Comagine Health

2021 ESRD Network 16 Annual Report
Alaska, Idaho, Montana, Oregon, Washington

This report will cover quality improvement efforts led by ESRD Network 16 from January 1, 2021 – May 31, 2021 and the Base Year of Task Order Number 75FCMC21F0003, June 1, 2021 – April 30, 2022
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COVID-19 continued to exact a toll in Network 16 in 2021 impacting patient and staff lives. With the first reported case in Seattle in March 2020, the impact of this disease transitioned the Network from business as usual to supporting facilities with immediate needs due to staffing shortages. With the overarching goal to protect the patients and staff, the Network provided solutions to the renal community and continued to be a trusted voice relaying consistent credible information during a time of rapid change. The lens of COVID-19 continued to impact the work of Network 16 the entire year. The Network continued its focus on individualized care planning, “Putting Patients First” throughout the contract period helping facilities shift from staff identified patient problems to patient identified goals. The Network continues to encourage facilities to do away with a cookie cutter approach to care planning to improve the patient experience of care.

**ESRD Demographic Data**

ESRD Network 16 serves the states of Alaska, Idaho, Montana, Oregon, and Washington — with urban centers and remote and rural areas— each of which has unique patient needs. For example:

- Rural populations and racial and ethnic minorities are disproportionately impacted by decreased access, higher mortality rates and higher obesity rates, and are hit hardest by the current pandemic.

- Idaho has the highest percentage of patients dialyzing at home with 26%, as compared to the entire Network 16 rate of 18% as of Dec. 31, 2021.

- Oregon and Washington are the only states with transplant centers, causing 19% of Network 16 patients who received a transplant in 2021 to travel out of state.

ESRD Network 16 geographic area spans four time zones and almost one million square miles. Although Network 16 includes several metropolitan centers, a substantial portion of the general and ESRD population is dispersed in more remote, rural areas. Travel in many areas within the Network is challenging, as some regions have limited road access and others are often impacted by severe weather events (e.g., ice storms, high winds, floods). In addition, natural disaster risks in the region include wildfires, earthquakes, tsunamis, avalanches and volcanic eruptions.

The vast geographic size, varying population densities and constraints on transportation found in the Network impact the size and location of ESRD facilities, and utilization of treatment modality options by ESRD patients. The percentage of facilities owned or operated by large dialysis organizations (LDOs) has been increasing for many years.

The ESRD Network Program collects data on incident (new) ESRD patients, prevalent (currently being treated) dialysis patients and renal transplant recipients. The Network uses data on patients’ clinical characteristics — including primary cause of ESRD, treatment modality and vascular access type — to focus its outreach and quality improvement activities. Idaho, Alaska and Montana continue to have the greatest proportion of patients dialyzing at home.

At the end of 2021, 26.5% of Idaho patients, 19.0% of Alaska patients and 18.7% of Montana patients were categorized as home dialysis patients, compared to 18.3% in Oregon and 16.9% in Washington. There were 736 reported kidney transplants performed in 2021 at the Network’s seven Medicare
certified transplant centers, an increase from 2020. 36 more kidney transplants also occurred at a VA facility in 2021. Of the 736 kidney transplants, 23% were from living donors.
Network 16: Count of Medicare-Certified Facilities by Treatment/Setting
2021

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 2022

Percent of National Prevalent Dialysis Patients by ESRD Network
2021

National total dialysis patients: 516,029
Source of data: EQRS May 2022
Percent of National Incident Dialysis Patients by ESRD Network 2021

National total incident patients: 132,071
Source of data: EQRS May 2022

Percent of Medicare-Certified Dialysis Facilities by ESRD Network 2021

National total ESRD Medicare-certified dialysis facilities: 7,969
Source of data: EQRS May 2022
Percent of National Home Hemodialysis and Peritoneal Dialysis Patients by ESRD Network 2021

National total home hemodialysis and peritoneal dialysis patients: 79,071
Source of data: EQRS May 2022

Percent of National Transplant Patients by ESRD Network 2021

National total transplant patients: 269,424
Source of data: EQRS May 2022
Percent of Medicare-Certified Kidney Transplant Facilities by ESRD Network 2021

National total ESRD Medicare-certified kidney transplant facilities: 227
Source of data: EORIS May 2022
ESRD NETWORK GRIEVANCE AND ACCESS TO CARE DATA

January – May 2021

GRIEVANCES:
The top category of grievances was Clinical Quality of Care Concerns (patient health and safety and access issues). The second most common category of concerns was staff related. For all case types (Immediate Advocacy, General Grievance and Clinical Area of Concern) staff-related complaints were the most common. Ninety-two percent of cases during this time frame had some reported staff concerns (communication, professionalism, staff relations, clinical competency, staff patient ratio, and physician relations). Fifteen percent of grievances were mental health related.

ACCESS TO CARE:
The top reason for notification to the Network of an involuntary discharge (IVD) was Disruptive/Abusive Behaviors, followed by Immediate Severe Threat. Network 16 was successful in averting 57% of ICD cases. Twenty-nine percent of access to care cases were mental health related.

The most utilized Network interventions to address grievances and access to care concerns included:

- Network mediation between the patient and IDT
- Working with regional leadership and quality staff in plans for improvement/sustainment
- Sharing Network 16 developed resources
  - Involuntary discharge guidance
  - Virtual peer to peer support resources
  - Good Relationships with Staff (addresses boundaries)
  - Nonverbal Nursing Assessment Tool
- Sharing additional community resources
  - Healio blog - How to Talk to Unhappy Patients
  - Forum of ESRD Networks – Grievance Toolkit
  - ESRD National Coordinating Center (NCC) – Managing Retaliation
  - Coalition for Supportive Care resources
  - National Kidney Foundation (NKF) – Stopping Dialysis
  - United Network for Organ Sharing (UNOS) – Financing a Transplant
  - Medicare – Dialysis Facility Compare
  - Medical Education Institute (MEI) – blog on Patient-Centered Behavior Agreements

June 2021 – April 2022

GRIEVANCES:
The top category of grievances was Clinical Quality of Care Concerns (patient health and safety, infection control, and access issues). The second most common category of concerns was treatment related (policies/procedures, scheduling, supplies/equipment, and temperature). For all case types (Immediate Advocacy, General Grievance and Clinical Area of Concern) staff-related concerns and scheduling were
common themes. COVID-19 disruptions and staff shortages contributed to significant concerns from patients regarding temporary closures, schedule changes, and relocations. Five percent of grievances were mental health related.

ACCESS TO CARE:

The top reason for notification to the Network of an involuntary discharge (IVD) was Immediate Severe Threat 35% of cases), followed by Disruptive/Abusive Behaviors (13%). Network 16 was successful in averting 59% of ICD cases. Thirty-one percent of access to care cases were mental health related.

Due to widespread outpatient dialysis staffing shortages, an unprecedented twenty-eight percent of access to care contacts to Network 16 were regarding ‘failure to place’ patients due to facilities having no capacity to take additional patients. Network 16’s Patient Advisory Council (PAC) and Medical Review Board (MRB) assisted with the development of a new letter for dialysis patients on navigating the impact of COVID-19 and dialysis staff shortages. This was shared in technical assistance calls with providers, and with patients who contacted the Network about disruptions in their care related to staffing.

The primary interventions for grievances and access to care were:

- Network mediation between parties
- Boundaries education for patients and staff
- Involuntary discharge guidance
- Network facilitated placement
- Technical assistance with patient-centered behavior agreements
- Home modality education
- Transplant education
- Resources shared:
  - CDC Workplace Violence Prevention for Nurses
  - NKF’s Stopping Dialysis brochure
  - Dialysis Facility Compare
  - Dialysis Patient/Provider Conflict (DPC) Toolkit
  - Network 16 list of virtual peer-to-peer support groups
  - Forum of ESRD Networks Grievance Toolkit
Network 16: Percent of Jan-May 2021 Grievances and Non-Grievances by Case Type

- Facility Concern: 52%
- Access to Care: 31%
- General Grievance: 4%
- Clinical Area of Concern: 9%
- Immediate Advocacy: 4%

Source of data: Patient Contact Utility (PCU) accessed April 2022

Network 16: Percent of Jun 2021-Apr 2022 Grievances and Non-Grievances by Case Type

- Facility Concern: 54%
- Access to Care: 23%
- General Grievance: 2%
- Clinical Area of Concern: 14%
- Patient concern: 3%
- Immediate Advocacy: 4%

Source of data: Patient Contact Utility (PCU) accessed May 2022
Transplant Waitlist Quality Improvement Activity through May 2021

The COVID-19 pandemic continued to impact provider staffing and facility procedures around transplant. The Network worked toward the goals of this quality improvement throughout the year but due to these barriers and subsequent contract goal adjustments, the Network was only evaluated on results from June 2021-April 2022.

Transplant Waitlist & Transplanted Quality Improvement Activity June-April 2022

Project Structure

The traditional project underwent innovation this year by continuing our focus on improving care of patients by focusing on the “Putting Patients First” initiative. In care planning, the focus was on appropriate modality education and identifying ways to support patients to get on to the transplant waitlist quickly. The Network challenged the dialysis providers to improve communication between the transplant centers and increase patient engagement in the process.

The Network provided a training on unconscious biases to make sure that biases did not inhibit patient access to a kidney transplant. Technical Assistance calls focused on facility specific issues and provided strategies to reduce barriers inhibiting each individual patient from pursuing a kidney transplant.
Root Cause Analysis (RCA) as the Foundation of Quality Improvement (QI)

Root Cause Analysis (RCA) was used at the onset of the project with every participant, and then individually as needed with participants who, under regular monitoring, were found to be underperforming. RCA came in written and digital formats, in addition to individual guidance with NW staff on the phone. RCA data was used to provide guidance on foundation of strong PDSA cycles with monthly follow up as needed. In collaboration with LDOs, individual RCA was performed on facilities that underperformed last year.

The Network 16 service area has transplant centers in 2 of our 5 states. These transplant facilities are on the western side of WA and OR with one exception. This presents a major economic challenge for patients to compensate for travel for wait listing, workup, and transplantation.

The COVID pandemic had a major impact on improving transplant wait listing and transplant rates. For example, the Transplant evaluation process was slowed and at times halted during pandemic surges. This increased the back log of diagnostics, which slowed down the capability of transplant centers to get more patients on to the waitlist. The Network advised dialysis providers to the use telemedicine to complete evaluation steps.

In the Fall of 2021 many dialysis providers and transplant centers implemented a COVID-19 vaccine requirement for both patients and staff. Many patients who were already listed as active on the waitlist declined to take the COVID-19 vaccine which resulted in their inactivation or removal from the transplant waitlist. The Network created and distributed a Transplant Center COVID-19 Vaccine requirements grid outlining the differences in requirements between transplant centers. This resource enabled dialysis providers and patients to have a better understanding of their options.

Staff illness also had an impact has it slowed the processing of referrals and challenged dialysis social workers conducting follow ups and reviews of patients’ barriers or waitlist inactivation.

Facilities had limited capacity to participate in QI activities due to staffing shortages or an overburdened workload. The Network QI activities were adjusted to be simple, relevant, and actionable included organizational leadership or connection with high performing facilities.

Collaborative Efforts with Stakeholders

The Network worked with Transplant coalition members to reduce barriers to transplantation. The coalition comprised of members from transplant centers, OPOs, CMS TAQIL, dialysis providers and patient representatives.

Throughout the year the Network tracked common complaints experienced by multiple facilities and escalated these challenges to coalition members for recommendations of best practices and targeted solutions. Some examples include:

- Updating dialysis provider electronic medical records to include a flag of a transplant candidate’s status and the standardization of transfer patient documents when a patient transfers between facilities
- Conducting a survey of all transplant centers to identify their COVID-19 vaccination requirements
Promoting strategies to obtain post-transplant housing, guidance to find and use post-transplant support persons, and methods to increase patient participation in the transplant process

The Network also involved EQRS/NCC stakeholders to resolve discrepancies found in EQRS data impacting capture of accurate transplantation rates.

**Robust Patient Engagement**

The Network accommodated each patient’s learning style by providing educational resources in a variety of formats such as written text and videos. To further support patient learning and success, the Network encourage patients to use the Network Peer Mentors programs, including the National Kidney Foundation program and local patient groups.

Through technical assistance, facilities reported challenges with patient motivation and lack of post-transplant support. The Network engaged the patient advisory council members to identify and develop resources to overcome these barriers. For example, the Network PAC/SMEs representatives provided guidance on how to overcome barriers to post transplant housing. Contributed to the creation of the “Value of Peer Mentorship” resource and “Key Resources for Living Donation”. Patient advisory council members developed Network tweets for the public that shared patient stories of hope. Additionally, Network PAC/SMEs contributed to NCC discussion on how to increase access to post transplant support persons and continued participation in the Network Transplant Coalition meetings.

**Results**

While the 2021 project year was challenging, the Network made 101.03% of the wait listing goal resulting in 587 patients being waitlisted and 89.72% of the transplantation goal resulting in 602 patients receiving a transplant. The Network achievement for wait listing was 0.4% higher than the national average and however the Network’s achievement for transplantation fell below the national average.
Home Therapy Quality Improvement Activity through May 2021
The COVID-19 pandemic continued to impact provider staffing and facility procedures around home therapy. The Network worked toward the goals of this quality improvement throughout the year but due to these barriers and subsequent contract goal adjustments, the Network was only evaluated on results from June 2021-April 2022.

![Graph showing the percent of patients starting home dialysis from January 2021 to April 2021. The graph indicates an increase in the percentage from 7.8% in January to 12.2% in April.](network-16-percent-patients-starting-home-dialysis-january-2021-april-2021)
Home Therapy Quality Improvement Activity June-April 2022

Project Structure

The traditional project underwent innovation this year by continuing our focus on care planning in the “Putting Patients First” initiative. In care planning for home dialysis, the focus was on appropriate modality education and finding a way to get any patient home that was interested in either home modality. The Network also challenged the dialysis providers to find a way to say “yes” to even non-traditional home patients.

The Network provided a training on health equity unconscious biases to make sure that biases were not stopping patient that wanted a home modality. Technical Assistance calls focused on facility specific issues around moving patients to a home modality.

The National Kidney Foundation and Comagine Health partnered to develop a pilot Project ECHO program. Project ECHO is a videoconference-based collaborative, CME/CE accredited, case-based learning program with the goal of building clinicians’ confidence levels and improving home dialysis uptake and retention. Learners presented cases from their own practices, followed by group discussion/recommendations and then education. The faculty hub included nine exemplary clinicians in nephrology from around the country and Canada representing all professions as well as patient representation. There were 20 sessions over a 12-month period covering an exhaustive range of topics in home dialysis.

Root Cause Analysis (RCA) as the Foundation of Quality Improvement (QI)

Root Cause Analysis (RCA) was used at the onset of the project with every participant, and then individually as needed with participants who, under regular monitoring, were found to be underperforming. RCAs came in written and digital formats, in addition to individual guidance with NW staff on the phone. RCA data was used to provide guidance on foundation of strong PDSA cycles with monthly follow up as needed. In collaboration with LDOs, individual RCA was performed on facilities that underperformed last year.

The COVID pandemic had a major impact on improving the rates of patients moving/starting on a home modality. Home training rooms were used to isolate dialysis patients that were COVID positive or had a COVID exposure. The virus impacted staffing as dialysis staff became COVID positive. Home dialysis nurses were covering multiple in-center shifts to keep the dialysis facilities open. Hospitals did have delayed peritoneal dialysis catheter placement at the beginning of the project year.

Starting in May 2021 staffing at dialysis providers started to rapidly decrease for causes like those staff choosing to leave healthcare and/or staff leaving for better paying positions. The Network did not challenge the dialysis providers that needed to use their home training rooms or home nursing to cover the in-center shifts since the objective was to treat as many of the provider’s patients as possible. The Network worked with providers to look at all tasks completed by nursing to see if clinical judgement was needed. If clinical judgement was not needed, the task might not need to be completed by a nurse. This type of task balancing was used to help with the nursing shortage.
Collaborative Efforts with Stakeholders

The Network worked with State Survey Agencies to approve additional stations, work to get exceptions to state staffing ratios and to complete task-based competency training to help with the nursing shortage. This allowed home nurses to be released from covering in-center shifts as soon as possible. State survey agencies assisted with fit testing for staff face mask that allowed the movement of COVID positive or suspected patient out of the home training room.

The Network worked with hospitals in the Network area to make sure that the dialysis access surgeries took place as soon as possible.

Robust Patient Engagement

Patients can learn differently from other patients and may be willing to ask different questions about a home modality. The Network encourage patients to use the Network Peer Mentors, including National Kidney Foundation and local patient groups, to ask about the patient’s real experience with home modalities.

The Network worked with local hospitals to ensure that dialysis accesses were placed as soon as possible and to encourage the hospital to use outside sources for dialysis modality education. As outpatient dialysis chairs became more and more scarce, the Network encouraged hospitals to support patients starting directly to dialysis where appropriate.

Results

While the 2021 project year was challenging, the Network made 91.67% of the incident patients starting on a home modality goal and 79% of the transition of in-center patient to a home modality. The Network has an overall 18.9% home modality rate for patient dialyzing in the Network, the highest rate in the nation which is also 4.2% higher than the national average.

For the Home EHCO program, at baseline, the participating center’s median home dialysis rate was 9.28% (0.00-18.52%) which increased to 12.8% (0.00-24.6%) (p=0.004) after the program. This program will be replicated in the future with other Networks participating.
Influenza June-April 2022

Project Structure

Interventions in influenza vaccination focused on supporting both patients and providers to increase influenza vaccination rates by addressing systemwide challenges and using community resources for success.

Root Cause Analysis (RCA) as the Foundation of Quality Improvement (QI)

Root cause analysis of past vaccination results was used to target facilities who would benefit from Network technical assistance. The RCA revealed a trend in low vaccination rates from multiple facilities owned by a specific company or facilities that were in specific geographic areas. Through technical assistance to these facilities challenges were reported.

The pandemic had a major impact on staffing, resulting in shortages at many facilities, which resulted in difficulty with updating patient records in real time. The Network identified facilities with the most turnover often had staff that lacked appropriate EMR access that was necessary to update patient records. This contributed to low vaccination rates recorded in EQRS. The Network facilitated use of county run medical reserve corps volunteers to update vaccination records in EMR. Resulting in an increase of administration and documentation of influenza vaccinations.

Staffing shortages limited vaccination efforts to address patient hesitancy and to update medical records in a timely manner. Engaged community and other healthcare organizations in vaccination efforts. The Network provided CDC guidance that allowed multiple vaccinations to be administered at the same time to dialysis providers.

Collaborative Efforts with Stakeholders

The Network involved the QIO CoFluPneu coalition on the development of vaccination best practice videos which were viewed by 70 facilities, impacting over 4,000 patients. The Network also facilitated use of county run medical reserve corps volunteers to administer vaccines and update vaccination records at the dialysis facilities. The Network continuously involved LDO regional leadership and corporate regulatory managers to provide rapid cycle improvement on facility identified barriers identified in Network technical assistance outreach.

For the Home ECHO project, the Network collaborated with the National Kidney Foundation. Additionally, the faculty were recruited from around the country providing additional collaboration. In Network 16 collaboration included the University of Washington and patient and clinician representation from Alaska and Montana.

Robust Patient Engagement

Facilities were encouraged to engage patients in open dialogue about the importance of vaccination and for patients to share their reasons “why” with each other.

Results
The Network achieved 81.75% towards the project goal 85% for patient influenza vaccinations resulting in an overall rate of 78.76%.
COVID-19 Vaccinations Patients and Staff June-April 2022

Project Structure

The COVID-19 vaccine was a new vaccine in 2021. Interventions focused on providing education on the necessity and effectiveness of the vaccine as well as technical assistance to support both patients and providers to increase COVID-19 vaccination rates by addressing systemwide challenges and using community resources for success. The Network continued to focus on the importance of individualized care planning, stressing the importance of patient choice regarding vaccination given scientific evidence of the benefits of vaccination.

Root Cause Analysis (RCA) as the Foundation of Quality Improvement (QI)

The Network utilized data from a newly develop NHSN COVID-19 vaccination module data base to initiate root cause analysis and QI efforts with facilities with the aim of increasing patient and staff vaccination rates. RCAs revealed low vaccination rates were the result of missing patient documentation in electronic medical records. Further analysis revealed that these records needed to transfer to a separate data batching software that often-required manual updates for NHSN reports to reflect vaccinations accurately. The Network provided weekly NHSN vaccination reports throughout the project cycle and follow up with facilities as they worked to resolve the issue. At the end of the project cycle a significant gap was noted in home dialysis providers vaccination data resulting in missed captured in the NHSN database of vaccinations previously administered.

Additionally, the newness of the vaccine and political atmosphere had an influence on vaccination hesitancy, especially amongst African American, Native American, and Samoan/AAPI populations of patients and staff. To resolve these concerns Network continuously provided COVID-19 vaccination education from credible and culturally relevant organizations such as the NAACP and PICAWA in addition to information found in State Department of Health and CDC guidance. The Network developed 15-minute on-demand recordings that provided best practices for COVID-19 immunization. This resource was accessed over 70 times by facilities impacting over 4,000 patients. The Network also promoted the use of the ESRD FORUM Vaccination Toolkit in QAPI meetings. As facilities worked to update records for both staff and patients, the Network provided guidance on utilizing state immunization registry to collect records from individuals vaccinated at mass FEMA run vaccination locations.

Collaborative Efforts with Stakeholders

The Network partnered with QIO LTPAC teams, community led nursing home coalitions and dialysis providers to enhance communication of patient COVID-19 vaccinations and booster doses. The Network participated in the QIO CoFluPneu coalition on the development of COVID-19 vaccination best practice videos. The Network involved State Departments of Health and Health Care Coalitions to clarify local level requirements and to develop educational resources such as patient specific booster flyer. The Network involved LDO regional leadership and the CDC to reduce NHSN data batching errors contributing to the high number of unknowns showing in NHSN reports.

Robust Patient Engagement
Vaccination hesitancy was a significant barrier for facilities, therefore the Network utilized CDC, NCC, and other culturally appropriate organizations such as the NAACP, PICAWA resources to support education to vulnerable populations. Facilities were encouraged to engage patients and staff in open dialogue about the importance of vaccination and to share their reasons “why” with each other. Facilities were instructed to provide ongoing question and answer sessions with staff and patients to reduce hesitancy and misinformation.

Results

The Network met and exceeded the Patient COVID-19 vaccination project goal of 80% by 0.10%. Surpassing the national average of 77.4% by 2.70%

The Network met 81.3% the staff COVID-19 vaccination project goal of 100% falling just below the national average of 82.0% by 0.7%.

QIA: Quality improvement Activity
Source of data: ESRD NCC accessed April 2022
Network 16: Percent of Fully Vaccinated Dialysis Facility Staff Receiving COVID Vaccination Booster
December 2021 - April 2022

GQA: Quality Improvement Activity
Source of data: ESRD NCC accessed April 2022
Data Quality (Admissions, CMS Form 2728, CMS Form 2746) June-April 2022

The Network was tasked with improving the timeliness of submissions in EQRS for patient admissions along with CMS forms 2728 and 2746 from baseline data. To decrease the burden at the facility level, the Network worked first with national organization staff. Through a series of meetings with the Large Dialysis Organizations (LDOs), the Network worked to understand barriers, coordinate education efforts, and compile and distribute resources to provide targeted assistance to improve data quality timeliness for each organization.

The largest barrier for the data quality measures reported by dialysis facilities was staffing issues, including both staff turnover and increased burden on existing staff. This led to new staff not always certain of the process or staff unable to prioritize timely completion of the CMS Form 2728 and 2746 and admissions. Network staff provided one-on-one onboarding appointments to new staff to assist them with EQRS requirements and navigation.

Facilities also reported the coordination and communication efforts required to obtain certain fields on the forms impacted form timeliness. Obtaining timely nephrologist signatures was the most common issue for the CMS 2728 form and a timely cause of death was the most common issue for the CMS 2746 form.

For admissions timeliness, the largest barrier reported was troubleshooting and/or resolving data issues impacting batch submissions of admission records. Facilities were usually able to resolve admission issues by working with their internal support teams, however issues could not always be resolved in time to be added to EQRS within five business days.

The Network also continued to focus on working with facilities on submission of overdue missing forms. The Network reduced the number of missing overdue CMS 2728 forms by 30% and CMS 2746 forms for dialysis patients by 60% from November to April (based on network tracking of missing forms due 2020 to present), however this contributed to a larger number of late forms submitted in EQRS.

Other Network interventions included:

Working with other Networks to create and share a resource outlining why timely submissions matter and the impact of untimely submissions on patients.

Creating and distributing a missing form report for facilities identifying due and overdue missing CMS 2728 and CMS 2746 forms along with a timeliness summary of the forms submitted during the year.

Providing data quality appointments that allowed facilities to schedule meetings for one-on-one technical assistance.
Network 16: CMS-2746 Forms Submitted within 14 Days of Death
July 2021 - April 2022

GIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2022
Hospitalization (Inpatient Admissions, ED Visits, Readmissions and COVID-19 Admissions) June-April 2022

Project Structure

The traditional project underwent innovation this year by continuing our focus on improving care of patients by focusing on care planning in the “Putting Patients First” initiative. Preventing hospitalizations and unplanned readmissions requires attention to the patient’s needs and test results more often than just annually. Facility specific barriers and hospitalization reasons mitigated on technical assistance calls.

The Network worked to use dialysis provider policies/interventions where possible. For example, the Network wanted post hospitalization assessments and had the facilities use their company’s post hospitalization assessment.

The Network has been encouraging dialysis providers to get EMR access to their primary admitting hospital for the last 8 years. This was continued and even expanded to include a secondary hospital when the local area to the dialysis provider has multiple hospitals.

The COVID pandemic did cause public changes in the use of healthcare. Hospitals were at or beyond capacity for much of the project year. Primary care offices and other specialist were booked out so far that it might take months to get an appointment. According to patients, this was one of the reasons that they were using the emergency departments.

The COVID pandemic also caused changes to dialysis care. If a patient tested positive for COVID, had symptoms, or was exposed they were isolated. This could mean a move to another clinic and/or a change in shift. Patients sometimes missed these treatments due to difficulty getting to the isolation clinic or the new time not meeting the needs of the patient’s life. Staffing issues caused dialysis treatments to be shortened and there was not the ability for patients to have extra treatments for fluid overload or to make up a missed treatment. Supply chain issues caused either shortened treatments or the rate of dialysate to be slowed. All these issues impact the quality of dialysis provided and can increase the need for hospitalization or emergency department use.

Root Cause Analysis (RCA) as the Foundation of Quality Improvement (QI)

Root Cause Analysis (RCA) was used at the onset of the project with every participant, and then individually as needed with participants who, under regular monitoring, were found to be underperforming.

During technical assistance calls, the Network reviewed facility results, primary/secondary discharge diagnosis and even patient level details. Many of the plans made revolved around facility specific issues, EMR and discharge coordination and then patient specific issues.

Challenges discovered during RCA that were difficult to address included mental health and substance abuse issues. Continued work will need to be done to improve care for these patients.

Collaborative Efforts with Stakeholders
While reviewing the primary discharge codes, the Network noted that the number one reason for hospitalization was sepsis. The Network reached out to the Washington, Idaho and Oregon health departments for partnership with COVID and sepsis. These efforts covered vaccination information, contract tracing, technical assistance, fit testing for respirators, etc. These partnerships are continuing and are expanding to cover the ICAR work.

The Network partnered with hospitals to assist with Special Purpose Dialysis Facilities, to identify ESRD patients early and to send them back out to an outpatient dialysis provider for dialysis treatment.

**Robust Patient Engagement**

Reducing hospitalizations, unplanned readmissions and emergency department visits takes individualized patient care. The Network encouraged patient directed care planning/goal setting. Various members of the interdisciplinary team needed to engage with the patients one on one to resolve that patient’s issues, for example missed dialysis treatment or the lack of a primary care provider.

The Network also encouraged patients who were missing treatments to connect with a peer mentor. Peer mentoring has been shown to help patient adjust to continued dialysis.

**Results**

The Network successfully met the goal to reduce hospital admission, unplanned readmissions and emergency department use. The goal for reducing COVID hospital admissions was not met. The Medical Review Board of the Network did not want the Network to have patients wait to go to the hospital when they had COVID. The concern was that these patients are so compromised that a delay in hospitalization can increase the complication/mortality. The Network emphasized the importance of COVID vaccinations and prevention measures to work on the COVID hospitalizations.
Network 16: Rate of ESRD-Related Hospital Admissions per 100 Patient-months (lower rates are better)
August 2021 - April 2022

QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2022

Network 16: Outpatient Emergency Department Visits per 100 Patient-months (lower rates are better)
August 2021 - April 2022

QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2022
**Network 16: Hospital 30-Day Unplanned Readmissions**
*(lower rates are better)*
*August 2021 - April 2022*

- Aug-21: 5.4%
- Sep-21: 6.3%
- Oct-21: 6.8%
- Nov-21: 7.1%
- Dec-21: 7.4%
- Jan-22: 7.8%
- Feb-22: 8.0%
- Mar-22: 8.1%
- Apr-22: 8.4%

QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2022

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**Network 16: COVID-19 Hospitalizations (lower values are better)**
*August 2021 - April 2022*

- Aug-21: 40
- Sep-21: 99
- Oct-21: 171
- Nov-21: 275
- Dec-21: 339
- Jan-22: 389
- Feb-22: 586
- Mar-22: 688
- Apr-22: 724

QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2022
Depression June 2021-April 2022
Due to data not being available, the Network worked toward the goals of this quality improvement activity but was not evaluated on results.

Network 16 convened a Behavioral Health (Depression) Coalition to oversee Depression activities. The Coalition consisted of dialysis social workers, nurses, and facility administrators; dialysis and transplant patients; and a Comagine health Behavioral Health Team psychiatrist. The Network reviewed with the Coalition challenges that were shared by dialysis providers during one-on-one technical assistance calls. The most common reported barriers were:

- Patient survey fatigue
- Reluctance to disclose depression due to stigma or potential impact on transplant eligibility
- Cultural barriers (also related to stigma)

Patients on the Coalition shared that they too are reluctant to disclose symptoms of depression, though they are actively involved in their care. Social workers endorsed that their patients are reluctant to disclose or discuss depression or other mental health concerns. The Coalition recommended that the Network provide psychoeducation that patients can review on their own and self-identify symptoms. Under Coalition and Patient Advisory Council (PAC) guidance, the Network developed and shared materials for patients that can be used for mental health lobby days or bulletin boards. One of these resources was a new one that leverages ‘warmlines’ that patients can call for support, receive regular ‘check-ins,’ and get help with finding a therapist. Final resources shared with social workers Network-wide included:

- Network 16 Warline Directory – Need to talk to someone? Call a warline!
- Forum of ESRD Networks – Dialysis Patient Depression Toolkit (adapted by Network 16 to add a QR code)
- National Institute for Mental Health Resource – My Mental Health: Do I Need Help?
- Alliant Health Solutions –
  - Zone Tool for Self-Management of Depression
  - Relax, Refresh...Reset
- Anxiety & Depression Association of America – How to Deal with Stress and Anxiety

Nursing Home June-April 2022
Due to contract goal adjustments, the Network worked toward the goals of this quality improvement activity.

Project Structure
The Network started the project year with no patients receiving a home modality by dialysis staff in a nursing home setting. Interventions included sharing information with the QIO nursing homes on the ability to have dialysis staff perform dialysis in the nursing home with the patients on a home modality. The Network also described the modality and its use in other areas of the country with the State Surveyors in our Network area.

Root Cause Analysis (RCA) as the Foundation of Quality Improvement (QI)
The Network had no dialysis access or blood transfusions in the patients receiving a home dialysis modality by dialysis staff in the nursing homes. To ensure good quality of care for these patients outside of dialysis, the Network provided training to nursing home staff. This training session was well received and recorded. The nursing home decided that all their staff needed this training session.

**Collaborative Efforts with Stakeholders**

The Network partnered with the State Survey agency prior to and during the initial surveys for the dialysis facility providing the staff and dialysis oversight for the patients receiving a home modality in a nursing home.

Partnership with the nursing home provider started by answering their questions around dialysis and providing a webinar training session for their staff.

**Robust Patient Engagement**

The Network included the patient point of view in the webinar provided to nursing home staff. Also, in the mode of “Putting Patient First” the Network encouraged care plan meeting that included the patient/family, dialysis staff and nursing home staff.

**Results**

The Network maintained a zero-dialysis access infection and zero transfusion rate during the contract year. The Network will strive to maintain this level but realizes that it is unrealistic to have a baseline of zero dialysis access infection and blood transfusions and expect to maintain the same level in the long term.
Network 16: Hemodialysis Catheter Infections in Home Dialysis Patients within Nursing Homes (lower values are better)
February 2022 - April 2022

QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2022

Network 16: Peritonitis Events in Home Dialysis Patients within Nursing Homes (lower values are better)
February 2022 - April 2022

QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2022
**Telemedicine June-April 2022**
Due to data issues preventing evaluation, the Network worked toward the nonfunctional goals of this quality improvement activity.

**Project Structure**
Patient centered interventions included supporting both providers and patients in using telemedicine, billing for telemedicine and using state and federal programs to obtain internet access and equipment.

**Root Cause Analysis (RCA) as the Foundation of Quality Improvement (QI)**
Barriers that needed to be overcome were both on the provider side and on the patient use side. Materials were used on provider preparation and telemedicine etiquette. Part of provider preparation for telemedicine included how to have support for patients on the platform used. Overall, most home providers in the area used telemedicine.

Barriers were discussed and mediations developed during the Network technical assistance calls which were facility/provider specific.

During the RCA for hospitalization, a spike in peritonitis was noted. While working with the dialysis provider, the RCA noted that infection control/technique training for peritoneal dialysis patients was not as strong/robust during telehealth visits. For this reason, the provider decided to discontinue their use of telemedicine.

**Collaborative Efforts with Stakeholders**
We engaged with QIO billing specialist to assist us in the use of billing codes for providers and to share telemedicine resources. Also, we worked with providers on their concerns for telemedicine. We worked to assist registered dieticians to register for their NPI number to allow for billing for telemedicine services.

**Robust Patient Engagement**
The Network answered patients’ questions regarding telemedicine. Tools were distributed to patients to assist them in using various federal and state programs to ensure they had the access needed for telehealth.

**Results**
The Network met our telemedicine goals for the contract year.
Vaccinations Pneumococcal 13 & 23 and Staff Influenza June-April 2022
Due to unavailability of data, the Network worked toward the nonfunctional goals of this quality improvement activity but was not evaluated on results.

Pneumococcal Vaccinations

Project Structure

The traditional project underwent innovation this year by continuing our focus on care planning in the “Putting Patients First” initiative. Interventions focused on supporting both patients and providers to increase pneumonia vaccination rates by addressing systemwide challenges and using community resources for success.

Root Cause Analysis (RCA) as the Foundation of Quality Improvement (QI)

PCV13 data EQRS data was not available during the initial project launch and PPSV23 vaccination data was not available during the entire project year. Therefore, the Network conducted RCA of Pneumonia hospitalizations to identify facilities for focused QI while awaiting data from EQRS. RCA’s revealed that staffing shortages inhibited facility level patient education. Traditionally pneumonia vaccinations were given by other providers such as the patients primary care physician. The large focus on COVID-19 vaccination had a compounding effect on patients feelings of “forced” to be vaccinated caused patients to not want any vaccinations. To remediate these concerns emphasis was placed on educating dialysis providers to administer more than one vaccine at a time as allowed by the CDC. When available the Network distributed new CDC guidance on the use of PCV20 vaccine which negated the need for the
multiple pneumonia vaccines for patients with not prior vaccinations or no clear pneumonia vaccination history.

**Collaborative Efforts with Stakeholders**

The Network encouraged cross reporting between hospitals, PCPs, nursing homes and dialysis providers to catch all vaccinations and prevent multi-dosing.

When EQRS Pneumonia vaccination data became available, facility results were included in the vaccination report shared with Regional Managers and facility Infection preventionists.

**Robust Patient Engagement**

Facilities were encouraged to engage patients in educational activities focused on emphasizing the necessity of vaccinations for health. Keeping patients vaccinated for health

**Results**

The Network achieved 90.94% of the PCV13 vaccination goal of 9,340 resulting in 8,494 patients having received their vaccination. Falling below the national average of 95.4% by 4.46%. The Network was unable to confirm PPSV23 vaccination performance due to the unavailability of information in the EQRS system by the end of the project year.

**Staff Influenza**

**Project Structure**

The Staff Influenza project focused on providing education on the necessity and effectiveness of the vaccine as well as technical assistance to support providers to increase influenza vaccination rates.

**Root Cause Analysis (RCA) as the Foundation of Quality Improvement (QI)**

Root Cause Analysis was conducted using historical vaccination rates and prevalent risk in conjunction with spread of COVID-19 illness. Facilities were provided 1:1 technical assistance that included updated guidance on co-administering the influenza vaccine with the COVID-19 vaccine. Facilities were also provided education on how to report staff influenza vaccinations into the new NHSN module. Staff hesitancy from the COVID-19 vaccination had an influence on the increase of flu vaccination hesitance. The Network provided strategies such as educational huddles and referenced the vaccination best practice videos located in ESRD online.

**Collaborative Efforts with Stakeholders**

The Network partnered with QIO CoFluPneu coalition on the development of influenza vaccination best practice videos in addition to collaborating with state departments of health for additional educational resources.

**Robust Patient Engagement**

Facilities were encouraged to involve the patient perspective when providing education to staff who decline to be vaccinated.
Results

The Network achieved 42.78% vaccination rate, resulting in 37.94% toward the 90% staff influenza vaccination goal. Falling below the highest achiever of 62.75% by 24.81%.

Network 16: ESRD Patients Receiving Pneumococcal Conjugate Vaccination (PCV 13)
December 2021 - April 2022

Network 16: Percent of Staff Receiving an Influenza Vaccination 2021/2022

QIA: Quality Improvement Activity
Source of data: ESRD NCC accessed May 2022
ESRD NETWORK RECOMMENDATIONS

There have been no facilities that have consistently failed to cooperate with network goals. Staff work regularly with individual facilities as well as regional provider leadership to address facilities who have areas needing improvement.

Network staff have consulted several hospital systems to assist in their designation as special use facilities. This has been a critical effort to help address the continuing staffing crisis.

Recommendation for the service area for Network 16 include:

- More outpatient chair availability in WA and OR where we are seeing delays in hospital discharges due to the need for outpatient dialysis
- More nocturnal shifts
- More outpatient dialysis chair availability for stable higher acuity patients (vents/trachs)
- Transplant evaluations and follow-ups closer to a patient’s home especially in state without transplant facilities
**ESRD NETWORK COVID-19 EMERGENCY PREPAREDNESS INTERVENTION**

COVID-19 continued to impact dialysis facilities in Network 16. The ongoing staffing crisis caused disruptions to facility operations with many reducing shifts or closing permanently. The Network convened facility administrators, regional leadership, and State Survey Agencies to address the staffing shortage including use of the Medical Reserve Corps. The Network provided clinical guidance on how to use RN and LPNs who come into the unit with no dialysis experience. Additionally, the Network identified and educated facilities on the use of staffing waivers and competency-based tasks specific training for all roles. The Network encouraged and supported facilities during this crisis, brainstorming with the community and regulators to develop and support mitigations to patient care barriers. The Network assisted several hospitals to set up a “special use facility” to dialyze patients while waiting for permanent placement at a dialysis facility. Providers were still held responsible for patient placement, but the Network worked with the community to get the extra patient treatments, shared hospital capacity knowledge with patients, and encouraged dietary and fluid restrictions.

Staffing shortages significantly increased in WA and OR in Quarter four 2021 while a new variant was increasing in transmissions. This surge resulted in limited chair availability, facility closures, and increased need to relocate. The Network collaborated with Washington state to increase dialysis station flexibility due to increased COVID positives (staff and patients). The Network shared recommendations on alternative staffing models and approval for emergency expansions and collaborated to capture best practices and opportunities to respond to staff shortages. With shift reductions and cohorting patients, dialysis clinic space was limited. In one facility, the Network developed a plan to use NxStage machines in the home treatment rooms for COVID cohorts in alignment with OSHA and CDC guidelines. All home programs could benefit from similar plans.

Another barrier to dialysis in 2021-22 was transportation of patients between care settings. Transportation barriers across county lines caused missed dialysis treatments. The Network convened a COVID-19 Transportation taskforce with hospitals, transportation companies, etc. for solutions.

In addition to providing technical assistance to facilities, education included current CDC COVID guidance. The Network developed on-demand learning on NW16’s ESRD Online learning system for self-paced knowledge access. The content was updated as new resources became available. The following was added to the learning system in 2021-22: 14 patient-specific and 38 provider specific resources. Topics include aids to help with mental health, telehealth, vaccination information and CDC updates. To address education for different ethnicities, the Network located and shared culturally appropriate resources from community partners such as PICA-WA, NAACP, and Tribal Health. Two key COVID-19 mental health-related resources developed by the Network include:

- Healthcare Workers – Coping with Infectious Disease Outbreaks in the Dialysis Setting; and
- COVID-19: Resources to Help Your Patients with Coping

The Network partnered with state Departments of Health to reduce facility burden, mitigate issues revealed and share best practices. The Network continued to adapt technical assistance to facilities to reduce risk factors, and partner with health departments and coalitions on infection prevention efforts.
Facilities experiencing staffing shortages had low primary series COVID-19 patient vaccination rates (see COVID-19 Vaccination Section). Concerns were escalated to corporate data batch submitters and regional leadership to improve reporting and resolve data discrepancies. Large scale EMR and corporate batching system misalignments were identified, that attributed to low facility primary series and booster vaccination rates. The Network pivoted from 1:1 documentation work with facilities to engagement with corporate batch submitters to resolve documentation issues.
**ESRD NETWORK SIGNIFICANT EMERGENCY PREPAREDNESS INTERVENTION**

**Emergency Prep Activities – January 2021 – April 2022**

March 2021 – In follow up from recent emergency events and resulting barriers to dialysis, the Network met with King County EOC and Multnomah County EOC regarding opportunities to improve disaster transportation.

July 2021 through April 2022 – July 2021 was the beginning of frequent facility closures, shift closures, changes in patient dialysis prescription/location for dialysis, etc. related to staff shortages. The Network tracked facility closures and prescription or schedule changes, worked with regional leadership, Emergency Management and Departments of Health officials to troubleshoot patient access to dialysis care concerns. Actions to address this crisis included brainstorming and instituting mitigation strategies such as use of competency-based tasks training for RNs, waivers, onboarding Medical Reserve Corps, and establishing hospitals as special purpose outpatient dialysis facilities,

January 2022 – The Network convened and facilitated a series of 3 calls with state and local emergency managers and key ESRD stakeholders, regarding dialysis transportation challenges in Washington.

February 2022 – The Network hosted and facilitated Network 16’s annual disaster drill with an earthquake scenario. There were sixty-eight participants representing 16 organizations from all 5 Network states. This exercise served to establish new relationships with several emergency management partners and share key resources to aid in real life emergency response, such as KCER’s shelter triage tools.

**Training and education provided:**

March 2021 - Network 16 staff presented at the KCER Summit on Safety at Work During the COVID-19 Pandemic, and a PAC member presented on her experiences with recent wildfires and winter storms.

April 2021 – Network hosted a webinar for regional leadership and State Survey Agencies on disaster and events reporting.

**Summary of emergency events:**

January 2021 – A winter storm impacted multiple facilities, primarily in Washington state. Worked with State Survey Agency and Certificate of need in approval of a special purpose facility to take patients from closed facilities.

February 2021 – A winter storm impacted 20 Oregon and Washington facilities, road conditions, staff, and patients unable to get to clinics, power outages, down trees, and transportation companies stopped service.

November 2021 – Flooding in Whatcom County, Washington resulted in a power outage at 2 dialysis facilities, and impacted road travel.
ACRONYM LIST APPENDIX
This appendix contains an acronym list created by the KPAC (Kidney Patient Advisory Council) of the National Forum of ESRD Networks. We are grateful to the KPAC for creating this list of acronyms 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.