Thank You for Joining the Webinar

We’ll be Getting Started Shortly
Let’s Get to Know Each Other…

What is your favorite holiday?

Put Your Answer in Chat
Who Wants to Play a Little Trivia?

On average, what is the thing that Americans do 22 times in a day?

Put Your Answer in Chat
Open the refrigerator
Let’s Get to Know Each Other…

What movie defined your generation?

Put Your Answer in Chat
Who Wants to Play a Little Trivia?

When did the website "Facebook" launch?

Put Your Answer in Chat
Answer

2004
Let’s Get to Know Each Other…

What is your go-to karaoke anthem?

*Put Your Answer in Chat*
Who Wants to Play a Little Trivia?

True or False.
An eggplant is a vegetable.

Put Your Answer in Chat
False
Let’s Get to Know Each Other…

What month were you born?

Put Your Answer in Chat
Who Wants to Play a Little Trivia?

In America, what became the 49th state to enter the union in 1959?

Put Your Answer in Chat
Answer

Alaska
Let’s Get to Know Each Other…

What is your most used phone app?

Put Your Answer in Chat
Who Wants to Play a Little Trivia?

What is the rarest M&M color?

Put Your Answer in Chat
Answer

Brown
Let’s Get to Know Each Other…

Team egg salad, tuna salad, or pasta salad?

Put Your Answer in Chat
Who Wants to Play a Little Trivia?

How many colors are there in a rainbow?

Put Your Answer in Chat
Answer

Seven (7)
Thanks for playing along

Let’s Get Started…
CMS Priorities, Goals, and Quality Improvement Activities

IPRO ESRD Network Program
Network Council Meeting

June 16, 2022
Welcome and Opening Remarks

Danielle Daley, MBA
Executive Director
ESRD Network 6 (GA, NC, SC)
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
  o Overview of CMS Statement of Work
  o Participation/Conditions for Coverage (CfC)
• Social Determinants of Health
• IPRO Learn
• ESRD Data Systems and Quality
• National Initiatives (Goals, Education, Interventions)
  o Quality Improvement
  o Patient Services
• Emergency Management
• Closing Remarks/Next Steps
ESRD Program Administration

Sue Caponi, MBA, RN, BSN, CPHQ
CEO, ESRD Network Program
Executive Director, ESRD Network 1 (CT, MA, ME, NH, RI, VT)
and 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 breath 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
- Dialysis Patients: 15,022
- Dialysis Facilities: 202
- Transplant Centers: 15

Network 2
NY
- Dialysis Patients: 28,843
- Dialysis Facilities: 354
- Transplant Centers: 14

Network 6
GA, NC, SC
- Dialysis Patients: 50,118
- Dialysis Facilities: 799
- Transplant Centers: 10

Network 9
OH, KT, IN
- Dialysis Patients: 32,493
- Dialysis Facilities: 651
- Transplant Centers: 14

Network 9
IN, KY, OH
- Dialysis Patients: 15,022
- Dialysis Facilities: 202
- Transplant Centers: 15

IPRO ESRD Program
- 126,476 Dialysis Patients
- 2,006 Dialysis Facilities
- 53 Transplant Centers
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 (SOW)

• Contract Cycle: June 1, 2021 – April 30, 2026
• Priorities and goals align with NQS and CMS initiatives designed to result in improvements in the care of individuals with ESRD
• Quality Improvement Activities (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 (AAKH), ESRD Treatment Choices (ETC) Payment Model, and the ETC Kidney Transplant Learning Collaborative
CMS Priorities, Goals, and QIAs

ESRD Statement of Work

• Supports achieving 25 quality improvement data driven goals
• 8 Advisory Groups with supporting coalitions conducting 6 month PDSA cycles
• 20% of Network Service Area Patient Record Data Audit Annually
• Networks deploy interventions that target patients, dialysis/transplant providers, other providers, and other stakeholders
• QIAs incorporate a focus on health equity, rural health and vulnerable populations
Network Processes - From Advisory Committee to a Community of Practice

Advisory Committee

Provides Data (Basecamp or Sharing Platform)

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

Community of Practice

Improve practices
Achieve quality of care

Community Coalitions

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

Patients
ESRD Conditions for Coverage (CfC)

- The CMS Federal Register cites Network-specific goals and the dialysis facility’s responsibility toward achieving these goals.
- State Survey Agencies utilize these goals and initiatives as a guideline for evaluations.
- Goals are achieved through the implementation of Quality Improvement Activities (QIAs) to be launched at the dialysis facility level, which are tracked and reported to CMS.
- Participation in Network activities is a condition of approval to receive Medicare reimbursement for the provision of End Stage Renal Disease services.
- Failure to comply may result in sanctions by CMS.
Network and Provider Role
Aligned to Improve the Lives of Those Living with Kidney Disease

**Network Role**
- Improve quality of life by reaching the goals outlined by CMS for ESRD population
- Ensure patients have access to care and the patient experiences care in an atmosphere of respect and safety
- Maintain the data quality of national datasets utilized to monitor ESRD (EQRS, NHSN)
- Support the ESRD community during emergency events

**Provider Role**
- Work with the Network to reach goals outlined by CMS in all areas of quality improvement outlined
- Provide a dialysis setting that is safe, respectful and ensures access to care
- Support accurate and timely data entry into EQRS and NHSN
- Collaborate with the Network to ensure all patients receive ESRD care during an emergency event
Health Equity

Danielle Andrews, MPH, MSW
Project Manager-Health Equities Specialist

weitzman institute
inspiring primary care innovation
Health Equity Check-In

- Do you wear glasses?
  - Yes
  - No
Health Equity Check-In

- Have you ever had to order specialty frames (not lenses)?
  - Yes
  - No
Health Equity Check-In
Health Equity Check-In

- Do you think health inequities exist within an average dialysis facility?
  - Yes
  - No
  - Unsure
What is Health Equity?

According the World Health Organization (WHO) health inequalities are systematic differences in healthcare outcomes.

- **Equity** is the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation). Health is a fundamental human right. **Health equity is achieved when everyone can attain their full potential for health and well-being.**

- **Health Inequities**: are differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age.
Social Determinants of Health

According to the World Health Organization (WHO), health inequalities are systematic differences in healthcare outcomes.

- **Social Determinants of Health (SDOH):** conditions in places where individuals live, learn, work, and play that affect a wide range of health and quality of life, risks, and outcomes.
  - Economic Stability
  - Education Access and Quality
  - Healthcare Access and Quality
  - Neighborhood and Built Environment
  - Social and Community Context

- **Examples of SDOH:**
  - Safe housing, transportation, and neighborhoods
  - Racism, discrimination, and violence
  - Education, job opportunities, and income
  - Access to nutritious foods and physical activity opportunities
  - Polluted air and water
  - Language and literacy skills
Social Determinants of Health-Access to Care

Figure 1 | Variation in pre-end-stage renal disease nephrology care by quintile in dialysis facilities across the US (N = 5,387).
Social Determinants of Health-Access to Care

- Large urban and rural counties see lower percentages of patients receiving pre-ESRD nephrologist care compared to suburban and medium/small urban counties (Yan et al., 2013).
- Females, whites, non-Hispanics, and older patients are more likely to receive pre-ESRD nephrology care (Hao et al., 2015).
- Low socioeconomic status and low educational attainment (fewer than 12 years) are associated with a higher prevalence of ESRD (Quiñones, 2020)
- Low educational attainment, African American race, poverty, and unemployment are all associated with lower rates of kidney transplantation (Hao et al., 2015).
Health Equity and Transplant

Which demographic and social factors predict the likelihood of receiving a kidney transplant?

**Likelihood of Black people receiving a:**

- Kidney transplant: 0.74 (0.55-0.99)
- Living-donor transplant: 0.49 (0.28-0.98)
- Deceased-donor transplant: 0.92 (0.67-1.28)

**Factors associated with lower probability of kidney transplant:**

- Black race
- Transplantation pre-change to Kidney Allocation System (KAS)
- Older age
- Greater religiosity
- Lower income
- Less social support
- Public insurance
- Less transplant knowledge
- More comorbidities
- Fewer learning activities

Conclusions: Race and social determinants of health are associated with the likelihood of undergoing kidney transplant.

Health Equity Check-In

- Have you ever heard of or discussed intersectionality?
  - Yes
  - No
  - Unsure
The concept of intersectionality describes the ways in which systems of inequality based on gender, race, ethnicity, sexual orientation, gender identity, disability, class and other forms of discrimination “intersect” to create unique dynamics and effects.

- All forms of inequality are mutually reinforcing and must therefore be analyzed and addressed simultaneously to prevent one form of inequality from reinforcing another. For example, tackling the gender pay gap alone – without including other dimensions such as race, socio-economic status and immigration status – will likely reinforce inequalities among women. (Intersectional Justice, 2022)
Health Equity Check-In

● Have you previously utilized intersectionality to develop patient specific health plans?
  ○ Yes
  ○ No
  ○ Unsure
Intersectionality and the Web of Oppression
Health Equity Sample Data from IPRO Learn

- 348 Facilities responded
- 26% of patients do NOT have a primary care provider
- 18% of facilities are located in food desert
- 85% Financial Reasons: Largest barrier identified by patients to following renal/diabetic/cardiovascular prescribed diets
- 61% Transportation: Largest barrier identified by patients to becoming/remaining active on the transplant waitlist
- 71% Limited space to host home therapy supplies or set-up: 2nd Largest barrier identified by patients on transitioning to home therapies
- 77% Experienced Mistrust in Healthcare System or Medical Racism: Top reason for vaccination hesitancy
Questions?
IPRO Learn

Svetlana Lyulkin, MBA
Director of Information Management
Why Utilize IPRO Learn

• To Participate in Monthly Network Quality Improvement Activities through the ESRD Facility Quality Improvement Collaborative

• Explore Toolkits which contain nationally vetted resources for multiple quality improvement initiatives

• Share and learn Best Practices

• To obtain CEs for professional development

• To learn about upcoming events and educational offerings

• For patient education on Network involvement and training to perform in the role of Peer Mentor
IPRO Learn 2022 - 2023

Two types of logins to https://learn.ipro.org/

1. Network-assigned facility Login/Password
   • For facility-level Quality Improvement Activities
   • Cannot be changed
   • Should be shared between staff

2. Personal user account
   • For earning IPRO Learn-issued CEs
   • For Peer Mentor training
ESRD Facility Quality Improvement Collaborative 2021-2022

What's New / Recent Announcements

- New Resource Available: Affordable Internet

To Do / Required Activities for June - Due June 30, 2022

May 2022 Data Entry is now Closed! Please complete June 2022 Activities by 6/30/2022

- Important QIA Information Session 6/16/22: Register Today for the IPRO ESRD Network Council Webinar
- General Annual Facility Critical Asset Survey (CAS) for 2022 [100% completion required in REDCap]

Achieving CMS Goals Using Quality Improvement Toolkits

- Behavioral Health Toolkit
- COVID-19 Toolkit
- Increasing Home Modality Rates Toolkit
Benefits of IPRO Learn include:

- Facility group login allows for divide and conquer approach to Network Activities
- All activities/resources posted to one site with consistent due-date to complete (fewer emails/reminders)
- Eliminates multiple-submissions (saves facilities time)
- Facilities able to provide feedback easily to Network'
- On Demand availability for everyone to use
IPRO Learn Participation

• Completion of Activities fulfills the facility’s Network participation requirements to meet your conditions for coverage.

• All submissions are received and reviewed by dedicated QI Leads in the Network

• Activities blanket all areas of quality improvement that CMS is targeting improvement in ESRD.

• Facilities who are enrolled in a Community Coalition will have specific assignments.

• All activities need to be reviewed by a member of the facility

• Split up the work between expert teammates. This should not all be done by 1 person.
ESRD Patient Facility Representative Alliance

What's New / Recent Announcements

Welcome to the IPRO ESRD Patient Facility Representative (PFR) Alliance!

Click Here to access resources that provided foundational information on the PFR Alliance, the different tiers, and the associated responsibilities.

We are thrilled to collaborate with you!

PFR Training

- PFR Alliance Orientation
- Patient Facility Representative January 2022 Meeting Recording
- Patient Facility Representative February 2022 Meeting Recording

To Do / PFR Activities

- Patient Experience of Care (PEOC): Improve PEOC by Resolving Grievances
- Behavioral Health: Your Mind and Your Body: Talking to Your Doctor about Mental Health
- Wallet Cards to Help Avoid Hospitalizations
- Living Donor Transplant: Your Best Option

PFR Alliance Newsletters:
Patient Voice-Expert Thoughts

- September 2021
- October 2021
- November 2021
- December 2021

Need Some Help?
Email ESRDNetworkProgram@ipro.us and put “PFR IPRO Learn Question” in the Subject line.
Instructions for creating a personal account:
https://iproesrdnetwork.freshdesk.com/support/solutions/articles/9000212344-earning-ces-in-ipro-learn
EQRS Reporting

Svetlana Lyulkin, MBA
Director of Information Management
Improve the Data Quality of the Patient Registry in the ESRD Quality Reporting System (EQRS)

- CMS EQRS Data Management Guidelines Require:
  - **Admits** within 5 business days of starting treatment
  - **2728 Forms** submitted within 45 days of ‘New ESRD’ Admit Date
  - **2746 Forms** submitted within 14 days of ‘Date of Death’

- Network sends monthly Reports to key personnel
- Rates monitored by CMS, goals adjusted based on Network-National performance

- EQRS Possible Duplicate or Near Match Form:
  [https://redcap.ipro.org/surveys/?s=9FN3KF8A7T](https://redcap.ipro.org/surveys/?s=9FN3KF8A7T)
EQRS Data Accuracy for Better QIA Outcomes

• (Most) QIA data from EQRS / connected to EQRS patient info
• Batched data not 100% accurate 100% of the time
• Inaccurate EQRS data → poor QIA performance → more assigned QIAs:
  • Missing admissions/discharges (Monthly Patient Roster Verification)
  • Incorrect modalities/treatment settings (EQRS Cleanup Reports)
  • Incomplete/late clinical submissions (Missing Clinical Verification)
  • QIA performance not where expected (Monthly QIA Facility Report)

• Maintain timely EQRS data
• Ensure staff access to EQRS
• Review Reports sent by the Network
• Submit questions to FreshDesk:
  https://iproesrdnetwork.freshdesk.com/support/tickets/new
IPRO ESRD Facility Contact Management System (Caspio)

- Maintain correct contact info to receive Network Reports
- [https://c1abd801.caspio.com/dp/4ebb7000068d9ae2c0504631875a](https://c1abd801.caspio.com/dp/4ebb7000068d9ae2c0504631875a)
- Login: IPROESRD
- PW: your facility CCN

Quality Improvement

Deb DeWalt, MSN, RN
Quality Improvement Director
National Clinical Objectives and Key Results (OKRs)

Goal 1: Improve Behavioral Health Outcomes
• Increase Remission of the Diagnosis of Depression

Goal 2: Improve Patient Safety and Reduce Harm
• Reduce catheter infection rate in patients receiving home dialysis within nursing homes

Goal 3: Improve Care in High Cost/Complex Chronic Conditions
• Home and Transplant modality, telemedicine and vaccinations
National Clinical Objectives and Key Results (OKRs)

Goal 4: Reduce Hospital Admissions, Readmissions, and Outpatient Emergency Visits

• Reduction in all areas

Goal 5: Improve Nursing Home Care in Low-Performing Providers

• Decrease the Rate of Blood Transfusions in ESRD Patients Dialyzing in a Nursing Home
Strategic Program Requirements: Improve Patient and Family Engagement

Improve Patient and Family Engagement at the Facility Level

• Increase the number of facilities that successfully integrate patients and families concerns into Quality Assurance and Performance Improvement (QAPI)
• Increase the number of facilities that successfully assist patients to develop a life plan
• Increase in the number of facilities that successfully develop and support a peer-mentoring program
Improve Behavioral Health Outcomes

Andrea Bates, MSW, LSW
QI Project Lead
GOAL 1: Improve Behavioral Health Outcomes
C.3.1 Increase Remission of Diagnosis of Depression

OY1 Year Goals:

• Increase the percentage of patients accurately screened for depression by 30%
• Increase the percentage of patients with depression receiving treatment by 20%
• Ensure 80% of all facilities report results of monthly screenings

Project Period:

• May 1, 2022 – April 30, 2023

Data:

• Data entry in EQRS (CMS data system of record).

Base Year Outcomes: No data available. Qualitative assessment expected

Activities: Conducted an RCA, Developed tools and shared specific services on IPRO Learn
1. Referrals and access to mental health care
2. Stigma associated with a mental health diagnosis
3. Other (misc. category)
IPRO Learn
Interventions and Resources
Improve Patient Safety and Reduce Harm/Improve Nursing Home Care

Kathy Cunningham, BS Ed, RN, CNN QI Project Lead
GOAL 2: Improve Patient Safety and Reduce Harm
Reduce catheter infection rate in patients receiving home dialysis within nursing homes

-Baseline: June 1, 2020 through April 30, 2021
-Goal: 4% reduction in catheter infection rates in patients receiving home dialysis nursing homes
-Re-Measure: June 2021-April 30, 2022
-Data Source: Claims Data & EQRS
-Goal Met: NW 9, NW1 N/A

Five Year Goal – 40% reduction
-Peritonitis – 29% reduction in 5yrs * No PD catheters in use
GOAL 5: Improve Nursing Home Care in Low-Performing Providers

Decrease the Rate of Blood Transfusions in ESRD Patients Dialyzing in a Nursing Home

- Baseline: June 1, 2020 through April 30, 2021
- Goal: 2% decrease of the Rate of Blood transfusions in Dialysis Patients who dialyze in Nursing Homes
- Re-Measure: June 1, 2021-April 30, 2022
- Data Source: Claims Data & EQRS
- Goal Met: NWs 2 and 9, NW 1 N/A
- Five Year Goal – 20% reduction
Current Resources on IPRO Learn

Guide: EQRS Patient Info Verification

Edit Treatment Information (07/26/2021)

Dialysis Treatment Information

- Treatment Start Date
  - Month: 07
  - Day: 26
  - Year: 2021

Primary Dialysis Setting:
- Home
- Dialysis Facility/Centre
- SNF/Long Term Care Facility

Transitions of Care Toolkit
Developed by the Forum of ESRD Networks’ Medical Advisory Council (MAC)

Tell us what you think! Please take a moment to complete a short questionnaire about this Toolkit. We appreciate your insight and suggestions to make our resources better.
https://www.fonesadvicecenter.com/care/medicalexpertise
Improve Care in High Cost/Complex Chronic Conditions: Home Dialysis
GOAL 3: Improve Care in High Cost/Complex Chronic Conditions

Increase Incident and Prevalent Patients to Home Dialysis Modality

- Baseline: June 1, 2020 through April 30, 2021
- Goal: 10% Increase of Incident Pts
- Re-Measure: June 1, 2021-April 30, 2022
- Data Source: EQRS
- Goal Met: No Network Met Goal

- Baseline: June 1, 2020 through April 30, 2021
- Goal: 2% Increase of Prevalent Pts
- Re-Measure: June 1, 2021-April 30, 2022
- Data Source: EQRS
- Goal Met: No Network Met Goal
GOAL 3: Improve Care in High Cost/Complex Chronic Conditions

Increase in rural patients using telemedicine to access a home modality

- Baseline: June 1, 2020 through April 30, 2021
- Goal: 2% increase in rural patients using telemedicine to access a home modality
- Re-Measure: June 1, 2021-April 30, 2022
- Data Source: Claims Data & EQRS
- Goal Met: NWs 1 and 2
Improve Education and Access to Empower Patient Choice of Home Modality

Facility Intervention/ Resources

https://www.youtube.com/watch?v=mXjdSeW3Pjs
Improve Education and Access to Empower Patient Choice of Home Modality

Patient Resources Intervention/ Resources
Benchmarking Performance
Facility Performance Score Cards

Home and Transplant Modalities Report
Report includes EQRS Data as of: 1/31/2022

<table>
<thead>
<tr>
<th>Measure</th>
<th>NW Rate</th>
<th>National Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home: Transitions</td>
<td>4.1%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Home: Incidents</td>
<td>14.7%</td>
<td>13.72%</td>
</tr>
<tr>
<td>Txp: Transplanted</td>
<td>1.8%</td>
<td>2.0%</td>
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<tr>
<td>Txp: Waitlisted</td>
<td>3.8%</td>
<td>3.4%</td>
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</table>

Home Modalities Quality Improvement Activity
For the Increasing Home Modality Quality Improvement Activity, the Network assigned a Goal for each facility based on prior years’ performance. If there is no data displayed below, then facility had 0 Transitions and/or Incidents since June 2021.
Home Modality Measures are defined as:

- Transition to a Home Modality includes patients who transition from any modality to a home modality (home hemodialysis, CAPD, CCPD).
- Incident patients are those whose first dialysis treatment are a home modality. This measure is assigned to dialysis facilities that offer a home modalities program.

CMS Home Modalities Goals 2021 - 2025
- 60% increase in the number of new patients starting a home modality
- 30% increase in patients that transition to a home modality

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline Pts added in 2020</th>
<th>(Facility Goal) June 2021 - April 2022</th>
<th>June 2021 to Date</th>
<th>Pts Still Needed to reach Goal</th>
<th>Facility Rate (NW and National Rates shown at top of Report)</th>
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<tr>
<td>Transition</td>
<td>5</td>
<td>6</td>
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<tr>
<td>Incident</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>1.49%</td>
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Improve Care in High Cost/Complex Chronic Conditions: Transplantation

Caroline Sanner, MSN, RN-BC
QI Project Manager
June 2021-April 2022
Network Program Performance: Wait Lists

Added to Waitlist Progress to Target (Counts)
SOW Goal: 2% Increase (Relative)
Hover over to see the percentage to goal.
June 2021-April 2022
Network Program Performance: Transplants

Transplanted Progress to Target (Counts)
SOW Goal: 2% Increase (Relative)
Hover over to see the percentage to goal.

<table>
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<tr>
<th>Network</th>
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<th>Baseline 1,035</th>
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<th>Remeasurement 965</th>
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Legend:
- count
- to target
- percent_of_target
Living Donor Transplant: Your Best Option.

How is a kidney from a living donor better than one from a deceased donor?

- Kidney from a deceased donor:
  - Kidney may last 3-5 years
  - Kidney may need to be matched
  - Kidney may be a match for multiple recipients

- Kidney from a living donor:
  - Kidney can last longer than 10 years
  - Kidney does not need to be matched
  - Living donor can be a match for any recipient

Facts About Living Donation That May Surprise You

- You do not need to ask anyone for their kidney. About 100 people each year donate a kidney to help someone they love.
- In the past, people needed to talk to a doctor or nurse who could help with the surgery. Now, there are donation programs that offer financial support to families who need medical care.
- It will not cost the donor money to give you a kidney. In fact, your health insurance will cover all or most of the costs involved.

Helpful tips after donating a kidney:

- Be sure to schedule your next medical check-up.
- Eat a healthy diet and exercise regularly.
- Try to get back to your normal routine as soon as possible.
- Your donor will have more

Waiting Less: SHORTEN YOUR WAIT FOR A KIDNEY TRANSPLANT

- It’s a big ask. Many doctors’ patients exploring living donation are interested in transplant because it often works faster than other options.

- The living donor will not need to be matched to you. All you have to do is agree to be a living donor.

- The living donor will be very happy to have a kidney.

- The living donor will have a new

Helpful advice for transplant recipients:

- Try to eat a healthy diet and exercise regularly.
- Take medications as prescribed.
- Visit your doctor regularly.
- Avoid smoking and alcohol.
- Stay in touch with your transplant center.

Waiting for a kidney from a deceased donor can take 3-5 years or more. There are many benefits to living donation, including shorter wait times.
Benchmarking Performance

Facility Performance Report Cards

Transplantation Waitlisting Quality Improvement Activity

For the increasing Transplantation and Waitlisting Quality Improvement Activity, the Network assigned a goal for each facility based on prior years’ performance. This number below from the UNOS national registry. If you note a discrepancy, please contact your transplant center to verify your listings.

Transplant Q/A Measures include the following:

- Waitlist: Patients added to a transplant waitlist at one (or multiple) transplant centers in the U.S.
- Transplant: Patient who receives a kidney transplant. Transplants should be documented in ECRS.

<table>
<thead>
<tr>
<th>Measure</th>
<th>(Baseline) Pts Added in 2020</th>
<th>(Facility Goal) June 2021 - April 2022</th>
<th>June 2021 to Date</th>
<th>Pts Still Needed to Reach Goal</th>
<th>Facility Rate (NW and National Rates shown at top of report)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waitlist</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>5.06%</td>
</tr>
<tr>
<td>Transplant</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>-1</td>
<td>3.03%</td>
</tr>
</tbody>
</table>
Reduce Hospital Admissions, Readmissions, and Outpatient Emergency Visits

Deb DeWalt, MSN, RN
Quality Improvement Director
GOAL 4: Reduce Hospital Admissions and Readmissions

- Baseline: June 1, 2020 - April 30, 2021
- Goal: 2% decrease
- Re-Measure: June 1, 2021 - April 30, 2022
- Data Source: Claims Data
- Goal Met: NWs 1, 6 and 9
GOAL 4: Reduce Outpatient Emergency Visits

Number of ED Visits per 100 patient-months (lower rates are better)
SOW Goal: 2% Decrease (Relative)

Legend:
- rate
- upper_limit

Baseline: June 1, 2020 - April 30, 2021
Goal: 2% decrease in ED visits
Re-Measure: June 1, 2021 - April 30, 2022
Data Source: Claims Data
Goal Met: NWs 2, 6 and 9
Performance Score Cards
New for 2022-2023!
Improve Care in High Cost/Complex Chronic Conditions: Vaccinations

Aisha Edmondson
QI Project Lead
Vaccines are one of our best defenses against serious diseases. Many diseases are becoming rare or eradicated in the United States because we have been vaccinated against them. This is a great public health accomplishment because the pain, suffering and death from these diseases are changing day to day due to vaccines.

- Vaccines work better when more people are vaccinated “herd immunity”
- Vaccines are one of the most convenient and safest preventive self care measures available.
- Vaccines are tested and undergo a robust approval process to ensure all licensed vaccines are safe and effective
- Potential side effects associated with vaccines are uncommon and much less severe than the diseases they prevent
GOAL 3: Improve Care in High Cost/Complex Chronic Conditions

Decrease Hospitalization of COVID-19 Positive ESRD Patients

- Baseline: June 1, 2020 through April 30, 2021
- Goal: 25% decrease
- Re-Measure: June 2021-April 30, 2022
- Data Source: Claims Data & NHSN
- Goal Met: NWs 2, 6 and 9
GOAL 3: Improve Care in High Cost/Complex Chronic Conditions

Ensure 90% of dialysis patients and 90% of Staff receive an influenza vaccination by the end of the base period.

Patient Influenza Vaccination Trend by Network

- Baseline: June 1, 2020 - April 30, 2021
- Goal: 85%
- Re-Measure: June 2021 - April 30, 2022
- Data Source: EQRS
- Goal Met: No Networks met goal

Staff Influenza Vaccination Trend by Network

- Baseline: June 1, 2020 - April 30, 2021
- Goal: 90%
- Re-Measure: June 2021 - April 30, 2022
- Data Source: NSHN
- Goal Met: No Networks met goal
Interventions/Resources

Staying Safe in Multigenerational Households

What is a multigenerational household?
A multigenerational household, or grandfamily, is one where more than two age groups live in the same home. This could be adults with children whose parents (the grandparents) also live with them. Or, it could be any other family members of different generations living together.

Multigenerational households have special needs when it comes to Coronavirus 2019 (COVID-19). This is true when someone has kidney disease and is living on dialysis or with a transplant. Remember—everyone needs to protect against COVID-19. Anyone of any age can get sick with the virus.

Here are some common needs and ideas on how to make it work.

Grandparents
People in this generation may be the most vulnerable like kidney failure. It is important to understand and follow the guidelines. As with most people, it is best to get back on track.

Please write after each vaccine the date it was received.

- Influenza (Flu)
  You should receive this vaccine once every year. Please list the date you received this vaccine each year.
<table>
<thead>
<tr>
<th>Influenza (Flu) Year 1</th>
<th>Influenza (Flu) Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza (Flu) Year 2</td>
<td>Influenza (Flu) Year 6</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza (Flu) Year 3</td>
<td>Influenza (Flu) Year 7</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza (Flu) Year 4</td>
<td>Influenza (Flu) Year 8</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Pneumococcal pneumonia
  You should receive up to three doses of this vaccine in your lifetime, with doses being five years apart.
  - Circle type: PCV 13 / PPV 23 Date:_____________
  - Circle type: PCV 13 / PPV 23 Date:_____________
  - Circle type: PCV 13 / PPV 23 Date:_____________

- TD (Tetanus/Diphtheria)
  You should receive this vaccine once every ten years.
  Date:_____________

- COVID-19

Vaccination Toolkit
Developed by the Forum of ESRD Networks’ Medical Advisory Council (MAC)

Tell us what you think!
Please take a moment to complete a short questionnaire on this Toolkit. We appreciate your insight and suggestions make your resources better.
http://www.isrdnetworking.com/forum/toolkit
Data Performance Scorecards/Interventions

Influenza Vaccination Report

CCN: 152517  FMC - CANAL DIALYSIS

152517 Sajid Habib  shabb@nephdocs.com  Facility Medical Director
152517 Angie Summers  angie.summer@fmc-na.com  Facility Head Nurse/Nurse Supervisor
152517 Danielle Boughton  danniel.boughton@freseniusmedical.com

This facility’s Patient Influenza (flu) Vaccination Rate for:

**Current Flu Vacc Count**: 34
**Current Eligible Patients**: 38
**Current Flu Vacc Rate**: 89.4%

Review the list of UPIs below and make sure they have Influenza (flu) Vaccinations. If the patient Declines or is deemed Medically-Ineligible, that still needs to be reported to EQRS.

Detailed Instructions (with screenshots) for reporting flu vaccinations are located here:

KnowledgeBase: Documenting Patient Influenza Vaccination

<table>
<thead>
<tr>
<th>Start of Remeasurement</th>
<th>End of Remeasurement</th>
<th>UPI No Flu Vaccinated / Not Medical</th>
<th>Vaccine Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/1/2021</td>
<td>3/31/2022</td>
<td>310372</td>
<td>Surveys</td>
</tr>
<tr>
<td>8/1/2021</td>
<td>3/31/2022</td>
<td>310362</td>
<td>Analysis</td>
</tr>
<tr>
<td>8/1/2021</td>
<td>3/31/2022</td>
<td>310371</td>
<td>COVID-19 Weekly Vaccination Summary</td>
</tr>
<tr>
<td>8/1/2021</td>
<td>3/31/2022</td>
<td>210552</td>
<td>Weekly Flu Vaccination Summary</td>
</tr>
</tbody>
</table>

IPRO ESRD Network Program
Submit a ticket: http://help.esrd.ipro.org

End of Report

Page 1 / 1
Improve Patient and Family Engagement at the Facility Level

Andrea Bates, MSW, LSW
QI Project Manager
Strategic Program Requirements: Improve Patient and Family Engagement

Plan of Care and QAPI Goals

Assist patients to develop a life plan, from which the dialysis facility develops the dialysis plan of care

Successful Integration of Patients into Quality Assurance and Performance Improvement (QAPI)

Goal Met: NWs 1, 2, 6 and 9
Interventions to Address Barriers

Patients involved with QAPI

- Top barrier to patients not being included in QAPI were concerns with patient confidentiality

- The Help with HIPAA handout was created to assist facilities who reported

- A short video was created for facilities outlining the basics of patient inclusion
  - Incorporating the Patient’s Voice into Your Facility’s QAPI Meetings
Strategic Program Requirements: Improve Patient and Family Engagement

Peer Mentoring Program

Increase the Number of Facilities that Successfully Develop and Support a Peer-Mentoring Program

- Baseline: June 1, 2021
- Goal: 5% Improvement
- Re-Measure: March 2022
- Data Source: Self-Reported

Goal Met: NWs 1, 2, 6 and 9
Improve the Patient Experience of Care

Danielle Daley, MBA
Executive Director
ESRD Network 6 (GA, NC, SC)
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.
Patient Services Team: 516-231-9767

Danielle Daley, MBA
Executive Director

Agata Roszkowski, LMSW
Patient Services Director
Network 1

Shezeena Andiappen, MSW
Patient Services Coordinator
Network 2

Brooke Andrews, MSW
Patient Services Coordinator
Network 6

Elizabeth Lehnes, MSW
Patient Services Coordinator
Network 9

Julia Dettmann, BSW
Patient Services Coordinator
Emergency Coordinator
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

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
# Grievance Case Management

## January - May 2022

<table>
<thead>
<tr>
<th>Case Categories</th>
<th>Network 1</th>
<th>Network 2</th>
<th>Network 6</th>
<th>Network 9</th>
<th>IPRO ESRD Network Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Advocacy</td>
<td>9</td>
<td>7</td>
<td>13</td>
<td>8</td>
<td>37</td>
</tr>
<tr>
<td>General Grievance</td>
<td>2</td>
<td>12</td>
<td>16</td>
<td>11</td>
<td>41</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>3</td>
<td>4</td>
<td>9</td>
<td>2</td>
<td>18</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14</strong></td>
<td><strong>23</strong></td>
<td><strong>38</strong></td>
<td><strong>21</strong></td>
<td><strong>96</strong></td>
</tr>
</tbody>
</table>
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

Tips for Dialysis Staff to Identify and Manage Retaliation

- Interpretation is occurring. It is experienced. It’s often subtle, for example, patient complaints can be ignored when making a request.
- I have felt cliets. I’ve been voicing a concern. My supervisor responded by telling me to “stop” or “hush” when they talked stop talking to me.
- I have received complaints from a manager and those that have a concern, such as “If you go to the nurse, you can always transfer to another nurse.”

Things said as a patient relationship; even a low, can harm patients’ relationships. This is important to the patient’s experience. If these are some tips to consider when communications become uncomfortable:

- Be objective – don’t take things personally.
- Acknowledge anger or if upset feelings.
- Notice your actions – they are louder than your words.

End Stage Renal Disease Network Program

V-TAGS & INTERPRETIVE GUIDANCE REGARDING PATIENT INVOLUNTARY DISCHARGE

CMS End Stage Renal Disease (ESRD) Program Interim Final Version Interpretive Guidance Version 1.1

TAG NUMBER

<table>
<thead>
<tr>
<th>TAG NUMBER</th>
<th>REGULATION</th>
<th>INTERPRETIVE GUIDANCE</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Patient Rights)</td>
<td>V60(V)</td>
<td>Patient may be given notice of a voluntary discharge and the facility’s discharge policies.</td>
<td>If the patient is discharged involuntarily, the notice must be given at least 30 days prior to the discharge.</td>
</tr>
<tr>
<td>(Patient Rights)</td>
<td>V60(V)</td>
<td>Patients must be given at least 30 days notice of a voluntary discharge.</td>
<td>If the patient is discharged involuntarily, the notice must be given at least 30 days prior to the discharge.</td>
</tr>
<tr>
<td>(Patient Rights)</td>
<td>V7(V)</td>
<td>The patient has the right to medical care, regardless of the facility’s discharge policies.</td>
<td>If the patient is discharged involuntarily, the notice must be given at least 30 days prior to the discharge.</td>
</tr>
</tbody>
</table>

Dialysis Facility Involuntary Discharge Guidelines

When considering an involuntary discharge, it is advisable to:

- Conduct a careful review of all patient records.
- Ensure that the patient is aware of their rights to treatment and their ability to appeal the decision.
- Notify the patient of the discharge and the reasons for the discharge.
- Provide the patient with the opportunity to seek further medical evaluation or treatment.
- Document the decision and the communication with the patient.

The patient has the right to:

- Attend medical care.
- Choose their own healthcare provider.
- Appeal the discharge decision.

Document everything:

- Initials and dates should always be included.
- Document the patient’s request for medical care.
- Document the patient’s refusal for medical care.
- Document the patient’s appeal for the discharge decision.

Dialysis Patient Toolkit

The National Forum of Care

Patient Experience of Care

Dialysis Facility Involuntary Discharge Guidelines

When considering an involuntary discharge, it is advisable to:

- Conduct a careful review of all patient records.
- Ensure that the patient is aware of their rights to treatment and their ability to appeal the decision.
- Notify the patient of the discharge and the reasons for the discharge.
- Provide the patient with the opportunity to seek further medical evaluation or treatment.
- Document the decision and the communication with the patient.

The patient has the right to:

- Attend medical care.
- Choose their own healthcare provider.
- Appeal the discharge decision.

Document everything:

- Initials and dates should always be included.
- Document the patient’s request for medical care.
- Document the patient’s refusal for medical care.
- Document the patient’s appeal for the discharge decision.
Access to Care

Upon the receipt of a access to care concern, the Network will classify the case as one of the following:

- **At Risk Involuntary Discharge**: Concerns related to possible patient discharge.
- **Involuntary Discharge**: Immediate or 30 day IVD. Volume monitored by the Network

Before considering an involuntary discharge (IVD), a facility’s interdisciplinary team (IDT) should:

- Conduct a thorough assessment of the situation
- Develop a plan to address any problems or barriers the patient may be experiencing

Note: Discharging a patient for “non-compliance” is not an acceptable reason for discharge per the Centers for Medicare & Medicaid Services (CMS) Conditions for Coverage (CfC).
IVD Guidelines

• Notify the Network **PRIOR** to discharge any potential IVD and notice provided to patient
• Have a policy and procedure in place for IVDs
• Train facility staff
• Document everything
• IVD should be the option of **LAST** resort
• Assist the patient with placement
• Notifying the State Survey Agency
## Access to Care Case Management

**January - May 2022**

<table>
<thead>
<tr>
<th>Case Categories</th>
<th>Network 1</th>
<th>Network 2</th>
<th>Network 6</th>
<th>Network 9</th>
<th>IPRO ESRD Network Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Concern</td>
<td>51</td>
<td>92</td>
<td>75</td>
<td>80</td>
<td>298</td>
</tr>
<tr>
<td>Access to Care</td>
<td>24</td>
<td>44</td>
<td>59</td>
<td>50</td>
<td>177</td>
</tr>
<tr>
<td>Averted Discharge</td>
<td>8</td>
<td>9</td>
<td>7</td>
<td>18</td>
<td>42</td>
</tr>
<tr>
<td>Involuntary Discharge</td>
<td>3</td>
<td>6</td>
<td>35</td>
<td>28</td>
<td>72</td>
</tr>
<tr>
<td>Failure to Place</td>
<td>3</td>
<td>6</td>
<td>1</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>75</strong></td>
<td><strong>136</strong></td>
<td><strong>134</strong></td>
<td><strong>130</strong></td>
<td><strong>475</strong></td>
</tr>
</tbody>
</table>
Emergency Management

Danielle Daley, MBA
Executive Director
ESRD Network 6 (GA, NC, SC)
Emergency Preparedness, Mitigation, and Response

Network Responsibilities

- Networks are the foundation of ESRD Emergency Management in collaboration with the Kidney Community Emergency Response (KCER) national response coordination contractor
- Networks monitor conditions that impact a facility’s ability to provide service to dialysis patients
- Networks establish relationships with state emergency management officials and healthcare coalitions
- During an emergency, Networks:
  - Work to identify challenges and barriers impacting patients and facilities
  - Collaborate with emergency response stakeholders at the local level to re-establish interrupted services
Emergency Preparedness, Mitigation, and Response

- **REPORT Closed/Altered Status**
- **Use the Closed/Altered Reporting Link:**
  https://redcap.ipro.org/surveys/?s=RR8K7RWETHM

**Why?**

- Network reports to CMS, State and local OEMS during events
- Assists in placing patients as needed
- Provides Situational Awareness in an emergency
Critical Asset Survey (CAS) for 2022

- Annual Critical Assets Survey (CAS)
  - [https://redcap.ipro.org/surveys/?s=FFNK EEHC9EYJAC8F](https://redcap.ipro.org/surveys/?s=FFNK EEHC9EYJAC8F)
  - 88% completion rate (1,752/2,002) for 2022
  - Represents preparedness activities and resources of dialysis Facilities

- Data Used By:
  - State OEMS
  - Healthcare Coalitions
  - Network Emergency Management

- Facility Summary Reports
  - Facility Summary Reports distributed mid-August, add this to your facility’s Emergency Plan
Critical Asset Survey (CAS) for 2022

Due 5/31/2022. Collection calls will begin next week.

• If you receive an email = no CAS submitted
• It is not considered Submitted if:
  • It was incomplete/abandoned
  • Wrong CCN was entered

Re-Enter your facility CCN as it appears in the drop down above (6 digits, no spaces, no dashes)
  • Only 1 submission per facility.
  • If you enter the correct CCN and get a "Duplicate Value!" message, it means that this Survey has already been submitted and no further action required!

* must provide value

Submit 1 per facility Only. If you see "Duplicate Value!" message, that means it has already been submitted and no further action needed.
Thank You

For more information about the IPRO ESRD Network Program, go to https://esrd.ipro.org/

Department Phone and Fax Lines:
Patient Services: 516-231-9767
Data Management: 516-268-6426
Administration: 516-686-9790

Toll-Free Patient Line: 800-238-3773 (ESRD)