ESRD NETWORK 2017
ANNUAL REPORT

Description of the patient and facility population in the ESRD (End Stage Renal Disease) Network program and the outcomes of the quality improvement activities performed by this Network compared to the Network program performance.
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ESRD DEMOGRAPHIC DATA
Network 15: Prevalent ESRD Patients by Treatment Modality
As of December 31, 2017

<table>
<thead>
<tr>
<th>Modality</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplant</td>
<td>13595</td>
</tr>
<tr>
<td>In-Center Dialysis</td>
<td>21851</td>
</tr>
<tr>
<td>Home Dialysis</td>
<td>3095</td>
</tr>
<tr>
<td>Total Dialysis Patients</td>
<td>24946</td>
</tr>
<tr>
<td>Total ESRD Patients</td>
<td>38541</td>
</tr>
</tbody>
</table>

Total Dialysis Patients = In-Center Dialysis + Home Dialysis
Total ESRD Patients = Transplant + Total Dialysis Patients

Source of data: CROWNWeb

Network 15: Number of ESRD Medicare-Certified Facilities by Modality Type Offered
As of December 31, 2017

<table>
<thead>
<tr>
<th>Modality</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplant</td>
<td>15</td>
</tr>
<tr>
<td>In-Center Hemodialysis and Home Dialysis</td>
<td>167</td>
</tr>
<tr>
<td>In-Center Hemodialysis (Only)</td>
<td>179</td>
</tr>
<tr>
<td>Home Dialysis (Only)</td>
<td>12</td>
</tr>
<tr>
<td>Total Dialysis Facilities</td>
<td>358</td>
</tr>
<tr>
<td>Total Facilities</td>
<td>373</td>
</tr>
</tbody>
</table>

Total Dialysis Facilities = In-Center Hemodialysis and Home Dialysis + In-Center Hemodialysis (Only) + Home Dialysis (Only)
Total Facilities = Transplant + Total Dialysis Facilities

Source of data: CROWNWeb
Source of data: CROWNWeb
National: Count of ESRD Medicare-Certified Dialysis Facilities by ESRD Network with Percent of Total
As of December 31, 2017

Source of data: CROWNWeb

National: Count of ESRD Medicare-Certified Kidney Transplant Facilities by ESRD Network with Percent of Total
As of December 31, 2017

Source of data: CROWNWeb
ESRD NETWORK
GRIEVANCE AND ACCESS TO CARE DATA
Network 15: Grievance Data for Calendar Year 2017

<table>
<thead>
<tr>
<th>Category</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Grievance Cases</strong></td>
<td></td>
</tr>
<tr>
<td>General Grievance</td>
<td>13</td>
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<tr>
<td>Immediate Advocacy</td>
<td>42</td>
</tr>
<tr>
<td>Clinical Area of Concern</td>
<td>10</td>
</tr>
<tr>
<td><strong>Non-Grievance Cases</strong></td>
<td></td>
</tr>
<tr>
<td>Facility Concern</td>
<td>50</td>
</tr>
<tr>
<td>Access to Care: Confirmed Involuntary Transfer/Discharge (IVT/IVD)</td>
<td>11</td>
</tr>
<tr>
<td>At-Risk Access to Care</td>
<td>48</td>
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<tr>
<td><strong>Additional Case Information</strong></td>
<td></td>
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<tr>
<td>Averted IVT/IVD</td>
<td>1</td>
</tr>
<tr>
<td>Failure to Place</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total Cases 2017</strong></td>
<td>174</td>
</tr>
</tbody>
</table>

Source of data: Patient Contact Utility (PCU)
Network 15: Grievance Timeliness by Case Type with National Comparison January - September 2017

The Network goal was to maintain a rate of at least 90% of all Immediate Advocacy cases completed within 7 business days, and a rate of at least 90% of all grievance cases completed within 50 calendar days for all cases received by the Network.

Source of data: October 2017 ESRD Network Dashboard

Network 15: Average Grievance Scores for Grievance Quality Improvement Activity (QIA) with National QIA Rate Comparison March 2017 - August 2017

Source of data: October 2017 ESRD Network Dashboard
Improving the Facility Grievance Process

In 2017, the Network conducted a Quality Improvement Activity (QIA) to improve the utilization of the grievance process at the facility-level, as well as improve communication between the patients at the QIA facilities, the facility staff, and the Network. There were 10 dialysis facilities targeted for inclusion in the QIA, with approximately 1,111 hemodialysis patients.

GOALS AND OUTCOMES

The goal for the QIA was to decrease the targeted facilities’ average grievance score (a weighted measure based on a five-point scale) by a relative 20.0% from March 2017 to September 2017. The baseline score was 13.1 setting a QIA goal of 10.5. The average score at final measurement was 4.9, which exceeded the QIA goal.

INTERVENTIONS

The interventions for the QIA supported facilities with developing and utilizing a grievance process to efficiently handle patient concerns related to environmental, interpersonal, and operational issues. Interventions included:

- Educating facility staff about the definition of a grievance; facility responsibilities for receiving, documenting, and investigating grievances; and how to foster an environment that encourages patients, family members, and care partners to voice their concerns.
- Requiring facility staff to view videos on empathy to foster a sense of connection and caring between the staff and patients.
- Conducting trainings for facility staff that were developed in partnership with the Patient Advisory Council and focused on improving listening skills and understanding retaliation from the patient perspective.
- Providing patient education resources to support utilization of the Dialysis Patient Grievance Toolkit, developed by the National Forum of ESRD Networks, and materials designed to teach patients the importance of speaking up about a treatment.

BEST PRACTICES

One best practice identified during the QIA was providing patient education using the Dialysis Patient Grievance Toolkit in conjunction with a Network-developed resource titled, The Benefit of Getting Your Grievance ‘In Order.’ Based on final evaluation results, 42.9% of patients who received this intervention reported increased comfort with filing a grievance.

BARRIERS

One barrier to achieving QIA goals was frequent staff turnover. Facilities reported that high turnover impacted the ability of patients and staff to build positive relationships, which impacted patient comfort with speaking up with concerns. Interventions to improve staff turnover were tested by QIA facilities and best practices were shared with all facilities in the Network service area.
ESRD NETWORK QUALITY IMPROVEMENT ACTIVITY DATA
Source of data: October 2017 ESRD Network Dashboard. Option 1 to use for Networks 2, 3, 5, 6, 7, 8, 10, 11, 12, 13, 14, 15, 16, 17, and 18.

*In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS)
Improving the Treatment Score Component of the In-Center Hemodialysis Consumer Assessment of Healthcare and Provider Systems (ICH CAHPS) Survey

In 2017, the Network conducted a QIA to improve the experience of care for patients by improving the ICH CAHPS score for a Network-selected survey question. To select the question, the Network reviewed survey results to identify questions with the lowest score, as well as the most reasonable opportunity for improvement. Based on this analysis, the question selected for the QIA was: Peritoneal dialysis (PD) is dialysis given through the belly and is usually done at home. In the last 12 months, did either your kidney doctors or dialysis center staff talk to you about PD?” The QIA included 20 dialysis facilities, with approximately 1,855 hemodialysis patients.

GOALS AND OUTCOMES

The QIA goal was to achieve at least a 5.0% relative improvement in the percentage of positive, or “Yes” responses, to the selected question. The baseline, which was based on Spring 2016 ICH CAHPS survey results, showed that 34.8% of respondents answered “Yes” to the question, setting a goal of 38.1%. As of the final measurement, 80.4% of respondents answered “Yes” to the selected question, exceeding the QIA goal, as well as the national rate for that same timeframe, which was 77.7%.

INTERVENTIONS

Interventions for the QIA included:

- Hosting a webinar titled, Introduction to PD for In-Center Hemodialysis Staff, that included a presentation provided by a clinical educator from Baxter Healthcare Home Dialysis.

- Implementing the Method to Assess Treatment Choices for Home Dialysis (MATCH-D) intervention, which was designed to assist facilities with identifying and assessing patients for different home dialysis treatment options.

- Providing facilities with strategies for educating patients, such as using the teach back method or sitting down for patient rounds.

- Distributing feedback reports that provided facilities with trending data to track progress toward meeting QIA goals, as well as information to track completion of required activities.

BEST PRACTICES

One best practice identified during the QIA was adding questions from MATCH-D to the care plan template to ensure that barriers for patients suitable for PD were identified and addressed. Another best practice identified by facilities that also had a home program was to hold a Lobby Day, or an interactive educational event for sharing and presenting information, on a day when PD patients are also seen, allowing in-center patients to interact with PD patients in the shared waiting room.

BARRIERS

A barrier that was identified by patient subject matter experts (SMEs) was related to the timing of treatment modality education, which is provided prior to, or within the first 90 days of, initiating treatment. This is a time when patients are often unable to fully understand all the information provided and may select a treatment based on physician recommendation, instead of making an informed decision. Interventions to address barriers were tested by QIA facilities and best practices were shared with all facilities in the Network service area.
Network 15: Long-Term Catheter (LTC) Rates for Quality Improvement Activity (QIA) Facilities with National QIA Rate Comparison
January 2017 - August 2017

Source of data: CROWNWeb
Reducing Long-Term Catheter (LTC) Rates in the Adult Hemodialysis Population

During 2017, the Network conducted a QIA to reduce LTC use (catheter in use for 90 days or longer) in a cohort of 119 facilities with rates greater than 10.0%. The Network implemented more intensive interventions for a subset of 26 facilities, with approximately 1,726 patients. The subset facilities were selected based on having low arteriovenous fistula rates, in addition to high LTC rates.

GOALS AND OUTCOMES

The baseline LTC rate for the cohort of 119 facilities, which was based on August 2016 CROWNWeb data, was 14.7%. By September 2017, the cohort facilities reduced their aggregate LTC rate to 12.5%, which was a decrease of 2.2 percentage points. This exceeded the QIA goal and was also lower than the final measurement at the national QIA level, which was 14.5%.

INTERVENTIONS

Interventions implemented with all facilities in the cohort included developing an action plan for all LTC patients, distributing Fistula First Catheter Last feedback reports, and providing technical support to ensure accurate vascular access reporting in CROWNWeb. In addition to cohort-wide activities, the subset facilities were required to conduct a root cause analysis (RCA) and use the results to develop small tests of change using the Plan-Do-Study-Act (PDSA) cycle. The Network provided individualized technical assistance to the facilities based on RCA and PDSA results, such as developing or updating processes or providing relevant tools and resources. To reinforce a patient focus, patient SMEs participated on QIA calls to provide their perspective on challenges to permanent access placement and how challenges can best be addressed.

BEST PRACTICES

Interventions to address barriers were tested by QIA facilities and best practices were shared with all facilities in the Network service area. Best practices identified by QIA facilities included:

- Encouraging vascular access surgeons to round at the facility, allowing them to establish vascular access plans and address any financial or transportation barriers in an outpatient setting.
- Setting the expectation of establishing a permanent access upon admission, before a patient becomes comfortable with a central venous catheter.
- Providing frequent patient education on infection prevention to create a heightened awareness of the risks associated with having an LTC.

BARRIERS

Facilities reported that a primary barrier to achieving QIA goals was the initiation of treatment in an urgent manner which did not allow time for patients to receive proper orientation, education, and vascular access planning. Another barrier reported by facilities was not having a designated staff member to monitor vascular access planning and maturing accesses, which caused delays in utilizing maturing accesses, detecting surgical issues requiring intervention, establishing procedure appointments, and removing existing catheters in a timely manner.
Network 15: Bloodstream Infections (BSI) and Quality Improvement Activity (QIA) by ESRD Network

Nationally, the Networks reduced 2,406 BSI in 2017

The Network goal was to decrease the rate of bloodstream infections (BSI) by a 5% or greater relative reduction in the pooled semi-annual mean in facilities participating in the quality improvement activity.

- BSI Required for Reduction to meet Goal
- Actual BSI Prevented

Source of data: June 2017 NHSN (National Healthcare Safety Network)
Reducing Rates of Dialysis Events in Adult Patients on Hemodialysis

In 2017, the Network conducted a QIA to reduce dialysis event rates, specifically bloodstream infections (BSIs), by improving infection control practices. The QIA was designed to support the National Action Plan to Prevent Healthcare-Associated Infections and the Centers for Disease Control and Prevention (CDC) Core Interventions for Dialysis BSI Prevention Program. The QIA included 63 facilities, with approximately 4,442 patients.

GOALS AND OUTCOMES

The Network used the National Healthcare Safety Network (NHSN) BSI pooled mean rate per 100 patient-months to target facilities for the QIA. The goal was to achieve at least a 5.0% relative reduction in the pooled mean rate of BSIs from January – June 2017, and to prevent at least 14 BSIs. By QIA completion, the aggregate BSI rate decreased from 1.0 to 0.0, and 112 BSIs were prevented, exceeding the QIA goal.

INTERVENTIONS

The primary intervention was use of the CDC BSI prevention audit tools. Additional activities included:

- Providing patient education on the importance of washing hands and vascular accesses and knowing the signs and symptoms of infection.
- Attending an educational webinar, developed with the Colorado Department of Health and Environment (CDHE), that focused on CDC approaches to preventing BSIs in the dialysis facility and reporting in NHSN.
- Encouraging patients to sign a pledge to engage as partners with infection prevention efforts.
- Tracking and analyzing facility processes, prevention measures, and BSIs to support rapid cycle improvement.
- Conducting monthly hand hygiene audits with patients.

BEST PRACTICES

Interventions to address barriers were tested by QIA facilities and best practices were shared with all facilities in the Network service area. Best practices identified during the QIA included:

- Engaging patients in infection control by including them in audits for hand hygiene, as well as documenting observations on the CDC hand hygiene audit tool.
- Using resources to guide discussion with patients about infection control, such as the CDC handout, **Conversation Starter**.
- Conducting hand hygiene audits to heighten staff awareness of hand washing practices.

BARRIERS

One barrier that was identified by QIA facilities was lack of patient interest in receiving education about infection prevention, especially after becoming established in the dialysis setting. Another barrier identified by facilities was staff being uncomfortable with patient participation in hand hygiene audits, fearing the audits might lead to scrutiny of staff when steps are perceived as “missed.” A barrier identified by patients was lack of staff enthusiasm or commitment to improving infection control, giving the perception that it was not important.
Network 15: Hepatitis B Vaccination (HBV) Rates for Quality Improvement Activity (QIA) Facilities with National QIA Rate Comparison January 2017 - July 2017

Source of data: CROWNWeb

Network 15: Pneumococcal Pneumonia Vaccination (PPV) Rates for Quality Improvement Activity (QIA) Facilities with National QIA Rate Comparison January 2017 - July 2017

Source of data: CROWNWeb
Increasing Hepatitis B Vaccination (HBV) and Pneumococcal Pneumonia Vaccination (PPV) Rates in the Dialysis Population

The 2017 Vaccination QIA aimed to support the CDC recommendations for HBV and PPV for patients with ESRD. The Network identified 25 dialysis facilities for inclusion in the QIA, with approximately 1,356 hemodialysis patients.

GOALS AND OUTCOMES

The QIA goal was to improve the aggregate HBV and PPV rates in the QIA facilities by three percentage points. Baseline data, which was collected through CROWNWeb, indicated a rate of 56.9% for HBV and 42.8% for PPV. At the end of the QIA, the facilities increased the aggregate HBV rate by 17.8 percentage points, reaching a vaccination rate of 74.7%. The PPV rate increased by 31.0 percentage points, for a vaccination rate of 73.8%. In addition to exceeding the QIA goal for both vaccinations, the Network also exceeded the final measurement at the national QIA level.

INTERVENTIONS

Patient SMEs provided the patient perspective for development of all QIA educational materials and interventions. In addition to providing individualized technical assistance, Network interventions included:

- Initiating an RCA and conducting tests of change using the PDSA cycle.
- Providing education on the vaccination section of CROWNWeb, as well as how to accurately report vaccinations in the system.
- Distributing education to facility staff on the importance of vaccinations and strategies for encouraging patients to receive them.
- Sharing CDC tools and materials that focused on vaccinations, including the health benefits of being vaccinated, vaccination safety, and how facilities can schedule and prepare a proactive approach to vaccinating patients.

BEST PRACTICES

One best practice identified by the QIA facilities was providing monthly staff education to improve knowledge and understanding of vaccinations and their benefits, allowing staff to better educate patients. Another best practice identified by the facilities was designating a staff member to be responsible for maintaining a vaccination log and reviewing it during Quality Assessment and Performance Improvement meetings.

BARRIERS

One barrier to achieving QIA goals was that both patients and facility staff often had inaccurate information about vaccinations, including the misperception that certain vaccinations are unsafe and should be declined or refused. A second barrier was inaccurate reporting in CROWNWeb caused by lack of staff education and incorrect processes. Interventions to address barriers were tested by QIA facilities and best practices were shared with all facilities in the Network service area.
**Network 15: Hospitalization Rates for Quality Improvement Activity (QIA) Facilities with Pilot Project Comparison Rate**

January 2017 - September 2017

<table>
<thead>
<tr>
<th>Month</th>
<th>Network 15 QIA</th>
<th>National Hospitalization QIA</th>
<th>Network 15 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>15.2%</td>
<td>10.2%</td>
<td></td>
</tr>
<tr>
<td>February</td>
<td>15.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>March</td>
<td>15.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>April</td>
<td>15.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>May</td>
<td>15.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>June</td>
<td>15.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>July</td>
<td>15.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>August</td>
<td>15.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>September</td>
<td>15.3%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source of data: October 2017 ESRD Network Dashboard

**Network 15: Disparate and Non-Disparate Quality Improvement Activity (QIA)**

by ESRD Network

January 2017 - September 2017

<table>
<thead>
<tr>
<th>Month</th>
<th>Network 15: Disparate</th>
<th>Network 15: Non-Disparate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>13.0%</td>
<td>16.3%</td>
</tr>
<tr>
<td>February</td>
<td>14.1%</td>
<td>16.3%</td>
</tr>
<tr>
<td>March</td>
<td>15.4%</td>
<td>16.3%</td>
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<tr>
<td>April</td>
<td>13.8%</td>
<td>16.3%</td>
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<tr>
<td>May</td>
<td>13.3%</td>
<td>16.3%</td>
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<tr>
<td>June</td>
<td>17.0%</td>
<td>16.3%</td>
</tr>
<tr>
<td>July</td>
<td>17.6%</td>
<td>16.3%</td>
</tr>
<tr>
<td>August</td>
<td>13.6%</td>
<td>16.3%</td>
</tr>
<tr>
<td>September</td>
<td>13.6%</td>
<td>16.3%</td>
</tr>
</tbody>
</table>

Source of data: October 2017 ESRD Network Dashboard

*Disparate population is Hispanic or Latino and non-disparate population is Not Hispanic or Latino*
Reducing Hospital Utilization QIA
In 2017, the Network conducted a QIA focused on reducing hospitalization rates for hemodialysis patients. A key element of the QIA was collaboration with stakeholders, including state hospital associations, Quality Innovation Network-Quality Improvement Organizations within the Network service area, as well as appropriate ESRD professionals. There were six facilities included in the QIA.

GOALS AND OUTCOMES
The baseline hospitalization rate for the six facilities, which was based on April – September 2016 CROWNWeb data, was 15.2%. By QIA completion, the hospitalization rate was 15.3%. The QIA included a secondary goal of reducing hospitalization rates by 1.0% among a disparate population (Hispanic or Latino), as compared to a non-disparate population (Not Hispanic or Latino). By the end of the QIA, the Network reduced the disparate rate from 18.4% to 16.3%. The baseline for the non-disparate was 13.0%, with a final measurement of 13.6%.

INTERVENTIONS
Interventions for the QIA included:

- Conducting RCAs and reviewing processes for tracking and trending hospitalizations, including patient ethnicity and cause for the hospitalization.
- Meeting with patients on the first treatment following a hospitalization to determine their understanding of the hospitalization, need for follow-up, and changes with appointments or medications.
- Collaborating with other QIA facilities to discuss frequent hospitalizations; share information and resources; and identify innovative responses to barriers.

BEST PRACTICES
Interventions to address barriers were tested by QIA facilities and best practices were shared with all facilities in the Network service area. Best practices identified by QIA facilities included:

- Conducting patient interviews on the first dialysis treatment post-hospitalization. Facilities reported that this interaction provided valuable information about the transition of care.
- Reconciling patient comprehension of discharge instructions with actual hospital records to identify gaps in knowledge and discussing discrepancies to close any gaps.
- Interfacing with other specialists, such as cardiology, to establish a process for record sharing. By obtaining records from specialists, facilities were able to develop a more complete plan of care and assess patient comprehension of instructions or recommendations.

BARRIERS
The following barriers were identified based on analysis of facility RCAs:

- Lack of access to local hospital electronic medical record (EMR) systems or inconsistency with obtaining medical records, both during and post-hospitalization.
- Lack of consistent processes for evaluating patient clinical status post-hospitalization.

Difficulty focusing on the multiple patient discharge diagnoses that were identified.
Network 15: Count of Quality Incentive Program (QIP) Quality Improvement Activity (QIA) Facilities That Successfully Completed Plan-Do-Study-Act (PDSA) Cycles and Met the Improvement Target for Three Consecutive Months April 2016 - September 2017

Source of data: October 2017 ESRD Network Dashboard
ESRD Quality Incentive Program (QIP) QIA

In 2017, the Network conducted a QIA to improve hypercalcemia rates for facilities that were at-risk for payment penalties based on recent ESRD QIP performance. The QIA focused on lowering the facilities’ percentage of patients with elevated calcium levels (uncorrected calcium values greater than 10.2). New participants were added as facilities met their goal and were released from the QIA.

GOALS AND OUTCOMES

The QIA goal was for each facility to achieve at least a 25.0% relative improvement over their baseline rate, and to maintain the improvement for three consecutive months. A secondary goal was to assist facilities to reduce the risk of losing points on the ESRD QIP for Calendar Year 2017/ Payment Year 2019. An additional goal for the Network was for at least eight facilities to successfully meet, and sustain, improvement. By completion of the RCA, all ten facilities had successfully achieved the required improvement, which exceeded the goal. To further assess sustainability of improvements, the Network monitored the facilities for six additional months. At conclusion of the monitoring period, 90.0% of facilities had sustained the 25.0% reduction consecutively over the six months and 20.0% of facilities had decreased to 0.0%.

INTERVENTIONS

The main intervention of the QIA was to conduct an RCA and make small tests of change using PDSA cycles. To support the intervention, the Network conducted an educational webinar to teach facilities about RCA and PDSA, including how to conduct them and use results for quality improvement. Facilities were also provided with individualized technical assistance, both telephonically and during onsite visits, to review progress and discuss barriers.

BEST PRACTICES

Best practices identified by QIA facilities included:

- Conducting an RCA for any patient with an elevated calcium level.
- Providing frequent patient education on dietary restrictions, such as tools and resources to assist patients with easily identifying high calcium foods.
- Attending the educational webinar about RCA and PDSA to better understand their purpose.

BARRIERS

Barriers to achieving QIA goals included:

- Lack of patient knowledge and understanding of what calcium levels are, why they are important, and how to improve them.
- Lack of staff knowledge regarding what should be reported in CROWNWeb, how to enter data in the system, and how to identify missing information.

Inadequate staff knowledge about quality improvement, including conducting RCAs, testing changes using PDSA cycles, and evaluating activities.
September 2016 - September 2017

Source of data: September 2017 NHSN (National Healthcare Safety Network)
NHSN Data Quality QIA
In 2017, the Network conducted a QIA to increase dialysis facility reporting of BSIs by improving information transfer from hospitals to outpatient dialysis. There were 20 facilities targeted for inclusion, with approximately 1,478 hemodialysis patients, as well as five local hospitals that received patients from the QIA facilities. The focus of the QIA was to assist providers with understanding and improving reliability of NHSN reporting; as well as to improve BSI surveillance and communication between the facility staff and their local hospitals.

GOALS AND OUTCOMES
The QIA goal was to increase facility reporting of BSIs identified within one calendar day following a hospital admission by 1.0% over the baseline. Based on NHSN data for January – June 2016, the baseline aggregate rate for the QIA was 0.0%. By the final QIA measurement, facility reporting improved to 51.5%, exceeding the QIA goal and the final measurement at the national QIA level, which was 32.9%.

INTERVENTIONS
Interventions for the QIA included:

- Conducting RCA and rapid cycle improvement to identify and address barriers related to obtaining medical records following a hospitalization and reporting positive blood cultures within one day following an admission.
- Attending educational webinars, hosted by the CDHE, that provided information on NHSN reporting and obligations to report.
- Gaining access to a hospital EMRs or to the state Health Information Exchange to facilitate sharing of patient records following a hospitalization.
- Providing resources to support accurate and timely reporting in NHSN, such as a quick reference guide with hints and tips for NHSN reporting; a list of events and definitions; and key terms for reporting positive blood cultures and their sources.

BEST PRACTICES
One best practice that was identified by the QIA facilities was to adjust current medical records request templates to support accurate and timely reporting. For example, adding a request for emergency department records and all microbiology. Another best practice was verifying accuracy of event reporting by comparing NHSN data with facility EMR data.

BARRIERS
Interventions to address barriers were tested by QIA facilities and best practices were shared with all facilities in the Network service area. Barriers to achieving QIA goals included:

- Difficulty obtaining access to EMRs and health information exchanges due to the time and effort involved to advance through the acceptance process.
- Lack of understanding about reporting BSIs when treatment was provided outside of dialysis facility.

Challenges with hospital infection preventionists (IPs) related to identifying positive blood cultures for patients who were seen in the emergency department. The IPs were more receptive to assisting with patients who were hospitalized for three days or longer.
Facilities that Consistently Failed to Cooperate with Network Goals

Section 1881(c) of the Social Security Act states that the ESRD Network can recommend to CMS the imposition of a sanction when an ESRD provider is not cooperating in achieving Network goals. The Federal Regulations that implement this statute are found in 42 CFR §405.2181.

The Network strived to maintain a cooperative and collaborative partnership with ESRD providers in all activities in 2017. The Network regularly interacted with facilities related to quality improvement activities and projects, patient grievances, data reporting, and the provision of technical assistance and education.

In 2017, the Network did not identify any facilities in its service area that consistently failed to cooperate with Network goals.

Recommendations to CMS for Additional Services or Facilities

The Network did not recommend to CMS additional facilities in its service area in 2017.
ESRD NETWORK

SIGNIFICANT EMERGENCY PREPAREDNESS INTERVENTION
Wildfires impacted facilities in the Network 15 service area beginning in March and continuing through September 2017. During that seven-month period, Network staff:

- Maintained constant contact with facilities via email.
- Requested regular updates on facilities’ operational status.
- Researched fire locations daily.
- Contacted facilities near fire locations to determine:
  - Any adverse impact on facilities.
  - Ability of facilities to provide treatment.
  - Patients’ ability to access the facility.
- Provided all facilities in the Network area with emergency preparedness information, including:
  - Contact information for healthcare coalitions.
  - Links to the Kidney Community Emergency Response (KCER) website for:
    - Resources on emergency preparedness for patients and providers in both English and Spanish, including the KCER Prep Rally campaign.
    - Live emergency updates.
    - ASPR TRACIE newsletters.
    - CMS Final Rule preparedness requirements and trainings.
    - Link to the updated CMS Preparing for Emergencies: A Guide for People on Dialysis
  - The KCER Watch newsletter.
  - KCER LAN materials (English and Spanish).

No facilities required assistance in providing services or placing patients due to the wildfires.

Network 15 also provided back-up telephone assistance to both KCER and the ESRD National Coordinating Center during Hurricane Irma in September 2017.