

**STATEMENT OF WORK (SOW)  
FOR  
End Stage Renal Disease (ESRD) Network**

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## C.1 PURPOSE:

The purpose of this Task Order is to delineate tasks to be conducted by each ESRD Network Organization contractor in support of achieving national quality improvement goals and statutory requirements as set forth in Section 1881 of the Social Security Act and the Omnibus Budget Reconciliation Act of 1986. The term “Network” is used in this Task Order to refer to the ESRD Network contractor. The tasks described in this Task Order are intended to align Network activities with the Department of Health and Human Services (HHS) National Quality Strategy (NQS), the Centers for Medicare & Medicaid Services (CMS) goals addressed in the CMS Quality Strategy, and the CMS 16 Strategic Initiatives designed to result in improvements in the care of individuals with ESRD.

The quality improvement activities in the task order may incorporate one (1) or more of the [CMS 16 Strategic Initiatives](#). To substantively support these priorities and goals, the Network may need to deploy interventions that target patients, dialysis/transplant providers, other providers, and/or other stakeholders. The Network shall incorporate a focus on rural health and vulnerable populations in the activities outlined in the Task Order.

The role of the Network shall be to act as patient care navigators and lead transformation of patient care in the dialysis community by:

- Serving as conveners, organizers, motivators, and change agents;
- Leveraging technology to provide outreach and education;
- Serving as partners in quality improvement with patients, practitioners, healthcare providers, other healthcare organizations, and other stakeholders;
- Securing commitments to create collaborative relationships with other stakeholders and partners;
- Achieving and measuring changes at the patient level through data collection, analysis, and monitoring for improvement;
- Disseminating and spreading best practices, including those relating to clinical care, quality improvement techniques, and data collection through information exchange;
- Participating in the development of a CMS national framework for providing emergency preparedness services for the ESRD community; and
- Targeting technical assistance to providers and communities in need based on data driven analysis.

## C.2 BACKGROUND:

The foundation of the ESRD Network program work is grounded on the concepts and design of the following:

- Section 1881 of the Social Security Act (SSA)
- HHS Secretary's Priorities
- Executive Order to launch *Advancing American Kidney Health*
- ESRD Treatment Choices (ETC) Payment Model
- ETC Kidney Transplant Learning Collaborative

The iQuality Improvement and Innovation Group (iQIIG) manages a dynamic portfolio of Strategic Quality Improvement Initiatives at a national scale. iQIIG is a primary driver in the improvement of healthcare quality, outcomes, and person & family experience, and is committed to the aims of the CMS Quality Strategy: better health, smarter spending, and healthier people. iQIIG has a mission to use quality improvement, innovation, data, and intensive pursuit of outcomes to achieve meaningful national impact that improves the health and healthcare experiences of the people we serve. The iQIIG vision supports leading, supporting, and empowering patients, caregivers, and partners through vibrant, aims-driven national learning networks that aspire to and achieve bold national results. iQIIG emphasizes the goals of:

- Focusing on person and family-centered values within our program activities and focus areas;
- Achieving excellence in the implementation and operation of national programs;
- Identifying high-impact, low-cost methods and opportunities to improve the quality and safety of the American healthcare system; and
- Showcasing high-performance and infusing professional joy into our staff, our networks, and our accountabilities.

As an agency, CMS is charged with executing The Executive Order on Advancing American Kidney Health (AAKH), signed into law on July 10, 2019. Health and Human Services (HHS) has three goals based on AAKH. One of the goals is to have 80 percent of new ESRD patients either receiving dialysis at home or receiving a transplant by 2025. A kidney transplant is the preferred treatment modality for ESRD. A kidney transplant can provide a patient with a better quality of life. Patients who receive a kidney transplant also have a longer life than those that continue on dialysis. Patients who choose to perform home dialysis also have a longer, better quality of life than patients who receive in-center dialysis treatment.

### C.2.1 Expectations- Goals and Operations:

CMS seeks to align the ESRD task orders with the goals and objectives stated in the Network of Quality Improvement and Innovation Contractor (NQIIC) Indefinite Delivery Indefinite Quantity (IDIQ) contract, which includes current CMS agency goals and priorities. These goals may evolve over the period of performance of this task order.

ESRD Network contractors, a subset of NQIICs, are uniquely positioned to reach a broad spectrum of healthcare providers, beneficiaries, and local communities, allowing them to serve as change agents to improve healthcare quality. The ESRD Network contractors will work to meet the current and future goals of CMS including the iQIIG goals:

- Improve Behavioral Health Outcomes;
- Improve Patient Safety and Reduce Harm;
- Improve Care in High Cost/Complex Chronic Conditions;
- Reduce Hospital Readmissions; and
- Improve Nursing Home Care in Low-Performing Providers, and provide Targeted Quality Improvement (QI) Response.

The NQIIC IDIQ contract allows for flexibility and responsiveness. As CMS goals and priorities change, NQIICs, including the ESRD Network contractors, must acclimate to the changes in healthcare.

### C.2.2 Flexibility & Agility in Operations and Teaming with CMS and Others:

CMS developed the NQIIC IDIQ contract to enable flexible contracting that allows contractors to rapidly respond to evolving needs, and for CMS to utilize various contracting methods to reach mutual healthcare quality improvement goals. This inclusive approach enables CMS, contractors, healthcare associations, hospitals, and other stakeholders to build relationships and teams to maintain responsiveness. NQIIC contractors shall develop agile teams, able to recognize emerging needs, team with CMS and other stakeholders to respond to emerging needs, and rapidly evolve to meet new priorities. The NQIIC IDIQ is built on the assumption that the expertise and reach of multiple NQIICs will team together to improve the continuum of care for patients with health issues, for this task order specifically patients with Chronic Kidney Disease (CKD). The continuum of other disease states may also be vital to this task order, for example, hypertension, diabetes, cardiovascular disease, or mental health issues.

### C.2.3 Cross-Cutting Focus:

To align all tasks exercised under the NQIIC IDIQ, the ESRD Network contractors are to target areas of CMS focus as follows:

- Health Equity- is achieved when every person has the opportunity to “attain his or her full health potential” and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances”;
- Rural Health- this includes addressing needs and barriers of those living in geographically rural areas; and
- Patient and Family Engagement- Ensuring patients and their families are involved in quality improvement activities and are empowered to have a voice in their own healthcare.

### C.2.4 Use of Community Coalitions to Drive Improvement:

ESRD Network contractors shall be committed to the use of community coalitions to drive improvement in multiple areas of quality improvement. Community coalitions function as bodies of stakeholders within a community dedicated to defining a healthcare issue within the designated community, producing a root cause analysis to identify areas for improvement, committing to work as a group to achieve quantitative aims, and implementing specific actions tied to the identified root causes that are designed to improve healthcare outcomes within the community. ESRD Network contractors may serve as conveners of community coalitions,

partners, stakeholders, and/or they may provide support by promoting community coalitions to their recruited partners and stakeholders. The primary focus of the community coalitions shall include identification and commitment to overcoming health equity issues, specific to each community coalition.

#### C.2.5 Tight on “What” Outcomes, Flexible on “How” Methods:

While CMS requires strong accountability from ESRD Network contractors in the form of measurable quality improvement outcomes, ESRD Network contractors are healthcare quality experts and will be provided flexibility to determine the best methods to achieve outcomes and metrics in an effort to determine if it is reproducible in other communities. CMS will work with contractors to spread best practices and innovative approaches learned through the quality improvement process. The ESRD Network contractors shall align their work with NQIC’s overall mission to use quality improvement, innovation, and data in the intensive pursuit of outcomes that impact the health and healthcare experiences of beneficiaries in a meaningful way.

#### C.2.6 Focus Improvement at Multiple Levels:

ESRD Network contractors shall utilize differing methods to focus improvement within the ESRD community:

- National: National Coordinating Center (NCC) Learning and Action Network (LAN) calls and activities, along with other national learning opportunities for the goals.
- Region: LAN work will focus on education at a regional level.
- Community: Community coalition work is driven by the community and focused on improving healthcare outcomes and addressing health equity.
- System: Community coalitions are driven by healthcare systems and specific technical assistance (TA) can provide additional needed education.
- Provider: Individual TA provides specialized assistance to further quality improvement aims.

It is critical to understand the difference between education and technical assistance. Education provides knowledge or instruction and can be accomplished through webinars, posters, brochures, and websites. Technical assistance provides targeted support to an organization or individual with an identified need. Technical assistance is individualized to the facility, in order to overcome an individualized problem related to the work identified in this task order.

### C.3 PROGRAM OBJECTIVES AND KEY RESULTS:

The ESRD Network shall support the following objectives for this statement of work by achieving the listed key results:

#### GOAL 1: Improve Behavioral Health Outcomes

##### C.3.1 Increase Remission of Diagnosis of Depression

Depression was identified in 39.3% of ESRD patients when evaluated by screening questionnaires, and 22.8% when evaluated by clinical interview. Psychosocial and biologic changes that accompany dialysis contribute to the high rates of depression in the ESRD patient population. ESRD patients that have a diagnosis of depression suffer with poor quality of life and increased

mortality.<sup>1</sup> Chronic pain in hemodialysis (HD) patients is associated with depression and insomnia and may predispose patients to consider withdrawal of dialysis.<sup>2</sup> Review of Medicare Claims data from 2017 revealed that 12% of prevalent patients and 7% of incident patients received mental health visits, out of the 7% of patients identified as depressed by the quality incentive program. The Network shall identify the issues with the low incidence of reporting and assist facilities to report depression more accurately. The Network shall meet with empowered patients, nephrologists, primary care providers, dialysis facility staff from all modalities, psychologists, psychiatrists, large and small dialysis organizations regional management, and other contractors with a relevant Task Order under the IDIQ, as an advisory committee (Deliverable #1). These meetings shall be used to plan, develop, and implement quality improvement concepts and strategies to be further developed and utilized by the Network to mitigate the incidence of depression in the ESRD patient community. These strategies include, but are not limited to, peer-mentoring, establishing a meaningful plan of care, and patient participation in the quality improvement at dialysis facilities. These strategies support identification and mitigation of any health equity issues that would impede a through accurate screening for depression and connecting patients to treatment. Only qualified healthcare personnel, with appropriate training as designated by their profession, will assess the results of screening for depression and perform any intervention on those persons referred for a positive finding on the screening tool utilized.

CMS will calculate the baseline for each measure below when the ESRD Quality Reporting System (EQRS), or another CMS data system approved to assess progress, has the ability to identify depression screenings. It will not change over the course of the task order period of performance.

Achieve a 75% increase (less 1% for each month that the depression feature is unavailable) in the percentage of patients accurately screened as having depression using EQRS, or another CMS approved data system, over the task order period of performance.

- Achieve a 15% increase (less 1% for each month that the depression feature is unavailable) in the percentage of patients accurately identified as having depression from baseline to the end of the base period.
- Achieve an additional 15% increase in the percentage of patients accurately identified as having depression, for a 30% total increase (less 1% for each month that the depression feature is unavailable in the base period) from baseline to the end of Option Period 1.
- Achieve an additional 15% increase in the percentage of patients accurately identified as having depression, for a 45% total increase (less 1% for each month that the depression feature is unavailable in the base period) from baseline to the end of Option Period 2.
- Achieve an additional 15% increase in the percentage of patients accurately identified as having depression, for a 60% total increase (less 1% for each month

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<sup>1</sup> Shirazian S, Grant CD, Aina O, Mattana J, Khorassani F, Ricardo AC. Depression in chronic kidney disease and end-stage renal disease: similarities and differences in diagnosis, epidemiology, and management. *Kidney Int Rep.* 2017;2:94–107.

<sup>2</sup> Davison SN, Jhangri GS. The impact of chronic pain on depression, sleep, and the desire to withdraw from dialysis in hemodialysis patients. *J Pain Symptom Manage.* 2005 Nov;30(5):465-73.

that the depression feature is unavailable in the base period) from baseline to the end of Option Period 3.

- Achieve an additional 15% increase in the percentage of patients accurately identified as having depression, for a 75% total increase (less 1% for each month that the depression feature is unavailable in the base period) from baseline to the end of Option Period 4.
- Achieve a 50% increase (less 1% for each month that the depression feature is unavailable) in the percentage of patients, within the subset of patients identified as having depression, who have received treatment by a mental health professional using EQRS, or another CMS approved data system, and Medicare Claims data over the task order period of performance.
  - Achieve a 10% increase (less 1% for each month that the depression feature is unavailable) in the percentage of patients, within the subset of patients identified as having depression, who have received treatment by a mental health professional from baseline to the end of the base period.
  - Achieve an additional 10% increase in the percentage of patients, within the subset of patients identified as having depression, who have received treatment by a mental health professional for a total of 20% (less 1% for each month that the depression feature is unavailable in the base period) from baseline to the end of Option Period 1.
  - Achieve an additional 10% increase in the percentage of patients, within the subset of patients identified as having depression, who have received treatment by a mental health professional for a total of 30% (less 1% for each month that the depression feature is unavailable in the base period) from baseline to the end of Option Period 2.
  - Achieve an additional 10% increase in the percentage of patients, within the subset of patients identified as having depression, who have received treatment by a mental health professional for a total of 40% (less 1% for each month that the depression feature is unavailable in the base period) from baseline to the end of Option Period 3.
  - Achieve an additional 10% increase in the percentage of patients, within the subset of patients identified as having depression, who have received treatment by a mental health professional for a total of 50% (less 1% for each month that the depression feature is unavailable in the base period) from baseline to the end of Option Period 4.

#### Non-Functional Goals:

- The Network shall ensure a minimum of 70% of dialysis facilities report the results of screening for depression quarterly in EQRS in the base period. The Network is expected to increase the percentage of dialysis facilities reporting the results of screening for depression quarterly in EQRS to a minimum of 80% in Option Period 1, 85% in Option Period 2, 90% in Option Period 3, and 95% in Option Period 4 (Deliverable #2).
- The Network shall assemble a coalition of high-performing dialysis facilities and experts in the subject matter stated above, from the Network service area. The coalition will assess local issues pertinent to the subject matter above and use a four-month plan – do – study – act (PDSA) format to solve issues and recommend interventions. If another quality

improvement contractor receives a Task Order under the NQIIC IDIQ, that has behavioral health issues as a task in their contract, the ESRD Network shall contact them to become a member of the coalition to fully collaborate and share knowledge and success across contracts. The Network shall report the activities of the coalitions, with a focus on mitigating health equity issues, in the Contracting Officer's Representative (COR) status and progress report (Deliverable #38).

- The Network shall identify facilities that are low performing based on ongoing data analytics and provide technical assistance to the facilities. The Network shall use the community coalition as advisors to the low performers. The PDSA cycle and interventions identified by the community coalition will align with the Network PDSA cycles with low performers. In this manner the high performing interventions identified in the Network service area will be utilized with low performers. The Network shall reevaluate the data regarding the performance of facilities, Network-wide, on a consistent basis to identify facilities in need of technical assistance. Facilities that achieve sustained improved results shall be removed from needing technical assistance. If a facility is removed from technical assistance and does not maintain stability or forward progress, the Network shall provide technical assistance to these facilities and perform an internal root cause analysis to identify the reason sustainability efforts failed.
- The Network shall report on technical assistance and outcome data related to assisting patients with depression, with a focus on health equity issues, in the format described by CMS (Deliverable #3).
- The Network shall educate and provide technical assistance to dialysis facilities regarding cognitive decline and the symptoms that are associated with it. Patients presenting with indications of possible cognitive decline should be referred to qualified providers for screening. The Network shall track and report any technical assistance provided to dialysis facilities in the technical assistance report. The Network shall capture the number of referrals from dialysis facilities to qualified providers in the technical assistance report. The Network shall support any other reporting mechanisms if and when they become available.
- The Network shall collaborate with any other task orders developed for other mental health issues, such as anxiety and bipolar disorder, as directed by CMS.

## GOAL 2: Improve Patient Safety and Reduce Harm

### C.3.2 Improve Health Outcomes and Access to Care in Vulnerable Populations

Vulnerable dialysis patient populations include, but are not limited to, dialysis patients who are elderly, receive dialysis services in a nursing home, reside or receive dialysis in a rural area, have an opioid use disorder, or have a mental health diagnosis. Vulnerable dialysis patients need support in areas that include but are not limited to:

- Adequacy of dialysis treatment;
- Anemia management;
- Medication compliance;
- Health care access;
- Healthy diet maintenance;
- Tobacco, recreational drugs, and alcohol misuse;
- Sedentary lifestyle;



- Dialysis treatment compliance;
- Social support system instability; and
- Financial issues.

These concerns create a vulnerable population that has self-care issues, such as but not limited to, access to food, shelter, transportation, clothing, medication, medical care, emotional support, access to care, and/or nursing home placement. The Network shall meet with empowered patients, nephrologists, primary care providers, dialysis facility staff from home modalities, nursing home staff, large and small dialysis organizations regional management, and other contractors with a relevant Task Order under the NQIIC IDIQ as an advisory committee (Deliverable #4). These meetings shall be used to plan, develop and implement quality improvement concepts and strategies, to be developed and utilized by the Network, including but not limited to peer mentoring, establishing a meaningful plan of care, and patient participation in the quality improvement at dialysis facilities. These strategies shall support identification and mitigation of any health equity issues that would impede improving infection rates for hemodialysis catheters or peritoneal infections.

CMS will calculate the baseline for each measure below when EQRS, or another CMS data system approved to assess progress, has the ability to identify nursing home patients. It will not change over the course of the task order period of performance.

- Achieve a 40% decrease (less 0.33% for each month that the nursing home patient feature is unavailable) in the national hemodialysis catheter infection rate, in dialysis patients receiving home dialysis at nursing homes based on EQRS, or another CMS approved data system, and Medicare Claims data over the task order period of performance. This measure is only applicable to Networks with patients receiving dialysis in nursing home settings. Refer to the alternate measure below for Networks with no patients receiving dialysis in nursing home settings. \*
  - Achieve a 4% decrease (less 0.33% for each month that the nursing home feature is unavailable) in the hemodialysis catheter infection rate, in dialysis patients receiving home dialysis within nursing homes from baseline to the end of the base period.
  - Achieve an additional 6% decrease in the hemodialysis catheter infection rate, in dialysis patients receiving home dialysis within nursing homes, for a 10% total decrease (less 0.33% for each month that the nursing home feature is unavailable in the base period) from baseline to the end of Option Period 1.
  - Achieve an additional 8% decrease in the hemodialysis catheter infection rate, in dialysis patients receiving home dialysis within nursing homes, for an 18% total decrease (less 0.33% for each month that the nursing home feature is unavailable in the base period) from baseline to the end of Option Period 2.
  - Achieve an additional 10% decrease in the hemodialysis catheter infection rate, in dialysis patients receiving home dialysis within nursing homes, for a 28% total decrease (less 0.33% for each month that the nursing home feature is unavailable in the base period) from baseline to the end of Option Period 3.
  - Achieve an additional 12% decrease in the hemodialysis catheter infection rate, in dialysis patients receiving home dialysis within nursing homes, for a 40% total

decrease (less 0.33% for each month that the nursing home feature is unavailable in the base period) from baseline to the end of Option Period 4.

- Achieve a 36% decrease in the hemodialysis catheter infection rate, in 10% of the nursing home residents receiving dialysis in-center based on EQRS, or another CMS approved data system, and Medicare Claims data over the task order period of performance. This measure serves as an alternate to the above measure and is only applicable to Networks with no patients receiving dialysis in nursing home settings. \*
  - Achieve a 6% decrease in the hemodialysis catheter infection rate, in 10% of the nursing home residents receiving dialysis in-center from baseline to the end of Option Period 1.
  - Achieve an additional 8% decrease in the hemodialysis catheter infection rate, in 10% of the nursing home residents receiving dialysis in-center, for a 14% total decrease from baseline to the end of Option Period 2.
  - Achieve an additional 10% decrease in the hemodialysis catheter infection rate, in 10% of the nursing home residents receiving dialysis in-center, for a 24% total decrease from baseline to the end of Option Period 3.
  - Achieve an additional 12% decrease in the hemodialysis catheter infection rate, in 10% of the nursing home residents receiving dialysis in-center, for a 36% total decrease from baseline to the end of Option Period 4.
  
- Achieve a 20% decrease (less 0.17% for each month that the nursing home patient feature is unavailable) in the national incidence of peritonitis in dialysis patients receiving home dialysis at nursing homes based on EQRS, or another CMS approved data system, and Medicare Claims data over the task order period of performance. This measure is only applicable to Networks with patients receiving dialysis in nursing home settings.
  - Achieve a 2% decrease (less 0.17% for each month that the nursing home feature is unavailable) in incidence of peritonitis in dialysis patients receiving home dialysis within nursing homes from baseline to the end of the base period.
  - Achieve an additional 3% decrease in incidence of peritonitis in dialysis patients receiving home dialysis within nursing homes for a 5% total decrease (less 0.17% for each month that the nursing home feature is unavailable in the base period) from baseline to the end of Option Period 1.
  - Achieve an additional 4% decrease in incidence of peritonitis in dialysis patients receiving home dialysis within nursing homes for a 9% total decrease (less 0.17% for each month that the nursing home feature is unavailable in the base period) from baseline to end of Option Period 2.
  - Achieve an additional 5% decrease in incidence of peritonitis in dialysis patients receiving home dialysis within nursing homes for a 14% total decrease (less 0.17% for each month that the nursing home feature is unavailable in the base period) from baseline to the end of Option Period 3.
  - Achieve an additional 6% decrease in incidence of peritonitis in dialysis patients receiving home dialysis within nursing homes for a 20% total decrease (less 0.17% for each month that the nursing home feature is unavailable in the base period) from baseline to the end of Option Period 4.

Non-Functional Goals:

- The Network shall assemble a coalition of high-performing experts in the subject matter stated above, from the Network service area. The coalition will assess local issues pertinent to the subject matter above and use a four-month PDSA format to solve issues and recommend interventions. If another quality improvement contractor receives a Task Order under the NQIIC IDIQ, that has patient safety as a task in their contract, the ESRD Network shall contact them to become a member of the coalition to fully collaborate and share knowledge and success across contracts. The Network shall report the activities of the coalitions, with a focus on mitigating health equity issues, in the COR status and progress report (Deliverable #38).
- The Network shall identify facilities that are low performing based on ongoing data analysis, and provide data based targeted technical assistance to the facilities. The Network shall use the community coalition as advisors to the low performers. The PDSA cycle and interventions identified by the community coalition will align with the Network PDSA cycles with low performers. In this manner the high performing interventions identified in the Network service area will be utilized with low performers. The Network shall reevaluate the performance of facilities, Network-wide, on a consistent basis to identify facilities in need of technical assistance. Facilities that achieve sustained improved results shall be removed as needing technical assistance. If a facility is removed from technical assistance and does not maintain stability or forward progress, the Network shall assist the facility with technical assistance and perform an internal root cause analysis to identify the reason sustainability efforts failed.
- The Network shall report on technical assistance and data outcomes related to assisting to decrease infection rates, with a focus on health equity issues, in the format described by CMS (Deliverable #5).
- Administer a survey to all nursing home dialysis facilities providing dialysis services within a nursing home, developed in conjunction with the Centers for Disease Control and Prevention (CDC), to gain information about the administration of dialysis to the patient population who received dialysis within nursing homes using a template provided by CMS (Deliverable #6).
- The Network shall report the number of home dialysis facilities that provide care to nursing home patients within the nursing home and the number of patients receiving dialysis in the nursing home (Deliverable #7).
- The Network shall build partnerships with community coalitions, Quality Improvement Organizations (QIOs), and other key stakeholders to track and monitor emerging issues for ESRD patients in the nursing home setting. This Non-Functional Goal is only applicable to Networks with no patients receiving dialysis in nursing home settings.
- The Network shall assist in the coordination of care/transfer of ESRD nursing home patients. This Non-Functional Goal is only applicable to Networks with no patients receiving dialysis in nursing home settings.
- The Network shall monitor and track developments around the expansion of home dialysis for ESRD patients in nursing homes in their respective Network areas (i.e. state legislation, new facilities/patients). This Non-Functional Goal is only applicable to Networks with no patients receiving dialysis in nursing home settings.

## GOAL 3: Improve Care in High Cost/Complex Chronic Conditions

### C.3.3 Improve Education and Access to Empower Patient Choice of a Home Modality

The choice of home modality enhances a patient's quality of life and is more convenient than traveling to an in-center clinic three times per week. Patients have also experienced better blood pressure control and fewer hospitalizations. Dialysis patients need education and support to determine the appropriate dialysis modality that fits their lifestyle, including but not limited to, how each modality will affect travel, diet and fluid consumption, school, work, social interaction, and well-being. The Network shall meet with empowered patients, nephrologists, primary care providers, dialysis facility staff from all modalities, nursing home staff, large and small dialysis organizations regional management and other contractors with a relevant Task Order under the NQIIC IDIQ as an advisory committee (Deliverable #8). These meetings shall be used to plan, develop and implement quality improvement concepts and strategies, which shall be developed and utilized by the Network, including, but not limited to, peer-mentoring, establishing a meaningful plan of care, and patient participation in the quality improvement at dialysis facilities. These strategies shall support patient choice, whether a prevalent or incident patient, of a home modality. In addition, the Network shall gain insight on the mitigation of barriers to access and maintenance of dialysis in the home setting, along with encouraging hesitant providers with education to foster acceptance of home modalities. These meetings shall support the identification and mitigation of any health equity issues that would impede a patient choosing a home modality.

CMS will calculate the baseline for each measure below at the start of the period of performance. It will not change over the course of the task order period of performance.

- Achieve a 60% increase in the number of incident ESRD patients starting dialysis using a home modality based on EQRS data over the task order period of performance.
  - Achieve a 10% increase in the number of incident ESRD patients starting dialysis using a home modality from baseline to the end of the base period.
  - Achieve an additional 10% increase in the number of incident ESRD patients starting dialysis using a home modality, for a 20% total increase from the baseline to the end of Option Period 1.
  - Achieve an additional 10% increase in the number of incident ESRD patients starting dialysis using a home modality, for a 30% total increase from the baseline to the end of Option Period 2.
  - Achieve an additional 15% increase in the number of incident ESRD patients starting dialysis using a home modality, for a 45% total increase from the baseline to the end of Option Period 3.
  - Achieve an additional 15% increase in the number of incident ESRD patients starting dialysis using a home modality, for a 60% total increase from the baseline to the end of Option Period 4.
  
- Achieve a 30% increase in the number of prevalent ESRD patients moving to a home modality based on EQRS data over the task order period of performance.
  - Achieve a 2% increase in the number of prevalent ESRD patients moving to a home modality from baseline to the end of the base period.

- Achieve an additional 4% increase in the number of prevalent ESRD patients moving to a home modality for a 6% total increase from the baseline to the end of Option Period 1.
- Achieve an additional 6% increase in the number of prevalent ESRD patients moving to a home modality for a 12% total increase from the baseline to the end of Option Period 2.
- Achieve an additional 8% increase in the number of prevalent ESRD patients moving to a home modality for a 20% total increase from the baseline to the end of Option Period 3.
- Achieve an additional 10% increase in the number of prevalent ESRD patients moving to a home modality for a 30% total increase from the baseline to the end of Option Period 4.

CMS will calculate the baseline for the below measure when EQRS, or another CMS data system approved to assess progress, has the ability to identify telemedicine usage monthly. It will not change over the course of the task order period of performance.

- Achieve a 20% increase (less 0.17% for each month that the identification of the use of telemedicine feature is unavailable) in the number of rural ESRD patients using telemedicine to access a home modality based on EQRS, or another CMS approved data system, over the task order period of performance.
  - Achieve a 2% increase (less 0.17% for each month that the identification of the use of telemedicine feature is unavailable) in the number of rural ESRD patients using telemedicine to access a home modality from baseline to the end of the base period.
  - Achieve an additional 3% increase in the number of rural ESRD patients using telemedicine to access a home modality for a 5% total increase (less 0.17% for each month that the identification of the use of telemedicine feature is unavailable in the base period) from the baseline the end of Option Period 1
  - Achieve an additional 4% increase in the number of rural ESRD patients using telemedicine to access a home modality for a 9% total increase (less 0.17% for each month that the identification of the use of telemedicine feature is unavailable in the base period) from the baseline to the end of Option Period 2.
  - Achieve an additional 5% increase in the number of rural ESRD patients using telemedicine to access a home modality for a 14% total increase (less 0.17% for each month that the identification of the use of telemedicine feature is unavailable in the base period) from the baseline to the end of Option Period 3.
  - Achieve an additional 6% increase in the number of rural ESRD patients using telemedicine to access a home modality for a 20% total increase (less 0.17% for each month that the identification of the use of telemedicine feature is unavailable in the base period) from the baseline to the end of Option Period 4.

#### Non-Functional Goals:

- The Network shall assemble a coalition of high-performing experts in the subject matter stated above, from the Network service area. The coalition will assess local issues pertinent to the subject matter above and use a four-month PDSA format to solve issues and

recommend interventions. If another quality improvement contractor receives a Task Order under the NQIIC IDIQ which has education of chronic kidney disease (CKD) as a task in their contract, the ESRD Network shall contact them to become a member of the coalition to fully collaborate and share knowledge and success across contracts. The Network shall report the activities of the coalitions, with a focus on mitigating health equity issues, in the COR status and progress report (Deliverable #38).

- The Network shall identify facilities that are low performing and provide data-based targeted, technical assistance to the facilities. The Network shall use the community coalition as advisors to the low performers. The PDSA cycle and interventions identified by the community coalition will align with the Network PDSA cycles with low performers. In this manner the high performing interventions identified in the Network service area will be utilized with low performers. The Network shall reevaluate the performance of facilities, Network-wide, on a consistent basis to identify facilities in need of technical assistance. Facilities that achieve sustained improved results shall be removed as needing technical assistance. If a facility is removed from technical assistance and does not maintain stability or forward progress, the Network shall assist the facility with technical assistance and perform an internal root cause analysis to identify the reason sustainability efforts failed.
- The Network shall report on technical assistance and outcome data related to home modalities, with a focus on mitigating health equity issues, in the format described by CMS (Deliverable #9).
- The Network shall utilize Attachment 5 Home Dialysis Change Package, which was developed from strategies utilized by high performers across the country.

#### C.3.4 Improve Education and Access to Empower Patient Choice of Transplant

The benefits of transplantation extend to ESRD patients regardless of age, gender, or ethnicity, as well as those with common comorbid conditions, including diabetes and hypertension. The AAKH has a goal of ensuring 80% of new kidney failure patients in 2025 are receiving either dialysis at home or a transplant. The Network shall meet with empowered patients, nephrologists, primary care providers, transplant surgeons, transplant and dialysis facility staff from all modalities, large and small dialysis organizations regional management, other contractors with a relevant Task Order under the NQIIC IDIQ, and the Technical Assistance Quality Improvement Learning (TAQIL) contractor as an advisory committee (Deliverable #10). These meetings shall be used to plan, develop and implement quality improvement concepts and strategies, including but not limited to peer-mentoring, establishing a meaningful plan of care, and patient participation in the quality improvement at dialysis facilities, in support of transplant education and choice including, but not limited to, the choice of high Kidney Donor Profile Index (KDPI) or expanded donor criteria kidneys. These meetings shall support the identification and mitigation of any health equity issues that would impede a patient from receiving a kidney transplant.

CMS will calculate the baseline for each measure below at the start of the period of performance. It will not change over the course of the task order period of performance.

- Achieve a 20% increase in the number of patients added to a kidney transplant waiting list based on EQRS data over the task order period of performance.
  - Achieve a 2% increase in the number of patients added to a kidney transplant waiting list from the baseline to the end of the base period.

- Achieve an additional 3% increase in the number of patients added to a kidney transplant waiting list for a 5% total increase from the baseline to the end of Option Period 1.
  - Achieve an additional 4% increase in the number of patients added to a kidney transplant waiting list for a 9% total increase from the baseline to the end of Option Period 2.
  - Achieve an additional 5% increase in the number of patients added to a kidney transplant waiting list for a 14% total increase from the baseline to the end of Option Period 3.
  - Achieve an additional 6% increase in the number of patients added to a kidney transplant waiting list for a 20% total increase from the baseline to the end of Option Period 4.
- Achieve a 30% increase in the number of patients receiving a kidney transplant based on EQRS data over the task order period of performance.
    - Achieve a 2% increase in the number of patients receiving a kidney transplant from the baseline to the end of the base period.
    - Achieve an additional 4% increase in the number of patients receiving a kidney transplant for a 6% total increase from the baseline to the end of Option Period 1.
    - Achieve an additional 6% increase in the number of patients receiving a kidney transplant for a 12% total increase from the baseline to the end of Option Period 2.
    - Achieve an additional 8% increase in the number of patients receiving a kidney transplant for a 20% total increase from the baseline to the end of Option Period 3.
    - Achieve an additional 10% increase in the number of patients receiving a kidney transplant for a 30% total increase from the baseline to the end of Option Period 4.

Non-Functional Goals:

- The Network shall assemble a coalition of high-performing experts in the subject matter stated above, from the Network service area. The coalition will assess local issues pertinent to the subject matter above and use a four-month PDSA format to solve issues and recommend interventions. If another quality improvement contractor receives a Task Order under the NQIIC IDIQ, that has CKD as a task in their contract, the ESRD Network shall contact them to become a member of the coalition to fully collaborate and share knowledge and success across contracts. The Network will include the TAQIL contractor for the ESRD Treatment Choices Learning Collaborative. The Network shall report the activities of the coalitions, with a focus on health equity issues, in the COR status and progress report (Deliverable #38).
- The Network shall utilize Attachment 6 Transplant Change Package, which was developed from strategies utilized by high performers across the country.
- The Network shall increase the number of patients that can complete all or part of a transplant work for being added to a transplant waitlist through telemedicine with a focus on rural patients and providers over the task order period of performance. The Network shall report the effort in the COR status and progress report (Deliverable #38).

- The Network shall identify facilities that are low performing and provide data-driven targeted technical assistance to the facilities. The Network shall use the community coalition as advisors to the low performers. The PDSA cycle and interventions identified by the community coalition will align with the Network PDSA cycles with low performers. In this manner the high performing interventions identified in the Network service area will be utilized with low performers. The Network shall reevaluate the performance of facilities, Network-wide, on a consistent basis to identify facilities in need of technical assistance. Facilities that achieve sustained improved results shall be removed as needing technical assistance. If a facility is removed from technical assistance and does not maintain stability or forward progress, the Network shall assist the facility with technical assistance and perform an internal root cause analysis to identify the reason sustainability efforts failed.
- The Network shall report on technical assistance and data outcomes related to kidney transplant, with a focus on health equity issues, in the format described by CMS (Deliverable #11).
- The Network shall develop education for dialysis facility staff and new and prevalent dialysis patients that supports the AAKH goal to increase the choice of dialysis patients to receive a high KDPI or expanded donor criteria kidneys.
- The Network shall collaborate with Organ Procurement Organizations (OPOs) and transplant centers especially in regards to the ETC model.
- The Network shall host a kickoff call to introduce the TAQIL contractor to all transplant center staff and leadership in the Network service area and to allow the TAQIL contractor the ability to introduce the transplant learning collaborative (Deliverable #12).
- The Network shall recruit patients to participate with the ESRD NCC and TAQIL contractor on a patient focused LAN quarterly.
- The Network shall be available to participate in kidney transplant quality improvement teams identified by the TAQIL contractor to collaborate as necessary.
- The Network shall provide a list of facilities and patients interested in participating with the TAQIL contractor (Deliverable #13).
- The Network shall participate with the ESRD NCC, TAQIL contractor, patients, dialysis facilities, a transplant centers to develop educational resources and refine the transplant change package.

### C.3.5 Educate and Manage Incidents of COVID-19 and Decrease Hospitalization of COVID-19 Positive ESRD Patients and Related Vaccinations

The number of ESRD patients receiving dialysis with Medicare fee-for-service (FFS) as the payer source between January 1, 2020 and June 30, 2020 was 375,940. The cumulative number of these patients receiving dialysis with Medicare FFS as the payer source who were identified as COVID-19 positive was 15,722 or 4.2%. The number of ESRD patients who were receiving dialysis with Medicare FFS as the payer source and were hospitalized with a COVID-19 diagnosis with a primary or secondary diagnosis was 7,982 or 50.5% of the population of dialysis patients that tested positive for COVID-19. Data was based on Medicare FFS claims and EQRS data as of June 30, 2020. One study identified three frequent comorbidities of



COVID-19 positive patients that were hospitalized: hypertension, obesity, and diabetes.<sup>3</sup> Another study identified hypertension, obesity, and diabetes in the top four comorbidities contributing to more severe disease outcomes such as hospitalization or death.<sup>4</sup> COVID-19 is a new disease and more information is identified about the risk and impact of the disease as the pandemic evolves. The Network shall meet with empowered patients, nephrologists, primary care providers, dialysis facility staff from all modalities, large and small dialysis organizations regional management, and other contractors with a relevant Task Order under the NQIC IDIQ, as an advisory committee (Deliverable #54). These meetings shall be used to plan, develop and implement quality improvement concepts and strategies, including but not limited to peer-mentoring, establishing a meaningful plan of care, and patient participation in the quality improvement at dialysis facilities, in support of patient education and choice regarding vaccination and the resolution of health issues that would predispose a person to be hospitalized for COVID-19. These meetings shall support the identification and mitigation of any health equity issues that would impede a patient from receiving vaccination and resolving health issues that would predispose one to COVID-19.

- Achieve a 25% decrease in the number of COVID-19 hospitalizations in the ESRD patient population with Medicare FFS as a payer source from June 1, 2021 through April 30, 2022 compared to June 1, 2020 through April 30, 2021, based on Medicare Claims data. The Network shall focus on ESRD patients identified as having one or more of the following comorbidities: hypertension, obesity, or diabetes. The data provided above shall guide development of proposed interventions until further data can be provided.

For Option Periods 1-4 of this task order, if COVID-19 hospitalization rates have been controlled, the ESRD Network shall continue to provide interventions that will seek to mitigate hypertension, obesity, and diabetes in the ESRD patient population. Baseline and goals shall be provided for mitigating hypertension, obesity, and diabetes by CMS, based on Medicare Claims data, when COVID-19 is controlled.

The ESRD Network shall encourage the entire Network service area to receive a primary COVID-19 vaccination and/or vaccination series, and any additional CDC and/or CMS recommended COVID-19 vaccinations, through technical assistance and education consistent with evolving CDC guidance surrounding all COVID-19 vaccine doses. The ESRD Network shall incorporate any additional vaccination recommendations from the CDC and/or CMS in their vaccination efforts among dialysis patients. CMS expects a minimum of 80% of dialysis patients to receive a primary COVID-19 vaccination and/or vaccination series. CMS expects a minimum of 80% of fully vaccinated dialysis patients to receive any additional CDC and/or CMS recommended COVID-19 vaccinations. This will be measured using National Healthcare Safety Network (NHSN) data, or another CMS approved data system.

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<sup>3</sup> Safiya Richardson MD, Jamie S. Hirsch MD, Mangala Narasimhan, DO, et al. Presenting Characteristics, Comorbidities, and Outcomes Among 5700 Patients Hospitalized With COVID-19 in the New York City Area. JAMA April, 22, 2020

<sup>4</sup> Adekunle Sanyaolu, et al. Comorbidity and its Impact on Patients with COVID-19. [SN Compr Clin Med](#) June 25,20

The ESRD Network shall encourage dialysis facility staff to receive a primary COVID-19 vaccination and/or vaccination series, and any additional CDC and/or CMS recommended COVID-19 vaccinations, through technical assistance and education consistent with evolving CDC guidance surrounding all COVID-19 vaccine doses. The ESRD Network shall incorporate any additional vaccination recommendations from the CDC and/or CMS in their vaccination efforts among dialysis facility staff. CMS expects 100% of dialysis facility staff to receive a primary COVID-19 vaccination and/or vaccination series. CMS expects 100% of fully vaccinated dialysis facility staff to receive any additional CMS and/or CDC recommended COVID-19 vaccinations. This will be measured using NHSN data, or another CMS approved data system.

The ESRD Network shall review COVID-19 vaccination data and target dialysis facilities with low patient/staff vaccination/booster rates. Education and assistance related to vaccination/boosters will include, at a minimum, distributing the latest guidance, vaccination/booster educational materials, conducting webinars supporting vaccination/booster uptake, and direct engagement with dialysis leadership. As the pandemic is continually evolving, the ESRD Network should be prepared to appropriately respond to changing guidance and direction.

- Achieve an increase to 90% of dialysis patients receiving an influenza vaccination based on EQRS data, by the end of Option Period 1 and maintain the rate throughout the task order period of performance.
  - Ensure 85% of dialysis patients receive an influenza vaccination by the end of the base period.
  - Ensure 90% of dialysis patients receive an influenza vaccination by the end of Option Period 1.
  - Ensure a minimum of 90% of dialysis patients receive an influenza vaccination by the end of Option Period 2.
  - Ensure a minimum of 90% of dialysis patients receive an influenza vaccination by the end of Option Period 3.
  - Ensure a minimum of 90% of dialysis patients receive an influenza vaccination by the end of Option Period 4.
- Ensure a minimum of 90% of dialysis facility staff receive an influenza vaccination annually, measured using NHSN data for the entire task order period of performance.

CMS will calculate the baseline for each measure below at the start of the period of performance. It will not change over the course of the task order period of performance.

- Achieve a 70% increase in the number of dialysis patients receiving a pneumococcal conjugate vaccination (PCV) 13 based on EQRS data, over the task order period of performance.
  - Achieve a 10% increase in the number of patients receiving a PCV 13 from the baseline to the end of the base period.

- Achieve an additional 10% increase in the number of patients receiving a PCV 13 for a 20% total increase from the baseline to the end of Option Period 1.
- Achieve an additional 10% increase in the number of patients receiving a PCV 13 for a 30% total increase from the baseline to the end of Option Period 2.
- Achieve an additional 20% increase in the number of patients receiving a PCV 13 for a 50% total increase from the baseline to the end of Option Period 3.
- Achieve an additional 20% increase in the number of patients receiving a PCV 13 for a 70% total increase from the baseline to the end of Option Period 4.

CMS will calculate the baseline for each measure below when EQRS, or another CMS data system approved to assess progress, has the ability to document pneumococcal polysaccharide vaccine (PPSV 23) monthly. It will not change over the course of the task order period of performance.

The Network shall ensure dialysis patients receive the full series of the PPSV 23, as age appropriate. Dialysis patients may receive the PPSV 23 up to three times in their lifetime. After the initial PPSV 23 is given, a second PPSV 23 shall be given in five years. Once a dialysis patient reaches the age of 65, the dialysis patient should receive a PPSV 23 if it has been at least five years from the previous injection.

- Achieve an increase to 90% of dialysis patients receiving a PPSV 23 based on EQRS, or another CMS approved data system, by the end of Option Period 1 and maintain that rate throughout the task order period of performance.
  - Ensure 87% (less 0.25% for each month that the PPSV 23 feature is unavailable) of dialysis patients receive a PPSV 23 the end of the base period.
  - Ensure 90% of dialysis patients receive a PPSV 23 by the end of Option Period 1.
  - Ensure a minimum of 90% of dialysis patients receive a PPSV 23 by the end of Option Period 2.
  - Ensure a minimum of 90% of dialysis patients receive a PPSV 23 by the end of Option Period 3.
  - Ensure a minimum of 90% of dialysis patients receive a PPSV 23 by the end of Option Period 4.
- Achieve a 70% increase (less 0.83% for each month that the PPSV 23 feature is unavailable) in the number of dialysis patients receiving a booster PPSV 23 based on EQRS, or another CMS approved data system, over the task order period of performance.
  - Achieve a 10% increase (less 0.83% for each month that the PPSV 23 feature is unavailable) in the number of patients receiving a booster PPSV 23 from the baseline to the end of the base period.
  - Achieve an additional 10% increase in the number of patients receiving a booster PPSV 23 for a 20% total increase (less 0.83% for each month that the PPSV 23 feature is unavailable in the base period) from the baseline to the end of Option Period 1.
  - Achieve an additional 10% increase in the number of patients receiving a booster PPSV 23 for a 30% total increase (less 0.83% for each month that the PPSV 23 feature is unavailable in the base period) from the baseline to the end of Option Period 2.

- Achieve an additional 20% increase in the number of patients receiving a booster PPSV 23 for a 50% total increase (less 0.83% for each month that the PPSV 23 feature is unavailable in the base period) from the baseline to the end of Option Period 3.
- Achieve an additional 20% increase in the number of patients receiving a booster PPSV 23 for a 70% total increase (less 0.83% for each month that the PPSV 23 feature is unavailable in the base period) from the baseline to the end of Option Period 4.
- Achieve an increase to 90% of dialysis patients over 65 years old receiving a PPSV 23 based on EQRS, or another CMS approved data system, by the end of Option Period 2 and maintain that rate throughout the task order period of performance.
  - Ensure 80% (less 0.17% for each month that the PPSV 23 feature is unavailable) of dialysis patients over 65 years old receive a PPSV 23 by the end of the base period.
  - Ensure 85% of dialysis patients over 65 years old receive a PPSV 23 by the end of Option Period 1.
  - Ensure a minimum of 90% of dialysis patients over 65 years old receive a PPSV 23 by the end of Option Period 2.
  - Ensure a minimum of 90% of dialysis patients over 65 years old receive a PPSV 23 by the end of Option Period 3.
  - Ensure a minimum of 90% of dialysis patients over 65 years old receive a PPSV 23 by the end of Option Period 4.

Non-Functional Goals:

- Educate patients and dialysis facilities on current and emerging credible information and data driven success regarding COVID-19 and telemedicine;
- Identify and spread highly effective practices, as identified by data, used in the transition of patients between the nursing home dialysis setting and in-center dialysis facilities. At a minimum, increase the communication between dialysis facilities and nursing homes regarding their shared patients;
- Provide education to nursing home facilities regarding the possibility of providing dialysis services to patients within the nursing home facility along with names of local home dialysis facilities and/or educate and discuss the possibility of the patient's current dialysis facility providing patient assisted dialysis at the nursing home facility;
- Identify and partner with local, community-based leaders (including faith-based organizations, volunteer organizations, etc.) in areas where there is an increase of COVID-19 cases in the dialysis population to identify and/or increase sources of support for dialysis patients to decrease the spread of COVID-19;
- Provide data-driven targeted technical assistance to dialysis facilities that are seeing an increase in COVID-19 cases in the Network service area to identify the source of the increase and provide infection control resources to decrease the rise in cases and provide outcome data information and information related to vaccination, with a focus on health equity issues.

- The Network shall report on technical assistance and data outcomes related to COVID-19 and related vaccinations, with a focus on health equity issues, in the format described by CMS (Deliverable #15);
- Partner with any IDIQ NQIIC contractor that has a relevant Task Order to provide technical assistance regarding dialysis provided in nursing homes as necessary or requested by CMS;
- Concentrate educational efforts on influenza vaccinations that have been shown to have the strongest immune response for immunocompromised patients for the specific influenza season.
- The Network shall assemble a coalition of high-performing experts in the subject matter stated above, from the Network service area or any infection control experts with subject matter expertise in COVID-19 or vaccinations. The coalition will assess local issues pertinent to the subject matter above and use a four-month PDSA format to solve issues and recommend interventions. If another quality improvement contractor receives a Task Order under the NQIIC IDIQ, that has COVID-19 or vaccinations as a task in their contract, the ESRD Network shall contact them to become a member of the coalition to fully collaborate and share knowledge and success across contracts. The Network shall report the activities of the coalitions, with a focus on health equity issues, in the COR status and progress report (Deliverable #38).
- The Network shall identify facilities that are low performing and provide data-driven targeted technical assistance to the facilities. The Network shall use the community coalition as advisors to the low performers. The PDSA cycle and interventions identified by the community coalition will align with the Network PDSA cycles with low performers. In this manner the high performing interventions identified in the Network service area will be utilized with low performers. The Network shall reevaluate the performance of facilities, Network-wide, on a consistent basis to identify facilities in need of technical assistance. Facilities that achieve sustained improved results shall be removed as needing technical assistance. If a facility is removed from technical assistance and does not maintain stability or forward progress, the Network shall assist the facility with technical assistance and perform an internal root cause analysis to identify the reason sustainability efforts failed.

#### GOAL 4: Reduce Hospital Admissions, Readmissions, and Outpatient Emergency Visits

##### C.3.6 Improve and Maintain the Health of ESRD Patients

There are numerous reasons a dialysis patient may not be able to achieve and maintain optimal health. Health deficits may be related to health conditions, such as but not limited to, anemia, diabetes, cardiovascular disease, or diagnosed and undiagnosed mental health issues. Health deficits may be related to patient behavior, such as but not limited to, not taking medication as prescribed, failure to attend check-ups, eating an unhealthy diet, smoking tobacco, using recreational drugs, excessive alcohol use, lack of exercise, or missing or shortening dialysis treatment. Health issues may be related to an unstable social support system and/or financial problems, such as but not limited to, access to food, shelter, transportation, clothing, medication, medical care, and/or emotional support, making patients potentially unable to care for themselves. The Network shall meet with empowered patients, nephrologists, primary care providers, transplant surgeons, transplant and dialysis facility staff from all modalities, large and small dialysis organizations regional management and IDIQ NQIIC contractors that have transitions of care as a task in the contract to reduce hospital admissions, readmissions, and outpatient

emergency visits (Deliverable #16). These meetings shall be used to plan, develop and implement quality improvement concepts and strategies, which will be developed and utilized by the Network, including but not limited to peer-mentoring, establishing a meaningful plan of care, and patient participation in quality improvement at dialysis facilities. These strategies shall support the reduction of all-cause hospitalizations, readmissions, and emergency department visits. The Network will incorporate a focus on the reasons for health deficits, including distinct measures related to health equity issues, to mitigate hospital admissions, hospital 30-day readmission, and outpatient emergency department visits.

CMS will calculate the baseline for each measure below at the start of the period of performance. It will not change over the course of the task order period of performance.

- Achieve a 20% decrease in national hospital admissions for the Primary Diagnosis Categories (see Appendix A) based on Medicare Claims data over the task order period of performance.
  - Achieve a 2% decrease in hospital admissions for the Primary Diagnosis Categories (see Appendix A) from the baseline to the end of the base period.
  - Achieve an additional 3% decrease in hospital admissions for the Primary Diagnosis Categories (see Appendix A) for a 5% total decrease from the baseline to the end of Option Period 1.
  - Achieve an additional 4% decrease in hospital admissions for the Primary Diagnosis Categories (see Appendix A) for a 9% total decrease from the baseline to the end of Option Period 2.
  - Achieve an additional 5% decrease in hospital admissions for the Primary Diagnosis Categories (see Appendix A) for a 14% total decrease from the baseline to the end of Option Period 3.
  - Achieve an additional 6% decrease in hospital admissions for the Primary Diagnosis Categories (see Appendix A) for a 20% total decrease from the baseline to the end of Option Period 4.
- Achieve a 20% decrease in the national hospital 30-day unplanned readmissions from the Primary Diagnosis Categories (Appendix A), following an admission for a diagnosis from the Primary Diagnosis Categories (Appendix A), based on Medicare Claims data over the task order period of performance.
  - Achieve a 2% decrease in hospital 30-day unplanned readmissions for a diagnosis from the Primary Diagnosis Categories (see Appendix A) following an admission for a diagnosis from the Primary Diagnosis Categories from the baseline to the end of the base period.
  - Achieve an additional 3% decrease in hospital 30-day unplanned readmissions for a diagnosis from the Primary Diagnosis Categories (see Appendix A) following an admission for a diagnosis from the Primary Diagnosis Categories for a 5% total decrease from the baseline to the end of Option Period 1.
  - Achieve an additional 4% decrease in hospital 30-day unplanned readmissions for a diagnosis from the Primary Diagnosis Categories (see Appendix A) following

- an admission for a diagnosis from the Primary Diagnosis Categories for a 9% total decrease from the baseline to the end of Option Period 2.
  - Achieve an additional 5% decrease in hospital 30-day unplanned readmissions for a diagnosis from the Primary Diagnosis Categories (see Appendix A) following an admission for a diagnosis from the Primary Diagnosis Categories for a 14% total decrease from the baseline to the end of Option Period 3
  - Achieve an additional 6% decrease in hospital 30-day unplanned readmissions for a diagnosis from the Primary Diagnosis Categories (see Appendix A) following an admission for a diagnosis from the Primary Diagnosis Categories for a 20% total decrease from the baseline to the end of Option Period 4.
- Achieve a 20% decrease in the national outpatient emergency department visits for diagnoses on the Primary Diagnosis Categories (see Appendix A) based on Medicare Claims data over the task order period of performance.
  - Achieve a 2% decrease in outpatient emergency department visits for a diagnosis on the Primary Diagnosis Categories (see Appendix A) from the baseline to the end of the base period.
  - Achieve an additional 3% decrease in outpatient emergency department visits for a diagnosis on the Primary Diagnosis Categories (see Appendix A) for a 5% total decrease from the baseline to the end of Option Period 1.
  - Achieve an additional 4% decrease in outpatient emergency department visits for a diagnosis on the Primary Diagnosis Categories (see Appendix A) for a 9% total decrease from the baseline to the end of Option Period 2.
  - Achieve an additional 5% decrease in outpatient emergency department visits for a diagnosis on the Primary Diagnosis Categories (see Appendix A) for a 14% total decrease from the baseline to the end of Option Period 3.
  - Achieve an additional 6% decrease in outpatient emergency department visits for a diagnosis on the Primary Diagnosis Categories (see Appendix A) for a 20% total decrease from the baseline to the end of Option Period 4.

Non-Functional Goals:

- The Network shall assemble a coalition of high-performing experts in the subject matter stated above, from the Network service area. The coalition will assess local issues pertinent to the subject matter above and use a four-month PDSA format to solve issues and recommend interventions. If another quality improvement contractor receives a Task Order under the NQIIC IDIQ, that has transition of care as a task in their contract, the ESRD Network shall contact them to become a member of the coalition to fully collaborate and share knowledge and success across contracts. The Network shall report the activities of the coalitions, with a focus on health equity issues, in the COR status and progress report (Deliverable #38).
- The Network shall identify facilities that are low performing, and provide data-based targeted technical assistance to the facilities. The Network shall use the community coalition as advisors to the low performers. The PDSA cycle and interventions identified by the community coalition will align with the Network PDSA cycles with low performers. In this manner the high performing interventions identified in the Network service area will be utilized with low performers. The Network shall reevaluate the performance of facilities,

Network-wide, on a consistent basis to identify facilities in need of technical assistance. Facilities that achieve sustained improved results shall be removed as needing technical assistance. If a facility is removed from needing technical assistance and does not maintain stability or forward progress, the Network shall assist the facility with technical assistance and perform an internal root cause analysis to identify the reason sustainability efforts failed.

- The Network shall report on technical assistance and outcome data related to hospitalizations and emergency department visits, with a focus on health equity issues, in the format described by CMS (Deliverable #17).

## GOAL 5: Improve Nursing Home Care in Low-Performing Providers

### C.3.7 Decrease the Rate of Blood Transfusions in ESRD Patients Dialyzing in a Nursing Home

“The USRDS [United States Renal Data System] ADR [Annual Data Report] has shown that nursing home ESRD patients have high rates of comorbid disease: 77.5% cardiovascular disease, 62.9% diabetes, 36.5% depression, 19.9% Alzheimer’s/dementia, and 15.5% COPD [Chronic Obstructive Pulmonary Disease]. Furthermore, mortality is significantly higher in nursing home ESRD patients compared to all ESRD patients. In the USRDS 1998-2000 ESRD cohort, the mean death rate for nursing home patients with ESRD was 3.5 times that of the ESRD population in general. In an independent study using data from the USRDS from June 1998 to October 2000, three and 12-month survival was 76% and 42% in nursing home patients initiating dialysis. In addition, the study noted a substantial and sustained decline in functional status. In the 2004-2006 incident ESRD cohort, incident mortality was estimated even higher, with survival rates of 50%, 26%, and 14% at the 3, 6, and 12-month time points. Age had a strong impact on mortality with one-year survival of 18.5% in those aged 65-74 compared to 10% for patients aged 85 or older”<sup>5</sup> Concerto Renal Services (Concerto) is one of the nation’s largest nursing home dialysis providers. Concerto reported preliminary unpublished data with a sample size of 1,800 ESRD patients who underwent dialysis with three weekly hemodialysis treatments in 2018, that only 50% of patients achieved an anemia goal between 9 and 11 g/dL. Additionally, there was a 35% readmission rate for patients admitted with hemoglobin <8 g/dL compared with <10 g/dL for others.<sup>6</sup> The Network shall meet with empowered patients, nephrologists, primary care providers, dialysis facility staff from home modalities, nursing home staff, large and small dialysis organizations regional management and NQIIC IDIQ contractors that have a Task Order related to nursing home care (Deliverable #18). These meetings shall include a focus on health equity issues and mitigation strategies to resolve anemia. These meetings shall be used to plan, develop and implement quality improvement concepts and strategies, including but not limited to peer-mentoring, establishing a meaningful plan of care, and patient participation in quality improvement at dialysis facilities, in support of the health outcomes of nursing home residents.

CMS will calculate the baseline for each measure below when EQRS, or another CMS data system approved to assess progress, has the ability to identify nursing home patients. It will not change over the course of the task order period of performance.

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<sup>5</sup> Yang A, Lee, W, Hocking, K. Health outcomes in nursing home patients on dialysis. Helio. 2014;Online.

<sup>6</sup> Sampson S. NURSING HOME DIALYSIS Rapidly Growing and Complicated. ASN Kidney News. 2018;4:14-15.



- Achieve a 20% decrease (less 0.17% for each month that the nursing home patient feature is unavailable) in the national rate of dialysis patients receiving dialysis at nursing homes that receive a blood transfusion based on EQRS, or another CMS approved data system, and Medicare Claims data over the task order period of performance. This measure is only applicable to Networks with patients receiving dialysis in nursing home settings. Refer to the alternate measure below for Networks with no patients receiving dialysis in nursing home settings. \*
  - Achieve a 2% decrease (less 0.17% for each month that the nursing home patient feature is unavailable) in the rate of dialysis patients receiving dialysis at nursing homes that receive a blood transfusion from the baseline to the end of the base period.
  - Achieve an additional 3% decrease in the rate of dialysis patients receiving dialysis at nursing homes that receive a blood transfusion for a 5% total decrease (less 0.17% for each month that the nursing home patient feature is unavailable in the base period) from the baseline to the end of Option Period 1.
  - Achieve an additional 4% decrease in the rate of dialysis patients receiving dialysis at nursing homes that receive a blood transfusion for a 9% total decrease (less 0.17% for each month that the nursing home patient feature is unavailable in the base period) from the baseline to the end of Option Period 2.
  - Achieve an additional 5% decrease in the rate of dialysis patients receiving dialysis at nursing homes that receive a blood transfusion for a 14% total decrease (less 0.17% for each month that the nursing home patient feature is unavailable in the base period) from the baseline to the end of Option Period 3.
  - Achieve an additional 6% decrease in the rate of dialysis patients receiving dialysis at nursing homes that receive a blood transfusion for a 20% total decrease (less 0.17% for each month that the nursing home patient feature is unavailable in the base period) from the baseline to the end of Option Period 4.
  
- Achieve an 18% decrease in the rate of 10% of the nursing home dialysis patients receiving dialysis in-center that receive a blood transfusion based on EQRS, or another CMS approved data system, and Medicare Claims data over the task order period of performance. This measure serves as an alternate to the above measure and is only applicable to Networks with no patients receiving dialysis in nursing home settings. \*
  - Achieve a 3% decrease in the rate of 10% of the nursing home dialysis patients receiving dialysis in-center that receive a blood transfusion from the baseline to the end of Option Period 1.
  - Achieve an additional 4% decrease in the rate of 10% of the nursing home dialysis patients receiving dialysis in-center that receive a blood transfusion for a 7% total decrease from the baseline to the end of Option Period 2.
  - Achieve an additional 5% decrease in the rate of 10% of the nursing home dialysis patients receiving dialysis in-center that receive a blood transfusion for a 12% total decrease from the baseline to the end of Option Period 3.
  - Achieve an additional 6% decrease in the rate of 10% of the nursing home dialysis patients receiving dialysis in-center that receive a blood transfusion for a 18% total decrease from the baseline to the end of Option Period 4.

#### Non-Functional Goals:

- The Network shall assemble a coalition of high-performing experts in the subject matter stated above, from the Network service area. The coalition will assess local issues pertinent to the subject matter above and use a four-month PDSA format to solve issues and recommend interventions. If another quality improvement contractor receives a Task Order under the NQIIC IDIQ, that has nursing home patient health and safety issues as a task in their contract, the ESRD Network shall contact them to become a member of the coalition to fully collaborate and share knowledge and success across contracts. The Network shall report the activities of the coalitions, with a focus on health equity issues, in the COR status and progress report (Deliverable #38).
- The Network shall identify facilities that are low performing and provide data-based targeted technical assistance to the facilities. The Network shall use the community coalition as advisors to the low performers. The PDSA cycle and interventions identified by the community coalition will align with the Network PDSA cycles with low performers. In this manner the high performing interventions identified in the Network service area will be utilized with low performers. The Network shall reevaluate the performance of facilities, Network-wide, on a consistent basis to identify facilities in need of technical assistance. Facilities that achieve sustained improved results shall be removed as needing technical assistance. If a facility is removed from technical assistance and does not maintain stability or forward progress, the Network shall assist the facility with technical assistance and perform an internal root cause analysis to identify the reason sustainability efforts failed.
- The Network shall report on technical assistance and outcome data regarding decreasing blood transfusions in patients receiving dialysis at a nursing home, with a focus on health equity issues, in the format described by CMS (Deliverable #19).
- Identify and maintain a list of the name of each nursing home where a home dialysis facility provides care.

#### C.4 SCOPE:

This SOW describes the requirements, level of effort, services and expected outcomes for the contractor to provide qualified personnel for successful completion of interventions across the ESRD Network Service area. This SOW covers support that will enhance and augment the knowledge, health outcomes, and safety outcomes of patients diagnosed with ESRD by providing overarching integrated support in the areas of education, quality improvement, data support and analysis, and patient support through patient and family engagement.

Through the efforts supported in this task order, the ESRD Networks will focus on:

- Demonstrating active participation of ESRD patients as empowered and informed participants in the renal community;
- Promoting home modalities and transplantation as appropriate treatments to support patient independence and improve clinical outcomes;
- Identifying innovative approaches to improving the Kidney Health of Medicare Beneficiaries;
- Showcase best practices for improving the quality of care for ESRD patients;
- Ensuring the safety and continuity of dialysis care in emergency situations;
- Analyzing data to formulate and effectuate data-driven interventions;

- Identifying health equity issues and collaborating with community coalitions to mitigate and resolve these inequities; and
- Reporting and analyzing outcomes from interventions to determine the viability of the intervention for spread or if there is a need to adapt or abandon.

## C.5 STRATEGIC PROGRAM FOUNDATIONS

The Network shall spread the knowledge gained from the exercise of the strategic program foundations broadly through the ESRD Network service area.

### C.5.1 Employ Sound Quality Improvement Principles

It is imperative that the Network identifies high performers in each objective and spreads identified proven methods of obtaining success in these facilities to lower performing facilities in the Network service area. The Network shall identify objectives and key results (OKR) to guide implementation of interventions to identify the success of the intervention and use agile practices to adopt, adapt, or abandon the intervention as necessary. Evidence of these efforts will be evident in the Continuous Internal Quality Improvement Program Plan (CIQIP) (Deliverable #43) which will be reported in the COR status and progress report (Deliverable #38). The Network shall utilize the monthly data from the ESRD NCC dashboard, other data sources as appropriate and approved by CMS, and triggers from the CIQIP as evidence-based guides to work toward successful completion of the goals of this task order. The Network shall solicit input from corporate entities regarding facilities that could benefit from assistance in the areas defined in this SOW. The Network shall develop a collaborative method with corporate entities for implementing best practices in lower performing facilities. The Network shall participate in any national strategy sessions with corporate entities to adopt and spread best practices with minimal facility burden as directed by CMS. The Network shall also use data to identify facilities in need of technical assistance. Education provides knowledge or instruction and can be accomplished through webinars, posters, brochures, and websites. Technical assistance provides targeted support to an organization or individual with an identified need. Technical assistance is individualized to the facility to overcome an individualized problem. The Network shall demonstrate, in the reports for technical assistance, the issue the facility is facing, the coaching provided by the Network, the results of the analysis and plan developed with the facility, and any promising practices or barriers. The ESRD Network shall identify strategies to reach the goals of the SOW. However, CMS understands that the work performed in this SOW is not static and that plans may need to be revised due to opportunities or barriers. If the ESRD Network alters the plan identified as the basis for the COR status and progress report, the Network, along with the COR, shall revise the report for future reporting.

### C.5.2 Improve Patient and Family Engagement at the Facility Level

Literature defines patient and family engagement in varying, but similar terms. There is a consensus among sources that patient and family engagement involves the inclusion of, “the perspectives of patients and families directly into the planning, delivery and evaluation of

healthcare, thereby improving the quality and safety of the care provided.”<sup>7</sup> Although patient and family engagement may be implemented differently across healthcare settings, all activities should support the patient’s values, preferences, and expressed needs. Additionally, activities should “provide clear, high quality information and education for the patient and family; include coordinated and integrated care and involvement of family members and friends, as appropriate”<sup>8</sup> and incorporate “the core concepts of dignity and respect, information sharing, active patient participation in their care, and collaboration.” The Network shall incorporate the patient’s voice in all of its activities and encourage the patients’ perspective within the renal community as a whole. The development and support of patient and family engagement includes, but is not limited to, patient and family involvement at the facility level through inclusion in the facility quality improvement activities, inclusion in the patient’s own plan of care, and peer-mentoring. The Network shall assist facilities to identify health equity issues that exist in the patient population and mitigate the health equity issues through integrating the patient voice into facility quality improvement activities, patient plans of care, and peer mentoring.

The baseline for each measure below is calculated in the base period and does not change over the course of the task order period of performance.

- Achieve a 50% increase in the number of facilities that successfully integrate patients and families into Quality Assurance and Performance Improvement (QAPI) over the task order period of performance. QAPI meetings are defined as meeting that include patient concerns regarding care provided in the dialysis facility, suggestions for improving care in the dialysis facility, and addressing the concern or suggestion with action.
  - Achieve a 10% increase in the number of facilities that successfully integrate patients and families into the QAPI meetings defined above from the baseline to the end of the base period.
  - Achieve an additional 10% increase in the number of facilities that successfully integrate patients and families into the QAPI meetings defined above for a 20% total increase from the baseline to the end of Option Period 1.
  - Achieve an additional 10% increase in the number of facilities that successfully integrate patients and families into the QAPI meetings defined above for a 30% total increase from the baseline to the end of Option Period 2.
  - Achieve an additional 10% increase in the number of facilities that successfully integrate patients and families into the QAPI meetings defined above for a 40% total increase from the baseline to the end of Option Period 3.
  - Achieve an additional 10% increase in the number of facilities that successfully integrate patients and families into the QAPI meetings defined above for a 50% total increase from the baseline to the end of Option Period 4.

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<sup>7</sup> Institute for Patient-and-Family-Centered Care. (no date) *Advancing the Practice of Patient-and-Family-Centered Care in Hospitals-How to Get Started*. Retrieved December 30, 2014, from Institute for Patient-and Family-Centered Care: [http://www.ipfcc.org/pdf/getting\\_started.pdf](http://www.ipfcc.org/pdf/getting_started.pdf)

<sup>8</sup> Committee on Quality of Health Care in America. Institute of Medicine. (2001). *Crossing the quality chasm: a new health system for the 21st century* (1st edition). Washington, DC: National Academies Press.

The Network shall be responsible for utilizing the modules developed by the ESRD NCC to educate patients, family members, caregivers and dialysis facility staff about the importance of and strategies for engaging the patients' thoughts and needs in QAPI meetings. The Network shall provide the percentage of facilities in the Network service area that include patient concerns in QAPI meetings as defined above for baseline (Deliverable #20). The Network shall provide the percentage of dialysis facilities that actively incorporate the patient voice into QAPI meeting as defined above (Deliverable #21).

- Achieve a 50% 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, over the task order period of performance.
  - Achieve a 10% 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, from the baseline to the end of the base period.
  - Achieve an additional 10% 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, for a 20% total increase from the baseline to the end of Option Period 1.
  - Achieve an additional 10% 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, for a 30% total increase from the baseline to the end of Option Period 2.
  - Achieve an additional 10% 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, for a 40% total increase from the baseline to the end of Option Period 3.
  - Achieve an additional 10% increase in the number of facilities that successfully assist patients to develop a life, from which the dialysis facility develops the dialysis plan of care, for a 50% total increase from the baseline to the end of Option Period 4.

The Network shall be responsible for utilizing the modules developed by the ESRD NCC to educate patients, family members, caregivers and dialysis facility staff about the importance of and strategies for engaging the patients' thoughts and needs into the patient plan of care. The Network shall provide the percentage of dialysis facilities that assist patients to develop a life plan, from which the dialysis facility develops the dialysis plan of care (Deliverable #22). The Network shall provide a list of facilities actively assisting patients to develop a life plan and developing the dialysis plan of care based on the life plan (Deliverable #23).

- Achieve a 25% increase in the number of facilities that successfully develop and support a Patient-Patient Support program over the task order period of performance.
  - Achieve a 5% increase in the number of facilities that successfully develop and support a Patient-Patient Support program from the baseline to the end of the base period.

- Achieve an additional 5% increase in the number of facilities that successfully develop and support a Patient-Patient Support program for a 10% total increase from the baseline to the end of Option Period 1.
- Achieve an additional 5% increase in the number of facilities that successfully develop and support a Patient-Patient Support program for a 15% total increase from the baseline to the end of Option Period 2.
- Achieve an additional 5% increase in the number of facilities that successfully develop and support a Patient-Patient Support program for a 20% total increase from the baseline to the end of Option Period 3.
- Achieve an additional 5% increase in the number of facilities that successfully develop and support a Patient-Patient Support program for a 25% total increase from the baseline to the end of Option Period 4.

The Network shall be responsible for utilizing modules and programs developed or recommended by the ESRD NCC for the Patient-Patient Support program. Additionally, CMS encourages the ESRD Networks to work with the ESRD NCC to ensure that Patient-Patient Support programs developed by other stakeholders and utilized by the ESRD Network are comparable to the NCC Patient-Patient Support program.

The Network is responsible for developing the peer mentors and supervising the Patient-Patient Support program in the Network service area. The Network shall recruit peer mentors and provide training (Deliverable #24). The Network shall provide the COR and the ESRD NCC with a list of peer mentors and information about the peer mentors to assist patients in the selection of a peer mentor (Deliverable #25). To be eligible to be a peer mentor the patient shall have experienced one of the following:

- Be receiving or have received treatment at the hemodialysis facility for one or more years, with at least six months of their treatment performed in-center, as confirmed by the patient's electronic health record; or
- Be receiving home dialysis and be a former patient of the hemodialysis facility; or
- Have received a transplant.

A peer mentor shall possess the following attributes:

- Complete all training activities associated with the program or a comparable stakeholder program (as identified by the NCC);
- May not be assigned more than two mentees at a time;
- Willing to dedicate the time necessary to provide ongoing one-on-one support to another patient;
- Mentors must also meet all mentee requirements.

Mentees shall have the following characteristics:

- Diagnosed by a physician with chronic kidney disease and receiving in-center hemodialysis treatment at the same hemodialysis facility as the assigned peer mentor (if the peer mentor is an in-center hemodialysis patient);
- Adults (over 18 years of age); and
- Ability to provide consent.

The Network shall closely collaborate with any NQIIC IDIQ contractor that has CKD as a task in the contract in their region, to ensure that appropriate mentees are identified for participation. The focus of the peer-mentoring program shall be to mentor patients with an initial diagnosis of CKD or ESRD, patients making decisions about treatment therapy (i.e. modality, access type), and/or patients considering a transplant. However, other patients are not discouraged from participating. The Network shall utilize the peer-mentoring modules developed by the ESRD NCC to educate mentors and provide the mentors with appropriate educational tool to use. The Network shall provide the percentage of facilities that are participating with the Network in the peer-mentoring program (Deliverable #26). The Network shall provide a list of facilities actively participating in the peer-mentoring program (Deliverable #27).

The Network shall meet with empowered patients, nephrologists, dialysis facility staff from all modalities, large and small dialysis organizations regional management and NQIIC IDIQ contractors with a CKD, patient empowerment, or grievance task in the contract as an advisory committee for patient and family engagement and patient experience of care (Deliverable #28). The meetings shall be used to plan, develop and implement strategies for patient and family engagement, patient empowerment, shared decision-making concepts, strategies in support of grievance resolution, and involuntary discharge prevention. The advisory coalition shall provide strategies for the objective and key results outlined in this task order including, but not limited to, support groups and patient and/or family engagement at the facility.

#### Non-Functional Goals:

- The Network shall assemble a coalition of high-performing experts in the subject matter stated above, from the Network service area. The coalition will assess local issues pertinent to the subject matter above and use a four-month PDSA format to solve issues and recommend interventions. If another quality improvement contractor receives a Task Order under the NQIIC IDIQ, that has patient engagement as a task in their contract, the ESRD Network shall contact them to become a member of the coalition to fully collaborate and share knowledge and success across contracts. The Network shall report the activities of the coalitions, with a focus on health equity issues, in the COR status and progress report (Deliverable #38).
- The Network shall identify facilities that are low performing and provide data-based targeted technical assistance to the facilities. The Network shall use the community coalition as advisors to the low performers. The PDSA cycle and interventions identified by the community coalition will align with the Network PDSA cycles with low performers. In this manner the high performing interventions identified in the Network service area will be utilized with low performers. The Network shall reevaluate the performance of facilities, Network-wide, on a consistent basis to identify facilities in need of technical assistance. Facilities that achieve sustained improved results shall be removed as needing technical assistance. If a facility is removed from technical assistance and does not maintain stability or forward progress, the Network shall assist the facility with technical assistance and perform an internal root cause analysis to identify the reason sustainability efforts failed.
- The Network shall report on technical assistance and outcome data in the format described by CMS (Deliverable #29).

- Engage patients, family members, and caregivers from a minimum of 10% of facilities in the Network service area to include representation from each state in the Network service area as patient subject matter experts (SMEs). The Network shall include facilities in rural areas and facilities in areas with health equity issues in addition to facilities that serve vulnerable populations. The Network shall provide a list of these facilities (Deliverable #30).
- The Network shall support the ESRD NCC National Patient/Family Engagement (N-PFE) Learning and Action Network (LAN) in its efforts to promote patient and family engagement to address the geographic area and patient population of the Network service area to ensure active participation in each identified group over the task order period of performance. The Network shall be responsible for recruiting a minimum of five individuals who are either a patient, family member, or caregiver to participate in the N-PFE LAN as SMEs. The Network shall recruit a SME from each state in the Network service area. If the Network has more than five states, they shall recruit more than five SMEs. The Network shall ensure the SME has a complete understanding of what the N-PFE LAN is, what the ESRD NCC is and who will be contacting them, and what the responsibilities of being an N-PFE LAN member entails. The Network shall submit the names of the N-PFE LAN SMEs (Deliverable #31). The Network shall stagger SME terms of participation to ensure that, at a minimum, one new SME is recruited each year to replace a SME that may move to the Legacy SME workgroup if the SME desires to continue to work with the N-PFE. The Network shall ensure that the SME understands the limitations on the term of participation. It is the responsibility of the Network to ensure the patient understands how the N-PFE functions and the expectations of participation. If a patient is physically unable to participate due to health or death, or the patient cannot attend due to work, the Network may replace the SME without consequence. The ESRD Network shall maintain an attendance rate of at least 60% over each task order period (i.e., the base period and each option period).
- The Network shall conduct a satisfaction survey of patient SMEs that represents a minimum of 10% of facilities in the Network service area using a template provided by CMS (Deliverable #32).
- The Network shall identify and plan for up to two patient SMEs to attend the CMS Quality Conference.
- The Network shall provide available staff at the CMS Quality Conference to guide patient SMEs to presentations, introduce patient SMEs to other patient SMEs and CMS representatives, and ensure the SMEs are engaged and comfortable during the CMS Quality Conference experience.

### C.5.3 Improve the Patient Experience of Care by Resolving Grievances and Access to Care Issues

Issues may arise at dialysis facilities that cannot be resolved without mediation. The Network has the responsibility to assist patients and dialysis facilities to resolve concerns in a manner that is satisfactory to all parties, as possible. A grievance is defined as a formal or informal written or verbal complaint that is made to any member of the dialysis or transplant center staff, by a patient, or the patient's representative, regarding the patient's care or treatment. If the grievant does not feel comfortable filing a grievance with the facility, a grievance may be filed directly to the Network. A facility concern is reported by dialysis facility to the Network when an issue is



identified and the dialysis facility requests assistance to resolve the issue. A patient concern is reported by a patient and does not meet the criteria for a grievance.

Non-Functional Goals:

- Educate patients and dialysis facility staff about the role of the Network in resolving grievance and access to care issues, the definition of grievance, and management of an anonymous process to report a grievance with the facility;
- Follow the grievance and access to care procedures in Attachment 9 Grievances and Patient-Appropriate Access to Care;
- Include a summary of grievance and access to care review activities and findings in the COR status and progress report (Deliverable #38);
- Document all information on grievance and access to care cases in the Patient Contact Utility (PCU);
- Maintain review timeliness, as directed by CMS, for at least 80% for all Immediate Advocacy cases (IA) (7 business days for all IA cases), and at least 90% of all grievance cases (60 calendar days for all grievances cases) entered into the current version of the PCU. If a case requires more than 60 calendar days to complete, COR approval must be received prior to the 50th day of the 60-day limit;
- Provide a focused audit of all grievance and access to care cases (Deliverable #33);
- Attend Community of Practice (CoP) and LAN calls as requested by CMS; and
- Identify and offer solutions to mitigate any health equity issues that may affect grievances, Involuntary Discharge (IVD) or Involuntary Transfers (IVT) situations, or the patients involved.

#### C.5.4 Improve the Data Quality of the Patient Registry in EQRS

Section 1881 of the SSA mandates that ESRD Networks collect, validate, and analyze data as necessary to prepare the reports regarding ESRD Network goals and to assure the maintenance of the ESRD patient registry. The ESRD Network shall employ sufficient staff capable of performing data validation and analysis. The ESRD Network shall use data provided by the EQRS. EQRS is a new system and the needs for data validation has not yet been thoroughly defined. CMS shall provide the Network, through the ESRD NCC, reports to utilize for data quality improvement and quality improvement activity reporting. Data quality is inclusive of resolving coverage issues for beneficiaries.

CMS will calculate the baseline for each measure below at the start of the period of performance. It will not change over the course of the task order period of performance.

- Achieve a 20% increase in the rate of patient admission records from dialysis facilities entered within five business days over the task order period of performance.
  - Achieve a 2% increase in the rate of patient admission records from dialysis facilities entered within five business days from the baseline to the end of the base period.
  - Achieve an additional 3% increase in the rate of patient admission records from dialysis facilities entered within five business days for a 5% total increase from the baseline to the end of Option Period 1.

- Achieve an additional 4% increase in the rate of patient admission records from dialysis facilities entered within five business days for a 9% total increase from the baseline to the end of Option Period 2.
- Achieve an additional 5% increase in the rate of patient admission records from dialysis facilities entered within five days for a 14% total increase from the baseline to the end of Option Period 3.
- Achieve an additional 6% increase in the rate of patient admission records from dialysis facilities entered within five business days for a 20% total increase from the baseline to the end of Option Period 4.
- Achieve a 10% increase in the rate of initial CMS-2728 forms submitted from dialysis facilities within 45 days over the task order period of performance.
  - Achieve a 2% increase in the rate of initial CMS-2728 forms submitted from dialysis facilities within 45 days from the baseline to the end of the base period.
  - Achieve an additional 2% increase in the rate of initial CMS-2728 forms submitted from dialysis facilities within 45 days for a 4% total increase from the baseline to the end of Option Period 1.
  - Achieve an additional 2% increase in the rate of initial CMS-2728 forms submitted from dialysis facilities within 45 days for a 6% total increase from the baseline to the end of Option Period 2.
  - Achieve an additional 2% increase in the rate of initial CMS-2728 forms submitted from dialysis facilities within 45 days for an 8% total increase from the baseline to the end of Option Period 3.
  - Achieve an additional 2% increase in the rate of initial CMS-2728 forms submitted from dialysis facilities within 45 days for a 10% total increase from the baseline to the end of Option Period 4.
- Achieve a 20% increase in the rate of CMS-2746 forms submitted from dialysis facilities within 14 days of the date of death over the task order period of performance.
  - Achieve a 2% increase in the rate of CMS-2746 forms submitted from dialysis facilities within 14 days of the date of death from the baseline to the end of the base period.
  - Achieve an additional 3% increase in the rate of CMS-2746 forms submitted from dialysis facilities within 14 days of the date of death for a 5% total increase from the baseline to the end of Option Period 1.
  - Achieve an additional 4% increase in the rate of CMS-2746 forms submitted from dialysis facilities within 14 days of the date of death for a 9% total increase from the baseline to the end of Option Period 2.
  - Achieve an additional 5% increase in the rate of CMS-2746 forms submitted from dialysis facilities within 14 days of the date of death for a 14% total increase from the baseline to the end of Option Period 3.
  - Achieve an additional 6% increase in the rate of CMS-2746 forms submitted from dialysis facilities within 14 days of the date of death for a 20% total increase from the baseline to the end of Option Period 4.

#### Non-Functional Goals:

- The Network shall ensure the accuracy of data in EQRS by using reports provided by the ESRD NCC to assess and correct patient information, either by working with dialysis facilities or acting as a data administrator in a timely manner.
- The Network shall identify facilities that are low performing and provide technical assistance to the facilities to submit timely and accurate data. The Network shall reevaluate the performance of facilities, Network-wide, on a consistent basis to identify facilities in need of technical assistance. Facilities that achieve sustained improved results shall be removed as needing technical assistance. If a facility is removed from technical assistance and does not maintain stability or forward progress, the Network shall assist the facility with technical assistance and perform an internal root cause analysis to identify the reason sustainability efforts failed.
- The Network shall report on technical assistance as part of the COR status and progress report (Deliverable #38).
- Participate with CMS, in calls and workgroups, to maintain the data in the data registry in EQRS, as necessary
- Resolve EQRS Near Matches, System Discharges, and Accretions to ensure resolution within 60 days. The Network shall report this information in the COR status and progress report (Deliverable #38).
- The ESRD Network shall audit the data systems of 20% of dialysis facilities in the Network service area, including patient medical records, to ensure the accuracy of the information entered on all CMS-2728 forms and CMS-2746 forms in EQRS (Deliverable #34). The Network shall review a minimum of ten records per facility or all of the records for the past task order period (i.e., Base Period, Option Period 1, etc.), if there are fewer than ten records. Additionally, the ESRD Network shall ensure the patient roster generated by the facility system matches the data in EQRS, along with their admission information, modality information, last four digits of the social security number (if this information is not available, the Network will ensure the social security number is entered), Medicare beneficiary identifier number, access information, and participation in vocational rehabilitation.
- The Network shall assist Veterans' Administration facilities and transplant centers to enter data into EQRS or shall enter the data for these entities to support data quality.
- The ESRD Network shall ensure data quality by resolving routine and acute termination reports for the Social Security Administration.

## C.6 Strategic Program Management Support

1. Act independently and not as an agent of the Government, the ESRD Network contractor shall furnish all of the necessary services, qualified personnel, material, equipment, and facilities, as needed to perform the requirements of the ESRD Network SOW
2. Acknowledge that all work performed under this task order is subject to inspection and final acceptance by the CMS Contracting Officer (CO) or another duly authorized representative of the Government. The CMS COR is a duly authorized representative of the Government and is responsible for inspection and acceptance of all items to be delivered under this task order.
3. Provide a roster of the medical review board (MRB), including at least one patient representative, and physicians, nurses, and social workers engaged in treatment relating to

ESRD to function as described in the SSA (Deliverable #35). Any MRB body with more than ten (10) members should have at least two (2) consumer representatives. The second consumer representative, being a contractual requirement rather than a legislative one, need not be a Medicare beneficiary.

4. Provide a roster of the network council of renal dialysis and transplant facilities located in the Network area, and patients to function as described in the SSA (Deliverable #36).
5. Provide a local presence in each state in the Network geographic area, which is directed and coordinated through the Network centralized office.
6. Maintain groups and meetings, including but not limited to advisory councils and coalitions, for the distinct Network region to account for well-defined regional issues and impact in accordance with the separation of regions by the SSA.
7. Convene educational opportunities for patients led by the Network or other credible stakeholders.
8. Maintain a national user-friendly, toll-free telephone number.
9. Maintain a Section 508 compliant Network website and comply with Section 508 regulations as applicable. Review and update the Network website at least quarterly to ensure the website is easy to navigate for patients and other ESRD stakeholders to find and utilize educational resources.
10. Maintain data security as described in the NQIC contract, including not releasing data without the permission of the CO and the Director of the Division of Kidney Health (DKH).
11. Adhere to the [Paper Reduction Act](#) (PRA).
12. Hold status and progress calls with the COR that include a least one patient (Deliverable #37).
13. Provide COR status and progress reports (Deliverable #38).
14. Identify facilities that have consistently failed to cooperate with network goals. Additionally, identify recommendations with respect to the need for additional or alternative services or facilities in the network, in order to meet the network goals, including self-dialysis training, transplantation, and organ procurement facilities (Deliverable #39).
15. Provide an annual report (Deliverable #40). The annual report shall include the following:
  - a. A full statement of the network's goals;
  - b. Data on the network's performance in meeting its goals, including data on the comparative performance of facilities and providers with respect to the identification and placement of suitable candidates in self-care settings and transplantation and encouraging participation in vocational rehabilitation programs;
  - c. Identification of those facilities that have consistently failed to cooperate with network goals; and
  - d. Recommendations with respect to the need for additional or alternative services or facilities in the network in order to meet the network goals, including self-dialysis training, transplantation, and organ procurement facilities.
16. Submit a Semi-Annual Cost Report. The cost information supplied should reflect actual costs incurred for the period, and be supported by Network financial records/general ledger and similar documentation. The Semi-Annual Cost Report template and instructions for use can be found in Attachment 8 and 8.1 (Deliverable #41).
17. Collaborate with State Survey Agencies.

18. Collaborate with ESRD Accrediting Organizations.
19. Adhere to the data management directives in the NQIIC IDIQ contract.
20. Identify security roles as identified in the NQIIC IDIQ contract.
21. Complete annual security training and any other training related to the use and safety of data as directed by CMS.
22. Submit a data use agreement (DUA) through the Enterprise Privacy Policy Engine (EPPE) (Deliverable #42).
23. Utilize, duplicate or disclose data CMS provides to the ESRD Network (and any applicable subcontractors) under this SOW only for the purposes of this SOW, unless the CO specifically permits another use in writing. Requests for uses of data other than for the purposes of this SOW will not be considered until the required amendments have been made to the DUA. At the conclusion of the use of CMS data or the expiration of the DUA (whichever comes first), the ESRD Network contractor shall fill out and submit to CMS a Certificate of Destruction (COD). The COD certifies that the ESRD Network has destroyed the data covered by the DUA and that data has not been used for any other purpose that was not covered in the DUA.
24. Establish a CIQIP, utilizing objectives and key results, which drives evidence-based success in the goals of SOW (Deliverable #43).
25. Provide results of the CIQIP monthly as part of the COR status and progress report (Deliverable #38).
26. Participate and support the ESRD NCC with the drafting and delivery of New ESRD Patient Orientation Packet (NEPOP), as necessary.
27. Attend program calls or CoP calls with CMS or the ESRD NCC acting on behalf of CMS, as requested.
28. Acknowledge that all software, documentation, and written products created under the ESRD Network SOW shall become the sole property of CMS.
29. Comply with all CMS guidelines regarding the appropriate de-identification of data, related to both individuals and practices consistent with agency privacy guidelines concerning disclosure of Network data.
30. Collaborate with the ESRD NCC to achieve the objectives and key results identified in the ESRD Network and the ESRD NCC SOWs.
31. Implement change packages as provided by the ESRD NCC.
32. Collaborate with the ESRD NCC in identifying the key results of the objectives of the task order to develop the monthly return on investment (ROI), using the calculations identified by CMS for inclusion in the monthly ESRD Network Dashboard.
33. Conduct and report the results of a satisfaction survey, using a template provided by CMS, with a minimum of 80% of facilities in the Network service area responding (Deliverable #44).
34. Prepare for and host the annual evaluation either on-site or virtually.
35. Encourage the use of treatment modalities most conducive to patient and dialysis facilities facilitating vocational rehabilitation.
36. Develop standards and criteria to assist providers and dialysis facilities, to encourage patients to participate in vocational rehabilitation.
37. Assist dialysis facilities to track patient access to vocational rehabilitation or employment network services and provide educational materials for patients about opportunities for assistance to find employment or education that could lead to employment.

38. Participate with the ESRD NCC and CMS, including the Office of Minority Health, in the identification of and strategies to remedy health equity issues, utilizing any modules developed and provided by the ESRD NCC.
39. Provide on-site education and mitigation strategies, as necessary, to achieve the goals of the SOW, technical assistance outcomes, and lead community level endeavors to support health equity.
40. Identify high and low performing dialysis facilities to participate in Expert Team Development and Sharing teams, in conjunction with the ESRD NCC. Track and report on activities as part of the education section of the COR status and progress report as necessary (Deliverable #38).
41. Provide a listserv for a point of contact at all dialysis facilities and transplant center in the Network service area (Deliverable #45).
42. Adjust invoice submissions in accordance with Modification P00001 (Deliverable #55).

## C.7 Additional Network Requirements

### C.7.1 Personnel

The Network shall provide necessary personnel to maintain performance standards and accomplish required services within specified timeframes. Contractor personnel shall be legal residents of the United States. The Government reserves the right to request and review documentation (e.g., certificates, training records, work records) certifying the personnel filling positions. The Government reserves the right to refuse to permit any Network employee to perform services under this SOW.

### C.7.2 Key Personnel

The Network shall identify an Executive Director of the ESRD Network service area and all key personnel, one of which shall be a full-time Master of Social Work (MSW) level Social Worker with experience in case review. The Network shall also employ, at a level appropriate to the demands of the task, a Registered Nurse (RN) with Nephrology experience for case review activities. The RN's Case Review activities shall take precedence over quality improvement and other activities, unless dictated otherwise by CMS. However, it is the responsibility of the Network to ensure that staffing levels are appropriate to ensure quality improvement and other activities are not affected by the absence of the RN. The Network shall assign Key Personnel who are integral to the performance of the task requirements. The contractor shall represent/acknowledge that all personnel assigned to this task order are capable of working independently and with demonstrated knowledge, skills and expertise in their respective functional areas, which are necessary to perform all assigned duties. If the contractor personnel do not possess the expertise necessary to perform the tasks required under this SOW, then the Network shall be responsible for appropriate training and/or replacing the personnel.

### C.7.3 Substitution of Key Personnel

The Network shall not substitute Key Personnel during the first ninety days of the task performance period unless the substitutions are unavoidable because of the incumbent's sudden illness, death or termination of employment. The contractor shall promptly notify the COR should these circumstances arise. After the initial ninety-day period, the Network shall submit to the COR all proposed substitutions at least thirty days in advance. All requests for approval of

substitutions here under must be in writing and provide a detailed explanation of the circumstances necessitating the proposed substitution(s). Requests must contain a complete resume for the proposed substitute, who shall have at least equal ability and qualifications to the incumbent, and any other information requested by the CO to approve or disapprove the proposed substitution. The CO and COR will evaluate such requests and promptly notify the contactor of approval or disapproval thereof, in writing.

#### C.7.4 Other than Key Personnel

Vacant positions for other than key personnel shall be filled within twenty calendar days from date of vacancy. The contractor shall notify the COR when a vacancy has occurred within one work day of the vacancy occurring.

#### C.7.5 Recommendations for Sanctions

The Network shall recommend sanctions pursuant to §1881(c) (2) of the Social Security Act and procedures outlined in Attachment 7, Recommendations for Sanctions. The Network shall conduct a thorough review of a facility reporting more than two IVD/IVTs per month or three IVD/IVTs per quarter to ensure regulatory or statutory compliance and to consider exercising its authority to recommend sanctions.

In addition, the Network shall consider recommending sanctions for facilities that:

- Engage in inappropriate practice patterns;
- Demonstrate a pattern of not accepting the Network's offers of technical assistance;
- Demonstrate a pattern of non-adherence to Network recommendations;
- Do not meet Network-determined benchmarks as required by CMS; and/or
- Do not meet CMS and Network goals relative to clinical performance measures and ESRD QIP measures.

The Network shall report any facilities being recommended for sanctions on the COR status and progress report (Deliverable #38) and provide the COR detailed documentation that supports the recommendation. If the COR concurs with the recommendation, the Network will schedule a call with the State Survey Agency to determine how to proceed.

#### C.7.6 Reporting of Discrimination

If it is suspected that care is being compromised or denied due to discrimination on the basis of race, color, national origin, disability, age, sex, or religion, the Network shall refer the case to the Office for Civil Rights (OCR) for investigation. The Network shall also notify the CMS COR, the Director of the Division of Kidney Health, and the Contracting Officer.

#### C.7.7 Emergency and Disaster Responsibilities of the Network

The 18 Networks are the foundation of the CMS ESRD emergency management structure. Under the direction of CMS, Kidney Community Emergency Response (KCER) is the national presence for ESRD-related emergency and disaster response. The Network shall assign staff to participate in one or more of the KCER committees. The Network shall recruit two (2) Patient SMEs and/or family members or caregivers to participate on the KCER LAN in two (2) year terms over the entirety of the task order period of performance. The Patient SMEs shall serve for

two (2) years and then be asked to serve in the Legacy program if they choose. The Network shall provide the names of the patients selected (Deliverable #46).

#### Non-Functional Goals:

- Provide a comprehensive disaster plan, to include but not limited to, interaction with state and local officials regarding support to patients and dialysis facilities for supplies, transportation, communication, and patient transfer (Deliverable #47).
- Provide emergency status reporting on data collected from all applicable facilities for each emergency using the KCER Emergency Situational Status Report (ESSR) and its associated Standard Operating Procedure (SOP).
- Educate dialysis facilities on the importance of reporting of any and all information required to manage an emergency, disaster, or pandemic. This information must be reported to the Network or the system of record as requested by KCER or CMS. The Network in conjunction with KCER will educate dialysis facilities on the appropriate manner of reporting.
- Invite KCER to emergency status calls held in response to an actual incident or emergency to ensure coordination at the national level with CMS Emergency Preparedness and Response Organization (EPRO) and to provide KCER with comprehensive situational awareness for their own required reporting.
- Provide technical assistance to dialysis facilities to develop feasible, comprehensive emergency/disaster plans.
- Participate with KCER and other Networks for an annual emergency exercise as directed by CMS.
- Participate in an annual emergency exercise for each state within the ESRD Network region
- Complete an After Action Report (AAR) using the template provided by KCER (Deliverable #48).
- Sign a Memorandum of Agreement (MOA) with a back-up Network (Deliverable #49).
- Provide an orientation program to the back-up Network (Deliverable #50).
- Test the toll-free hotline for patients annually to ensure that the telephone line can be transferred to the back-up Network.
- Obtain a Government Emergency Telephone System (GETS) card to facilitate communication during an emergency situation.
- Contact and collaborate with local and state emergency officials during a pandemic or other emergency.
- Ensure that all patient and facility needs are identified and that resources are located during a pandemic or other emergency.
- Ensure CMS is aware of all challenges and barriers in the area experiencing the emergency
- Attend KCER summit during Quality Conference.

#### C.7.8 Data Systems Management

The EQRS is the patient registry built on the legacy system of CROWNWeb. CMS relies on the data in EQRS, NHSN and other data systems to establish performance on the Network goals as described in this SOW, ESRD QIP and other quality improvement initiatives. To ensure fair



facility payment and appropriate stewardship of quality improvement resources, these data systems must contain the most complete and accurate data possible. The Network can help CMS achieve this goal by providing technical assistance to facilities in several areas.

Non-Functional Goals:

- Provide technical assistance to dialysis facilities to submit data into EQRS.
- Assure accuracy of data entered into EQRS by reconciling data reports provided by CMS, including but not limited to, alerts and notifications.
- Confirm that all dialysis facilities have successfully completed and submitted a CMS-2744A form and that all transplant centers have successfully completed and submitted a CMS-2744B form (Deliverable #51).
- Participate in data demonstrations and provide feedback on the design of current functionality and additional features to EQRS.
- Assist new and previously nonparticipating facilities with NHSN enrollment if requested by facilities.
- Provide assistance to facilities to improve facility processes related to the submission of data to NHSN.
- Assure the confidentiality of NHSN data. The data may not be used for research or purposes other than outlined in this SOW.

### C.7.9 Support of Other CMS Quality Initiatives

QIP changed the way CMS pays for the treatment of patients with ESRD by linking a portion of payment directly to facilities' performance on quality of care measures. These types of programs are known as "pay-for-performance" or "value-based purchasing" (VBP) programs. Star Ratings provide transparency to assist consumers in quickly and easily understanding quality of care information. Care Compare provides the public with a space to compare the service and quality of individual dialysis facilities.

Non-Functional Goals:

- Ensure that all Network staff are fully knowledgeable about measures and specifications related to the ESRD QIP and Star Ratings.
- Respond to questions from patients, caregivers, or dialysis facility staff regarding the ESRD QIP, Care Compare, and Star Ratings.
- Register provider Master Account Holders (MAH) to access websites designated by CMS to enable facilities to view facility-level quality reports, such as Care Compare and Dialysis Facility Reports. Provide MAH updates if needed (Deliverable #52).
- Post links to CMS' Web pages related to the ESRD QIP, Care Compare, and Star Ratings on the Network website.
- Upon request by CMS, enlist any five Patient SMEs and/or their families/caregivers to provide feedback for the ESRD QIP, Care Compare, Star Ratings, Dialysis Facility Reports, or any related patient-directed materials.
- Notify facilities of the procedures required to access their ESRD QIP Performance Score Reports (PSRs), Quarterly Care Compare Preview Reports, and Dialysis Facility Reports.
- Monitor access to the PSRs and contact providers that have not accessed the report

within five days of its release; encourage facilities to review their PSRs and submit necessary clarification questions or formal inquiries during the annual 30-day preview period.

- Assist facilities with accessing, printing, and posting the Performance Score Certificate (PSC) each year within five business days of its release date.
- Inform CMS if a facility has not posted its PSC as directed in Medicare Improvements for Patients and Providers Act (MIPPA).
- Provide technical assistance for any facilities in its service area requesting assistance with quality improvement efforts related to topics addressed by ESRD QIP and/or Star Ratings measures.
- Establish relationships and collaborate with stakeholders to achieve improvements on ESRD QIP and Care Compare measures on behalf of patients.
- Analyze and inform CMS or its designees of potential changes in facility practices reported to or observed by the Network that may adversely affect patients. Changes in practices may include changes in access to care or admission or transfer practices. The Network shall monitor information including grievance data, clinical data, anecdotal reports, and information from other sources available to the Network to identify these changes. The Network shall report these monitoring activities and findings to CMS on the COR status and progress report (Deliverable #38).

## C.8 Transition

1. The ESRD Network shall begin the phase-in efforts immediately after task order award. The ESRD Network shall submit a Transition Plan as part of their proposal. In this plan, the ESRD Network shall specify how it will phase-in seamless personnel staffing and support so that no delay or down time is experienced and perform phase-out at task order completion. In the plan, the ESRD Network shall include adequate time to:
  - a. Hire appropriate personnel;
  - b. Become familiar with patient SMEs and peer mentors in the ESRD Network service area;
  - c. Become familiar with successful and unsuccessful strategies for reaching patients, dialysis staff and regional dialysis management with education and quality improvement efforts;
  - d. Become familiar with current grievances and access to care issues, and any ongoing issues that could impact future work;
  - e. Issue subcontracts, etc. after task order award.
2. The Government will provide familiarization training of various Government organizations to the contractor, should the Government determine that such familiarization training is necessary. During the phase-in period, the contractor shall be responsible for finalizing all employee security requirements. The contractor shall complete the necessary steps for assumption of the operation during the phase-in period and shall meet all requirements as specified in the SOW prior to the beginning of the base period of performance.
3. During the phase-out transition period, the incumbent contractor shall provide required training pertaining to the current status and pending transactions. (Deliverable #53)

## Appendix A: List of Priority Diagnosis Categories

- A419 Sepsis, unspecified organism
- E875 Hyperkalemia
- E8770 Fluid overload unspecified
- I214 Non-ST elevation (N STEMI) myocardial infarction
- I120 Hypertensive chronic kidney disease stage 5 or end stage renal disease
- T82868 Thrombosis due to vascular prosthetic devices, implants and grafts
- I161 Hypertensive Emergency
- T8571 Infection and inflammatory reaction due to peritoneal dialysis catheter
- T80211 Bloodstream infection due to central venous catheter
- T82838 Hemorrhage due to vascular prosthetic devices, implants and grafts
- E8779 Other fluid overload
- I2510 Atherosclerosis heart disease of native coronary artery without angina pectoris
- J810 Acute pulmonary edema
- A4101 Sepsis due to Methicillin Susceptible Staphylococcus aureus
- A4102 Sepsis due to Methicillin Resistant Staphylococcus aureus
- T82858 Stenosis of other vascular prosthetic devices, implants and grafts
- R079 Chest pain, unspecified
- D649 Anemia unspecified
- E1110 DM Type 2 with ketoacidosis without coma
- A4181 Sepsis due to Enterococcus
- E1122 Diabetes type 2 with diabetic chronic kidney disease
- I169 Hypertensive Crisis, Unspecified
- E871 Hypo-osmolality and hyponatremia
- E876 Hypokalemia
- E162 Hypoglycemia, unspecified
- A4150 Gram-negative sepsis, unspecified