ESRD Network 2020 Annual Report

ESRD Network 16
Alaska, Idaho, Montana, Oregon, Washington
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COVID-19 exacted a toll in Network 16 in 2020 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 quickly reacting to support clinics and provide critical information to CMS to quickly disseminate throughout the country. With the overarching goal to protect the patients and staff, the Network quickly mobilized to be a 24/7 resource to the renal community and was a trusted voice relaying credible information. The lens of COVID-19 impacted the work of Network 16 the entire year.

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.
- In Montana, American Indian/Alaska Native is the second largest patient population by race.
- In Alaska, Asian, Black or African-American, and Native Hawaiian or Other Pacific Islander make up 44% of the dialysis patient population.
- Idaho has the highest percentage of patients dialyzing at home with 27%, as compared to the entire Network 16 rate of 17% as of Dec. 31, 2019.
- Oregon and Washington are the only states with transplant centers, causing 20% of Network 16 patients who received a transplant in 2019 to travel out of state— a 17% increase from 2018.

ESRD Network 16 geographic area spans three time zones and almost one million square miles. The distance from Anchorage, Alaska to Billings, Montana is similar to the distance between Seattle, Washington and West Palm Beach, Florida. Although Network 16 includes several metropolitan centers, a substantial portion of the general and ESRD population is dispersed in more remote, rural areas. The state of Washington has half of the dialysis population of Network 16, but less than 7% of the geographic area. 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 2020, 26.8% of Idaho patients, 22.9% of Alaska patients and 20.1% of Montana patients were categorized as home dialysis patients, compared to 17.7% in Oregon and 15.7% in Washington.
There were 685 reported kidney transplants performed in 2020 at the Network’s seven Medicare certified transplant centers, a decrease from 2019. 82 more kidney transplants also occurred at a VA facility in 2020. Of the 685 kidney transplants, 18% were from living donors.
Count of Prevalent ESRD Patients by Treatment/Setting as of 12/31/2020

Network 16: Count of Prevalent ESRD Patients by Treatment/Setting
2020

Count of Incident ESRD Patients by Initial Treatment/Setting

Network 16: Count of Incident ESRD Patients by Initial Treatment/Setting
2020

Source of data: EGRS accessed June 21, 2021
Network 16: Count of Medicare-Certified Facilities by Treatment/Setting 2020

- Total Dialysis Facilities = In-Center and Home Dialysis + Home Dialysis Only + In-Center Only
- Total ESRD Facilities = Transplant + Total Dialysis Facilities

Source of data: ESRD accessed June 21, 2021
Percent of National Prevalent Dialysis Patients by ESRD Network as of 12/31/2020

![Bar Chart: Percent of National Prevalent Dialysis Patients by ESRD Network 2020]

National total dialysis patients: 525,148
Source of data: EQRS accessed June 21, 2021

Percent of National Incident Dialysis Patients by ESRD Network

![Bar Chart: Percent of National Incident Dialysis Patients by ESRD Network 2020]

National total incident patients: 128,323
Source of data: EQRS accessed June 21, 2021
Percent of Medicare-Certified Dialysis Facilities by ESRD Network as of 12/31/2020

Percent of National Home Hemodialysis and Peritoneal Dialysis Patients by ESRD Network as of 12/31/2020
Percent of National Transplant Patients by ESRD Network as of 12/31/2020

Percent of Medicare-Certified Kidney Transplant Facilities by ESRD Network as of 12/31/2020
ESRD NETWORK GRIEVANCE AND ACCESS TO CARE DATA

GRIEVANCES:
The top two categories of grievances for 2020 were Clinical Quality of Care and Staff Related.

- **Clinical Quality of Care** – Patient safety and health issues reported primarily were about unsafe staffing levels or staff schedules putting patients at risk. Access site issues related to infiltration or clinical competency. The primary concern around infection control was COVID-19 protocols not being followed (disinfecting of equipment, enforcing masking or eating policies, screening process).
- **Staff Related** – Communication, professionalism, and staff relations were the most common themes.

The most utilized Network interventions to address grievances included:

- Network mediation between patients and staff – both on site (prior to pandemic social distancing) and via Zoom calls
- Working with facility regional leadership and quality staff on a plan for improvement and sustainment
- Keeping patients and providers up to date with the latest CDC pandemic guidance
- Fostering patient and family involvement in care plan development
- Sharing training materials on culture of safety and compassion fatigue/burnout
- Sharing Network 16 resources that were developed based on identified trends:
  - Resources for patient and staff on boundaries
  - A resource for both patients and staff on dialysis schedules
  - Overcoming COVID-19 screening fatigue

**Grievance Survey Results for 2020**

Network 16 began Option Year 4 (December 2019) with an 85.87 grievance satisfaction score and ended the year at 80.62. Except for one month (September’s score was 79.40), the score consistently measured above 80.

ACCESS TO CARE:
The top reason for notification to the Network of an involuntary discharge (IVD) was Immediate Severe Threat, followed by Disruptive and Abusive Behavior. Network 16 was successful in averting 49% of IVD cases in 2020. The primary interventions related to IVD and Failure to Place cases were:

- Providing guidance to Medical Directors on the physician role in overseeing IVDs.
- Working with social workers in their role as patient advocates, educators, and mediators to help patients at risk for IVD adapt.
- Assisting patients with access to outpatient dialysis care, which included finding nephrologists and dialysis facilities to accept patients and exploring the patient’s ability to transfer to a home modality.
FACILITY CONCERNS:

Sixty-two percent of contacts to the Network in 2020 were facility concerns (compared to twenty-nine percent in 2019). This increase is attributed to uncertainty and stress experienced by patients and providers related to the pandemic. Thirty-eight percent of 2020 facility concern contacts were related to COVID-19.

Calls from facility staff present the opportunity for the Network to provide education/technical assistance and share resource materials to help diffuse situations that, without appropriate intervention, could result in an involuntary discharge.

MENTAL HEALTH RELATED CASES:

Sixty percent of 2020 access to care cases and thirty-six percent of facility concern cases were mental health related. During this world-wide pandemic, ESRD providers and patients need ready access tools that address mental health concerns now more than ever.

At the start of the pandemic in March 2020, providers in the greater Seattle, WA region asked the Network for help with supporting the mental health of their staff, so they could take care of their patients’ needs. In response, the Network developed a resource for staff ‘Healthcare Workers – Coping with Infectious Disease Outbreaks in the Dialysis Setting.’ In June 2020, the Network queried dialysis social workers about the psychosocial needs of their patients, and their responses indicated notable exacerbation of already present psychosocial, behavioral, and emotional concerns. The Network followed up with developing a tool for social workers ‘COVID-19: Resources to Help Your Patients with Coping.’ The tool lists each behavior or mood change associated with trauma, and correlating interventions that staff can use to help their patients get past their pandemic-related stress.

COVID-19 RELATED CASES:

- Grievances – Only three grievance cases were related to COVID-19. Two cases involved the new masking requirements, and one case involved concern that the facility was not enforcing COVID-19 safety protocols.
- Access to care – Four access to care cases were related to COVID-19. Three involuntary discharges were patient reactions to the new mask requirements (two immediate severe threat cases where the police were called, and one patient refused the mask and was purposely coughing on other patients). One patient was at risk for involuntary discharge due to mask refusal, and that discharge was averted.
Network 16: Percent of Grievances and Non-Grievances by Case Type
December 2019 - December 2020

Facility Concern 62%
Access to Care 17%
General Grievance 6%
Immediate Advocacy 8%
Clinical Area of Concern 7%

Source of data: Patient Contact Utility (PCU) accessed April 2021

Network 16: Percent of Mental Health Related Grievances and Non-Grievances by Case Type
May 2020 - December 2020

Access to Care 60%
Facility Concerns 36%
Grievances 4%

Grievances include Immediate Advocacy, General Grievance, and Clinical Quality of Care
Source of data: Patient Contact Utility (PCU) accessed April 2021
Long Term Catheter Quality Improvement Activity
Due to the COVID-19 pandemic limiting provider staffing and procedures, along with contract goal adjustments, the Network worked toward the goals of this quality improvement activity but was not evaluated on results.

Project Restructure
This year the Network revolutionized the traditional project structure with a responsive activity structure called “Putting Patients First” which centers on individualized care planning for vascular access management. Participants in the long-term catheter project demonstrated strong understanding of patient-centered care in removing CVCs. Innovations include focus on patient plan of care, 1:1 nursing report for CVC facilities, an original best practice resource, and tracking new data for analysis of CVC removal barriers.

Pandemic Adaptability
In the tumultuous COVID-19 pandemic environment, the Network responded with education and targeted technical assistance to disseminate changes in CMS expectations. Facing limited access to vascular surgeons and interventional procedures, the Network provided advanced clinical education to our nurses based on the latest KDOQI guidelines to promote best practice in fistula assessment for RNs, to prevent conversions to CVC and reduce preventable procedures in the PHE environment.

Variety of Educational Resources
Resources were identified from a multitude of sources. NCC LANs provided interventions in infection prevention from fellow clinics and widened the distribution of best practices, such as tips for more efficient CVC dressing changes. Furthermore, the CDC identified discrepancies in the CVC infection data and pushed this year for standardized blood culture collection practices in dialysis. The Network refocused infection prevention education accordingly on standardization and best practices in blood culture collection and how it affects CVC infection rates. The Telemedicine Rapid Response initiative assisted providers in understanding, utilizing, and billing for telehealth to support opportunities such as vascular surgeons to do telehealth visits for permanent access placement and catheter removal. In May, their telehealth initiative assisted with billing info for vascular surgeons to do telehealth follow up visits for permanent access placement and catheter removal.

Integrative Feedback Processes
The Network has continuously provided an open environment of staff feedback to evaluate the effectiveness of interventions and directly from patients themselves via the SME network. Facilities and patients both provided feedback on effectiveness of tools and resources provided, and all patient education was reviewed by the PAC. Patient SMEs were recruited in all project participants with monthly requirements for staff to engage them in specific activities. The Network required patient participation in QAPI and for patients to use CDC put-on/take-off check lists to audit staff for CVCs. Participants were expected to demonstrate strong understanding of patient-centered care in supporting patient
adherence to keeping appointments to support timely removal. Patients with chronic catheters overwhelmingly cite feeling coerced out of choice in access and having medical contraindications for CVC removal; they feel unheard and unacknowledged in the "war" on catheters. The Network responded with educational interventions that promote informed patient choice in access options to prevent ongoing stigma of CVC patients.

**Best Practices and Barriers**

Additionally, the Network proactively sought best practices on refusals and appointment support based on facility-identified needs and compiled/distributed these BDPs. Top performers were identified as having a ‘CKD Coordinator’ to proactively manage the plan of care to improve CVC removal. Best practices were promoted that originated with the facilities and an original resource was created to disseminate practices such as one that three separate facilities identified: using software that alerts staff to abnormal trends in patient access function. Since wide-spread adoption of the FFCL is inherent across the industry, the most effective intervention was found to be one-on-one conferences with each participant. For those without access to corporate resources, the Network utilized the AKF “First 30” Toolkit in July to support transitions of incident patients and decrease time to CVC removal. Incident patients account for more than 90% of patients with a CVC and need support in the steps to removal.

**Data Accuracy and Integrity**

Rethinking data collection proved a new area of opportunity. Facilities were required to watch the Network-recorded video on correctly reporting vascular access data into CROWNWeb in order to reinforce basic expectations in an environment of high turnover. Analysis of Environmental Scan results revealed best practices according to facilities center around timely internal workflow. In response, the Network reimagined data collection on CVCs to include information not available in CROWNWeb, such as count of revisions and chronic CVCs.

This data provides an actionable foundation for improving care coordination with hospitals and vascular surgeons: all facilities struggle with not being able to start the removal process for new patients prior to admission and universally state that the 90-day removal expectation is unrealistic. Data collection on barriers revealed systemic barriers continue to impede progress below 15% long term CVC rate for many individual facilities, although the Network-wide average ranges from 10-11%. These barriers include lack of vascular surgeons to perform procedures, and patients feeling coerced into getting a fistula rather than having a choice.
Blood-Stream Infection Quality Improvement Activity

Project Restructure

In 2020, the Network launched a dynamic framework for QI projects in which all facilities focused on better care planning in the “Putting Patients First” initiative. It emphasizes individualized care planning based on outcomes and not just check boxes. Innovations include focus on patient plan of care, QAPI integration step by step guide, best practice resource, and SME infection champions. The care plan focus QIA structure allowed for flexibility in identifying and responding to needs. Network 16 met 80% goal in influenza vaccinations thanks to early head start prior to flu season with Network hitting 89% prior to deadline.

Pandemic Adaptability

The pandemic environment of constant change and stress made it difficult to follow all guidelines at all times. In June the Network held a webinar for providers on ways to manage stress and crisis for HCP. To support their success, patient SMEs were recruited in all project participants with monthly requirements for staff to engage them in specific activities. QAPI participation was one of those activities; the Network established boundaries and reinforced expectations. Patients conducted CDC put-on/take-off audits as well. Facilities are encouraged to aim for their goals using a whole-team approach with a formal support structure in the form of policies/procedures.

Root Cause Analysis as the Foundation of 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 or in person. 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. RCA revealed need for flu readiness in pandemic environment, leading to Flu Precautions toolkit with ready-made CDC guidelines to in-service staff, resources to share with patients, and tools to communicate with SNF/hospital. In the tumultuous pandemic environment, the Network responded with education and targeted technical assistance to disseminate changes in CMS expectations.

Collaboration and Connectivity

While nationwide efforts are underway to connect the acute and chronic settings over the next few years, this Network continues to encourage facilities to find ways to reduce harms more immediately. Network 16 collaborated with state health authorities in OR, ID, and WA to provide robust data validation and individualized education/support for implementing CDC audit tools. The Network has worked to improve communication between the acute and chronic setting as well, promoting best practices such as timely records retrieval, participation in infection prevention collaborations, and RN handoffs. EMR/HIE access documentation provided evidence of permanent adoption of best practice in post-hospitalization patient care. Data was collected and analyzed for successes and barriers monthly. Technical support was provided with facilities to clarify requirements and knowledge around HIE and NHSN using HEALTHIT.gov materials as reference to further highlight the value and need for better interoperability.

Variety of Educational Resources

PFE LANs were instrumental in providing patient-reviewed resources from points of view outside the PAC and SME pool (such as the NCC NPFE patient-created resource, the Clean Hands Count badge). The Network was one of the first to participate in the collaborative effort with all Networks to produce an effective hand sanitizer audit tool for dialysis at CMS’ request, which was subsequently implemented in their facilities by August. All nine core interventions were incorporated in a monthly education plan with supportive resources and diligent project monitoring/follow up. The Network provided staff education on 3-step plan to integrate CDC Core Interventions into monthly QAPI using simplified regulations, follow up, and PDSA documentation for easy applicability for time-strapped staff.

The Network utilized numerous CDC educational tools including annual NHSN training, Core Interventions, and Dialysis Audit Tools. This Network promoted evidence-based practice based on updated guidelines coming from recent research conducted by the CDC; wall box cleaning and disinfection guidance were provided with supporting documentation and follow up to ensure adoption. The Network continuously sought staff and patient feedback to evaluate the tools and resources provided. Educational materials for patients were provided in English and Spanish based on the needs of the population, and other languages as available or requested.

NHSN Support and Technical Assistance

The Network supported NHSN data accuracy consistent with regulatory changes in the PHE environment and in day-to-day technical assistance, in addition to educational resources on PPM, DE protocol, QIP requirements, annual training, etc. With the November launch of weekly required reporting, the Network launched a complex structure for education and support with relentless follow up and the
Network was able to show over 90% compliance within 30 days. Furthermore, despite a pervasive belief among the NWs that NHSN cannot provide any disparity data, the Network provided CMS with the means to collect demographic data from NHSN for future incorporation into the BSI project. This data includes age, gender, and ethnicity, but does not include race or rural/urban status.
Network 16: Reduction in Bloodstream Infections (BSI) in QIA Facilities

Nationally, the Networks reduced 3,495 BSI in 2020

- Goal Reduction: 24
- Actual Reduction: 69

The Network goal was to decrease the rate of BSI by 20% or greater relative reduction in the pooled semi-annual mean in facilities participating in the QIA.

QIA: Quality Improvement Activity

Network 16: Percent of Dialysis Facilities with At Least One Person Who Has Completed the NHSN Dialysis Event Surveillance Training
January 2020 - September 2020

Network 16: Percent of BSI QIA Facilities with a Health Information Exchange or Evidence-Based Highly Effective Information Transfer System
January 2020 - September 2020

QIA: Quality Improvement Activity
BSI: Bloodstream Infection
Source of data: ESRD NCC 2020 Dashboard accessed March 2021
Transplant Waitlist Quality Improvement Activity
Due to the COVID-19 pandemic limiting provider staffing and procedures, along with contract goal adjustments, the Network worked toward the goals of this quality improvement activity, but was not evaluated on results.

Project Overview and Goals:
The Network’s Transplant Waitlist Quality Improvement project for 2020 focused on increasing the rate of patients on the Transplant waiting list by 1.25%. To achieve this goal, the Network utilized the ABC methodology to identify facilities that were top performers and low performers. The Network selected 78 low-performers for project focus facilities.

Project Activities:
The Network project focused on "Putting Patients First" which emphasized the need to include transplant waitlist options in individualized care planning meetings with patients. The Network focused on educating the low-performing facilities on the benefits of a transplant modality, patient options for receiving a transplant, and on improving discussions between facility staff and patients. For example, educating staff on how patient perception and readiness to learn impacts modality choices. After this improvement was made, the Network activities shifted focus to reducing barriers inhibiting each individual patient from pursuing a kidney transplant.

Interventions:
The Network convened a Dual Network Transplant SME Coalition to collaborate on strategies for improvement. Network Transplant Coalition successfully identified key systemwide challenges and strategized on network specific interventions and QI opportunities. Key challenges addressed throughout the year included: Patient Adherence to treatment, patient disinterest in transplant due to long wait times, and financial barriers. Interventions were identified and developed based on the results of the Network environmental scan, feedback from PAC Transplant Advisors from all five states, Medical Review Board input and literature review. Network 16 transplant project implemented interventions such as, the use of an Online Learning Management System, Transplant QIA Project Facility Technical Assistance, Dual Network Transplant SME Coalition, Patient Engagement Activities.

Online Learning Management System: The Network developed a Transplant Resource Book in our online learning management system (LMS). The Transplant Resource Book is a repository of best practices and interventions created by the Network and by industry partners such as the NCC, NKF, CMS and UNOS. The Network ensured patient level educational materials were made available in both English and Spanish. The Transplant Resource Book has been accessed more than NW16 11.5K times by facilities throughout the year. The top resources accessed by facilities includes:

- Most popular resource was the direct contact information of the transplant centers. NW16 740.
- Transplant Center Criteria Matrix NW16 635.
- Transplant Candidates - Now is the Time to Check out VR NW16 433.
- Overcoming Barriers to Waitlisting Best Practices series: NW16 1184.

Overcoming Waitlist Barriers & Best Practices: Using the barriers to wait listing information was collected from the Environmental Scan, the Network asked the top-performing facilities on how they
overcome these barriers, and aggregated their responses into a collection of Best Practices that were shared with all facilities, including the low-performing focus group. Best Practices were rolled out monthly and were accessible to all facilities in the Network’s online learning system Transplant Resource Book:


**Patient Engagement Activities:** The Network hosted the annual in person board meeting where staff and Patient Advisory Council members and continuously collaborated with members on the development and use of interventions, including three new NCC resources; *Partnering Along the Road to Transplant*, *Why Transplant is a Good Idea for Me*, and the *Is a Transplant Right for Me? Kidney Transplant Tool Kit*.

**Transplant QIA Technical Assistance:** The Network conducted 1:1 QI Calls to poor performing facilities to identify current workflow practices and challenges inhibiting success with patient transplant wait listing. The Network successfully identified common systemic barriers and provided strategic guidance and targeted resources and interventions to address specific challenges. Some examples of technical assistance provided includes, referral to specific chapters in the Network’s transplant resource book, the use of The National FORUM of ESRD Networks’ MAC Transplant Toolkit, and key resources on living kidney donation, high KDPI organs, and best practices to improve tracking of the transplant wait listing process. Through this process, facilities noted an increased interest in transplant as a treatment modality.

**Innovation:**

**Transplant Center Situational Analysis Survey (Telehealth impacts from COVID-19):** Early in the pandemic, the Network recognized a need to identify organizations utilizing telehealth technology. The Network conducted a situational analysis survey which clarified which transplant centers are using virtual visits as a result of COVID-19 and promoted the use of telehealth visits with transplant centers during facility level 1:1 technical assistance. The majority of transplant centers have adopted the use of this technology.

**Transplant Waitlist Report:** The Network provided dialysis facilities with UNOS reports of patients waitlisted monthly. Facilities were provided transplant center contact information and were trained on how to collaborate with Transplant Coordinators to validate and reactivate (when applicable) “Inactive patients” on the Waitlist. Dialysis facilities were taught how approach patients who were not on the waitlist to discuss their concerns about the waitlist process and to provide patients with appropriate resources that will help them make informed decisions. Transplant waitlist report sent to Transplant Centers was positively received.
Increasing Access to Rural Patients: The Network identified and facilitated the correction of an error with the SRTR Transplant Program database search tool that was causing the Providence/ Sacred Heart transplant center in Spokane, WA to be excluded from search results. Impacting access to transplant for hundreds of rural patients. SRTR was able to promptly correct the error. Rural patient’s living near this transplant center are now able to see this center in their search results allowing for greater access and patient choice.

Final QIA rate:
2020 was a challenging year for the healthcare industry. In kidney transplantation, many transplant centers halted operations to divert resources to the pandemic and protect patient safety. This led to impacts to patient access to transplant in early Q1 and Q2 of 2020. In addition to these challenges, during Q3, a transition of records occurred between CrownWeb and EQRS. Resulting in a lack of access to final data from the NCC for 2020 until Q2 of 2021. The Network’s performance from Jan 2020 to October 2020 fell just shy of our goal of 2.86% by 0.42%. However, By the end of Jan 2021 the Network had met and surpassed the baseline by 80 patients and exceeded our goal of 2.86% by 111 patients.
Network 16: Percent of Patients Added to the Transplant Waitlist
January 2020 - September 2020

QIA: Quality Improvement Activity
Source of data: ESRD NCC 2019 Dashboard accessed March 2021
Home Therapy Quality Improvement Activity

Due to the COVID-19 pandemic limiting provider staffing and procedures, along with contract goal adjustments, the Network worked toward the goals of this quality improvement activity, but was not evaluated on results.

Project Restructure

The traditional project structure underwent innovation this year by focusing on improvements to care planning in the “Putting Patients First” initiative. Interventional innovations included a heat map for home training, creation of a best practices reference, telehealth education prior to the PHE, a patient communication toolkit, staff education plans, and Network-wide SMEs. Patient SMEs were recruited in all project participants with monthly requirements for staff to engage them in specific activities, including QAPI.

Root Cause Analysis (RCA) as the Foundation of QI

The care plan QIA structure allowed for flexibility in identifying and responding to needs. RCA was used at the onset of the project with every participant as part of their staff education plans, Network-wide to assess barriers, and individually as needed with participants who, under regular monitoring, were found to be underperforming. RCA data was used to provide guidance on foundation of strong PDSA cycles with monthly follow up as needed. Network-wide RCA was utilized throughout the PHE such as in April when limited staffing and accessibility of home programs was revealed as exacerbated in the pandemic environment. No elective procedures in hospitals put a stop to patient transitions and RNs from home programs were mobilized to work in-center, no longer available to provide education and training. The Network responded accordingly with interventions aimed at sustainability and greater impact with less burden.

Top performers revealed significant reliance on the medical director as the leader of home transitions. This makes application highly variable in mobilizing the care plan in a timely manner, unless the nephrologist is proactive with colleagues. The Network responded with a communication toolkit to empower patients to self-advocate for their personal priorities. The Network polled facilities that cited staffing issues as a top barrier to placing patients in home programs, so interventions were formed with sustainability in mind. Facilities were encouraged to aim for their goals using a whole-team approach with formal support from policies and procedures.

An April needs assessment on telehealth led to formation of a Telemedicine Rapid Response initiative to assist providers in understanding, utilizing, and billing for telehealth to support opportunities such as follow up visits for home access placement. Furthermore, the Network addressed an existing knowledge gap by providing a framework for education and follow through. We provided ongoing updates on infection control guidelines from the CDC to promote home patient retention.

Collaborative Efforts with Stakeholders

Home patients, the Network PAC, Home Dialyzers United, Renal Support Network, and Homedialysis.org all provided support and valuable patient insight to facilities by serving as resources for patient and staff education. Collaboration with MEI led to the innovative "Teachable Moments" webinar/recording to raise understanding of patient perception, modality choices, and readiness to learn. In July and August, the Network released a PAC-advised toolkit to address common pitfalls in communication. Throughout
the pandemic we provided ongoing updates on infection control guidelines from the CDC to promote home patient retention. In July the Network collaborated the QIO NH team to assist providers in education and coordination of patient transitions and infection prevention through virtual education events, creation of a protocol template, and identifying gaps in educational resources.

The Network collaborated with LDO home programs throughout the Network for an aggressive push towards lofty goals. Network 16 exceeded the 70% goal in telehealth prior to the June deadline. All in-center participants partnered with nearby home programs to conduct onsite education prior to the pandemic and improve care coordination. The innovative heat map supported the effort with the LDOs, highlighting areas of opportunity. The Network held LDO leadership calls throughout the year to discuss opportunities for modality education and opportunities in acute dialysis services. The Network sought patient feedback both from facilities evaluating the effectiveness of interventions and directly from patients via the SME network. Patients expressed that home modalities education efforts were too aggressive, so the Network responded with an interventional toolkit on communication to address patient priorities that approach home modalities from different angles.

**Robust Patient Engagement**

Patients provided feedback on refusal reasons to identify intervenable root causes. PAC provided foundation for patient education materials created by the Network. PFE LANs were instrumental in providing points of view from outside the PAC/SME pool and additional resources such as the “Let’s Talk” Questions Card Deck. NCC LANs provided interventions in home modality infection prevention such as use of the educational tool called a “dummy tummy” and widened the distribution of best practices. Educational materials were provided in English and Spanish based on the needs of the population, and other languages as available or requested (for example, the International Society of Peritoneal Dialysis guidelines on Strategies Regarding COVID-19 in PD). The most popular resource with patients was the "Unhappy with Dialysis" communication tool which was created with the close assistance of the PAC.

**In-Center and Home Program Collaboratives**

The Network developed an interactive heat map which highlighted home training availability based on monthly data. All were encouraged to utilize the map as a decision tool to support patients to begin home dialysis training at the nearest facility to them, regardless of corporate affiliation. In-center facilities were partnered with nearby home programs to conduct education and improve collaboration. Partners were included in the staff education plan, such as requiring a home RN educator or nephrologist in-service the staff and counsel prospective patients. The Network conducted extensive data collection on barriers and best practices that revealed that many top-performing facilities show reliance on additional teammates that most other facilities do not have access to, such as insurance counselors and RN case managers. Partnership with regional LDO leadership resulted in widespread telehealth adoption by home programs in 2020.
Network 16: Percent of Patients Starting Home Dialysis
January 2020 - September 2020

QIA: Quality Improvement Activity
Source of data: ESRD NCC 2020 Dashboard accessed March 2021
Population Health Focus Pilot Project Quality Improvement Activity

Due to the COVID-19 pandemic limiting provider staffing and procedures, along with contract goal adjustments, the Network worked toward the goals of this quality improvement activity, but was not evaluated on results.

Project Overview and Goals:

The Network’s PHFPQ project for 2020 focused on supporting gainful employment of ESRD patients (Vocational Rehabilitation or VR). Focusing on 16 facilities representing 11.33% of the Network’s patient population, three of which are rural, the project goals were to achieve:

- 50% relative improvement in patients referred to VR
- 1% improvement in patients that were referred becoming active with VR (receiving services)
- 95% of eligible patients screened for VR
- Demonstrate referral of at least 10 eligible patients, between the ages of 55-64, by September 30, 2020

Project Activities:

Facilities were selected for this project and each completed a Root Cause Analysis (RCA) in December 2019. The top improvement needs were 1) Staff comfort with educating on VR, 2) Review of VR in QAPI, and 3) Building relationships with VR counselors. Interventions to aid in improvement in these areas were shared by the Network in a February 2020 VR Kickoff Webinar. Attendees were also oriented on how to navigate the Network’s Learning Management System (LMS) to find the VR Resource Library and complete their monthly assignments.

Network 16’s focus on ‘Putting Patients First: Individual Care Planning’ set the stage for facilities to help improve the quality of life for their patients outside of the dialysis clinic. The VR project was designed to:

- Gather information to determine the most effective project interventions and implemented facility processes as a result of learning,
- Promote an interdisciplinary team approach to learning about VR,
- Have patients who become active with VR generate and share their own success stories, and
- Utilize QAPI to demonstrate social work interventions and outcomes.

Focus on Rural Facilities

The Network tracked facility feedback regarding barriers to VR in LMS and compared rural vs. non-rural facility responses.

The Network and its’ patient advisory council (PAC) developed education for the rural population on Virtual and Work at Home Options. These materials proved to be helpful during the pandemic-related social distancing.

Network VR Activities During COVID-19:

The first known COVID-19 dialysis patient death occurred in Washington State in late February 2020, and the requirements for this project were suspended. Network 16 continued its’ focus on VR throughout the year. Some key activities are listed below:
• Network staff provided VR-related resources and technical assistance to individual staff and patients.
• Social Security Ticket to Work Program webinar announcements were shared with patients and providers.
• Staff authored a section on VR in the Forum of ESRD Networks KPAC Transplant Toolkit.
• Staff and a patient representative from the Network’s PAC presented on ‘Vocational Rehabilitation and Safety at Work During COVID-19’ for an August 11, 2020 ESRS NCC Patient Education Webinar.
• Staff and a PAC representative presented to Comagine Health Board members on workplace equity and protections under the Americans with Disabilities Act, and the role of VR in helping to reduce or eliminate workplace barriers to perform essential job functions (work accommodations).
Network 16: Percent of Eligible Patients Referred to an Employment Network or a Vocational Rehabilitation Agency
January 2020 - September 2020

QIA: Quality Improvement Activity
Source of data: ESRD NCC 2020 Dashboard accessed March 2021

Network 16: Percent of Referred Patients Receiving Services from an Employment Network or Vocational Rehabilitation Agency
January 2020 - September 2020

QIA: Quality Improvement Activity
Source of data: ESRD NCC 2020 Dashboard accessed March 2021
ESRD NETWORK RECOMMENDATIONS

ESRD Network 16 did not recommend any sanctions in 2020. We did refer 3 cases/facilities to the appropriate state agency for state survey.

Network 16 had one facility permanently close in 2020. The Network service area would be better served by increasing the number of facilities with nocturnal dialysis shifts, home hemodialysis program and potentially taking higher acuity level patients (for example stable long-term tracheotomy patients). These recommended programs would increase patient choice and allow more flexibility to nephrologist to individualize the type of dialysis treatment to best meet the patients’ needs.
ESRD NETWORK COVID-19 EMERGENCY PREPAREDNESS INTERVENTION

Network 16 was notified via phone message from a dialysis provider of a patient that had passed due to COVID-19 on March 01, 2020. Network leadership team met and discussed reliable information and decided on a timeline and method of distribution of information/guidance. The first information/guidance on COVID-19 was distributed to dialysis providers on March 02, 2020. Network staff joined state, county and Health and Human Services/Centers for Disease Control (CDC) list serves and monitored guidance to communicate to dialysis providers and dialysis/kidney transplant patients. Updated contact list for EOC/ESF8, local coalitions and other local/national resources were updated and distributed.

The Network used several methods to communicate guidance to the dialysis providers and kidney transplant/dialysis patients including:

1. Weekly/ad hoc COVID-19 email updates to dialysis providers
2. COVID-19 Q&A webinars for providers with patients invited
3. Network Blog- provider, community and patient members
4. Emails to patient SMEs and Patient Advisory Council
5. COVID-19 Helpline (started April 1st) and phone/email responses
6. ESRD Learning Management System- resources highlighted and on demand
7. COVID-19 resources section added to the Network website

By March 09, 2020 the Network 16 website had links to important resources and information for dialysis providers and kidney transplant/dialysis patients that was updated throughout the year.

A COVID-19 helpline and targeted technical assistance were used to assist providers and patients with information and issue surrounding COVID-19. All staff were cross-trained to support the pandemic response and an internal Helpline Guide served as a fluid resource for on-call staff to answer questions and refer to the appropriate and up-to-date guidance. Helpline/targeted assistance topics varied widely over the year to include basic information and guidance, transportation issues, supply issues, staffing issues, masking requirements, guidance on return to work and removal from isolation precautions post COVID-19 or COVID-19 exposure, becoming a vaccination provider, vaccination information, etc.. We partnered with our State Survey Agencies to get emergency approval for facilities and extra stations for COVID-19 cohorts.

Due to the infection nature of COVID-19, the Network required all dialysis providers to perform the CDC hand hygiene and dialysis station disinfection tools, as well as the hand sanitizer audit tool when it was available, monthly. The Network analyzed the missed opportunities and developed education to improve infection control. Starting in May 2020, the Network started to discuss the potential of dialysis providers becoming COVID-19 vaccine providers with the dialysis companies and state/county departments of health.

Network 16 contributed to new interventions/tools for COVID-19 in various methods including:
• Developed tools on COVID-19 Screening Fatigue tools for dialysis providers and patients
• Contribute to and Medical Review Board/Board of Directors input to the NCC Hand Sanitizer Tool
• Developing a Mental Health Guide
• Contributing to the COVID-19 vaccination toolkit
• Developing a resource to help medical providers prepare/be comfortable with telehealth visits- Tele-Etiquette for Providers
• PAC developed a tool to discuss dialysis modality with their doctor
• Collaborated with Medical Education Institute on a blog “Dialysis Travel During the COVID-19 Pandemic”
ESRD NETWORK SIGNIFICANT EMERGENCY PREPAREDNESS INTERVENTION

In addition to managing a pandemic, the Network experienced a historic wildfire season, events of civil unrest, and power outages.

During the 2020 fire season, the Network monitored and responded to an unprecedented number of large wildfires in all 5 states. The Network used the ArcGIS mapping software to monitor and track weather conditions, identify and distribute warnings and evacuation information to clinics, and LDO leadership. The Network contacted at risk facilities directly and offered technical assistance, support, and information.

The use of innovative mapping technology proved beneficial as an early warning system for the Network and facilities. The Network was able to identify fire locations and notify at risk facilities early enough to activate their internal emergency plans and respond appropriately. The Network continued to provide supplemental support for displaced patients and assistance to facilities in coordinating alternative treatment locations.

Additionally, the Network tracked evacuations of facilities treating COVID-19 patients.

**Most notable activities include:**

The Network conducted safety outreach calls daily to facilities in the impacted regions. This process was successful with catching and mitigating challenges arising due to a significant number of patient and staff evacuations and displacements. For example, the Network received reports of staffing challenges due to the widespread impacts of the fires in Oregon state. The Network was able to successfully coordinate a plan between large dialysis organizations to share staff and keep clinics in non-impacted areas open and able to provide treatment for a growing number of displaced patients.

The Network also successfully collaborated with emergency operations centers to find housing for displaced home dialysis patients evacuated by wildfires. As a result, these patients were able to obtain housing, and avoided the risk of exposure to COVID-19 while staying in a shelter.

The Network was also successful with coordinating with charitable assistance organizations to support disaster recovery: For example, the Network was able to successfully coordinate and expand the allocation of disaster funding through the American Kidney Fund to include all areas impacted by wildfires in both OR and WA state. The Network developed and distributed a list of disaster support and recovery resources to facilities with patients or staff impacted by the wildfires.

The Network was recognized by FMC corporate executive leadership for successfully coordinating Emergency Response efforts in both Washington state and Oregon.
Training and Education Provided:

The Network developed and provided education and training to facilities, including an overview of the ICS/NIMS emergency response infrastructure, use of a newly developed comprehensive disaster contact list, education on the process of disconnecting from dialysis in the event of an emergency, and reporting of emergency events or facility interruptions in service to the Network. Similarly, the Network shared updates on any CMS Emergency Preparedness Testing Exercise Requirements and KCER resources such as the “How to Complete an After-Action Report” training.

The Network maintained 100% participation and attendance at all KCER Meetings including attending the KCER summit in Baltimore with a Patient SME.

Summary of Events:

1/2020- One facility closed in WA due to RO problems. Worked with SSA, Survey & Certification and Certificate of Need to obtain additional temporary stations at 2 nearby facilities who received the displaced patients. An ESSR was submitted.
2/2020 - An OR FMC facility closed due to mandatory flood evacuation. Patients were sent to the nearest facility in WA, and 2 nurses licensed in both states followed. They resumed operations within 72 hours. ESSR was submitted.
2/2020 - A Kirkland dialysis facility reported to the Network that 2 of their patients had been hospitalized, and both tested positive for COVID-19. Both expired at the hospital. All staff at this unit were sent home on quarantine/furlough for 14 days, and relief staff were brought in. Network, CMS, SSA, County Health Department and local HCC were notified and are providing support to facility leadership. The Network had been monitoring COVID-19 all month, sending CDC updates as they were released. See COVID-19 response details in preceding section.
6/2020- The Network notified all facilities regarding riots and provided instructions regarding the completion of Facility Interruption in Service Form.
7/2020- Tracked wildfires in Chelan and Douglas counties in WA. No impact to dialysis to date. Blogged reminder of process for facility notification of service disruptions.
8/2020- Network began utilizing a new ArcGIS software tool for more efficient monitoring and tracking of wildfires.
9/2020- Several clinics were impacted by the Pacific Northwest Fires. Among those, 3 were evacuated then re-opened the following day. Five were evacuated and re-opened several days later. An ESSR was submitted.
10/2020 – Earthquake in Sand Point, AK, which is very remote from dialysis facilities. Monitored for any tsunami activity and alerted KCER/COR. No ESSR submitted.
10/2020- Shared an HHS alert re: an imminent cybersecurity threat originating from North Korea that is specifically targeting healthcare and public health entities.
11/2020- Facility closure reported d/t RO pump failure. Facility resumed normal operations w/in 24hrs. No ESSR submitted.
11/2020- Facility reported closure d/t staff illness, facility was unable to find replacement RN resulting in facility closure. Coordinated expansion of stations with State Survey Agency. ESSR was submitted.
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.