End-Stage Renal Disease
Network of the Ohio River Valley

2023 Annual Report

Fourteenth Street Bridge over the Ohio river, connecting Kentucky and Indiana

This report will cover quality improvement efforts led by ESRD Network 9
Task Order Number 75FCMC21F0004 from May 1, 2023 - April 30, 2024

July 2024 - Revised February 2025
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IPRO ESRD Network of the Ohio River Valley
http://esrd.ipro.org

Submitted to:
U.S. Department of Health and Human Services (HHS)
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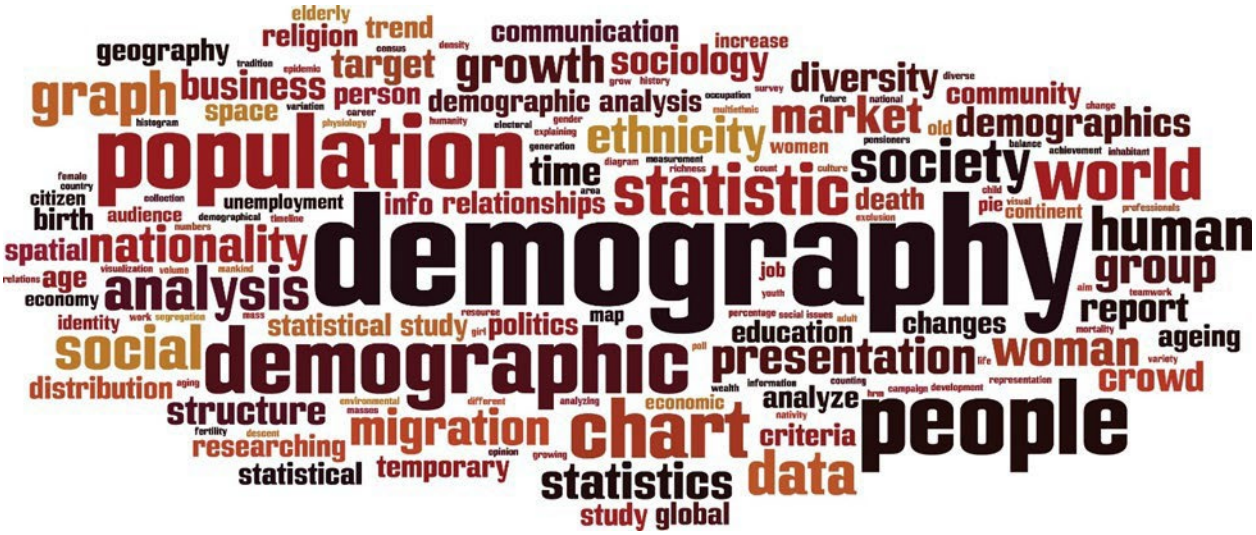
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ESRD Demographic Data

IPRO End Stage Renal Disease (ESRD) Network of the Ohio River Valley (Network 9) is one of four End Stage Renal Disease (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 9 service area, IPRO manages the ESRD Network of New England (Network 1), ESRD Network of New England (Network 2), and ESRD Network of the South Atlantic (Network 6), 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.

The Network serves ESRD patients, dialysis providers, and transplant centers in the states of Kentucky, Indiana, and Ohio. 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), the Centers for Medicare & Medicaid Services (CMS) goals addressed in the CMS Quality Strategy, and the CMS Sixteen (16) Strategic Initiatives designed to result in improvements in the care of individuals with ESRD. Our goals, our methodology for attaining them, and our achievements are described throughout this report.

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 nationally.

As the fifth largest ESRD Network in the country in 2023, the Network 9 patient population included 52,338 individuals either on dialysis or receiving a kidney transplant. There were 31,804 prevalent dialysis patients (6.2% of the national number) and 8,688 incident dialysis patients (7.1% of the national number) reported receiving treatment from dialysis facilities in the Network service area. Of the individuals living with a kidney transplant nationally, there were 20,534 kidney transplants completed in the Network's region since the start of the ESRD Network Organization Program in 1988 (6.7% 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 25,486 ICHD patients (80.1%) in the Network service area, which comprised 5.0% 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 6,318 home dialysis patients (19.9%) in the Network 9 service area. This represents 7.6% of the ESRD population nationally. The rate of home modality

utilization in the Network 9 region (19.9%) exceeded the national rate of 15.5% and the rate of transplants in the Network service area (39.2%) exceeded the national rate of 36.7%.

In 2023, there were 7,830 ESRD Medicare-certified dialysis facilities in the United States. The Network service area included 639 dialysis facilities (10.1% of the national number), five of which were in Veterans Affairs (VA) hospitals. There were 326 dialysis facilities (51.0%) 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, 13 centers (5.7% of the national number) offered kidney transplants within the Network service area.

ESRD Community Engagement and Collaborations

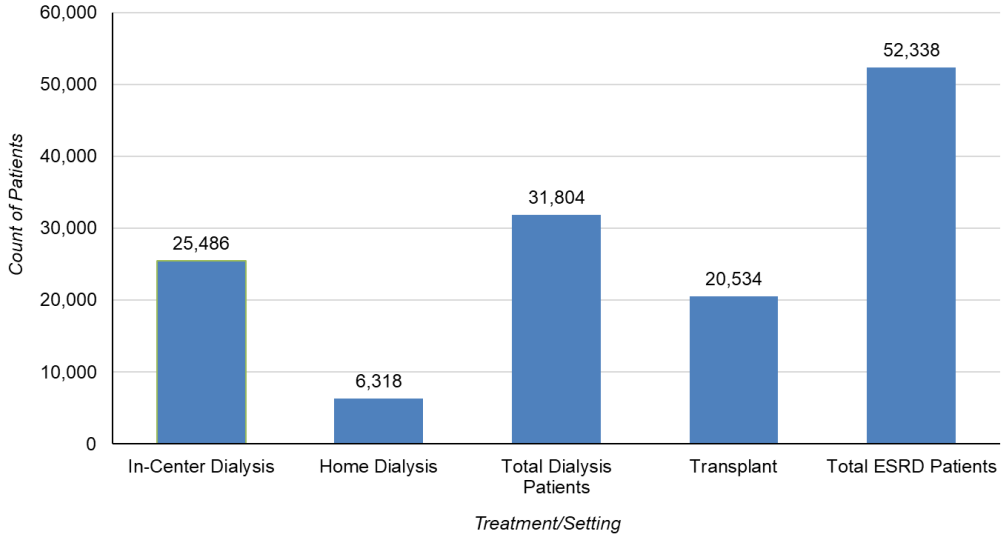
Patient Facility Representatives (PFRs) who were nominated by facility staff to engage with their peers, provided feedback about quality improvement activities and helped develop the Network's educational materials. Nominated PFRs participated in the Network's calls and events as well as national calls. The PFR Alliance group met virtually on a monthly basis. During these meetings, the Network provided 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 (RCAs) 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 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 Network 9 service area.

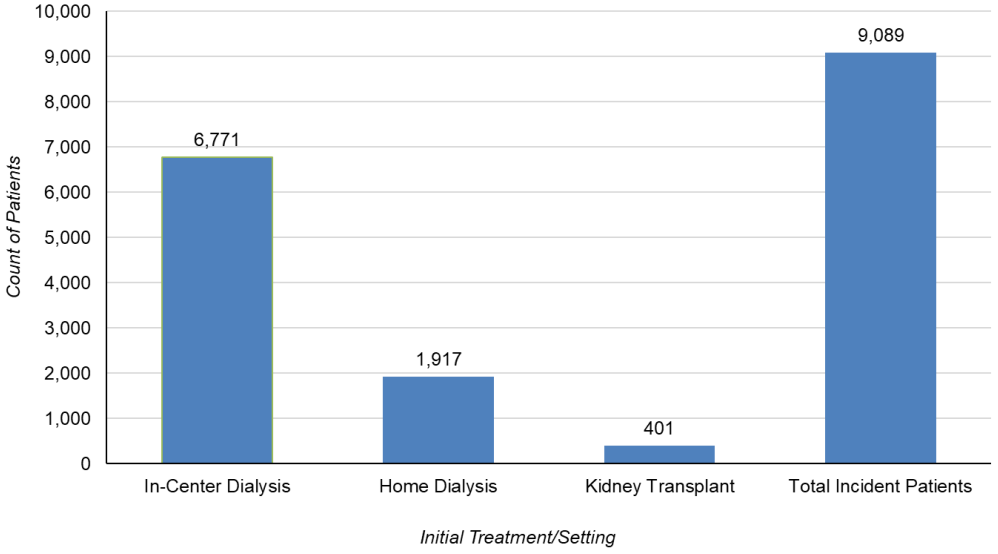
The Network deployed interventions through its online education platform, *IPRO Learn*, that targeted patients, dialysis and transplant providers, and other stakeholders. These interventions, which focused on engaging patients, reducing disparities, and improving quality of care for ESRD patients are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

Network 9: Count of Prevalent ESRD Patients by Treatment/Setting
2023



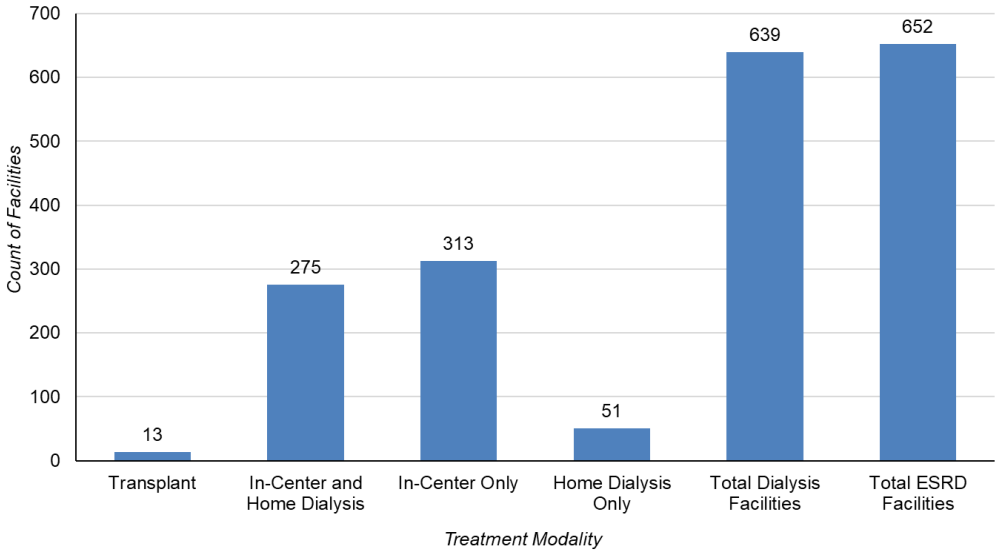
Total Dialysis Patients = In-Center Dialysis + Home Dialysis
Total ESRD Patients = Transplant + Total Dialysis
SNF dialysis patients are not shown due to small numbers
Source of data: EQRS May 2024

Network 9: Count of Incident ESRD Patients by Initial Treatment/Setting
2023

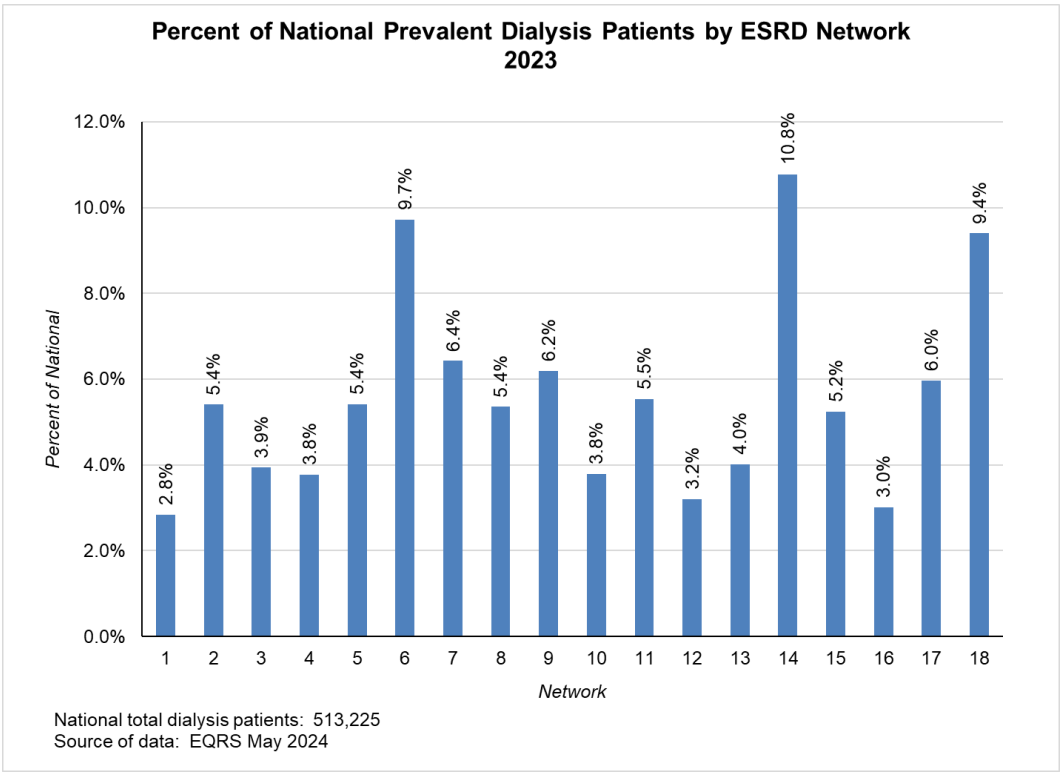


Total Incident Patients = In-Center + Home + Kidney Transplant
Source of data: EQRS May 2024

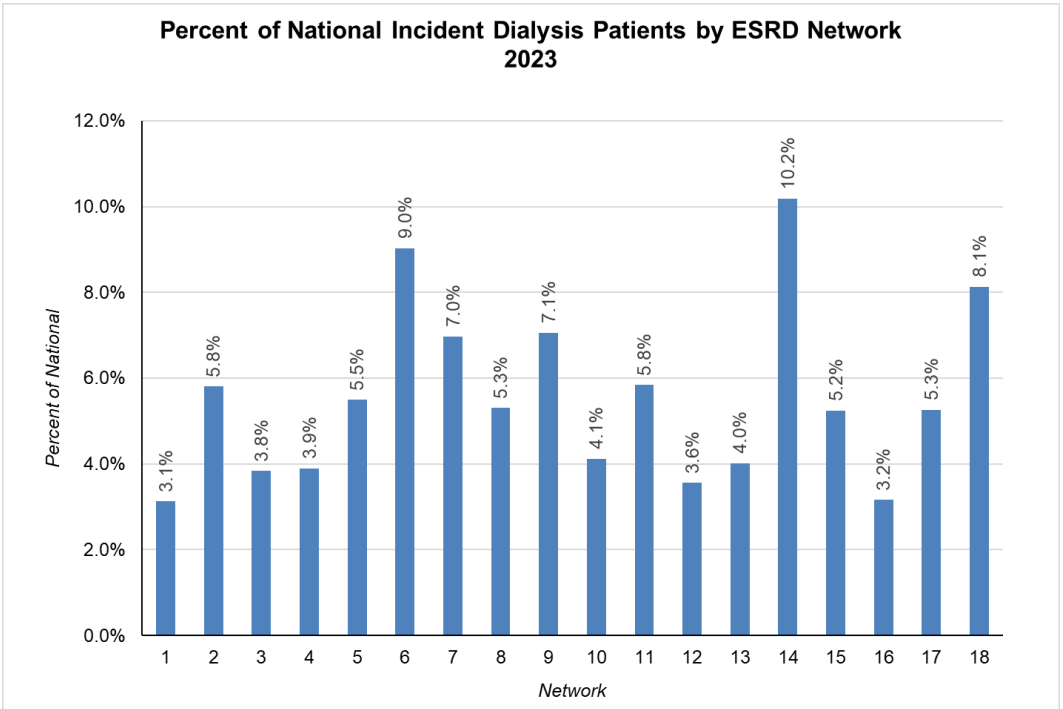
Network 9: Count of Medicare-Certified Facilities by Treatment/Setting 2023



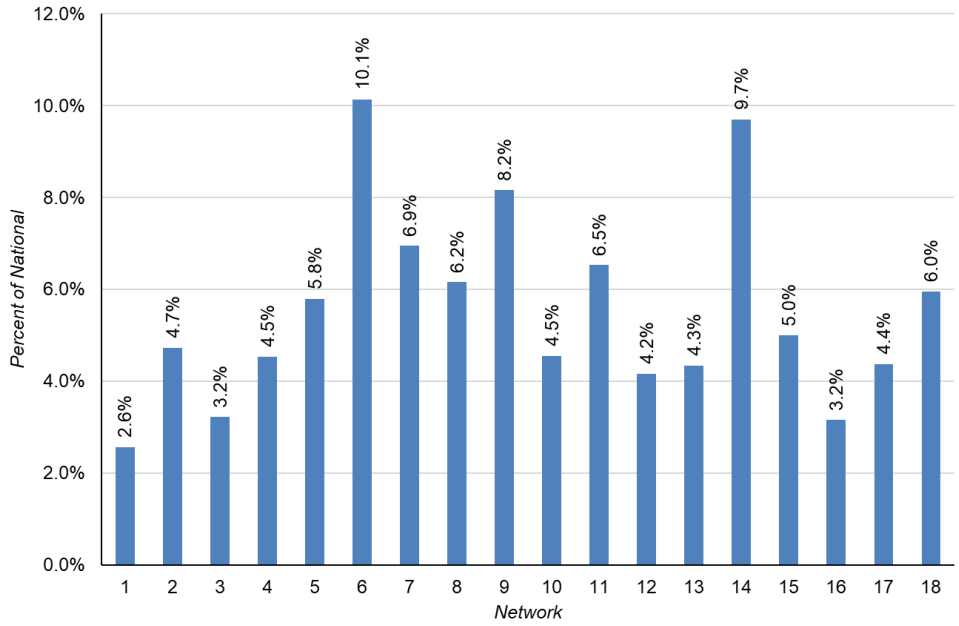
Total Dialysis Facilities = In-Center and Home Dialysis + Home Dialysis Only + In-Center Only
Total ESRD Facilities = Transplant + Total Dialysis Facilities
Source of data: EQRS May 2024



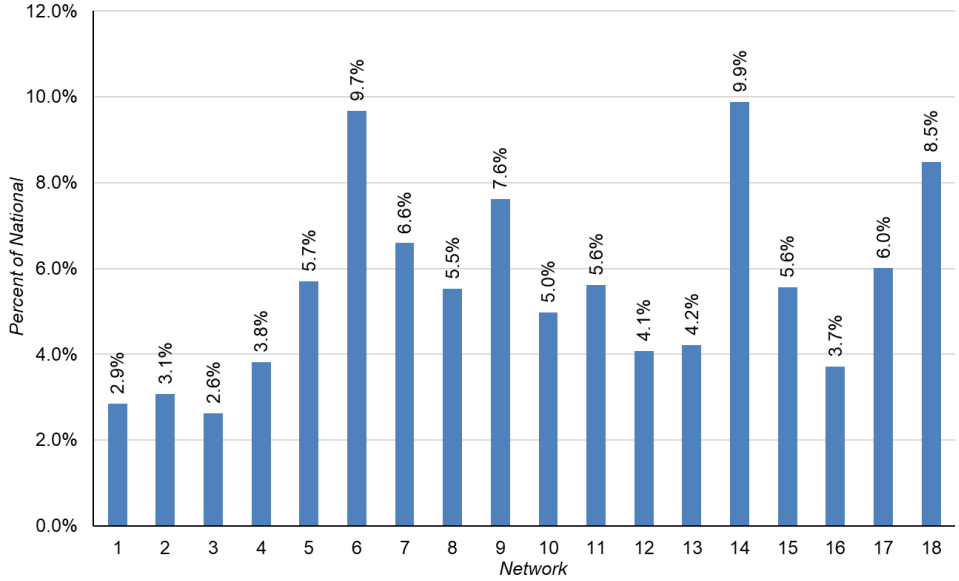
National total dialysis patients: 513,225
Source of data: EQRS May 2024



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

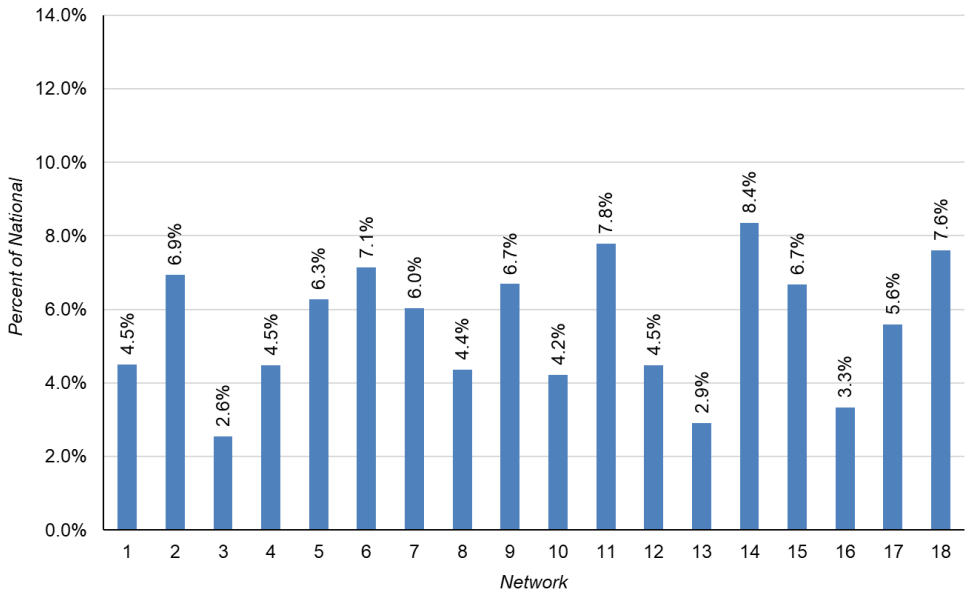


National total ESRD Medicare-certified dialysis facilities: 7,830
Source of data: EQRS May 2024



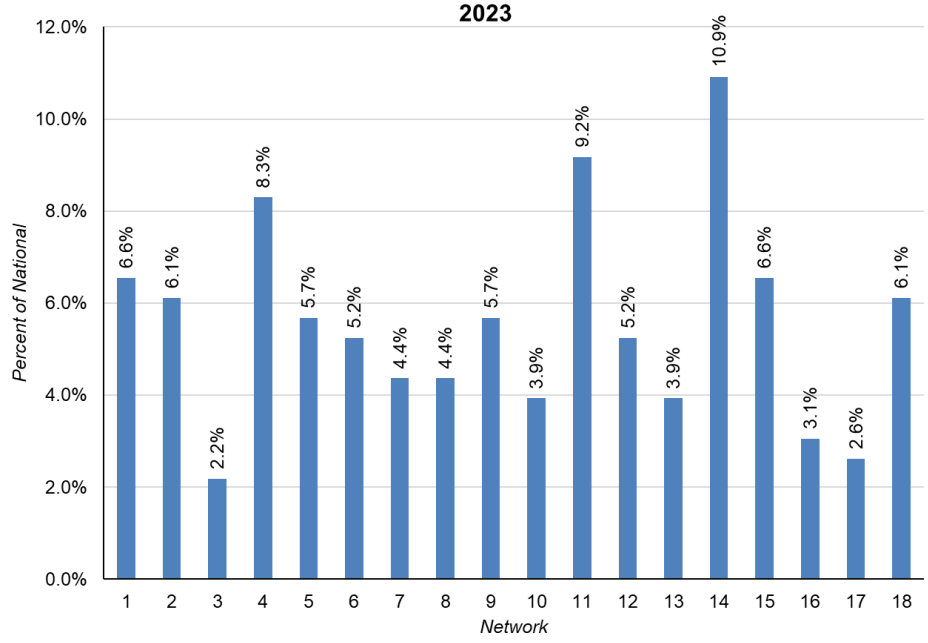
National total home hemodialysis and peritoneal dialysis patients: 82,964
Source of data: EQRS May 2024

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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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, or ethnicity. By 2025, it is the goal of HHS's Advancing American Kidney Health (AAKH) that 80% of ESRD patients will be treated with either home dialysis or a kidney transplant. The IPRO ESRD Network has been committed to supporting this goal by meeting with empowered patients, nephrologists, primary care providers, transplant center staff, and dialysis providers to plan, develop, and implement quality improvement strategies to support transplant education and patient choice.

The Network's goals for this performance period were to increase the number of patients on the United Network for Organ Sharing (UNOS) waitlist (the national transplant waitlist) by 1,573 (9%) and increase the number of people receiving a kidney transplant by 1,595 patients (12%).

Interventions

Interventions deployed in the Network 9 region consisted of the launch of *Kidney Transplant Compare*, educating and assisting dialysis facilities in identifying and overcoming their barriers to transplantation via community coalitions, living donation education, and promoting the acceptance of high Kidney Donor Profile Index (KDPI) kidneys.

Kidney Transplant Compare

In 2018, the Ohio River Valley Transplant Coalition began the *Transplant Center Compare* project which was a set of documents highlighting each transplant center's patient selection criteria, support services, and data outcomes to encourage the patient choice in transplant center. This project was a collaboration of the 10 adult transplant centers in the Ohio River Valley. In 2023, the IPRO ESRD Network 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 is based on patients' responses when asked what they would have liked to know about transplant centers before starting their transplant journey. This 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. The application 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 48 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 barrier, as expressed by patients, to waitlist and transplant. Network staff guided the facilities through a PDSA cycle that facilitated testing and evaluation strategies to mitigate patients' resistance to transplant as a treatment option, increase the number of patients considering transplant as well as the number of patients on the UNOS waitlist. 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.

Living Donation
As an additional strategy to overcome the region's transplant barriers, the Network implemented a plan to educate the dialysis provider community about the value of suggesting to their patients the option of living donation as a path to transplant and to provide resources and approaches that would assist patients in finding a donor.

This intervention began with data collection to better understand the prevalence of living donor education, if and how dialysis providers were discussing living donation with their patients, and what they were doing to help interested patients identify a living donor. The Network learned that 33% of the facilities in its service area "sometimes," "rarely," or "never" promoted the option of living donation at their facility.

To address that, the Network shared a resource that emphasized the importance of living donation discussion at the dialysis facility level and housed an updated list of approaches that patients have used to find a donor, such as utilizing community programs, printed materials, and social media platforms. Included were also seven unique patient campaign stories of finding a kidney donor. Eighty-two percent of the Network completed this activity and 94% stated they would adopt the intervention into their practice.

High KDPI Kidneys
The Network also worked to encourage dialysis providers to suggest that patients consider kidneys with a high KDPI or expanded donor criteria. Kidneys with a high KDPI score may not function as well as those with a lower KDPI.

Better Than Dialysis Kidneys, a resource made available by the ESRD NCC, was shared with dialysis facilities to provide staff with information and resources about KDPI and expanded donor criteria kidneys. This resource offered dialysis staff suggestions for ways to start a conversation about KDPI with patients who are considering transplant.
Eighty-four percent of the facilities in the Network service area completed this activity about KDPI on *IPRO Learn*, the Network's online education platform, with 92% of those facilities choosing to adopt the intervention into their practice.

Outcomes

The Network's activities during the performance period contributed to an increase of 1,691 patients on the transplant waitlist (exceeding its goal of a 9% increase) and an increase of 1,447 patients transplanted (exceeding its goal of a 12% increase).

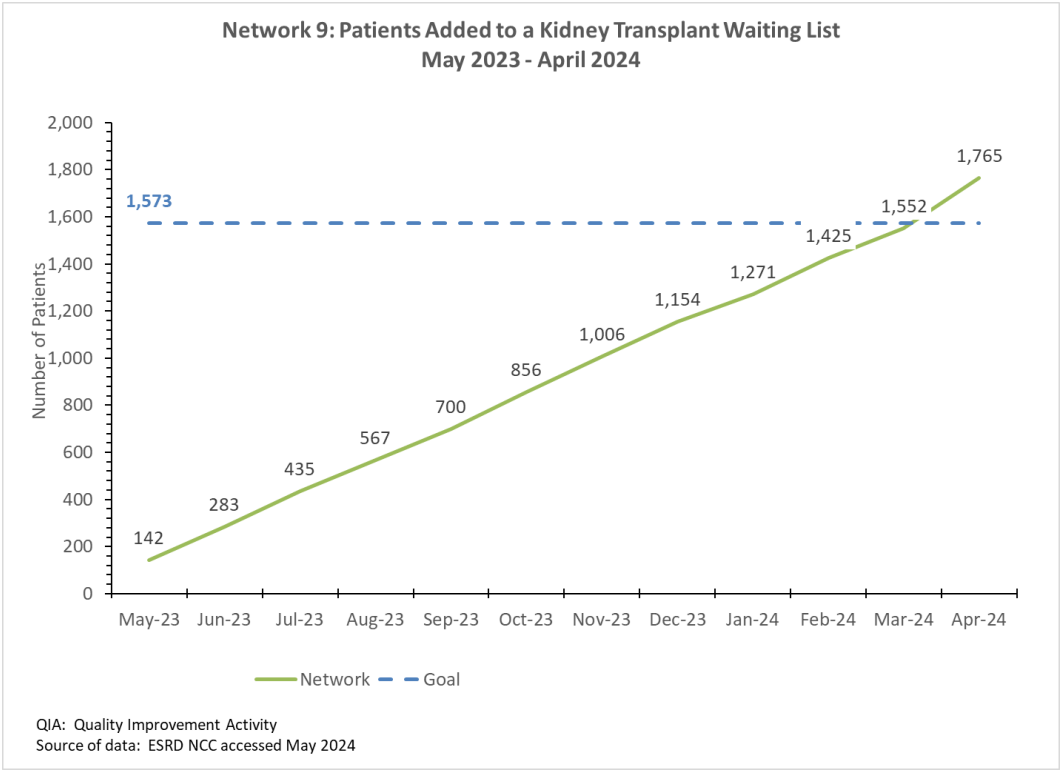
Barriers to Achieving Goals

Baseline measurements for this project were established using calendar year 2020 data. A systemic change in kidney organ allocation occurred on a national level on March 15, 2021, with the implementation of the Kidney Allocation System to increase equity in transplant access for all candidates. For this to occur, kidneys that were abundant in one area, such as in the Network 9 service area, were outsourced to other areas in need. The effect of this reallocation continued through the performance period and remained a barrier to increasing transplant rates.

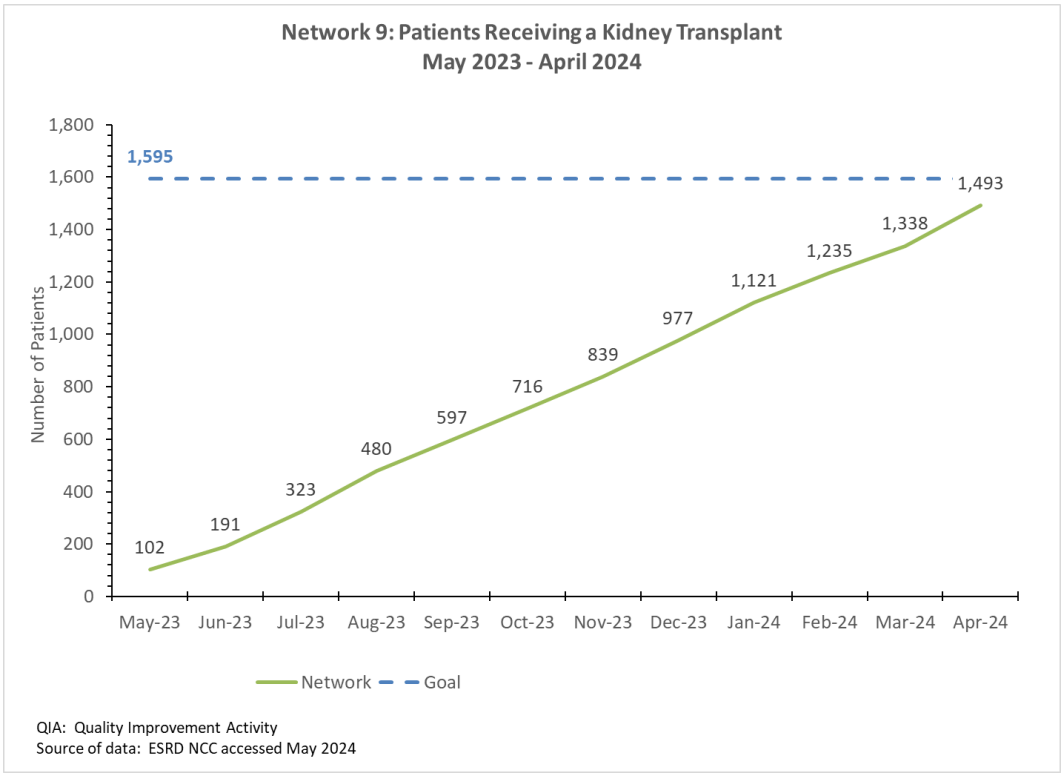
To compensate for this reduction in the supply of organs, the Network placed a strong focus on working with ESRD facilities and transplant centers to raise awareness and understanding about living donation, use of high-KDPI kidneys, and acceptance of organs that require more intensive support to place.

Best Practices Spread to Achieve Goals

The Network focused on best practice sharing through the interventions implemented for the community coalitions and the *Kidney Transplant Compare*, *Living Donation*, and *Kidney Donor Profile Index* initiatives. 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 they (through data analysis and process changes) overcame common barriers and succeeded in increasing the number of patients considering transplant and/or registering on the waitlist.



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



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

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

Project Overview - Incident

Home dialysis has been proven to provide an enhanced quality of life for patients diagnosed with ESRD. Patients who choose a home modality benefit both mentally and physically, specifically they gain an increased sense of independence, advanced knowledge of their disease, and a more flexible schedule that allows them to maintain their current lifestyle, including work and travel. Physical benefits of home dialysis include improved blood pressure control and improved fluid volume status leading to decreased hospitalizations as compared with patients who receive in-center treatment. When patients with chronic kidney disease (CKD) start directly on a home modality, it can help preserve residual kidney function due to the more frequent, gentler dialysis, which also helps to reduce hospitalizations and improved patient outcomes. With the numerous mental and physical benefits of home dialysis, the goal for this performance period was to increase the number of patients starting directly on a home modality by 30%.

Interventions

The Network met with high-performing facilities to learn and identify best practices in overcoming common barriers when starting patients directly on a home modality. Through these meetings, the Network learned that one of the biggest barriers was lack of treatment modality education for patients with CKD stages 1 - 4.

The Network also participated in the National Kidney Foundation (NKF) Ohio Stakeholder Summits Working Groups on *Ending Disparities in Chronic Kidney Disease (CKD)*. Network staff participated in four work groups:

- Clinical Considerations for CKD in Primary Care — A discussion of strategies and approaches that can be employed to improve CKD recognition and care in primary care settings.
- Engaging Community and Community-Based Solutions —A forum for developing strategies to advance CKD awareness through community engagement and to ensure that healthcare providers are aware of availability of community resources to delay CKD progression..
- CKD in a Population Health Model — A forum for developing a strategy to incorporate CKD testing and diagnosis into wellness and prevention practices.
- Policy, Payment, and HEDIS Measurement — A discussion to develop a strategy to streamline CKD testing in primary care from a policy and payment perspective.

The Network also provided education to dialysis facilities on the benefits of urgent start peritoneal dialysis (PD). This treatment option allows patients to initiate PD soon after PD catheter placement, and well in advance of the standard of practice of a 14-day delay after PD catheter placement for patient training. After surveying home programs in the Network service

area to identify barriers in caring for patients with urgent starts, Network staff provided a research article[1] including a table on mitigation tactics to address common barriers.

Outcomes

The Network's activities during the performance period contributed to a total of 2,070 incident patients (22.12%) starting renal replacement therapy on a home modality, surpassing its goal of a 30% increase over the baseline period.

Barriers to Achieving Goals

The Network identified several barriers common to facilities when starting patients on a home modality. These barriers included lack of CKD education, staffing shortages, lack of support in the home, and lack of access in rural areas.

An additional barrier involved patients with acute kidney injuries (AKI); these patients are not covered by Medicare for home modalities. If AKI patients were able to treat on a home modality, they would have the potential to thrive as urgent-start patients.

Best Practices Spread to Achieve Goals

The Network held a Best Practice Call during which a facility with a top performing home program treating incident patients shared how they used Lean Six Sigma processes and principles, changed staffing schedules to address staffing shortages, transitioned to a relationship-based care nursing model, and implemented group home training sessions in their facility to train 57 incident patients during the previous performance period.

Additionally, the Network shared best practices and resources with its CKD educator stakeholder group through a variety of vehicles throughout the year. Using its *IPRO Learn* platform, the Network shared its bi-monthly CKD newsletter to expand and enhance resources that CKD educators could use when providing education to patients. One example of information shared was the American Kidney Foundation course, *Kidney Health Coach*, which offered continuing education credits to all participants and helped those who took it develop a CKD education program.

Project Overview - Transition

The choice of a home modality (PD and 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.

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[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

The Network's goal for this performance period 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

IPRO Learn is the Network's online education platform designed to disseminate education to staff at dialysis facilities. One of the educational pieces posted to *IPRO Learn* was the journal article *Home Dialysis in Older Adults: Challenges and Solutions*. Comments collected from 488 (80%) facility staff who read the article indicated that the article answered questions related to challenges and solutions to training and maintaining older adults on home therapies.

As a follow-up to information gathered from facility staff related to challenges of and solutions to providing training to older adults to help them transition to a home therapy, the Network created a resource, *How Old is Too Old for Home Dialysis*? The resource reviewed the benefits of home dialysis as well as tips to help patients starting a home therapy make a successful transition. Of the 460 facility staff members (76%) who read the resource, 96% stated that they would share the resource with patients who are ages 65 and older.

Outcomes

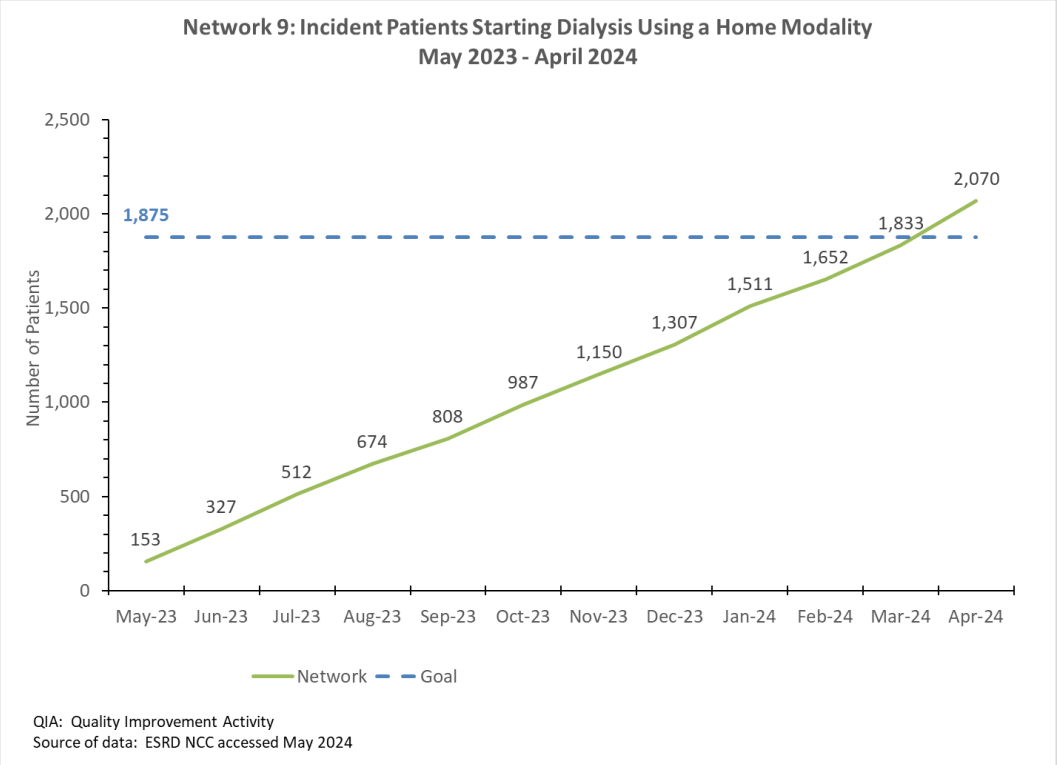
The Network exceeded its goal to transition in-center hemodialysis patients to a home therapy, with 3,497 patients transitioning to a home modality (119% of goal).

Barriers to Achieving Goals

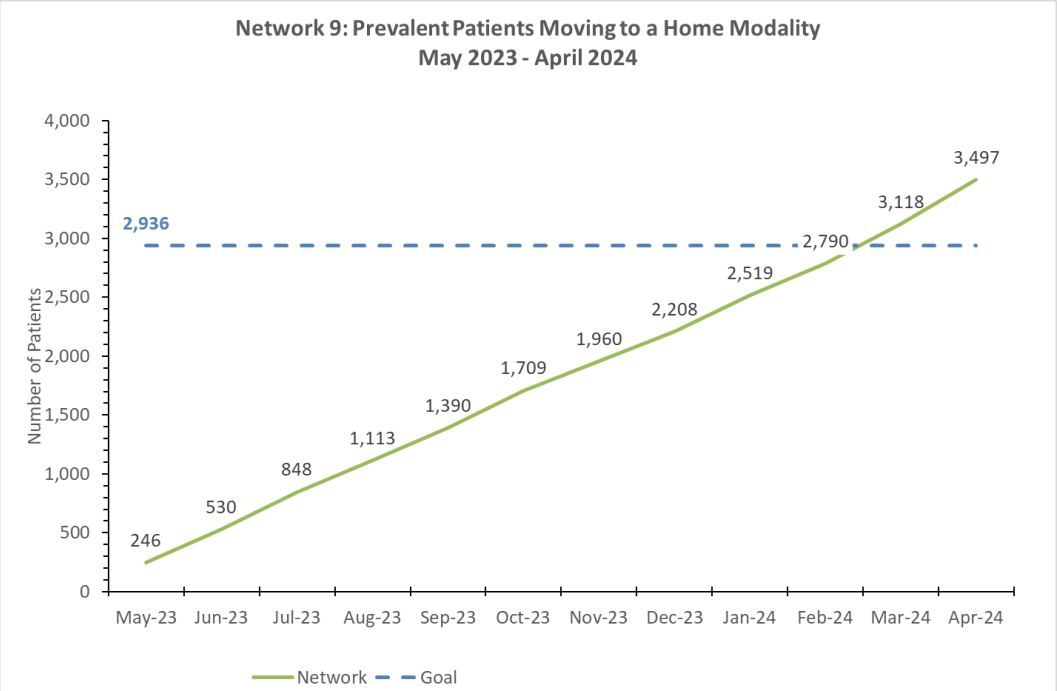
There are some socioeconomic factors related to why some patients do not transfer to a home therapy. An RCA conducted by the Network's community coalition found that many patients do not have support systems to help them carry out their therapy at home and/or act as a backup. There is no respite care or staff assisted home dialysis to help the patients with poor support systems transition to or maintain treatment using a home therapy. Many patients chose to stay in-center where they can have their dialysis needs met.

Best Practices Spread to Achieve Goals

A top performing facility in the Network service area shared how they used group training to be successful with transitioning patients to home dialysis, as well as retaining patients on home therapies. The facility staff found that group therapy helped to make patients comfortable with transitioning to another therapy whether that be PD or home hemodialysis.



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 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 a weakened immune system 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 efforts 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 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

Of the 160 facilities that were sent letters, 54% participated in one-to-one calls. From those interactions, the Network learned that 27 facilities had problems due to a data glitch within their EMRs; 26 facilities were provided training regarding where to enter the vaccine in the database; and three facilities emailed back requesting further data analysis, as they felt the data were inaccurate. For 31 facilities that opted to join the Open Office Hours webinar, the Network demonstrated best practices on data clean-up, batching process reviews, and download locations to improve data records.

As an added intervention to help overcome vaccination fatigue for both patients and healthcare workers, the Network introduced the concept of focusing on vaccination as a component of preventative care in living a healthy life. A bingo game to introduce the concept of healthy living was released as a fun, interactive approach to bring awareness to the importance of maintaining a healthier lifestyle. The focus of the game was to address the three key barriers to vaccination acceptance: health literacy, vaccination fatigue caused by overload of information on vaccines, and lack of information about benefits of the influenza vaccine. Through the game,

[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

the Network sought to increase patients' understanding of and engagement with healthy lifestyle initiatives. Of the facilities that reviewed the game, 68% indicated they would add it to their practice using a PFR from their facility. Many stated they felt that the game offered an opportunity to provide a fun, enjoyable forum for educating staff and patients, and many of the participants said they were looking forward to implementing the game on a regular basis, either on holidays or quarterly.

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

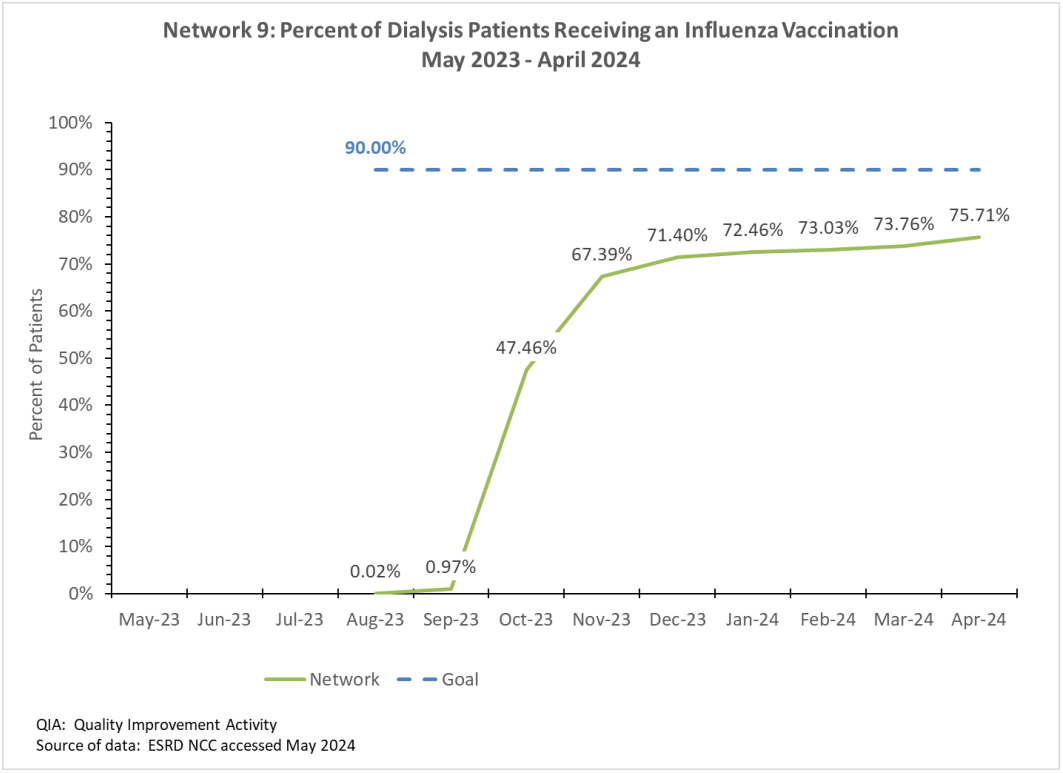
At the end of the performance period, 23,333 patients (78%) and 4,465 healthcare workers (43%) in the Network service area had received an influenza vaccine. This was a decrease of 3.83% over the prior year for patients and 0.45% for healthcare workers. Due to this, the Network did not achieve its goal to have 90% of patients and healthcare workers vaccinated for influenza.

Barriers to Achieving Goals

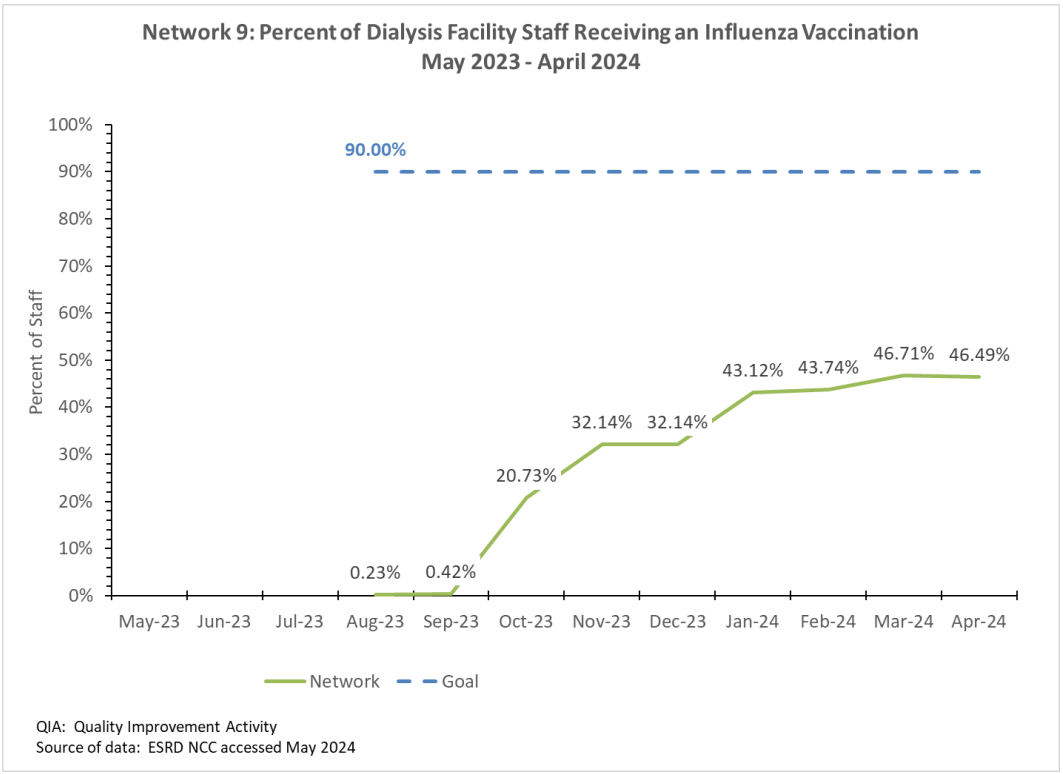
Despite the proven efficacy of vaccinations, burden and burnout remained the primary barriers. A wide range of other reasons for denying administration of the vaccine had been identified in all communities; these include the frequency that vaccinations are required, vaccine side effects, misconceptions of the need to vaccinate, and the lack of trust in the government/healthcare system. Another barrier that impacted the Network's outcomes were issues with data entry which revolved around a lack of understanding on how to document, as well as computer glitches that did not batch over information to update the vaccination records.

Best Practices Spread to Achieve Goals

One of the most important steps the Network took was to offer open discussions during Office Hours webinars as well as the quarterly national calls. The use of open dialogue allowed low-performing facilities to learn how to implement best demonstrated practices from high-performing facilities. While generally not conducive to covering large amounts of content, the interactive approach effectively provided clear and understandable education using a comfortable format that encouraged people to ask questions, as well as share ideas.



QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 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 continued to be staying up to date with COVID-19 vaccination. A majority of new COVID-19 cases in the U.S. reported during the performance period were caused by a sub-variant of the COVID-19 Omicron variant, otherwise known as XBB. The monovalent vaccines released in the fall of 2023 were effective against these COVID-19 virus strains. The elderly and immunocompromised individuals, including those with kidney disease, remained to be at greater risk than others for infection, so immunization continued to be the best defense against serious illness and death for this population.

Throughout the performance period, the Network worked 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 are 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 are based on NHSN, or another CMS-approved data system.

Interventions

An important intervention implemented by the Network involved providing facilities with the *CDC Quick Reference Guide: Reporting Up-to-Date COVID-19 Vaccination Status through the COVID-19 Vaccination Modules*. This resource aimed to enhance facility staff's understanding of what "up-to-date" means for both facility patients and staff. The guide outlined key points and provided examples illustrating the current definition of up-to-date vaccinations.

Facilities were tasked with reviewing their most recent facility performance report to compare their data against the outlined criteria. Additionally, facilities were queried about whether they had received and reviewed Network performance reports, further emphasizing the importance of staying informed and actively engaging with provided resources to ensure compliance and alignment with vaccination status reporting standards. This intervention aimed to promote clarity and consistency in vaccination status reporting practices across facilities within the Network service area.

Outcomes

The Network's efforts resulted in the following outcomes in the Network 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 1,170 (13.01%) of patients and 594 (10.58%) facility staff members received the COVID-19 vaccination.

Barriers to Achieving Goals

The Network identified several key barriers impeding the achievement of COVID-19 vaccination goals among patients and staff. Among these challenges was a widespread sense of confusion and mistrust surrounding vaccination, exacerbated by factors such as fatigue and misinformation. Despite multiple rounds of vaccinations, many individuals perceived a diminished necessity for COVID-19 vaccination. Some expressed skepticism, believing they did not require vaccination or viewed the pandemic as a conspiracy. Additionally, individuals who contracted COVID-19 despite being vaccinated had lost faith in vaccination effectiveness, while others remained uncertain about what constituted being "up to date" following the transition from a bivalent series to a single monovalent dose.

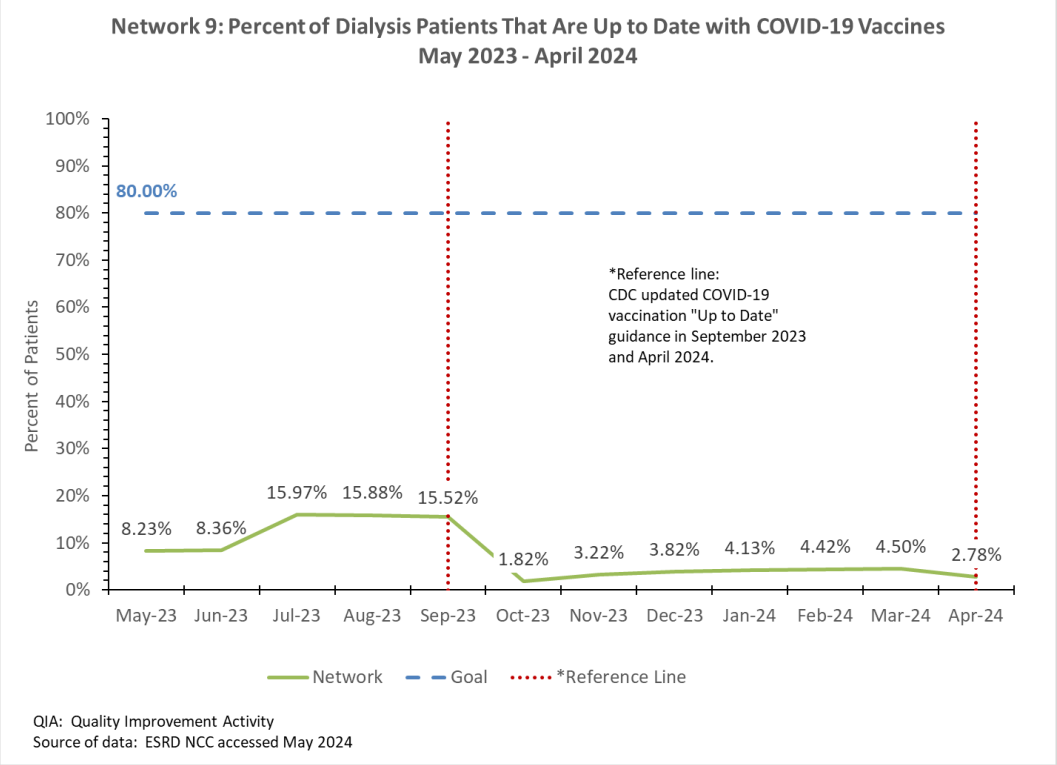
These challenges led to disruptions in vaccine administration, particularly in the fall of 2023, when many dialysis facilities did not offer the new monovalent vaccine on-site. Consequently, reported COVID-19 vaccination rates among both patients and staff declined. These barriers underscored the need for targeted interventions to address confusion, mistrust, and misinformation surrounding COVID-19 vaccination. It also revealed the need for strategies to ensure equitable access to vaccination services for all individuals, including those with unique cultural beliefs and preferences.

Best Practices Spread to Achieve Goals

As part of the Network's ongoing efforts to achieve vaccination goals, a best practice spread strategy was implemented to support facilities within its service area. Through assistance provided in personalized 1:1 onsite and virtual meeting assistance, Network staff facilitated the sharing of best-demonstrated practices from facilities that were successful in achieving high rates of COVID-19 vaccination for their patients and staff. A few of the suggestions offered to facilities included connecting with statewide immunization records, reaching out to local hospitals for updated vaccination records, and for those clinics that did not house vaccines in-house, encouraging visitation to local agencies offering vaccines. By showcasing these success stories and providing tailored guidance, facilities gained valuable insights and practical strategies for enhancing their vaccination efforts.

In addition to sharing success stories, the Network provided information to facilities about recent changes to the CMS Quality Incentive Program (QIP). Specifically, the Network highlighted the inclusion of healthcare workers in the reporting of vaccine status as a performance measure linked to payment. This information served as added incentive for facilities to align their vaccination efforts with QIP requirements, ensuring compliance and maximizing performance outcomes.

Facilities also received targeted guidance on educating patients about the importance of staying up to date with vaccinations, particularly those targeted for seasonal variants. By equipping clinics with the necessary knowledge and resources, the Network sought to empower them to effectively communicate the importance of vaccination to their patient populations. This comprehensive approach not only supported vaccination goals but also promoted better health outcomes within the community.



QIA: Quality Improvement Activity
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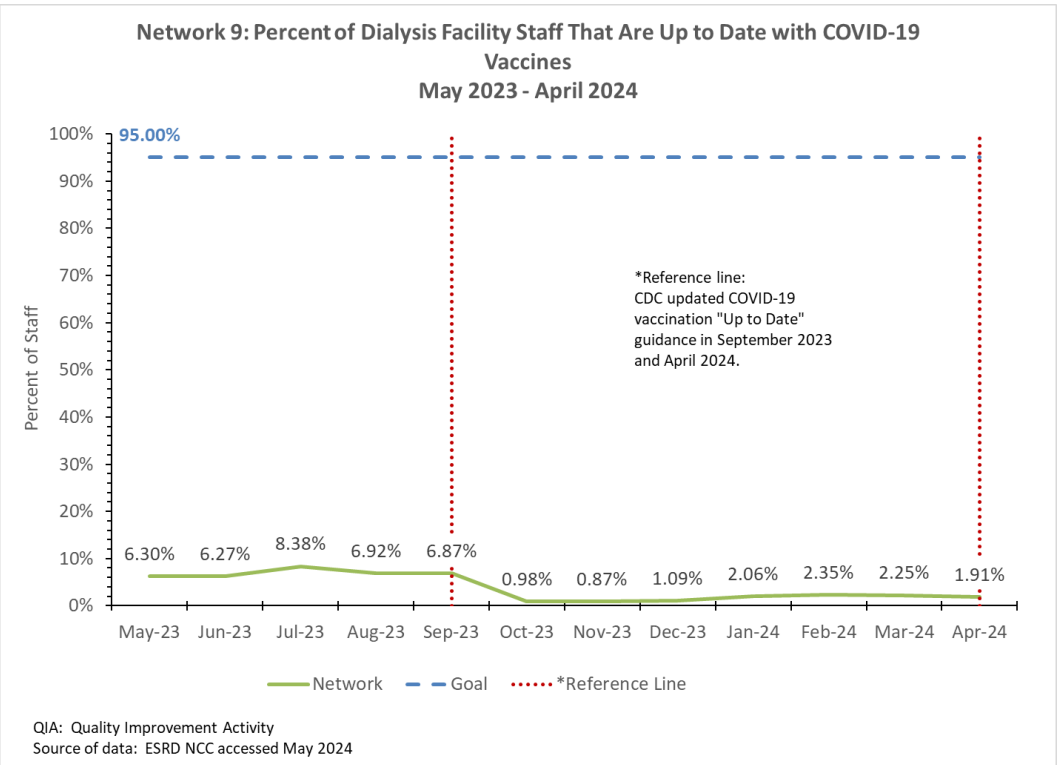

QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2024

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 costs[3]." 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 ages 65 and older receiving the vaccine.

Interventions

The Network provided one-to-one (1:1) technical assistance to improve pneumococcal vaccination rates for low-performing facilities, which included facilities with less than 50% of patients having been vaccinated. This was determined via calls, email, and group meetings. In addition, the Network distributed to all facilities, monthly performance reports that provided the current rates for patients in the facility who were "up to date." To best focus their efforts, a list of those patients who were missing vaccinations was also included. The Network created the tool *Pneumococcal Vaccination: Summary of Who and When to Vaccinate,* that was made available on its online education platform, *IPRO Learn*; 75% of facilities in the Network service area completed the activity, which provided a pneumococcal vaccination outline with a tracking system to help patients ensure proper timing of their vaccinations. Feedback received included:

- "Great tool to collaborate with Interdisciplinary Team"
- "It's a great concept. Buy-in would be hard for some of our patients due to age/infirmity, but there are a few who would benefit."

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 15,826 patients vaccinated (53%).

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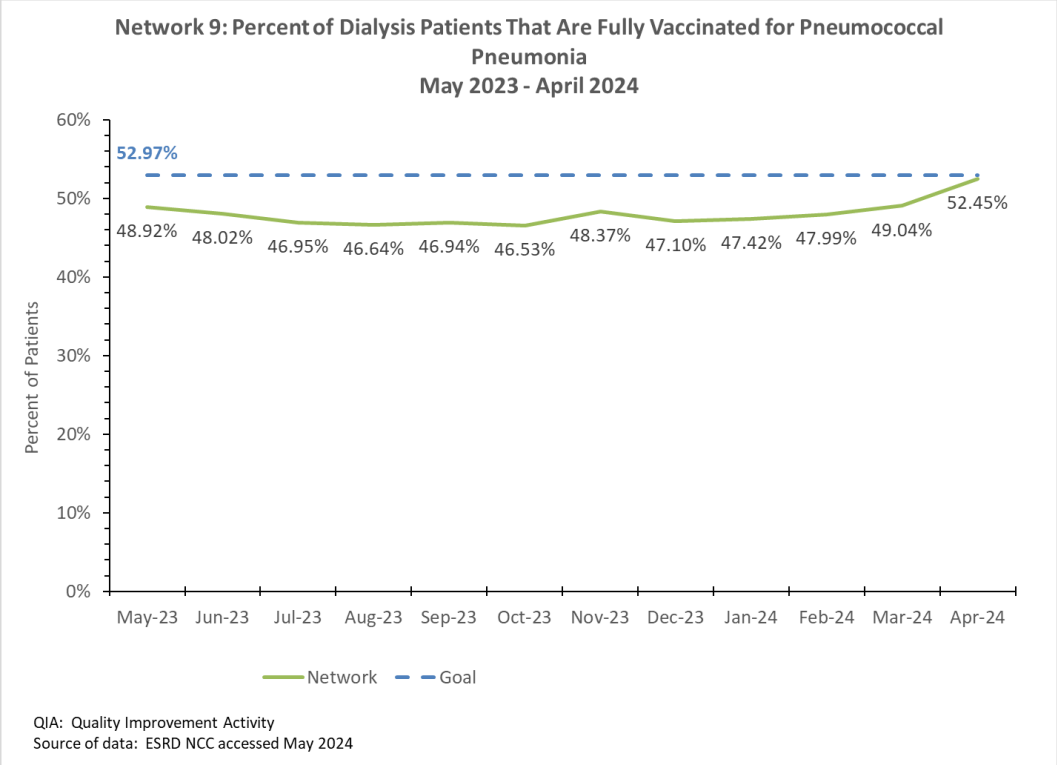
[3] Laressa Bethishou, P. (n.d.). *Pneumonia vaccines: Current recommendations and advocacy opportunities*. Pharmacy Times. https://www.pharmacytimes.com/view/pneumonia-vaccines-current-recommendations-and-advocacy-opportunities

Barriers to Achieving Goals

Barriers to achieving goals were primarily related to the lack of awareness and confusion about the CDC's requirements for being considered up to date with the pneumonia vaccine. This included appropriate steps needed to review and update records to match the facilities' internal systems versus national databases. Confusion was widespread, especially in light of the different vaccines that were available and the varying time ranges for administration. It's also important to note that the Network service area includes a large Amish community and barriers within the population are related to cultural and religious beliefs. Due to this, vaccine rates varied across the region.

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 Learning and Action Network (LAN) 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 EMRs 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 service area.



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 9 worked with dialysis facilities in its service area to improve the timely submission of forms to CMS through the 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. 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 [2764 Forms submitted on time] divided by the [number of total 2746 Forms submitted] in the most recent 12-month period.

Interventions

Network 9 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 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 156 Forms. Network facilities successfully submitted 185 2728 Forms that were over one year past due.

For the 2728 Forms due within 45 days, facilities successfully submitted 5,611 Forms on time, for a 78.92% compliance rate.

For the 2746 Forms due within 14 days, facilities successfully submitted 4,576 Forms on time, for a 65.51% 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 people 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.

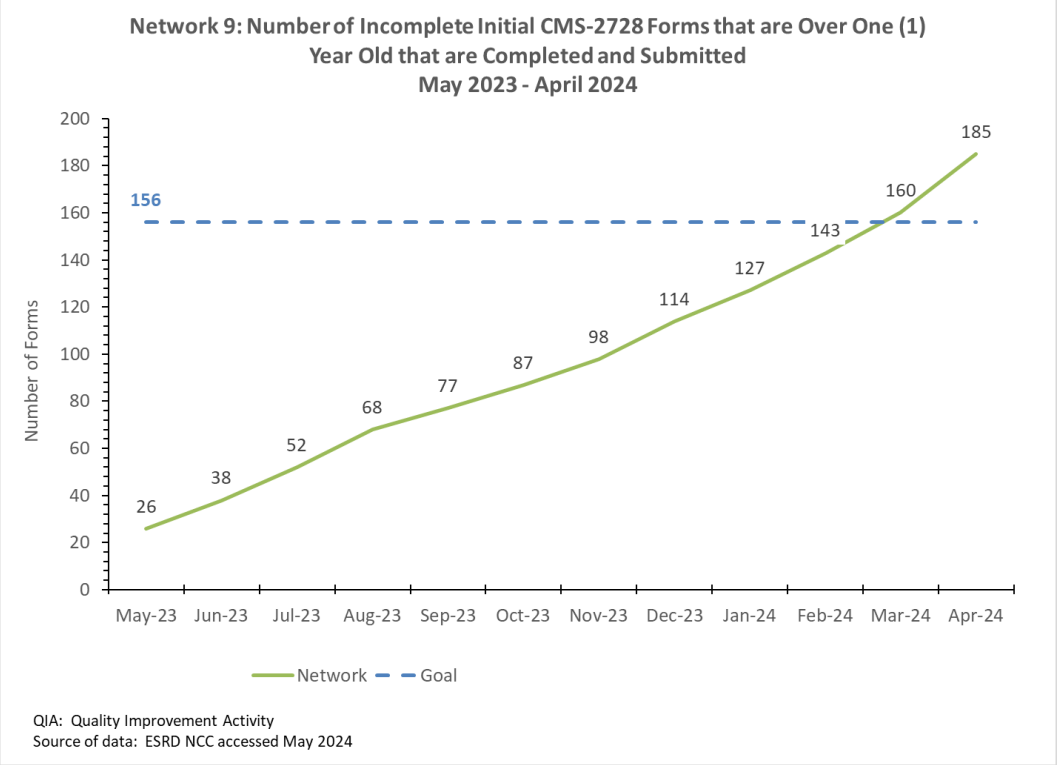
When completing 2746 Forms, facilities often were not made aware of the patient's cause of death within the first 14 days, especially if the patient was hospitalized. In such cases, the facility often selected 'unknown' as the cause of death, and later requested that the cause of death be updated once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



QIA: Quality Improvement Activity
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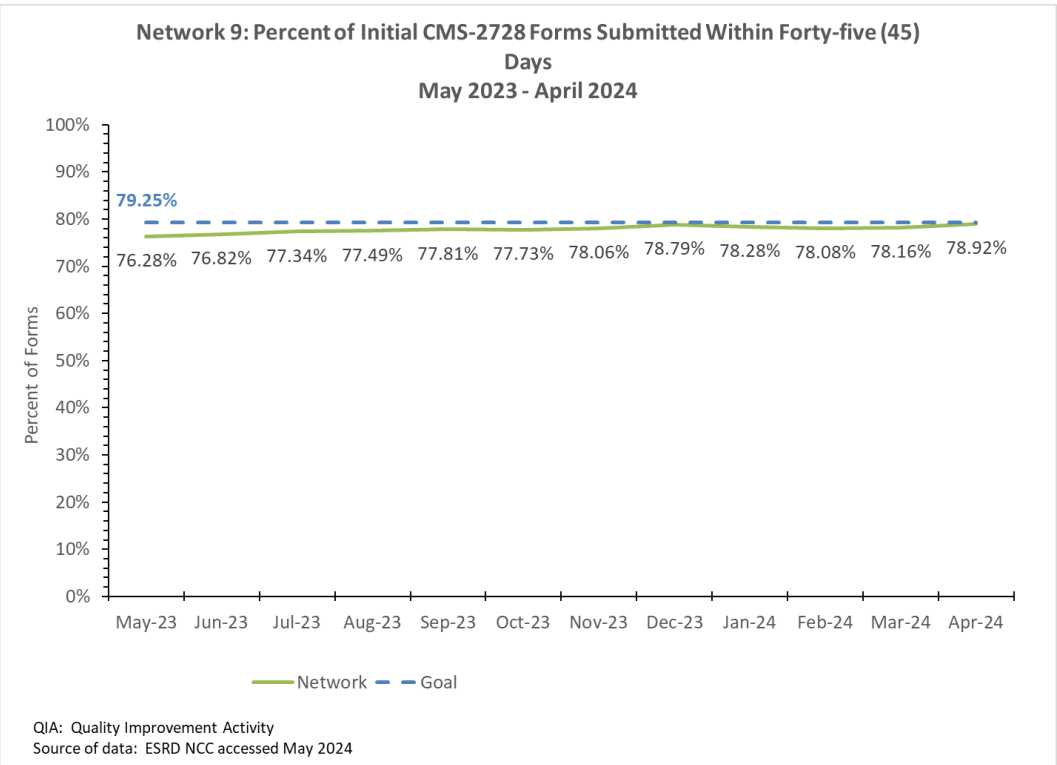

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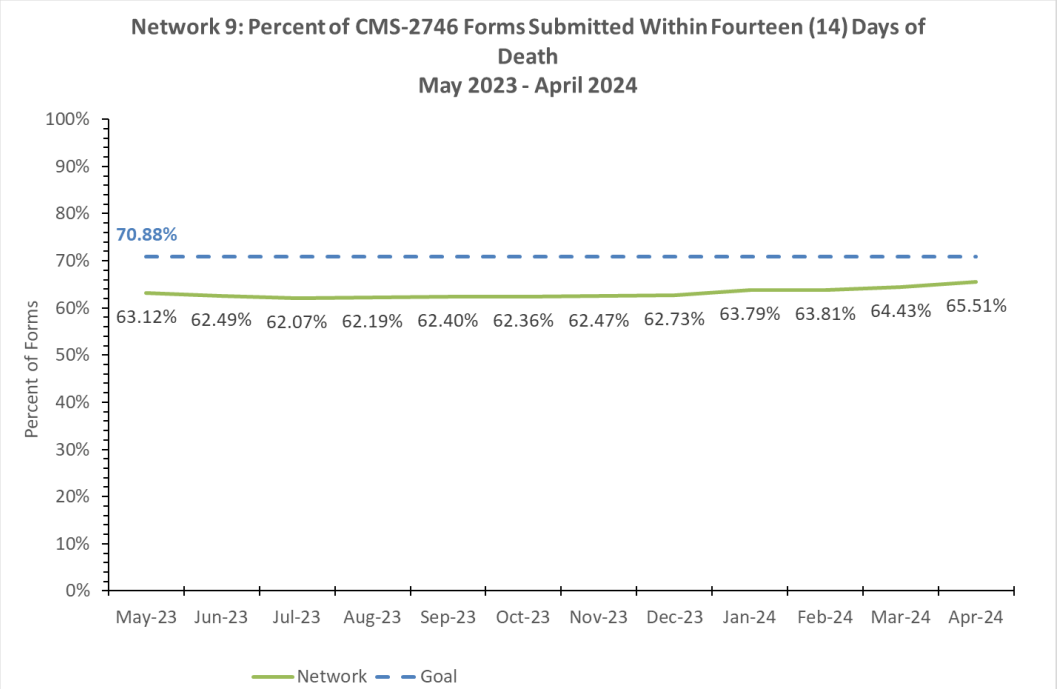


QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2024

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

Project Overview

ESRD patients are at a higher risk of needing urgent medical care, like 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 patients' physical state caused by kidney disease (e.g., diabetes, hypertension, cardiovascular disease, anemia, and blood chemistry imbalances). Dialysis patients are also more susceptible to infections because of weakened immune systems. Patients who experience more hospital stays and trips to the ED have a higher mortality and morbidity rate than those who rarely access acute care settings.

Considering these challenges, the Network worked to reduce, by 4%, hospitalizations, ED visits, and readmissions within 30 days related to specific CMS Primary Diagnosis Codes The baseline for the measurement was Medicare Claims data for May 2022 to April 2023.

Interventions

The Network recognized that health literacy plays a crucial role in effective patient-provider communication and that effective communication between providers and patients is a key factor in averting unnecessary hospitalizations, rehospitalizations, and ED visits. RCAs conducted throughout our community coalition confirmed that health literacy and patients' ability to comprehend health information were among the top causes of unnecessary hospitalizations and ED visits.

In practical terms, low health literacy can lead to misunderstandings or confusion regarding medical instructions, treatment plans, or medication regimens. Patients may not understand the importance of adhering to prescribed treatments or dietary restrictions, resulting in non-compliance and subsequent adverse health outcomes. Similarly, healthcare providers may inadvertently use medical jargon or complex language, exacerbating patient confusion.

To address these challenges, the Network developed a health literacy course tailored to various healthcare roles (nurses, dieticians, patient care technicians, and social workers) with continuing education credits available to nurses, registered dietitians, and technicians. This activity was designed to increase staff awareness of the critical role of effective communication in patient care and to equip them with strategies for communicating in a way that is clear and fully understandable to patients.

Participants engaged in a curriculum that emphasized the importance of empowering patients to actively participate in their healthcare decisions. It included an interactive component that featured the teach back method as an intervention to help patients understand how to manage their medical needs. Essential aspects of health literacy were covered, including barriers, effective communication strategies, and patient education techniques to use when discussing

the patient's medical issues and recent hospitalizations. Through this effort, the Network sought to empower patients to make informed decisions about their health and reduce the incidence of avoidable hospitalizations and ED visits.

The administration of the health literacy course also uncovered a need for a new patient resource to guide patients in determining the most appropriate place to seek care based on their specific condition or symptoms. Titled *What Type of Care Do I Need?* this resource used plain language to guide patients in understanding when their condition or symptoms require that they reach out to their primary care physician, an urgent care facility, or their hospital ED.

Outcomes

The Network's activities during the performance period resulted in a reduction in ED visits to 0.76%, exceeding the goal of 0.85%. The Network also reduced inpatient hospitalization rates to 2.02% and readmission rates to 10.5%, respectively 0.06% and 0.42% short of the goals. However, these results demonstrated reductions in overall hospitalizations. Using CDC's Center for Health Statistics calculated average inpatient hospital cost (2019) of $14,101[4], by reducing hospital stays by 326 from the 2022-2023 baseline rate, Network 9's work resulted in savings of $4,596,926.

Barriers to Achieving Goals

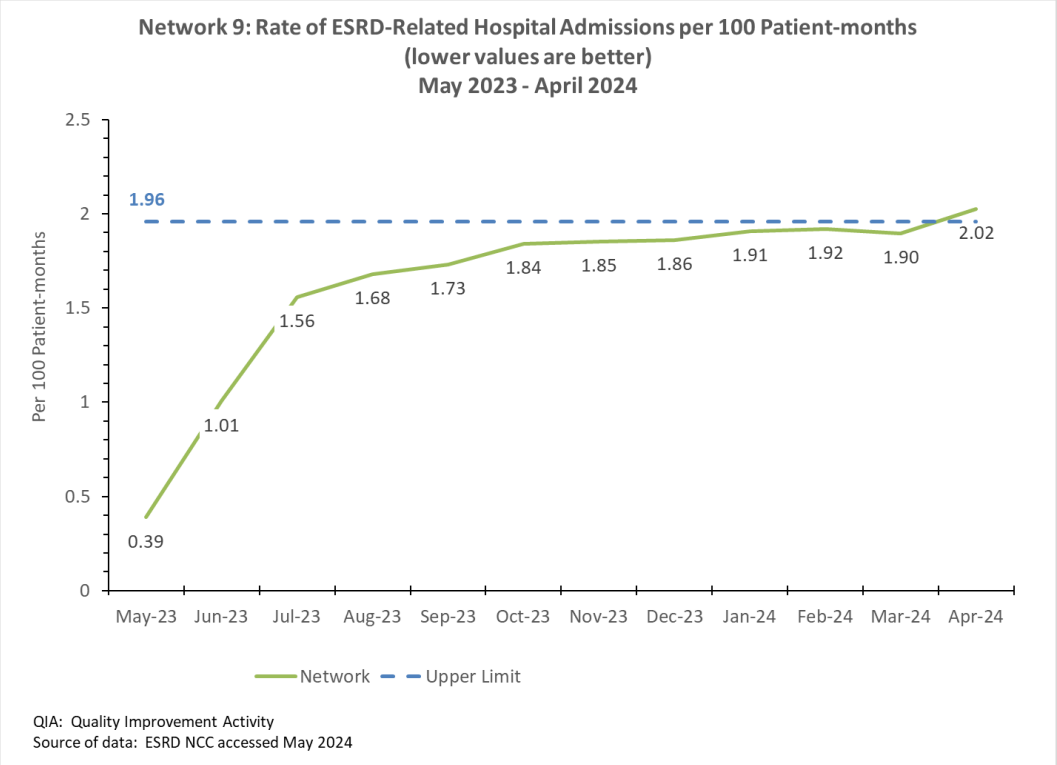
One obstacle the Network encountered was the difficulty in tracking patient hospitalizations and ED visits due to the lack of identifiable admitting primary diagnoses in the current dataset. The dataset provided to the Network contained 25 lines of ICD-10 codes, none of which indicated the primary admitting diagnosis. CMS prioritizes certain diagnosis codes, and if any of these codes appear 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 one of the ESRD National Coordinating Center's scheduled Learning and Action Network calls, the Network highlighted a standout best practice from a facility in the Network 9 service area. The facility focused on reducing hospitalizations, readmissions, and ED visits by addressing fluid overload and access infections. This facility prioritized patient engagement and involvement, introducing a creative approach with patient cards featuring catchy slogans. Each card contained 12 squares, providing patients with 12 opportunities to monitor fluid intake or access care. Staff members signed and dated the back of the cards, and once fully completed, patients would submit their card to the facility manager and receive a treat bag as a reward.

[4] Cost savings projected by using https://www.cdc.gov/nchs/hus/topics/hospitalization.htm average adjusted cost per inpatient stay.

The slogans on the cards included phrases like "Here's a tip, just take a sip and you'll avoid a hospital trip." Patients who maintained a weight gain of less than 2.7 kg between treatments would receive a signature on this card. Another card slogan was "Wash your access and remove the grime, and it will save your lifeline." Patients who washed their AV fistula or AV graft prior to each treatment session would earn a signature on the card. This approach not only encouraged patients to actively monitor their health but also incentivized positive behaviors, contributing to a reduction in hospitalizations, readmissions, and ED visits.



QIA: Quality Improvement Activity
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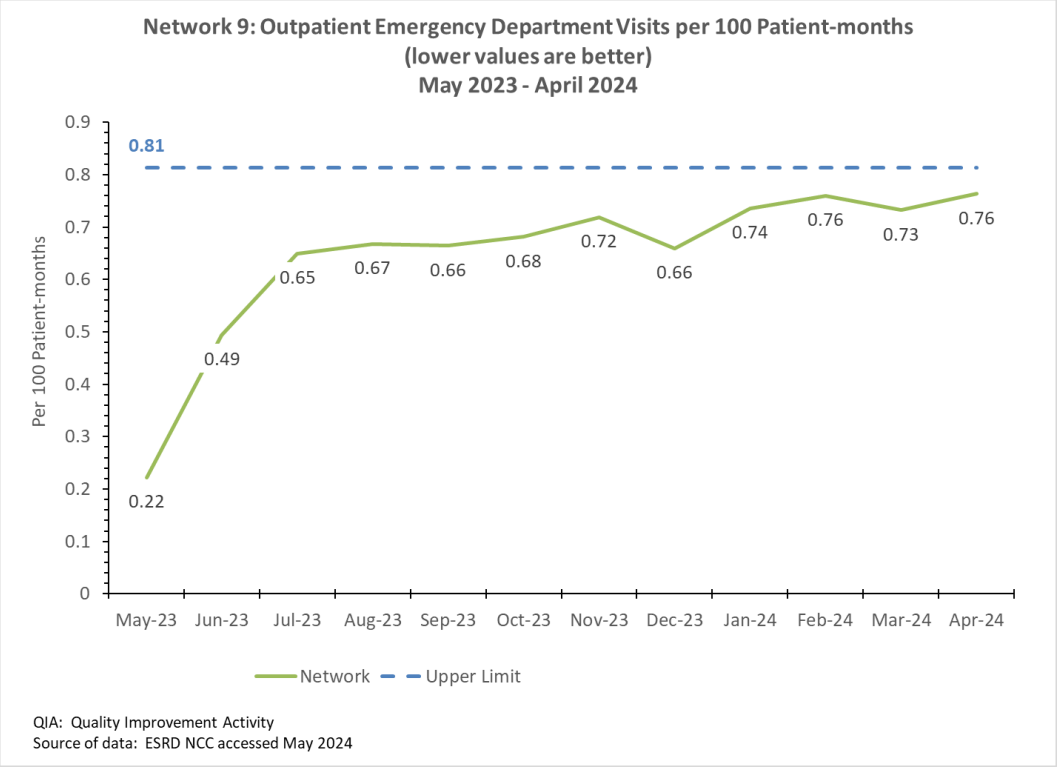

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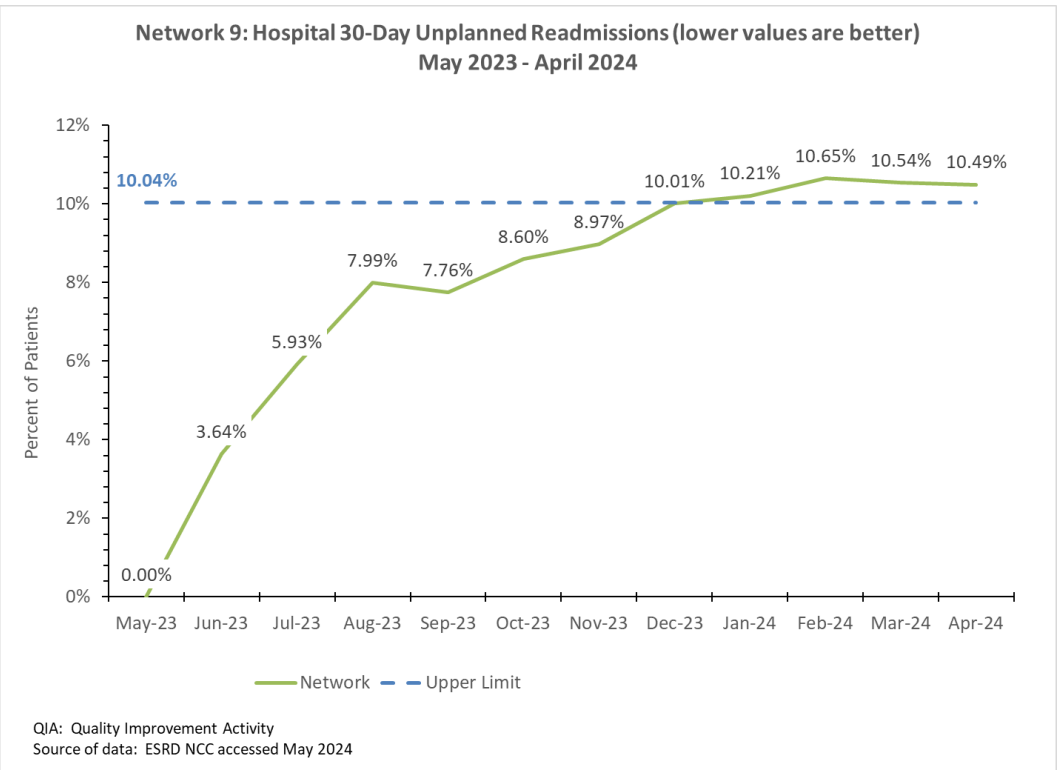


QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2024

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 ESRD patients receiving dialysis in the nursing home in which they reside, 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 as compared to the broader ESRD population, as evidenced by data from the United States Renal Data System. The Network's overarching 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 Too*l 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 *IPRO 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 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.

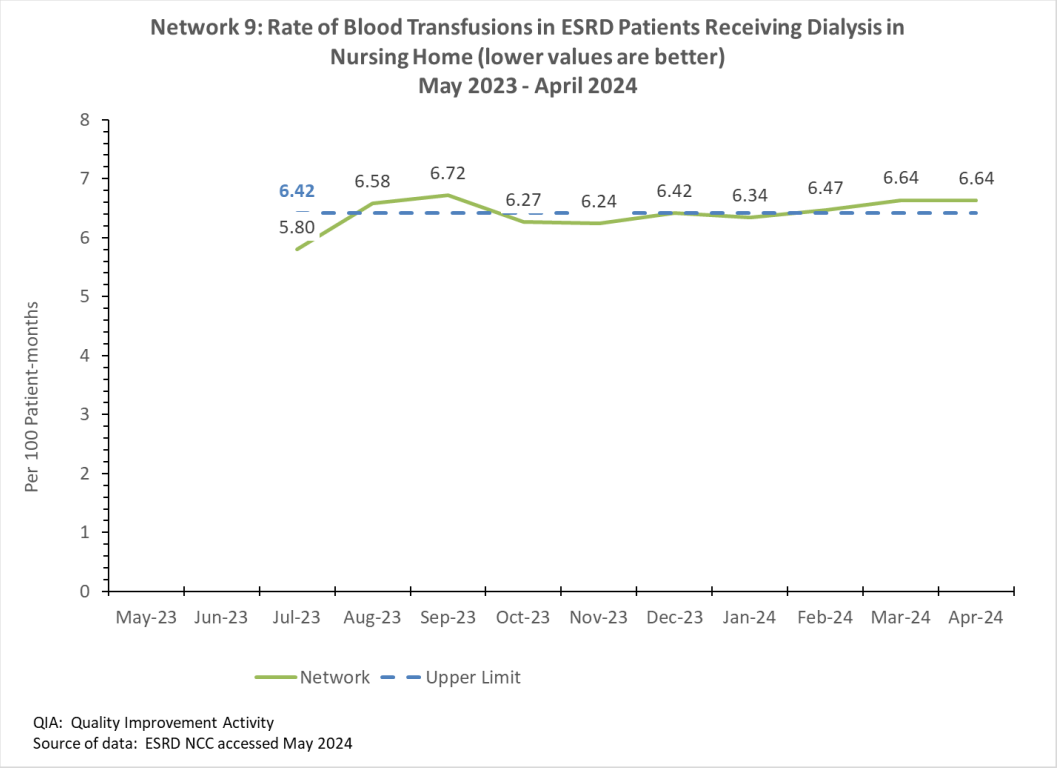
These challenges were exacerbated by the volume and acuity of patients. Network staff conducted in-depth reviews of the data and provided customized assistance to facilities based on issues identified through the reviews. Any systemic issues identified were forwarded to the ESRD NCC for further review.

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 RCA 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.



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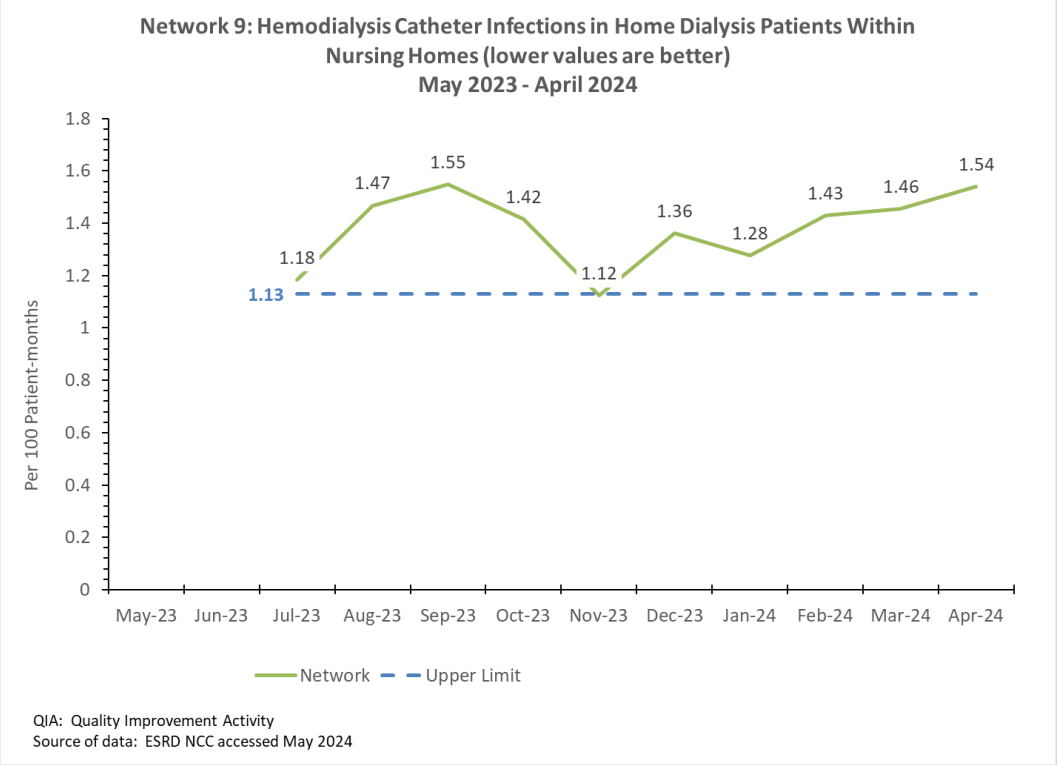

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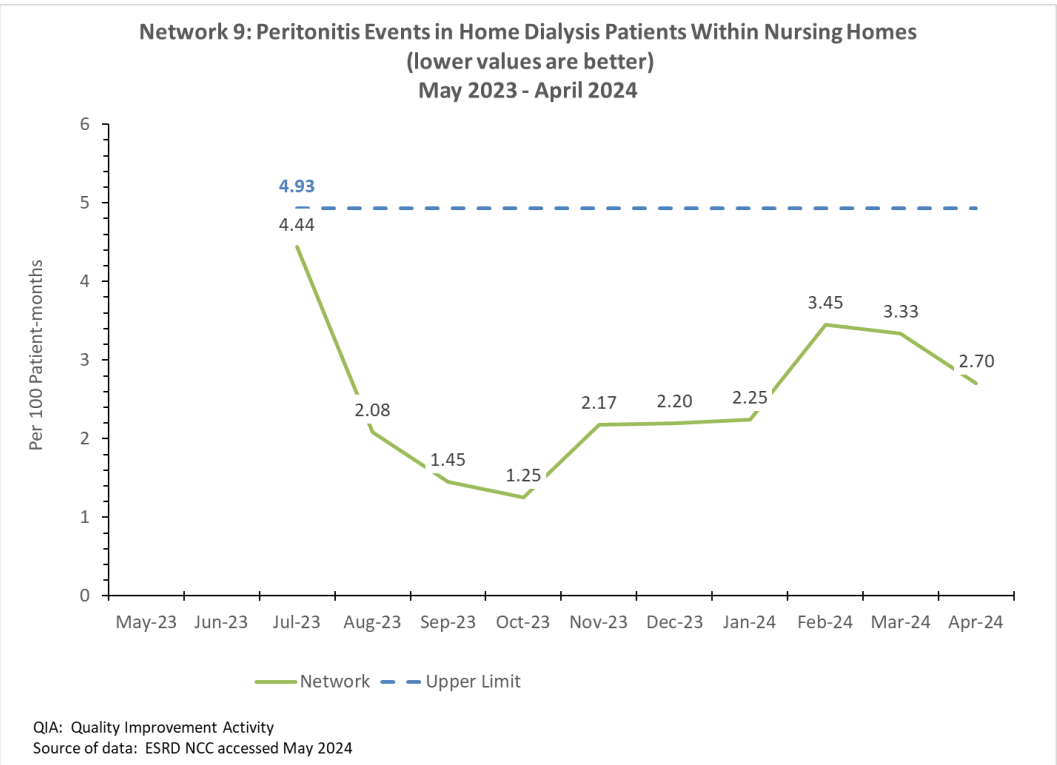


QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2024

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 a long distance from their care team in rural settings. During the performance period, the Network focused on increasing the number of rural patients participating in telemedicine visits by 3%. Based on zip codes, the Network identified facilities that have 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

The Network collected information from facilities in its service area to better understand if and how facilities were using telemedicine to provide care to patients in rural settings and/or on a home modality. Among the information gathered was the platforms used, whether patients needed to download/install anything on their personal devices to engage in a telemedicine visit, and whether the facility's physician team supporting the use of telemedicine.
Of the 467 facilities that responded

- 29% indicated that their platform did not need to be downloaded
- 60% stated that patients were able to join a call using a link
- 27% stated that patients needed to set up an account and password to join
- 78% indicated that their facility's physician team supported the use of telemedicine.

The Network hosted a Telemedicine Kickoff call for facilities that had patients on home dialysis in rural zip codes and/or facilities that were in rural zip codes. The kickoff call reviewed the goals of telemedicine and explained why those facilities that were invited to the call were included in the project. The Network reviewed the benefits of having patients who live in rural areas transition to home dialysis and use telemedicine to communicate with their care team. The Network also reviewed resources related to connectivity, laptops, smartphones, and devices as well as the EveryONE Project's *Neighborhood Navigator.*

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

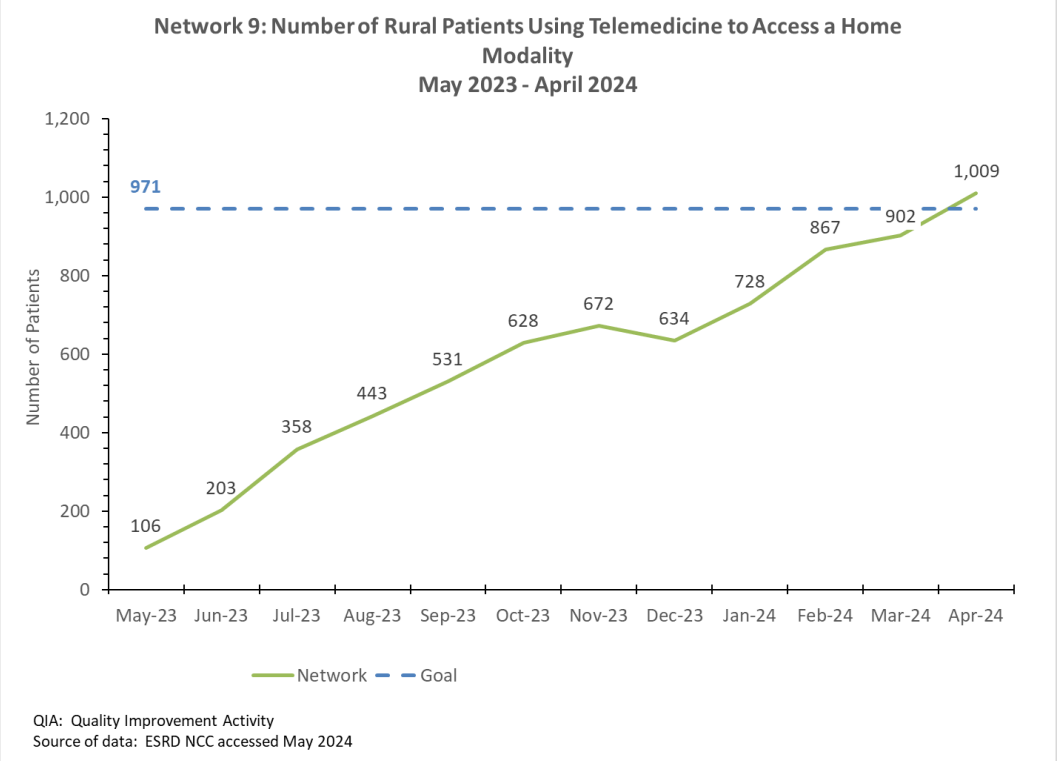
Working closely with the dialysis facilities, the Network 9 team exceeded the goal to increase use of telemedicine visits in its service area by 3% for a total of 1,009 rural telemedicine visits during the performance period.

Barriers to Achieving Goals

Facilities indicated that patients were having problems related to the platform the facility was using for telemedicine. Problems included setting up an account, needing a password to access the telemedicine visit, joining from a link, and having a physician who did not support telemedicine. Some physicians were resistant to telemedicine because they wanted to see patients face-to-face to properly assess them.

Best Practices Spread to Achieve Goals

The Network found that facilities with the most success used an interdisciplinary team approach for the telemedicine visits. They also took time to teach patients how to use their personal devices to conduct a telemedicine visit and how to use the platform on which their physician was hosting the visit. The same information was shared with patients during their home therapy training.



Depression Treatment September 2023-April 2024

Project Overview

Patients diagnosed with ESRD have an increased risk for depression due to both the psychosocial and biological changes associated with the disease. Depression is not only a mental health issue but can also have negative impacts on patients' physical health. Depression in ESRD patients is known to lead to a diminished quality of life and may even lead to an increased risk of mortality. Due to the high incidence of depression in the ESRD population, the goal of this project was to increase patients' awareness that their feelings are normal and that they can get help in dealing with feelings of depression and loss. At the beginning of the performance period, the goal of this project was to ensure that facilities were screening at least 80% of patients for depression, with an additional goal of increasing by 10% the number of those patients who screened positive and received treatment. During the performance period, CMS removed the depression treatment metric as a goal; however, it continued to be a top priority for the Network.

Interventions

The Network worked closely with facilities participating in the community coalition. The coalition comprised both high- and low- performing facilities; their performance was based on their depression treatment rates. These facilities completed a RCA and a PDSA cycle to identify the barriers to patients not seeking treatment for mental health. High-performing facilities shared how they overcame common barriers during an open office call.

Common barriers identified included stigma and patients' shame related to their emotional struggles. The Network developed the patient-facing resource *Working Through Feelings of Loss and Sadness* to help normalize depression, explaining that patients may experience a variety of emotions when faced with a diagnosis of a chronic disease such as ESRD. The resource explains that these feelings may align with the process outlined in the five stages of grief model, due to the life changes encountered when starting on dialysis.

The Network shared the ESRD NCC's *Depression Change Package* on its online education platform, *IPRO Learn*. This resource provided facilities with strategies for building trust and rapport with patients, with the understanding that building trust with patients can increase their comfort level in discussing mental health concerns with the dialysis staff.

To address appointment fatigue and limited access to mental health providers, the Network shared the *Psychology Today* website to assist patients in finding a therapist with whom they could feel comfortable. Through this resource, they were also able to search for providers that offer virtual appointments to help lessen the burden of traveling to an appointment.

Outcomes

The depression treatment rate goal was removed from Network goals early in 2024; however, the Network continued to monitor facilities for both their depression screening and treatment

rates. Overall, facilities in the Network service area screened 99.35% of patients for depression and had a depression treatment rate of 12.8%.

Barriers to Achieving Goals

Throughout the performance period, the Network worked closely with facilities through one-on-one technical assistance, community coalitions, and *IPRO Learn*. Through this work, the Network was able to identify several common barriers standing in the way of patients seeking treatment for depression. These barriers include stigma and shame, appointment fatigue, and lack of interest by patients.

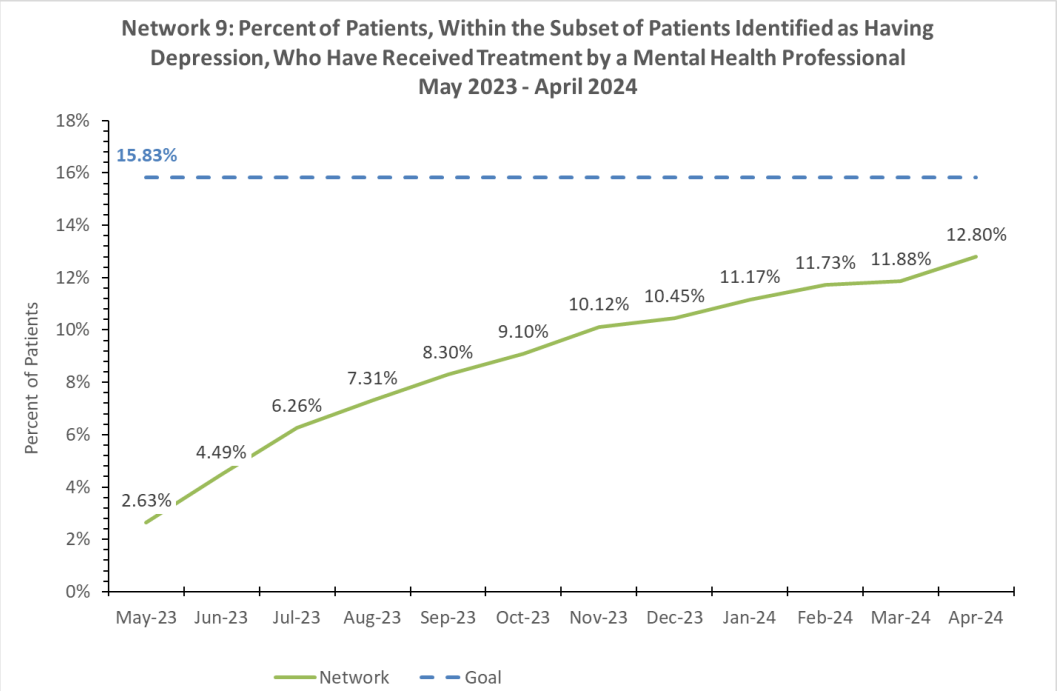
The Network also found that many patients were receiving support through pastoral care, patient support groups, and/or peer mentors. Since these programs do not bill Medicare, these patients were not included in the measurement of patients receiving treatment.

Best Practices Spread to Achieve Goals

The Network worked to build comradery and best practice sharing across facilities in its service area by creating a post on its *Behavioral Health Forum*, inviting facilities to share their best practices in increasing depression treatment rates. A total of 111 facilities posted on this forum and all facilities within the Network Service Area were able to view and comment on other postings.

On an ESRD NCC Expert Teams call, a high performing facility shared how they initiated a patient support group to address chronic disease and the benefits patients experienced from all that the support group offered.

On an ESRD NCC Community of Practice call, the Network shared a best practice that was identified during a facility site visit. This organization used art therapy during treatments to assist patients in expressing their emotions. The Network also met with a Patient Facility Representative to explore how art therapy benefited them. The positive impact of art therapy from the perspective of the patient was then shared with other Networks during this call.



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

Patient and Family Engagement May 2023-April 2024

Project Overview

Working with facilities to establish a culture in which the perspectives and values of patients and family members were included in the planning, delivery, and evaluation of the patient's care has been an ongoing focus of the Network's work. During the performance period, the Network worked to incorporate the patient's voice at the facility level through inclusion in quality improvement activities, active participation in their own plan of care, and peer mentorship.

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

1. Increase the number of facilities in which the patients' 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

The Patient Facility Representative Alliance

The Patient Facility Representative (PFR) Alliance is an organized group of dialysis and transplant patients, family members, and care partners across the network service area 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 and contributed their perspectives in the creation of the 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*

Using *IPRO Learn*, the Network's online education platform, the Network created an educational module to disseminate educational materials and resources about the Agency for Healthcare Research and Quality's (AHRQ) SHARE approach to encourage life planning. This activity was completed by 426 facilities (66%), and 87% stated they would adopt the resources in their facility practices. Feedback from this activity included the belief that the SHARE approach is a great tool to encourage patients to play an active role in their own care. Patients who let others speak for them (e.g., medical professionals or care partners) often are not aware of the importance of participating in their own care decisions. Using the SHARE approach to encourage these conversations can help allow patients to use their voice and advocate for their needs. Another line of feedback was that the SHARE approach was a good resource, particularly

with ESRD patients who often do not get sufficient information about their disease or dialysis before starting treatment.

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 on the principals 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 outreach strategies deployed at the conclusion of the community coalitions project cycles. Once recruited, patients participated in training that took place 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 attendance by:

- Providing reminders to members in advance of meetings using Text-Em-All, a mass messaging platform that delivers personalized text message and direct phone calls to large groups 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 200 facilities in the Network service area integrating the patient perspective in QAPI; a rate of 33.1%
- 392 facilities assisting patients in developing a life plan; a rate of 65%
- An additional 267 facilities developing and supporting a patient-to-patient support program; a rate of 44.2%
- Maintaining a patient attendance rate of 76% for N-PFE LAN 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 Ohio River Valley was able to expand the PFR Alliance to 135 new ESRD patients and care partners.

Barriers to Achieving Goals

Despite the success in meeting the goals during this performance period, finding patients who were willing to participate in activities outside of their dialysis schedule was identified as a barrier to patient engagement in QAPI meetings. Lack of patient participation impacted the facility's willingness to allocate time to foster better engagement.

Best Practices Spread to Achieve Goals

The Network hosted calls during which best practices identified by high performing facilities that had successful patient engagement strategies were shared with other facilities in the Network service area. Resources that outlined best practices in patient inclusion in QAPI and life planning were shared continually with the provider and patient communities, and live peer mentoring training sessions were conducted regularly to support, strengthen, and expand the peer mentorship program across the Network service area.

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 at a disadvantage in achieving this goal 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. Disproportionately 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, as identified by CMS were targeted by the Network based on the association of "food deserts" and high ADI areas[5]. A "food desert" or a "food swamp" is defined as an area in which the population has multiple barriers preventing access to healthy food. The Network conducted an environmental scan to better understand factors used by each facility to screen patients for existing social determinants of health (SDOH), including food insecurity. While most facilities were already screening for SDOH barriers, the Network assisted staff in streamlining the screening process by providing CMS SDOH screening expectations for future ESRD QIP measures.

The Network used internal data to further explore specific areas where barriers were significantly impacting health equity. The data identified many facilities with low waitlists and transplantation rates located in rural areas. The Network met with individual facilities virtually and in face-to-face onsite meetings to further explore the disparities and to identify contributing factors. For patients treated at rural facilities with low waitlist and transplantation, transplant centers were inaccessible due to distance. Cultural barriers, personal values and beliefs, were also identified; many of these barriers were identified in the Appalachian region, which runs along the state borders of Network 9. This includes 32 counties in Ohio and 54 counties in Kentucky. The geographic area is described as rural with limited access to quality

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[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

healthcare, widespread poverty, education gaps, and limited access to employment[4]. The population's sociocultural barriers have a large impact on the community's health outcomes. This included the community's perception of the healthcare system, health literacy, and the cultural competency of healthcare workers. Facilities were provided with Culturally and Linguistically Appropriate Services (CLAS) educational resources to help staff provide patient care in a way that respects the culture and background of the individual patient and responds to individuals' healthcare needs and preferences.

Culturally and Linguistically Appropriate Services (CLAS) May 2023-April 2024

Project Overview

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

Interventions

To advance health equity and improve the quality of care provided to all their patients, the Network encouraged dialysis facilities to adopt CLAS standards. The Network distributed to all facilities in its service area an assessment of National CLAS standards to gather data on facility staff members' baseline knowledge about CLAS standards. Analysis of this 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 names, 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 how CLAS can be integrated into organizations' current policies and procedures.

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, where indicated. To conclude the training, facilities were given a CLAS Implementation Checklist and a post-training assessment to identify areas of improvement and to track improvement in the 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 to set actionable goals to meet the guidelines of CLAS. Facilities indicated their intention to use the CLAS Implementation Checklist to guide staff in taking the necessary steps to improve health equity at an organizational level.

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% or 125 of the dialysis facilities in its service area, whichever figure was less. Onsite technical assistance offered dialysis providers, patients, leaders, and other stakeholders an 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.

Selection of facilities 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 visits 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

Interventions provided included data sharing, facility-specific coaching, facility-specific resources for quality improvement, information on community resources, and ongoing follow-up support. The onsite manager also met with patient representatives to gauge engagement. Facilities were provided with education, resources, and ongoing support to help build patient and family engagement as needed. Examples of interventions include:

- Distribution of resources including the EveryONE Project's *Neighborhood Navigator, Ride United, What Type of Care Do I Need?* and a demonstration of how to use the Network's *Kidney Transplant Compare* application. This application allowed staff or patients to search transplant locations in a geographical area by zip code to compare eligibility criteria, success rates, and wait times.
- Educating clinic staff about the *Neighborhood Navigator*, a search tool that allows the user to enter a zip code that will display all patient resources in that area for food, housing, financial assistance, transportation, and employment aid.
- Referring staff to the *IPRO Learn Helpdesk* and providing a demonstration of how to submit a help desk ticket to troubleshoot data reports and request other Network assistance.

Outcomes

The Network was successful in completing the required 125 sites visited.
Outcomes of these visits included:

- 13 new patients registering to be PFRs
- Increases in *IPRO Learn* engagement in 77 clinics
- Decrease of hospitalization admissions in 41 clinics
- Decrease of readmissions in 21 clinics
- Decrease of ER visits in 47 clinics
- Increase in flu vaccines in 72 clinics
- increase in pneumonia vaccines in 80 clinics
- Increase in 2728 submission in 60 clinics
- Increase in 2746 submissions in 46 clinics
- Increase of prevalent patients in 53 clinics
- Increase of incident patients in 15 clinics
- Increase of waitlisted patients in 43 clinics, while the number of patients transplanted increased in 35 clinics.

Barriers to Achieving Goal

Although barriers varied from state to state, the consensus was that they focused on transportation, access to care, staffing, patient and family engagement, and misuse/lack of use of Network resources. However, in Kentucky an additional barrier was identified as the lack of access to a path toward transplantation or to be waitlisted. Most clinics that were visited are considered "rural," with transplant centers located 1.5 to 3.5 hours away by car. In addition, a large percentage of the population were of low socioeconomic status and had minimal job opportunities. All these factors contributed to barriers that prevented patients from being able to access a transplant center or find a job post-transplant.

Best Practices to Spread Goal

Facilities in the Network service area implemented process improvements, designated staff to perform quality improvement work recommended by the Network and developed a sustainable process to improve metrics and completion of coalition work. Patient and family engagement was improved by increasing the enrollment and activity of PFRs. The Network trained facilities to ensure that all staff contact information was maintained accurately in the Network's Contact Management System, so that Network communication and EQRS cleanup reports would reach the appropriate people responsible for EQRS tasks, as well as those who provided oversight. The Network collaborated with small dialysis organizations to encourage them to improve their EQRS compliance process and utilize IPRO resources. The Network gathered best practices for improving compliance from successful dialysis facilities and distributed this information to facilities across the region.

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successful
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risk

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 Indiana, Kentucky, and Ohio, with a goal to address and mitigate concerns.

Grievances

The Network received and responded to 382 cases, including 21 (5.5%) general grievance cases and 10 (2.6%) clinical quality of care (QoC) cases that were mediated. For all cases with clinical components, the Network reviewed patients' medical records and participated in care conferences to effectively communicate the findings. A review of grievance cases from the time period revealed that the most common areas of concern included staffing, communication, clinical competency, professionalism, and treatment environment. Patients expressed concerns related to staffing issues, specifically the lack of communication skills, competency, and empathy on the part of staff, for both clinical and general grievance processes. In addition, the Network reviewed four (1%) immediate advocacy cases, which are similar to general grievances but can be resolved in a shorter time frame. Patient concern cases, cases for which patients did not file grievances, but instead requested support or outreach on their behalf, comprised approximately 14 cases (3.7%).

Upon initiation of each grievance case, the Network provided patients with information on their rights and responsibilities, the Network's role in resolving the grievance, the parameters of what the Network could do, and how the grievance process would be executed. The Network provided mediation and assistance via phone meetings with clinics, sometimes including the grievant and their care partners (as desired). Mediation was directed at de-escalating ongoing patient concerns and creating an environment of safety and inclusion.

The Network received calls from facilities to address clinic staff concerns about patients' behavior, treatment, rights, mental health, and ability to adjust to and cope with dialysis. The Network provided technical assistance to address more than 257 (67.3%) cases, including cases related to staff shortages, disruptive/abusive behavior, nonadherence, mental health issues, and cognitive concerns; many were case-specific scenarios that did not fit into specific categories. Those clinics that contacted the Network received technical assistance and resources via *IPRO Learn,* the Network's online education platform and email. Interventions focused on supporting facility staff in implementing de-escalation techniques 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 plan. These interventions provided facilities with the necessary guidance to improve their patients' overall quality of care.

The Network observed that staff shortages within dialysis facilities often resulted in fewer staff members available to work with patients and seriously affected patient care. These situations sometimes resulted in grievances or situations in which incidents that would have been addressed on-site at the time of the event were not uniformly addressed. As a related issue,

dialysis social workers and other leadership that were trained and experienced in de-escalation were often covering multiple clinics and were unable to devote full time to their assigned patients. To help address potential issues caused by situations as described above, the Network employed strengths-based approaches in assessing patients and acknowledged staff burnout and compassion fatigue at the clinic level.

Access to Care and Involuntary Discharge (IVD) Cases

During the performance period, the Network received a total of 76 (19.9%) cases related to Access to Care concerns. These concerns involved patients who were at risk of losing their ability to be dialyzed at their outpatient clinic, patients who already lost admission to their dialysis clinics, or patients who contacted the Network for assistance with obtaining placement. Of these cases, some were considered at-risk, some were involuntary discharges, and some were failure-to-place cases. In each case, the Network provided technical assistance to help facility staff support and protect their patients' access to treatment. The Network recognized that a patient's unresolved grievance could be the gateway to their dissatisfaction, leading to frustration and potential patient/staff conflicts. To address this, the Network worked to increase patient education and encouraged patients to become more engaged in their care as a strategy to improve patient understanding and acceptance. During the performance period, many at-risk reported cases were resolved, thereby averting an involuntary discharge. After receiving Network support, many patients who had previously been labeled "failure to place," were able to obtain placement. 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 continued to provide educational resources to both patients and clinic staff on patients' rights, including the *Dialysis Patient-Provider Conflict Manual* and addendums, and the *CMS Conditions for Coverage Interpretive Guidance*.

Additionally, clinic staff members were encouraged to incorporate patients into QAPI meetings.

Network Assistance and Quality Improvement

Throughout the performance period, the Network worked to achieve several overarching goals that included:

- Resolving grievances within specific time frames
- Supporting dialysis facility staff in managing mental, emotional, and psychosocial issues of patients
- Increasing patients' awareness of the Network and its educational resources
- Providing educational resources with each grievance resolved
- Increasing the use of *IPRO Learn* modules.

The Network supported patients in advocating for their rights and encouraged them to more freely express their concerns with their facilities. To improve communications among patients and staff, the Network met with PFRs to discuss topics such as:

- Grievance process
- Emergency preparedness
- Mental health

- Access to care
- Communication
- Support groups
- Depression
- Coping.

When facilities contacted the Network for assistance, facility staff received technical assistance as well as resources and tools to address their specific issues. Resources (also available on *IPRO Learn)* focused on topics such as:

- Decreasing patient and provider conflict
- Critical Assets Survey
- Addressing various types of non-adherence and what might cause this in our setting via American Kidney Fund (AKF), NKF, ESRD NCC resources
- Addressing mental health signs, symptoms, management techniques through de-escalation, Substance Abuse and Mental Health Services Administration (SAMHSA), and local resources through *Neighborhood Navigator.*

A new feature of the support provided to facilities during this performance period was the provision of on-site visits by Network staff. As a result of these visits, facilities reported either first being acquainted with or once again becoming involved with the Network and its resources.

The Network also provided direct support to the three facilities that were placed in "Immediate Jeopardy" status. Network staff conducted supportive planning sessions during which best practices in areas of deficiencies were shared and made recommendations for training, educational materials, and resources to mitigate issues with patients, staff members, or facility wide.

In all cases, interventions focused on supporting facility staff in exercising de-escalation techniques and effectively communicating to ensure that potential barriers (triggers) that could negatively affect a patient's ability to remain compliant with their treatment plan were identified and understood. Network staff provided guidance tailored to each situation. These interventions provided facilities with the necessary guidance to improve their patients' overall quality of care.

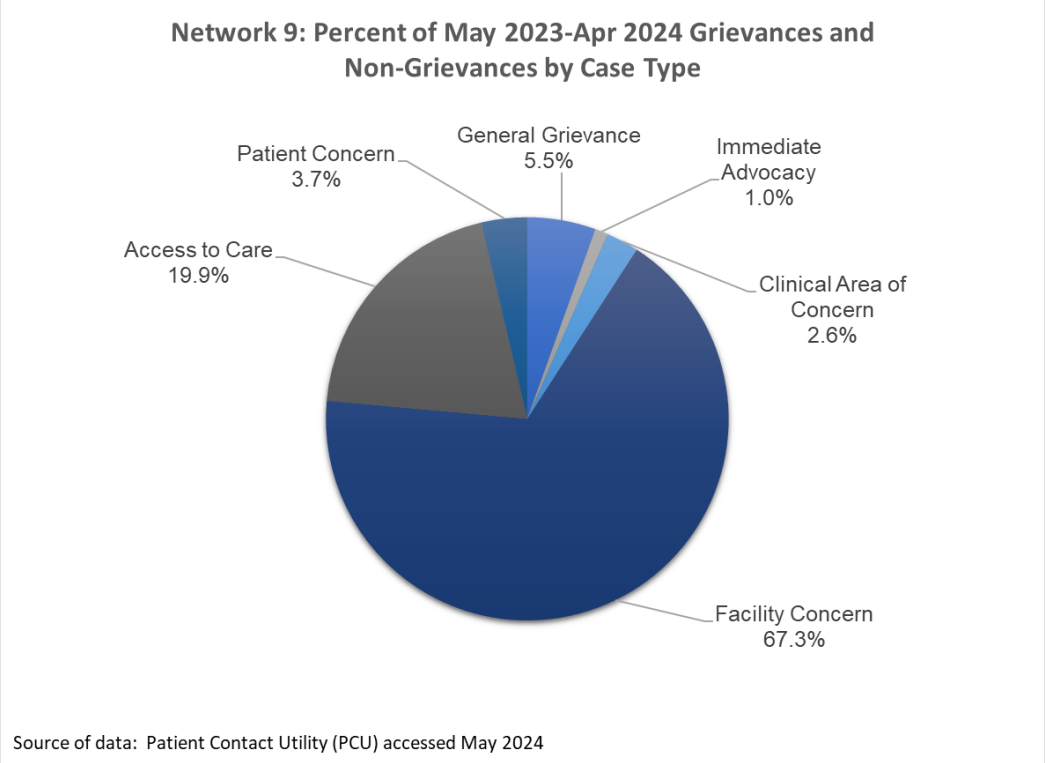
The Network provided patients and facilities with various resources including:

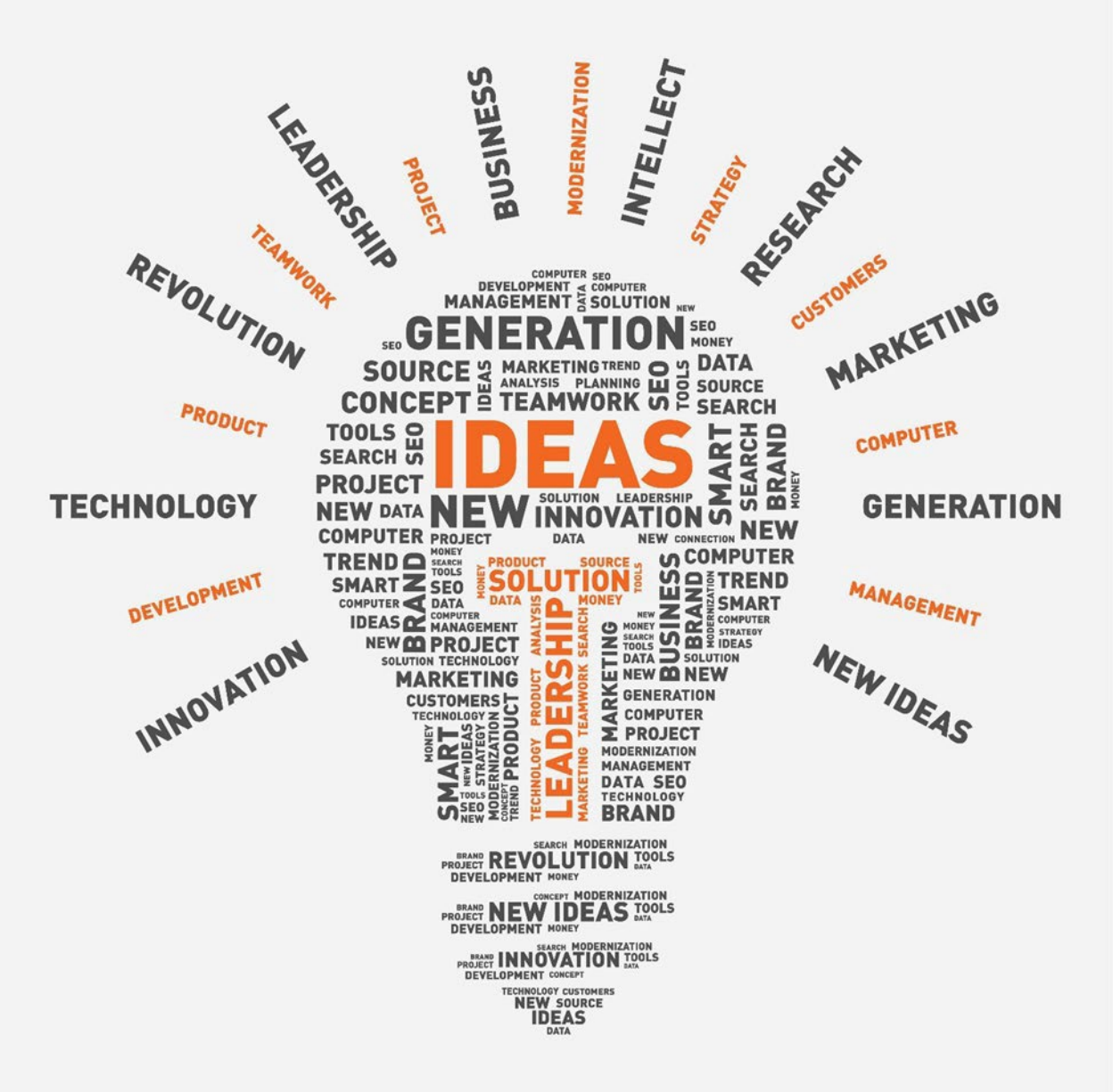
- The *Dialysis Patient Grievance Toolkit* created by the Forum of ESRD Networks' Kidney Patient Advisory Council (KPAC)
- Grievance preparation worksheets from the *Grievance Toolkit*
- Educational posters and flyers
- The *Dialysis Patient-Provider Conflict Manual (DPC) and Addendum* dealing with Access to Care concerns
- Brochures and flyers about the *Second Chance Trial Program*

- The Crisis Prevention Institute (CPI's) *Top 10 De-Escalation Tips* (for healthcare professionals), *Trauma Informed Care*, *Seven Principles for Effective Verbal Intervention*, and updated versions.

All Network-implemented interventions incorporated the basic elements of quality improvement, including environmental scan/needs assessment of dialysis clinic staff; provision of technical assistance (TA) to support clinic staff in using quality improvement tools, such as RCA and PDSA cycles; ongoing emphasis of the value of establishing professional boundaries with patients; and early introduction and ongoing reinforcement of the value of integrating quality improvement methodologies into the culture of the clinic.

During the performance period, 41 facilities were closed due to weather related events, 33 facilities closed due to emergency events, and 50 facilities altered their schedules. In total, 44 facilities were temporarily closed and 20 were closed permanently.

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MANAGEMENT
INNOVATION
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SOLUTION
LEADERSHIP
NEW
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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 9 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 cite 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 care partners for home health care; greater support and success in home modalities would exist if Medicare paid for staff-assisted home dialysis for appropriate patients.


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public safety
ambulance
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damage
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preparedness
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medical
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disaster
supplies
protection
emergency room
service
help
kit
evacuation
stretcher
paramedic
business
alarm
medic
safe
jeopardy
resilience
emergency
incident
equipment
disease
urgency
threat
natural disaster
natural
information
property
recovery
nurse
crisis
doctor
government
situation
health
environmental
risk management
public
response
rescue
hospital
security
room
intervention
operations
life
accident
risk
medicine
education
loss
system

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 care partners 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 349 users of the *ESRD Emergency Hub Mobile Application* within the Network service area.

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

- Weather-Related Events – 41
- Emergent Events – 33
- Altered Schedule – 50
- Staff Shortage – 36
- Temporary Closures – 44
- Permanent Closures – 20

There were 20 closures of facilities reported in the Network service area and 36 reports of staffing shortages 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.

Significant Weather Event

On April 8, 2024, a total solar eclipse moved across North America, passing over Mexico, the United States, and Canada. A total solar eclipse happens when the moon passes between the sun and earth, completely blocking the face of the sun. Communities within the Network's region were impacted by the solar eclipse, with the greatest areas of concern being the movement of large crowds of people to the path of totality, temporarily ballooning the populations of small towns and rural areas and causing closures of facilities and infrastructures, other social conditions, staffing concerns, and transportation delays. In preparation for the solar eclipse, the Network provided 1:1 technical assistance to facilities in the service area that requested a review of their preparation plan. The Network also collaborated with the Medicare

Quality Innovation Network – Quality Improvement Organization to develop resources for patients and providers that encouraged preparation, including altering treatment schedules.

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.