What You Need to Know About CMS Priorities, Goals, and Quality Improvement Activities

IPRO ESRD Network Program
Network Council Meeting

September 22, 2021
Welcome and Opening Remarks

Danielle Daley, MBA
Executive Director
ESRD Network 1 (CT, MA, ME, NH, RI, VT)
Meeting Reminders

- This WebEx will be recorded and slides made available on the Network Website
- All phone lines have been muted to avoid background noise
- Be present and engaged in the presentations
- Be prepared for active participation in the WebEx chat board
Meeting Reminders

• Be prepared for active participation in polling questions
Agenda Topics

• Welcome
• ESRD Program Administration
• National Initiatives (Goals, Education, Interventions)
  o Quality Improvement
  o Patient Services
• Emergency Management
• CMS ESRD Data Systems Management
• Communication Systems
• Closing Remarks/Next Steps
ESRD Program Administration

Sue Caponi, MBA, RN, BSN, CPHQ
CEO, ESRD Network Program
Executive Director, ESRD Network 2 (NY)
IPRO Capabilities

- Founded in 1984
- Not-for-profit organization
- Holds contracts with federal, state, and local government agencies
- Provides services to enhance healthcare quality to achieve better patient outcomes
- Proven track record of excellence, culture of innovation, and breadth of expertise
- Implementation of innovation programs that bring policy ideas to life
- Creative use of clinical expertise, emerging technology and data solutions to make healthcare systems work better
- Headquartered in Lake Success, NY
ESRD Networks

- Puerto Rico and Virgin Islands are part of Network 3
- Hawaii, Guam, American Samoa are part of Network 17
IPRO ESRD Network Program
Network Service Areas

Network 1
CT, MA, ME, NH, RI, VT
Patients: 15,178
Facilities: 202
Transplant: 13

Network 2
NY
Patients: 30,080
Facilities: 343
Transplant: 13

Network 3
IN, KY, OH
Patients: 15,178
Facilities: 202
Transplant: 15

Network 4
NW1
Patients: 15,178
Facilities: 202
Transplant: 15

Network 5
NW2
Patients: 15,178
Facilities: 202
Transplant: 15

Network 6
NC, SC, GA
Patients: 51,430
Facilities: 804
Transplant: 10

Network 7
Network 8
Network 9
OH, KY, IN
Patients: 34,070
Facilities: 645
Transplant: 14

Network 9
IN, KY, OH
Patients: 15,178
Facilities: 202
Transplant: 15

Network 10
NW2
Patients: 15,178
Facilities: 202
Transplant: 15

Total:
130,758 ESRD Patients
1,994 Dialysis Facilities
52 Transplant Centers
Mission Statement

The Mission of the IPRO End Stage Renal Disease (ESRD) Network Program is to promote health care for all ESRD patients that is safe, effective, efficient, patient-centered, timely, and equitable.
CMS Priorities, Goals, and QIAs

ESRD Statement of Work

- Contract Cycle: June 1, 2021 – April 30, 2026
- Supports achieving quality improvement (QI) goals
- Activities align with NQS and CMS initiatives designed to result in improvements in the care of individuals with ESRD
- QIAs incorporate one or more of the CMS 16 Strategic Initiatives
  https://www.cms.gov/About-CMS/Story-Page/unleashing-innovation
- Networks deploy interventions that target patients, dialysis/transplant providers, other providers, and/or other stakeholders
- QIAs incorporate a focus on rural health, health equity, and vulnerable populations
- Grounded on the concepts and design of Section 1881 of the SSA, HHS Secretary’s Priorities, Executive Order to launch Advancing American Kidney Health, ESRD Treatment Choices (ETC) Payment Model, and the ETC Kidney Transplant Learning Collaborative
CMS Expectations
Role of the Network

• Improve quality of care for ESRD patients
• Provide assistance to ESRD patients and providers
• Encourage patient engagement
• Evaluate and resolve patient grievances
• Collect data to measure quality of care
• Support emergency preparedness and disaster response
Quality Improvement

Victoria Cash, MBA, BSN, RN
Executive Director
ESRD Network 9 (IN, KY, OH)
Advisory Committees

The Network shall meet with empowered patients, nephrologists, primary care providers, dialysis facility staff from all modalities plus key stakeholders, such as:

• Psychologists, Psychiatrists (Depression)
• Nursing home professional associations and home therapy managers, interdisciplinary (ID) professionals (Nursing Homes)
• Transplant surgeons, coordinators, OPOs (Transplant)
• LDO and SDO leadership and home modality leads (Home Therapies)
• QIN/QIO and Hospital Administrators (Hospitalizations)
• State Department of Health and ID professionals (Vaccinations)
• Engagement specialists and patient advocate organizations (Patient and Family Engagement)
Advisory Committees / Community of Practice

- CC – Community Coalitions
- CP – Community of Practice

- CC Transplant
- CC Home Dialysis
- CC Depression
- CC Vaccination
- CC Reducing Hospitalizations
- CC Nurse Home
- CC Patient & Family Engagement
- Snowflake Model/ Hub and Spoke

CC – Community Coalitions
CP – Community of Practice
Advisory Committees / Community of Practice

Provides Data
(Basecamp private platform)

Analyze Data
Identify best practices and low performing
Identify regional/local challenges
Provide recommendations
Support CC's PDSA Cycles
Recruit CC Members

AC

Community of Practice

Support vision and recommendations
Provide guidance to low performing facilities
Help providers overcome barriers
Perform PDSA Cycles

Community Coalitions

Improve practices
Achieve quality of care

Patients

Improve practices
Achieve quality of care
Technical Assistance

- Assist facilities to perform an RCA to identify barriers to improvement and focus areas
- Lead facilities through a Plan-Do-Study-Act process to test plans for improvement
- Provide resources, connections, ideas
- Benchmark and support facilities to improve over the course of the year

ESRD NWs → Improve practices
<table>
<thead>
<tr>
<th>RCA</th>
<th>PDSA</th>
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<tbody>
<tr>
<td>Provide recommendation, resources, connections</td>
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Achieve quality of care

Patients
Program Wide Interventions

• Provide resources and strategies proven to lead to improving patient outcomes
  ○ IPRO Learn - Resource sharing and feedback source
  ○ Develop toolkits - Resources, strategies and education from best practices

• Celebrate Success
  ○ Directed recognition of top performers
  ○ Quarterly best practice sharing

• Use data to benchmark performance and drive outcomes
  ○ Monthly facility progress reports in all QI work
  ○ Tableau dashboard reporting

• Integrate patients into QI processes
  ○ Participate in QAPI
  ○ Build Life Plans
  ○ Encourage Support Groups and Peer Mentoring

• Provide Technical Assistance
Improve Care in High Cost/Complex Chronic Conditions
National Clinical Objectives and Key Results

Improve Care in High Cost/Complex Chronic Conditions

• Improve Education and Access to Empower Patient Choice of a Home Modality
• Improve Education and Access to Empower Patient Choice of Transplant
• Educate and Manage Incidents of COVID-19 and Decrease Hospitalization of COVID-19 Positive ESRD Patients and Related Vaccinations
Increase Rates of Incident Patients and Prevalent Patients Initiated on a Home Therapy

Objectives
- Increase the amount of incident patients initiating a home therapy by 10%
- Increase the amount of prevalent patients initiating a home therapy by 2%
- Increase the amount of patients using a telehealth at home by 2%

Project Period
- June 1, 2021 – June 30, 2022

Requirements
- Use the NCC Change Package as an intervention to improve home initiations
- Monitor the use of telehealth and support increased use to ease access for patients
- Engage patients in the work, and share best practices nationally
Home Modality Interventions and Education

• Support ongoing education on home modality options for facility staff and patients
• Provide resources and tools proven to increase home initiations
  o NCC Change Package
  o Network Resource Packet
  o Credible resources for patients
• Focus on performance
  o Release monthly facility performance reports showing progress to goal for incident and prevalent patient home initiations
  o Celebrate Success - Identify and share success stories of top performers
• Start a campaign with compelling patient stories
  o Produced recorded patient vignettes sharing personal stories of success
Home Modality Educational Resources

- Patient (preparation) and Provider Telehealth Toolkits (operations)
- Resource guide
- Checklist
- Fact sheet
- Recorded presentation

Screening and Management of CKD Mobile Apps

Healthy at Home Campaign
Improve Education and Access to Empower Patient Choice of Transplant

Increase Rates of Patients Waitlisted and Transplanted

Objectives

• Increase the amount of patients waitlisted by 2%
• Increase all transplants in the Network Service Area by 2%

Project Period

• June 1, 2021 – June 30, 2022

Requirements

• Use the NCC Change Package as an intervention to increase wait listing and transplantation
• Support the work of Technical Assistance Quality Improvement Learning (TAQIL)
• Engage patients in the work and share best practices nationally
Transplant Interventions and Education

• Support ongoing education on transplant for facility staff and patients
• Provide resources and tools proven to increase transplant
  o Providers: Review and utilize NCC Change Package, Network Resources
  o Patients: Recruit patient SMEs to assist with education
• Focus on performance
  o Release monthly facility performance reports showing progress to goal for wait listing and transplant
  o Celebrate Success - Identify and share success stories of top performers
• Engage the transplant community
  o Work with transplant programs and TAQIL in the region to ease access, improve communication and increase patient access
Transplant Educational Resources

Transplant Toolkit

Staff Educational Videos

Patient Education & Activities
Manage Incidents of COVID-19 and Decrease Hospitalization of COVID-19 Positive ESRD Patients

Decrease COVID Related Hospitalizations

Objective

• Decrease COVID Hospitalizations by 25% from 2020

Project Period

• June 1, 2021 – June 30, 2022

Requirements

• Encourage use of CDC Infection Prevention strategies to reduce spread
• Support obtaining patient and staff recommended vaccination levels
• Report data from National Health and Safety Network (NHSN) to CMS
Increase Patient & Staff COVID-19 Vaccination Rates

Objective

• Increase Patient COVID Vaccination to 80%

Project Period

• June 1, 2021 - June 30, 2022

Requirements

• Encourage use of CDC Vaccination Toolkit
• Report data from National Health and Safety Network (NHSN) to CMS

<table>
<thead>
<tr>
<th>Network</th>
<th>Staff</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>New England (Network 1)</td>
<td>69.7%</td>
<td>80.0%</td>
</tr>
<tr>
<td>New York (Network 2)</td>
<td>60.4%</td>
<td>70.3%</td>
</tr>
<tr>
<td>South Atlantic (Network 6)</td>
<td>50.9%</td>
<td>64.8%</td>
</tr>
<tr>
<td>Ohio River Valley (Network 9)</td>
<td>50.7%</td>
<td>68.5%</td>
</tr>
</tbody>
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Increase Vaccination Rates

<table>
<thead>
<tr>
<th>Virus</th>
<th>Timing</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVID-19</td>
<td>Initial vaccination</td>
<td>&gt; 80% patients &amp; staff fully vaccinated</td>
</tr>
<tr>
<td>Influenza</td>
<td>Annual</td>
<td>&gt; 85% patients</td>
</tr>
<tr>
<td>Influenza</td>
<td>Annual</td>
<td>&gt; 90% dialysis staff</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>PCV-13</td>
<td>&gt; 10% increase of patients receiving</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>PPSV 23</td>
<td>As age appropriate &gt;87% patients</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>PPSV 23</td>
<td>&gt; 80% patients over 65 receiving</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>PPSV Booster</td>
<td>10% increase (from 2020) in patients receiving booster</td>
</tr>
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Monthly Data Source NHSN & EQRS
COVID / Vaccination Interventions and Education

• Support Ongoing Education on COVID transmission and vaccination recommendations for facility staff and patients
• Provide resources and tools proven to increase vaccinations:
  • IPRO Vaccination Planning Module Presentation *** Free CE
    o NCC Vaccination Toolkit and CDC Vaccination Toolkit
    o 10 Essential Nurse Communication Skills for Success
    o IPRO Resources: Get the Vaccines You Need! (English and Spanish), My Vaccination Record
• Focus on performance
  o Release monthly facility performance reports showing progress to goals for vaccinations
  o Celebrate Success - Identify and share success stories of top performers
• Provide Directed Technical Assistance to Lower Hospitalizations in regions with increase
  o One-on-one interaction with dialysis facilities and hospitals in regions of high hospitalization rates to review infection prevention practices and areas to improve
Reduce Hospital Admissions, Readmissions, and Outpatient Emergency Visits
National Clinical Objectives and Key Results

Reduce Hospital Admissions, Readmissions, and Outpatient Emergency Visits

- Improve and Maintain the Health of ESRD Patients
Improve and Maintain the Health of ESRD Patients

Reduce Hospital Admissions, Readmissions, and Outpatient Emergency Visits

Objective
• Decrease hospitalizations, unplanned 30 day readmissions, & ED visits by 2% from 2020

Project Period
• June 1, 2021 - June 30, 2022

Requirements
• Focus on primary diagnosis codes:

<table>
<thead>
<tr>
<th>Primary Diagnosis Codes (not all inclusive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>VA infections</td>
</tr>
<tr>
<td>BSIs</td>
</tr>
<tr>
<td>CHF</td>
</tr>
<tr>
<td>Fluid Overload</td>
</tr>
<tr>
<td>Sepsis</td>
</tr>
<tr>
<td>Hyperkalemia</td>
</tr>
<tr>
<td>Clotted Access</td>
</tr>
<tr>
<td>Chest Pain</td>
</tr>
<tr>
<td>Anemia</td>
</tr>
<tr>
<td>Hypokalemia</td>
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<tr>
<td>Hyperglycemia</td>
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</tbody>
</table>
Transitions of care refers to the movement of patients between health care practitioners, settings, and home as their condition and care needs change.

In the dialysis setting the most frequent transitions are between long term care facilities/in-center hemodialysis units or in-center hemodialysis facilities and hospitals.

• Results of Poor Transitions in the ESRD community?
  o 37% of ESRD patients are hospitalized
  o ⅓ of those admitted will be readmitted in 30 days
  o Patient Outcomes deteriorate with each hospital and ER visit
  o Patients greater than 65 years readmitted for same diagnoses have a 10% chance of dying in the same year
Transitions Champion Role Description

• Establish person/process to communicate with hospital system regarding ESRD patients
• Interview each patient 24 hours post each hospitalization/ED discharge
  o Medication Reconciliation
  o Determine patient understanding of follow up visits
  o Identify with patient important signs and symptoms to report
• Lead Hospitalization Discussion in QAPI
  o Make those patients with multiple hospitalization “UNSTABLE” for life/care plan review
• Perform RCA with each “frequent flyer” and educate on proper utilization of emergency room
• Integrate patient voice and participation in project at facility
• Prepare transitions packets for each patient/facility
Hospitalization Interventions and Education

• Support Ongoing Education on Methods to lower use of acute care
  o Providers: Transitions in Care Toolkit Review
  o Patients: Know Your Dialysis Center Contacts

• Provide Resources and Tools Proven to Decrease Acute Care Utilization
  o Create a Transition Champion in every facility to communicate and work with hospitals
  o Support use of transition checklist to follow all patients post hospital admission
  o Educate patients on the effects of Missing Treatment Time
  o Initiate use of patient wallet cards to dialysis information transferred

• Focus on Performance
  o Release monthly hospitalization data with a correlation to QIP metrics by facility.
  o Celebrate Success - Identify and share success stories of top performers

• Provide Directed Technical Assistance to Lower Hospitalizations
  o One-on-one interaction with dialysis facilities and hospitals in regions of high hospitalization rates to review infection prevention practices and areas to improve
Hospitalizations Interventions

• Identify regional low performers to work small test of change/community coalitions (Data not expected until October 2021)
  o Elect a Transitions Champion for each facility to promote smooth transitions
  o Record your elected Champion in IPRO LEARN

• Development of Patient Facing Campaigns
  o Wallet cards for patients to carry with Medicare Card to provide dialysis facility contact information
  o “Don’t Cut Yourself Short” Flyer
  o Visual Displays to Share Goal Progress with patients

• Review, Update and Adapt the ESRD Forum Toolkit: Chapter 8, Pages 48-68
Improve Patient Safety and Reduce Harm

Improve Nursing Home Care in Low-Performing Providers
National Clinical Objectives and Key Results

Improve Patient Safety and Reduce Harm
• Improve Health Outcomes and Access to Care in Vulnerable Populations

Improve Nursing Home Care in Low-Performing Providers
• Decrease the Rate of Blood Transfusions in ESRD Patients Dialyzing in a Nursing Home
Improve Patient Safety and Reduce Harm

Improve Nursing Home Care in Low-Performing Providers

Objective

• Decrease the hemodialysis catheter infection rate in dialysis patients receiving home dialysis within nursing homes by 4%
• Decrease incidents of peritonitis in dialysis patients receiving home dialysis within nursing homes by 2%
• Decrease the rate of dialysis patients receiving dialysis at nursing homes that receive a blood transfusion by 2%

Project Period

• June 1, 2021 - June 30, 2022

Requirements

• Improve Health Outcomes and Access to Care in Vulnerable Populations
Nursing Home Interventions and Education

• Support Ongoing Education on Methods to lower infection and improve care
  o ESRD and Nursing Home Provider Focus - Care of the Frail and Elderly Education
• Provide Resources and Tools to develop approaches
  o Better Together: Collaborative Approaches to Prevent Nursing Home Infections educational video [https://www.youtube.com/watch?v=j7CrEkuHggY](https://www.youtube.com/watch?v=j7CrEkuHggY)
  o CDC: Preventing Bloodstream Infections in Outpatient Hemodialysis Patients [https://www.youtube.com/watch?v=0zhY0JMGCA](https://www.youtube.com/watch?v=0zhY0JMGCA)
• Focus on Performance
  o Create shared care planning focus Nursing Home and Dialysis Providers.
  o Monitor and report on catheter infection rates and blood transfusions in all quality meetings
• Provide Directed Technical Assistance
  o Work one on one dialysis providers in nursing homes to support continued education and communication between both providers
Patient Services

Jeanine Pilgrim, MPH, PMP, CPHQ, CHES, CPXP
Program Director
ESRD Network 2 (NY)
Improve Behavioral Health Outcomes
National Clinical Objectives and Key Results

Improve Behavioral Health Outcomes

• Increase Remission of Diagnosis of Depression
Improve Behavioral Health Outcomes

Increase Remission of Diagnosis of Depression

Objective

• Increase the percentage patients accurately screened as having depression by 15%
• Increase the percentage of patients with depression receiving treatment by 10%

Project Period

• June 1, 2021 - June 30, 2022

Requirements

• Data entry in EQRS (CMS data system of record)
Behavioral Health Interventions

Education and Technical Assistance
• Review and develop plan to implement use in your facility of resources in the Network’s compiled toolkit comprised of various national sources
• Incorporate these resources during your monthly depression screenings and assessments
  • Depression and Mental Health Screening Tools
  • Treatment options for depression
  • Addressing barriers to patient referrals for treatment
• Enroll and engage with the Network on IPRO Learn platform (check your email for an invite)
  • Sharing of best practices

Patient and Family Engagement
• Recruit Patient Facility Representative (PFR)
• Invite your PFR to QAPI related to project- either on site or a prepared report of their work, patient interest, etc.
• Develop Life Plans with patients and care partners during care planning that incorporates behavioral health screenings and wellness goals
• Allow your PFR to help with creation of educational bulletin boards
• Collect PFR feedback on Network provided materials and resources
Behavioral Health Educational Resources

- Dialysis Patient Depression Toolkit
- Coping, Living, and Thriving with Kidney Disease
- Zone Tool: Self-Management for Depression
Improve Patient and Family Engagement
National Initiatives

Improve Patient and Family Engagement at the Facility Level

• Increase in the number of facilities that successfully integrate patients and families concerns into Quality Assurance and Performance Improvement (QAPI)

• Increase in the number of facilities that successfully assist patients to develop a life plan, from which the dialysis facility develops the dialysis plan of care

• Increase in the number of facilities that successfully develop and support a peer-mentoring program
Increase Successful Integration of Patient and Family Concerns into Quality Assurance and Performance Improvement (QAPI)

Objective

• Increase in the number of facilities including patients and/or families into monthly QAPI meetings by 10%

Project Period

• June 1, 2021 - June 30, 2022

Requirements

• Self-reported data to the Network through IPRO Learn platform
• Enroll in the Network IPRO Learn platform (check your email for an invite)
• Recruit Patient Facility Representative (PFR)
Increase Patient Assistance with Developing a Life Plan to Implement a Successful Dialysis Plan of Care

Objective

• Increase in the number of facilities successfully assisting patients with developing a life plan by 50%

Project Period

• June 1, 2021 - June 30, 2022

Requirements

• Self-reported data to the Network through IPRO Learn platform
• Enroll in the Network IPRO Learn platform (check your email for an invite)
• Recruit Patient Facility Representative (PFR)
Increase the Number of Facilities that Successfully Develop and Support a Peer-Mentoring Program

Objective

• Increase in the number of facilities successfully developing and supporting a peer mentoring program by 25%

Project Period

• June 1, 2021 - June 30, 2022

Requirements

• Self-reported data to the Network through IPRO Learn platform
• Enroll in the Network IPRO Learn platform (check your email for an invite)
• Recruit Patient Facility Representative (PFR)
Patient and Family Engagement Educational Resources
Courses one through three Mentoring Basics are required

Mentors may choose at least one course under Topic Courses

You must create an account or just login

https://www.kidneylearninghub.com/
NCC Kidney Learning Hub Referring Potential Patients

- Complete the referral form once mentors and mentees are identified and fax to the Network at (516)231-9767

- Once the referral is received, both the mentor and mentee need to complete the application and fax it to the Network at (516)231-9767

- Not all patients meet the requirements to be peer mentors or mentees. Refer to the handout Talking Points for Turning Down a Mentor or Mentee Applicant
Patient Facility Representative (PFR) Alliance
PFR Role Description

• The Patient Facility Representative (PFR) Alliance provides an opportunity for patients, transplant recipients, and care partners to support facilities in the promotion of patient-centered care in quality improvement activities.

• Facilities who are working on a Quality Improvement Activity will designate a minimum of one PFR to assist with QI interventions and activities in the facility.

• Levels of Engagement:
  o PFR Members
  o QIA Champions
  o Patient Subject Matter Experts (PSME)
PFR Recruitment

- Ideal Patients to Serve as PFRs
  - Desire to have a positive impact on the care patients receive at the facility
  - Desire to be part of a larger group
  - Be available to listen, support and guide fellow patients
- Identify a patient to fulfill the PFR role in your facility
  https://redcap.ipro.org/surveys/?s=7L7FWPTPE7
PFR Engagement/Activation

• Ways of engaging your nominated Patient Facility Representative (PFR)
  o Ask your PFR to assist you in distributing patient education materials
  o Have your PFR participate in designing and completing bulletin boards
  o Invite your PFR to QAPI meetings to report on progress of their work including successes and challenges
  o Discuss with the PFR about becoming a peer mentor

• Remind patients to attend monthly PFR meetings with the Network (first Thursday each month, 5:30-7PM) and participate in educational activities at the facility-level

• First PFR Orientation meeting scheduled for 10/7/21
Improve the Patient Experience of Care
National Initiatives

Improve the Patient Experience of Care by Resolving Grievances/Access to Care Issues

• Educate patients and dialysis facility staff about the role of the Network in resolving grievance and access to care issues

• Provide a focused audit of all grievance and access to care cases

• The Network’s case review responsibilities include investigating and resolving grievances filed with the Network and addressing non-grievance access to care cases.
Network Role in Patient Experience of Care

The Network may assume one or more of the following roles in addressing a grievance filed by an ESRD patient, an individual representing an ESRD patient, or another party:

• **Facilitator:** Mediate concerns raised by patients and facilities.
• **Expert Investigator:** Investigate concerns raised by patients
• **Educator:** Provide patients and facilities with tools and resources to improve the patient experience of care.
• **Advocate** for the access to care of all ESRD patients
• **Referral Source:** Provide patients and facilities on all sources to report concerns.
• **Quality improvement Specialist:** Support the improvement of facility processes to improve the overall quality of care for all patients.
Grievances and Access to Care

Upon the receipt of a grievance, the Network will classify the case as one of the following:

• **Immediate Advocacy:** Concerns that are non-clinical in nature and do not require a complex investigation; resolved in 7 days or less

• **General Grievance:** Concerns that are non-clinical in nature but require complex investigation and review of records; resolved in 60 days or less

• **Clinical Quality of Care:** Concerns that involve clinical or patient safety issues and requires a clinical review of records by an RN and/or the Medical Review Board (MRB); resolved in 60 days or less

• **At Risk Involuntary Discharge:** Concerns related to possible patient discharge.

• **Involuntary Discharge:** Immediate or 30 day IVD. volume monitored by the Network
Patient Education and Support

- As required by the conditions for coverage, all patients must be educated on the grievance process and the various options when filing a grievance.

- Provide ongoing individualized education as well as displaying the Network "Speak Up!" poster in a common area that patients and visitors have access to (such as the unit lobby).
Grievance and Access to Care

Educational Resources
Community Outreach
Patient Community Outreach

• Conducting a “Healthy Living Campaign” through our PFR Alliance Facebook Group

• The Healthy Living Campaign has encompassed all aspects of ESRD/CKD treatment including:
  o Medical and treatment adherence
  o Maintaining the Renal Diet and understanding fluid restrictions
  o Open Communication with members of your medical team
  o Creation of a self-care plan to promote mental health and self awareness
Community Awareness Campaigns

September
• National Recovery Month
• Pain Awareness Month
• National Suicide Prevention Day (September 10th)
• World Sepsis Day (September 13th)
• World Heart Day (September 29th)

October
• Long-Term Care Planning Month
• Health Literacy Month
• Emotional Wellness Month
• Global Diversity Awareness Month

November
• American Diabetes Month
• National Hospice and Palliative Care Month
• World Diabetes Day (November 14th)

December
• National Human Rights Month
• Universal Human Rights Month
Emergency Management

Shannon Wright, BSW
Executive Director
ESRD Network 6 (GA, NC, SC)
Emergency Preparedness, Mitigation, and Response

• Annual Critical Assets Survey (CAS)
  o 98% completion rate (1,942/1,990) for 2021
  o Represents Preparedness activities and resources of Dialysis Facilities

• Data Used By:
  o State OEMS
  o Healthcare Coalitions
  o Network Emergency Management

• Facility Summary Reports
  o Facility Summary Reports distributed mid-August, add this to your facility’s Emergency Plan
Emergency Preparedness, Mitigation, and Response

- REPORT Closed/Altered Status
- Use the Closed/Altered Reporting Link: https://redcap.ipro.org/surveys/?s=R8K7RWETHM

Why?
- Network reports to CMS, State and local OEMS during events
- Assists in placing patients as needed
- Provides Situational Awareness in an emergency
ESRD
Data Systems

Shannon Wright, BSW
Executive Director
ESRD Network 6 (GA, NC, SC)
ESRD Data Systems Management

• CMS ESRD Primary Data Systems
  o ESRD Quality Reporting System (EQRS)
  o National Healthcare Safety Network (NHSN)

• Data Collected is used to:
  o Establish facility performance related to quality improvement goals
  o Determine QIP score which impacts your facilities reimbursement rate
  o Establishes your facilities Star Rates which provides transparency in quality of care provided by your facility

• The Network provides technical assistance to facilities in being compliant with CMS Data Management guidelines in support of these initiatives.
Improve the Data Quality of the Patient Registry in the ESRD Quality Reporting System (EQRS)

• CMS EQRS Data Management Guidelines Require:
  o Patients are admitted within 5 business days of starting dialysis at facility
  o CMS-2728 forms are submitted within 45 days of the date dialysis began
  o CMS-2746 forms submitted within 14 days of the date of death

Goal for Each Measure = 100%
Supporting Facilities with Admission Timeliness

Possible Duplicate or Near Match Patients Form
https://redcap.ipro.org/surveys/?s=9FN3KF8A7T

IPRO ESRD Program Transplant Event Form
https://redcap.ipro.org/surveys/?s=AR4PATFFMJ
Strategies to Improve Data Quality

Network Actions

• Provide missing data and compliance monitoring reports
• Provide Training on data management best practices in EQRS and NHSN
• Monitor improvement and provide technical assistance until goals are met
• Select facilities for interventions starting January 2022 based on performance data

Facility Actions

• Follow Clinical Submission Schedule in EQRS and NHSN reporting Requirements
• Understand routine data management activities in EQRS
• Verify Patient Roster Monthly in IPRO Learn
• Resolve missing data and compliance issues provided in Network distributed reports
• Establish internal IQI process to meet the timelines
• Incorporate the measures in their overall facility QAPI process
Introducing
IPRO Learn
IPRO Learn
Learning Management System (LMS)

• IPRO Learn = Learning Management System (LMS)
  https://learn.ipro.org/

At the request of facilities:
• Organized resources & initiatives to meet CMS Goals
• creates a one-stop-shop for collaboration
• reduces number of emails sent
• provides centralized location to submit self-reported data

What facilities are saying:
• The ability to share the user name and password with across facility staff get more staff involved to participate in Network initiatives
• Love going to one place for all Network activities and reduction of emails

• Allows staff to create a personal account in addition to your facility account to obtain Continuing education hours for Nurses, Dieticians, and Technicians for FREE!
Introducing IPRO Learn

The IPRO ESRD Network Program is excited to announce a new and innovative virtual platform to connect the ESRD provider community to the quality improvement initiatives the Centers for Medicare & Medicaid Services (CMS) is requiring of all dialysis facilities. Facility-specific login information is Attached.

This new platform, known as IPRO Learn, will become a one stop shop to:
- Learn about upcoming national and regional educational events
- Manage Quality Improvement Activities and complete interventions the Network is requiring dialysis facilities to participate in as part of achieving the CMS objectives and key results (OKRs)

Check your email for the ‘Welcome to IPRO Learn’ Letter!

https://learn.ipro.org/

Do not try to change the Password that was provided

Team effort for facility staff: share the login/password: divide and conquer!
The Network will:
• Provide education and training
• Gather and disseminate best practices
• Vet (QI) tools and resources
• Link you to events and educational offerings
• Collect self reported data

Facilities will:
• Log in using CCN and provided password weekly
• Share Toolkits with teammates
• Participate in Discussion Forums
• Submit self-reported data collections
What’s New/ Recent Announcements
- Upcoming Webinars
- Event Invites
- General Network Announcements

To Do/ Required Activities
- Intervention Activities to support achieving facility performance goals
- Collection of your feedback through self reported assessments and surveys

Achieving CMS Goals Using Quality Improvement Toolkits
- QIA-specific resources
- Network-developed tools
- Nationally-recognized best practices

September data is due October 3rd
New and Improved…
**NEW**
IPRO ESRD Facility Contacts Management System

- Facilities can maintain their own Key Personnel using our new IPRO ESRD Facility Contacts Management System

Facilities can login any time:
- Login: IPROESRD
- Password: facility CCN

Link is available in:
- KnowledgeBase help.esrd.ipro.org
- IPRO Learn learn.ipro.org
IPRO ESRD Customer Support Portal
Fastest Way to Connect with Staff!

Submit a ticket

- I acknowledge that I have not included any patient PHI/PII (e.g., Name, SSN, DOB, etc.). Only use the ESRD Patient UPI to identify a patient; I have also not included any attachments including PHI/PII.

Name
Phone Number
Email Address
Add cc
Network
CON (CMS Certification Number)
Facility Name
Topic
Subject (Brief Description / Action Requested)
Description - Be Specific, provide the following: What (Do), Who (By), When (Date of Event) - Do not submit PHI/PII

Remember: Never Submit PHI or PII, use the patient UPI to prevent security violation

http://help.esrd.ipro.org/

How can we help you today?
Enter your search term here...

New Support Ticket  Check Ticket Status

- Submit tickets for any issues such as Data, QI initiatives, Emergency, Patient Experience of Care and Patient Engagement
- Search the knowledge base for frequently asked questions
ClosingRemarks

Danielle Daley, MBA
Executive Director
ESRD Network 1 (CT, MA, ME, NH, RI, VT)
The mission of the End Stage Renal Disease (ESRD) Network Program is to promote health care for all ESRD patients that is safe, effective, efficient, patient-centered, timely, and equitable.

To learn more about what ESRD Networks can do for you, please choose a Network below.

https://esrd.ipro.org/
Follow Us on Social Media

IPRO ESRD Network Program and PFR Alliance Facebook Pages
- https://www.facebook.com/IPROESRDNetwork
- https://www.facebook.com/groups/IPROESRDPAC

Twitter
- https://twitter.com/IPROESRDNetwork

LinkedIn
- https://www.linkedin.com/in/iproesrdnetwork/

Instagram
- https://www.instagram.com/ipro_esrd_network/
Next Steps

- Recruit PFRs, submit online applications
- Recruit Peer Mentors, submit referral forms
- Check out IPRO Learn: Log in using facility ID credentials
- Visit Network Program website for additional resources
- Follow us on Twitter, LinkedIn, Facebook, Instagram
- Ask questions and find answers in the IPRO ESRD Customer Support Portal
- Update Facility personnel in the Contact Management System

Please complete the post event survey!
Thank You for your ongoing dedication to providing quality care to individuals with ESRD