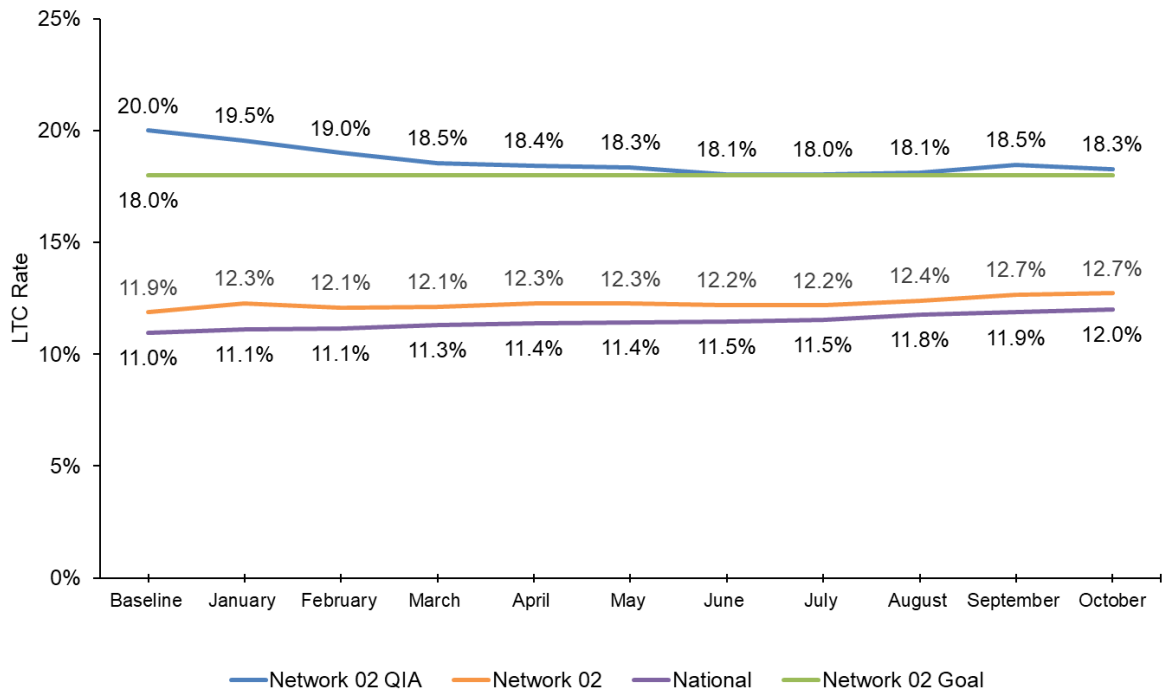
Barriers to achieving goals

- Patients discharged to outpatient facilities from the acute setting with a catheter and no scheduled follow up appointment with a vascular surgeon as part of their care plan.
- Limited access to and availability of vascular access surgeons specializing in dialysis care access placement.
- Delays in care coordination and timelines for patients getting appointments with interventional radiologists and surgeons.
- Lack of commitment and patient follow-up with appointments once referrals are made to vascular surgery centers.
- Surgical challenges with permanent access placement in a vulnerable population of patients identified as high-risk with multiple co-morbidities.
- Patient fears and/or refusal of permanent access placement.

Best practices spread to achieve goals

- Assignment of a dedicated staff member (Vascular Access Coordinator) to serve as an *Access Ambassador* to champion Network interventions. This role included: educating staff members and patients, monitoring patients’ progress toward permanent access placement, and documenting timely removal of LTCs.
- Collaboration between facility leadership and the facility’s most frequent referring hospital, vascular access surgeons, and interventional radiologists to achieve improvement in timelines for access placement prior to discharge and/or schedule access appointments prior to patient discharge.
- Frequent communication between facilities and vascular access centers, supporting coordination of regular meetings to discuss all patients with CVCs and recurring issues or barriers at the facility-level.

Network 02: Long-Term Catheter Rates January 2019 - October 2019



QIA: Quality Improvement Activity

Source of data: ESRD NCC 2019 Dashboard accessed October 2019

Bloodstream Infection Quality Improvement Activity

Project Overview

The Network supports the CMS national initiative to reduce the rate of bloodstream infection (BSI) by 50% over the next five years. Hemodialysis patients are at higher risk than the general population for acquiring healthcare associated infections (HAIs) and specifically bloodstream infections (BSIs), due to the regular and frequent use of catheters and other forms of access to their bloodstream while dialyzing. The BSI QIA is designed to increase facility use of the *Nine CDC Core Interventions* in support of the reduction of bloodstream infections.

Targeted Facilities

The Network identified 156 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, 2019). The Network worked intensively with the top 20% cohort of 62 facilities with the highest rates of infection in the Network's service area; ranging from -2.90 to 7.88 per 100 patient months. The Network also worked with facilities in the 50% cohort to support their efforts to join a Health Information Exchange (HIE) or another evidence-based, effective information transfer system to bridge communication gaps that often exist between the dialysis facility and hospital or physician's office.

Goals and Outcomes

The goals of the BSI QIA were to increase awareness and reporting of BSIs as well as achieve a 20% relative reduction in the pooled mean BSI rate in 20% of facilities in the Network's service area. 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 Centers 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 2018, with the re-measure period being the semi-annual quarterly pooled mean BSI rate for January to June 2019.

The Network's interventions succeeded in achieving a significant decrease in the pooled mean BSI rate from 1.11% at baseline to 0.70%, at re-measurement, exceeding the targeted goal of 0.89% and achieving an overall 36.85% relative reduction. Of the facilities in the 50% cohort, the Network support resulted in 38.5% joining an HIE, exceeding the 20% enrollment goal; 83.3% using all nine *CDC Core Interventions*; and exceeding the 90% completion goal with a rate of 97.5% target facilities completing NHSN Dialysis Event Surveillance Training.

Interventions

To help identify best practices, challenges, barriers and areas for improvement, the Network implemented a *Knowledge and Practice Assessment* as part of the root cause analysis tool for identified facilities. The information from the RCA guided the selection of interventions and educational webinar topics for this project.

- Distribution of the CDC-created poster: *Core Interventions for Dialysis BSI Prevention*; to support facilities in the use of the CDC Core interventions as part of a targeted approach to prevent BSIs. The Network provided staff training and education on infection prevention using the *CDC – Infection Prevention in Dialysis Setting Training Course for Outpatient Hemodialysis Healthcare Workers*.
- Distribution of CDC developed educational materials and resources for staff and patients, consisting of: *CDC Conversation Starter*, *Clean Hands Count* for patients and providers and

CDC audits and checklists for practice observations.

- Identification of an Infection Control Coach and Patient Prevention Champion to facilitate staff/patient education, and conduct audits with the CDC recommended audit tools and provide real time feedback and support on infection prevention behavior.
- Facility leadership engagement was achieved by establishing virtual collaborative meetings with facilities that showed low and high performance in order to spread best practices and mitigate barriers.
- Root cause analysis (RCA) was conducted for every identified BSI during the project period, with findings discussed during Quality Assessment Performance Improvement (QAPI) meetings.
- Distribution to facilities of bi-monthly performance metric reports. These Network- developed data feedback reports allowed facilities to monitor outcomes, trends and, if necessary, to identify barriers that impeded progress toward the project end-goal.
- The Network worked with those responsible for infection prevention/control monitoring at the facility to ensure that the yearly training about BSI reporting was completed and entered in NHSN.
- Facility staff were encouraged to attend to the ESRD National Coordinating Center HAI Learning and Action Network (LAN) meetings with stakeholders and other dialysis facilities. Meetings featured experts in the area of BSI/LTC reduction.
- Facility staff and patients worked together to host facility lobby days focused on infection prevention and control practices.

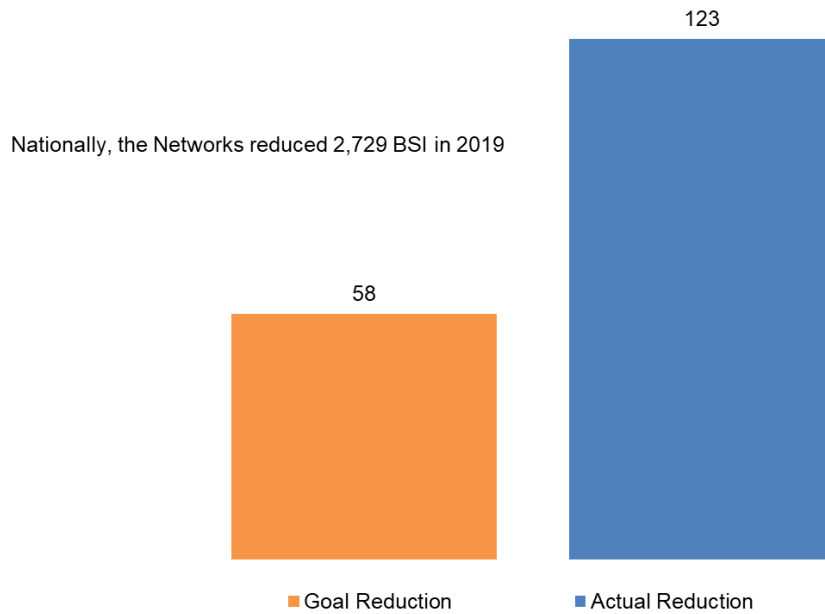
Barriers to achieving goals

- A large number of patients coming from hospitals were admitted with a catheter to dialysis facilities causing a higher risk of BSI. The inability to control and monitor patient hygiene outside of the dialysis facility sometimes resulted in the spread of infection.
- Incomplete implementation of the nine CDC Core interventions; specifically omitting the intervention regarding use of antimicrobial ointment. Over 70% of facilities reported that they did not use antimicrobial ointment.
- Staff missed opportunities to discuss/demonstrate hand hygiene techniques with patients.
- Patients not performing hand hygiene when entering and exiting unit or while outside of the unit.
- Lack of communication between staff at skilled nursing facilities and dialysis facilities.

Best practices spread to achieve goals

- Network interventions promoted the implementation of an Infection Control Coach to champion interventions and conduct audits with the CDC recommended audit tools and provide real time feedback and support to staff and patients in infection prevention behavior.
- When barriers or areas for improvement were identified through the Plan-Do-Study-Act (PDSA) cycle, the Network implemented interventions for the following month that addressed issues identified in the facility-conducted RCA.
- To support achievement of BSI reduction goals, the Network promoted use of patient success stories and CDC Core intervention resources, which included an educational poster and accompanying resources focused on nine components to prevent infections in a dialysis setting.
- 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 for each facility's performance and one-to-one coaching for low performing facilities.
- Data transparency across the Network, dialysis facility staff and State Surveyor Agency was achieved through monthly distribution of the *BSI Progress Report/Achievement Level Report* to facilities, indicating the progress toward BSI reduction goals as well as facility participation in interventions. In addition, starting in 2019, these data were provided to state surveyors for reference during their onsite facility visits.

Network 02: Reduction in Bloodstream Infections (BSI) in QIA Facilities

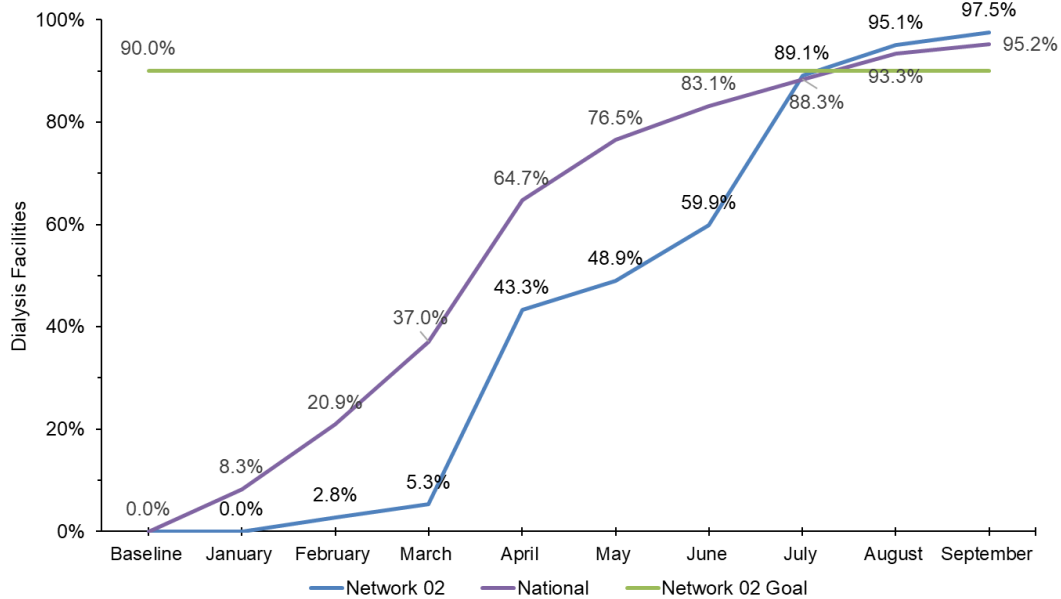


The Network goal was to decrease the rate of BSI by 20% or greater relative reduction in the pooled semi-annual mean in facilities participating in the QIA

QIA: Quality Improvement Activity

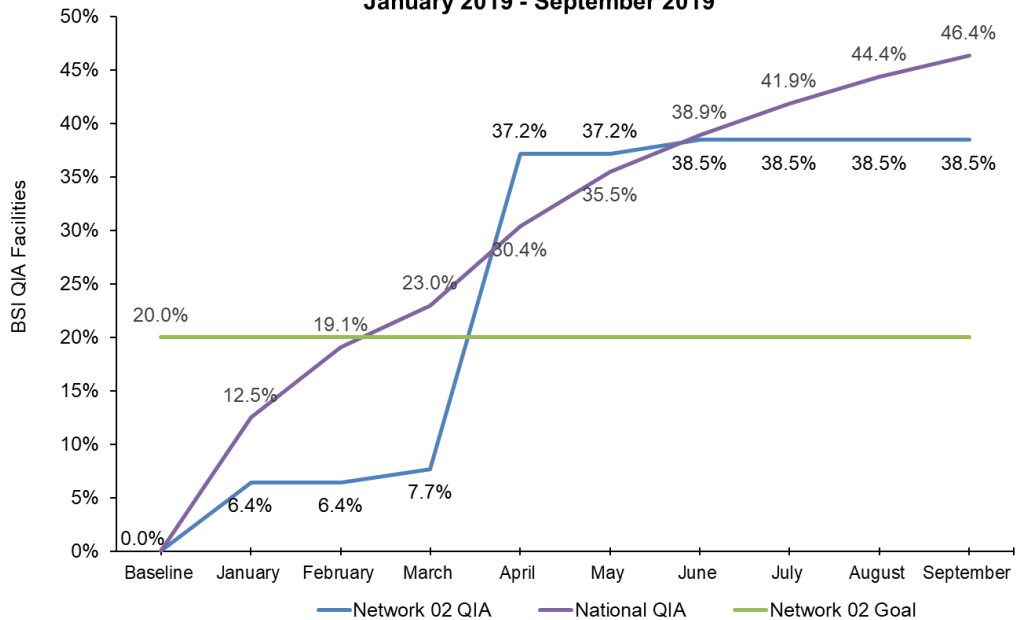
Source of data: National Healthcare Safety Network (NHSN) January 2019 - June 2019 compared to January 2018 - June 2018

Network 02: Percent of Dialysis Facilities with At Least One Person Who Has Completed the NHDN Dialysis Event Surveillance Training
January 2019 - September 2019



Source of data: ESRD NCC 2019 Dashboard accessed October 2019

Network 02: Percent of BSI QIA Facilities with a Health Information Exchange or Evidence-Based Highly Effective Information Transfer System
January 2019 - September 2019



QIA: Quality Improvement Activity

BSI: Bloodstream Infection

Source of data: ESRD NCC 2019 Dashboard accessed October 2019

Transplant Waitlist Quality Improvement Activity

Project Overview

Despite ongoing education about the benefits of transplantation and transplant referrals being a CMS Conditions of Coverage (CfC) requirement for dialysis facilities, barriers to the referral to transplant of interested patients still exist. In 2019, Network staff designed a quality improvement activity to increase the number of dialysis patients pursuing transplant as a treatment option, by supporting and tracking their progress through the transplant workup process toward a living donor transplant or through steps they are taking to be listed with UNOS for a deceased donor transplant.

In 2019, Network staff partnered with the New York Center for Kidney Transplantation (NYKidney), a transplant focused stakeholder dedicated to enhancing the quality of kidney transplant services. The partnership focused on addressing communication breakdowns between dialysis facilities and transplant centers. In addition, through an innovative, multi-agency collaboration with NYKidney-created Project ECHO Monthly e-University, staff from NYKidney the Network, Lawyers for Public Interest Law, and transplant centers worked together to find ways to assist patients who otherwise were unable to consider transplant.

During the nine month QIA performance period, Network staff worked with other Networks, the ESRD NCC and stakeholders to provide participating facilities with educational webinars to support sharing of best practice models, educational articles, resources, and recommendations for interventions.

The goal of this project was to streamline the transplant referral and wait listing process by

- Bridging the communication, information and resource gaps between dialysis facility providers and transplant center care settings; and
- Overcoming known variables in the transplant coordination process (e.g., patient health status, patient eligibility, varying referral options by transplant facility, transplant center program criteria, and availability of donors).

Targeted Facilities

Network staff worked with 93 facilities (30%) that had the lowest UNOS waitlist rates in the Network's service area. This resulted in a challenging landscape comprising skilled nursing facilities, hospital based programs, and facilities treating patients with significant socio-economic challenges (undocumented and under insured patients, patients with multiple comorbidities, and many patients who had returned to dialysis after having a failed transplant).

Goals and Outcomes

The Network was able to achieve a 2.80 percentage point improvement in the natural trend of UNOS listings at the 93 targeted facilities. The Network attained a significant improvement of 83% (231/278) in the number of patients on the transplant waitlist in the targeted 30% of facilities in the QIA, but this improvement did not meet the CMS goal of a two percentage point improvement over the natural trend (278 patients listed with UNOS by 9/30/2019). Overall, the facilities in the QIA project finished 5th nationally in the overall ESRD Network Program.

Improvement was achieved through patient and staff education, and action-oriented interventions that facilitated practice changes or process improvements including promoting facility partnerships with transplant stakeholders to broaden their resources for transplant education at the facility level. These engagement efforts to improve communication and coordination between dialysis facilities and transplant center programs, led to the availability of additional resources and options to help patients and their family members better understand and begin the transplant process.

Interventions

The following interventions and facility self-assessment tools were found to help increase transplant referrals, wait listing, and ultimately patient opportunity to achieve transplantation, resulting in 67/93 (72%) facilities demonstrating progress in the QIA.

The most common and successful facility-level interventions included: Engaging patients (both pre- and post-transplant) through educational events and lobby days within the facilities; partnering with transplant facilities NOT in the Network service area, to bring in a fresh new perspective to staff and patients; Utilizing Project ECHO for case review with transplant centers; creating excitement in the facility through lobby days and creation of engaging displays that promoted the different treatment options available to patients; and engaging with family members to discuss living donation.

The Network provided support in developing a visual display/resource area dedicated to transplant education. The Transplant “Education Station” intervention culminated with a QIA Education Station photo contest that drew 93 facility entries and resulted in selection of 15 contest finalists. By improving the transplant referral process, and providing tools to monitor and assist patients as they took the steps to transplant, and in some cases multi listing with transplant facilities outside of the Network service area, facility staff and patients were better equipped to make informed choices, and streamline the transplant work up process.

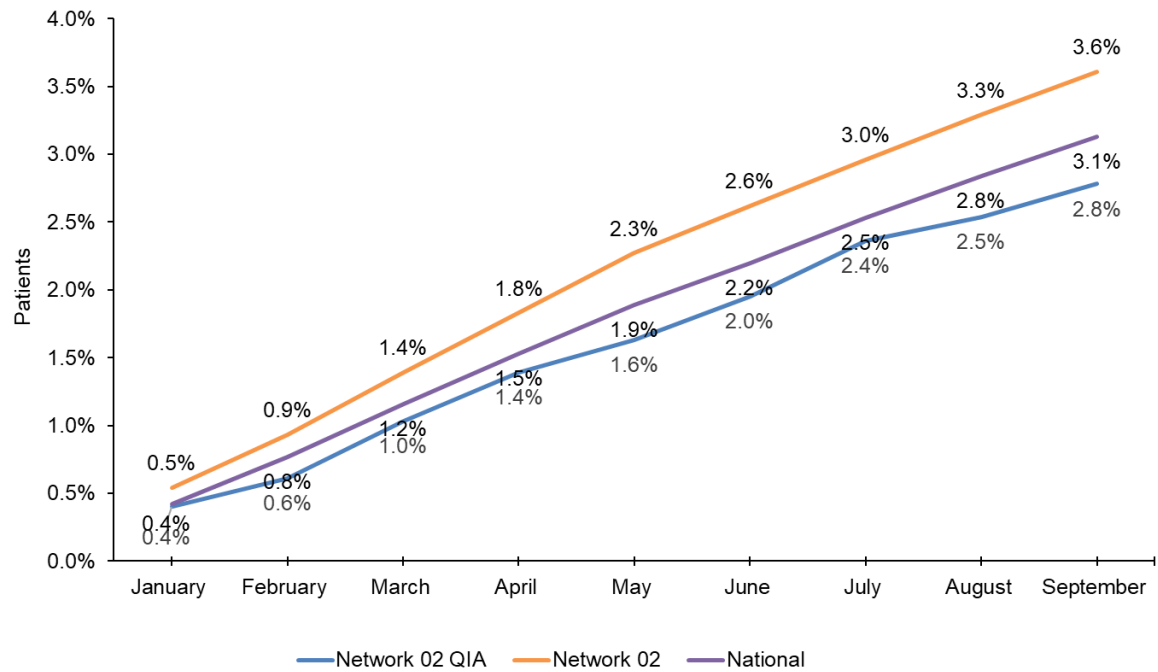
Barriers to achieving goals

- Patient fears and misconceptions about the transplant process and waitlist timeframes.
- Patients being overwhelmed by the number of appointments required to complete the transplant evaluation process, as well as post-transplant care and medications.
- Lack of communication between the dialysis facilities and the transplant centers.
- Patients and dialysis facilities losing track of where patients are in the work up process.
- Medical and non-medical contraindications, financial and insurance issues, along with patient noncompliance and/or lack of follow through with transplant related appointments and other requirements were also identified as strong barriers to transplant by QIA facilities.

Best practices spread to achieve goals

- Having dialysis facilities develop working relationships with a transplant center was vital to ensuring involvement of transplant facility staff in providing patient education at the dialysis facility level.
- Developing a process for facilities to order printed materials from the Network for distribution to patients significantly contributed to promoting transplant as a treatment option. By utilizing the Network’s Transplant Center Guide; the most widely requested Network tool in 2019, facilities were able to provide patients, family members, care partners and provider staff information that was readily available in all settings (at the facility, at home and at doctors’ offices – to encourage better communication between provider staff and patients.)
- Regular (monthly) monitoring of patient transplant status: Facility staff were able to reconcile patient level UNOS data for the first time; and this improved communication between dialysis facilities and transplant centers, sparking collaborative conversations on overcoming barriers to transplant.

Network 02: Percent of Patients Added to the Transplant Waitlist January 2019 - September 2019



QIA: Quality Improvement Activity

Source of data: ESRD NCC 2019 Dashboard accessed October 2019

Home Therapy Quality Improvement Activity

Project Overview

A diagnosis of ESRD requires life-sustaining kidney replacement therapy. Patients with ESRD have several treatment options, including in-center hemodialysis, home hemodialysis, peritoneal dialysis or transplantation. Home dialysis (hemodialysis or peritoneal dialysis) offers several benefits for the patient, including improved patient outcomes, increased quality of life, flexible treatment schedules, reduced costs associated with travel to the dialysis unit, and a feeling of being in control. Despite these benefits, home dialysis continues to be underutilized.

According to the CMS ESRD CfCs, dialysis practitioners are responsible for educating their patients about treatment modalities. In addition, the CfCs state that a patient must have an "evaluation of the preferred modality," which means that all modality options (hemodialysis, peritoneal dialysis) and settings (in-center, home) must be presented to each patient and that the patient's goals, preferences, and expectations are given priority in decision-making. The patient's plan of care must incorporate the interdisciplinary team's evaluation of the patient's suitability for home dialysis.

Targeted Facilities

An evaluation of performance data for facilities participating in the Network's home therapy QIA in 2018 identified 53.26% of those facilities for participation in the 2019 QIA due to underperformance. Additional facilities were targeted based on their low home therapies utilization rates, resulting in 30% (93) Network service area facilities targeted for QIA activities.

Goals and Outcomes

Network 2 attained a 74% (257/349) improvement in the number of patients in training for a home modality in the targeted 30% of facilities in the QIA. This improvement fell short by 92 patients, and did not meet the CMS goal of a two percentage point increase (349 patients) in the natural trend of patients utilizing home therapies by 9/30/2019.

Interventions

As with all QIAs, the Network launched the Home Therapies QIA with an initial activity – a facility level root cause analysis conducted to establish facility level awareness of unique barriers to home therapies utilization. After identifying barriers, facilities were asked to utilize interventions to overcome barriers using Plan, Do, Study, Act methodology. Through the nine month QIA performance period, the Network implemented the following interventions:

- Patient Knowledge "Conversation Starter" Assessment;
 - Facility staff and patients were asked if they could name four treatment options for ESRD – prompting a conversation about different treatment options.
- Virtual and on-site visits by the Network team to educate staff and talk to patients in facilities that did not demonstrate improvement during the project period;
 - These visits resulted in a deep review of patient level data and individual barrier review which led to a better understanding of facility and patient needs.
- Home Therapies Champions launched to engage patients at the facility level. Utilizing trained staff Champions and Patient Peer Champions.
 - Home Therapies Champions served as leaders in all facility events and educational activities. In addition to leading activities, Champions also worked to create education stations and visual displays to highlight treatment options available to patients.
- Collaboration with patient Subject Matter Experts (SMEs), the ESRD NCC Home Dialysis Learning and Action Network (LAN), stakeholders, the State Survey Agency, LDO management, independent providers and local and national patient groups;

- These collaborations led to better Network processes for distributing educational materials, facility staff presentations on National LAN webinars, and sharing patient success stories with facilities across the Network service area.
- Support was provided to facilities as they were asked to develop a dedicated visual display/resource area, the Home Therapies “Education Station,” This intervention culminated with a multi-QIA Education Station photo contest that drew 93 entries and resulted in 15 finalists.

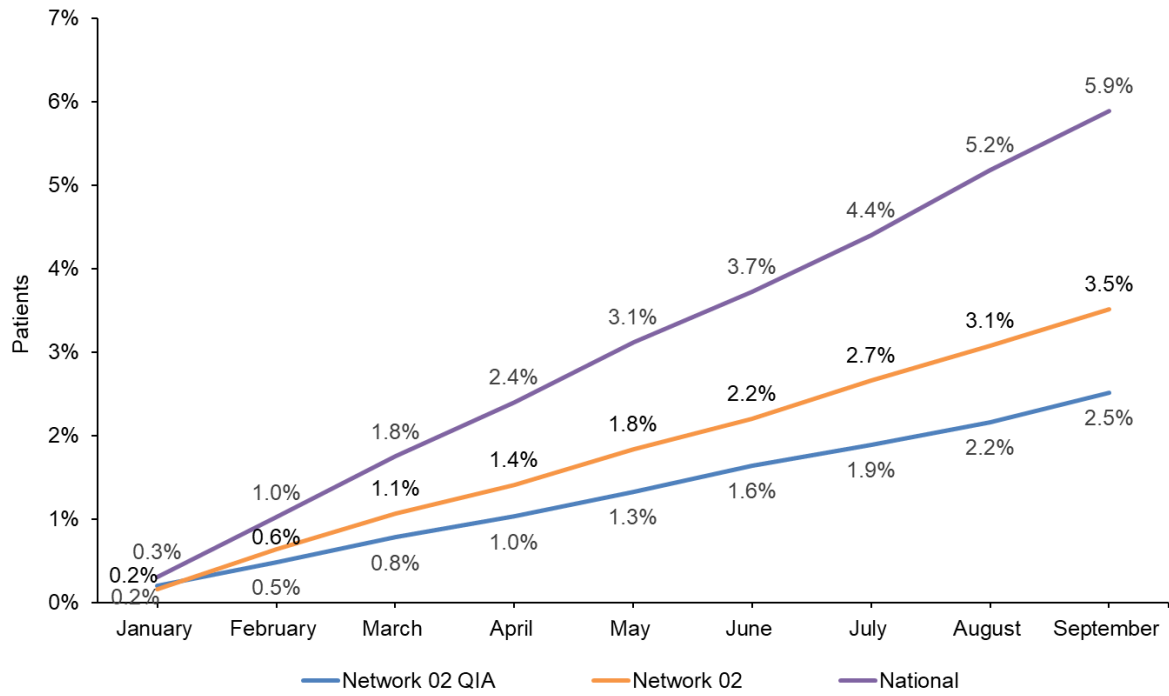
Barriers to achieving goals

- A consistent barrier among targeted facilities was that patients chose to stay in-center because they were comfortable and didn’t want to change modalities.
- Some facilities identified that lack of referrals to home was a barrier, as physicians were not comfortable with promoting or managing patients on a home therapy.
- Through regional collaborative calls, the Network identified that there was a lack of access to home training programs in rural areas.

Best practices spread to achieve goals

- ESRD NCC LAN Webinars offering continuing education: These webinars were invaluable to the community (as evidenced by facility staff members rating the effectiveness of this intervention >90% successful impact) and provided information, resources and the opportunity for peer-to peer motivation as well as encouragement for dialysis facility staff.
- Creation of treatment options education display boards and the hosting of lobby day activities increased awareness by patients and their family members and generated interest and referrals to home modalities.
- Utilizing Patient Home Therapies Champions to educate and share interventional resources with staff and patients about home modality options.
- Facility virtual site visits (Network staff used WebEx technology to meet with facility staff and patient representatives to discuss QIA requirements, activities, reporting and trends towards goals).
- The Network’s educational toolkit (a collection of posters, pamphlets and flyers to promote home therapies) scored a >90% success rating by targeted QIA facilities.

Network 02: Percent of Patients Starting Home Dialysis January 2019 - September 2019



QIA: Quality Improvement Activity

Source of data: ESRD NCC 2019 Dashboard accessed October 2019

Population Health Focus Pilot Project Quality Improvement Activity

Project Overview

The goal of this QIA project was to assist ESRD patients with seeking gainful employment and/or returning to work. The Network worked with 10% of the dialysis facilities in its service area to help increase utilization of the services provided by the New York Adult Career and Continuing Education Services: Vocational Rehabilitation (ACCES-VR) agency and employment networks (ENs).

Targeted Facilities

Thirty-three facilities in the Network's service area were selected to participate in the QIA. Although all patients were encouraged to participate in activities geared toward employment, education and hobbies to enhance quality of life, patients between the ages of 18 and 54 were targeted for referral to VR and EN agencies.

Goals and Outcomes

The goals of the QIA were to achieve the following results from the baseline period (October 2017 through June 2018) to re-measurement (September 30, 2019):

- Achieve a 10 percentage point increase in the number of patients referred to an EN or VR agency.
- Achieve a five percentage point increase in the number of patients utilizing the services of an EN or VR agency.

Both goals were exceeded in this QIA, with a 35.57 percentage point improvement in VR/EN referrals and a 7.96 percentage point improvement in VR/EN utilization.

Interventions

- A RCA was completed by each participating facility at the start of the QIA.
- The Network provided resources and materials to support staff in helping patients achieve S.M.A.R.T. goals toward attaining employment; these included EN materials, vocational rehab resources, Veteran's Administration resources, and Ticket to Work Program information.
- The Network collaborated with the ENs to support the needs of the ESRD community. This collaboration resulted in webinars, remote access for patients in the Network's service area, and easier access for facility staff to create relationships with EN contacts that would bring opportunities and resources to all interested patients.

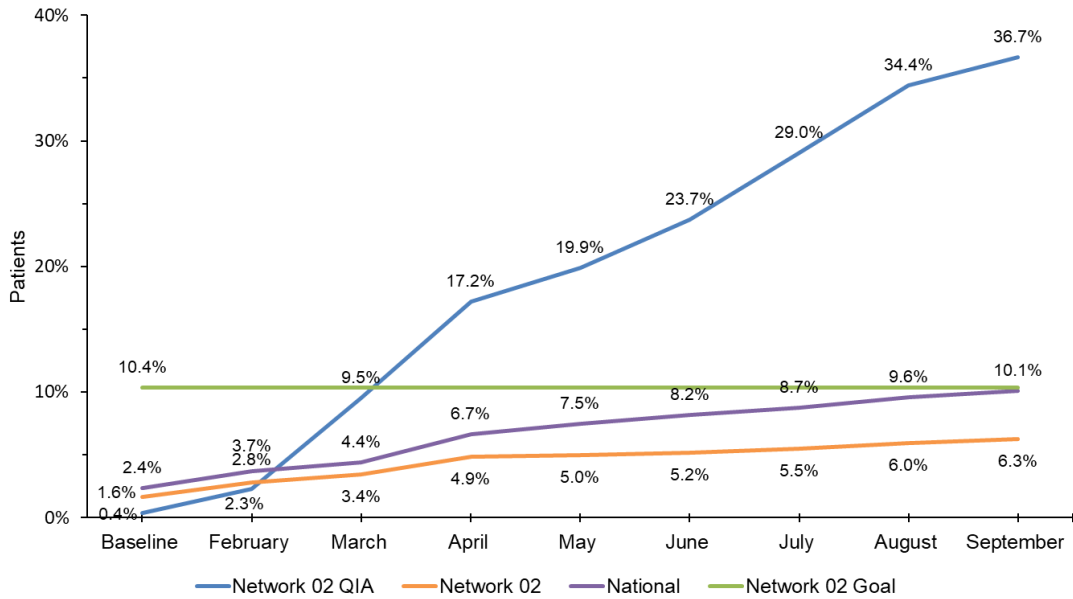
Barriers to achieve goals

- Dependence on VR/EN agencies and the lag time from referral to first evaluation appointment was outside of the control of dialysis facilities.
- Lack of staff knowledge on CROWNWeb documentation for Vocational Rehab Referral, Use of Service, School and Work status resulted in reported facility rates being much lower than actual results. VR interest/status not always communicated to CROWNWeb entry staff for record management
- Lack of patient interest in returning to work, mostly related to fear of losing disability benefit
- Lack of available resources for patients in urban areas, and communication with eligible patients about VR opportunities.

Best practices spread to achieve goals

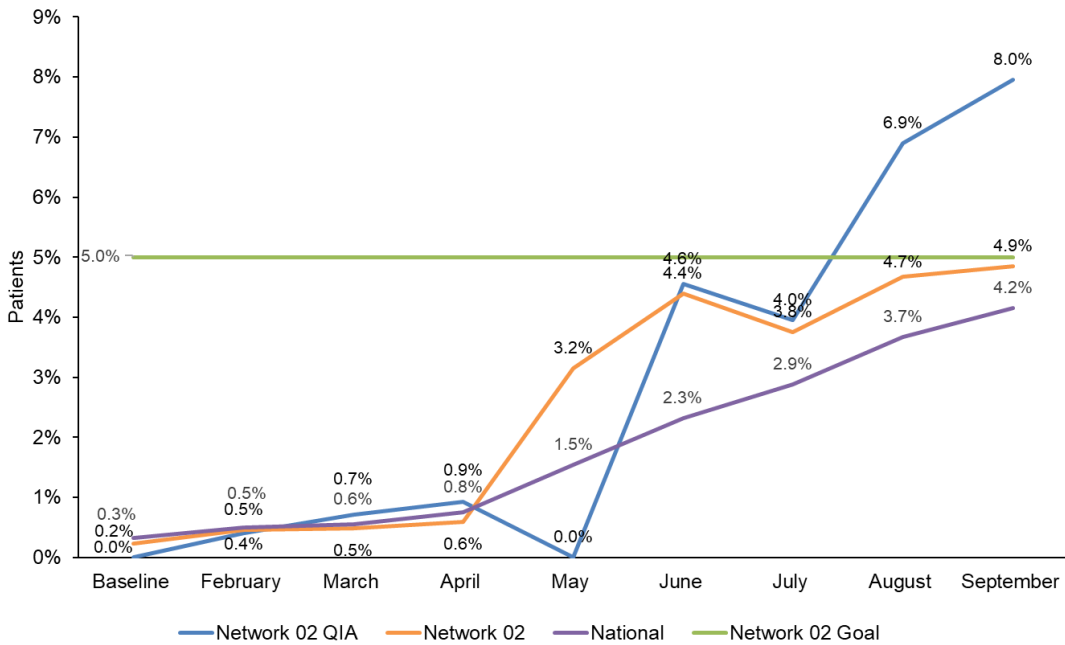
- Ongoing review and evaluation of identified barriers.
- Increased education for patients regarding the VR program and other services that could improve their quality of life:
 - Patient Roadmap: S.M.A.R.T. Goals
 - Ticket to Work education
 - Inclusion of a conversation regarding VR during care plan meetings.
- Utilization of EN and stakeholder web based services/webinars
- Educating and training of dialysis staff about the need for following the correct process for documentation of VR referrals in CROWNWeb.
- Held 1:1 calls with facilities in order to help them identify patients that were referred or receiving services, but were not accurately documented in CROWNWeb. This resulted in improved accuracy of data.
- Routine follow-up with patients to monitor employment and/or vocational rehabilitation interest/involvement and offering support to patients throughout the process.
- Collaborative calls helped bridge communication between providers, creating a network of support and sharing of best practices.
- Provider staff established a peer network to share resources, and discuss patient barriers. These collaborations resulted in a documentation tool for initial contact with an EN/VR agency, and the integration of the ESRD Smart Goals worksheet into the workflow at a number of VR agencies.

**Network 02: Percent of Eligible Patients Referred to an
Employment Network or a Vocational Rehabilitation Agency
February 2019 - September 2019**



QIA: Quality Improvement Activity
Source of data: ESRD NCC 2019 Dashboard accessed October 2019

**Network 02: Percent of Referred Patients Receiving Services from an
Employment Network or Vocational Rehabilitation Agency
February 2019 - September 2019**



QIA: Quality Improvement Activity
Source of data: ESRD NCC 2019 Dashboard accessed October 2019



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 2019.

Recommendations for Sanctions

No recommendations were made to CMS for additional services or facilities in the Network service area during 2019.

Recommendations to CMS for Additional Services or Facilities

In 2019, 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 The Kidney Community Emergency Preparedness Coalition (KCER), 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 2019, 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.

In 2019, the Network successfully managed 39 emergency events that required intervention, response, and/or tracking. These events accounted for a total of four calendar days of facility closures and 35 schedule alterations.

Connect, Plan, Train, Report: Active Shooter Preparedness

On June 25, 2019, the Network presented a webinar for dialysis facility staff on preparing for an Active shooter event. This webinar featured Mark Kreyer, CPP Protective Security Advisor, Buffalo District US Department of Homeland Security. In this webinar, Mr. Kreyer discussed available training and drill resources as well as resources to help staff Connect, Plan, Train, and Report with local law enforcement prior to any security events. This event was attended by 284 registrants from more than seven states, and was the highest rated Network webinar in 2019 with 95% rating the content Above Average/Excellent, and 90% responding YES to “this information will enrich your practice”

Network Critical Assets Survey

The Network concluded the year with a 95% completion rate by dialysis facilities in its service area required to complete a “Critical Assets Survey,” which includes a detailed inventory of preparedness activities, transportation resources and supplies demonstrates a comprehensive knowledge of facility preparedness and vulnerabilities in case of a major event.

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.