STATEMENT OF WORK (SOW)
FOR
END STAGE RENAL DISEASE (ESRD) NETWORK

CONTENTS

C.1. PURPOSE

The purpose of this task order is to delineate tasks to be conducted by each ESRD Network 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 Sixteen (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:

1. Serving as conveners, organizers, motivators, and change agents;

2. Leveraging technology to provide outreach and education;

3. Serving as partners in quality improvement with patients, practitioners, healthcare providers, other healthcare organizations, and other stakeholders;

4. Securing commitments to create collaborative relationships with other stakeholders and partners;

5. Achieving and measuring changes at the patient level through data collection, analysis, and monitoring for improvement;

6. Disseminating and spreading best practices, including those relating to clinical care, quality improvement techniques, and data collection through information exchange;

7. Participating in the development of a CMS national framework for providing emergency preparedness services for the ESRD community; and

8. 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:

1. Section 1881 of the Social Security Act (SSA);

2. HHS Secretary's Priorities;

3. Executive Order to Launch *Advancing American Kidney Health*;

4. ESRD Treatment Choices (ETC) Payment Model; and

5. 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 and 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:

1. Focusing on person and family-centered values within our program activities and focus areas;

2. Achieving excellence in the implementation and operation of national programs;

3. Identifying high-impact, low-cost methods and opportunities to improve the quality and safety of the American healthcare system; and

4. 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. HHS has three goals based on AAKH. One of the goals is to have eighty (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 to:

1. Improve Behavioral Health Outcomes;
2. Improve Patient Safety and Reduce Harm;
3. Improve Care in High Cost/Complex Chronic Conditions;
4. Reduce Hospital Admissions, Readmissions, and Outpatient Emergency Visits;
5. Improve Nursing Home Care in Low-Performing Providers; and
6. Provide Targeted Quality Improvement (QI) Response(s).

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 and 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, including, 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:

1. Health Equity, which 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";

2. Rural Health, which includes addressing needs and barriers of those living in geographically rural areas; and

3. Patient and Family Engagement, which is defined as ensuring that 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, including efforts to determine if methods are 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 NQIIC'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 at multiple levels.

1. National Level: The contractor shall engage in ESRD National Coordinating Center (NCC) Learning and Action Network (LAN) calls and activities, along with other national learning opportunities, to support improvement at the national level.

2. Regional Level: The contractor shall engage in regional LAN work, with a focus on wide-spread education, to support improvement at the regional level.

3. Community Level: The contractor shall engage in community coalition work, driven by the community and focused on improving healthcare outcomes and addressing health equity, to support improvement at the community level.

4. System Level: The contractor shall engage in community coalition work, driven by healthcare systems, technical assistance, and additional education, to support improvement at the system level.

5. Provider Level: The contractor shall engage in individual technical assistance, which provides specialized assistance, to support improvement at the provider level.

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 objectives for this Statement of Work by achieving the following goals and key results:

C.3.1. GOAL 1: Improve Behavioral Health Outcomes

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

Depression was identified in 39.3% of ESRD patients when evaluated by screening questionnaires, and 22.8% of ESRD patients 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.[1] Chronic pain in hemodialysis (HD) patients is associated with depression and insomnia, and may predispose patients to consider withdrawal of dialysis.[2] 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 (QIP). 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 NQIIC 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 meetings shall support the identification and mitigation of any health equity issues that would impede a thorough and 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.

Key Result #1: The Network shall achieve a 15% increase in the percentage of patients accurately identified as having depression from the baseline to the end of Option Period 1. Data for this measure is based on the ESRD Quality Reporting System (EQRS), or another CMS approved data system. This measure is only applicable to Option Period 1.

This measure is not applicable to the Base Period, because the data necessary to assess progress toward meeting the measure, and adjust interventions in order to achieve the measure, was unavailable.

CMS will calculate the baseline for this measure when 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.

Key Result #2: The Network shall achieve a 6% increase in the percentage of patients, within the subset of patients identified as having depression, who have received treatment

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[1] 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.

[2] 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.

by a mental health professional from the baseline to the end of Option Period 1. Data for this measure is based on the EQRS, or another CMS approved data system, and Medicare Claims. This measure is only applicable to Option Period 1.

This measure is not applicable to the Base Period, because the data necessary to assess progress toward meeting the measure, and adjust interventions in order to achieve the measure, was unavailable.

CMS will calculate the baseline for this measure when 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.

Key Result #3: The Network shall increase the percentage of patients receiving, or having received, treatment by a mental health professional after having been screened positively for depression, as identified in the QIP attestation, over the task order period of performance. Data for this measure is based on EQRS, or another CMS approved data system, and Medicare Claims. This measure is only applicable to Option Periods 2-4.

CMS will calculate the baseline for this measure at the end of Option Period 1, using up to twelve (12) months of available data to establish a trend. It will not change over the course of the task order period of performance.

This measure is broken down as follows:

1. Option Period 2: In Option Period 2, the Network shall achieve a 10% increase, from the baseline, in the percentage of patients receiving, or having received, treatment by a mental health professional after having been screened positively for depression, as identified in the QIP attestation.

2. Option Period 3: In Option Period 3, the Network shall achieve a 25% increase, from the baseline, in the percentage of patients receiving, or having received, treatment by a mental health professional after having been screened positively for depression, as identified in the QIP attestation.

3. Option Period 4: In Option Period 4, the Network shall achieve a 40% increase, from the baseline, in the percentage of patients receiving, or having received, treatment by a mental health professional after having been screened positively for depression, as identified in the QIP attestation.

The Network is also responsible for the following supporting tasks:

1. The Network shall assemble a coalition of high-performing facilities and experts in the subject matter stated above, from the Network service area, to mentor and advise low-performing facilities. The high-performing facilities in this coalition will assess local issues pertinent to the subject matter above and provide examples of data-driven successful interventions to recommend to low-performing

facilities. The high-performing facilities will also mentor low-performing facilities on the utilization of 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.

2. The Network shall identify facilities that are low-performing based on ongoing data analytics, and provide data-based targeted technical assistance to these facilities. The interventions identified as successful by the high-performing facilities in the community coalition will be used to enhance the Network Plan-Do-Study-Act (PDSA) cycles with low-performing facilities. In this manner, the high-performing interventions identified in the Network service area will be shared with and implemented in low-performing facilities, as applicable based on the needs of the low-performing facilities. The Network shall re-evaluate 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 again provide technical assistance to these facilities and perform an internal root cause analysis to identify the reason sustainability efforts failed.

3. 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).

4. 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 related to cognitive decline 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.

5. The Network shall collaborate with any other task orders and/or contracts developed for other mental health issues, such as anxiety and bipolar disorder, as directed by CMS.

C.3.2. GOAL 2: Improve Patient Safety and Reduce Harm

C.3.2.A. 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:

1. Adequacy of dialysis treatment;
2. Anemia management;
3. Medication compliance;
4. Health care access;
5. Healthy diet maintenance;
6. Tobacco, recreational drugs, and alcohol misuse;
7. Sedentary lifestyle;
8. Dialysis treatment compliance;
9. Social support system instability; and
10. 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, 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 further 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 meetings shall support the identification and mitigation of any health equity issues that would impede the improvement of infection rates for hemodialysis catheters or peritoneal infections.

Key Result #4: The Network shall achieve a 6% decrease in the hemodialysis catheter infection rate, in dialysis patients receiving home dialysis within nursing homes from the baseline to the end of Option Period 1. Data for this measure is based on EQRS, or another CMS approved data system, and Medicare Claims. This measure is only applicable to Networks with patients receiving dialysis in nursing home settings. Refer to Key Result #6 below, as an alternate measure for Networks with no patients receiving dialysis in nursing home settings. This measure is only applicable to Option Period 1.

This measure is not applicable to the Base Period, because the data necessary to assess progress toward meeting the measure, and adjust interventions in order to achieve the measure, was unavailable.

CMS will calculate the baseline for this measure 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.

Key Result #5: The Network shall decrease the hemodialysis catheter infection rate, among dialysis patients receiving home dialysis within nursing homes, over the task order period of performance. Data for this measure is based on EQRS, or another CMS approved data system, and Medicare Claims. This measure is only applicable to Networks with patients receiving dialysis in nursing home settings. Refer to Key Result #6 below, as an alternate measure for Networks with no patients receiving dialysis in nursing home settings. This measure is only applicable to Option Periods 2-4.

CMS will calculate the baseline for this measure at the end of Option Period 1, using up to twelve (12) months of available data to establish a trend. It will not change over the course of the task order period of performance. However, CMS reserves the right to recalculate the baseline at any point during the task order period of performance, for Networks that have a baseline of zero (0).

Networks with a baseline of zero (0) shall maintain a rate of zero (0) in order to achieve this Key Result.

This measure is broken down as follows:

1. Option Period 2: In Option Period 2, the Network shall achieve a 6% decrease, from the baseline, in the hemodialysis catheter infection rate, among dialysis patients receiving home dialysis within nursing homes.

2. Option Period 3: In Option Period 3, the Network shall achieve a 14% decrease, from the baseline, in the hemodialysis catheter infection rate, among dialysis patients receiving home dialysis within nursing homes.

3. Option Period 4: In Option Period 4, the Network shall achieve a 24% decrease, from the baseline, in the hemodialysis catheter infection rate, among dialysis patients receiving home dialysis within nursing homes.

Key Result #6: The Network shall decrease the hemodialysis catheter infection rate, among 10% of the nursing home residents receiving dialysis in-center, over the task order period of performance. Data for this measure is based on EQRS, or another CMS approved data system, and Medicare Claims. This measure serves as an alternate to Key Result #4 and Key Result #5, and is only applicable to Networks with no patients

receiving dialysis in nursing home settings. This measure is only applicable to Option Periods 1-4.

This measure is not applicable to the Base Period, because the data necessary to assess progress toward meeting the measure, and adjust interventions in order to achieve the measure, was unavailable.

CMS will calculate the baseline for this measure at the end of the Base Period, using up to twelve (12) months of available data to establish a trend. It will not change over the course of the task order period of performance. However, CMS reserves the right to recalculate the baseline at any point during the task order period of performance, for Networks that have a baseline of zero (0).

Networks with a baseline of zero (0) shall maintain a rate of zero (0) in order to achieve this Key Result.

This measure is broken down as follows:

1. Option Period 1: The Network shall achieve a 6% decrease in the hemodialysis catheter infection rate, among 10% of the nursing home residents receiving dialysis in-center, from the baseline to the end of Option Period 1.

2. Option Period 2: In Option Period 2, the Network shall achieve a 14% decrease, from the baseline, in the hemodialysis catheter infection rate, among 10% of the nursing home residents receiving dialysis in-center.

3. Option Period 3: In Option Period 3, the Network shall achieve a 24% decrease, from the baseline, in the hemodialysis catheter infection rate, among 10% of the nursing home residents receiving dialysis in-center.

4. Option Period 4: In Option Period 4, the Network shall achieve a 36% decrease, from the baseline, in the hemodialysis catheter infection rate, among 10% of the nursing home residents receiving dialysis in-center.

Key Result #7: The Network shall achieve a 3% decrease in incidence of peritonitis in dialysis patients receiving home dialysis within nursing homes from the baseline to the end of Option Period 1. Data for this measure is based on EQRS, or another CMS approved data system, and Medicare Claims. This measure is only applicable to Networks with patients receiving dialysis in nursing home settings. This measure is only applicable to Option Period 1.

This measure is not applicable to the Base Period, because the data necessary to assess progress toward meeting the measure, and adjust interventions in order to achieve the measure, was unavailable.

CMS will calculate the baseline for this measure 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.

Key Result #8: The Network shall decrease the peritonitis infection rate, among dialysis patients receiving home dialysis within nursing homes, over the task order period of performance. Data for this measure is based on EQRS, or another CMS approved data system, and Medicare Claims. This measure is only applicable to Networks with patients receiving dialysis in nursing home settings. This measure is only applicable to Option Periods 2-4.

CMS will calculate the baseline for this measure at the end of Option Period 1, using up to twelve (12) months of available data to establish a trend. It will not change over the course of the task order period of performance. However, CMS reserves the right to recalculate the baseline at any point during the task order period of performance, for Networks that have a baseline of zero (0).

Networks with a baseline of zero (0) shall maintain a rate of zero (0) in order to achieve this Key Result.

This measure is broken down as follows:

1. Option Period 2: In Option Period 2, the Network shall achieve a 3% decrease, from the baseline, in the peritonitis infection rate, among dialysis patients receiving home dialysis within nursing homes.

2. Option Period 3: In Option Period 3, the Network shall achieve a 7% decrease, from the baseline, in the peritonitis infection rate, among dialysis patients receiving home dialysis within nursing homes.

3. Option Period 4: In Option Period 4, the Network shall achieve a 12% decrease, from the baseline, in the peritonitis infection rate, among dialysis patients receiving home dialysis within nursing homes.

The Network is also responsible for the following supporting tasks:

1. The Network shall assemble a coalition of high-performing facilities and experts in the subject matter stated above, from the Network service area, to mentor and advise low-performing facilities. The high-performing facilities in this coalition will assess local issues pertinent to the subject matter above and provide examples of data-driven successful interventions to recommend to low-performing facilities. The high-performing facilities will also mentor low-performing facilities on the utilization of 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.

2. The Network shall identify facilities that are low-performing based on ongoing data analytics, and provide data-based targeted technical assistance to the facilities. The interventions identified as successful by the high-performing facilities in the community coalition will be used to enhance the Network PDSA cycles with low-performing facilities. In this manner, the high-performing interventions identified in the Network service area will be shared with and implemented in low-performing facilities, as applicable based on the needs of the low-performing facilities. The Network shall re-evaluate 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 again provide technical assistance to these facilities and perform an internal root cause analysis to identify the reason sustainability efforts failed.

3. The Network shall report on technical assistance and data outcomes related to decreasing infection rates, with a focus on health equity issues, in the format described by CMS (Deliverable #5).

4. The Network shall administer a survey, developed in conjunction with the Centers for Disease Control and Prevention (CDC), to all nursing home dialysis facilities providing dialysis services within a nursing home, using a template provided by CMS (Deliverable #6). The purpose of this survey is to gain information about the administration of dialysis to the patient population who receives dialysis within nursing homes.

5. 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 task is only applicable to Networks with no patients receiving dialysis in nursing home settings.

6. The Network shall assist in the coordination of care and transfer of ESRD nursing home patients. This task is only applicable to Networks with no patients receiving dialysis in nursing home settings.

7. The Network shall monitor and track developments (i.e., state legislation, new facilities/patients, etc.) regarding the expansion of home dialysis for ESRD patients in nursing homes, within their Network service area. This task is only applicable to Networks with no patients receiving dialysis in nursing home settings.

C.3.3. GOAL 3: Improve Care in High Cost/Complex Chronic Conditions

C.3.3.A. 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 utilizing a home modality 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 to be further 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, among both prevalent and incident patients, of a home modality. Additionally, the Network shall gain insight on mitigating barriers to access and maintenance of dialysis in the home setting, and encourage hesitant providers to foster acceptance of home modalities, through education and other methods of encouragement. These meetings shall support the identification and mitigation of any health equity issues that would impede a patient's choice of home modality.

Key Result #9: The Network shall increase the number of incident ESRD patients starting dialysis using a home modality, over the task order period of performance. Data for this measure is based on EQRS.

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

This measure is broken down as follows:

1. Base Period: The Network shall achieve a 10% increase in the number of incident ESRD patients starting dialysis using a home modality from the baseline to the end of the Base Period.

2. Option Period 1: The Network shall 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.

3. Option Period 2: In Option Period 2, the Network shall achieve a 30% increase, from the baseline, in the number of incident ESRD patients starting dialysis using a home modality.

4. Option Period 3: In Option Period 3, the Network shall achieve a 45% increase, from the baseline, in the number of incident ESRD patients starting dialysis using a home modality.

5. Option Period 4: In Option Period 4, the Network shall achieve a 60% increase, from the baseline, in the number of incident ESRD patients starting dialysis using a home modality.

Key Result #10: The Network shall increase the number of prevalent ESRD patients moving to a home modality, over the task order period of performance. Data for this measure is based on EQRS.

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

This measure is broken down as follows:

1. Base Period: The Network shall achieve a 2% increase in the number of prevalent ESRD patients moving to a home modality from the baseline to the end of the Base Period.

2. Option Period 1: The Network shall 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.

3. Option Period 2: In Option Period 2, the Network shall achieve a 12% increase, from the baseline, in the number of prevalent ESRD patients moving to a home modality.

4. Option Period 3: In Option Period 3, the Network shall achieve a 20% increase, from the baseline, in the number of prevalent ESRD patients moving to a home modality.

5. Option Period 4: In Option Period 4, the Network shall achieve a 30% increase, from the baseline, in the number of prevalent ESRD patients moving to a home modality.

Key Result #11: The Network shall achieve a 3% increase in the number of rural ESRD patients using telemedicine to access a home modality from the baseline to the end of Option Period 1. Data for this measure is based on EQRS, or another CMS approved data system. This measure is only applicable to Option Period 1.

This measure is not applicable to the Base Period, because the data necessary to assess progress towards meeting the measure, and adjust interventions in order to achieve the measure, was unavailable.

CMS will calculate the baseline for this 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.

Key Result #12: The Network shall increase the number of rural ESRD patients using telemedicine to access a home modality, over the task order period of performance. Data for this measure is based on EQRS, or another CMS approved data system. Networks whose entire Network service area (i.e., all states and/or territories within the Network service area) contains restrictions on the use of telemedicine due to licensure laws are exempt from this measure. This measure is only applicable to Option Periods 2-4.

CMS will calculate the baseline for this measure at the end of Option Period 1, using up to twelve (12) months of available data to establish a trend. It will not change over the course of the task order period of performance.

This measure is broken down as follows:

1. Option Period 2: In Option Period 2, the Network shall achieve a 3% increase, from the baseline, in the number of rural ESRD patients using telemedicine to access a home modality

2. Option Period 3: In Option Period 3, the Network shall achieve a 7% increase, from the baseline, in the number of rural ESRD patients using telemedicine to access a home modality.

3. Option Period 4: In Option Period 4, the Network shall achieve a 12% increase, from the baseline, in the number of rural ESRD patients using telemedicine to access a home modality.

The Network is also responsible for the following supporting tasks:

1. The Network shall assemble a coalition of high-performing facilities and experts in the subject matter stated above, from the Network service area, to mentor and advise low-performing facilities. The high-performing facilities in this coalition will assess local issues pertinent to the subject matter above and provide examples of data-driven successful interventions to recommend to low-performing facilities. The high-performing facilities will also mentor low-performing facilities on the utilization of interventions. If another quality improvement contractor receives a task order under the NQIIC IDIQ, that has education of 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.

2. The Network shall identify facilities that are low-performing based on ongoing data analytics, and provide data-based targeted technical assistance to these facilities. The interventions identified as successful by the high-performing

facilities in the community coalition will be used to enhance the Network PDSA cycles with low-performing facilities. In this manner, the high-performing interventions identified in the Network service area will be shared with and implemented in low-performing facilities, as applicable based on the needs of the low-performing facilities. The Network shall re-evaluate 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 again provide technical assistance to these facilities and perform an internal root cause analysis to identify the reason sustainability efforts failed.

3. The Network shall report on technical assistance and outcome data related to home modalities, with a focus on mitigating heath equity issues, in the format described by CMS (Deliverable #9).

4. The Network shall utilize Attachment 5 Home Dialysis Change Package, which was developed from strategies utilized by high-performing dialysis facilities across the country.

5. The Network shall implement efforts to identify the number of patients in the Network service area that could benefit from the use of telemedicine. Additionally, the Network shall advocate to state licensure boards for the expanded use of home dialysis in rural areas, specifically for patients that might benefit from the use of telemedicine in rural areas. The Network shall report on these efforts, including the number of facilities and patients that indicate a desire to use telemedicine, if made available, to support home dialysis in rural areas (Deliverable #61). This task is only applicable to Networks whose entire Network service area (i.e., all states and/or territories within the Network service area) contains restrictions on the use of telemedicine due to licensure laws.

C.3.3.B. 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 that 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, and Learning (TAQIL) contractor as an advisory committee (Deliverable #10). These meetings shall be used to plan, develop, and implement quality improvement concepts and strategies to be further 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 concepts and strategies shall support 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.

Key Result #13: The Network shall increase the number of patients added to a kidney transplant waiting list, over the task order period of performance. Data for this measure is based on EQRS.

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

This measure is broken down as follows:

1. Base Period: The Network shall 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.

2. Option Period 1: The Network shall 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.

3. Option Period 2: In Option Period 2, the Network shall achieve a 9% increase, from the baseline, in the number of patients added to a kidney transplant waiting list.

4. Option Period 3: In Option Period 3, the Network shall achieve a 14% increase, from the baseline, in the number of patients added to a kidney transplant waiting list.

5. Option Period 4: In Option Period 4, the Network shall achieve a 20% increase, from the baseline, in the number of patients added to a kidney transplant waiting list.

Key Result #14: The Network shall increase the number of patients receiving a kidney transplant, over the task order period of performance. Data for this measure is based on EQRS.

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

This measure is broken down as follows:

1. Base Period: The Network shall achieve a 2% increase in the number of patients receiving a kidney transplant from the baseline to the end of the Base Period.

2. Option Period 1: The Network shall 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.

3. Option Period 2: In Option Period 2, the Network shall achieve a 12% increase, from the baseline, in the number of patients receiving a kidney transplant.

4. Option Period 3: In Option Period 3, the Network shall achieve a 20% increase, from the baseline, in the number of patients receiving a kidney transplant.

5. Option Period 4: In Option Period 4, the Network shall achieve a 30% increase, from the baseline, in the number of patients receiving a kidney transplant.

The Network is also responsible for the following supporting tasks:

1. The Network shall assemble a coalition of high-performing facilities and experts in the subject matter stated above, from the Network service area, to mentor and advise low-performing facilities. The high-performing facilities in this coalition will assess local issues pertinent to the subject matter above and provide examples of data-driven successful interventions to recommend to low-performing facilities. The high-performing facilities will also mentor low-performing facilities on the utilization of 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.

2. The Network shall utilize Attachment 6 Transplant Change Package, which was developed from strategies utilized by high-performing facilities across the country.

3. The Network shall increase the number of transplant centers that utilize telemedicine for patients to complete all or part of the work necessary to be added to a transplant waiting list, with a focus on rural patients, over the task order period of performance.

4. The Network shall identify facilities that are low-performing based on ongoing data analytics, and provide data-driven targeted technical assistance to these facilities. The interventions identified as successful by the high-performing facilities in the community coalition will be used to enhance the Network PDSA cycles with low-performing facilities. In this manner, the high-performing interventions identified in the Network service area will be shared with and implemented in low-performing facilities, as applicable based on the needs of the low-performing facilities. The Network shall re-evaluate 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 again provide technical assistance to these facilities and perform an internal root cause analysis to identify the reason sustainability efforts failed.

5. The Network shall report on technical assistance and outcome data related to kidney transplant, with a focus on health equity issues, in the format described by CMS (Deliverable #11).

6. The Network shall develop education for nephrologists, nephrology office staff, renal hospital staff and/or educators, dialysis facility staff, incident dialysis patients, prevalent dialysis patients, and any healthcare professionals that might provide education for incident and/or prevalent patients, that supports the AAKH goal to increase dialysis patients' choice of high KDPI or expanded donor criteria kidneys.

7. The Network shall collaborate with Organ Procurement Organizations (OPOs) and transplant centers, with a focus on the ETC Payment Model.

8. 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).

9. The Network shall recruit patients to participate with the ESRD NCC and TAQIL contractor(s) on a patient-focused LAN, quarterly.

10. The Network shall be available to participate in kidney transplant quality improvement teams identified by the TAQIL contractor. Additionally, the Network will collaborate with the TAQIL contractor for the ETC Learning Collaborative (ETCLC).

11. The Network shall provide a list of facilities and patients interested in participating in activities with the TAQIL contractor (Deliverable #13).

12. The Network shall participate in collaboration with the ESRD NCC, TAQIL contractor, patients, dialysis facilities, a transplant centers to develop educational resources and refine the Transplant Change Package.

13. The Network shall educate patients and providers about the new Medicare benefit to transplant patients that provides coverage for immunosuppressive medication beyond thirty-six (36) months post-transplant, and any other upcoming benefits that support transplant efforts and/or transplant patients.

C.3.3.C. Educate and Manage Public Health Emergencies (PHEs), 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. The above data is based on Medicare FFS Claims and EQRS, as of June 30, 2020.

One study identified three frequent comorbidities of COVID-19 positive patients that were hospitalized: hypertension, obesity, and diabetes.[3] Another study identified hypertension, obesity, and diabetes in the top four comorbidities contributing to more severe disease outcomes, such as hospitalization or death.[4] 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 NQIIC IDIQ, as an advisory committee (Deliverable #54). These meetings shall be used to plan, develop, and implement quality improvement concepts and strategies to be further 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, 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(s) and resolving health issues that would predispose a person to COVID-19 and/or adverse health outcomes related to COVID-19.

Key Result #15: Until the point in which COVID-19 is controlled, as determined by CMS, the Network shall achieve a 25% decrease in the number of COVID-19 hospitalizations, among the ESRD patient population with Medicare FFS as a payer source, per task order period (i.e., Base Period, Option Period 1, etc.). Data for this measure is based on Medicare Claims. This measure is only applicable to the Base Period and Option Periods 2-4.

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[3] 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

[4] Adekunle Sanyaolu, et al. Comorbidity and its Impact on Patients with COVID-19. SN Compr Clin Med June 25,20

This measure is not applicable to Option Period 1, because the modification necessary to implement this measure beyond the Base Period will not be executed until the beginning of Option Period 2.

This measure is only applicable until COVID-19 is controlled, as determined by CMS. At the point in which COVID-19 is controlled, as determined by CMS, Key Result #15 shall be replaced by Key Result #16.

The Network shall focus on ESRD patients identified as having one (1) 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.

This measure is broken down as follows:

1. Base Period: The Network shall achieve a 25% decrease in the number of COVID-19 hospitalizations, among 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.

2. Option Period 2: The Network shall achieve a 25% decrease in the number of COVID-19 hospitalizations, among the ESRD patient population with Medicare FFS as a payer source, from May 1, 2023 through April 30, 2024 compared to May 1, 2022 through April 30, 2023.

3. Option Period 3: The Network shall achieve a 25% decrease in the number of COVID-19 hospitalizations, among the ESRD patient population with Medicare FFS as a payer source, from May 1, 2024 through April 30, 2025 compared to May 1, 2023 through April 30, 2024.

4. Option Period 4: The Network shall achieve a 25% decrease in the number of COVID-19 hospitalizations, among the ESRD patient population with Medicare FFS as a payer source, from May 1, 2025 through April 30, 2026 compared to May 1, 2024 through April 30, 2025.

Key Result #16: The Network shall decrease average body weight, among prevalent ESRD patients identified as obese, over the task order period of performance. Data for this measure is based on EQRS.

This measure is only applicable after COVID-19 is controlled, as determined by CMS. At the point in which COVID-19 is controlled, as determined by CMS, Key Result #15 shall be replaced by Key Result #16.

CMS will calculate the baseline for this measure at the point in which COVID-19 is controlled, as determined by CMS, using up to twelve (12) months of available data to establish a trend. It will not change over the course of the task order period of performance.

This measure is broken down as follows:

1. First Applicable Option Period: In the first applicable option period, the Network shall achieve a 1% decrease, from the baseline, in average body weight, among prevalent ESRD patients identified as obese.

2. Second Applicable Option Period: In the second applicable option period, the Network shall achieve a 4% decrease, from the baseline, in average body weight, among prevalent ESRD patients identified as obese.

3. Third Applicable Option Period: In the third applicable option period, the Network shall achieve a 9% decrease, from the baseline, in average body weight, among prevalent ESRD patients identified as obese.

Key Result #17: The Network shall ensure that a minimum of 80% of dialysis patients receive a primary COVID-19 vaccination and/or vaccination series. Data for this measure is based on National Healthcare Safety Network (NHSN), or another CMS approved data system. This measure is only applicable to the Base Period and Option Period 1.

Key Result #18: The Network shall ensure that a minimum of 80% of fully vaccinated dialysis patients receive any additional CDC and/or CMS recommended COVID-19 vaccinations. Data for this measure is based on NHSN, or another CMS approved data system. This measure is only applicable to the Base Period and Option Period 1.

Key Result #19: The Network shall ensure that a minimum of 80% of dialysis patients are fully vaccinated for COVID-19, including boosters, as determined by the CDC and/or CMS. Data for this measure is based on NHSN, or another CMS approved data system. This measure is only applicable to Option Periods 2-4.

Key Result #20: The Network shall ensure that 100% of dialysis facility staff receive a primary COVID-19 vaccination and/or vaccination series. Data for this measure is based on NHSN, or another CMS approved data system. This measure is only applicable to the Base Period and Option Period 1.

Key Result #21: The Network shall ensure that 100% of fully vaccinated dialysis facility staff receive any additional CDC and/or CMS recommended COVID-19 vaccinations. Data for this measure is based on NHSN, or another CMS approved data system. This measure is only applicable to the Base Period and Option Period 1.

Key Result #22: The Network shall ensure that a minimum of 95% of dialysis facility staff are fully vaccinated for COVID-19, including boosters, as determined by the CDC and/or CMS. Data for this measure is based on NHSN, or another CMS approved data system. This measure is only applicable to Option Periods 2-4.

Key Result #23: The Network shall achieve an increase to 90% of dialysis patients receiving an influenza vaccination by the end of Option Period 1, and maintain, at a minimum, that rate throughout the task order period of performance. Data for this measure is based on EQRS.

This measure is broken down as follows:

1. Base Period: The Network shall ensure that 85% of dialysis patients receive an influenza vaccination by the end of the Base Period.

2. Option Period 1: The Network shall ensure that 90% of dialysis patients receive an influenza vaccination by the end of Option Period 1.

3. Option Period 2: The Network shall ensure that a minimum of 90% of dialysis patients receive an influenza vaccination by the end of Option Period 2.

4. Option Period 3: The Network shall ensure that a minimum of 90% of dialysis patients receive an influenza vaccination by the end of Option Period 3.

5. Option Period 4: The Network shall ensure that a minimum of 90% of dialysis patients receive an influenza vaccination by the end of Option Period 4.

Key Result #24: The Network shall ensure that a minimum of 90% of dialysis facility staff receive an influenza vaccination, per task order period (i.e., Option Period 1, Option Period 2, etc.). Data for this measure is based on NHSN. This measure is only applicable to Option Periods 1-4.

This measure is not applicable to the Base Period, because the data necessary to assess progress towards meeting the measure, and adjust interventions in order to achieve the measure, was unavailable.

Key Result #25: The Network shall achieve a 20% increase in the number of dialysis patients receiving a pneumococcal conjugate vaccination (PCV) 13 over the task order period of performance. Data for this measure is based on EQRS. This measure is only applicable to the Base Period and Option Period 1.

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

This measure is broken down as follows:

1. Base Period: The Network shall achieve a 10% increase in the number of dialysis patients receiving a PCV 13 from the baseline to the end of the Base Period.

2. Option Period 1: The Network shall achieve an additional 10% increase in the number of dialysis patients receiving a PCV 13, for a 20% total increase from the baseline to the end of Option Period 1.

Key Result #26: The Network shall ensure that 90% of dialysis patients receive a pneumococcal polysaccharide vaccine (PPSV 23) by the end of Option Period 1. Data for this measure is based on EQRS, or another CMS approved data system. This measure is only applicable to Option Period 1.

This measure is not applicable to the Base Period, because the data necessary to assess progress towards meeting the measure, and adjust interventions in order to achieve the measure, was unavailable.

Key Result #27: The Network shall achieve a 10% increase in the number of patients receiving a booster PPSV 23 from the baseline to the end of Option Period 1. Data for this measure is based on EQRS, or another CMS approved data system. This measure is only applicable to Option Period 1.

This measure is not applicable to the Base Period, because the data necessary to assess progress towards meeting the measure, and adjust interventions in order to achieve the measure, was unavailable.

CMS will calculate the baseline for this measure when EQRS, or another CMS data system approved to assess progress, has the ability to document PPSV 23 monthly.

Key Result #28: The Network shall ensure that 85% of dialysis patients over sixty-five (65) years old receive a PPSV 23 by the end of Option Period 1. Data for this measure is based on EQRS, or another CMS approved data system. This measure is only applicable to Option Period 1.

This measure is not applicable to the Base Period, because the data necessary to assess progress towards meeting the measure, and adjust interventions in order to achieve the measure, was unavailable.

Key Result #29: The Network shall increase the percentage of dialysis patients that are fully vaccinated for pneumococcal pneumonia over the task order period of performance. Data for this measure is based on EQRS, or another CMS approved data system. This measure is only applicable to Option Periods 2-4.

CDC guidance will be used to establish a patient's status as "fully vaccinated." There are multiple pathways to achieve "fully vaccinated" status for pneumococcal pneumonia, and all possible pathways will be considered toward this measure.

CMS will calculate the baseline for this measure at the end of Option Period 1, using up to twelve (12) months of available data to establish a trend. It will not change over the course of the task order period of performance.

This measure is broken down as follows:

1. Option Period 2: In Option Period 2, the Network shall achieve a 7% increase, from the baseline, in the percentage of dialysis patients that are fully vaccinated for pneumococcal pneumonia.

2. Option Period 3: In Option Period 3, the Network shall achieve a 17% increase, from the baseline, in the percentage of dialysis patients that are fully vaccinated for pneumococcal pneumonia.

3. Option Period 4: In Option Period 4, the Network shall achieve a 27% increase, from the baseline, in the percentage of dialysis patients that are fully vaccinated for pneumococcal pneumonia.

The Network is also responsible for the following supporting tasks:

1. The Network shall educate patients and dialysis facilities on current and emerging credible information and data-driven successes regarding COVID-19 and emerging PHEs, with an emphasis on infection control practices and vaccinations.

2. The Network shall identify and spread highly effective practices, as identified by data, used in the transition of patients to a nursing home dialysis setting from an in-center dialysis facilities, as this could limit patient exposure to contagions. At a minimum, the Network shall increase the communication between dialysis facilities and nursing homes regarding their shared patients.

3. The Network shall 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 provide education and discuss the possibility of the patient's current dialysis facility providing patient-assisted dialysis at the nursing home facility, as receiving dialysis within the nursing home could limit patient exposure to contagions.

4. The Network shall identify and partner with local, community-based leaders (e.g., faith-based organizations, volunteer organizations, etc.) in areas where there is an increase of COVID-19 cases and/or emerging PHEs in the dialysis population. Through these partnerships, the Network shall identify and/or increase sources of support for dialysis patients, in order to decrease the spread of COVID-19 and/or address emerging PHEs.

5. The Network shall provide data-driven targeted technical assistance, with a focus on health equity issues, to dialysis facilities that are seeing an increase in COVID-19 cases and/or emerging PHEs in the Network service area. The Network shall identify the source of the increase or emergence and provide (1) infection and emergency control resources to decrease the rise in cases or address emerging

PHEs, (2) outcome related data information, and (3) information related to vaccination(s), if applicable.

6. The Network shall report on technical assistance and outcome data related to PHEs, COVID-19, and related vaccinations, with a focus on health equity issues, in the format described by CMS (Deliverable #15).

7. The Network shall partner with any IDIQ NQIIC contractor that has a relevant task order, to provide technical assistance regarding (1) shared patients of nursing homes and dialysis facilities and (2) dialysis provided in nursing homes or in-center, as necessary or requested by CMS.

8. The Network shall concentrate educational efforts on influenza vaccinations that have been shown to have the strongest immune response for immunocompromised patients for the specific influenza season.

9. The Network shall assemble a coalition of high-performing facilities and experts in the subject matter stated above, from the Network service area or any infection control experts with subject matter expertise in COVID-19, PHEs, or vaccinations, to mentor and advise low-performing facilities. The high-performing facilities in this coalition will assess local issues pertinent to the subject matter above and provide examples of data-driven successful interventions to recommend to low-performing facilities. The high-performing facilities will also mentor low-performing facilities on the utilization of interventions. If another quality improvement contractor receives a task order under the NQIIC IDIQ, that has COVID-19, PHEs, 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.

10. The Network shall identify facilities that are low-performing based on ongoing data analytics and provide data-driven targeted technical assistance to these facilities. The interventions identified as successful by the high-performing facilities in the community coalition will be used to enhance the Network PDSA cycles with low-performing facilities. In this manner, the high-performing interventions identified in the Network service area will be shared with and implemented in low-performing facilities, as applicable based on the needs of the low-performing facilities. The Network shall re-evaluate 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 again provide technical assistance to these facilities and perform an internal root cause analysis to identify the reason sustainability efforts failed.

C.3.4. GOAL 4: Reduce Hospital Admissions, Readmissions, and Outpatient Emergency Visits

C.3.4.A. 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 Patient Subject Matter Experts (SMEs), nephrologists, primary care providers, transplant surgeons, transplant and dialysis facility staff from all modalities, large and small dialysis organizations regional management, and other contractors with a relevant task order under the NQIIC IDIQ, as an advisory committee (Deliverable #16). These meetings shall be used to plan, develop, and implement quality improvement concepts and strategies to be further developed and utilized by the Network, focusing on the primary medical conditions that have a propensity for causing emergency department visits and hospitalizations. 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 readmissions, and outpatient emergency department visits.

Key Result #30: The Network shall achieve a 5% decrease in hospital admissions for the Primary Diagnosis Categories (see Appendix A dated December 17, 2020) over the task order period of performance. Data for this measure is based on Medicare Claims. This measure is only applicable to the Base Period and Option Period 1.

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

This measure is broken down as follows:

1. Base Period: The Network shall achieve a 2% decrease in hospital admissions for the Primary Diagnosis Categories (see Appendix A dated December 17, 2020) from the baseline to the end of the Base Period.

2. Option Period 1: The Network shall achieve an additional 3% decrease in hospital admissions for the Primary Diagnosis Categories (see Appendix A dated December 17, 2020), for a 5% total decrease from the baseline to the end of Option Period 1.

Key Result #31: The Network shall decrease the rate of hospital admissions for a diagnosis on the List Primary Diagnosis Categories (see Appendix A dated March 9, 2023) over the task order period of performance. Data for this measure is based on Medicare Claims. This measure is only applicable to Option Periods 2-4.

CMS will calculate the baseline for this measure at the at the end of Option Period 1, using up to twelve (12) months of available data to establish a trend. It will not change over the course of the task order period of performance.

This measure is broken down as follows:

1. Option Period 2: In Option Period 2, the Network shall achieve a 4% decrease, from the baseline, in the rate of hospital admissions for a diagnosis on the List of Primary Diagnosis Categories (see Appendix A dated March 9, 2023).

2. Option Period 3: In Option Period 3, the Network shall achieve a 9% decrease, from the baseline, in the rate of hospital admissions for a diagnosis on the List of Primary Diagnosis Categories (see Appendix A dated March 9, 2023).

3. Option Period 4: In Option Period 4, the Network shall achieve a 15% decrease, from the baseline, in the rate of hospital admissions for a diagnosis on the List of Primary Diagnosis Categories (see Appendix A dated March 9, 2023).

Key Result #32: The Network shall achieve a 5% decrease in hospital thirty (30)-day unplanned readmissions for a diagnosis from the Primary Diagnosis Categories (see Appendix A dated December 17, 2020) following an admission for a diagnosis from the Primary Diagnosis Categories (see Appendix A dated December 17, 2020) over the task order period of performance. Data for this measure is based on Medicare Claims. This measure is only applicable to the Base Period and Option Period 1.

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

This measure is broken down as follows:

1. Base Period: The Network shall achieve a 2% decrease in hospital thirty (30)-day unplanned readmissions for a diagnosis from the Primary Diagnosis Categories (see Appendix A dated December 17, 2020) following an admission for a diagnosis from the Primary Diagnosis Categories (see Appendix A dated December 17, 2020) from the baseline to the end of the Base Period.

2. Option Period 1: The Network shall achieve an additional 3% decrease in hospital thirty (30)-day unplanned readmissions for a diagnosis from the Primary Diagnosis Categories (see Appendix A dated December 17, 2020) following an admission for a diagnosis from the Primary Diagnosis Categories (see Appendix

A dated December 17, 2020), for a 5% total decrease from the baseline to the end of Option Period 1.

Key Result #33: The Network shall decrease the rate of hospital thirty (30)-day unplanned readmissions for a diagnosis on the List of Primary Diagnosis Categories (see Appendix A dated March 9, 2023), following an admission for a diagnosis on the List of Primary Diagnosis Categories (see Appendix A dated March 9, 2023), over the task order period of performance. Data for this measure is based on Medicare Claims. This measure is only applicable to Option Periods 2-4.

CMS will calculate the baseline for this measure at the at the end of Option Period 1, using up to twelve (12) months of available data to establish a trend. It will not change over the course of the task order period of performance.

This measure is broken down as follows:

1. Option Period 2: In Option Period 2, the Network shall achieve a 4% decrease, from the baseline, in the rate of hospital thirty (30)-day unplanned readmissions for a diagnosis on the List of Primary Diagnosis Categories (see Appendix A dated March 9, 2023), following an admission for a diagnosis on the List of Primary Diagnosis Categories (see Appendix A dated March 9, 2023).

2. Option Period 3: In Option Period 3, the Network shall achieve a 9% decrease, from the baseline, in the rate of hospital thirty (30)-day unplanned readmissions for a diagnosis on the List of Primary Diagnosis Categories (see Appendix A dated March 9, 2023), following an admission for a diagnosis on the List of Primary Diagnosis Categories (see Appendix A dated March 9, 2023).

3. Option Period 4: In Option Period 4, the Network shall achieve a 15% decrease, from the baseline, in the rate of hospital thirty (30)-day unplanned readmissions for a diagnosis on the List of Primary Diagnosis Categories (see Appendix A dated March 9, 2023), following an admission for a diagnosis on the List of Primary Diagnosis Categories (see Appendix A dated March 9, 2023).

Key Result #34: The Network shall achieve a 5% decrease in outpatient emergency department visits for a diagnosis on the Primary Diagnosis Categories (see Appendix A dated December 17, 2020) over the task order period of performance. Data for this measure is based on Medicare Claims. This measure is only applicable to the Base Period and Option Period 1.

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

This measure is broken down as follows:

1. Base Period: The Network shall achieve a 2% decrease in outpatient emergency department visits for a diagnosis on the Primary Diagnosis Categories (see Appendix A dated December 17, 2020) from the baseline to the end of the Base Period.

2. Option Period 1: The Network shall achieve an additional 3% decrease in outpatient emergency department visits for a diagnosis on the Primary Diagnosis Categories (see Appendix A dated December 17, 2020), for a 5% total decrease from the baseline to the end of Option Period 1.

Key Result #35: The Network shall decrease the rate of outpatient emergency department visits for a diagnosis on the List of Primary Diagnosis Categories (see Appendix A dated March 9, 2023) over the task order period of performance. Data for this measure is based on Medicare Claims. This measure is only applicable to Option Periods 2-4.

CMS will calculate the baseline for this measure at the at the end of Option Period 1, using up to twelve (12) months of available data to establish a trend. It will not change over the course of the task order period of performance.

This measure is broken down as follows:

1. Option Period 2: In Option Period 2, the Network shall achieve a 4% decrease, from the baseline, in the rate of outpatient emergency department visits for a diagnosis on the List of Primary Diagnosis Categories (see Appendix A dated March 9, 2023).

2. Option Period 3: In Option Period 3, the Network shall achieve a 9% decrease, from the baseline, in the rate of outpatient emergency department visits for a diagnosis on the List of Primary Diagnosis Categories (see Appendix A dated March 9, 2023).

3. Option Period 4: In Option Period 4, the Network shall achieve a 15% decrease, from the baseline, in the rate of outpatient emergency department visits for a diagnosis on the List of Primary Diagnosis Categories (see Appendix A dated March 9, 2023).

The Network is also responsible for the following supporting tasks:

1. The Network shall assemble a coalition of high-performing facilities and experts in the subject matter stated above, from the Network service area, to mentor and advise low-performing facilities. The high-performing facilities in this coalition will assess local issues pertinent to the subject matter above and provide examples of data-driven successful interventions to recommend to low-performing facilities. The high-performing facilities will also mentor low-performing facilities on the utilization of 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.

2. The Network shall identify facilities that are low-performing based on ongoing data analytics, and provide data-based targeted technical assistance to these facilities. The interventions identified as successful by the high-performing facilities in the community coalition will be used to enhance the Network PDSA cycles with low-performing facilities. In this manner, the high-performing interventions identified in the Network service area will be shared with and implemented in low-performing facilities, as applicable based on the needs of the low-performing facilities. The Network shall re-evaluate 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 again provide technical assistance to these facilities and perform an internal root cause analysis to identify the reason sustainability efforts failed.

3. 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).

C.3.5. GOAL 5: Improve Nursing Home Care in Low-Performing Providers

C.3.5.A. 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"[5]

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, in which 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.[6] 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 (e.g., a task order related to nursing home care) under the NQIIC IDIQ, as an advisory committee (Deliverable #18). These meetings shall be used to plan, develop, and implement quality improvement concepts and strategies to be further 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, in support of the health outcomes of nursing home residents. These meetings shall include a focus on health equity issues and mitigation strategies to resolve anemia.

Key Result #36: The Network shall achieve a 3% decrease in the rate of dialysis patients receiving dialysis at nursing homes that receive a blood transfusion from the baseline to the end of Option Period 1. Data for this measure is based on EQRS, or another CMS approved data system, and Medicare Claims. This measure is only applicable to Networks with patients receiving dialysis in nursing home settings. Refer to Key Result #38 below, as an alternate measure for Networks with no patients receiving dialysis in nursing home settings. This measure is only applicable to Option Period 1.

This measure is not applicable to the Base Period, because the data necessary to assess progress towards meeting the measure, and adjust interventions in order to achieve the measure, was unavailable.

CMS will calculate the baseline for this measure 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.

Key Result #37: The Network shall decrease the rate of blood transfusions, among patients receiving dialysis in nursing homes, over the task order period of performance. Data for this measure is based on EQRS, or another CMS approved data system, and

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[5] Yang A, Lee, W, Hocking, K. Health outcomes in nursing home patients on dialysis. Helio. 2014;Online.
[6] Sampson S. NURSING HOME DIALYSIS Rapidly Growing and Complicated. ASN Kidney News. 2018;4:14-15.

Medicare Claims. This measure is only applicable to Networks with patients receiving dialysis in nursing home settings. Refer to Key Result #38 below, as an alternate measure for Networks with no patients receiving dialysis in nursing home settings. This measure is only applicable to Option Periods 2-4.

CMS will calculate the baseline for this measure at the end of Option Period 1, using up to twelve (12) months of available data to establish a trend. It will not change over the course of the task order period of performance. However, CMS reserves the right to recalculate the baseline at any point during the task order period of performance, for Networks that have a baseline of zero (0).

Networks with a baseline of zero (0) shall maintain a rate of zero (0) in order to achieve this Key Result.

This measure is broken down as follows:

1. Option Period 2: In Option Period 2, the Network shall achieve a 3% decrease, from the baseline, in the rate of blood transfusions, among patients receiving dialysis in nursing homes.

2. Option Period 3: In Option Period 3, the Network shall achieve a 7% decrease, from the baseline, in the rate of blood transfusions, among patients receiving dialysis in nursing homes.

3. Option Period 4: In Option Period 4, the Network shall achieve a 12% decrease, from the baseline, in the rate of blood transfusions, among patients receiving dialysis in nursing homes.

Key Result #38: The Network shall decrease the rate of blood transfusions, among 10% of the nursing home dialysis patients receiving dialysis in-center, over the task order period of performance. Data for this measure is based on EQRS, or another CMS approved data system, and Medicare Claims. This measure serves as an alternate to Key Result #36 and Key Result #37, and is only applicable to Networks with no patients receiving dialysis in nursing home settings. This measure is only applicable to Option Periods 1-4.

This measure is not applicable to the Base Period, because the data necessary to assess progress towards meeting the measure, and adjust interventions in order to achieve the measure, was unavailable.

CMS will calculate the baseline for this measure at the end of the Base Period, using up to twelve (12) months of available to establish a trend. It will not change over the course of the task order period of performance. However, CMS reserves the right to recalculate the baseline at any point during the task order period of performance, for Networks that have a baseline of zero (0).

Networks with a baseline of zero (0) shall maintain a rate of zero (0) in order to achieve this Key Result.

This measure is broken down as follows:

1. Option Period 1: The Network shall achieve a 3% decrease in the rate of blood transfusions, among 10% of the nursing home dialysis patients receiving dialysis in-center, from the baseline to the end of Option Period 1.

2. Option Period 2: In Option Period 2, the Network shall achieve a 7% decrease, from the baseline, in the rate of blood transfusions, among 10% of the nursing home dialysis patients receiving dialysis in-center.

3. Option Period 3: In Option Period 3, the Network shall achieve a 12% decrease, from the baseline, in the rate of blood transfusions, among 10% of the nursing home dialysis patients receiving dialysis in-center.

4. Option Period 4: In Option Period 4, the Network shall achieve an 18% decrease, from the baseline, in the rate of blood transfusions, among 10% of the nursing home dialysis patients receiving dialysis in-center.

The Network is also responsible for the following supporting tasks:

1. The Network shall assemble a coalition of high-performing facilities and experts in the subject matter stated above, from the Network service area, to mentor and advise low-performing facilities. The high-performing facilities in this coalition will assess local issues pertinent to the subject matter above and provide examples of data-driven successful interventions to recommend to low-performing facilities. The high-performing facilities will also mentor low-performing facilities on the utilization of 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.

2. The Network shall identify facilities that are low-performing based on ongoing data analytics, and provide data-based targeted technical assistance to these facilities. The interventions identified as successful by the high-performing facilities in the community coalition will be used to enhance the Network PDSA cycles with low-performing facilities. In this manner, the high-performing interventions identified in the Network service area will be shared with and implemented in low-performing facilities as applicable based on the needs of the low-performing facilities. The Network shall re-evaluate 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 again provide technical assistance to these facilities and perform an internal root cause analysis to identify the reason sustainability efforts failed.

3. The Network shall report on technical assistance and outcome data related to decreasing blood transfusions in nursing home patients receiving dialysis in-center or in a nursing home, as described in the above measures, with a focus on health equity issues, in the format described by CMS (Deliverable #19).

C.4. SCOPE

This SOW describes the requirements, level of effort, services, and expected outcomes for this task order. The contractor shall provide qualified personnel for successful completion of interventions across the ESRD Network service area. The contractor shall provide 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 their efforts under this task order, the ESRD Networks will focus on:

1. Demonstrating active participation of ESRD patients as empowered and informed participants in the renal community;

2. Promoting home modalities and transplantation as appropriate treatments to support patient independence and improve clinical outcomes;

3. Identifying innovative approaches to improving the kidney health of Medicare beneficiaries;

4. Showcasing best practices for improving the quality of care for ESRD patients;

5. Ensuring the safety and continuity of dialysis care in emergency situations;

6. Analyzing data to formulate and effectuate data-driven interventions;

7. Identifying health equity issues and collaborating with community coalitions to mitigate and resolve these inequities; and

8. 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 interventions.

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-performing facilities in each objective and spreads identified proven methods of obtaining success in these facilities to low-performing facilities in the Network service area. The Network shall identify objectives and outcomes to guide implementation of interventions, identify the success of the intervention, and use agile practices to adopt, adapt, or abandon the intervention, as necessary, to achieve the goals and key results within this task order. Evidence of these efforts will be evident in the Continuous Internal Quality Improvement Program (CIQIP) (Deliverable #43). 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 and key results 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 low-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. 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 and key results 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 Contracting Officer's Representative (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."[7] Although patient and family engagement may be implemented differently across healthcare settings, all

[7] 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

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 [and] include coordinated and integrated care and involvement of family members and friends, as appropriate"[8] 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 Network shall meet with empowered patients, nephrologists, dialysis facility staff from all modalities, large and small dialysis organizations regional management, and other contractors with a relevant task order (e.g., CKD, patient empowerment, or grievance) under the NQIIC IDIQ, as an advisory committee (Deliverable #28). The meetings shall be used to plan, develop, and implement strategies for patient and family engagement, patient empowerment, shared decision-making concepts, grievance resolution, and involuntary discharge prevention. The advisory committee shall provide strategies for the key results outlined in this task order including, but not limited to, support groups and patient and/or family engagement at the facility. These meetings shall support the identification and mitigation of any health equity issues that would impede patient involvement in attending a support group, developing a life plan, and/or participating as a Patient-Patient mentor.

Key Result #39: The Network shall achieve a 50% increase in the number of facilities that successfully integrate patients and families into Quality Assurance and Performance Improvement (QAPI) meetings over the task order period of performance. QAPI meetings are defined as meetings 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. Data for this measure is based on self-reporting.

CMS will calculate the baseline for this measure in the Base Period. It will not change over the course of the task order period of performance.

This measure is broken down as follows:

[8] 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.

1. Base Period: The Network shall achieve a 10% increase in the number of facilities that successfully integrate patients and families into QAPI meetings, as defined above, from the baseline to the end of the Base Period.

2. Option Period 1: The Network shall achieve an additional 10% increase in the number of facilities that successfully integrate patients and families into QAPI meetings, as defined above, for a 20% total increase from the baseline to the end of Option Period 1.

3. Option Period 2: The Network shall achieve an additional 10% increase in the number of facilities that successfully integrate patients and families into QAPI meetings, as defined above, for a 30% total increase from the baseline to the end of Option Period 2.

4. Option Period 3: The Network shall achieve an additional 10% increase in the number of facilities that successfully integrate patients and families into QAPI meetings, as defined above, for a 40% total increase from the baseline to the end of Option Period 3.

5. Option Period 4: The Network shall achieve an additional 10% increase in the number of facilities that successfully integrate patients and families into QAPI meetings, as defined above, for a 50% total increase from the baseline to the end of Option Period 4.

The Network is 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 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 the baseline (Deliverable #20). The Network shall provide the percentage of dialysis facilities that actively incorporate the patient voice into QAPI meetings, as defined above (Deliverable #21).

Key Result #40 The Network shall 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. Data for this measure is based on self-reporting.

CMS will calculate the baseline for this measure in the Base Period. It will not change over the course of the task order period of performance.

This measure is broken down as follows:

1. Base Period: The Network shall 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.

2. Option Period 1: The Network shall 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.

3. Option Period 2: The Network shall 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.

4. Option Period 3: The Network shall 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.

5. Option Period 4: The Network shall 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 is 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, for the baseline (Deliverable #22). The Network shall provide a list of facilities actively assisting patients to develop a life plan, from which the dialysis facility develops the dialysis plan of care (Deliverable #23).

Key Result #41: The Network shall 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. Data for this measure is based on self-reporting.

CMS will calculate the baseline for this measure in the Base Period. It will not change over the course of the task order period of performance.

This measure is broken down as follows:

1. Base Period: The Network shall 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.

2. Option Period 1: The Network shall 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.

3. Option Period 2: The Network shall 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.

4. Option Period 3: The Network shall 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.

5. Option Period 4: The Network shall 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 is 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 ESRD 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 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:

1. 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;

2. Be receiving home dialysis and be a former patient of the hemodialysis facility; or

3. Have received a transplant.

A peer mentor shall adhere the following requirements:

1. Complete all training activities associated with the ESRD NCC Patient-Patient Support program or a comparable stakeholder program, as identified by the ESRD NCC;

2. May not be assigned more than two mentees at a time;

3. Be willing to dedicate the time necessary to provide ongoing one-on-one support to another patient;

4. Meet all mentee requirements.

Mentees shall have the following characteristics:

1. Diagnosed by a physician with chronic kidney disease;

2. Adults (over 18 years of age); and

3. Ability to provide consent.

The Network shall closely collaborate with any NQIIC IDIQ contractor that has CKD as a task in the contract within the Network service area, to ensure that appropriate mentees are identified for participation. The focus of a Patient-to-Patient Support program shall be to mentor patients with an initial diagnosis of CKD or ESRD, patients making decisions about treatment therapy (i.e., modality and 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 tools to use. The Network shall provide the percentage of facilities that are participating with the Network in a Patient-to-Patient Support program, for the baseline (Deliverable #26). The Network shall provide a list of facilities actively participating in a Patient-to-Patient Support program (Deliverable #27).

Key Result #42: The Network shall maintain a National Patient/Family Engagement (N-PFE) LAN attendance rate of at least 60% for each task order period (i.e., Base Period, Option Period 1, Option Period 2, etc.).

The Network shall support the ESRD NCC N-PFE LAN in its efforts to promote patient and family engagement in the geographic area and patient population of the Network service area, by ensuring 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 and/or territory in the Network service area. If the Network has more than five states and/or territories, 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, who will be contacting them, and the responsibilities that being a 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 LAN. The Network shall ensure that the SMEs understand the limitations on the terms 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 Network is also responsible for the following supporting tasks:

1. The Network shall assemble a coalition of high-performing facilities and experts in the subject matter stated above, from the Network service area, to mentor and advise low-performing facilities. The high-performing facilities in this coalition will assess local issues pertinent to the subject matter above and provide examples of data-driven successful interventions to recommend to low-performing facilities. The high-performing facilities will also mentor low-performing facilities on the utilization of 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.

2. The Network shall identify facilities that are low-performing, based on ongoing data analytics, and provide data-based targeted technical assistance to these facilities. The interventions identified as successful by high-performing facilities in the community coalition will be used to enhance the Network PDSA cycles with low-performing facilities. In this manner, the high-performing interventions identified in the Network service area will be shared with and implemented in low-performing facilities, as applicable based on the needs of the low-performing facilities. The Network shall re-evaluate 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 again provide technical assistance to these facilities and perform an internal root cause analysis to identify the reason sustainability efforts failed.

3. The Network shall report on technical assistance and outcome data related to patient and family engagement, with a focus on health equity issues, in the format described by CMS (Deliverable #29).

4. The Network shall engage patients, family members, and caregivers from a minimum of 10% of facilities in the Network service area, including representation from each state and/or territory in the Network service area, as Patient SMEs. The Network shall include facilities in rural areas, facilities in areas with health equity issues, and facilities that serve vulnerable populations. The Network shall provide a list of these facilities (Deliverable #30).

5. 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).

6. The Network shall identify and plan for up to two Patient SMEs to attend the CMS Quality Conference.

7. 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, to the greatest extent 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 a 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.

The Network is also responsible for the following supporting tasks:

1. The Network shall 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.

2. The Network shall educate all dialysis facilities within the Network on the contents of the Decreasing Patient-Provider Conflict (DPC) toolkit, with specific reference to de-escalation of conflicts arising at the dialysis facility, and safety within the dialysis facility environment due to potential violent acts.

3. The Network shall follow the grievance and access to care procedures in Attachment 9 Grievances and Patient-Appropriate Access to Care.

4. The Network shall document all information on grievance and access to care cases in the Patient Contact Utility (PCU), or other system(s) provided by CMS. The Government's Case Review SME will provide access to the PCU, as needed, upon review of the position of the requester and the need posed by the Network.

5. The Network shall maintain review timeliness, as directed by CMS, for at least 80% of all Immediate Advocacy (IA) cases, and at least 90% of all grievance cases entered into the current version of the PCU, or other system(s) provided by CMS. IA cases shall be reviewed within ten (10) calendar days and grievance cases shall be reviewed within sixty (60) calendar days. If a grievance case requires more than sixty (60) calendar days to complete, COR approval must be received prior to the fiftieth (50^{th}) day of the sixty (60)-day limit.

6. The Network shall provide a focused audit of all grievance and access to care cases (Deliverable #33).

7. The Network shall attend Community of Practice (CoP) and LAN calls, as requested by CMS.

8. The Network shall 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 have 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.

Key Result #43: The Network shall achieve a 5% increase in the rate of patient admission records from dialysis facilities entered within five (5) business days over the task order period of performance. Data for this measure is based on EQRS. This measure is only applicable to the Base Period and Option Period 1.

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

This measure is broken down as follows:

1. Base Period: The Network shall achieve a 2% increase in the rate of patient admission records from dialysis facilities entered within five (5) business days from the baseline to the end of the Base Period.

2. Option Period 1: The Network shall achieve an additional 3% increase in the rate of patient admission records from dialysis facilities entered within five (5) business days, for a 5% total increase from the baseline to the end of Option Period 1.

Key Result #44: The Network shall increase the number of incomplete initial CMS-2728 forms that are over one (1) year old, that are completed and submitted over the task order period of performance. Data for this measure is based on EQRS. This measure is only applicable to Option Periods 2-4.

CMS will calculate the baseline for this measure at the end of Option Period 1, using up to twelve (12) months of available data to establish a trend. It will not change over the course of the task order period of performance.

This measure is broken down as follows:

1. Option Period 2: In Option Period 2, the Network shall achieve a 1% increase, from the baseline, in the number of incomplete initial CMS-2728 forms that are over one (1) year old, that are completed and submitted.

2. Option Period 3: In Option Period 3, the Network shall achieve a 2% increase, from the baseline, in the number of incomplete initial CMS-2728 forms that are over one (1) year old, that are completed and submitted.

3. Option Period 4: In Option Period 4, the Network shall achieve a 3% increase, from the baseline, in the number of incomplete initial CMS-2728 forms that are over one (1) year old, that are completed and submitted.

Key Result #45: The Network shall achieve a 4% increase in the rate of initial CMS-2728 forms submitted from dialysis facilities within forty-five (45) days over the task order period of performance. Data for this measure is based on EQRS. This measure is only applicable to the Base Period and Option Period 1.

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

This measure is broken down as follows:

1. Base Period: The Network shall achieve a 2% increase in the rate of initial CMS-2728 forms submitted from dialysis facilities within forty-five (45) days from the baseline to the end of the Base Period.

2. Option Period 1: The Network shall achieve an additional 2% increase in the rate of initial CMS-2728 forms submitted from dialysis facilities within forty-five (45) days, for a 4% total increase from the baseline to the end of Option Period 1.

Key Result #46: The Network shall increase the rate of initial CMS-2728 forms that are submitted from dialysis facilities within forty-five (45) days over the task order period of performance. Data for this measure is based on EQRS. This measure is only applicable to forms due during the previous twelve (12) months. This measure is only applicable to Option Periods 2-4.

CMS will calculate the baseline for this measure at the end of Option Period 1, using up to twelve (12) months of available data to establish a trend. It will not change over the course of the task order period of performance.

This measure is broken down as follows:

1. Option Period 2: In Option Period 2, the Network shall achieve a 4% increase, from the baseline, in the rate of initial CMS-2728 forms that are submitted from dialysis facilities within forty-five (45) days.

2. Option Period 3: In Option Period 3, the Network shall achieve a 9% increase, from the baseline, in the rate of initial CMS-2728 forms that are submitted from dialysis facilities within forty-five (45) days.

3. Option Period 4: In Option Period 4, the Network shall achieve a 15% increase, from the baseline, in the rate of initial CMS-2728 forms that are submitted from dialysis facilities within forty-five (45) days.

Key Result #47: The Network shall increase the rate of CMS-2746 forms submitted from dialysis facilities within fourteen (14) days of the date of death over the task order period of performance. Data for this measure is based on EQRS.

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

This measure is broken down as follows:

1. Base Period: The Network shall achieve a 2% increase in the rate of CMS-2746 forms submitted from dialysis facilities within fourteen (14) days of the date of death from the baseline to the end of the Base Period.

2. Option Period 1: The Network shall achieve an additional 3% increase in the rate of CMS-2746 forms submitted from dialysis facilities within fourteen (14) days of the date of death, for a 5% total increase from the baseline to the end of Option Period 1.

3. Option Period 2: In Option Period 2, the Network shall achieve a 9% increase, from the baseline, in the rate of CMS-2746 forms submitted from dialysis facilities within fourteen (14) days of the date of death.

4. Option Period 3: In Option Period 3, the Network shall achieve a 14% increase, from the baseline, in the rate of CMS-2746 forms submitted from dialysis facilities within fourteen (14) days of the date of death.

5. Option period 4: In Option Period 4, the Network shall achieve a 20% increase, from the baseline, in the rate of CMS-2746 forms submitted from dialysis facilities within fourteen (14) days of the date of death.

The Network is also responsible for the following supporting tasks:

1. 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.

2. The Network shall identify facilities that are low-performing based on ongoing data analysis, and provide data-based targeted technical assistance to these facilities, in order to support the facilities in submitting timely and accurate data. The Network shall re-evaluate 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 again provide technical assistance to these facilities and perform an internal root cause analysis to identify the reason sustainability efforts failed.

3. The Network shall participate with CMS, in calls and workgroups, to maintain the data in the data registry in EQRS, as necessary.

4. The Network shall resolve EQRS Near Matches, System Discharges, and Accretions, ensuring resolution within sixty (60) days of being informed of the Near Match, System Discharge, or Accretion.

5. The Network shall assist Veterans' Administration facilities and transplant centers to enter data into EQRS, or enter the data for these entities, to support data quality, until these entities can access and enter data in EQRS.

6. The Network shall ensure data quality by resolving routine and acute termination reports for the Social Security Administration.

C.5.5. Health Equity

The purpose of health equity work is to ensure that beneficiaries with the greatest needs have access to services, to align with the CMS, HHS and White House priorities.

Based on data provided by the ESRD NCC, the Network shall stratify patients to determine where health disparities exist within the Network quality improvement projects, based on the following health equity categories:

1. Race/Ethnicity;

2. Disability Status (based on Medicare entitlement, not age); and

3. Sex/Gender.

The Network is also responsible for the following supporting tasks:

1. The Network shall propose a list of specific interventions and/or activities to be conducted, in order to reduce health disparities, ensuring that interventions deployed

do not include race/ethnicity-exclusionary actions or sex/gender-exclusionary actions (Deliverable #56).

2. The Network shall deploy interventions to the entire applicable population (e.g., all incident patients, all transplant patients, etc.), not targeting a specific race, ethnicity, disability status, sex, or gender.

3. The Network shall measure progress toward improvement of health disparities through the Health Equity Dashboard, provided by the ESRD NCC, once available.

4. The Network shall improve communication to Medicare beneficiaries in areas with low health literacy, to enhance equitable community responses.

5. The Network shall collaborate with the Quality Innovation Network (QIN)-QIO and all members of the Partnership for Community Health (i.e., clinical, non-clinical, faith-based, and other entities) in the Network service area.

6. The Network shall identify facilities that are low-performing based on ongoing data analytics and provide data-based technical assistance to those facilities. The Network shall re-evaluate 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 again provide technical assistance to these facilities and perform an internal root cause analysis to identify the reason sustainability efforts failed.

7. The Network shall report on technical assistance and outcome data related to health equity, in the format described by CMS (Deliverable #57).

C.5.6. Culturally and Linguistically Available Services (CLAS)

The Network will collaborate with other ESRD Networks and large dialysis organizations, as directed and coordinated by the ESRD NCC, to assist in developing a CLAS Implementation Action Plan, which will be utilized by the Network once developed. In developing a CLAS Implementation Action Plan, the Network shall utilize the HHS CLAS Checklist (An Implementation Checklist for the National CLAS Standards), in addition to other widely available CLAS publications.

The Network will work with small dialysis organizations, medium dialysis organizations, and independent facilities to implement the National CLAS Standards. Using the CMS Toolkit (https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CLAS-Toolkit-12-7-16.pdf), as well as the Agency for Healthcare Research and Quality (AHRQ) Guide, the Network shall provide training to providers on updating their health education, communication, and beneficiary-engagement products to ensure the inclusion of CLAS

considerations, in order to advance health equity. The Network will also provide training and resources to help providers implement CLAS. Resources for these efforts are provided at https://www.ahrq.gov/sdoh/clas/index.html, and include the Re-Engineered Discharge (RED) Toolkit, Universal Precautions Toolkit, Seek, Help, Assess, Reach, Evaluate (SHARE) Approach, and TeamSTEPPS Limited English Proficiency Module.

The Network is also responsible for the following supporting tasks:

1. The Network shall identify facilities that are low-performing based on ongoing data analytics and provide data-based technical assistance to those facilities. The Network shall re-evaluate 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 again provide technical assistance to these facilities and perform an internal root cause analysis to identify the reason sustainability efforts failed.

2. The Network shall report on technical assistance and outcome data related to CLAS, in the format described by CMS (Deliverable #58)

C.6. STRATEGIC PROGRAM MANAGEMENT SUPPORT

C.6.1. General Program Management Support

In conducting the work detailed under this task order, the Network is responsible for the following:

1. The Network shall act independently, and not as an agent of the Government. The Network 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. The Network shall 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. The Network shall 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. The Network shall provide a roster of the Network Council of Renal Dialysis and Transplant Facilities located in the Network service area, and patients to function as part of this council, as described in the SSA (Deliverable #36).

5. The Network shall provide a local presence in each state and/or territory in the Network service area, which is directed and coordinated through the Network centralized office.

6. The Network shall 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. The Network shall convene educational opportunities for patients, led by the Network or other credible stakeholders;

8. The Network shall maintain a national user-friendly, toll-free telephone number.

9. The Network shall maintain a Section 508 compliant Network website and comply with Section 508 regulations, as applicable. The Network shall 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. The Network shall maintain data security as described in the NQIIC IDIQ contract, including not releasing data without the permission of the CO and the Director of the Division of Kidney Health (DKH).

11. The Network shall adhere to the Paper Reduction Act (PRA).

12. The Network shall hold Status and Progress Calls with the COR, that include at least one patient, and provide meeting minutes for these Status and Progress Calls (Deliverable #37).

13. The Network shall provide COR Status and Progress Reports, using Attachment 4 Monthly Status Report (Deliverable #38).

14. The Network shall identify facilities that have consistently failed to cooperate with Network goals and/or key results. Additionally, the Network shall identify recommendations with respect to the need for additional or alternative services or facilities in the Network, in order to meet the Network goals and key results, including self-dialysis training, transplantation, and organ procurement facilities (Deliverable #39).

15. The Network shall provide an Annual Report (Deliverable #40). The Annual Report shall include the following:

a. A full statement of the Network's goals and key results;

b. Data on the Network's performance in meeting its goals and key results, 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 key results; 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 and key results, including self-dialysis training, transplantation, and organ procurement facilities.

16. The Network shall submit a Semi-Annual Cost Report (Deliverable #41). 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 Semi-Annual Report Template and Attachment 8.1 Semi-Annual Cost Reporting Instructions.

17. The Network shall collaborate with State Survey Agencies.

18. The Network shall collaborate with ESRD Accrediting Organizations.

19. The Network shall adhere to the data management directives in the NQIIC IDIQ contract.

20. The Network shall identify security roles, as identified in the NQIIC IDIQ contract.

21. The Network shall complete annual security training and any other training related to the use and safety of data, as directed by CMS.

22. The Network shall submit a data use agreement (DUA) through the Enterprise Privacy Policy Engine (EPPE) (Deliverable #42).

23. The Network shall utilize, duplicate, or disclose data CMS provides to the 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 Network shall fill out and submit to CMS a Certificate of Destruction (COD). The COD certifies that the

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. Reserved

25. Reserved

26. The Network shall participate and support the ESRD NCC with the drafting and delivery of a New ESRD Patient Orientation Packet (NEPOP), as necessary.

27. The Network shall attend program calls or CoP calls with CMS, or the ESRD NCC acting on behalf of CMS, as requested.

28. The Network shall acknowledge that all software, documentation, and written products created under the ESRD Network SOW shall become the sole property of CMS.

29. The Network shall 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. The Network shall collaborate with the ESRD NCC to achieve the objectives and key results identified in the ESRD Network and the ESRD NCC SOWs.

31. The Network shall implement change packages, as provided by the ESRD NCC.

32. The Network shall collaborate with the ESRD NCC in identifying the objectives and key results 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. The Network shall 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. The Network shall prepare for and host the annual evaluation, either on-site or virtually.

35. The Network shall encourage the use of treatment modalities most conducive to patient and dialysis facilities facilitating vocational rehabilitation.

36. The Network shall develop standards and criteria to assist providers and dialysis facilities, to encourage patients to participate in vocational rehabilitation.

37. The Network shall assist dialysis facilities to track patient access to vocational rehabilitation or employment network services and provide educational materials for

patients regarding opportunities for assistance to find employment or education that could lead to employment.

38. The Network shall participate with the ESRD NCC and CMS, including the Office of Minority Health, in the identification of strategies to remedy health equity issues, utilizing any modules developed and provided by the ESRD NCC.

39. Reserved

40. The Network shall identify high-performing and low-performing dialysis facilities to participate in Expert Team Development and Sharing Teams, in conjunction with the ESRD NCC.

41. The Network shall provide a listserv, containing a point of contact at all dialysis facilities and transplant centers in the Network service area (Deliverable #45).

42. The Network shall provide a list of low-performing facilities that are mentored and advised by each community coalition (Deliverable #59).

C.6.2. Invoice Adjustments

The contractor shall adjust invoice submissions in accordance with any modifications that occur during the performance of a task order period (i.e., Base Period, Option Period 1, etc.) (Deliverable #55).

C.6.3. On-Site Technical Assistance

The Network shall provide on-site education and mitigation strategies, as necessary, to achieve the goals and key results of the SOW, support technical assistance outcomes, and lead community level endeavors to support health equity.

The Network is expected to provide on-site technical assistance sessions to 25% of the dialysis facilities in the Network service area, or one-hundred and twenty-five (125) dialysis facilities in the Network service area, whichever figure is less, per task order period (i.e., Option Period 2, Option Period 3, etc.), beginning in Option Period 2. The Network shall focus the provision of on-site technical assistance to dialysis facilities identified in Attachment 12 Priority Zip Codes for Use in Health Equity.

If the Network provides on-site assistance to all facilities identified in Attachment 12 Priority Zip Codes for Use in Health Equity prior to meeting the required volume of facility visits detailed above, the Network is expected to subsequently expand their on-site technical assistance efforts to include facilities that are not located within the priority zip codes. The Network shall utilize quality improvement data to identify and provide on-site technical assistance to additional dialysis facilities that are low-performing in one or more areas of the SOW. The Network shall prioritize dialysis facilities that are low-performing in more than one area of the SOW.

If the dialysis facilities identified in Attachment 12 Priority Zip Codes for Use in Health Equity account for more than the required volume of facility visits detailed above, the Network shall utilize quality improvement data to identify and provide on-site technical assistance to dialysis facilities identified in Attachment 12 Priority Zip Codes for Use in Health Equity, that are low-performing in one or more areas of the SOW. The Network shall prioritize dialysis facilities that are low-performing in more than one area of the SOW.

The contractor shall incorporate new dialysis facilities that open in a zip code identified in Attachment 12 Priority Zip Codes for Use in Health Equity, into on-site technical assistance, in the same manner as if that facility was included in the original list.

The contractor shall provide a list of the facilities at which on-site technical assistance occurred (Deliverable #60). Within this list, the Network shall report on identified barriers related to hospitalizations, transplant, home modalities, and vaccination, for each facility at which on-site technical assistance occurred. The contractor shall ensure that facilities demonstrate progress related to the topic area in which on-site technical assistance was provided, within three (3) months of the on-site technical assistance.

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. The Network shall also employ 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 (90) 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 (90)-day period, the Network shall submit to the COR all proposed substitutions at least thirty (30) days in advance. All requests for approval of substitutions described herein 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

In addition to the key personnel, the contractor shall dedicate one (1) full-time equivalent (FTE) to on-site technical assistance. The one (1) FTE dedicated to on-site technical assistance may be composed of multiple staff members. The staff member(s) dedicated to on-site technical assistance will travel to facilities a minimum of thirty-six (36) weeks per task order period (i.e., Option Period 2, Option Period 3, etc.), beginning in Option Period 2. During the remaining weeks of the task order period, it is expected that the staff member(s) dedicated to on-site technical assistance will assist in supporting the other quality improvement areas of this task order, including the health equity and CLAS activities.

The thirty-six (36) week minimum travel period may be waived or adjusted by the COR, if the Network demonstrates their ability to meet the contractual requirements in a shorter timeframe. If the Network requests to waive or adjust the thirty-six (36) week minimum travel period, they must ensure that they conduct no more than three (3) on-site technical assistance visits per week, to maintain a high level of quality in performing technical assistance during the shortened travel period.

Vacant positions for other than key personnel shall be filled within twenty (20) calendar days from date of vacancy. The contractor shall notify the COR when a vacancy has occurred within one (1) business 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 the 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:

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

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 eighteen (18) ESRD 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) year terms and then be asked to serve in the Legacy program, if they choose to continue participation. The Network shall provide the names of the Patient SMEs and/or family members or caregivers selected to participate on the KCER LAN (Deliverable #46).

The Network is also responsible for the following supporting tasks:

1. The Network shall 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).
2. The Network shall 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).

3. The Network shall educate dialysis facilities on the importance of reporting 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.

4. The Network shall 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.

5. The Network shall provide technical assistance to dialysis facilities to develop feasible, comprehensive emergency/disaster plans.

6. The Network shall participate with KCER and other Networks for an annual emergency exercise, as directed by CMS.

7. The Network shall participate in an annual emergency exercise for each state and/or territory within the ESRD Network service area.

8. The Network shall complete an After Action Report (AAR) using the template provided by KCER (Deliverable #48).

9. The Network shall sign a Memorandum of Agreement (MOA) with a back-up Network (Deliverable #49).

10. The Network shall provide an orientation program to the back-up Network (Deliverable #50).

11. The Network shall test the toll-free hotline for patients annually, to ensure that the telephone line can be transferred to the back-up Network.

12. The Network shall obtain a Government Emergency Telephone System (GETS) card to facilitate communication during an emergency situation.

13. The Network shall contact and collaborate with local and state emergency officials prior to, at the greatest extent possible, and during a pandemic or other emergency.

14. The Network shall ensure that all patient and facility needs are identified and that resources are located during a pandemic or other emergency.

15. The Network shall ensure that CMS is aware of all challenges and barriers in the area experiencing the emergency.

16. The Network shall attend the KCER Summit during the CMS 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 and key results, 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 shall help CMS achieve this goal by providing technical assistance related to data systems to facilities.

The Network is also responsible for the following supporting tasks:

1. The Network shall provide technical assistance to dialysis facilities to related to submitting data into EQRS.

2. The Network shall assure accuracy of data entered into EQRS by reconciling data reports provided by CMS, including but not limited to, alerts and notifications.

3. The Network shall 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).

4. The Network shall participate in data demonstrations and provide feedback on the design of current functionality and additional features to EQRS.

5. The Network shall assist new and previously non-participating facilities with NHSN enrollment, if requested by facilities.

6. The Network shall provide assistance to facilities to improve facility processes related to the submission of data to NHSN.

7. The Network shall 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. The Network shall provide technical assistance related to these programs and resources to facilities.

The Network is also responsible for the following supporting tasks:

1. The Network shall ensure that all Network staff are fully knowledgeable about measures and specifications related to the ESRD QIP and Star Ratings.

2. The Network shall respond to questions from patients, caregivers, or dialysis facility staff regarding the ESRD QIP, Care Compare, and Star Ratings.

3. The Network shall 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.

4. The Network shall post links to the CMS and KCER webpages related to the ESRD QIP, Care Compare, and Star Ratings on the Network website.

5. Upon request by CMS, the Network shall 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.

6. The Network shall notify facilities of the procedures required to access their ESRD QIP Performance Score Reports (PSRs), Quarterly Care Compare Preview Reports, and Dialysis Facility Reports.

7. The Network shall monitor access to the PSRs and contact providers that have not accessed the report within five (5) days of its release.

8. The Network shall encourage facilities to review their PSRs and submit necessary clarification questions or formal inquiries during the annual thirty (30)-day preview period.

9. The Network shall assist facilities with accessing, printing, and posting the Performance Score Certificate (PSC) each year, within five (5) business days of its release date.

10. The Network shall inform CMS if a facility has not posted its PSC, as directed in Medicare Improvements for Patients and Providers Act (MIPPA).

11. The Network shall provide technical assistance for any facilities in the Network service area requesting assistance with quality improvement efforts related to topics addressed by ESRD QIP and/or Star Ratings measures.

12. The Network shall establish relationships and collaborate with stakeholders to achieve improvements on ESRD QIP and Care Compare measures, on behalf of patients.

13. The Network shall 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, 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.

C.8. TRANSITION

The Network shall begin the phase-in efforts immediately after task order award. The Network shall submit a Transition Plan as part of their proposal. In this plan, the 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 Network shall include adequate time to:

1. Hire appropriate personnel;

2. Become familiar with Patient SMEs and peer mentors in the ESRD Network service area;

3. Become familiar with successful and unsuccessful strategies for reaching patients, dialysis staff, and regional dialysis management with education and quality improvement efforts;

4. Become familiar with current grievances and access to care issues, and any ongoing issues that could impact future work; and

5. Issue subcontracts, etc. after task order award.

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.

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

Blood Pressure Management

I161 Hypertensive Emergency

I169 Hypertensive Crisis, Unspecified

I160 Hypotensive Urgency

Fluid Balance-Related

E8770 Fluid overload unspecified

E8779 Other fluid overload

J810 Acute pulmonary edema

I509 Congestive Heart Failure, Unspecified

E8770 Hypervolemia

I5021 Acute systolic (congestive) heart failure

I5023 Acute on chronic systolic (congestive) heart failure

I5031 Acute diastolic (congestive) heart failure

I5033 Acute on chronic diastolic (congestive) heart failure

I5041 Acute combined systolic (congestive) and diastolic (congestive) heart failure

Infection-Related

A419 Sepsis, unspecified organism

A4101 Sepsis due to Methicillin Susceptible Staphylococcus aureus

A4102 Sepsis due to Methicillin Resistant Staphylococcus aureus

T8571 Infection and inflammatory reaction due to peritoneal dialysis catheter

T80211 Bloodstream infection due to central venous catheter

T827 Infection and Inflammatory Reaction due to Other Cardiac and Vascular Devices, Implants and Grafts

Anemia Management

D631 Anemia of Chronic Kidney Disease

Endocrine-Related

E162 Hypoglycemia, unspecified

Electrolyte and Mineral Metabolism Disorders

E871 Hypo-osmolality and hyponatremia

E875 Hyperkalemia

E876 Hypokalemia

E8339 Hyper- and Hypophosphatemia

E8351 Hypocalcemia

E8352 Hypercalcemia

Vascular-Related

T82838 Hemorrhage due to vascular prosthetic devices, implants and grafts

T82858 Stenosis of other vascular prosthetic devices, implants and grafts