



End-Stage Renal Disease
Network of the South Atlantic

2023 Annual Report



Myrtle Beach Boardwalk, South Carolina

This report will cover quality improvement efforts led by ESRD Network 6
Task Order Number 75FCMC21F0003 from May 1, 2023 - April 30, 2024

July 2024 - Revised February 2025
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ESRD Demographic Data

IPRO End Stage Renal Disease (ESRD) Network of the South Atlantic (Network 6) is one of four ESRD Networks managed by IPRO, a non-profit organization that works with government agencies, providers, and consumers to implement innovative programs that improve healthcare. In addition to serving as the ESRD contractor for the Network 6 service area, IPRO manages the ESRD Network of New England (Network 1), ESRD Network of New York (Network 2), and ESRD Network of the Ohio River Valley (Network 9), collectively known as the IPRO ESRD Network Program. IPRO is fully committed to the goals and vision of the ESRD Network Program and supports the renal community in ensuring safe, effective, patient-centered care for the more than 201,572 ESRD patients in the four Network areas it manages.

Network 6 serves ESRD patients, dialysis providers, and transplant centers in the states of Georgia, North Carolina, and South Carolina. The role of the Network is to improve the quality of care for people who require dialysis and/or kidney transplantation. The Network aligns its mission and activities with the U.S. Department of Health and Human Services (HHS) National Quality Strategy (NQS), 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. Our goals, our methodology for attaining them, and our achievements are described throughout this report.

Racial minority populations have a disproportionately high risk of kidney failure: Black individuals have a 3.4 times greater risk, as compared with people who are White. This disproportionate difference, combined with the demographics of the Network service area, led to an exceptionally high number of patients needing kidney care in the Network 6 region. The states that comprise the Network service area have more than twice the national rate of Black or African American residents (27.4% compared to 13.6%, according to U.S. Census estimates for 2023). Georgia has the second highest rate of Black or African American residents in the nation (33.1% or 3.65 million), followed by South Carolina (26.3% or 1.4 million) and North Carolina (22.2% or 2.4 million).

End Stage Renal Disease (ESRD) in the Network Service Area

According to December 30, 2023, data from the ESRD National Coordinating Center (ESRD NCC), the ESRD community in the United States included 948,917 individuals with renal insufficiency: 513,225 prevalent dialysis patients, 128,814 incident dialysis patients, and 306,878 patients living with a transplant.

The Network 6 ESRD patient population, which was the second largest Network in the country in 2023, included 71,761 individuals either on dialysis or receiving a kidney transplant. There were 49,857 prevalent dialysis patients (9.7% of the national number) and 11,260 incident dialysis patients (9.0% of the national number) reported receiving treatment from dialysis facilities in the Network's region. Of the individuals living with a kidney transplant nationally,

there were 21,904 kidney transplants completed in the Network's service area since the start of the ESRD Network Organization Program in 1988 (7.1% of the national number).

As of December 30, 2023, there were 430,261 individuals in the United States receiving in-center hemodialysis (ICHD) treatments. This included 41,828 ICHD patients (83.9%) in the Network's service area, which makes up 8.2% of the ESRD population nationally. Of the 82,964 individuals in the United States using a home dialysis modality, including continuous-cycling peritoneal dialysis (CCPD), continuous-ambulatory peritoneal dialysis (CAPD), or home hemodialysis (HHD), there were 8,029 home dialysis patients (16.1%) in the Network's service area. This represents 9.7% of the ESRD population nationally. The rate of home modality utilization in the Network's region (16.1%) exceeded the national rate of 15.5% and the rate of transplants was 30.5%.

In 2023, there were 7,830 ESRD Medicare-certified dialysis facilities in the United States. The Network region included 794 dialysis facilities (10.1% of the national number), eight of which were in Veterans Affairs (VA) hospitals. There were 277 dialysis facilities (34.9%) that provided treatment after 5 pm; access to care after normal business hours can greatly improve quality of life for ESRD patients who are able to work full-time while receiving treatment. Of the 229 transplant centers in the United States, 12 centers (5.2% of the national number) offered kidney transplants within the Network service area.

ESRD Community Engagement and Collaborations

In 2023, 28 Medicare-certified dialysis facilities closed, and nine new facilities were opened. 76.7% of the dialysis facilities were owned or managed by a large dialysis organization (LDO), 16.9% were owned or managed by medium or small dialysis organizations; and 5.9% were independently owned.

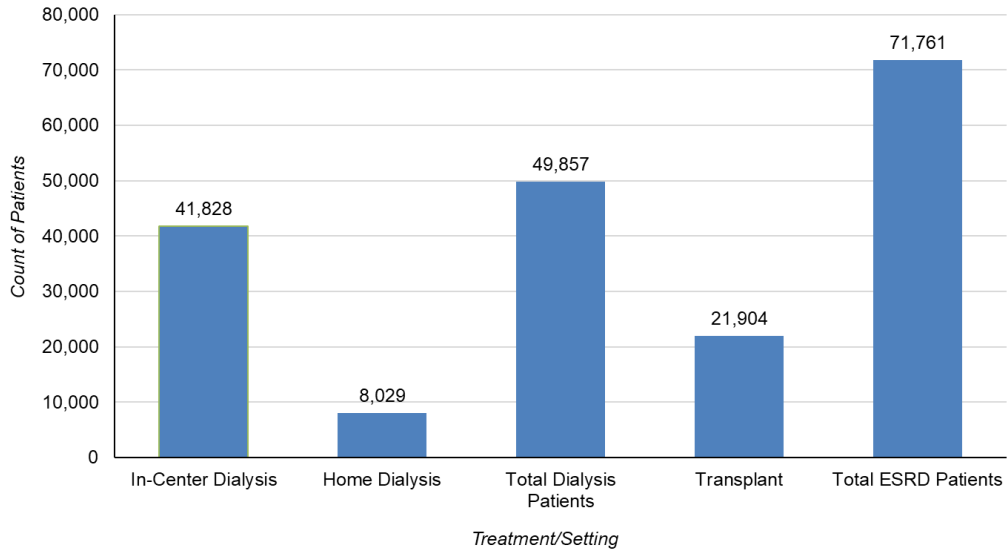
Patient Facility Representatives (PFRs), nominated by facility staff to engage with their peers, provided feedback about quality improvement activities and helped develop the Network's educational materials. Meeting monthly as the PFR Alliance group, the PFRs participated in Network calls and events as well as national calls. During their monthly meetings the Network provided the PFR Alliance with an overview of the status of projects as well as monthly assignments. The Network worked with community coalitions, a subgroup of dialysis facilities within its service area that included both high- and low- performing facilities. These facilities completed root cause analyses and participated in a Plan-Do-Study-Act (PDSA) cycle of four months.

During the PDSA cycle, the Network engaged the community coalition facilities in interventions to drive improvement at the Network and facility level and assisted with mitigating barriers by providing 1:1 technical assistance based on data and facility specific needs. Upon completion of the PDSA cycle, best practices identified within the coalitions were spread to facilities across the Network's service area to form a community of practice.

During the performance period, the Network worked in collaboration with its Network Council, Medical Review Board, PFR Alliance, and Advisory Committees to develop quality improvement projects aligned with the CMS-identified goals for the ESRD Network program. The Network worked closely with ESRD patients, patients' family members and care partners, nephrologists, dialysis facilities and other healthcare organizations, ESRD advocacy organizations, and other ESRD stakeholders to improve the care for ESRD patients throughout the South Atlantic region.

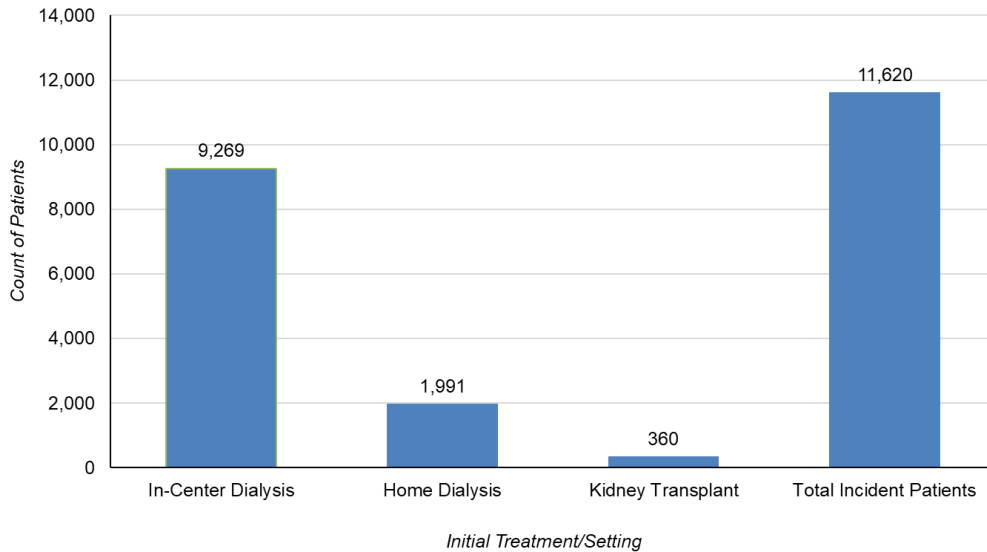
The Network deployed interventions through its online education platform, *I PRO Learn*, that targeted patients, dialysis and transplant providers, and other stakeholders. These interventions, which focused on engaging patients, reducing disparities, and improving quality of care for ESRD patients, are detailed in this report.

Network 6: Count of Prevalent ESRD Patients by Treatment/Setting 2023



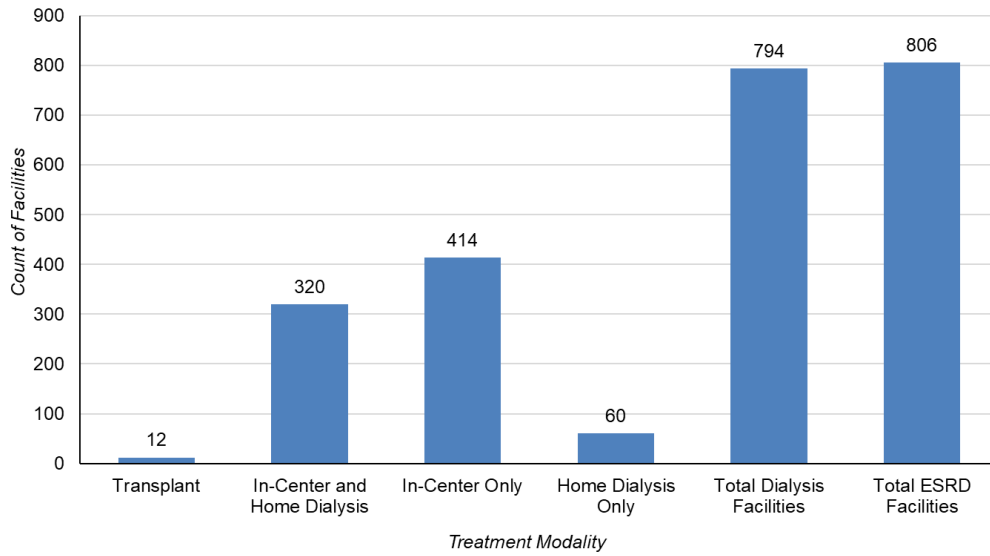
Total Dialysis Patients = In-Center Dialysis + Home Dialysis
 Total ESRD Patients = Transplant + Total Dialysis
 SNF dialysis patients are not shown due to small numbers
 Source of data: EQRS May 2024

Network 6: Count of Incident ESRD Patients by Initial Treatment/Setting 2023



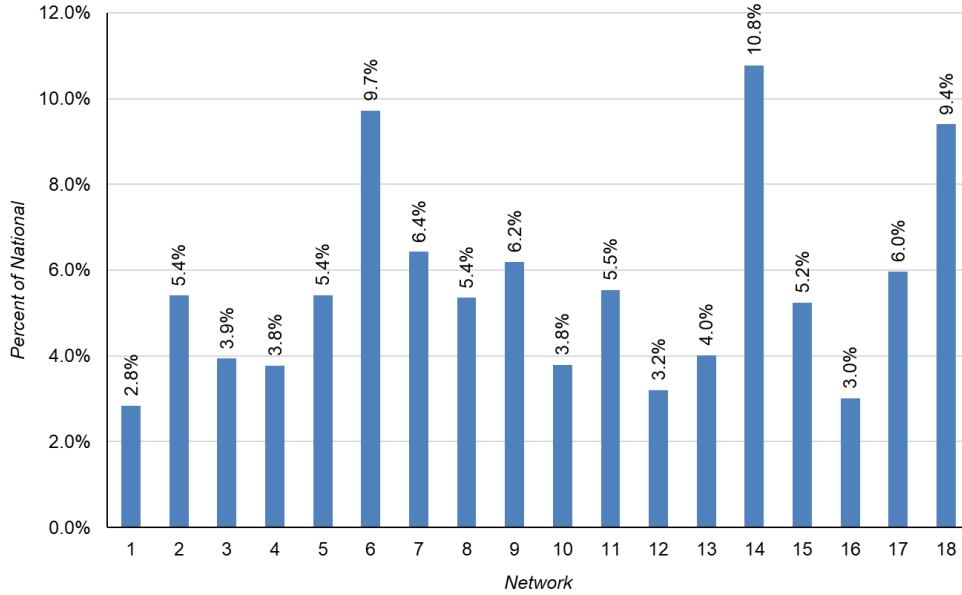
Total Incident Patients = In-Center + Home + Kidney Transplant
 Source of data: EQRS May 2024

**Network 6: Count of Medicare-Certified Facilities
by Treatment/Setting
2023**



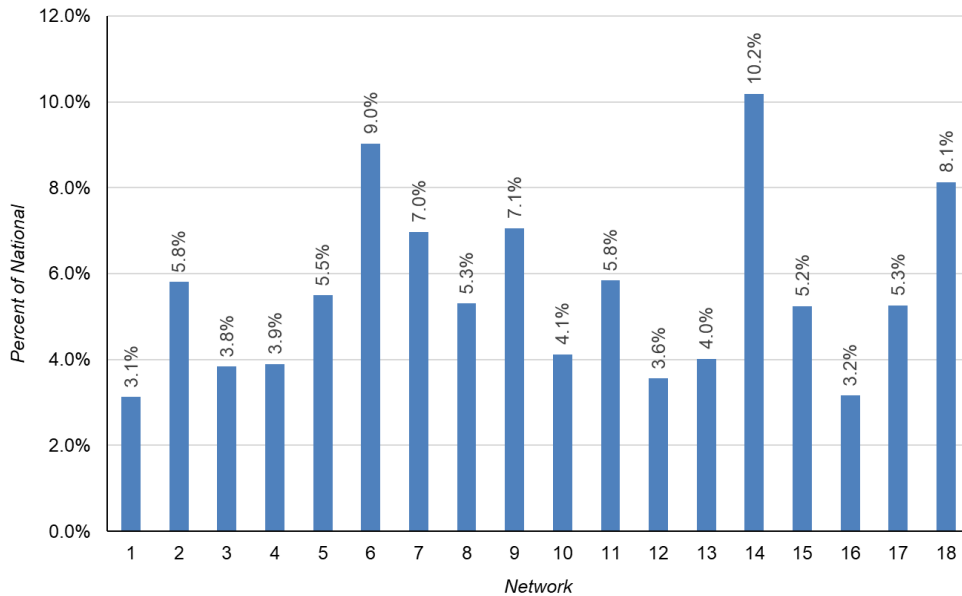
Total Dialysis Facilities = In-Center and Home Dialysis + Home Dialysis Only + In-Center Only
Total ESRD Facilities = Transplant + Total Dialysis Facilities
Source of data: EQRS May 2024

Percent of National Prevalent Dialysis Patients by ESRD Network 2023



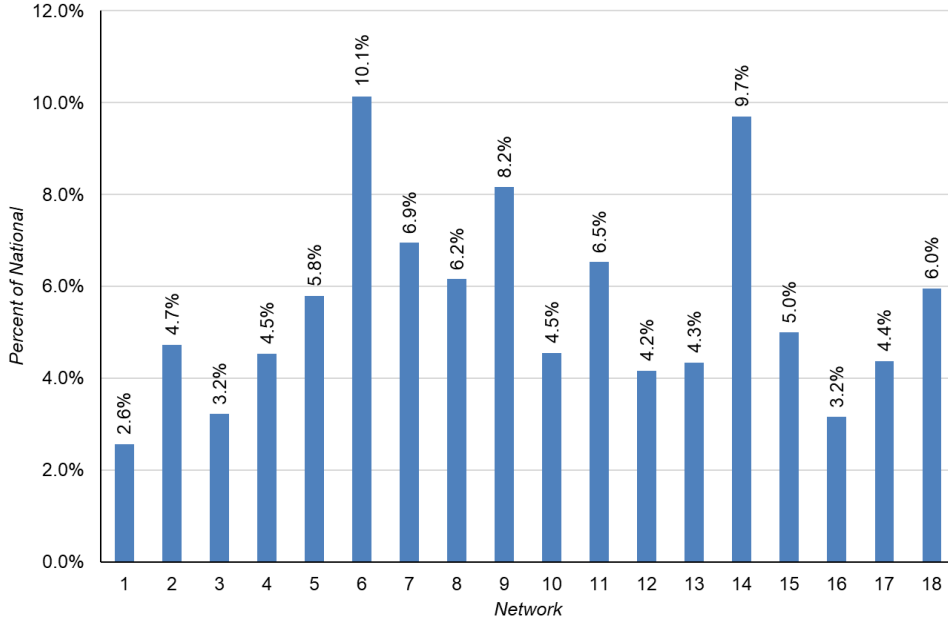
National total dialysis patients: 513,225
 Source of data: EQRS May 2024

Percent of National Incident Dialysis Patients by ESRD Network 2023



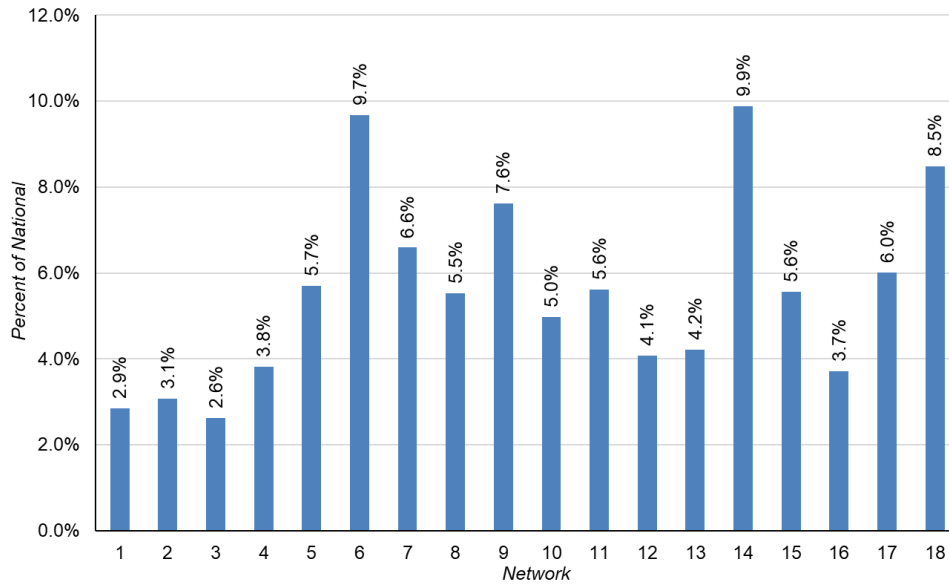
National total incident patients: 128,814
 Source of data: EQRS May 2024

**Percent of Medicare-Certified Dialysis Facilities by ESRD Network
2023**



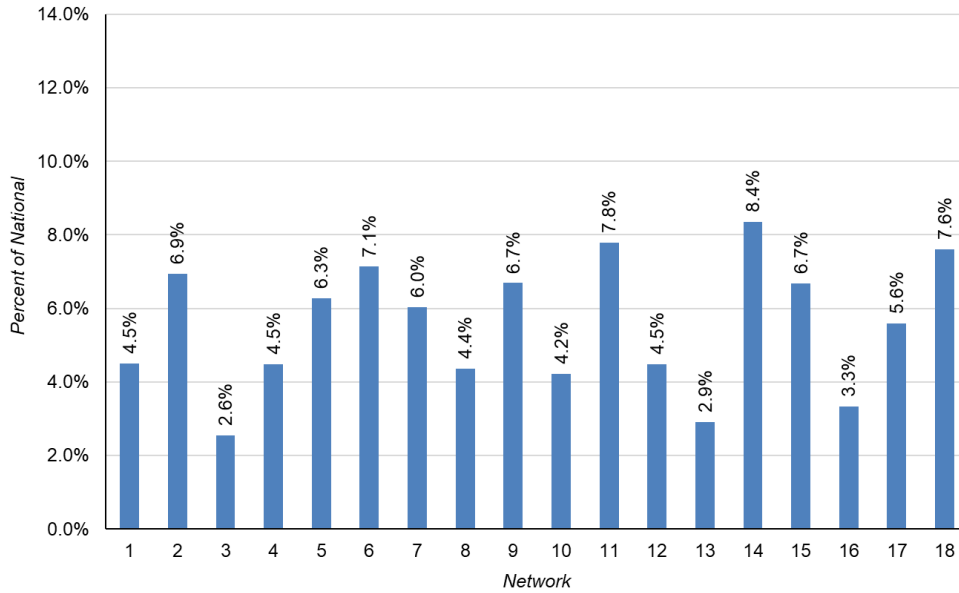
National total ESRD Medicare-certified dialysis facilities: 7,830
Source of data: EQRS May 2024

**Percent of National Home Hemodialysis and Peritoneal Dialysis
Patients by ESRD Network
2023**



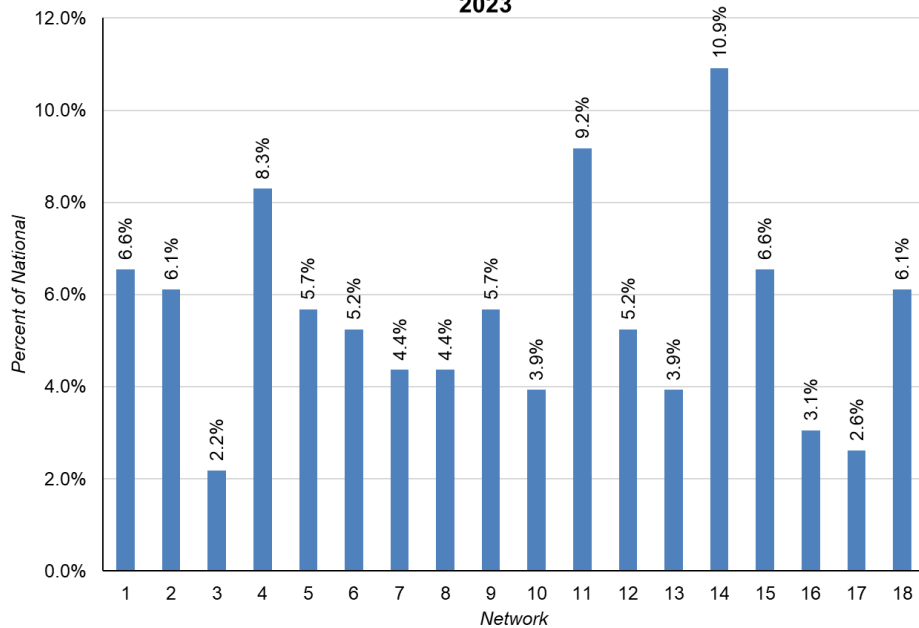
National total home hemodialysis and peritoneal dialysis patients: 82,964
Source of data: EQRS May 2024

**Percent of National Transplant Patients by ESRD Network
2023**



National total transplant patients: 306,878
Source of data: EQRS May 2024

**Percent of Medicare-Certified Kidney Transplant Facilities by
ESRD Network
2023**



National total ESRD Medicare-certified kidney transplant facilities: 229
Source of data: EQRS May 2024

Transplant Waitlist & Transplanted Quality Improvement Activity May 2023-April 2024

Project Overview

Kidney transplantation is the best treatment option for patients with end stage renal disease regardless of age, sex, and ethnicity. The U.S. Department of Health and Human Services' Advancing American Kidney Health (AAKH) initiative has established as one of its goals that 80% of ESRD patients will be treated with either home dialysis or a kidney transplant by 2025. Network 6 has been committed to supporting these goals by meeting with empowered patients, nephrologists, primary care providers, transplant center staff, and dialysis providers to plan, develop, and implement quality improvement concepts and strategies to support transplant education and patient choice.

The Networks goals for this performance period were to increase the number of patients on the United Network for Organ Sharing (UNOS), the national transplant waitlist, by 2,495 (9%) and increase the number of people receiving a kidney transplant by 1,851 patients (12%).

Interventions

Collaborations

The Network continued its long-standing partnership with the Southeastern Kidney Transplant Coalition (SEKTC) of Georgia, North Carolina, and South Carolina, an academic and community partnership that was formed with the mission to improve access to kidney transplantation and reduce disparities among African American ESRD patients in the Southeastern United States. The Coalition comprises a group of experts from transplant centers and organ procurement organizations, dialysis and transplant providers, and local representation from the National Kidney Foundation (NKF), Georgia Transplant Foundation (GTF), and the American Association of Kidney Patients (AAKP). The Network also collaborated with colleagues from Emory University and the Regenstrief Institute to support data collection for a community-based participatory research process study, formally known as RaDIANT. This study aimed to improve equity in access to kidney transplantation for ESRD patients in the southeast. Since inception, these initiatives have resulted in a tangible reduction in disparities in transplant treatment access across the region. Preemptive transplant rates within the Network region have surged by an impressive 74%, while simultaneously narrowing racial disparities among African American patients by 23%.

Kidney Transplant Compare

In 2018, the Network began work on the *Transplant Center Compare* project which started as a set of documents highlighting transplant center patient selection criteria, support services, and data outcomes, to encourage patients to make informed choices when selecting a transplant center. In 2023, the IPRO ESRD Network Program expanded and enhanced this project to create a patient- and provider-facing mobile and desktop application: *Kidney Transplant Compare*. This comprehensive resource offers more than 130 key information points about each participating center. The information included in the resource was based on patients' responses when asked

what they would have liked to know about transplant centers before starting their transplant journey. The application launched in June 2023 and allows the user to search, save, and compare more than 41 transplant centers across 13 states. In less than a year, *Kidney Transplant Compare* has made a significant impact, with 10,000 desktop users and 500 mobile downloads to date. Furthermore, the application has garnered positive feedback from both patients and providers, who attest to its effectiveness in boosting interest in transplant procedures, increasing the number of referrals submitted, promoting waitlisting at multiple transplant centers, and reducing the time spent referring patients to centers that may not fully meet their unique needs.

Community Coalitions

During the performance period, the Network chose 51 facilities to engage in a six-month quality improvement project as part of a community coalition. Participating facilities were asked to identify their most common barriers to waitlist and transplant as expressed by patients. Network staff guided facility staff through a PDSA cycle that facilitated testing and evaluation strategies to mitigate patients' resistance to transplant as a treatment option and to increase the number of patients considering transplant and becoming waitlisted. Network staff engaged the facilities' patient advocates throughout the project. Facilities participating in the community coalition were provided with continuous feedback and resources, while the Network gathered best practices to share with all facilities in the region.

Outcomes

The Network's activities during the performance period contributed to an increase of 3,124 patients on the transplant waitlist (exceeding its goal of a 9% increase) and an increase of 1,962 patients transplanted (exceeding its goal of a 12% increase).

Barriers to Achieving Goals

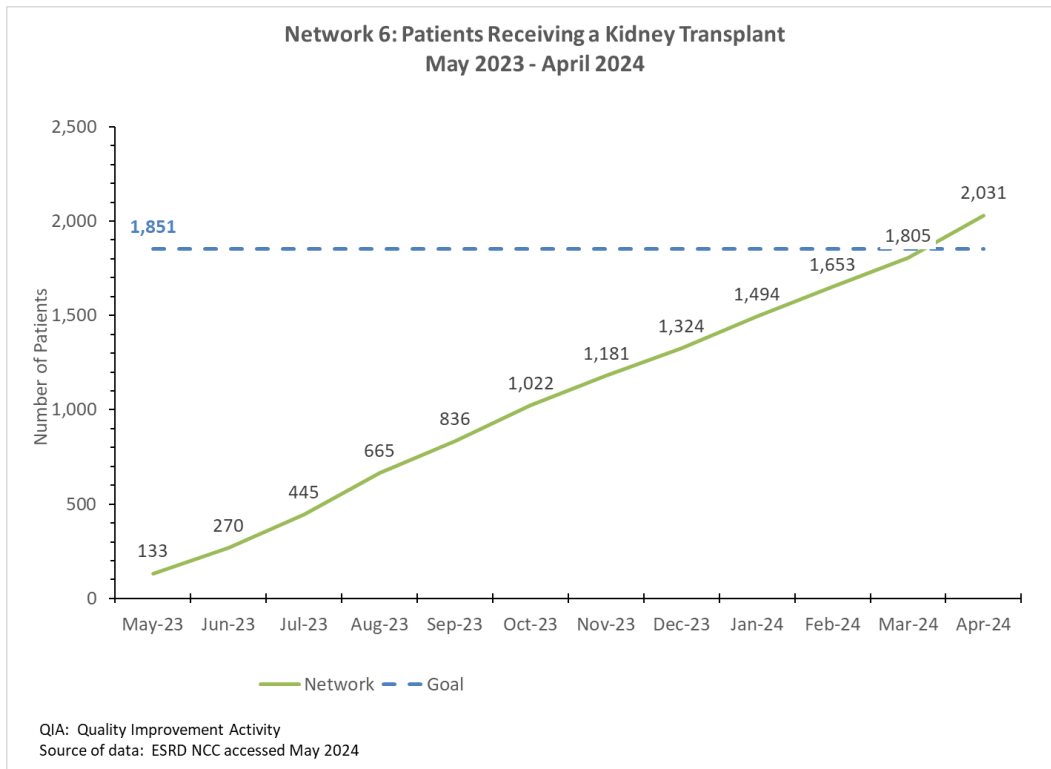
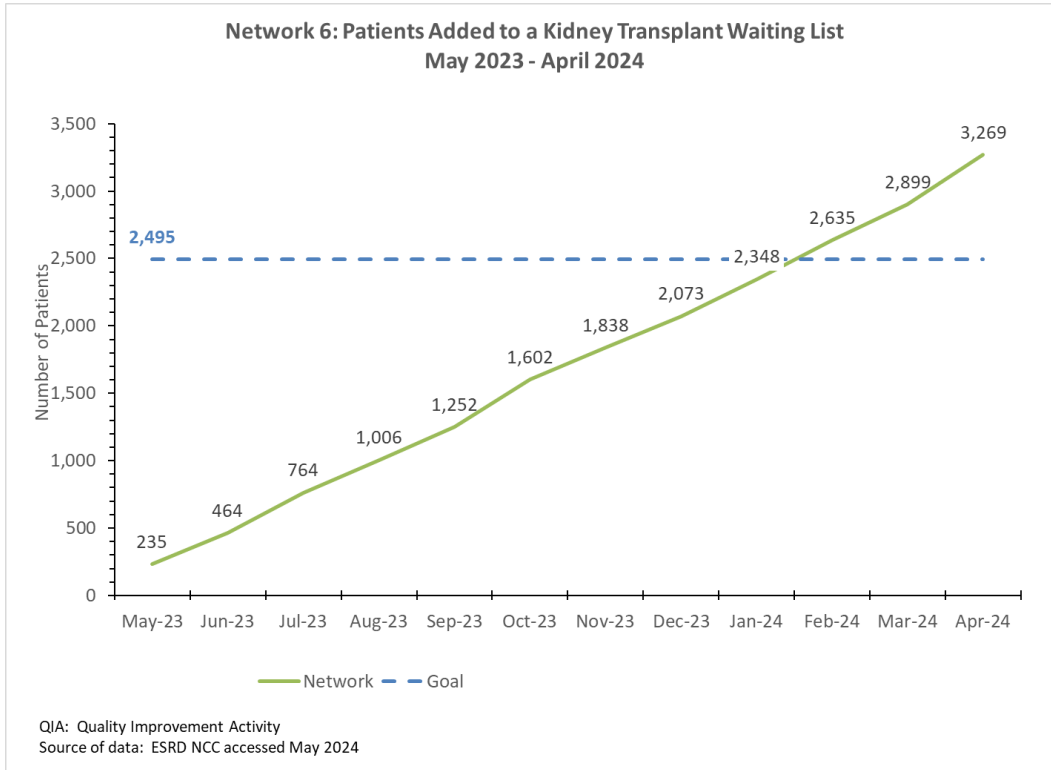
Despite the success and improvements in the region during this performance period, barriers related to medical comorbidities, lack of patient interest and access to transplant, and health literacy still existed.

Best Practices Spread to Achieve Goals

Much of the Network's success in meeting its goals can be attributed to strong and active engagement in coalition activities by community stakeholders and transplant centers in the SEKTx Coalition. In addition, Network 6 has seen improvements in referral and waitlist communications, with heavy adoption of electronic transplant referral exchange applications.

The Network focused on best practice sharing through the interventions implemented for the community coalitions and the *Kidney Transplant Compare*. The Network hosted calls that featured facilities sharing successes in their transplant processes, including how they were able to reduce inequities and increase awareness of and access to transplantation for all kidney patients. In addition, the Network highlighted the work of high performers in current and past community coalitions and shared how, through data analysis and process changes, they

overcame common barriers and succeeded in increasing the number of patients considering transplant and/or registering on the waitlist.



Home Therapy (Incident & Transition to Home) Quality Improvement Activity May 2023-April 2024

Project Overview - Incident

Home dialysis is known to enhance a patient's quality of life on many levels, both mentally and physically. Selection of a renal replacement therapy performed at home offers patients a more flexible schedule, increased independence, a sense of empowerment, and a heightened knowledge of their disease. Home modalities can also provide many physical benefits including better blood pressure control and improved fluid volume status, leading to a decrease in the likelihood of hospitalizations.

These benefits are further enhanced when patients with chronic kidney disease (CKD) begin dialysis on a home therapy as soon as they need renal replacement treatment. Home dialysis helps patients preserve their residual kidney function and has fewer negative effects on the cardiovascular system when compared to in-center hemodialysis. With the numerous mental and physical benefits of home dialysis, the goal for this performance period was to increase the number of newly diagnosed patients starting directly on a home modality by 30% over the baseline year, 2020.

Interventions

Partnering with the American Kidney Fund, the Network organized and then participated in *Living Your Best Life with Kidney Disease*, a patient expo in Atlanta, Georgia. More than 80 patients and family members from the Network's service area attended this live event, which featured a keynote speaker who shared his personal story about how kidney disease affected his family and the importance of not giving up hope. Along with other topics including early detection of kidney disease/healthy living and transplant, the event featured several interactive skits highlighting the benefits of home dialysis and performed by the CKD Champions, a group of ESRD patients who formed a speaker panel to help patients understand treatment options. During breaks, attendees were given the opportunity to view home dialysis machines and ask experts questions about home dialysis. Of the 47 surveys the Network received following the expo, 30 included comments indicating that attending the expo helped encourage them to consider a home dialysis therapy or transplant.

The Network shared best practices and resources with its CKD educator stakeholders throughout the performance period. Resources were shared via a bi-monthly CKD newsletter and *IPRO Learn*. Information about and access to *IPRO's CKD Screening* application was prominently featured in educational presentations. Among the other resources shared were the AKF course, *Kidney Health Coach*, which offered continuing education credits to all participants and helped those who took it develop a CKD education program. The Network also shared educational resources from the National Kidney Foundation, the International Society of Nephrology and Kidney Disease Improving Global Outcomes' *CKD Early Identification & Intervention Tool Kit*, and Medscape's *Why is Kidney Disease So Often Missed?*

To help increase awareness of the importance of early CKD education, screening, and detection, the Network participated in the NKF's Greater Georgia Stakeholder Summits Working Groups *Ending Disparities in Chronic Kidney Disease (CKD)*. Network staff participated in two work groups: *Wellness and Prevention* and *Policy, Payment, and Quality Measures*.

Outcomes

The Network's activities during the performance period contributed to a total of 2,117 incident patients (17.44%) starting renal replacement therapy on a home modality, missing its goal of a 30% increase over the baseline period.

Barriers to Achieving Goals

One barrier for patients starting directly on a home modality is that Medicare does not currently reimburse for patients with Acute Kidney Injury (AKI) who are on a home modality. Medicare covers only in-center treatment for these patients. Currently legislators are lobbying CMS to allow AKI patients to have the option of home dialysis.

Staffing shortages in home programs and the overall healthcare staffing crisis created additional barriers within the Network's service area. The shortage impacted the ability to recruit and train home dialysis nurses. To help mitigate this barrier the Network shared with all facilities in its service area a recording of an ESRD NCC Best Practice call during which a top performing facility presented information on how they created an innovative staffing model to help recruit and retain home staff.

One of the most significant barriers was the lack of early education about dialysis treatment options for patients with CKD. The early introduction of education about the disease would assist patients in understanding how they might slow the progression of the disease and make informed decisions about a treatment option once they must start dialysis.

Best Practices Spread to Achieve Goals

The Network shared education about urgent start peritoneal dialysis with facilities via its *I^{PRO} Learn* online education platform. After surveying facilities to identify which had the capability to treat urgent start patients and to better understand barriers that those facilities face with urgent starts, the Network shared with all facilities an article¹ that listed common barriers and mitigation strategies.

¹ Arramreddy R, Zheng S, Saxena AB, Liebman SE, Wong L. Urgent-start peritoneal dialysis: a chance for a new beginning. *Am J Kidney Dis*. 2014 Mar;63(3):390-5. doi: 10.1053/j.ajkd.2013.09.018. Epub 2013 Nov 15. PMID: 24246221; PMCID: PMC4124939

Project Overview - Transition

The choice of a home modality (peritoneal dialysis or home hemodialysis) enhances quality of life, reduces healthcare costs, and provides flexibility for patients' treatments. During the performance period the Network worked to increase education and awareness about these treatment options and to provide the resources needed to help patients determine the appropriate dialysis modality to fit their individual lifestyle.

The Network's goal was to increase the number of patients transitioning to a home therapy to 12% above the baseline measurement (April 30 - 2020 - May 1, 2021).

Interventions

Body image is one barrier that patients may struggle with when making the transition to peritoneal dialysis at home. Patients who start dialysis deal with changes in their body including weight gain, bloating, and feeling full, hernias and how the peritoneal dialysis catheter may look to them. With input from the Network's PFRs the Network created the flyer, *Seeing Yourself in a Positive Light with a Peritoneal Dialysis Catheter* and shared it with 534 facilities.

A review of the data collected from facilities about this resource revealed that of the 534 facilities that completed the intervention (70% of the facilities in the Network's service area), 405 (76%) agreed with the statement that body image is a barrier to patients transitioning to a home modality and 487 facilities (91%) stated that they would distribute the flyer to their patients. In total, the flyer was shared with 3,860 community partners and stakeholders as well as 15,825 patients, families, and caregivers.

The Network also introduced a *Meet the Challenge* activity for facilities that had successfully met their goals early in the performance period. These facilities were asked to increase their transition goal by one patient. The Network followed the facilities' metrics and recognized and congratulated facilities that were able to perform higher than the goals they were given.

The Network also provided one-on-one technical assistance to facilities that had transitioned zero patients and asked if they needed support or resources to transition one patient. The Network sent resources and met with facilities to help identify processes that needed to be modified or put into place.

Outcomes

In the Network's service area, 3,119 patients (98%) who had been receiving in-center dialysis transitioned to home therapy during the performance period. While the Network's efforts resulted in a steady increase in patients transitioning to a home modality throughout the performance period, the Network did not meet its goal to attain an increase of 12% of in-center patients transitioning to home treatment.

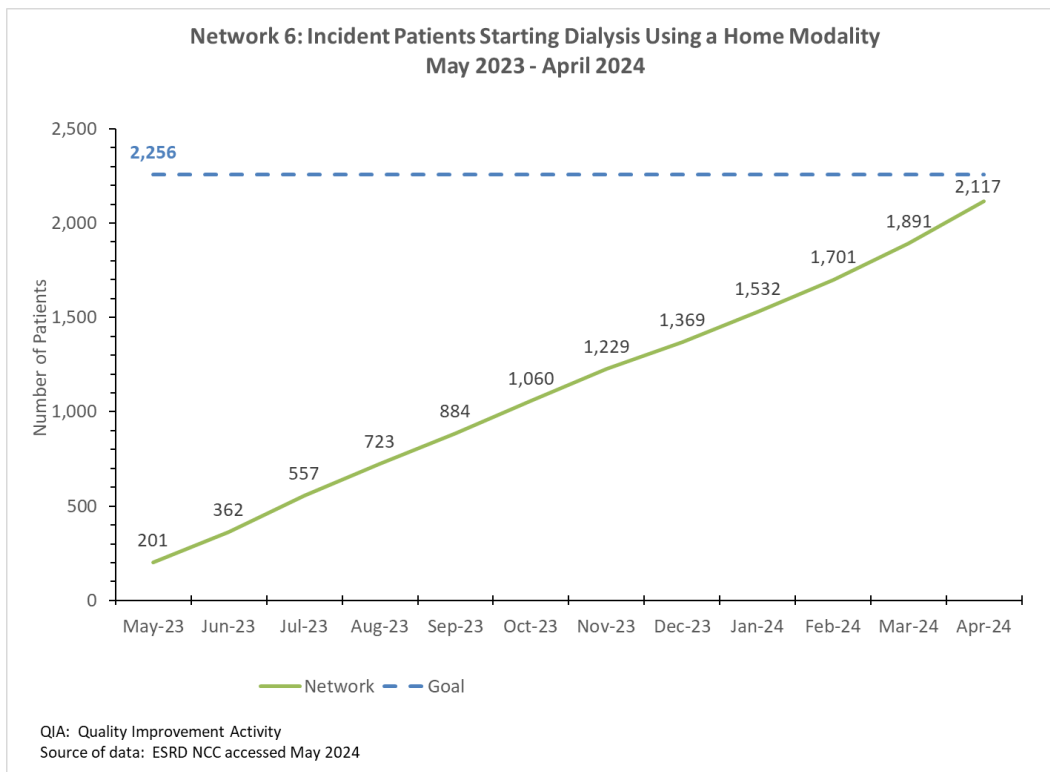
Barriers to Achieving Goals

Through its provision of technical assistance, the Network found that while many of the facilities still had staffing problems, a carryover from the COVID-19 pandemic, most were

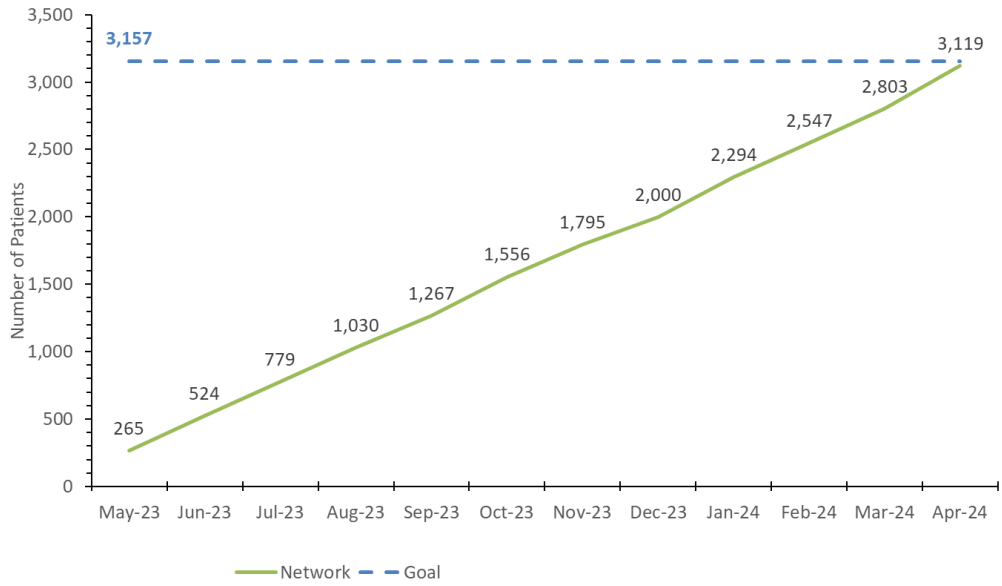
experiencing a shift in staff availability and were on their way to becoming fully staffed. Many of these facilities were beginning to put processes back into place to start transitioning interested patients to home therapy.

Best Practices Spread to Achieve Goals

Community coalitions functioned as bodies of stakeholders within the Network’s service area, dedicated to identifying barriers related to patients transitioning to a home therapy 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 were designed to improve healthcare outcomes within the community. Network staff routinely invited members of community coalitions to attend the ESRD NCC-hosted Learning and Action Network (LAN) and Expert Team calls.



**Network 6: Prevalent Patients Moving to a Home Modality
May 2023 - April 2024**



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2024

Influenza Vaccinations (Patient and Staff) May 2023-April 2024

Project Overview

Individuals with ESRD are less able to ward off, and more likely to contract, infections than the general public. These individuals have weakened immune systems and are frequently exposed to infections as they receive dialysis. For these reasons, the ESRD patient is at a high risk of contracting influenza, leading to an increased likelihood of seasonal patterns of respiratory illness and even death.

While “vaccination rates in the general population have been associated with improved outcomes, ESRD patients have received little attention in determining the potential benefits.”² During the performance period, the Network focused on educating facility staff about the importance of increasing vaccine administration for both patients and staff, with a goal to ensure that at least 90% of patients and healthcare workers in the Network’s service area were vaccinated for influenza. All individuals were deemed eligible for the influenza vaccine unless they had been given an exemption due to allergies or religious beliefs.

To monitor these metrics, facilities were responsible for reporting influenza vaccine rates using their electronic medical records (EMR) and ensuring that the data reports were transmitted to the National End Stage Renal Disease Quality Reporting System (EQRS) for patients and the National Healthcare Safety Network (NHSN) for staff.

Interventions

To increase vaccination awareness, the Network introduced a *Healthy Living Initiative* as an opportunity to focus on the overall health of a patient, rather than solely concentrating on vaccinations. This approach allowed the patient to have the opportunity, capability, and motivation to act in a way that positively affected their physical and mental well-being. To support a healthy living approach, the Network released an online resource created by the HHS and the Office of Disease Prevention and Health Promotion (ODPHP). *My Healthfinder* provides a prevention and wellness resource that health professionals can recommend to individuals and families to get information about clinical preventive services, including prevention and wellness topics, and interactive quizzes and tools.

To educate patients and healthcare workers about healthy living, the Network released the *Healthy Living Bingo Game*. By incorporating health education into a game format such as bingo, the Network encouraged patients and staff to become advocates for their health and to make better choices for a healthy lifestyle. The Network polled facilities within its service area to determine whether a Bingo activity would create positive patient and staff engagement and provide an effective learning platform. Of the 502 respondents (more than half of the facilities

² David T. Gilbertson, Mark Unruh, A. Marshall McBean, Annamaria T. Kausz, Jon J. Snyder, Allan J. Collins, Influenza vaccine delivery and effectiveness in end-stage renal disease, *Kidney International*, Volume 63, Issue 2, 2003, Pages 738-743

in the Network's service area), 93% expressed their belief that the game would improve staff morale and eventually encourage patients to focus on healthy lifestyle choices.

Additional interventions implemented by the Network included efforts to improve processes related to the capture of data on influenza vaccinations given to patients and staff via a system of checks and balances. Facilities were encouraged to download internal data systems and cross-reference them to the national databases.

Outcomes

At the end of the performance period, 38,043 patients (77%) and 5557 healthcare workers (36%) in the Network's service area had received an influenza vaccine; a decrease of 2.33% over the prior year for patients and 2.25% for healthcare workers. Due to this, the Network did not achieve the goal to have 90% of patients and healthcare workers vaccinated for influenza.

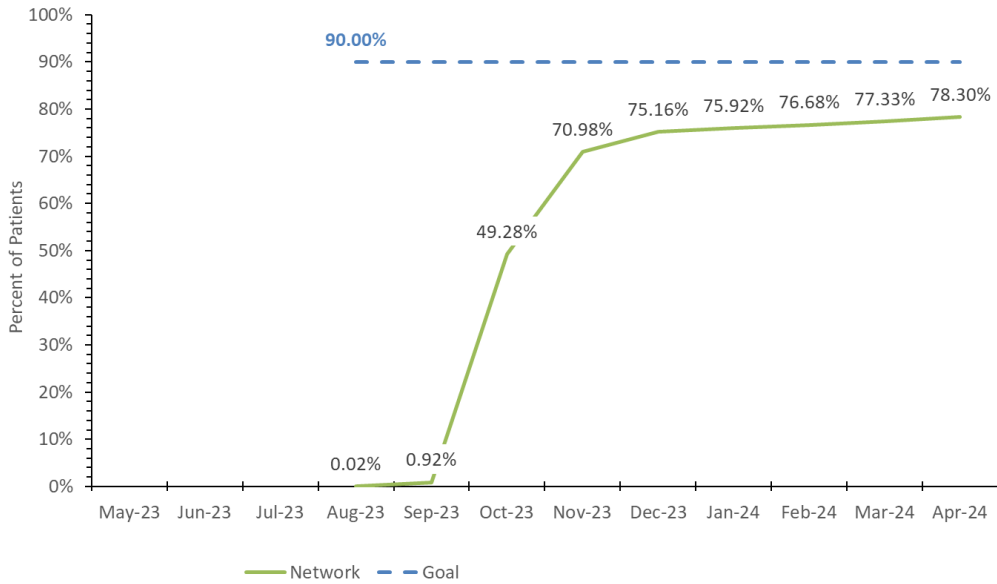
Barriers to Achieving Goals

Vaccines are key to the prevention and spread of influenza. Efforts to increase the administration of the influenza vaccine among patients and healthcare workers are important to reduce the transmission of the disease, especially for high-risk patients. However, despite the proven efficacy of vaccinations, burden and burnout remained the primary barriers. A wide range of reasons for denial had been identified in all communities, including the frequency that vaccinations are required, vaccine side effects, misconceptions of the need to vaccinate, and the lack of trust in the government/healthcare system. Another major barrier the Network worked with facilities to improve was the lack of reliable data capture on influenza vaccination. This occurred for many reasons, ranging from poor vaccination tracking mechanisms to computer issues in downloading data. The Network created focused strategies to deal with each data capture issue throughout the program year.

Best Practices Spread to Achieve Goals

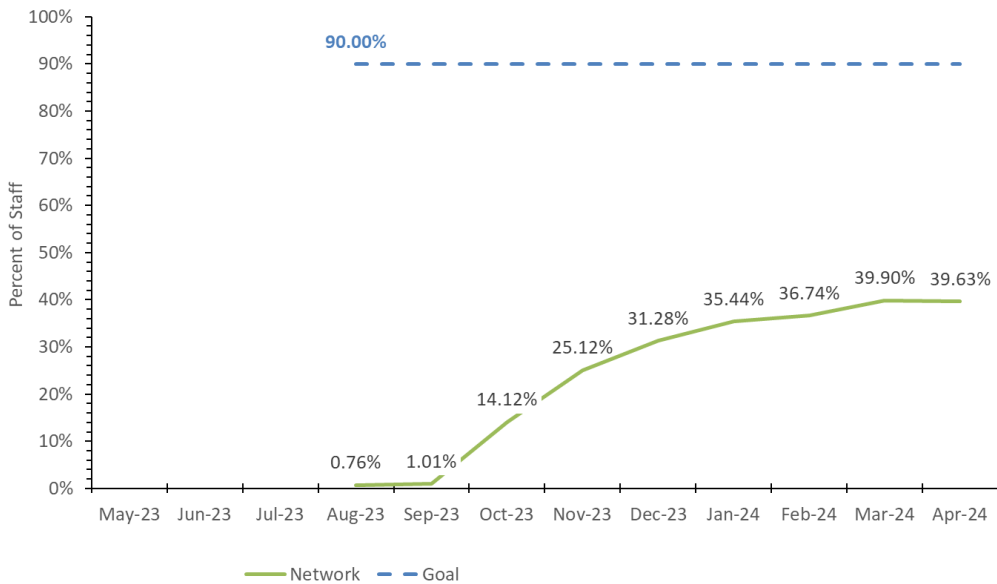
One of the most important steps the Network took was to facilitate discussions during Open Office Hours calls as well as on quarterly national calls. The use of open dialogue allowed low performing facilities to learn best demonstrated practices from high performing facilities. While generally not conducive to covering large amounts of content, there were benefits to the interactive approach that included education, effective communication, understanding, and the ability to share ideas.

**Network 6: Percent of Dialysis Patients Receiving an Influenza Vaccination
May 2023 - April 2024**



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2024

**Network 6: Percent of Dialysis Facility Staff Receiving an Influenza Vaccination
May 2023 - April 2024**



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2024

COVID-19 Vaccinations (Patients and Staff) May 2023-April 2024

Project Overview

There have been many improvements in the prevention and treatment of COVID-19 since the pandemic started four years ago. However, the best protection remains staying up to date with COVID vaccination. A majority of new COVID cases in the U.S. reported during the performance period were caused by a sub-variant of the COVID-19 Omicron variant, known as XBB. The current monovalent vaccines released in the fall of 2023 are effective against these COVID virus strains. Elderly and immunocompromised individuals, such as those with kidney disease, are still at greater risk than others for infection, so immunization remains the best defense against serious illness and death for this population.

During the performance period, the Network focused efforts on working to:

- Ensure that a minimum of 80% of dialysis patients were fully vaccinated for COVID-19, including boosters, as determined by the Centers for Disease Control and Prevention (CDC) and/or CMS. Data for this measure is based on the NHSN, or another CMS approved data system.
- Ensure that a minimum of 95% of dialysis facility staff were 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.

Interventions

During the month of August 2023, the Network provided facilities with the *CDC Quick Reference Guide: Reporting up to date COVID-19 vaccination status through the COVID-19 Vaccination Modules* to help facility staff better understand what being “up to date” means for facility patients and staff. This document outlined some key points and examples for the current definition of up-to-date vaccinations. Facilities were asked to review their most recent facility performance reports, cross-reference them with their internal facility data and then compare it against the outlined criteria.

The Network also reached out to facilities to inquire if any of their patients’/staff members’ barriers to vaccination was related to insurance. Based on responses, the Network provided facilities with a resource that enabled them to locate nearby agencies offering free vaccinations; The Biden administration released the *Bridge to Access Project*. A program that offered free COVID-19 and influenza vaccines to individuals with limited or no insurance through 2024.

Outcomes

The Network’s efforts resulted in the following outcomes in the Network’s service area at the end of the performance period: The Network did not exceed or meet the goal of 80% for patients and 95% for healthcare workers. A total of 3,309 (3.48%) of patients and 745 (2.01%) facility staff members received the COVID-19 vaccination.

Barriers to Achieving Goals

The Network actively addressed significant barriers related to COVID-19 vaccination among patients and staff. A significant barrier was the prevailing confusion surrounding vaccination stemming from factors such as burnout, fatigue, mistrust, and misunderstanding. In addition, following multiple rounds of vaccinations mandated during the pandemic, the sense of urgency and need for additional vaccinations was challenged by many patients and staff members.

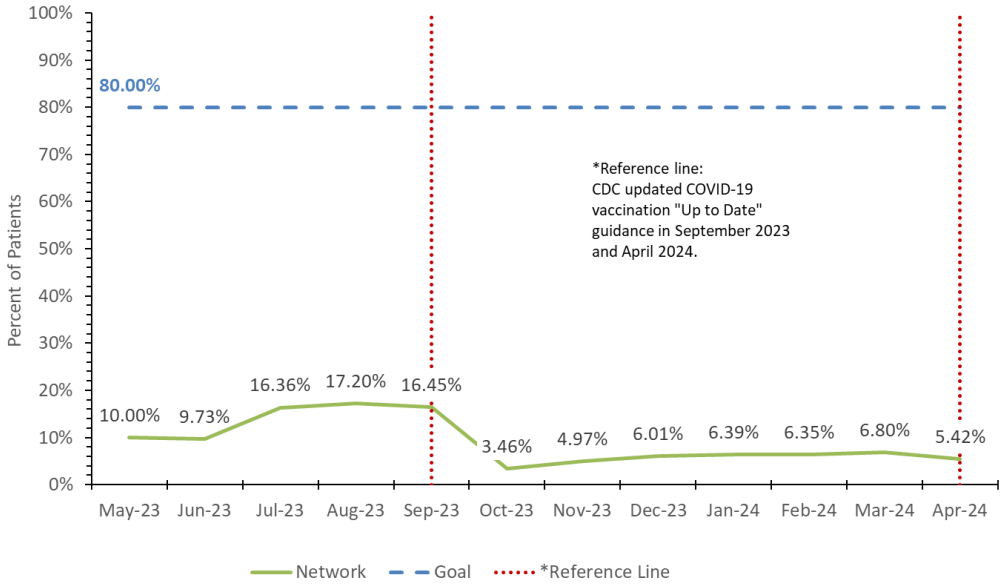
Cultural narratives often cite religion or political ideology as sources of skepticism and conflict with science, further complicating vaccination efforts. Theological issues that raise moral questions or influence individuals' attitudes about the COVID-19 vaccine tend to generate more skepticism among religious individuals. Similarly, political ideology plays a role, with individuals viewing free will and self-determination as primary drivers of outcomes and reacting negatively to perceived restrictions on their freedom.

These factors all contributed to the overall confusion and disruptions in vaccine administration, particularly in the fall of 2023. In addition, a significant percentage of dialysis facilities did not offer the new monovalent vaccine onsite, another factor leading to a lower reported rate of COVID-19 vaccination among both patients and staff.

Best Practices Spread to Achieve Goals

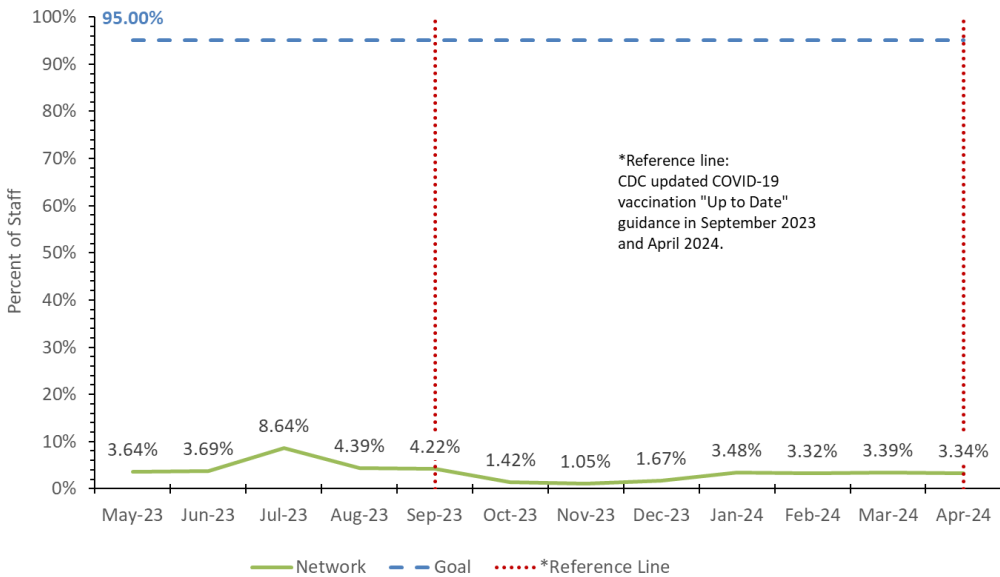
Via 1:1 onsite and virtual assistance, the Network presented and facilitated sharing of best demonstrated practices with facilities in its service area in order to demonstrate how facilities who had achieved high levels of COVID vaccination had made their goals. In addition, the Network advised facilities on changes to the CMS Quality Incentive Program, which started to include reporting on the vaccine status of healthcare workers as a performance measure linked to facility payment. In addition, clinics were provided guidance on how to educate their patients about the importance of staying up to date with vaccinations targeted for seasonal variants.

**Network 6: Percent of Dialysis Patients That Are Up to Date with COVID-19 Vaccines
May 2023 - April 2024**



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2024

**Network 6: Percent of Dialysis Facility Staff That Are Up to Date with COVID-19
Vaccines
May 2023 - April 2024**



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2024

Pneumococcal Vaccinations (PCV13 & PPSV23) May 2023-April 2024

Project Overview

Pneumococcal pneumonia is an infectious, potentially serious bacterial lung disease that is spread from person to person through coughing or close contact. It is defined as an infection of the upper respiratory tract that can inflame air sacs in one or both lungs. According to the Pharmacy Times, “pneumonia accounts for more than 50,000 annual deaths, 423,000 emergency department visits and \$16.2 billion in healthcare costs³.” Common symptoms, such as high fever, coughing, and chills can vary for all age groups; however, those who suffer the most tend to have chronic health conditions. The most vulnerable patients are those with immunocompromised systems, which includes individuals with ESRD.

During the performance period the Network had a goal to increase the adult pneumococcal vaccine rate for adults by 20% over the previous year’s rate. The Network was committed to implementing quality improvement strategies in its service area that would result in 90% of adult dialysis patients and 85% of dialysis patients age 65+ receiving the vaccine.

Interventions

The Network provided 1:1 technical assistance to facilities that had a minimum of 30 in-center patients and had less than 50% percent of both patients and healthcare staff vaccinated.

All facilities in the Network’s service area were provided with performance reports to give staff an opportunity to review the accuracy of the data. Each report documented the results of patients’ pneumococcal vaccine records and a listing of patients served by that facility who were due for vaccination. Facilities were also provided tools on the most current CDC standards related to requirements for being up to date with the pneumococcal vaccine. These tools included: *Pneumococcal Vaccine Timing for Adults*, a guide to help clinicians select the correct vaccine at the right time for their adult ESRD patients, and *Pneumococcal Vaccination: Summary of Who and When to Vaccinate*, a resource that provides CDC guidance on vaccination options for adults who had previously received a pneumococcal conjugate vaccine.

Facilities were polled to evaluate the effectiveness of the resources in improving staff members’ understanding of the pneumococcal vaccination pathways. Sixty-three percent (486) of the facilities in the Network’s service area completed the intervention and agreed the information provided a better understanding of the vaccination pathways for pneumococcal equating to a 95% Adapt/Adopt rate.

³ Laressa Bethishou, P. (n.d.). *Pneumonia vaccines: Current recommendations and advocacy opportunities*. Pharmacy Times. <https://www.pharmacytimes.com/view/pneumonia-vaccines-current-recommendations-and-advocacy-opportunities>

Outcomes

During the performance period, the Network's efforts resulted in a 10% increase over baseline in the number of adults receiving the adult pneumococcal vaccine. The remeasurement rate for adult dialysis patients receiving the adult pneumococcal vaccine was 23,063 patients vaccinated (46%).

Barriers to Achieving Goals

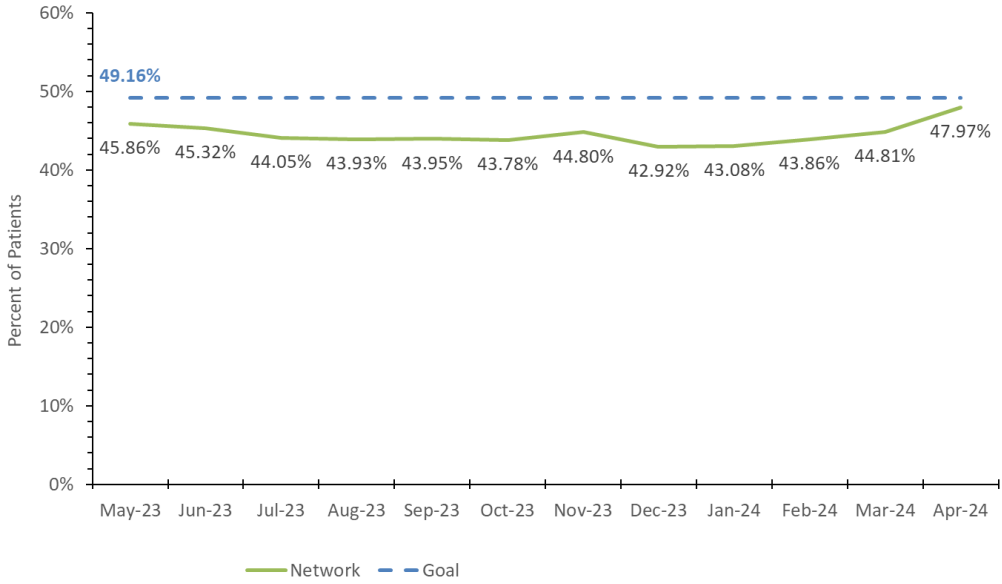
Barriers to achieving goals were primarily due to a lack of awareness of the requirements of the CDC's "up to date" guidelines, especially considering the different vaccines that were available and the different time ranges for administration. Vaccine hesitancy continued to be an ongoing barrier.

Best Practices Spread to Achieve Goals

Data quality in healthcare is crucial when dealing with patient medical records, especially regarding vaccination history. The accuracy and completeness of the medical data can directly impact the value of vaccination history. A best practice shared was the Network engaging audiences to participate in group meetings (e.g., Open Office hours, ESRD NCC Best Practice and Learning and Action Network calls), to discuss the importance of data accuracy and the newly recommended PCV20. These meetings provided feedback on the benefits of reviewing reports for accuracy, cross referencing with internal electronic medical records (EMR) and updating the national database with "up to date" vaccines given to patients. In addition, high performing facilities were asked to spread best practices to low performing clinics within the Network's service area.

Another best practice was to connect with regional management of large dialysis organizations to collaborate on ways to overcome the barriers associated with the administration of pneumococcal vaccinations in the facilities they managed.

**Network 6: Percent of Dialysis Patients That Are Fully Vaccinated for Pneumococcal Pneumonia
May 2023 - April 2024**



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2024

Data Quality (2728 Forms Over 1 Year, CMS Form 2728, CMS Form 2746) May 2023-April 2024

Project Overview

Network 6 worked with dialysis facilities in its service area to improve the timely submission of CMS Forms to CMS through the End Stage Renal Disease Quality Reporting System (EQRS). The Network's efforts focused on increasing the rate of timely submission for the following forms:

- **The Initial 2728 New ESRD/Medicare Application Forms - More Than One Year Past-Due submission.**

The Network worked with facilities to increase the number of Initial 2728 Forms that were more than one year past their 45-day due date. The CMS goal was a 1% increase in the number of 2728 Forms submitted during the baseline period, or the prior performance period.

- **The Initial 2728 New ESRD/Medicare Application Form - due within 45 days of a 'New ESRD' admission.**

The Network worked to help facilities increase the rate of timely submission of Initial 2728 Forms by 4% as compared to the baseline rate, which was recalculated using the prior performance period data. The rate was calculated to exclude 2728 Forms that were more than one year past due, using the number of 2728 Forms submitted on time divided by the number of total 2728 Forms submitted in the most recent 12-month period.

- **The 2746 Patient Death Notification Form - due within 14 days of Date of Death.**

The Network also worked with facilities to increase the rate of timely submission of 2746 Forms by 9% as compared to the baseline rate, which was recalculated using the prior performance period's data. The rate was calculated using the number of 2746 Forms submitted on time divided by the number of total 2746 Forms submitted in the most recent 12-month period.

Interventions

Network 6 continually trained facility staff on ways to maintain accurate contact information to ensure that appropriate staff members received timely communications, including detailed instructions and announcements intended to help facilities meet CMS deadlines. Facilities in the Network's service area received weekly EQRS Cleanup Reports itemizing Forms due in EQRS, as well as reports of patients who required corrections in EQRS so that Forms, such as 'First Admit Not New ESRD' were made available for completion and submission.

The Network sent each facility a monthly EQRS Form Compliance Report Card, which included the facility's timely submission rates for each Data Quality measure during the performance period, as well as a list of EQRS Unique Patient Identifiers (UPIs) that were not submitted within the required time frames. The Network routinely instructed staff at facilities that were out of compliance to examine the possible causes that contributed to late submissions and to establish processes to ensure that the issues leading to the late submissions did not reoccur.

The Network prioritized efforts to assist facilities with submission of forms due within 10 days. Network staff called facility staff and sent additional reminders to be sure that facilities were assisted with any last-minute questions or issues that prevented the Forms from being submitted earlier.

The Network also provided hands-on support to mitigate ongoing challenges for facilities that continued to miss deadlines for 2728 or 2746 Forms.

Outcomes

For 2728 Forms over One Year, the goal was to submit 152 Forms. Network facilities successfully submitted 183 2728 Forms that were over 1 year past due.

For the 2728 Forms due within 45 days, facilities successfully submitted 7,788 Forms on time, for an 84.93% compliance rate.

For the 2746 Forms due within 14 days, facilities successfully submitted 6,085 Forms on time, for a 66.56% compliance rate.

Barriers to Achieving Goals

Dialysis facilities experienced significant staff turnover, which caused gaps in staff knowledge and understanding about EQRS, and for those facilities in which contact information was not current, the right personnel didn't receive the Network's communications about EQRS.

Facilities also continued to express challenges related to obtaining nephrologist signatures on the 2728 Form, specifically if the forms needed to be sent via fax to the nephrologist's office outside of the dialysis facility, or if the nephrologist who diagnosed the patient as having ESRD visited the facility only once a month.

The Network helped the ESRD NCC identify a report discrepancy that, when fixed, triggered several hundred new 2728 Forms to appear in EQRS for facilities to complete. Though these forms were critical to patients receiving Medicare benefits and getting waitlisted for a transplant, most of them were already outside of the 45-day timeliness window, and any submission counted against the facility's 2728 Form compliance rate.

CMS made improvements in EQRS by populating the database with previously missing data from the Social Security Administration on patients' Date of Death. This triggered the creation of thousands of 2746 Forms that were not previously available in EQRS. Most of these forms were beyond their 14-day timeliness period, causing a decrease in the facility's 2746 compliance rate once submitted.

After a 2728 Form or 2746 Form was submitted, any modifications made to it changed the submission date and often caused the form to appear as 'late' even if it was originally submitted on time.

For 2728 Forms, patient demographic information (such as the correct spelling of the name or complete Social Security number) or diagnosis code were, at times, not available to the facility within the first 45 days after a new admission. These omissions were sometimes identified only after the Social Security Administration reviewed the forms.

When completing 2746 Forms, facilities often were not made aware of the patient's cause of death within the first 14 days, especially if the patient was hospitalized. In such cases, the facility often selected 'unknown' as the cause of death, and later requested that the cause of death be updated once that information became available.

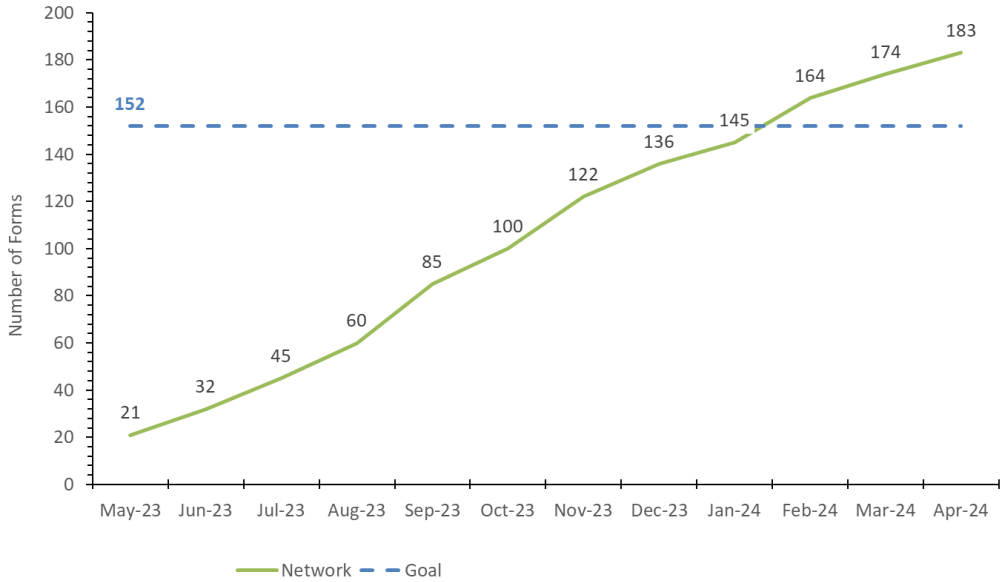
Best Practices Spread to Achieve Goals

The Network continually worked to engage facility staff in EQRS compliance improvement activities that included training opportunities, one-on-one support appointments, and *Live EQRS Help* webinars. Invitations to the *Live EQRS Help* webinars were included in all weekly Cleanup Reports and monthly EQRS Report Cards. Notices about the webinars were also included in the *Announcements* section of *IPRO Learn*, the Network's online education platform.

The Network used *IPRO Learn* to collect facility input on whether the Network-developed resources and instructions were clear and helpful, what best practices helped their facility stay timely with form submission, and what other types of support the Network should offer the facility at a critical time.

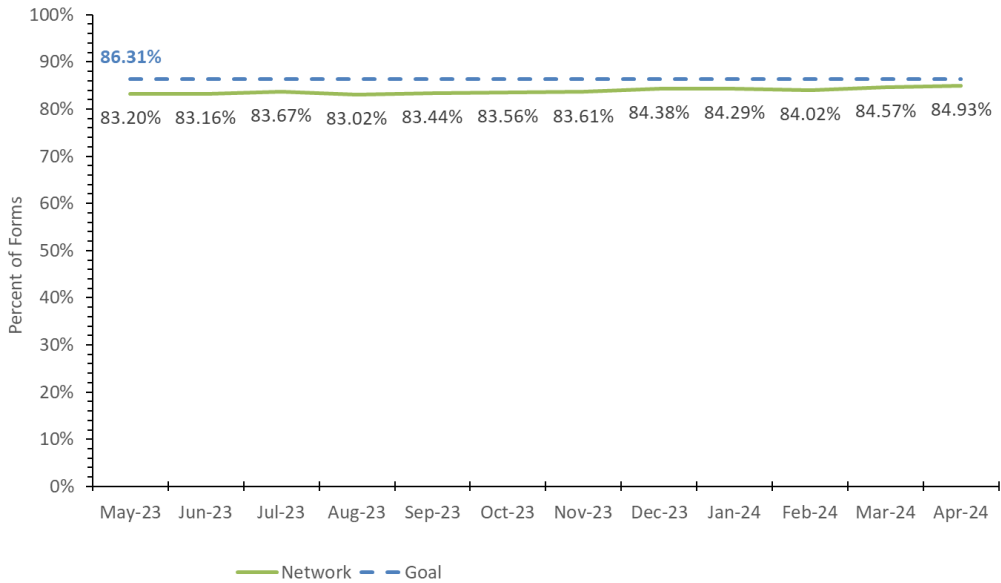
The Network collaborated with the data leadership teams of both large and small dialysis organizations by providing them with lists of facilities within their organization that consistently performed poorly or showed declining compliance, with a goal to facilitate corporate-level interventions to assist the struggling facilities.

**Network 6: Number of Incomplete Initial CMS-2728 Forms that are Over One (1) Year Old that are Completed and Submitted
May 2023 - April 2024**



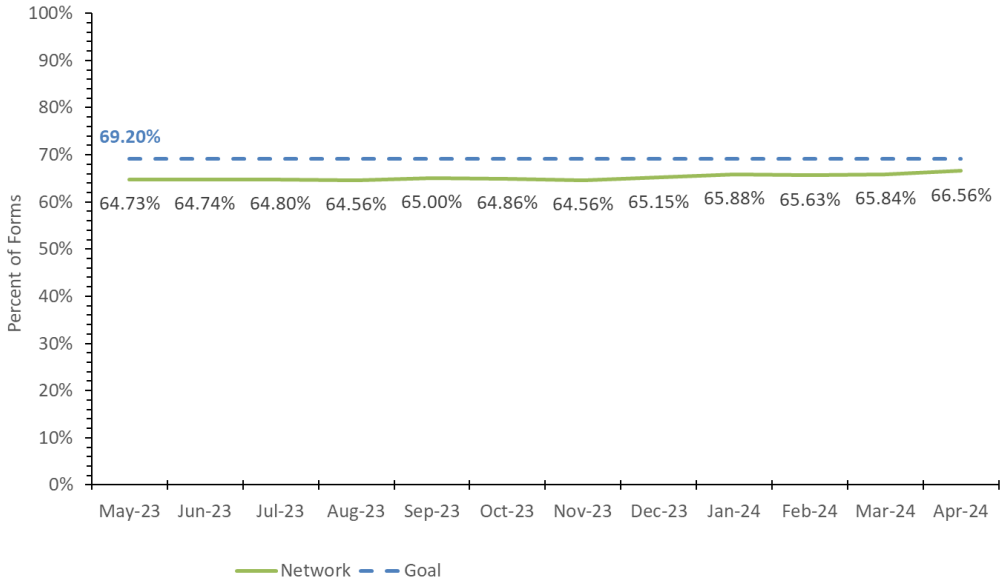
QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2024

**Network 6: Percent of Initial CMS-2728 Forms Submitted Within Forty-five (45) Days
May 2023 - April 2024**



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2024

**Network 6: Percent of CMS-2746 Forms Submitted Within Fourteen (14) Days of Death
May 2023 - April 2024**



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2024

Hospitalization (Inpatient Admissions, ED Visits, Readmissions) May 2023-April 2024

Project Overview

Individuals with ESRD are at a higher risk of requiring urgent medical attention, including hospital stays and emergency department (ED) visits, than are individuals with healthy kidneys. The need for acute care is elevated in dialysis patients due to conditions that led to kidney failure or changes in their physical state caused by kidney disease (e.g., diabetes, hypertension, cardiovascular disease, anemia, and blood chemistry imbalances). Dialysis patients are more susceptible to infections because of weakened immune systems.

People who frequently experience hospital stays and ED visits face higher risks of mortality and morbidity compared to those who rarely seek acute care. Considering these challenges, the Network worked with dialysis facilities and patients with ESRD to reduce, by 4% from baseline, ED visits, hospitalizations, and rehospitalizations (related to specific CMS Primary Diagnosis Codes) within 30 days after being discharged from a hospital stay. Baseline data was obtained from Medicare claims data between May 2022 and April 2023.

Interventions

The introduction of the Health Resources and Services Administration's (HRSA) Health Center Program was driven by the need to increase access to healthcare for the dialysis population and address the root causes of unnecessary ED visits and rehospitalizations. Root cause analyses conducted within the Network revealed that limited access to primary care services, particularly among vulnerable populations including individuals experiencing homelessness or residing in public housing, contributed to the reliance on acute care solutions.

To address this issue, the Network introduced a resource highlighting HRSA's Health Center Program, which specializes in serving underserved populations. By providing facilities across its service area with detailed information about the program while emphasizing the importance of access to care, the Network aimed to connect patients with appropriate healthcare resources and reduce reliance on emergency services.

Facilities were provided with direct links to identify nearby health centers, making it easier for patients to locate and access primary care services. This intervention aimed to empower patients to proactively manage their health needs, seek timely preventive care, and address medical concerns before they escalate into more serious issues requiring emergency treatment.

Outcomes

The Network's activities during the performance period resulted in facilities within its service area successfully achieving the targeted reduction rates for readmissions and ED visits, achieving a 10.2% readmission rate (goal: 10.27%) and a 0.64% ED Visit rate (goal: 0.67%). The Network came within 0.02% of the hospitalization reduction rate, achieving a 1.88% rate. Using the CDC's Center for Health Statistics calculated average inpatient hospital cost (2019) of

\$14,101⁴, the Network's efforts during the performance period resulted in a reduction of 801 hospital stays from the 2022 – 2023 baseline period and a savings of \$11,294,901.

Barriers to Achieving Goals

One obstacle the Network encountered was the difficulty in tracking patient hospitalizations and ED visits due to the lack of identifiable admitting primary diagnoses in the current dataset. The dataset provided to the Network contained 25 lines of ICD-10 codes, none of which indicated the primary admitting diagnosis. CMS prioritizes certain diagnosis codes, and if any of these codes appeared within the 25 lines of ICD-10 codes in the dataset, the Network automatically attributed the hospitalization to this key result. The complexity of the issue increased when the Network struggled to identify the primary admitting diagnosis, making it challenging to pinpoint the causes of preventable admissions/readmissions and provide facilities with strategies to reduce these types of hospitalizations.

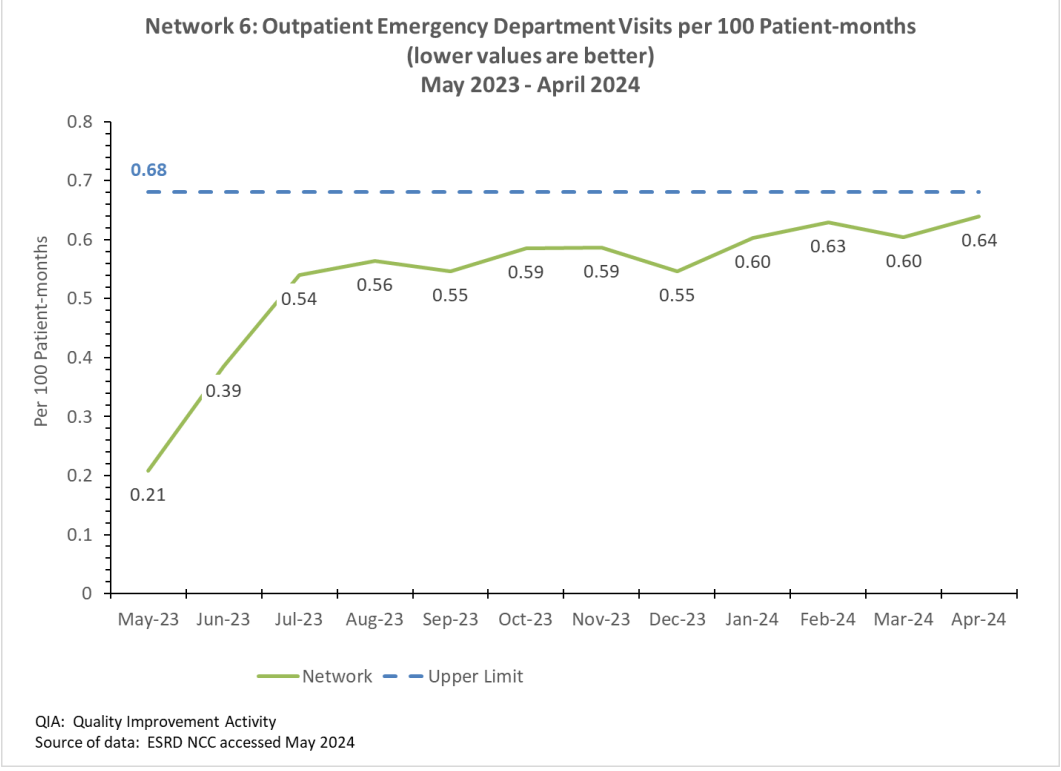
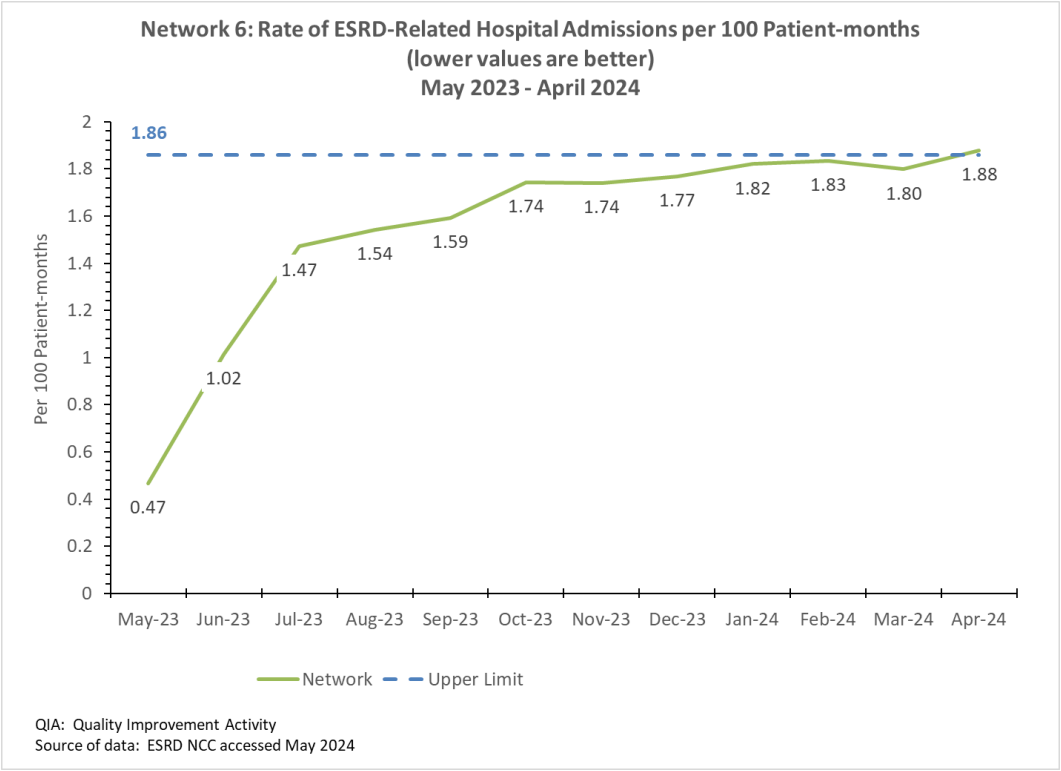
Best Practices Spread to Achieve Goals

During the ESRD NCC's LAN calls, the Network showcased the best practice efforts of facilities in its service area aimed at reducing hospitalizations. Among these efforts were several strategies implemented to address issues potentially leading to unnecessary hospitalizations and ED visits.

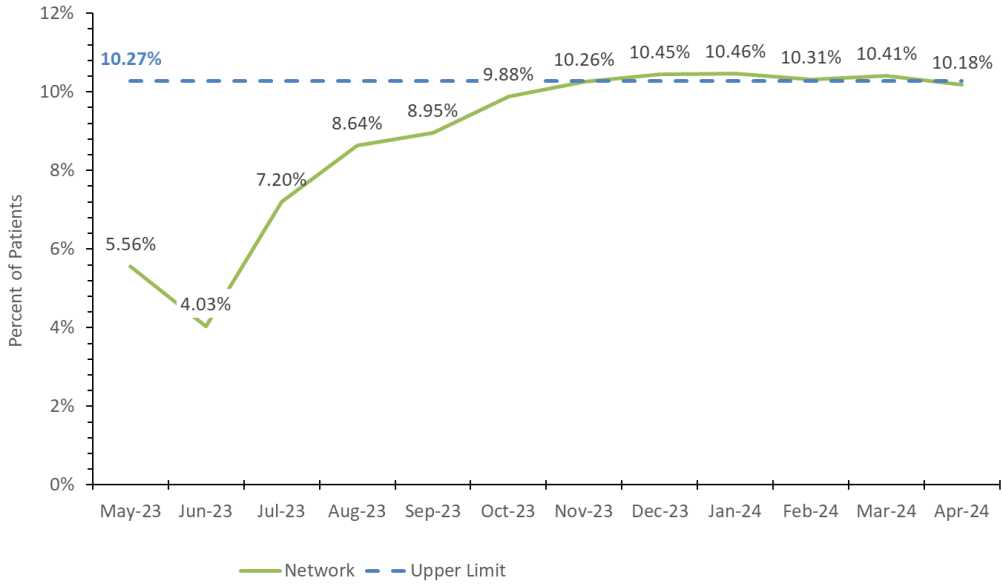
One such strategy involved the implementation of a structured script for handling calls from patients regarding missed treatments. This script provided staff with effective language to offer patients alternative times and dates to make up missed treatments, thereby fostering treatment adherence. The effectiveness of the script was in its ability to provide patients with clear options for rescheduling their missed treatments and minimizing the likelihood of missed appointments.

Another initiative introduced was the missed treatment board, featuring a unique theme each month. Patients who attended their scheduled treatments were represented on the board, demonstrating their progress. This approach aimed to create positive reinforcement and motivate attendance.

⁴ Cost savings projected by using <https://www.cdc.gov/nchs/has/topics/hospitalization.htm> average adjusted cost per inpatient stay.



**Network 6: Hospital 30-Day Unplanned Readmissions (lower values are better)
May 2023 - April 2024**



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2024

Nursing Home (Blood Transfusion, Catheter Infection, and Peritonitis) May 2023-April 2024

Project Overview

Throughout the performance period, the Network was committed to addressing the healthcare needs of end-stage renal disease (ESRD) patients receiving dialysis in the nursing home setting, with a strong focus on improving the quality of care they received and ultimately improving their overall well-being and health outcomes.

These patients have higher rates of comorbidities and mortality compared to the broader ESRD population, as evidenced by data from the United States Renal Data System. The Network's objective was to facilitate the provision of high-quality care through successful care coordination by identifying and mitigating risks and improving patient safety practices, with a specific goal to reduce hemodialysis catheter infections, peritonitis, and transfusions.

In collaboration with ESRD providers offering dialysis within nursing home settings, as well as nursing home facilities, patients, and other stakeholders, the Network worked to enhance patient safety, reduce harm, and improve care for ESRD patients residing in and receiving dialysis treatments in nursing homes. The Network's activities focused on achieving a 6% reduction in hemodialysis catheter infections, 3% decrease in cases of peritonitis and a 3% reduction in blood transfusion rates for nursing home facilities providing dialysis.

Interventions

To improve patient care coordination for individuals undergoing dialysis treatment while residing in nursing homes, the Network implemented a collaborative intervention with the Quality Innovation Network – Quality Improvement Organization (QIN-QIO) working within the same region.

One of the primary interventions was distribution of an updated *Dialysis-Nursing Home Hand-Off Tool* that was a product of the collaboration between the QIN-QIO and the Network. Recognizing the critical role of effective communication in healthcare, especially during transitions of care, the Network aimed to address communication challenges between dialysis providers and nursing home staff. The *Dialysis-Nursing Home Hand-Off Tool* was designed to streamline communication, ensure continuity of care and reduce adverse events that may occur during care transitions.

The intervention emphasized the importance of robust communication between healthcare providers in ensuring optimal patient outcomes and reducing the likelihood of adverse events. Providers were encouraged to integrate the *Dialysis-Nursing Home Hand-Off Tool* as one of their standard procedures. The Network facilitated the implementation of this tool and solicited feedback from providers to continually improve its effectiveness. The tool was then shared with a leading dialysis provider for nursing home dialysis, which in turn distributed it to the nursing homes they serviced. To further promote adoption, the tool was uploaded to the *I PRO Learn*

platform, allowing facilities to review and provide feedback. Out of 431 facilities that reviewed the resource, 320 indicated they would adopt it. This widespread adoption helped standardize communication between dialysis providers and nursing homes, thereby reducing errors and improving patient outcomes. By addressing the critical transition points in patient care, the tool contributed to a decrease in infections and transfusions, aligning with the goals of the project.

Outcomes

The Network's efforts during the performance period resulted in the following results for nursing home dialysis providers in the Network's service area:

- Success in attaining the 6% reduction goal in the rate of hemodialysis catheter infections from 0.58 at baseline to 0.28 at remeasurement
- Success in attaining the 3% reduction goal in the rate of transfusions from 9.88 at baseline to 6.05 at remeasurement
- Success in attaining the 3% reduction goal in the rate of peritonitis from 4.48 at baseline to 3.49 at remeasurement.

Barriers to Achieving Goals

In addressing an ongoing challenge with data entry in EQRS, specifically regarding the completion of a non-mandatory field related to patients' admissions to nursing homes, the Network encountered difficulties in accurately identifying patients with infections or transfusions. This issue arose because facilities often did not enter the nursing home admission date, leading to patients being mistakenly categorized as nursing home patients when they were not at the time of the incident. As a result, patients were inaccurately classified as living in a nursing home at the time of transfusion or infection, which complicated the identification and management of these incidents.

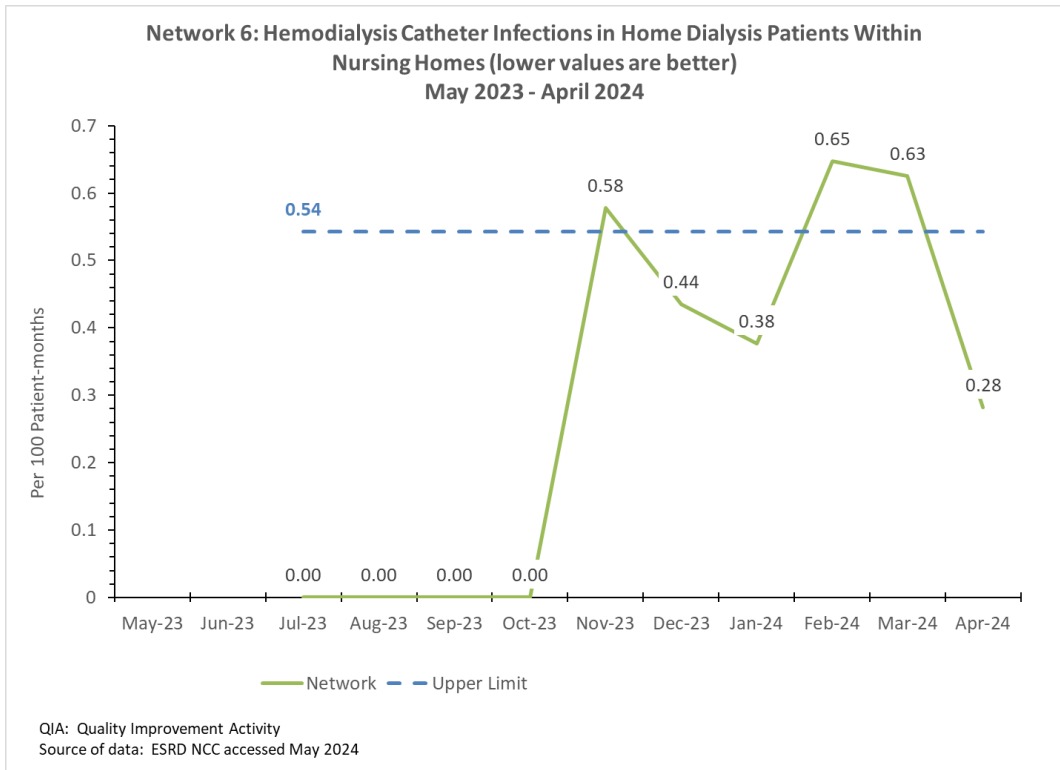
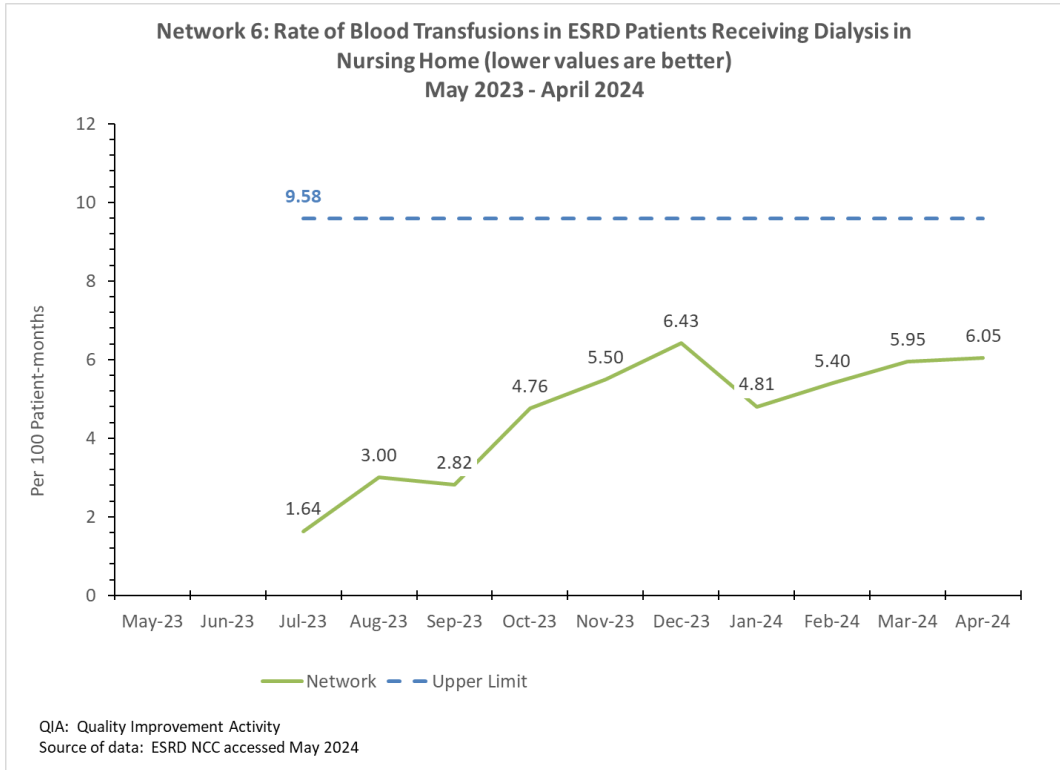
These challenges were exacerbated by the volume and acuity of patients. Network staff conducted in-depth reviews of the data and provided customized assistance to facilities based on issues identified through the reviews. Any systemic issues identified were forwarded to the ESRD NCC for further review.

Best Practices Spread to Achieve Goals

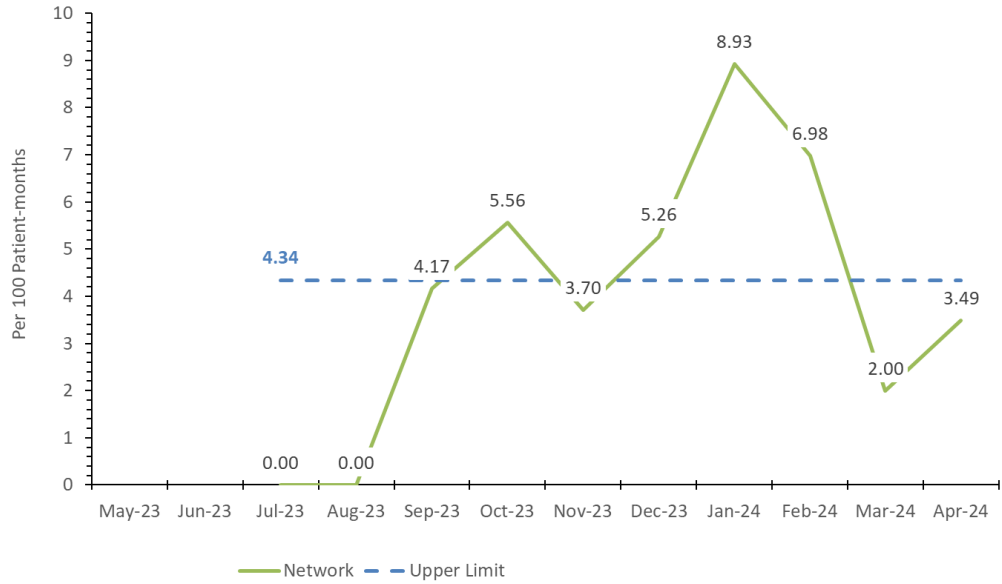
During an ESRD NCC Expert Teams call, the Network presented best practices in reducing transfusions identified by a leading dialysis provider operating in the nursing home setting. The dialysis provider shared information about its initiative aimed at eliminating unnecessary blood transfusions. This call was attended by all 18 ESRD Networks and included dialysis facility personnel. The following features were identified and presented as best practices by the dialysis provider

- Establishing a dedicated anemia management team
- Conducting monthly reviews of all incidents and performing root cause analyses in collaboration with the Network
- Implementing changes in the dosage of erythropoietin stimulating agents (transitioning from Aranesp once weekly to Epogen three times a week)
- Reducing the incidence of missed doses

- Having the ability to make immediate dose adjustment.



Network 6: Peritonitis Events in Home Dialysis Patients Within Nursing Homes
 (lower values are better)
 May 2023 - April 2024



QIA: Quality Improvement Activity
 Source of data: ESRD NCC accessed May 2024

Telemedicine May 2023-April 2024

Project Overview

Telemedicine has been found to be a useful tool to improve access to care for home dialysis patients who live in rural settings and a long distance from their care team. During the performance period, the Network focused on increasing by 3% the number of patients living in rural areas who participate in telemedicine visits. Based on zip codes, the Network identified facilities that had rural patients and then worked with this group of facilities as a community coalition to share information, interventions, and resources to improve use of telemedicine with their rural patients on home dialysis,

Interventions

Patients who live in rural areas may have limited access to care, and telehealth can help link them to their dialysis care team. The Network shared an article, *Preparing for a Telehealth Appointment with Older Adults* with facilities in its service area. The article provided insight about sensory and motor changes as well as cognitive changes that most older adults experience, as well as strategies for providing technology support. When asked if facilities planned to incorporate this intervention into their practice, of the 68% that completed the intervention, 84% responded by saying they would adopt this resource.

The Network compiled a telemedicine toolkit with resources to help facilities implement telemedicine. The toolkit, which included the following resources, was available on *IPRO Learn*:

- Telehealth visit checklist for providers
- Resources providing assistance with using the internet.
- Resources to help with use of smart devices and laptops.

The Network distributed report cards to all participating facilities as a tool to track their rural patients who were participating in telemedicine visits. The monthly report cards provided each facility with its own performance on key metrics that included their goal, as well as their progress in reaching their goal. The Network also worked with facilities to help identify patients who had not yet had a telemedicine visit but would benefit from one.

Outcomes

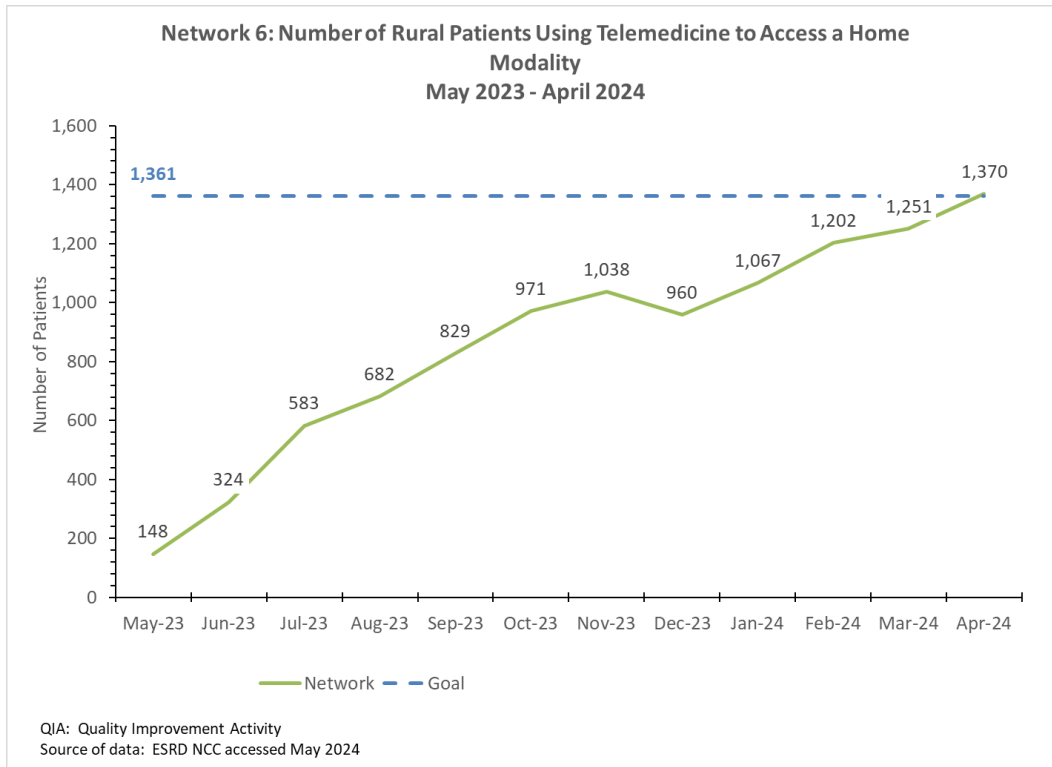
Working closely with the dialysis facilities in the community coalition, the Network 6 team met the goal to increase use of telemedicine visits in its service area by 3%, for a total of 1,370 rural telemedicine visits during the performance period.

Barriers to Achieving Goals

One barrier to implementation of telemedicine was that some facilities were not tracking patients who were participating in telemedicine visits and didn't identify patients in rural areas who might benefit from telemedicine. This barrier was mitigated by implementation of the monthly report cards, as described above.

Best Practices Spread to Achieve Goals

During the month of January 2024, the Network invited all facilities that were either located in a rural zip code or that had a patient who used a home modality and lived in a rural zip code, with a request to send the Network a telemedicine success story. These success stories were posted to *the IPRO Learn* platform. One facility stated that telemedicine was able to help them continue to see patients who were ill or recovering from surgery.



Depression Treatment September 2023-April 2024

Project Overview

Dialysis patients encounter both psychosocial and biological changes when faced with ESRD. These changes often lead to an increased risk for depression within this population. Patients who are depressed have a diminished quality of life and are at greater risk of mortality due to the negative effects of depression on physical health. Increasing screening as well as increasing the number of patients who screen positive and receive treatment were the goals of this quality improvement activity. Specifically, the Network's efforts focused on attaining a minimum rate of 80% of ESRD patients being screened for depression, and once screened positive, the goal was to achieve a 10% improvement in the number of patients who received treatment. During the performance period, CMS removed the depression treatment metric as a goal; however, it remained a top focus for the Network.

Interventions

The Network worked closely with facilities in its service area to understand why patients were not seeking treatment for their mental health issues. The Network engaged facilities in this effort through its community coalition; by providing technical assistance to individual facilities; and by sharing resources, supporting interventions, and requesting feedback on interventions using *IPRO Learn*.

Community coalitions, comprised both high- and low-performing facilities, completed a root cause analysis (RCA) and implemented a PDSA cycle. The barriers to mental health treatment most commonly identified in coalitions across the Network service area included stigma and shame, lack of interest by patients, and limited access to services. Once these barriers to treatment were identified, the Network worked to create strategies and identify resources to assist facilities in mitigating those barriers. These strategies included sharing resources and best practices as well as providing on-site technical assistance.

The Network developed a new patient resource, *Working Through Feelings of Loss and Sadness*, to help patients understand the emotions and reactions common to many individuals who receive a diagnosis of a chronic condition such as ESRD. The resource also highlights the importance of seeking treatment, should patients identify with any of the feelings discussed. This resource was shared during a PFR call and with the facilities in the Network's service area via the *IPRO Learn* platform. Of the 546 facilities that viewed this resource on *IPRO Learn*, 93% reported that they would adapt/adopt this resource for their practice.

One of the most widely used resources shared on *IPRO Learn* was the ESRD NCC *Depression Change Package*. This resource shared strategies that facilities could incorporate into practice to promote a culture of trust and caring for patients, which would allow patients to feel more comfortable discussing and addressing depression with the dialysis healthcare team.

Outcomes

During the performance period, CMS removed the depression treatment metric from the Network's goals. However, the Network continued to monitor facilities for both their depression screening and treatment rates. Overall, facilities in the Network's service area screened 99.59% of patients for depression and had a depression treatment rate of 11.17%.

Barriers to Achieving Goals

While working closely with facilities, the Network identified several barriers common to patients across the Network service area that prevented them from seeking treatment for mental health issues. These barriers include stigma, shame, and lack of patient interest.

The Network also found that many patients receive treatment through pastoral care, peer mentors, patient support groups, or through other mental health providers that do not bill through Medicare. Treatment received by patients through these services is not tracked and therefore not included in the outcome metric.

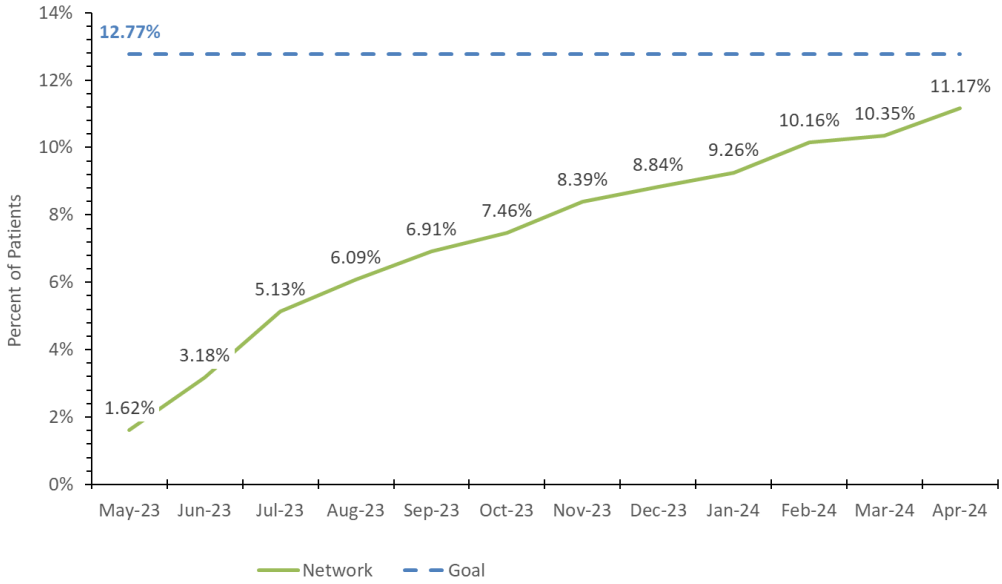
Best Practices Spread to Achieve Goals

The Network started a post in its *IPRO Learn* Behavioral Health Forum titled *Share Your Success Stories* in mental health treatment. In addition to sharing success stories, facilities were able to view success stories that other facilities had shared. A total of 174 facilities from the Network's service area shared a success story. Additionally, facilities that did not share stories still had the opportunity to review and potentially adopt best practices described by others.

The Network presented on an ESRD NCC Depression Community of Practice call, sharing best practices used by a nephrologist working within the facilities to help increase depression treatment rates. The nephrology team developed a resource binder to increase staff knowledge on warning signs of depression, contact information for local mental health providers, and what to do for mental health emergencies. Additionally, the nephrologist normalized reviewing patients' depression screenings when rounding and during an annual wellness visit, while creating a team approach to addressing mental health issues. This practice also created an algorithm for providers to use when prescribing medications that treat depression, including dosages that are safe for ESRD patients.

On an ESRD NCC Expert Teams call, a high performing facility in the Network's service area presented a case study demonstrating how their use of motivational interviewing and applied behavioral analysis helped patients gain a new sense of hope. They found that this led to an increase in patient compliance and an overall improvement in patients' mental and physical health.

**Network 6: Percent of Patients, Within the Subset of Patients Identified as Having Depression, Who Have Received Treatment by a Mental Health Professional
May 2023 - April 2024**



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2024

Patient and Family Engagement May 2023-April 2024

Project Overview

A major focus common to all CMS quality improvement activities is the engagement of patients, care partners, and family members in the design, delivery, and evaluation of the patient's care. The strategy is based on proactive, clear, appropriate communication, collaborative decision-making, and building relationships with patients that are based on trust and inclusion of individual values, preferences, needs, and beliefs.

In this project, the Network worked to incorporate the patient's voice at the facility level through inclusion of patients in the development of plans of care that include life goals and peer mentorship and in incorporating the patient perspective in quality improvement activities.

The Network focused on achieving four goals throughout this performance period:

1. Increase the number of facilities in which the patient's voice is incorporated into facility Quality Assurance and Performance Improvement (QAPI) meetings by 30%.
2. Increase the number of facilities that assist patients in developing a life plan by 30%.
3. Increase the number of facilities that successfully develop and support a patient-patient support program by 15%.
4. Maintain a patient attendance rate of at least 60% for the National Patient and Family Engagement (N-PFE) LAN.

Interventions

Assembly of a Patient Facility Representative Alliance

The PFR Alliance is an organized group of dialysis and transplant patients, family members, and care partners who volunteer their time to represent the Network in their dialysis or transplant facility and represent the perspective and concerns of their facility to the Network. Throughout the performance period members of the Alliance reviewed and provided input on the quality improvement work conducted by the Network; contributed their perspectives in the creation of resources and patient education materials that were being developed; shared resources and education with patient peers within their facilities; and worked within their facilities to improve patient engagement in care.

Release of education and interventions via IPRO Learn

The Network released educational resources and tools on its online education platform, *IPRO Learn*, to teach facility staff strategic ways to incorporate the patient perspective in QAPI activities. These resources were based on best practices and addressed topics such as giving the patient options in how they want to be involved in meetings (e.g., presenting in person via a written report, or by calling in to the meeting). In addition, the Network shared educational resources with facility staff, including the *Professional Module: Patient Engagement in QAPI*, a resource that distills QAPI into basic levels for the provider and illustrates opportunities in which patient concerns can contribute to the success of the facility's quality improvement activities.

Inclusion of Patient and Family Engagement in Community Coalition Project Cycles

Patient and family engagement (PFE) principles were incorporated into community coalition quality improvement processes. Within the community coalitions, the Network led facility staff members through a quality improvement process, or a PDSA cycle. Throughout this cycle, the Network guided facility staff in changes that should be implemented monthly at the facility level and at the patient level to generate the most successful quality improvement outcomes. The patient level activities included a focus on learning and executing life planning to support positive change as well as inclusion of the patient into QAPI.

Strengthening the Peer Mentor Community

With a strong history of building and sustaining a successful peer mentorship program, the Network continued to recruit and train interested patients in the principles and skills required to be a peer mentor. Interested patients were recruited from the PFR Alliance roster and via facility staff nominations as well as through outreach strategies deployed at the conclusion of the community coalitions' project cycles. Once recruited, patients participated in training that occurred once a month in a virtual format.

Supporting Participation in N-PFE LAN Activities

In support of the ESRD NCC, the Network recruited five patients to participate in the N-PFE LAN activities and monitored participation by:

- Providing reminders to members in advance of meetings using Text-Em-All, a mass messaging platform that delivers personalized text messages and direct phone calls to large groups, and direct phone calls to promote attendance and active participation
- Offering patients technical assistance to help in completing the required pre-work surveys
- Recruiting new patients for inclusion in the group in the event an existing patient no longer wanted to continue their involvement.

Outcomes

The Network's activities during the performance period contributed to

- An additional 271 facilities in the Network's service area integrating the patient perspective in QAPI, a rate of 35.33%
- 424 facilities assisting patients in developing a life plan, a rate of 55.28 %
- An additional 119 facilities developing and supporting a patient-to-patient support program, a rate of 39.24%
- Maintaining an attendance rate of 64% of all patients for N-PFE activities throughout the year.

Through collaborative efforts with the PFR Alliance, dialysis facility community coalition work, and onsite technical assistance, the IPRO ESRD Network of the South Atlantic was also able to expand the PFR Alliance to 216 new ESRD patients and care partners.

Barriers to Achieving Goals

Despite the success in meeting the goals during this performance period, barriers related to facilities' willingness to incorporate patients into QAPI still existed. Facilities noted HIPAA concerns as the primary cause of this lack of engagement. Others reported that barriers to inclusion in QAPI involved a lack of patient interest in participation or, for some facilities, not having a suitable patient candidate to involve in the process.

Effectively reaching all PFR patients was an area of concern. To support effective communication with patients, the Network adopted a variety of platforms including social media (Facebook and Instagram), broadcast texting (Text-Em-All), Emails, virtual PFR Alliance meetings, and direct phone calls. In addition, Network staff met regularly with the PFR Alliance members to discuss barriers related to patient care and issues they may be facing in their facilities; and to gain their insight and perspective on quality improvement educational resources and interventions in development. Maintaining ongoing communications in ways that addressed and met the communication needs of the PFRs helped to overcome previously existing communication gaps between the Network and PFR Alliance members.

Best Practices Spread to Achieve Goals

Partnering with the American Kidney Fund, Home Dialyzors United, and the Chronic Kidney Disease Champions, the Network hosted a patient symposium for more than 80 patients and care partners titled *Living Your Best Life with Kidney Disease*. During this symposium, patients and their care partners heard from others in the kidney community about best practices in health equity and treatment modalities, and ways they can live their best life with kidney disease.

Health Equity May 2023-April 2024

Project Overview

The Network worked to address health inequities to ensure that every ESRD patient within its service area has the opportunity to attain his or her full health potential and that no one is disadvantaged from achieving their potential because of social position or other socially determined circumstances. The Network strove to drive improvements in patient care by identifying health disparities and implementing strategies to improve health equity.

Disproportionate poor health outcomes were identified through data gathered from the ESRD NCC and data analysis conducted by the Network. This analysis determined the direction of the Network's health equity work by identifying facilities that performed poorly in specific program objectives and key results areas.

Interventions

Addressing disparities associated with the lack of access to quality food was a focus in the Network's health equity work. Facilities located in neighborhoods with high area deprivation index (ADI) scores and priority zip codes were considered based on the correlation of food deserts and high ADI areas⁵. The Network conducted an environmental scan to identify the screening process used to identify existing social determinants of health (SDOH), including food insecurity, at all dialysis facilities. While most facilities were already screening for SDOH barriers, the Network assisted facility staff in streamlining the screening process by providing CMS SDOH screening expectations for future QIP measures.

The Network also provided interventions for patients that could be distributed once food insecurity was identified. These interventions included a toolkit to implement a food drive at the dialysis facility. In addition, renal friendly shopping lists were distributed to help patients independently follow a renal diet. Facilities were encouraged to adopt these innovative practices to address food insecurity, while also promoting a healthy diet. Interventions included disseminating educational resources to patients, incorporating ways to distribute renal friendly foods at dialysis facilities, and building partnerships with local food banks and pantries.

The Network used data to further explore specific areas where barriers to adoption of home dialysis modalities were identified. The data showed that geographic barriers, whether they affected rural areas or urban areas, contributed to the utilization rates for home dialysis. Additional barriers identified included low health literacy, lack of preventive education, and lack

⁵ Agarwal, S., Fertig, A. R., Trofholz, A. C., Tate, A. D., Robinson, J., & Berge, J. M. (2022). Exploring the associations between neighbourhood food environment, household food insecurity and child weight-related outcomes in socio-economically and racially/ethnically diverse families. *Public health nutrition*, 25(12), 1–10. Advance online publication. <https://doi.org/10.1017/S1368980022002130>

Jin, H., & Lu, Y. (2021). Evaluating Consumer Nutrition Environment in Food Deserts and Food Swamps. *International journal of environmental research and public health*, 18(5), 2675. <https://doi.org/10.3390/ijerph18052675>

of social support at home. In rural locations across the three Network states, the Black population was disproportionately affected due to these SDOH. This resulted in the Black population having the lowest rates of home dialysis utilization when compared to their White counterparts. One-on-one meetings between the dialysis facilities and the Network were scheduled to address the identified barriers and gain insight about other factors contributing to low rates of home dialysis modalities. The Network worked directly with facilities to address the related issues by providing health literacy training, sharing best practices, and identifying local resources from community-based organizations.

Culturally and Linguistically Appropriate Services (CLAS)

May 2023-April 2024

Project Overview

The Network designed and executed an approach to support education and implementation of CLAS standards for staff at small, medium, and independent dialysis facilities. In addition, the Network collaborated with the ESRD NCC on the development of a CLAS implementation action plan for LDOs.

Interventions

To advance health equity and improve the quality of care provided to all patients, the Network encouraged dialysis facilities to adopt CLAS standards. The Network distributed to all facilities in its service area an assessment to gather data on facility staff members' baseline knowledge about CLAS standards. Analysis of the baseline CLAS assessment showed that LDOs had a better understanding of CLAS standards but were unfamiliar with the acronym "CLAS." Many of the LDOs referred to activities included in implementing CLAS standards using other terms, such as Diversity, Equity, and Inclusion or Cultural Competency Training. Data analysis of the assessments of small, medium, and independent dialysis facilities presented various areas for improvement in their understanding of CLAS standards and ways that CLAS could be integrated into their current policies and procedures for implementation.

The Network developed and distributed monthly training modules via its online education platform, *IPRO Learn*. Each training module focused on a CLAS theme and the corresponding standards and was followed by an assessment to gauge staff members' understanding of the module and improvements in the staff's baseline knowledge. One-on-one technical assistance was provided to facilities when assessments indicated a lack of understanding of CLAS standards, incorrect implementation of CLAS standards, or if additional support was requested.

The Network worked with facilities to identify barriers to specific CLAS standards and introduced resources and strategies to overcome these issues. To conclude the training, the facilities were given a CLAS Implementation Checklist and a post CLAS assessment to identify areas that needed improvement and to track improvement in staff members' understanding of CLAS, as compared to the baseline assessment. The CLAS Implementation Checklist was also used to help facilities identify how well the organization had integrated CLAS standards into their own policies and procedures and how the facility could set actionable goals to meet the guidelines of CLAS.

Onsite Technical Assistance May 2023-April 2024

Project Overview

The Network's goal for this performance period was to provide onsite technical assistance sessions to 25% of the dialysis facilities in its service area, or 125 dialysis facilities, whichever figure was less.

Onsite technical assistance offered dialysis providers, patients, leaders, and other stakeholders a unique opportunity to engage, learn, collaborate, exchange ideas, share data, disseminate best practices, and identify barriers and opportunities. These sessions also provided an avenue to customize interventions to specific patient groups based on demographics, SDOH, health literacy, and available community resources, with a major focus on health equity.

Facilities that received onsite visits were selected by CMS. The selection was based on the area deprivation index, a metric derived from SDOH and stratified by zip code to identify facilities serving highly vulnerable populations. Zip codes with such populations were referred to as priority zip codes. The Network geocoded the list on the appropriate state map to aid in community resource mapping, identify commonalities among facilities within the same and similar zip code characteristics, and facilitate the pre-visit planning process.

The visit included a review of data at different levels (facility, state, Network, and national), coaching on quality improvement processes, discussion of best practices, patient interviews, resource distribution, review of performance trends to identify barriers and mitigation strategies, and relationship building to enhance collaboration between the Network and dialysis providers to sustain improvement.

Interventions

The Network conducted 125 onsite technical assistance sessions in facilities within its service area and focused interventions to address the following objectives:

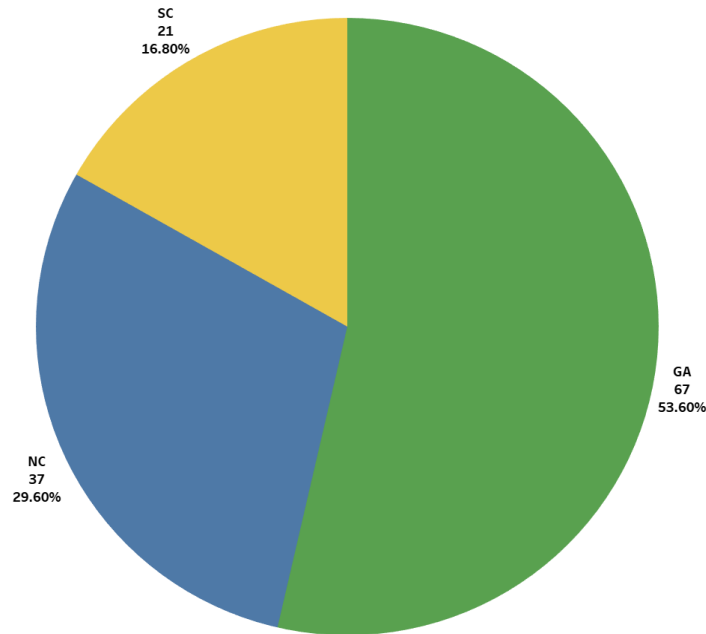
- Capacity Building. Empowering facility leaders with quality improvement skills needed to define, measure, analyze, improve, and control all key quality outcomes/measures including home conversions, hospitalization, depression, transplant, and vaccination.
- Empowerment of the clinical teams with resources and strategies to address barriers identified (health literacy strategies, dealing with resistant patients, community resources, continuing education).
- Care integration. Facilitating the establishment of care pathways with nursing homes, local hospitals, mental health providers, and other community providers aimed at streamlining transitions of care, communication, and cost reduction.
- Patient empowerment. Encouraging and facilitating patient involvement in QAPI processes and the recruitment of PFRs.
- Data sharing. The Network provided facilities with local, state, and national data on key performance outcomes and facilitated the development of data driven facility-specific interventions based on these benchmarks. The data were also used to identify

disparities and to help facilities to initiate disparity tracking processes aimed at enhancing health equity.

Outcomes

The Network conducted 125 onsite technical assistance sessions. Distribution of facilities by state is shown below.

NW6 OP2 Onsite Visit Facilities Count Distribution By State



The following key measure outcomes were identified during post visit follow-up engagements:

- 85% of facilities visited indicated that they had initiated a quality improvement process such as assigning leads to specific clinical outcome measures and the utilization of data to identify trends, track outcomes and design interventions.
- 96% of facilities increased their compliance with Network monthly quality improvement interventions measured through *I PRO Learn*.
- 80% indicated that they enhanced their patient and family participation in QAPI.
- 25 facilities recruited PFRs.
- 60% of the facilities had an increase in patients waitlisted for transplant, 40% increased their transplantation rates, there was a 50% increase in transitions to a home modality, 20 facilities had cleaned up their vaccination data and increased influenza vaccination rates, all facilities achieved above 90% depression screening rates, and 30% had decreased hospitalization rates based on pre- and post-visit data.

Barriers to Achieving Goals

All the dialysis facilities that received an onsite visit are in areas or zip codes identified to have areas of high deprivation and social vulnerability indices. These indices are associated with low health literacy, poor social support, transportation challenges, and inadequate community resources⁶, which drive many but not all the key barriers listed below:

- Staffing. The majority of facilities stated that staffing was one of their top barriers to service delivery and quality improvement.
- Transportation. Almost all the facilities cited inadequate and inefficient transportation systems as negatively affecting treatment compliance, access to vascular placement, home training, and transplant service.
- Health Literacy. Low health literacy remained an ongoing challenge. Facilities did not demonstrate effective processes of assessing health literacy. This was a major focus area for the Network.
- Data. Ineffective use of data was another barrier identified in 59% of the facilities. Interventions were not data driven, and outcomes were not tracked effectively.
- Quality Improvement Framework. There were no established quality improvement structures and processes in the majority of facilities visited, which negatively affected care delivery, integration and Network interventions.
- Patient-related Factors. Factors such as lack of social support, mistrust of the healthcare system, relationship with providers, and compliance with services provided was a common theme among facilities across the Network service area.

Best Practices Spread to Achieve Goal

Transfer of knowledge, skills and best practices is one of the pillars of success associated with face-to-face onsite sessions. The Network staff had the opportunity to identify and transfer best practices and processes from high performing facilities to low performing facilities. The Network also analyzed differences in performance among facilities with similar patient characteristics and within the same geographic location to unearth key drivers to varying patient outcomes. For this performance period, the Network focused on spreading the following best practices:

- Adoption of Network resources, which was reported by facilities to have the most impact on patient outcomes. Examples included the *Seeing Yourself in a Positive Light with a Peritoneal Dialysis Catheter* resource and the *Kidney Transplant Compare* mobile application.
- Incorporation of quality improvement processes into facility practices, specifically the RCA and PDSA structure, process, and outcome quality improvement model.
- Enhancement of patient and family engagement practices through recruitment of PFRs, advocating for physical presence and participation of patient representatives in facility quality improvement meetings. We also worked on the empowerment of patients by training peer mentors and helping patients disseminate Network resources to their peers.
- Utilization of community resources, specifically the EveryONE Project's *Neighborhood Navigator* resource aimed at linking patients to community resources.

⁶ (<https://www.atsdr.cdc.gov/placeandhealth/svi/index.html>)

- Use of the Network's transplant evaluation tracking tool and the nursing home care transition tool. These tools have facilitated early identification of trends and proactive interventions by high performing facilities.
- Intra- and inter-facility collaboration. The Network facilitated and promoted collaboration between low performing and high performing facilities with the same organization and geographic proximity to enhance knowledge and skill transfer.



ESRD Network Grievance and Access to Care Data

During the performance period, the Network responded to grievances filed by or on behalf of ESRD patients in the states of North Carolina, South Carolina and Georgia, with a goal to address and mitigate concerns.

Grievances

The Network received and responded to 529 cases, including 23 (4.35%) clinical quality of care cases and 55 (10.4%) general grievance cases. Communication between staff and patients was one of the most frequently reported concerns among patients in the Network 6 service area. Patients reported that they felt that the staff did not communicate with them in an effective or timely way. The Network's review of clinical quality of care cases verified this as an issue, in part due to ongoing changes in staffing within the facilities. The Network also reviewed a total of 27 (5.1%) immediate advocacy cases. Areas of concern included communication, staffing, chair time changes, and building/facility interruptions.

Network interventions implemented to address these issues included providing staff with in-service training to improve communication with patients. The Network provided technical assistance to resolve 295 (55.77%) facility concern cases.

Staffing continued to be an ongoing issue for dialysis clinics in Network 6. This had a serious impact on patient care and was reflected in patients' reported grievances. Staffing roles affected included nurses, dialysis technicians, social workers, and dietitians. Using a strengths-based approach, the Network created resources and webinars to provide staff with effective ways to improve communications, decrease patient-provider conflict, and familiarize patients and staff with the Network. The Network continued to provide ongoing support to patients and facilities, while working to identify and leverage resources within the community.

Access to Care and Involuntary Discharge (IVD) Cases

During the performance period, the Network received 95 (17.96%) Access to Care cases. For each of these cases, the Network provided technical assistance (TA) to help facility staff effectively support and protect their patients' access to treatment. The reasons for the patient discharges that did occur were serious and included significant threats, behavioral health issues, and violence. As part of the TA provided by the Network, clinic staff members were encouraged to evaluate the identified areas of concern and strategize long-term solutions and action plans during the facility's monthly QAPI meetings. The Network encouraged clinic staff to implement peer-to-peer support using the Network's *Peer Mentoring Program* for patients who experienced challenges. The Network also continued promoting its *Second Chance Program* to clinics for patients with a history of behavioral and non-adherence issues, with a goal to reduce the number of patients using hospital emergency departments for life sustaining treatment. The Network's innovative *Second Chance Program* was initiated by the IPRO ESRD Network of New York in 2016 to help facilities accept patients who had previously been involuntarily discharged (IVD) from their dialysis facility. Through the program, dialysis units are offered a 30-

day trial period, after which they can accept the patient for treatment. The Network worked to successfully place patients through its *Second Chance Program* or through transfers to other facilities. In addition, the Network continued to provide educational resources on patients' rights and the *CMS Conditions of Coverage* to both patients and clinic staff.

An analysis of the IVD cases by Network staff revealed that most of the discharges were due to patients' mental health issues and involved immediate and severe threats. The Network discovered that patients often didn't have the resources to seek the help that they needed or were not interested in receiving services. This continued to be an ongoing problem across all three states in the Network's service area. To address this issue, Network staff supported clinic social workers by identifying local, state, and federal resources that could assist their patients.

Network Assistance and Quality Improvement

The Network continually promoted an environment of advocacy for all ESRD patients and their care partners. Through advocacy work, the Network provided educational training and resources on patient rights, including the rights of patients to participate in their healthcare, and emphasized the importance of patients voicing their perspectives about the services provided by the facility.

Network staff focused on accomplishing the following overarching goals during the performance period:

- Resolve grievances within required time frames: 10 calendar days for Immediate Advocacy and 60 calendar days for General Grievance and Clinical Quality of Care.
- Support dialysis facility staff, who have limited time, skills and training in conflict resolution; with an ultimate goal to improve their ability to manage and deal with patients who have mental, emotional and/or psychosocial issues.
- Increase patients' awareness of the Network and the educational resources it provides by sharing information during the monthly PFR Alliance Meetings.
- Provide educational resources with each grievance resolved.
- Increase use of *I PRO Learn* as a platform to deliver educational resources and tools, including the pre-recorded webinar, *Effective Communication*.

Interventions shared through *I PRO Learn* and emails focused on supporting facility staff in exercising de-escalation and effective communication skills, as well as offering guidance in identifying potential barriers that could negatively affect a patient's ability to remain compliant with their treatment. The Network mediated cases to help de-escalate patients' concerns with the facility and implemented QIAs that included interventions shared through *I PRO Learn* and emails. These interventions were designed to provide facility staff with guidance on communication techniques and de-escalation strategies that would

- better support their patients' care,
- support an environment of safety and inclusion, and
- assist staff in identifying potential barriers that could negatively affect a patient's ability to remain compliant with their treatment plan.

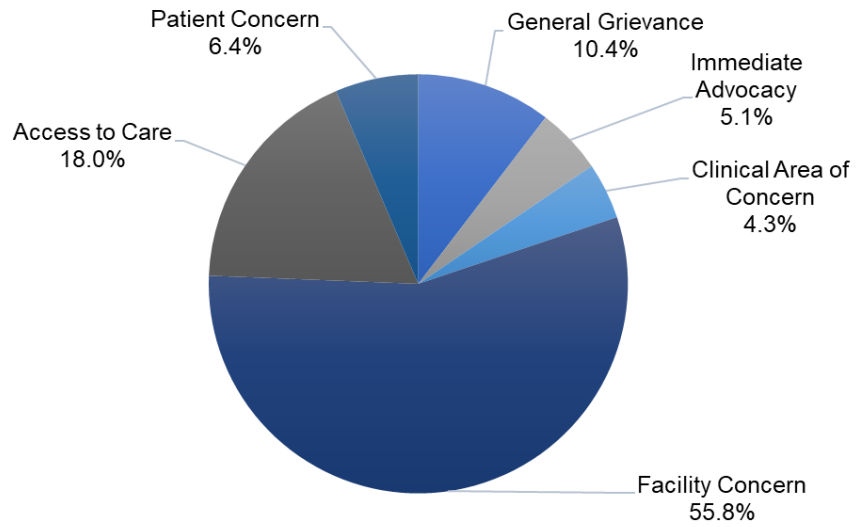
The Network's interventions provided facilities with the necessary guidance to improve their patients' overall quality of care. While each intervention focused on a different topic, all Network-implemented interventions incorporated the basic elements of quality improvement:

- Ongoing in-service training for staff on topics including emotional intelligence and communication.
- Provision of TA to support clinic staff in using quality improvement tools, including RCA and PDSA cycles.
- Ongoing emphasis of the value of establishing professional boundaries with patients.
- Early introduction and ongoing reinforcement of the value of integrating quality improvement methodologies into the culture of the clinic.

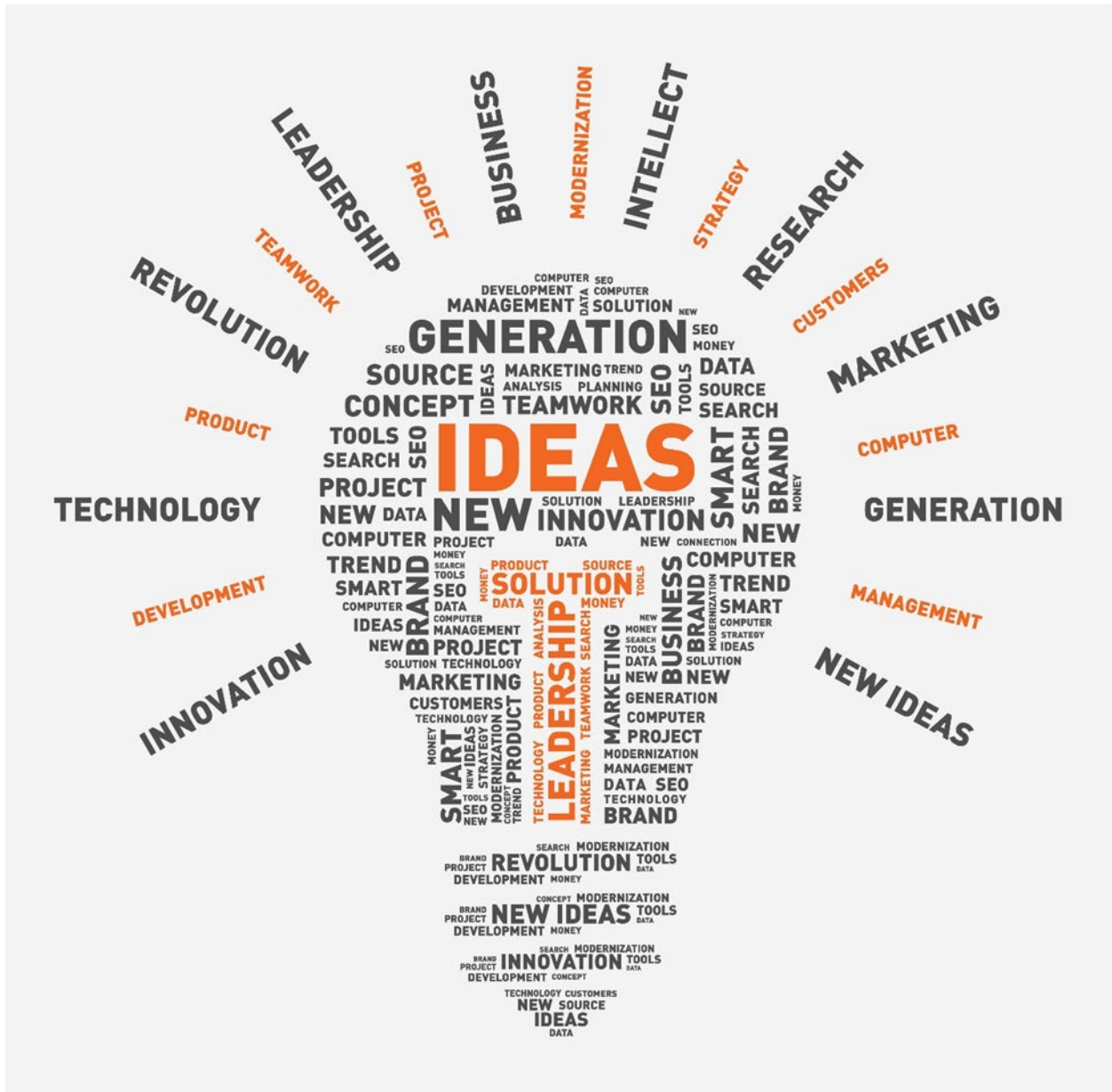
The Network provided patients and facilities with the following resources:

- The *Dialysis Patient Grievance Toolkit* created by the Forum of ESRD Networks' Kidney Patient Advisory Council (KPAC).
- Grievance preparation worksheets and a poster to create awareness of the educational resources available to dialysis patients.
- A poster and flyer, *What the Network Staff Can and Cannot Do*, outlining for patients clearly defined parameters of the support that the Network is able to provide.
- Crisis Prevention Institute (CPI's) *Top 10 De-Escalation Tips* resource. During the month of November, the Network released an *I PRO Learn* activity on de-escalating resources to educate facility staff about de-escalation techniques. Staff representing 508 of the 766 facilities in the Network's service area completed the activity which included a quiz to assess knowledge gained that 62% of participants passed.
- A webinar on successful communication strategies presented on *I PRO Learn* for staff members to reference during training with their teams.
- A webinar on IVD presented on *I PRO Learn*. Of the 766 clinics in the Network 6 region, 551 clinics utilized and responded to the activity.
- An *I PRO Learn* educational resource on non-adherence was posted in March 2024. Of the 766 clinics in the Network 6 region, 583 clinics utilized and responded to the activity.
- A webinar and resources on mental health were posted on *I PRO Learn* in January 2024, Of the 766 clinics in the Network 6 region, 551 clinics utilized and responded to the activity.

Network 6: Percent of May 2023-Apr 2024 Grievances and Non-Grievances by Case Type



Source of data: Patient Contact Utility (PCU) accessed May 2024



ESRD Network Recommendations

Facilities that Consistently Failed to Cooperate with Network Goals

The Network has garnered the support of facilities throughout its community to aid in the implementation of Network initiatives and to collaborate in meeting Network goals. The Network did not identify any facilities in its service area that failed to cooperate with activities that support its goals.

Recommendations for Sanctions

Network 6 does not recommend any facility for sanctions.

Recommendations to CMS for Additional Services or Facilities

In working with the facilities across the region the Network identified these additional services which would benefit our provider community:

1. Improving the availability of transportation services for dialysis is a consistently requested additional service that facilities believe would improve their process.
2. Build services to support the growth of ESRD resources for rural patients; specifically, access to transplant and home dialysis services.
3. Medicare currently covers the cost of caregivers for home health care. Greater support and success in home modalities would exist if Medicare paid for staff-assisted home dialysis for appropriate patients.

ESRD Network COVID-19 Emergency Preparedness Intervention

The CDC declared May 11, 2023, to be the end of the COVID-19 pandemic. As COVID-19 infection numbers decreased, the Network continued to communicate information and support dialysis facilities in maintaining adherence to safe health practices, with the ultimate goal of preventing the occurrence and transmission of COVID-19 among patients and staff.

ESRD Network Significant Emergency Preparedness Intervention

During the performance period, the Network documented all effects on facility operations due to emergency events using its *Emergency Operational Status Report*. This information was combined with data from the EQRS, Critical Asset Annual Survey data, and information provided by the dialysis organizations. The combined data sets were provided to the Kidney Community Emergency Response (KCER) coalition.

The Network continued to use the ESRD Emergency Hub Mobile Application, developed by IPRO in 2022, to enable patients and their caregivers to subscribe to alerts regarding emergencies in their geographic area. The application also allows patients to store their treatment and medication information and preferred emergency contacts. By the end of the performance period, there were 608 users of the ESRD Emergency Hub Mobile Application within the Network's service area.

The Network addressed situations arising from the following events affecting dialysis facilities and patients during the performance period:

- Weather-Related Events – 92
- Emergent Events – 20
- Altered Schedule – 62
- Staff Shortage – 23
- Temporary Closures – 73
- Permanent Closures – 29

There were 29 closures of facilities and 23 reports of staffing shortages reported in the Network's service area during the performance period. A review of the data provided to the Network revealed that most of the closures were due to staffing constraints. Because of the reduced number of staff members at outpatient dialysis clinics, facilities relied on all staff members being present for successful daily operations. There were incidents in which a nurse or patient care technician could not report to work, and patients had to be rerouted to a nearby clinic for safe treatment. The Network contacted facilities struggling with staff shortages, encouraging them to utilize travel staffing agencies or reroute patients to sister clinics.

Acronym List Appendix

The Kidney Patient Advisory Council (KPAC) of the National Forum of ESRD Networks has created a list of Frequently Used Acronym available through [this link](#). We are grateful to the KPAC for creating this list to assist patients and stakeholders in the readability of this annual report. We appreciate the collaboration of the National Forum of ESRD Networks, especially the KPAC.

This material was prepared by the End Stage Renal Disease National Coordinating Center (ESRD NCC) contractor, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy nor imply endorsement by the U.S. Government.